Introduction

The prevalence of cardiac tumours at autopsy ranges from 0.001% to 0.3% of which more than 50% are benign. Myxomas are the most common primary tumor of the heart. Typical myxomas are pedunculated and gelatinous in consistency. Tumors vary in size from 1-15cms; weighing, 15-180 g.-n-? 35% of myxomas are villous and friable with increased tendency for embolization. Large tumours are more likely to be associated with cardiovascular symptoms. Interleukin-6 synthesized by the myxoma is responsible for the constitutional symptoms.

Case report

We present a 64 year old female who presented with symptoms of dyspnea NYHA class III, and palpitations for two months duration. Clinical examination revealed pallor, and a mid diastolic murmur in mitral area. ECG was within normal limits. Echocardiogram showed a cauliflower like mass with multiple protruding villous appearance attached to the inter atrial septum near the foramen ovale suggestive of left atrial myxoma traversing the mitral valve orifice causing mitral valve obstruction. Patient was referral to cardiothoracic surgeon for surgical excision.

Discussion

Atrial Myxoma being the most common primary cardiac tumour is usually solitary [90%] and presents more frequently in women. Symptoms depend upon the site, size and mobility of the tumour. Most common site is the left atrium. An extensive literature review has been performed to present comprehensive review of the cause and pathophysiology of atrial myxoma. Clinical manifestations include triad of Constitutional symptoms.

Obstructive symptoms and embolic manifestations

Constitutional symptoms include fever, weight loss, myalgia, rash, arthralgia, clubbing, weakness and Raynauds phenomenon.
Obstructive symptoms comprise exertional dyspnea, paroxysmal nocturnal dyspnea, syncope, and even sudden death. Embolic manifestations comprise stroke, seizures, and infarctions involving cerebellum, brainstem, spinal cord, and retina. It masquerades as mitral stenosis. Myxoma is classified as familial myxoma, sporadic myxoma, and villous myxoma. Syndromes associated with myxomas include Carney’s complex, NAME syndrome, LAMB syndrome. Cardiovascular examination reveals loud S1, LV S3+, LV S4, tumor plop sound -100ms after S2, mid-diastolic murmur due to obstruction-wrecking ball effect. Laboratory investigations reveal elevated ESR, thrombocytosis, polycythemia, anemia, increased IL-6. X-Ray Chest may reveal cardiomegaly and left atrial enlargement, calcification. ECG may show - left atrial enlargement, various tachyarrhythmias, and heart block. Echo classification - Class I Small and prolapsing through mitral valve, Class II Small and non prolapsing, Class III - Large and prolapsing, Class IV - Large and non prolapsing. 2D Echo adequate to diagnose myxoma with 95% sensitivity. TEE is the most sensitive method to diagnose myxoma. CT Scan: may demonstrate soft tissue discrimination, myocardial infiltration, and calcification. MRI: reveals excellent demonstration of myxoma. Angiogram shows filling defect in the chamber. Biopsy: Fine needle aspiration and immuno histochemistry with Vimentin stain and Annexin V2 is valuable in the diagnosis. Histopathological examination is characteristic of lipid cells.

Recurrence of cardiac myxoma is due to familial myxoma. Recurrence rate 1-3% for sporadic myxoma and 10-20% for familial myxomas. Conventional treatment of atrial myxoma is surgical removal. Complete operative resection is the treatment of choice. Annuloplasty is indicated for damaged valves. Prosthetic valve replacement is necessary in case of severe obstruction and destruction of the valve. Cardiac transplantation recommended for multiple, recurrent atrial myxoma. Myxoma cause excessive proliferation of mesenchymal cells which produce excessive glycosaminoglycan production.

**Conclusion**

This case of villous left atrial myxoma is presented for its rarity and since it remained asymptomatic till the age 64 inspite of its virulent villous nature and tendency to embolise.

**Acknowledgments**

None.

**Conflict of interest**

Author declares that there is no conflicts of interest.

**References**