

Case Report

Stroke and Cardiac Papillary Fibroelastoma: Mechanical Thrombectomy after Thrombolytic Therapy

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We describe a case of a 34-year-old man with a sudden development of right hemiparesis and aphasia because of infarction of the left middle cerebral artery that was submitted to intravenous (IV) recombinant tissue plasminogen activator and mechanical thrombectomy. Transesophageal echocardiogram showed a small mass on the *anterior leaflet* of the mitral valve. Cardiac surgery was performed, and histological examination of the removed material was consistent with cardiac papillary fibroelastoma (CPF). Experience in using IV thrombolysis for the treatment of embolic stroke because of CPF is limited. To the best of our knowledge, only 3 patients are reported in literature in whom acute ischemic stroke and associated CPF were treated with thrombolytic therapy. A discussion of the efficacy of IV thrombolysis and the possible superiority of mechanical thrombectomy is included. **Key Words:** Cardiac papillary fibroelastoma—stroke—thrombolytic therapy—mechanical thrombectomy.

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Introduction

Cardiac papillary fibroelastoma (CPF) is a rare primary cardiac tumor, with a significant propensity to embolize.^{1,2} We describe a patient in whom emboli originating from

CPF caused cerebral infarction; he was submitted to intravenous (IV) recombinant tissue plasminogen activator and mechanical thrombectomy.

Case Report

A 34-year-old man, smoker, was admitted at the emergency room with right hemiparesis, right homonymous hemianopsia, and mild aphasia of sudden onset (National Institutes of Health Stroke Scale [NIHSS] 13). Brain computed tomography was normal. IV recombinant tissue plasminogen activator was started 80 minutes after symptom onset. By the end of perfusion, NIHSS was 10. At 120 minutes after thrombolysis, deterioration occurred (NIHSS 17). Urgent brain computed tomography excluded hemorrhage, and endovascular approach was decided with cerebral angiography disclosing a left middle cerebral artery occlusion (Fig 1). Mechanical clot extraction was performed with partial recanalization of the left middle cerebral artery territory (Fig 1)—symptom recanalization time: 315 minutes. At the end of thrombectomy, NIHSS was 20. Brain magnetic resonance imaging showed only the ischemic infarct (Fig 1). Transesophageal echocardiogram revealed

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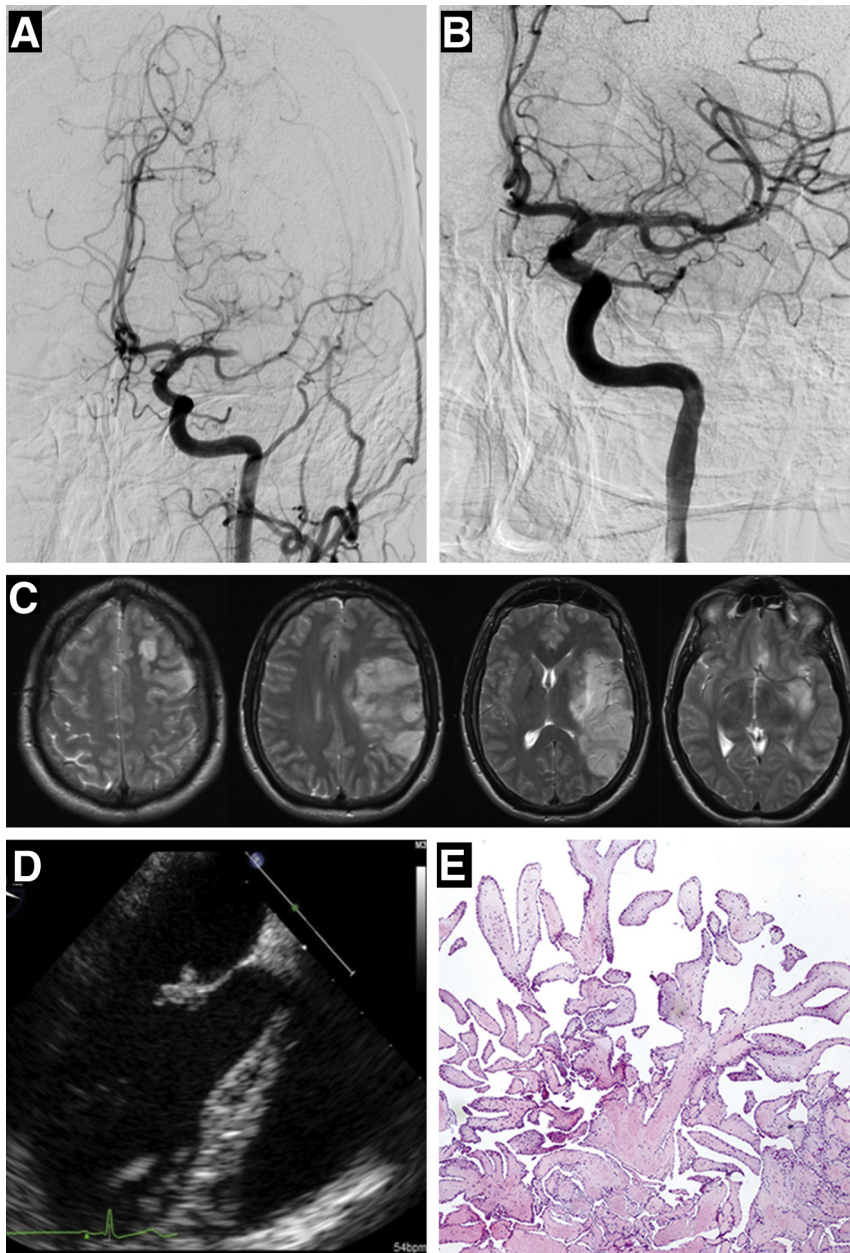


Figure 1. Cerebral angiography, brain magnetic resonance imaging, transesophageal echocardiogram view, and histological examination. Cerebral angiography showing left M1 middle cerebral artery occlusion (A). After mechanical clot extraction, there was partial recanalization of the left middle cerebral artery territory (B). Axial T2-weighted turbo spin-echo image showing an extensive left cortical-subcortical frontotemporo-parietal hypodensity with extension to the insula and striatocapsular region (C). Transesophageal echocardiogram revealing a small mass on the anterior leaflet of the mitral valve, suggestive of cardiac papillary fibroelastoma (D). Histological examination (hematoxylin-eosin stain, $\times 40$) showing a lesion with a papillary configuration lined by flat endocardial cells and with a densely hyalinized central core (E).

a small mass on the *anterior leaflet* of the mitral valve, suggestive of CPF (Fig 1). Twenty-eight days after stroke, he was submitted to cardiac surgery. Histological examination was consistent with CPF (Fig 1). Clinical evolution was favorable; however, he remained aphasic, with preserved comprehension, and hemiparetic (NIHSS 14).

Discussion

CPF is a potentially treatable cause of stroke. Transesophageal echocardiogram is frequently required for accurate assessment.² Definite diagnosis is based on histopathological features.¹ Because of its rarity, there are few data regarding safety and efficacy of thrombolytic therapy

in acute ischemic strokes caused by CPF. Only 3 previous reports presented patients with acute ischemic stroke and associated CPF treated with thrombolytic therapy—1 received alteplase intravenously³ and 2 intra-arterially^{4,5}—in one of them intra-arterially thrombolysis was combined with mechanical clot disruption.⁵ When embolization is from the thrombotic material surrounding the neoplasm, it could be successfully treated with alteplase; if the embolizing material is a fragment from the tumor, fibrinolytic therapy is probably futile. Patients with known CPF should not be excluded from receiving alteplase but as the embolization could originate in the tumor itself, mechanical thrombectomy might represent a safe and effective treatment option. In our case, the clot removed

during thrombectomy was not submitted to histological examination. But, as its composition can explain the differences in treatment outcome, we suggest routine histological examination for all clots or masses removed during thrombectomy procedures in acute ischemic stroke.

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