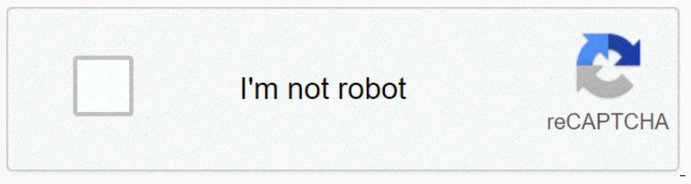

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Aha guidelines hypertrophic cardiomyopathy

November 20, 2020 | Supriya Shore, MD Authors: Ommen SR, Mital S, Burke MA, and others. Excerpt: 2020 Guidelines for diagnosis and treatment of patients with AHA/ACC Hypertrophic Cardiomyopathy: Report of the Joint Committee of the American College of Cardiology/American Heart Association Clinical Practice Guide. J Coll Cardiol 2020; November 20:[Epub before printing]. Key perspectives from the 2020 American Heart Association/American College of Cardiology (AHA/ACC) guidelines for the management of hypertrophic cardiomyopathy (HCM) patients are below: Recommended for all aspects of HCM care, including joint decision-making, genetic testing, activity, lifestyle, and therapy options. Referral to an HCM centre of excellence should be considered to address complex management decisions. Initial diagnostic evaluation for all HCM patients should include a comprehensive physical examination with a family history of three generations. Clinical features associated with HCM phenocopenes should be evaluated. First electrocardiogram (ECG) and 24-48 hours of ambuluar ECG follow-up follow-up surveillance ECG is recommended every 1-2 years. For palpitations or stings, extended monitoring is recommended, which should only be considered diagnostically if symptoms occurred during monitoring. Transthoracic echocardiogram (TTE) is recommended for all patients with suspected HCM. If resting left ventricle exit pathway (LVOT) gradient cardic magnetic resonance imaging echocardiography is inaccessive, if there is a suspicion for an alternative diagnosis (such as infiltrative/storage diseases), the risk of sudden cardic death may be necessary for stratization, and for the selection and planning of septal reduction therapy. Computed tomography (CT) or invasive coronary angiography should be considered for HCM patients with symptoms of myocardial iskemia. Invasive or CT angiography should be performed before surgical myectomy. Invasive hemodynamic evaluation was recommended for patients who were candidates for septal reduction treatment but were uncertainty about the presence of LVOT obstruction in noninvasive studies. Genetic tests should be offered to HCM patients to explain the genetic basis and allow for family screening. Genetic counseling before and after testing is recommended for individuals with genetic test etabi. For HCM patients with unspecified genetic variants, serial reassessment of test results is recommended to evaluate for variant reclassification, as it can trigger tests for family members. Preconception and prenatal reproduction and genetic counseling should also be offered. First-degree relatives of patients with HCM should take part in the initial evaluation according to their age (1-2 years in adolescents, 3-5 years in adults) or ECG and TTE during periodic follow-up if the clinical condition changes. If there is probandpatogenic or possible pathogenic cascading genetic tests should be presented in genetic tests. Additional clinical screening is not recommended nearby, which tests negatively in cascading genetic testing. Cardiac arrest or continuous ventricular tachycardia (VT) is recommended as Class I advice for HCM patients with one-room transvenous or subcune implantable cardiooverter-defibrillator (ICD) implantation. As a Class IIa recommendation, it makes sense not to implant systolic dysfunction with large LV hypertrophy ≥ 30 mm, suspected cardiac syncope history, LV apical aneurysm, ejection fraction (EF), especially for the purpose of participating in competitive athletics. Nonvasodilating beta-blockers (BBs) are recommended for symptomatic HCM patients with LVOT obstruction. If BBs is not ineffective or tone, verapamil or diltiazem is recommended. Verapamil and diltiazem are contrainidced in case of hypothesis, children are recommended for symptomatic patients with severe dyspnea at rest, non-obstructive HCM and preserved LVEF, BB, verapamil or diltiazem. In patients with HCM and clinical atrial fibrillation, anticoagulation is recommended as the first line after directly effective oral anticoagulants warfarin, regardless of cha2ds2-VASc score. For HCM patients with subclinical atrial fibrillation, anticoagulation is recommended if atrial fibrillation lasts more than 24 hours. Despite the use of BB, antiarrhythmic treatment with amiodaron, mexiletine, sotalol or dofetilide can be considered for patients with VT or recurrent ICD shock HCM. If VT remains antiarithmic refractory, heart transplant evaluation should be considered. Comprehensive evaluation and joint decision-making on the risk of participating in sports is recommended for HCM patients who develop systolic dysfunction with EF for HCM patients participating in athletics. For most HCM patients, non-competitive exercise is useful for light medium, recreational, recreational purposes. BB's for pregnant HCM patients should be continued with monitoring fetal growth and care should be coordinated between cardiology and obstetrics. If anticoagulation is indicated by atrial fibrillation or other causes, low molecular weight heparin or warfarin (maximum dose Clinical Issues: Anticoagulation Management, Arrhythmies and Clinical EP, Heart Failure and Cardiomyopathies, Invasive Cardiovascular Angiography and Intervention, Noninvasive Imaging, Prevention, Sports and Exercise Cardiology, Atherosclerotic Disease CAD (PAD), Anticoagulation Management and Atrial Fibrillation, Implantable Devices, SCD/Ventricular Arrhythmies, Atrial Fibrillation/Supraventriular Arrhythmia, Acute Heart Failure, Interventions and Coronary Artery Disease, Interventions and Imaging, Interventions and Structural Heart Disease, Angiography, Echocardiography/Ultrasound, Magnetic Resonance Imaging, Nuclear Imaging, Sports and Exercise and Imaging Keywords: beta-Antagonists, Anticoagulants, Arrhythmics, Cardiomic, Atrial Fibrillation, Cardiomyopathy, Hypertrophic, Coronary Artery Disease, Coronary Angiography, Death, Ani, Cardiomic, Defibrillators, Implantable, Diagnostic Imaging, Echocardiography, Electrocardiography, Genetic Test, Heart Failure, Magnetic Resonance Imaging, Myocardial Ischemia, Physical Examination, Pregnancy, Risk Factors, Secondary Prevention, Sports < Back Listings Better discuss with hypertrophic cardiomyocyopathy and expand your understanding of hypertrophic cardiomyopathy. Listen, learn, and increase your knowledge of the latest HCM science. Hypertrophic cardiomyopathy is most commonly caused by abnormal genes in the heart muscle. These genes cause the heart chamber ventricles (left ventricle) to contract harder and become thicker than normal. Thickened walls harden. This reduces the amount of blood taken and is pumped out into the body with each heartbeat. Obstructive and Nonobstructive HCM Obstructive HCM thicken the wall (septum) between the two lower chamber of the wall. The walls of the pumping chamber can also harden. It can block or reduce blood flow from the left ventricle to the aorta. Most people who have HCM have this kind. Nonobstructive HCM, the main pumping chamber of the heart is still hard. This limits how much blood the ventricle can take and pump out, but blood flow is not blocked. Symptoms, Symptoms and Risks Some people with hypertrophic cardiomyopathy have no symptoms. Others may not have symptoms or symptoms in the early stages of the disease, but they may develop them over time. It is important to know the signs and symptoms of HCM. This treatment can help with early diagnosis, which can be most effective. Symptoms and symptoms of HCM include: Chest pain, especially with shortness of breath of physical exertion, especially physical exertion Fatigue Arrhythmies (abnormal heart rhythms) Dizziness Fainting (syncope) Swelling of the ankles, feet, legs, abdominal and neck HCM vessels are a chronic disease that can worsen over time. This can lead to worse function and quality of life, long-term complications and more financial and social burdens. People with HCM often need to make lifestyle changes, to adjust for their illness, such as limiting their activity. As HCM progresses, it can cause other health problems. People with HCM are at higher risk for the development of atrial fibrillation, which can lead to blood clots, injury and other heart-related complications. HCM can also lead to heart failure. It can also lead to sudden cardiac arrest, but this is rare. HCM has been shown as the most common cause of sudden cardiyak death for teenagers and athletes under the age of 35. Diagnosis Hypertrophic cardiomyopathy is most commonly hereditary. HCM is the most common form of genetic heart disease. It may be at any age, but most middle age you get a diagnosis. Every 500 There is HCM, but a large percentage of patients have not been diagnosed. Two-thirds of those diagnosed have obstructive HCM, and a third have non-obstructive HCM. A cardiologist or pediatric cardiologist usually treats Diagnosis and HCM. You can also be directed to a cardiomyopathy center where the medical team receives special training. HCM is diagnosed according to medical history, family history, physical examination and diagnostic test results. Medical and Family Hisds Knowing your medical history and any signs and symptoms you may have is an important first step. Your doctor will also want to know if any of your family have been diagnosed with HCM, heart failure or cardiac arrest. Physical Examination The heart and lungs will be checked. Your doctor will listen to some voices with the stethoscope. For example, the sound, timing, and position of a heart murmur may suggest obstructive HCM. Diagnostic Tests Diagnosis is usually done with an echocardiogram. Controls the thickness of the heart's cae and blood flow from the heart. In some cases, another type of echocardiogram, transesophageal echo (or TEE), can be performed. The tee is made using a sedition inserted into the throat while the patient is under sedation. Other diagnostic tests may include: Cardioc catheterization Coronary angiography Therapy and HCM Management There are currently no disease-specific drugs for hypertrophic cardiomyopathy. For people with HCM without symptoms, medications are recommended for lifestyle changes and situations that may contribute to cardiovascular disease. For those with symptoms, the focus is on symptom management using drugs and procedures. Drugs called beta-blockers, calcium channel blockers and diuretics offer limited and varied relief of symptoms. They can help with function but can also have side effects. Procedures Various surgical and non-surgical procedures can be used in the treatment of HCM: Septal myectomy – Septal myectomy is open heart surgery. Obstructive HCM and is accepted for people with severe symptoms. This surgery is usually reserved for young patients and people who do not have good medications. A surgeon removes a thickened piece of septum bulging into the left ventricle. This increases blood flow to the body inside and out of the heart. Alcohol septal ablation (non-surgical procedure) - In this process, ethanol (type of alcohol) is injected by HCM into a tube into the small artery that provides blood to the thickened heart muscle area. Alcohol causes these cells to die. Thickened tissue shrinks to a more normal size. The risks and complications of cardiac surgery will increase with age. Therefore, ablation may be preferred to myectomy in elderly patients with other medical conditions. Surgically implanted devices – Surgeons can implant Types of devices to help the heart work better, including: Implantable cardioverter

defibrillator (ICD) – If an irregular heartbeat is detected, it helps maintain an ICD normal heartbeat by sending an electric shock to the heart. This reduces the risk of sudden cardiyak death. Pacemaker – This small device uses electric pulses to allow the heart to beat at normal speed. Cardaric resynchronization therapy (CRT) device – This device coordinates contractions between the left and right ventricles of the heart. Heart transplantation – Heart transplantation can be considered in HCM patients with advanced stage disease. In this procedure, a person's diseased heart is replaced by a healthy donor heart. Download our printable information pages: What is Hypertrophic Cardiomyopathy? (PDF) | Other types of Spanish (PDF) Cardiomyopathy: Last Review: Nov 17, 2020 2020