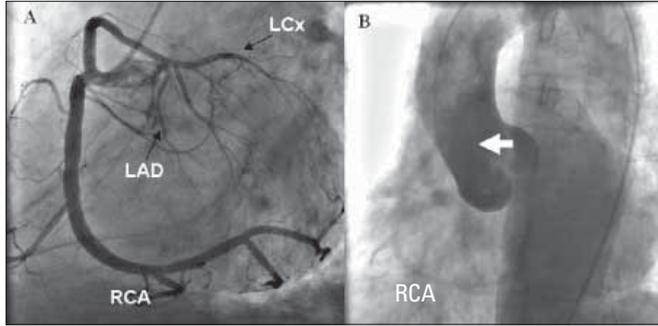


## A single coronary artery branching out a hyper-dominant right coronary artery and small left coronary arteries

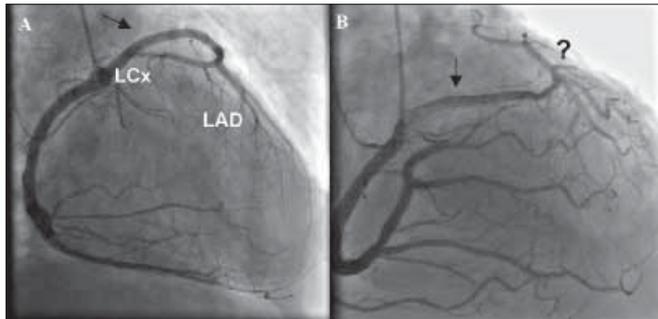
### *Hiperdominant sağ koroner arter ve küçük sol koroner arterlere dallanan tek koroner arter*

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](http://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



**Figure 1. A) Left lateral angiographic view of the single coronary artery. RCA is hyperdominant and supplies the left ventricular apex. LAD and LCx are rudimentary (black arrows) B) Left caudal oblique (450-150) aortography view shows that the solitary ostium (thick white arrow) may not originate from right or left aortic sinuses.**

RCA - right coronary artery, LAD - left anterior descending artery, LCx - left circumflex artery



**Figure 2. The right oblique angiographic view (A) shows that the distribution of the left anterior descending artery (LAD) and left circumflex artery (LCx) is atypical and seems to course in opposite directions. The anteropostero-cranial view (B) does not clearly separate LAD and LCx (question mark). Left main coronary artery (black arrows) is very long (A,B)**

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.

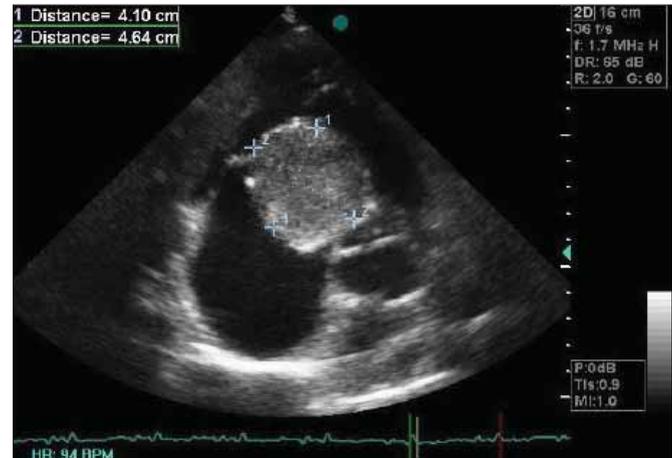
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## Severe tricuspid stenosis caused by myxoma originated from septal leaflet of tricuspid valve

### *Triküspid septal yapraktan köken alan ciddi triküspid darlığına neden olan miksoma 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



**Figure 1. Preoperative echocardiographic four-chamber view of a large echo dense 4.1x4.6 cm mass on the atrial side of the right heart originating from the septal leaflet of the tricuspid valve**

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](http://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 7<sup>th</sup> 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

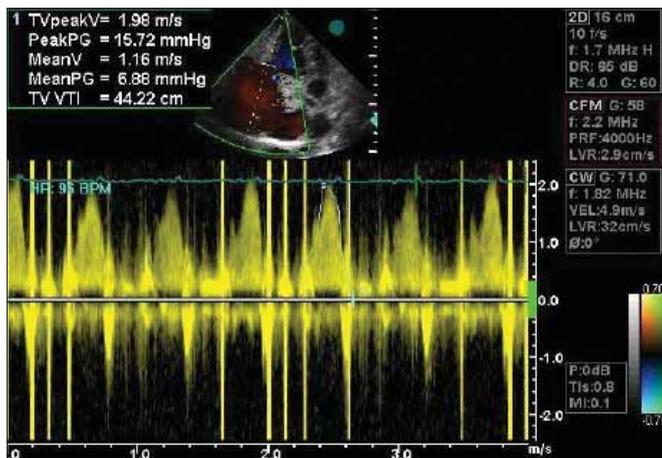


Figure 2. Preoperative echocardiography shows peak diastolic transvalvular tricuspid gradient caused by large echo dense mass

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## 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 showed 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](http://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.

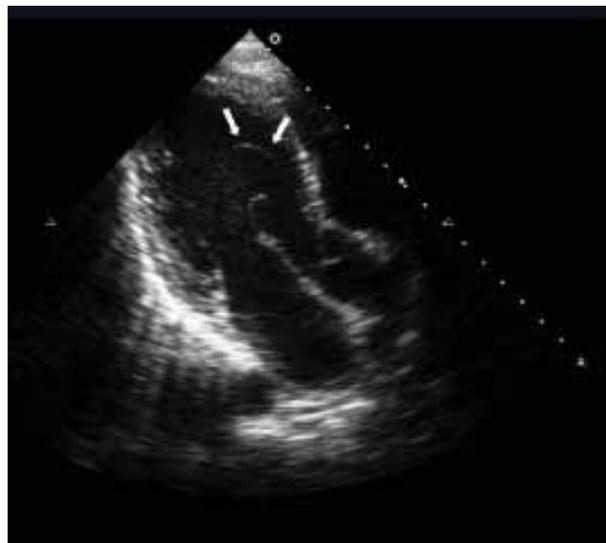


Figure 1. Transthoracic echocardiography (modified apical 5-chamber view) demonstrates an elongated anterior mitral chordae tendinae swinging in the left ventricle

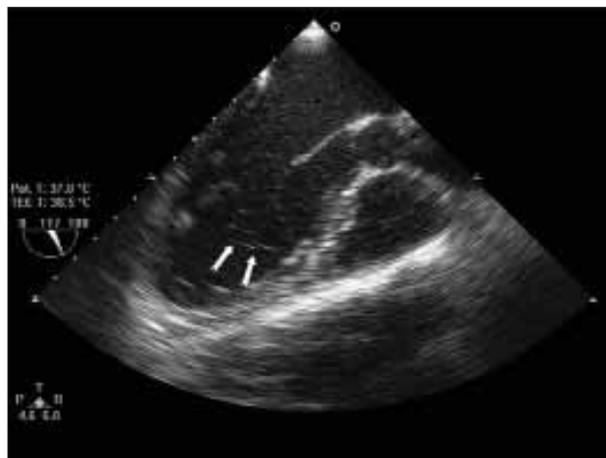


Figure 2. Transesophageal echocardiography view of an abnormal elongated chordae swinging in the left ventricle

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