

Correspondence

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VENTRICULAR MYXOMA

It is unusual for a surgeon to have the opportunity to operate on a patient with a primary tumour of the heart, especially when that tumour is located entirely within the left ventricle. We recently encountered such a case and wish to report it to readers of the Journal.

CASE REPORT

A 67-year-old woman presented to her cardiologist with symptoms of malaise, fatigue and dyspnea on exertion. Two years before she had been seen for atrial fibrillation. The results of all investigations at that time, including echocardiography, were normal. However, her condition worsened and she was suffering from chronic atrial fibrillation.

An echocardiogram was again obtained. It revealed a mobile, round mass, 1 cm in dimension, in the posterior portion of the left ventricle (Fig. 1). No mitral valve abnormality or left atrial abnormality was demonstrated. The cardiologist, internist and cardiothoracic surgeon, after consul-

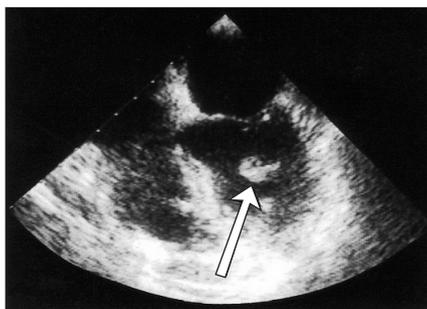


FIG. 1. Echocardiogram demonstrates a mass (arrow) in the left ventricle.

tation, believed that surgical excision of the tumour was the best course.

One month later, through a standard left atrial incision and with cardiopulmonary bypass, the mass was visualized beneath the posterior leaflet of the mitral valve. The mass was contained entirely within the papillary muscle and closely associated with the muscle head, so complete excision of the mass rendered the mitral valve incompetent. The valve was replaced with a St. Jude mechanical prosthesis.

Postoperatively, the woman did well. Echocardiography demonstrated normal left ventricular action and normal function of the mitral valve prosthesis. No residual mass or abnormality was seen within the left ventricle.

Histologic examination of the excised tumour revealed a myxoma.

DISCUSSION

Myxoma is the most common primary cardiac tumour.¹ Most myxomas are benign and arise from the left heart. Fewer than 5% of myxomas arise from within the left ventricular cavity, and this is the first report, to our knowledge, of a myxoma originating from papillary muscle.^{2,3} The most feared complication of myxoma is embolism, which is usually what prompts surgical intervention.⁴ Although recurrence is rare, complete resection is essential to prevent any recurrence. In our patient, the tumour base was intimately associated with the papillary muscle head and complete excision rendered the mitral valve incompetent, necessitating replacement of the

valve with a prosthesis. A mitral valve-sparing technique should be considered if technically feasible since it avoids the problems associated with prosthetic valves, such as infection and the lifelong need for anticoagulation.

Reconstruction of the valve or valvular apparatus will improve function and increase survival and should be considered if the valve can be spared after complete tumour excision. However, incomplete resection in order to spare the mitral valve is not recommended.

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References

1. McAllister HA Jr. Primary tumors and cysts of the heart and pericardium. *Curr Probl Cardiol* 1979;4(2):1-51.
2. Wrisley D, Rosenberg J, Giambartolomei A, Levy I, Turiello C, Antonini T. Left ventricular myxoma discovered incidentally by echocardiography. *Am Heart J* 1991;121(5):1554-5.
3. Meller J, Teichholz LE, Pichard AD, Matta R, Litwak R, Herman MV, et al. Left ventricular myxoma: echocardiographic diagnosis and review of the literature. *Am J Med* 1977;63(5):816-23.
4. Colucci V, Alberti A, Bonacina E, Gordini V. Papillary fibroelastoma of the mitral valve. A rare cause of embolic events. *Texas Heart Inst J* 1995;22(4):327-31.