

# Evaluation of the Right Ventricular Function in Hypertrophic Obstructive Cardiomyopathy: A Strain and Tissue Doppler Study

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## Summary

We investigated the utility of strain, strain rate, and tissue Doppler imaging (TDI) for the evaluation of the right ventricle (RV) impairment in patients with a hypertrophic obstructive cardiomyopathy (HOCM) who underwent a successful alcohol septal ablation (ASA) and were without RV hypertrophy. A group of 19 patients suffering from HOCM with 22 controls was compared. The parameters of TDI were evaluated in mitral and tricuspid annulus. Strain and strain rate derived from TDI were assessed in an apical free wall of RV, as well as in basal segments of the left ventricle. Between both groups, there were significant differences only in isovolumic pre-ejection time ( $79.2 \pm 17.3$  ms vs.  $58.5 \pm 8.1$  ms,  $p < 0.01$ ), isovolumic relaxation time ( $104.7 \pm 26.2$  ms vs.  $77.3 \pm 24.5$  ms,  $p < 0.01$ ), myocardial performance (Tei) index measured from TDI ( $0.61 \pm 0.14$  vs.  $0.49 \pm 0.09$ ,  $p < 0.01$ ), and early peak diastolic velocity of TDI ( $10.6 \pm 1.67$  cm/s vs.  $12.6 \pm 2.21$  cm/s;  $p < 0.05$ ). Our results suggest the impairment of both systolic and diastolic RV function in patients suffering from HOCM. TDI-related parameters appear to be more sensitive than strain and strain rate for evaluation.

## Key words

Hypertrophic obstructive cardiomyopathy • Right ventricle • Strain • Strain rate • Tissue Doppler imaging • Tei index

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## Introduction

Hypertrophic obstructive cardiomyopathy (HOCM) is characterized by myocardial hypertrophy with the impairment of myocardial contraction. Conventional echocardiography provides a useful morphological information for the diagnosis of HOCM, the most characteristic finding among them being the myocardial hypertrophy of the left ventricle (LV) (Elliott *et al.* 2008). Tissue Doppler imaging (TDI), strain and strain rate (SR) imaging are relatively newly developed echocardiographic techniques that allow a better assessment of regional myocardial function. Several studies have suggested that TDI of mitral annulus, strain, and SR offer more sensible tools for a functional evaluation of the left ventricle in HOCM patients (Nagueh *et al.* 2003, Kato *et al.* 2004). The above mentioned techniques provide possibilities to differentiate the patient suffering from HOCM from a healthy subject in the absence of hypertrophy, and to distinguish HOCM between other diseases with hypertrophy such as hypertension and “athletes” heart. TDI of tricuspid annulus was also identified as an independent prognostic factor in patients suffering from HOCM (Efthimiadis *et al.* 2007). Since HOCM is a global disease of the myocardium due to genetic defect, we assume that strain, SR, and TDI should be sensitive parameters to find any differences between right ventricle (RV) in patients suffering from HOCM and normal subjects. Up to now, RV in HOCM has been studied only by TDI, but not examined by strain and strain rate (Mörner *et al.* 2008).

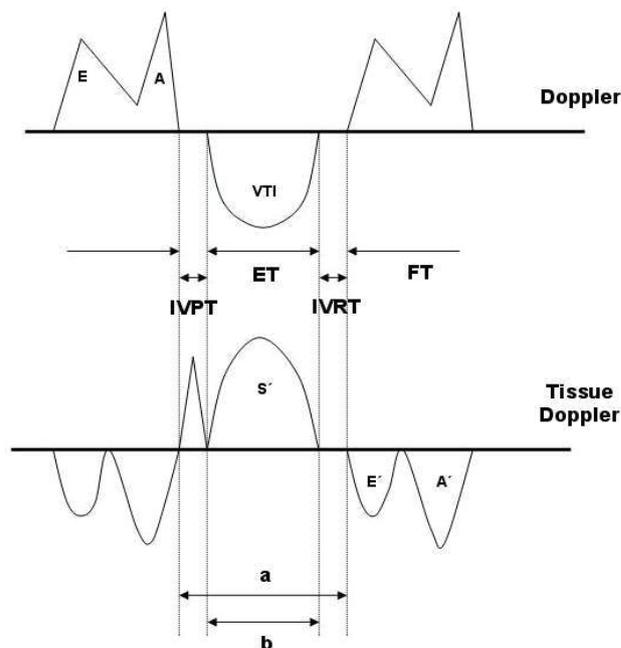
The aim of our study was evaluated RV by strain and SR and TDI parameters together.

## Methods

Seventy-five consecutive patients after alcohol septal ablation (ASA) for HOCM with an obstruction underwent simultaneous clinical and echocardiographic investigation between January 2007 and November 2008. Inclusion criteria for involvement in this study were a successful ASA for HOCM with the obstruction more than one year after the treatment. Exclusion criteria were a poor echocardiographic image quality, resting obstruction in the left ventricular outflow tract (LVOT) pressure gradient more than 15 mm Hg, present hypertrophy of RV (wall thickness  $\geq 6$  mm), echocardiographic markers of pulmonary hypertension (peak systolic gradient on tricuspid valve more than 30 mm Hg), implantation of pacemaker, moderate to severe valve disease, coronary artery disease, pulmonary and liver disease. The group finally consisted of 19 patients. This group was then compared with 22 subjects of control group matched for sex, age and major cardiovascular risk factors (hypertension, diabetes, smoking, and hyperlipidemia).

Echocardiography images were obtained in the parasternal long- and short-axis views, and apical 2- and 4-chamber views, using a standard transducer position with a Philips 7500 ultrasound system (Philips, Andover, MA, USA) by a single operator, and subsequently analyzed by two experienced cardiologists. The parameters of LV, RV, left and right atrium, and wall thickness, were measured in a parasternal long-axis or apical 4-chamber view. The hypertrophy was calculated according to the recommendation of the American Society of Echocardiography with limitation of asymmetrical distribution of LV hypertrophy (Lang *et al.* 2005). The volume of LV, left atrium, and ejection fraction of LV were calculated by a simplified Simpson's method in a monoplane projection.

TDI parameters were measured in a septal margin of mitral annulus for LV, and in a lateral margin of tricuspid annulus for RV from pulsed Doppler. Longitudinal strain and SR were obtained from a basal segment of LV (lateral, anterior and inferior wall), and in an apical half of the free wall of RV. The basal segment of interventricular septum was excluded from the analysis, because of being affected by ASA. Apical half of the RV free wall was evaluated thanks to a better image quality. Using the dedicated software (Q-Lab,



**Fig. 1.** Schema of the relation between Doppler and Tissue Doppler parameters during the heart cycle (IVPT – isovolumic pre-ejection time, ET – systolic ejection time, IVRT – isovolumic relaxation time, FT – diastolic filling time, a – mitral closing-to-opening time, b – ejection time = ET, E – early diastolic peak flow, A – late diastolic peak flow, VTI – velocity time integral in outflow tract of the ventricle, S' – peak systolic velocity, E' – peak early diastolic velocity, A' – peak late diastolic velocity)

Philips, The Netherlands), strain and SR were measured from a color Doppler imaging off-line. Strain and SR profiles were averaged over three consecutive cardiac cycles and integrated over time to derive natural strain profiles using an end-diastole as the reference point. Peak systolic SR (“first negative peak” – SRs), peak early diastolic SR (“first positive peak” – SRe), and peak strain (maximal negative deviation – PS) were measured from strain and strain rate (Marwick 2006). TDI was analyzed using the following parameters: peak systolic velocity (S'), peak early diastolic velocity (E'), peak late diastolic velocity (A'), isovolumic pre-ejection time (time interval between the end of the late diastolic wave and the onset of the systolic wave – IVPT), isovolumic relaxation time (time interval between the end of the systolic wave and the onset of the diastolic wave – IVRT), and myocardial performance index (this index is defined as  $(a-b)/b$ , where  $a$  is the interval between the end and the onset of the tricuspid inflow, and  $b$  is the ejection time of RV outflow – Tei index) (Fig. 1). Using the TDI for the measurement RV time intervals and Tei index has been previously certified (Harada *et al.* 2002).

The categorical variables are described with numbers and percentages. All the values were expressed

**Table 1.** Clinical characteristics of patients with hypertrophic obstructive cardiomyopathy (HOCM) and controls.

	HOCM group	Control group	P value
Age (years)	55.2 ± 10.4	55.6 ± 7.7	n.s.
Sex (male, %)	42	50	n.s.
BSA (m <sup>2</sup> )	1.9 ± 0.2	2.0 ± 0.2	n.s.
Systolic pressure (mm Hg)	132.6 ± 10.7	134.4 ± 10.3	n.s.
Diastolic pressure (mm Hg)	83.2 ± 9.8	83.9 ± 8.5	n.s.
Heart rate (beat/min)	63.2 ± 7.2	68.5 ± 8.3	<0.05
Hypertension (%)	58	68	n.s.
Diabetes mellitus (%)	11	9	n.s.
Dyslipidemia (%)	37	41	n.s.
Smoking (%)	32	27	n.s.
Beta-blockers (%)	89	45	<0.05
Ca channel antagonists (%)	11	18	n.s.
ACE inhibitors (%)	26	41	n.s.

BSA – body surface area, ACE – angiotensin-converting enzyme

**Table 2.** Parameters of left ventricle and left atrium in HOCM patients and controls.

	HOCM group	Control group	P value
LVEDD (mm)	43.4 ± 3.8	46.9 ± 3.8	<0.01
LVESD (mm)	25.5 ± 3.0	29.0 ± 3.5	<0.01
LV max. thickness (mm)	18.7 ± 2.7	10.4 ± 1.0	<0.01
EF (%)	71.6 ± 4.9	66.5 ± 5.1	<0.01
LVH/BSA (g/m <sup>2</sup> )	136.0 ± 14.7	86.8 ± 15.8	<0.01
LA (ml)	71.4 ± 16.0	48.9 ± 11.2	<0.01
E' (cm/s)	5.4 ± 1.7	8.4 ± 2.3	<0.01
A' (cm/s)	7.6 ± 1.7	9.6 ± 2.0	<0.01
LVOT gradient (mm Hg)	8.5 ± 3.3	5.2 ± 1.2	<0.01
PS septal (%)	6.9 ± 4.5	11.9 ± 3.8	<0.01
PS lateral (%)	11.3 ± 2.6	16.2 ± 2.6	<0.01
PS inferior (%)	8.7 ± 2.2	12.6 ± 2.8	<0.01
PS anterior (%)	11.9 ± 3.9	16.8 ± 3.6	<0.01

LVEDD – LV end-diastolic diameter, LVESD – LV end-systolic diameter, EF – ejection fraction, LVH/BSA – left ventricular hypertrophy/body surface area, LA – left atrium, E' – TDI peak early diastolic velocity, A' – TDI peak late diastolic velocity, LVOT – the left ventricular outflow tract, PS – peak strain.

as mean ± S.D. Data were compared with unpaired T-test to estimate the difference between the two selected groups. The normal (Gaussian) probability distribution was confirmed for this testing. The differences were considered significant at P<0.05.

## Results

Clinical and demographic characteristics of both

groups are presented in Table 1. The groups were not significantly different in sex, age, body surface area, blood pressure, and in the presence of main cardiovascular risk factors. We only found a difference in heart rate which resulted from a high prevalence of using beta-blockers in HOCM group. There was no difference in other cardiovascular medications, such as ACE inhibitors, AT<sub>1</sub> blockers and calcium channel antagonists. The echocardiographic parameters of LV and left atrium

**Table 3.** Parameters of right ventricle and right atrium in HOCM patients and controls.

	HOCM group	Control group	P value
<i>Diameter of RV (mm)</i>	24.9 ± 2.8	23.5 ± 1.9	n.s.
<i>Diameter of RA (mm)</i>	50.2 ± 4.7	49.5 ± 4.2	n.s.
<i>TAPSE (mm)</i>	2.9 ± 0.3	2.9 ± 0.3	n.s.
<i>ACT (ms)</i>	136.8 ± 16.6	121.1 ± 32.5	n.s.
<i>S' (cm/s)</i>	15.4 ± 4.7	15.8 ± 2.8	n.s.
<i>E' (cm/s)</i>	11.2 ± 1.8	12.9 ± 2.6	<0.05
<i>A' (cm/s)</i>	16.8 ± 4.1	17.6 ± 4.0	n.s.
<i>IVPT (ms)</i>	79.2 ± 17.3	58.5 ± 8.1	<0.01
<i>IVRT (ms)</i>	104.7 ± 26.2	77.3 ± 24.5	<0.01
<i>Tei index</i>	0.61 ± 0.14	0.49 ± 0.09	<0.01
<i>PS (%)</i>	17.7 ± 5.6	21.6 ± 9.1	n.s.
<i>SRs (s<sup>-1</sup>)</i>	1.2 ± 0.3	1.2 ± 0.3	n.s.
<i>SRe (s<sup>-1</sup>)</i>	1.2 ± 0.4	1.3 ± 0.5	n.s.

RV – right ventricle, RA – right atrium, TAPSE – tricuspid annular plane systolic excursion, ACT – acceleration time, S' – TDI peak systolic velocity, E' – TDI peak early diastolic velocity, S' – TDI peak late diastolic velocity, IVPT – isovolumic pre-ejection time, IVRT – isovolumic relaxation time, Tei index – myocardial performance index, PS – peak strain (maximal negative deviation), SRs – peak systolic strain rate, SRe – peak early diastolic strain rate.

are summarized in Table 2. These results are in agreement with the previous evidence of impaired systolic and diastolic LV functions in HOCM. We confirmed significant difference for strain (peak strain) for basal segments of LV (lateral, inferior and anterior) between HOCM and controls. Septal basal segment was excluded due to a possible affection by the scar after ASA. The parameters of RV and right atrium are presented in Table 3. There was no difference in conventional parameters of RV either. Among the parameters of tricuspid annulus TDI, we observed a significant difference in the value of early diastolic wave (E') and time intervals measured from TDI (IVPT, IVRT, and RV myocardial performance (Tei) index). We found no significant difference for strain and SR, only a trend for PS of RV was observed.

The reproducibility of technical and logical strain and strain rate measurement was confirmed by intra- and interobserver variability, which is also agreed with previous references and has a similar value for RV and LV (strain: intraobserver 8.8 % and interobserver variability 12.6 %, SR: intraobserver 16.6 % and interobserver variability 18 %).

## Discussion

We demonstrated a functional impairment of RV

in HOCM patients without a significant RV hypertrophy in our study. Moreover, to the best of our knowledge, this study is the first one to demonstrate the higher sensitivity of TDI compared to strain and SR derived from TDI in the evaluation of RV function.

The IVPT represents a systolic function, the IVRT represents a diastolic function and the Tei index is more complex. We found no significant difference for strain and SR in measured parameters. Despite the above mentioned findings, we confirmed the difference for strain and strain rate in LV. These results suggest that the impairment of non-hypertrophied RV in contrast to the left ventricle appears to be less pronounced. The TDI of tricuspid annulus seems to be more sensitive to detect these mild abnormalities than strain and strain rate.

The changes of the left ventricle in HOCM are well recognized and described, but in the case of the right ventricle the situation is quite different. The problem was in evaluation of RV that is influenced by dominant LV and that is also highly load-sensitive (Mandysová and Niederle 2007). The morphological impairment of RV in HOCM was recently documented by a magnetic resonance (Maron *et al.* 2007). Our findings confirmed the previously reported systolic and diastolic impairment of RV measured by TDI similar to previous study (Mörner *et al.* 2008) also for non-hypertrophied RV. The RV dysfunction is suggested mainly a primary

phenomenon related directly to a genetic defect of RV myocardium.

However, IVPT and IVRT are affected by a number of hemodynamic and electromechanical variables, including heart rate. Hence Tei *et al.* (1995) proposed a “myocardial performance index” (or “Tei index”) that is independent of the electromechanical delay. The Tei index has been found to be of a prognostic and clinical value in a number of heart disease including HOCM (Mikkelsen *et al.* 2006, Veselka *et al.* 2005). Although the Tei index has been proposed for the evaluation of the LV function, it can also be useful for the RV investigation (Vonk *et al.* 2007). The use of TDI for the measurement RV time intervals has been previously validated (Harada *et al.* 2002). In our study we observed a significant difference for the Tei index, corroborating the prolongation of IVPT and IVRT, confirming the impairment of both systolic and diastolic RV functions.

The failure of strain and strain rate derived from TDI to detect abnormalities in systolic function may be explained by several limitation of this technique including angle dependence, apico-basal gradient, etc. (Marwick 2006). The apico-basal gradient for strain and strain rate parameters was observed for LV in previous studies. LV basal segments have a better diagnostic value than the apical segments for the determination of HOCM (Serri *et al.* 2006). However, we evaluated only an apical half of RV free wall since it was impossible to obtain a good quality image of the basal part of non-hypertrophied RV in most of our patients, especially upward tricuspid annulus. Another possible reason could be a limitation caused by an angle deviation between the RV free wall longitudinal axis and the axis of measurement in some patients from an apical view. In addition, the TDI of the tricuspid annulus evaluates global changes in RV, while strain and SR the regional ones. Although a similar study with hypertensive patients showed a significant

difference for the RV peak systolic strain ( $p < 0.05$ ), the TDI of tricuspid annulus was more sensitive than strain and SR in this study as well (Tumuklu *et al.* 2007). The prevalence of hypertension was similar between groups in our study.

The limitation of this study was also a relatively small number of patients. However, HOCM is a relatively rare disease and previous investigations were performed with a similar number of patients (Nagueh *et al.* 2003, Kato *et al.* 2004, Serri *et al.* 2006). Moreover, we evaluated only patients following a successful alcohol septal ablation, who represent a small subgroup within the total HOCM cohort. We studied these patients because they represent a relatively homogenous group, and because the ASA excluded the hemodynamic influence of obstruction in LVOT to left ventricle and subsequently right ventricle function. The function of RV free wall should not be influenced by the interventricular scar after ASA. Our intra- and interobserver variability was in accordance with previous references.

Our findings support a general involvement of the whole myocardium in HOCM due to a genetic defect. Probably due to a technical imaging limitation, the tricuspid annular tissue Doppler imaging seems to be more sensitive to detect an early systolic and diastolic dysfunction of non-hypertrophied RV than strain and strain rate.

### Conflict of Interest

There is no conflict of interest.

### Acknowledgements

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