



A stroke of bad luck -Atrial Myxoma

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Brief case presentation

A 57 year old Sri Lankan female, presented to a medical ward for further management following left sided weakness of both the upper and lower limbs with headache, suggestive of a stroke. She otherwise had a preserved sensorium. She was a diagnosed type II diabetic for two years and hypertensive patient for 10 years on treatment and regular follow up. Incidentally she had two prior episodes of cerebrovascular events, i.e. a transient ischaemic attack 15 years prior to her presentation and a minor CVA of similar nature 5 years prior as well, both of which were not completely investigated. She had otherwise been well with no constitutional symptoms.

Clinical examination confirmed the left side stroke. Cardiovascular examination revealed marginally elevated blood pressure at 150mmHg systole and 90mmHg diastole. Auscultation revealed a diastolic murmur at the apex. Rest of the systemic examination was normal.

ECG showed sinus rhythm. Chest Xray revealed mild cardiomegaly. Transthoracic echo demonstrated a large mass within the left atrium, with classic morphological appearance favoring that of a large myxoma. It was noted to be mobile, attached to the anterior mitral valve from within the left atrium and tended to prolapse into the left ventricle and measured 35mmx28mm (Figure 1, 2, 3).

Urgent preparations were made and patient was sent for surgery for resection of the atrial myxoma.

Brief discussion

Atrial myxoma's (AM) are the commonest type of benign primary cardiac tumours [1]. They usually originate from the endocardium. Commonly being gelatinous in nature, they are pedunculated and have been known to vary in size[2],



Figure-1: Long axis view demonstrates large atrial myxoma (3.94 cmx2.39 cm) occupying the left trial cavity



Figure-2: Modified short axis view demonstrates large atrial myxoma occupying the left trial cavity

and surprisingly remain clinically undiagnosed even up to a decade[1]. Commonly sporadic but can be familial as in the CARNEY complex[1]. Mostly found in the left atrium (85%) few can be found in the right(10%) and even less in the ventricle(5%)[3]. It is common in middle aged women(30-60 years)[1] peaking at 50 years of age [4], with an incidence twice more than in men[5].



Figure-3: Four chamber view delineates the large atrial myxoma protruding into the left ventricle.

Atrial myxomas can have a varied pattern of presentation from being asymptomatic, to pyrexia of unknown origin, angina, ECG aberrations (atrial hypertrophy, conduction defects, arrhythmias and rarely AF), incidental murmurs (diastolic tumour plop, diastolic murmur), cardiomegaly, heart failure[5] & even rarely stroke (0.5%) [4](ischaemic & hemorrhagic with recurrence) to mention a few. Presentation depends on its anatomy, dimensions and attachment. Transoesophageal echo gives near 100% sensitivity in detection. Cardiac MRI is further useful in defining the tumour which the surgeons may appreciate prior to intervention[1].

Simultaneous haematological abnormalities may be appreciated including, elevated ESR, CRP, , leucocytosis , anemia and hyperglobulinemia. Anticoagulation doesn't have a role in the management and is discouraged due to the risk of embolism[3]. The definitive treatment is surgical resection. The rate of growth is controversial and varies from 1.3 to 6.9 mm/month in diameter[6]. Recurrence is noted between 1-3% and vigilance is advised with annual echo in these subjects for at least 4 years[1].

Our patient is a typical example of delayed diagnosis in a background of multiple strokes over a span of several years.

Conclusion

A high level of clinical suspicion is required to detect AM. It must not be a foregone conclusion that when a stroke occurs in a middle aged patient with coexistent multiple non-communicable

disease that its aetiology can be attributed to those. Though uncommon, when the clinical picture is suspicious rarer entities like AM should be actively sought. Delay in diagnosis and intervention will increase morbidity and mortality in these patients.

References

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