gave no information about any liver problem and no screening for hepatic function was performed by this time. There was no symtom or sign of congestive heart failure in the preoperative period.
Results: The patient underwent coronary artery bypass grafting procedure. Laboatory findings on postoperative 1st day and 2nd day revealed elevated liver function tests (AST 1430, ALT 880, LDH 3360 and AST 6680, ALT 2600, LDH 9150, respectively). The patient died on the 2nd postoperative day due to fulminant hepatic failure and metabolic encephalopathy. Postoperative period was highly progressive with aggressive worsening of hepatic functions which caused multi organ failure and eventually death.
Conclusions: Fulminant hepatic failure is a rare condition seen after open heart surgery is constantly progressive and fatal. Preoperative HbsAg positivity should be taken under consideration as a strict risk factor. Careful preoperative evaluation should be performed and HbsAg positivity should force the doctors to eveluate liver function in detail. To minimize fulminant hepatic failure, further efforts should focus on off-pump surgery, shorter X-clamp time, shorter cardiopulmonary bypass time, avoidance of potential hepatotoxic medication.

PP-266
SURGICAL MANAGEMENT OF INFECTED RIGHT ATRIAL THROMBUS RELATED TO TEMPORARY UNTUNNELLED HEMODIALYSIS CATHETER IN END-STAGE RENAL DISEASE

A.I. Rezk. *King Fahad Military Hospital, Jeddah, Saudi Arabia*

Temporary untunnelled haemodialysis catheters for vascular access are regularly used for haemodialysis in patients with end-stage renal disease. In our hospital as elsewhere worldwide, the use of such catheters is more widely used than tunneled catheters in patients with renal failure planned for dialysis prior to forming an arterio-venous shunt. The preferred site for a temporary catheter is the jugular vein with its tip in the right atrium. Sizable right atrial thrombus with infection on top was recorded in fife cases over the past four years period.
All these cases were successfully managed with surgical approach. We describe our experience with these infected right atrial thrombus that were detected by echocardiography.

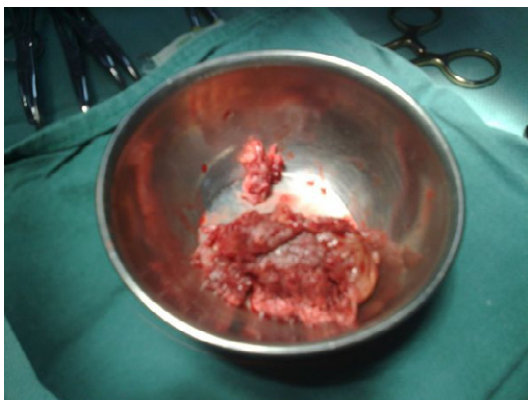

Figure: Right atrial mass.

PP-270
AN INTERVENTRICULAR SEPTUM RUPTURE PRESENTING WITH CARDIAC TAMPONADE: DIAGNOSIS AND TREATMENT

C. Amarelli[1], M. Buonocore[2], D. Avitabile[2], A. Carozza[1], A. Nunziata[2], G. Romano[1], C. Maiello[1], M. Scardone[1]. *[1]Department of Cardiovascular Surgery and Transplants, Monaldi Hospital, Naples, Italy; [2]Department of Cardiothoracic and Respiratory Sciences, Second University of Naples, Italy*

Objective: Treatment of Posterior Interventricular Rupture is really challenging.
Despite the evolution of tecniques of repair the incidence of postoperative shunt is still high and the residual myocardial function after surgery is poor.
Methods: A young patient was referred to our istitution with a low output syndrome due to AMI with a cardiac tamponade.
The Trans-thoracic ECHO showed a massive interventricular septum rupture localized in the posterior part of septum and very poor myocardial function.
Results: Due to the very poor myocardial contractility the patient underwent central ECMO implantation and application of a fibrin sealant on the right venticular wall as bridge to decision or recovery. Revascularization was not feasible due to a diffuse atherosclerotic pathology of Right Coronary and Interventricular posterior artery.
The patient was estubated after 5 hours. After 5 days of stable ECMO support, in absence of recovery of any myocardial contractility, the patient underwent cardiac tranplantation.
On day 22 the patient was discharged in good clinical conditions.
Conclusions: Posterior Interventricular Septum Rupture is associated with an extensive myocardial necrosis; recovery of a sufficient myocardial contractility may be unlikely also after an effective repair of the ruptured septum.
ECMO positioning as bridge to decision may be a good chance to warrant the best outcome to a challenging pathology.

Experiences in Medical and Surgical Management of Valvular Heart Disease

PP-271
SUCCESSUL REPLACEMENT OF MITRAL VALVE IN A PATIENT WITH ANTIPHOSPHOLIPID SYNDROME

S. Gürkan[1], Ö. Gür[1], D.Ö. Gür[3], C. Arar[1], T. Ege[2]. *[1]Department of Cardiovascular Surgery, Namık Kemal University, Tekirdağ, Turkey; [2]Department of Cardiovascular Surgery, Trakya University, Edirne, Turkey; [3]Department of Cardiology, State Hospital, Tekirdağ, Turkey*

Objective: Primary antiphospholipid syndrome is defined by the presence of antiphospholipid antibodies, venous or arterial thrombosis, recurrent fetal abortion, and thrombocytopenia in the absence of systemic lupus erythematosus (SLE) or any other disease. In fact these antibodies have been found in about 5% of healthy population
Methods: We report a 51 year-old patient with the diagnosis of mitral insufficiency was admitted to hospital for surgical treatment. Four years ago primary antiphospholipid syndrome (PAPS) had been diagnosed, and a history of thrombocytopenia.
Results: Mitral valve replacement was successfully performed with postoperative strict anticoagulant therapy and postoperative course was uneventful. Cardiac surgery in APS patients has been reported with high morbidity and mortality. It is very important to initiate anticoagulant therapy immediately after the operation to prevent thrombosis.
Conclusions: Although appropriate care with aggressive anticoagulation and close monitoring can significantly reduce complications, the risk of thromboembolism still remains high and is the major cause of perioperative morbidity and mortality in this population. There have been no large studies with newer anticoagulants such as direct thrombin inhibitors (lepuridin, argatroban, etc.) and factor X-A inhibitors (Fondoparinux).
A careful follow-up including close monitoring of the anticoagulation therapy is mandatory in PAPS. It is very important to initiate anticoagulant therapy immediately after the operation to prevent thrombosis.