mitral valve replacement was replaced. Further complications including an important hemorrhagic diathesis reliably caused by long cross-clamping time (260 minutes totally), occurred and lead to the death of a patient.

We describe our experience in the therapeutical management of a calcified ASV. We believe that the calcification of aneurysm wall is a factor that could contribute to increase mortality rate.

Ali Vefa Özcan, *Harun Evrengül, Ibrahim Gökşin, Gokhan Önem
From Departments of Cardiovascular Surgery and *Cardiology, Faculty of Medicine, Pamukkale University, Denizli, Turkey

Address for Correspondence/Yazılıma Adresi: Dr. Ali Vefa Özcan
Sıtele Mah. Barbaros Cad. 6248 Sok. C-Blok No: 3, 20070 Kınıklı, Denizli, Turkey
Phone: +90 258 212 34 94 Gsm: +90 532 574 49 57 Fax: +90 258 212 99 22
E-mail: vefaozcan@yahoo.com

Coronary to pulmonary artery fistula associated with significant coronary atherosclerosis

Ciddi koroner aterosklerozun eşlik ettiği koroner arter fistülü olgusu

A 47-year-old man with history of smoking was admitted to our institution having exercise dyspnea and substernal chest pain for 3 months. He had no history of cardiac disease or trauma and his physical examination was normal. The 12-lead electrocardiogram revealed T wave inversion in leads V4–V6. The exercise treadmill stress test showed ST depression of 1.5 mm in leads V1-6. Coronary angiogram demonstrated a coronary artery fistula (CAF) originating from the proximal left anterior descending coronary artery superior to a critical atheromatous stenosis (Fig. 1), draining into the pulmonary artery (Fig. 2). See corresponding video/movie images at www.anakarder.com. The patient was planned to undergo coronary surgery.

Among coronary vessel anomalies CAF is the rare entity(1). Although it is suggested that coronary arterial atherosclerosis affects patients with CAF in the same way as in normal humans (2); the combination of fistula and significant obstruction of the same coronary artery is by far a less frequent phenomenon (2-3). Myocardial ischemia resulting from fistula steal phenomenon cannot be clinically distinguished from that of coronary atherosclerosis, if these conditions coexist in the same patient. Although noninvasive imaging may facilitate the diagnosis and identification of the origin and insertion of CAF, coronary angiography is necessary to show the presence of concomitant atherosclerosis (4).

Nesligül Yıldırım, Sait M. Doğan, Metin Gürsürer, Mustafa Aydın
Department of Cardiology, Faculty of Medicine, Zonguldak Karaelmas University, Zonguldak, Turkey

References

Address for Correspondence/Yazılıma Adresi: Nesligül Yıldırım
Zonguldak Karaelmas University Faculty of Medicine Department of Cardiology 67600, Kozlu, Zonguldak, Turkey
Phone: +90 372 261 01 69 E-mail: nesligu2004@hotmail.com

Aortopulmonary window associated with anomalous right coronary artery: a rare combination

Anormal sağ koroner arter ile aortopulmoner pencere birlikteligi görüntülenmesi

A 4-month-old boy was admitted to our department with dyspnea and clinical findings of congestive heart failure. He had no family history of cardiac disease and consanguineous marriage. At prenatal period, he had no risk factor for developing congenital heart disease. On