Case Report

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Extra Cardiac Manifestation of Right Atrial Myxoma-Ascites A Rare Case

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ABSTRACT

Right atrial myxoma is less commonly seen in our day to day clinical practice. Usually the most common site of myxoma is the left atrium. Ascites is a rarest clinical presentation of such myxoma. Many times, clinician is unable to diagnosis the cause of transudative ascitic fluid. One has to be highly suspicious arrive at the correct diagnosis of right atrial myxoma giving rise to ascites (transudative) in such situation.

INTRODUCTION

Cardiac tumors represent 0.2% of all tumors found in humans, and myxoma is the most common type. The commonest of these primary tumors are myxoma, and of the myxomas 74% occur in the left atrium, and 26% in the right atrium [1]. Atrial myxoma patients may be asymptomatic, but, symptomatic patients may present with one of the following triads that include either blood flow obstruction, embolization, or other constitution symptoms. Generally, right atrial myxoma differential diagnosis includes thrombus, metastatic tumors, and sarcoma [2,3]. Here we present a case report showing a rare right atrial myxoma which is completely obstructing the flow of inferior vena cava and tricuspid valve partially, leading to ascites formation.

CASE REPORT

A 62-year male patient nondiabetic, normotensive came to our hospital with complaints of abdominal swelling with loss of appetite in the last 10 days. There is no co-morbidity or past drug history. Her is nonalcoholic and nonsmoker. On general examination his blood pressure was 98/58 mmhg, pulse 80/min, irregular, afebrile with oxygen saturation of 94 % on room air. There was no icterus, pallor, clubbing, lymphadenopathy, mild bilateral pitting pedal oedema was noticed. On examination of abdomen there was appreciable ascites noticed. Cardiovascular, respiratory system examination revealed normal study. Routine Investigations showed hemoglobin 12 g/dl, total white cell count 10,100/cmm, ESR 75 mm, serum liver and renal function test were normal. Viral markers HBsAg, HCV and HIV were negative. Urine routine was normal. Ultrasonography of abdomen suggested moderate ascites and prominent inferior vena cava. Chest X ray was normal. ECG showed atrial fibrillation features. Diagnostic ascitic fluid showed transudative picture with ADA level 14. The patient was put on low dose diuretics and patient was advised for follow up in OPD. After 2 days, patient returned with complaints of diaphoresis and giddiness. Diuretics were stopped immediately. His blood pressure was 90/54 mmhg with pulse of 96/min. He was planned for 2 D echocardiography to exclude cardiac cause. Echocardiography showed right atrial myxoma obstructing flow of inferior vena cava completely and tricuspid valve partially and grossly enlarged IVC (21.4 mm). Patient was diagnosed as a case of right atrial myxoma causing ascites. He was then referred to cardiothoracic surgeon for further management.

DISCUSSION

In our patient right atrial myxoma lead to transudative ascites and peripheral oedema due to inferior vena cava obstruction.

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Obstruction of inferior vena cava was causing less blood flow to pulmonary circulation therefore less blood flow to systemic circulation, ultimately leading low blood pressure and giddiness. The large atrial myxoma produced arrhythmogenic effect leading to atrial fibrillation in the patient. The complaint of poor appetite of patient may be explained by systemic effect of the tumor itself.

CONCLUSION

Clinicians are advised to look for right atrial myxoma as a cause of transudative ascites in unexplained circumstances.

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