Long term outcome in patients with silent versus symptomatic ischaemia during dobutamine stress echocardiography

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Objectives: To compare the long term prognosis of patients having silent versus symptomatic ischaemia during dobutamine stress echocardiography (DSE).

Design: Observational study.

Setting: Tertiary referral centre.

Patients: 931 patients who experienced stress induced myocardial ischaemia during DSE.

Results: Silent ischaemia was present in 643 of 931 patients (69%). The number of dysfunctional segments at rest (mean (SD) 9.6 (5.1) v 8.8 (5.0), p = 0.1) and of ischaemic segments (3.5 (2.2) v 3.8 (2.1), p = 0.2) was comparable in both groups. During a mean (SD) follow up of 5.5 (3.3) years, there were 169 (18%) cardiac deaths and 86 (9%) non-fatal infarctions. Multivariable Cox regression analysis showed age (hazard ratio (HR) 1.1, 95% confidence interval (CI) 1.02 to 1.05), previous myocardial infarction (HR 1.4, 95% CI 1.1 to 2.0), and number of ischaemic segments during the test (HR 2.0, 95% CI 1.0 to 3.7) as independent predictors of cardiac death and myocardial infarction. For every additional ischaemic segment there was a twofold increment in risk of late cardiac events. The annual cardiac death or myocardial infarction rate was 3.0% in patients with symptomatic ischaemia and 4.6% in patients with silent ischaemia (p = 0.01). Silent induced ischaemia was an independent predictor of cardiac death and myocardial infarction (HR 1.7, 95% CI 1.1 to 2.0). During follow up symptomatic patients were treated more often with cardioprotective therapy (p < 0.01) and coronary revascularisation (145 of 288 (50%) v 174 of 643 (27%), p < 0.001).

Conclusions: Patients with silent ischaemia had a similar extent of myocardial ischaemia during DSE compared to patients with symptomatic ischaemia but received less cardioprotective treatment and coronary revascularisation and experienced a higher cardiac event rate.

Although angina pectoris is one of the cardinal manifestations of myocardial ischaemia, many patients have ischaemia during stress testing without associated symptoms. Studies of stress induced silent ischaemia reported discordant results with respect to the extent of ischaemia. Some studies reported a similar extent of ischaemia in patients with and without angina, whereas others reported more extensive ischaemia in the presence of angina. Dobutamine-atropine stress echocardiography (DSE) is commonly used to assess the extent, location, and severity of coronary artery disease. The diagnosis of myocardial ischaemia during DSE is based on the detection of new or worsening wall motion abnormalities. The extent of these abnormalities is a powerful predictor of adverse outcome. A large number of studies have reported discordant data regarding the prognostic importance of stress induced silent ischaemia, the likelihood of future coronary events related to the amount of ischaemic myocardium, and the influence of medical treatment or revascularisation techniques on the outcome of silent stress induced ischaemia. Accordingly, the objective of this study was to compare the long term prognosis of silent versus symptomatic ischaemia in a large group of patients undergoing DSE.

PATIENTS AND METHODS

Patient selection

Between 1990 and 2002, 949 consecutive patients experienced stress induced myocardial ischaemia during DSE. Follow up was successful in 944 patients (99.5%). Thirteen patients underwent early coronary revascularisation in the first 60 days after DSE and were excluded from the analysis. Data from the remaining 931 patients are reported. The protocol was approved by the hospital ethics committee. All patients gave informed consent before the test. A structured interview and clinical history were taken and cardiac risk factors were assessed before DSE.

Dobutamine stress protocol

Dobutamine-atropine stress testing was performed according to a standard protocol as previously reported. Dobutamine was administered intravenously, starting at a dose of 5 µg/kg/min for five minutes, followed by 10 µg/kg/min for five minutes. Subsequently, incremental dobutamine doses of 10 µg/kg/min were given at three minute intervals up to a maximum dose of 40 µg/kg/min. If the test end point was not reached at a dobutamine dose of 40 µg/kg/min, atropine (up to 2 mg) was given intravenously. Blood pressure, heart rate, and ECG were constantly monitored. Test end points were achievement of the target heart rate (85% of maximum age and sex predicted heart rate), maximum dose of dobutamine and atropine, horizontal or downsloping ST segment depression > 2 mm at an interval of 80 ms after the J point compared with baseline, severe angina, systolic blood pressure fall > 40 mm Hg, blood pressure > 240/120 mm Hg, or significant cardiac arrhythmia. An intravenous β blocker was available to reverse the adverse effects of dobutamine and atropine.

Stress echocardiography

Two dimensional echocardiographic images were acquired at rest, during dobutamine stress, and during recovery. The
echocardiograms were recorded in a quad screen format. Two experienced observers, unaware of the clinical data, scored the echocardiograms according to a standard 16 segment model. Regional wall motion and systolic wall thickening were scored on a five point scale (1 indicating normal; 2, mild hypokinesia; 3, severe hypokinesia; 4, akinesia; and 5, dyskinesia). Ischaemia was defined as new or worsened wall motion abnormalities during stress induced by an increase of wall motion score ≥ 1 grade in ≥ 1 segments. Ischaemia was not considered to be present when akinetic segments at rest became dyskinetic during stress. Symptomatic ischaemia was defined as the presence of typical chest pain or anginal equivalent symptoms (epigastric pain, jaw pain, and dyspnoea) during DSE. Coronary arteries were assigned to myocardial segments based on echocardiographic localisation, as previously described.44 The anterior, apical, septal, and anteroseptal walls were assigned to the left anterior descending coronary artery, the posterior and lateral wall to the left circumflex, and the inferior and basal septal segments to the right coronary artery. The apical lateral segment was considered to be an overlapping segment between the left anterior descending coronary artery and the left circumflex, and the apical inferior segment was considered to be an overlapping segment between the left anterior descending coronary artery and the right coronary artery. Overlapping segments were assigned to the regions with concomitant abnormalities.

Follow up
Follow up data were collected by contacting the patient’s general practitioner and by review of hospital records. The date of the last review or consultation was used to calculate follow up time. Outcome events were overall death, cardiac death, and non-fatal myocardial infarction. Cardiac death was defined as death caused by acute myocardial infarction, significant cardiac arrhythmias, or refractory congestive heart failure. Sudden death occurring without another explanation was regarded as cardiac death. Non-fatal myocardial infarction was defined by two of the following symptoms: typical chest pain, increased cardiac enzyme concentrations, and typical changes on ECG.

Statistical analysis
Continuous data were expressed as mean (SD). Student’s t test was used to analyse continuous data. Differences between proportions were compared with the χ² test. Univariate and multivariate Cox proportional hazard regression models (BMDP Statistical Software Inc, Los Angeles, California, USA) were used to identify independent predictors of late cardiac events.25 Variables were selected in a stepwise forward selection manner, including clinical and DSE data, with entry and retention set at a significance level of 0.05. The risk of a variable was expressed as a hazard ratio (HR) with a corresponding 95% confidence interval (CI). The probability of survival was calculated by the Kaplan-Meier method and survival curves were compared by the log rank test. A probability value of p < 0.05 was considered significant.

RESULTS
Patient characteristics and haemodynamic results
Silent myocardial ischaemia was present in 643 of 931 (69%) patients. Clinical risk factors were not significantly different between patients with and patients without angina during DSE, with the exception of history of angina, which was more often observed in patients with symptomatic ischaemia (table 1). Table 2 shows DSE characteristics of patients with silent and symptomatic myocardial ischaemia. There was no significant difference between patients with and patients without silent ischaemia with respect to the number of abnormal segments at rest and the number of ischaemic segments during DSE. No patient experienced a myocardial infarction during the test. Side effects among the 931 patients were non-sustained ventricular tachycardia (< 10 complexes) in 28 (3%), sustained ventricular tachycardia (> 10 complexes) in 13 (1%), severe hypotension (decrease in systolic blood pressure > 40 mm Hg compared with baseline) in seven (1%), atrial fibrillation in six (1%), and ventricular fibrillation in one (0.1%).

DSE and outcome
During a mean (SD) 5.5 (3.3) years follow up of the 931 patients, there were 265 (28%) deaths, of which 169 (18%) were attributed to cardiac causes. Non-fatal infarction

<table>
<thead>
<tr>
<th>Table 1 Clinical characteristics of patients with and without angina during dobutamine stress echocardiography (DSE)</th>
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</thead>
<tbody>
<tr>
<td>Silent ischaemia (n = 643)</td>
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<tr>
<td>-----------------------------</td>
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<tr>
<td>Age (years)*</td>
</tr>
<tr>
<td>Men</td>
</tr>
<tr>
<td>Previous infarction</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
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<td>Hypertension</td>
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<td>Hypercholesterolaemia</td>
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<tr>
<td>Smoking</td>
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<tr>
<td>History of angina</td>
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<td>History of heart failure</td>
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<td>Previous coronary angiography</td>
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<td>Previous coronary angioplasty</td>
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<td>lI Blockers</td>
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<td>Calcium channel blockers</td>
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<tr>
<td>Nitrates</td>
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<tr>
<td>Aspirin</td>
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<tr>
<td>Statins</td>
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<tr>
<td>Indication for DSE</td>
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<tr>
<td>Diagnosis of CAD</td>
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<tr>
<td>Preoperative evaluation before non-cardiac surgery</td>
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<tr>
<td>Risk stratification after MI</td>
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</tbody>
</table>

*Mean (SD).
CAD, coronary artery disease; MI, myocardial infarction.
occurred in 86 (9%) patients and late revascularisation was performed in 319 (34%) patients. The annual cardiac death rate was 2.2% in the group of patients with symptomatic ischaemia during DSE and 3.8% in the group with silent ischaemia (p = 0.01). The annual myocardial infarction or cardiac death rate was 3.0% in patients with symptomatic ischaemia and 4.6% in patients with silent ischaemia (p < 0.01). Late revascularisation was more often performed in patients with symptomatic ischaemia (145 of 288 (50%) v 174 of 643 (27%), p < 0.001). Medical treatment was changed after detection of ischaemia by DSE in both groups but patients with angina during DSE were significantly more often treated with β blockers, aspirin, and statins (table 3). On the other hand, the fact that fewer of these patients were treated with nitrates and calcium channel blockers at follow up is related to the higher incidence of coronary revascularisation in this group.

Figures 1 and 2 present Kaplan-Meier survival curves for the end point cardiac death and the combined end point cardiac death or non-fatal infarction, respectively. Patients with silent ischaemia had a significantly lower probability of long term survival during DSE and 3.8% in the group of patients with silent ischaemia during DSE have a higher incidence of long term cardiac death and myocardial infarction than do patients with symptomatic myocardial ischaemia. This association was observed irrespective of the presence and extent of resting or dobutamine stress induced new wall motion abnormalities.

### Table 2 DSE data for patients with and without angina during DSE

<table>
<thead>
<tr>
<th></th>
<th>Silent ischaemia (n = 643)</th>
<th>Symptomatic ischaemia (n = 288)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peak heart rate (beats/min)</td>
<td>127 (21)</td>
<td>124 (20)</td>
<td>0.03</td>
</tr>
<tr>
<td>Peak systolic blood pressure (mm Hg)</td>
<td>135 (31)</td>
<td>134 (28)</td>
<td>0.7</td>
</tr>
<tr>
<td>Peak rate pressure product</td>
<td>16 573 (4290)</td>
<td>17 119 (4767)</td>
<td>0.1</td>
</tr>
<tr>
<td>Peak dobutamine dose (μg)</td>
<td>37 (7)</td>
<td>38 (5)</td>
<td>0.09</td>
</tr>
<tr>
<td>Atrioventricular block</td>
<td>230 (36%)</td>
<td>96 (33%)</td>
<td>0.5</td>
</tr>
<tr>
<td>ST segment depression</td>
<td>248 (38%)</td>
<td>179 (62%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Number of dysfunctional segments at rest</td>
<td>9.6 (5.1)</td>
<td>8.8 (5.0)</td>
<td>0.1</td>
</tr>
<tr>
<td>Number of ischaemic segments</td>
<td>3.5 (2.2)</td>
<td>3.8 (2.1)</td>
<td>0.2</td>
</tr>
<tr>
<td>Arrhythmias and hypotension during the test</td>
<td>43 (7%)</td>
<td>12 (4%)</td>
<td>0.2</td>
</tr>
</tbody>
</table>

### Table 3 Medication at follow up of patients with and without angina during DSE

<table>
<thead>
<tr>
<th></th>
<th>Baseline (n = 643)</th>
<th>Follow up (n = 288)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silent ischaemia</td>
<td>Symptomatic ischaemia</td>
<td>Silent ischaemia</td>
<td>Symptomatic ischaemia</td>
</tr>
<tr>
<td>β blockers</td>
<td>243 (38%)</td>
<td>99 (34%)</td>
<td>0.04</td>
</tr>
<tr>
<td>Calcium channel blockers</td>
<td>177 (27%)</td>
<td>193 (30%)</td>
<td>0.06</td>
</tr>
<tr>
<td>Nitrates</td>
<td>180 (28%)</td>
<td>89 (31%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Aspirin</td>
<td>302 (47%)</td>
<td>334 (52%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Statins</td>
<td>174 (27%)</td>
<td>263 (41%)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

No sex differences for cardiac death or hard cardiac events were present in the overall population, in the two groups of patients with symptomatic or silent ischaemia, or in the two groups of patients with single or multivessel disease.

### Incremental prognostic value

Independent predictors of cardiac death in a multivariate analysis were age (HR 1.1, 95% CI 1.04 to 1.08), male sex (HR 1.8, 95% CI 1.2 to 2.7), smoking (HR 1.5, 95% CI 1.1 to 2.0), and the number of ischaemic segments during DSE (HR 2.1, 95% CI 1.1 to 4.1). Independent predictors of cardiac death or myocardial infarction were age (HR 1.1, 95% CI 1.02 to 1.05), previous myocardial infarction (HR 1.4, 95% CI 1.1 to 2.0), and the number of ischaemic segments during DSE (HR 2.0, 95% CI 1.0 to 3.7). For every ischaemic segment there was a twofold increment in risk of late cardiac events. Silent induced ischaemia was also an independent predictor of cardiac death and myocardial infarction (HR 1.7, 95% CI 1.1 to 2.0). An interaction term between silent induced ischaemia and the presence of ischaemia was not significant.

### DISCUSSION

The current results show that patients with silent myocardial ischaemia during DSE have a higher incidence of long term cardiac death and myocardial infarction than patients with symptomatic myocardial ischaemia. This association was observed irrespective of the presence and extent of resting or dobutamine stress induced new wall motion abnormalities.
Significant changes were observed in medical treatment of patients with and without angina during DSE. Patients with silent myocardial ischaemia during DSE were less often prescribed β blockers, aspirin, and statins than were patients with symptomatic ischaemia. In addition, late revascularisation was less often performed in patients with asymptomatic ischaemia during DSE. Moreover, in patients with multivessel disease and symptomatic or silent ischaemia during DSE, cardiac death occurred more often in medically treated patients than in patients who underwent myocardial revascularisation.

The worse long term prognosis of patients with asymptomatic myocardial ischaemia may be associated with less aggressive anti-ischaemic medical treatment and coronary revascularisation. β Blockers have been unequivocally shown in multiple studies to reduce angina and the incidence, frequency, and extension of episodes of silent ischaemia.26–28 The combination of β blockers with other anti-ischaemic medical treatment such as calcium channel antagonists has also been found to reduce the incidence of myocardial ischaemia more than either type of these medications alone.29–30 Also, statins have been shown to decrease transient myocardial ischaemia, probably due to improved endothelial function.31 Furthermore, myocardial revascularisation was previously shown in a prospective study to be associated with decreased asymptomatic ischaemia and improved clinical outcome compared with angina or ischaemia guided strategy.22 In the present study, the decision to perform coronary angiography was made on clinical grounds by the treating cardiologist. The prescription rate of β blockers or calcium antagonist was relatively low. It seems that in some patients symptoms of angina instead of signs of ischaemia on DSE were the reason to prescribe β blockers or calcium antagonists and to perform myocardial revascularisation.

Additionally, in this study absence of symptoms during dobutamine stress induced ischaemia was often observed (69%); this is in line with previous studies33 34 and is physiologically explained by the ischaemic cascade, since systolic dysfunction precedes the development of angina pectoris.

**Comparison with previous studies**

There are only a few studies on the long term prognostic implications of silent myocardial ischaemia during DSE. Bigi and colleagues35 studied 407 survivors from a first uncomplicated myocardial infarction who had myocardial ischaemia during DSE and were followed up for a 10 month period. Cardiac death and non-fatal myocardial infarction occurred, respectively, in six of 407 (1%) and 13 of 407 (3%) patients. No significant difference in spontaneous event-free survival was observed among patients with silent ischaemia. Bonou and colleagues33 studied 289 patients with...
advanced age undergoing DSE. During a 35 (13) month follow-up period, 15 (5%) cardiac deaths and 19 (7%) non-fatal myocardial infarctions occurred. There was no significant difference in prognosis between patients with silent ischaemia and patients with symptomatic myocardial ischaemia. In the present study the cardiac event rate was higher than in the previous studies; this may be related to the longer and nearly complete (99.5%) follow-up. Previous data from 224 patients who underwent dobutamine stress myocardial perfusion imaging showed a similar outcome between patients with silent ischaemia and patients with symptomatic ischaemia. However, the extent of ischaemia was comparable between patients with and without symptomatic ischaemia during DSE. The mechanism underlying the pathogenesis of silent or symptomatic ischaemia is complex and may include variations in pain threshold, a central nervous system alteration, or a particular biochemical pattern of inflammatory system activation. The relation between angina and extent of ischaemia is not clear. Several studies have assessed the extent of ischaemia in the presence and in the absence of symptomatic myocardial ischaemia during stress test with contradictory results. Some investigators have reported a greater extent and severity of ischaemia in symptomatic patients than in those with silent myocardial ischaemia, whereas other studies reported no difference in the amount of ischaemic myocardium between patients with and patients without symptomatic myocardial ischaemia during exercise or pharmacological stress testing. In the present study there are no significant differences between dysfunctional segments at rest and the number of ischaemic segments at peak in patients with and without symptomatic myocardial ischaemia. Moreover, the extent of ischaemia during DSE was an independent predictor of cardiac death and myocardial infarction, and the number of diseased vessels was related to an increased rate of cardiac events, particularly in patients with symptomatic ischaemia. This is in line with previous studies that show the total amount of ischaemic territory at risk is related more to the outcome than to the presence of symptoms.

Study limitations

Data on coronary angiography were not available for all patients.

Conclusion

This study showed that patients with asymptomatic myocardial ischaemia during DSE had a worse long term cardiac event-free survival rate than did patients with symptomatic myocardial ischaemia. Patients with asymptomatic ischaemia should be treated with a complete medical therapy or revascularisation as patients with symptomatic myocardial ischaemia.

## References

ELECTRONIC PAGES

Heart Online case reports: www.heartjnl.com

The following electronic only articles are published in conjunction with this issue of Heart.

Rheumatic involvement of all four cardiac valves

K Jai Shankar, P K Jaiswal, K M Cherian

Rheumatic involvement of all four heart valves is rare. A 35 year old woman presented with gradually progressive exertional dyspnoea for the preceding 10 years. On evaluation she was in atrial fibrillation with congestive heart failure. Clinical examination found evidence of stenosis of the mitral aortic and tricuspid valves with a history of rheumatic fever in childhood. Transthoracic echocardiography showed the involvement of all four cardiac valves. Few reports are available in the literature describing rheumatic quadrivalvar damage. Operator awareness of possible rheumatic involvement of all four valves is essential for appropriate diagnosis.

(Heart 2005;91:e50) www.heartjnl.com/cgi/content/full/91/6/e50

Fatal infection after rapamycin eluting coronary stent implantation

F Alfonso, R Moreno, J Vergas

Septic complications after coronary stenting are extremely rare. The occurrence of cardiac related sepsis after rapamycin eluting stent deployment has not been previously reported. The potential role of drug eluting stents in locally blunting the innate response to bacterial agents is discussed.

(Heart 2005;91:e51) www.heartjnl.com/cgi/content/full/91/6/e51