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Longitudinal measures of deformation are associated with a composite measure of contractility derived from pressure–volume loop analysis in children

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Aims

The relationship between echocardiographic measures of left ventricular (LV) systolic function and reference-standard measures have not been assessed in children. The objective of this study was to assess the validity of echocardiographic indices of LV systolic function via direct comparison to a novel composite measure of contractility derived from pressure–volume loop (PVL) analysis.

Methods and results

Children with normal loading conditions undergoing routine left heart catheterization were prospectively enrolled. PVLs were obtained via conductance catheters. A composite invasive composite contractility index (ICCI) was developed using data reduction strategies to combine four measures of contractility derived from PVL analysis. Echocardiograms were performed immediately after PVL analysis under the same anesthetic conditions. Conventional and speckle-tracking echocardiographic measures of systolic function were measured. Of 24 patients, 18 patients were heart transplant recipients, 6 patients had a small patent ductus arteriosus or small coronary fistula. Mean age was 9.1 ± 5.6 years. Upon multivariable regression, longitudinal strain was associated with ICCI ($\beta = -0.54$, $P = 0.02$) while controlling for indices of preload, afterload, heart rate, and LV mass under baseline conditions. Ejection fraction and shortening fraction were associated with LV mass and load indices, but not contractility.

Conclusion

Speckle-tracking derived longitudinal strain is associated ICCI in children with normal loading conditions. Longitudinal measures of deformation appear to accurately assess LV contractility in children.

Keywords

speckle-tracking echocardiography • contractility • pressure–volume relations • systolic function

Introduction

The accurate assessment of left ventricular (LV) systolic function has long been a goal in paediatric echocardiography. This assessment is most often performed via the measurement of LV dimensions and volumes to calculate shortening fraction (SF) and ejection fraction (EF), respectively.1 In children at risk for heart failure, such as those with cardiomyopathies, cardiotoxicity, or metabolic diseases, the assessment of LV systolic function often entails the use of measures derived from tissue Doppler imaging (TDI) and speckle-tracking echocardiography (STE) that are purportedly more sensitive to changes in contractility than conventional measures.2–4 Some of these measures have been suggested to be load-independent measures of contractility.5,6 If true, these indices of LV systolic function have the potential to provide valuable insights into the natural history and results of medical and surgical interventions in children with heart failure. However, the relationship between these echocardiographic
measures and reference-standard measures of LV systolic function have not been assessed in children.

A number of reference-standard measures of LV systolic function are derived from pressure-volume loop (PVL) analysis. Left ventricular end-systolic elastance (Ees) is one such measure of myocardial contractility, defined as the slope of the end-systolic pressure–volume relationship. Some have attempted to use this index to validate echocardiographic measures of systolic function in animals and adults. However, using this index as a lone measure of contractility has a number of limitations. First, Ees is only one component of the end-systolic pressure–volume relationship. The other component, the ventricular volume at the point where the ventricular pressure equals 0 mmHg (V0), is also a measure of contractility. Both Ees and V0 must be interpreted simultaneously in order to accurately assess contractility. In addition, the assumption that Ees is linear at baseline equals 0 mmHg (derived from PVL analysis that included Ees, via direct comparison to a composite measure of contractility, and (v) significantly abnormal loading conditions (Qp:Qs > 1.5 or left ventricular outflow tract gradient > 15 mmHg). The protocol was approved by our institutional review board. Informed consent was obtained from the parent or legal guardian of minors or from the participants of age ≥ 18.

**Methods**

Children undergoing a clinically indicated diagnostic left heart catheterization at the Medical University of South Carolina were recruited prospectively. Exclusion criteria included: (i) Age > 21 years, (ii) medical status for which participation in the study presented more than minimal risk as determined by the attending physician, (iii) non-sinus rhythm, (iv) patients with right-sided cardiac patholgy (tetralogy of Fallot, atrial septal defect, etc.), and (v) significantly abnormal loading conditions (Qp:Qs > 1.5 or left ventricular outflow tract gradient > 15 mmHg). The protocol was approved by our institutional review board. Informed consent was obtained from the parent or legal guardian of minors or from the participants of age ≥ 18.

**Study catheterization and PVL analysis protocol**

We have described the pressure–volume loop acquisition in this cohort previously in a study validating echocardiographic estimates of Ees.
The distribution of data as parametric or non-parametric was assessed using the Shapiro–Wilk test. Differences between patient groups (heart transplant vs. non-heart transplant) were assessed using independent t-tests or Mann Whitney U tests. The correlation between echocardiographic measures of systolic function and the composite contractility index was assessed using Pearson’s correlation and corrected to avoid overfitting by bootstrap validation of 1000 repetitions. Multiple variable linear regression was used to assess the effects of load confounders on each echocardiographic measure of systolic function by entering each echocardiographic variable as the dependent variable, the ICCI as the independent variable, and LV mass, heart rate, the composite afterload indexes, and the composite preload index as covariables. Regression validation (outlier exclusion, residual homoscedasticity, and evaluation for significant interactions and nonlinearities) was performed for all models. Intra- and inter-observer variability was assessed using intraclass correlation coefficients. A P-value <0.05 was considered statistically significant. All statistics were performed using IBM® SPSS® Statistics software v. 23 (New York, NY, USA).

**Results**

Twenty-four patients were enrolled; 18 patients were status post heart transplant, 5 patients had a trivial or small patent ductus arteriosus, and one had a small coronary fistula. Patent ductus arteriosus and coronary fistula patients were referred for catheterization for intervention - all were successfully intervened upon. Heart transplant patients were referred for catheterization for their routine yearly assessment - no transplant patients had evidence of coronary artery disease or rejection. Demographic, clinical, and catheterization data from these patients, and a comparison between patients with heart transplant and those without, are presented in Table 1. Representative analyses of PVLs during preload reduction, and the derivative measures of contractility, are shown in Figure 1. Comparisons of less-conventional echocardiographic measures of ventricular function are reported in Supplementary data online, Appendix Table S1. Interobserver variability of the speckle-tracking measures are reported in Supplementary data online, Appendix Table S2.

### Statistics

In order to develop the ICCI from PVL indices, we integrated Ees, V₀, PRSW, and SCI into a synthetic surrogate of contractility using data reduction strategies via principal component analysis.20 This method of variable clustering simplifies regression modeling by avoiding the separate analysis of multiple factors that are theoretically measuring the same phenomenon. Thus, we calculated the ICCI as the first principal component of the principal component analysis based on the correlation matrix of Ees, V₀, PRSW, and SCI. The correlations between ICCI and each of its individual components were $r = 0.84$, $r = 0.87$, $r = 0.60$, and $r = 0.84$, respectively. A similar analysis was performed to assess preload and afterload as neither of these variables can be absolutely characterized by a single haemodynamic measurement.21 The composite index of preload was developed by integrating LV EDV and end-diastolic pressure using the same method. Correlation coefficients of these individual variables with the composite index of afterload were $r = 0.87$, $r = 0.89$, and $r = 0.92$, respectively.

The composite index of afterload was developed by integrating Ees, systemic vascular resistance, and wall stress. The correlation coefficients of these individual variables with the composite index of afterload were $r = 0.87$, $r = 0.89$, and $r = 0.92$, respectively.

### Table 1 Patient demographics and invasive data

<table>
<thead>
<tr>
<th></th>
<th>Heart transplant (n = 18)</th>
<th>Non-heart transplant (n = 6)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>10.0 ± 5.9</td>
<td>8.4 ± 5.6</td>
<td>0.56</td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>9 (50%)</td>
<td>3 (50%)</td>
<td>0.64</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>125 ± 33</td>
<td>138 ± 29</td>
<td>0.40</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>22.6 (35.0)</td>
<td>35.2 (43.3)</td>
<td>0.54</td>
</tr>
<tr>
<td>BSA (m²)</td>
<td>1.03 ± 0.47</td>
<td>1.16 ± 0.45</td>
<td>0.58</td>
</tr>
<tr>
<td>Systolic blood pressure (mmHg)</td>
<td>89 ± 9</td>
<td>87 ± 9</td>
<td>0.75</td>
</tr>
<tr>
<td>Diastolic blood pressure (mmHg)</td>
<td>46 ± 7</td>
<td>51 ± 8</td>
<td>0.23</td>
</tr>
<tr>
<td>Baseline heart rate (bpm)</td>
<td>87 ± 15</td>
<td>78 ± 25</td>
<td>0.28</td>
</tr>
<tr>
<td>Ejection fraction (%)</td>
<td>58.2 (7.6)</td>
<td>55.4 (16.8)</td>
<td>0.82</td>
</tr>
<tr>
<td>Shortening fraction (%)</td>
<td>30.4 (9.8)</td>
<td>31.2 (14.9)</td>
<td>0.77</td>
</tr>
<tr>
<td>LV mass (g)</td>
<td>31.9 (41.7)</td>
<td>51.1 (36.9)</td>
<td>0.35</td>
</tr>
<tr>
<td>EDP (mmHg)</td>
<td>10.9 ± 3.5</td>
<td>9.7 ± 3.0</td>
<td>0.45</td>
</tr>
<tr>
<td>Cardiac index (L/min/m²)</td>
<td>3.4 ± 1.0</td>
<td>3.7 ± 1.7</td>
<td>0.69</td>
</tr>
<tr>
<td>Measured (mmHg/mL)</td>
<td>74 ± 4</td>
<td>79 ± 7</td>
<td>0.09</td>
</tr>
<tr>
<td>Rp (Wood units)</td>
<td>1.9 (0.9)</td>
<td>1.0 (0.9)</td>
<td>0.02</td>
</tr>
<tr>
<td>Rs (Wood units)</td>
<td>19.5 (9.6)</td>
<td>19.2 (14.0)</td>
<td>0.67</td>
</tr>
<tr>
<td>Qp/Qs</td>
<td>1.0 (0)</td>
<td>1.0 (0.3)</td>
<td>0.45</td>
</tr>
<tr>
<td>Ees (mmHg/mL)</td>
<td>2.2 (3.3)</td>
<td>1.0 (2.1)</td>
<td>0.12</td>
</tr>
<tr>
<td>V₀ (mL)</td>
<td>-8.8 (29.9)</td>
<td>-26.8 (45.7)</td>
<td>0.28</td>
</tr>
<tr>
<td>PRSW (mmHg)</td>
<td>45.3 ± 19.7</td>
<td>38.6 ± 18.0</td>
<td>0.47</td>
</tr>
<tr>
<td>SCI (mmHg/s/mL)</td>
<td>8.6 (9.4)</td>
<td>7.4 (6.5)</td>
<td>0.58</td>
</tr>
<tr>
<td>Ea (mmHg/mL)</td>
<td>2.4 ± 0.9</td>
<td>1.6 ± 0.4</td>
<td>0.05</td>
</tr>
<tr>
<td>Ea/Ees</td>
<td>1.3 (0.9)</td>
<td>1.5 (1.5)</td>
<td>0.63</td>
</tr>
<tr>
<td>Preload composite</td>
<td>-0.05 ± 1.06</td>
<td>0.14 ± 0.88</td>
<td>0.71</td>
</tr>
<tr>
<td>Afterload composite</td>
<td>-0.08 ± 1.05</td>
<td>0.23 ± 0.88</td>
<td>0.53</td>
</tr>
<tr>
<td>Contractility composite</td>
<td>0.14 ± 0.95</td>
<td>-0.41 ± 1.13</td>
<td>0.25</td>
</tr>
</tbody>
</table>

Results reported as mean ± standard deviation for parametric data and median (interquartile range) for non-parametric data. BSA, body surface area; EDP, end-diastolic pressure; Ea, arterial elastance; Ees, end-systolic elastance; Measured, mixed venous oxygen saturation; PRSW, preload recruitable stroke work; Qp/Qs, ratio of pulmonary to systemic blood flow; Rp, pulmonary vascular resistance; Rs, systemic vascular resistance; SCI, Starling’s contractility index; V₀, ventricular volume at pressure of 0 mmHg.

### Correlations between echocardiographic measures of systolic function and contractility

Correlations between ICCI and echocardiographic measures of systolic function are reported in Table 2. Correlations between echocardiographic variables and the four invasive components of ICCI are reported in Supplementary data online, Appendix Table S3. Global longitudinal strain (Figure 2) and strain rate displayed the strongest correlations with ICCI. Global circumferential strain rate showed a significant, but weaker, correlation with ICCI. EesNI showed a moderate correlation with ICCI. Conventional measures of systolic function, EF and SF showed no significant correlation with ICCI. Advanced measures of systolic function derived from tissue Doppler (peak s', isovolumic contraction time, isovolumic acceleration slope) and VCFC vs. WS Z-score also showed no significant correlation with ICCI.
Load, mass, and heart rate effects on echocardiographic measures of systolic function

The association between echocardiographic measures of systolic function vs. composite measures of contractility, afterload, preload, LV mass, and heart rate derived from multiple variable linear regression are shown in Table 3. Variables that had no association with the composite measures (TDI lateral and septals’, lateral and septal isovolumic acceleration, and VCFZ Z-score) were not included in the table. LV longitudinal strain had a significant relationship with ICCI and no significant relationship with preload, afterload, LV mass, or heart rate. LV longitudinal strain rate was significantly associated with ICCI and LV mass. EF and SF were associated with load indices, but not contractility. Autocorrelations between echocardiographic measures of systolic function and composite measures of contractility, load, LV mass, and heart rate derived from principal component analysis are displayed graphically in Figure 3.

Discussion

This is the first study to comprehensively evaluate the association between echocardiographic measures of systolic function and a
composite measure of contractility derived from invasive PVL acquisition. The main finding of this study is that longitudinal strain derived from speckle-tracking echocardiography showed a moderate relationship with ICCI after accounting for preload, afterload, LV mass, and heart rate. In comparison, conventional measures, such as EF and shortening fraction, were significantly associated with load and LV mass.

The results of this study suggest that LV longitudinal strain is associated with contractility in children with normal loading conditions. This is in line with clinical studies suggesting longitudinal strain is a sensitive marker of early cardiac dysfunction and is associated with outcomes in disease processes known to impair contractility, such as chemotherapy cardiotoxicity, myocardial infarction, amyloidosis, etc. We found no significant relationship between longitudinal strain and load or LV mass. While it is clear from previous studies that longitudinal strain is influenced by acute changes in load, our findings suggest that, in the absence of acute loading changes, longitudinal strain is more closely related to contractility than load or LV mass under baseline conditions. As most patients are followed at their baseline state, longitudinal strain provides important insight into the contractile state of patients at risk for systolic dysfunction.

Few studies have compared echocardiographic vs. PVL measures of systolic function. Longitudinal measures of deformation have been associated with Ees in animals and in children with single ventricle physiology. Yotti et al. compared echocardiographic measures of LV systolic function and Ees in a cohort of adults. Similar to the current study, they found significant associations between conventional echocardiographic measures of LV systolic function and load. However, they found no association between longitudinal strain and Ees. There are number of potential explanations behind these discrepant results. First, longitudinal strain was only measured from the apical 4-chamber view, compared to the full 18 segment analysis performed in the current study. Second, speckle-tracking was also performed using different software packages, each of which uses a unique algorithm to calculate strain. It is conceivable that different speckle-tracking software vary in their accuracy when compared to invasive measures. Finally, similar to all previous studies assessing the correlation between echocardiographic and PVL measures of systolic function, Yotti et al. used Ees as the lone measure of systolic function. This may be problematic because in addition to Ees, \( V_0 \) is required when using the end-systolic pressure–volume relationship to assess contractility. For example, when comparing two patients with equal Ees, preload, and afterload, the patient with a lower \( V_0 \) displays better contractility.

**Limitations**

The ICCI is a composite measure derived from multiple reference-standard contractile indices, however, it has not been validated.
experimentally as a measure of contractility independently. Therefore, its load dependency, response to inotropy and heart rate are unknown. The study population was relatively small; our results may deserve validation in a larger cohort. The majority of our patients were status post heart transplantation, and therefore cannot be considered to have absolutely normal cardiac function or loading conditions. We did not perform repeated measures after a change in loading conditions or inotropic states to avoid further complexity in the PVL catheterization procedure. However, as most patients do not undergo acute changes in loading conditions during follow-up assessment in chronic disease states, we feel the most clinically relevant analysis was performed. To be applicable to the broader congenital heart disease population, further validation may be warranted to ensure that these associations hold after acute and chronic changes in loading conditions, contractile states, a broader range of heart rates, ventricular sizes, masses, and morphologies. The associations between these echocardiographic measures of systolic function and patient outcomes need to be separately assessed to determine their usefulness in children.

**Clinical implications**

The validation of echocardiographic measures of systolic function has the potential to provide important insights into disease progression and response to treatment in patients at risk for heart failure, including those patients with chemotherapy cardiotoxicity, familial or acquired cardiomyopathy, heart transplantation, and congenital heart disease. As new inotropic therapies are developed, using these echocardiographic measures to understand the relationship between the resultant changes in contractility, load, and LV mass may assist in the evaluation of these therapies’ efficacy.

Measures of myocardial deformation and Ees have been shown to be associated with mortality, B-type natriuretic peptide, and exercise performance in adults with cardiovascular disease. In addition, they can be used to elucidate the mechanism of improvement in heart failure symptoms after therapy. This is important in paediatrics because children with heart failure have not shown the same response to heart failure therapy as adults. Investigating these measures may allow us to gain insight into the pathophysiology behind the lack of efficacy of standard heart failure therapies in children.

**Conclusion**

We developed a composite invasive measure of contractility derived from PVL analysis, the ICCI. Speckle-tracking derived longitudinal strain is associated with the ICCI in children with normal loading conditions. This association is independent from loading conditions, LV mass, and heart rate under baseline conditions. Longitudinal measures of deformation appear to accurately assess LV contractility in children under baseline conditions.

**Supplementary data**

Supplementary data are available at European Heart Journal - Cardiovascular Imaging online.


