


Isolated left ventricular apical hypoplasia

Carlos Galvão Braga1*, Paulo Silva2,3, Sónia Magalhães1, Nuno Bettencourt4,5, and Raquel Themudo4,6

1Department of Cardiology, Hospital de Braga, Braga, Sete Fontes – São Victor, 4710-243, Portugal; 2Clínica Jácome, Famalicão, Portugal; 3Hospital de Dia de Famalicão, Famalicão, Portugal; 4Hospital Privado de Alfena, Alfena, Portugal; 5Department of Cardiology, Centro Hospitalar de Vila Nova de Gaia-Espinho, VN Gaia, Portugal; and 6Department of Radiology, Karolinska University Hospital, Stockholm, Sweden

* Corresponding author. Tel: +351 915301245. E-mail: carlos.galvaobraga@gmail.com

A 66-year-old woman with hypertension, dyslipidaemia and history of stable angina was referred for cardiological assessment after a transthoracic echocardiogram raising the suspicion of right ventricular arrhythmogenic dysplasia. The patient reported atypical chest pain. The 12-lead electrocardiogram showed sinus rhythm with a complete left bundle branch block. The echocardiogram was repeated and demonstrated mild left ventricular (LV) systolic dysfunction with apical hypokinesia, abnormal interventricular septal motion and elongated right ventricle (RV). A myocardial perfusion scan showed a small fixed apical attenuation defect and absence of reversible ischaemia. To clarify diagnosis, cardiac MRI was performed and demonstrated the four phenotypical features of isolated LV apical hypoplasia: a bizarre LV with spherical configuration, truncated apex, interventricular septum bulging to the right and impaired systolic function (ejection fraction of 48%; Panel A and Supplementary data online Video S1); elongated RV wrapping around the deficient LV apex (*, Panel A; Supplementary data online Video S1); anomalous origin of anterior LV papillary muscle from the LV apex (*, Panel B); and replacement of the LV apex with fatty material [arrows, Panels B and C, which represent T1-weighted black-blood images without and with fat suppression (STIR) in four-chamber view, respectively], in this case with extension to the mesocardium of anterior, lateral and inferior midwall segments and continuity with the epicardial fat (arrow, Panel D, which represents cine-balanced steady-state-free precession in three-chamber view).

Isolated LV apical hypoplasia is a rare entity and MRI provides an excellent method to completely characterize the disease and evaluate the extent of myocardial fat replacement.

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

Published on behalf of the European Society of Cardiology. All rights reserved. © The Author 2014. For permissions please email: Journals.permissions@oup.com.