Incision is usually 3 advantages associated with this technique. The classical biatrial approach interatrial septum point that allows right atrial excision of the tumor with an adequate rim of under direct visualization through left atriotomy and provides a reference diagnosis and location of the myxoma are confirmed using this incision. Next, a right atriotomy is performed and the right atrium and the ventricle include those described by St Rammos and Massetti and colleagues. Whether the surgeon is confronting a huge myxoma or secondary mitral valve damage, the biatrial incision or one of its modifications gives better degree relatives.

We have a few questions for the authors regarding their management. First, did the patient have any of the above mentioned manifestations? If this is the case, then the diagnosis is highly suspected, therefore molecular genetic testing of PRRK1A must be carried out to confirm the diagnosis. PRRK1A is the only gene currently known to be associated with CC. If the mutation is present in their patient, then additional genetic screening must be conducted to identify family members at risk for the disease. In a proband diagnosed with CC, the following evaluations are recommended: imaging or biochemical screening for endocrine tumors for diagnostic purposes only, thyroid ultrasonography in pediatric and young adults, testicular ultrasonography at the initial evaluation in males and abdominal ultrasonography during the first evaluation in females. We completely concur with the statement that recurrence is more common in familial variant (40% of patients with familial myxoma) and that echocardiogram follow-up must be recommended. Nonetheless, we should point out the importance of repeat echocardiography twice a year after surgery during the first four years, then on a yearly basis [4]; with close follow-up relapses can be detected early and adequately treated.

References


eComment: Utility of genetic testing in multisite myxoma to rule out Carney complex

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We read with great interest the report by Diaz and colleagues [1] reporting successful removal of multi-centric myxoma in a young female. Interestingly, the authors used the right atrial trans-septal approach and not the biatrial approach as they claim. Whether this was a typographical mistake, editorial oversight or a conceptual error on the part of the authors we feel that it provides us the opportunity to describe to the general readership of the article the historical background, technique and modifications of the actual biatrial approach for excising large as well as multi-centric atrial myxomas.

Left atrial access alone does not enable complete heart inspection, requires significant tumor manipulation in the event of a large mass, and may not permit radical resection. Similarly, a right atriotomy with septal incision may not accommodate removal of a large tumor mass without fragmentation. Kabbani and Cooley [2] excised a left atrial myxoma using a biatrial approach in 1973 and Jones and colleagues [3] described many advantages associated with this technique. The classical biatrial approach involves a left atriotomy incision made posterior to the interatrial groove. This incision is usually 3–5 cm and is not used to mobilize the tumor. The diagnosis and location of the myxoma are confirmed using this incision. Next, a right atriotomy is performed and the right atrium and the ventricle are explored for the possibility of tumor extension from left atrium or for a second myxoma. A right-angle clamp or the operator’s finger is introduced under direct visualization through left atriotomy and provides a reference point that allows right atrial excision of the tumor with an adequate rim of interatrial septum [2, 3].

Over the years several modifications of the biatrial incision have been described. The first of these is the inverted T-shaped incision. The inverted T-shaped incision was first described by Campanella and co-authors to expose the mitral valve in a small left atrium, and then it was used by Morishita and associates in resecting a large left atrial myxoma [3]. Other modifications include those described by St Rammos [4] and Massetti and colleagues [5]. Whether the surgeon is confronting a huge myxoma or secondary mitral valve damage, the biatrial incision or one of its modifications gives better exposure. Furthermore, these incisions enable controlled tumor removal, excellent mitral valve exposure, and four-chamber inspection [3–5], while reducing the risk of sinus node damage that accompanies a vertical right atrial incision and secure closure of the atrial septal defect directly or using Dacron [3] or autologous patch [5].

References


eComment: Multiple myxomas -- surgery and diagnosis

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We have carefully examined this report and completely agree with the authors that the described case is extremely rare and interesting [1]. Myxomas are the most frequently encountered type of heart tumor. Seventy-five percent of myxomas are found in the left atrium, 20% are located in the right atrium and 5% appear elsewhere [2]. The Bakoulev Center for Cardiovascular Surgery has an experience of more than 400
successful cases of heart tumor surgery, and there has been only a single case of giant tandem myxoma of left and right atria, which has been described [3]. The neoplasm consisted of two parts which measured 9×8×8 cm in the right atrium and 7×6×6 cm in the left atrium, protruding from the middle third of the atrial septum. The tumor was successfully removed.

It is worth mentioning that, according to our observations, the location of points of attachment of myxomas in the atria has been subject to some sort of evolution in recent times. Previously, the most common (90% of cases) location for attachment of the myxomas was the fossa ovalis. Nowadays more and more of them are found attached to other areas. In addition, we would also like to point out that, from our point of view, transthoracic echocardiography is sufficient to diagnose a myxoma, and the transesophageal method is necessary only in complicated cases where it is required to precisely locate the point of attachment of the stalk of the myxoma.

References

