Mitral Annulus Disjunction and Arrhythmic Mitral Valve Prolapse: Emerging Role of Cardiac Magnetic Resonance Imaging in the Workup

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Introduction

Mitral valve prolapse is classically defined as the superior displacement of the mitral valve leaflet for >2 mm during systole. It results from myxomatous degeneration of valve leaflets.¹ The adverse effects include mitral regurgitation, heart failure, infective endocarditis, cardiac arrhythmias, and rarely sudden cardiac death.² Various studies have been performed to identify those patients with a higher risk of fatal ventricular arrhythmias. Timely identification of these high-risk patients will help in the planning of preventive intervention.

Mitral annular disjunction (MAD) is a recently described entity that is frequently associated with mitral valve prolapse. It is a structural abnormality of the annulus, characterized by separation of mitral valve annulus from left ventricular myocardium. Resultant fibrosis acts as an arrhythmic substrate. This can result in ventricular arrhythmia and hence the terminology of arrhythmic mitral valve prolapse is coined² (►Fig. 1).

Cardiac magnetic resonance imaging (CMR) provides excellent morphological information and also helps in the assessment of fibrosis.

Abstract

Mitral valve prolapse is a commonly described entity with a highly variable and benign course. However, it is associated with ventricular arrhythmias and sudden cardiac death in a small subset of patients. Recent studies have yielded insight into myocardial mechanics and the causation of ventricular arrhythmias in these groups of patients. Mitral annular disjunction (MAD) characterized by detachment of mitral annulus from left ventricular myocardium is associated with morphological and functional remodeling of the left ventricular myocardium. Resultant fibrosis acts as a substrate of ventricular arrhythmia and sudden cardiac death.

We present two such cases of arrhythmic mitral valve prolapse associated with MAD.

Keywords

► mitral regurgitation  
► mitral valve prolapse  
► mitral annulus disjunction  
► cardiac MRI

Case Series

Mitral valve prolapse is classically defined as the superior displacement of the mitral valve leaflet for >2 mm during systole. It results from myxomatous degeneration of valve leaflets.¹ The adverse effects include mitral regurgitation, heart failure, infective endocarditis, cardiac arrhythmias, and rarely sudden cardiac death.² Various studies have been performed to identify those patients with a higher risk of fatal ventricular arrhythmias. Timely identification of these high-risk patients will help in the planning of preventive intervention.

Mitral annular disjunction (MAD) is a recently described entity that is frequently associated with mitral valve prolapse. It is a structural abnormality of the annulus, characterized by separation of mitral valve annulus from left ventricular (LV) myocardium. Resultant myocardial curling (posterobasal wall) and fibrosis act as an arrhythmic substrate. This can result in ventricular arrhythmia and hence the terminology of arrhythmic mitral valve prolapse is coined² (►Fig. 1).

Cardiac magnetic resonance imaging (CMR) provides a better assessment of leaflet morphology and mitral annular plane. Myocardial mechanics and function can also be assessed using cine images. Moreover, tissue characterization with late gadolinium enhancement (LGE) images helps in the identification of fibrosis. Thus, CMR provides valuable prognostic information in these patients.³,⁴

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Case Report

Case 1
A 43-year-old male diagnosed with mitral valve prolapse presented with occasional palpitations and mild chest discomfort. Clinical examination revealed tachycardia with a midsystolic click. An invasive cardiac angiogram performed 2 years ago showed unobstructed coronary arteries. His troponins were negative and electrolytes were normal. Two-dimensional (2D) echocardiography showed normal wall motion and function. The mitral valve showed myxomatous morphology with bileaflet prolapse. The presence of spiked systolic lateral mitral annular velocities (Pickelhaube sign) was noted with moderate mitral regurgitation (►Fig. 2).

CMR confirmed mitral valve prolapse and moderate mitral regurgitation (regurgitant volume = 37 mL and regurgitant fraction = 31%). Cine images in the long axis reveal separation of LV myocardium from mitral valve annulus, suggesting annular disjunction (separation for 13 mm). Systolic curling of the posterobasal left ventricle was also evident. There was no significant late gadolinium enhancement, however. Mild reduction of global longitudinal strain (GLS; 18.5%) and increased T1 values (1,250 ms; normal values: 1,150 ± 50 ms) were observed. The left ventricular ejection fraction (LVEF) was normal 60% (►Fig. 3).

Case 2
A 40-year-old female with a history of mitral valve prolapse presented with two episodes of sustained ventricular tachycardia, reverted with adenosine. Clinical examination revealed a holosystolic murmur. 12-lead electrocardiogram (ECG) showed sinus rhythm without signs of ischemia. 2D echocardiography showed depressed LV systolic function, myxomatous mitral valve, bileaflet mitral valve prolapse (MVP), and severe mitral regurgitation. There was a separation of LV myocardium from mitral valve annulus, suggestive of mitral annulus disjunction. There was also the presence of ostium secundum atrial septal defect with left to right shunt (►Fig. 4).

CMR showed thickened myxomatous mitral valve leaflets and mitral valve prolapse with severe mitral regurgitation (regurgitant volume = 42 mL, regurgitant fraction = 40%). Cine images reveal separation of LV myocardium from mitral valve annulus suggesting annular disjunction (longitudinal distance: 9 mm). There is systolic curling of the posterobasal left ventricle. Bowing of interatrial septum toward right side noted with subtle defect and dephasing jet suggestive of ostium secundum atrial septal defect. No regional wall motion abnormality was seen. Focal late gadolinium enhancement was observed at the LV posterobasal wall. There was a reduction of GLS (20.6%) and increased T1 values (1,321 ms; normal values: 1,150 ± 50 ms). LVEF is mildly reduced 52% (►Fig. 5).
Methodology

Contrast-enhanced CMR was performed on 3-Tesla MRI scanner (Magnetom Verio; Siemens, Erlangen, Germany) with a phased-array body coil. ECG gated spin-echo and gradient-echo images were obtained with 25 phases of the cardiac cycle. Cine steady-state free precession pulse sequences were acquired in two-chamber, four-chamber, three-chamber, and parallel contiguous short-axis stack. Phase-contrast images of the aorta and main pulmonary artery were obtained.

0.15 mmol/kg gadobutrol (Gadovist, Bayer Pharma AG, Leverkusen, Germany) was administered intravenously with acquisition of postcontrast perfusion. Delayed enhancement images were acquired at a 10-minute interval after administration of gadolinium. Data analysis and postprocessing was performed on dedicated CMR postprocessing software (suite-HEART; NeoSoft LLC, Wisconsin, United States).

Multiplanar capability, superior spatial resolution, accurate assessment of chamber size and function are few reasons why CMR is the preferred modality for workup in these groups of patients. More importantly, tissue characterization obtained with late gadolinium enhancement images is the gold standard for the evaluation of myocardial fibrosis. The following table (► Table 1) is a summary of MRI findings and an ideal view/sequence for the assessment of different pathological abnormalities.3–8

Mitral valve annulus is a three-dimensional (3D) structure; hence, assessment of the entire circumference is essential. High-quality images and multiple planes obtained during tailored MRI protocol will be essential for a complete assessment. Additional CMR sequences may be performed for detailed assessment of mitral valve, prolapse, regurgitation and circumferential MAD as shown in (►Fig. 6).3,9 However, these could not be performed in our cases due to time constraints.

Discussion

The mitral annulus is a 3D saddle-shaped structure exhibiting dynamic changes during the cardiac cycle. The motion of the annulus is passive and determined by the contraction and relaxation of adjacent structures. Normally the annulus contracts during systole and moves downward and anteriorly. This is important for the balanced distribution of mechanical stresses.10,11

Mitral valve prolapse is estimated to affect approximately 2 to 3% of the general population. The clinical outcomes are highly variable and depend on factors like age, degree of...
Table 1 CMR workup³⁻⁸

| Abnormality                          | CMR findings                                                                 | CMR workup.                                                                 | Implications                                                                 |
|--------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Prolapse                             | Superior displacement of valve leaflet >2 mm                                   | 2C, 4C, 3C cine (end systole)                                              | >8.5 mm increased risk of ventricular arrhythmias                           |
| Classic/myxomatous                    | Leaflet thickening >5 mm                                                     | 2C, 4C, 3C cine                                                            |                                                                           |
| Longitudinal distance for mitral annular disjunction | Distance between left atrial (LA) wall-posterior mitral valve (MV) leaflet junction to the top of the LV inferobasal wall during end-systole. (if >1 mm) | 2C, 3C cine (end systole) | >8.5 mm increased risk of ventricular arrhythmias                           |
| Left ventricular (LV) basal to mid ventricular thickness | Ratio of LV thickness of basal and mid segments of the inferolateral wall | 2C, 3C cine (end diastole) | ≥1.5 indicates basal LV hypertrophy Locally increased stretch and myocardial function |
| Curling of myocardium                | Line between the top of LV inferobasal wall and the LA wall–posterior MV leaflet junction, and from this line, a perpendicular line to the lower limit of the mitral annulus | 2C, 3C cine (end systole) | ≥3.5 mm severe curling                                                      |
| Paradoxical annulus expansion        | Positive difference between end-systolic diameter and end-diastolic diameter | Cine images                                                                 | Increased risk of failure of Mitral Valve repair                           |
| Fibrosis                             | LV wall or papillary muscle LGE                                              | Delayed enhanced images                                                    | LV fibrosis acts as a substrate for electrical instability                 |
| Severity of MR                       | LV stroke volume—forward flow of aorta (for regurgitant volume/fraction)     | Cine and phase-contrast images                                              |                                                                           |
| Global longitudinal strain           | Deformation analysis                                                         | Feature tracking                                                           |                                                                           |
| T1 mapping                           | Increased values with interstitial fibrosis                                   | Parametric mapping (MOLLI/SHMOLLI)                                         |                                                                           |

Abbreviations: C, chamber, CMR, cardiac magnetic resonance imaging; MOLLI, Modified Look-Locker inversion recovery; ShMOLLI, shortened MOLLI.
mitral regurgitation, LVEF, ventricular ectopy, and atrial diameters. High-risk populations may develop significant MR, heart failure, infective endocarditis, stroke, cardiac arrhythmias, and even sudden cardiac death.\(^\text{12}\)

The classification of MVP is shown in the following table (Table 2).\(^\text{13,14}\)

| Clinical classification               | Histological classification                      |
|--------------------------------------|-------------------------------------------------|
| Primary/nonsyndromic                 | Barlow's Disease                                 |
|                                      | Classic/myxomatous degeneration                   |
| Secondary/syndromic                 | Fibroelastic deficiency                           |
|                                      | Diffusely thinned leaflets with focal thickening  |

MAD is defined as a wide separation between the left atrium-mitral valve junction and left ventricular free wall. In simpler words, it is the superior displacement/atrialization of the posterior leaflet base. It leads to paradoxical annular enlargement and flattening during systole with systolic curling of the LV, increasing stress on the leaflets and chordae which may accelerate the degenerative process. The mechanical traction on the papillary muscles and posterolateral LV wall can lead to morphological and functional remodeling including myocardial hypertrophy or fibrosis which could be the substrate of ventricular arrhythmias and sudden cardiac death. In fact, due to these underlying myocardial involvements, this condition is also known as “concealed cardiomyopathy.”\(^\text{4,15}\)

MAD can also occur “de novo,” in normal individuals without mitral valve prolapse. However, an increased prevalence of arrhythmias is associated with this abnormality.\(^\text{3}\)

Arrhythmic mitral valve prolapse is characterized by myxomatous degeneration, bileaflet prolapse, mitral annular disjunction, and papillary muscle fibrosis. A combination of mechanically triggered premature ventricular contractions (PVCs) from the mitral valve apparatus with the increased autonomic tone, predisposes for the development of sudden cardiac death in these high-risk individuals.\(^\text{12}\)

Close surveillance monitoring and medications like β-blockers will provide first-line therapy in symptomatic individuals. Catheter ablation is reserved for cases where electrical triggers can be mapped. Defibrillator therapy and mitral valve surgery are other long-term options.\(^\text{12}\)

**Conclusion**

Mitral annulus disjunction shows an increased prevalence of arrhythmic events. Hence timely diagnosis is crucial in patient management. Though it can be identified on 2D echocardiography/TEE, CMR undoubtedly adds value to diagnosis.

The mitral annular plane is a 3D structure; hence, assessment of the entire circumference can be archived with focused CMR study. Correct planning and tailored CMR protocol will provide diagnostic, as well prognostic information of this life-threatening condition.

**Note**

The study was undertaken by conforming to the Declaration of Helsinki.
Conflict of Interest
None declared.

Acknowledgments
All cardiac magnetic resonance imaging data postprocessing has been done using suiteHEART; NeoSoft LLC, Wisconsin, United States.

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