**LARGE HEPATIC CYST AND PATENT FORAMEN OVALE: UNUSUAL COMBINATION PRODUCING PLATYPNEA-ORTHODEOXIA SYNDROME**

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Platypnea-orthodeoxia syndrome (POS) is an infrequently encountered cause of dyspnea that is accompanied by arterial desaturations in the upright position, relieved by lying supine. Two unrelated conditions must co-exist to produce POS, most commonly a previously clinically silent patent foramen ovale (PFO). A second component, usually occurring later in life, contributes to right-to-left shunting via the inter-atrial connection, such as liver cirrhosis, pulmonary embolism, or tortuous aorta.

68-year-old-man presented with progressive dyspnea over six months. He was hypoxic with large A-a gradient: PaO2 42 mmHg with SaO2 82% on room air, no improvement with supplemental oxygen. Dyspnea occurred when standing up, accompanied by documented hypoxia, both resolving immediately with recumbency. CT chest ruled out pulmonary embolism but showed multiple large hepatic cysts causing mass effect on right atrium. Transesophageal echocardiography showed compressed right atrium and right-to-left shunt across PFO, increasing with Valsalva. Attempt at percutaneous PFO closure was unsuccessful. Percutaneous drainage of the largest hepatic cyst resulted in immediate improvement in oxygen saturation and symptoms.

POS is an uncommon cause of dyspnea that requires a high index of suspicion to recognize. As symptoms occur opposite to those seen with heart failure and other cardiopulmonary conditions, patients with POS can be a medical mystery. Thorough history and exam is crucial, paying particular attention to postural changes in symptoms. Although the anatomic component is present from birth, patients typically present with POS later in life, with symptoms correlating to another cardiac or extracardiac event increasing the degree of shunting. A large hepatic cyst compressing the right atrium, accentuating right-to-left flow across the PFO, leading to platypnea and orthodeoxia is unique, with only one previous case documented.

Our case demonstrates resolution of symptoms with percutaneous drainage of liver cyst, whereas typical definitive treatment is PFO closure.