A 64-year-old woman presented to clinic with 2 months of episodic chest tightness at rest, which would last several minutes before spontaneous resolution. Her pertinent medical history included tobacco abuse, hypertension, and hypothyroidism. In addition, she had resection of a left atrial myxoma in the year 2000, after she presented with similar chest discomfort. That procedure involved resection and a patch repair of a wide-based myxoma with negative margins from the interatrial septum. Her cardiac catheterization before resection had revealed minimal coronary artery disease.

Computed tomographic angiography revealed no significant epicardial coronary artery disease, but noted a pedunculated mass attached to the interatrial septum (Figure 1). Transesophageal echocardiography revealed that this was an isolated, highly mobile mass arising from the atrial septum with a long stalk and a head characteristic of myxoma (Figure 2).

Because of a suspicion of recurrent myxoma and the risk for embolic phenomenon, the patient was taken for resection of the entire interatrial septum, including the old patch, with the use of a right atrial approach (Figure 3B). The gross specimen appeared identical to the 3D transesophageal echocardiography images, suggesting no interval embolism from the mass. The patient tolerated the procedure, and her atypical chest pain resolved.

Pathology of multiple sections through the lesion revealed no evidence of myxoma recurrence. The base of the mass (Figure 4) consisted predominantly of fibrin with neutrophils in sheets and associated granulation tissue (Figure 5). A giant-cell response was noted around the old sutures and the base.

From Aurora Cardiovascular Services, Aurora Sinai/Aurora St. Luke’s Medical Centers, University of Wisconsin School of Medicine and Public Health, Milwaukee, WI (V.P.K., K.A.A., S.C.P.); Cardiovascular and Thoracic Surgery, Aurora Medical Group, Milwaukee, WI (D.P.O.); and ACL Laboratories/Great Lakes Pathologists S.C., Milwaukee, WI (D.M.K.).

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Correspondence to Steven C. Port, MD, 2801 W. Kinnickinnic River Parkway, #845, Milwaukee, WI 53215. E-mail publishing21@aurora.org

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focal, mural myxoid change was present, but no neoplastic process could be identified. Her old myxoma specimen was reviewed (Figure 6), showing the characteristic cleared neoplastic myxoma cells. The extensive sheets of neutrophils seen on the current specimen raised the possibility of infection, but no organisms were seen on gram or alternative stains. On questioning, the patient denied dental intervention, surgery, or known bacteremia in the year prior to presentation.

This case demonstrates an unusual macroanatomic appearance of granulation tissue mimicking recurrent myxoma. A history of previous myxoma at the same site warranted careful histopathologic examination of the entire lesion before ruling out recurrence. It is unclear why this patient had a delayed inflammatory response with thrombus at the site of prior resection and patch repair. Several case reports demonstrate a thrombus mimicking myxoma, but this may be the first report of organized granulation tissue mimicking myxoma at the site of a previous myxoma resection.

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None.

Reference
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Vincent P. Keating, Khawaja A. Ammar, Darly M. Knoedler, Daniel P. O'Hair and Steven C. Port

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