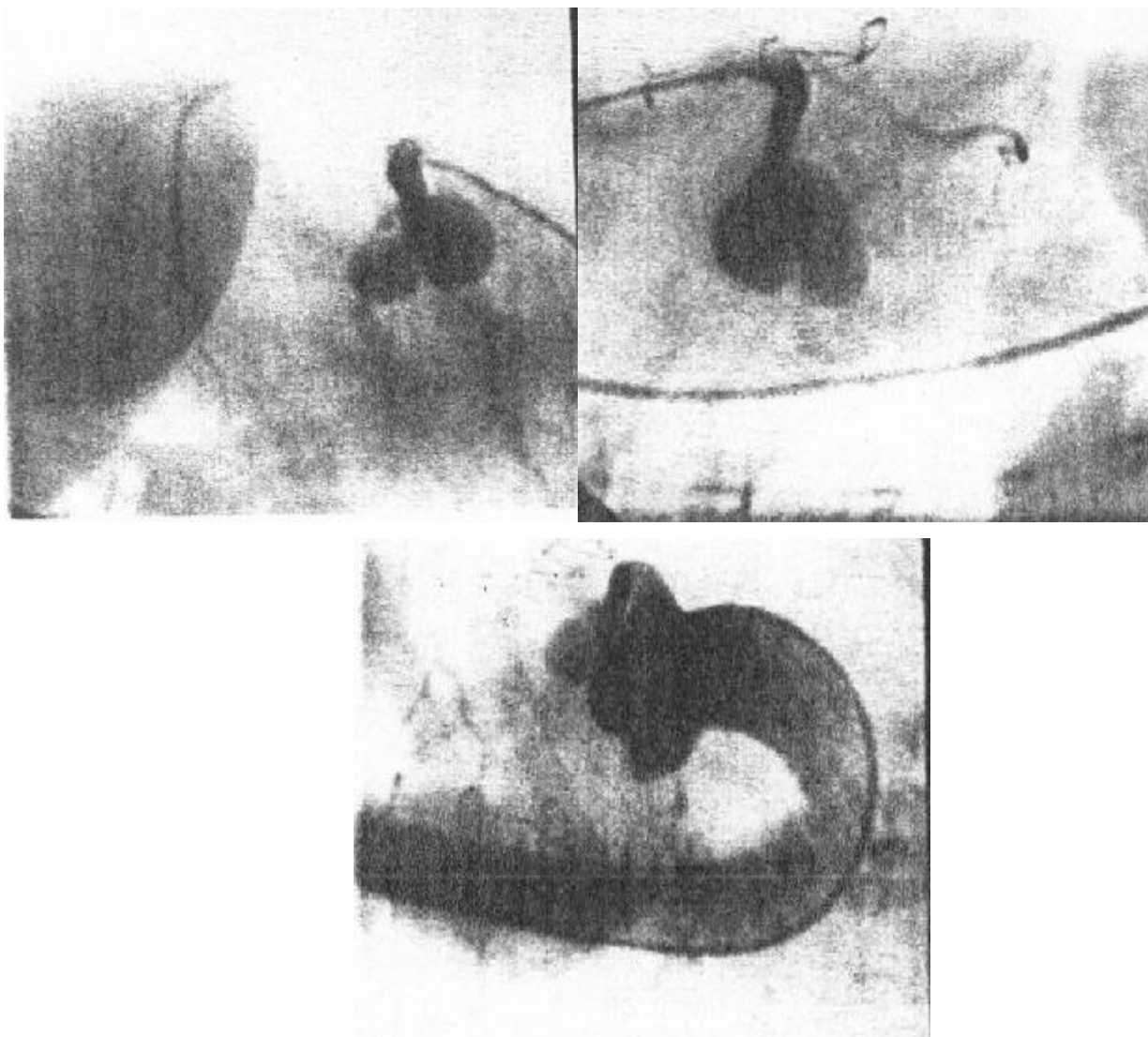


PHOTOCLINIC



A 12-year-old girl was referred to our hospital with shortness of breath and exertional chest pain lasting for 2 years. She had a history of heart surgery about 5 years ago for a coronary artery fistula. The right coronary artery communicates with the right atrium, and it seems that the surgeon closed one side of the fistula during surgery.

Physical examination revealed the following: normal heart sounds without any murmur; lungs, clear; pulse rate, 80 min regular; blood pressure, 110/70 mmHg; routine lab tests, normal; electrocardiography, normal pattern; chest-X ray,

cardiothoracic ratio normal; echocardiography, normal. Cardiac catheterization and coronary angiography were performed. There were no atrial septal defects, ventricular septal defect or patent ductus arteriosus. Coronary angiography results are shown in the Figure above.

Your Diagnosis?

See next page for diagnosis

The coronary arteriovenous fistula (CAVfs) is an unusual anomaly that consists of a communication between one of the coronary arteries and a cardiac chamber.¹ The right coronary artery is the site of fistula in about 55% of cases, the left coronary artery is involved in about 35%, and both coronary arteries in 5% of connections between the coronary system and a cardiac chamber, representing the persistence of embryonic intertrabecular space and sinusoids.¹

In the vast majority of cases (about 90%), the CAVfs terminates in the right side of the heart; the right ventricle is the most common site of termination, but the right atrium and pulmonary artery are often seen as sites of termination. The site of termination may be single entry or multiple entry sites.²

The shunt through the fistula most often is of small magnitude and myocardial blood flow is not

compromised.¹ Spontaneous closure may occur, with potential complications including exertional chest pain, congestive heart failure and pulmonary hypertension. If a large left to right shunt exists, bacterial endocarditis, rupture or thrombosis of the fistula may occur.¹

References

- 1 Braunwald E, Zipes DP, Libby P. *A Textbook of Cardiovascular Medicine*. 6th ed. Philadelphia: Saunders; 2001.
- 2 Garson A. *The Science and Practice of Pediatric Cardiology*. 2nd ed. Baltimore: William and Wilkins; 1998.

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Erratum

1. The word "Patients" in the title of the article entitled "Polymerase Chain Reaction-Sequence Specific Primer (PCR-SSP) Versus Serology in Typing of HLA-A,-B And -C in Iranian Patients" published in the previous issue of the journal (page 23, Volume 6, Number 1, January 2003,) must be replaced by the word "Population".
2. The legend of the Figure 2 must be replaced by the legend of Figure 3 and vice versa in page 64 Volume 6, Number 1, January 2003. You see the two figures in their right format as follow.



Figure 2. A cross-section of the worm illustrating the thick cuticle and developed muscle cells (X 250).

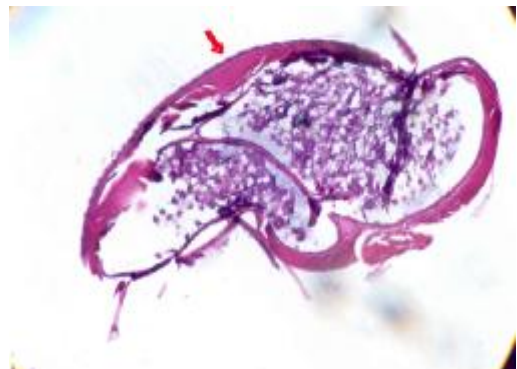


Figure 3. Transverse section of *Dirofilaria*, showing prominent longitudinal cuticular ridges on the external surface (arrow), polymyarian type muscle cells and tall lateral cords (X 400).