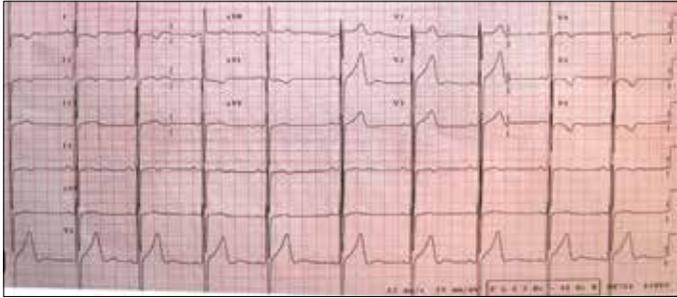


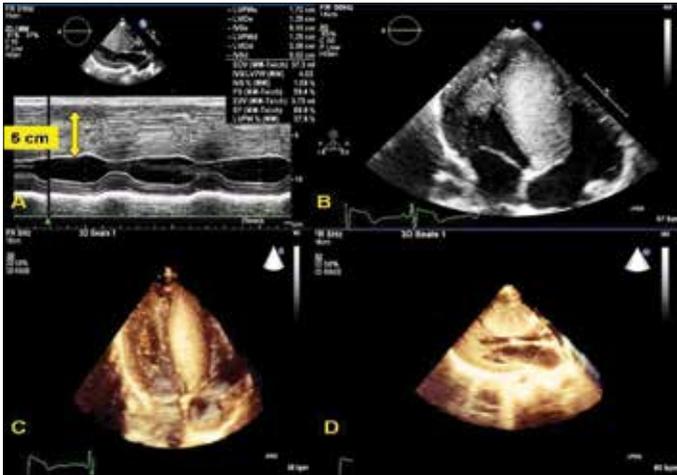
## Giant septal hypertrophic cardiomyopathy

### Dev septal hipertrofik kardiyomiopati

A 21-year-old man was admitted to cardiology department with exertional dyspnea. His medical history was unremarkable. Heart and



**Figure 1.** A 12 - lead ECG shows normal sinus rhythm with left ventricular strain findings  
ECG - electrocardiogram



**Figure 2.** A. TTE image in parasternal long axis view shows interventricular septal thickness measurement is 5.1 cm B. TTE apical 4-chamber appearance of the giant interventricular septum C. 3D apical 4-chamber TTE shows giant interventricular septum D. 3D TTE parasternal long axis view of the giant interventricular septum

TTE - transthoracic echocardiography

lung sounds were normal on physical examination. Patient's blood pressure was 120/80 mmHg and his pulse was 72/min and rhythmic. Electrocardiography showed normal sinus rhythm and left ventricular strain findings (Fig. 1). 2D and 3D transthoracic echocardiography (TTE) revealed that normal left ventricular systolic functions with severe septal hypertrophy (5.1 cm) (Fig. 2A-D and Video 1-3. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). TTE also showed systolic anterior motion of mitral valve, physiological mitral regurgitation and normal left atrial dimension (Video 4-6. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). There was no gradient at left ventricular outflow tract and midventricular level by rest and Valsalva maneuver. The patient was diagnosed with hypertrophic cardiomyopathy. 48-hour ambulatory ECG recording was normal. Beta-blocker therapy was initiated to the patient and medical follow-up was recommended. Family member evaluation also recommended to the patient.

Investigation of the family revealed that his mother and one sibling have hypertrophic cardiomyopathy.

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**Video 1.** Severely increased interventricular septum is seen at TTE parasternal long axis view

**Video 2.** Parasternal short axis TTE image at the level of papillary muscle shows hypertrophic myocardial segments except for septum

**Video 3.** Giant interventricular septum is seen at TTE apical 4-chamber view

**Video 4.** TTE apical 4-chamber X-plane view shows giant interventricular septum

**Video 5.** Giant interventricular septum is seen at 3D TTE 4-chamber view

**Video 6.** 3D TTE parasternal long axis view of the giant interventricular septum

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## Unusual case with venous channels connecting the left and the right brachiocephalic veins

### Sol ve sağ brakiyosefalik venleri bağlayan venöz kanalları olan olağandışı vaka

A 55-year-old female patient was admitted to the cardiology clinic with complaint of chest pain. She had no known any conspicuous medical history. Physical examination, electrocardiogram, echocardiography and all biochemical values were in normal range. Chest roentgenogram revealed suspicious mediastinal mass. The computed tomography displayed that the veins were visible and ran in the anterior mediastinum as a venous tuft from brachiocephalic veins (Fig. 1 and Video 1. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). Thymus gland, vessel structures or any other tissue was not observed in the venous tuft region or in the mediastinum. The possibility of vascular access flow reduction was discussed with our patient and surgeons, but because of the absence of fistula, cardiovascular anomaly and patient remained asymptomatic, we decided to follow up patient for future symptoms. These malformations have importance at implantation of catheter and pacemaker. If this kind of malformation was bypassed, they can accidentally conclude or damage during surgery and may lead to serious hemorrhage. Also, they may obscure the surgical field or confused with other vessels.

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