Primary cardiac fibroma in infants: A case report and review of cases of cardiac fibroma managed through orthotopic heart transplant

Moises Rodriguez-Gonzalez¹, Alvaro A. Pérez-Reviriego¹, Elena Gómez-Guzmán², María Ángeles Tejero-Hernández², Alicia Zorrilla Sanz³, Israel Valverde⁴
¹Pediatric Cardiology Department, Puerta del Mar University Hospital, Cadiz, Spain, ²Pediatric Cardiology Department, Reina Sofia University Hospital, Córdoba, Spain, ³Department of Pathology and Laboratory Medicine Clinical Anatomic Pathology of Reina Sofia University Hospital, Córdoba, Spain, ⁴Pediatric Cardiology Unit, Virgen del Rocío University Hospital/Institute of Biomedicine of Sevilla (IBIS) of Seville, CIBER-CV, Seville, Spain

ABSTRACT
Cardiac fibromas (CF) are the second most common cardiac tumors in children. They can be aggressive tumors despite their benign histopathologic nature, accounting for the highest mortality rate among primary cardiac tumors. CF usually show a progressive growth and spontaneous regression is rare. Therefore, a complete surgical excision is the preferred therapeutic approach when patients become symptomatic or if mass-related life-threatening complications are anticipated, even in asymptomatic patients. However, some cases are not good candidates for surgical excision due to the impossibility of preserving a normal cardiac anatomy or function after the tumor resection. Orthotopic heart transplantation (OHT) can be an exceptional but adequate alternative for some giant unresectable CF in children. In this article, we report our experience with the case of a 7-month-old infant with a giant unresectable cardiac fibroma who was successfully managed through OHT.

Keywords: Cardiac fibroma, orthotopic heart transplant, infants.

INTRODUCTION
Cardiac fibromas (CF) are the second most common cardiac tumors (20%) in children. The clinical presentation includes heart murmurs, heart failure, ventricular arrhythmias, and even sudden cardiac death, but patients asymptomatic at presentation are also at risk of future complications. Complete surgical excision is the preferred therapeutic approach when patients become symptomatic or if mass-related life-threatening complications are anticipated, even in asymptomatic patients. However, some cases are not good candidates for surgical excision due to the impossibility of preserving a normal cardiac anatomy or function. In this article, we report our experience with the case of an infant with a giant unresectable cardiac fibroma that was successfully managed through orthotopic heart transplantation (OHT).

CASE REPORT
A previously healthy 7-month-old girl was referred to our pediatric cardiology outpatient clinic for evaluation of a heart murmur. She was asymptomatic. Prenatal echocardiographic studies showed no anomalies. The latest physical exam at 4 months of age was unremarkable. The 12-lead-electrocardiogram (ECG) showed no anomalies. The chest X-ray showed a global cardiomegaly. A transthoracic echocardiogram revealed a noncontractile heterogeneous solid large mass (35 mm × 40 mm) located at the muscular interventricular septum (IVS), which caused a moderate left ventricular outflow tract obstruction (LVOTO) [Figure 1]. The...
cardiac magnetic resonance imaging (MRI) findings were consistent with a giant CF on the IVS that produced a very extensive occupation of both ventricles with mechanical LVOTO [Figure 2]. The endomyocardial biopsy confirmed the CF [Figure 3]. The coronaryography showed a displacement of the trajectory of the main coronary arteries, which were partially draped over the mass, with no perfusion defects. During the admission, the patient remained asymptomatic, but frequent ventricular ectopia and episodes of nonsustained ventricular tachycardia were recorded on the continuous ECG-monitoring. These episodes disappeared after starting propranolol 1 mg/kg/day.

Based on the occurrence of ventricular arrhythmias and the risk of sudden cardiac death, the decision of the multidisciplinary meeting was to favor surgical intervention over a conservative approach. Due to its location and size, surgical resection was excluded because of the potential risk of damaging essential cardiac structures and of leaving not enough residual functional myocardium. An OHT was selected as the definitive therapy. The patient was successfully transplanted through the bi-caval anastomosis technique at 11 months of age. The macroscopic examination of the explanted heart revealed a large fibrous, white, and nonencapsulated tumor (40 mm × 31 mm × 43 mm) localized within the IVS and bulging into both ventricles. The microscopic examination confirmed the diagnosis of CF [Figure 3]. At the latest follow-up (4 years old), the patient remained asymptomatic on treatment with tacrolimus and everolimus, without any complication.

**DISCUSSION**

CF can be aggressive tumors despite their benign histopathologic nature. Thus, they account for the highest mortality rate (20%–33%) among primary cardiac tumors. Although CF can be encapsulated, they are usually nonencapsulated masses. This nature favors the infiltration and the replacement of the contiguous functioning myocardium and the conduction system, leading to low cardiac output and ventricular arrhythmias. CF has a high incidence of ventricular arrhythmia (64%–89%) and sudden cardiac death (10%–30%).[2] CF usually grows progressively with somatic cardiac growth and spontaneous regression rarely occurs. Therefore, asymptomatic patients at presentation are also at risk of future complications. Thus, a timely and complete surgical resection has been advocated for asymptomatic cases if mass-related life-threatening complications are anticipated. This occurs in tumors of large size, IVS location, and producing inflow–outflow obstruction or ventricular arrhythmias. The main limitation of this approach is the location being near to essential cardiac structures, such as coronary arteries and the conduction system, which could be injured during the surgical procedure. Furthermore, in the case of large tumors, the resection may leave insufficient myocardial mass, causing severe impairment of the myocardial function. Of note, most cases of death, failure from weaning off cardiopulmonary bypass, and the need for postoperative extracorporeal membrane oxygenation support after surgical resection of CF are reported in large tumors involving the superior IVS and crux of the heart.[3] Subtotal resection can also be a good option to avoid the damage of essential structures, but it could be concerning to leave some tumoral mass in the heart in
Our case is one of the few published cases of CF managed by OHT in children [Table 1]. Similarly to our case, the OHT has always been indicated in patients with large size masses located at the IVS or the LV free wall, occupying a large percentage of the ventricular cavity and producing ventricular arrhythmias or heart failure. Furthermore, most OHTs have been performed in small infants younger than 2 years old. There has been no early mortality related to the surgical procedure. The long-term follow-up of most cases is limited due to the case report nature of publications, but most worrisome is that four patients died due to late OHT complications. Of note, in three cases a surgical resection was attempted before the OHT, and the three patients needed an urgent OHT due to severe ventricular dysfunction secondary to coronary artery damage or large myocardial mass resection. The only study that compares outcomes between OHT and surgical resection found a reduced long-term survival of patients managed by OHT. Therefore, the authors advised that surgical resection should be attempted whenever possible, even in large masses.

In summary, OHT can be an exceptional but adequate alternative for some giant unresectable CF in children. Complete surgical resection is the preferred therapeutic option for symptomatic patients or those asymptomatic patients perceived as high-risk cases for sudden death. If a surgical resection is going to be attempted for high-risk those cases with documented ventricular arrhythmia as was the case for our patient. In these challenging cases, OHT may remain the only therapeutic option.

Table 1: Characteristics of the cases of pediatric cardiac fibroma managed by orthotopic heart transplantation that we found in our literature review

| Reference                     | Age at OHT | Tumor Location | Clinical presentation | Previous procedure | Urgent OHT | Outcomes                           |
|-------------------------------|------------|----------------|-----------------------|-------------------|------------|-----------------------------------|
| Jamieson et al. (1981)        | 17 years   | LV free wall   | ?                     | -                 | -          | Exitus (AR 75 months after OHT)   |
| Marx et al. (1991)            | 2 years    | LV free wall   | ?                     | -                 | -          | Exitus (AR 8 months after OHT)    |
| Valente et al. (1993)         | 2 months   | LV free wall   | ?                     | -                 | -          | Alive (36 months after OHT)       |
| Michler et al. (1997)         | 3 months   | LV free wall   | ?                     | -                 | -          | Alive (105 months after OHT)      |
| Beghetti et al. (1984)        | 1 month    | IVS            | VA                   | Partial resection | Yes        | Alive (20 months after OHT)       |
| Stiller et al. (2000)         | 5 months   | LV free wall   | CHF                  | Systemic to      |            | Alive (5.5 years after OHT)       |
| Waller et al. (2006)          | 7 months   | IVS            | CHF                  | pulmonary fistula|            |                                   |
| Sharma et al. (2007)          | 13 years   | IVS            | VA                   |                  |            | Alive (2 years after OHT)         |
| Kobayashi et al. (2008)       | 6 months   | IVS            | CHF                  |                  |            | Alive (3 years after OHT)         |
| Padalino et al. (2011)        | 7 months   | IVS            | CHF                  |                  |            | Alive (19 months after OHT)       |
| Padalino et al. (2011)        | 7 months   | IVS            | CHF                  |                  |            | Exitus (cerebral tumor 3 years after OHT) |
| Padalino et al. (2011)        | 7 months   | IVS            | CHF                  |                  |            | Exitus (AR 11 years after OHT)    |
| Prakash Rajakumar et al. (2015)| 7 years    | LV free wall   | VA and CHF           | Complete resection| Yes        | Alive (18 months after OHT)       |
| Liu et al. (2016)             | ?          | LV free wall   | VA and CHF           | Complete resection| Yes        | Alive (2 years after OHT)         |
| Delmo-Walter and Javier (2011)| 5 months   | LV free wall   | CHF                  | Complete resection| Yes        | Alive (6 years after OHT)         |

Our case is not added to the table. ?: Data no available; CHF: Congestive heart failure; VA: Ventricular arrhythmia; OHT: Orthotopic heart transplantation; AR: Allograft rejection; LV: Left ventricular; IVS: Interventricular septum.
tumors (IVS or cardiac crux location, large size, coronary compression), we think that it should be done in a center with an OHT program, to be ready for an urgent OHT if necessary.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

**REFERENCES**

1. Tzani A, Doulamis IP, Mylonas KS, Avgerinos DV, Nasioudis D. Cardiac tumors in pediatric patients: A systematic review. World J Pediatr Congenit Heart Surg 2017;8:624-32.

2. Padalino MA, Vida VL, Boccuzzo G, Tonello M, Sarris GE, Berggren H, et al. Surgery for primary cardiac tumors in children: Early and late results in a multicenter European Congenital Heart Surgeons Association study. Circulation 4 ed. 2012;126:22-30.

3. Delmo Walter EM, Javier MF. Primary cardiac tumors in infants and children: Surgical strategy and long-term outcome. Ann Thorac Surg 2016;102:2062-9.

4. Beghetti M, Gow RM, Haney I, Mawson J, Williams WG, Freedom RM. Pediatric primary benign cardiac tumors: A 15-year review. Am Heart J 1997;134:1107-14.

5. Stiller B, Hetzer R, Meyer R, Dittrich S, Pees C, Alexi-Meskishvili V, et al. Primary cardiac tumours: When is surgery necessary? Eur J Cardiothorac Surg 2001;20:1002-6.

6. Waller BR, Bradley SM, Crumbley AJ, Wiles HB, McQuinn TC, Bennett AT. Cardiac fibroma in an infant: Single ventricle palliation as a bridge to heart transplantation. Ann Thorac Surg 2003;75:1306-8.

7. Sharma K, Rohliceck C, Cecere R, Tchervenkov CI. Malignant arrhythmias secondary to a cardiac fibroma requiring transplantation in a Teenager. J Heart Lung Transplant 2007;26:639-41.

8. Kobayashi D, L’Ecuyer TJ, Aggarwal S. Orthotopic heart transplant: A therapeutic option for unresectable cardiac fibroma in infants. Congenit Heart Dis 2012;7:E31-6.

9. Prakash Rajakumar A, Ejaz Ahmed S, Varghese R, Kothandam S, Murmu UC, Sethuratnam R. Pediatric heart transplant for unresectable primary cardiac tumor. Asian Cardiovasc Thorac Ann 2017;25:207-9.

10. Liu X, Hong H, Zhang H, Xu Z, Liu J, Qiu L. Treatment strategies for primary tumors of the heart in children: A 10-year experience. Ann Thorac Surg 2015;100:1744-9.