CASE REPORT

Cardiac actinomycosis in a patient presenting with acute cardiac tamponade and a mass mimicking pericardial tumour

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A case of pericardial actinomycosis mimicking a pericardial tumour is reported. After the appearance of non-specific subpleural pulmonary nodules, a 48 year old woman presented with fever and clinical signs of pericardial tamponade. Subxiphoid pericardiotomy yielded a culture negative fluid and inflammatory reactive histopathology in the pericardial biopsy specimen. Because of suspected infection cefamandole was administered for 10 days and the patient became afebrile. The pericardial effusion recurred with no clinical signs two weeks later. Steroid medication resulted in rapid regression of the pericardial effusion. Subsequent echocardiography controls showed a tumour-like pericardial mass, confirmed by cardiac magnetic imaging. Surgical exploration led to the final histological diagnosis of actinomycosis. After high dose and long term penicillin G treatment the patient recovered fully with no recurrence during two years’ follow up.

Cardiac actinomycosis is a rare disease. Pericardial involvement in actinomycosis was discussed in two comprehensive reviews1 2 and only a few case reports have been published.2 7 Pericardial involvement has been characterised by pericardial effusion that evolves into cardiac tamponade or constrictive pericarditis. We report a case of pericardial actinomycosis mimicking a pericardial tumour.

A 48 year old woman presented to our outpatient clinic in June 1999 because of moderate dyspnoea and left sided chest pain on deep inspiration. There was nothing peculiar in her history. She had been a moderate smoker (3–4 cigarettes a day) and consumed about one alcoholic drink a day. Physical and routine laboratory findings did not show any abnormality. On chest radiography we noted normal heart contours, a small, not well delineated shadow in the lateral part of the left middle lung field, and a small left sinus pleural effusion. Chest computed tomography showed multiple subpleural nodules of 3–5 mm and a larger one consistent with the pericardium. On chest radiography we noted normal heart contours, and routine laboratory findings did not show any abnormality. Physical and routine laboratory findings did not show any abnormality. On 13 October 1999 a left sided axillary thoracotomy was performed. Multiple rice sized greyish nodules were seen upon. A mass 3–5 cm suspected to be a tumour is reported. After the appearance of non-specific subpleural pulmonary nodules, a 48 year old woman presented with fever and clinical signs of pericardial tamponade. Subxiphoid pericardiotomy yielded a culture negative fluid and inflammatory reactive histopathology in the pericardial biopsy specimen. Because of suspected infection cefamandole was administered for 10 days and the patient became afebrile. The pericardial effusion recurred with no clinical signs two weeks later. Steroid medication resulted in rapid regression of the pericardial effusion. Subsequent echocardiography controls showed a tumour-like pericardial mass, confirmed by cardiac magnetic imaging. Surgical exploration led to the final histological diagnosis of actinomycosis. After high dose and long term penicillin G treatment the patient recovered fully with no recurrence during two years’ follow up.

CARDIOVASCULAR DISORDERS

DISCUSSION

In a most detailed analysis by Cornell and Shookhoff1 presumably all 68 cases of cardiac actinomycosis published by 1944 were summarised. Since this publication it has been suggested that the heart has been involved in only about 2% of all cases of this infection, with the pericardium as the most common site. The usual presentation of pericardial actinomycosis is pericardial effusion that may evolve into cardiac tamponade or constrictive pericarditis.1 7 Diagnosis of...
actinomycosis is generally hampered by the difficulty in isolation and culture of the organism. It must be cultured in strictly anaerobic conditions. In the review of Fife and colleagues,2 purulent pericardial fluid was obtained from 10 (53%) of 19 patients. However, *A israelii* was successfully cultured from the fluid in only two cases. In the majority of cases in the literature actinomycosis has been diagnosed by histopathology. The so called sulphur granules of actinomycosis feature surface clubs visible by light microscopy. In the case reported by Shinagawa and colleagues,7 the pericardial biopsy failed to provide convincing evidence for pericardial actinomycosis but culture of the pericardial effusion gave a positive growth of *A israelii*. Pulmonary or anterior mediastinal masses with pericardial effusion have been reported in the literature but to our knowledge our case is the first where pericardial actinomycosis mimicked a pericardial tumour.

In conclusion, we described a case of pericardial actinomycosis. After the appearance of non-specific subpleural pulmonary nodules the patient presented with symptoms of acute pericardial tamponade. Pericardial fluid culture and biopsy did not lead to a diagnosis of actinomycosis. Echocardiography showed a tumour-like pericardial mass confirmed by MRI. Surgical exploration led in the final histological diagnosis of actinomycosis. After high dose and long term penicillin treatment, the patient recovered fully with no recurrence during two years’ follow up.

**REFERENCES**


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