

Secondary cardiac tumor

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Background: Cardiac secondaries of peripheral tumors can occur by means of hematogenous or lymphogenous spread.¹ With an incidence of up to 1% at necropsy, metastatic deposits to the heart are more than 20 times more common than are primary tumours.¹⁻³ There are several clinical features, that are seen commonly with cardiac tumors: embolization, obstruction, arrhythmias. Metastases to the heart are, clinically silent in 90% of cases. Echocardiography is the first diagnostic procedure. Owing to the small numbers of cases there is no evidential basis for the optimal treatment regime.

Case report: 49-year-old patient was admitted to our department due to dyspnea, palpitation, hemodynamic instability. 12-lead ECG: supraventricular tachycardia 208 bpm, right bundle branch block. Medical history: hysterectomy with adnexectomy 5 years ago, due to sarcoma of uterus with high degree of malignancy. Completed treatment of chemotherapy and radiotherapy. Laboratory results: elevated tumor marker Ca 125: 366 U/ml and D dimmer 7.46 ug/ml, others found neat. Echocardiography: the enlargement of right heart cavities dimensions, along the entire free wall of the right ventricle (RV) visible tumor mass that starts from the free wall and affects more than 2/3 of the volume of RV, fills the RV outflow tract and is partly seen in the pulmonary artery and the mobile formation 21x23 mm passes through the tricuspid valve and pendulates between right atrium and RV causing an almost severe tricuspid stenosis - with TV PGmax of 4.5mmHg. After introducing into the sinus rhythm, the patient was hemodynamically stable for 30 days, until a new episode of disease progression occurred. X-ray and CT scan of the lung s confirm the enlarged shadow of the heart. The lower right pulmonary lobe consists of the secondary deposit mutually with smaller pleural effusions. Abdominal CT: ascites, enlarged aorto-caval lymph nodes. Ca 125 increasing: 2092 U/ml. Two months after the onset of cardiorespiratory symptoms Superior vena cava syndrome started to dominate. In consultation with a cardiac surgeon, oncologist, gynecologist, because of the aggressiveness of the tumor process, we have decided to conduct palliative medical care.

Conclusion: The development of cardiorespiratory symptoms in a patient with carcinoma should raise the suspicion of cardiac metastases. Surgical management is generally critical, as the metastases are often neither solitary nor confined to the heart.

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