

defect. On the other hand, aneurysm formation has the potential complications of thromboembolism, arrhythmia, endocarditis, right ventricular outflow tract obstruction. Echocardiographic evaluation is important in diagnosis of ventricular septal aneurysm and its complications.

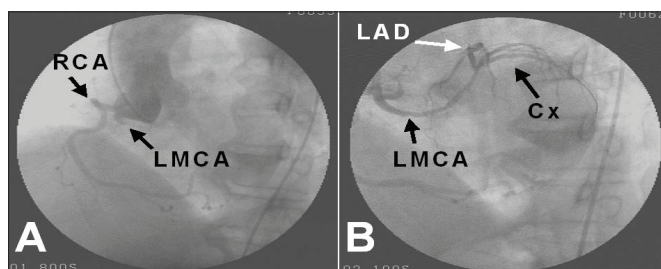
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## Primary stenting of the anomalous left main coronary artery originating from right coronary sinus: multislice computerized tomography angiography imaging

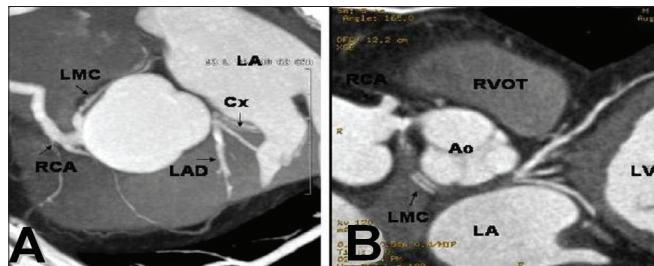
*Sağ koroner sinüsten çıkan sol ana koroner artere primer stentleme girişimi: Çok kesitli bilgisayarlı tomografi anjiyografi görüntülemesi*

A 50-year-old man presenting with acute myocardial infarction (AMI) was urgently transferred to the catheterization laboratory. We were unable to cannulate the left main coronary artery (LMCA). Aortography demonstrated that the LMCA was originating from the right coronary sinus and was totally occluded (Fig. 1A, Video 1. See corresponding video/movie images at www.anakarder.com). During intervention, JR-4 catheter did not provide sufficient backup, so we changed it with the hockey stick guiding catheter. Crossing total occlusion, the lesion was predilated, afterwards a 3.5x20 mm "bare metal stent" was implanted into the LMCA. Subsequent angiography demonstrated TIMI III flow and good myocardial contrast blush (Fig. 1B, Video 2. See corresponding video/movie images at www.anakarder.com). The patient was followed up in the coronary care unit for 48 hours and discharged 5 days later. At the sixth-month control, coronary multislice computerized tomography (MSCT) angiography demonstrated that the LMCA was coursing in the dorsal wall of the aorta and subsequently, between aorta and left atrium (retroaortic course) (Fig. 2A-B). This congenital anomaly is subclassified into four types based on the relationship of the LMCA to the great vessels: septal, anterior free wall, retroaortic and interarterial courses. The first three are considered benign, while the last one causes symptoms, which vary from angina to



**Figure 1. A) Aortogram in the LAO projection before primary percutaneous intervention. (B) Selective left coronary angiogram in the LAO projection after stenting**

Cx - circumflex coronary artery, LAO - left anterior oblique, LMCA - left main coronary artery, RCA - right coronary artery



**Figure 2. Coronary MSCT angiographical images of the stented LMCA**  
LMCA - left main coronary artery, MSCT - multislice computerized tomography

syncope or sudden cardiac death. Coronary MSCT angiography revealed also restenosis of the implanted stent. Conventional coronary angiography confirmed restenosis and coronary artery bypass surgery was performed successfully.

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## Coincidentally determined floating right ventricular thrombus in a patient with coronary artery disease

*Koroner arter hastalığı olan bir hastada tesadüfen tespit edilmiş olan yüzen sağ ventriküler trombus*

A 65-year-old male patient presented to our hospital with complaints of unstable angina pectoris. The coronary angiography revealed 60% stenosis of the left main coronary artery, 80% stenosis of the left anterior descending artery (LAD) and a total occlusion of the right coronary artery (RCA). Transthoracic echocardiography before the surgery disclosed a floating right ventricular mass attached to the subvalvular apparatus of the tricuspid valve, moving in and out through the pulmonary valve in each systole and diastole (Video 1. See corresponding video/movie images at www.anakarder.com).

The patient was accepted for surgery urgently. Initial access to the thrombus was tried to be gained via an incision through right atrial wall. However, exploration through tricuspid valve failed to detect any thrombus inside the right atrium and ventricle. The mass lesion was thought to be embolized to the pulmonary artery during the surgical intervention. Coronary artery bypass grafting was performed on the LAD, RCA and the obtuse marginal branch. After the release of cross-clamp, main pulmonary artery was opened and embolectomy was performed using Fogarty