Left Ventricular Mechanics in Functional Ischemic Mitral Regurgitation in Acute Inferoposterior Myocardial Infarction

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Ischemic mitral regurgitation (MR) is an established adverse prognostic factor after myocardial infarction (MI). Functional ischemic mitral regurgitation in acute phase of MI remains under-investigated due to its often transient and dynamic nature. We aimed to assess left ventricular (LV) mechanics by speckle-tracking echocardiography in acute inferoposterior MI and ischemic mitral regurgitation (MR).

Methods: Sixty-nine patients with no structural cardiac valve abnormalities and first acute inferoposterior MI were prospectively enrolled into the study. Two-dimensional transthoracic echocardiography for regional myocardial function and valve assessment was performed within 48 hours of presentation after reperfusion therapy (percutaneous coronary intervention). Based on degree of MR, patients were divided into no significant MR (NMR) group (N = 34, with no or mild (grade 0–I) MR) and ischemic MR (IMR) group (N = 35, with grade ≥2 MR). Thirty-five age- and gender-matched healthy individuals served as a normal reference group. Offline 2D speckle tracking analysis was performed with GE EchoPAC software. Results: LV ejection fraction and longitudinal myocardial deformation parameters were significantly better in healthy subjects, but did not differ between both study groups. All circumferential myocardial deformation parameters were significantly worse in IMR group compared to healthy subjects and NMR group. Global, basal, and mid-ventricular radial strain was significantly lower in IMR group compared to both—healthy subjects and NMR group. Conclusion: Ischemic mitral regurgitation in acute inferoposterior MI is associated with worse radial and circumferential LV deformation parameters assessed by 2D speckle tracking echocardiography. (Echocardiography 2016;33:1131–1142)

Key words: speckle tracking echocardiography, ischemic mitral regurgitation

Funding Sources: There were no external sources of funding obtained for this study.

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obtained for the study, and all participants gave written informed consent prior to enrollment.

All patients with MI presented within 12 hours of symptom onset and were treated by primary or ad hoc percutaneous coronary intervention. Exclusion criteria were as follows: history of ischemic heart disease (any form of angina, previous MI, coronary artery bypass surgery, or occlusive/subocclusive lesions in nonculprit coronary arteries, suggestive of previous ischemic events), mechanical complications of myocardial infarction, suboptimal echocardiographic imaging quality, rhythm and conduction abnormalities (atrial fibrillation, atrioventricular node or His bundle branch block, implanted pacemaker), organic mitral valve disease, previously known mitral valve insufficiency, other left-sided valvular heart disease (including previous valvular heart surgery), other noncardiac disorders that may influence myocardial contractility (diabetes mellitus, renal insufficiency), and cardiogenic shock.

Acute MI was confirmed according to ESC recommendations of MI definition and guidelines based on clinical symptoms, electrocardiographic (ECG) findings, and cardiac enzyme abnormalities. Family history of IHD, cardiovascular risk factors, time of symptom onset, and current treatment were recorded using a standard questionnaire. Hypertension was defined as the presence of elevated systolic (>140 mmHg) and/or diastolic (>90 mmHg) blood pressure or current use of antihypertensive drugs. A patient was considered as a smoker if he was currently smoking or was a smoker in the past. Dyslipidemia was defined if any of the following criteria were present: serum total cholesterol ≥5.2 mmol/l, low-density lipoproteins >2.6 mmol/l, triglycerides ≥1.7 mmol/l, or current use of statin medication.

Patients were consented and enrolled into the study after routine transthoracic echocardiogram, which has been performed within 48 hours of presentation and reperfusion therapy as routine investigation. If they agreed to participate, written informed consent was obtained and additional images were acquired for speckle tracking and mitral regurgitation analysis during the same examination. Thirty-four patients who met inclusion criteria and had competent or only trivially (grade I) incompetent mitral valve were enrolled into no or only mild MR (NMR) group. Due to multiple exclusions criteria, study patients were not enrolled in a consecutive manner.

Control Group:

Control group consisted of 35 healthy age-matched nonobese individuals with no history of ischemic heart disease or other non-cardiac disorders that may affect myocardial contractility (arterial hypertension, renal failure, or diabetes mellitus). They all had normal electrocardiograms and no structural or functional cardiac abnormalities detectable by echocardiography. Control group participants were not on any form of medication (prescribed or over-the-counter).

Coronary Angiography Data Interpretation:

Coronary angiography data were analyzed and interpreted by one experienced interventional cardiologist.

Coronary dominance was defined according to the artery, which supplies the posterior descending artery (PDA) and labeled as right (if PDA originates from right coronary artery), left (if PDA originates from left circumflex coronary artery), or balanced (if PDA branches originate from both—right and left circumflex coronary arteries). Coronary blood flow was assessed by “Thrombolysis In Myocardial Infarction” (TIMI) grading (0—no antegrade flow, 1—weak contrast penetration beyond occlusion, 2—slow flow, 3—normal flow in the coronary artery).

Collateral development to the culprit artery was quantified according to Rentrop classification.

Echocardiography:

2D echocardiography was performed within 48 hours of presentation and reperfusion therapy (PCI) by one experienced physician-echocardiographer. Patients were imaged in the left lateral decubitus position using GE Vivid 7 echocardiography system (GE-Vingmed Ultrasound AS, Horten, Norway). Standard images were obtained using 3.5-MHz transducer in the parasternal (long-and short-axis views) and apical (four-, two-chamber, and long-axis) views. The frame rates of acquired images were between 82 and 95 frames/sec. Standard 2D and color Doppler data of at least three consecutive cardiac cycles, triggered to QRS complex, were saved in a cine loop format at a breath hold at shallow expiration.

2D echocardiography was used to assess conventional echocardiographic parameters. LV end-diastolic diameter (LVEDD), LV end-systolic diameter (LVESD), and left atrium (LA) diameters were measured from parasternal long-axis view (LVEDD at end-diastole, LVESD and LA diameters at end-systole). End-diastole was defined as the cardiac cycle time and frame when LV internal diameter was largest and end-systole as the frame when the LV cavity was smallest. LV dimensions were measured perpendicularly to LV long axis from the endocardial border of interventricular septum to the endocardial border of posterior LV wall immediately below the level of the mitral valve leaflet tips. LA anteroposterior diameter was measured from the endocardial border of
anterior LA wall to the endocardial border of posterior LA wall at the level of aortic valve perpendicularly to LA long axis.

LV ejection fraction (LVEF), LV end-diastolic volume (LVEDV), and LV end-systolic volume (LVESV) were automatically calculated by 2D biplane Simpson’s method by manually tracing endocardial border of LV cavity in the largest (end-diastolic) and smallest (end-systolic) frames at the apical 4- and 2-chamber views. Myocardial mass (MM) was calculated by Devereux formula. Myocardial mass index (MMI) was calculated by dividing MM (g) by body surface area, BSA (m²).

Left ventricular regional function was quantified by 16-segment model. Each myocardial segment was scored individually based on myocardial thickening and endocardial motion: 1—normal/hyperkinetic, 2—hypokinetic/reduced thickening, 3—akinetic/absent thickening, 4—dyskinetic/aneurysmal. Total semiquantitative wall-motion score index (WMSI) was derived by dividing the global wall-motion score by the number of segments analyzed.

RV diameter was measured from apical 4-chamber view perpendicularly to the long RV axis at mid-ventricular level at end-diastole (cardiac cycle frame when RV internal diameter was largest).

**Measurements of the Mitral Apparatus:**
All measurements were obtained by one experienced echocardiographer from 2D echocardiographic views at end-systole, defined as the cardiac cycle frame where the LV cavity is smallest and mitral valve leaflets are closed. Mitral annular (MA) dimensions were obtained from apical long-axis (3-chamber) view (anteroposterior (AP) diameter) and apical bicommissural view (inter-commissural (IC) distance) when P1-A2-P3 mitral leaflet scallops are visualized, as the distance between opposite sites of leaflet insertion to the fibrotic annulus. MA area was calculated using the formula of an ellipse: MAA = π*r₁*r₂/4, where r₁ and r₂ were AP and IC mitral annular dimensions, respectively. Mitral leaflet tenting area was derived by manually tracing the triangular zone comprised by MA, valve leaflets, and the coaptation point from the apical 3-chamber view. Mitral leaflet tethering height was measured as the shortest perpendicular distance between the MA plane (reflected by the line connecting contralateral leaflet insertion points to the annulus) and the leaflet coaptation point at apical 3-chamber view. The posteromedial papillary muscle (PMPM) displacement was quantified as the distance between the PMPM tip and contralateral anterior mitral annulus (the site of anterior leaflet insertion) in the apical 3-chamber view. Inter-papillary muscle distance (IPMD) was measured between the endocardial borders of the papillary muscle heads from parasternal short-axis mid-ventricular level view with both papillary muscles visible in cross section. All mitral apparatus measurements were indexed to individual BSA to obtain standardized values.

**Quantification of MR:**
Mitral regurgitation was quantified by standard PISA method according to the recommendations provided by European Association of Cardiovascular Imaging and reported as none (grade 0), mild (grade I, regurgitant orifice area (ROA) <0.2 cm²), moderate (grade II, ROA 0.2–0.3 cm²), or severe (grade III–IV, ROA ≥0.3 cm² or ≥0.4 cm², respectively). Based on mitral regurgitation degree, all study patients were divided into two subgroups: no significant mitral regurgitation group (NMR) (no or mild mitral regurgitation, grade 0–I) and ischemic mitral regurgitation (IMR) group (grade II–IV) (Fig. 1).

**Myocardial deformation analysis:**
2D speckle tracking imaging analysis was performed off line with GE EchoPAC software. For speckle tracking imaging analysis, end-systole was defined as the time of aortic valve closure from pulsed-wave Doppler tracing over LV outflow tract. All study population subjects had optimal segmental tracking in all LV segments and regions.

The following myocardial deformation parameters were evaluated:

- Longitudinal: global and global peak systolic strain (GLS and GLPSS), basal and basal peak systolic strain (BLS and BLPSS), mean and peak mid-ventricular systolic strain (MLS and MLPPS), apical and apical peak systolic strain (ALS and ALPSS), and global peak systolic strain rate (GLPSSr);
- Circumferential: global and global peak systolic strain (GCS and GCPSs), basal and basal peak systolic strain (BCS and BCPSS), mid-ventricular and mid-ventricular peak systolic strain (MCS and MCPSS), apical and apical peak systolic strain (ACS and ACPSS), and global, basal, mid-ventricular, and apical peak systolic strain rate (GCPSSr, BCPSSr, MCPSSr, and ACPSSr);
- Radial: global and global peak systolic strain (GRS and GRPSS), basal and basal peak systolic strain (BRS and BRPSS), mid-ventricular and mid-ventricular peak systolic strain (MRS and MRPPSS), apical and apical peak systolic strain (ARS and ARPSS), and global, basal, mid-ventricular, and apical peak systolic strain rate (GRPSSr, BRPSSr, MRPSSr, and ARPSSr);
Peak systolic strain was defined as the maximal strain value during the ejection phase (between the beginning of the QRS complex and the aortic valve closure reference time points): peak negative deflection for longitudinal and circumferential deformations (myocardial shortening), and peak positive deflection for radial deformation (myocardial thickening). Peak systolic strain rate was defined as the maximal strain rate value during ejection phase depending on the plane of myocardial deformation measurement: peak negative deflection for longitudinal and circumferential planes, and maximal positive deflection for radial plane. Global LV strain values were derived from averaged peak systolic strain measures using semiautomated software from 3 apical views: 4-chamber, 2-chamber, and apical long-axis views. Strain rate values represent change in strain over time (s⁻¹) and were measured automatically.

LV twist (degrees, °) was estimated as the difference between maximal apical and basal rotation parameters. To standardize the location from which basal and apical short-axis views were obtained, the basal short-axis plane was obtained just below the mitral valve annulus, where the LV myocardium appears in the scanning plane throughout the cardiac cycle and the apical short-axis plane was obtained just above the apex, where the LV cavity is visualized throughout the cardiac cycle.

Statistical Analysis:
Continuous variables were expressed as means ± standard deviations (SD). Continuous variables were assessed using the unpaired Student’s t-test and Mann–Whitney U-test, as appropriate. Categorical variables are presented as absolute numbers and percentages and were compared using Chi-square test. A P value <0.05 was considered statistically significant.

The Kolmogorov–Smirnov test was used to detect the normality of distribution of the data. The Student’s t-test was used to compare normally distributed variables, and Mann–Whitney U-test was used for abnormally distributed variables among groups. Chi-square test was used for comparison of categorical variables.

Linear logistic regression analysis was used to determine whether myocardial deformation parameters predict PISA radius in ischemic mitral regurgitation. First, for selection of myocardial deformation parameters that might independently predict ischemic MR, univariate analysis was performed. Univariate analysis was followed by forward stepwise multivariate linear regression: the variables with a P value <0.05 in the univariate analysis were entered into the model and those with P > 0.1 were removed; standardized coefficients (β) and 95% confidence intervals (CI) were obtained.

Pearson’s correlation coefficient (r) was used to evaluate correlations between PISA radius and myocardial deformation parameters assessed by speckle tracking echocardiography; |r| ≥ 0.4 was interpreted to show a substantial correlation.

Intra-observer variability was evaluated for the measurements of systolic longitudinal, circumferential, and radial strains in 15 randomly selected cases. Intra-class correlation coefficients (ICC) and Bland–Altman plot diagrams were used for the evaluation.

Figure 1. 2D transthoracic echocardiographic image with color flow (CF) and continuous-wave (CW) Doppler of a patient with an inferior myocardial infarction and severe functional ischemic mitral regurgitation (MR). A. Apical four-chamber view demonstrating severe laterally directed functional MR jet with Coanda effect (“wall-hugging” appearance of the regurgitant flow resulting from jet dispersion along adjacent left atrial (LA) wall). Due to Coanda-like effect eccentric regurgitant, MR jets are often underestimated based solely on CF Doppler methods. Proximal isovelocity surface area (PISA) method is a more reliable quantitative tool recommended for grading severity of MR. B. Apical two-chamber view at the same aliasing velocity (Nyquist limit 40 cm/sec) illustrating a hemispheric PISA radius of 6.5 mm and a large central MR jet reaching the posterior LA wall. Basal inferior left ventricular myocardial segment appears bulging and echo-intense and corresponds to the infarct region. C. CW Doppler of MR jet allows quantification of the effective regurgitant orifice area (EROA = 0.32 cm²) and regurgitant volume (RV = 48 mL). Dense appearance of CW Doppler signal is a qualitative indicator of severe MR.
All statistical analyses were performed using Software Package for Social Sciences (SPSS) version 21.0 (SPSS, Chicago, IL, USA).

Results:
General demographic and conventional echocardiographic characteristics of all study participants are summarized in Table I.

All the study groups contained participants of similar age and BMI. Patients with MI had more ischemic heart disease risk factors (arterial hypertension, dyslipidemia, and smoking history) as compared to the control group. Patients with significant mitral regurgitation (IMR group) were more often females compared to patients with no or only mild MR (NMR group).
Control group population had higher LVBEF, lower LVESV, LVESV index (LVESVi), MMI, LA diameter, and LA index (LAI). Majority of conventional echocardiographic parameters were similar in IMR and NMR groups, except for LVEDDi, which was higher in IMR group. Some other echocardiographic dimensions (LVEDD and LVEDD index (LVEDDi)), LVEDV index (LVEDVi), LVESD index (LVESDi) were higher only in IMR group as compared to the control subjects. LV wall-motion abnormalities were similar in both study groups and were not present in control subjects.

Characteristics of mitral apparatus are presented in Table I. Both study groups had significantly larger MAA, greater MA AP diameter index, and tethering height compared to control group. These parameters were also greater in IMR than in NMR group. MA IC distance was similar between control and NMR groups, however significantly increased in IMR group. Statistically significant difference in mitral valve tenting area was observed only between control and IMR groups. IPMD was increased in both groups of patients with MI and was greater in IMR group compared with NMR group. IPMD displacement was insignificant in NMR group compared to control group. In the meantime, IMR group had significantly increased PMPM-anterior MA distance compared to healthy subjects and patients with inferoposterior MI without significant MR (NMR group).

Clinical and angiographic characteristics of study patients with myocardial infarction are summarized and compared in Table II.

NMR and IMR group patients had similar distribution of timing from symptom onset to reperfusion therapy. IMR patients were more often found to have culprit lesion in LCx artery with no antegrade flow (TIMI flow grade 0) on initial coronary angiogram. NMR group more often had RCA being the culprit artery with preserved antegrade flow in MI region (TIMI flow grade 3). TIMI flow after PCI procedure was similar in both groups. Patients in IMR group had better developed collaterals compared to NMR group. Both groups did not differ in regard to PCI success (TIMI flow in the culprit artery after PCI).

2D speckle tracking myocardial deformation analysis results are depicted in Figures 2–9.

Almost all longitudinal myocardial deformation parameters (except for ALS and ALPSS, which were similar in NMR group and healthy subjects) were significantly better in healthy subjects as compared to the patients with MI. NMR and IMR groups did not differ in regard to longitudinal LV strains (Fig. 2). Figure 3 illustrates 2D longitudinal myocardial strain patterns of a healthy subject (2A) and selected patients from different study groups (3B and 3C) derived from apical 2-chamber view.

Global, basal, and mid-ventricular circumferential deformation parameters (GCS, GCPSS, BCS, BCPSS, MCS, and MCPSS) in control group had significantly higher values compared with other study groups. Apical circumferential myocardial deformation (ACS and ACPSS) was similar between control and NMR groups, but lower in IMR group. All circumferential deformation parameters were significantly lower in IMR group compared with NMR group (Fig. 4). Figure 5 illustrates 2D circumferential myocardial strain patterns of a healthy subject (5A) and selected patients from both study groups (5B and 5C) derived from parasternal short-axis view in the mid-ventricular level of LV.

Healthy subjects and NMR group patients were similar regarding all radial myocardial deformation parameters. Global, basal, and mid-ventricular radial strains (GRS, GRPSS, BRS, BRPSS, MRS, and MRPSS) were significantly lower in IMR patients as compared to both—NMR and control groups. There was no statistically significant difference in apical radial strain values among all

### TABLE II

<table>
<thead>
<tr>
<th>Time from symptom onset to reperfusion</th>
<th>IMR Group n = 35</th>
<th>NMR Group n = 34</th>
<th>P</th>
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<tr>
<td>≤4 h</td>
<td>16 (47.1)</td>
<td>10 (28.6)</td>
<td>0.116</td>
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<tr>
<td>4–8 h</td>
<td>9 (26.5)</td>
<td>10 (28.6)</td>
<td>0.846</td>
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<tr>
<td>8–12 h</td>
<td>9 (26.5)</td>
<td>15 (42.9)</td>
<td>0.156</td>
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<tr>
<td>Culprit lesion, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCA</td>
<td>31 (91.2)</td>
<td>22 (62.9)</td>
<td>0.006</td>
</tr>
<tr>
<td>LCx</td>
<td>3 (8.8)</td>
<td>13 (37.1)</td>
<td>0.006</td>
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<td>TIMI flow before PCI</td>
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<td></td>
</tr>
<tr>
<td>0</td>
<td>14 (41.2)</td>
<td>23 (67.6)</td>
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<td>1</td>
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<td>1 (2.9)</td>
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<td>2</td>
<td>7 (20.6)</td>
<td>6 (17.6)</td>
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</tr>
<tr>
<td>3</td>
<td>11 (32.4)</td>
<td>3 (8.8)</td>
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<td>TIMI flow after PCI</td>
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<td></td>
<td></td>
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<tr>
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<td>0 (0)</td>
<td>3 (8.8)</td>
<td>0.083</td>
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<tr>
<td>3</td>
<td>30 (88.2)</td>
<td>28 (82.4)</td>
<td>0.354</td>
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<td>Collateral flow</td>
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<td></td>
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<tr>
<td>0</td>
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<td>16 (45.7)</td>
<td>0.02</td>
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<td>7 (20.6)</td>
<td>4 (11.4)</td>
<td>0.302</td>
</tr>
<tr>
<td>2</td>
<td>2 (5.9)</td>
<td>15 (40)</td>
<td>&lt;0.001</td>
</tr>
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</table>

NMR = no significant mitral regurgitation (grade 0–1) group; IMR = ischemic mitral regurgitation group; RCA = right coronary artery; LCx = left circumflex coronary artery; TIMI = Thrombolysis in Myocardial Infarction coronary flow grade; PCI = percutaneous coronary intervention.
study groups (Fig. 6). Illustrative examples of radial strain patterns in different study groups are depicted in Figure 7.

Distribution of LV strain rate patterns among the study groups is illustrated in Figure 8. GLPSSr was better in control, and similar between the study groups. GCPSSr, MCPSSr, ACPSSr, GRPSSr, BRPSSr, MRPSSr, and ARPSSr were similar between control and NMR groups and worse in IMR group. There was no significant difference in BCPSs among the groups.

Both groups of patients with MI had worse basal LV rotational parameters compared to control group. Apical rotation was similar in all three groups. LV twist was better in healthy subjects than in IMR group, but did not differ between control–NMR and NMR–IMR groups (Fig. 9).

GCS, GCPSS, GRS, and GRPSS had weak but significant correlations with PISA radius of MR (Table III). Longitudinal deformation parameters did not correlate to the grade of MR (PISA radius).

Table IV presents results of linear logistic regression analysis with PISA radius as dependent variable and myocardial deformation parameters as independent variables. Of all myocardial deformation parameters GRPSSr, MCS and MCPSS
were found to be the most significant predictors of ischemic mitral regurgitation.

**Intra-Observer Variability:**

Two-way random-effects model for absolute agreement showed strong intra-observer correlations for systolic longitudinal strain (ICC, 0.87; 95% confidence interval, 0.72–0.92), systolic circumferential strain (ICC, 0.91; 95% confidence interval 0.75–0.94), and systolic radial strain (ICC 0.94; 95% confidence interval, 0.88–0.97) measurements.

Intra-observer variation in Bland–Altman analysis were best for longitudinal strain measurements.
(-3.6% to +2.3%) and worst for radial strain measurements (-12.7% to +11.8%).

Discussion:
Speckle tracking echocardiography (STE) is advantageous compared to conventional echocardiographic determinants of LV systolic function (EF, wall-motion score) as is not influenced by tethering of adjacent myocardial segments, ultrasound beam alignment, and allows assessment of cardiac mechanics in all spatial planes: longitudinal, circumferential, and radial. Understanding alterations of myocardial contractility in various myocardial disorders may have important clinical and prognostic implications. Functional ischemic mitral regurgitation in inferoposterior myocardial infarction is predominately predisposed by impaired regional LV contractility resulting in tethering and systolic restriction of posterior mitral valve leaflet, thus impeding mitral valve closure. This study has illustratively depicted changes in mitral anatomy resulting from inferoposterior MI, which are more exaggerated in the presence of ischemic MR: increased MAA and dimensions, mitral valve tenting, and subvalvular apparatus displacement. The aforementioned findings have been extensively described and discussed in a variety of published literature.
The major findings in our study were that the underlying myocardial dysfunction is attributable to impaired circumferential and radial myocardial deformation in patients with ischemic MR in acute inferoposterior MI. Subendocardial layer is the major contributor to longitudinal myocardial function as sustains...
the greatest deformational changes during systole leading to higher oxygen demand and susceptibility to ischemia compared to other myocardial layers. Consequently, ischemia caused by acute myocardial infarction invariably affects the subendocardium and therefore longitudinal strain. Although longitudinal LV function (strain) is reduced in both study groups, it does not appear to be related to acute ischemic MR in acute inferoposterior MI.

Circumferential and radial deformation of myocardial fibers during systolic contraction (circumferential and radial strains) have also been demonstrated to be reduced in myocardial ischemia. Our study has demonstrated that circumferential strain is significantly reduced globally and regionally in patients with IMR compared to both control groups (healthy subjects and MI patients with no significant MR), and apparently has important role in genesis of ischemic MR. Circumferential systolic strain reflects shortening of myocardial fibers around LV cavity. Reduced circumferential strain is an indirect indicator of increased LV systolic sphericity, which may account for lateral traction of papillary muscles and subvalvular mitral apparatus. Also, lower circumferential strain values are associated with greater transmurality scar formation.

Lower radial strain in patients with ischemic MR emphasizes the importance of radial myocardial thickening in basal and mid-ventricular regions in maintaining MV competence in acute inferoposterior MI and may lead to contractile papillary muscle dysfunction.

Circumferential and radial myocardial deformation parameters reveal important mechanistic determinants of ischemic MR in patients with acute inferoposterior MI with otherwise comparable conventional echocardiographic parameters (global EF, WMS) and longitudinal LV function. Above-mentioned findings once again prove superiority of STE over routine 2D echocardiographic measures (biplane EF or visual wall-motion assessment) in detecting left ventricular systolic dysfunction.

Myocardial infarction from histologic analysis is known to affect the myocardial layers to a different extent, resulting in either homogenous transmural ischemic injury or alterations limited to specific layers. Higher extent of impaired LV mechanics suggests higher transmurality of myocardial injury and dysfunction in IMR patients. Circumferential strain represents subepicardial layer; therefore, significant reduction in all circumferential strains supports this hypothesis. Studies involving cardiac magnetic resonance imaging would be beneficial to further confirm this finding.

Impaired basal rotational mechanics in inferoposterior MI has been described to be associated with increased MR. Rotational motion of LV myocardium is essential to ensure normal function of a complex three-dimensional mitral apparatus structure (saddle-shaped annulus with inherent systolic contraction, etc.). Although our study has shown no difference in rotation between the patients with or without ischemic MR, this difference may become evident with LV remodeling over time. Further follow-up studies comparing LV mechanics in acute and chronic ischemic MR forms would reveal interesting mechanistic insights.

Time to reperfusion and preserved antegrade coronary flow in the culprit artery appear to be the most important angiographic factors in preventing ischemic MR. Although recent reports emphasize the importance of collateral supply in ischemic MR reduction, a considerable proportion of our study participants exhibited ischemic MR despite well-developed collateral circulation to occluded culprit artery territory. Recent findings revealed that collateral circulation compensates for antegrade flow reduction and relieves ischemia in stable coronary artery disease with chronic total occlusion in less than 5% of patients. Likely collateral flow reserve is even less in acute ischemic event. Developed collateral circulation to the infarct zone in patients presenting with acute MI has also been reported to represent previously underlying silent ischemia and left ventricular remodeling, as well as indicates a higher likelihood for the patient to exhibit ischemic MR upon presentation.

Ischemic mitral regurgitation is strongly associated with adverse LV remodeling. Some patients are known to develop MR over time despite normal valve competence in acute MI period. As well, MR is known to resolve in some patients on longer-term follow-up; therefore, further studies are desirable to assess how LV mechanics contribute or predict remote MR progression or regression.

Study Limitations:
The study samples are small and may have been influenced by multiple exclusion criteria described at methodology part of this study, therefore preclude definitive conclusions.

IMR study group consisted of less males, who are known to have normally lower myocardial deformation values. However, this influence is negligible as myocardial deformation indices in other study groups consisting of more males were still proven superior to the IMR study group.
Conclusion:
Ischemic mitral regurgitation in acute phase of inferoposterior MI is associated with worse radial and circumferential LV deformation parameters assessed by 2D speckle tracking transthoracic echocardiography.

References