Advanced Technology: Clinical Blessing or Clinical Blinders?

To the Editor:

In their article “Occult anomalous pulmonary venous drainage: the clinical value of cardiac magnetic resonance imaging,” 1 Dr Tan and colleagues present elegant magnetic resonance images from a patient with total anomalous right pulmonary venous drainage into the inferior vena cava (Scimitar syndrome). Their article demonstrates the superb graphic capability of MRI and also provides evidence of the hemodynamic or functional value of magnetic resonance flow mapping in quantitating the magnitude of a left-to-right shunt.

The authors’ addition of “occult” to their title, however, implies that high-tech MRI was critical to the diagnosis. I question the occult nature of this anomaly. Given that the ratio of pulmonary blood to systolic blood flow was 2.7:1, one would anticipate highly suggestive bedside findings such as a palpable lift over the right ventricle, a pulmonary ejection murmur, a persistently split second sound, and even a tricuspid inflow rumble. The contrast-enhanced magnetic resonance pulmonary venous angiogram (Figure 3 in Tan et al) 1 suggests that this “scimitar” might even have been visible on plain chest radiography. Further, transthoracic and transesophageal echocardiography, which were performed before MRI, seem to have replaced, rather than augmented, the physical examination.

At right-heart catheterization, a left-to-right shunt was identified at the right atrial level. The careful collection of a series of blood samples to document oxygen saturation from the superior vena cava to the inferior vena cava would have pinpointed the location of the shunt to the high inferior vena cava. Moreover, manipulation of the catheter would have permitted entry into the common vein draining the right upper and lower pulmonary veins. There, an injection of contrast medium would have illuminated the “occult.”

Undeniably, MRI and other technical advances of the recent past have added immeasurably to our diagnostic and therapeutic acumen. It is not correct, however, to create the impression that MRI was, in this case, required to bring light out of darkness. The proper performance of a right-heart catheterization in searching for a shunt, a skill best appreciated nowadays by our pediatric cardiology colleagues, still needs to be taught to our adult cardiology trainees if we are to expect them to recognize conditions that might otherwise be considered occult. In this time of escalating medical costs, we have an obligation to use all of our resources with care and reason.

Robert J. Hall, MD
Texas Heart Institute
St Luke’s Episcopal Hospital
Houston, Tex


Response

We agree with Dr Hall that a good bedside clinical examination, chest x-ray, echocardiography, proper right-heart catheterization, and sampling for oxygen saturation are all important in the diagnosis of left-to-right shunt caused by anomalous venous drainage. We used the word “occult” in our report to describe an interesting case of a patient with anomalous pulmonary venous drainage diagnosed first on MRI, who had escaped diagnosis despite full clinical evaluation and several prior tests. 1 Dr Hall enumerated several physical signs associated with atrial septal defect with significant intracardiac shunt. Though useful, these signs alone would not have been adequate for the exact anatomic diagnosis. Although a “scimitar” appearance on chest roentgenogram may suggest the diagnosis, the need for further functional work-up of the lesion remains. Right-heart catheterization alone might have yielded the diagnosis and enabled visualization of the anomalous vein (provided it was successfully cannulated), but in this case the anatomy was not clearly appreciated. The choice of the most optimal and cost-efficient diagnostic test would depend on the availability of expertise and equipment. Cardiovascular magnetic resonance is not widely available, but the technique should be considered, if available, in the work-up of a patient suspected of having anomalous venous drainage.

Ru-San Tan, MBBS, MRCP
Department of Cardiology
National Heart Center
Singapore
Elijah Raphael Behr, MA, MBBS, MRCP
William John McKenna, MD, FRCP, DSC
Department of Cardiology
St George’s Hospital
London, United Kingdom
Raad H. Mohiaddin, MD, PhD, MRCP, FRCR, FESC
Cardiac Magnetic Resonance Unit
Royal Brompton Hospital,
London, United Kingdom

Advanced Technology: Clinical Blessing or Clinical Blinders?
Robert J. Hall

Circulation. 2002;106:e20
doi: 10.1161/01.CIR.0000023456.08727.AF
Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2002 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the
World Wide Web at:
http://circ.ahajournals.org/content/106/5/e20

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published
in Circulation can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial
Office. Once the online version of the published article for which permission is being requested is located,
click Request Permissions in the middle column of the Web page under Services. Further information about
this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation is online at:
http://circ.ahajournals.org//subscriptions/