A single coronary artery branching out a hyper-dominant right coronary artery and small left coronary arteries

We described single coronary artery (SCA) in a 62-year-old male patient with chest pain who would have undergone a complicated non-cardiac operation (Fig. 1-2, Video 1. See corresponding video/movie images at www.anakarder.com). In angiographic series, SCA is a rare congenital anomaly with an incidence of 0.024 percent. Three types of SCA have been characterized according to the origination from left, right or non-coronary aortic sinuses by Shirani and Roberts in an actual classification. The authors have determined up to 20 different subclasses of SCA so far (type IA1, B1-4 or type IIA1, B1-4, C1-4, D1-3, E1-2). However, SCA arising from non-coronary aortic sinus (type III) or above the aortic sinuses (unclassified) have not been defined yet. The pathway of the branches of SCA indicates its prognosis, which is worst if a major coronary artery courses between aorta and pulmonary artery or inside the heart. In our case, the SCA ramified a hyper-dominant right coronary artery and small left coronary arteries after a short main segment. We suggested that it is a type IIB1 SCA which is benign, originating from right aortic sinus and coursing anterior to the aorta and pulmonary artery and/or right ventricle. The appearance of higher location of the solitary ostium needs more definitive evaluation to characterize a new type of SCA (Fig. 1).

It has a vital importance to define some subclasses of SCA for surgical treatment regardless of whether or not significant coronary atherosclerosis is present because they could be associated with serious consequences such as angina pectoris, myocardial infarction, ventricular arrhythmia and sudden death.

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Severe tricuspid stenosis caused by myxoma originated from septal leaflet of tricuspid valve

Triküspid septal yapraktan köken alan ciddi triküspid darlığı neden olan miyom olgusu

A 26-year old man was admitted to our clinic with progressive symptoms of dyspnea and palpitation. He had no history of any diseases. On his physical examination blood pressure was 110/70 mmHg, pulse rate was 80/min and the diastolic murmur was heard on the mesocardiac area. Electrocardiography, telecardiography and laboratory values were all normal. Transthoracic echocardiography revealed a 4.1x4.6 cm mass on the atrial side of the right heart originating from the septal leaflet of the tricuspid valve (Fig. 1). Although the mass has relatively homogeneous structure some parts of mass has increased echogenicity, some parts of mass has echolucent area, which were concordant with calcification and hemorrhage, respectively. In each diastole the mass protrudes into...
the right ventricle, obstructing the tricuspid inflow significantly (peak transvalvular tricuspid gradient 15 mmHg) (Fig. 2, Video 1. See corresponding video/movie images at www.anakader.com).

The patient underwent open-heart surgery and successful tricuspid valve repair after en bloc resection of a myxoma involving the septal leaflet of the tricuspid valve. The pathologic diagnosis was myxoma and the patient was discharged on the 7th postoperative day.

Myxoma is the most common primary cardiac tumor that mostly originates from left atrium. Myxomas that originate from tricuspid leaflets obstructing the tricuspid inflow are seen extremely rare.

Abnormal elongated chordae tendinea protruding to the left ventricular outflow tract

Sol ventrikül çıkış yoluna salınım gösteren anormal uzun korda tendinea

A 22-year-old man was referred to our institution for cardiac evaluation before non-cardiac surgery. The patient had excellent functional capacity. Cardiac examination revealed a mild systolic murmur at left sternal border. The chest X-ray and electrocardiogram were normal. Transthoracic and transesophageal echocardiography revealed an elongated anterior mitral chordae tendinae swinging in the left ventricle and it was also protruding into the left ventricular outflow tract (LVOT) during systole (Fig. 1, 2. Video 1. See corresponding video/movie images at www.anakader.com). No other structural abnormalities of the mitral valve or signs of obstructive cardiomyopathy were noted. Doppler examination demonstrated no significant pressure gradient across the LVOT at rest and during Valsalva maneuver. One year later the patient was found to be in asymptomatic condition with the same echocardiographic picture. Elongated mitral chordae tendinae is an uncommon, benign echocardiographic finding. Its unusual fashions require differential diagnosis from other pathological entities. In this instance, transesophageal echocardiography may reveal anatomic and functional details.