A cute massive mitral regurgitation attributable to rupture of the chordae tendineae is a serious condition in which the patient experiences the sudden onset of circulatory and respiratory failure.¹⁻³ This disease generally occurs in older children, adolescents, and adults, and the underlying conditions are diverse;²,³ for example, myxomatous change of the mitral valve,³ systemic connective tissue disorders such as Marfan syndrome or Ehlers-Danlos syndrome,²,⁴,⁵ infectious endocarditis,²,⁶,⁷ rheumatic fever,²,³,⁸,⁹ hypertension,¹⁰,¹¹ labor and delivery,¹² blunt chest trauma,¹³ and abnormalities of mitral apparatus such as single papillary muscle or double orifice mitral valve.¹⁴,¹⁵

Background—Recently, infant cases of acute heart failure attributable to rupture of the mitral chordae tendineae have been reported. However, little is known about the pathogenesis and clinical course of this condition.

Methods and Results—Ninety-five children with rupture of mitral chordae tendineae were identified in nationwide surveys of Japan diagnosed from 1995 to 2013. The clinical manifestations, management strategies, and prognosis were investigated. Eighty-one (85%) patients were between 4 and 6 months (median, 5 months) of age. In 63 (66%) patients, rupture occurred during the spring or summer. The underlying conditions before rupture included Kawasaki disease (10 cases), maternally derived anti-SSA antibodies (2 cases), and infective endocarditis (1 case). Surgery was performed in 80 patients (94 operations), and the final operations included plasty of mitral chordae in 52 cases and mechanical valve replacement in 26 cases. The histopathologic examinations of the mitral valves and chordae (n=28) revealed inflammatory reactions with predominant mononuclear cell infiltration in 18 cases (64%) and increased fibrous and myxoid tissue in 11 cases (39%), suggesting that nonbacterial infectious or autoimmune endocarditis and myxoid changes are involved in the pathogenesis. Eight patients (8.4%) died before (n=6) and shortly after (n=2) the operation, and significant neurological complications persisted in 10 cases (11%).

Conclusions—Acute heart failure attributable to rupture of the mitral chordae tendineae in infants is a unique disease resulting from diverse causes. This condition should be recognized as a significant cardiovascular disorder that may cause sudden onset of cardiogenic shock and death in infants. (Circulation. 2014;130:1053-1061.)

Key Words: heart failure ■ mitral regurgitation ■ pathology, surgical ■ pediatrics
of pediatrics or pediatric cardiology. Consequently, pediatricians, and even pediatric cardiologists, do not know much about the disease.

To elucidate the cause, clinical manifestations, appropriate medical and surgical treatment, and prognosis of the disease, we conducted a nationwide retrospective survey of acute rupture of the chordae tendineae of the mitral valve in children in Japan. Although the cases reported here are limited to Japanese infants, this disease does occur in other countries. Some patients may have gone unnoticed after dying or being misdiagnosed with other conditions such as sudden infant death syndrome. Therefore, acute rupture of the mitral chordae tendineae in infants is a new syndrome and should be recognized as a significant cardiovascular disorder that may cause sudden onset of cardiogenic shock and death.

Methods

Study Patients

This study is a retrospective cohort study of acute rupture of the mitral chordae tendineae in children occurring between July 1995 and August 2013. A primary questionnaire was sent to 532 clinical training hospitals approved by the Japanese Society of Pediatrics, requesting information on cases of children (under 15 years of age) with rupture of the mitral chordae between 1995 and 2013. Two hundred fifty-two hospitals (56.3%) responded to the first questionnaire, and 64 (12.0%) hospitals gave affirmative responses to such cases. The second questionnaire was forwarded to the 64 institutes, inquiring about clinical manifestations, medical and surgical treatments, and prognoses of patients. Ninety-five cases were investigated in the study. Seventeen cases previously reported17,18,20,22 were included in this nationwide survey. The diagnosis of Kawasaki disease was conducted by Board Certified Pediatricians of each hospital according to the diagnostic guidelines for Kawasaki disease.25,24 The institutional review committee of National Cerebral and Cardiovascular Center approved the study.

Pathological Diagnosis and Immunohistochemistry

A pathologist at the National Cerebral and Cardiovascular Center examined the actual specimens in 13 of 28 cases, whereas the study group relied on written documents and microphotographs of the specimens in the 15 remaining cases reported by board-certified pathologists at each institute. The immunohistochemistry procedures for tenascin C (mouse monoclonal, clone: 4F10TT, dilution 1:1000; Immuno-Biological Laboratories Inc), CD3 (rabbit polyclonal, dilution 1:1000; Immuno-Biological Laboratories Inc), CD68 (mouse monoclonal, dilution 1:10; Dako Japan Inc), and CD3 (rabbit polyclonal, dilution 1:1000; Immuno-Biological Laboratories Inc), CD68 (mouse monoclonal, dilution 1:10; Dako Japan Inc) were performed on formalin-fixed, paraffin-embedded chordal sections using an established method. All the immunohistochemical studies were performed in the department of pathology, National Cerebral and Cardiovascular Center.

Statistical Analysis

The data of the patients are presented as the median with interquartile range values for continuous demographic variables and laboratory findings. The Wilcoxon signed rank test was used to compare the laboratory data obtained at the onset of symptoms and discharge from the hospital because of the skewed nature of distribution. For the rate of pulmonary congestion, the McNemar test was conducted. Cumulative event-free survival curves were estimated using the Kaplan–Meier method. Cox proportional hazards models were used to identify factors associated with the time to aortic valve replacement and time to death. Hazard ratios and 95% confidence intervals (CIs) were also estimated. P value of $<0.05$ was considered to be statistically significant.

Results

Clinical Features of the 95 Patients

A typical case of acute rupture of the mitral chordae tendineae is shown in Figure 1. A 4-month-old female infant without a history of significant illnesses exhibited the sudden onset of a cyanosis and dyspnea after 2 days of fever. The initial diagnosis was pneumonia (Figure 1A); however, severe mitral regurgitation and rupture of the chordae tendineae were diagnosed in secondary and tertiary hospitals, respectively (Figure 1B and 1C). Surgical repair using artificial chordae was performed in association with mitral annuloplasty (Figure 1D). The intraoperative findings demonstrated that 4 chordae tendineae on the posterior leaflet were lacerated. After surgery, severe regurgitation successfully reduced to a trivial level.

The clinical characteristics of 95 patients are shown in Table 1 and Figure 2. There were 52 males and 43 females (Figure 2A), and ages ranged from 21 days to 16 months after birth (median, 5 months). The majority of patients were infants: 81 patients (85%) were between 4 to 6 months of age (Figure 2C), with body weight of 6.83 kg. Patients were born at 39 gestational weeks (median), with a body weight of 2.97 kg. Apgar score at 1 minute after birth was 9 (interquartile range, 8–10), indicating that perinatal asphyxia with myocardial ischemia was not an underlying condition of rupture.

![Figure 1. Case presentation of acute rupture of the mitral chorda tendineae in an infant (a 4-month-old female).](image)

A Chest X-ray shows pulmonary congestion with mild cardiomegaly (cardiothoracic ratio=0.60). B, An echocardiogram of the left parasternal long axis view demonstrating the severely prolapsed posterior leaflet of the mitral valve (arrow). C, A 2-dimensional Doppler cardiogram showing severe mitral regurgitation and an enlarged left atrium. D, The operative record of the mitral valve and ruptured chordae tendineae. The arrows indicate ruptured chordae tendineae. The arrowhead indicates yellowish degeneration of the anterior mitral leaflet (AML). PML indicates posterior mitral leaflet.
Diagnosis of Kawasaki disease was made in 10 patients (11%) before the onset of the rupture; acute and convalescent stage in 3 patients and beyond convalescent stage in 7 patients. The remaining 85 patients did not meet the clinical criteria for Kawasaki disease.23,24 In 1 patient (a 5-month-old female), Staphylococcus epidermidis endocarditis was diagnosed by positive blood culture tests and histopathologic examinations of the resected mitral valve.

Next, we analyzed seasonal epidemics of the disease (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B). The disease had a seasonal epidemic in spring and summer (65 patients, 68%). There were no sibling cases (Figure 2B).

Table 2. Laboratory Findings of the 95 Patients

<table>
<thead>
<tr>
<th>Examinations</th>
<th>On Admission</th>
<th>At Discharge</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBC (/uL)</td>
<td>15440</td>
<td>9160</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Hb (g/dL)</td>
<td>(11.990–21.650)</td>
<td>(7.330–11.100)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>PLT (×10^3/uL)</td>
<td>10.2 (8.9–11.1)</td>
<td>11.8 (10.9–13.0)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>CRP (mg/dL)</td>
<td>501 (338–600)</td>
<td>368 (302–439)</td>
<td>0.0003</td>
</tr>
<tr>
<td>AST (IU/L)</td>
<td>44 (30–105)</td>
<td>36 (29–44)</td>
<td>0.0003</td>
</tr>
<tr>
<td>ALT (IU/L)</td>
<td>21 (13–135)</td>
<td>22 (16–36)</td>
<td>0.0160</td>
</tr>
<tr>
<td>LDH (IU/L)</td>
<td>421 (267–763)</td>
<td>332 (264–484)</td>
<td>0.0046</td>
</tr>
<tr>
<td>CPK-MB (IU/L)</td>
<td>119 (77–247)</td>
<td>76 (45–123)</td>
<td>0.0002</td>
</tr>
<tr>
<td>BNP (pg/mL)</td>
<td>1450 (839–2545)</td>
<td>72 (32–114)</td>
<td>0.0007</td>
</tr>
<tr>
<td>cTnT (ng/mL)</td>
<td>0.027 (0.0–0.132)</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Data are presented as median (interquartile range). ALT indicates alanine aminotransferase; AST, aspartate aminotransferase; BNP, brain natriuretic protein; CPK, creatine phosphokinase; CRP, C reactive protein; cTnT, cardiac troponin T; Hb, hemoglobin; LDH, lactate dehydrogenase; MB, myocardial band; PLT, platelets; and WBC, white blood cells.
Chest X-Ray, ECG, and Echocardiography Findings

Although bilateral pulmonary congestion was recorded in 71 patients (75%), cardiomegaly was not evident; the median cardio-thoracic ratio in chest X-ray was 56 (51–59%). In the majority of patients, electrocardiograms revealed nonspecific ST-T changes in the precordial leads, which had normalized by the time of discharge. No abnormal Q waves were recorded in any of the patients.

The diagnosis of rupture of the mitral chordae was confirmed on echocardiography. Fractional shortening ([left ventricular end-diastolic diameter – left ventricular end-systolic diameter]/[left ventricular end-diastolic diameter]) of the left ventricle on admission was seemingly high (median, 0.41; range, 0.36–0.46). Doppler echocardiography on admission showed severe mitral regurgitation in 70 patients (73%), moderate in 22 (23%), and mild in 4 (4%). To exclude the possibility that preceding chronic mitral regurgitation induced the rupture, end-diastolic diameter (body surface area indexed) z score of the left ventricle was assessed. The median value of the z score was 1.47, indicating that the rupture is an acute event. A noteworthy echocardiographic finding was the presence of high echoic lesions at the top of the mitral papillary muscle adjacent to the chordae (8 patients, 8.4%). Abnormal thickening of the mitral valve leaflets was also detected in 9 patients (9.5%). No coronary artery aneurysms or abnormal origins of the left coronary arteries were detected. Dilatation of aortic root was assessed. The median value of the left ventricle (body surface area indexed) z score of the left ventricle on admission was seemingly high (median, 0.41; range, 0.36–0.46). Doppler echocardiography on admission showed severe mitral regurgitation in 70 patients (73%), moderate in 22 (23%), and mild in 4 (4%). To exclude the possibility that preceding chronic mitral regurgitation induced the rupture, end-diastolic diameter (body surface area indexed) z score of the left ventricle was assessed. The median value of the z score was 1.47, indicating that the rupture is an acute event. A noteworthy echocardiographic finding was the presence of high echoic lesions at the top of the mitral papillary muscle adjacent to the chordae (8 patients, 8.4%). Abnormal thickening of the mitral valve leaflets was also detected in 9 patients (9.5%). No coronary artery aneurysms or abnormal origins of the left coronary arteries were detected. Dilatation of aortic root was not detected, either.

Surgical Treatment

A total of 95 surgical operations (Figure 3) were performed on 80 patients (84%). Plasty of the mitral apparatus included reinforcement of the ruptured chordae with autologous pericardium, suture of the lacerated mitral valve leaflet, and mitral valve annuloplasty (52 patients). Twenty-six mechanical valves (16–19 mm in diameter) were implanted. In 9 patients, mitral regurgitation deteriorated after the surgical repair, primarily as a result of newly emerged rupture of the chordae tendineae. Although mitral regurgitation remained after the surgical repair, significant mitral stenosis was noted only in 1 patient (right ventricular/left ventricular pressure=0.86), who is a candidate for mechanical valve replacement.

In 83 patients, the details of the portions of the ruptured mitral chordae were recorded in the clinical charts. Rupture in 1, 2, 3, and 4 portions was noted in 38, 33, 9, and 3 patients, respectively. Rupture of the anterior leaflet alone, the posterior leaflet alone, and both leaflets was identified in 28, 33, and 22 patients, respectively. Thickened and myxoid mitral valve leaflets were identified in 13 patients at the time of surgery. No vegetation on the mitral valve apparatus was detected.

Rupture of the chordae tendineae of the tricuspid valve was detected in 6 patients; 5 patients survived after chordae repair, and 1 patient died before undergoing surgery. In 9 patients, surgical repair was not performed because the mitral regurgitation was limited in the small area and the patients became asymptomatic after medical treatment. These patients were carefully followed up with echocardiography and medical treatment, including diuretics and angiotensin-converting enzyme inhibitors.

Histopathologic Findings

Macroscopic (Figure 4A) and histopathologic examinations (Figure 4B–4L) of the mitral chordae or valves were performed in 28 patients. In the majority of patients, mononuclear cells had infiltrated the endocardium of the mitral valve leaflets and chordae tendineae (18 patients, 64%; Figure 4B and 4C). Polymorphonuclear leukocyte infiltration was also detected in the inflammatory lesions (Figure 4C); however, the number of polymorphonuclear leukocytes was far less than that of monocellular cells. Ruptured portions were replaced by scar formation with fibrin deposition and fibrous tissue (Figure 4E and 4F). Myxoid change of the mitral valve leaflets and chordae tendineae was detected in 11 patients (39%). Thickening of the spongiosa accompanied by infiltration of the fibrous component was also identified (Figure 4G). Immunohistochemical examinations revealed that tenascin C, a characteristic component of the extracellular matrix during embryonic development, inflammatory reactions, and tissue repair, was expressed in all layers of chordal tissue (Figure 4J). Immunohistochemical study revealed that infiltrated mononuclear cells consisted of CD3-positive T-lymphocytes (Figure 4K) and CD68-positive macrophages (Figure 4L).

In a 5-month-old female with Staphylococcus epidermidis–positive blood culture tests, predominant polymorphonuclear leukocyte infiltration was identified and she was diagnosed with bacterial endocarditis. None of the specimens showed any histopathologic characteristics of rheumatic endocarditis.25 Histopathologic examinations of the 2 autopsied cases revealed no obvious infiltration of inflammatory cells in the ventricular myocardium. No inflammatory reactions were detected in any other organs, such as the liver, kidneys, and gastrointestinal tract. Biopsy specimens were not obtained in the 2 patients with positive anti-SSA antibodies.

Figure 3. Surgical procedures and prognoses of the 95 patients. MVR indicates mitral valve replacement; and Op, operation.
Prognosis
Eight patients (8.4%) died of circulatory failure or multiple organ dysfunctions (2 male and 6 female; 6 before surgery and 2 after surgery). The median ages of the 8 patients was 4 months. All 6 patients who died before surgery exhibited serious cardiorespiratory failure at the initial stage of shock and were immediately transferred to a tertiary care hospital. After the surgical repair or medical treatment, the patients were discharged from the hospital with normal left ventricular FS values in echocardiography (0.36). During the 3 months to 18 years of follow-up (median, 5.4 years), mitral regurgitation persisted in 9 patients; 5 cases were slight and 4 cases were moderate. The left ventricular FS at present were almost within normal limits (median, 0.37; range, 0.24–0.57). Only 3 patients showed impaired echocardiographic FS <0.28 (0.24, 0.25, and 0.26). The brain natriuretic protein levels at presentation were within normal range (median, 34.8 pg/mL).

Neurological complications, such as significant developmental delays or cerebral palsy, were detected in 10 patients (11%; 95% CI, 4.2%–14.1%). As a whole, significant complications remained in 32 patients (34%; mitral replacement in 26, neurological complications in 10, both in 4), indicating a mortality and morbidity of the disease of 8.4% (95% CI, 2.73–14.1) and 42% (95% CI, 32.0%–52.2%), respectively.

Forty-eight (51%; 95% CI, 40.3%–60.8%) patients continue to take drugs (ie, angiotensin-converting enzyme inhibitors in 31 patients, diuretics in 22 patients, coumadin in 29 patients, antiplatelet drugs in 17 patients, and antiarrhythmia drugs in 3 patients). At present, arrhythmias persist in 8 patients (8.4%; 95% CI, 2.7%–14.1%), including atrial flutter in 3 patients, atrial tachycardia in 2 patients, and complete atrioventricular block with pacemaker implantation in 3 patients. All arrhythmias are well controlled with medication.

Factors Associated With Artificial Valve Replacement and Death
To detect predictors of artificial valve replacement and death in the patients, the cumulative probability of freedom from artificial valve replacement was analyzed according to the Kaplan–Meier method (Figure 5). The probability of artificial valve replacement–free survival was lower among the patients who developed chordal rupture in summer than among those who developed this complication in other seasons (Figure 5A). The artificial valve replacement–free survival was also lower in the patients who developed 3 to 4 chordae than in those who...
developed 1 to 2 chordae (Figure 5B). Significant predictors of artificial valve replacement identified in the Cox proportional hazard models are shown in Table 3. Rupture in the summer and the number of ruptured chordae tendineae were significantly associated with the risk of artificial valve replacement. In contrast, no significant clinical or laboratory factors were associated with the risk of death in the univariable analyses.

Discussion

Rupture of the chordae tendineae of the mitral valve in infants is rare. The majority of affected patients present with the sudden onset of severe cardiorespiratory shock. Some patients die, whereas others require urgent surgical treatment, such as mitral chordae plasty or mechanical valve replacement. In infants treated surgically with prosthetic valves, reoperation to “up-size” the valves is likely to be necessary as the patients grow, depending on the size of initial prosthesis. To improve the prognosis of these patients, providing an early diagnosis, appropriate medical treatment, and successful surgery are crucial. Because the disease is not currently recognized worldwide, some patients may have remained undiagnosed or been misdiagnosed. Some cases may have occurred in other countries as well. Therefore, acute rupture of the mitral chordae tendineae needs to be considered a significant cardiac disease that may cause sudden onset of acute cardiac failure in infants.

Causes of the Disease

In adolescents and adults, the underlying causes of the rupture of the chordae tendineae are diverse; mitral valve prolapse, myxomatous degeneration, and infectious endocarditis are the leading causes, particularly in the last 2 decades. In infants, causes of the rupture appear to be different from those in adults; most pediatric cases of mitral rupture were diagnosed as idiopathic because a direct cause could not be demonstrated. In a small number of cases, Kawasaki disease, a child-specific cause, was the documented cause for this condition. Rupture of the mitral chordae or papillary muscles may occur in Kawasaki disease after myocardial ischemia or infarction of the ventricular inferior wall. Mitral regurgitation without coronary arterial lesions may also occur during the acute or convalescent stage of Kawasaki disease, in which the histopathologic findings indicate the involvement of endocarditis and valvulitis. In our patients, no signs of myocardial ischemia or infarction were detected. Endocarditis or valvulitis in Kawasaki is a potential cause of the chordal rupture.

The actions of maternally derived anti-SSA/SSB antibodies appear to reflect another child specific pathogenesis particularly in neonates and early infancy. The transplacental passage of antibodies against SSA or SSB auto-antigens has been proven to be an cause of congenital complete atrioventricular block in neonates. Dilated cardiomyopathy or endocardial fibroelastosis may also develop as a late-onset cardiac complication. Molecular studies have clarified that these antibodies initially bind to the L-type calcium channel on fetal cardiomyocytes, where they induce calcium dysregulation, apoptosis, inflammation, and subsequent conduction tissue disturbance. Echocardiography has demonstrated high echoic lesions at the top of the papillary muscles. Similar cellular mechanisms may be involved, where fibrous scar formation develops during the fetal period and subsequent rupture may occur early after birth.

Myxoid change of the mitral valve leaflets and chordae tendineae was detected in 39% of available specimens. Histological examinations revealed abnormal deposition and disorganization of collagen and elastin and accumulation of proteoglycans in the myxoid mitral valve with ruptured chordae tendineae, suggesting that these histological changes are the predisposing cause of the rupture. Because changes in the structure of the mitral leaflets such as those seen in myxomatous degeneration take time to develop, further studies are necessary to elucidate the contribution of myxoid change to mitral chordal rupture in infants.

Table 3. Univariable Analyses of Risk Factors for Mechanical Valve Replacement

<table>
<thead>
<tr>
<th></th>
<th>HR</th>
<th>z</th>
<th>P Value</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summer</td>
<td>2.44</td>
<td>2.26</td>
<td>0.024</td>
<td>1.12 5.28</td>
</tr>
<tr>
<td>Number of ruptured chordae</td>
<td>1.98</td>
<td>2.88</td>
<td>0.004</td>
<td>1.24 3.14</td>
</tr>
<tr>
<td>Number of ruptured chordae&gt;=3</td>
<td>4.86</td>
<td>3.53</td>
<td>&lt;0.001</td>
<td>2.02 11.69</td>
</tr>
</tbody>
</table>

CI indicates confidence interval; and HR, hazard ratio.
Indirect evidence supports the theory of an infectious or para-infectious inflammatory cause in many cases: (1) inflammatory cells were detected on the histochemistry analysis in 69% of available specimens; (2) prodromal symptoms similar to viral infections; (3) seasonal epidemics having peaked in summer; (4) high incidence in the middle of infancy when maternal antibodies become undetectable; and (5) lymphocyte predominant infiltration in the specimen. As the presence of inflammatory cells involving the ruptured chordae may have developed as a consequence of rupture rather than be a causal factor, further studies including the detection of viral genomes and isolation of viruses are being considered.

Finally, why acute mitral chordal rupture in infants is predominant in the Japanese population remains uncertain. In countries other than Japan, this condition seems to be rare, as no cases other than 1 case of an anti-SSA antibody–positive infant have been described in literature thus far. Some genetic background factors appear to be responsible for the disease, as Kawasaki disease is dominant in Japanese and Asian children. Further studies are therefore needed to elucidate the genetic susceptibility of the disease.

Medical and Surgical Treatment
The initial treatment should include medical support, such as the intravenous infusion of inotropes, diuretics, and vasodilators, and mechanical ventilation with tracheal intubation. If the circulatory and respiratory failure is uncontrollable, surgical repair of the ruptured chordae tendineae should be immediately considered. Plasty of the lacerated chordae using reinforcement with or without artificial chordae is the first choice of surgery because mechanical valve replacement in infancy always requires upsizing reoperation as the patient ages. However, if the rupture includes multiple, particularly ≥3 chordae, a risk factor for mechanical valve replacement, and is difficult to repair with the plasty technique, mechanical valve replacement should be considered.

Study Limitations
There are several limitations to this study. First, this study was based on a retrospective nationwide survey of mitral chordal rupture in Japan. Because of the emergent condition of each patient, data concerning clinical manifestations and laboratory findings particularly relevant to the pathogenesis were not satisfactory. Specimens for histochemistry were available in only 28 of 95 patients (presumably weighted toward the most serious cases requiring valve replacement or resulting in death), thus limiting the generalizability of the histological findings to the whole group. Further nationwide prospective studies are therefore essential, including isolation of viruses and investigation of virus genome from blood and tissues samples. Second, appropriate medical and surgical therapy to prevent the progression of rupture has not yet been established. Prospective studies concerning additional medical and surgical treatment are also necessary. Third, this study was conducted in Japanese children only. Although the possible causes are diverse and various ethnic or genetic background factors are likely responsible, it is highly possible that this disease develops in countries other than Japan. Worldwide surveys are needed to clarify the incidence, pathogenesis, and prognosis of the disease.

Conclusions
Acute rupture of the mitral chordae tendineae in infants is a unique disease that predominantly affects patients aged 4 to 6 months, with high mortality and morbidity. Kawasaki disease, maternally derived anti-SSA antibodies, myxoid change of the mitral valve, and lymphocytic endocarditis are possible candidate causes of the chordal rupture; however, precise pathogenesis is uncertain and the patients are diagnosed as idiopathic. Although the reason why the disease is predominant in Japanese infants remains to be elucidated, acute rupture of the mitral chordae tendineae should be recognized as a significant cardiovascular disorder that may cause sudden onset of cardiogenic shock or death in infants all over the world.

Appendix
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Disclosures

None.

References

Acute massive mitral regurgitation attributable to rupture of the chordae tendineae is a serious condition in which patients experience the sudden onset of circulatory and respiratory failure. This condition was thought to be rare in young children. However, several child cases have been reported in Japan, and most cases are infants aged between 4 and 6 months. We conducted a nationwide survey of the disease and analyzed 95 cases. The disease has a seasonal epidemic that peaked in the spring and summer. Eight patients died of acute heart failure and 26 patients underwent mechanical valve replacement. The direct cause of rupture remains unknown, and the patients are diagnosed as idiopathic. However, Kawasaki disease, maternal anti-SSA antibody, infectious cause, and myxoid change of the mitral valve appear to be underlying conditions. As the clinical entities and criteria of the disease have not been established yet, some patients may have gone unnoticed after dying or being misdiagnosed with other conditions such as sudden infant death syndrome. Acute rupture of the mitral chordae tendineae in infants is a new syndrome. This disease does occur in countries other than Japan and should be recognized as a significant cardiovascular disorder in infants.
Acute Rupture of Chordae Tendineae of the Mitral Valve in Infants: A Nationwide Survey in Japan Exploring a New Syndrome

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