Clinical Case

A 37-year-old woman who was previously healthy and had no history of interest consulted for chest pain and acute dyspnea. At admission, clinical and radiological signs of pulmonary congestion without cardiomegaly were appreciated. The electrocardiogram showed only sinus tachycardia. The clinical situation quickly stabilized with conventional treatment consisting of furosemide and morphine.

Transthoracic and transesophageal echocardiography (Figure 1) revealed two oval masses in the posterolateral and anterior wall of the left atrium that caused severe obstruction of atrial flow. The large

posterior mass (7×3.5 cm) was of cystic appearance: it had a thick capsule-like outer wall and anechoic content except for the central region, where irregular echodense zones were visible. The retroaortic or anterior mass was 2×2 cm and of essentially solid appearance. There was a slight mural thickening that extended throughout the lateral region and atrial roof, and converged in the anterior and posterior nodular formations. No communication between the masses and atrial lumen was detected by color echo-Doppler. The drainage of the pulmonary veins was not obstructed, but blood flow through the left atrium was. The atrial lumen was reduced to a narrow medial conduit where a markedly turbulent flow was appreciated, with a mean intra-atrial gradient of 12 mm Hg calculated by Doppler.

Magnetic resonance imaging showed that the echocardiographic findings corresponded to a single process arising from the atrial wall. MRI confirmed the absence of any solution of continuity between the large mass on the posterior wall, the nodulation of the retroaortic region, and the laminar thickening of lateral
of mural hematoma and non-specific focal fibrosis of the atrial myocardium, with no neoplastic or myxoid tissue, vascular malformations, or findings of hydatidosis. In the study by magnetic resonance imaging made 2 weeks after the intervention, there was only a small residual hematoma in the posterolateral wall of the left atrium. The patient recovered without complications and remains asymptomatic without treatment.

DISCUSSION

The intramural hematomas reported in the medical literature have been related for the most part with trigger factors such as heart surgery,\(^1\) annular endocarditic abscesses,\(^2\) cardiac trauma,\(^3\) hemangioma of the atrial wall,\(^4\) or aortic dissection,\(^5\) with spontaneous cases being exceptional.\(^6,7\) Intramural hematomas are usually located in the left atrium\(^1,5-7\) or in relation with the interatrial septum,\(^2\) those of the right atrium being less frequent.\(^1,4\)
In the echocardiographic differential diagnosis of masses of lobular or cystic appearance related with the atrial wall, a large variety of processes have been described: hydatidosis, cystic myxomas, pseudocysts of the right atrium in relation to ventriculo-pulmonary shunts, extrinsic compression by neoplasms like bronchogenic or pleuropulmonary cysts, simple hematic cysts, atrial dissection, and intramural hematomas.

In analogy with aortic pathology, the conceptual difference between dissection and mural hematoma is established by the presence or absence of a connection between the mural hematoma and vascular lumen. Left atrial dissection is generally characterized by a relation with mitral valve replacement or endocarditis, a port of entry in the atroventricular annulus, and the involvement of either the atrial wall or interatrial septum. The false chamber may or may not be connected with the atrial lumen and form masses of lobular appearance that can compress the true lumen as intramural hematomas do.

To date, only three cases of spontaneous atrial intramural hematomas, including the present case, have been reported in the literature. The clinical manifestations that have been reported include chest pain, dyspnea, and palpitations (in one patient the case was documented by atrial fibrillation). Echocardiography studies (transesophageal in two cases) provided a diagnosis of atrial mass with a greater or lesser degree of luminal obstruction, but did not establish the cause of the process. The echocardiographic finding of masses of lobular or cystic appearance raised the question of the differential diagnosis with hydatidosis in all cases. The mouth of the pulmonary veins was not affected in any of the three cases reported.

The availability and improvements in imaging techniques, such as echocardiography, helical computed tomography, and magnetic resonance imaging, have increased knowledge of intra and paracardiac masses. In spite of the excellent anatomic resolution of each of these techniques, two or more of these techniques may sometimes be required for the diagnosis of the etiology or extension of the cardiac masses because the techniques often provide complementary information. In the case presented, the three-dimensional resolution and capacity for tissue characterization of magnetic resonance imaging studies were decisive in visualizing the spatial distribution and hemorrhagic nature of the lesions seen in the echocardiogram. Previously, magnetic resonance imaging had been used only in the diagnosis of the case reported by Delgado, in which it typified the lesion as a cystic mass with hematic content. In all three cases, the diagnosis was confirmed in the operating theater and followed by a very favorable outcome.

We conclude that atrial intramural hematomas should be included in the differential diagnosis of atrial masses. Intramural hematomas can have an echocardiographic appearance of pseudomas, sometimes of cystic or lobular appearance. The capacity for anatomic and tissue characterization of magnetic resonance imaging should give it a determinant role in the diagnosis of this rare pathology.

REFERENCES