Clinical Implications and Determinants of Left Atrial Mechanical Dysfunction in Patients With Stroke

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Background and Purpose—The evaluation of sources of cardioembolism with transesophageal echocardiography (TEE) in patients with stroke is crucial but semi-invasive. We hypothesized that the size and mechanical function of the left atrium (LA) assessed by transthoracic echocardiography (TTE) could provide useful information on high risk of cardioembolism on TEE in patients with stroke. Furthermore, we sought to define the determinants of LA mechanical dysfunction in these patients.

Methods—A total of 248 patients with acute ischemic stroke (147 men; 64±13 years) who underwent 2-dimensional and speckle tracking TTE followed by TEE were analyzed.

Results—LA appendage emptying velocity, prevalence of LA or LA appendage thrombus, prevalence of aortic plaques, and incidence of embolic stroke showed significant differences among the 4 groups classified according to the median values of the LA volume index and global LA longitudinal strain (LALS). Patients at high risk of cardioembolism evidenced by TEE revealed significantly larger LA volume index and lower global LALS than those without. Global LALS (cutoff, 11.5%); area under the curve, 0.947; sensitivity, 100%; specificity, 91%; P<0.001) revealed a significantly better diagnostic power (P=0.04) for LA or LA appendage thrombus than LA volume index (cutoff, 36.2 mL/m²; area under the curve, 0.823; sensitivity, 88%; specificity, 75%; P=0.002). Age, left ventricular systolic function, LA volume index, and pulse wave velocity were independent determinants for global LALS.

Conclusions—LA mechanical dysfunction is closely associated with high risks of cardioembolism. Global LALS assessed by speckle tracking TTE well discriminates the presence of LA or LA appendage thrombus on TEE in patients with acute ischemic stroke. (Stroke. 2016;47:00-00. DOI: 10.1161/STROKEAHA.115.011656.)

Key Words: atrial appendage • echocardiography, transesophageal • heart atria • pulse wave analysis • stroke • thrombosis

Cardiovascular evaluation in patients presenting with acute ischemic stroke is clinically important not only for the evaluation of potential sources of cardioembolism but also for the assessment of coexisting cardiovascular disease and risk of future events. During the past few decades, transesophageal echocardiography (TEE) has been the most sensitive technique for the detection of thrombi or flow stasis in the left atrium (LA) or LA appendage (LAA), as well as aortic atheroma.1–3 TEE is widely available for patients with acute ischemic stroke; however, some patients, particularly those with neurological disabilities, cannot undergo TEE because of its semi-invasive nature.4 Therefore, dual-enhanced cardiac computed tomography with electrocardiographic gating has been suggested as an alternative imaging modality for detecting LA or LAA thrombi.4 However, it also has several issues, including radiation exposure, renal dysfunction, and allergic reaction to contrast media.

Recent studies suggest that enlargement of LA is associated with both first and recurrent episodes of stroke.5,6 Association of LA size and stroke is not well understood; however, compromised LA function would result in flow stasis and increase the risk of embolism. The global LA longitudinal strain (LALS) assessed by 2-dimensional (2D) speckle tracking TTE is a relatively simple and reproducible technique to assess LA function.6 We hypothesized that enlargement and impaired mechanical function of LA assessed by TTE with speckle tracking imaging could provide useful information for high risk of cardioembolism detected from TEE in patients.
with stroke. Furthermore, we sought to define the major determinants of LA mechanical dysfunction in these patients.

**Methods**

**Study Subjects**

The study population consisted of 316 acute patients with ischemic stroke who were referred to the cardiology division for both TTE and TEE based on part of the standard evaluation except in patients with decreased consciousness, impending brain herniation, poor systemic conditions, inability to accept an esophageal transducer because of swallowing difficulty or tracheal intubation, or lack of informed consent from April 2012 to June 2013. Exclusion criteria were significant valvular heart disease (n=28), previous history of valve repair or replacement (n=7), previous history of radiofrequency ablation (AF; n=20), and newly documented AF (n=11) during TEE or TTE. Finally, a total of 248 patients were analyzed. All underwent TTE and TEE within 1 week of the initial stroke. Ischemic stroke was confirmed by a focal neurologic deficit of sudden onset and magnetic resonance imaging findings. Patients with a transient ischemic attack and negative imaging findings were not included. Clinical information of patients was determined at the time of examination. The subtypes of ischemic stroke were classified according to the Trial of Org 10172 in Acute Stroke Treatment criteria (TOAST criteria) by neurologists. Twelve-lead electrocardiography was done at admission, and continuous 12-lead electrocardiographic monitoring was performed on the stroke unit within the first 48 to 72 hours after admission to detect silent paroxysmal AF.

To assess the various parameters in relation to size and mechanical function of LA, patients were categorized into 4 groups according to their median LA volume index (28 mL/m²) and global LALS (23%): group 1 (n=81), small LA with preserved LALS; group 2 (n=43), large LA with preserved LALS; group 3 (n=43), small LA with impaired LALS; and group 4 (n=81), large LA with impaired LALS.

**Conventional Transthoracic Echocardiography**

Each patient underwent a comprehensive TTE study using a Vivid 7 or Vivid 9 cardiovascular ultrasound system (GE Medical Systems, Horten, Norway), equipped with 2.5- to 3.5-MHz phased-array sector probes. During TTE, 1-lead electrocardiographic recording was done at admission, and continuous 2D and Doppler measurements were performed per the recommendations of the American Society of Echocardiography guidelines.

**Speckle Tracking Echocardiography**

Each patient underwent a 2D speckle tracking echo of the LA. Three consecutive cardiac cycles were recorded and averaged, and the frame rates were set to 60 to 80 frames per second. The analysis was performed offline using customized software (EchoPAC PC; GE Medical Systems). The LA endocardial border was manually traced in both 4-chamber and 2-chamber views. Because 2 segments of the LA roof demonstrated a lower longitudinal strain curves than those of the other 4, they were excluded from both the 4-chamber and the 2-chamber views. Therefore, global peak LALS during the ventricular systole was then measured by averaging the values obtained in the 8 other LA segments. The time to peak LALS is also measured as the average of the 8 segments and by calculating the time delay from the QRS to the positive peak LALS. An experienced cardiologist unaware of the patients’ information analyzed all echocardiographic values.

**Transthoracic Echocardiography**

TEE was performed immediately after TTE using a 5- to 7-MHz multplane, and images were independently reviewed by 2 experienced cardiologists. Multiple standard tomographic planes were imaged, and LAA emptying velocity, the presence of LAO or LAA thrombus, the presence of patent foramen ovale, and severity of spontaneous echo contrast in the LA or LAA were determined. Peak LAA emptying velocities were measured using pulsed Doppler by placing the sample volume ≈1 cm inside of the orifice of the LAA. The peak emptying wavelets were measured in 3 consecutive cycles, and the maximal velocities were then averaged. An LA or LAA thrombus was diagnosed by the presence of an echo-dense mass in the LA or LAA, distinct from the endocardium and the pectinate muscles of the LAA.

The spontaneous echo contrast was diagnosed by the presence of characteristic dynamic smoke-like swirling echo in the LA or LAA, and the severity was classified into 1 of the 4 grades as previously described. A patent foramen ovale was considered to be present if any microbubble was seen in the left-sided cardiac chambers within 3 cardiac cycles using saline contrast injections.

Aortic assessment was performed in all patients. The proximal aorta (aortic arch and ascending aorta) was imaged in short and long axes. An aortic plaque was defined as a hyperchogenic thickened area causing protrusion in the aortic lumen with >2 mm. Aortic plaques were classified as simple or complex on the basis of morphologic features. A complex aortic plaque was defined as a plaque that protrudes at least 4 mm into the aortic lumen or that is associated with ulceration or mobile features. Maximal aortic wall thickness was measured in the descending aorta perpendicular to the aortic wall. After comprehensive assessments, high-risk findings of cardioembolism from TEE were defined by the presence of thrombi at LA or LAA, LAA emptying velocity <20 cm/s, or the presence of complex atheroma.

**Pulse Wave Velocity**

Brachial ankle pulse wave velocity (baPWV) was obtained by 1 measurement within 7 days of admission in the supine position using an automated device (VP-1000; Colin Co Ltd, Komaki, Japan) as described previously. For analysis, the averaged value of baPWV from both sides was calculated.

**Statistical Analysis**

Continuous variables were presented as mean±SD and categorical variables as absolute and relative frequencies (%) of the group total. Among the data, continuous variables were compared between the groups using the Student t test (for 2-group comparisons) and analysis of variance (for 4-group comparisons), whereas the categorical variables were compared by χ² test or analysis of variance. We constructed the receiver operating characteristic curves to determine the diagnostic ability of global LALS or LA volume index. The diagnostic performances of the global LALS and LA volume index were compared through the Delong tests. To find the independent determinants of global LALS, multiple linear regression analysis was performed.

**Results**

**Clinical Characteristics**

The mean age of patients was 64±13 years, and men made up 58.1% of the population. Table 1 shows baseline clinical characteristics of the 4 groups. Patients in group 4, who were characterized by large LA volume and decreased global LALS, were significantly older than those in the other groups. There was no statistically significant difference in the distribution of sex or comorbidities. In terms of type of stroke, embolic stroke was the most frequent in group 4 with statistical significance. Systolic blood pressure and pulse pressure in group 4 were significantly higher than those in group 1, and baPWV increased from group 1 to 4 in a stepwise manner.

**Echocardiographic Characteristics**

Echocardiographic parameters are described in Table 2. Because the patients were classified into 4 groups based on their LA volume index and global LALS, the LA volume index and global LALS were significantly different among the
groups. Time to peak LALS was significantly shorter in group 1 than in other groups, whereas \( A' \) velocity was significantly lower in group 4 than other groups. The parameters representing LV structure, systolic function, and diastolic function were also different among the groups. The patients in groups 2 and 4, who had a large LA size, tended to have a larger LV dimension and higher LV mass index than those in groups 1 and 3. Patients in group 4 showed an impaired LV longitudinal systolic and diastolic function and higher estimated LV filling \((E/e')\) pressure than other groups. In terms of TEE parameters, LAA emptying velocities were significantly lower in group 4, and the incidences of thrombus or spontaneous echo contrast in LA or LAA also differed significantly. No patients in group 1 or 2 showed an LA or LAA thrombus. Aortic wall thickness increased gradually from group 1 to 4. The incidence of aortic arch plaque was significantly higher in group 4. Interestingly, the incidence of complex aortic plaques increased in a stepwise manner from group 1 to 4. Incidence of patent foramen ovale was significantly different among 4 groups and most frequently found in group 1.

**Diagnostic Performance of LA Volume Index and Global LALS for High Risk of Cardioembolism**

A global LALS <11.5% showed a significantly better diagnostic performance \((P=0.04)\) for the presence of an LA or LAA thrombus (area under the curve [AUC], 0.95; sensitivity, 100%; specificity, 91%; \(P<0.001\)) than the LA volume index (cutoff, 36.2 mL/m²; AUC, 0.82; sensitivity, 88%; specificity, 75%; \(P=0.002\); Figure 1A). All 8 patients who presented with thrombi at LA or LAA showed LALS <11.5%, whereas their LA volume index showed a wide range of distribution (Figure 1B). Patients with the global LALS <11.5% were significantly older than those with the global LALS >11.5% (71±10 versus 62±12 years; \(P<0.01\)).

For the decreased LAA emptying velocity <20 cm/s, which is prone to thrombus formation, both global LALS (cutoff, 10.8%; AUC, 0.91; sensitivity, 80%; specificity, 92%; \(P<0.01\)) and LA volume index (cutoff, 41.6 mL/m²; AUC, 0.91; sensitivity, 80%; specificity, 88%; \(P<0.001\)) showed good diagnostic values without significant difference between 2 parameters \((P=0.95)\). On the other hand, the global LALS (cutoff, 24.2%; AUC, 0.74; sensitivity, 55%; specificity, 84%; \(P<0.001\)) showed better diagnostic performances of the preserved LAA emptying velocity ≥40 cm/s than LA volume index (cutoff, 29.5 mL/m²; AUC, 0.64; sensitivity, 57%; specificity, 73%; \(P<0.01\)) with a significant difference \((P=0.03)\).

Both global LALS and LA volume index showed good diagnostic performances for the complex aortic plaque (AUC, 0.64; sensitivity, 72%; specificity, 51%; \(P<0.01\) and AUC, 0.61; sensitivity, 61%; specificity, 55%; \(P=0.011\)).

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**Table 1. Clinical Characteristics**

<table>
<thead>
<tr>
<th></th>
<th>Group 1 (n=81)</th>
<th>Group 2 (n=43)</th>
<th>Group 3 (n=43)</th>
<th>Group 4 (n=81)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>57.9±12.2</td>
<td>59.6±11.9</td>
<td>64.1±11.2*</td>
<td>70.1±10.2*†‡</td>
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<tr>
<td>Male sex, n (%)</td>
<td>52 (64)</td>
<td>25 (58)</td>
<td>26 (61)</td>
<td>44 (54)</td>
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<td>Body mass index, kg/m²</td>
<td>24.0±3.6</td>
<td>24.0±3.0</td>
<td>24.3±2.9</td>
<td>23.5±3.3</td>
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<td>Hypertension, n (%)</td>
<td>47 (58)</td>
<td>31 (72)</td>
<td>27 (63)</td>
<td>61 (76)*</td>
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<td>Diabetes mellitus, n (%)</td>
<td>24 (30)</td>
<td>14 (33)</td>
<td>18 (42)</td>
<td>27 (33)</td>
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<tr>
<td>Dyslipidemia, n (%)</td>
<td>22 (27)</td>
<td>8 (19)</td>
<td>10 (23)</td>
<td>12 (15)</td>
</tr>
<tr>
<td>Smoking, n (%)</td>
<td>26 (32)</td>
<td>15 (35)</td>
<td>15 (35)</td>
<td>27 (33)</td>
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<tr>
<td>Previous stroke, n (%)</td>
<td>15 (19)</td>
<td>9 (21)</td>
<td>8 (19)</td>
<td>20 (25)</td>
</tr>
<tr>
<td>Previous MI, n (%)</td>
<td>1 (1)</td>
<td>1 (2)</td>
<td>3 (7)</td>
<td>3 (4)</td>
</tr>
</tbody>
</table>

**Type of stroke, n (%)**

<table>
<thead>
<tr>
<th></th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Group 4</th>
</tr>
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<tr>
<td>Large artery atherosclerosis</td>
<td>27 (33)</td>
<td>12 (28)</td>
<td>14 (32)</td>
<td>25 (31)</td>
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<tr>
<td>Cardioembolism</td>
<td>13 (16)</td>
<td>8 (19)</td>
<td>6 (14)</td>
<td>29 (36)*†‡</td>
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<tr>
<td>Lacunar</td>
<td>23 (28)</td>
<td>14 (33)</td>
<td>11 (26)</td>
<td>13 (16)</td>
</tr>
<tr>
<td>Cryptogenic</td>
<td>19 (34)</td>
<td>9 (21)</td>
<td>12 (28)</td>
<td>14 (19)</td>
</tr>
<tr>
<td>Systolic blood pressure, mmHg</td>
<td>136±19</td>
<td>143±20</td>
<td>137±17</td>
<td>142±19*</td>
</tr>
<tr>
<td>Diastolic blood pressure, mmHg</td>
<td>81±15</td>
<td>84±14</td>
<td>81±13</td>
<td>81±13</td>
</tr>
<tr>
<td>Pulse pressure, mmHg</td>
<td>55±17</td>
<td>59±17</td>
<td>56±12</td>
<td>61±16*</td>
</tr>
<tr>
<td>Brachial ankle PWV, m/s</td>
<td>1797±497</td>
<td>1802±361</td>
<td>2067±652*†</td>
<td>2111±425*†</td>
</tr>
</tbody>
</table>

Group 1, small LA with preserved LALS; group 2, large LA with preserved LALS; group 3, small LA with impaired LALS; and group 4, large LA with impaired LALS. LA indicates left atrium; LALS, left atrial longitudinal strain; MI, myocardial infarction; and PWV, pulse wave velocity.

*\(P<0.05\), compared with group 1.
†\(P<0.05\), compared with group 2.
‡\(P<0.05\), compared with group 3.
respectively) without significant differences between 2 parameters ($P=0.44$).

Figure 2 describes different LA size and mechanical function in patients with or without high-risk findings of cardioembolism detected from TEE. Patients at high risks of cardioembolism revealed significantly larger LA volume index (36±14 versus 29±10 mL/m²; $P<0.01$) and lower global LALS (19±6% versus 25±8%; $P<0.01$) than those without.

**Determinants of LA Mechanical Function**

Simple correlation analysis data are shown in Table I in the online-only Data Supplement. Global LALS revealed significant negative correlations with age, LV mass index, E’/e′, aortic wall thickness, and baPWV. Global LALS showed significant positive correlations with LV ejection fraction, e’ velocity, and $S’$ velocity. Global LALS showed a better correlation with $E’$ ($r=0.169; P=0.008$) and $S’$ ($r=0.445; P<0.001$) compared with the LA volume index. The global LALS also showed a better correlation with baPWV ($r=0.335; P<0.001$) and aortic wall thickness ($r=0.304; P<0.001$) compared with the LA volume index. Multiple linear regression analysis showed that age, LV ejection fraction, $S’$ velocity, LA volume index, and baPWV were independent determinants of global LALS (Table 3).

**Discussion**

The principal findings in the present study are that (1) LA enlargement and impaired mechanical function assessed comprehensively by 2D TTE with speckle tracking imaging reflect the presence of high-risk findings for cardioembolism on TEE in patients with acute ischemic stroke; (2) global LALS from

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### Table 2. Echocardiographic Characteristics of the LA, LV, and Aorta

<table>
<thead>
<tr>
<th></th>
<th>Group 1 (n=81)</th>
<th>Group 2 (n=43)</th>
<th>Group 3 (n=43)</th>
<th>Group 4 (n=81)</th>
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<tr>
<td><strong>Transthoracic echo</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>LA volume index, mL/m²</td>
<td>22.9±4.3</td>
<td>35.3±5.3*</td>
<td>21.3±5.2†</td>
<td>42.9±11.4*,†,‡</td>
</tr>
<tr>
<td>Global LALS, %</td>
<td>31.2±4.9</td>
<td>28.4±3.9*</td>
<td>18.5±4.1†</td>
<td>14.7±6.7*,†,‡</td>
</tr>
<tr>
<td>Time to peak LALS, ms</td>
<td>379±66</td>
<td>418±65*</td>
<td>426±67*</td>
<td>417±71*</td>
</tr>
<tr>
<td>LVEDD, mm</td>
<td>48±4</td>
<td>50±5*</td>
<td>46±5†</td>
<td>50±5*,‡</td>
</tr>
<tr>
<td>LVESD, mm</td>
<td>31±4</td>
<td>33±5*</td>
<td>31±5†</td>
<td>34±7*,‡</td>
</tr>
<tr>
<td>LV ejection fraction, %</td>
<td>67±6</td>
<td>66±9</td>
<td>67±7</td>
<td>62±9*,†,‡</td>
</tr>
<tr>
<td>LV mass index, g/m²</td>
<td>91.3±21.7</td>
<td>100.8±20.6*</td>
<td>87.3±16.5†</td>
<td>112.7±25.2*,†,‡</td>
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<tr>
<td>$e’$ velocity, cm/s</td>
<td>6.3±2.1</td>
<td>5.9±1.4</td>
<td>5.2±1.7*</td>
<td>5.5±2.0*</td>
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<tr>
<td>$A’$ velocity, cm/s</td>
<td>8.7±1.5</td>
<td>8.8±1.6</td>
<td>8.5±1.3</td>
<td>7.9±1.8*,†,‡</td>
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<tr>
<td>$S’$ velocity, cm/s</td>
<td>7.2±1.3</td>
<td>6.9±1.3</td>
<td>6.8±1.2</td>
<td>5.6±1.6*,†,‡</td>
</tr>
<tr>
<td>$E/e’$</td>
<td>10.3±2.8</td>
<td>12.2±3.3*</td>
<td>10.7±3.3†</td>
<td>13.2±5.1*,†</td>
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<tr>
<td><strong>Transesophageal echo</strong></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>LAA emptying velocity, cm/s</td>
<td>69.7±21.5</td>
<td>65.5±17.7</td>
<td>67.4±21.2</td>
<td>45.1±21.7*,†,‡</td>
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<tr>
<td>LA or LAA thrombosis, n (%)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (2.3)</td>
<td>7 (8.6)*,†,‡</td>
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<tr>
<td>LA or LAA SEC, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>3 (4)</td>
<td>1 (2)</td>
<td>1 (2)</td>
<td>28 (35)*,†,‡</td>
</tr>
<tr>
<td>Mild</td>
<td>3 (4)</td>
<td>1 (2)</td>
<td>0 (0)</td>
<td>16 (20)*,†,‡</td>
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<tr>
<td>Moderate</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>6 (7)*</td>
</tr>
<tr>
<td>Severe</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (0)†</td>
<td>6 (7)*</td>
</tr>
<tr>
<td>Aortic wall thickness, mm</td>
<td>1.7±0.9</td>
<td>1.9±0.9</td>
<td>2.2±1.0*</td>
<td>2.5±1.1*,†</td>
</tr>
<tr>
<td>Aortic arch plaque, n (%)</td>
<td>35 (44)</td>
<td>20 (48)</td>
<td>24 (56)</td>
<td>55 (71)*,†</td>
</tr>
<tr>
<td>Overall</td>
<td>22 (28)</td>
<td>12 (29)</td>
<td>15 (35)</td>
<td>28 (36)</td>
</tr>
<tr>
<td>Simple</td>
<td>13 (16)</td>
<td>8 (19)</td>
<td>9 (21)†</td>
<td>27 (35)*†</td>
</tr>
<tr>
<td>Complex</td>
<td>37 (46)</td>
<td>11 (26)*,‡</td>
<td>19 (44)†</td>
<td>18 (23)*,†</td>
</tr>
</tbody>
</table>

Group 1, small LA with preserved LALS; group 2, large LA with preserved LALS; group 3, small LA with impaired LALS; and group 4, large LA with impaired LALS. $A’$ indicates late diastolic mitral annular; $E$, early diastolic mitral inflow; $e’$, early diastolic mitral annular; LA, left atrium; LAA, left atrial appendage; LALS, left atrial longitudinal strain; LV, left ventricle; LVEDD, left ventricular end-diastolic dimension; LVESD, left ventricular end-systolic dimension; $S’$; systolic mitral annular; and SEC, spontaneous echo contrast.

* $P<0.05$, compared with group 1.
† $P<0.05$, compared with group 2.
‡ $P<0.05$, compared with group 3.
TTE speckle tracking showed good diagnostic values for the presence of flow stasis, thrombus in the LA and LAA, and complex aortic plaques in patients with ischemic stroke; and (3) LA mechanical function was independently correlated with age, LV function, LA volume index, and aortic stiffness.

Overall, the assessment of LA size and mechanical function with comprehensive TTE is useful for the risk assessment of cardioembolism in patients with ischemic stroke. The results of our study suggest clinical importance of LA mechanical function in patients with stroke and potential diagnostic usefulness of global LALS when patients with acute ischemic stroke cannot undergo a TEE.

Clinical Effect of LA Mechanical Function in Stroke

Previous studies showed a strong relationship between LA volume and disease prognosis in various cardiovascular diseases, such as heart failure, myocardial infarction, cardiomyopathy, and AF.20–22 Enlargement of LA is reported to be associated with both the initial ischemic stroke and recurrent cardioembolism or cryptogenic stroke.7 Although mechanism is still unclear, association of LA size with stroke incidence implicates clinical significance of LA function in patients with stroke. Two-dimensional speckle tracking is a new technique that allows a more direct measurement of LA contractility of endocardium and passive deformation.8 Global LALS more sensitively reflects the LA function than does LA volume as functional change precedes morphological changes.

Previous studies have consistently reported that global LALS predicts thromboembolic risks in AF population. Kuppahally et al23 described that LA fibrosis is inversely correlated with LALS in patients with AF, implying that fibrosis impairs LA compliance. Obokata et al reported that LALS provides incremental diagnostic information over the CHA2DS2-VASc score (a risk factor-based risk stratification schemes for embolisms in patients with AF) alone in patients with AF, emphasizing the role of LALS in risk stratification for stroke.12 A previous cross-sectional study by Saha et al24 demonstrated that global LALS was a predictor of stroke in patients with AF. In contrast to previous studies that were limited to patients with AF, the current study included acute ischemic stroke patients with normal sinus rhythm, which reflects real-world data.

Our results in this study confirm that impaired global LALS correlates with a decreased LAA emptying velocity, the presence of flow stasis, thrombus in LA or LAA, or complex aortic athromata. Notably, the diagnostic performance of global LALS to detect thrombus in LA or LAA was significantly better than that of LA volume index. Eight patients from our cohort who presented with thrombus in LA or LAA showed relatively wide distribution of LA volume index, whereas all had decreased LALS <11.5%. Therefore, in real-world practice, when a patient with stroke cannot undergo TEE because of various reasons, such as contraindications for TEE, expense of medical cost, or neurological disabilities, the global LALS may be used as an alternative to rule out the likelihood of thrombus and to determine subsequent needs for other imaging assessments. The global LALS may give valuable additive information for the possible presence of thrombus in LA or LAA. Thus, if a patient shows low LALS <11.5%, TEE should be performed to verify thrombus to decide on the necessity of anticoagulant treatment. If TEE cannot be performed, alternative imaging modalities, such cardiac computed tomography or magnetic resonance imaging, may be used cost effectively in patients with significant LA mechanical dysfunction.

From our results, both global LALS and LA volume index showed good diagnostic values for LAA emptying velocity <20 cm/s with no significant differences in diagnostic performance. However, when diagnosing thrombus in LA or LAA or LAA emptying velocity ≥40 cm/s, the diagnostic power of the global LALS was significantly better than that of the LA volume index. This discrepancy can be explained by different stages of diseased LA and higher sensitivity of the global LALS for detecting LA dysfunction. This indicates that the global LALS better reflects LA function than LA volume index even in subclinical stage when LAA emptying velocity ≥40 cm/s. When the function of the LA is impaired enough to decrease LAA emptying velocity <20 cm/s, it is most often accompanied by an enlargement of the LA. In such stages, the diagnostic power of the global LALS becomes similar to that of the LA volume index. Moreover, global LALS may also be
informative even with a similar LA volume. In our study, we grouped patients into 4 groups according to the median values of global LALS and LA volume index to demonstrate different stages of LA dysfunction according to size and function. When comparing groups with an already large LA volume index (group 2 versus 4), the presence of LA or LAA thrombosis or overall spontaneous echo contrast was significantly different even with a similar LA volume. Overall, the clinical usefulness of global LALS may be appreciated more in patients with early- or advanced-stage LA dysfunction. Thus, LALS can provide additive information to LA volume index.

Mechanical Linkage Between Aortic Stiffness and LA Function

Previous studies have consistently revealed relationships between aortic stiffness and LV diastolic dysfunction in various populations.25–28 In our study, LALS was closely correlated with baPWV (r = 0.36; P < 0.001). This result provides an insight into atrial ventricular–arterial coupling in concordance with previous studies. Impaired LA and LV relaxation in longitudinal directions has been demonstrated to be the early signs of abnormal LA–LV coupling related to the arterial stiffness in preclinical patients with cardiovascular risk factors, and only peak LA strain rate during ventricular systole was significantly related to carotid arterial stiffness.29 In our study, multivariate regression analysis revealed that baPWV showed an independent correlation with the global LALS even after controlling for age, sex, body mass index, comorbidity, and LV functional parameters.

Our study also showed a close correlation between the global LALS and the presence of aortic plaques. We cautiously interpreted that the linkage between the global LALS and aortic plaque can be explained by increased stroke burden. Aortic plaque is one of the parameters in CHA2DS2-VASc score and clearly is one of clinical risk factors for stroke. Recent studies have already shown an association between global LALS and CHA2DS2-VASc although limited in AF population.24 Also, patients with aortic atheroma are likely to have other underlying cardiovascular diseases, such as hypertension, which may affect LV diastolic function, and decreased function of LA. Therefore, the results from our study provide potential role for global LALS for cardiovascular risk evaluation and the presence of complex aortic atheroma in aorta especially when TEE cannot be done because of its semi-invasive nature.

From our result, age was also an important determinant for LA mechanical function. Multivariate analysis showed independent correlation between age and global LALS after adjustment of other variables, which is consistent with previous studies.30 Normal aging is associated with reduced LV diastolic function and atrial fibrosis, which leads to deterioration of LA function. A previous study suggested that although normal aging is associated with enlargement of LA volume, it does not significantly alter LA volume index until the eighth decade of life.30 Global LALS may be more appreciated than LA volume index as it better reflects earlier change of LV function.

Study Limitations

A few limitations should be addressed in this study. First, this study is a cross-sectional study from a single center with a

| Table 3. Determinants of Left Atrial Mechanical Function |
|---------------------------------------------|-------|------|------|
| Global LALS (R²=0.444) | β      | T    | P Value |
| Age                        | −0.219 | −3.20| 0.002 |
| Male sex                   | −0.061 | −1.11| 0.269 |
| Body mass index            | −0.096 | −1.78| 0.076 |
| Presence of hypertension   | −0.008 | −0.13| 0.894 |
| Presence of diabetes mellitus | −0.022 | −0.40| 0.687 |
| LV ejection fraction       | 0.148  | 2.53 | 0.012 |
| LV mass index              | 0.095  | 1.53 | 0.127 |
| e’ velocity                | −0.013 | −0.19| 0.850 |
| S’ velocity                | 0.187  | 2.96 | 0.003 |
| LA volume index            | −0.376 | −5.97| <0.001 |
| Brachial ankle PWV         | −0.137 | −2.16| 0.032 |

LALS indicates left atrial longitudinal strain; LV, left ventricle; PWV, pulse wave velocity; and; S’, systolic mitral annular.
limited number of patients who underwent TEE. Therefore, there would be a selection bias in this study’s stroke population because of the observational nature of our study. Further longitudinal study with larger population is needed to determine interactions of clinical variables with LA mechanical function, as well as the causality of the global LALS and clinical outcome. However, the results from our study provide insightful information for future investigations on LA mechanical function in relation to future risk of cardioembolism in patients with stroke. Second, the global LALS was analyzed in patients who had a sinus rhythm when TTE and TEE were performed. We excluded patients with paroxysmal AF; however, some of silent paroxysmal AF may have been underdiagnosed and classified into cryptogenic stroke in our cohort. Although 24-hour electrocardiography was not performed on the study patients to exclude paroxysmal AF, this limitation seems minimal as continuous electrocardiographic monitoring was done when the patients were first admitted to the stroke unit. Third, persistent AF, which constitutes a significant portion of patients with stroke, was excluded for quality control of acquired strain images, which may have biased the study population. This provides an explanation for the small incidence of thrombus in LA or LAA (8/248) in this study. Although it may not represent general stroke patient population, our data reflect real-world practice. Given the small percentage of thrombus in LA and LAA in stroke patients with sinus rhythm in the real world, results from our study suggest noninvasive, easily applicable, alternative method for evaluation of abnormal flow stasis or thrombus in LA or LAA in patients with stroke. Our study demonstrates possible application of the global LALS in real-world practice where TEE is difficult to perform. Fourth, a total incidence of cardioembolism stroke was not low although we only included patients with sinus rhythm. Considering the possibility of underdiagnosed incidence of paroxysmal AF and the mean age of our cohort, the incidence of cardioembolism stroke (22.6%) is not unusual. In addition, cardiac conditions other than AF may have contributed to cardioembolism stroke.

Conclusions
LA mechanical dysfunction is closely associated with high risks of cardioembolism. Global LALS assessed by TTE speckle tracking methods well discriminates the presence of LA or LAA thrombus detected from TEE in patients with acute ischemic stroke. Therefore, comprehensive assessment of LA size and mechanical function can be useful for risk stratification of cardioembolism in patients with acute ischemic stroke.

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Disclosures
None.

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SUPPLEMENTAL MATERIAL

Supplementary material for method

Speckle tracking echocardiography

The intra-observer and inter-observer reproducibility for the assessment of global LALS were determined by the Bland-Altman analysis. Intra-observer reproducibility was determined by repeating the strain measurements at two different time points by one experienced reader in 15 randomly selected patients. A second experienced reader performed the strain analysis in the same 15 patients, providing the inter-observer data. The Bland Altman analysis and intra-class correlation coefficient (ICC) showed good intra-and inter-observer agreement for global LALS. For inter-observer agreement of global LALS, the mean difference was 1.7 (-1.3, 4.4) and the ICC was 0.88; for intra-observer agreement, the mean difference was 1.2 (-2.0, 3.1) and the ICC was 0.90.

Supplementary material for results

Clinical determinants for LA or LAA thrombus and complex aortic plaques

Multiple regression analysis was performed to determine independent clinical parameters for LA or LAA thrombus and complex aortic plaques. From multiple regression analysis, the global LALS was the only significant determinant (p<0.01) for the presence of a LA or LAA thrombus, even after adjustment for age (p=0.18) and LA volume index (p=0.53). For complex aortic plaque, age was an independent determinant of complex aortic plaque (p<0.01), but the global LALS was not. This result might be explained by a significant mechanistic association among age, increased aortic stiffness which is often combined with complex aortic plaques, and the low global LALS.
**Supplementary Table I.** Simple correlation analysis.

<table>
<thead>
<tr>
<th></th>
<th><strong>LA volume index, ml/m²</strong></th>
<th></th>
<th><strong>Global LA LS, %</strong></th>
<th></th>
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<tr>
<td></td>
<td>Correlation coefficient</td>
<td>P-value</td>
<td>Correlation coefficient</td>
<td>P-value</td>
</tr>
<tr>
<td>Age</td>
<td>0.304</td>
<td>&lt;0.001</td>
<td>-0.440</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Body mass index</td>
<td>-0.108</td>
<td>0.090</td>
<td>0.041</td>
<td>0.518</td>
</tr>
<tr>
<td>LV ejection fraction</td>
<td>-0.233</td>
<td>&lt;0.001</td>
<td>0.310</td>
<td>&lt;0.001</td>
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<tr>
<td>LV mass index</td>
<td>0.394</td>
<td>&lt;0.001</td>
<td>-0.226</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>e’ velocity</td>
<td>-0.008</td>
<td>0.896</td>
<td>0.169</td>
<td>0.008</td>
</tr>
<tr>
<td>S’ velocity</td>
<td>-0.370</td>
<td>&lt;0.001</td>
<td>0.445</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>E/e’</td>
<td>0.255</td>
<td>&lt;0.001</td>
<td>-0.221</td>
<td>0.001</td>
</tr>
<tr>
<td>Aortic wall thickness</td>
<td>0.212</td>
<td>0.001</td>
<td>-0.304</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>baPWV</td>
<td>0.172</td>
<td>0.008</td>
<td>-0.355</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

LA, left atrium; LA LS, left atrial longitudinal strain; LV, left ventricle; e’, early diastolic mitral annular; S’, systolic mitral annular; baPWV, brachial-ankle pulse wave velocity
卒中患者左心房机械功能障碍的临床意义及决定因素

Clinical Implications and Determinants of Left Atrial Mechanical Dysfunction in Patients With Stroke

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背景及目的：经食道超声心动图（transesophageal echocardiography, TEE）可用于评估卒中患者心源性栓塞的来源，是一项极其关键却又半侵入式的检查。我们推测，经胸超声心动图（transthoracic echocardiography, TTE）评估左心房的大小和机械功能，可以为 TEE 上的心源性栓塞高风险卒中患者提供有用信息。此外，本文旨在明确此类患者左心房机械功能障碍的决定因素。

方法：共有 248 例急性缺血性卒中患者（147 例男性；64±13 岁）在二维斑点追踪 TTE 检查之后进行了 TEE 检查。

结果：按左心房容积指数和总左心房收缩期纵向应变率（left atrium longitudinal strain, LALS）的中位数将患者分成 4 组，左心耳排空速度、左心或左心耳血栓、主动脉斑块的患病率和脑栓塞的发病率表现出显著的组间差异。经 TEE 证实存在心源性栓塞高风险的患者左心房容积指数更大、总 LALS 更低。总 LALS（截断值 11.5%；曲线下面积 0.947；敏感度 100%；特异度 91%；P < 0.001）与左心房容积指数（截断值 36.2 ml/m²；曲线下面积 0.823；敏感度 88%；特异度 75%；P=0.002）相比，诊断左心房或左心耳血栓方面展现了更好的效能（P=0.04）。左心室收缩功能、左心房容积指数和脉搏波传导速度是总 LALS 的独立决定因素。

结论：左心房机械功能障碍与心源性栓塞高风险的关联密切。通过二维斑点追踪 TTE 评估所得的总 LALS 指标能很好地区分急性缺血性卒中患者在 TEE 上左心房或左心耳血栓的存在。

关键词：心耳；经食道超声；心房；脉搏波分析；卒中；血栓形成

卒中患者左心房机械功能障碍的临床意义及决定因素

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关键词：心耳；经食道超声；心房；脉搏波分析；卒中；血栓形成
斑点跟踪成像技术
每个患者均进行心脏的二维斑点跟踪成像。摄影帧频设置为每秒 60~80 帧，记录连续 3 次心动周期并取其平均值。数据分析采用离线的专业软件（EchoPAC PC；GE Medical Systems）。从四腔和二腔切面视图形成数据延长至左心房和左心耳的范围。13~15 因为左心房顶部的 2 个节段纵向应变曲线明显低于其他 4 个节段，故在后续的统计分析中只取这两个节段中其余 8 个节段数据的均值作为左心房 LALS，同上记录 QRS 波出现到正向 LALS 峰值产生之间的平均时间间隔。行超声心动图检查的神经科医生对患者的信息未知。

统计分析
连续变量以均值 ± 标准差表示，分类变量以绝对和相对频率（%）表示。不同组间连续变量的比较采用 t 检验（组 2）和方差分析（组 4），分类变量间的比较采用 χ2 分析或方差分析。本研究构建受试者工作特征曲线确定 LALS 或左心房容积指数的诊断效能，通过 DeLong 试验比较总 LALS 和左心房容积指数的诊断性能，采用多重线性回归分析发现总 LALS 的独立决定因素。
临床信息

患者平均年龄为64±13岁，其中男性占58.3%。表1为4组的基线临床信息。组4为左心房增大及总LALS降低的患者，其年龄大于其他分组，差异有显著性。性别及共存病差异无显著性。关于卒中类型，栓塞性卒中在组4中比例较大，差异有显著性。组4患者收缩压及脉压显著高于组1，baPWV从组1至组4呈阶梯状上升。

超声心动图特点

表2描述了超声心动图参数，根据左心房容积指数和总LALS将患者分成4组，故左心房容积指数和总LALS在该4组中差异有显著性。LALS达峰时间在组1显著短于其他分组，组4患者的A′速度显著低于其他组。4组中代表左心室结构、收缩功能、舒张功能的参数也截然不同。组2及组4患者的左心房容积指数较大，其较组1及组3患者具有更大的左心室体积及更高的左心室质量指数。组4患者的左心室纵向收缩及舒张功能受损，其较其他组患者具有更高的左心室充盈压。根据TEE参数，组4患者的左心耳排空速度显著降低，其栓塞的发生率及左心房或左心耳的自发超声显影与其他组存在显著差异。组1或组2患者均未有左心房或左心耳血栓。主动脉壁厚度在组1至组4中逐渐上升。组4中主动脉斑块的发生率显著增加。有趣的是，复合性主动脉斑块的发生率在组1至组4中呈阶梯状上升。卵圆孔未闭的发率在组1和组4中有显著差异。

左心房容积指数及总LALS对心源性栓塞高风险的诊断价值

总LALS<11.5%（曲线下面积0.95；敏感性100%；特异性91%；P<0.001）对诊断左心房或左心耳血栓的存在较左心房容积指数（截断点36.2ml/m²；曲线下面积0.82；敏感性88%；特异性75%；P=0.002；图1A）更有效力。8位存在左心房或左心耳血栓的患者其LALS均<11.5%，而其左心房容积指数分布范围较宽（图1B）。总LALS<11.5%的患者其年龄较总LALS>11.5%的患者显

<table>
<thead>
<tr>
<th>组别</th>
<th>n</th>
<th>左心房容积指数，ml/m²</th>
<th>总LALS，%</th>
<th>达峰时间LALS，ms</th>
<th>LVEDD，mm</th>
<th>LVESD，mm</th>
<th>LV射血分数，%</th>
<th>LV质量指数，g/m²</th>
<th>e′速率，cm/s</th>
<th>A′速率，cm/s</th>
<th>S′速率，cm/s</th>
<th>E/e′</th>
<th>LAA排空速率，cm/s</th>
<th>LA或LAA血栓形成，数目（%）</th>
<th>LA或LAASEC，数目（%）</th>
<th>主动脉壁厚度，mm</th>
<th>主动脉斑块，数目（%）</th>
<th>卵圆孔未闭，数目（%）</th>
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<tr>
<td>组1(n=81)</td>
<td></td>
<td>22.9±4.3</td>
<td>35.3±5.3*</td>
<td>379±66</td>
<td>48±4</td>
<td>31±4</td>
<td>67±6</td>
<td>67±7</td>
<td>6.3±2.1</td>
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<td>0(0)</td>
<td>3(4)</td>
<td>1.7±0.9</td>
<td>35(44)</td>
<td>23(46)</td>
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<tr>
<td>组2(n=43)</td>
<td></td>
<td>31.2±4.9</td>
<td>28.4±3.9*</td>
<td>483±65*</td>
<td>50.4±5*</td>
<td>33.5±4*</td>
<td>426±67*</td>
<td>66±4</td>
<td>5.9±1.4</td>
<td>8.8±1.6</td>
<td>6.9±1.3</td>
<td>12.2±3.3*</td>
<td>65.5±17.7</td>
<td>0(0)</td>
<td>3(4)</td>
<td>1.9±0.9</td>
<td>20(48)</td>
<td>12(29)</td>
</tr>
<tr>
<td>组3(n=43)</td>
<td></td>
<td>21.3±5.2</td>
<td>18.5±4.1*</td>
<td>426±67*</td>
<td>46.5±5*</td>
<td>31.5±4*</td>
<td>417±7*</td>
<td>67±7</td>
<td>5.2±1.7</td>
<td>8.5±1.3</td>
<td>6.8±1.2</td>
<td>10.7±3.3*</td>
<td>67.4±212</td>
<td>1(2)</td>
<td>1(2)</td>
<td>2.2±10.0</td>
<td>24(56)</td>
<td>15(35)</td>
</tr>
<tr>
<td>组4(n=81)</td>
<td></td>
<td>42.9±11.4*</td>
<td>14.7±6.7*</td>
<td>417±7*</td>
<td>50.5±5*</td>
<td>31.5±4*</td>
<td>417±7*</td>
<td>67±7</td>
<td>5.5±2.0</td>
<td>7.9±1.8</td>
<td>5.6±1.6</td>
<td>13.2±5.1*</td>
<td>45.1±21.7**</td>
<td>7(8.6)**</td>
<td>28(35)**</td>
<td>23±1.1**</td>
<td>55(71)**</td>
<td>28(36)</td>
</tr>
</tbody>
</table>

*P<0.05,与组1相比。
†P<0.05,与组2相比。
‡P<0.05,与组3相比。
著增大（71±10 vs 62±12岁；P<0.01）。

对于左心耳排空速度<20 cm/s的患者，其易于形成血栓，总LALS（截断点10.5%；曲线下面积0.91；敏感性80%；特异性92%；P<0.01）及左心房容积指数（截断点41.6 ml/m²；曲线下面积0.91；敏感性80%；特异性88%；P<0.001）显示良好的诊断价值，但两参数差异无显著性（P=0.95）。另一方面，总LALS（截断点24.2%；曲线下面积0.74；敏感性56%；特异性84%；P<0.001）显示出左心耳排空速度≥40 cm/s有较好的诊断效能相比左心房容积指数（截断点29.5 ml/m²；曲线下面积0.64；敏感性57%；特异性73%；P<0.01），差异有显著性（P=0.03）。

对于诊断复杂性主动脉斑块，总LALS和左心房容积指数均显示出良好的诊断价值（曲线下面积0.64；敏感性72%；特异性51%；P<0.01）及曲线下面积0.61；敏感性61%；特异性56%；P=0.011），且两参数间差异有显著性（P=0.44）。

图2描述了是否存在TEE检测的心源性栓塞高风险患者不同左心房大小及机械功能。心源性栓塞高风险患者的心左房容积和机械功能与年龄、左心房容积指数、主动脉僵硬度独立相关。

### 左心房机械功能的决定因素

单因素相关分析结果在网上数据补充材料的表1。总LALS与年龄、左心房容积、左心耳容积指数、左心耳排空速度、主动脉弓壁厚度及baPWV呈负相关。总LALS与左心房射血分数、e′波波速及S′波波速呈正相关。总LALS与左心房容积指数相关，与e′波（r=0.169；P=0.008）及S′波（r=0.445；P<0.001）有良好的相关性。总LALS与左心房容积指数相关，与baPWV（r=0.335；P<0.001）和主动脉弓壁厚度（r=0.137；P<0.001）具有较好的相关性。

### 谈论

本研究的主要结果如下：

1. 通过斑点追踪显像二维TEE评估的左心房容积和机械功能损害可反映急性缺血性卒中患者存在心源性栓塞高风险；
2. 通过斑点追踪显像TEE得到总LALS对于诊断急性缺血性卒中患者血液瘀滞、左心房和左心耳的血栓及复杂性主动脉斑块情况具有较好的价值；
3. 左心房机械功能与年龄、左心室功能和左心房容积指数、主动脉僵硬度独立相关。

综上所示，通过全面的TEE评估左心房大小及机械功能对缺血性卒中患者的心源性栓塞风险判断很有价值。我们研究结果显示左心房机械功能在卒中患者的临床意义及总LALS在不能耐受TEE检查的急性卒中患者中潜在的诊断应用价值。
左心房机械功能在卒中患者中的临床作用

既往研究表明，左心房容积和许多心血管疾病的预后有密切联系，比如心脏衰竭、心肌梗死、心肌病和房颤等。当左心房增大与原发性缺血性卒中、复发性心源性栓塞型卒中或病因不明型卒中相关时，左心房容积指数具有重要的临床意义。二维斑点追踪新技术能更直接测量左心房心内膜的收缩和被动变形情况，总 LALS 比左心房容积指数能更敏感地反映左心房功能。

左心房容积指数 (ml/m²)

总左心房纵向应变力（%）

* 心源性栓塞风险: 在左心房 / 左心房 + 左心耳存在血栓时，排空速度 <20 cm/s + 复杂斑块

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主动脉僵硬度与左心房功能的联系

既往针对不同人群的研究一致揭示了动脉僵硬度与左心室舒张功能不全的关系。本研究结果显示 LALS 与 baPWV 具有相关性（r=0.36; P < 0.01），这与既往研究结果一致，有助于加深对心房心室动脉耦合的理解。左心房及左心室舒张功能异常被认为是心房心室异常耦合的早期征象，而这往往与具有心血管危险因素但尚未发生临床事件患者的心房心室僵硬度增高相关。左心室收缩期的左心房峰值应变率与颈动脉僵硬度显著相关。本研究显示，在多因素回归分析中，通过控制校正年龄、性别、体重指数、共存病及左室功能参数后，baPWV 仍与总 LALS 呈独立相关性。

本研究同样显示了总 LALS 与主动脉瓣口线扩张与否具有密切关系。我们目前谨慎地认为这一相关性可能与左室负担增加相关。主动脉瓣口线扩张与否具有相关性，总 LALS 比左心房容积指数更敏感地反映左心房的机械功能。因此，左心房容积指数和总 LALS 对检测左心房功能不全更具有良好的敏感性能解释上述情况。总 LALS 比左心房容积指数能更敏感地反映左心房的机械功能，即使是在左心耳排空流速 > 40 cm/s 的亚临床阶段。左心房功能损害严重导致左心耳排空流速 < 20 cm/s，此时常合并左心房扩大，在该阶段，总 LALS 的诊断能力逐渐接近左心房容积指数。而左心耳容积指数<br

图 2 根据心源性栓塞存在高风险时，左心房的大小和机械特性。A: 左心房容积指数; B: 左心房总纵向应变力。
从本研究结果看，年龄同样影响左心房机械功能的一个重要因素。在多因素回归分析中，通过校正控制其他变量，年龄与总LALS之间仍呈现出独立的相关性（p=0.01）。年龄老化的左心室舒张功能受限，心房纤维化相关，而后者最终导致了左心房的功能恶化。一项既往研究显示，尽管正常老龄化与左心房体积增大相关，但直到80岁之后才会造成左心房容积指数的显著改变。总LALS较与左心房容积指数更有临床价值，因为后者能反应出早期的左心室功能变化。

研究的局限性

本研究中仍存在以下不足。第一，本研究为单中心的横断面研究。完成TEE检查的患者数量有限，因此纳入样本量很少；同时，由于该研究属于观察性研究，不可避免的存在选择偏倚。未来需要大样本队列研究来进一步证实上述临床参数与左心房功能的相关性以及探究总LALS改变与临床结局的因果关系。然而，本研究为日后关于左心房机械功能对未来心源性脑栓塞风险评估的相关研究提供了重要信息。第二，研究排除了阵发性房颤的患者，因此只有恒性的房颤患者中完成了TEE、TTE检查及总LALS分析；部分无症状阵发性房颤患者未被发现而归入了隐源性卒中。尽管入组患者并没有实施24 h动态心电图以排除阵发性房颤，但这一缺陷对研究结果的影响较小，因所有患者在首次收入卒中中心时都曾有过持续心电监护。第三，为了获得良好的图像，持续性房颤的患者被排除在入组之外，这可能导致入组样本的人群偏倚，可能会造成研究中左心房及左心耳血栓发生率低的原因（8/248）。尽管不能代表普通的人群，我们的研究仍具有临床意义；考虑到临床实践中左心房机械障碍患者的心房及左心耳血栓发生率很低，我们所采用的技术正好可以作为一种非侵入、易实施的替代手段用于卒中患者评估心房及心内异常血流及血栓情况。第四，尽管我们纳入的患者都是窦性心律，但最终确诊为心源性卒中的比例仍然不低。考虑到可能在未被诊断的阵发性房颤患者混入以及入组患者的平均年龄，本研究心源性卒中的比例（22.6%）是可以接受的。此外，除房颤之外的其他心脏病也可能导致心源性卒中的发生。

结论

左心房机械功能的改变被认为是心源性脑栓塞的高危因素。借由超声显像成像技术，TEE能够获取总LALS参数，而后者能很好地判断有无左心房或左心耳内部的血栓形成（金标准TEE食道超声心动图可证实）。因此，对左心房大小以及机械功能的全面评估有助于确定急性缺血性卒中患者发生心源性栓塞的危险分层。

参考文献