ACC.14
TCT@ACC-i2 | innovation in intervention

A619
JACC April 1, 2014
Volume 63, Issue 12

FIT Clinical Decision Making

CORONARY EMBOLIZATION FROM A LARGE LEFT ATRIAL MYXOMA WITH A CONCOMITANT MALIGNANT B-CELL LYMPHOMA

Moderated Poster Contributions
Hall C
Sunday, March 30, 2014, 3:45 p.m.-4:00 p.m.

Session Title: FIT Clinical Decision Making: Interventional Cardiology and Acute Coronary Syndrome
Abstract Category: Acute Coronary Syndromes
Presentation Number: 1245M-370A

Authors: *Andres M. Pineda, Christos Mihos, Francisco Nascimento, Orlando Santana, Joseph Lamelas, Nirat Beohar, Mount Sinai Medical Center, Miami Beach, FL, USA*

Background: Primary cardiac tumors have a calculated prevalence of 0.2% on autopsy studies, most of which are benign (75%) and Myxomas (50%). Primary cardiac lymphomas are extremely rare (<2% of primary cardiac tumors). Systemic embolization occurring in 65% of the left sided myxomas. However, the incidence of coronary embolization is only 0.06%.

Case Presentation: A 50-year-old white male presented with 1-hour history of severe chest pain. His past medical history was significant for hypertension and dyslipidemia, but no history of smoking, drug use, or family history premature coronary artery disease. Cardiopulmonary examination was within normal limits. The initial ECG showed inferolateral ST-segment elevation with reciprocal changes in the anteroseptal leads. His emergent coronary angiogram revealed an acute occlusion of the first obtuse marginal branch in its mid-segment with otherwise healthy coronary arteries. After an attempted aspiration without recovering any material, balloon angioplasty was performed. Repeat angiogram showed no significant residual plaque or dissection at the level of the original occlusion, but revealed distal branch embolization, and therefore an embolic source was suspected. His echocardiogram showed a normal left ventricular function and no significant valvular disease; however, it revealed a large polypoid left atrial mass attached to the interatrial septum, which was markedly mobile and prolapsing into the left ventricle. He underwent minimally invasive resection of a 6.5 x 3.0 cm left atrial myxoma via a right minithoracotomy, confirmed by pathologic analysis. Atypical lymphoid cells with high mitotic activity and staining positive for CD3, CD20, and PAX-5 were also identified at the tumor edge, consistent with a concomitant high-grade B-cell lymphoma. A PET/CT scan failed to demonstrate additional areas of malignant involvement and his HIV test was negative.

Conclusions: This unique case of a large left atrial myxoma with a concomitant primary malignant lymphoma presenting with an acute myocardial infarction highlights the need to actively look for sources embolism in patients presenting with STEMI.