LEFT ATRIAL MYXOMA MASQUERADING AS AN ISCHEMIC INFARCT

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Case Vignettes

Background: Cardiac myxomas cause <1% of ischemic strokes and are most common in young females(1). When considering left atrial myxomas, the cerebral arteries are affected in more than 2/3 of cases (2). We present a case of large atrial myxoma that caused a life-threatening ischemic stroke.
Case: 54-year-old Hispanic female with a past medical history of rheumatoid arthritis was found to have left upper arm flaccidity, left pupil sluggishness, and slurred speech. On arrival to the ED, vitals are BP 96/63, HR 72, R22, T99.2F, saturating 99% on room air. Cardiac exam was unremarkable. Neurological exam revealed left upper motor neuron facial palsy and flaccidity of her left side. In the ED, patient was intubated for airway protection given her altered mental status and was considered ineligible for thrombolysis due to unknown time of onset of symptoms. There is no noted history of recreational drugs, alcohol or nicotine use. A subsequent CTA head and perfusion scan revealed a completed right holo-hemispheric stroke with MCA occlusion, therefore ineligible for thrombectomy. The patient developed significant subfalcine and uncal herniation, which was treated with hypertonic saline and later underwent a right frontoparietal temporal decompressive craniectomy. A transthoracic echocardiogram revealed a 7cm x 2cm mass in the left atrium, occupying more than 50% of the cavity and floating into the left ventricle in diastole. Despite the medical interventions, patient's clinical status deteriorated, and her family elected to transition the patient's care to comfort measures and the patient passed away within 3 days of admission. Autopsy revealed the etiology of the brain infarct to be embolic stemming from the cardiac myxoma.
Decision-making: This case is very rare given this is a fatal stroke from an embolic cause and the data regarding neurologic symptoms from myxoma are anecdotal. Moreover, there are no clear guidelines regarding the management of patients with embolic strokes stemming from cardiac myxoma (3). Studies have shown that initial neurological symptoms are the initial manifestation of a cardiac myxoma (4). Given this, it is vital that when a young patient with a limited past medical history presents with symptoms suggestive of a stroke, a broad differential is needed, and thus it is important to consider myxomas as sources of emboli. Due to the nonspecific presenting symptoms of myxomas, it is a difficult pathology to diagnose. Early diagnosis can ensure curative treatment with myxoma resection thereby protecting the patient from further embolic events.
Conclusion: The presence of embolic phenomena, especially in young patients with neurological symptoms, should prompt early neuroimaging and echocardiography, even in the absence of cardiac exam or electrocardiographic abnormalities.

References

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