ventricle walls showed the thrombus localized in the lateral wall of the left atrium (Figure 1C). Two-dimensional transesophageal echocardiography basal short-axis (Figure 2A) and long-axis image (Figure 2B) demonstrated 22×45 mm size of a giant thrombus in the left atrial appendage. Three-dimensional transesophageal echocardiography zoom modality image also showed the thrombus in the left atrial appendage (Figure 2C).

Atrial fibrillation is the most common chronic arrhythmia and is associated with increased left atrial thrombus. Its presence and location have important implications in deciding on the therapeutic approach. Echocardiography is essential in establishing the diagnosis in patients with cardiac masses. Because the source of left atrial thrombus is often appendage, it may not be identified by transthoracic echocardiography. We herein demonstrated a huge left atrial appendix thrombus that was identified by transthorasic echocardiography easily.

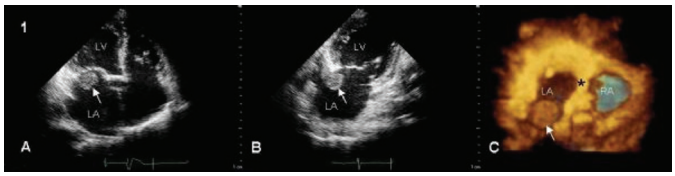

Figure 1.

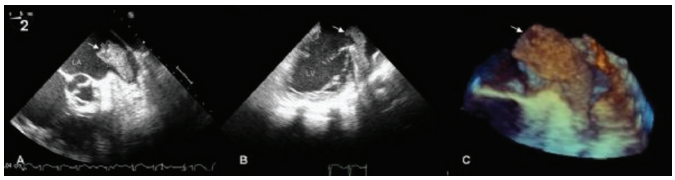

Figure 2.

PP-023
LEFT ATRIAL MYXOMA IN ADVANCED AGE: A CASE REPORT

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Cardiac myxomas are the most common primary cardiac tumors. They are usually benign and occur more frequently in women. In this case, we present a female patient with a left atrial myxoma in the advanced age.

Case: A 75-year-old female patient with a history of hypertension and diabetes for 3 years admitted to the hospital for evaluation of progressive effort dyspnea and atypical chest pain. Her functional capacity was II according to the New York Heart Association classification. An ECG revealed that nonspecific ST-T wave changes, left anterior hemiblock with normal ventricular rate. Two dimensional echocardiogram demonstrated minimal mitral and tricuspid valve regurgitation with normal systolic function (ejection fraction: 60%) and a big left atrial tumor attached to the interatrial septum (2.3×2.9×2.0 cm). Before the operation coronary angiography was performed and it revealed that severe two-vessel disease. The tumor was resected with the underlying heart tissue by transseptal approach and LIMA-LAD and circumflex-aorta-saphenous bypass graft anastomoses were performed. Histologic analysis confirmed a myxoma. Postoperative echocardiographic examination revealed no abnormalities.

Discussion: Myxomas are mesenchymal tumors, which can occur at any age; however, they mainly exist between the third and sixth decade of life. They are histologically benign tumors but they may be lethal because of their strategic position. This disease is approximately two to three times more prevalent in women than in men. Two-dimensional echocardiography is the first diagnostic procedure of choice for myxoma. Prior to myxoma resection, coronary angiography is important in order to determine attendant severe coronary artery disease. Operative resection of the myxoma is the gold standard for the treatment. Our case is interesting because its diagnosed in the advanced age with severe coronary heart disease.

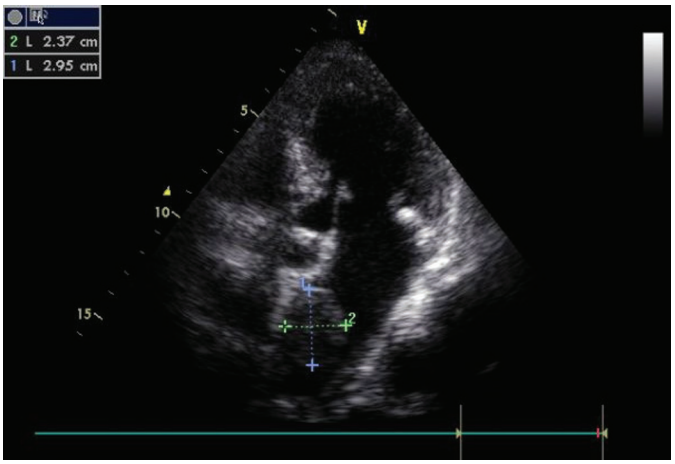

Figure 1. Two dimensional echocardiogram demonstrated a left atrial myxoma attached to the interatrial septum.

PP-024
FORAMEN OVALE ACCOMPANIED WITH INTERATRIAL SEPTAL POUCH EVALUATED BY THREE-DIMENSIONAL TRANSESOPHAGEAL ECHOCARDIOGRAPHY

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Patent foramen ovale (PFO) is a common clinical finding, affecting 10 to 24% of the general population. Double interatrial septum (IAS) is a rare anomaly in which there is a double-walled atrial septum with a persistent midline space between the two atria. These anomalies are resulting from the same etiopathogenesis that is incomplete fusion of the interatrial septum and they can be a potential source of emboli. A 34-year-old male patient was admitted to our outpatient clinic to evaluate the cardiac source of emboli after transient ischemic attack (TIA). His medical history has no comorbidities and coronary artery risk factors. Arrhythmias were not documented and no thrombophilic risk factors could be identified. There was nothing remarkable on his physical examination and routine blood sample tests. An electrocardiography showed a sinus rhythm. Two-dimensional transthorasic echocardiograpy revealed drop-out at interatrial septum. Two-dimensional transesophageal echocardiography detected a high mobile membrane adjacent and parallel to the IAS (Figure 1A) and also showed PFO (Figure 1B).

In order to better define the cardiac and IAS anatomy, three-dimensional transoesophageal echocardiography (3-D TEE) was performed. 3-D TEE confirmed double IAS (Figures 1C,D, asterisk). Incomplete fusion of septum secundum (SS) and septum primum (SP) leads to foramen ovale or double IAS. Until now, few cases with double IAS have been reported, most of them are associated with PFO. Transient ischemic attack is seen in approximately 5% of patients with PFO. Double IAS is a rare anomaly in which there is a double-walled atrial septum with a persistent midline space between the two atria and it may cause TIA. This case demonstrated PFO and double IAS in the same patient, which may be source of embolic events. TEE was performed in order to define better the IAS anatomy.