probably would have demonstrated sonolucency posterior to the posterior left atrial wall. This would suggest a cause other than pericardial effusion for the sonolucency.2

The right atrial angioangiogram demonstrated an irregular right atrial endocardial border and a 2-cm separation between the right cardiac border and right atrial wall. If the thickness of the separation on the cineangiogram does not change with cardiac action (the patient had a regular heart rate of 140 beats per minute, which, from the echocardiogram of the mitral valve, appeared to be sinus), then causes other than pericardial effusion should be considered.2 A description of the presence or absence of such fluid waves on angiograms would be of interest.

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To the Editor:

Sassé has raised an important point that deserves further comment. In performing our echocardiographic studies, we have routinely swept the posterior left atrial wall in the plane of the aortic and mitral valves; however, we have not routinely determined the superior extent of pericardial effusions posterior to the left atrium by employing stepwise reductions in gain in that region. As speculated by Sassé, retrospectively there appears to be an approximate 1-cm intrapericardial sonolucency posterior to the left atrial wall in echocardiographic recordings from that area (not shown in Figure 2 of our article1).

At necropsy, some intrapericardial tumor extended superiorly behind the left atrium, as shown in Figure 3 of our article.1 This correlates well with the echocardiographic appearance. After our case report was written, Feigenbaum stated that it is rare for pericardial effusion to extend behind the left atrial wall; however, he further stated that there is a small potential intrapericardial space behind the left atrium. Figure 15-6 of Feigenbaum’s textbook shows a small echo-free space posterior to the left atrium in a patient with a large pericardial effusion. That echocardiogram is essentially identical to that obtained in our patient. Furthermore, Lemire et al recently presented five cases with large pericardial effusions which extended superiorly behind the left atrium. Thus, it is possible to have superior extension of pericardial effusion behind the posterior left atrial wall.

I am not aware of any data concerning the incidence of this phenomenon, especially in patients with large pericardial effusions, as our patient appeared to have. Until such data are available, I think it would be premature to conclude that intrapericardial superior extension of sonolucency posterior to the left atrium would suggest some cause other than pericardial effusion. A possible exception might be that of sonolucency present only behind the left atrium. I would agree that the latter would be most unusual for pericardial effusion.

Finally, Millman et al have concurrently reported a very similar case of metastatic pericardial tumor mimicking pericardial effusion by echocardiographic studies. Their echocardiogram shows a sonolucent space posterior to the left ventricular epicardium. No mention is made whether the echo-free space extended superiorly behind the left atrium; however, as in our case, the pericardial space behind the left atrium appears to contain tumor in the specimen of the heart from autopsy.

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Pseudotumoral Mediastinal Mass Associated with Portal Hypertension

To the Editor:

With progressive portal hypertension, portosystemic collateral circulation develops, with major shunting into the azygos-hemiazygos venous system. Chest radiographic manifestations of this shunting include dilatation of the azygos vein, lobulated paravertebral venous densities, and displacement of the left paravertebral shadow by dilatation of the hemiazygos vein. This communication reports a pseudotumoral retrocardiac mass due to massive esophageal and paraesophageal collateral vessels, a rare and potentially deceptive finding not previously reported in the literature on the chest.

CASE REPORT

A 48-year-old man with no significant past medical history was evaluated for hypersplenism and an abnormal chest x-ray film. Except for mild splenomegaly, the findings from
physical examination were unremarkable. Chest fluoroscopic and radiographic studies (Fig 1A) demonstrated a large retrocardiac mass, which changed in size with position and with Valsalva's maneuver. Esophagogastroduodenoscopic examination and a barium esophagram demonstrated esophageal varices. A biopsy of the liver revealed postnecrotic cirrhosis.

Portal angiographic studies were performed by selective injection of high volumes of contrast material into the superior mesenteric and splenic arteries, with delayed filming. A subtraction print of the venous phase of the splenic arteriogram (Fig 1B) confirmed that the mass represented massive portosystemic collateral vessels of the esophageal and paraesophageal venous plexus.

**DISCUSSION**

Retrocardiac masses occur in less than 5 percent of persons with esophageal varices and typically appear as smoothly margined densities located centrally or on either side of the lower middle mediastinum. The vascular nature of the mass may be indicated by a decrease in size with Valsalva's maneuver or an enlargement on x-ray films obtained with the patient in the supine position. Indeed, the mass may be evident only on the supine examination. Furthermore, failure of the mass to diminish on erect studies might be expected when the portal venous pressure exceeds the erect hydrostatic pressure, whether this be secondary to portal venous thrombosis or other causes.

In all reported cases the barium esophagram has demonstrated the varices, and it is the preferred initial examination. Portal angiographic studies confirm the vascular nature of the mass, which may represent either a tangle mesh of many esophageal and paraesophageal veins or only several massively ectatic veins.

It is suggested that both supine and erect chest x-ray films should be obtained in cases of known or suspected portal hypertension and that this entity should be considered in the differential analysis of retrocardiac masses. Furthermore, as chest x-ray films have demonstrated disappearance of this mass following portosystemic shunting procedures, this examination would seem to be appropriate in the follow-up evaluation of the adequacy of the shunt.

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Chicken Soup

To the Editor:

Regarding chicken soup, I learned belatedly of this remarkable panacea featured more than two years ago in a mock serious report1 and subsequent correspondence in Chest. The soup’s active agent was said to be Bobamycin® (or, more commonly, bobamycin); and in this respect, I must claim priority. Eleven years ago, in a South African journal called Medical Proceedings (12:519, 1996), I published an account of bobamycin (literally “grandmother’s tales”), a most versatile cure-all; and in subsequent correspondence, it was disclosed that bobamycin had a chicken soup derivation. Most of my report was reprinted in the Journal of Irreproducible Results (17:42, 1968), and (would you believe it?) a sober abstract appeared in a Russian medical journal over the name of one M. Zabolotskay.

The fact that markedly similar lunatic constructions were penned independently in South Africa and the United States lends support to diffusionist (as opposed to autochthonous) theories of culture; the authors of the American spoof, like myself, are Litvaks, with origin in Lithuania (I was born there, in a village called Posvel).

As a mark of respect, let me conclude: my late mother’s chicken soup was unnatural.

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REFERENCE


A Simple Aid in the Catheterization of the Left Pulmonary Artery

To the Editor:

The Grollman pulmonary-artery-seeking catheter (Cook, Inc.) (Fig 1) has been recommended for pulmonary angiographic studies because of its increased safety and ease of use, as compared with other available catheters;1 however, we have occasionally encountered difficulty with the Grollman catheter when attempting to selectively catheterize the left pulmonary artery. Because of the secondary curve (designed to facilitate passage into the pulmonary outflow tract), the catheter often preferentially enters the right pulmonary artery. Taking advantage of the patient’s respiratory cycle may overcome this difficulty.

With the catheter placed in the main pulmonary artery, the patient is instructed to take a deep breath or cough. The leftward-pointing catheter is then advanced during deep inspiration or immediately after expiration. Apparently the slight change in the relationship of the main pulmonary artery and the left pulmonary artery during inspiration allows easier negotiation of the angle formed by these two vessels.

Analysis of a cine pulmonary arteriogram obtained during deep respiration showed that the main pulmonary artery descended slightly relative to the left pulmonary artery during inspiration. This descent decreases the acuteness of the angle between the two vessels.

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