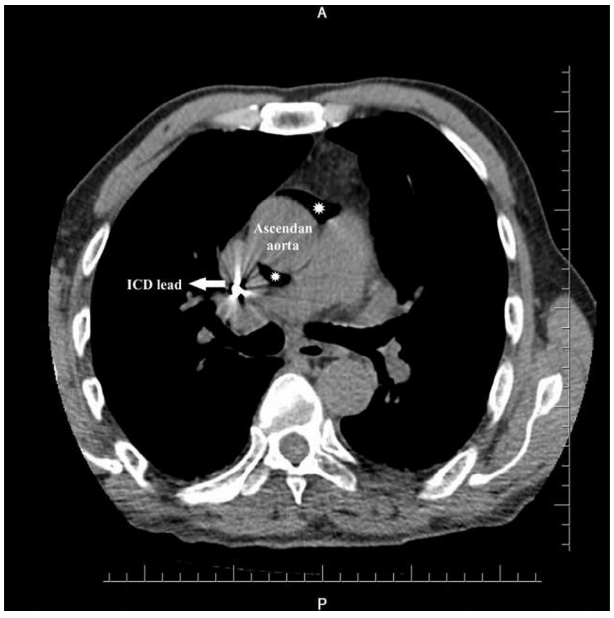


Figure 1.

center. During electrophysiologic study clinical ventricular tachycardia with pseudo-delta waves was induced. Epicardial activation and voltage mappings using Carto-3 system were obtained via subxiphoid route. Critical isthmus was detected at basal inferior right ventricular epicardium near the atrioventricular groove and radiofrequency ablation immediately stopped the tachycardia. No recurrence was seen with control stimulations. Severe retrosternal pain occurred during catheter manipulations. Transthoracic echo showed no remarkable pericardial effusion. Chest computed tomography demonstrated air localized in the periaortic area compatible with pneumomediastinum without additional complication (Figure 1, white stars). Chest-surgeon advised conservative follow-up and the patient was discharged with pain relief on the fifth postoperative day.

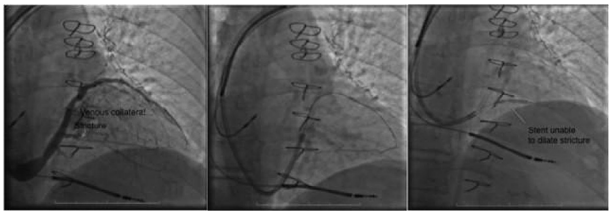
This is the first case with pneumomediastinum related with epicardial ablation. Pneumomediastinum should be considered in differential diagnosis of severe pleuritic pain emerged during or after epicardial electrophysiologic study.

Topic: AJC » Cardiac Resynchronization Therapy

PP-331

Stenting of a Stricture of Posterolateral Vein of Coronary Sinus by Retrograde Wiring Technique for Left Ventricular Lead İmplantation. *Ali Deniz, Buğra Karaarslan, Onur Sinan Deveci, Mesut Demir, and Mehmet Kanadaşı. Çukurova University, Adana.*

A 55 year-old male patient with ischemic cardiomyopathy was admitted to our hospital with heart failure symptoms. His functional status was NYHA III, His ECG demonstrated LBBB, and ejection fraction was 27%. After stabilization of acute decompensated heart failure symptoms, we decided to implant biventricular ICD. We detected a stricture in posterolateral vein which prevented left ventricular lead implantation. We tried to dilate the stricture by an angioplasty balloon, but we could not introduce balloon antegradely. Therefore, we sent a 0.014 inch guidewire retrogradely with the help of a microcatheter through a collateral vein extending from anterior interventricular vein. We recapture the wire into guiding catheter and made a loop. Then we introduced and inflated a balloon antegradely. Then we implanted a 2.5 × 15 mm stent, though it was unsuccessful to dilate the stricture. We completed the procedure with DDD ICD.



Topic: AJC » Cardiac Imaging - Echocardiography

PP-337

Angiosarcoma of the Heart Presenting as Deep Hypoxemia. *Dilek Çiçek Yılmaz, Murat Özeren, Ozan Sakarya, Kerem Karaca, Ayşegül Büyükbaş, and İclal Gürses. Mersin University Medical Faculty, Mersin, Turkey.*

Introduction: Angiosarcoma is a rare malignant primary cardiac tumor found mainly in the right atrium. We have reported a case of cardiac huge angiosarcoma of the right atrium causing significant tricuspid valve obstruction and severe hypoxemia.

Case report: A 21-year-old white male was admitted to our emergency department with complaints of dispnea and cough for about 1 week prior to presentation. He had no previous medical history. His vital signs were: temperature 36.3°C, pulse 130 bpm, respiratory rate 30 per minute, BP 130/100 mm Hg, and peripheral arterial oxygen saturation of 70% on room air. The electrocardiography demonstrated sinus tachycardia with non-specific ST-T changes.

Firstly, acute pulmonary embolism was suspected in the patient. D-dimer was 552 ng/mlt. Urgent contrast computed tomography scan of thorax showed no evidence of pulmonary embolism or parenchymal lung disease but revealed a mass abutting the right atrium. Also, ventilation-perfusion lung scintigraphy was not correlated with pulmonary embolism.

Transthoracic and transesophageal echocardiogram demonstrated 6,3 × 4,0 cm mass attaching lateral wall the right atrium with mobile component causing an obstruction through the tricuspid valves (Figure 1, Video 1).

Patient was undertaken to the urgent surgery due to tricuspid valve inflow obstruction by the huge mass which leads to deep hypoxemia. Right atrium opened and invasive hemorrhagic in nature mass starting from the wall of right atrium and invading to the atrioventricular grove was seen (Figure 2A). Prolapsing of the mass was also blocking the tricuspid valve. Mass was removed totally from the right atrial and near the AV groove wall because of invasion (Figure 2B). Resected areas of

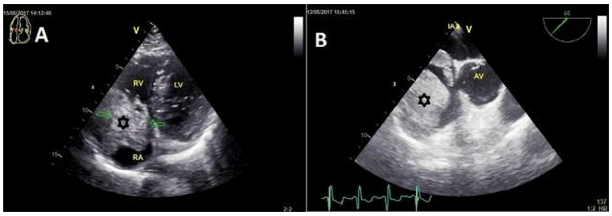


Figure 1.

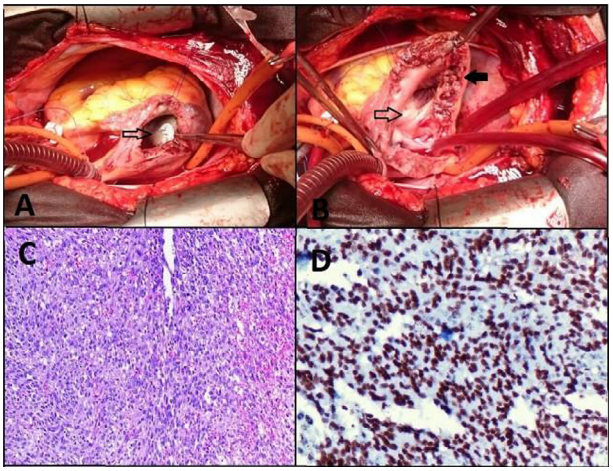


Figure 2. Intra-operative photo showing the huge atrial tumor *(open arrow) (A)*, unresectable tumor near the AV groove *(closed arrow)* and tricuspid valve after resection *(open arrow) (B)*, solid areas of the angiosarcoma *(C)* and staining with Friend leukemia virus integration-1 *(D)*.

right atrial wall was reconstructed by using large gluteraldehyde treated autologous pericardium. There was no patent foramen ovale in surgical exploration. Histologically, the tumor was an angiosarcoma (Figure 2C, D). Postoperatively, the hypoxemia of patient was recovered as 96% oxygen saturation in room air. Patient had an uneventful recovery and was discharged on post-operative day 5. Chemotherapy was planned.

Discussion: Primary malignant tumors of the heart are rare, and among them, angiosarcoma is the least rare. It usually affects young or middle-aged adults and men at least twice as frequently as women. Nearly 90% of tumors occur in the right atrium as a multicentric mass. The most common clinical presentation in adults is dyspnea or central nervous system/embolic phenomena. Hypoxemia are seen if tumor are associated with pulmonary embolism or patent foramen ovale. We have reported a case of cardiac angiosarcoma of the right atrium presenting with deep hypoxemia without pulmonary embolism or patent foramen ovale. After surgery with relief of obstruction, oxygen saturation of patients recovered totally. Therefore, we postulated that the cause of hypoxemia was severe tricuspid valve obstruction.

Conclusion: In case of hypoxemia and cardiac tumor, we have to investigate pulmonary embolism, patent foramen ovale and valvular obstruction like in this case. Surgery is the most important initial management to correct the hemodynamic sequelae and maximize survival.

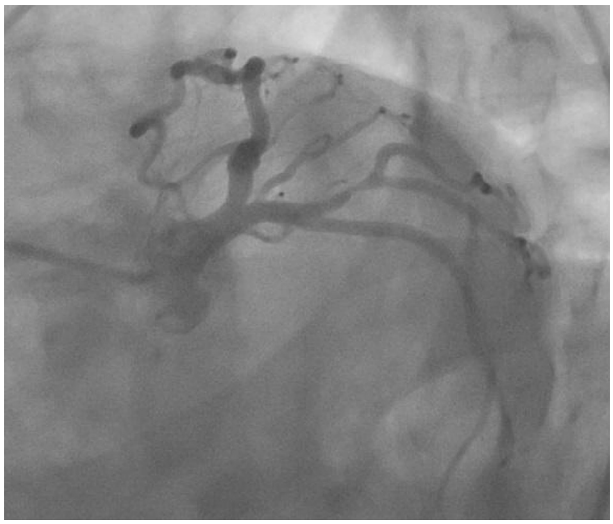


Figure 1.

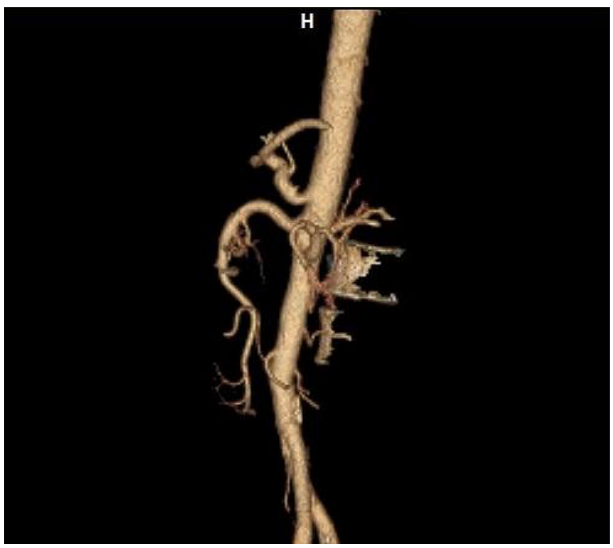


Figure 2.

Topic: AJC » Percutaneous Coronary Interventions

PP-350

Which Should Be Treated First; Coronary Artery Disease or Celiac Artery Compression Syndrome?. *Ismail Biyik[1], Erol Bahtiyar[1], and Nilgun Isiksacan[2]. [1]Usak University, School of Medicine, Education and Research Hospital, Usak; [2]Bakirkoy Dr. Sadi Konuk Education and Research Hospital, Istanbul.*

Introduction: Celiac artery compression syndrome is rare. The differential diagnosis and the choice of therapeutic intervention in this syndrome are controversial. Herein, we report of a case of celiac artery compression syndrome and concomitant coronary artery disease and discuss differential diagnosis and treatment strategies.

Case presentation: A forty three years old male patient presented to our out-patient clinic of cardiology with the symptoms of long-standing epigastric pain, abdominal swelling and loss of appetite. His habitual history revealed excessive alcohol and cigarette consumption. His physical examination was unremarkable except abdominal obesity. Exercise electrocardiography showed horizontal ST segment depressions in leads DII, III and AVF at mid-level exercise. Coronary angiography displayed critical stenosis visually about 80 to 85% at the proximal level of well-developed obtuse margin branch of circumflex artery (Figure 1). Computed tomography angiography of abdominal arteries and reconstruction of data confirmed overhead external compression of celiac artery causing critical stenosis and post-stenotic dilatation of the artery (Figure 2). After successful stenting procedure for the obtuse margin branch of circumflex artery, the symptoms of the patient quickly relieved, and he was discharged without symptoms.

Discussion: There are a lot of reports on this syndrome in literature but its association with coronary artery disease has not been established

POSTER ABSTRACTS