A 33-year-old man, not treated before, had a history of one episode of atrial fibrillation (AF). A tumor behind the left atrium was revealed in a transthoracic echocardiogram (FIGURE 1A–C). The patient was admitted to the hospital, where a thoracic X-ray showed linear and nodular opacities in the superior segments of the upper lobes suggesting inactive tuberculosis. A thoracic computed tomography (CT) and magnetic resonance (MRI) were performed, and revealed a benign tumor not enhanced by contrast media (diameter, 63 mm) in the posterior mediastinum. The tumor compressed the upper surface of the left atrium and the inferior wall of the right pulmonary artery causing blood flow limitation. Additionally, enlargement of subcarinal, lower paratracheal, and right hilar lymph nodes was diagnosed. At that time, inflammatory markers were within the reference range. In the thoracic surgery department, after bronchoscopy and endobronchial
A cyst could not be diagnosed easily by thoracic radiography due to subcarinal location. Complete surgical resection should be recommended for all presumed mediastinal cysts, because they may become symptomatic and there have been some reports of the neoplasm occurring within these cysts.

In sarcoidosis, cardiac involvement is unusual and can have various manifestations triggered by infiltration of the heart tissue by granulations. In our case, the patient suffered from asymptomatic sarcoidosis where AF was not caused by sarcoidal infiltration. According to recent guidelines for AF management, transthoracic echocardiography has only IIa class of recommendation in patients without severe symptoms, documented or suspected heart disease, or risk factors; however, this noninvasive technique allowed identification of the real substrate of AF and, in the reported case, it allowed us to initiate the appropriate treatment.

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REFERENCES