Atrial Myxoma - A Dramatic Tale !

By Elizabeth Harris, R.N., CNOR.

Having a spare moment on Wednesday, her day off, Mrs. B. dropped in for her echocardiogram. She had no idea of the sharp curve the course of her life was about to take.

Mrs. B. is a 36 year old Caucasian female, the mother of a nine year old boy and a seven year old girl. She has worked for eighteen years in a local nursing home as a personal care attendant. She is a very health conscious individual who follows an excellent program of diet and exercise with no alcohol or tobacco use. She is active as a Brownie leader, in her church, with craft sales and family projects - never a dull moment.

It all began in September 1989, while on duty at a local nursing home. While moving a patient, she felt "something" in her chest, was slightly dyspneic, and thought she'd pulled a muscle. It was 6 AM, the end of her three 12 hour nights, that she, upon the insistence of her supervisor, reluctantly went to a nearby hospital. It was determined that she probably had "pulled a muscle". After two weeks of rest she returned to a lighter work schedule without discomfort.

Four months later, in January she began to experience some shortness of breath upon climbing stairs, however, she dismissed this as not being a problem. She had a physical exam and no problems were detected.

In March, while at the doctor's office for her children's visit, she again mentioned her occasional shortness of breath, the doctor was not concerned. She was back, now, hard at work rarely ill.

The registered nurse, with whom she worked, noted her dyspnea after climbing stairs, and suggested that she have a stress test. Her physician didn't feel this was necessary, however, he suggested that she see a cardiologist, which she finally did because her nurse friend was so insistent.

She went to visit the cardiologist, was given a very thorough, unusual exam. He spent almost an hour listening to her heart sounds as she sat, stood, knelt, and turned one way, then the other. He wanted her to have an echocardiogram ASAP.

Two days following, she had her echocardiogram. Later that same day she received a call from her doctor to tell her that she had a tumor inside her heart and must go to the hospital immediately. Calmly she packed a small bag and went to the hospital, somewhat amazed as she was feeling fine.

She was scheduled to have a cardiac catheterization on Thursday, however, it was cancelled, as the tumor was shown on the echocardiogram to be very large.

Her family history indicated that a maternal grandmother had had a "leaky valve", otherwise there was nothing pertinent. Her personal history showed increasing fatigue over a four month period with detection of a heart murmur. Also of note was detection of systolic and diastolic murmurs with a thrill. The chest x-rays showed upper lobe vessels slightly prominent, suggestive of possible raised venous pressure with the

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LA enlarged in both PA and lateral views. Her Hct. was 0.341, Hbg was 113 with a normal ESR. Other lab values were normal. EKG showed a regular sinus rhythm with some anteroseptal ST-T wave changed. The echocardiogram showed a large atrial myxoma.

Textbook and article information re: atrial myxoma was somewhat scarce, however, I did find the following textbook description:

> "Tumors within cardiac cavities are usually myxomas, fibromas, or sarcomas and are most commonly found in the atria. Right atrial tumors produce symptoms and signs of inflow tract obstruction; left atrial tumors are characterized by evidence of lesser circulation obstruction. Because of the similarity of the clinical presentation of left atrial tumors and mitral stenosis and the importance of differentiation, left atrial tumors (particularly atrial myxoma) are here discussed as a prototype of tumors. Atrial myxoma must also be differentiated from infective endocarditis.
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> **Data Base: Atrial Myxoma** The history may include syncope, seizure activity, weight loss, bizarre behaviour, fatigue, angina pectoris, dyspnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, and haemoptysis. There is a wide array of physical findings, which frequently change with the position of the patient. Findings include cyanosis, gangrene of extremities, shock, coma, atrial fibrillation, fever, clubbing, and cardiac murmurs (related to obstruction of the atrioventricular valve). The most specific murmur is a low-pitched diastolic rumble at the apex, which may be intermittent and may vary with the position of the patient. A "tumor plop" may be heard in early diastole.
> This sound is caused by movement of the tumor near or across the mitral orifice during early diastole and is similar in timing and quality to the opening snap of mitral stenosis. Other physical findings may include variation of blood pressure with position, a petechial rash, and endocardial friction rubs due to physical contact of the tumor with the endocardium. Laboratory data may reflect haemolytic anemia and often an elevated sedimentation rate. Electrocardiographic abnormalities include arrhythmias, conduction distances, abnormal P waves, and ST-segment changes; changes of myocardial infarction have been reported. Chest x-ray may be normal except in the late stages of the disease, when pulmonary edema and cardiac enlargement are seen; at times the tumor may be calcified."[1]

On Friday morning I was Mrs.B's patient nurse, i.e. the one greeting her in the holding area, accompanying her while intravenous and arterial lines were started, then continuing on into the operating room. As we talked, I found Mrs. B's main concern was that someone be at home to greet her children when they returned from school. She had arranged for a relative to be there, and, as I tried to reassure her that this seemed to be acceptable, she was able to relax considerably.

Once in the operating room, the induction, preparation, chest opening, and cardiopulmonary bypass proceeded, as we had anticipated, without incident.

The heart was opened; with aplomb the surgeon inserted his left hand and, by blunt dissection, plucked the largest atrial myxoma that anyone in the room had ever seen, from her left atrium.

It was the size of a large black Friar plum - measuring 8 cm x 5 cm x 3 cm. Medical media came in to photograph the myxoma and the intraoperative course continued as expected, without complications. The heart and chest were closed in the usual fashion and the patient was transported to the intensive care unit in quite satisfactory condition.

I interviewed her on the eleventh post-operative day. She had experienced a somewhat difficult first three post-operative days, with nausea, vomiting and chest discomfort. On the eleventh post operative day she was actively moving around and looking forward to going home the next day.

A recent telephone conversation (one year later) confirmed that she is feeling very well and enjoying her normal life style.

References

1. Nanette K. Wenger, J. Willis Hurst, Mildred C. McIntyre, *Cardiology for Nurses* (McGraw-Hill Book Company 1980).

Conference Calendar

1991

November 1st and 2nd, 1991.
The Operating Room Nurses Association of South Central Ontario
presents their: Annual Fall Seminar
Haliburton Highlites
at the Pinestone Inn Haliburton, Ontario
Tentative Programs and Pre-Registration Forms to follow. Inquiries may be directed to:
Kathy Bruce, R.N.
c/o Whitby General Hospital
Gordon St., Whitby, ON
L1N 5T2
Phone: (416) 668-6831
Fax: (416) 430-3421

1992

The Operating Room Nurses of Ontario
are sponsoring a three day conference in Toronto
April 12th-15th, 1992
at the Western Harbour Castle Hotel.
The Topics are applicable to all operating room and day surgery nurses.
The Conference Committee Members are:
Hilda Gatchel, (Conference Committee Chairperson), Oshawa General Hospital, Oshawa. **Vija Hay**, (Vice-chair and Protocol), Queensway Carelton Hospital, Ottawa. **Jocelyn Staynes**, (Treasurer), St. Catharines General Hospital, St. Catharines. **Carole Starr** (Exhibitors), Peterborough Civic Hospital, Peterborough. **Wanda Ward**, (Hospitality), Orthopaedic and Arthritic Hospital, Toronto. **Darlene Beaudet**, (Registration) Metropolitan Hospital, Windsor. **Judi Tyndall**, (Publicity), Henderson General Hosptial, Hamilton, and **Diana Jorgensen**, (Hostesses), North York General Hospital, Toronto.

1993

Québec City, Québec

13th National
Operating Room Nurses Conference
June 6th -11th, 1993 .
Theme:
"Global Vision of Care, Guide in the Midst of Automation"
Watch the Operating Room Nursing Journal for additional information in upcoming issues

Operating Room Nurses Day November 14th, 1991

Prepare now for November 14th, OR Nurses Day across Canada - the day recognized and promoted by the Operating Room Nurses Association of Canada,(ORNAC). This one day a year is set aside to give recognition to perioperative nurses in hospitals and day surgery clinics.

On this day the public as well as other care professionals are invited beyond the "sterile doors" to see perioperative nursing in action and view the highly complex technology used in today's surgery.

Gloria Stephens, President of ORNAC, stated: "There's a lot of versatility in the area of perioperative nursing and that is why there is such a low turnover rate in Canada's ORs. It is a very rewarding field and Operating Room Nurses Day, November 14th, provides an opportunity to demonstrate this versatility-both the nursing practice and the technical aspects of perioperative nursing

Plan your activities and demonstrations today. Contact your Provincial O.R. Association president for posters and buttons.

ORNAC

Recommended Standards

The Recommended Standards for Operating Rooms in Hospitals, as established by the Operating Room Nurses Association of Canada, are available for sale
Recommended Standards
@ $12 per copy
Recommended Technical Standards
@ $20 per copy
Cheques and money orders should be made payable to:
The Operating Room Nurses Association of Canada. Postage and GST @ 7% will be added.
Direct your orders with a return address to:
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