Left ventricular myxoma presenting with prolonged fever

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Left ventricular (LV) myxoma presenting with fever of unknown origin is rare, with only one reported case (1). Here we present a patient with LV myxoma initially presenting as prolonged fever. The fever disappeared after operative excision of the myxoma.

CASE REPORT

A 45-year-old man presented with low-grade fever of 1-month duration. An extensive investigation did not reveal the cause of the fever. There was no palpitations, breathlessness, chest pain, syncope, loss of vision, night sweats, cough, loss of weight, or loss of appetite. On examination, the patient was febrile. A precordial systolic murmur was detected at the apex. The spleen was not palpable.

Routine blood and urine examination revealed no abnormalities. Hepatic and renal function were normal, as was the chest radiograph, tuberculin test, brucella antigen test, ultrasonography of the abdomen, and blood cultures. In addition, rheumatoid factor, antinuclear factor, and antineutrophil cytoplasmic antibody results were negative, and retroviral antibody and surface antigen for hepatitis B were nonreactive. The bone marrow examination was also normal.

Electrocardiography showed sinus tachycardia and left ventricular hypertrophy with a strain pattern. Two-dimensional

Figure 1. Two-dimensional transthoracic echocardiography (parasternal long-axis view) showing a round, pedunculated mass measuring 3.7×2.3 cm arising from the left ventricular apex. LV indicates left ventricle; LA, left atrium.

Figure 2. Macroscopic appearance of the excised brownish-colored tumor with a pedicle.

transthoracic echocardiography showed a mass measuring 3.7×2.3 cm arising from the LV apex, with a normally contracting adjacent myocardium (*Figure 1*). The LV ejection fraction was 68%. The morphology and function of cardiac valves were normal.

On cardiopulmonary bypass, a soft brownish mass was seen arising from the LV apex (*Figure 2*). The tumor was surgically removed, and histology confirmed the diagnosis of myxoma (*Figure 3*). The patient's postoperative period was uneventful; he had a smooth recovery, with resolution of the fever, and was discharged on the 10th postoperative day in sinus rhythm.

DISCUSSION

The cause of the fever in our patient is unclear, but it disappeared after excision of the tumor. Overproduction of

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Figure 3. Histopathology of the excised mass showing myxomatous cells suggestive of myxoma.

interleukin-6 has been linked to the principal mediator of the acute-phase protein responsible for symptoms such as fever, anemia, and arthralgia experienced by patients with cardiac myxomas, and raised serum levels may become undetectable after resection of the neoplasm (2).

1. Kapoor A, Radhakrishnan S, Sinha N. Unusual presentation during childhood of left ventricular myxoma. *Cardiol Young* 1998;8(1):126–127.
2. Uçkaya I, Widmera U, Jost CA, Seifert B, Jenni R. Usefulness of serum interleukin-6 to discriminate between cardiac myxomas and non-myxomatous cardiac masses. *Kardiovaskuläre Medizin* 2005;8:361–369.