LETTERS TO THE EDITOR

revealing that the cardiac mass was not a thrombus, but rather part of the abdominal tumor, which had grown to occupy the inferior vena cava segment and had reached the right atrium (Figure 2).

The abdominal mass was resected en bloc in a second procedure. The histologic study showed an aggressive angiomyxoma, with a diameter of 36 cm, affecting the uterus and both fallopian tubes. Complete removal of the tumor was not possible. The postoperative course was good and the patient was discharged home 13 days after the abdominal surgery.

One year after surgery, the patient remained asymptomatic despite local recurrence of the mass in the abdominal area. Given the benign nature of the tumor and the difficulty of removal, it was decided to perform follow-up with periodic monitoring by abdominal CT.

The interest of this case lies in the unusual extension to the cardiac cavities, the first such case reported in the medical literature. Only one other case involving pulmonary and mediastinal metastases has been described. In our patient, cardiac involvement does not appear to have occurred by remote tumor implants, but rather by invasion of the inferior vena cava and progression toward the cardiac cavities.4,5

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Kawasaki Disease With Coronary Involvement in Adults

To the Editor,

Kawasaki disease (KD) is a systemic vasculitis of unknown etiology that can produce coronary artery aneurysms in up to 25% of untreated cases. The disease presents mainly in young children and is rare in adulthood.1

We describe a 28-year-old man, a smoker of 4 cigarettes a day as the only cardiovascular risk factor. The only pathological history of interest was hospitalization 6 months earlier for fever of one month’s duration, accompanied by generalized erythema and musculoskeletal pain. Following various examinations and blood tests that revealed thrombocytosis, hypoalbuminemia, an abnormal liver profile, and elevated erythrocyte sedimentation rate and C-reactive protein, the

Figure 1. Coronary angiography: right anterior oblique view showing a giant aneurysm (9 mm in diameter) of the left main coronary artery and the proximal left anterior descending artery, affecting the origin of the first septal and first diagonal (arrows), with occlusion of the proximal circumflex and severe diffuse disease of the distal vessel.

Figure 2. Coronary angiography: left anterior oblique view depicting a dominant right coronary, with aneurysm of the proximal and middle segments, approximately 7 mm in diameter (arrows), and severe diffuse disease of the distal vessel.
The patient was discharged with a diagnosis of fever of unknown origin. Six months later he was readmitted for exertional angina. Coronary angiography showed severe diffuse disease of the entire coronary vasculature (Figures 1 and 2). The clinical symptoms and findings of the additional examinations led to a diagnosis of KD that had gone undiagnosed in the acute phase (6 months previously). Treatment with aspirin, acenocoumarol, and an antianginal drug was started. The patient was discharged and after 2 months' follow-up, presented stable exertional angina in functional class I.

The classic diagnosis of KD is based on the presence of fever lasting 5 or more days and 4 or more of the following clinical signs: cutaneous alterations in the limbs, polymorphic rash, nonexudative bilateral conjunctivitis, involvement of the lips and oral cavity, and cervical adenopathies. In patients with fever lasting 5 or more days that meet fewer than four of the above clinical signs, the diagnosis can be made if coronary disease is detected, usually by 2D echocardiography or angiography. Multislice computed tomography has recently been described as a useful technique to detect coronary aneurysms in KD, particularly in patients with a poor echocardiographic window (as tends to occur in adults) and no clear indication for invasive studies, although this does not specifically correspond to the case we describe. Coronary dilation or ectasia is defined as an inner vessel diameter ≥ 2 SD above the age- and body surface-adjusted mean, but < 4 mm. Aneurysm is defined as a diameter ≥ 4 mm and < 8 mm, and giant aneurysm as a diameter ≥ 8 mm.

The onset of KD in adulthood is extremely rare and, to our knowledge, only 63 cases have been published to date. Several cases of myocardial infarction attributed to KD undiagnosed in childhood have been reported in young adults, one of them published in the REVISTA ESPAÑOLA DE CARDIOLOGÍA. The case we present is the first clinical case of KD of adult onset with coronary involvement described in the Spanish medical literature.

In children, diagnosis and early immunoglobulin treatment is associated with a lower incidence of coronary aneurysms and therefore, with lower morbidity and mortality. Although KD is a rare entity in adults, it should be considered in the differential diagnosis of febrile syndrome with skin rash, because early diagnosis and treatment is also likely to decrease the incidence of coronary involvement, as well as morbidity and mortality in adults.

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