A follow up study of myocardial involvement in patients with mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes (MELAS)

Y Okajima, Y Tanabe, M Takayanagi, H Aotsuka

Abstract

Objective—To investigate cardiac function in patients with mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes (MELAS) and clarify the clinical features of cardiomyopathy in MELAS.

Patients—11 consecutive patients with MELAS (mean age at initial examination 11.3 years, range 4 to 16 years) were enrolled in the study. Six were followed for more than five years.

Results—On echocardiographic examination, three patients showed increased left ventricular end diastolic posterior wall thickness (LVPWTd), exceeding 140% of the normal value. Four patients, including these three, had an ejection fraction of less than 50%, and two also had increased left ventricular end diastolic volume (LVEDV) exceeding 140% of the normal value (%N). The LVPWTd%N was correlated positively with the LVEDV%N (R = 0.669, p < 0.05) and negatively with the ejection fraction (R = −0.6701, p < 0.05). One patient died of heart failure aged 22 years.

Conclusions—The cardiomyopathy in MELAS is characterised by an abnormally thick left ventricular wall with progressive dilatation and poor left ventricular contraction developing over several years, indicating hypertrophic cardiomyopathy advancing to dilated cardiomyopathy.

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Keywords: MELAS; cardiomyopathy

Table 1: Results of genetic and cardiac analyses in patients with MELAS

<table>
<thead>
<tr>
<th>Case</th>
<th>Sex</th>
<th>Age at final examination (years)</th>
<th>mtDNA mutation</th>
<th>ECG findings</th>
<th>UCG diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>23</td>
<td>3243</td>
<td>Intermittent WPW; inverted T wave in II, III, aVF, V5, V6;</td>
<td>HCM</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>22 (lost)</td>
<td>3243</td>
<td>Inverted T wave in III, V6;</td>
<td>HCM—DCM</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>21</td>
<td>3243</td>
<td>WPW</td>
<td>HCM—DCM</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>6</td>
<td>3243</td>
<td>WPW</td>
<td>Normal</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>8</td>
<td>3243</td>
<td>Flat T wave in V5-V6;</td>
<td>Normal</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>7</td>
<td>3243</td>
<td>STT down slope at first, then normalised;</td>
<td>Normal</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>15</td>
<td>3471</td>
<td>Normal; initially LV dilatation; during follow up, normal size</td>
<td>Not done</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>22</td>
<td>3243</td>
<td>Inverted T wave in aVL;</td>
<td>Normal</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>11</td>
<td>3243</td>
<td>Normal;</td>
<td>Not done</td>
</tr>
<tr>
<td>10</td>
<td>M</td>
<td>17 (lost)</td>
<td>3243</td>
<td>Inverted T wave in II, III, aVF, V5, V6;</td>
<td>Normal</td>
</tr>
<tr>
<td>11</td>
<td>M</td>
<td>13</td>
<td>3243</td>
<td>PVC</td>
<td>Normal</td>
</tr>
</tbody>
</table>

DCM, dilated cardiomyopathy; HCM, hypertrophic cardiomyopathy; LV, left ventricle; mtDNA, mitochondrial DNA; MELAS, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes; PVC, premature ventricular contractions; UCG, ultrasound cardiogram; WPW, Wolff-Parkinson-White syndrome.
area, and expressed as percentages of the normal values (%N). To evaluate ventricular size or wall thickness in paediatric patients, it is important to normalise the data because body mass in this age group is quite variable, especially during follow-up. We therefore used normalised equations for patients at our institution, which enabled us to compare cardiac size among patients of different ages or body masses and to assess the degree of abnormal deviation objectively.

**Results**

**ECG FINDINGS**

Six patients showed depolarisation abnormalities, such as inverted T wave in leads II, III, aVF, and V5–V6. Three showed Wolff-Parkinson-White (WPW) syndrome. One showed premature ventricular contraction. Nine of the 11 patients underwent echocardiography.

**ECHOCARDIOGRAPHIC FINDINGS**

The data for the most recent echocardiographic examination are summarised in table 2. The mean LVEDV was 85 ml (range 33 to 191 ml) and the mean (SD) LVEDV%N was 108.2 (45.1)% (range 50.9% to 194.9%). Two patients showed increased LVEDV exceeding 140% of the normal value. The mean (SD) ejection fraction was 50.7 (16.5)% (range 24.7% to 66.7%). The mean LVPWTd was 9.2 mm (range 5.7 to 18.0 mm) and the mean (SD) LVPWTd%N was 131 (45)% (range 92% to 237%); three patients showed increased LVPWTd%N exceeding 140%. Four patients, including these three, showed decreased ejection fraction values of less than 50%.

The LVPWTd%N was correlated positively with the LVEDV%N ($y = 0.665x + 21.2$, $r = 0.669$, $p < 0.05$) and negatively with the ejection fraction ($y = 101e^{-0.0057x}$, $r = -0.6701$, $p < 0.05$) (fig 1).

**RESULTS OF FOLLOW UP**

During the follow up of six patients for more than five years (mean 6.9 years), three (patients 1, 2, and 3) showed a worsening ejection fraction of less than 50% and an increased LVPWTd%N and LVEDV%N exceeding 140% within several years (fig 2). In patient 6, who had congestive heart failure at the onset, cardiac function improved with a decrease in LVEDV%N from 141% to 116% after initiation of treatment with digitalis, diuretics, and vasodilators. His condition has remained stable during follow up, although the ejection fraction has been gradually worsening with an increase of LVPWTd%N.

Two patients have died, one from encephalopathy and the other, patient 2, from congestive heart failure. In this case, the echocardiographic findings had shown severe left ventricular wall hypertrophy (237% of the normal value), enlargement (194.9% of the normal value), and poor contraction (ejection fraction 24.7%) (fig 3).

**Discussion**

Cardiomyopathy is a common cardiac manifestation in MELAS-like conduction abnormalities such as the Wolff-Parkinson-White syndrome, and it has been categorised as hypertrophic on the basis of morphological assessment with echocardiography and necropsy examination. In idiopathic hypertrophic cardiomyopathy, left ventricular contractility usually remains within the normal

![Figure 1](image1.png)

**Figure 1** Correlation of percentages of the normal values of left ventricular posterior wall thickness (LVPWTd%N) with ejection fraction (left), and with percentages of the normal values of left ventricular end diastolic volume (LVEDV%N) (right). The LVPWTd%N showed significant negative correlation with ejection fraction and a positive correlation with LVEDV%N.
range. Sudden cardiac arrhythmia is the major cause of death and only 10–15% of these patients show transition to dilated cardiomyopathy.\textsuperscript{17,18}

Although, cardiac dysfunction resembling dilated cardiomyopathy has sometimes been observed in MELAS,\textsuperscript{13} a change in the condition from hypertrophic to dilated cardiomyopathy has not been described. In MELAS with cardiac manifestation, as in idiopathic hypertrophic cardiomyopathy, left ventricular wall thickness gradually increases. With advancing hypertrophy, however, cardiac function gradually deteriorates until cardiac dilatation occurs as a result of an increase in left ventricular end diastolic volume and a decrease in the ejection fraction, while wall thickness steadily increases. We found a positive correlation of LVPWT\textsubscript{d} with LVEDV\%N and a negative correlation with ejection fraction in these patients, and there was an association between increased wall thickness and impaired systolic function. These findings are characteristic of the cardiomyopathy in MELAS and have not been described in patients with hypertrophic cardiomyopathy secondary to the sarcomeric protein mutations.

The causes of the progression of hypertrophic cardiomyopathy to dilated cardiomyopathy have not been established, although several studies have shown that myocardial ischaemia is involved in hypertrophic cardiomyopathy\textsuperscript{19–22} and the progression was observed after wall thinning had begun.

The mechanism of cardiac deterioration in patients with MELAS is thought to be the degeneration of cardiac muscle fibres\textsuperscript{8} and microangiopathy detected using \textsuperscript{201}Tl scintigraphy.\textsuperscript{23} It has been reported that the presence of interstitial fibrosis in cardiomyocytes in MELAS is a point of resemblance between the cardiomyopathy of MELAS and idiopathic hypertrophic cardiomyopathy.\textsuperscript{4–6} In other reports the abnormalities have been described as diffuse vacuolar degeneration of cardiomyocytes detectable by light microscopy, and a marked increase of aggregates of enlarged mitochondria with proliferated cristae seen on electronmicroscopy;\textsuperscript{9} these findings were very different from those in idiopathic hypertrophic cardiomyopathy. The vacuolisation in the cardiomyocyte might result in the muscle fibre hypertrophy and morphological hypertrophic cardiomyopathy, eventually leading to hypertrophic dilated cardiomyopathy.

It is usually difficult to improve cardiac function once the deterioration has begun. One of our patients, however, responded well to conventional treatment for heart failure. Accordingly, it should be emphasised that routine checks of cardiac function are essential for the follow up of patients with MELAS and that treatment should be started without delay when the clinical presentation deteriorates.

Although the clinical diagnosis of MELAS in our patients had already been confirmed before the study, there are reports of patients with mitochondrial disorders in whom the cardiac manifestation is the only abnormality.\textsuperscript{4–6} The characteristic echocardiographic findings such as wall thickening and decreased left ventricular contraction, together with characteristic ECG depolarisation abnormalities, may

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure2}
\caption{Follow up results for left ventricular end diastolic volume (LVEDV\%N), ejection fraction, and left ventricular posterior wall thickness (LVPWT\textsubscript{d}\%N) in six patients. Patients 1, 2, and 3 showed left ventricular wall hypertrophy, and 2 and 3 showed deterioration of left ventricular contraction during follow up.}
\end{figure}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure3}
\caption{Echocardiography in patient 2, which showed severe hypertrophy of the left ventricular wall and poor contraction. She died of heart failure.}
\end{figure}
Cardiac function in MELAS

suggest the diagnosis of MELAS; other features include a family history of short stature, diabetes mellitus, abnormal renal function, hearing loss, and other disorders.

The etiology of the hypertrophic cardiomyopathy of MELAS syndrome has not been fully established, and the diagnosis is based solely on the morphology of the ventricular wall thickness. However, it is clear that the clinical course is quite dependent on the pathogenesis of the disease. We suggest that it is important to confirm whether this involves mitochondrial disorders or other abnormalities.

The underlying causes of myocardial hypertrophy remain unanswered in conditions where there are mutations of sarcomeric protein or mitochondrial DNA. This hypertrophy might induce degeneration of cardiac function. An understanding of the pathogenesis of the myocardial hypertrophy may allow the disease process to be modified in hypertrophic cardiomyopathy.

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