Primary Cardiac Lymphoma: Importance of Tissue Diagnosis

Lauren Mendelson
University of Massachusetts Medical School

Let us know how access to this document benefits you.
Follow this and additional works at: https://escholarship.umassmed.edu/oapubs

Part of the Cardiovascular Diseases Commons, Diagnosis Commons, Hematology Commons, Hemic and Lymphatic Diseases Commons, Neoplasms Commons, Pathological Conditions, Signs and Symptoms Commons, and the Tissues Commons

Repository Citation

Creative Commons License
This work is licensed under a Creative Commons Attribution 4.0 License.
This material is brought to you by eScholarship@UMMS. It has been accepted for inclusion in Open Access Articles by an authorized administrator of eScholarship@UMMS. For more information, please contact Lisa.Palmer@umassmed.edu.
Case Report

Primary Cardiac Lymphoma: Importance of Tissue Diagnosis

Lauren Mendelson,1 Emily Hsu,1 Hojune Chung,1 and Andrew Hsu1,2

1Department of Medicine, University of Massachusetts Medical School, Worcester, MA, USA
2Department of Hematology and Oncology, Warren Alpert School of Medicine of Brown University, Providence, RI, USA

Correspondence should be addressed to Lauren Mendelson; lauren.mendelson@umassmemorial.org

Received 27 April 2018; Accepted 3 July 2018; Published 25 July 2018

Academic Editor: Kostas Konstantopoulos

Copyright © 2018 Lauren Mendelson et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Primary cardiac lymphoma (PCL) is a rare disease entity that can present with severe cardiac and cardioembolic symptoms. We present a 79-year-old male with history of polymyalgia rheumatica on chronic prednisone who presented with a two-week history of progressively worsening dyspnea, cough, and a 10 pound weight loss. Transthoracic echocardiogram (TTE) and computed tomography (CT) of the chest showed a large mediastinal mass with invasion of the pericardium. A biopsy of an abdominal soft-tissue mass confirmed the diagnosis of PCL. The patient was treated with two cycles of rituximab plus cyclophosphamide, doxorubicin, vincristine, and prednisone (R-CHOP) which was complicated by progressive heart failure requiring substitution of liposomal doxorubicin. The epidemiology, presentation, diagnosis, and treatment options of PCL are discussed.

1. Case Presentation

We present a 79-year-old male with history of polymyalgia rheumatica on chronic prednisone who presented with a two-week history of progressively worsening dyspnea, cough, and a 10 pound weight loss. He initially presented to an urgent care and had been prescribed antibiotics without improvement in his symptoms. He returned to the urgent care and underwent a chest X-ray, which was remarkable for cardiomegaly. Given this finding in conjunction with his respiratory symptoms, he was referred to the emergency department (ED).

In the ED, a CT of the chest showed a large mediastinal mass with invasion of the pericardium (Figure 1); a soft-tissue mass within the right atrium; compression of the left atrial appendage; encapsulation of the thoracic aorta and pulmonary artery; and extensive mediastinal, hilar, and subcarinal lymphadenopathy—the largest of which measured 3 cm in diameter. CT of the abdomen and pelvis showed numerous intra-abdominal and retroperitoneal soft-tissue masses.

The patient was admitted to the intensive care unit (ICU) where a TTE showed a left ventricular ejection fracture of 55% along with a large, homogenous adherent mass infiltrating the right atrium and ventricle, abnormal thickening of the interatrial and interventricular septum of the right heart, severe right ventricular dysfunction, severe basal to apical hypokinesis to akinesis, and a pulmonary artery pressure of 21.8 mmHg (Figures 2 and 3).

Initial differential included primary lymphoma, cardiac sarcoma, or metastatic involvement of the heart. The patient underwent a biopsy of an abdominal soft-tissue mass. Pathology showed diffuse large B-cell lymphoma (DLBCL), nongerminal center type, with BCL2 and MYC.

The patient received intravenous (IV) methylprednisolone 250 mg daily for five days for debulking. He was initially treated with two cycles of R-CHOP; however, given his persistently reduced ejection fraction, the patient was changed to liposomal doxorubicin (R-CDOP) for the third and fourth cycle. Furthermore, his first cycle was also complicated by new onset first-degree atrioventricular block and a right bundle branch block. A positron emission tomography (PET)/CT scan and TTE were scheduled prior to the next cycle of R-CDOP. In addition to his systemic chemotherapy, the patient received three cycles of central nervous system prophylaxis with high-dose methotrexate.
2. Discussion

Malignancy of the heart is most often secondary to metastatic disease or direct invasion. Lymphoma, leukemia, and melanoma are the most frequent primaries that metastasize to the heart [1]. Primary cardiac tumors on the contrary are rare—200 were found in an autopsy series of 1,000,000 patients [2]. Within primary cardiac tumors, benign tumors are far more common than malignant tumors [3]. The most common benign cardiac tumors include myxoma, papillary fibroelastoma, and lipoma—these tumors account for almost 75% of all primary cardiac tumors. Malignant primary cardiac tumors are far less common and are primarily sarcomas. Far more rare malignant primary tumors include paragangliomas, extramedullary plasmacytomas, and primary lymphomas [1].

The World Health Organization (WHO) defines PCL as a lymphoma involving only the heart/pericardium or a lymphoma with the bulk of the tumor in the heart in the setting of clinical cardiac symptoms [4]. PCL accounts for 1.3% of primary cardiac tumors and 0.5% of extranodal lymphomas. Cardiac lymphoma can be either Hodgkin or non-Hodgkin B-cell lymphoma but are most commonly DLBCL. PCL is more common in the immunosuppressed patient (AIDS, post-transplant) secondary to Epstein–Barr virus-related lymphoproliferation [5].

Primary cardiac tumors including PCL do not have a pathognomonic presentation, rather they present based on...
their location in the heart. Right-sided tumors present with signs and symptoms of right-sided heart failure if they are obstructing blood flow, or they can present with symptoms of pulmonary emboli from embolic tumor fragments into the lungs. Left-sided tumors can present with signs and symptoms of left-sided heart failure if they are obstructing blood flow, or they can present as an ischemic stroke from embolic tumor into the CNS. Lastly, left ventricular tumors that are intramural can present with arrhythmias or conduction defects. An institutional study at the Mayo Clinic found the most common patient complaint on presentation to be dyspnea on exertion (79%) followed by nonspecific chest pain (38%) and cough (21%) [6].

The diagnosis of primary cardiac tumors is based upon imaging and biopsy findings. TTE is often the initial image modality but is limited by operator-expertise and body habitus. CT of the chest can be used but is limited in soft-tissue contrast. Cardiac magnetic resonance imaging (MRI) is the preferred imaging modality, as it provides an unrestricted view, high temporal resolution, and good soft-tissue contrast to help characterize a cardiac mass. In PCL, the tumor often appears as a large nodular mass that is isoattenuating to myocardium on CT, isointense to myocardium on T1, and hyperintense to myocardium on T2 [7].

Imaging often greatly helps characterize the type of primary cardiac tumor. Often the differentiation between benign and malignant or even the specific disease diagnosis can be made based upon imaging alone. Depending on the imaging and suspected etiology of malignancy, tissue sampling may or may not be warranted. If imaging cannot characterize the mass, a discussion of the risks and benefits of an invasive biopsy must take place. Methods of obtaining a tissue diagnosis include myocardial biopsy during exploratory thoracotomy, pericardiocentesis if pericardial effusion present, TEE-guided biopsy, mediastinoscopy, and endomyocardial transvenous biopsy [8]. In our case, it was imperative to obtain a tissue diagnosis with malignant cardiac tumor on the differential. Tissue was obtained from an abdominal mass, which had a lower complication rate than the procedures listed above.

Primary cardiac tumors are treated differently based on the specific pathologic disease. There is no gold standard of treatment for PCL. In reported cases, anthracycline-based chemotherapy and rituximab was associated with prolonged survival [9, 10]. There is a limited role for surgery in PCL, unlike many other cardiac tumors. There is utility in surgical resection if the tumor causes life-threatening hemodynamic compromise; however, there is no evidence of prolonged survival with surgery alone or combined with chemotherapy in a hemodynamically stable patient [11]. It is unclear based on a small number of cases whether radiotherapy combined with chemotherapy is superior to chemotherapy alone; furthermore, the risk of cardiopulmonary radiation-induced injury makes it a less preferred treatment modality [9, 10, 12]. The median survival ranges from 1.5−26.5 months [13]. Our patient was treated with two cycles of R-CHOP which was complicated by progressive heart failure requiring substitution of liposomal doxorubicin.

3. Conclusion

In conclusion, PCL is a rare disease that accounts for 1.3% of primary cardiac tumors and 0.5% of extranodal lymphomas. The disease does not have a pathognomonic presentation, rather it presents based on its location in the heart with signs of heart failure or cardioembolic phenomena. PCL is diagnosed based on imaging and tissue biopsy. If there is a high suspicion for PCL based on imaging, it is important to obtain a tissue biopsy. Definitive tissue diagnosis of PCL can then be treated with anthracycline-based chemotherapy plus rituximab, which has been associated with prolonged survival.

Conflicts of Interest

The authors declare that there are no conflicts of interest regarding the publication of this paper.

References

Submit your manuscripts at www.hindawi.com