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A CASE OF LEFT ATRIAL MYXOMA

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SUMMARY

Left atrial myxoma almost always arises in the inter-atrial septum. A case is described where it arose from the posterior wall of the left atrium. Clinical presentation was suggestive of mitral stenosis and sub-acute bacterial endocarditis and diagnosis was arrived at necropsy.

INTRODUCTION

Atrial myxoma can present with a variety of clinical pictures which may be suggestive of mitral stenosis or insufficiency. [1] They can also present with heart failure, fatigue and weight loss of rapid development in a middle aged patient with no history of rheumatic fever. [2] Most myxomas arise in the left atrium and less commonly in the right atrium. Left atrial myxomas predominantly arise from the interatrial septum and rarely from the atrial wall. [1] The following case illustrates it's presentation as mitral stenosis and subacute bacterial endocarditis and at necropsy, the tumour was found to arise from the posterior wall.

CASE REPORT

A 39 year old woman was admitted to hospital because of dyspnoea on exertion for three weeks. She had been treated with Cephalexin for six days prior to admission by her doctor for cough which was productive of yellow sputum. There was no past history of rheumatic fever.

On examination, she was febrile with a temperature of 38°C, orthopnoeic and cyanosed. There was no ankle oedema, clubbing, petechiae, splinter haemorrhages or Roth spots. Her pulse was irregular with a rate of 140/min and all the peripheral pulses were palpable. The blood pressure was 18.6/13.3 kPa and the heart was clinically not enlarged. The first heart sound was loud and there was a mid-diastolic murmur with a pre-systolic accentuation in the mitral area. There were bilateral basal crepitations and the liver and spleen were not palpable.

A provisional diagnosis of rheumatic heart disease with mitral stenosis and pulmonary oedema was made.

Her Hb was 13.5 g/dl, ESR 40 mm/hr, WBC 14.5 x 10^9/l with a leucocytosis of 81%. Blood urea was 5 mm ol/l, ASOT was 12 Todd Unit, urinalysis was negative and chest X-ray showed bilateral basal congestion with small bilateral basal effusions. The heart was normal. The electrocardiogram showed multiple ventricular ectopic beats with no atrial fibrillation.

The patient was treated with Furosemide, Slow-K, Digoxin and oxygen and made considerable improvement. Two days later, the patient developed pain in the left calf together with coldness of the extremities. Both right and left dorsalis pedis, posterior tibial, popliteal and the left radial pulses were impalpable. Patient was pyrexial

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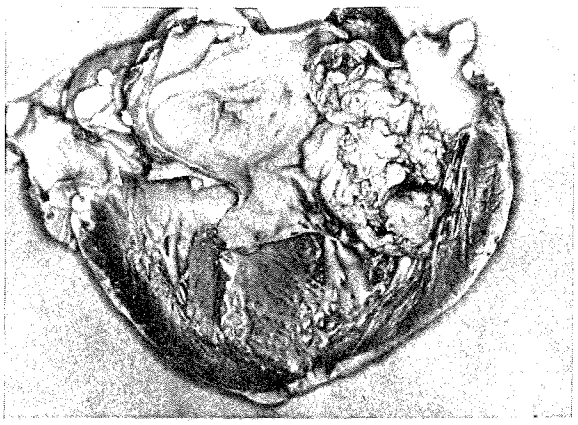

Fig. 1 Left atrium showing polypoidal tumour mass arising from the posterior wall.

with a temperature of 38.1°C. Although there were no splinter, petechial haemorrhages, Roth spots or splenomegaly, the patient was managed as a case of subacute bacterial endocarditis with intravenous Penicillin. The patient improved and became apyrexial. Blood cultures done earlier grew no organisms. Six days after admission the patient developed sudden left hemiplegia and lapsed into a coma and died.

At necropsy there were large bilateral pleural effusions and the lungs were oedematous. Arising from the posterior wall of the left atrium (Fig. 1) was a polypoidal tumour mass which filled the chamber which had prolapsed through plugging the mitral valve which showed a few fibrin deposits but was otherwise normal. The myocardium was pale and the coronary arteries were normal. Emboli originating from the cardiac tumour were present in the bifurcation of the right carotid artery, at the point of origin of the right middle cerebral artery but without infarction, in the aorta plugging the inferior mesenteric and left renal arteries and as a saddle embolus at the aortic bifurcation (Fig. 2). The small bowel, spleen and both kidneys showed recent infarction.

COMMENT

Clinical recognition of atrial myxoma is difficult and the presenting symptoms and signs can lead to a diagnosis of rheumatic heart disease with valvular involvement and subacute bacterial endocarditis as in this patient. In retrospect, there were some aspects in the history and clinical findings that were suggestive of myxoma, namely the rapid development of symptoms of mitral stenosis, multiple embolic phenomenon in the absence of atrial fibrillation and other signs of subacute bacterial endocarditis such as petechial, splinter haemorrhages, Roth spots, Splenomegaly and negative urinalysis and a relatively small left atrium in spite of signs of significant mitral valve disease.

Fig. 2 Emboli in the aorta plugging the inferior mesenteric and left renal arteries.

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