They are most commonly found as an incidental finding on echocardiogram. There are case reports of patients presenting with myocardial infarction [2], pulmonary embolisation [3], or cerebral embolisation [4].

There were several important lessons from this patient’s case.

The ejection systolic murmur was not mentioned on the request for the first echocardiogram in 2002. The cardiology department does approximately 25 echocardiograms per day and has two consultants available to report them. Therefore correct clinical details on requests are vital.

A repeat echocardiogram was needed, as her clinical picture did not fit the original echocardiogram result. If in doubt go with your clinical judgement.

Clinically this lady did not have infective endocarditis, as supported by the microbiological findings. However, the mass had grown so quickly that it looked on echocardiogram that it had to be infective. This led to a problem with the diagnosis of a very rare condition.

The papillary fibroelastoma in this patient was not causing any problems (apart from diagnostic). This lady was not initially keen on valve surgery. However, once her aortic valve was replaced she improved rapidly and is now living independently again.

Key points
- Papillary fibroelastomas are rare benign cardiac valve tumours that can mimic infective endocarditis.
- Despite causing a diagnostic dilemma, the fibroelastoma was not causing any symptoms in this case.
- Cardiac valve surgery in elderly patients can be very effective and restore functional independence.
- Insufficient clinical details on request forms for investigations can cause delays in diagnosis.

References

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Natural history of an atrial myxoma

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Abstract

The case described is an 89-year-old male patient with a left atrial myxoma, first visualised in 1997, who was a poor operative candidate owing to severe chronic obstructive pulmonary disease (COPD). The tumour had a cross-sectional growth rate of only 0.2 cm² per year and was asymptomatic over 79 months follow-up: the longest reported follow-up period of a non-calcified
myxoma. The report highlights the variety of growth rates described for myxoma in the literature and raises the possibility of a conservative management approach, particularly in high-risk operative candidates.

**Keywords:** myxoma, growth rate, asymptomatic, management, elderly

**Case report**

An 89-year-old male was admitted to the Elderly Care Unit with a collapse. The patient’s left atrial myxoma was first diagnosed in 1997 on transthoracic echocardiography (TTE) and confirmed using transoesophageal echocardiography (TOE). TOE showed a pedunculated mass arising from the foramen ovale. Operative management of the tumour was rejected on the basis of the patient’s severe chronic obstructive pulmonary disease (COPD). Consequently, the decision to warfarinise the patient was taken.

Serial TTEs were carried out over 79 months. The myxoma was non-calcified, had a smooth surface, was not causing obstruction of the mitral valve and demonstrated little movement during the cardiac cycle. The cross-sectional area was determined by the tumour’s largest width and height. The myxoma increased in area by around 0.2 cm² per year (Figure 1) and the width of the myxoma increased by 0.05 cm per year.

In 2001 the patient had an episode of haemoptysis with gastritis observed on endoscopy: as a consequence, his warfarin was changed for aspirin. The patient has had multiple admissions since 1996 with acute onset shortness of breath, most commonly ascribed to infective exacerbations of his COPD and less frequently to pulmonary oedema. The patient had no strokes during this period. During his admission, the patient had two myocardial infarctions (MIs).

**Discussion**

Almost half of all benign cardiac tumours are myxomas and of these around three-quarters occur in the left atrium [1]. They most commonly present with three kinds of symptoms: obstructive, relating to obstruction of the mitral valve (the most common presentation) [2]; embolic, most frequently cerebral [1]; and systemic, involving non-specific features such as fever or tiredness [1].

Generally, the management of myxoma is urgent operative removal. There are few examples in the literature where this has not been the case [3–5]. While prolonged follow-up has been described in the case of a calcified myxoma [5], this is the first reported case where a non-calcified primary myxoma has been followed for a prolonged period.

There is a great deal of variety in the reported growth rate of myxoma. In a review of recurrent myxoma, an average rate of growth of 0.15 cm per month in one plane was described [6]. More rapid rates than this have been described for recurrent myxoma [7]. As most myxomas are urgently operated upon, rates of growth for primary myxomas are harder to establish. In two cases, there was essentially no change in the myxoma’s size during follow-up [3, 5]. In another paper the growth rate was not stated, but from the data provided, the horizontal length increased by around 1.2 cm per year [4]. The growth rate in the current study (cross-sectional growth 0.2 cm² per year, width 0.05 cm per year) is far more in keeping with the stable myxoma of the former studies than with the rapidly growing one described in the latter.

An issue with the current patient is whether his multiple presentations can be attributed to the myxoma. His frequent presentations with shortness of breath were more likely to have been caused by his COPD. The episodes of pulmonary oedema could have been secondary to myxoma-induced mitral valve dysfunction; this is unlikely though in view of the lack of tumour impingement on the mitral valve, and the patient’s known poor left ventricular function. MIs secondary to myxoma have been reported in the literature [8] but are rare events: only 3.5% of cases presenting with this in one series [1], with cerebral emboli being more common [1]. While it is possible that the patient’s MIs were secondary to the tumour, if the patient’s myxoma was originating emboli, it would be expected that he would also have had cerebral emboli. We found no evidence of these. The presence of aortic atheroma on the 1997 TOE rather suggests that the patient had coronary artery disease as a cause of his infarctions.

The current case raises interesting issues regarding management. Operative management is undoubtedly indicated in the case of symptomatic presentations or rapidly enlarging tumours. Surgery need not be the automatic choice in patients where the myxoma is clinically silent. The characteristics of a myxoma on ECHO can predict its behaviour: the presence of a villous rather than smooth surface is more...
significantly associated with emboli [1], and calcification may also be associated with a more stable myxoma [5]. Monitoring the growth of the tumour on TTE could also play a role in determining the necessity of operative intervention, as the size of the myxoma is significantly related to the presence of cardiac manifestations such as pulmonary oedema [1]. For those tumours unlikely to cause symptoms, a conservative approach involving annual TTEs, anticoagulation and monitoring for development of symptoms may be preferable to immediate surgery, especially where the patient presents a high operative risk.

**Key points**
- Conservative management of atrial myxomas may be appropriate in some cases.
- Asymptomatic, smooth-surfaced, calcified, small and slow-growing myxomas, and high operative risk patients would be features favouring a conservative approach.
- Conservative management would involve anticoagulation, and regular monitoring of the patient and myxoma.

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**References**

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**Acute hepatitis C in a nursing home resident**

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**Abstract**
Elderly patients commonly present with jaundice from a multitude of causes. We present an unusual case of acute hepatitis C in an elderly nursing home resident who had no risk factors. Possible causes and treatment are discussed.

**Keywords:** acute hepatitis C, elderly, jaundice

**Case report**
A 74-year-old woman was admitted from a nursing home with a 4 day history of painless jaundice. She had had learning difficulties since childhood, was wheelchair bound and had been in full-time care for 64 years. There was no history of previous jaundice. She had taken carbamazepine for 10 years for epilepsy. She was on no other hepatotoxic drugs.