Lipomatous hypertrophy of the interatrial septum is a benign cardiac mass characterised as a non-encapsulated mass of fatty tissue that infiltrates the atrial septum. Although once described as a relatively rare finding, with the widespread use of echocardiography lipomatous hypertrophy is now being increasingly recognised and should be considered as part of the differential diagnosis for any atrial cardiac tumours. As most patients with this condition remain asymptomatic the majority of cases are generally picked up as an incidental finding at the time of cardiac imaging, surgery, or necropsy. Consequently this condition remains under-recognised by most clinicians and can thus be easily mistaken for a more sinister malignant lesion, subsequently leading to unwarranted surgical removal. We describe one such case where unnecessary intervention was avoided by a surgeon referring the patient back to a physician for a fresh opinion.

**CASE REPORT**

An 82 year old woman was referred from her local hospital with a suspected malignant intracardiac mass for a surgical biopsy followed by possible surgical removal. She had originally presented with a 12 month history of shortness of breath on exertion. At that time she had no history of weight loss or any other cardiorespiratory symptoms. On examination she was thin with no overt signs of heart failure. She had the murmur of moderate mitral regurgitation. Investigations included posteroanterior chest radiography, which showed an extrathoracic shadow initially thought to be a breast lesion. Subsequent mammography and computed tomography (CT) of her chest were reported as normal.

**Abbreviations:** CT, computed tomography; MRI, magnetic resonance imaging; TOE, transoesophageal echocardiography
was first described at a postmortem examination in 1964.4 Lipomatous hypertrophy of the cardiac interatrial septum

**DISCUSSION**

Lipomatous hypertrophy of the cardiac interatrial septum was first described at a postmortem examination in 1964.4 Since then this condition has been reported widely in 88 case reports and original articles. Associated with increasing age and body mass, lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and methods used to detect the lesion (necropsy 1%,5 transthoracic echocardiography 8%). In a recent large prospective study, 1292 patients undergoing multislice CT for other indications were reviewed for the presence of this disorder.7 The incidence was as high as 2.2% (29 patients) and was clearly associated with increasing age, confirming that lipomatous hypertrophy is more common than previously suspected. Although it is a benign tumour remaining asymptomatic in most people it may be associated with atrial arrhythmias often requiring antiarrhythmic agents.6 Only in the rare extreme cases of large lesions, which can cause circulatory obstruction, are patients required to undergo surgical resection and septal reconstruction.8 The best management consists of rapid diagnosis, reassurance, and mastery inactivity.

Histologically the lesion is characterised by a non-encapsulated mass of adipocytes interspersed with atypical and hypertrophied myocytes.1 Lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and body mass, lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and methods used to detect the lesion (necropsy 1%,5 transthoracic echocardiography 8%). In a recent large prospective study, 1292 patients undergoing multislice CT for other indications were reviewed for the presence of this disorder.7 The incidence was as high as 2.2% (29 patients) and was clearly associated with increasing age, confirming that lipomatous hypertrophy is more common than previously suspected. Although it is a benign tumour remaining asymptomatic in most people it may be associated with atrial arrhythmias often requiring antiarrhythmic agents.6 Only in the rare extreme cases of large lesions, which can cause circulatory obstruction, are patients required to undergo surgical resection and septal reconstruction.8 The best management consists of rapid diagnosis, reassurance, and mastery inactivity.

Histologically the lesion is characterised by a non-encapsulated mass of adipocytes interspersed with atypical and hypertrophied myocytes.1 Lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and body mass, lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and methods used to detect the lesion (necropsy 1%,5 transthoracic echocardiography 8%). In a recent large prospective study, 1292 patients undergoing multislice CT for other indications were reviewed for the presence of this disorder.7 The incidence was as high as 2.2% (29 patients) and was clearly associated with increasing age, confirming that lipomatous hypertrophy is more common than previously suspected. Although it is a benign tumour remaining asymptomatic in most people it may be associated with atrial arrhythmias often requiring antiarrhythmic agents.6 Only in the rare extreme cases of large lesions, which can cause circulatory obstruction, are patients required to undergo surgical resection and septal reconstruction.8 The best management consists of rapid diagnosis, reassurance, and mastery inactivity.

Histologically the lesion is characterised by a non-encapsulated mass of adipocytes interspersed with atypical and hypertrophied myocytes.1 Lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and methods used to detect the lesion (necropsy 1%,5 transthoracic echocardiography 8%). In a recent large prospective study, 1292 patients undergoing multislice CT for other indications were reviewed for the presence of this disorder.7 The incidence was as high as 2.2% (29 patients) and was clearly associated with increasing age, confirming that lipomatous hypertrophy is more common than previously suspected. Although it is a benign tumour remaining asymptomatic in most people it may be associated with atrial arrhythmias often requiring antiarrhythmic agents.6 Only in the rare extreme cases of large lesions, which can cause circulatory obstruction, are patients required to undergo surgical resection and septal reconstruction.8 The best management consists of rapid diagnosis, reassurance, and mastery inactivity.

Histologically the lesion is characterised by a non-encapsulated mass of adipocytes interspersed with atypical and hypertrophied myocytes.1 Lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and methods used to detect the lesion (necropsy 1%,5 transthoracic echocardiography 8%). In a recent large prospective study, 1292 patients undergoing multislice CT for other indications were reviewed for the presence of this disorder.7 The incidence was as high as 2.2% (29 patients) and was clearly associated with increasing age, confirming that lipomatous hypertrophy is more common than previously suspected. Although it is a benign tumour remaining asymptomatic in most people it may be associated with atrial arrhythmias often requiring antiarrhythmic agents.6 Only in the rare extreme cases of large lesions, which can cause circulatory obstruction, are patients required to undergo surgical resection and septal reconstruction.8 The best management consists of rapid diagnosis, reassurance, and mastery inactivity.

Histologically the lesion is characterised by a non-encapsulated mass of adipocytes interspersed with atypical and hypertrophied myocytes.1 Lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and methods used to detect the lesion (necropsy 1%,5 transthoracic echocardiography 8%). In a recent large prospective study, 1292 patients undergoing multislice CT for other indications were reviewed for the presence of this disorder.7 The incidence was as high as 2.2% (29 patients) and was clearly associated with increasing age, confirming that lipomatous hypertrophy is more common than previously suspected. Although it is a benign tumour remaining asymptomatic in most people it may be associated with atrial arrhythmias often requiring antiarrhythmic agents.6 Only in the rare extreme cases of large lesions, which can cause circulatory obstruction, are patients required to undergo surgical resection and septal reconstruction.8 The best management consists of rapid diagnosis, reassurance, and mastery inactivity.

Histologically the lesion is characterised by a non-encapsulated mass of adipocytes interspersed with atypical and hypertrophied myocytes.1 Lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and methods used to detect the lesion (necropsy 1%,5 transthoracic echocardiography 8%). In a recent large prospective study, 1292 patients undergoing multislice CT for other indications were reviewed for the presence of this disorder.7 The incidence was as high as 2.2% (29 patients) and was clearly associated with increasing age, confirming that lipomatous hypertrophy is more common than previously suspected. Although it is a benign tumour remaining asymptomatic in most people it may be associated with atrial arrhythmias often requiring antiarrhythmic agents.6 Only in the rare extreme cases of large lesions, which can cause circulatory obstruction, are patients required to undergo surgical resection and septal reconstruction.8 The best management consists of rapid diagnosis, reassurance, and mastery inactivity.

Histologically the lesion is characterised by a non-encapsulated mass of adipocytes interspersed with atypical and hypertrophied myocytes.1 Lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and methods used to detect the lesion (necropsy 1%,5 transthoracic echocardiography 8%). In a recent large prospective study, 1292 patients undergoing multislice CT for other indications were reviewed for the presence of this disorder.7 The incidence was as high as 2.2% (29 patients) and was clearly associated with increasing age, confirming that lipomatous hypertrophy is more common than previously suspected. Although it is a benign tumour remaining asymptomatic in most people it may be associated with atrial arrhythmias often requiring antiarrhythmic agents.6 Only in the rare extreme cases of large lesions, which can cause circulatory obstruction, are patients required to undergo surgical resection and septal reconstruction.8 The best management consists of rapid diagnosis, reassurance, and mastery inactivity.

Histologically the lesion is characterised by a non-encapsulated mass of adipocytes interspersed with atypical and hypertrophied myocytes.1 Lipomatous hypertrophy has been reported to have an incidence between 1–8% depending on the series and methods used to detect the lesion (necropsy 1%,5 transthoracic echocardiography 8%). In a recent large prospective study, 1292 patients undergoing multislice CT for other indications were reviewed for the presence of this disorder.7 The incidence was as high as 2.2% (29 patients) and was clearly associated with increasing age, confirming that lipomatous hypertrophy is more common than previously suspected. Although it is a benign tumour remaining asymptomatic in most people it may be associated with atrial arrhythmias often requiring antiarrhythmic agents.6 Only in the rare extreme cases of large lesions, which can cause circulatory obstruction, are patients required to undergo surgical resection and septal reconstruction.8 The best management consists of rapid diagnosis, reassurance, and mastery inactivity.
we suggest that this condition is still under-recognised by all specialities and may easily, as in this case, lead to a misdiagnosis. Had the receiving surgeon not requested an expert echocardiogram our patient may well have undergone an unnecessary major surgical procedure, which carries in itself a significant risk. Good communication and discussion of new cases between complementing specialities is not only good medical practice but is also essential in correctly diagnosing common but under-recognised conditions such as this.

Important lesson
With patient transfers a fresh opinion from complementing specialities can often revise the working diagnosis and possibly avoid the need for unnecessary intervention. Imaging modalities do not lie, rather interpretation may vary depending on the level of expertise, no matter which modality this is.

Authors’ affiliations
I Nadra, D Dawson, P Nihoyannopoulos, Department of Cardiology, National Heart and Lung Institute, Imperial College, Hammersmith Hospital, London, UK
S A Schmitz, Imaging Sciences Department, Clinical Sciences Centre, Faculty of Medicine, Imperial College
P P Punjabi, Department of Cardiothoracic Surgery, National Heart and Lung Institute, Imperial College

Funding: none.

Conflict of interest: none.

I Nadra wrote the report. D Dawson and SA Schmitz carried out the imaging of the patient. PP Punjabi and P Nihoyannopoulos were involved in managing the patient.

Correspondence to: Dr I Nadra, Department of Cardiology, National Heart and Lung Institute, Imperial College, Hammersmith Hospital, Du Cane Road, London W12 0HS, UK; i.nadra@imperial.ac.uk

Accepted 4 August 2004

REFERENCES