Extracellular Volume Detects Amyloidotic Cardiomyopathy and Correlates With Neurological Impairment in Transthyretin-familial Amyloidosis

María Gallego-Delgado, a,⁎ Esther González-López, a,b,◊ Francisco Muñoz-Beamud, c Juan Buades, d Lucía Galán, e José Luis Muñoz-Blanco, f Javier Sánchez-González, g,h Borja Ibáñez, h Jesus G. Mirelis, a,b and Pablo García-Pavía a,b,*

a Servicio de Cardiología, Hospital Universitario Puerta de Hierro, Madrid, Spain
b Área de Fisiopatología del Miocardio, Centro Nacional de Investigaciones Cardiovasculares (CNIC), Madrid, Spain
c Servicio de Medicina Interna, Hospital Juan Ramón Jiménez, Huelva, Spain
d Servicio de Medicina Interna, Hospital Son Llàtzer, Palma de Mallorca, Spain
e Servicio de Neurología, Hospital Clínico San Carlos, Madrid, Spain
f Servicio de Neurología, Hospital General Gregorio Marañón, Madrid, Spain
g Philips Healthcare Iberia, Madrid, Spain
h Unidad de Imagen Cardiaca Avanzada, Centro Nacional de Investigaciones Cardiovasculares (CNIC), Madrid, Spain

A B S T R A C T

Introduction and objectives: Cardiac involvement determines prognosis and treatment options in transthyretin-familial amyloidosis. Cardiac magnetic resonance T1 mapping techniques are useful to assess myocardial extracellular volume. This study hypothesized that myocardial extracellular volume allows identification of amyloidotic cardiomyopathy and correlates with the degree of neurological impairment in transthyretin-familial amyloidosis.

Methods: A total of 31 transthyretin-familial amyloidosis patients (19 mean age, 49 ± 12 years; 26 with the Val30Met mutation) underwent a T1 mapping cardiac magnetic resonance study and a neurological evaluation with Neuropathy Impairment Score of the Lower Limb score, Norfolk Quality of Life questionnaire, and Karnofsky index.

Results: Five patients had cardiac amyloidosis (all confirmed by 99mTc-DPD scintigraphy). Mean extracellular volume was increased in patients with cardiac amyloidosis (0.490 ± 0.131 vs 0.289 ± 0.035; P = .026). Extracellular volume correlated with age (R = 0.467; P = .008), N-terminal pro-B-type natriuretic peptide (R = 0.846; P < .001), maximum wall thickness (R = 0.621; P < .001), left ventricular mass index (R = 0.685; P < .001), left ventricular ejection fraction (R = 0.378; P = .036), Neuropathy Impairment Score of the Lower Limb (R = 0.604; P < .001), Norfolk Quality of Life questionnaire (R = 0.529; P < .003), and Karnofsky index (R = 0.517; P = .004). A cutoff value of extracellular volume of 0.357 was diagnostic of cardiac amyloidosis with 100% sensitivity and specificity (P < .001). Extracellular volume and N-terminal pro-B-type natriuretic peptide were the only cardiac parameters that significantly correlated with neurologic scores.

Conclusions: Extracellular volume quantification allows identification of cardiac amyloidosis and correlates with the degree of neurological impairment in transthyretin-familial amyloidosis. This noninvasive technique could be a useful tool for early diagnosis of cardiac amyloidosis and to track cardiac and extracardial amyloid disease.

© 2016 Sociedad Española de Cardiología. Published by Elsevier España, S.L.U. All rights reserved.

SEE RELATED ARTICLE:

⁎ Corresponding author: Servicio de Cardiología, Hospital Universitario Puerta de Hierro, Manuel de Falla 2, 28222 Majadahonda, Madrid, Spain.

E-mail addresses: JESUS.GMIRELIS@telefonica.net; pablogpavia@yahoo.es (P. García-Pavía).

◊ M. Gallego-Delgado and E. González-López contributed equally to this work.
El volumen extracelular detecta la amiloidosis cardíaca y está correlacionado con el deterioro neurológico en la amiloidosis familiar relacionada con la transtiretina

RESUMEN

Introducción y objetivos: La afección cardíaca determina el pronóstico y las opciones de tratamiento en la amiloidosis familiar relacionada con la transtiretina. Las técnicas de mapeo T1 de resonancia magnética cardíaca son útiles para determinar el volumen extracelular miocárdico. En este estudio se planteó la hipótesis de que el volumen extracelular miocárdico permite la identificación de la amiloidosis cardíaca y está correlacionado con el grado de deterioro neurológico en la amiloidosis familiar relacionada con la transtiretina.

Métodos: A un total de 31 pacientes con amiloidosis familiar relacionada con la transtiretina (19 varones; media de edad, 49 ± 12 años; 26 pacientes con la mutación Val30Met), se les realizaron estudios de mapeo T1 con resonancia magnética cardíaca y una evaluación neurológica con la Neurpathy Impairment Score of the Lower Limb, el cuestionario Norfolk Quality of Life y el índice de Karnofsky.

Resultados: Cinco pacientes tenían amiloidosis cardíaca (en todos los casos, confirmada mediante gammagrafía con $^{99m}$Tc-DPD). El valor medio del volumen extracelular estaba aumentado en los pacientes con amiloidosis cardíaca (0.490 ± 0.131 frente a 0.289 ± 0.035; p = 0.026). El volumen extracelular mostró correlación con la edad ($R = 0.467$; $p = 0.008$), fracción aminoterminal del propéptido natriurético tipo B ($R_s = 0.846$; $p < 0.001$), el grosor máximo de la pared ($R = 0.621$; $p < 0.001$), el índice de masa ventricular izquierda ($R = 0.685$; $p < 0.001$), la fracción de eyecisión del ventrículo izquierdo ($R = -0.378$; $p = 0.036$), la puntuación de la Neurpathy Impairment Score de la pierna ($R = 0.604$; $p < 0.001$), el cuestionario Norfolk-Question of Life ($R_s = 0.529$; $p = 0.003$) y el índice de Karnofsky ($R_s = -0.517$; $p = 0.004$). Se consideró que un valor de corte del volumen extracelular de 0.357 es diagnóstico de amiloidosis cardíaca con sensibilidad y especificidad del 100% ($p < 0.001$). El volumen extracelular y la fracción aminoterminal del propéptido natriurético tipo B son los únicos parámetros cardiaco que mostraron correlación significativa con las puntuaciones neurológicas.

Conclusiones: La cuantificación del volumen extracelular permite la identificación de la amiloidosis cardíaca y está correlacionada con el grado de deterioro neurológico en la amiloidosis familiar relacionada con la transtiretina. Esta técnica no invasiva puede ser un instrumento útil para el diagnóstico precoz de amiloidosis cardíaca y el seguimiento de la afección cardíaca extracardíaca.

© 2016 Sociedad Española de Cardiología. Publicado por Elsevier España, S.L.U. Todos los derechos reservados.

INTRODUCTION

Transtiretina (TTR) familial amiloidosis, also known as familial amyloid polyneuropathy (TTR-FAP), is an autosomal dominant inherited disorder caused by mutations in the TTR gene. The disorder, mutated TTR protein precipitates as extracellular amyloid deposits, mainly in peripheral nerves and in the heart. Although neurological impairment usually dominates clinical manifestations, heart involvement frequently determines the prognosis.

Available treatments for TTR-FAP include liver transplantation and the TTR stabilizer tafamidis. Several other compounds are under investigation with promising initial results. Currently, it is recommended to start drug therapy or proceed with liver transplantation when the first signs and symptoms of neurological impairment are identified.

Unfortunately, when the first symptoms appear, amyloid deposits could be large enough to compromise the patient’s clinical course thereafter. Methods to detect early amyloid deposits are therefore needed. Moreover, a method that quantifies the amount of amyloid in the tissues over time would be desirable to monitor treatment response and to establish a cutoff point to start treatment.

Amyloidotic cardiomyopathy (AC) is one of the leading causes of death in TTR-FAP patients and a significant number of TTR-FAP patients have underdetected cardiac involvement.

The definitive diagnosis of AC requires histological evidence of amyloid deposits; however, endomyocardial biopsy has associated risks and a noninvasive diagnostic approach with imaging techniques is commonly preferred. In patients with genetically confirmed TTR-FAP, AC is accepted in cases of unexplained increased ventricular thickness/mass and typical findings of AC either on $^{99m}$Tc-DPD scintigraphy or on cardiac magnetic resonance (CMR).

T1 mapping CMR techniques allow, through a simple equation, an estimate of the heart volume occupied by extracellular components. As TTR amyloid deposits are extracellular, cardiac extracellular volume (ECV) value reflects the amount of TTR amyloid deposits in the myocardium and could serve as a tool to diagnose AC and to monitor its progression. Furthermore, cardiac ECV could reflect the amount of amyloid deposits that are present in other tissues.

The purpose of this study was 2-fold: to determine if increased ECV allows the identification of AC in TTR-FAP patients, and to explore if cardiac ECV correlates with the degree of neurological impairment caused by TTR amyloid extracardiac deposits.

METHODS

Study Population

After approval from the institutional review board, 31 genetically proven TTR-FAP participants (19 men; mean age, 49 ± 12 years; 26 patients with the Val30Met mutation) were included.
Clinical Evaluation

All participants underwent a detailed clinical history and physical examination and provided a blood sample prior to CMR study. Creatinine, albumin, hematocrit and N-terminal pro-B-type natriuretic peptide (NT-proBNP) levels were determined. Orthostatic challenge was also investigated by examining lying-to-standing blood pressure changes.15

Neurological assessment was performed by a trained physician on the same day and included the following tests: Neuropathy Impairment Score-Lower limbs (NIS-LL) scale, Norfolk QOL-DN (Norfolk Quality of Life–Diabetic Neuropathy) questionnaire, and Karnofsky index. These scales were selected because of their low complexity and their use in previous TTR-FAP drug trials.6,7 The scales were applied by the same physician to reduce their variability. The NIS-LL (0 to 88) is the sum of score of motor, reflex and sensory (vibration, joint point position, and pinprick sensation of the index finger) functions in the lower limbs (firstly affected in TTR-FAP).16 A patient with no neurologic abnormalities would have a score of 0. Norfolk QOL-DN is a 35-item questionnaire (47 items in the Spanish version) arranged thematically into 5 domains: physical functioning/large fiber neuropathy, activities of daily living, symptoms, small fiber neuropathy, and autonomic neuropathy.17 The total quality of life score is the sum of all domains with a range from 0 (best quality of life) to 138 (worst possible quality of life). Karnofsky performance status reflects the overall health of the patient (normal 100 to 0).18 Neurological evaluation was not carried out in 2 patients because of the coexistence of other conditions affecting the lower limbs (poliomyelitis and spondylarthritis with radiculopathy). These 2 patients were not included in the statistical analysis of the neurological correlation with ECV or in the division by clinical subgroups. However, they were included in the analysis of cardiac parameters and none had AC.

Positive cardiac involvement was based on 99mTc-DPD scintigraphy and CMR findings. Amyloidotic cardiomyopathy was defined as the presence of biventricular intense tracer uptake (grade 2 or 3 as defined by Perugini et al)19 in patients with a 99mTc-DPD scintigraphy (22 participants). Amyloidotic cardiomyopathy was also considered if CMR showed left ventricular hypertrophy (LVH) (> 12 mm, in the absence of hypertension and valvular disease) plus rapid gadolinium wash out/typical amyloidotic late gadolinium enhancement (LGE) and biopsy-proven extracardiac amyloidosis.3–4,11,20 In 9 patients, scintigraphy was not available in the referring centers. For these patients, only data from the CMR were considered to define AC (Figure 1). For the statistical analysis, the included patients were divided into 3 groups according to their clinical status: asymptomatic mutation carrier (n = 5), neurological impairment with no AC (n = 19), and AC (n = 5). All patients with AC had also neurological impairment.

Cardiac Magnetic Resonance Protocol

All participants underwent a standard CMR study on a 3-T clinical scanner (Achieva, Philips Healthcare; Best, The Netherlands). A standard volume and LGE study was performed.21 Before contrast administration, T1 mapping sequences of the Modified Look-Locker Inversion Recovery (MOLLI) in short-axis geometry at a basal and mid-cavity level (2 sections) and 4-chambers (1 section) views were acquired. A 0.1 mmol/kg bolus of gadolinium-based contrast (gadopentetate dimeglumine, Magnevist, Bayer; Berlin, Germany) was administered and standard LGE images were acquired 15 min later. Next, gadolinium DTPA was administered through an infusion system at a rate of 0.00115 mmol/kg/min for at least 20 min to achieve blood-myocardial contrast equilibrium. After continuous infusion was completed, a new T1 mapping MOLLI image acquisition was undertaken, which allowed measurement of the change in T1 before and after a steady-state, as previously published.12 All CMR images and maps were analyzed offline in a workspace Philips platform (Philips; Best, The Netherlands).

Extracellular Volume Calculation

T1 maps where generated by nonlinear fitting of the signal intensity to the model previously proposed.22 The T1 value was the average of the complete T1 measurements at the basal and medium ventricular short axis views (complete myocardium ROI [region of interest]). Extreme values of ± 2 standard deviations of the mean T1 value of a ROI placed in the septum were automatically excluded. Cardiac extracellular volume was calculated as previously reported.12

![Figure 1. Cardiac amyloidosis diagnosis flowchart. CMR, cardiac magnetic resonance; LGE, late gadolinium enhancement; LVH, left ventricular hypertrophy.](image-url)
Examples of ECV values in an asymptomatic mutation carrier and in a patient with AC are shown in Figure 2.

**Statistical Analysis**

Categorical data are expressed as percentages and were compared using Fisher’s exact test. Normally distributed variables are expressed as the mean ± standard deviation while nonnormally distributed variables are expressed as the median [interquartile range]. For the statistical analysis, Student’s t test and Mann-Whitney nonparametric test were used in 2-group comparisons.

The correlation between variables was assessed using Pearson’s (R) or Spearman’s Rho (R_s) coefficient. A 1-way ANOVA (analysis of variance) or Kruskal-Wallis analysis was used to assess the correlation of continuous variables with clinical status. Statistical significance was defined as P < .05. The entire analysis was performed using the SPSS package, version 20.0.0 (IBM Corp.; Armonk, New York, United States).

**RESULTS**

Thirty-one patients (mean age, 49 ± 12 years [range, 34–71]; 19 men [61%]) with genetically diagnosed TTR-FAP were studied. The most common mutation was Val30Met (n = 26 [84%]). Other mutations were delV122 (n = 3 [10%]), Glu89Gln (n = 1 [3%]), and Glu89lys (n = 1 [3%]). Twenty-one patients (68%) came from the 2 Spanish Val30Met TTR-FAP endemic regions: Huelva (n = 14) and Mallorca (n = 7). Five participants (4 men) with a mean age of 40 ± 6 years were considered mutation carriers, defined as individuals with no evidence of disease. Mutations of asymptomatic genetic carriers were delV122 (n = 3), Glu89lys (n = 1), and Val30Met (n = 1).

Thirteen patients (42%) had undergone liver transplantation previously and no patient was receiving tafamidis when the CMR study was performed. All transplanted patients in this cohort were Val30Met and belonged to one of the endemic regions. None of them were in the subgroup of asymptomatic carriers as this treatment is only indicated when there are disease manifestations. However, only 1 of these patients had cardiac involvement.

Nineteen patients (61%) showed signs of isolated neurological impairment. Orthostatic hypotension was present in 9 patients (33%) and 12 patients (39%) had gastrointestinal disturbances (constipation/diarrhea). No patient reported urinary tract infections.

Five patients (4 men; mean age, 65 ± 8 years) were diagnosed with AC (Figure 1). Patients with AC were Val30Met (n = 4) and Glu89Gln (n = 1). All patients with AC showed also some degree of neurological impairment.

On CMR study, all patients with AC showed LVH and fast wash-out of gadolinium. The pattern of LGE in patients with AC was diverse: global transmural LGE (n = 2); transmural LGE except in lateral basal and middle segments (n = 1), nonischemic patched LGE (n = 1), and no LGE (n = 1). None of the patients with transmural LGE pattern had other features that suggested the existence of a previous myocardial infarction, such as wall motion abnormalities or thinning of the ventricular wall.

A summary of clinical features and CMR findings is presented in Table 1.

**Extracellular Volume and Clinical Features**

Mean ECV values increased across clinical groups: 0.242 ± 0.02, 0.296 ± 0.027 and 0.490 ± 0.130) for asymptomatic mutation carriers, only neurological symptoms, and AC, respectively (P < .001) (Figure 3). Inter- and intraobserver variability in ECV showed no significant differences (R = 0.66; P < .005 and R = 0.94; P < .005, respectively).

Although there was a direct correlation between ECV and age (Table 2), we found no differences in mean ECV by sex (male, 0.325 ± 0.103 vs female, 0.316 ± 0.085; P = .794), cardiovascular risk factors (hypertension 0.357 ± 0.125 vs no hypertension 0.307 ± 0.078; P = .184; and diabetes 0.305 ± 0.000 vs no diabetes 0.322 ± 0.096; P = .864) or type of mutation (Val30Met 0.324 ± 0.084 vs other mutations 0.309 ± 0.151; P = .752).

**Extracellular Volume and Cardiac Parameters**

Extracellular volume correlated with several cardiac parameters (Table 2). Cardiac ECV correlated directly with indexed left ventricular mass, left ventricle maximum wall thickness, right ventricular thickness, and indexed left atrial area/volume and NT-proBNP. Extracellular volume also correlated inversely with left ventricular ejection fraction (Table 2); however, the strongest correlation occurred with NT-proBNP (R_s = 0.820; P < .001).

Cardiac ECV and T_1 native values were significantly higher in patients with positive LGE (0.522 ± 0.126 vs 0.292 ± 0.037; P = .034, and 1283 ± 35 vs 1188 ± 49 ms; P = .007, respectively) and with rapid
Table 1
Clinical Characteristics, Neurological Involvement and Cardiac Magnetic Resonance Findings

<table>
<thead>
<tr>
<th></th>
<th>Study population (n = 31)</th>
<th>No cardiac amyloidosis (n = 26)</th>
<th>Cardiac amyloidosis (n = 5)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>19 (61)</td>
<td>15 (58)</td>
<td>4 (80)</td>
<td>.624</td>
</tr>
<tr>
<td>Age, y</td>
<td>49 ± 12</td>
<td>46 ± 11</td>
<td>65 ± 8</td>
<td>.001</td>
</tr>
<tr>
<td>Val30Met</td>
<td>26 (84)</td>
<td>22 (85)</td>
<td>4 (80)</td>
<td>1.000</td>
</tr>
<tr>
<td>Endemic region</td>
<td>21 (68)</td>
<td>19 (73)</td>
<td>2 (40)</td>
<td>.296</td>
</tr>
<tr>
<td>Hypertension</td>
<td>9 (29)</td>
<td>6 (23)</td>
<td>3 (60)</td>
<td>.131</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1 (3)</td>
<td>1 (4)</td>
<td>0 (0)</td>
<td>1.000</td>
</tr>
<tr>
<td>disease duration, months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GI disturbances</td>
<td>12 (39)</td>
<td>10 (38)</td>
<td>2 (40)</td>
<td>1.000</td>
</tr>
<tr>
<td>Orthostatic hypotension</td>
<td>9 (30)</td>
<td>5 (20)</td>
<td>4 (80)</td>
<td>.019</td>
</tr>
<tr>
<td>Liver transplantation</td>
<td>13 (42)</td>
<td>12 (46)</td>
<td>1 (20)</td>
<td>.368</td>
</tr>
<tr>
<td>nBMI, kg/m²</td>
<td>1074 ± 199</td>
<td>1071 ± 209</td>
<td>1086 ± 175</td>
<td>.884</td>
</tr>
<tr>
<td>Creatinine clearance, mL/min</td>
<td>105 ± 30</td>
<td>111 ± 29</td>
<td>77 ± 12</td>
<td>.016</td>
</tr>
<tr>
<td>NT-proBNP, pg/mL</td>
<td>113 [36-203]</td>
<td>49 [30-147]</td>
<td>873 [387-1285]</td>
<td>.001</td>
</tr>
<tr>
<td>Neurologic scores</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norfolk QOL</td>
<td>34 [10-50]</td>
<td>20 [0-40]</td>
<td>50 [34-51]</td>
<td>.052</td>
</tr>
<tr>
<td>Karnofsky</td>
<td>90 [80-100]</td>
<td>90 [90-100]</td>
<td>80 [60-90]</td>
<td>.035</td>
</tr>
<tr>
<td>CMR parameters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LVEF, %</td>
<td>62 ± 5</td>
<td>63 ± 4</td>
<td>58 ± 7</td>
<td>.242</td>
</tr>
<tr>
<td>LVEDVi, ml/m²</td>
<td>63 ± 13</td>
<td>64 ± 13</td>
<td>60 ± 8</td>
<td>.545</td>
</tr>
<tr>
<td>LVESVi, ml/m²</td>
<td>24 ± 6</td>
<td>24 ± 6</td>
<td>25 ± 5</td>
<td>.715</td>
</tr>
<tr>
<td>LAVI, ml/m²</td>
<td>36 ± 9</td>
<td>35 ± 9</td>
<td>44 ± 9</td>
<td>.047</td>
</tr>
<tr>
<td>LVMI, g/m³</td>
<td>75 ± 26</td>
<td>67 ± 16</td>
<td>121 ± 23</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>LVMWT, mm</td>
<td>12 ± 4</td>
<td>11 ± 2</td>
<td>19 ± 3</td>
<td>.003</td>
</tr>
<tr>
<td>RVWT, mm</td>
<td>3.7 ± 1</td>
<td>3.5 ± 0.6</td>
<td>5.0 ± 1.6</td>
<td>.095</td>
</tr>
<tr>
<td>T1 native, ms</td>
<td>1197 ± 54</td>
<td>1184 ± 47</td>
<td>1265 ± 31</td>
<td>.001</td>
</tr>
<tr>
<td>Cardiac ECV</td>
<td>0.321 ± 0.095</td>
<td>0.289 ± 0.035</td>
<td>0.490 ± 0.131</td>
<td>.026</td>
</tr>
</tbody>
</table>

CMR, cardiac magnetic resonance; ECV, extracellular volume; GI, gastrointestinal; nBMI, modified body mass index; LAVI, left atrial volume index; LVEF, left ventricular ejection fraction; LVEDVi, left ventricular end-diastolic volume indexed; LVESVi, left ventricular end-systolic volume indexed; LVMI, left ventricular mass indexed; LVMWT, left ventricular maximum wall thickness; NIS-LL, Neuropathy Impairment Score-Lower Limbs; NT-proBNP, N-terminal pro-B-type natriuretic peptide; QOL, Quality of Life; RVWT, right ventricular wall thickness.

Data are expressed as no. (%), mean ± standard deviation or median [interquartile range].

gadolinium kinetics (0.461 ± 0.137 vs 0.288 ± 0.036; P = .027, and 1264 ± 27 vs 1181 ± 45 ms; P < .001, respectively).

All patients with AC showed increased ECV values. Mean ECV was increased in patients with AC vs patients without AC.

Figure 3. Cardiac ECV according to TTR-FAP clinical status. ECV, extracellular volume; TTR-FAP, transthyretin-familial amyloid polyneuropathy.

Table 2
Correlations of Myocardial Extracellular Volume With Diverse Parameters

<table>
<thead>
<tr>
<th></th>
<th>ECV</th>
<th>R</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.467</td>
<td>.&lt;.1</td>
<td>.364</td>
</tr>
<tr>
<td>mBMI</td>
<td>−0.185</td>
<td>.&lt;.1</td>
<td>.364</td>
</tr>
<tr>
<td>Symptomatic disease</td>
<td>0.366</td>
<td>.&lt;.5</td>
<td>.01</td>
</tr>
<tr>
<td>LV maximum wall thickness</td>
<td>0.621</td>
<td>.&lt;.1</td>
<td></td>
</tr>
<tr>
<td>RV thickness</td>
<td>0.440</td>
<td>.&lt;.5</td>
<td>.01</td>
</tr>
<tr>
<td>LV mass indexed</td>
<td>0.685</td>
<td>.&lt;.1</td>
<td>.01</td>
</tr>
<tr>
<td>LVEDVi</td>
<td>0.018</td>
<td>.925</td>
<td>.01</td>
</tr>
<tr>
<td>LVESVi</td>
<td>0.143</td>
<td>.442</td>
<td></td>
</tr>
<tr>
<td>LVEF</td>
<td>−0.378</td>
<td>.&lt;.5</td>
<td>.01</td>
</tr>
<tr>
<td>LA area index</td>
<td>0.592</td>
<td>.&lt;.1</td>
<td>.01</td>
</tr>
<tr>
<td>LA volume index</td>
<td>0.418</td>
<td>.&lt;.5</td>
<td>.01</td>
</tr>
<tr>
<td>NT-proBNP</td>
<td>0.820</td>
<td>.&lt;.1</td>
<td></td>
</tr>
<tr>
<td>NIS-LL</td>
<td>0.604</td>
<td>.&lt;.1</td>
<td>.01</td>
</tr>
<tr>
<td>Norfolk QOL</td>
<td>0.529</td>
<td>.&lt;.1</td>
<td>.01</td>
</tr>
<tr>
<td>Karnofsky</td>
<td>−0.517</td>
<td>.&lt;.1</td>
<td>.01</td>
</tr>
</tbody>
</table>

ECV, extracellular volume; LA, left atrium; LV, left ventricle; LVEDVi, left ventricular end-diastolic volume indexed; LVEF, left ventricular ejection fraction; LVESVi, left ventricular end-systolic volume indexed; mBMI, modified body mass index; NT-proBNP, N-terminal pro-B-type natriuretic peptide; NIS-LL, Neuropathy Impairment Score-Lower Limbs; QOL, quality of life; RV, right ventricle.

* Rho Spearman coefficient. R represents Pearson correlation coefficient except in variables with asterisk.
would be particularly useful in TTR-FAP. Furthermore, despite recent advances in noninvasive techniques, the diagnosis of AC is still challenging, and characteristic and easily recognizable features are often found only at advanced stages.\textsuperscript{2,11} If our findings are confirmed by additional studies, ECV could be extremely useful to diagnose early cardiac involvement in TTR-FAP.

Calculation of ECV by CMR and T\textsubscript{1} mapping techniques have the potential to become the method of choice for objective amyloid quantification in TTR-FAP. T\textsubscript{1} mapping has already shown its usefulness in the differential diagnosis of LVH and both ECV and T\textsubscript{1} native values have been reported to be higher in patients with AC than in healthy controls, patients with hypertrophic cardiomyopathy, and those with severe aortic stenosis.\textsuperscript{13}

To date, ECV has been studied in a AC setting mainly in AL (amyloid light-chain) amyloidosis patients.\textsuperscript{25–28} The first ECV values of cardiac involvement in amyloidosis were published by Sado et al\textsuperscript{13} in 27 cardiac AL amyloidosis patients using a 1.5T scanner and a fast low-angle single-shot inversion recovery (FLASH IR) sequence at increasing inversion times from 140 to 900 ms to allow quantification of T\textsubscript{1}. That study revealed a dramatic difference in ECV between AC patients and patients with other cardiac conditions.\textsuperscript{13} Later, several other groups reported their experience mainly in AL amyloidosis and also with a 1.5T scanner.\textsuperscript{25–28} The reported ECV values ranged between 0.44 ± 0.12 and 0.46 ± 0.07. Some of the published data for AL amyloidosis were reported on the basis of T\textsubscript{1} values, with precontrast T\textsubscript{1} times of 1140 ± 61,\textsuperscript{27} 1130 ± 68,\textsuperscript{28} and 1080 ± 87\textsuperscript{28} in a 1.5T scanner with a ShMOLLI sequence. Thus far, only 1 group has reported their experience in ATTR (amyloidogenic transthyretin) AC, but only precontrast T\textsubscript{1} values were reported.\textsuperscript{25} In that study, a group of 85 patients with ATTR (35 with hereditary ATTR) showed a native T\textsubscript{1} time of 1097 ± 43 ms and ECV data were not reported. Considering prior ECV data, our ECV results in TTR-FAP patients with cardiac involvement, 0.490 ± 0.131, are in agreement with previous reports on AL cardiac amyloidosis.

In our cohort, an ECV value of 0.357 was diagnostic of AC with 100% sensitivity and specificity. Studies with a larger sample size are needed to adequately address the spectrum of ECV in this disease and to determine the best diagnostic cutoff value.

That ECV accurately reflects cardiac involvement in TTR-FAP is further supported in our study by the fact that ECV correlated with several cardiac parameters and very strongly with NT-proBNP values (R\textsubscript{p} = 0.820; P < .001). The NT-proBNP has been reported as a prognostic factor in AL amyloidosis,\textsuperscript{25} but there are limited data in TTR amyloidosis.\textsuperscript{10,30} Recent evidence suggests that NT-proBNP and change in LV mass are markers of disease progression in TTR-FAP patients.\textsuperscript{31,32}

Finally, our study has shown that ECV correlates with neurological involvement in TTR-FAP patients and that ECV progresses across the disease spectrum of the condition. These findings support the concept that ECV monitoring of amyloid burden could be possible in TTR-FAP patients as has already been reported in murine models.\textsuperscript{31}

As discussed before, liver transplantation is a therapeutic alternative for these patients that avoids the production of amylogenic protein. Only 1 of the 13 liver transplanted patients in our study had evidence of AC. The “protective cardiac effect” of liver transplantation in these individuals could be argued based on our results, but we believe that prospective studies with a larger sample size are still needed to determine the usefulness of ECV in monitoring the different treatments for ATTR-FAP.

Finally, ECV is a promising tool for human research and could be used as a surrogate marker of the response to new compounds, facilitating the performance of clinical trials in a rare disease. From a clinical viewpoint, ECV could be used to monitor drug response
and to help with decision-making on liver transplantation, even though simple amyloid burden quantification may not reflect the unique pathological mechanism of amyloidosis.

**Limitations**

This study is limited by its modest patient size, despite its multicenter nature. The TTR-FAP is a rare disease and conduction disorders requiring a pacemaker and nephropathy are not infrequent complications of this disease, limiting CMR research studies. Further studies in larger patient series with diverse mutations will be needed to confirm our findings.

Another limitation of our study is the absence of endomyocardial biopsies to confirm AC. Endomyocardial biopsies implies some risks and therefore AC is currently accepted in TTR-FAP patients, in the presence of a pathogenic mutation and findings suggestive of AC on cardiac imaging tests.\(^3\) In particular, the 5 patients with AC in our study had typical findings of heart involvement both on CMR and scintigraphy (Figure 1).

Some patients in our study had hypertension or diabetes. These cardiovascular risk factors were not considered exclusion criteria as in previous studies in the field,\(^{25-26}\) although we cannot rule out their influence on ECV.

Cardiac ECV is likely to correlate with the burden of cardiac involvement in AC but this still needs to be proven with biopsy or autopsy findings. Although \(T_1\) mapping techniques in 3T scanners have been previously validated in healthy volunteers,\(^{26-28}\) there are few data on 3T ECV values in amyloidosis.

Finally, a significant portion of patients had undergone liver transplantation and the impact on cardiac involvement of this therapy is unknown.

**CONCLUSIONS**

Cardiac ECV quantification by CMR allows identification of AC and correlates with the degree of neurological impairment in TTR-FAP patients. Furthermore, ECV increases across the disease spectrum of the condition. This noninvasive technique could become a highly useful tool for early diagnosis of AC and to track cardiac and extracardiac amyloid deposits in this disease if our findings are confirmed by additional studies.

**ACKNOWLEDGMENTS**

We gratefully acknowledge Kenneth McCreath for English editing and Noemi Escalera, Maite Dubraska, Angel Macias, and Braulio Perez for their excellent technical assistance.

**FUNDING**

This work was partially funded by a research grant from Fundación Mutua Madrileña and by Instituto de Salud Carlos III (RD12/0042/0066 and RD12/0042/0054). Grants are supported by the Plan Estatal de Investigación Científica y Técnica y de Innovación 2013-2016 and the European Regional Development Fund “A way of making Europe”.

**CONFLICTS OF INTEREST**

J. Sánchez-González is an employee of Philips.

**WHAT IS KNOWN ABOUT THE TOPIC?**

- Hereditary transthyretin amyloidosis is a rare disease in which deposits increase progressively involving mainly the nerves and the heart. Cardiological and neurological tests to monitor disease progression have several limitations.
- New tissue characterization techniques in CMR are particularly interesting in amyloidosis as they allow quantification of extracellular space and amyloid deposits. Native \(T_1\) and ECV values are reported to be higher in cardiac amyloidosis than in healthy controls and other causes of hypertrophy.
- Cardiac ECV values are reported to correlate with cardiac parameters in other types of cardiac amyloidosis such as AL amyloidosis.

**WHAT DOES THIS STUDY ADD?**

- The present study shows that ECV values enable the identification of cardiac involvement among patients with hereditary transthyretin amyloidosis.
- Cardiac ECV values increase across the severity of the disease.
- This is the first study that demonstrates cardiac ECV correlation with the neurological manifestations of the condition.
- These results suggest the capability of ECV to be used as a tool to diagnose the disease, monitor disease progression, and evaluate treatment response.

**REFERENCES**


