Persistent Diastolic Dysfunction Late After Valve Replacement in Severe Aortic Regurgitation

Bruno Villari, MD, PhD; Samuel Sossalla, MD; Quirino Ciampi, MD, PhD; Bruno Petruzziiello, MD; Juraj Turina, MD; Jakob Schneider, MD; Marko Turina, MD; Otto M. Hess, MD

Background—Regression of left ventricular (LV) hypertrophy with normalization of diastolic function has been reported in patients with aortic stenosis late after aortic valve replacement (AVR). The purpose of the present study was to evaluate the effect of AVR on LV function and structure in chronic aortic regurgitation early and late after AVR.

Methods and Results—Twenty-six patients were included in the present analysis. Eleven patients with severe aortic regurgitation were studied before, early (21 months) and late (89 months) after AVR through the use of LV biplane angiograms, high-fidelity pressure measurements, and LV endomyocardial biopsies. Fifteen healthy subjects were used as controls. LV systolic function was determined from biplane ejection fraction and midwall fractional shortening. LV diastolic function was calculated from the time constant of LV relaxation, peak filling rates, and myocardial stiffness constant. LV structure was assessed from muscle fiber diameter, interstitial fibrosis, and fibrous content. LV muscle mass decreased significantly by 38% early and 55% late after surgery. Ejection fraction was significantly reduced preoperatively and did not change after AVR ($P=\text{NS}$). LV relaxation was significantly prolonged before surgery (89±28 ms) but was normalized late after AVR (42±14 ms). Early and late peak filling rates were increased preoperatively but normalized postoperatively. Diastolic stiffness constant was increased before surgery (22±6 versus 9±3 in control subjects; $P=0.0003$) and remained elevated early and late after AVR (23±4; $P=0.002$). Muscle fiber diameter decreased significantly after AVR but remained increased at late follow-up. Interalstitial fibrosis was increased preoperatively and increased even further early but decreased late after AVR. Fibrosis was positively linearly correlated to myocardial stiffness and inversely correlated to LV ejection fraction.

Conclusions—Patients with aortic regurgitation show normalization of macroscopic LV hypertrophy late after AVR, although fiber hypertrophy persists. These changes in LV myocardial structure late after AVR are accompanied by a change in passive elastic properties with persistent diastolic dysfunction.

Clinical Trial Registration—URL: http://www.clinicaltrial.gov. Unique identifier: NCT00976625.

Key Words: diastole ▪ hypertrophy ▪ regurgitation ▪ structure ▪ surgery

Pressure and volume overload induce different adaptations of the left ventricle, the first generating concentric and the latter eccentric left ventricular (LV) hypertrophy. These changes in macroscopic LV anatomy are accompanied by alterations in the microscopic structure and consequently LV dysfunction. Diastolic dysfunction has been demonstrated to precede the alteration in systolic function in patients with LV hypertrophy from aortic valve disease. After successful aortic valve replacement (AVR), regression of LV hypertrophy with normalization of LV diastolic dysfunction has been reported in patients with severe aortic stenosis; an early decrease in muscle hypertrophy with a relative increase in interstitial fibrosis followed by a late decrease in collagen constant was found in these patients. Several investigators have suggested that chronic volume overload is specifically harmful for the ventricle because an increase in end-diastolic and end-systolic stress is already present in the compensated phase of chronic regurgitation. Furthermore, we have demonstrated that adaptation to chronic overload is dependent on the severity of valvular regurgitation and on the specific loading condition, ie, low versus high impedance leak; thus, aortic regurgitation (AR) is more harmful to the left ventricle than mitral regurgitation.

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The purpose of the present study was to evaluate the effect of AVR on systolic and diastolic LV function in chronic volume overload secondary to AR and to differentiate be-
between structural and functional changes during long-term follow-up.

Methods

Eleven patients with pure AR (mean age, 44±12 years; range, 21 to
58 years) were studied preoperatively and early (21 months; range,
14 to 30 months) and late (89 months; range, 60 to 120 months) after
successful AVR. Fifteen subjects with normal LV function (mean
age, 46±10; range, 33 to 60 years) served as controls (Table 1).

Inclusion Criteria

Inclusion criteria included severe AR (regurgitant fraction ≥0.45),
no concomitant aortic stenosis (pressure gradient ≤15 mm Hg), no
postoperative prosthesis mismatch, no coronary artery disease, sinus
rhythm, no severe comorbidities (chronic pulmonary disease, history
of stroke, renal failure), willingness to undergo postoperative heart
catheterization, and no left or right bundle-branch block. In women
of childbearing age, a pregnancy test was carried out to exclude
pregnancy. Written informed consent was obtained from all patients.

Exclusion Criteria

Exclusion criteria were unwillingness to undergo postoperative
cardiac catheterization, insulin-dependent diabetes mellitus, arterial
ehypertension (>160/90 mm Hg), bleeding disorder, active cancer, or
pulmonary hypertension.

Cardiac Catheterization

Informed consent was obtained from all patients. Cardiovascular
medications were withheld for 24 hours before the procedure. Premedication consisted of 10 mg chloralazepoxide orally 1 hour
before catheterization. Right and left heart catheterizations were
carried out in all patients postoperatively. Biplane left ventricu-
lography was performed in the right anterior oblique (30°) and left
antero-oblique (60°) projections (Cardioscope, Siemens-Albis,
Zurich, Switzerland) at a filming rate of 50 frames per second. LV
pressure was measured simultaneously with ventriculography with a
Millar 7F micromanometer catheter (Millar Instruments, Houston,
Texas) introduced transeptally into the LV via an 11.5F Brockenbrough guiding catheter. In control subjects, a Millar 8F pigtail
micromanometer was introduced retrogradely into the LV. Central
aortic pressure was measured through a fluid-filled 8F pigtail
catheter in patients with AR. Cardiac index was measured by the
Fick method.

LV angiographic silhouettes were drawn manually from an ade-
quately opacified sinus beat, excluding extrasystolic and postextra-
systolic beats. LV volumes were determined on a frame-by-frame
basis with the area-length method.1,3 Dimensional and volumetric
data were filtered with the moving average technique. Pressure and
volume data were digitized (time resolution, 20 ms) every 20
milliseconds for 1 cardiac cycle. End diastole was defined as the
time point of the rapid upstroke of dP/dt; end systole was defined as the
time of incisural pressure in the aortic pressure curve. LV mass was
determined as previously described.1,3,8 Circumferential wall stress
was calculated from a simplified version of a thick-wall model.3,8
Mean systolic circumferential wall stress was defined as mean wall
stress occurring during systolic ejection period.

The ratio of LV end-diastolic volume to mass was calculated and
used as a parameter for assessing chamber geometry of the LV.
Postoperative recatheterization was performed from the right femoral
vein with transeptal puncture and a Brockenbrough guiding catheter
for access to the left ventricle. Pressure measurements, biplane LV
angiography, and LV endomyocardial biopsies were obtained as
described earlier. Calculations were carried out as described above,
and morphometry of LV biopsies was performed according to the
method of Villari et al.8 Postoperative pressure gradients across the
aortic valve prosthesis were estimated from LV systolic pressure and
brachial cuff pressure (noninvasive, peak pressure gradient). No
patient showed >12-mm Hg pressure gradient with this semi-
invasive pressure measurement. No complications occurred. Patients
were sent home 2 to 3 hours after catheterization (venous puncture).

Aortic Valve Replacement

AVR was carried out under deep hypothermia with cold crystalloid
cardioplegic arrest. Either a mechanical valve prosthesis (n=2) in
younger patients (<40 years of age) or a biological valve prosthesis
(n=9) in older patients (>40 years of age) was implanted success-
fully. Only patients with a good hemodynamic and clinical result
were included. Patients with valve prosthesis mismatch (postopera-
tive pressure gradient >15 mm Hg) or left bundle-branch block
(including pacemaker implantation) were excluded from the study.
Patients and referring physicians were asked by letter to agree to a
first and, later, to a second cardiac recatherization on an ambula-
tory basis. The study protocol was approved by the local ethics
committee. There were no complications in regard to preoperative
and postoperative catheterization.

Assessment of LV Function

Systolic function was determined from biplane LV ejection fraction,
midwall fractional shortening, LV end-diastolic pressure, and mean
systolic wall stress as previously described.6,9 Diastolic function was
evaluated from isovolumic relaxation, peak diastolic filling rates, and
passive elastic properties. LV relaxation was determined from the
time constant of isovolumic pressure decline, which was calculated
as the negative reciprocal of the slope of the linear relation between
LV pressure and −dP/dt.3 The isovolumetric relaxation period was
defined as the time interval beginning immediately after maximal
diastolic negative dP/dt and ending when pressure had decreased
by 5 mm Hg above LV end-diastolic pressure.6,8 From this time interval,
usually 7 to 14 points were available for calculation of the time constant
of isovolumic pressure fall in the individual patient.

Peak diastolic filling rate was defined as the largest value of
diastolic inflow (milliliter per meter squared per second) during the
first half (early peak filling rate) and the second half (late peak filling
rate) of diastole. The filling phase was considered to begin 20 ms
before the first frame showing the entry of unopacified blood into the
left ventricle and to finish at end diastole.13 To minimize error
resulting from random noise, raw data were filtered with the
fifth-grade moving average. Diastolic filling rate (FR) was calculated
from the following equation: FR(t)=[(V(t +20)−V(t−20))/0.04, where
V(t) is time and V is volume.

Diastolic passive elastic properties were determined during the
period from minimum ventricular pressure to end diastole.6 LV
myocardial properties were evaluated from the diastolic stress-strain
relation using an elastic model with shifting asymptote: S=a·e^{k−c}+d
or dS/dF=b(S−c), where S is LV circumferential wall stress
(kilodynes per centimeter squared), a is an elastic constant (kilo-
dynes per centimeter squared), b is the myocardial stiffness constant,
F is diastolic strain (Lagrangian definition), c is asymptote of the
stress-strain relation (kilodynes per centimeter squared), and dS/dF is
instantaneous myocardial stiffness (kilodynes per centimeter squared).
The 3 constants (a, b, and c) were determined by an
iteration procedure.6 The constant of myocardial stiffness is mathe-
matically represented by the slope of the stress-strain curve, and the

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Table 1. Patient Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Control Subjects (n=15)</th>
<th>Patients With AR (n=11)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>46±10</td>
<td>44±12</td>
<td>0.4963</td>
</tr>
<tr>
<td>∆P, mm Hg</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>FAO, %</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ejection fraction, %</td>
<td>65±4</td>
<td>7±4</td>
<td>-</td>
</tr>
<tr>
<td>Cl, L · min⁻¹ · m⁻²</td>
<td>4.1±0.6</td>
<td>3.9±0.1</td>
<td>0.2630</td>
</tr>
<tr>
<td>Bicuspid valve</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Aortoannular dilatation</td>
<td>-</td>
<td>7</td>
<td>-</td>
</tr>
</tbody>
</table>

∆P indicates mean aortic gradient; FAO, aortic regurgitant fraction; and Cl, cardiac index.

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tangent to this function is defined as the operative instantaneous myocardial stiffness, \( dS/dF \).

### Endomyocardial Biopsies

LV endomyocardial biopsies were performed with the King’s College biopompe (Olympus), which was introduced into the LV through the 11.5F Brockenbrough catheter. In each patient, 2 to 4 biopsy samples were taken from the anterolateral wall of the LV. Immediately after biopsy, specimens were fixed in glutaraldehyde, cut into tangents to this function is defined as the operative instantaneous myocardial stiffness, \( dS/dF \).

### Assessment of Cellular Hypertrophy and Interstitial Nonmuscular Tissue

Morphometric analyses were carried out in glutaraldehyde-fixed specimens. The following 4 parameters were determined: muscle fiber diameter, which is the average fiber diameter of at least 100 measurements determined at the level of the nucleus from several randomly chosen sections with the use of a mechanical-optical pen (Kontron, Zürich, Switzerland); interstitial nonmuscular tissue, which is defined with the point-counting system excluding areas with arterioles and perivascular tissue as previously described; and fiber diameter, which is the average fiber diameter of at least 100 measurements determined at the level of the nucleus from several randomly chosen sections with the use of a mechanical-optical pen (Kontron, Zürich, Switzerland). We used the term interstitial fibrosis [as did others] for this tissue because fibrous tissue is the predominant component of the interstitial space; volume fraction of myofibrolasts, which is evaluated at a magnification of 1000:1 with oil immersion and phase-contrast microscopy; and fibrous content, which is an index calculated as follows: FC \( = \) (LV muscle mass\( \times \)IF)/100, where IF is interstitial nonmuscular tissue.

### Statistical Analysis

All data are given as mean±SD. Normal distribution of all continuous variables was tested with the 1-sample Kolmogorov-Smirnov test. Statistical comparisons between patients and control subjects were carried out with an unpaired Student \( t \) test with Welch correction to account for different variances. Preoperative and early and late postoperative data were compared by use of an ANOVA for repeated measurements. Posthoc tests were performed with the Bonferroni method (Tables 2 through 4). The test was considered statistically significant at values of \( P<0.05 \). A linear regression analysis was used for comparing stiffness data with myocardial fibrosis, LV ejection fraction, and LV muscle mass. The degree of linear relationship was measured by the Pearson correlation coefficient. All statistical calculations were performed with SPSS for Windows, release 12.0 (SPSS Inc, Chicago, Ill).

### Results

#### Patient Characteristics

The mean age was similar in the 2 groups (Table 1). In patients with AR, the aortic regurgitant fraction was 61% and mean systolic pressure gradient 7 mm Hg. Cardiac index was slightly, although not significantly, reduced in preoperative patients with AR compared to control subjects. After valve replacement, AR was absent in all patients at the early and late follow-up examinations.

#### Hemodynamics

Heart rate was comparable in the different groups (Table 2). LV peak systolic pressure was comparable in the study groups, whereas end-diastolic pressure was significantly increased preoperatively and late after operation in patients with AR compared to control subjects. End-diastolic and late peak filling rate, and b, myocardial stiffness constant.

### Table 2. Hemodynamics

<table>
<thead>
<tr>
<th>Control Subjects</th>
<th>Preoperative</th>
<th>Early After AVR</th>
<th>Late After AVR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart rate, bpm</td>
<td>74±12</td>
<td>73±13</td>
<td>71±15</td>
</tr>
<tr>
<td>LVSP, mm Hg</td>
<td>131±11</td>
<td>143±29</td>
<td>141±32</td>
</tr>
<tr>
<td>LVEDP, mm Hg</td>
<td>10±4</td>
<td>17±4</td>
<td>13±6</td>
</tr>
<tr>
<td>EDVI, mL/m²</td>
<td>84±17</td>
<td>221±46</td>
<td>135±41</td>
</tr>
<tr>
<td>ESVI, mL/m²</td>
<td>29±7</td>
<td>94±44</td>
<td>60±35</td>
</tr>
<tr>
<td>Ejection fraction, %</td>
<td>65±4</td>
<td>55±11</td>
<td>56±12</td>
</tr>
<tr>
<td>mFS, %</td>
<td>23.0±1.4</td>
<td>21.4±6.4</td>
<td>20.8±5.8</td>
</tr>
<tr>
<td>LMMI, g/m²</td>
<td>86±10</td>
<td>195±601</td>
<td>125±42</td>
</tr>
<tr>
<td>LV wall thickness, cm</td>
<td>0.79±0.06</td>
<td>0.99±0.17</td>
<td>0.89±0.15</td>
</tr>
<tr>
<td>EDVI/LMMI</td>
<td>1.00±0.15</td>
<td>1.21±0.33</td>
<td>1.11±0.20</td>
</tr>
<tr>
<td>Mean stress, kdyne/cm²</td>
<td>270±39</td>
<td>343±89</td>
<td>339±95</td>
</tr>
<tr>
<td>ED stress, kdyne/cm²</td>
<td>38±11</td>
<td>70±15</td>
<td>58±24</td>
</tr>
</tbody>
</table>

LVSP indicates LV systolic pressure; LVEDP, LV end-diastolic pressure; EDVI, end-diastolic volume; ESVI, end-systolic volume; mFS, midwall fractional shortening; LMMI, LV muscle mass; and ED, end-diastolic.

### Table 3. Diastolic Function Data

<table>
<thead>
<tr>
<th>Control Subjects</th>
<th>Preoperative</th>
<th>Early After AVR</th>
<th>Late After AVR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relaxation, ms</td>
<td>47±11</td>
<td>89±28‡</td>
<td>67±19§</td>
</tr>
<tr>
<td>Filling, mL/m²/s</td>
<td>PFR₁</td>
<td>284±74</td>
<td>532±115</td>
</tr>
<tr>
<td>PFR₂</td>
<td>238±59</td>
<td>370±88</td>
<td>291±69§</td>
</tr>
<tr>
<td>Passive elastic properties</td>
<td>b</td>
<td>9±3</td>
<td>22±6‡</td>
</tr>
</tbody>
</table>

\( r \) indicates time constant of LV pressure decay; PFR, and PFR₂ early and late peak filling rate; and b, myocardial stiffness constant.

### Table 4. Structural Data

<table>
<thead>
<tr>
<th>Control Subjects</th>
<th>Preoperative</th>
<th>Early After AVR</th>
<th>Late After AVR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscle fiber diameter, μm</td>
<td>21±2</td>
<td>30±3‡</td>
<td>27±3§</td>
</tr>
<tr>
<td>Interstitial fibrosis, %</td>
<td>7±2</td>
<td>20±5§</td>
<td>28±8</td>
</tr>
<tr>
<td>Volume fraction of myofibrils, %</td>
<td>57±3</td>
<td>54±5§</td>
<td>56±2§</td>
</tr>
<tr>
<td>Fibrous content, g/m³</td>
<td>6±2</td>
<td>39±14‡</td>
<td>34±10‡</td>
</tr>
<tr>
<td>FC/EDVI, g/mL</td>
<td>0.07±0.02</td>
<td>0.18±0.06</td>
<td>0.26±0.09</td>
</tr>
</tbody>
</table>

FC/EDVI indicates fibrous content/end-diastolic volume ratio.

\( *P<0.05, \dagger P<0.01, \ddagger P<0.001 \) versus control subjects; \( \S P<0.05, \| P<0.01 \) versus preoperative; \( \|\| P<0.001 \) versus early postoperative.

FC/EDVI indicates fibrous content/end-diastolic volume ratio.
end-systolic volumes were significantly larger preoperatively and early after AVR than in control subjects but were normalized late postoperatively. Ejection fraction and mid-wall fractional shortening were slightly reduced in preoperative patients with AR and did not change after operation. LV wall thickness was significantly increased before surgery and was normalized after AVR. LV muscle mass was significantly elevated in patients with AR and remained increased early after surgery, although there was a 38% decrease in mass. Late after valve replacement, there was a further decrease by 17%. LV end-diastolic volume-to-mass ratio was comparable in patients with AR and control subjects. Mean systolic stress and end-diastolic stress were significantly increased preoperatively and early after valve replacement compared to control subjects but were normalized late after operation.

**Diastolic Function Data**

LV relaxation was significantly prolonged before surgery and returned toward control levels early and late after valve replacement (Table 3). Early and late peak filling rates were increased preoperatively and normalized early after valve replacement. Myocardial stiffness constant was increased in all patients with AR preoperatively but decreased significantly after valve replacement. However, it remained increased in all patients early and in 7 of 10 patients late after AVR (Figure 1). The time constant of LV relaxation (Figure 2) was significantly increased preoperatively in AR patients compared to control subjects. It remained slightly elevated during early but was normalized during late follow-up.

**Structural Data**

Muscle fiber diameter was increased in patients with AR before and after surgery compared with control subjects (Figure 3). However, it decreased significantly early and late after valve replacement compared to preoperative data but remained hypertrophied even late after surgery (Table 4). Interstitial fibrosis was larger before surgery than in control subjects but increased even further early after operation, whereas it decreased significantly late after valve replacement (Figure 4). However, it was significantly increased with respect to controls at the late follow-up examination. Fibrous content (Figure 5) was significantly increased preoperatively and remained increased during early and late follow-up, although it decreased slightly after AVR. Interstitial fibrosis was positively linearly correlated to myocardial stiffness \((r=0.596, P=0.002)\) and inversely correlated to LV ejection fraction \((r=-0.57, P=0.004)\) but not to LV hypertrophy or other hemodynamic parameters (Figure 6).

**Discussion**

AVR has led to a dramatic change in the natural history of AR. According to the 2006 guidelines of the American...
College of Cardiology/American Heart Association. AVR is indicated for symptomatic patients with severe AR regardless of LV systolic function and for asymptomatic patients with chronic severe AR and LV systolic dysfunction. AVR is also indicated for asymptomatic patients with severe AR with normal LV systolic function but with severe LV dilatation. In the majority of patients, valve replacement results in a reversal of LV dilatation and an increase in LV systolic performance. The guidelines of the European Society of Cardiology on valvular heart disease suggest that LV systolic function is an important determinant of long-term prognosis in patients with chronic AR undergoing AVR. However, concerns remain about the long-term sequelae of LV hypertrophy. Whether the regression of LV hypertrophy is inherently a salutary or deleterious process has been questioned. In patients with aortic stenosis, we have demonstrated that reversal of diastolic dysfunction takes years and is accompanied by a slow regression of interstitial fibrosis. Approximately 6 to 7 years after AVR, normalization of LV diastolic structure and function has been observed in aortic stenosis patients.

The present study demonstrates that a rapid and complete normalization of muscular tissue occurs in patients with AR followed by an incomplete regression of fibrotic tissue and delayed ventricular remodeling. These abnormalities in LV structure are accompanied by abnormal passive elastic properties with persistent diastolic dysfunction late after AVR.

LV Structure and Function After AVR

In a subset of patients with preoperative LV dysfunction, AVR is associated with a diminished reduction in LV diastolic volume and no demonstrable improvement in LV function despite correction of valvular regurgitation. This observation has led to the assumption that irreversible myocardial dysfunction with structural alterations has occurred before valve replacement; thus, negative remodeling parallel to the reduction in volume overload is no longer possible.

In the present study, we observed that changes in LV structure are similar to those in aortic stenosis with regard to the early postoperative period. There is a relative increase in interstitial fibrosis (Figure 4) and a significant reduction in muscle fiber diameter (Figure 3) in both pressure- and volume-overloaded ventricles. The increase in interstitial fibrosis is relative to the decrease in muscle mass because the total amount of fibrous tissue remains unchanged. In patients with pressure and volume overload, myocardial stiffness increased in the early postoperative period as a result of the relative increase in interstitial fibrosis.

In contrast to aortic stenosis, patients with AR do not show normalization of diastolic dysfunction late after valve replacement (Figure 1). This differing behavior must be explained by the different geometry of the left ventricle with concentric and eccentric hypertrophy in pressure and volume overload. Percent fibrosis was larger in AR than aortic stenosis mainly because of a diminished regression late after valve replacement. This could be explained by the higher wall stress (Table 2) with a slightly eccentric left ventricle, more than that in aortic stenosis patients late after valve replacement. Thus, eccentric remodeling seems to be worse than concentric remodeling.

Clinical Implications

Severe AR is a serious condition complicated by excess mortality and high morbidity; even when valve replacement is timely, regression of eccentric hypertrophy is often delayed, and LV remodeling is incomplete. Previous studies have indicated that microvascular dysfunction with changes in extracellular matrix may be responsible for adverse responses to chronic volume overload involving myocardial fibrosis with disproportionate increases in noncollagen tissue with changes in fibronectin gene expression and synthesis. In the present study, we observed similar changes with an increase in interstitial fibrosis (Figure 4) and a persistent myocardial fiber hypertrophy (Figure 3) that persisted 7 to 10 years after AVR. This indicates delayed or incomplete regression of the collagen tissue, which is different from that...
in chronic pressure overload. These changes are paralleled by alterations in diastolic but not systolic function, ie, a persistent increase in diastolic stiffness (Figure 1) late after valve replacement. The residual hypertrophy at the microscopic but not macroscopic level suggests persistent muscle fiber overload, although loading conditions are normal. This may be attributed to the mild residual pressure gradient associated with the artificial valve prosthesis.

**Fibrosis and Myocardial Stiffness**

Because structural changes of the myocardium are associated with functional alterations of the heart, we plotted interstitial fibrosis versus myocardial stiffness and found a positive correlation; ie, the higher the stiffness is, the higher the myocardial fibrosis is \((r=0.596, P=0.002)\). Interstitial fibrosis is negatively correlated to LV ejection fraction \((r=-0.570, P=0.004)\) but not to LV hypertrophy (Figure 6). Thus, the more fibrosis there is, the stiffer the myocardium is and the lower the LV ejection fraction becomes.

**Study Limitations**

One limitation of the present study is the small number of patients included in the analysis. This could have some influence on the statistical power of variables. However, the study protocol is complicated, including recatheterizations and endomyocardial biopsies over several years. The same patient had to undergo 3 different catheterizations, 1 or 2 of which were carried out on an ambulatory basis. All patients gave written informed consent to participate in the study, and no complications occurred in any patients. The family physician of each patient was contacted and informed about the nature of the procedure.

The number of patients is relatively small because of the invasive nature of the present study. Over a similar observation period, 8 to 10 patients with severe AR and without concomitant coronary artery disease were operated each year. Our study population was recruited from these patients and followed for up to 7 years. These patients represent roughly 5%–10% of patients undergoing AVR for severe AR in the time period studied.

The number of biopsy specimens obtained in a given patient per cardiac catheterization was 2 to 4 in the present study. It has previously been shown that at least 5 biopsy samples are necessary to establish correlations between ventricular structure and function in patients with cardiomyopathies. However, in patients with AR, morphological changes in the myocardium are more or less uniformly distributed over the entire ventricle, so 4 biopsy samples should adequately reflect myocardial collagen and myocyte size in this select cohort of patients. Although the relation between function and structure (cause and effect) is not known, our correlations suggest that relaxation is influenced by the extent of hypertrophy, whereas passive elastic properties are correlated to the changes of the nonmuscular tissue.

Only patients with severe AR were selected for evaluation. LV end-diastolic volume was severely increased with significant dilatation of the left ventricle (Table 2). Stroke volume was more than doubled in preoperative patients (2.3 times normal) compared to control subjects.

Postoperative follow-up was not standardized, but 7 of 11 patients were restudied 2 years and 9 were restudied 7 years after AVR. The other 6 patients refused restudy at the allotted time.

**Conclusions**

Persistent diastolic dysfunction can be observed late after AVR in patients with chronic AR. This finding can be explained by the incomplete regression of the extracellular matrix late after AVR because interstitial fibrosis remained unchanged compared to the preoperative situation. Persistent diastolic dysfunction with maintained systolic ejection performance has been shown to be associated with increased filling pressures during strenuous exercise and signs of exertional dyspnea.

**Acknowledgment**

This work is dedicated to the late Hans-Peter Krayenbuehl, University Hospital, Zürich, Switzerland.

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**Disclosures**

None.

**References**

CLINICAL PERSPECTIVE

Patients with severe aortic regurgitation show eccentric left ventricular hypertrophy and structural changes of the myocardium. Reversibility of functional and structural changes after successful valve replacement may be limited. Persistent diastolic dysfunction was observed in the present study late after aortic valve replacement. This finding is explained by incomplete regression of the extracellular matrix 7 years after valve replacement. Interstitial fibrosis remains unchanged compared with the preoperative situation but was increased early after operation as a result of the reduction in left ventricular muscle mass. Regression of left ventricular hypertrophy was 38% after 2 years and 55% after 7 years of valve replacement. Myocardial muscle fibers decreased slightly but remained hypertrophied even late after operation. Interstitial fibrosis was found to be positively correlated to myocardial stiffness and inversely correlated to left ventricular ejection fraction. Thus, persistent diastolic dysfunction with maintained systolic ejection performance can be observed late after successful valve replacement in patients with severe aortic regurgitation.
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