FIGURE 2. Intraoperative view of the junction between the left main coronary aneurysm and the ectatic circumflex artery (A) and the circumflex artery to the coronary sinus fistula (B). A, Left main aneurysm; CS, coronary sinus; CX, circumflex artery; DX, first diagonal coronary artery; PDA, posterior descending coronary artery.

Lipomatous septal hypertrophy

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A 76-year old obese woman with a body mass index (BMI) of 36.8 was referred for evaluation of an intracardiac mass, incidentally detected with computed tomography (CT). The CT scan showed massive thickening of the intra-atrial septum with the septal tissue clearly hypointense to normal myocardium and isointense to subcutaneous fat (Figure 1, A) and sparing of the fossa ovalis (Figure 1, B, arrows). Cardiac magnetic resonance imaging confirmed septal thickening of either side of the foramen ovale (Figure 1, C, arrows), being isointense to the subcutaneous fat. Echocardiographic studies (Figure 1, D) revealed hypertrophy of the atrial septum with bright echogenicity of the thickened tissue and

a typical dumbbell-shaped appearance. The diagnosis of lipomatous hypertrophy of the interatrial septum was made.

Lipomatous septal hypertrophy is a rare, benign, often asymptomatic condition primarily seen in older patients and is frequently confused with other cardiac tumors.^{1,2} Histologically, it is characterized by proliferation of adipocytes and interspersed hypertrophied cardiomyocytes.³ With imaging studies, lipomatous septal hypertrophy is indistinguishable from lipomas but occurs exclusively in the atrial septum and has no tendency to grow like a tumor. Massive fat deposition in the atrial wall results in a thickness of the atrial septum greater than 20 mm up to 60 mm³ and is associated with a higher incidence of atrial arrhythmias.¹ The diagnosis of lipomatous septal hypertrophy can be established by complementary imaging studies using transthoracic or transesophageal echocardiography, CT scanning, and magnetic resonance tomography. Characteristic features include a typical single mass in the interatrial septum, which is isointense to subcutaneous fat and does not involve the fossa ovalis.^{1,4} In the absence of severe arrhythmias, conduction problems, or signs of obstruction owing to protrusion into the atrium, no specific therapy is required.^{2,3,5}

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FIGURE 1. CT scans. LA, Left atrium; RA, right atrium; LV, left ventricle; RV, right ventricle; LVOT, LV outflow tract; d, diaphragm; as, atrial septum.

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Takotsubo cardiomyopathy after repair of ruptured abdominal aortic aneurysm

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Takotsubo cardiomyopathy was reported by Dote and associates¹ in a Japanese patient who had peculiar wall motion abnormalities and a balloon-shaped left ventricle with normal coronary arteries. Although the precise mechanism of Takotsubo cardiomyopathy remains unclear, several possible mechanisms have been proposed, including multivessel epicardial coronary spasm, microvascular coronary spasm, and catecholamine-mediated toxicity.² Recently, several