

CASE IMAGE

Rare cause of recurrent pericardial tamponade: Cardiac angiosarcoma

Tekrarlayan perikardiyal tamponadın nadir nedeni: Kardiyak anjiyosarkom

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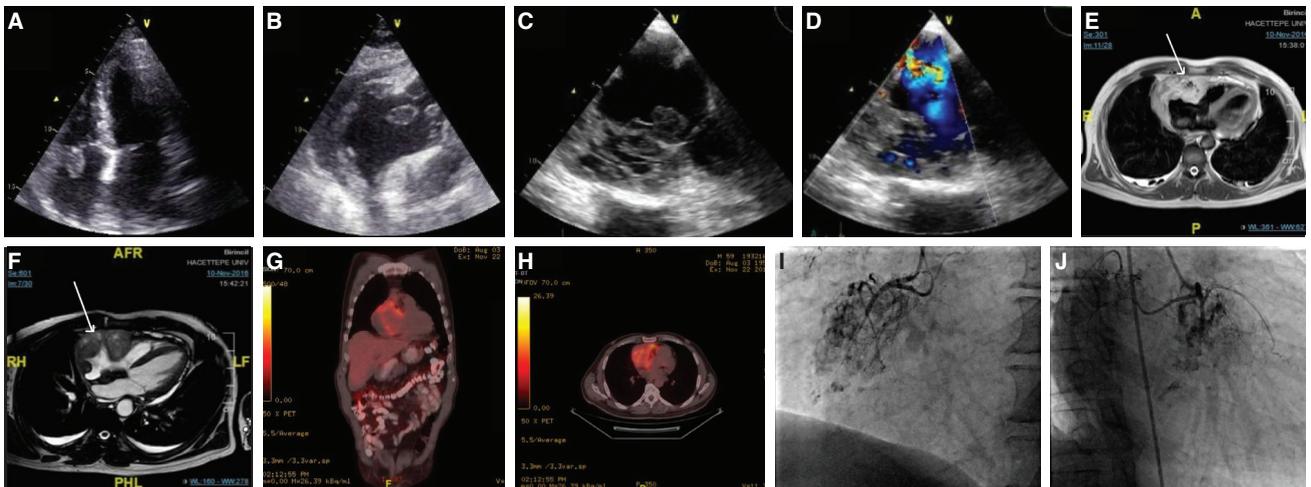
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A 59-year-old male patient with a diagnosis of diabetes, hypertension, and prostatic cancer presented at the outpatient clinic due to recurrent pericardial tamponade and 2 instances of non-diagnostic emergent pericardiocentesis performed at another medical center in the previous 2 weeks.

His examination was unremarkable. All laboratory test results were within normal reference limits. Electrocardiography indicated sinus tachycardia without any other abnormality. Chest X-ray was normal. Transthoracic echocardiography revealed an increased wall thickness of the right atrium with a mobile mass (20x13 mm) at the junction of the atrial free wall and the tricuspid valve with minimal pericardial effusion near the right atrium (Figures A, B; Video 1*). Transesophageal echocardiography also demonstrated a heterogeneous mass infiltrating the free wall of the right atrium with an increased vascularity

and a mobile thrombus-like appearance (22x15 mm) just over the right atrial mass (Figures C, D). Cardiac magnetic resonance imaging confirmed the presence of a right atrial heterogeneous mass with necrotic components, which was invading the pericardium and compatible with primary cardiac angiosarcoma (Figures E, F). The mass also extended throughout the anterior mediastinum, the right ventricle, and both vena cavae, without distant metastasis. Positron emission tomography-computed tomography revealed a right atrial mass with high fluorodeoxyglucose uptake (maximum standardized uptake value: 9.3) without any other significant lesions (Figures G, H). Right coronary artery (RCA) occlusion due to tumoral invasion with fistulization of the RCA to the right heart chambers, and nonsignificant stenotic lesions in the left coronary system were detected using coronary angiography (Figure I, J; Video 2*). Surgical exploration revealed that the tumor was too aggressive and invasive for resection, and therefore was accepted as inoperable. Incisional biopsy specimen was compatible with angiosarcoma. The patient was referred for chemotherapy, but he declined the treatment and was discharged.



Figures– (A) Transthoracic echocardiography in apical 4-chamber and (B) modified subcostal views. (C, D) Transesophageal echocardiography images showing a right atrial mass with increased vascularity and thrombus-like appearance over the mass. (E, F) Cardiac magnetic resonance imaging revealing a right atrial mass invading the atrioventricular groove and the pericardium. (G, H) Positron emission tomography-computed tomography illustrated a right atrial mass with high fluorodeoxyglucose uptake (maximum standardized uptake value: 9.3) without any other significant lesions. (I, J) Right coronary artery (RCA) occlusion due to tumoral invasion and vascularization of the tumor from the RCA.

*Supplementary video files associated with this presentation can be found in the online version of the journal.