A 76-year-old man was scheduled for coronary artery bypass graft surgery and mitral annuloplasty using cardiopulmonary bypass. His medical history included a right subarachnoid hemorrhage, angina pectoris, myocardial infarction 23 yr earlier, and percutaneous coronary intervention. Because of progressive dyspnea, he underwent cardiac catheterization that revealed severe three-vessel coronary artery disease. Preoperative transthoracic echocardiography revealed severe hypokinesis of the inferior and posterior left ventricular walls and Grade III mitral valve incompetence, but no other abnormality. After induction of general anesthesia, transesophageal echocardiography examination revealed a 10 × 7 mm mass arising from the root of the left atrial appendage in the midesophageal aortic valve short axis view and left atrium (LA) appendage views (Figs. 1 and 2, please see video loop available at www.anesthesia-analgesia.org). The mass was mobile and arose from a 1- to 5-mm pedicle. Examination of the mass at the time of surgery confirmed the attachment of a pedunculated mass to the LA wall between the LA appendage and mitral valve annulus. Macroscopic examination demonstrated a white, smooth appearance with a long stalk, but without surrounding thrombus. Histological examination showed multiple branching papillary fronds consisting of dense fibroelastic tissue surrounded by a layer of loose connective tissue consistent with the diagnosis of cardiac papillary fibroelastoma (CPF).

Primary cardiac tumors are very rare, with a frequency of approximately 0.02%. CPF is the third most common primary benign cardiac tumor after myxoma and lipoma (1). Most patients with CPF do not present with cardiac symptoms; rather, CPF is identified at autopsy or incidentally during cardiac surgery. The
most common clinical symptoms are due to systemic embolization resulting in transient ischemic attack or stroke (2). In a large series \((n = 611\) patients\), the most common location of CPF was aortic valve \((n = 223\) patients\). Rarely, CPF was found in the LA \((n = 10\) patients\), LA appendage \((n = 2\) patients\), and the Eustachian valve \((n = 2\) patients\) (2). As in our case, others have found transesophageal echocardiography to be more sensitive than transthoracic echocardiography for detecting CPF (3). The discordant diagnostic sensitivity was attributed to varying size, location, and diameter of CPF (3).

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