Massive intracardiac lymphoma spreading across the interatrial septum into major intrathoracic vessels

A 22-year-old female was referred from a distant institution with a 3-week history of palpitations, dizziness, facial swelling, cyanosis and syncope. Upon admission, transthoracic echocardiography revealed a solid mass collapsing the right atrium protruding into the tricuspid valve, displacing the interatrial septum extending across it into the left atrium and infiltrating the aortic wall (figure 1—movies 1, 2). Emergency surgical exploration was indicated owing to the poor condition of the patient. At surgery, there was pericardial effusion, and infiltration of the right cavities, superior and inferior venae cavae, right superior pulmonary vein and pulmonary artery. A right atrial biopsy was taken, and the case was deemed to be non-resectable.

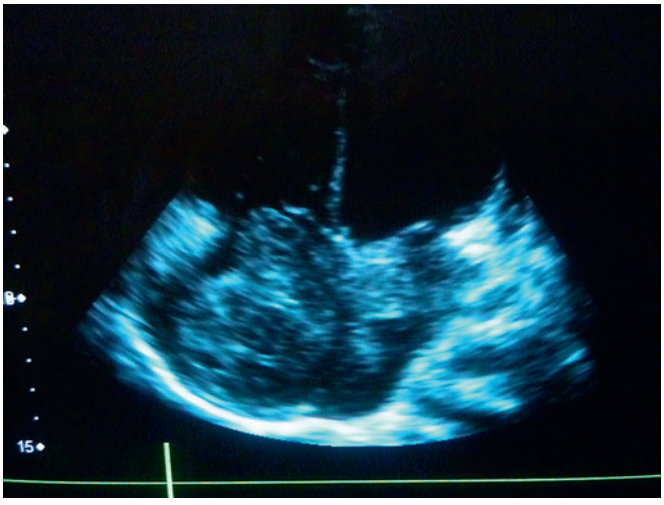

Figure 1 Four-chamber view showing filling of the right atrium, which is completely occupied by a mass that displaces the interatrial septum towards the left atrium. There is a tumour mass inside the left atrium as well. The tricuspid orifice is also compromised.

Histological examination of a 1.5×0.5 cm sample confirmed large areas of necrosis. There were lymphoid-like round cells with oval nuclei, multiple areas of mitosis and karyorrhexys. Immunohistochemistry was performed. Tumour cells were immunoreactive to anti-CD20. There was no immunoreaction to CD3, CD30, EMA and α-phetoproteine. The final histopathological and immunohistochemistry diagnosis was cardiac infiltration by large B-cell lymphoma.

Primary intracardiac lymphomas are uncommon but not exceptional. Aggressive clinical presentation is frequent including signs and symptoms of superior vena cava syndrome or other according to location. Some cases are amenable for surgical resection. Reported experiences with or without surgical excision are consistent with a poor short-term prognosis even with chemotherapy.[1 2] This case particularly depicts the way an intracardiac lymphoma grew silent until massive spread through the interatrial septum and cavities involved major left and right vascular structures leading to cardiovascular collapse.

Carlos A Mestres, Abdulsamee Hemdan, José M Bernal

Department of Cardiovascular Surgery, Tajoura National Heart Center, Tajoura, Tripoli (Libya)

Correspondence to Dr Carlos A Mestres; 14144@comb.es

Acknowledgements General support was given in care by AM Alewa and A Ifthikar.

► Additional movies are published online only. To view these files please visit the journal online (http://heartasia.bmj.com).

Competing interests None.

Ethics approval This study was approved by Department of Cardiovascular Surgery—Medical Director.

Provenance and peer review Not commissioned; internally peer reviewed.

Heart Asia 2011:47. doi:10.1136/heartasia-2011-010013

REFERENCES

1. **Pérez-Baztarrica G,** Nieva N, Gariglio L, *et al*. Primary cardiac lymphoma: a rare case of pulmonary tumor embolism. *Circulation* 2010;**121**:2249—50.
2. **Ohashi T,** Yoshida T, Oka F, *et al*. Primary giant cardiac lymphoma occupying right atrium. *Asian Cardiovasc Thorac Ann* 2009;**17**:437—8.

Heart Asia: first published as 10.1136/heartasia-2011-010013 on 14 June 2011. Downloaded from http://heartasia.bmj.com/ on April 10, 2024 by guest. Protected by copyright.