Diastolic Mitral Regurgitation
Haemodynamic and Angiographic Correlation

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A better understanding of the factors involved in ensuring competence of the mitral valve based on knowledge of the function of the leaflets, chordae tendineae, and papillary muscles has expanded the clinical range of systolic mitral regurgitation. For all this, diastolic mitral regurgitation remains a curiosity. Late diastolic mitral regurgitation has been described together with reversal of the left atrioventricular pressure gradient in experimental and clinical studies (Williams et al., 1968; Rutishauser et al., 1966; Lochaya, Igarashi, and Shaffer, 1967). In these reports the mitral valve was established or judged to be normal, and, therefore, in-complete closure of the valve was a causal factor of mitral regurgitation. A diseased mitral valve unable to close tightly during systole might be regurgitant during diastole as well if left ventricular pressure were to exceed left atrial pressure. In the past year we have recognized systolic and diastolic reflux across abnormal mitral valves in 4 patients who represent a spectrum of valvular heart disease. We wish to present the haemodynamic and angiographic evidence for diastolic mitral regurgitation. Its incidence in 4 of 50 consecutive patients studied for rheumatic heart disease is frequent enough to make it something to consider in any patient with mitral valve disease.

SUBJECTS AND METHODS

Each patient was selected for pre-operative cardiac catheterization on the basis of his clinical condition. The need for premedication was decided individually, and Cases 1, 2, and 3 received hydroxyzine hydrochloride (“Vistaril” 100 mg.) intramuscularly before the study. Right heart catheterization was performed using No. 7 Goodale-Lubin catheters passed from an antecubital vein. The left heart was catheterized with No. 8 Lehman or Gensini catheters introduced from a brachial arteriotomy or percutaneously from a femoral artery. Cardiac output was determined from either duplicate indocyanine-dilution curves or by the Fick method. Simultaneous pulmonary artery wedge and left ventricular pressures were measured immediately before and within two minutes after the injection of contrast media for angiography. The pressures were obtained using Statham P23D strain-gauges and were recorded by a Sanborn multichannel photographic recorder. The calibrations and sensitivities of the gauges were matched; and the zero levels of each gauge were referred to the mid-chest plane. Baselines were checked against the zero reference before and during each recording. Left ventriculograms were obtained on 35 mm. cinefilm at 30 or 60 frames per second with the patient lying in the right anterior oblique plane. Aortograms were taken with the same technique with the patient lying in the left anterior oblique position. Injections of 70 to 100 ml. of 76 per cent Hypaque were used for each exposure and were delivered in 2 to 3 seconds with a Cordis injector.

RESULTS

In Table I the pertinent clinical data are summarized, and anatomical findings observed at open heart operation are indicated.

The reported auscultatory findings represent the agreed observations of several examiners. All the patients had atrial fibrillation.

At operation the mitral valves showed typical rheumatic changes with shrunken leaflets. In Case 1 the anterior leaflet was flail; in Cases 2 and 3 the valve was stenotic as well as regurgitant. All 3 patients required mitral and aortic valve prostheses. Operation was not recommended at the time of study for Case 4.

The catheterization and angiography data are listed in Table II. Two sets of heart rates and pressures are given for each patient. The upper sets are averaged values observed before the ven-
### TABLE I

**DIASTOLIC MITRAL REGURGITATION—CLINICAL AND SURGICAL FINDINGS**

<table>
<thead>
<tr>
<th>Case No., sex, age</th>
<th>Aetiology</th>
<th>Final diagnoses</th>
<th>Functional class</th>
<th>Auscultatory findings</th>
<th>Electrocardiograms</th>
<th>Surgical findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 M 43</td>
<td>Rheumatic heart disease</td>
<td>Aortic and mitral regurgitation</td>
<td>III–IV</td>
<td>S1 accentuated and palpable, S2 single and loud, S3, opening snap inconstant, ASM 1/6, ADM 3/6, MSM 2/6, MDM 2/6</td>
<td>Atrial fibrillation, QRS-60°, left ventricular hypertrophy, digitalis effect</td>
<td>Mitral valve: attenuation of both leaflets, fixed anterior leaflet, nodular edges, no calcium</td>
</tr>
<tr>
<td>2 M 41</td>
<td>&quot;</td>
<td>&quot;</td>
<td>III</td>
<td>S1 normal intensity, aortic closure absent, S2, no opening snap, ASM 4/6, ADM 3/6, MDM 1/6</td>
<td>Atrial fibrillation, QRS + 30°, digitalis effect</td>
<td>Mitral valve: fibrosis and heavy calcification of both leaflets, area 1-25 cm²</td>
</tr>
<tr>
<td>3 M 34</td>
<td>&quot;</td>
<td>&quot;</td>
<td>III</td>
<td>S1 diminished, aortic closure absent, pulmonary closure loud, S2, no opening snap, ASM 4/6, ADM 3/6, MSM 2/6, MDM 1/6</td>
<td>Atrial fibrillation, QRS + 75°, left ventricular hypertrophy, digitalis effect</td>
<td>Mitral valve: fibrotic, thickened, and stenotic</td>
</tr>
<tr>
<td>4 M 44</td>
<td>&quot;</td>
<td>Mitral regurgitation</td>
<td>II-III</td>
<td>S1 normal intensity, S2 widely split, pulmonary closure accentuated, S3, no opening snap, MSM 3/6, MDM 2/6, ASM 1/6 transmitted? no ADM</td>
<td>Atrial fibrillation, QRS + 60°; tall R waves, digitalis effect</td>
<td>Operation not performed</td>
</tr>
</tbody>
</table>

ASM, aortic systolic murmur; ADM, aortic diastolic murmur; MSM, mitral systolic murmur; MDM, mitral diastolic murmur; QRS, mean axis in frontal plane.

### TABLE II

**DIASTOLIC MITRAL REGURGITATION—CATHETERIZATION AND ANGIOGRAPHY FINDINGS**

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Body surface area (m²)</th>
<th>Cardiac index (l/min/m²)</th>
<th>Heart rate* (beats/min.)</th>
<th>Pressures (mm Hg)</th>
<th>Angiograms†</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2-14</td>
<td>1-7</td>
<td>67 72</td>
<td>18</td>
<td>86/25</td>
</tr>
<tr>
<td>2</td>
<td>1-80</td>
<td>2-4</td>
<td>48 56</td>
<td>14</td>
<td>57/8</td>
</tr>
<tr>
<td>3</td>
<td>1-80</td>
<td>2-4</td>
<td>54 53</td>
<td>5</td>
<td>36/4</td>
</tr>
<tr>
<td>4</td>
<td>1-66</td>
<td>2-5</td>
<td>81 83</td>
<td>6</td>
<td>31/5</td>
</tr>
</tbody>
</table>

* Figures in left hand column refer to heart rates during left ventricular opacification.
† Chamber volume and severity of valvular regurgitation are graded on 1+ to 4+ scale.
‡ Brachial arterial pressure.

Diastolic Mitral Regurgitation

Diastolic Mitral Regurgitation

Mitral regurgitation may be diastolic, occurring during ventricular relaxation, or systolic, occurring during ventricular contraction. The former is more common. It may be caused by aortic or mitral valve disease, pericardial effusion, or other conditions.

1. **Diastolic Mitral Regurgitation**

   - **Clinical Findings**
     - Auscultatory findings: S3, early diastolic murmur, systolic and diastolic regurgitation, and pulmonary artery pressure.  
     - Electrocardiograms: Left atrial appendage, atrial fibrillation, left atrioventricular block, and left atrioventricular block.

   - **Surgical Findings**
     - Mitral valve closure.

2. **Diastolic Aortic Regurgitation**

   - **Clinical Findings**
     - Auscultatory findings: S3, early diastolic murmur, and pulmonary artery pressure.  
     - Electrocardiograms: Atrial fibrillation, atrial flutter, and left atrioventricular block.

   - **Surgical Findings**
     - Aortic valve closure.

3. **Diastolic Pulmonic Regurgitation**

   - **Clinical Findings**
     - Auscultatory findings: S3, early diastolic murmur, and pulmonary artery pressure.  
     - Electrocardiograms: Atrial fibrillation, atrial flutter, and left atrioventricular block.

   - **Surgical Findings**
     - Pulmonic valve closure.

4. **Diastolic Tricuspid Regurgitation**

   - **Clinical Findings**
     - Auscultatory findings: S3, early diastolic murmur, and pulmonary artery pressure.  
     - Electrocardiograms: Atrial fibrillation, atrial flutter, and left atrioventricular block.

   - **Surgical Findings**
     - Tricuspid valve closure.

**Diastolic Mitral Regurgitation**

Mitral regurgitation may be diastolic, occurring during ventricular relaxation, or systolic, occurring during ventricular contraction. The former is more common. It may be caused by aortic or mitral valve disease, pericardial effusion, or other conditions.

1. **Diastolic Mitral Regurgitation**

   - **Clinical Findings**
     - Auscultatory findings: S3, early diastolic murmur, systolic and diastolic regurgitation, and pulmonary artery pressure.  
     - Electrocardiograms: Left atrial appendage, atrial fibrillation, left atrioventricular block, and left atrioventricular block.

   - **Surgical Findings**
     - Mitral valve closure.

2. **Diastolic Aortic Regurgitation**

   - **Clinical Findings**
     - Auscultatory findings: S3, early diastolic murmur, and pulmonary artery pressure.  
     - Electrocardiograms: Atrial fibrillation, atrial flutter, and left atrioventricular block.

   - **Surgical Findings**
     - Aortic valve closure.

3. **Diastolic Pulmonic Regurgitation**

   - **Clinical Findings**
     - Auscultatory findings: S3, early diastolic murmur, and pulmonary artery pressure.  
     - Electrocardiograms: Atrial fibrillation, atrial flutter, and left atrioventricular block.

   - **Surgical Findings**
     - Pulmonic valve closure.

4. **Diastolic Tricuspid Regurgitation**

   - **Clinical Findings**
     - Auscultatory findings: S3, early diastolic murmur, and pulmonary artery pressure.  
     - Electrocardiograms: Atrial fibrillation, atrial flutter, and left atrioventricular block.

   - **Surgical Findings**
     - Tricuspid valve closure.
sisted after angiography in Cases 1 and 4. In Case 2, though the post-injection pulmonary artery wedge pressure was not recorded, the reversed atrio-ventricular gradient probably remained in view of the continued slow heart rate and extremely high end-diastolic pressure of 44 mm. Hg. In Case 3 only, the heart rate accelerated after the angiographic study and pulmonary artery wedge pressure increased, producing a forward mitral gradient which persisted throughout diastole.

Angiographic estimation of left ventricular and left atrial volumes revealed a variation from marked enlargement in Case 1 to slight enlargement in Case 4. Aortic valvular regurgitation was shown in 3 patients but was severe only in Case 1. In Case 4 an aortogram was not performed because aortic regurgitation was clinically absent. Systolic mitral regurgitation occurred in all 4 patients and was minimal to moderate. In all patients a small but definite jet of contrast media regurgitated across the mitral valve during late diastole in one to five cardiac cycles, and was not associated with ventricular premature beats. In Case 2, the diastolic regurgitant jet appeared to be larger than the systolic jet. The heart rates during ventricular opacification, translated from mean R-R intervals, approximated pre-injection heart rates. Fig. 5 illustrates the diastolic mitral regurgitation in Case 4.

**DISCUSSION**

Diastolic mitral regurgitation resulting from incomplete closure of a normal mitral valve has been
FIG. 5.—Case 4. Retrograde left ventricular cine-angiogram in RAO projections. Late systole: the left atrium is opacified by mitral regurgitation and is delineated anteriorly by the anterior mitral leaflet (AML); the regurgitant jet occurs near the postero-medial commissure. Late diastole, 0·3 sec. later: left atrial opacification is lighter due to the preceding rapid emptying of left atrial contents; the posterior fornix (PF), lying between the posterior mitral leaflet and basilar endocardium of the ventricle, is continuous with a small diastolic regurgitant jet in the left atrium.
demonstrated in experimental and clinical heart block. Williams et al. (1968) analysed, with a video-
densitometer, left ventricular injections of contrast media, and detected small amounts of left atrial
opacification. Similarly, Rutishauser et al. (1966), using thermodilution methods, injected cold saline
into the ventricle and recorded temperature drops in the atrium. In both studies diastolic mitral regur-
gitation occurred after every atrial systole which was not followed after a normal interval by ven-
tricular systole, when a reversed atrioventricular pressure gradient of 2 to 4 mm. Hg was recorded.

Reversal of late diastolic pressure between the left ventricle and atrium or wedged pulmonary
ey has been recorded in patients with aortic regurgitation in normal sinus rhythm, first degree
AV block, and atrial fibrillation (Meadows et al., 1963; Oliver, Gazetopoulos, and Deuchar, 1967;
Rees et al., 1964). Distinctive features were severe aortic reflux and high left ventricular end-diastolic
pressures. The reversal of the atrioventricular gradient was related by some authors to increased
ventricular inflow and reduced ventricular distensibility. Its significance was thought to be that it
would produce premature closure of the mitral valve. Again in patients with severe aortic regur-
gitation, Lochaya et al. (1967) demonstrated, angiographically, diastolic mitral regurgitation which was
associated with a reversed atrioventricular gradient, and Aldridge, Lansdown, and Wigle (1966), in a
published abstract, reported similar findings. The former group did not see systolic mitral reflux, and
suggested that the diastolic mitral reflux was a consequence of incomplete valve closure.

In the past year, we have recognized late diastolic mitral regurgitation in 4 patients, and in each there
was an associated reversal of the atrioventricular gradient. We have not seen the one without the
other. Unlike the previous reports, aortic regurgitation was not uniformly severe in our cases, and the
left ventricular end-diastolic pressures were not invariably or inordinately raised. Indeed, in 1
patient aortic regurgitation was clinically absent, and in 2 patients the end-diastolic pressures were
normal, or nearly so. Notably, the mitral valves were anatomically abnormal in all 4 patients.

Anatomical incompetence of the mitral valves in these patients is adequate basis for the defective
valve closure during late diastole. Atrial fibrilla-
tion excludes an atrial mechanism producing the
diastolic mitral regurgitation. Therefore, the
mechanism of the diastolic reflux in our patients
becomes a question of the validity of the atrioven-
tricular gradient. Strict equivalence of pulmonary
artery wedge pressure and left atrial pressures,
recorded through catheter-manometer systems of
identical dynamic characteristics, is precluded by
the transmission of the pulmonary artery wedge
pressure through the pulmonary vessels. Pressures
recorded through a wedged catheter-manometer
system tend to be overdamped and the amplitude
between the peaks and valleys of the pulmonary
artery wedge pressure compared to the left atrial
pressure may be less (Connolly, Kirklin, and Wood,
1954). The “y” point of the pulmonary artery
wedge pressure would then be falsely high and more
likely to conceal a reversed gradient than to produce
one as an artefact. For these reasons we feel that
if left ventricular end-diastolic pressure exceeds
pulmonary artery wedge pressure, it very likely
exceeds left atrial pressure.

Large injections of contrast media made into the
left ventricle under pressure alter ventricular per-
formance immediately (Hallermann, Rastelli, and
Swan, 1964). It is, therefore, speculative to con-
sider that atrioventricular pressure relationships are
comparable before and during the angiographic
study. However, we are arguing from the position
that despite any probable alteration, the angiogra-
phic events agreed with the pressure data measured
immediately before the injection. In addition,
soon after the injection the reversed mitral gradient
persisted in 2 patients and probably did in a third
whose heart rates did not change significantly.
Furthermore, if forceful left ventricular injections
of contrast media alone produced artefactual dia-
static mitral reflux, we should see it more frequently
than we do.

The appearance and magnitude of the reversed
diastolic atrioventricular gradient are dependent in
part upon the diastolic pressure-volume characteris-
tics or distensibility of the ventricle. To what
point on its pressure-volume curve the ventricle
progresses in diastole is determined by the ventricu-
lar filling rate and the length of the diastolic filling
period. Recent observations in experimental ven-
tricular asystole have shown that the left ventricular
diameter reaches its maximal dimension within one
second of asystole and does not increase further
even when asystole is prolonged to 30 seconds (Van
Citters and Ruttenberg, 1967). In patients with
increased ventricular filling rates due to either aortic
regurgitation or systolic mitral regurgitation, the
distension limits of the ventricle may possibly be
reached at normal heart rates. The reversed atrio-
ventricular gradients are also influenced by the
ability of the atrium to empty and to relax. In this
regard the reversed mitral gradient observed with
completely normal pressures in Case 4 is pertinent.
The smallness of the left atrium plus its rapid
Diastolic Mitral Regurgitation

Evacuation by cine-angiographic estimation probably affected the low "y" point of the pulmonary artery wedge pressure. We presume that both rapid ventricular filling and rapid atrial emptying must concur in reversing the atrioventricular gradient at normal levels of pressure.

The studies from these 4 patients show that anatomically incompetent mitral valves permit regurgitation whenever, in the cardiac cycle, systole or diastole, left ventricular pressure even minimally exceeds left atrial pressure. Left ventricular end-diastolic pressure need not be greatly increased to reverse the atrioventricular gradient. The feasibility of a small gradient producing mitral regurgitation illustrated in these patients is consistent with the earlier studies on heart block.

Our inability to quantify the diastolic mitral regurgitation makes its haemodynamic and clinical significance conjectural. In these patients the reversed atrioventricular gradients were small and the amount of diastolic reflux was not large, and probably did not compromise effective stroke volume. However, in Case 2, the amount of diastolic regurgitation appeared to be at least equivalent to the systolic reflux and, therefore, the reduction of forward stroke flow from diastolic mitral regurgitation is potentially important in patients with high end-diastolic pressures. Additionally, in patients with severe aortic regurgitation, mitral valve incompetence in diastole allows raised diastolic pressures to be reflected into the lungs (Welch, Braunwald, and Sarnoff, 1957). The possible detriment of diastolic mitral reflux in patients with normal ventricular pressures and volumes would be a decrease in ventricular end-diastolic fibre stretch, with resultant loss in stroke volume.

SUMMARY

Late diastolic mitral regurgitation associated with a reversal of the left atrioventricular pressure gradient occurred in 4 patients with mitral valve disease. Aortic regurgitation was severe in only one patient and absent in another. Left ventricular end-diastolic pressures were not invariably and inordinately raised. The incidence of diastolic mitral reflux in this experience was 4 in 50 patients consecutively studied for rheumatic heart disease.

It is concluded that anatomically incompetent mitral valves permit regurgitation in both systole and diastole whenever left ventricular pressure exceeds left atrial pressure.

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Diastolic mitral regurgitation. Haemodynamic and angiographic correlation.

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