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). 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/mm3 (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 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

**Uğur Canpolat, Hikmet Yorgun1, Levent Şahiner, Kudret Aytemir**

Department of Cardiology, Faculty of Medicine, Hacettepe University, Ankara

Cardiology Clinic, Develi State Hospital, Kayseri-Turkey

Address for Correspondence/Yazışma Adresi: Dr. Uğur Canpolat
Hacettepe ÜniversitesiTip Fakültesi, Kardiyoloji Anabilim Dalı, 06100, Sihhiye, Ankara-Türkiye
Phone: +90 312 305 17 80 Fax: +90 312 305 41 37
E-mail: dru_canpolat@yahoo.com

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

**Ciddi sağ ventriküll hipterotofisi 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...
revealed massive right ventricular hypertrophy (Video. 1, 2. See corresponding video/movie images at www.anakarder.com), obliterating right ventricular cavity with the maximum gradient of 178 mmHg across the pulmonary valve (Fig. 2, 3). He did not accept any interventional or surgical treatment.

**Video 1.** Parasternal short-axis echocardiographic views of the right ventricular hypertrophy

**Video 2.** Parasternal long-axis echocardiographic views of the right ventricular hypertrophy

![Figure 2. Modified apical four-chamber view of right ventricular hypertrophy](image1)

![Figure 3. Parasternal short-axis view of pulmonary artery velocity and gradient](image2)

**Figure 2. Modified apical four-chamber view of right ventricular hypertrophy**

**Figure 3. Parasternal short-axis view of pulmonary artery velocity and gradient**