Asymptomatic right ventricular outflow tract (RVOT) myxoma is quite rare. We report an unusual case of asymptomatic myxoma arising from the RVOT which was successfully surgically removed.

KEY WORDS: Intracardiac myxoma · Right ventricle · Echocardiography.
cells that were arranged in a cord-like pattern with an abundant myxoid background, consistent with a benign myxoma (Fig. 4B). The patient’s postoperative course was uneventful and she was discharged 10 days after surgery.

**DISCUSSION**

Cardiac myxoma is usually seen in adults, but also accounts for 24-40% of all cardiac tumors that occur between birth and adolescence. The majority of myxomas (75%) are located in...
the left atrium, whereas RV myxoma is only found in 2-4% of cases, and RVOT myxoma is quite rare. Only 4 cases of RV myxoma have been reported in Korea; these were located in the RV free wall, the tricuspid valve, the anterior papillary muscle and the interventricular septum, causing significant flow obstruction. Right-sided cardiac tumors can present with symptoms and signs of right heart failure or RVOT obstruction, and, particularly in the case of RV myxoma, complications of vena cava syndrome, pulmonary embolism and RV dysfunction have been reported. The tumor mass in this case was originated from the RVOT, and no flow acceleration was observed by color Doppler. Although RVOT flow obstruction cannot be excluded completely because of the absence of pulse wave Doppler measurement, this case seems to be unique in that peripheral edema, hepatomegaly, harsh systolic murmur by flow obstruction and other incidental findings typical to previously reported cases were absent. Surgical removal is regarded as the gold standard treatment for cardiac myxoma, and various surgical approaches through the right atrium or the right ventricle have been reported. The right atrial approach is effective in most cases of small- to average-sized right ventricular myxoma; the right ventriculotomy approach may cause postoperative right ventricular dysfunction, and is therefore not advisable. In this case, successful excision was performed through the right atrial approach.

This patient had multiple tumors prior to cardiac myxoma, including breast nodules, a parotid gland tumor, and uterine myoma. However, there was no family history of cardiac tumor and the Carney’s complex was absent on examination. Although our patient did not meet the diagnostic criteria for Carney’s complex, to the best of our knowledge, cardiac myxoma accompanied by the tumors mentioned above has not been reported previously. Further evaluation with genetic study and serial follow-up may be required to establish any relevant association between the multiple tumors in this patient.

The present case indicates that serial TTE follow-up might be helpful in detecting incidental cardiac tumors, especially in patients with a history of multiple tumors.

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