Reply to Letter to the Editor: “Recurrent Cardiac Myxoma: A Puzzle to be Solved”

To the Editor,

We appreciate your interest and contribution to our case.1 Your comments2 on the importance of systemic inflammation and its association with recurrence in patients with cardiac myxoma are invaluable. When we retrospectively scanned the patient’s acute phase reactants, we found that erythrocyte sedimentation rate was mildly elevated above the threshold. C-reactive protein (CRP) levels were normal on the previous admissions. However, in the most recent recurrence, we found that the CRP level was mildly elevated without any further increase or decrease during the perioperative period. There were no existing constitutional symptoms. Frequent recurrence might have been associated with inflammation. However, the patient was on chronic glucocorticoid therapy because of a history of bilateral adrenalectomy. Thus, we expect the patient’s inflammatory response to be suppressed.3

As you mentioned, parenchymal seeding of cardiac myxoma was previously reported.4 In our patient, encephalomalous changes compatible with chronic infarct sequelae were observed on magnetic resonance imaging. There were no cerebrovascular involvement or parenchymal lesions consistent with tumoral embolization. Thus, we considered these cerebrovascular events to be of embolic origin.

Cardiac troponin was mildly elevated above the threshold without any rise or fall pattern. As patients with takotsubo cardiomyopathy (TTC) usually have a lesser degree of elevation of cardiac myonecrosis markers, it is possible that our patient might have had an atypical pattern of TTC that might have contributed to the left ventricular systolic dysfunction.5 We generally expect improvement in systolic dysfunction in TTC during follow-up; however, systolic dysfunction did not recover in our patient.6 In addition, when we looked at the previous medical records of the patient, there was systolic dysfunction in repeated echocardiograms. These findings move us away from the diagnosis of TTC.

We would have expected valvular dysfunction due to a large myxoma protruding to the mitral valve and recurring 4 times. However, the patient had only mild mitral regurgitation without any structural deterioration of the mitral valve. Thus, he did not have valvular surgery during previous myxoma surgeries.

We thank you for your valuable contribution to our paper.

REFERENCES
