

Accidental Discovery of Isolated Left Ventricular Non-compaction Using Contrast Echocardiography

S Moustafa, D Auger, R Amyot, M Di Lorenzo

Citation

S Moustafa, D Auger, R Amyot, M Di Lorenzo. *Accidental Discovery of Isolated Left Ventricular Non-compaction Using Contrast Echocardiography*. The Internet Journal of Cardiology. 2008 Volume 6 Number 2.

Abstract

We describe a case of accidental discovery of isolated left ventricular non-compaction using contrast echocardiography

CASE REPORT

A 46-year-old woman presented with a 10-year history of dyspnea. In 1996, she had been diagnosed with non-obstructive hypertrophic cardiomyopathy with normal systolic function by transthoracic echocardiography (TTE). This was confirmed in 2000 by repeat TTE. In 2004, she developed repeated syncopal attacks and was diagnosed with non-sustained ventricular tachycardia and treated with amiodarone. Repeated TTE revealed no change from the previous studies. Subsequently, the patient symptoms worsened with severe progressive dyspnea (NYHA functional class = III/IV), palpitations and repeated syncope. Physical examination uncovered elevated jugular venous pressure with paradoxical S2 by auscultation. Her ECG demonstrated first degree heart block and left bundle branch block. Repeat TTE using second harmonic mode was technically difficult and probably showed concentric left ventricular (LV) hypertrophy with mild impairment of systolic function (Video 1). Multiple boluses of 0.1 to 0.2 mL of perflutren (Definity™, Bristol-Myers Squibb Medical Imaging, North Billerica, MA, USA) were administered intravenously to obtain a more detailed evaluation of these findings. This technique surprisingly revealed several prominent trabeculations and deep intertrabecular recesses which had a synchronous movement of contraction with ventricular myocardium. It also clearly

showed the direct communication between the interventricular spaces and LV cavity (Video 2). These findings are pathognomonic for left ventricular non-compaction (LVNC).

In this report, CE allowed for the diagnosis of LVNC that was missed for a decade. With CE, the LV endocardial borders are sharply demarcated allowing an optimal visualization of the prominent myocardial trabecular recesses, an intertrabecular flow from the LV cavity and an accurate diagnosis of LVNC.

VIDEOS

Video 1: Technically difficult TTE in apical 4-chamber view without CE probably showing concentric LV hypertrophy and mildly impaired LV systolic function.

Video 2: TTE in apical 4-chamber view with CE clearly showing excessive and prominent trabeculations of the LV

ADDRESS FOR CORRESPONDENCE

Maria Di Lorenzo, M.D, F.R.C.P.(C) Associate Professor,
University of Montreal Sacre-Coeur Hospital 5400 Boul.
Gouin W, Montreal, Quebec, H4J 1C5, Canada Tel: (514)
338-2222 ext 3809 Fax: (514) 338-2381 Email:
Mariadilorenzo@videotron.ca

References

Author Information

Sherif Moustafa, MD

Department of Cardiology, Sacre-Coeur Hospital, University of Montreal

Dominique Auger, MD

Department of Cardiology, Sacre-Coeur Hospital, University of Montreal

Robert Amyot, MD, FRCPC

Department of Cardiology, Sacre-Coeur Hospital, University of Montreal

Maria Di Lorenzo, MD, FRCPC

Department of Cardiology, Sacre-Coeur Hospital, University of Montreal