We present a case of a rare presentation of an intracardiac tumor, which manifested with symptoms of acute mitral obstruction. The patient underwent surgical excision and recovered uneventfully.

Cardiac myxomas are rare, slow-growing, benign intracardiac tumors which most commonly arise in the left atrium. Clinical presentation is varied, but the most common presenting symptoms are angina, dyspnea, or syncope, followed by constitutional symptoms thought to be due to cytokine release. More extreme presentations have been reported, such as tumor embolization, acute mitral obstruction, and intermittent drop attacks.

A 68 year-old female presented to hospital after suffering a syncopal event at work, having been previously completely asymptomatic. She was found hypoxicemic and was brought to the emergency department where she was promptly intubated. She was noted to be hypotensive on initial assessment, with combined hypoxicemic and hypercapnic respiratory failure and cardiogenic shock. Chest X-ray demonstrated extensive pulmonary opacities, and CT scan of the chest revealed a 7.9 x 3.2 cm mass within the left atrium adjacent to the atrial septum. Transesophageal echocardiography (TEE) demonstrated a left atrial mass attached to the fossa ovalis, and moving back and forth through the mitral valve. A pulmonary artery (PA) catheter was placed, and her PA systolic pressures were noted to be approximately three-quarters systemic systolic pressure.

Transthoracic echocardiography (TTE) demonstrated a left atrial mass measuring 8 x 3 cm. The patient was removed from bypass, the chest was closed, and she was transferred to the Cardiovascular Intensive Care Unit.

Post-operatively, her shortness of breath, pulmonary edema and heart failure symptoms resolved promptly. Her hospital course was remarkable only for junctional bradycardia requiring pacemaker placement, and the patient was discharged home on post-operative day nine. Pathologic evaluation demonstrated cardiac myxoma with negative margins at the stalk.

Given the findings concerning for acute mitral obstruction and cardiogenic shock due to the bulky mass, the patient was taken emergently to the operating room for mass removal. Under cardiopulmonary bypass, the right atrium and the dome of the left atrium were opened. The area of attachment to the atrial septum was identified and the septum was incised around the stalk, removing the tumor which measured 8 x 3 cm. The patient was removed from bypass, the chest was closed, and she was transferred to the Cardiovascular Intensive Care Unit.

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A giant left atrial myxoma causing acute mitral obstruction is a rare but life-threatening presentation of cardiac myxomas. A high index of suspicion is required to identify this rare clinical entity. Prompt surgical resection is required to alleviate the nidus of the obstructive shock, and to prevent embolic phenomena.

REFERENCES