Giant left atrial myxoma as a cause of recurrent cerebral emboli

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A 78-year-old woman with mild left-side hemiplegia and aphasia was admitted to the neurological ward. It was her third stroke within 2 years. She had been treated for hypertension and diabetes for several years; she had no cardiac arrhythmia in history. Echocardiography performed 10 years earlier gave normal results. Computed tomography of the brain revealed a hypoattenuating ischemic lesion within the right anterior limb of the internal capsule and other small multiple ischemic lesions in various vascular territories. Carotid and vertebral ultrasound did not show any significant stenosis. Holter monitoring performed during the previous and current hospitalization showed no arrhythmia. Despite that, in the period between the second and current episodes, the patient was taking rivaroxaban prescribed by a general practitioner owing to a suspicion of atrial fibrillation as a probable cause of recurrent stroke. The patient was referred for transthoracic echocardiography, which showed a large left atrial mobile tumor (40 × 24 mm) attached to

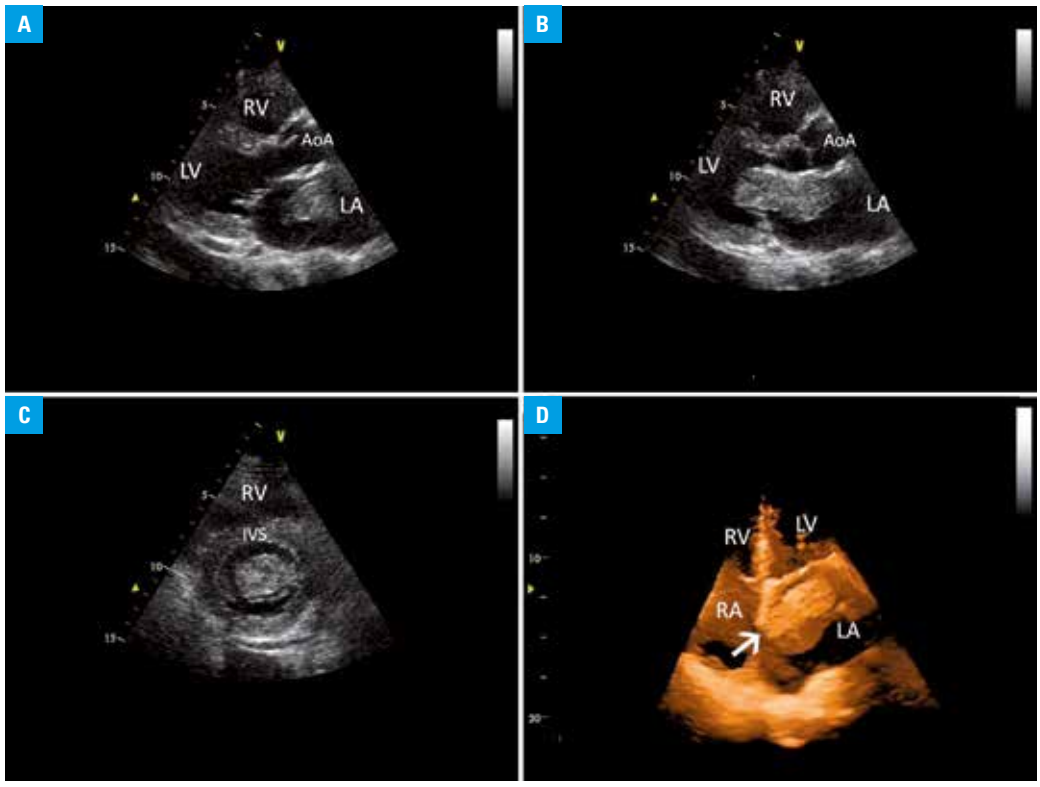

FIGURE 1 Transthoracic echocardiography; **A** – parasternal long axis-view, systole; **B** – parasternal long-axis view, diastole; **C** – parasternal short-axis view; **D** – four-chamber view (three-dimensional echocardiography)
Abbreviations: AoA – aortic arch, IVS – interventricular septum, LA – left atrium, LV – left ventricle, RA – right atrium, RV – right ventricle

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Received: May 16, 2013.
Revision accepted: May 20, 2013.
Conflict of interest: none declared.
Pol Arch Med Wewn. 2013; 123 (7-8): 417-418

the interatrial septum (FIGURE 1AB), prolapsing into the left ventricle through the mitral valve, and partially enclosing the left ventricular inflow tract during diastole (FIGURE 1CD). Because repeated continuous cardiac monitoring and 24-hour Holter monitoring did not reveal any arrhythmias, anticoagulant therapy with rivaroxaban was stopped. The patient was referred for urgent cardiac surgery. During preoperative evaluation, coronary angiography was performed to search for any significant lesions in the coronary arteries.

Myxoma is the most common primary cardiac tumor. It can develop in all cardiac chambers but, in 75% of the cases, it originates in the left atrium. The clinical manifestation of myxoma usually includes 1 or more symptoms with the classic triad: embolism, intracardiac obstruction, or constitutional symptoms (fever, weight loss, and connective tissue disease). Echocardiography is sufficient to make the diagnosis, define the location, and identify potential hemodynamic consequences. The treatment of choice is cardiac surgery, including the resection of myxoma with the margin of normal tissue. Due to the risk of recurrence, which is the highest up to 4 years following the surgery, the echocardiographic follow-up (every 6 months) is recommended.

All patients after acute cerebrovascular events should undergo a 12-lead and continuous electrocardiogram monitoring. In the case of suspected arrhythmias or difficulties in establishing other causes of stroke, 24-hour Holter monitoring is recommended. Echocardiography can help detect numerous causes of stroke but it is not routinely indicated in all patients. It is recommended in selected cases such as: evidence of cardiac disease, suspected cardiac source of embolism, suspected aortic disease, suspected paradoxical embolism, and lack of other identifiable causes of stroke. In the above case, it allowed us to establish a definite diagnosis and decide on radical treatment.

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