Three-Dimensional Electroanatomic Voltage Mapping Increases Accuracy of Diagnosing Arrhythmogenic Right Ventricular Cardiomyopathy/Dysplasia

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Background—Three-dimensional electroanatomic voltage mapping offers the potential to identify low-voltage areas that correspond to regions of right ventricular (RV) myocardial loss and fibrofatty replacement in patients with arrhythmogenic RV cardiomyopathy/dysplasia (ARVC/D).

Methods and Results—Thirty-one consecutive patients (22 men and 9 women; mean age, 30.8±7 years) who fulfilled the criteria of the Task Force of the European Society of Cardiology and International Society and Federation of Cardiology (ESC/ISFC) for ARVC/D diagnosis after noninvasive clinical evaluation underwent further invasive study including RV electroanatomic voltage mapping and endomyocardial biopsy (EMB) to validate the diagnosis. Multiple RV endocardial, bipolar electrograms (175±23) were sampled during sinus rhythm. Twenty patients (group A; 65%) had an abnormal RV electroanatomic voltage mapping showing ≥1 area (mean 2.25±0.7) with low-voltage values (bipolar electrogram amplitude <0.5 mV), surrounded by a border zone (0.5 to 1.5 mV) that transitioned into normal myocardium (>1.5 mV). Low-voltage electrograms appeared fractionated with significantly prolonged duration and delayed activation. In 11 patients (group B; 35%), electroanatomic voltage mapping was normal, with preserved electrogram voltage (4.4±0.7 mV) and duration (37.2±0.9 ms) throughout the RV. Low-voltage areas in patients from group A corresponded to echocardiographic/angiographic RV wall motion abnormalities and were significantly associated with myocyte loss and fibrofatty replacement at EMB (P<0.0001) and familial ARVC/D (P<0.0001). Patients from group B had sporadic disease and histopathological evidence of inflammatory cardiomyopathy (P<0.0001). During the time interval from onset of symptoms to the invasive study, 11 patients (55%) with electroanatomic low-voltage regions received an implantable cardioverter/defibrillator because of life-threatening ventricular arrhythmias, whereas all but 1 patient with a normal voltage map remained stable on antiarrhythmic drug therapy (P=0.02).

Conclusions—Three-dimensional electroanatomic voltage mapping enhanced accuracy for diagnosing ARVC/D (1) by demonstrating low-voltage areas that were associated with fibrofatty myocardial replacement and (2) by identifying a subset of patients who fulfilled ESC/ISFC Task Force diagnostic criteria but showed a preserved electrogram voltage, an inflammatory cardiomyopathy mimicking ARVC/D, and a better arrhythmic outcome. (Circulation. 2005;111:3042-3050.)

Key Words: cardiomyopathy ■ death, sudden ■ electrophysiology ■ mapping ■ myocarditis

Arrhythmogenic right ventricular cardiomyopathy/dysplasia (ARVC/D) is a heart muscle disease, often familial, that is characterized pathologically by RV myocardial atrophy with fibrofatty replacement and clinically by peculiar RV electric instability predisposing to life-threatening ventricular arrhythmias and sudden death.1-6 At this stage of knowledge, molecular diagnosis of ARVC/D is not feasible in the majority of cases because of a large genetic heterogeneity and limitation of screening to the few genes discovered thus far.7-11 Clinical diagnosis may be difficult because of several problems with the specificity of ECG abnormalities, with the different potential etiology of RV arrhythmias, and with the assessment of the RV structure and function by current imaging technique.12-14

Although MRI has the unique ability to characterize tissue, particularly discriminating fat from muscle, several limitations and a high degree of interobserver variability in the evaluation of RV free wall thinning and fatty infiltration have
been reported.\textsuperscript{15,16} Therefore, a definitive phenotypic diagnosis of ARVC/D relies on the histopathological demonstration of fibrofatty substitution of the RV myocardium, either at postmortem or in vivo by endomyocardial biopsy (EMB).\textsuperscript{2,4,5,17} This latter option, however, has diagnostic limitations related to the segmental nature of the disease and its inability to assess transmural changes of RV wall. Moreover, there may be difficulty in differentiating ARVC/D biopsy findings from either the normal amount of subepicardial adipose tissue or other cardiomyopathy/myocarditis.\textsuperscript{14}

Three-dimensional electroanatomic voltage mapping has been recently demonstrated to accurately identify the presence, location, and extent of the pathological substrate of ARVC/D by detection of low-voltage regions that reflect RV fibrofatty myocardial atrophy.\textsuperscript{18}

The present study was designed to test whether characterization of the RV wall by electroanatomic voltage mapping increases the accuracy for diagnosing ARVC/D in a consecutive series of patients fulfilling noninvasive Task Force criteria.

**Methods**

The study comprised 31 patients (22 men and 9 women; mean age, 30.8±7 years). Clinical characteristics are reported in Tables 1 and 2.

**Noninvasive Study**

Noninvasive evaluation in all patients included history, physical examination, laboratory tests, chest radiograph, 12-lead ECG recording, 24-hour Holter monitoring, signal-averaged ECG, exercise stress testing, and 2D and color Doppler echocardiography. Technical equipment, protocols, and reference values of each investigation have been reported in detail elsewhere.\textsuperscript{6} ARVC/D cases were considered “familial” on the basis of pedigree analysis showing other affected individuals or premature (<40 years) sudden deaths by family history and noninvasive clinical screening of nuclear family members. In the absence of another family member with ARVC/D or with sudden death, the disease was defined as “sporadic.” After noninvasive study, all patients fulfilled criteria for diagnosis of ARVC/D as recommended by the European Society of Cardiology and International Society and Federation of Cardiology (ESC/ISFC) Task Force.\textsuperscript{12,13}

**Invasive Study**

All patients underwent invasive study that included left and RV cineangiography (in the right and left anterior oblique views) and coronary angiography as previously reported,\textsuperscript{19} EMB, and 3D electroanatomic voltage mapping. An electrophysiological study with programmed ventricular stimulation was performed in 20 patients (65%) clinically presenting with life-threatening ventricular tachyarrhythmias, syncope, or strong family history of sudden death. The study was approved by the institutional review board, and all patients gave their informed consent.

**Endomyocardial Biopsy**

EMB of the RV was obtained via the femoral vein with the use of the long sheath technique (disposable Cordis bioprome) in all patients. The samples were obtained at the junction between the ventricular septum and the anterior RV free wall. Three to 5 biopsy specimens (mean, 3.4) were obtained from each patient, fixed in 10% phosphate-buffered formalin (pH 7.35), and then processed for histological examination. Seven-micrometer-thick paraffin-embedded sections were serially cut and stained according to the hematoxylin-eosin and Heidenhain trichrome techniques. Histopathological diagnosis of ARVC/D was made independently by 2 observers (C.B., G.T.), blinded to voltage mapping results on the basis of a significant amount of fibrofatty myocardial atrophy with residual myocyte <45%, evaluated by histomorphometric analysis.\textsuperscript{17} Dallas criteria were used for histological diagnosis of myocarditis.\textsuperscript{20}

To characterize cellular infiltrates, additional paraffin-embedded tissue sections were stained with a panel of monoclonal antibodies according to the avidin-biotin peroxidase complex method (Vector). Agreement of interobserver analysis was 94%, and discrepancies were resolved by consensus.

**TABLE 1. Clinical Characteristics of Overall Sample and According to Results of Voltage Mapping**

<table>
<thead>
<tr>
<th></th>
<th>Overall Sample (n=31)</th>
<th>Abnormal Voltage Mapping (Group A) (n=20)</th>
<th>Normal Voltage Mapping (Group B) (n=11)</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>30.8±7</td>
<td>30.5±12</td>
<td>31.3±9</td>
<td>0.23</td>
</tr>
<tr>
<td>Sex, male</td>
<td>22 (71)</td>
<td>14 (70)</td>
<td>8 (73)</td>
<td>0.80</td>
</tr>
<tr>
<td>Family history</td>
<td>13 (42)</td>
<td>13 (65)</td>
<td>0</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Competitive athletes</td>
<td>12 (39)</td>
<td>7 (35)</td>
<td>5 (45)</td>
<td>0.85</td>
</tr>
<tr>
<td>Clinical symptoms</td>
<td>26 (84)</td>
<td>17 (85)</td>
<td>9 (82)</td>
<td>0.78</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>2 (6)</td>
<td>2 (10)</td>
<td>0</td>
<td>0.52</td>
</tr>
<tr>
<td>Syncope</td>
<td>10 (32)</td>
<td>9 (45)</td>
<td>1 (9)</td>
<td>0.05</td>
</tr>
<tr>
<td>Palpitations</td>
<td>14 (45)</td>
<td>6 (30)</td>
<td>8 (73)</td>
<td>0.05</td>
</tr>
<tr>
<td>No symptoms</td>
<td>5 (16)</td>
<td>3 (15)</td>
<td>2 (18)</td>
<td>1.0</td>
</tr>
<tr>
<td>Antiarrhythmic drug therapy</td>
<td>28 (90)</td>
<td>19 (95)</td>
<td>9 (82)</td>
<td>0.58</td>
</tr>
<tr>
<td>Sotalol</td>
<td>11 (35)</td>
<td>7 (35)</td>
<td>4 (36)</td>
<td>1.00</td>
</tr>
<tr>
<td>Amiodarone</td>
<td>8 (26)</td>
<td>6 (30)</td>
<td>2 (18)</td>
<td>0.67</td>
</tr>
<tr>
<td>β-Blockers</td>
<td>6 (19)</td>
<td>4 (20)</td>
<td>2 (18)</td>
<td>1.00</td>
</tr>
<tr>
<td>Amiodarone + β-blockers</td>
<td>3 (10)</td>
<td>2 (10)</td>
<td>1 (9)</td>
<td>1.00</td>
</tr>
<tr>
<td>Interval between onset of symptoms</td>
<td>40.3±23</td>
<td>39±26</td>
<td>42±19</td>
<td>0.30</td>
</tr>
</tbody>
</table>

Values in parentheses are percentages.
*Comparison between group A and B.
According to the definition and classification of cardiomyopathies of the World Health Organization/ISFC Task Force, inflammatory cardiomyopathy was defined as myocarditis with cardiac dysfunction.21

**Electroanatomic Voltage Mapping**

All patients underwent 3D electroanatomic voltage mapping technique by the CARTO system (Biosense-Webster) during sinus rhythm, as previously reported.22–30 In brief, the magnetic mapping system includes a magnetic sensor in the catheter tip that can be localized in 3D space with the ultralow magnetic field generators surrounding sites, were eliminated.

The mapping catheter was manipulated primarily by the CARTO system with fluoroscopy used only secondarily (mean, 9 ± 1.2 minutes). A recording was accepted and integrated in the map when the variability in cycle length, local activation time stability, and

**TABLE 2. Instrumental Findings of Overall Sample and According to Results of Voltage Mapping**

<table>
<thead>
<tr>
<th>Abnormal Voltage Mapping (Group A)</th>
<th>Abnormal Voltage Mapping (Group B)</th>
<th>Normal Voltage Mapping (Group B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Voltage Mapping (Group A)</td>
<td>Overall Sample (n=31)</td>
<td>Normal Voltage Mapping (Group B)</td>
</tr>
<tr>
<td>Sustained ventricular tachycardia</td>
<td>15 (48)</td>
<td>6 (55)</td>
</tr>
<tr>
<td>Nonsustained ventricular tachycardia</td>
<td>12 (39)</td>
<td>4 (36)</td>
</tr>
<tr>
<td>Frequent premature ventricular beats</td>
<td>4 (13)</td>
<td>1 (9)</td>
</tr>
<tr>
<td>Global RV dilatation/dysfunction</td>
<td>23 (74)</td>
<td>8 (73)</td>
</tr>
<tr>
<td>RV wall motion abnormalities</td>
<td>25 (81)</td>
<td>7 (64)</td>
</tr>
<tr>
<td>Angiographic RV ejection fraction, %</td>
<td>47.9±7</td>
<td>48.3±9</td>
</tr>
<tr>
<td>Angiographic RV end-diastolic volume, mL/m²</td>
<td>110±18</td>
<td>111±20</td>
</tr>
<tr>
<td>LV dilatation/dysfunction and/or regional hypo-akinesia</td>
<td>16 (52)</td>
<td>7 (64)</td>
</tr>
<tr>
<td>ARVC/D</td>
<td>15 (48)</td>
<td>15 (75)</td>
</tr>
<tr>
<td>Inflammatory cardiomyopathy</td>
<td>10 (32)</td>
<td>10 (91)</td>
</tr>
<tr>
<td>Normal</td>
<td>6 (19)</td>
<td>1 (9)</td>
</tr>
<tr>
<td>Programmed ventricular stimulation</td>
<td>11/20 (55)</td>
<td>2/7 (28)</td>
</tr>
<tr>
<td>Inducible ventricular tachycardia</td>
<td>8/20 (40)</td>
<td>1/7 (14)</td>
</tr>
<tr>
<td>Inducible ventricular fibrillation</td>
<td>3/20 (15)</td>
<td>1/7 (14)</td>
</tr>
<tr>
<td>ICD therapy</td>
<td>12 (39)</td>
<td>11 (55)</td>
</tr>
<tr>
<td>Values in parentheses are percentages. LV indicates left ventricular; ICD, implantable cardioverter/defibrillator. *Comparison between group A and B. †Assessed by echocardiography/angiography.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reference value for electrogram amplitude used to define normal RV endocardium was set at 1.5 mV, which was the value above which 95% of all bipolar signal voltages from the endocardium of normal RVs were included. According to previous experiences on intraoperative\textsuperscript{30} and catheter mapping,\textsuperscript{24,25,28–31} “electroanatomic scar” area was defined as an area including at least 3 adjacent points with bipolar signal amplitude $<0.5$ mV. The color display for depicting normal and abnormal voltage myocardium ranged from red, representing electroanatomic scar tissue (amplitude $<0.5$ mV), to purple, representing electroanatomic normal tissue (amplitude $\geq 1.5$ mV). Intermediate colors represented the electroanatomic border zone (signal amplitudes between 0.5 and 1.5 mV) (Figures 1 to 3). Regions showing low-amplitude electrograms were mapped with greater point density to delineate the extent and borders of electroanatomic scar areas.

The concordance between location of low-voltage areas and RV wall motion abnormalities was assessed in each patient by a comparison of electroanatomic bipolar voltage mapping and echocardiographic/angiographic imaging by 3 blinded observers (D.C., B.B., L.D.). According to a previously reported protocol\textsuperscript{6,19} ventricular wall motion abnormalities were analyzed qualitatively by 2 observers blinded to voltage maps. Interobserver discrepancies were resolved by consensus.

Electrophysiological Study
All antiarrhythmic drugs were discontinued 5 half-lives (6 weeks for amiodarone) before the study. Programmed ventricular stimulation protocol included 3 drive-cycle lengths (600, 500, and 400 ms) and 3 ventricular extrastimuli while pacing from 2 RV sites (apex and outflow tract). Programmed ventricular stimulation was considered positive if either a ventricular fibrillation or a sustained ventricular tachycardia, ie, one that lasted $\geq 30$ seconds or required termination because of hemodynamic compromise, was induced.

Statistical Analysis
Continuous variables are expressed as range and mean$\pm$SD. Categorical differences between groups were evaluated by Fisher exact text or $\chi^2$ test. Differences between group means were compared by unpaired $t$ test. All probability values reported are 2 sided, and a probability value $<0.05$ was considered statistically significant. SAS software (SAS Institute) was used for statistical analysis.

Results
Clinical characteristics and instrumental findings are summarized in Tables 1 and 2. The study population included 31 consecutive patients (22 men and 9 women; age range, 19 to 57 years; mean age, 30.8$\pm$7 years). Thirteen patients had a family history of ARVC/D or of premature ($<40$ years) sudden death due to proven or suspected ARVC/D. Five patients remained asymptomatic, whereas the remaining 26 had arrhythmia-related symptoms. Structural and functional RV abnormalities were observed at echocardiography/angiography in all patients. Wall motion abnormalities of the RV free wall were documented in 25 patients and affected $\geq 1$ of the following RV regions: anterior in 17 patients, inferobasal in 13, inferior in 8, anteroapical in 7, infundibular in 7, lateral in 6, and inferoapical in 3. Ventricular arrhythmias were documented in all patients and included sustained
monomorphic ventricular tachycardia in 15, nonsustained ventricular tachycardia in 12, and frequent premature ventricular beats in 4. All types of ventricular arrhythmias showed a left bundle branch pattern with a superior axis in 14 cases, inferior axis in 11, and undetermined axis in 6. Eleven of the 20 patients (55%) undergoing electrophysiological study were inducible at programmed ventricular stimulation to either sustained monomorphic ventricular tachycardia (8 patients) or ventricular fibrillation (3 patients). The time interval from onset of symptoms to the invasive study including electroanatomic voltage mapping ranged from 7 to 75 months (mean, 40.3 ± 23 months).

Endomyocardial Biopsy
In 15 patients, histological analysis of EMB samples demonstrated a diagnostic amount of myocardial atrophy and fibrofatty replacement (Figure 2), confirming the diagnosis of ARVC/D.

Of the remaining 16 patients, 6 were normal, and 10 had EMB histopathological changes that were consistent with the diagnosis of inflammatory cardiomyopathy (Figure 3). In 7 of these latter 10 patients, there were associated myocyte nucleocytoplasmic changes and interstitial and/or focal replacement fibrosis (Figure 3). The inflammatory infiltrates mainly consisted of activated T lymphocytes (CD45, CD45RO +, and CD43), with a few macrophages (CD68 +) (Figure 3). No patients showed histological features of granulomatous and/or giant cell myocarditis.

Electroanatomic Voltage Mapping
The mean number of sites sampled in RV electroanatomic mapping was 175 ± 23, with an average mapping period of 27 ± 6 minutes. Twenty of 31 patients (65%) had an abnormal RV electroanatomic voltage mapping (group A) showing ≥1 area (mean, 2.25 ± 0.7), including contiguous bipolar electrograms with voltage values < 0.5 mV (ie, electroanatomic scar tissue). Low-voltage areas were sharply demarcated and typically surrounded by a border zone with reduced signal amplitudes (0.5 to 1.5 mV), which merged into normal myocardium (> 1.5 mV). Examples of abnormal RV voltage maps are shown in Figures 1 and 2. The most frequently involved RV regions were anterior in 13 patients, inferobasal in 12, infundibular in 6, anteroapical in 5, lateral in 4, inferior in 3, and inferoapical in 2. Seventeen patients showed a
widespread RV disease with demonstration of electroanatomic scar tissue in ≥2 RV regions, whereas 3 patients had a localized RV disease with segmental involvement of the inferobasal (2 patients) and infundibular (1 patient) RV free wall. The septum was spared in all but 2 patients, both showing a selective involvement of the apical region. Compared with electrograms sampled from unaffected areas, those recorded from within electroanatomic scar tissue showed significantly lower amplitude (0.4±0.08 versus 4.9±0.4 mV; \( P<0.001 \)) and prolonged duration (77.2±21 versus 35.8±6.3 ms; \( P<0.001 \)) and also significantly more often appeared to be fragmented (79%; \( P<0.001 \)) and extended beyond the offset of the surface QRS (61%; \( P<0.001 \)) (Figure 1B, 1C).

In the remaining 11 patients (35%), electroanatomic voltage mappings were normal (group B), with preserved bipolar electrogram amplitude (4.4±0.7 mV) and duration (37.2±0.9) throughout the RV free wall and septum (Figure 3C).

Correlation of Results

Compared with patients from group B, those from group A significantly more often had a positive family history for ARVC/D or sudden death (\( P<0.0001 \)), fibrofatty myocardial replacement at EMB (\( P<0.0001 \)), depolarization/conduction ECG abnormalities such as low-voltage QRS in limb leads (\( P=0.03 \)), right precordial QRS duration ≥110 ms (\( P=0.003 \)), and late potentials at signal-averaged ECG (\( P=0.03 \)); syncopal episodes, either unexplained or caused by sustained ventricular tachycardia, and palpitations reached only borderline statistical significance (\( P=0.05 \)) (Tables 1 and 2).

A concordance between the location of electroanatomic low-voltage areas and akinetic/dyskinetic regions at echocardiography/angiography was found in all but 2 patients in whom electroanatomic low-amplitude areas involving the RV inflow portion had been missed at wall motion analysis by echocardiography/angiography.

Patients from group B distinctively had nonfamilial disease (\( P<0.0001 \)) and significantly more often showed histopathological evidence of inflammatory cardiomyopathy (\( P<0.0001 \)). Eleven patients (55%) from group A received an implantable cardioverter/defibrillator because of either ventricular tachyarrhythmias associated with hemodynamic compromise or unexplained syncopal episodes, whereas all but 1 patient from group B remained stable on antiarrhythmic therapy (\( P=0.02 \)).
Abnormal Electroanatomic Voltage Mapping

The finding of significant loss of myocardium resulting in the recording of low-amplitude, fractionated endocardial electrograms has been previously well established in patients with ischemic or nonischemic ventricular scar by intraoperative mapping. Conventional endocardial mapping, and 3D electroanatomic mapping has the ability to identify areas of myocardial atrophy by recording and spatially associating low-amplitude electrograms to generate a 3D electroanatomic map of the RV chamber. The electroanatomic low-amplitude areas were significantly associated with the histopathological finding of myocyte loss and fibrofatty replacement at EMB, thus confirming that RV loss of voltage reflects the replacement of action potential―generating myocardial tissue with electrically silent fibrofatty tissue. A sampling error of EMB due to segmental RV involvement may explain the apparently normal findings obtained in 5 patients of group A, 3 of whom showed low-voltage values limited to a single RV region.

There was a concordance between the presence and location of RV low-voltage areas identified by electroanatomic map and akinetic/dyskinetic regions detected by echocardiography and/or angiography. The low-amplitude electrogram values were distinctively recorded in the RV free wall, predominantly involving the anterolateral, infundibular, and inferobasal regions, and spared the interventricular septum. Such a spatial distribution is similar to that observed in autopsy hearts of patients who died from ARVC/D, in whom the most severe RV myocardial atrophy and wall aneurysms are mostly localized in the anteroinfundibular free wall and underneath the tricuspid valve.

In the present study the majority of patients with an abnormal electroanatomic voltage mapping had a familial form of ARVC/D. This finding is in agreement with the genetic background of the disease, which has been demonstrated in >50% of ARVC/D patients with either the autosomal or, less frequently, the recessive pattern of inheritance and age-related and variable penetrance.

Normal Electroanatomic Voltage Mapping

Thirty-five percent of patients who fulfilled the Task Force diagnostic criteria for ARVC/D at noninvasive evaluation showed neither evidence of electroanatomic low-voltage regions nor fibrofatty replacement at voltage mapping and EMB. Comparison of mapping results and clinical patient characteristics in the present study suggests that the finding of normal RV voltage values characterizes a distinct subgroup of patients with a peculiar etiopathogenetic, clinical, and prognostic profile.

Patients with normal and abnormal electroanatomic voltage mapping did not differ with regard to mean age and mean time interval between symptom onset and time of electroanatomic evaluation. Moreover, extent of precordial ECG repolarization changes and severity of morphofunctional abnormalities such as global or segmental RV dilatation/ dysfunction, RV wall motion abnormalities, and left ventricular involvement, which were detected by echocardiography/angiography, were similar in both subgroups of patients. These findings argue against the possibility that failure to detect electroanatomic RV low-voltage areas reflects early stages or minor variants of ARVC/D.

All patients with a normal electroanatomic voltage mapping were sporadic cases, showing neither a familial history of sudden death nor evidence of familial ARVC/D at clinical screening of family members. Of importance, all but 1 patient showed EMB histopathological changes consistent with the diagnosis of inflammatory cardiomyopathy.

Chronic myocarditis mimicking ARVC/D has been previously reported in nonfamilial patients. In the majority of our patients, the association between inflammatory changes and focal fibrosis suggested a longstanding disease with either a persistent or recurrent myocardial inflammatory process at different stages of healing. Although such a patchy fibrosis is frequently observed in patients with inflammatory cardiomyopathy, extensive and transmural areas of myocardial depletion with scarring are noted exceptionally, thus explaining the absence of low-voltage areas.

Involvement of ventricular myocardium by sarcoid may also mimic ARVC/D. In our study cardiac sarcoidosis was ruled out by EMB histological findings that did not show any suggestive well-formed, nonnecrotizing inflammatory granulomas.

Study Limitations

Our study was limited by a small sample size that may have led to type II error for some clinical differences observed in the subgroup analysis. However, the population of patients with ARVC/D is also limited because of the low disease prevalence. We studied a selected patient population fulfilling the ESC/ISFC criteria for ARVC/D, and the study results may not be generalizable to patients affected by different heart muscle diseases causing scarring in the RV such as sarcoidosis, skeletal-muscle dystrophies, and other right-sided cardiomyopathies, either ischemic or nonischemic.

Clinical Implications and Conclusions

At least 30% of cases of dilated cardiomyopathy are familial and linked to genetic defects in “force transmission” proteins, whereas a significant percentage of the remaining sporadic cases recognizes a viral and/or immune myocarditis pathogenesis. Similarly, the results of the present study indicate that ARVC/D includes both familial cases, characterized by a
distinctive loss of myocardium reflecting a genetically determined dystrophic process, and sporadic forms that in part may be the result of an inflammatory myocardial disease predominantly involving the RV. ESC/ISFC Task Force guidelines show significant limitations in specificity when used for diagnosing nonfamilial ARVC/D. There were sporadic cases who fulfilled diagnostic criteria for ARVC/D but showed negative voltage map findings in association with histopathological evidence of inflammatory cardiomyopathy. Such patients with RV inflammatory myocardial disease mimicking ARVC/D can be detected by an electroanatomic voltage map that rules out RV regions with loss of electrogram voltage.

The only noninvasive parameters significantly associated with electroanatomic low-voltage areas were right precordial QRS prolongation, low-voltage QRS in the limb leads, and late potentials. Accordingly, intracardiac electrograms recorded from within the electroanatomic RV low-voltage areas often appeared fractionated with a significantly prolonged duration and extended beyond the offset of the surface QRS compared with electrograms recorded from normal-voltage regions all. All of these electric abnormalities, either surface or intracardiac, reflect the distinctive pathoarrhythmogenic substrate of ARVC/D, i.e., a fibrofatty scar, which accounts for a right intraventricular conduction defect and predisposes to life-threatening ventricular arrhythmias. Abnormal electroanatomic voltage mapping was associated with a worse arrhythmic clinical course. During the time interval from onset of symptoms to the invasive study, 55% of patients with electroanatomic evidence of low-voltage areas required an implantable cardioverter/defibrillator because of serious arrhythmical complications, whereas all but 1 patient with preserved myocardial voltage values remained stable on antiarrhythmic therapy. The predictive accuracy of voltage mapping to identify those patients more prone to sudden death remains to be assessed by a prospective follow-up study.

Acknowledgments

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References


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