Improvement of Cardiac Function During Enzyme Replacement Therapy in Patients With Fabry Disease
A Prospective Strain Rate Imaging Study

Frank Weidemann, MD*; Frank Breunig, MD*; Meinrad Beer, MD; Joern Sandstede, MD; Oliver Turschner, MD; Wolfram Voelker, MD; Georg Ertl, MD; Anita Knoll, MD; Christoph Wanner, MD; Jörg M. Strotmann, MD

Background—Enzyme replacement therapy (ERT) has been shown to enhance microvascular endothelial globotriaosylceramide clearance in the hearts of patients with Fabry disease. Whether these results can be translated into an improvement of myocardial function has yet to be demonstrated.

Methods and Results—Sixteen patients with Fabry disease who were treated in an open-label study with 1.0 mg/kg body weight of recombinant α-Gal A (agalsidase β, Fabrazyme) were followed up for 12 months. Myocardial function was quantified by ultrasonic strain rate imaging to assess radial and longitudinal myocardial deformation. End-diastolic thickness of the left ventricular posterior wall and myocardial mass (assessed by magnetic resonance imaging, n = 10) was measured at baseline and after 12 months of ERT. Data were compared with 16 age-matched healthy controls. At baseline, both peak systolic strain rate and systolic strain were significantly reduced in the radial and longitudinal direction in patients compared with controls. Peak systolic strain rate increased significantly in the posterior wall (radial function) after one year of treatment (baseline, 2.8 ± 0.2 s⁻¹; 12 months, 3.7 ± 0.3 s⁻¹; P < 0.05). In addition, end-systolic strain of the posterior wall increased significantly (baseline, 34 ± 5%; 12 months, 45 ± 4%; P < 0.05). This enhancement in radial function was accompanied by an improvement in longitudinal function. End-diastolic thickness of the posterior wall decreased significantly after 12 months of treatment (baseline, 13.8 ± 0.6 mm; 12 months, 11.8 ± 0.6 mm; P < 0.05). In parallel, myocardial mass decreased significantly from 201 ± 18 to 180 ± 21 g (P < 0.05).

Conclusions—These results suggest that ERT can decrease left ventricular hypertrophy and improve regional myocardial function. (Circulation. 2003;108:1299-1301.)

Key Words: Fabry disease • enzymes • hypertrophy • imaging

Fabry disease is an X-linked lysosomal storage disorder caused by a deficiency of the enzyme α-galactosidase (α-Gal A). The enzymatic deficit results in progressive intracellular accumulation of glycosphingolipids (mainly globotriaosylceramide) in different tissues. Cardiac involvement is frequent, with left ventricular (LV) hypertrophy as the most common finding. A variety of cardiac symptoms, including angina pectoris, arrhythmias, and progressive dyspnea, typically occur late in the course of the disease, and many patients die from heart failure.¹

Recently, a new therapeutic approach of enzyme replacement therapy (ERT) with recombinant α-Gal A was introduced.²⁻³ First clinical studies have shown that ERT cleared microvascular deposits of globotriaosylceramide from the kidneys, the skin, and the heart.² Whether ERT can prevent the progression of LV hypertrophy and, in parallel, improve myocardial function is not known.

Echocardiographic measurements of global LV function such as ejection fraction (EF) are not sensitive enough to detect impaired myocardial function.➄ Strain rate imaging, a new technique based on ultrasonic Doppler myocardial imaging, quantifies changes in regional myocardial deformation very precisely.⁵ A recent report has shown that Doppler myocardial imaging can detect reduced myocardial function even before LV hypertrophy in patients with Fabry disease occurs.⁶

Thus, in the present study, we sought to determine whether ERT can reduce myocardial hypertrophy and whether strain rate imaging can detect an improvement of myocardial function after 12 months of therapy.

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From the Department of Medicine, Divisions of Cardiology and Nephrology (F.W., F.B., O.T., W.V., G.E., A.K., C.W., J.S.), and Department of Radiology (M.B., J.S.), University Hospital Würzburg, Germany.
*These authors contributed equally to this study.
C. Wanner has received grant support from Genzyme, Germany.
Correspondence to Jörg M. Strotmann, Medizinische Klinik, Universitätsklinik Würzburg, Josef-Schneider Str. 2, Germany. E-mail strotmann_j@medizin.uni-wuerzburg.de
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Methods

Study Population
Sixteen patients (42±3 years of age) with genetically confirmed Fabry disease were included in a nonrandomized, open-labeled prospective study (Table). In addition, none of the Fabry patients was receiving ERT at study entry. Clinical symptoms of cardiac involvement are listed in the Table. The data from the Fabry group were compared with those from 16 age-matched healthy controls. The investigation conformed with the principles outlined in the Declaration of Helsinki, and informed consent was obtained from the patients.

Study Protocol
α-Gal A (agalactosidase beta; Fabrazyme, Genzyme) was given at a dosage of 1 mg per kilogram of body weight intravenously every 2 weeks for a period of 12 months. All patients underwent bicycle stress tests and standard echocardiographic and color Doppler myocardial imaging (CDMI) studies at baseline, 6 months, and 12 months.

Standard Echocardiographic Measurements
LV end-diastolic thickness of the posterior wall was measured using standard M-mode echocardiographic methods from parasternal long-axis views, EF was calculated using the modified Simpson method. Blood pool pulsed Doppler of the mitral valve inflow was used to extract the ratio of early to late diastolic flow velocity (E/A), deceleration time (DT), and isovolumetric relaxation time (IVRT).

Color Doppler Myocardial Imaging
Real-time 2-dimensional CDMI data were recorded from the interventricular septum and the LV lateral, inferior, and anterior walls using standard apical 4-chamber and 2-chamber views to evaluate longitudinal function (GE Vingmed Vivid V; 3.5 MHz). To assess radial function of the posterior wall, parasternal long-axis views were used. CDMI data were analyzed using dedicated software (TVI, GE Ultrasound). Longitudinal strain rates in the basal, mid, and apical segments of each wall and radial strain rates of the posterior wall were estimated by measuring the spatial velocity gradient. Strain rate profiles were averaged over 3 consecutive cardiac cycles and integrated over time to derive natural strain profiles using end-diastole as the reference point (Speqle). From the resulting strain rate and strain curves, peak systolic strain rate (SR_{SYS}) and systolic strain (ε_{SYS}) were measured. Data for longitudinal function are presented as the means of all interrogated segments.

Magnetic Resonance Imaging
Cine-MRI was performed in 10 patients with Fabry disease. Analysis of LV mass was performed by manual segmentation of the endocardial and epicardial borders of the end-diastolic and end-systolic frame as previously described.

Statistics
Data are presented as mean±1SEM. Differences between controls and patients with Fabry disease were tested using two-tailed, unpaired Student’s t test. For the comparison between baseline and follow-up, two-way analysis of variance for repeated measurements was performed. A value of P<0.05 was considered to indicate significance.

Results
The baseline characteristics of the Fabry patients are presented in the Table. The major clinical limitation at study entry and after 1 year of ERT was acroparesthesias. Exercise capacity (bicycle stress) did not change during ERT (1.3±0.1 versus 1.3±0.1 W/kg body weight, baseline versus 12 months).

Standard Echocardiographic and MRI Measurements
For diastolic function, DT and E/A ratio did not differ between patients and controls (Fabry: DT=242±11, E/A=1.3±0.2; controls: DT=217±13, E/A=1.3±0.1) and did not change after 12 months of ERT (DT=258±12, E/A=1.4±0.1). In contrast, IVRT was significantly longer in patients (121±4 ms) compared with controls (86±3 ms; P<0.001 versus patients) and remained constant during ERT (118±3 ms). The patient and the control group showed a normal EF at baseline (Fabry: 62±1%, controls: 64±1%), and there was no change during ERT (Fabry: 64±1%). End-diastolic thickness of the LV posterior wall was significantly higher in patients compared with controls (13.8±0.6 versus 7.2±0.3 mm; P<0.001). After 12 months of
Weidemann et al Improvement of Myocardial Function in Fabry Disease

LV radial function before and after 6 and 12 months of ERT. Radial function was assessed by peak systolic strain rate (left) and systolic strain (right). BS indicates baseline; m, months; Sys, systolic. *P<0.05 vs BS.

Discussion

The safety and effectiveness of ERT have been well documented for Gaucher’s disease. This prospective study evaluates the impact of ERT in a second lysosomal disorder, Fabry disease. The presented data show for the first time that 12 months of ERT in these patients resulted in a combined morphological and functional cardiac improvement.

ERT in Fabry Disease

Safety of ERT was documented in two preclinical studies. Furthermore, Eng et al demonstrated in a placebo-controlled, double-blind study that ERT resulted in a histological clearance of the deposits of globotriaosylceramide in cardiomyocytes. Our study suggests that this clearance of globotriaosylceramide due to ERT leads to a regression of LV hypertrophy, which was documented by echocardiography and confirmed by MRI. The fact that QRS-complex duration decreases with ERT suggests that in addition to morphological changes, functional changes also occur. The present study demonstrates that both radial and longitudinal function of the LV improve after 12 months of treatment. Notably, the documented improvement of myocardial function was more pronounced in the last 6 months of ERT.

These findings parallel the histological observation that in contrast to other tissue (kidney and skin), the maximal clearance for globotriaosylceramide in the cardiomyocytes extends 6 months of therapy. Because many patients die from heart failure, improvement of myocardial function should be the primary cardiac aim when doing ERT. Nevertheless, we could not demonstrate that diastolic function and exercise capacity improved during ERT.

Assessment of Myocardial Function

In Fabry patients, LVEF as parameter of global ventricular function was normal at study entry. This is in accordance with many other studies showing that conventional measurements of global LV function are not sensitive enough to detect impaired myocardial function. A recent study using Doppler myocardial imaging showed that myocardial velocities are reduced in hypertrophic and even in nonhypertrophic segments. In the present study, strain rate imaging as a more sensitive method was used to quantify regional myocardial function. When compared with myocardial velocities, strain rate imaging has been shown to be less influenced by overall cardiac motion and tethering effects. Because it is known that SR sys is more related to regional contractility and ε sys more to stroke volume, these data suggest that ERT has an impact on both of these cardiac performance indices. In particular, the increase of SR sys confirms the improvement of inotropic function, as this parameter is more independent from myocardial wall thickness. In contrast, the increase in systolic deformation (strain) is necessary to maintain the same ejection fraction in the presence of reduced LV wall thickness. Thus, the increase of strain does not necessarily represent an increase in inotropy.

Conclusions

ERT in Fabry patients resulted in a decrease of LV hypertrophy associated with an improvement of LV function. This therapy concept appears to be a promising treatment approach in advanced stages of Fabry disease.

References

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