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A patient had a history of right to left shunting through a patent foramen ovale without pulmonary hypertension. A right heart catheterization revealed a pulmonary to systemic flow ratio of 2.0:1. The patient was advised to undergo a balloon occlusion catheter for treatment.

In the present study, we employed a canine model to compare the effects of direct current shocks on myocardial and cardiac electrical variables. In the control group, a single 300-joule shock was administered. In the treatment group, a single 300-joule shock was administered after a 10-minute interval. The treatment group showed a significant decrease in myocardial injury compared to the control group.

A similar study was performed using a canine model to compare the effects of direct current shocks on myocardial and cardiac electrical variables. In the control group, a single 300-joule shock was administered. In the treatment group, a single 300-joule shock was administered after a 10-minute interval. The treatment group showed a significant decrease in myocardial injury compared to the control group.
the retrohepatic segment of the inferior vena cava (Fig 2). A balloon catheter was directed to the right atrium, then advanced through the septal defect into the left atrium under fluoroscopic guidance. The balloon was inflated with contrast medium and gently pulled back, occluding the defect. The ability of the inflated balloon to temporarily stop shunting was documented by oxymetric studies after closure of the foramen (Fig 3) and 100 percent oxygen breathing (Table 1).

Unfortunately, renal failure followed angiographic study and the patient died one month later despite intensive care follow-up. A large patent foramen ovale was seen at autopsy. A large eustachian valve was noted that could easily direct the blood flow from inferior vena cava into the left atrium.

**DISCUSSION**

The presence of cyanosis and right-to-left shunting in patients with atrial septal defect has traditionally been regarded as indicative of pulmonary hypertension. However, there have been case reports of right-to-left shunting at the atrial level without pulmonary hypertension either as a result of anomalies of systemic venous return or as a result of streaming of inferior vena caval blood flow into the left atrium across an atrial septal defect. Uncomplicated atrial septal defect may cause inconsequential streaming of blood flow from the vena cava through the defect; however, several reports have described significant right-to-left shunts at this level.

The anatomy of the inferior vena cava, the eustachian valve, or the septal defect may allow for marked right-to-left shunting in the absence of a pressure gradient or a mediastinal mechanical distortion. Similar right-to-left shunting cases have also been described after acute events that either reduce ventricular compliance or reduce left ventricular afterload.

However, lung resection has been recognized as the main cause of right-to-left shunting through a patent foramen ovale without pulmonary hypertension. A shift in the relationships of the inferior vena cava and interatrial septum...
entity is important because a definitive treatment is generally obtained after surgical correction.

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MRI of Askin's Tumor*

Case Report at 1.5 T

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This represents the first case of an Askin's tumor demonstrated on MRI. It showed a large pleural-based mass which trapped pleural fluid in large pseudotumors. The disease was unilateral and involved the mediastinum as well. Magnetic resonance imaging was helpful in demonstrating extrathoracic disease in the area of the right brachial plexus. (Chest 1990; 97:1252-54)

Askin's tumor is a separate clinicopathologic entity that is a primitive neuroectodermal tumor of the thoracopulmonary region.1 The histogenesis of this tumor remains uncertain.4,14 It is suspected to arise from intercostal nerves.14 Frequently, this entity presents as a chest wall mass, with rapid growth that may involve the pleura.5,7 It tends to occur in young females, it is seen almost exclusively in one hemithorax and commonly presents with local rib destruction.4

Case Report

A 20-year old black woman was admitted to the hospital after a two-month history of "cold" symptoms and a 13-pound weight loss. The patient's initial chest x-ray film showed a small pleural effusion. She was treated for pneumonia. Two weeks later, a repeat chest x-ray film revealed a much larger right pleural effusion (Fig

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