admitted to our department with palpitation, syncope, and dyspnea of exertion from 5 days ago. ECG and monitoring showed intermittent VT with a heart rate of 170 bpm (Fig. 1). On the transthoracic echocardiography (TTE), a cystic mass was noted in the left ventricular cavity. The cystic mass was developing inside the left ventricle and mildly compressing the outflow tract. There was no subaortic gradient and regurgitation or stenosis for the mitral and aortic leaflets. Transesophageal echocardiography (TEE) confirmed TTE and hydatid cyst, and the localization was determined (Fig. 2A and B, Video 1-2). Serial cardiac enzymes were positive for myocardial damage. A diagnostic coronary angiography was performed, which revealed no significant atherosclerotic stenosis of the coronary arteries. Abdominal ultrasonography showed an extracardiac cyst in the liver. The CT showed cystic lesions in the left ventricular cavity protruding into the left ventricular outflow tract and in the liver (Fig. 3). Finally, he underwent cardiac surgery under general anesthesia, and the large hydatid cyst was evacuated. There was no evidence of residual cyst in the intraoperative TEE. Our patient, interestingly and originally, presented with exertion syncope and ventricular tachycardia, with positive cardiac enzymes for myocardial damage, which, in this particular context, was mimicking acute coronary syndrome. However, the exercise-induced syncope and ventricular tachycardia was probably explained by obstruction of the left ventricular outflow tract, such as in obstructive cardiomyopathies. We could not determine the subaortic gradient by continuous wave Doppler, but the reason couldn’t be measured perpendicular to flow.

Isa Öner Yüksel, Gülşüm Meral Yılmaz, Erkan Köklü, Nermin Bayar, Selçuk Küçükseymen, Şakir Arslan
Department of Cardiology, Antalya Education and Research Hospital; Antalya-Turkey

Video 1-2. Transesophageal and transthoracic echocardiography showing an intraventricular cystic mass completely covering to the outflow tract

Address for Correspondence: Dr. Isa Öner Yüksel,
Kültür Mah. 3805 Sok, Durukent Sit. H Blok No: 22
07090 Kepez, Antalya-Türkiye
Phone: +90 242 249 44 00
Fax: +90 242 249 44 63
E-mail: drisayuksel2@hotmail.com
Available Online Date: 25.12.2014
©Copyright 2015 by Turkish Society of Cardiology - Available online at www.anakarder.com
DOI:10.5152/akd.2014.5918

Asymptomatic giant pseudoaneurysm in the ascending aorta after Bentall procedure

A 31-year-old female patient underwent Bentall procedure due to an aortic aneurysm and aortic regurgitation, with an uneventful postop-
The transthoracic echocardiography and computed tomography demonstrated normal aortic valve function and a prosthetic vascular conduit at discharge and the 6-month follow-up. In the 1-year follow-up, 3-dimensional contrast-enhanced computed tomography (CT) of the thoracic aorta revealed a giant pseudoaneurysm, sized 3.4 x 3.5 x 5.4 cm, behind the ascending aorta originating from the distal portion of the vascular prosthesis conduit due to anatomic leakage between the aorta and prosthesis (Fig. 1). Cross-examine history, at the 7th postoperative month, the patient was admitted to the local hospital because of high fever (40.1℃), dyspnea, chest pain, and fatigue but unfortunately was not given a CT to check the prosthetic vascular conduit. She underwent a secondary surgery for aneurysm removal and vascular conduit replacement. The patient recovered fully and was discharged 1 week after surgery and remained stable without any sign; the prosthetic vascular conduit was normal by 3-dimensional contrast-enhanced computed tomography 3 months after discharge (Fig. 2).

Aortic pseudoaneurysm is a rare complication after aortic surgery and has fatal outcomes if not recognized. Most patients will display symptoms, such as chest pain, heart failure, and aortic regurgitation, while many of them may still be totally asymptomatic. Immediate surgery is necessary because of the high morbidity and mortality rates. Preoperative 3-dimensional contrast-enhanced computed tomography is of paramount for the evaluation of aortic pseudoaneurysm.

Acknowledgments: The study was supported in part by grant No. 81170288 from the National Research Foundation of Nature Science, China.

Jun Gu, Da Zhu, Eryong Zhang
Department of Cardiovascular Surgery, Sichuan University, West China Hospital, Cheng du, Sichuan-People’s Republic of China

Address for Correspondence: Eryong Zhang, MD,
Department of Cardiovascular Surgery, Sichuan University
West China Hospital, Lane outside the southern No.37 Cheng du, Sichuan-People’s Republic of China
Fax: 0086-028-85422887
E-mail: zhangeryong0504@gmail.com

Available Online Date: 25.12.2014
©Copyright 2015 by Turkish Society of Cardiology - Available online at www.anakarder.com
DOI:10.5152/akd.2014.5792