An unusual cause of chest pain

INTRODUCTION
A 19-year-old male patient with a history of asthma was in good health until he developed a sudden-onset, right side pleuritic chest discomfort and shortness of breath. At that time, he was on a cruise to Puerto Rico. He returned home 1 week later and was evaluated in the emergency room at that time. On further history, he denied cough, fever, chills, night sweats, weight loss, sputum production, haemoptysis or other symptoms. He did not recall recent sick contacts or exposure to tuberculosis. He was born in the USA and this cruise was his only recent travel.

Figure 1  (A) Chest radiograph showing significant mediastinal shift and volume loss on the right side, with prominent vascular markings only seen on the right side. (B) Chest CT scan showing right-sided volume loss with hypolucency, prominent right interstitial markings, subsegmental atelectasis, very small right pleural effusion and small right hilar and mediastinal adenopathy.

REFERENCES

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the tissue is such that we were unable to have an equal age distribution. We also acknowledge that the three age groups are made up of subjects from different areas, and that these are not longitudinal data. Despite the above limitations, we consider the large number of subjects, whose deaths were not respiratory related, and the wide age range included provides a strong basis for establishing the time of appearance and pattern of thickening that occurs to the bronchial RBM, and its positive relationship with epithelial height, during normal development. These data indicate that future paediatric and adult biopsy studies assessing RBM thickness should include age-matched controls.

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Competing interests None.

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history of lung or cardiovascular disease. Tachycardia was the only abnormality on his physical examination, and initial laboratory testing were completely normal. His pulse oximetry measurement was 97% O₂ saturation on room air at rest. His ECG was consistent with sinus tachycardia, with a rate of 108/min and no ST–T wave changes. He was admitted to the hospital for further investigation of his chest pain.

His chest radiograph (figure 1A) and chest CT scan (angiogram protocol) (figure 1B) were abnormal but showed no evidence of pneumothorax or pulmonary embolism. A small unilateral pleural effusion was present but was too small to sample using bedside ultrasonography. All subsequent blood tests in the hospital including cardiac enzymes, immunoglobulins levels and vasculitis screen were all unremarkable. The chest x-ray and CT scan were remarkable for the predominance of right-sided findings with relative sparing of the left side. This suggested the possibility of unilateral interstitial lung disease. Therefore, the patient underwent bronchoscopy to further narrow the differential diagnosis. Airway examination revealed prominent submucosal blood vessels with mucosal oedema and hyperaemia involving the surface of the right side airways with complete sparing of the left side airways. The biopsies revealed interstitial oedema and early fibrotic changes (figure 2A,B). On further review of the CT scan, an extraneous septum within the left atrium was noted and the diagnosis was made (figure 3).

**QUESTION**

What is the diagnosis?

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ANSWER

From the question on page 285

This is an unusual case of cor triatriatum sinistrum with secondary unilateral pulmonary venous hypertension and right lung hypoplasia. The interstitial changes in the parenchyma were secondary to a state of chronic congestion as a result of reduced interstitial fluid drainage due to elevated pressures in the right pulmonary vein. Our biopsy specimens highlight how persistent interstitial oedema can result in chronic inflammation and the development of interstitial fibrosis. The enlarged mediastinal lymph nodes were probably hyperplastic and the gross findings on bronchoscopy reflected compensatory hypertrophy of the bronchial circulation draining into the right pulmonary vein.

Transoesophageal echocardiogram revealed a membrane in the left atrium (LA), preferentially obstructing the right pulmonary venous inflow. The obstruction was incomplete, and high velocity flow across the membrane suggested elevated right pulmonary venous pressure of 25–30 mm Hg (figure 4A,B). This was confirmed by cardiac MRI which showed asymmetric pulmonary blood flow, with ~15–20% more flow to the left lung than the right, with delay enhancement within the LA (figure 5). In our patient, despite the paucity of literature, surgical options were carefully considered. The patient underwent median sternotomy with surgical excision of the pulmonary vein membrane, and a 3-month follow-up confirmed improved cardiac function and reduced pulmonary venous hypertension.

Figure 4 (A) Echocardiogram: apical four-chamber view showing the septum (arrow) and extra atrial chamber (asterisk) (B) Echocardiogram: colour Doppler enhanced showing different flow velocities within the left atrium (arrow).

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improvement in the flow differential between the right and left pulmonary veins on MRI.

**DISCUSSION**

To our knowledge, this is the first report in the literature of a patient with unilateral pulmonary venous hypertension and unilateral hypoplastic lung related to an atypical cor triatriatum sinistrum. Therefore, it is very important to distinguish this unusual case from other reported cases of classic cor triatriatum sinistrum. Typically, all of the pulmonary venous drainage enters the proximal chamber and then crosses the septum through small fenestration(s) into the distal chamber (figure 7A). As a consequence, pulmonary venous hypertension (bilateral) develops and results in recurrent pulmonary oedema. This clinical syndrome resembles (and is frequently misdiagnosed as) congenital mitral stenosis. Surgical resection in these circumstances is the optimal therapeutic option.

In our patient, the intra-atrial septum separated the right from the left pulmonary veins, creating a small chamber in the left atrium that received left pulmonary venous return. This created significant isolated pulmonary venous congestion and pulmonary venous hypertension in the right lung with significant difference in pulmonary blood flow between the right and left lungs as demonstrated at cardiac MRI.

This case highlights the need to consider a cardiac aetiology in patients with prominent unilateral interstitial lung markings on chest x-ray or CT scan, and how echocardiography and cardiac MRI are valuable tools in the diagnosis and follow-up of such conditions. Surgical resection of the membrane appears to be the optimal treatment option for all age groups.


**REFERENCES**


