Transthyretin Cardiac Amyloidosis: A Noninvasive Multimodality Approach to Diagnosis Using Transthoracic Echocardiography, 99m-Tc-Labeled Phosphate Bone Scanning, and Cardiac Magnetic Resonance Imaging

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INTRODUCTION

This case report highlights the utility of noninvasive imagining modalities, specifically transthoracic echocardiography in conjunction with nuclear medicine bone scan and cardiac magnetic resonance imaging (MRI) for the diagnosis of transthyretin (TTR) cardiac amyloidosis. Historically, the differentiation of this diagnosis from amyloid light chain (AL) amyloidosis is made via invasive endomyocardial biopsy, which has the risks of an invasive procedure, is limited by sampling errors, and does not provide information about the extent of involvement of different organs.[1] This case demonstrates a noninvasive approach to the differentiation of these two clinically distinct forms of amyloid.

CASE PRESENTATION

A 77-year-old man with a long-standing history of polyarthritis consulted his musculoskeletal physician for investigation of worsening neck and shoulder discomfort. As part of his workup, a Tc99m-hydroxymethylene diphoshonate (HDP) bone scan with single photon emission computed tomography (CT) imaging of the upper spine and delayed whole-body imaging demonstrated arthropathy of the cervical spine and shoulder girdle (see Figure 1A). Unexpectedly, this bone scan also demonstrated moderately increased, diffuse tracer uptake throughout the myocardium of the left ventricle (see Figure 1B).

This man had a background of hypertension controlled by a single antihypertensive agent as well as gout. He had no neuropathy, bowel symptoms, orthostatic hypotension, or visible periorbital or tongue infiltration. He had moderate exertional dyspnea (New York Heart Association class 2) and mild peripheral edema but clear lungs. His electrocardiogram did not show the classical low voltages of AL cardiac amyloidosis but rather demonstrated significant conduction disease with first-degree atrioventricular block, leftward axis, and a right bundle branch block (see Figure 1C). He had previously undergone a CT coronary angiogram, which demonstrated only minor coronary artery plaque.

Transthoracic echocardiography demonstrated moderately increased left ventricular wall thickness (septum, 17 mm; posterior wall, 15 mm; mass index, 142 g/m^2) and right ventricular thickness (13 mm), consistent with an infiltrative process (see Figure 2A and 2B, Videos 1-5). There was evidence of elevated left ventricular filling pressures (American Society of Echocardiography 2016 guidelines[2]) with mitral E/A = 0.75, E = 70 cm/sec, average E/e′ = 15, and left atrial volume index 35 mL/m^2. There was no pulmonary hypertension (right ventricular systolic pressure = 20 mm Hg) and normal transpulmonary gradient as indicated by an echocardiographic pulmonary to left atrial ratio of 0.14 m/sec.[3] Myocardial strain imaging of the left ventricle demonstrated a mild reduction in global longitudinal strain at −18.8%. Importantly, the polar map demonstrated the typical apical sparing pattern, which has become pathognomonic of cardiac amyloidosis[4] (see Figure 2C).

Cardiac MRI, with its unique ability to define myocardial infiltration and enhancement, was performed to supplement the echocardiogram. A 3 T scanner (Skyra, Siemens, Erlangen Germany) was used to acquire CINE views of the whole heart. Functional parameters were acquired by means of ARGUS analytical Software (Siemens, Germany). T1 mapping was performed pre- and 5 minutes postcontrast (0.2 mmol/kg of gadolinium), as early-phase postcontrast timing has the greatest point of discrimination in the setting of amyloidosis (see Videos 5 and 6).[5] There was increased left ventricular myocardial wall thickening (mean, 17 mm) and increased myocardial mass (145 g/m^2), which would be consistent with both light chain (AL) and TTR amyloidosis. There was excellent correlation of the left ventricular mass and wall thickness with the echocardiographically derived data. On T1 mapping, extracellular volume indices were supportive of a diagnosis of amyloidosis (see Figure 2D and 2E) with diffuse, predominantly transmural enhancement.

The usual workup for patients with the anatomic and functional features of cardiac amyloidosis focuses on first ruling in or ruling out the marrow diseases, multiple myeloma, and AL amyloidosis (see Figure 3).[6] In this patient, serum immunofixation electrophoresis studies excluded monoclonal paraproteinemia and urine immunofixation electrophoresis studies showed no suggestion of Bence-Jones protein. Bone marrow aspirate showed no clonal abnormality or immunoproliferative disorder. Abdominal wall fat pad biopsy showed no morphological features of amyloid deposition. However, rectal

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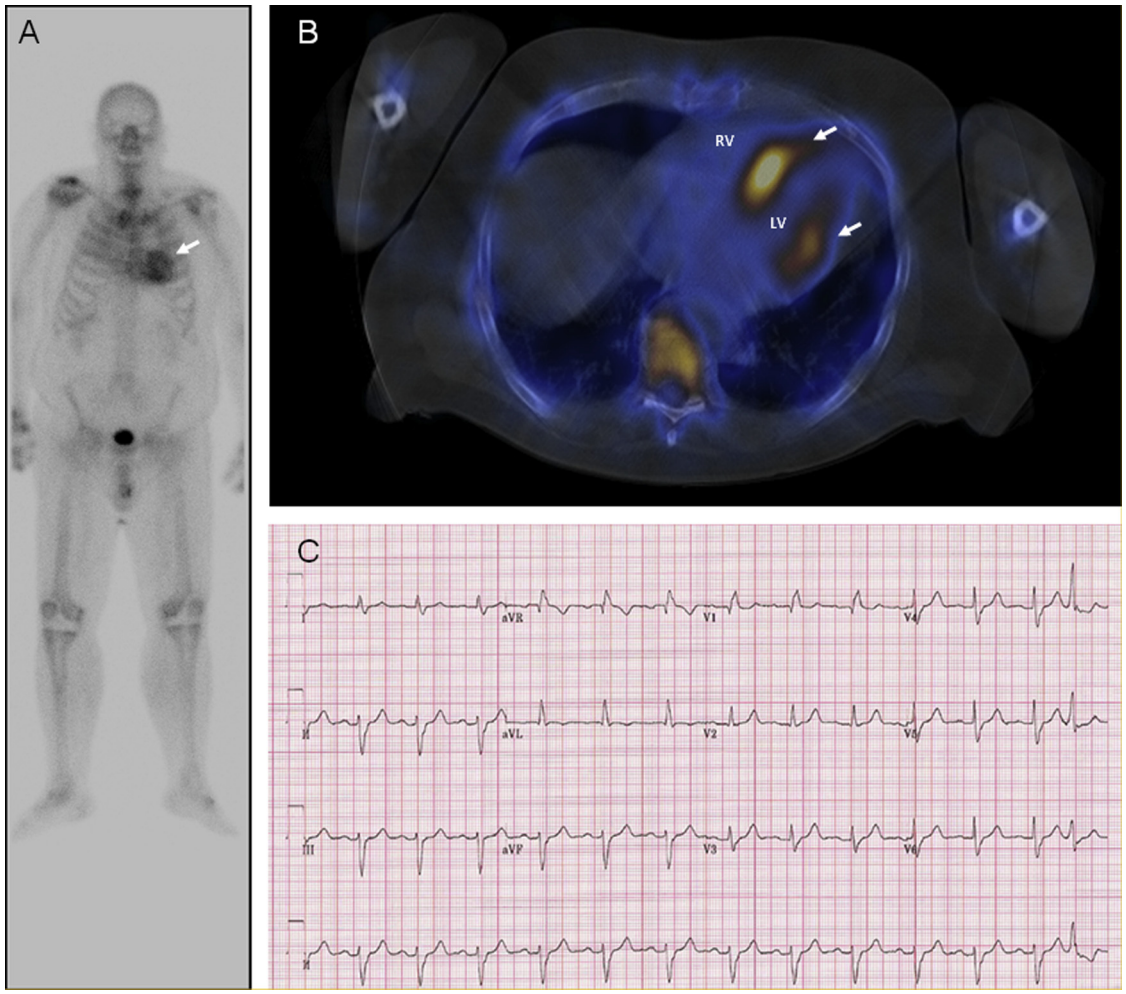

Figure 1 **(A)** Tc99m-HDP whole-body bone scan with single photon emission CT imaging demonstrating diffusely increased tracer uptake throughout the myocardium (*arrow*) and the right shoulder. **(B)** Axial tomographic scan, as viewed from the feet, of Tc99m-HDP bone scan tracer (*yellow*) in the walls (*arrows*) of the left ventricle (LV; RV, right ventricle). **(C)** Twelve-lead electrocardiogram did not show the classical low voltages of AL cardiac amyloidosis but rather showed significant conduction disease with first-degree atrioventricular block, leftward axis, and a right bundle branch block.

biopsy was positive on congo-red stain, indicative of submucosal amyloid. Genetic testing was declined by the patient. With the provisional diagnosis of TTR cardiac amyloidosis, conservative management was chosen by the patient. Six-month follow-up repeat transthoracic echocardiography showed no progression of disease. The clinical status remained stable.

DISCUSSION

Amyloidosis results from extracellular deposition of insoluble fibrillary protein. Clinical manifestations of these diseases are myriad and depend on the various organ and tissue infiltrates in any given patient.[7] The nature of the unique protein in each case determines the pattern of organ involvement including nephropathy, polyneuropathy, ophthalmopathy, and cardiomyopathy. The classification of subtypes of amyloidosis is based on the source of production of the protein and includes the following.

- AL amyloid—plasma cell disorders, including multiple myeloma, with production of amyloid-forming monoclonal immunoglobulin (e.g., light chains). Cardiac involvement occurs in about 50% of cases. Prognosis is poor, with survival reported as 48 months, dropping to 5-8 months with cardiac involvement.[8]
- TTR—127 amino acid tetramer protein (formerly known as prealbumin) produced in the liver.[9]
  - Age-related (senile/wild-type) systemic amyloidosis is a sporadic, nongenetic disease misaggregation of a wild-type TTR monomer in the myocardium and other sites (gastrointestinal tract 25%). Untreated survival is measured in years to decades.
  - Mutant TTR amyloidosis—typically familial/autosomal dominant with peripheral and/or autonomic neuropathy and cardiomyopathy.[1]
- AA amyloid (chronic inflammation, serum amyloid A)—rarely results in cardiac involvement.
- Dialysis-related amyloidosis.
- Organ-specific amyloidosis.
- Heritable amyloidosis.

Cardiac amyloidosis is a progressive disorder beginning with subclinical myocardial deposition of fibrils, left and right ventricular wall thickening, and impairment of diastolic function.[10] As the volume of infiltration increases, patients develop clinical heart failure with preserved ejection fraction. Finally, end-stage cardiac amyloidosis involves systolic and diastolic dysfunction, cardiac conduction defects, and arrhythmias.[11]