Abstract: 476

An unusual location and size of a papillary fibroelastoma

Authors:
AA Valentim Goncalves¹, MJ Sousa², P Matos³, E Pinto¹, N Banazol¹, L Branco¹, R Cruz Ferreira¹, ¹Hospital de Santa Marta - Lisbon - Portugal, ²Unidade Local de Saúde do Baixo Alentejo, Cardiology - Beja - Portugal, ³CUF Infante de Santo, Cardiology - Lisbon - Portugal,

Topic(s):
Echocardiography: Masses and Sources of Emboli

Citation:

Background:
The incidence of primary cardiac tumours is low. Although histologically benign, left-sided, larger sized (= 1 cm) and highly mobile tumors have a higher risk of embolization.
Papillary fibroelastomas frequently occur on the aortic or mitral valves, with only 10% arising from nonvalvular surfaces. Since they are small and usually attached to moving valves, CT and MRI technique modalities have more difficulty in detecting them, with echocardiography remaining the most common exam for the diagnosis.

Clinical case description:
A 69-year-old woman, with known history of breast cancer treated with chest radiation ten years ago. She was completely asymptomatic, but in a routine echocardiography a left ventricular heterogeneous round mass with 22x25mm with a likely pedunculated attachment in the apical region was diagnosed. The remaining exam was remarkably normal, namely with normal left ventricular size and function with no wall motion abnormalities. Because the wall motion appeared normal, the mass was interpreted as a tumour. However, a thrombus could not be excluded. After four weeks of therapy with Warfarin and aspirin, a MRI was performed. The apical mass had similar dimensions (22x23mm) and the exam was inconclusive (myxoma? fibroma? thrombus?) despite no signs of left ventricular fibrosis with late gadolinium enhancement.
Since the risk of embolization was high and there was no reduction in size with anticoagulation therapy, surgery was performed. Using a transaortic valve route, a 28x30mm mass with a pedunculated attachment in the apical region was removed. The mass had a macroscopic appearance of a sea anemone with gelatinous material. Histological examination made the final diagnosis of a papillary fibroelastoma.

Conclusion:
Large, left-sided mobile tumors should be excised to prevent sudden death and embolization. Here we present the case of a papillary fibroelastoma with a rare localization and an unusual size. Some clinical cases have raised the question for a relation between previous chest radiotherapy and the occurrence of papillary fibroelastomas.
Abstract: An unusual location and size of a papillary fibroelastoma

Authors: AA Valentim Goncalves1, MJ Sousa2, P Matos3, E Pinto1, N Banazol1, L Branco1, R Cruz Ferreira1

Hospital de Santa Marta – Lisbon – Portugal, 2 Unidade Local de Saúde do Baixo Alentejo, Cardiology – Beja – Portugal, 3 CUF Infante de Santo, Cardiology – Lisbon – Portugal

Topic(s): Echocardiography: Masses and Sources of Emboli

Citation:

Background: The incidence of primary cardiac tumours is low. Although histologically benign, left-sided, larger sized (= 1 cm) and highly mobile tumors have a higher risk of embolization. Papillary fibroelastomas frequently occur on the aortic or mitral valves, with only 10% arising from nonvalvular surfaces. Since they are small and usually attached to moving valves, CT and MRI technique modalities have more difficulty in detecting them, with echocardiography remaining the most common exam for the diagnosis.

Clinical case description: A 69-year-old woman, with known history of breast cancer treated with chest radiation ten years ago. She was completely asymptomatic, but in a routine echocardiography a left ventricular heterogeneous round mass with 22x25mm with a likely pedunculated attachment in the apical region was diagnosed. The remaining exam was remarkably normal, namely with normal left ventricular size and function with no wall motion abnormalities. Because the wall motion appeared normal, the mass was interpreted as a tumour. However, a thrombus could not be excluded. After four weeks of therapy with Warfarin and aspirin, a MRI was performed. The apical mass had similar dimensions (22x23mm) and the exam was inconclusive (myxoma? fibroma? thrombus?) despite no signs of left ventricular fibrosis with late gadolinium enhancement.

Since the risk of embolization was high and there was no reduction in size with anticoagulation therapy, surgery was performed. Using a transaortic valve route, a 28x30mm mass with a pedunculated attachment in the apical region was removed. The mass had a macroscopic appearance of a sea anemone with gelatinous material. Histological examination made the final diagnosis of a papillary fibroelastoma.

Conclusion: Large, left-sided mobile tumors should be excised to prevent sudden death and embolization. Here we present the case of a papillary fibroelastoma with a rare localization and an unusual size. Some clinical cases have raised the question for a relation between previous chest radiotherapy and the occurrence of papillary fibroelastomas.