

Cardiac hydatid cyst: a comment/ Cardiac hydatid cyst case recovered with medical treatment

Kardiyak hidatik kisti: Bir yorum/Tıbbi tedavi ile düzelen kardiyak kist hidatik olgusu

Dear Editor,

Sir, the recent report on cardiac hydatid cyst is very interesting (1). Tekin et al. (1) noted for importance on concern of this disease and concluded that "In case of refusal of surgical treatment, medically inoperable patients and surgical high risks (because of the critical localization of the cyst), medical treatment is an available alternative treatment technique. "The skipping of surgical removal of the cyst is very challenging. Indeed, the use of surgical removal accompanied with the medical treatment is widely used for the cardiac hydatid cyst (2). The long term following up to determine the recurrence and complication of medical treatment without surgical removal of the cyst is very interesting. Finally, seeking for possible cystic lesions at other sites in the body is required since multiple organ involvement is possible (3).

Viroj Wiwanitkit
Wiwanitkit House, Bangkhae, 10160, Bangkok-Thailand

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Address for Correspondence/Yazışma Adresi: Dr. Viroj Wiwanitkit
Wiwanitkit House, Bangkhae, 10160, Bangkok-Thailand
Phone: 6624132436 E-mail: wviroj@yahoo.com
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Author's Reply

Dear Editor,

We thank the comments on the hydatid case (1). We agree with the comments on the possibility of recurrence in the long term following up of the patient. On the other hand, we would like to emphasize on the availability of medical treatment in case of refusal of surgical treatment, surgical contraindication and medically inoperable patients. Unique medical treatment could be remembered for treatment of similar patients. The case will be followed up for future recurrence.

Thank you for the contribution.

Editöre Mektuplar Letters to the Editor

Recep Tekin
Clinical Microbiology and Infectious Diseases, Diyarbakır
Children's Hospital, Diyarbakır-Turkey

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Address for Correspondence/Yazışma Adresi: Dr. Recep Tekin
Diyarbakır Çocuk Hastanesi, Klinik Mikrobiyoloji ve Enfeksiyon Hastalıkları
Bölümü, Diyarbakır-Türkiye
Phone: +90 412 224 57 51 Fax: +90 412 229 01 47
E-mail: rectek21@hotmail.com

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The importance of Himalayan P-wave in differentiation of cardiomyopathies

Kardiyomiyopatilerin ayırımında Himalaya P dalgasının önemi



Dear Editor,

A 22-year-old female who had been previously diagnosed as hypertrophic cardiomyopathy presented with increased exertional dyspnea (NYHA Class III), orthopnea and bilateral pretibial edema for last 6 months. Family history included sudden cardiac death in her brother without known etiology. Physical examination revealed jugular venous distension, S3(+), S4(+), hepatomegaly and bilateral rales at basal segments of the lung. Complete blood count and peripheral smear demonstrated no eosinophilia ($0.1 \times 10^3/\mu\text{L}$; Normal: $0.1-0.5 \times 10^3/\mu\text{L}$). Electrocardiogram showed unexpectedly tall "P" waves (9 mm in lead V2) and right axis deviation (Fig. 1A). Chest X-ray showed evidence of biatrial enlargement (Fig. 1B). Transthoracic echocardiography disclosed left ventricular (LV) ejection fraction of 20% by M-mode technique and 30% by modified Simpson method, LV end-diastolic diameter of 49 mm, LV septal thickness 16 mm (Fig. 1C, Video 1. See correspond-

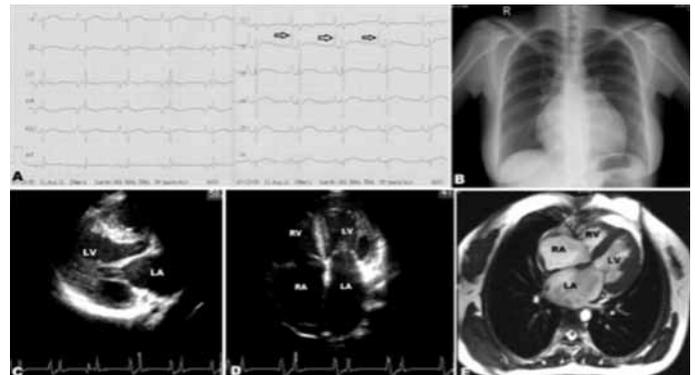


Figure 1. (A) ECG showing huge "P" waves in lead V2 (arrow) and low precordial R wave voltage. **(B)** Chest X-ray revealed biatrial enlargement. **(C)** Echocardiography showing increased septal thickness at parasternal long axis. **(D)** Echocardiography demonstrated biatrial dilatation and pericardial effusion adjacent to right atrium. **(E)** Cardiac MRI confirmed the diagnosis of RCMP

ECG - electrocardiogram, MRI - magnetic resonance imaging, RCMP - restrictive cardiomyopathy