

Mechanisms of Platypnea-Orthodeoxia: What Causes Water to Flow Uphill?

To the Editor:

Platypnea-orthodeoxia is a relatively uncommon but striking clinical syndrome characterized by dyspnea and deoxygenation accompanying a change to a sitting or standing from a recumbent position. Since Burchell et al¹ described this rare syndrome over half a century ago, no more than 50 cases have been reported in the literature.²

Two conditions must coexist to cause platypnea-orthodeoxia: an *anatomical* component in the form of an interatrial communication and a *functional* component that produces a deformity in the atrial septum and results in a redirection of shunt flow with the assumption of an upright posture. The former may be an atrial septal defect, a patent foramen ovale, or a fenestrated atrial septal aneurysm. The latter may be cardiac, such as pericardial effusion or constrictive pericarditis; pulmonary, such as emphysema, arteriovenous malformation, pneumonectomy, or amiodarone toxicity; abdominal, such as cirrhosis of the liver or ileus; or vascular, such as aortic aneurysm or elongation.²

Under normal conditions an interatrial communication allows blood to shunt from left to right due to a higher pressure in left atrium than right atrium and a greater compliance of the right ventricle than the left ventricle. Right-to-left interatrial shunting is usually associated with spontaneous or induced pulmonary hypertension and, therefore, in the absence of a right-to-left pressure gradient, what is the mechanism for a right-to-left shunt? Or put in another way, what causes water to flow uphill?² A persistent Eustachian valve can cause interatrial right-to-left shunting with a normal right atrial pressure.³ Platypnea-orthodeoxia could be explained on the basis of positional modification of abnormal shunting. Standing upright could stretch the interatrial communication, be it a patent foramen ovale, an atrial septal defect, or a fenestrated atrial septal aneurysm, thus allowing more streaming of venous blood from inferior vena cava through the defect, whether or not a persistent Eustachian valve coexists.³ This redirection of flow caused by an anatomic distortion of the right atrium or the atrial septum also might occur from a loculated pericardial effusion, an aortic aneurysm, or aortic elongation.²

The elegant echocardiographic demonstration by Medina et al⁴ is an example of the last mentioned situation. The readers are referred to my recent editorial for a more detailed discussion of the etiology, differential diagnosis, and management of platypnea-orthodeoxia.² Suffice it to say that the definitive treatment for platypnea-orthodeoxia is closure of the interatrial communication, which can be carried out nowadays by transcatheter techniques,⁵ as was done in the case of Medina et al.⁴

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Response

We appreciate very much Dr Cheng's comments regarding the definition, pathophysiology, differential diagnosis, and management of platypnea-orthodeoxia syndrome, and we completely agree with them.¹

From our point of view, Dr Cheng's articles²⁻⁴ help explain the underlying mechanisms of this condition and offer current recommendations for its treatment.

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