Establishing stable sinus rhythm in an endurance athlete with paroxysmal supraventricular tachycardia improves haemodynamical performance during exercise testing

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DESCRIPTION

Atrial fibrillation is a commonly known heart rhythm abnormality that occurs not only in the general population but also in endurance athletes. Various studies have even described an increased prevalence among athletes.1–4

We recently presented the case of a well-experienced 60-year-old man endurance Ironman-triathlon athlete (187 cm, 92 kg, average training level: 10–15 hours/week) who had presented with intermittent shortness of breath and heart palpitations during his training sessions in his daily routine.5 His medical history showed an isthmus ablation caused by typical atrial flutter and a clinically stable arterial hypertension. The echocardiographic data showed a normal size of the left ventricle (left ventricular end diastolic diameter (LVedd) 42 mm), no hypertrophia of the left ventricular walls (interventricular septum thickness (IVSd) 11 mm, posterior wall thickness in systole (PWTs) 11 mm), a minimal enlargement of the left atrium (LA 21 qcm) and a normal ejection fraction (55%). Cardiopulmonary exercise testing (CPEX, ergometer bike) revealed an episode of paroxysmal supraventricular tachycardia (SVT, maximum effort 250 W). We were able to graphically record the degree to which the athlete’s performance was reduced (figures 1 and 2). The patient’s oxygen pulse decreased pathologically and his VO2 oxygen uptake during the SVT was limited (figures 1 and 2).

In the course of a recently conducted further examination and therapy of the same patient, we performed an electrophysiological examination with an ablation of the pulmonary veins (pulmonary vein isolation with a three-dimensional mapping system) and re-evaluated the patient’s clinical performance with a further echocardiographic examination and a CPEX on an ergometer bike. The echocardiographic data showed a stable trend in the follow-up appointment (LVedd 43 mm, IVSd 11 mm, PWTs 11 mm, LA 20 qcm, normal ejection fraction 55%–60%). After the CPEX testing, the patient recovered fast and no episodes of SVT were detected. The haemodynamic influence of the established stable sinus rhythm was recorded graphically in the comparison of pre-interventional and postinterventional CPEX figures (figures 1 and 2 vs figures 3 and 4).

Our case graphically shows the haemodynamic influence of a paroxysmal atrial fibrillation and the consequent reduced performance of a patient during CPEX. According to the clinical appearance and the athlete’s reporting, it highlights the...
In this context, we recently presented our first findings before establishing a stable sinus rhythm. By mapping the LA during the electrophysiological examination with an ablation of the pulmonary veins (pulmonary vein isolation with a three-dimensional mapping system), signs of atrial myocardial fibrosis could be detected in our athlete. This is one of the various aspects of this condition, which are widely discussed, presupposing the relation between high endurance training and the prevalence of atrial fibrillation. Causes for the higher prevalence of atrial fibrillation include: (1) myocardial fibrosis, which is sometimes caused by the accumulation of lifelong training hours and increased atrial filling pressure, (2) varying amplitude of the autonomic nervous system, (3) increased baroreflexive responsiveness and (4) increased sensitivity of cardiomyocytes to cholinergic stimulation.

The development of atrial fibrillation in endurance athletes with prior ablation of atrial flutter is a commonly known occurrence. The recently reported ‘paroxysmal AF in young and middle-aged athletes’ (PAFIYAMA) syndrome is also an interesting fact in this context; our athlete might fulfill these criteria.

In summary, the presented case shows the importance of establishing a stable sinus rhythm in endurance athletes to improve their haemodynamic performance in CPEX. As mentioned above, these facts have been graphically proved and our findings emphasised the importance of an individualised patient’s treatment strategy in PAFIYAMA syndrome. Therefore, a sustained cardiac functional improvement after establishing a stable sinus rhythm suggests an improvement of quality of life and an objective improvement of cardiac function and exercise capacity in these athletes/patients.

Contributors

PZ and CL designed data collection tools, monitored data collection for the Case Report, cleaned and analysed the data and drafted and revised the paper. Both authors have read and approved the final version of the manuscript.

Funding

The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests

None declared.

Patient consent for publication

Obtained.

Provenance and peer review

Not commissioned; externally peer reviewed.

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