A 24-year-old man in congestive heart failure was admitted to the hospital. He had worsening exertional dyspnea and palpitations for the past 2 months and was in New York Heart Association functional class IV. There was no history of fever, joint pains, or weight loss. Examination revealed a heart rate of 118 beats per minute, blood pressure of 90/70 mm Hg, and severe mitral regurgitation. Chest radiography showed a cardiothoracic ratio of 0.65% and bilateral pleural effusions. The echocardiogram showed a mass involving the posterior mitral leaflet and adjacent left ventricle (Figure 1 and Movie I). The posterior mitral leaflet was thickened and prolapsing into the left atrium. Severe mitral regurgitation was present, but the left ventricular systolic function was normal (Movie II). The estimated pulmonary artery pressure from the tricuspid regurgitation jet was 60 mm Hg. A contrast-enhanced magnetic resonance image (MRI) substantiated the findings (Figure 2). The mass had a well-defined outline in the luminal aspect but was inseparable from the posterolateral wall. The mass was isointense relative to the myocardium on the T1-weighted images and minimally hyperintense on the T2-weighted images. The mass showed homogenous enhancement after intravenous injection of gadolinium. On the basis of the MRI features, a benign mass, possibly of chronic inflammatory origin, was suspected. Because of severe mitral regurgitation and the ventricular mass, an operation was performed. A 5 × 6 × 4-cm fixed mass of rubbery consistency involving the posterior mitral valve leaflet and extending into the adjacent chordae, posterobasal segment of left ventricular wall, and anterolateral papillary muscle was seen. The anterolateral commissure was involved; however, the anterior mitral leaflet and posteromedial commissure were normal (Figure 3). Severe mitral regurgitation with no mitral stenosis was present. On histopathologic examination, intense myocarditis involving the posterior mitral leaflet and the papillary muscle was found. Aschoff bodies were present, indicating rheumatic carditis (Figure 4). The antistreptolysin O titer sent after receiving the histopathology report was 900 U, and the C-reactive protein level was 18.6 mg/L. The patient was treated with a short course of steroids for 6 weeks and recovered completely. Subsequently, he received 3 weekly prophylactic penicillin therapy. Inflammatory intracardiac mass lesions have been described with infections such as tuberculosis and actinomycosis and in conditions such as sarcoidosis, Wegener granulomatosis, and cardiac pseudotumor. The rare possibility of rheumatic myocarditis causing a ventricular mass lesion should be kept in mind, especially when the valve leaflets are also involved.

Disclosures
None.

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Figure 3. Left ventricular growth involving left ventricular (LV) wall, anterolateral papillary muscle, and posterior mitral leaflet (PML) with normal anterior leaflet. AML indicates anterior mitral leaflet.

Figure 4. A section from the papillary muscle shows the presence of an Aschoff nodule (cellular phase) in a perivascular location (hematoxylin and eosin, magnification ×240).
Rheumatic Myocarditis Masquerading as Left Ventricle Tumor
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