Correspondence

Lumbar puncture in Guillain–Barre syndrome

Sir,
Maurya and colleagues describe a man with weakness and respiratory failure, subsequently lead to Guillain–Barre syndrome.1 I was wondering if the authors have performed lumbar puncture in the patient. Though the authors encountered the patient in the first week when cerebrospinal fluid protein concentrations are often normal in Guillain–Barre syndrome, a clearly increased cerebrospinal fluid cell count should raise the possibility of other disorders, such as a leptomeningeal malignancy, human immunodeficiency virus-related Guillain–Barre syndrome, or poliomyelitis, particularly in developing countries.2

Lastly, absolute contraindication for lumbar puncture is increased intracranial pressure. If suspected, cranial-computed tomography may be performed before.3

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Histologically benign but clinically malignant: an unusual case of recurrent atrial myxoma

Sir,
A 59-year-old male was admitted following an episode of chest pain and a ventricular fibrillation (VF) arrest in the community from which he was successfully resuscitated. He had a past medical history of moderate rheumatic mitral stenosis and atrial fibrillation and 12 months previously had uneventfully undergone 6 pulses of rituximab, cyclophosphamide, doxorubicin, vincristine and prednisolone (R-CHOP) chemotherapy for high-grade diffuse B-cell gastric lymphoma. Electrocardiogram (ECG) following restoration of sinus rhythm revealed antero-septal T-wave inversion and Tropinin I (TnI) was raised at 4.5 ng/ml indicating acute myocardial infarction (MI). Coronary angiography revealed normal epicardial coronary arteries and echocardiography showed no progression of his mitral stenosis but now demonstrated a left ventricular (LV) antero-septal wall motion abnormality, in keeping with the territorial ECG changes, and a large (2.5 cm x 3.5 cm) mobile left atrial (LA) mass.

Following stabilization in the coronary care unit, he underwent surgical excision of the mass with histology confirming an atrial myxoma.

Three years later, he presented acutely to medical receiving with a 1-month history of worsening shortness of breath, orthopnoea, paroxysmal nocturnal dyspnoea and ankle swelling. Examination revealed bi-basal pleural effusions, raised jugular venous pressure, peripheral oedema and a fourth heart sound. There were no new ECG changes and TnI was negative. Chest X-ray confirmed bilateral pleural effusions with significant pulmonary congestion and plasma B-type natriuretic peptide levels were raised. Echocardiography at this time revealed no worsening in his LV systolic function but
a recurrent and larger (3.5 cm x 3 cm) LA mass (Figure 1) was noted and seen to prolapse through the stenotic mitral valve significantly impairing LV filling with resultant congestion and signs of heart failure. He improved symptomatically with intra-venous diuretics and, once euvoelaemic, uncomplicated resection was undertaken with pathology again confirming a myxoma. He recovered uneventfully from his surgery and continues to do well.

Myxomas are the most common of the primary cardiac tumours. The vast majority of these are benign and 75% occur in the LA most commonly arising from the inter-atrial septum. This case is notable for a number of reasons. First, with regards to its associations. The occurrence of a LA myxoma in a patient with rheumatic mitral stenosis is a rare association having been reported seldomly in the literature as has the association of myxoma and lymphoma. However, as far as we are aware this is the first reported case of recurrent LA myxoma in a patient with either rheumatic mitral stenosis or lymphoma. The presentations in this case are also noteworthy. LA myxoma presenting with MI is a rare but recognized phenomenon, however, presentation with a VF arrest has only been reported once before. Sudden cardiac death due to myxoma is extremely rare and usually associated with asystolic or pulseless electrical activity (PEA) arrest secondary to mechanical obstruction of the mitral valve. Moreover, there have been no reports of recurrent LA myxoma with distinct presentations both requiring hospitalization on separate occasions in the same patient. In summary, this case adds to the paucity of literature on the recurring nature, the associations and the spectrum of presentations of LA myxoma and also underlines the importance of in-patient echocardiography in patients presenting with acute coronary syndromes or heart failure.

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