CONCLUSION

Tricuspid regurgitation is present in 90 - 95% of patients with pulmonary hypertension, Doppler echocardiography exhibit high sensitivity and high specificity as a non - invasive assessment of tricuspid regurgitation. By applying the modifie Bernoulli equation, we can estimate the right ventricular systolic pressure .

Clinically; estimation of right atrial pressure is not necessary to achive accurate results in patients without right ventricular outflow tract obstruction, the estimated right ventricular systolic pressure also predicts the pulmonary artery systolic pressure on the basis of Doppler catheters correlative study in a large number of patients. we suggest that continuos wave Doppler echocardiography is an accurate non - invasive technique for the estimation of pulmonary artery systolic pressure in patients with wide spectrum of cardiac lesions .

In the absence of Tricuspid regurgitation jet, by Doppler as in cases of sever pulmonary hypertention. There is another non - invasive methods to predict the PASP by pulmonary flow acceleration time recorded by pulsed Doppler .Although, The pulmonary flow acceleration time is valueless to evaluate PASP ***(Okamoto et al., 1984)***.

M-Mode echocardiography as a possible non- invasive alternative methods, was studied by in 20 patients with pulmonary hypertention.

The interval from the Q wave of the electrocardiogram (ECG) to the mitral valve closure on mitral valve .M-mode echocardiogram (Q-MVC) the interval between the aortic valve closure and mitral valve E point (AVC - E) on aortic and mitral valve. M-mode ECG respectively and the ratio of there intervals (Q-MVC / AVC-E) was correlated to the mean PASP measured at catheterization ($r = 0.89$, $P < 0.001$) ***(Sharma et al., 1994)*** .