Mitral Regurgitation

Impaired Systolic Function, Eccentric Hypertrophy, and Increased Severity Are Linked to Lower Phosphocreatine/ATP Ratios in Humans

Michael A. Conway, MD, MSc, MRCP; Paul A. Bottomley, PhD; Ronald Ouwerkerk, PhD; George K. Radda, DPhil, FRS; Bheeshma Rajagopalan, DPhil, FRCP

Background—A number of phosphorus ($^{31}$P) magnetic resonance spectroscopy (MRS) studies link alterations of high-energy phosphate metabolism in valvular disease and cardiomyopathy to the clinical severity of heart failure. However, correlations between MRS and indexes of ventricular dysfunction are inconclusive to date. We examined whether changes in $^{31}$P MRS are associated with the impaired contractility, which predisposes to chronic congestive heart failure in patients with mitral regurgitation.

Methods and Results—Thirteen normal control subjects and 22 patients with echocardiographically characterized chronic mitral regurgitation were studied by $^{31}$P MRS. The apical phosphocreatine-to-ATP ratio (PCr/ATP) was lower in severe disease ($P<.02$) and those on therapy ($n=13, 1.29 \pm 0.29, P<.01$) in contrast to control subjects ($n=13, 1.61 \pm 0.3$). Compared to those with mild mitral regurgitation, patients with more severe incompetence had lower mean myocardial PCr/ATP ratios (mild, $n=6, 1.73 [0.17], P<.05$ and $P<.01$; moderate, $n=5, 1.49 [0.18], P<.05$; and severe, $n=11, 1.29 [0.32], P<.01$). PCr/ATP in those referred for mitral valve replacement was lower ($n=8, 1.17 \pm 0.23$) although not significantly decreased compared with the ratio among subjects on medical therapy alone ($n=5, 1.48 \pm 0.29$). PCr/ATP correlated with the end-systolic diameter ($r^2=.7, P<.001$), end-diastolic diameter ($r^2=.32, P<.05$), left ventricular wall thickness ($r^2=.38, P<.01$), left atrial dimension ($r^2=.36, P<.05$), and derived measurements such as the percent fractional shortening ($r^2=.5, P<.01$), and left ventricular mass/body surface area ($r^2=.5, P<.001$) but not with wall stress.

Conclusions—These results demonstrate that abnormalities of PCr/ATP in mitral regurgitation are related to disease severity as measured by dimensional indexes of left ventricular dilatation. They suggest that impaired high-energy phosphate metabolism is a marker of hypertrophy and heart failure. (Circulation. 1998;97:1716-1723.)

Key Words: mitral valve | spectroscopy | heart failure | echocardiography | myocardium

The mechanisms underlying deterioration of myocardial contractility in conditions such as MR (mitral incompetence) are poorly understood. Abnormal high-energy phosphorus and other metabolism appears to play a role, and several recent reports using $^{31}$P MRS describe altered PCr/ATP among patients with aortic valve disease, eccentric hypertrophy, and severity of dilated cardiomyopathy, and other disorders affecting the LV (for reviews, see References 14 through 16).

One observation, the reduced PCr/ATP of the hypertrophied failing myocardium, has focused attention on structural changes in the ventricle that may be relevant to the biochemical changes. To explore this, we studied MR, a valvular disorder characterized by a range of abnormalities in contractility, eccentric hypertrophy, and severity of dilated cardiomyopathy, and we examined for links between symptoms of heart failure, echocardiographic abnormalities, and changes in PCr/ATP.

Subjects

Twenty-two patients (age range, 17 to 78 years; mean \pm SD, 54.6 \pm 17 years; height, 173 \pm 11 cm; weight, 66.4 \pm 12.9 kg; BSA, 1.76 \pm 0.2 m$^2$; 17 men, 5 women) with MR were compared with 13 age- and sex-matched normal control subjects. To limit the effects of confounding factors, all patients fulfilled the following criteria: (1) they had clinically stable MR for at least 3 months, (2) they were able to tolerate lying prone, (3) they were in sinus rhythm ($n=16$) or well-controlled atrial fibrillation ($n=6$) and did not suffer from lung disease, pulmonary or systemic hypertension, acute or healed myocardial infarction, angina pectoris, significant aortic valve disease, or LV dilatation caused by idiopathic, myocarditic, or ischemic cardiomyopathy. Disease severity was characterized from the degree of dyspnea (NYHA classes I through IV) at the time of the MRS study. Patients were recruited and studied randomly as they presented within a month of referral or soon after annual outpatient review. Patients with mild incompetence had been referred with palpitations or a clinically detected mitral murmur.

The symptomatic status and echocardiographic severity of the patients with MR are listed in Table 1.

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Patients were fully informed about the study, permission for which was provided by the Central Oxford Regional Ethics Committee.

**Echocardiography**

The degree of mitral valve leakage was determined from the flow-jet on Doppler echocardiography (mild, < 4.0 cm²; severe, > 8.0 cm²) with a Hewlett-Packard Sonos 1000, 2.5/2.0-MHz phased-array transducer, narrow-sector angle for color flow (30°). The hearts were further characterized by measuring EDD, ESD, LA dimensions, and Th (all in centimeters) (Table 2). The EDD and Th measurements were recorded with the echo beam directed at the LV just caudal to the mitral leaflet tips and angled so that the septum and posterior wall endocardium lay perpendicular to the beam (left parasternal long-axis view). Derived measurements such as FS% = (EDD – ESD)/EDD, LVMI in grams/cm² adjusted for BSA, and LV meridional wall stress in grams per square centimeter based on cusp sphygmomanometry. The mean of three measurements was used for final analysis (the mean for atrial fibrillation patients was derived from six ventricular contractions).

Tables 2, 3, and 4 summarize the measured and derived echocardiographic parameters and show the differences among mild, moderate, and severe cases of incompetence with respect to the ESD, EDD, Th, LA, LVMI/BSA, and FS%. The echocardiographic characteristics of dyspneic patients and those on treatment for heart failure are also listed (Table 4), and the intercorrelations between the echocardiographic measurements are tabulated in Table 5.

**31P MRS**

Seventeen patients and 8 control subjects were studied successfully with 1D CSI in a 1.9-T magnet (Oxford Instruments). Five patients and 5 control subjects underwent examination with a comparable 1D technique, PMRFI in a 1.9-T magnet equipped with the same Biospec NMR spectrometer (Oxford Research Systems). Acquisition and analysis of data were unsuccessful in 1 patient with severe MR and 3 control subjects.

Patients were positioned prone on a 6.5-cm-diameter 31P MRS receiver coil, and an ECG was attached. Coil location relative to the apex and free wall of the LV was optimized before MRS acquisitions by prone echocardiography and also by MRI in the CSI studies.

The 1D CSI spectroscopy was performed using a surface coil consisting of a balanced three-turn 6.5-cm-diameter 31P receiver coil and a 0.4×0.4-m transmission coil. A 0.4×0.4×0.4-m 1H transmit coil and an 8×13-cm figure-eight 1H receiver coil were used for MRI and for shimming the magnet to optimize the field homogeneity for the 31P MRS study by use of an unlocalized water spectrum. Scout ECG-gated MRI was performed with a spin-echo sequence (TE, 34 ms; NEX, 2; acquisition delay, 0.15 seconds after the R wave), giving 2.5-mm-per-pixel resolution from 1.0-cm-thick slices. After MRI and shimming, cardiac-gated 31P MRS was performed with excitation pulses adjusted to optimize the PCr signal in an unlocalized eight-scan spectrum. A 64-step 1D CSI 31P data set was then collected at the heart rate in ~12 minutes with 1.0-cm resolution as a function of depth through the chest wall and heart. After the 1D CSI acquisition, two unlocalized cardiac-gated spectra were recorded to determine saturation correction factors for PCr/ATP. One spectrum (NEX, 100) was acquired at the heart rate as in the CSI study, and the other (NEX, 16 scans) was acquired with a 15-second repetition delay.

PMRFI 31P MRS studies were carried out with a double-concentric surface coil (transmitter diameter, 15 cm; receiver diameter, 6.5 cm) from cylindrical sections calibrated from experiments on multicompartment samples. A phantom of diphenylphosphate located at the center of the coil served as a reference marker. Acquisitions were cardiac-gated at twice the cardiac period (TR, ~2 seconds). Scout MRI was performed with a figure-eight 20×20-cm surface coil.

Cardiac spectra were identified from both MRI (Figure 1) and depth profiles. The latter plot (Figure 3) reveals the prominent PCr and higher PCr/ATP in the chest wall and demonstrates the transition to the lower ratios characteristic of the myocardium. Spectral analysis: PMRFI and 1D CSI spectra were quantified by measuring peak areas by triangulation and by automated curve fitting in the frequency domain with standard Bruker Instrument integration software. Metabolite ratios were cross-checked blindly by two independent investigators. All PCr/ATP calculations were based on the gamma ATP resonance because of off-resonance effects on the βATP peak in some patients.

Myocardial PCr/ATP from CSI data sets was corrected for partial saturation by use of the correction factors calculated from PCr/ATP measured in the unlocalized spectra acquired at the heart rate and at 15 seconds. Examples of such spectra are shown in Figure 2. The saturation correction factors were similar for each subject, so the mean was used for correction in eight CSI studies in which the individual saturation factors had not been measured. PMRFI data were similarly adjusted by use of the known flip angle and heart rate of the individual patients and the spin-lattice relaxation times (T1). Adjustments for blood contamination was performed by reducing the size of the ATP by an amount equal to one sixth of the area of the combined peaks representing 2,3 DPG when this peak was prominent. In practice, the correction was applied when (1) the area

<table>
<thead>
<tr>
<th>TABLE 1. Symptomatic Status and Echocardiographic Severity of MR</th>
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</thead>
<tbody>
<tr>
<td>Symptom Grade (NYHA)</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Mild</td>
</tr>
<tr>
<td>Asymptomatic</td>
</tr>
<tr>
<td>Dyspnea</td>
</tr>
<tr>
<td>Treated CHF</td>
</tr>
<tr>
<td>MVR*</td>
</tr>
</tbody>
</table>

CHF indicates congestive heart failure.

*One man died postoperatively owing to LV dysfunction.
of the signal from combined 2,3 DPG resonances (at 5.3 and 6.2 ppm) was equal to or greater than that of the γATP and (2) the amplitude of the 3 phosphoglycerate was equal to or lower than that of the 2 phosphoglycerate. Such corrections were applied to cardiac spectra from five normal control subjects and five patients with MR (moderate 5; severe 5). (This suggests that the presence of prominent blood signals is not a particular feature of dilated cardiomyopathy and is likely to reflect the depth and position of the sampling volume in a proportion of both the control subjects and valvular heart disease patients.) Data are presented as mean±SD and compared by use of both the Student unpaired t test and the Welch modified two-sample t test. The comparison of PCr/ATP with the grade of mitral incompetence was examined with ANOVA. Normal distribution of the data was checked with the Kolmogorov-Smirnov test. The nonparametric Spearman test was applied when the data were not normally distributed, eg, wall stress. Simple correlations were examined, and values of P<.05 and r2>.45 were accepted as significant and as evidence favoring a relationship. There were no significant differences in myocardial PCr/ATP measured by CSI and PMRFI either before or after saturation and blood correction (uncorrected control subjects: CSI, n=8, 1.66±0.38 versus PMRFI, n=5, 1.52±0.14). The individual ratios for patients are tabulated in Table 2 (from which the correction factors can be derived), and both the uncorrected and saturation corrected mean values are presented in Tables 3 and 4.

Results

Steady-State High-Energy Phosphorus Metabolism in Mitral Incompetence

Representative 1D CSI spectra from a control and patients with normal and reduced PCr/ATP are illustrated in Figure 3. A midplateau PMRFI heart spectrum of one patient with severe MR is also shown. The amplitude and area of PCr relative to ATP are highest in the normal and mild MR spectra. To determine whether myocardial high-energy phos-
Some previous reports suggest that LV metabolism may be altered by and correlated with disease severity in mitral incompetence, we compared PCr/ATP in MR with data from control subjects and measurements from patients categorized according to the severity of incompetence, simple and derived echocardiographic parameters, and symptomatic status.

**PCr/ATP: MR Compared With Control Subjects**

Some previous reports suggest that LV metabolism may be different among MR patients compared with control subjects. Within the current study group, patients with severe regurgitation (n = 11, 1.29 ± 0.3, P < .02), dyspneic subjects (n = 10, 1.21 ± 0.24, P < .003), and those on therapy for heart failure (n = 13, 1.29 ± 0.29, P < .01) had significantly lower ratios compared with control subjects (n = 13, 1.61 ± 0.3). However, the control ratio was not significantly different from the ratio in patients classified echocardiographically with mild or moderate disease, among patients without dyspnea, or in those who did not require treatment for heart failure. These data are presented in Tables 3 and 4.

**PCr/ATP: Mild Versus Moderate Versus Severe MR**

The severity of incompetence may determine the extent to which metabolism becomes deranged over time. Compared with the ratio in patients with mild MR (1.73 ± 0.17, P < .05, P < .01), patients with moderate (1.49 ± 0.18, P < .05) and severe (1.29 ± 0.32, P < .01) incompetence had lower PCr/ATP, suggesting that the degree of leakage is related to intracellular high-energy phosphate changes. However, normal ratios are not exclusive to patients with mild and moderate disease, as evidenced by the normal values in some cases with severe valve leakage (Table 2).

**PCr/ATP Versus Measured Echocardiographic Parameters**

To explore possible structural or functional correlates of the above finding, the relationship between individual PCr/ATP and standard echocardiographic indexes of LA, LV dimensions, and LV Th was examined. Figure 4 shows PCr/ATP compared with ESD, EDD, and Th. PCr/ATP was closely related to ESD (r² = .7, P < .001), and a significant relationship with other parameters was also identified (Th: r² = .38, P < .01; EDD: r² = .32, P < .05; and LA: r² = .36, P < .05).

**PCr/ATP Versus Derived Echocardiographic Measurements**

Correlation was found between the metabolic ratio and both the LVM/BSA (r² = .52, P < .0001) and FS% (r² = .5, P < .001), but the measured wall stress was not related to PCr/ATP (r² = .14, P = NS) even when tested with the nonparametric Spearman test (Table 5).

**TABLE 4. Comparison of Mean Biochemical and Echocardiographic Measurements in Treated Compared With Untreated Patients in Relation to Symptoms of Dyspnea and According to Whether They Underwent MVR**

<table>
<thead>
<tr>
<th></th>
<th>No SOB (n=12)</th>
<th>SOB (n=10)</th>
<th>No Therapy (n=9)</th>
<th>Treated (n=13)</th>
<th>P</th>
<th>Med Rx Only (n=5)</th>
<th>Med Rx &amp; MVR (n=8)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCr/ATP</td>
<td>1.66±0.20</td>
<td>1.21±0.24</td>
<td>&lt;.0001</td>
<td>1.69±0.15</td>
<td>.01</td>
<td>1.48±0.29</td>
<td>1.17±0.23</td>
<td>NS</td>
</tr>
<tr>
<td>Sat corr</td>
<td>1.92±0.29</td>
<td>1.42±0.28</td>
<td>&lt;.0006</td>
<td>1.93±0.16</td>
<td>.01</td>
<td>1.69±0.53</td>
<td>1.42±0.30</td>
<td>NS</td>
</tr>
<tr>
<td>EDD, cm</td>
<td>5.46±0.83</td>
<td>6.27±0.98</td>
<td>&lt;.05</td>
<td>5.19±0.77</td>
<td>.007</td>
<td>5.74±0.84</td>
<td>6.60±0.72</td>
<td>NS</td>
</tr>
<tr>
<td>ESD, cm</td>
<td>3.21±0.65</td>
<td>4.38±0.74</td>
<td>&lt;.0008</td>
<td>3.01±0.43</td>
<td>.004</td>
<td>3.64±0.74</td>
<td>4.63±0.58</td>
<td>NS</td>
</tr>
<tr>
<td>Th, cm</td>
<td>0.97±0.15</td>
<td>1.13±0.22</td>
<td>&lt;.05</td>
<td>0.97±0.17</td>
<td>NS</td>
<td>0.96±0.18</td>
<td>1.18±0.18</td>
<td>NS</td>
</tr>
<tr>
<td>LA, cm</td>
<td>4.33±1.16</td>
<td>5.64±1.23</td>
<td>&lt;.02</td>
<td>3.86±0.75</td>
<td>.005</td>
<td>5.24±1.45</td>
<td>5.94±0.92</td>
<td>NS</td>
</tr>
<tr>
<td>FS %</td>
<td>41.30±8.50</td>
<td>31.00±7.30</td>
<td>&lt;.007</td>
<td>41.80±7.50</td>
<td>.02</td>
<td>36.30±10.50</td>
<td>29.90±6.80</td>
<td>NS</td>
</tr>
<tr>
<td>LVM/BSA, g/cm²</td>
<td>136.50±42.70</td>
<td>215.40±87.00</td>
<td>&lt;.01</td>
<td>133.00±47.50</td>
<td>.04</td>
<td>131.00±45.00</td>
<td>242.00±70.00</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>WS, dynes/cm²</td>
<td>228.30±92.20</td>
<td>329.30±127.50</td>
<td>&lt;.04</td>
<td>200.00±46.00</td>
<td>.01</td>
<td>315.00±114.00</td>
<td>332.00±142.00</td>
<td>NS</td>
</tr>
</tbody>
</table>

SOB indicates shortness of breath/dyspnea; Sat corr, saturation corrected; Med, medical; and Rx, treatment.

**TABLE 5. Intercorrelation of Echocardiographic and Biochemical Measurements:**

<table>
<thead>
<tr>
<th>EDD</th>
<th>Th</th>
<th>FS %</th>
<th>LVM/BSA</th>
<th>WS</th>
<th>LA</th>
<th>PCr/ATP</th>
<th>PCr/ATP Sat corr</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EDD</td>
<td>.6†</td>
<td>.17</td>
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<td>.32†</td>
<td>.17</td>
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<tr>
<td>ESD</td>
<td>. .</td>
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<td>.</td>
<td>.55†</td>
<td>.</td>
<td>.70§</td>
<td>.47‡</td>
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<tr>
<td>Th</td>
<td>. .</td>
<td>. .</td>
<td>.</td>
<td>. .</td>
<td>.05</td>
<td>.38†</td>
<td>.22‡</td>
</tr>
<tr>
<td>FS %</td>
<td>. .</td>
<td>. .</td>
<td>.</td>
<td>. .</td>
<td>.</td>
<td>.50‡</td>
<td>.42‡</td>
</tr>
<tr>
<td>LVM/BSA</td>
<td>. .</td>
<td>. .</td>
<td>.</td>
<td>. .</td>
<td>.36</td>
<td>.52§</td>
<td>.36</td>
</tr>
<tr>
<td>WS</td>
<td>. .</td>
<td>. .</td>
<td>.</td>
<td>. .</td>
<td>.28</td>
<td>.14</td>
<td>.10</td>
</tr>
<tr>
<td>LA</td>
<td>. .</td>
<td>. .</td>
<td>.</td>
<td>. .</td>
<td>.</td>
<td>.36†</td>
<td>.23*</td>
</tr>
</tbody>
</table>

WS indicates wall stress; Sat corr, saturation corrected. Correlations are not presented for parameters in which there is a common measurement in the numerator and denominator, eg, EDD and LVM/BSA.

*P<.05; †P<.01; ‡P<.001; §P<.0001.
PCr/ATP and Clinical Variables: Dyspnea, Antifailure Therapy, Referral for MVR

Twelve patients reported no limitation caused by dyspnea at the time of the MRS study and had higher PCr/ATP (1.66 ± 0.2) compared with the symptomatic subjects (1.21 ± 0.24, P < 0.001). The findings were similar on separation of the patients into groups according to whether or not antifailure therapy was required. Those on regular oral antifailure treatment (n = 13, 8 of whom subsequently underwent MVR) had lower PCr/ATP (1.29 ± 0.29) compared with the untreated group (n = 9, 1.69 ± 0.15, P < 0.001). PCr/ATP of subjects treated both medically and referred for MVR within 2 months was lower than that of those on medical therapy alone, but the difference did not achieve conventional statistical significance (1.17 ± 0.23, n = 8 versus 1.48 ± 0.29, n = 5; Table 4).

Discussion

In the current study, intracellular myocardial biochemistry of the LV free wall and apex of the heart with mitral incompetence was examined by use of an index based on measurements of phosphate atomic nuclei in PCr and ATP. The findings show that patients have normal PCr/ATP when MR is mild but develop reduced PCr/ATP with severe disease, indicative of a reduced potential for maintaining the ATP supply for muscular contraction. Patients with symptoms of heart failure and those receiving antifailure therapy also exhibited lower PCr/ATP compared with the asymptomatic and untreated groups. The latter observations are consistent with previous studies of steady state high-energy phosphorus metabolism in valvular heart disease and heart failure caused by cardiomyopathy.

The clearest correlation between a simple echocardiographic measurement and the biochemical index is PCr/ATP versus ESD. Patients whose LVs are larger than normal at end systole have decreased PCr compared with ATP concentrations, and the greater the dilatation, the lower the ratio. This finding is consistent with the significant correlation between PCr/ATP and FS%. Such observations suggest that the prevailing PCr/ATP may be linked to factors determining the efficiency of contractility. Hence, it represents a potential biochemical marker of LV function.

The biochemical index also links LV growth to the changes in PCr/ATP. Mass is derived using cubed EDD and LV myocardial thickness and is subject not only to the variability in these measurements but also to patient size and the effects of conditions that increase wall thickness such as hypertension. The measurements presented were adjusted for BSA, and confounding conditions were excluded during patient recruitment, thereby supporting the proposal that increased LVM is associated with an altered PCr/ATP, as has been shown with animal models.

Correlation of derived echocardiographic measurements such as FS% and LVM/BSA with PCr/ATP reflects the relationship with the measured echocardiographic parameters from which these are calculated. Our data show no correlation between the biochemical ratio and the calculated wall stress.

The altered PCr/ATP reflects altered homeostasis of high-energy phosphorus metabolism in MR. The abnormality results perhaps from one or more of the many biochemical mechanisms that maintain efficient cellular contractility.
Recently, Massie et al. showed that the proportion of glucose that the heart oxidizes is higher in pigs with LV hypertrophy. They argued that a different substrate preference could offer a partial explanation for the lower PCr/ATP in LV hypertrophy because a low ratio has been observed when glucose is the sole substrate in perfused hearts. However, as they pointed out, the relevance of their finding to humans in whom a mixture of substrates is available remains uncertain. Reduction of PCr/ATP may be determined by chronic myocardial hypoperfusion, but it is unlikely that decreased PCr/ATP and impaired systolic function among patients with chronic stable regurgitation is analogous to the PCr depletion that occurs during global myocardial ischemia in the isolated heart preparation. In contrast, intracellular biochemical changes associated with concentric hypertrophy may depend more on perfusion to the endocardium (especially rate related). Altered biochemistry is reported by other investigators who studied patients with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse. The arterial and coronary sinus blood lactate levels were increased in a group with mitral valve prolapse.

Our findings demonstrate that deteriorating myocardial function in mitral incompetence is associated with altered PCr/ATP. The mechanism of this may be inefficient creatine phosphorylation by creatine kinase and decreased intracellular creatine. Because creatine uptake into muscle occurs through specific sodium-dependent membrane transport that requires energy, this process may be particularly susceptible to abnormal myocardial energy demand and may represent an adaptive change.

The present metabolic findings are relevant not only to the understanding of myocardial metabolism but also to the possible role of MRS as a technique for investigating and clinically managing patients with valvular heart disease. We have previously proposed that serial noninvasive biochemical monitoring represents a potentially important investigation for improving management decisions relating to valve surgery. This applies particularly to MR, a condition in which the optimal timing of MVR is often difficult to choose. Our study identified a close relationship between MRS measurements and systolic function. The latter, as measured by echocardiography, determines morbidity and mortality both with and without surgery. The link between systolic function and PCr/ATP presents a further biochemical marker for these epidemiological observations. In support of the observations, low PCr/ATP has been found to be associated with increased mortality in patients with dilated cardiomyopathy.

The current measurements were made at 1.9 to 2.0 T with two currently accepted techniques from patients who were carefully chosen on the basis of clinical criteria and from whom metabolic measurements could be made with good MRS signal-to-noise ratios. Standard corrections were applied, and data adjustment for partial saturation and blood contamination.
tion was performed. High magnetic field strengths of $\approx 4$ T offer further potential for increasing the sensitivity and scope of such studies. MR was assessed here with echocardiography but ultimately could be evaluated during combined conventional/tagging MRI and MRS examination.

In conclusion, $^{31}$P MRS demonstrates altered PCr/ATP in patients with MR. Lower PCr/ATP ratios are linked to echocardiographic indexes of severity, including systolic function and eccentric hypertrophy, and to symptoms of heart failure. The findings may reflect altered creatine homeostasis and may be helpful in the management of patients awaiting MVR.

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