replaced by a low-caliber 15-mm catheter (LassoNav®, Biosense Webster) to access the inside of the right inferior PV. The catheter shifted into the left ventricle during placement and remained trapped in the subvalvular apparatus. An unsuccessful attempt was made to free it by gently advancing the catheter with a clockwise rotation and traction on the catheter, with and without the support of the Mullins sheath, which was advanced to the distal end of the catheter in an effort to straighten it. These maneuvers were repeated, without success, during ventricular pacing at 220 bpm to reduce cardiac output during adenosine-induced asystole, and under Isoproterenol infusion administered to increase inotropism. A 4-mm ablation catheter with a deflectable distal tip was introduced by a retrograde approach to surround the distal end of the multipolar guide and modify the traction point, like a “lasso” catheter to encircle the distal tip of the circular catheter. However, this too failed to release it. The fluoroscopic view of the circular tip of the catheter made us suspect a fracture of the distal portion (Fig. 1), and given the high risk of valvular lesion, as reported in similar cases, we decided to terminate the procedure and proceed with surgical extraction. The mitral valve was accessed through median sternotomy and transverse aortotomy while under surgical intervention due to failure of extraction attempts or performing these maneuvers, although most have required surgical intervention due to failure of extraction attempts or development of acute MR due to rupture of the subvalvular apparatus or commissural tearing. There are also reports of catheter release and extraction using minimally invasive surgery.

This complication is rare but probably also underestimated. In a recent record of 8745 patients that underwent AF ablation, only one case of unspecified valvular damage was reported. However, a retrospective review of 348 patients found that the incidence of circular catheter entrapment in the mitral valve apparatus was significantly higher (0.9%).

There are no reports on the usefulness of maneuvers designed to reduce cardiac output or increase contractility in an effort to facilitate the release of the catheter, but in our case they were not effective.

The published data indicate the need to consider the risk of injury to the mitral valve and to rely mainly on the maneuver of advancing the sheath over the catheter using clockwise rotation, resorting to surgical extraction if this maneuver is not effective.

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Available online 28 January 2011

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doi:10.1016/j.rec.2010.08.008

Giant Aneurysm in a Coronary–Pulmonary Artery Fistula

Aneurisma gigante de fístula coronariopulmonar

To the Editor,

A 67-year-old woman, with no cardiovascular risk factors and asymptomatic from the cardiologic point of view, was referred to our unit for the study of a cystic mass adjacent to the cardiac outline, detected incidentally on a chest radiograph (Fig. 1). The transthoracic echocardiogram showed a large spherical mass with a hyperechoic wall and heteroechoic content, situated at the level of the atrio-ventricular sulcus, adjacent to the aortic root (Fig. 1, Video 1). Multislice computerized tomography and coronary angiography showed a fistula between the right coronary artery and the pulmonary artery, which originated near the ostium of the right coronary artery and...
**Figure 1.** The left side of the image is the chest radiograph of the patient, showing a paracardiac cystic mass. The transthoracic echocardiogram shows a heteroechoic mass adjacent to the aortic root.

**Figure 2.** Multidetector computed tomography and invasive coronary angiogram: fistula of the right coronary artery to the pulmonary artery with a giant thrombosed aneurysm.
drained into the main pulmonary artery via a giant aneurysm, with parietal calcification and mural thrombus (Fig. 2, Video 2). Once the presence of a major left-to-right shunt and myocardial ischemia had been ruled out, a wait-and-see attitude was adopted.

Coronary fistulas are anomalous communications, either congenital or acquired, between a coronary artery and a cardiac chamber or blood vessel, present in 0.1%–0.8% of all coronary angiographies. The development of saccular aneurysms in coronary–pulmonary fistulas is even less common. Most arise from the right coronary artery or the left anterior descending artery, and about 90% drain into the venous circulation (right chambers, pulmonary artery, superior vena cava or coronary sinus). Its spectrum of clinical presentation varies, and depends on the severity of the left-to-right shunt. The entity is usually an incidental finding, though it may cause myocardial ischemia, arrhythmias, heart failure or sudden death. As shown by our case, multislice computerized tomography permits clear definition of the origin of these fistulas, their path and their distal site of drainage, as well as their relationship to other cardiac structures, and represents a very important advance in diagnostics, compared with coronary angiography. The main indications for closure of these fistulas are the development of clinical symptoms, especially myocardial ischemia or heart failure. In childhood, treatment can be considered in asymptomatic patients with a high-flow left-to-right shunting to avoid complications. Both surgical treatment and percutaneous closure have shown excellent results with respect to effectiveness, morbidity and mortality.

APPENDIX . SUPPLEMENTARY MATERIAL

Supplementary material associated with this article can be found in the online version available at doi:10.1016/j.rec.2010.08.002.

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Available online 28 December 2010

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3. Stephenson et al both published series (22 and 8 patients, respectively).
4. Renewal 4 generator was implanted. It was confirmed that
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