Below Radar
Contributions of Cardiac Magnetic Resonance to the Understanding of Myonecrosis After Percutaneous Coronary Intervention

Eric Larose, DVM, MD, FRCPC

With >900,000 procedures performed annually in North America, percutaneous coronary intervention has dramatically altered the landscape of cardiology since its inception in 1977. Despite procedural success rates now exceeding 90%, biomarker rise indicating myonecrosis has been reported after up to 30% of otherwise successful procedures. Most agree with the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction recommendation that the same biochemical marker cutoffs be applied regardless of the clinical circumstances. However, available data suggest that mild periprocedural marker rise may not confer substantial risk in an otherwise successful procedure. Several reports have identified non–Q-wave infarctions with creatine kinase (CK)–MB elevations 3 to 5 times the upper limit of normal) and Q-wave myocardial infarctions,3 which are largely related to procedural complications. Troponin T and I elevation occurs more frequently than CK-MB increase after percutaneous coronary intervention; 29% demonstrated HE, representing a mean loss of new HE. All patients with troponin rise after PCI demonstrated that HE occurs after irreversible myocellular injury but not after severe but reversible injury such as myocardial stunning.12 DE-CMR is superior to SPECT in identifying discrete areas of subendocardial necrosis. In a report from Ricciardi et al13 studying periprocedural infarct by DE-CMR in 14 subjects, the 9 subjects with raised CK-MB had a median mass of infarcted myocardium of 2 g. In comparison, 10 g myocardium must be injured before it will be detected by radionuclide perfusion imaging. In a report designed to clarify the significance of periprocedural troponin rise, Selvanayagam et al14 studied 50 subjects after intervention; 29% demonstrated HE, representing a mean loss of myocardial tissue of 6.0 g (5% of myocardial mass). A strong correlation was observed between troponin rise and mass of new HE. All patients with troponin rise after PCI presented new necrosis by DE-CMR.
In this issue of Circulation, Porto and colleagues combine DE-CMR with IVUS and coronary angiography to explore periprocedural myocardial necrosis after percutaneous coronary stenting in 64 native vessels from 52 consecutive patients. The authors selected higher-risk procedures in which necrosis was more likely: long lesions, presence of a major side branch at the site of stenting, or 2-vessel intervention. Important exclusions were prior stenting, recent severe unstable angina, and left ventricular dysfunction, presumptively to limit previous HE burden on DE-CMR. Importantly, nearly 10% of subjects were excluded because of excessive calcifications precluding IVUS interpretation, highlighting a significant limitation of IVUS for such purposes, because one would expect plaque composition (including calcification) to influence periprocedural necrosis. Roughly one quarter of study patients included a bifurcation intervention, and one quarter had chronic total occlusion. Procedural complexity was illustrated by average preintervention TIMI class of 2 and 28% incidence of decreased TMPG. All subjects benefited from aspirin and clopidogrel pretreatment and procedural intravenous heparin and abciximab, which emphasizes the use of therapies known to reduce periprocedural CK-MB rise. DE-CMR interpretation followed accepted and validated methodology. An ingenious use of DE-CMR determined the spatial relationship of new HE relative to the stent: New HE in the same short-axis slice as the stent represented “adjacent” necrosis, whereas HE at least 2 short-axis slices (ie, at least 10 mm) distal to the stent denoted “distal” necrosis. Although this methodology can be traced back to Ricciardi et al, Porto and colleagues are the first to systematically apply it to study mechanisms of periprocedural necrosis. Porto and colleagues should be commended for combining the use of DE-CMR for necrosis burden, angiographic analysis for myocardial tissue perfusion (by TMPG) and side-branch impairment, and IVUS for plaque burden, providing powerful synergy to explore these mechanisms. The “distal” pattern of new HE was associated with distal embolization, whereas the “adjacent” pattern was associated with side-branch occlusion. In this series of complex procedures, nearly one quarter of vessels had new HE, which was distributed equally between side-branch impairment and distal embolization. Side-branch impairment carried an odds ratio of 16.2 and distal embolization carried an odds ratio of 8.0 for new HE. Surprisingly, no subject presented simultaneous adjacent and distal HE, a fact possibly related to relatively small sample size, because one cannot expect these phenomena to be mutually exclusive. The mean mass of new necrosis was 7.6 g, roughly 5% of left ventricular myocardial mass, without any significant difference in necrosis mass between side-branch impairment and distal embolization. A greater decrease in plaque volume at the time of intervention was associated with a greater likelihood of distal necrosis compared with adjacent necrosis (or no new necrosis). The decrease in plaque volume also was correlated to the mass of new distal necrosis in grams but not to the mass of new adjacent necrosis. These observations strongly support the contention that of the 2 main mechanisms of periprocedural myonecrosis, distal embolization appears to be a consequence of plaque disruption and “drifting” into circulation in which the volume of drifting material correlates to the mass of new necrosis. The mass of necrosis associated with side-branch occlusion remained independent of the decrease in plaque volume, suggesting that this mechanism may be related to mechanical phenomena or local plaque “shift” occluding the ostium of the side branch rather than drifting of material into circulation of the side branch. This concept of shifting (side-branch impairment) or drifting (distal embolization) of atheroma at the time of stenting may explain the occurrence of new necrosis despite aggressive antithrombotic therapy. Accordingly, reduced thrombus burden would be expected to limit platelet embolization but not embolization of plaque components or side-branch impairment. In this sample, stent length and stent overlap did not independently predict new HE. Overlapping paclitaxel-eluting stents tended toward association with new “adjacent” HE, a fact that is consistent with reports of greater periprocedural enzyme rise with overlapping TAXUS. Too few Cypher stents were used in this study to allow comparison between the devices. Although the report by Porto and colleagues provides important new information about mechanisms underlying periprocedural myonecrosis, will it change and improve current practice? A recent report by Kwong and colleagues established that even small areas of necrosis identified as HE on DE-CMR (1.4% of left ventricular mass) in patients without known prior myocardial infarction portended a >7-fold-increased risk for major adverse cardiac events. The incremental risk conferred by new HE may arise from an increased substrate for life-threatening ventricular arrhythmias and from the associated greater atherosclerosis burden demonstrated here. To better orient future efforts in the prevention of periprocedural myonecrosis, further studies should explore whether both mechanisms of new myonecrosis, distal embolization, and side-branch impairment confer the same increase in risk. Periprocedural myonecrosis may be reduced by pharmacological intervention, including aspirin, clopidogrel, glycoprotein IIb/IIIa inhibitors, statins, β-blockers, and adenosine, but the report by Porto and colleagues emphasizes that new HE occurs despite many of these therapies in close to a quarter of patients undergoing complex procedures. The greatest risks for periprocedural myonecrosis come from saphenous vein graft angioplasty and interventions in thrombus-laden vessels (ie, acute coronary syndromes), 2 situations associated with incremental risk for distal embolization. Although mechanical intervention with distal protection devices decreases myonecrosis in saphenous vein grafts, no benefit in ST resolution from distal protection was noted in ST-elevation myocardial infarction. Perhaps differences in the nature, particle size, and sheer volume of embolic material may explain this disparity. In the case of ST-elevation myocardial infarction, embolic burden may overload distal microcirculation before intervention occurs, defeating any beneficial effect of distal protection. Perhaps in light of the increasing use of DE-CMR illustrated here, millimeter ST-segment resolution may not be the most appropriate end point for future trials. Several important questions remain to be addressed. Notably, we have yet to explore the nature of plaque characteris-
tics in relation to risk of periprocedural myonecrosis. Are atheromas carrying larger lipid and inflammatory burdens more prone to the release of material into the circulation and distal embolization? Research harnessing the ability of MRI to characterize plaque composition may provide future insights and new opportunities to improve procedural and clinical success.20

Sources of Funding
Dr Larose receives research funding from the Canadian Stem Cell Network and the Quebec Heart Institute Foundation.

Disclosures
None.

References
11. Deleted in proof.

Key Words: Editorials  magnetic resonance imaging  myocardial infarction  ultrasonics
Below Radar: Contributions of Cardiac Magnetic Resonance to the Understanding of Myonecrosis After Percutaneous Coronary Intervention

Eric Larose

Circulation. 2006;114:620-622
doi: 10.1161/CIRCULATIONAHA.106.644732

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/114/7/620

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation is online at:
http://circ.ahajournals.org//subscriptions/