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Miscellaneous clinical manifestations of an intracardiac tumour

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A 60 years old female was admitted to the emergency department presenting signs and symptoms of heart failure, complaining of extreme breathlessness, fatigue, haemoptysis, orthostatic hypotension. The patient didn't have any medical history besides two physiological pregnancies (35 years ago) and grade I arterial hypertension. Vital signs were stable with a blood pressure of 106/65 mmHg, PR 125 bpm, RR of 19 brpm and subfebrility (37.7 °C). Lungs were clear to auscultation bilaterally with bilateral basal crackles. Cardiovascular exam was notable for a holosystolic murmur at the apex and regularly regular accelerated rhythm. Pulses were intact bilaterally in upper and lower extremities with no edema. Levels of serum electrolytes, glucose, blood urea and creatinine, and complete blood counts were normal, D-dimers were positive, high level of blood lipids and slight hyperglycemia were noted. In the emergency room the patient didn't respond to conventional diuretic and anticoagulation therapy and presented with worsening of symptoms and alteration of the hemodynamic parameters. Transthoracic echo exam showed normal ejection fraction (EF 58%), moderate mitral regurgitation, moderate to severe tricuspid regurgitation, high probability pulmonary hypertension (PSAP 60 mmHg) and a large mass in the left atrium, attached to interatrial septum, filling the whole chamber with slight protrusion into the anterior mitral valve leaflet and left

ventricle during diastole. It measured 5.6x3.8x5,3 cm (14,8 cm2). A diagnosis of left atrial myxoma was made, the patient was immediately transferred to another hospital and underwent resection of the left atrium myxoma and left atrial wall with pericardial reconstruction. Post-operatively the patient showed significant clinical and haemodynamic improvement, the postoperative echo exam didn't reveal any signs of a cardiac tumour with a normal ejection fraction and mild mitral and tricuspid regurgitation.

Conclusions: Atrial myxomas are the most common primary cardiac tumours in adults, accounting for nearly half of primary cardiac tumours, developing in any of the cardiac cavities, but up to 90% of them are located in the left atrium, mainly adhered to the atrial septum near the fossa ovalis (1). The large spectrum of symptoms and signs as dyspnea, orthopnea, paroxysmal nocturnal dyspnea, pulmonary edema, could easily mislead to several diagnoses, making it difficult for clinicians to consider atrial myxoma (2). Transthotacic echo exam is the cornerstone in the appraisal of the right diagnosis, performing the differential diagnosis and tumour classification according to the tissue appearance. As soon as the suspicion of a myxoma has been raised and the diagnosis by an imaging method was performed expeditious surgery becomes imperative, as the risk of cardiovascular complications is extremely high (3). Generally the results of the surgery are positive, with a low rate of reccurence and a relatively low mortality (4).