

coronary angiography via right brachial artery. Guidewire and diagnostic catheter directed to the unexpected route rather than ordinary position. Right subclavian artery angiography showed the well-developed collateral circulation from ascending to descending aorta and right subclavian artery arising from descending aorta (Fig. 2, 3. Video 2. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com) ). Therefore, left brachial artery approach was chosen. Although we used different catheters in order to reach ascending aorta (Fig. 4, Video 3. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com) ), we could not succeed. Procedure was aborted and patient was referred to the multislice computed cardiac



Figure 3. Demonstration of aberrant right subclavian artery

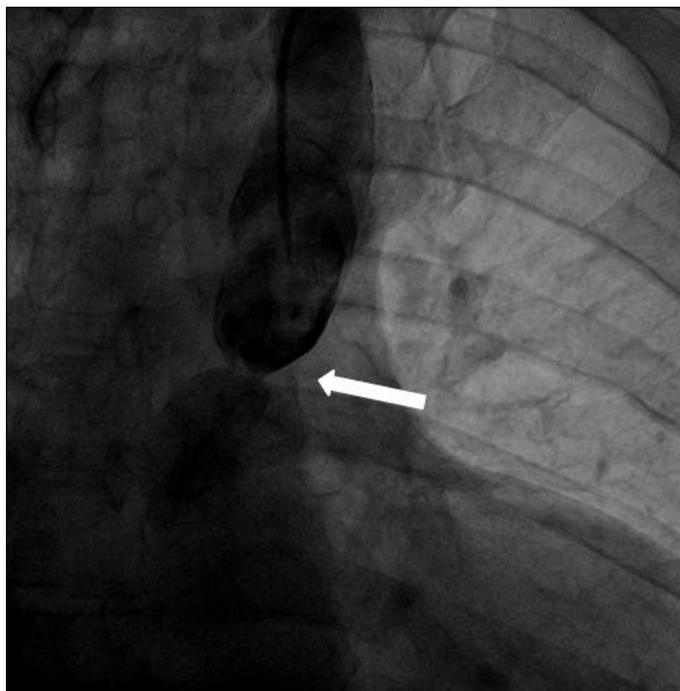


Figure 4. Aortography imaging of aortic coarctation (white arrow)

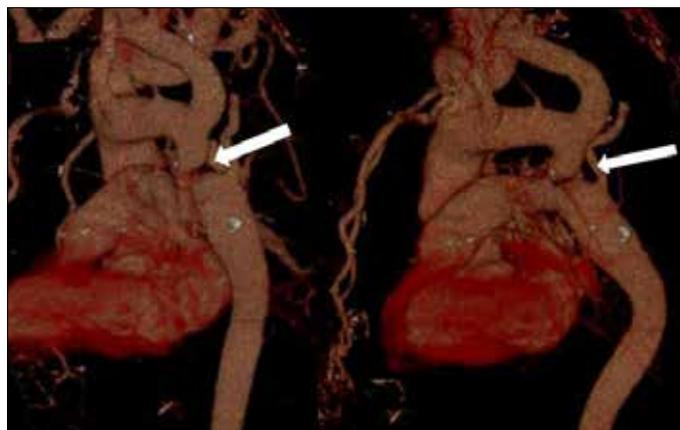


Figure 5. Multislice computed tomography angiography views of aortic coarctation in different positions

tomographic (MSCT) angiography. MSCT demonstrated aortic coarctation and critical left anterior descending artery lesion (Fig. 5). Although decision of stenting of coarctation with bare metal stent rather than graft stent because of increased risk of compromising flow of right subclavian artery and coronary angiography at the same session was taken, patient declined to go ahead.

**Video 1.** Preserved left ventricular systolic function and moderate left ventricular hypertrophy on transthoracic apical 5-chamber echocardiographic examination on

**Video 2.** Imaging of aberrant right subclavian artery and collateral circulation in antero-posterior position

**Video 3.** Demonstration of aortic coarctation in anterior posterior position

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## Hydatid cyst of the interventricular septum presenting as supraventricular tachycardia



*Supraventriküler taşikardi ile başvuran  
interventriküler septum yerleşimli kist hidatik*

A 55-year-old male presented with palpitation and dyspnea. Past medical history was unremarkable except for frequent palpitations and lasting for several hours approximately every month for the last 2 years. Examination revealed blood pressure of 110/60 mmHg and pulse of 170 bpm without any other abnormality. Electrocardiography (ECG) showed

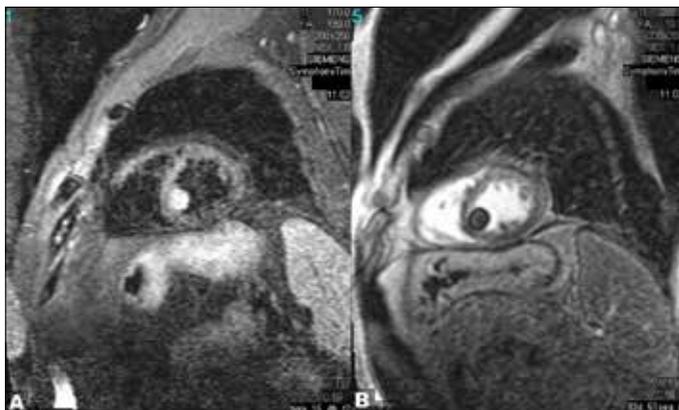
narrow-QRS complex tachycardia with a rate of 190 bpm (Fig. 1). Sinus rhythm was achieved after i.v. administration of verapamil which showed 0.5-1 mm ST segment elevation in septal leads (V1-V3). Chest X-ray revealed normal findings. Transthoracic echocardiography revealed left ventricular (LV) ejection fraction of 65%, LV end-diastolic diameter of 45 mm and cystic appearance at mid segment of the interventricular septum with 19x15 mm in diameter (Fig. 2, Video 1. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). Cardiac magnetic resonance imaging demonstrated a cystic lesion, 20x13 mm in size, in the left ventricular side of interventricular septum, protruding into the lumen. The cystic lesion was hypointense on T1A sequences and hyperintense on T1 and T2A images, but was not suppressed on fat suppression sequences, which was compatible with cardiac hydatid cyst (Fig. 3). Cranial, thoracic and abdominal tomographic imaging showed no lesions of hydatid cyst. Preoperative coronary angiography revealed normal coronary arteries. Leukocyte count was 8400/mm<sup>3</sup> (1.2% eosinophils). However, serological findings with indirect hemagglutination test were negative for echinococcal disease. Albendazole was initiated preoperatively for three weeks. The patient was operated with right



**Figure 1. Electrocardiogram showing narrow QRS complex tachycardia (180 bpm)**



**Figure 2. Transthoracic echocardiography showing cystic appearance within the interventricular septum at parasternal long-axis (A), parasternal short-axis (B) and apical 4-chamber (C) views**



**Figure 3. Cardiac magnetic resonance scans showing cystic lesion within the interventricular septum. The cyst is hyperintense on T1- and T2A-weighted black blood images, not suppressed in fat suppression sequences. Cystic dense content is hyperintense (A) on T2A sequence and hypo intense on T1A sequence (B)**

ventriculotomy and cyst excision was performed with no complication. Pathological examination also confirmed the diagnosis of hydatid cyst. The patient was well at 3rd month control without any palpitation. Echocardiography revealed no defect or lesion at the interventricular septum. Additionally, 24-h Holter monitoring revealed sinus rhythm without any conduction blocks or dysrhythmia.

**Video 1.** Apical 4-chamber view of the cystic lesion within the interventricular septum

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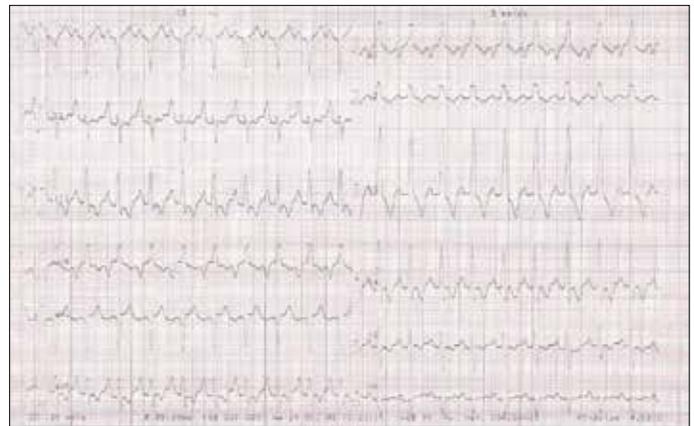
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## A patient with severe congenital pulmonary stenosis and severe right ventricular hypertrophy

### *Ciddi sağ ventrikül hipertrofisi ve ciddi konjenital pulmoner darlığı olan bir hasta*

A 20-year-old male patient was admitted to hospital with the complaints of frequent syncope on exertion, shortness of breath and chest pain. His weight and height were 55 kg and 147 cm, respectively. General appearance showed increased lumbar lordosis. Both the blood pressure and pulse were normal. There was 3-4/6° systolic murmur in pulmonary area with a strong heave in left lower sternal area. Electrocardiogram showed a huge P-pulmonale and right ventricular hypertrophy with secondary ST-T changes, and right axis deviation (Fig. 1). Transthoracic echocardiography



**Figure 1. A 12-derivation electrocardiogram of the patient**