Abnormal Fetal Heart Videos

Hypoplastic Left Heart Syndrome (HLHS).

Ebstein Anomaly.

Tetralogy of Fallot (TOF).

Isolated Ventricular Septal Defect.

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Rhabdomyoma.

Hypoplastic Left Heart Syndrome (HLHS).

https://obimages.net/wp-content/uploads/2013/08/HLHS1.mp4

Above. Hypoplastic Left Heart Syndrome (HLHS). Basal four chamber view demonstrating HLV (hypoplastic left ventricle). Note larger RV (right ventricle) and RA (right atrium). The echogenic portion of the left ventricular wall suggests EFE (endocardial fibroelastosis).

https://obimages.net/wp-content/uploads/2013/08/HLLH2color.mp4

Above. HLHS. Basal four chamber view. Color Doppler. Note the hypoplastic LV (left ventricle) and the larger RV (right ventricle) as well as the RA (right atrium) and the TV (tricuspid valve).

https://obimages.net/wp-content/uploads/2013/08/CriticalAS.mp4

Above. Critical Aortic Stenosis – precursor to HLHS (Hypoplastic Left Heart Syndrome). Note the globular enlarged LV (left ventricle) and a thickened, atretic, dysplastic AV (aortic valve) as well as the AO (aorta).

https://obimages.net/wp-content/uploads/2013/08/CAS.Col_.Ao_..mp4

Above. Critical Aortic Stenosis – precursor to HLHS. Again, note the (GLV) globular left ventricle and the AO (aorta) arising from the atretic aortic valve. The PV (pulmonary valve) is seen entering the left atrium.

https://obimages.net/wp-content/uploads/2013/08/HLV.mp4

Above. HLHS. The HLV (hypoplastic left ventricle) is barely visible. The RV (right ventricle) is dominant.

https://obimages.net/wp-content/uploads/2013/08/DAtest2.mp4

Above. HLHS. Color Doppler. Vaginal View. Note the ductal arch.

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Ebstein Anomaly.

https://obimages.net/wp-content/uploads/2013/08/Ebstein.mp4

Above. Ebstein Anomaly. Note location of the LV (left ventricle). The RA (right atrium) is markedly enlarged compared to the LA (left atrium).

https://obimages.net/wp-content/uploads/2013/08/Ebstein2.mp4

Above. Ebstein Anomaly. Transverse four chamber view. Right atrial enlargement. Note the thickened, DTV (dysplastic tricuspid valve) and the small PV (pulmonary valve).

https://obimages.net/wp-content/uploads/2013/08/Eb4.mp4

Above. Ebstein Anomaly. Note the RV (right ventricle) and the LV (left ventricle)

and the large RA (right atrium). The thickened, dysplastic TV (tricuspid valve) divides the FRV (functional right ventricle) from the ARV (arterialized right ventricle).

https://obimages.net/wp-content/uploads/2013/08/EB.TR_.mp4

Above. Ebstein Anomaly. Color Doppler flow. Note the RV (right ventricle) and the enlarged RA (right atrium). Color Doppler suggests TR (tricuspid regurgitation).

https://obimages.net/wp-content/uploads/2014/07/TVDysplasia.mp4

Above. Tricuspid Valve Dysplasia. No displacement of the TV (tricuspid valve). RA= large right atrium, LV=left ventricle, RV=right ventricle.

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Tetralogy of Fallot (TOF).

https://obimages.net/wp-content/uploads/2014/01/tof4cv.vsd_..mp4

Above. Tetralogy of Fallot (TOF). Apical 4 chamber view. Note the RV (right ventricle) and the LV (left ventricle) and the presence of a VSD (ventricular septal defect). The AV (atrioventricular) valves are linear in this case.

https://obimages.net/wp-content/uploads/2014/01/tof.ov_..mp4

Above. TOF. Again, note the RV (right ventricle) and the LV (left ventricle). Also note the VSD and the large OA (overriding aorta).

https://obimages.net/wp-content/uploads/2014/01/TOF.oA_.VSD_..mp4

Above. TOF. Aortic outflow with OA (overriding aorta). Note the AV (aortic valve) and the VSD (ventricular septal defect).

https://obimages.net/wp-content/uploads/2014/01/TOF.RVOT_.mp4

Above. TOF. Color Doppler. RVOT (right ventricular outflow tract). Note the MPA (main pulmonary artery) arising from the RV (right ventricle). There is mild stenosis of the PV (pulmonary valve).

https://obimages.net/wp-content/uploads/2014/01/TOF.dif_.4cv..mp4

Above. TOF. Apical four chamber view. Note the OA (overriding aorta) and the VSD (ventricular septal defect). The LV (left ventricle) and the RV (right ventricle) are of similar size.

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Isolated Ventricular Septal Defect.

https://obimages.net/wp-content/uploads/2014/01/FN.-VSDMem.Tri18.mp4

Above. Isolated Ventricular Septal Defect. Basal four chamber view. Membranous VSD in a patient with Trisomy 18.

https://obimages.net/wp-content/uploads/2014/01/FN.MusculVSD.mp4

Above. Isolated VSD. Transverse view. Muscular defect in the lower one third of the interventricular septum.

https://obimages.net/wp-content/uploads/2014/01/VSDnone.mp4

Above. No VSD evident. Color Doppler. No color bleed noted across interventricular septum during diastole.

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Atrioventricular Septal Defect (AVSD).

https://obimages.net/wp-content/uploads/2013/12/AVSDtri21.mp4

Above. Atrioventricular Septal Defect (AVSD). Apical four chamber view. Note the common linear AV valves and the AV defect in diastole.

https://obimages.net/wp-content/uploads/2013/12/asvd.dia_.colortri..mp4

Above. AVSD. Apical four chamber view in color Doppler. Note the common AV valve allowing biventricular inflow during diastole.

https://obimages.net/wp-content/uploads/2013/12/AVCD1.mp4

Above. Complete AVSD. Note the flat, common AV valve and the central AV canal

defect.

https://obimages.net/wp-content/uploads/2013/12/AVCD.MN_.mp4

Above. Complete AVSD. Note the flat, common AV valve and central AV canal defect.

https://obimages.net/wp-content/uploads/2013/12/UnbalAVC..mp4

Above. Unbalanced AVSD. Apical four chamber view. Note the dissimilarity in size between the ventricles, the common AV valve, and the AV canal defect.

https://obimages.net/wp-content/uploads/2013/12/Unbal.AVSD_.mp4

Above. Unbalanced AVSD. There is a common AV valve which allows the inflow into both ventricles during diastole. Note the smaller LV (left ventricle) compared to the RV (right ventricle) accommodating less LV inflow.

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Coarctation of the Aorta (COA).

https://obimages.net/wp-content/uploads/2014/01/COA.1.mp4

Above. Coarctation of the Aorta (COA). Mild coarctation of the aorta at 25 weeks. Sagittal view of the aortic arch. Note narrowing in the Isthmus distal to the subclavian artery.

https://obimages.net/wp-content/uploads/2014/01/COA.Vent_.size_.mp4

Above. COA. Apical four chamber view. Note the LV (left ventricle) is more narrow than the RV (right ventricle).

https://obimages.net/wp-content/uploads/2014/01/COA.mp4

Above. COA. Sagittal view of the aortic arch. Color flow Doppler. Note narrowing of the aortic arch in the area of the isthmus.

https://obimages.net/wp-content/uploads/2014/01/HAA.mp4

Above. Hypoplasia of the Aortic Arch. The DA (descending aorta) is normal. The dimension in the area of narrowing is 2.2 mm.

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Aortic Stenosis.

https://obimages.net/wp-content/uploads/2014/01/AS.mp4

Above. Aortic Stenosis. Note post stenotic dilatation of the ascending aorta with narrowing of the aortic arch. The head neck vessels are visible and the caliber of the descending aorta is normal.

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Pulmonary Stenosis.

https://obimages.net/wp-content/uploads/2014/01/1.PSV_.mp4

Above. Pulmonary Stenosis. Patient 1. Video 1. Four chamber apical view. Note hypertrophy of the RV (right ventricle) and the normal LV (left ventricle) with mild dilatation of the RA (right atrium). The tricuspid valve between the RA and the RV is thick and dysplastic.

https://obimages.net/wp-content/uploads/2014/01/2.PS_.MPA_.mp4

Above. Pulmonary Stenosis. Patient 1. Video 2. Apical four chamber view with right outflow tract. Note RV (right ventricle) hypertrophy and post-stenotic dilatation of the MPA (main pulmonary artery).

https://obimages.net/wp-content/uploads/2014/01/3.PS_.color_.mpa_.mp4

Above. Pulmonary Stenosis. Patient 1. Video 3. Apical four chamber view with right outflow tract. Color Doppler. Note RV (right ventricle) hypertrophy and post-stenotic dilatation of the MPA (main pulmonary artery).

https://obimages.net/wp-content/uploads/2014/01/1PSV1.mp4

Above. Mild Valvular Pulmonary Stenosis. Patient 2. Video 1. Note the dysplastic PV (pulmonary valve) and mild post-stenotic dilatation of the MPA (main pulmonary artery).

https://obimages.net/wp-content/uploads/201

4/01/2.PVmot_.mp4

Above. Mild Valvular Pulmonary Stenosis. Patient 2. Video 2. Note the dysplastic PV (pulmonary valve) and mild post-stenotic dilatation of the MPA (main pulmonary artery).

https://obimages.net/wp-content/uploads/2014/01/V1.4cv.pul_.st_.mp4

Above. Pulmonary Valvular Stenosis. Patient 3. Video 1. Apical four chamber view in pulmonary valvular stenosis showing hypertrophy of the RV (right ventricle) and dilatation of the RA (right atrium).

https://obimages.net/wp-content/uploads/2014/01/V2.RVOT_.PS_.mp4

Above. Pulmonary Valvular Stenosis. Patient 3. Video 2. Pulmonary valvular stenosis showing both inlet and outlet view. Note the TV (tricuspid valve) and the RV (right ventricle). The outlet view is also seen with the PV (pulmonary valve) with the entrance into the mildly dilated MPA (main pulmonary artery) and its division into the RPA (right pulmonary artery) and the DA (ductus arteriosus). Note the proximity of the Ao (ascending aorta) to the PV (pulmonary valve).

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Tricuspid Valve Abnormalities.

https://obimages.net/wp-content/uploads/2014/01/Video-1.-TR.AT_.he_.Outflow.mp4

Above. Tricuspid Dysplasia. Patient 1. Video 1. Five vessel view. Note the LVOT (left ventricular outflow tract) with the MV (mitral valve) and the aorta arising from the LV (left ventricle). The small, dysplastic RV (right ventricle) is illustrated.

https://obimages.net/wp-content/uploads/2014/01/Video-2.-TRAT1.mp4

Above. Tricuspid Atresia. Patient 1. Video 2. Four chamber view. The dysplastic TV (tricuspid valve), a large VSD, and a small RV (right ventricle) are seen. Note the LVOT (left ventricular outflow tract) and the RVOT (right ventricular outflow tract).

https://obimages.net/wp-content/uploads/2014/01/mit.tri_.regur_.mp4

Above. Tricuspid Regurgitation. Patient 2. Video 1. Color Doppler. Note the LV (left ventricle) and the RV (right ventricle). Color is towards the transducer during diastolic cardiac filling.

https://obimages.net/wp-content/uploads/2014/01/V1.TA2_.mp4

Above. Tricuspid Valve Dysplasia. Patient 3. Video 1. Note the LV (left ventricle) and the thickened, dysplastic TV (tricuspid valve);. The RV (right ventricle) is hypoplastic.

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Double Outlet Right Ventricle (DORV).

https://obimages.net/wp-content/uploads/2014/01/V1.DORV_.mp4

Above. Double Outlet Right Ventricle (DORV). Note the RV (right ventricle) and the PA (pulmonary artery) identified by branching. The aorta is parallel and to the right of the PA.

https://obimages.net/wp-content/uploads/2014/01/V1.DORV_.V3.k.mp4

Above. DORV. Basal four chamber view. Note the RA (right atrium) and the VSD (ventricular septal defect) as well as the parallel great vessels, the AO (aorta) and the PA (pulmonary artery).

https://obimages.net/wp-content/uploads/2014/01/V2.DORV4A.mp4

Above. DORV. Basal four chamber view. Again, note the VSD (ventricular septal defect) as well as the parallel great vessels, the AO (aorta) and the PA (pulmonary artery) arising from the RV (right ventricle).

https://obimages.net/wp-content/uploads/2014/01/V3.DORV2_.vkl_.mp4

Above. DORV. Parasaggital view. Note the anterior AO (aorta) and PA (pulmonary artery), both arising from the right ventricle. Note the inlet to the right ventricle with the TV (tricuspid valve) marked.

https://obimages.net/wp-content/uploads/2014/01/V4.DORV_.mp4

Above. DORV. Another parasagittal view. Color Doppler. Note the anterior AO (aorta) and PA (pulmonary artery), which are both arising from the RV (right ventricle).

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Dextro Transposition of the Great Arteries (D-TGA).

https://obimages.net/wp-content/uploads/2014/01/V1.D-TGA.r.mp4

Above. Dextro-Transposition of the Great Arteries (D-TGA). Patient 1. Video 1. Five chamber view. Note the LV (left ventricle) and the RV (right ventricle). Note the PA (pulmonary artery) arises from the LV and the AO (aorta) arises from the RV. Note the branching of the PA (pulmonary artery). The parallel nature of the great arteries can also be seen.

https://obimages.net/wp-content/uploads/2014/01/V2.BR_.PA_.r.mp4

Above. D-TGA. Patient 1. Video 2. Five chamber view. Note the PA (pulmonary artery) arising from the LV (left ventricle) and note the PA branching, which is key to identifying the pulmonary artery.

https://obimages.net/wp-content/uploads/2014/01/V3.AO_.RV_.r.mp4

Above. D-TGA. Patient 1. Video 3. Five chamber view. Note the AO (aorta) as it arises from the RV (right ventricle).

https://obimages.net/wp-content/uploads/2014/01/V4Para.dtga_.r.mp4

Above. D-TGA. Patient 1. Video 4. Parasagittal view. The AO (aorta) can be defined by the HNV (head and neck vessels). Note that the AO is the anterior vessel which is usual in D-TGA. The PA (pulmonary artery) and the AO are parallel. A portion of the inflow anatomy is also seen with the RA (right atrium), the RV (right ventricle), and the intervening tricuspid valve.

https://obimages.net/wp-content/uploads/2014/01/V5.col_.dopDtga.r.mp4

Above. D-TGA. Patient 1. Video 5. Color Doppler. Note the parallel arrangement of the PA (pulmonary artery) and the AO (aorta).

https://obimages.net/wp-content/uploads/2014/01/V1.FN_.V1.GTA_.mp4

Above. D-TGA. Patient 2. Video 1. The left and the right ventricles are labeled. The PA (pulmonary artery) is arising from the LV (left ventricle) and the AO (aorta) is arising from the RV (right ventricle). The pulmonary artery branching can be seen.

https://obimages.net/wp-content/uploads/2014/01/V2.GTA2_.mp4

Above. D-TGA. Patient 2. Video 2. Similar views from above video. Note the relationship between the PA (pulmonary artery) and the LV (left ventricle).

https://obimages.net/wp-content/uploads/2014/01/V3.AX_.View_.mp4

Above. D-TGA. Patient 2. Video 3. Transverse views demonstrating the LV (left ventricle) and the RV (right ventricle). The PA arises from the LV and the AO arises from the RV. Note the parallel arrangement of the great vessels. The PA has been defined by its branching.

https://obimages.net/wp-content/uploads/2014/01/V4.TGA_.mp4

Above. D-TGA. Patient 2. Video 4. Sagittal aortic arch view. Note the HNV (head and neck vessels) defining the AO (aorta), which is anterior to the PA (pulmonary

artery).

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Congenitally Corrected Transposition of the Great Arteries (CC-TGA).

https://obimages.net/wp-content/uploads/2014/01/V1.CC-TGA.mp4

Above. Congenitally Corrected-Transposition of the Great Arteries (CC-TGA). Apical four chamber view demonstrating the RV (right ventricle) on the fetal left side and the LV (left ventricle) on the fetal right side. The PA (pulmonary artery) arises from the LV (left ventricle) and the AO (aorta) arises from the RV (right ventricle).

https://obimages.net/wp-content/uploads/2014/01/V2.cc-tga2.mp4

Above. CC-TGA. Similar views show in detail the PA (pulmonary artery) arising from the LV (left ventricle) and the AO (aorta) arising from the RV (right ventricle).

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Heterotaxy.

https://obimages.net/wp-content/uploads/2014/01/1.Heterocompl1.mp4

Above. Complex cardiac malformations with arrhythmia (Complete Heart Block). Patient 1. Video 1. 20 weeks. Heart findings include a hypoplastic LV (left ventricle) and a large RV (right ventricle) and RA (right atrium). Note retrocardiac vascular structures: the AO (aorta) and the AZ (azygous vein).

https://obimages.net/wp-content/uploads/2014/01/2.InterI.mp4

Above. Interrupted Inferior Vena Cava (Interrupted IVC) with azygous continuation. Patient 1. Video 2. Note the parallel vessels with the AZ (azygous vein) inferior to the DA (descending aorta).

https://obimages.net/wp-content/uploads/2014/01/redo.mp4

Above. Abdominal Situs Inversus. Patient 2. Video 1. The fetal stomach is on the fetal right side and the fetal liver is on the left side. However, the cardiac apex points to the left side as usual.

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Hypertrophic Cardiomyopathy (HCM).

https://obimages.net/wp-content/uploads/2014/02/V1P1.-HCM.mp4

Above. Hypertrophic Cardiomyopathy (HCM). Patient 1. Video 1. Etiology unknown. Note myometrial wall thickening of both the LV (left ventricle) and the RV (right ventricle).

https://obimages.net/wp-content/uploads/2014/02/V2P1.mp4

Above. HCM. Patient 1. Video 2. Etiology unknown. Note RVW (right ventricular wall) thickening.

https://obimages.net/wp-content/uploads/201

4/02/V3P2.mp4

Above. HCM. Patient 1. Video 3. Hypertrophic cardiomyopathy in recipient fetus of twin to twin transfusion syndrome probably due to volume overload. There is LVH (left ventricular hypertrophy) and RVH (right ventricular hypertrophy). Hydramnios is present in the recipient fetus. Note the thin monochorionic membrane.

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Idiopathic Dilated Cardiomyopathy.

https://obimages.net/wp-content/uploads/2014/01/V1.DCM_.mp4

Above. Idiopathic Dilated Cardiomyopathy. Patient 1. Video 1. Idiopathic Dilated Cardiomyopathy demonstrating dilatation of the LV (left ventricle) and LA (left atrium). Note last dilatation of the RV (right ventricle) and RA (right atrium).

https://obimages.net/wp-content/uploads/2014/01/DCM.MV_.mp4

Above. Idiopathic Dilated Cardiomyopathy. Patient 1. Video 2. Color Doppler. Note the massively dilated LV (left ventricle) and LA (left atrium). Note also the position of the MV (mitral valve) demonstrating mild mitral regurgitation.

https://obimages.net/wp-content/uploads/2014/01/dcm.rvo_.mp4

Above. Idiopathic Dilated Cardiomyopathy. Patient 1. Video 3. Color Doppler. Right ventricular outflow tract. Note the RV (right ventricle) and the PA (pulmonary artery).

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Single Ventricle (SV).

https://obimages.net/wp-content/uploads/2014/02/1.DILV_.mp4

Above. Single Ventricle (SV). Patient 1. Video 1. 21 weeks. Double inlet left ventricle. Note 2 AV (atrioventricular) valves and the truncus arteriosus (TA). The PA (pulmonary artery) arises from the TA (truncus arteriosus).

https://obimages.net/wp-content/uploads/2014/02/2.SV_.TA_.mp4

Above. Single Ventricle (SV). Patient 1. Video 2. 21 weeks. Note the SV (single ventricle) and the TA (truncus arteriosus). Also note the PA (pulmonary artery) arising from the TA (truncus arteriosus).

https://obimages.net/wp-content/uploads/2014/02/1.SV_.SL_.mp4

Above. Single Ventricle (SV). Patient 2. Video 1. 33 5/7 weeks. Single Ventricle (SV) physiology: Severe hypoplasia of the left ventricle, large right ventricle, and common AV valve.

To List of Cardiac Videos

Rhabdomyoma.

https://obimages.net/wp-content/uploads/2014/02/Rhab.1.mp4

Above. Rhabdomyoma. Large, ovoid, echo dense intracardiac mass. Origin appears from the left ventricular wall. A rim of fluid surrounds the heart.

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