episodes of PLM. Although the exact pathogenesis of this patient’s PLM episodes is uncertain, the stress of breathing against CPAP may be a sufficient stimulus to the sympathetic nervous system to activate PLM. It is unclear whether inappropriate administration of excessive CPAP to patients with obstructive apnea induces PLM, but clinicians should recognize the potential for disrupting sleep with inappropriate CPAP administration.

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Disappearing Intracardiac Thrombi in Both Atria After Mumps in a Patient With Turner Syndrome*

Ali Bahni Bakiler, M.D.; Sukru Cangar, M.D.; Sudik Aksit, M.D.; Adnan Unver, M.D.; Isin Yaprak, M.D.; and Suat Caglayan, M.D.

A girl with Turner syndrome was admitted with an acute cerebrovascular occlusive disease 15 days after mumps infection. Imaging techniques such as Doppler echocardiography, computed tomography and angiography of the heart revealed the existence of masses in both atria. Eight days after the last radiologic study the patient had an operation, but no masses were found in either atrium. It was thought that atrial thrombi, probably formed after viral infection, had broken down to form emboli and disappeared. It is proposed that the patients with congenital cardiopathy should be regularly examined after viral infections for possible intracardiac thrombus formation. If such a mass is found and the decision is to operate, the existence of the mass must be confirmed even in the operating room just before intervention. (Chest 1993; 103:1611-12)

*From S. S. K. Tıpçık Teaching Hospital (Drs. Bakiler, Aksit, Unver, and Yaprak), State Pediatric Hospital Alsancak (Dr. Cangar), and Ege University Medical School (Dr. Caglayan), İzmir, Turkey.

Since the introduction of new imaging techniques such as two-dimensional echocardiography and tomography, diagnosis of intracardiac masses is no longer problematic. In addition to neoplasms and valvular vegetations,1 thrombi, which are often pedunculated,2,3 also are a cause of intracardiac masses. Because of the potential risk of pulmonary and systemic embolization1,4 these lesions must be surgically removed as early as possible after diagnosis. Due to the fragility of a thrombus, an intracardiac pedunculated mass may dissolve and totally disappear6 with or without signs of arterial obstruction.

CASE REPORT

A 9-year-old girl was admitted to Social Security Teaching Hospital with acute left-sided hemiplegia and right central facial paralysis. Fifteen days before the admission, she had mumps and 6 months previously she had a tonsillectomy while under general anesthesia without any bleeding problems.

She was born spontaneously after 34 weeks of gestation with a birth weight of 2,100 g. An echocardiographic study was performed at 2 years of age for the evaluation of a heart murmur and was reported to be normal. Her weight and height were below the third percentiles. Her neck was short and webbed. Cubitus valgus, widely spaced nipples and clinodactyly of the fifth finger were other findings, in addition to facial paralysis and left-sided hemiplegia.

Blood pressure in the right arm was 130/90 mm Hg, but peripheral pulse and blood pressure could not be determined in the left arm and in the lower extremities. Heart auscultation revealed a grade 2 to 3 systolic murmur along the left sternal border and in the back, between the left scapula and the spinal column. The existence of the Turner syndrome phenotype, the difference in blood pressure in the extremities, and the characteristic heart murmur on the back were suggestive of coarctation of the aorta proximal to the left subclavian artery. On a Doppler echocardiogram, a pedunculated mass 18 × 18 mm in size was noted in the left atrium, and another mass was suspected in the right atrium. The left atrial mass was limiting the movement of the posterior mitral cusps but was not obstructing the mitral valve. Computed tomography (CT) supported the existence of a right atrial mass as well as a pedunculated left atrial mass (Fig 1). Right heart catheterization 22 days after hospitalization confirmed the existence of the masses in both atria. Biochemical and routine coagulation studies were within normal limits except for high levels of gonadotropins and 45 XO chromosomal pattern. Brain CT showed changes probably secondary to arterial occlusions on the right side. Eight days after catheterization,
open-heart surgery was performed. After mediastinotomy, the aorta and vena cava inferior were cannulated, and systemic hypothermia (28°C) and cold cardioplegia were performed during the procedure. No masses were found in either atrium after bilateral atriotomy, but agenesis of the superior vena cava was found and the operation was terminated without intervention for coarctation. Ten days after the operation, a normal echocardiogram was obtained. The patient did fairly well and her neurologic deficit improved gradually.

**DISCUSSION**

We present an interesting case of disappearing intracardiac masses following mumps infection. This is the first report described in a child with Turner syndrome, since previously reported patients were all adults. The cause of the patient's referral was cerebral stroke probably originating from an embolus coming from intracardiac thrombus. It may be speculated that previously contracted mumps infection was a triggering factor for thrombus formation because it is known that viral infections can disturb platelet function. However, we could not discern any coagulation abnormalities, although we did not investigate platelet function. After the occurrence of a thrombus in such a patient, surgical intervention to remove it must be done immediately, because of the loose structure of the thrombus and because an active cardiac environment can give rise to the formation of emboli resulting in life-threatening obstructions of the arteries. It can be proposed that after a viral infection (mainly mumps?) any patient with congenital cardiopathy should be checked for intracardiac thrombus formation. Further, because intracardiac masses, mainly pedunculated ones, may dissolve and disappear during the time between the day of diagnosis and the day of the operation, the existence of the mass must be confirmed even in the operating room.

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**Agenesis of the Right Upper Lobe**

Francis P. V. Maesen, M.D., Ph.D., F.C.C.P.; Wiel H. Geraedts, M.D.; and Reginald Goel, M.D., Ph.D.

*From the Departments of Pneumology (Drs. Maesen and Geraedts) and Radiology (Dr. Goel), De Wever Hospital Heerlen, the Netherlands.

Reprint requests: Dr. Maesen, De Wever Ziekenhuis Heerlen 6419 PC, the Netherlands

Brachoscopy and bronchography revealed a very rare abnormality in the embryonal anatomy of the right bronchial tree in a 54-year-old woman with cough. There was a proximal migration of the apical branch of the right upper bronchus toward the trachea and a distal migration of the two other branches toward the middle lobe bronchus. The proximal migration was accompanied by a narrowing of the trachea. This case is considered an extremely rare embryonal variation in the development of the right bronchial tree.

(Chest 1993; 103:1612-14)