

**Address for Correspondence/Yazışma Adresi:** Dr. Sait Demirkol  
Gülhane Askeri Tıp Akademisi, Kardiyoloji Bölümü, Tevfik Sağlam Cad. 06018  
Etlik, Ankara- Türkiye  
Phone: +90 312 304 42 81 Fax: +90 312 304 42 50  
E-mail: saitedemirkol@yahoo.com

**Available Online Date/Çevrimiçi Yayın Tarihi:** 23.05.2012

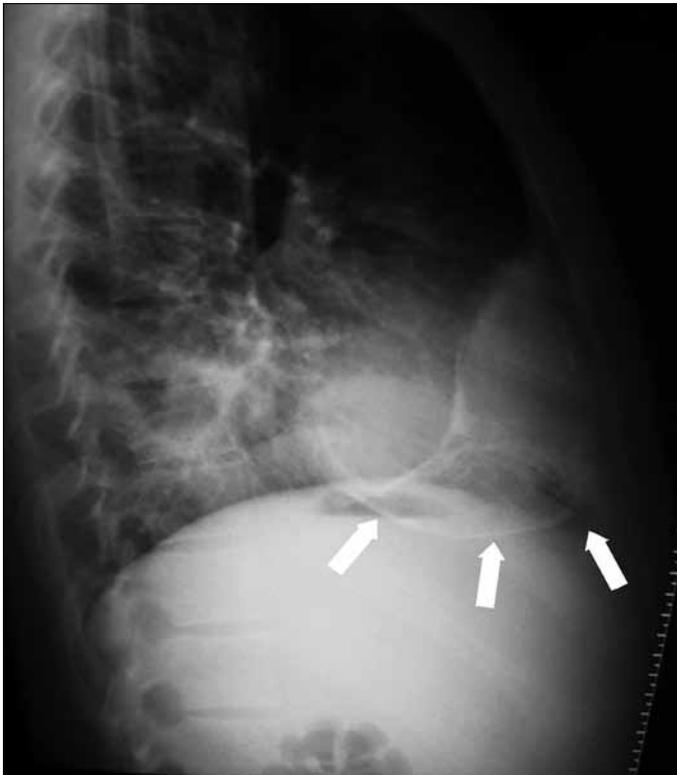
©Telif Hakkı 2012 AVES Yayıncılık Ltd. Şti. - Makale metnine www.anakarder.com web sayfasından ulaşılabilir.

©Copyright 2012 by AVES Yayıncılık Ltd. - Available on-line at www.anakarder.com doi:10.5152/akd.2012.143

## Pseudocirrhosis; constrictive pericarditis due to huge calcific pericardial cystic mass compressing right cardiac chambers

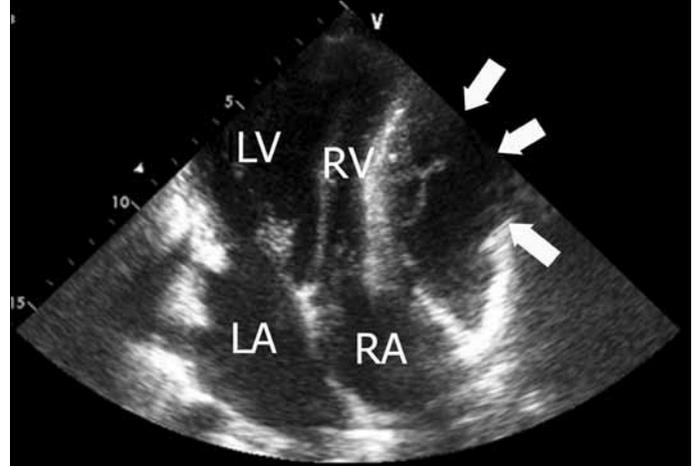
*Yalancı siroz; sağ kalp boşluklarına bası yapan dev kalsifik perikardiyal kistik kitlenin neden olduğu konstriktif perikardit*

A 29-year-old- male patient was admitted to our cardiology department with the complaints of an exertional dyspnea, abdominal distention of six months' duration. On physical examination, muffled heart sounds without murmur, venous dilatation of the extremities, neck vein distension, hepatojugular reflux, significant hepatomegaly and abdominal ascites were detected. Chest X-ray demonstrated a huge hyperdense calcific mass under the sternum (Fig. 1). Transthoracic echocar-



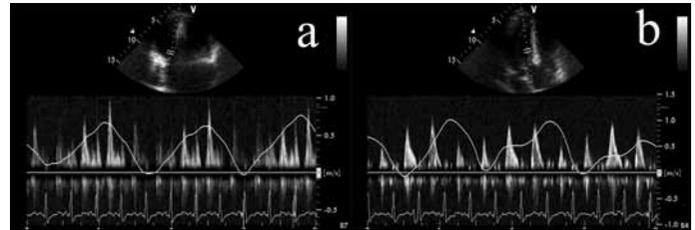
**Figure 1. Chest X-Ray showing huge hyper-dense, double layered cystic mass just beneath the sternum (arrows)**

diography showed a large hyperechoic cystic lesion (10x7.5 cm in size) which compressed the right ventricle (RV) and atrium (RA) (Fig. 2). Constrictive filling pattern was found by Doppler echocardiographic evaluation (Fig. 3). Computed tomography (CT) displayed a low-density area, cystic lesion which was located in the anterior mediastinum adja-



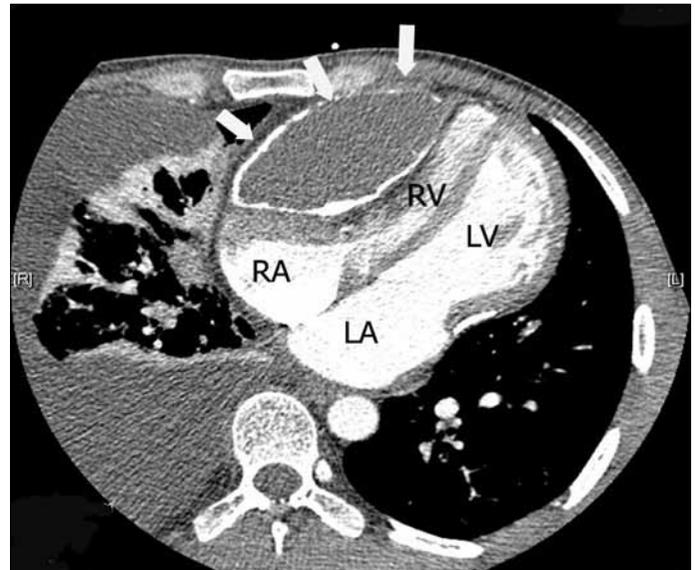
**Figure 2. Two-dimensional echocardiographic evaluation of pericardial cystic mass (arrows)**

LA - left atrium, LV - left ventricle, RA - right atrium, RV - right ventricle



**Figure 3. Doppler echocardiography showing respiratory changes in mitral-tricuspid inflow pattern (a-b) Inspiration results in increased tricuspid inflow, decreased mitral inflow and expiration results in decreased tricuspid inflow, increased mitral inflow.**

LA - left atrium, LV - left ventricle, RA - right atrium, RV - right ventricle



**Figure 4. Computed tomography image indicates calcific cystic mass compressing right cardiac chambers (arrows)**

LA - left atrium, LV - left ventricle, RA - right atrium, RV - right ventricle

cent to the RV and RA (Fig. 4). At the surgery, cystic mass with thickened calcific fibrous tissue located anterior to right cardiac chambers was removed and hemorrhagic fluid was aspirated (Fig. 5a). The contents of the cyst included old coagulated blood. Histopathologic examination of the excised pericardial cysts revealed moderate nonspecific-noncellular inflammation, calcification and thickened connective tissue. There was no pathogen agent. The pathological diagnosis was compatible with idiopathic constrictive pericarditis (CP) (Fig. 5b). Follow-up period after surgery was uneventful.

The diagnosis of CP is often difficult to make. In fact, restrictive cardiomyopathy has similar clinical features to constrictive pericarditis. Differential diagnosis is made by diagnostic modalities such as echocardiography, computed tomography and chest X-ray. If the patient presents with cirrhosis-like symptoms, CP should be kept in mind among the differential diagnosis.



**Figure 5. a) Intraoperative view; prominent calcification of the cystic mass, b) Pathologic appearance; moderate inflammation, increased calcification, thickened connective tissue compatible with constrictive pericarditis (Hematoxylin & Eosin stained section, X40)**

**İbrahim Akpınar, Omaç Tüfekçioğlu<sup>1</sup>, Ertan Yücel<sup>2</sup>, Rıza Sarper Ökten<sup>3</sup>**  
Department of Cardiology, Faculty of Medicine, Bulent Ecevit University, Zonguldak-Turkey  
Clinics of <sup>1</sup>Cardiology, <sup>2</sup>Cardiovascular Surgery and <sup>3</sup>Radiology, Türkiye Yüksek İhtisas Hospital, Ankara-Turkey

**Address for Correspondence/Yazışma Adresi:** Dr. İbrahim Akpınar  
Bülent Ecevit Üniversitesi Tıp Fakültesi, Kardiyoloji Anabilim Dalı  
67600, Zonguldak-Türkiye  
Phone: +90 372 261 20 01 (2167) Fax: +90 372 261 01 55  
E-mail: dr.ibrahimakpınar@gmail.com

**Available Online Date/Çevrimiçi Yayın Tarihi:** 23.05.2012

©Telif Hakkı 2012 AVES Yayıncılık Ltd. Şti. - Makale metnine [www.anakarder.com](http://www.anakarder.com) web sayfasından ulaşılabilir.

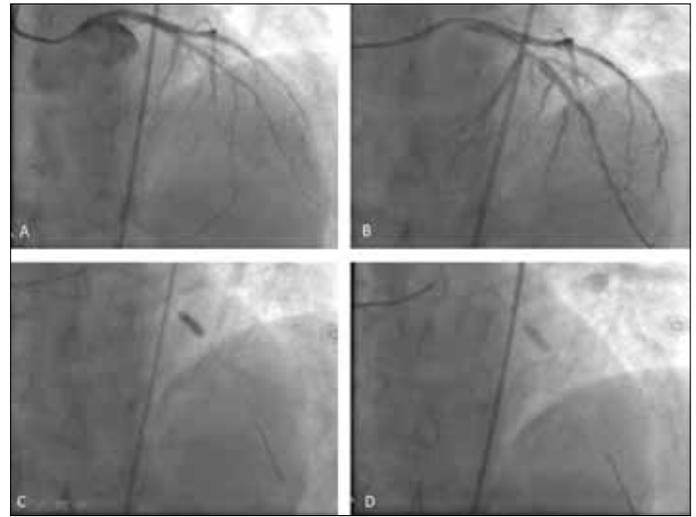
©Copyright 2012 by AVES Yayıncılık Ltd. - Available on-line at [www.anakarder.com](http://www.anakarder.com)  
doi:10.5152/akd.2012.144

## Ruptured covered stent in a ruptured coronary artery: A catheterization laboratory nightmare

*Rüptüre koroner arterde rüptüre olan greft stent: Bir kateter laboratuvar kabusu*

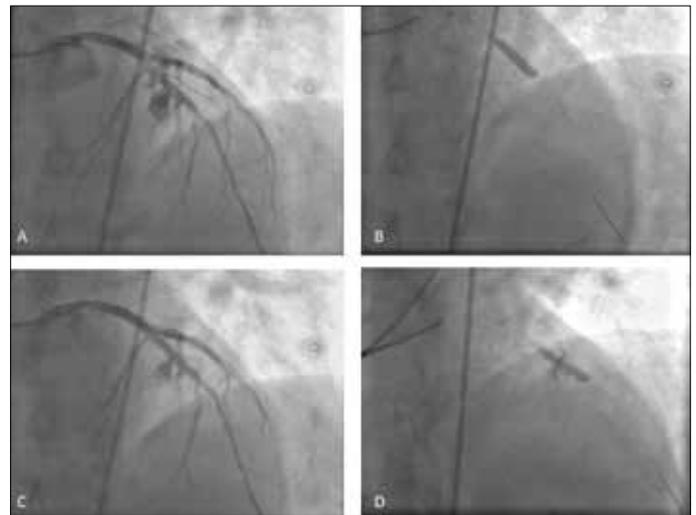
A 64-year-old male patient was admitted to our emergency department with subacute anterior myocardial infarction. Left anterior

descending artery (LAD) was occluded after the first diagonal branch (Fig. 1A). The lesion was crossed with a J-tipped soft guidewire then predilated with 2.5x12 mm balloon at 14 atmosphere pressure (atm) and 3.5x16 mm sirolimus-eluting stent (SES) at 18 atm was deployed to the lesion (Figure 1B). Post dilatation with 3.5x12 mm noncompliant balloon (NC) at 24 atm was performed due to residual stenosis (Fig. 1C). However, mid portion was not expanded optimally thus lesion was post dilated with 4.0x12 mm NC at 22 atm (Fig. 1D). Control injection revealed type-3 perforation of the LAD beneath the stent at the under-expanded area (Fig. 2A, Video 1-See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). Heparin anticoagulation was reversed with protamine and a 3.5x16 mm balloon was dilated proximal to the stent before the implantation of 3.5x16 mm covered stent (CS) over the perforated segment at 16 ATM (Fig. 2B). Control injection showed the passage of



**Figure 1. A- Coronary angiography view of subtotal occlusion of LAD after the first diagonal branch B) A SES was deployed to the lesion C- D) Post dilatation with NC was performed**

LAD - left anterior descending artery, NC - noncompliant balloon, SES - sirolimus-eluting stent



**Figure 2. A) Control injection revealed type-3 perforation of the LAD beneath the stent B) A CS was implanted over the perforated segment C) Control injection showed the passage of contrast material at the perforated segment to the pericardium D) The second CS was implanted to the perforated segment**

CS - covered stent, LAD - left anterior descending artery