the medical literature available. Further antiplatelet/anticoagulant therapy after device implantation is advised although evidence regarding the optimal antithrombotic regimen and duration remains empirical.

In conclusion, although rare, aorto-atrial fistulas are a severe complication that can lead to refractory heart failure. Closure of the fistulous tract is often advised. Evidence on this regard is scarce and mostly based on case reports or case series. More data is needed to better define optimal therapeutic strategies in this scenario.

FUNDING
M. Tamargo was partially supported by grants from Fundación para la Investigación Biomédica Gregorio Marañón, Madrid, Spain, and CM20/00054 from Instituto de Salud Carlos III, Madrid, Spain.

AUTHORS’ CONTRIBUTIONS
All the authors contributed equally to this work.

CONFLICTS OF INTEREST
None whatsoever.

SUPPLEMENTARY DATA
Supplementary data associated with this article can be found in the online version available at https://doi.org/10.24875/RECICE.M23000387.

REFERENCES
At the office, she complained of exertional dyspnea that had just appeared after walking from the waiting room to the office. Then, a pulse oximeter was placed on her, and she was told to go for a walk. Oxygen saturation progressively dropped down to 87%, and symptoms relapsed. However, they quickly normalized with rest even in an upright position. The treadmill exercise stress testing revealed the presence of significant saturation changes during exercise (values between 88% and 96%) followed by a sudden increase of ventilation, ventilatory equivalents (VE/VO₂ and VE/VCO₂), a quick drop of end-tidal carbon dioxide pressure (PETCO₂), and a sudden increase of end-tidal oxygen pressure (PETO₂) (figure 1A,C,E; Wasserman plots 1, 6, and 9, respectively).

The presence of a shunt was suspected, and a transesophageal echocardiography was performed that revealed a large PFO (a 15 mm tunnel and a 3 mm to 5 mm separation) with bidirectional shunt whose right-to-left flow increased significantly with the Valsalva maneuver (figure 2 and video 1 of the supplementary data).

After diagnosis of a variant of the platypnea-orthodeoxia syndrome known as PFO related exercise-induced desaturation, the right heart catheterization confirmed the absence of pulmonary hypertension and then the percutaneous closure of the defect using an Occlutech ASD 13 device with a 28.5 mm left disc. The patient was discharged the next day.

Two weeks later, she joined the cardiac rehabilitation unit, where the new treadmill exercise stress testing conducted (figure 1B,D,F) confirmed the patient’s improved functional capacity and without desaturation.

PFO related exercise-induced desaturation is a rare and likely underdiagnosed condition that requires a high level of suspicion.
Listening to and interacting with the patient is key to being able to diagnose this condition as it allows us to see, in situ, the drop of oxygen saturation that is indicative of a shunt. Without thorough history-taking and physical examination of the patient, we will be blind in our diagnostic process.

Exercise-induced desaturation should be considered in the presence of both exertional dyspnea and desaturation with exercise. However, to achieve diagnosis, a pulse oximeter should be put on the patient who should also be told to go for a walk. This is not a common practice though. Confirmation comes through an echocardiogram that shows the right-to-left shunt through the PFO.

Very few series have been published on this condition being the study conducted by Devendra et al. worth mentioning. They reported a series of 10 cases where closure of the PFO resolved the shunt and exercise-induced desaturation, which improved the patients’ functional capacity.

The mechanisms involved in right-to-left shunting in PFO related exercise-induce desaturation are still not fully understood. However, several may be involved to varying degrees of significance in each patient. During exercise, terrestrial gravity and muscular effort change the anatomical arrangement of the chest cavity, viscera, blood vessels, and filling pressures of the different cardiac chambers. In cases of diagnostic uncertainty, exercise right heart catheterization can be useful to screen for other causes of right ventricular failure like early pulmonary vasculopathy or changes to the diastolic dysfunction that can compromise cardiac output after closure.

Patients who develop PFO related exercise-induce desaturation may remain asymptomatic for years. However, as they age, pressure or anatomical changes (chest cavity changes, interatrial septum modification or aortic dilatation/elongation, among others) may redirect blood flow from the vena cava towards the PFO. This facilitates the passage of deoxygenated blood from the right atrium to the left cavities even in the absence of a significant pressure difference.

The use of a device to close the atrial septal defect was decided because the PFO tunnel intermittently detached widely, leaving a wide trajectory. Similarly, the goal here was to make sure that the diameter of discs would adapt, as closely as possible, to the length of the septum, allowing them to embrace the septal aneurysm almost in its entirety and reduce device mobility after implantation.

This case is an example of the significant clinical impact that follows the occurrence of this condition and demonstrates that the percutaneous closure of the PFO is a safe and effective strategy.

The patient’s written informed consent and authorization was obtained to publish both figures and videos.

FUNDING
None whatsoever.

AUTHORS’ CONTRIBUTIONS
V. Juárez, O. González, and C. Contreras drafted the manuscript preliminary version and selected the figures. A. Castro, A. Jurado, and S. Jiménez conducted the manuscript critical review by providing comments in later changes and reviewed its final version.

CONFLICTS OF INTEREST
None reported.

SUPPLEMENTARY DATA
Supplementary data associated with this article can be found in the online version available at https://doi.org/10.24875/RECIC.M23000388.

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