Cardiorespiratory changes in progressive muscular dystrophy

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Incipient cardiac failure was detected in 56 per cent of cases of pseudohypertrophic muscular dystrophy, 50 per cent of limb girdle type of myopathies, and 2 of the 3 cases with 'unclassified' variety.

'Myopathic pattern' in the electrocardiogram was seen in 82 per cent of the cases of pseudohypertrophic muscular dystrophy who showed abnormal haemodynamics. This suggests that this pattern is due to myocardial damage. Thus the electrocardiogram can be used as a simple and safe procedure for the detection of dys trophy heart disease.

Though 'myopathic pattern' is seen only in pseudohypertrophic muscular dystrophy the haemodynamic evidence of dystrophic heart disease is seen in other myopathies as well.

Pulmonary ventilatory function tests revealed restrictive changes in 57 per cent of cases of myopathy when muscles of the chest wall were involved. This abnormality in pulmonary function tests had no apparent haemodynamic effect.

Cardiopulmonary complications are well known in muscular dystrophy (Globus, 1923; Nothacker and Netsky, 1950; Hurwitz, 1936). They occur in the form of cardiac arrhythmias, congestive cardiac failure, electrocardiographic changes, pulmonary infections, and pulmonary insufficiency (Rubin and Buchberg, 1952; Weisenfeld and Messinger, 1952; Manning and Cropp, 1958; Gilroy et al., 1963; Arce-Gomez et al., 1964).

A specific 'myopathic pattern' in the electrocardiogram in cases with pseudohypertrophic muscular dystrophy has been described by us. This pattern consists of sinus tachycardia, short PR interval, R/S in V1 more than 1.5, high amplitude R wave and deep Q wave in V4–6 and other left precordial leads, and prolonged QTc (Fig. 1). It was suggested that these electrocardiographic changes were probably due to myocardial damage (Wahi, 1961, 1963).

Detailed pulmonary and haemodynamic studies in progressive muscular dystrophy are few (Gailani, Danowaki, and Fisher, 1958; Storstein, 1964; Perloff, de Leon, and O'Doherty 1966; Perloff et al., 1967; Gilroy et al., 1963; Wahi et al., 1968; Arce-Gomez et al., 1964). The incidence of pulmonary infections, mostly pneumonias, is high in advanced cases of myopathy. Ventilatory function studies in these cases have shown restrictive changes with limitation of all lung volumes. In our total experience of 180 cases of myopathy we have encountered bronchiectasis in two cases, bronchopneumonia in one, and congestive cardiac failure in two cases.

Pulmonary insufficiency and cardiac failure do not manifest early owing to restricted physical activity because of disability. Pulmonary function tests and cardiac catheterization can be useful means of detecting early changes and latent heart failure.

Material and methods

The present study is of 41 cases of progressive muscular dystrophy. Out of a large series of 180 cases of myopathy 32 were studied haemodynamically in the Nehru Hospital of the Postgraduate Institute of Medical Education and Research, Chandigarh, and 9 were studied for us by Professor S. B. Roy at All India Institute of Medical Sciences, New Delhi, before our own laboratories were set up. There were 30 cases with pseudohypertrophic muscular dystrophy (sex-linked, Duchenne type), 8 cases of limb girdle myopathy, and another 3 cases were atypical and were grouped as 'unclassified'. Muscle biopsy was done in all cases where the clinical picture was even slightly atypical (14 cases). After detailed clinical examination a radiograph of the chest for heart size and lung fields was done at a standard distance. A 12-lead electrocardiogram was taken in all these cases.

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showed frank congestive cardiac failure or any physical signs in the chest. Radiography showed cardiac enlargement in 4 cases. There was no pulmonary pathology. Twenty out of 30 patients (66%) with pseudohypertrophic muscular dystrophy showed a 'myopathic pattern' in the electrocardiogram (Wahi, 1963).

**Haemodynamic studies** Twenty-seven patients had normal values for resting pressures. Twelve had abnormal right ventricular end-diastolic pressure and in another two cases the pressures were on higher limits of normal (6 mm.) (Fig. 2). Leg-raising exercise for three minutes could be given in 6 patients, and only one of these showed distinct elevation of right ventricular end-diastolic pressure (Fig. 3). Right hypochondriac compression was applied in 32 patients. Eleven patients with normal or borderline resting pressure showed elevation of right ventricular end-diastolic pressure after right hypochondriac compression (Fig. 4). Generally the patients having abnormal right ventricular end-diastolic pressure at rest also had abnormal mean right atrial pressure. Right atrial mean pressure showed an increase corresponding to changes in right ventricular end-diastolic pressure after right hypochondriac compres-

**Findings**
The clinical examination found associated atrial septal defect in one patient and another had mild hypertension. None of these patients

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**FIG. 1** Showing typical myopathic pattern in electrocardiogram — R/S in V1, r^5, and deep Q waves in lead I, aVL, and V4-6.  

**FIG. 2** Showing abnormal right ventricular end-diastolic pressure at rest.  

**FIG. 3** Showing normal right ventricular end-diastolic pressure at rest and its abnormal increase after 2 min exercise.
ventricular end-diastolic and mean right atrial pressure developed ventricular tachycardia during catheterization but was successfully revived.

Pulmonary function studies The details of the ventilatory pulmonary function tests are described in different groups separately (Tables 1, 2, 3). Vital capacity and maximum breathing capacity were reduced in two-thirds

### TABLE 1 Pseudohypertrophic muscular dystrophy

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Vital capacity (l.)</th>
<th>% of predicted vital capacity</th>
<th>Maximum breathing capacity (l.)</th>
<th>% of predicted maximum breathing capacity</th>
<th>FEV&lt;sub&gt;1&lt;/sub&gt;</th>
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* Co-operation was not adequate.

### TABLE 2 Limb girdle type

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<th>Case No.</th>
<th>Vital capacity (l.)</th>
<th>% of predicted vital capacity</th>
<th>Maximum breathing capacity (l.)</th>
<th>% of predicted maximum breathing capacity</th>
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### TABLE 3 Unclassified variety

<table>
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<th>Maximum breathing capacity (l.)</th>
<th>% of predicted maximum breathing capacity</th>
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<td>88</td>
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</table>
of the cases of pseudohypertrophic muscular dystrophy. Similar changes were seen in 44.4
per cent of limb girdle type of myopathy, but the cases with 'unclassified' variety of
myopathy had normal values. Timed vital capacity (FEV1) did not suggest any obstruc-
tive airway disease. Functional residual capacity and total lung capacity were done in
8 cases and were found to be normal in 4 cases which showed other function to be normal.
Four cases had reduced values, and they also showed restrictive airway disease as judged
from vital capacity and maximum breathing capacity.

Discussion

Fifty-six per cent of cases of myopathy studied by us showed raised right ventricular end-
diastolic or mean right atrial pressure, or both, at rest or when challenged with exercise
or right hypochrondriac compression, though none of them had shown clinical evidence of
right heart failure. A rise of right ventricular end-diastolic pressure or mean right atrial
pressure, or both, after abdominal compression may reflect reduced distensibility of the
right ventricle and its inability to handle augmented volume overloading.

Out of 17 cases of Duchenne type of muscular dystrophy who showed abnormal
haemodynamics, 14 (82%) showed typical 'myopathic pattern' in the electrocardiogram.
This supports our contention that this pattern is an evidence of dystrophic heart disease and
not a conduction defect. Similar studies by Perloff et al. (1966) also support this hypo-
thesis.

However, 'myopathic pattern' was seen in 20 cases of pseudohypertrophic muscular
dystrophy, while haemodynamic abnormalities were seen in 17 only. Besides, some
patients with abnormal haemodynamics did not show the characteristic electrocardi-
ographic changes. It is possible that the electrocardiographic pattern is suggestive of
predominantly localized dystrophic changes in the myocardium in the region of the poste-
rolateral wall of the left ventricle which may occur earlier than the disturbed haemo-
dynamics. The cases with more diffuse damage may not show characteristic electro-
cardiographic changes but depict abnormal haemodynamics. Such a view is supported by
the observation of Perloff et al. (1966, 1967).

Our study suggests that, though 'myopathic pattern' in the electrocardiogram was limited
in the cases of pseudohypertrophic muscular dystrophy, abnormal haemodynamics and
thus the 'dystrophic heart disease' is equally common in limb girdle and unclassified
varieties.

The ventilatory pulmonary function tests showed that 57 per cent of cases had changes
suggestive of restrictive airway disease, which were present in Duchenne and limb girdle
type of myopathies. These changes were not seen in the unclassified variety because of
the predominantly distal muscular involvement. The ventilatory function abnormality is due
to inadequate expansion of lungs because of weakness of the respiratory muscles. In spite
of these restrictive changes there were no symptoms of respiratory insufficiency, most
probably because of limited physical activity due to generalized muscular weakness. None
of the cases showed any evidence of obstructive airway disease. The changes in the
pulmonary functions had no apparent haemodynamic effect, as pulmonary artery pressure
and peripheral oxygen saturation were normal in all these cases.

We are grateful to Professor J. N. Berry and his team for doing some of the haemodynamic
studies.

References

Arce-Gomez, E., Palma-Garcia, S., Yanez, J. L.,
Lopez-Portillo, M., Lombardo, L., Brandt, H.,
and Marquez, M. H. (1964). Study of cardio-
respiratory function in patients with progressive

Muscular dystrophy. Catheterization studies indi-
cating latent congestive heart failure. Circulation,
17, 583.

Gilroy, J., Cahalan, J. L., Berman, R., and Newman,
M. (1963). Cardiac and pulmonary complications
in Duchenne's progressive muscular dystrophy.
Circulation, 27, 484.

Globus, J. H. (1923). The pathologic findings in the
heart muscle in progressive muscular dystrophy.
Archives of Neurology and Psychiatry, 9, 59.

Hurwitz, S. (1936). Primary myopathies, report of 36
cases and review of the literature. Archives of
Neurology and Psychiatry, 36, 1294.

Manning, G. W., and Cropp, G. J. (1958). The electro-
cardiogram in progressive muscular dystrophy.
British Heart Journal, 20, 416.

Nothacker, W. G., and Netsky, M. G. (1950). Myo-
cardial lesions in progressive muscular dystrophy.
Archives of Pathology, 50, 578.

Perloff, J. K., de Leon, A. C., and O'Doherty, D.
(1966). The cardiomyopathy of progressive

Perloff, J. K., Roberts, W. C., de Leon, A. C., and
O'Doherty, D. (1967). The distinctive ECG of
Duchenne's progressive muscular dystrophy (an
ECG-pathologic correlative study). American
Journal of Medicine, 48, 179.

Rubin, I. L., and Buchberg, A. S. (1952). The heart in
progressive muscular dystrophy. American Heart
Journal, 43, 161.

Storstein, O. (1964). The heart in progressive muscular
dystrophy. Experimental Medicine and Surgery, 22,
13.
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