



Atrial Myxoma and Hypersomnia

Atriyal Miksoma ve Aşırı Uyku Eğilimi

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Anahtar Kelimeler: Aşırı somnolans bozuklukları, atriyal miksoma, ailesel serebral infarktüs

Dear Editor,

A 27-year-old male patient was admitted to our clinic because of somnolence for 2 days. The patient's symptom started after an argument in his family. The patient was able to communicate normally and did not experience any difficulty in his daily tasks when he was awake. The patient was first admitted to a psychiatry clinic with this complaint that was diagnosed as depression.

The patient's physical examination revealed no disturbance in his orientation and cooperation. He had no signs of meningeal irritation, his pupils were isochoric, his direct-indirect pupillary reflexes were normal bilaterally. His cerebellar examination was normal, he had no pyramidal findings with normal deep tendon reflexes.

His biochemical tests revealed that C-reactive protein level was above normal with 12.9 mg/dL, urea was 15.6 mg/dL and creatinine was below normal with 0.63 mg/dL. In his whole blood analyses, white blood cell count was 10.81 K/uL, neutrophil count was above normal with 8.82 K/uL and other parameters were within normal limits.

A cerebral magnetic resonance imaging (MRI) (sagittal T2 FSE, axial T2 FSE, axial T1 FLAIR, and coronal T2 FLAIR-weighted imaging) was performed with the possible diagnosis of a cerebrovascular event. The imaging showed that the brain stem, pons, cerebellum and fourth ventricle were normal. There were no lesions in thalami, basal ganglia, internal and external capsules,

and centrum semiovale with normal ventricles. No intracranial developmental abnormality or space-occupying lesions were seen except a retention cyst in the inferior wall of the right maxillary sinus and hypertrophy in the nasal conchae on predominantly the left. The patient's diffusion-weighted MRI and apparent diffusion coefficient map (ADC map) images revealed an acute infarction with a size of 57x29 mm, extending from the left centrum semiovale to the cortex of the inferior part of left parietal lobe (Figure 1). The patient's echocardiography revealed a mobile mass in 4x3 cm size in the anterior mitral valve 'anterior mitral leaflet' with a heterogeneous border. The ejection fraction was 55%. Although the morphology of the valves was normal, mild mitral valve insufficiency and very mild tricuspid valve deficiency were also detected.

Based on his medical history, physical examination, laboratory analyses and radio imaging findings, the patient was diagnosed with ischemic cerebrovascular event due to the left atrial myxoma. The patient was referred to the Clinic of Cardiovascular Surgery. After the excision of the myxoma, the patient's symptoms disappeared almost completely.

The clinical findings of atrial myxomas depend on the tumor's location, dimension, and mobility. Embolism may present with symptoms caused by intracardiac obstruction such as dyspnea, edema, syncope or by non-specific symptoms such as fever, arthralgia, myalgia, erythematous rash, anemia, and an increase

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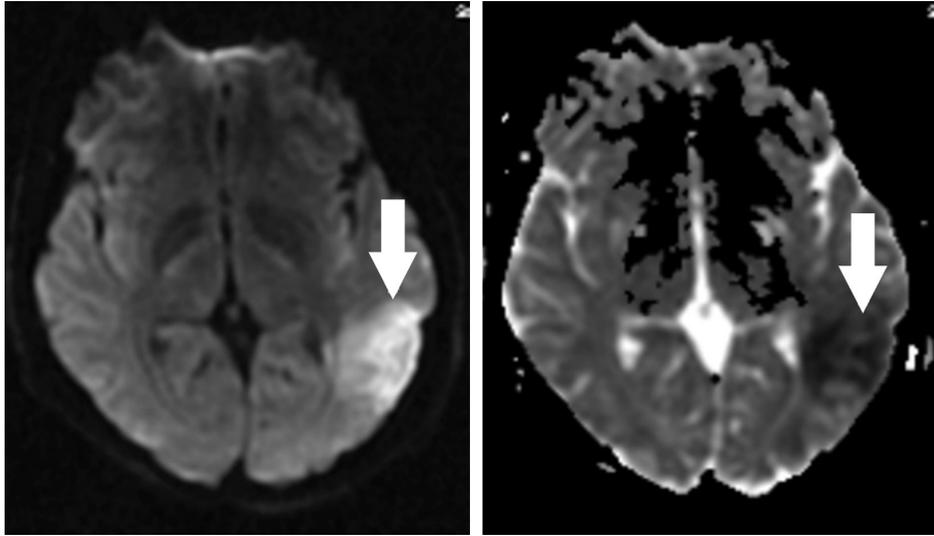


Figure 1. Diffusion-weighted and apparent diffusion coefficient map images of the patient

in erythrocyte sedimentation rate (1). On the other hand, some patients may also present with transient or permanent vision loss, symptoms related to occlusion of renal or coronary arteries, cough, hemoptysis and pulmonary hypertension due to the occlusion of pulmonary vessels caused by myxomas in the right atrium (2,3). Prolonged somnolence in patients with atrial myxoma is very rare and can sometimes be the sole symptom like our patient (4,5).

In summary, clinician should keep in mind that cerebral infarction due to atrial myxoma may manifest itself as prolonged somnolence.

Ethics

Informed Consent: Consent form was filled out by all participants.

Peer-review: Internally peer-reviewed.

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