

was 45/minute, arterial blood pressure was 270/100 mmHg and systolic murmur (2/6 at the right side of umbilicus) was present. Electrocardiography revealed complete atrioventricular block with a ventricular rate of 45/minute.

Coronary angiography documented 75% narrowing at left anterior descending coronary artery (LAD) and 70% narrowing at first diagonal branch. After VVI mode pacemaker implantation, balloon angioplasty was performed to the diagonal artery and stent was implanted to the LAD.

Renal angiography documented 85% narrowing at proximal of right renal artery (RRA) and 70% narrowing at proximal of left renal artery (LRA) (Fig. 1). Using a guiding catheter and a guidewire, the stenosis at LRA was passed. A stent was implanted (5/15mm) at 10 atm without pre-dilatation (Fig. 2, Video 1. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). Later, same catheter was placed to RRA. After pre-dilatation using a balloon catheter (5.0x20 mm), a balloon-expandable renal stent (6.0/14 mm) was



**Figure 1.** Right renal artery angiography view of 85% narrowing in proximal region of left renal artery (arrow)



**Figure 2.** Nonselective renal artery angiography view of 70% narrowing in proximal region of left renal artery (arrow)



**Figure 3.** Angiography view of left renal artery after stenting



**Figure 4.** Angiography view of right renal artery after stenting

implanted at 12 atm without residual stenosis (Fig. 3, 4, Video 2, 3. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). A few days after renal artery stenting, blood pressure gradually improved and antihypertensive medications were decreased. Duplex carotid ultrasonography revealed a 60% narrowing at proximal part of left internal carotid artery.

Percutaneous intervention can be safely used in a patient with coronary artery disease and renal artery stenosis. We emphasized that it should be never forgotten that atherosclerosis is a diffuse and multisystem disease.

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## Antiagregant and anticoagulant therapy of free-floating thrombus in left atrium

### *Sol atriyumda serbest dolaşan trombüsün antiagregan ve antikoagulan ajanlarla tedavisi*

A 43-year-old female patient presented with dyspnea and palpitation. Electrocardiogram showed atrial fibrillation. Echocardiography showed a large left atrial thrombus with moving to left ventricle. A transesophageal echocardiogram (TEE) showed the large thrombus in left atrial appendix with floating and erratically moving in left atrium (Fig. 1). It was moving freely from the upper part of left atrium to the lower part and protruding to left ventricle through the mitral valve (Fig. 2). There was no another abnormal finding by echocardiography. The diagnosis was lone atrial fibrillation with large thrombus in the left atrium. There was a particular concern about embolisation given the highly mobile appearance of the thrombus. The patient denied the surgery. Treatment with continuous infusion of heparin (aPTT ratio>2.5) and coumadin (5mg/day) in addition to aspirin (100mg) and clopidogrel (75mg/day) were started. Bisoprolol

(10mg/day) was also ordered to control the ventricular rate. When the INR value was 2.5, heparin was stopped. Coumadin treatment adjusted to INR value to be 3-4. The patient was followed by echocardiography. It was determined that a loss of sensation in the left arm not to persist long.



Figure 1. Transesophageal echocardiography view of the large thrombus in left atrial appendix, floating and erratically moving in left atrium

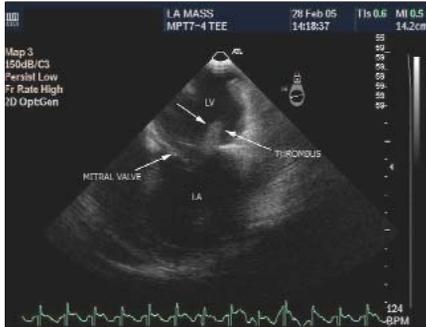


Figure 2. Transesophageal echocardiography view of the thrombus entrapping to the left ventricle through the mitral valve

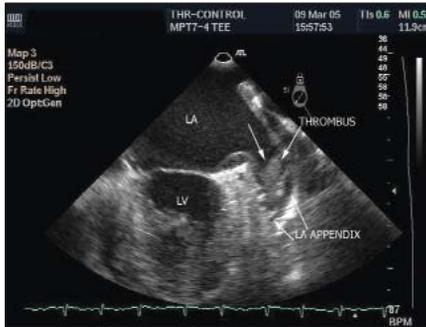


Figure 3. Transesophageal echocardiography at the 11th day of the therapy shows partly resolved thrombus in left atrial appendix



Figure 4. Transesophageal echocardiography at the end of the 2<sup>nd</sup> month of the therapy shows highly resolved thrombus adjacent to the appendix wall

Follow-up TEE was carried out at the eleventh day of therapy. It was determined that left atrial thrombus was clearly resolved and it was only observed in left atrial appendix (Fig. 3). Therefore, the patient was discharged with coumadin, aspirin and clopidogrel. The INR value was checked to be 3-3.5 weekly. The TEE repeated two months later showed thrombus only in form of thin layer adjacent to the appendix wall (Fig. 4).

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## Asymptomatic accessory mitral valve tissue diagnosed by echocardiography

### *Ekokardiyografi ile teşhis edilmiş bir asemptomatik aksesuar mitral kapak dokusu olgusu*

A 52-year-old man was referred to our hospital because of an apical first degree pansystolic murmur heard on routine cardiac examination. The patient was free of cardiac symptoms and his electrocardiogram and telecardiogram showed no pathology. Transthoracic echocardiography showed cyst-like formation on the anterolateral mitral chordae without pressure gradient across the mitral valve and subaortic region (Fig. 1, 2). Transesophageal echocardiography demonstrated this formation was an accessory mitral valve tissue with a mild regurgitation (Video 1. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). The surgical procedure was not considered and it was decided that the patient would be followed by periodical echocardiographic examinations and aspirin was prescribed.

The accessory mitral valve tissue (AcMV) is an anomaly of embryological development of the endocardial cushion. The accessory mitral valve is usually associated with complex cardiac congenital malformations and very rarely seen as an isolated congenital anomaly. The most common clinical presentation is symptomatic left ventricular outflow tract (LVOT) obstruction occurring as a result of mass effect in the early years of life or progressing gradually due to the continued accumulation of fibrous tissue within the LVOT and generally becomes symptomatic as dyspnea on exertion, chest pain, syncope or very rarely cerebrovascular accident. Echocardiography is a useful diagnostic tool for an accurate

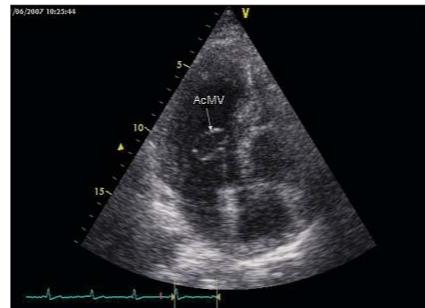


Figure 1. Transthoracic echocardiography shows the accessory mitral valve tissue (AcMV) on the anterolateral mitral chordae in 2-dimensional view