There were two stillbirths and four preterms; in three newborns, intrauterine growth retardation was observed.
Conclusions: In conclusion, PVHD is associated with fetal/maternal morbidity and mortality. The optimal management of pregnancy in case of valvular heart disease requires the active collaboration of an obstetrician, a cardiologist, and a cardiothoracic surgeon.

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CONCOMITANTLY FOUND SINGLE CORONARY OSTIUM AND MITRAL VALVE PROLAPSUS IN A YOUNG FEMALE WITH ALPORT SYNDROME
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Objective: Alport syndrome (AS) is a rare inherited disorder characterized by involvement of the kidneys because of the defect in the genes encoding a connective tissue protein, one of several subunits of collagen (particularly type IV) ultimately leading to renal failure at an early age. Cardiac involvement have been reported rarely which most commonly includes conduction system abnormalities. Valvular abnormalities in AS have not been reported previously. In our case, concomitant occurrence of previously unreported AS with MVP may be due to mutation at the level of collagen synthesis. Also single coronary ostium may contribute to this association coincidentally.
Methods: A 23-year-old female with chronic renal failure because of Alport syndrome (AS) consulted for cardiac evaluation before renal transplantation. She described dyspnea with minimal effort and atypical chest pain. Past medical history includes AS, hypertension and chronic renal failure for 4 years. She was taking carvedilol and amlodipine for hypertension.

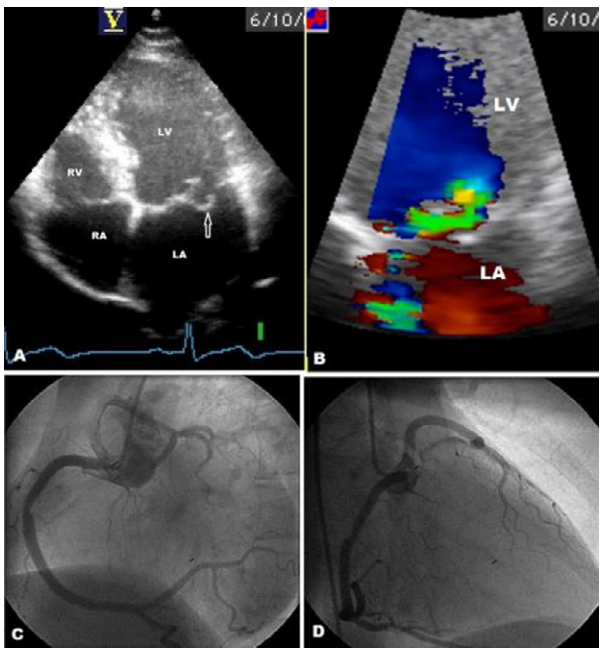

Figure 1.

Results: Examination showed arrhythmic pulse, apical 3/6 systolic murmur, other systems and biochemical parameters were unremarkable except renal function tests. Electrocardiogram revealed atrial fibrillation. Transthoracic echocardiography (TTE) revealed left ventricular ejection fraction of 55%, LV end-diastolic diameter of 59 mm, prolapsus of the posterior mitral leaflet and severe mitral regurgitation (MR) (Figs. 1A,B). Transesophageal echocardiography confirmed mitral valve prolapsus (MVP) and severe egzantric MR. Coronary angiography demonstrated both left main coronary artery (LMCA) and right coronary artery (RCA) were originating from the right sinus of Valsalva (RSV) via single ostium (Fig. 1C). Coronary system was free of atherosclerosis except 30% stenosis at proximal RCA. The LMCA was oriented retro-aortic and coursed down as LAD in the interventricular groove after giving rise to intermediate and circumflex arteries (Lipton RI-P) (Fig. 1D). Left ventriculography confirmed severe mitral regurgitation.
Conclusions: So, the patient was referred for mitral repair before renal transplantation.

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AUTOLOGOUS PERICARDIUM PLASTY OF THE TRICUSPID ANNULUS REINFORCEMENT
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Objective: Our hospital from May 2000 to October 2011, 32 patients had significant tricuspid regurgitation in patients with autologous pericardium plasty of the tricuspid annulus reinforcement.
Methods: 32 patients, 12 males, 20 females, aged 22–67 years, mean (40.6±12.2) years of age. 32 patients were tricuspid regurgitation grade II or more. The simultaneous implementation of the mitral valve replacement surgery in 18 cases, mitral valvuloplasty in 2 cases, double valve replacement surgery in 6 cases, adult atrial septal defect surgery in 5 cases, left atrial myxoma resection in 1 case. Specific methods are as follows: from the pericardium of the body length 6–7 cm, width 0.8 cm, with 0.56% glutaraldehyde-fixed 15 minutes to spare. Use of non-invasive needle through the pericardium along the tricuspid annulus as a horizontal mattress suture, front to back across the border across the border, a total of 5–6 sewing needle, the needle on the tricuspid annulus is greater than the distance of the pericardium gauge, tie a knot after the tricuspid valve before and after the narrow valve ring and fixed to the pericardium of the valve ring. The order is also used to tie a knot across the junction to the junction after the interval, usually after the first hit four knot, ring the size of the tricuspid valve exploration, observation of parallel injection test whether there is tricuspid regurgitation.
Results: before and after surgery are used HP5500 ultrasonic Doppler cardiac chamber size and the atrioventricular tricuspid regurgitation were measured. The degree of tricuspid regurgitation is divided into four (0–III grade), 0: no regurgitation; grade I: tricuspid regurgitation beam confined to the mouth; grade II: reflux of right atrial central; grade III: reflux beam up to the superior vena cava opening. After right atrial, right ventricular diastolic diameter was significantly reduced compared with the preoperative, preoperative/postoperative right atrial size of 6.3±1.0 cm/4.8±0.9 cm ($P < 0.01$); preoperative/postoperative right ventricular size is 5.8±1.1 cm/4.9±0.7 cm ($P < 0.01$). Postoperative tricuspid regurgitation were 0–I level than before surgery significantly reduced. Follow-up of 3–18 months, mean (6.2±2.7) months. Follow-up found one case of tricuspid regurgitation increased by the Class I to Class II, but had no effect on right ventricular function.
Conclusions: autologous pericardium plasty of the tricuspid annulus reinforcement of clinical observations, the significant effect of surgery, postoperative right atrial, ventricular cavity was significantly reduced, tricuspid regurgitation improved significantly.

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MID-TERM RESULTS OF TRICUSPID VALVULOPLASTY OF GRADE I TRICUSPID REGURGITATION WITH LEFT-SIDED VALVULAR HEART DISEASE
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Objective: Nowadays, surgical treatment is highly recommend-edeven for themild tricuspid regurgitationwith left-sided valvular