A 56-year-old woman was referred for investigation of bibasal interstitial infiltrates on chest x-ray film. The patient gave a six-month history of increasing dyspnea on exertion and palpitations. Vital signs included a regular heart rate of 90 beats/min; blood pressure, 100/70 mm Hg; and respiratory rate, 15/min. Cardiovascular examination was normal apart from some accentuation of the first heart sound, and respiratory examination revealed bibasal fine end-inspiratory crepitations. Pulmonary function tests showed a restrictive ventilatory defect with impaired diffusion capacity (Table 1). The ECG was normal and the chest x-ray film is shown in Figure 1.

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†Clinical Registrar.
‡Consultant Respiratory Physician.

**Table 1—Lung Function Tests**

<table>
<thead>
<tr>
<th></th>
<th>Preoperative, %</th>
<th>Postoperative, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>FVC</td>
<td>60</td>
<td>108</td>
</tr>
<tr>
<td>FEV$_1$</td>
<td>54</td>
<td>100</td>
</tr>
<tr>
<td>FEV$_1$/FVC ratio</td>
<td>77</td>
<td>73</td>
</tr>
<tr>
<td>TLC</td>
<td>60</td>
<td>94</td>
</tr>
<tr>
<td>FRC He</td>
<td>64</td>
<td>96</td>
</tr>
<tr>
<td>DCO</td>
<td>44</td>
<td>61</td>
</tr>
</tbody>
</table>

*Expressed as percent of predicted.

**Figure 1**
**Diagnosis: Interstitial pulmonary edema secondary to left atrial myxoma**

The chest x-ray film showed cardiomegaly with left atrial enlargement and bibasal pulmonary interstitial infiltrates consistent with pulmonary edema. The ESR was 73 mm/hour. Echocardiogram showed a left atrial myxoma (Fig 2) which was confirmed at cardiac catheterization and successfully resected ten days after admission (Fig 3).

Two months postoperatively, the patient was completely asymptomatic. Clinical examination results and chest x-ray film were normal. The ESR was 15 mm/hour, and pulmonary function tests were normal apart from decreased diffusion capacity (Table 1).

This patient presented with prolonged interstitial pulmonary edema secondary to a left atrial myxoma. Cardiac myxomas are the most common benign cardiac tumors, but are nevertheless rare, with an autopsy incidence of 0.03 percent. They are more common in women and may be diagnosed at any age. Seventy-five percent occur in the left atrium, usually arising from the interatrial septum. Multiple cardiac myxomas are rare and may be associated with mucocutaneous or mammary myxomas, spotty mucocutaneous pigmentation, and endocrine overactivity.

Cardiac myxomas may present with cardiac symptoms or signs, systemic or pulmonary emboli, or constitutional symptoms, such as fatigue, anorexia, weight loss, arthralgia, and pyrexia. Because of their frequent location in the left atrium, they most commonly mimic mitral valve disease, as in our patient, with dyspnea on exertion and orthopnea. Auscultation may be normal, but typical findings include a loud or split first heart sound and mitral stenosis and/or incompetence murmurs. A fourth heart sound may be present, and a characteristic low-pitched “tumor plop” may be heard in diastole. Postural variation of auscultatory findings is highly characteristic. Myxomas may also present with arrhythmias, syncope, sudden death, chest pain, pericarditis, raised JVP, hepatomegaly, and peripheral edema. Clubbing, Raynaud’s phe-nomenon, anemia, polycythemia, thrombocytopenia, thrombocytopenia, raised ESR level, and hypergamma-globulinemia may be present.

The ECG may show arrhythmias or changes secondary to mechanical effects such as left atrial hypertrophy, right ventricular hypertrophy, right axis deviation, and right atrial hypertrophy. Similarly, the chest x-ray film may show left atrial dilatation, pulmonary venous hypertension, and right ventricular dilatation. Calcification in the tumor may also be seen. Echocardiography is usually diagnostic, but differential diagnosis includes atrial ball-valve thrombus, massive mitral valve vegetations, and flail mitral valve leaflet. Left atrial myxomas characteristically prolapse through the mitral valve in diastole. Cardiac catheterization may show increased pulmonary capillary wedge and right-sided pressures and a space-occupying lesion consistent with myxoma.

Surgery is usually curative, and prognosis is excellent if there are no preoperative or operative complications. Tumor recurrence after complete resection...
has been reported.6

This patient presented with classical symptoms of dyspnea on exertion and palpitations, but without the characteristic auscultatory findings apart from borderline accentuation of the first heart sound. The diagnosis was easily made on two-dimensional echocardiogram. Diagnosis may be much more difficult in patients who present with noncardiac abnormalities, but correct diagnosis is of the utmost importance as surgery is usually curative and complications may occur if surgery is delayed.

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