IMAGE FOCUS

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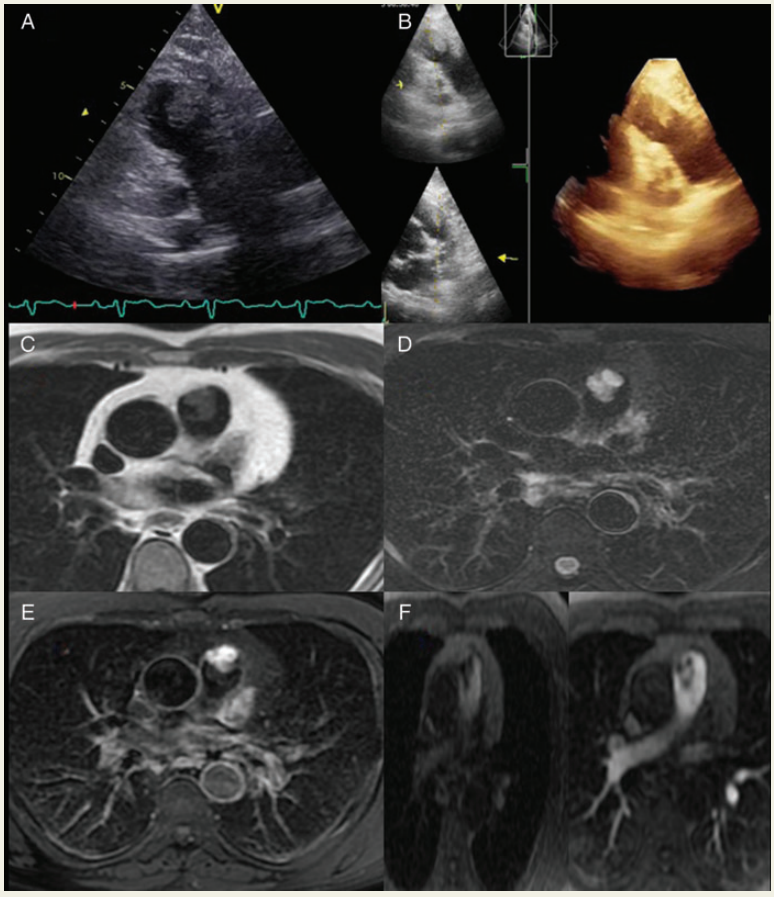
Rare cause of dyspnoea: pulmonary artery myxoma

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A 55-year-old male presented with dyspnoea and cough. Physical examination revealed Levine grade 2 early systolic murmur at left upper sternal border. There were no pathological findings on electrocardiography or chest X-ray. Transthoracic echocardiography (TTE) showed a mass in the main pulmonary artery and maximal resting outflow gradient of 20 mmHg (*Panel A*). Live three-dimensional TTE revealed image of the mass above the pulmonary valve (*Panel B*). For further evaluation, cardiac magnetic resonance imaging (CMRI) was performed and demonstrated a septated mass with diameters of 2.5 cm × 2 cm × 1.8 cm that return hypointense T1-weighted sequence (*Panel C*, Supplementary data online, *Video S1*), hyperintense T2-weighted sequence (*Panel D*), and fat-saturated sequence in the main pulmonary artery (*Panel E*). The mass showed more heterogeneous enhancement on late gadolinium enhancement sequences (*Panel F*). These features were most consistent with pulmonary artery myxoma. The mass was removed because of an increased risk of embolism and dyspnoea, and pathology showed spindle- and stellate-shaped cells with myxoid stroma that were typical for myxoma.



Pulmonary artery tumours are very uncommon, and most of them are sarcomas. Although myxoma is the most common primary benign cardiac tumour, extra cardiac myxomas are extremely unusual clinical condition. Less than five cases of primary pulmonary artery myxoma have been reported in the literature. Myxomas can be asymptomatic, or its symptoms are frequently non-specific. Echocardiography, computed tomography, and CMRI are useful diagnostic tools for myxomas. To our knowledge, this is the first case that clarify CMRI features of pulmonary artery myxoma.

Supplementary data are available at *European Heart Journal – Cardiovascular Imaging* online.

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