Acute stroke developed just only three patients. In our case, we diagnosed TCMP within 24 hours after acute stroke. Therefore, it is a dilemma that which caused to another? Since patient was relatively young and her symptoms started after a huge emotional stress, we suppose that TCMP developed first and stroke followed it.

**Conclusion**

We may suggest that when patients are presented with acute stroke especially after an emotional stress and they have low risk of atherosclerotic vascular disease, TCMP should be considered.

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**Address For Correspondence**
Dr. Ali Riza Akyüz, Açıkaabat Haçkalı Baba Devlet Hastanesi, Kardioloji Bölümü, 61300 Akçaabat, Trabzon- Türkiye
Phone: +90 462 227 77 77
Fax: +90 462 227 77 89
E-mail: dralirizaakyuz@gmail.com
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Complex atrial septal defect referred for percutaneous closure-do we need three-dimensional echocardiography and magnetic resonance imaging?

Karolina Kupczynska, Tomasz Jezewski, Bartlomiej Wozniakowski, Jaroslaw D. Kasprzak, Piotr Lipiec
Department of Cardiology, Medical University of Lodz; Lodz-Poland
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Percutaneous intervention is not always problem-solving in prosthetic paravalvular leakage

Mohammad Hossein Mandegar, Bahieh Moradi*, Farideh Roshanali*, Hossein Nazari Hayano*
Department of Cardiothoracic Surgery and *Echocardiography, Day General Hospital; Tehran-Iran

Introduction

Many studies have shown the long-term durability and gratifying results of the Cooley-Cutter valve (1, 2). Nonetheless, many of the complications cannot be prevented or predicted despite optimal prosthesis function in the individual patient; so careful clinical follow-up are, therefore, essential. We report the case of a well-functioning Cooley-Cutter prosthetic mitral valve (PMV), complicated almost four decades after implantation.

Case Report

A 54-year-old man with history of mitral valve replacement (MVR) was admitted to Department of Cardiothoracic Surgery, Day General Hospital; Tehran, Iran. The MVR was performed with a caged- disk Cooley-cutter valve for severe rheumatic involvement in 1975. He reported no serious complaint until the last few years. The patient had undergone two percutaneous interventions for paravalvular leak (PVL) in the last two years.

At admission, the patient presented with increasing dyspnea with New York Heart Association functional Class III. His evaluation revealed a systolic murmur, mild hemolytic anemia, increased lactate dehydrogenase (LDH) and negative blood cultures. The International Normalized Ratio was within target range.

Transthoracic echocardiography (TTE) illustrated a PMV with increased mean gradient (12 mm Hg), Doppler velocity index (DVI)=0.4, effective orifice area (EOA)=1 cm², severe pulmonary hypertension (systolic pressure=100 mm Hg), left ventricular ejection fraction about 48%, and moderate tricuspid regurgitation. The detailed transesophageal and real-time three-dimensional echocardiography demonstrated two side-by-side Amplatzer ductal occluder devices (Fig. 1) and confirmed significant stenosis (Video 1) and moderate PVL at the posterior segment of the prosthesis and significant annular calcification.

At operation, the PMV was intact without any dysfunction and no abscess or evidence of endocarditis (Fig. 2). The annulus was heavily calcified, and the sutures were neither cut nor loosened (Fig. 3A). The valve was replaced with a new mechanical valve and retrieval of the occluder devices was performed (Fig. 3B). The tricuspid valve ring annuloplasty was also performed. On postoperative studying, the PMV had mean gradient of 5 mm Hg, the pressure of the right ventricle decreased to 40 mm Hg and there was no residual PVL. LDH decreased dramatically. The recovery was uneventful, and he was discharged 8 days after surgery.

Discussion

Most PVLs become apparent in the first half-year after the operation (3, 4), although our patient was complicated with PVL more than 35 years after MVR. The suggested possible causes of late PVLs include long-term degenerative change of the suture site, small tears in the calcified portion, and accumulated stress on the annulus allowing a small area of detachment and unidentified cured infective process in the remnant valve tissue (4).

The presence of a severely increased gradient cannot be equated with intrinsic prosthesis dysfunction. Hence, a high gradient can be due...