

Figure 2. A) Multislice CT angiogram, vascular-window image of PLSVC and pericardial calcification, B) Multislice CT angiogram, vascular-window image of anomalous drainage of hemiazygos (ADH)
CT - computerized tomography, PLSVC - persistent left superior vena cava

the right atrium. In her right and left ventricular (RV-LV) catheterization, RV and LV pressure curve showed signs of dip and plateau (square root) indicating constrictive pericarditis. RV and LV end-diastolic pressure (EDP) were measured as of 35 and 40 mmHg consecutively. Because of symptoms, severe calcification in the pericardium (Fig. 1A-2A) and high end-diastolic pressure, redo-operation was planned. Although there are different combinations of this conditions, we have not found all in one case in the literature.

Abdurrahman Tasal, Osman Sönmez, Ercan Erdoğan, Ömer Göktekin
Department of Cardiology, Faculty of Medicine, Bezmialem Vakıf University, İstanbul-Turkey

Address for Correspondence/Yazışma Adresi: Dr. Abdurrahman Tasal, Bezmialem Vakıf Üniversitesi Tıp Fakültesi, Kardiyoloji Anabilim Dalı, Fatih, İstanbul-Türkiye
Phone: +90 212 453 18 00 Fax: +90 212 621 75 80
E-mail: tasal01@hotmail.com

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Severe pulmonary vein stenosis due to invasion of metastatic lung cancer

Metastatik akciğer kanseri invazyonuna bağlı gelişen ciddi pulmoner ven darlığı

A 40-year-old-woman presented to the emergency department with dyspnea and hemoptysis. She had been complaining of dyspnea and hemoptysis for about eleven months. On admission, she had dyspnea (class IV according to the New York Heart Association) and respiratory rate of 28 breaths/min, regular pulse rate of 110 beats/min. The electrocardiogram showed sinus tachycardia and chest radiography revealed left sided pleural effusion (Fig. 1A). Transthoracic echocardiography revealed a turbulent flow in the upper left pulmonary vein in the entrance of left atrium on apical long-axis position (Fig. 2A). No other cardiac structural abnormalities were found on transthoracic echocardiography but estimated pulmonary artery systolic pressure was 70 mmHg. Transesophageal echocardiography and

multislice computed tomography (MSCT) revealed severe obstruction in the anastomotic site of left upper pulmonary venous confluence to the left atrium (Fig.1B) and invasion of the wall of the left atrium. Pulmonary vein stenosis was diagnosed by spectral Doppler interrogation of the pulmonary veins (continuous, turbulent flow with calculated mean gradient up to 36 mm Hg) (Fig. 2B, 1C). MSCT also revealed a small mass in the middle lobe of the lung and metastatic invasion of left upper pulmonary vein (Fig. 1D). For further staging and therapeutic evaluation patient was sent to a hospital of respiratory and oncology center.

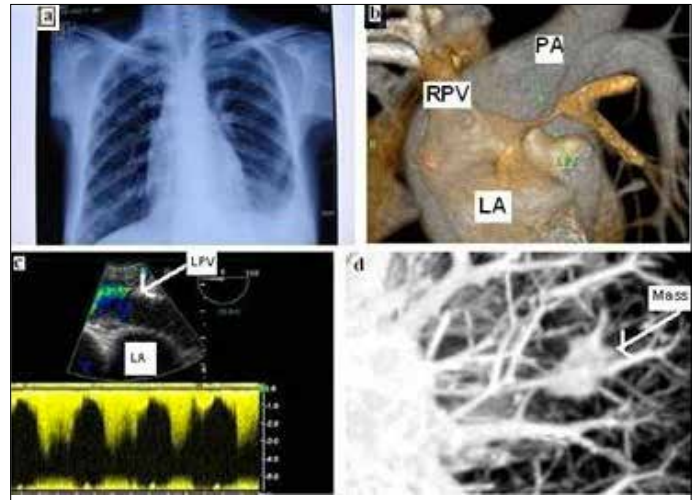


Figure 1. A) Chest radiography view of left sided pleural effusion, B) Computed tomography view of stenosis of upper left pulmonary vein of left atrial wall, C) 2D transesophageal echocardiography apical four-chamber view of high pulmonary venous gradient (36 mmHg), D) Computed tomography; view of a mass in the middle lobe

LA - left atrium, LPV - left pulmonary vein, PA - pulmonary artery, RPV - right pulmonary vein

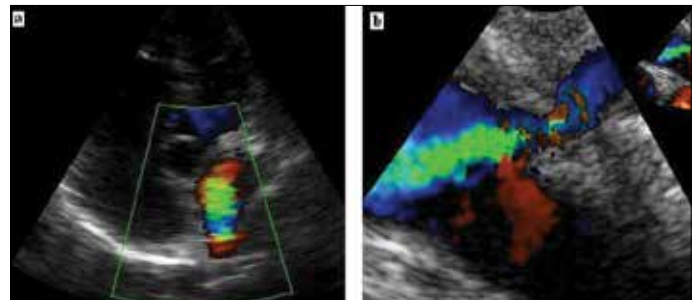


Figure 2. A) 2D transthoracic echocardiographic apical four-chamber view of a color imaging turbulent flow in upper left pulmonary vein in entrance of left atrium. B) 2D transesophageal echocardiography apical four-chamber view of obstruction of left upper pulmonary vein

LA - left atrium, LUPV - left upper pulmonary vein, LV - left ventricle, RA - right atrium, RV - right ventricle

Mehmet Mustafa Can
Clinic of Cardiology, Malatya State Hospital, Malatya-Turkey

Address for Correspondence/Yazışma Adresi: Dr. Mehmet Mustafa Can, Bağcılar Eğitim ve Araştırma Hastanesi, Kardiyoloji Kliniği, İstanbul-Türkiye
Phone: +90 212 440 40 00 E-mail: mehmetmustafacan@yahoo.com
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