sis of atrial myxoma. Microscopic examination of the excised material revealed that myxoid degeneration and large vegetation with fibrin-platelet thrombi (Fig. 2). During the follow-up, pancytopenia (hemoglobin 10.9 gr/dL, leukocyte 3400/µL, platelet 22000/µL) and acute renal failure (creatinine 1.9 mg/dL) were emerged. Analysis of serologic markers showed that LA was positive, ACA IgM-G and antiphospholipid antibody were high. The patient was diagnosed with secondary APS. The medical therapy was optimized with immunosuppressive agents and warfarin. Her further clinical course was uneventful.

Double-chambered right ventricle associated with ventricular septal defect and subaortic stenosis in an adult

Erşkinde subaortik stenoz ve ventriküll septum defekti ile birlikte çift odacıklı sağ ventrikül

Double-chambered right ventricle (DCRV) is a relatively uncommon congenital cardiac defect.

In a 47-year-old man admitted to our unit for chest pain, a Doppler transthoracic echocardiogram (TTE) was performed, showing: middle right ventricle (RV) hypertrophy, dividing the cavity into two chambers, with significant intraventricular gradient (85 mmHg) (Fig. 1, 2); dilatation of RV outlet part and of pulmonary artery trunk with mild pulmonary regurgitation; perimembranous ventricular septal defect (VSD) (7 mm) with moderate left to right shunt and interventricular gradient of 88 mmHg; subaortic spur with mild left ventricle output tract obstruction (systolic anterior movement of the mitral valve, midsystolic notch on aortic valve, gradient of 14 mmHg); fibrocalcification of aortic cusp and mild-moderate regurgitation; mild LV hypertrophy with normal systolic and diastolic function; mild dilatation of right and left atrium; mild tricuspid regurgitation and normal pulmonary artery pressure.

Subsequently, a transesophageal echocardiogram (TEE) was performed (Fig. 3, 4), confirming the result of the TTE.
Left main coronary artery compression by a giant pulmonary artery aneurysm associated with large atrial septal defect and severe pulmonary hypertension

A 27-year-old woman having exercise intolerance, shortness of breath and substernal chest pain was admitted to our institution. On admission, physical examination revealed, a blood pressure of 110/60 mmHg, 2/6 mid-systolic murmur at the apex, 3/6 systolic murmur in the tricuspid area and fixed splitting of the second heard sound during all respiration phases. Chest X-ray showed cardiomegaly and a prominent bilateral pulmonary artery enlargement (Fig.1). Transthoracic echocardiography was performed for the first time in her life, and it revealed an 1.8 cm in size prominent secundum type atrial septal defect with severe pulmonary hypertension and dilated right cardiac chambers (Fig. 2, Video 1. See corresponding video/movie images at www.anakarder.com). Moreover a giant pulmonary artery aneurysm (5.3 cm) was seen on the parasternal short-axis view. She