In December 2009, a 79-year-old white man was admitted to the Department of Cardiology for a moderate dyspnea (New York Heart Association II) with breath. His past medical history included a cardiac surgery with double coronary arteries bypass grafting in 1996 and thyroid cancer treated with surgery and radiotherapy.

On admission, the physical examination revealed regular heart sounds at 60 bpm, and blood pressure was 100/60 mm Hg. No cardiac murmur was heard. Chest x-ray showed a mild cardiomegaly with a retrocardiac mass without pulmonary edema or pleural effusion. The left ventricular (LV) ejection fraction on echocardiography was at 67%. No LV hypertrophy and no LV dilation (LV end-diastolic diameter, 46 mm; index LV end-diastolic diameter, 40 mm/m²) were found. The transthoracic echocardiography showed a homogeneous nonmobile mass at the left atrium (LA) level associated with reverberations (Figures 1 to 3 and Movies I and II in the online-only Data Supplement). The transesophageal examination showed the apparently extracardiac mass behind the LA, which seemed to repulse the LA wall (Figure 4). Subsequently, a contrast-enhanced computed tomographic examination of the chest showed a well-defined homogeneous mass (70×64×55 mm) with a soft density (36 H), without calcification, gas bubbles, or contrast enhancement, and with what seemed to be an intra-LA (Figure 5). On the sagittal incidence, it seemed that the mass repulsed the LA (Figure 6). There was no evidence of lymphadenopathy, or pleural or pericardial effusion.

Figure 1. Transthoracic examination with parasternal long-axis view showed a homogeneous mass at the left atrial level. LV indicates left ventricle; RV, right ventricle; and AO, aorta.

Figure 2. Transthoracic echocardiography view showed a non-mobile mass (47×45 mm) associated with reverberations on the subcostal view. LV indicates left ventricle; RV, right ventricle; and RA, right atrium.

Figure 3. Subcostal echocardiography view with the measure of the mass. LV indicates left ventricle; RV, right ventricle; and RA, right atrium.

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On the basis of the imaging findings and the patient’s history of thyroid cancer and cardiac surgery, differential diagnosis included the suspicion of hematoma, gossypitoma (textiloma), myxoma, or a malignant tumor. The patient subsequently underwent mediothoracotomy with dissection of a retrocardiac mass (Movie I in the online-only Data Supplement). There is a retained surgical field (Figure 7). Histological examination revealed dense hyalinized tissue with foreign-body giant cell reaction and fragment of surgical field. Transesophageal echocardiography, after resection of textiloma, showed a normal LA (Figure I in the online-only Data Supplement). The subcostal echocardiography view, after the resection of textiloma, showed left atrial vacuity (Figure 8 and Movie III in the online-only Data Supplement).

In conclusion, it is difficult to diagnose textilomas because of their inconsistent radiological appearance. The diagnosis needs a high index of suspicion in patients with previous surgery. Meticulous analysis of radiological incidences is necessary to understand the relation between the mass and adjacent structures.

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Disclosures
None.

References

Figure 4. Transesophageal examination, during cardiac surgery, showed the apparently extra cardiac mass behind the LA which seemed to repulse the LA wall. LA indicates left atrium.

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References

Figure 5. Computed tomographic scan showed an inhomogeneous tumor (70×64×55 mm).
Figure 6. A sagittal computed tomographic scan showed a homogeneous mass without contrast and demonstrated that there was a repulsed wall of the left atrium.

Figure 7. Photograph of excised mass showing surgical fields.

Figure 8. The subcostal echocardiography view, after the resection of textiloma, showed left atrial vacuity. LV indicates left ventricle; RV, right ventricle; RA, right atrium; LA, left atrium.
Retrocardiac Textiloma Mimicking a Left Atrium Myxoma
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Frédérique Jault and Iradj Gandjbakhch

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