Intracardiac mass masking severe mitral valve regurgitation

Masa wewnątrzsercowa maskująca cieżką niedomykalność zastawki mitralnej

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A 70-year-old woman was admitted to our institution due to a two-month history of progressive dyspnoea. Physical examination did not reveal abnormalities. Electrocardiogram showed sinus tachycardia. Transthoracic echocardiography demonstrated a giant mobile undefined mass located on the left atrium (LA). The tumour prolapsed on the left ventricle through the mitral valve (MV) during diastole (Fig. 1A–C). The absence of MV regurgitation was detected. Cardiac surgery was scheduled. Under general anaesthesia and continuous transoesophageal echocardiography (TEE) monitoring, a medium sternotomy was performed. Standard cardiopulmonary bypass was established through bicaval cannulation. Access to the LA was made via septal-superior approach. An encapsulated yellowish-red 7 × 6 cm mass arose from the LA. It was attached to the LA septum next to the anterior leaflet of MV. The tumour was completely excised (Fig. 1D, E). However, at the moment of weaning from cardiopulmonary bypass, intraoperative TEE revealed severe MV regurgitation that was previously unknown. Cardiopulmonary bypass was established again to access the LA. No clear MV annulus dilatation or leaflet abnormalities were detected. MV annuloplasty was decided. After second weaning of cardiopulmonary bypass, TEE confirmed the absence of MV regurgitation. Pathology determined myxoma diagnosis. The patient was discharged uneventfully, eight days postoperatively.

Figure 1. A. Transoesophageal echocardiography apical four-chamber view showing left atrial myxoma through mitral valve (MV); B, C. Transoesophageal echocardiogram Doppler focusing on MV regurgitation. A 7 × 6 cm mass attached to the interatrial septum and protruding into the left ventricle is shown; D, E. Surgical specimen that exposes tumour appearance. Intratumoural heterogeneity is patent, with haemorrhagic and calcification areas in its interior.

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