Figure 1. Aortic regurgitation as seen on apical 5-chamber view on echocardiogram in colour Doppler mode.

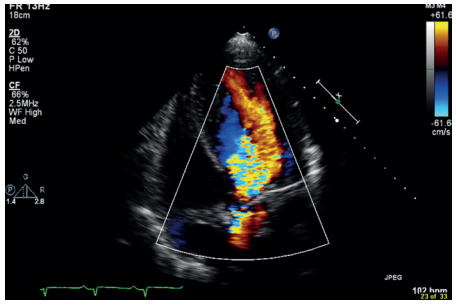
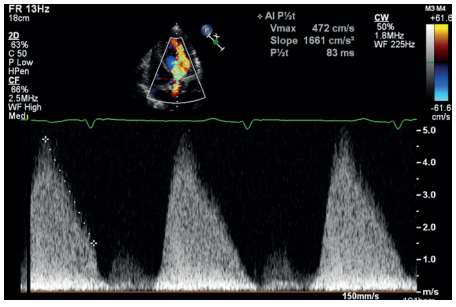


Figure 2. Continuous wave Doppler with pressure half-time of 83 ms – quantifying aortic regurgitation as severe.



noted an ostial stenosis at the right coronary artery with left-sided arteries unobstructed.

Cardiovascular syphilis should be considered as a diagnosis in new onset aortic regurgitation, especially when present in combination with coronary ostial stenosis. A simple blood test can provide a timely diagnosis and early treatment with antibiotics and/or aortic valve replacement will help prevent accelerated aortic regurgitation with irreversible damage and subsequent heart failure. Unfortunately this patient presented late, when degeneration of the aortic root and valve was extensive. The patient refused surgery because of procedural risk and despite diagnosis and treatment of syphilis, he died. BJHM

LEARNING POINTS

- New cardiac valve pathologies should be investigated for an underlying cause before changes are considered to be age-related. A thorough history is needed to guide the clinician in investigation and an open mind must be kept to include rare causes in the differential diagnosis.
- At times, rare pathologies can be easily managed. Early diagnosis of such pathologies will result in early treatment and thus better prognosis.
- Cardiovascular syphilis should be considered in a case of new aortic regurgitation, especially combined with coronary ostial stenosis on angiography.

Golden MR, Marra CM, Holmes KK (2003) Update on syphilis: resurgence of an old problem. *JAMA* **290**(11): 1510–1514. https://doi.org/10.1001/jama.290.11.1510

Roberts WC, Ko JM, Vowels TJ (2009) Natural history of syphilitic aortitis. *Am J Cardiol* **104**(11): 1578–1587. https://doi.org/10.1016/j.amjcard.2009.07.031

Saraiva RS, César CA, Mello MA (2010) Syphilitic aortitis: diagnosis and treatment. Case report. *Rev Bras Cir Cardiovasc* **25**(3): 415–418. https://doi.org/10.1590/S0102-76382010000300021

Tanaka M, Okamoto M, Murayama T (2016) A case of acute myocardial infarction due to cardiovascular syphilis with aortic regurgitation and bilateral coronary ostial stenosis. *Surgical Case Reports* **2**(1): 138. https://doi.org/10.1186/s40792-016-0267-x

Giant liver cyst causing haemodynamic instability

An otherwise healthy 56-year-old woman presented acutely with multiple episodes of loss of consciousness, breathlessness, cyanosis and tachycardia. She was acutely hypoxic, with blood oxygen saturation of 84% on 15 litres high flow oxygen.

On computed tomography pulmonary angiography there was no haemodynamically significant pulmonary embolism, but a giant, simple-appearing liver cyst causing significant pressure effect (*Figure 1*), as confirmed by echocardiogram. The patient improved clinically following drainage of the cyst.

Symptomatic cysts can cause right upper quadrant pain, nausea and vomiting (Kanai et al, 1999), portal hypertension and biliary stasis (Ishikawa et al, 2002). Pressure over the inferior vena cava can lead to thrombosis with lower limb oedema, and very rarely a pulmonary embolism (Buyse et al, 2004).

This rare presentation of a common disease can be added to the wide range of common and rare presentations of simple liver cysts. BJHM

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Buyse S, Asselah T, Vilgrain V et al (2004) Acute pulmonary embolism. *Eur J Gastroenterol Hepatol* **16**(11): 1241–1244. https://doi.org/10.1097/00042737-200411000-00026

Ishikawa H, Uchida S, Yokokura Y et al (2002) Nonparasitic solitary huge liver cysts causing intracystic hemorrhage or obstructive jaundice. *J Hepatobiliary Pancreat Surg* **9**(6): 764–768. https://doi.org/10.1007/s005340200107

Kanai T, Kenmochi T, Takabayashi T et al (1999) Obstructive jaundice caused by a huge liver cyst riding on the hilum: report of a case. *Surg Today* **29**(8): 791–794. https://doi.org/10.1007/BF02482330

Figure 1. **a**. Axial, (**b**) coronal and (**c**) sagittal contrast-enhanced computed tomography of the abdomen and pelvis in the portal venous phase showing a giant simple liver cyst replacing the right lobe of the liver and causing pressure effect. Note the ill-defined hypodensities at the left lobe of the liver (black arrows, **a**) as a result of hypoperfusion. Compression of the right lung, right side of the heart and inferior vena cava and displacement of the right kidney also seen.