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of CardiologyEuropean Heart Journal - Cardiovascular Imaging (2017) 18, 1191–1204  
doi:10.1093/ehjci/jew333**EACVI APPROPRIATENESS  
CRITERIA**

# EACVI appropriateness criteria for the use of transthoracic echocardiography in adults: a report of literature and current practice review

**Richard P. Steeds<sup>1\*</sup>, Madalina Garbi<sup>2</sup>, Nuno Cardim<sup>3</sup>, Jaroslaw D. Kasprzak<sup>4</sup>, Elif Sade<sup>5</sup>, Petros Nihoyannopoulos<sup>6</sup>, Bogdan Alexandru Popescu<sup>7</sup>, Alexandros Stefanidis<sup>8</sup>, Bernard Cosyns<sup>9</sup>, Mark Monaghan<sup>10</sup>, Svend Aakhus<sup>11</sup>, Thor Edvardsen<sup>12</sup>, Frank Flachskampf<sup>13</sup>, Leonarda Galiuto<sup>14</sup>, George Athanassopoulos<sup>15</sup>, and Patrizio Lancellotti<sup>16</sup>**

This document was reviewed by members of the 2014–2016 EACVI Scientific Documents Committee: **Dr Victoria Delgado, Prof Erwan Donal, Dr Maurizio Galderisi, Dr Massimo Lombardi, Dr Denisa Muraru, Assoc Prof Kristina Haugaa.**

<sup>1</sup>University Hospital Birmingham NHS Foundation Trust, Mindelsohn Road, Edgbaston, Birmingham, UK B15 2GW and Honorary Reader, Institute of Cardiovascular Sciences, University of Birmingham; UK; <sup>2</sup>King's College Hospital NHS Foundation Trust, Denmark Hill, London, SE5 9RS UK; <sup>3</sup>Echocardiography Laboratory, Hospital da Luz Av. LusÚada, n° 100 - 1500-650, Lisbon, Portugal; <sup>4</sup>Department of Cardiology, Bieganski Hospital Medical University of Lodz, Kniaziewiczza 1/5, 91-347, Lodz, Poland; <sup>5</sup>Department of Cardiology, Baskent University School of Medicine, Fevzi úakmak Cad. 10. Sok. Bahcelievler 06490 Ankara, Turkey; <sup>6</sup>Imperial College London, NHLI Hammersmith Hospital, Du Cane Road, London W12 0NN, UK and University of Athens, Greece; <sup>7</sup>University of Medicine and Pharmacy "Carol Davila"—Eurocolab, Institute of Cardiovascular Diseases, Sos. Fundeni 258, sector 2, 022328, Bucharest, Romania; <sup>8</sup>1st Department of Cardiology, General Hospital of Nikea, 3 P. Mela str., 184 54, Athens, Greece; <sup>9</sup>Department of Cardiology, CHVZ (Centrum voor Hart en Vaatziekten)Universitair Ziekenhuis, VUB, Laarbeeklaan 101, 1090 Jette, Brussel, Belgium; <sup>10</sup>King's College Hospital NHS Foundation Trust, Denmark Hill, London, SE5 9RS UK; <sup>11</sup>Department of Cardiology, Oslo University Hospital, postboks 4950 Nydalen, 0424 Oslo and Faculty of Medicine, Norwegian University of Science and Technology, NTNU, 7491 Trondheim; <sup>12</sup>Department of Cardiology, Oslo University Hospital, Rikshospitalet, Sognsvannsveien 20, NO-0027 Oslo, Norway; <sup>13</sup>Department of Medical Sciences, Clinical Physiology, Uppsala University, Akademiska ingang 40, 751 85 Uppsala, Sweden; <sup>14</sup>Department of Cardiovascular Sciences, Catholic University of the Sacred Heart, Policlinico Agostino Gemelli, Largo A Gemelli 8, 00168 Roma, Italy; <sup>15</sup>Cardiology Section, Onassis Cardiac Surgery Center, Sygrou, 17674, Athens, Greece; and <sup>16</sup>Departments of Cardiology, University of Lie'ge Hospital, GIGA Cardiovascular Sciences, Heart Valve Clinic, CHU Sart Tilman, Lie'ge, Belgium and Gruppo Villa Maria Care and Research, Anthea, Hospital, Bari, Italy

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The European Association for Cardiovascular Imaging (EACVI) has outlined the rationale for setting appropriate use criteria (AUC) in cardiovascular (CV) imaging. Transthoracic echocardiography (TTE) is the most common imaging modality in CV disease and is a central tool in diagnosis, follow-up, management planning and intervention. The purpose of AUC is to inform referrers, both to avoid under-use, which may result in incomplete or incorrect diagnosis and treatment, and also over-use, which may delay correct diagnosis, lead to 'treatment cascade', and wastes resources. The first step in defining AUC for TTE in the adult has been for a panel of experts in echocardiography to review the evidence, guidelines, recommendations, and position papers from the European Society of Cardiology, EACVI and other specialist societies, and current state-of-the-art clinical practice. The attached document summarizes this work, which will be used to under-pin the development of AUC.

## Keywords

transthoracic echocardiography • appropriateness • indications

## Introduction

Transthoracic echocardiography (TTE) is a central tool in the diagnosis and management of cardiovascular (CV) disease that has contributed to a halving in the frequency of major diagnostic errors over the last

20 years.<sup>1</sup> Although use of TTE appears to grow inexorably and excessive use is discouraged given the increasing costs of health-care, there is evidence that it continues to be under-utilized in critical CV conditions.<sup>2</sup> This literature review aims to inform the development of European Appropriate Use Criteria (AUC) for TTE in the adult.

\*Corresponding author. Tel: 0044 121 371 4035; Fax: 0044 121 371 4044. E-mail: rick.steeds@uhb.nhs.uk

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criteria for the diagnosis of PE have been identified which mostly rely on secondary consequences of pressure overload on the right ventricle, in which situation TTE has higher specificity.<sup>10</sup> Although the negative predictive value for PE overall is only 40–50%, TTE has a role in promoting the diagnosis, for example with McConnell's sign, excluding differential diagnoses and in defining management. If clinical suspicion remains after TTE, further imaging using alternate modalities is required to confirm or refute the diagnosis of PE.<sup>11</sup> Routine TTE is not mandatory in the emergency setting in all cases but should be performed in the non-urgent setting with a view to assessment of complications.

While TTE has a limited role in diagnosis, in the emergency setting in normotensive patients, tricuspid annular plane systolic excursion below 15 mm carries adverse prognostic significance.<sup>12</sup> In normotensive patients with RV dysfunction on TTE, the benefits of rescue reperfusion therapy appear to be limited to the avoidance of haemodynamic compromise but at greater bleeding risk.<sup>13</sup> In acute PE with haemodynamic collapse, rescue reperfusion therapy may be indicated without TTE.

### Acute pulmonary disease

TTE may be used to diagnose a large pleural effusion or pneumothorax, and to differentiate interstitial pulmonary oedema from pneumonia by the identification of linear artefacts called 'lung comets'.<sup>14</sup> The acoustic windows used and views required are not however standard, and additional training may be required for this use.

### Acute valvular heart disease

A murmur in a patient with acute cardiorespiratory compromise is an indication for urgent TEE. Echocardiography detects abnormalities of valve morphology and function, aetiology including IE, and haemodynamic effects on chamber size and function. In emergency admissions, VHD is likely to be severe and to affect the left-sided valves, including flail MV and AV leaflets, prosthetic valve dehiscence, and valve perforation in infective endocarditis.<sup>4</sup>

### Chest pain

Identifying the aetiology of acute chest pain is often challenging and requires careful history and examination, with the first step a 12-lead electrocardiogram (ECG) if acute coronary syndrome is suspected. When the history, ECG and biomarker findings are inconclusive, TTE is then the most important imaging modality in the emergency setting, not only because it can demonstrate transient wall motion abnormalities during ischaemia and tako-tsubo but also because it may highlight differential diagnoses including aortic dissection, PE, and pericardial disease.<sup>15</sup> TTE has a limited role in the diagnosis of acute myocarditis, although the identification of PEff due to acute pericarditis presenting with haemodynamic compromise is important.<sup>16</sup>

### Acute coronary syndrome (ACS)

In those patients with a history and examination suggestive of ACS, current guidelines recommend immediate angiography following 12-lead ECG in those with ST-segment elevation MI.<sup>17</sup> In those cases when history, clinical risk score, and ECG fail to diagnose an ACS, both myocardial contrast for perfusion and strain TTE may improve diagnostic accuracy before serum biomarker results become available

dependent on local expertise.<sup>18</sup> While the sensitivity of 2D-TTE wall motion analysis for detecting an acute coronary occlusion in ACS is only 71% in the modern biomarker era, this is substantially improved with the addition of regional strain analysis to 90%.<sup>19</sup> LV opacification contrast should be used where image quality is sub-optimal and two or more myocardial segments cannot be adequately visualized. In addition, focused TTE should be available in the emergency room and chest pain unit as it can be helpful to detect alternative pathologies, such as proximal aortic dissection involving the coronary ostia, without delaying revascularization.

### Acute aortic syndromes

This term refers to the spectrum of aortic pathologies, comprising aortic dissection, intramural haematoma, penetrating aortic ulcer, and aortic aneurysm rupture. Prompt and accurate diagnosis of these conditions is paramount due to their potentially lethal nature. Non-invasive imaging techniques that play a core role include computed tomography (CT), transesophageal echocardiography (TEE), magnetic resonance imaging (CMR) and TTE. The sensitivity of TTE has improved such that it can be considered as the first-line imaging modality in the emergency room but, if negative, further imaging should be performed.<sup>20</sup> For any test performed under these circumstances, expert interpretation is required to minimize risk of false positive and false negative results, which may be a particular problem in this clinical scenario.

### Chest trauma

TTE should be used to assess the consequences of penetrating cardiac trauma, although blunt cardiac contusion is more common. The latter may cause a spectrum of pathology from transient regional wall motion abnormalities to cardiac rupture, valve lesions (frequently tricuspid), and aortic dehiscence. Echocardiography has high sensitivity for detection of the complications of contusion, including intracardiac shunts or thrombosis, PEff or tamponade, and ventricular dilatation.<sup>21</sup>

### Syncope or palpitations

There is a broad overlap in the clinical presentations of patients with syncope in the emergency room that may potentially be due to ventricular and supraventricular arrhythmias, as well as to other non-arrhythmic causes such as hypovolaemia, pericardial tamponade, dynamic LV outflow tract obstruction in HCM and severe VHD. The management and prognosis of each patient depends both on their hemodynamic status on arrival and on severity of underlying CV disease. TTE is the first line imaging modality for diagnosis of underlying myocardial, valvular and congenital disorders in highly symptomatic patients with high-grade atrio-ventricular block, ventricular and supraventricular arrhythmia and in complicated new-onset atrial fibrillation. The aims of imaging are not only diagnosis but also prognosis, guidance of therapy and monitoring.<sup>4</sup> A normal TTE in this setting is an important finding that helps to direct the clinician in diagnosis and management. Presentation with palpitations may require the same diagnostic and prognostic assessment as for syncope, although urgency of imaging depends on haemodynamic compromise.

## Cardiac emergency suspected following other investigation

This section refers to the use of TTE following another investigation that has highlighted a serious, unexpected, potentially life-threatening condition that may require immediate action. Most commonly the investigations include elevated cardiac biomarkers and abnormal radiological findings.

### Elevated troponin

Cardiac troponin testing is essential in the assessment of acute chest pain. The role of TTE in those with suspected ACS has been discussed but particularly with high sensitivity assays, circulating troponin can be detected within 2–3 hrs in many other conditions, including heart failure, aortic valve disease, acute aortic syndromes, hypertrophic and restrictive cardiomyopathies, Tako-tsubo syndrome, endocarditis, and myocarditis. Dependent on clinical circumstances, early TTE may be important to direct treatment in these circumstances, particularly in patients with shock, when troponin may be elevated in critical illness due to non-cardiac causes including sepsis, acute renal failure and burns. In these cases, TTE has an important role not only in excluding a cardiac component to hemodynamic compromise but also in monitoring filling pressure, response to volume-loading and pharmacotherapy.<sup>22</sup>

### Elevated natriuretic peptides

Natriuretic peptides as markers of myocardial stretch are typically elevated when heart chambers dilate as in HF, especially acutely, but also in acute cardiomyopathies, severe VHD and arrhythmias.<sup>23</sup> Natriuretic peptides may be elevated in non-primary cardiac illnesses, including critical sepsis, severe anemia, stroke and pulmonary disease, including PH.<sup>24</sup> TTE may provide important additional diagnostic and prognostic information in the critically ill patient.

### Radiological abnormality

While a standard chest-X-ray is not an accurate method for diagnosis of cardiomegaly or thoracic aortic dilatation, such a finding in the emergency room in a patient with relevant symptoms, signs or past medical history mandates early TTE.

## Assessment of the patient prior to non-cardiac emergency surgery

Prior to emergency non-cardiac surgery, the utility of TTE is unclear due to the need for urgent intervention. Although there is a lack of data, expert consensus suggests that TTE does not change the course and outcomes of an urgent intervention, such as those for ruptured abdominal aortic aneurysm, major trauma or perforated viscus, whether or not the patient has a history of CV disease.<sup>25</sup>

## Echocardiography in the non-urgent, first assessment of the patient

This section relates to the first use of TTE in patients hospitalized (in-patient) or investigated as out-patients (Table 2). TTE will usually

follow the same protocol in either setting and there may be no difference in the indication for examination in many cases. This section outlines evidence relating to the first use of TTE.

### Shortness of breath

SOB is a common symptom affecting up to half of all acute hospital admissions and a quarter of ambulatory patients and it may be the primary manifestation of CV disease, lung disease, anaemia, obesity, deconditioning and a host of other causes. In any setting, clinical history and examination remain the first step in evaluation, although TTE may improve accuracy in diagnosis and provide incremental information.<sup>26</sup>

### Acute and chronic heart failure

In all patients with suspected heart failure, early TTE is mandated. The aims of TTE are to confirm or exclude the diagnosis, quantify chamber volumes, systolic and LV diastolic function, wall thickness and to identify the aetiology of heart failure. TTE provides an initial diagnosis and treatment plan in the majority of patients; other imaging may only be required if the diagnosis remains unclear.<sup>5</sup> It is the primary imaging modality to identify HF with preserved, mid range or reduced EF in those with breathlessness. TTE is also mandated in patients with known HF presenting with acute exacerbation, for identification of a precipitating factor for deterioration.

### Valvular heart disease (VHD)

SOB is the leading symptom of mitral valve disease, and is a common presentation for a patient with VHD of any type. In patients presenting with SOB and suspected VHD based on history and/or examination, TTE is the primary imaging modality for diagnosis, assessment of severity and of hemodynamic consequences.<sup>27</sup>

### Cardiomyopathy (CM)

SOB may be a presenting symptom in CM of all types and TTE is a fundamental step in diagnosis and classification of type, specifically hypertrophic, dilated, arrhythmogenic, restrictive and unclassified cardiomyopathies.<sup>28</sup> It is also recognized that TTE should form the first step in differentiating the heart of the athlete from serious cardiovascular disease that may share morphological features.<sup>29</sup>

#### *Hypertrophic cardiomyopathy (HCM)*

TTE is the primary imaging modality in patients with HCM, providing information on diagnosis, anatomy (LV hypertrophy, mitral valve apparatus, intraventricular and LV outflow tract obstruction), ventricular systolic and diastolic function, mitral regurgitation, ischaemia, staging and risk stratification. Supplementary manoeuvres, including Valsalva and ergometric testing, may be necessary to identify significant LVOT obstruction. TTE is an important tool to separate HCM from phenocopies.<sup>30</sup>

#### *Dilated cardiomyopathy (DCM)*

DCM is defined by the presence of LV dilatation and LV systolic dysfunction in the absence of abnormal loading conditions (hypertension, valve disease) or coronary artery disease sufficient to cause global systolic impairment. TTE is the primary imaging modality in

**Table 2** Clinical scenarios for echocardiography in the non-urgent, first assessment of the patient

Scenario	Conditions identified on TTE	Focus of assessment
Shortness of breath	Acute and chronic HF, VHD, cardiomyopathy, pericardial disease, pulmonary vascular disease, pulmonary hypertension	LV size, wall thickness and function, RV size and function, valve function, pericardium
Chest pain	Acute coronary syndrome, chronic stable angina, VHD, acute aortic syndromes, pulmonary embolism, and pericardial disease	LV size and function, RV size and function, valve function, aorta, pericardium
Syncope, palpitations, arrhythmia	Structural heart disease leading to haemodynamic instability and arrhythmia, including acquired and congenital heart disease	LV size, wall thickness and function, RV size and function, valve function, arterial and venous connections
Cardiac disease identified by other investigation	Acute and chronic HF, acute coronary syndromes, VHD, cardiomyopathy, pericardial effusion	LV size and function, RV size and function, valve function
Infective endocarditis	Supporting evidence of IE and/or complications thereof	High resolution valve assessment and complications
Emboli and cardiac masses	Mass consistent with thrombus, tumour, vegetations	Characterization of mass, size, location and involvement of adjacent structures
Patients at risk of CV disease	Hypertension, genetic predisposition to cardiac disease, exposure to cardiotoxic medications	LV size, wall thickness and function, including advanced characterization of diastolic function and deformation, RV size and function
Adult congenital heart disease	Broad range of inherited conditions with de novo presentation or previous surgery	Segmental analysis to define arterial and venous connections, valve and ventricular morphology and function, intracardiac pressure and shunts
Prior to planned non-cardiac surgery	Active cardiovascular symptoms or proven CV disease	LV size, wall thickness and function, RV size and function, valve function

DCM, providing information on diagnosis, severity of ventricular dysfunction, staging and risk stratification.

#### *Arrhythmogenic right ventricular cardiomyopathy (ARVC)*

ARVC is characterized histologically by progressive replacement of RV myocardium with adipose and fibrous tissue, frequently leading to functional and morphological abnormalities that may be diagnosed on TTE.<sup>31</sup> Detection of RV dilatation and RV dysfunction in association with regional hypokinesis represent major and minor diagnostic imaging criteria, while it is also important to ensure there is a low likelihood of pulmonary hypertension. TTE is the primary imaging modality, although ARVC may be present in the absence of imaging criteria of any type.

#### *Restrictive cardiomyopathies (RCM)*

RCMs are defined by the presence of restrictive ventricular physiology with normal or reduced diastolic volumes (of one or both ventricles), normal or reduced systolic volumes, and normal ventricular wall thickness.<sup>28</sup> These may be familial, including haemochromatosis, Anderson-Fabry disease and glycogen storage disease, or non-familial, including AL and wild-type TTR amyloid, endomyocardial fibrosis and carcinoid heart disease. TTE is not only the main diagnostic imaging modality for RCM but is also useful for risk stratification.<sup>32</sup>

#### **Lung disease**

Two categories of patients with SOB and lung disease have been defined: (a) those presenting for the first time; (b) those presenting with an established diagnosis that may cause SOB but which has

deteriorated for no apparent reason.<sup>33</sup> The role of TTE in patients with primary lung disease presenting for the first time is not clear, except in those with suspected PE or PH. In those with established lung disease that may cause SOB but with unexplained deterioration, for example in chronic obstructive pulmonary disease and sleep apnoea syndrome, careful CV evaluation and TTE is necessary in order to detect complicating factors such as HF.<sup>34</sup>

#### *Pulmonary vascular disease*

CT, ventilation-perfusion imaging and pulmonary angiography are the imaging modalities of choice in the diagnosis of the non-urgent patient with suspected PE. TTE has a role during hospitalization as it identifies those at risk of acute deterioration and determines prognosis.<sup>35</sup> Furthermore, persistence of RV dysfunction on TTE at hospital discharge is a marker for recurrence of PE.<sup>36</sup>

#### *Pulmonary hypertension (PH)*

The diagnosis of PH requires a high index of suspicion, as symptoms and clinical signs are frequently non-specific and often relate to onset of RV dysfunction. Doppler echocardiography is used to estimate the pulmonary pressure from the maximal velocity of the tricuspid regurgitant jet (TR Vmax >2.8 m/sec), combined with additional variables including relative RV to LV size, RV/LV eccentricity index, RA area > 18 cm<sup>2</sup>, RV outflow tract acceleration time (<105 ms), pulmonary regurgitant velocity (>2.2 m/s), inferior vena cava dimensions and the pulmonary artery diameter > 25 mm.<sup>37</sup> Assessment of RV size and function by TTE can be complicated by the need to use multiple acoustic windows and is less accurate than CMR in this respect. In



those with confirmed or suspected PH, TTE may help to determine a cause, in particular confirming or excluding the presence of left heart disease and Doppler can distinguish pre- and post-capillary pulmonary hypertension.

## Chest pain

Ambulatory patients presenting with chest pain are common, although only a small proportion will have an ACS. In the community, the most common causes include chest wall pain (e.g. costochondritis), and gastro-oesophageal reflux disease, with other considerations including pulmonary aetiologies (pneumonia, pulmonary embolism) and psychological disorders (anxiety, panic disorder). The first step is to exclude ACS, usually based on clinical parameters, initial ECG and biomarker measurement.

### Acute coronary syndrome

In patients with non-ST segment elevation ACS, management depends on information additional to history and clinical examination which comprises: the response to anti-ischaemic treatment, biomarker measurement (high sensitivity troponin), repeat ECG or continuous ST-segment monitoring, ischaemic risk score assessment (GRACE score) and TTE.<sup>38</sup> TTE is useful not only as a diagnostic tool but is important in risk stratification. The presence of LV systolic dysfunction has an independent prognostic role in predicting both short- and long-term cardiac events.<sup>39,40</sup>

### Chronic stable angina

Although overall LV function is often normal in patients with stable angina, regional wall motion abnormalities may be identified that provide evidence in support of a diagnosis of CAD. In those with a confirmed diagnosis of chronic stable angina, TTE is useful to quantify global LV function, which is an important prognostic parameter.<sup>41</sup> In addition to 2D, tissue Doppler and myocardial deformation imaging, along with assessment of diastolic function are useful for detecting early myocardial dysfunction in those with preserved LV ejection fraction as an explanation for exercise-induced symptoms.<sup>42</sup>

### Acute pericarditis

Acute pericarditis is an inflammatory syndrome with or without PEff. TTE is recommended in all patients in whom the diagnosis is suspected.<sup>16</sup> The aim of TTE is to identify PEff and to exclude ventricular dysfunction due to myocardial involvement. The presence of a large PEff (>20 mm) is one of the major risk factors for poor prognosis.<sup>43</sup>

### Valvular heart disease

The development of chest pain during exercise in a patient with severe aortic stenosis in the absence of CAD is a clear indication for intervention and TTE is mandated in any patient presenting in this way who has a murmur or clinical evaluation consistent with this diagnosis.<sup>27</sup>

### Acute aortic syndromes

Although TTE may be used in the emergency room, particularly in the assessment of the proximal ascending aorta, CT is the recommended first line imaging modality for those with suspected aortic syndromes in the non-emergent setting.<sup>20</sup> In the stable patient, TTE

may complement CT by adding information on presence, severity and mechanism of aortic regurgitation, PEff, and LV function.

## Syncope, palpitations, and arrhythmia

Syncope and palpitations are among the most common symptoms leading to medical presentation and the role of TTE is to rule out structural cardiac disease where there is a clinical suspicion on examination or following a 12-lead ECG.<sup>44,45</sup> A normal TTE in this setting is an important finding that helps to direct the clinician in diagnosis and management. It is uncommon for TTE to define a sole cause for syncope or presyncope without the need for additional tests in the absence of a clinical suspicion of structural abnormality, since the most commonly identified causes such as aortic stenosis, HCM, DCM, ARVC, and pulmonary hypertension are usually at an advanced stage. In the presence of impaired LV function, other tests to evaluate a cardiac cause for syncope should be performed.<sup>44</sup> Diagnosis of the cause of palpitations is provided by electrocardiographic recording of a rhythm disorder or the absence of it at the time of symptoms and TTE is not indicated unless there is a clinical suspicion of structural heart disease on examination or following a 12-lead ECG. Likewise, in those patients with confirmed multiple premature ventricular complexes and/or sustained or non-sustained arrhythmias, including atrial fibrillation, supraventricular tachycardia and ventricular tachycardia, TTE is required for diagnosis of underlying structural CV disease, for risk stratification and planning treatment.<sup>46,47</sup>

## Cardiac disease suspected following other investigation

### Elevated troponin

Although cardiac troponin testing is integral to the diagnosis of chest pain in the acute medical patient, elevation is not synonymous with ACS. The value of TTE in patients with elevated troponin and suspected ACS has been discussed but the role of TTE in the patient with an alternative cause is more complex. All cardiac troponin elevations are important and may have prognostic significance. Firstly, in patients with an acute elevation in troponin but no evidence of ischaemia, for example in severe sepsis, stroke, or other critical illness, a dynamic change in biomarker is associated with high risk and TTE is useful for measurement of LV function.<sup>48</sup> Secondly, in patients with a chronic elevation in troponin, for example HF and kidney disease, while this is associated with adverse prognosis, the role of TTE in management is not clear. Thirdly, measurement of troponin may be used as a sensitive and specific marker of myocardial injury, for example in patients receiving cancer therapy. In these patients, elevation in biomarkers may be used to monitor the effects of chemotherapy, with elevation then a stimulus to TTE.<sup>49</sup> While change in ejection fraction is the most common method of diagnosis of cancer therapy-related cardiac dysfunction, global longitudinal strain is the optimal parameter of deformation for monitoring of sub-clinical LV dysfunction.<sup>50</sup>

### Elevated natriuretic peptides

Since HF symptoms are non-specific, use of natriuretic peptides is recommended for screening patients with acute onset, worsening or gradual onset of symptoms.<sup>51</sup> TTE is then required to confirm or



versatility, lack of radiation exposure, and safety in patients with concomitant renal disease.<sup>49</sup> Recommended protocols using TTE encompass not only 2D assessment of structure and function but recommend the routine use of 3D and also deformation analysis for reproducible quantification of volumes and function, as well as standard assessment of strain, diastolic function, valvular abnormalities, and pericardial consequences of chemotherapy and radiotherapy.<sup>50</sup>

## Adult congenital heart disease (ACHD)

ACHD encompasses a broad range of patients, from de novo presentations in adulthood to the assessment of patient with previous palliative repair and its consequences. Survival to adulthood is increasing, although varies with severity of disease, from 98% of those with mild disease to 56% of those with severe forms of ACHD.<sup>67</sup> With increasing life expectancy, there is the additional interaction between acquired disease and the consequences of ACHD, either precipitating symptoms in hitherto stable disease or onset of consequences from undiagnosed disease. TTE represents the first-line investigation for diagnosis and follow-up of ACHD, since a segmental approach will help to define arterial and venous connections, valve and ventricular morphology and function, and estimate intracardiac pressure and shunts.<sup>68</sup> While TTE is first-line, it is recognized that it is user-dependent and requires special expertise in ACHD populations.

## Assessment of the patient prior to planned non-cardiac surgery

The risk of CV complications during non-cardiac surgery depends upon the condition of the patient before surgery, the severity of his or her co-existing morbidity, and the magnitude, type and duration of surgery proposed. Alongside the risk attributable to specific types of surgery, the functional capacity of the patient is the most important patient-related factor to determine likelihood of peri-operative cardiac events.<sup>25</sup> Although TTE can identify patients at higher risk, its use should be reserved for those patients in whom the result would influence or change management and routine use is not recommended. For example, TTE is not recommended in those patients with stable heart disease undergoing low and intermediate-risk surgery but in symptomatic, unstable patients undergoing high risk surgery, careful evaluation of the patient by a team of integrated multidisciplinary specialists may be informed by TTE.

## Repeat echocardiography following first study

This section relates to the second or repeated use of TTE in an in-patient or out-patient setting (Table 3). The echocardiographic examination will in most cases be a complete study acquiring a comprehensive set of images and measurements.<sup>69</sup> In the majority of cases, TTE will be performed in patients with CV disease confirmed on previous assessment.

## Heart failure

HF is a dynamic syndrome characterized by gradual deterioration and episodic, acute exacerbations. TTE is the imaging modality of choice for follow-up of HF to determine progression or response to

treatment, focussing on ventricular volumes, function, associated valve disease and PH.<sup>5</sup> TTE is used to investigate symptoms, acute or chronic deterioration and to determine prognosis, the latter being important to inform decisions on treatment with devices or transplantation, and patient counselling with respect to end-of-life. Estimating prognosis takes into account age, aetiology, NYHA class and co-morbidities including renal failure, anaemia and hyperuricaemia, while integrating imaging variables such as ejection fraction, wall thickness, geometry and filling pattern.<sup>70</sup> The routine repeat assessment of ventricular function however, in the absence of changing clinical status or a change in treatment, is not warranted.

## Indications for device therapy

TTE has a central role in selection of patients with symptomatic HF who may benefit from an implantable cardioverter-defibrillator for prevention of sudden cardiac death, based on LV ejection fraction (LVEF < 35%).<sup>47</sup> Although the decision to implant a cardiac resynchronization device is based primarily on QRS duration > 150 ms, TTE is used to quantify LVEF < 35% and thereby acts as a gate-keeper for appropriate device implantation. TTE may also identify patients with secondary mitral regurgitation who would benefit from implantation.<sup>71</sup> The role of TTE in those with borderline QRS duration 120–150 ms continues to be a source of debate.<sup>72</sup> TTE is not recommended for routine optimization of all resynchronization devices.

TTE is also acts as a gate-keeper to select suitable candidates with end-stage heart failure for mechanical circulatory support, based on both LVEF < 25% and on identification of right ventricular dysfunction. Repeat TTE in patients with mechanical circulatory support is useful, not only to optimize function and trouble-shoot complications but also to monitor response, with a view either to removal of the assist device (bridge to recovery) or to listing for transplantation (bridge to candidacy).<sup>51</sup> TTE may be indicated early post-implantation when PEff and tamponade are suspected, and whenever there is a suspicion of device-related infection.

## Cardiac transplantation

The International Society for Heart and Lung Transplantation recommends the use of TTE for pre-operative assessment of the donor and recipient. TTE measurement of ventricular function is a component of the Heart Failure Survival Score, which identifies cut-points for transplant listing.<sup>73</sup> While TTE is used in the early post-transplant phase to monitor right ventricular function and tricuspid regurgitation, longer term routine TTE to monitor rejection is not considered useful as an alternative to endomyocardial biopsy.<sup>74</sup> TTE is commonly used however, when there is a clinical suspicion of acute allograft rejection and a baseline TTE is performed at least 6 months from the transplantation and then following endomyocardial biopsies, usually every 6 months.<sup>75</sup>

## Ischaemic heart disease

There is no indication for use of TTE on a regular basis in patients with stable CAD in the absence of a change in clinical status. Sudden deterioration with recurrence of chest pain or other evidence of clinical compromise should trigger re-evaluation, specifically searching







frequency with which screening TTE should be performed is not clear in the absence of clinical concern.

### Pericardial constriction (PC)

Suspicion is raised in patients with signs of predominantly right-sided heart failure although in the majority PC is a chronic condition that is often diagnosed late. TTE is recommended 5 years after exposure in those who are at high risk for radiotherapy-induced heart disease and 10 years after exposure in others.<sup>84</sup> Repeat TTE is recommended in patients following pericardiocentesis, medical treatment or pericardiectomy in effusive-constrictive pericarditis and transient PC.<sup>83</sup>

### Aortic disease

While TTE is useful for evaluating the aortic root and proximal ascending aorta, CT or MRI are preferred for routine surveillance of thoracic aortic dimensions.<sup>20</sup> CT or MRI are also recommended for routine surveillance following aortic dissection, intramural haemorrhage and penetrating aortic ulcer. TTE can be used for routine follow-up in Marfan syndrome and BAV-associated aortopathy but only when dilatation is restricted to the root and proximal ascending aorta, and when concordance between the dimensions measured by TTE and CT or MRI has been documented.<sup>20</sup>

## Repeat echocardiography in the assessment of the patient at risk of cardiac disease

### Hypertension

Repeat TTE to monitor for onset of CV complications of hypertension in the absence of symptoms or signs is not recommended and there is no role in evaluating response to treatment.<sup>60</sup> Conversely, repeat TTE should be performed if there is a change in clinical status or with poor control of blood pressure.<sup>85</sup>

### Risk factors and asymptomatic adults

There is no incremental benefit to history and clinical risk estimation in repeat TTE in asymptomatic individuals with or without DM, dyslipidaemias or other risk factors for CAD.

### Genetic predisposition and screening

In first-degree relatives of patients with HCM in whom genetic status is unknown, clinical assessment with ECG and TTE should be considered every 1–2 years between 10 and 20 years of age, and every 5 years thereafter (12 monthly if non-diagnostic abnormalities are present) as late-onset hypertrophy can occur.<sup>86</sup> First-degree relatives who do not share the same disease-causing mutation as the proband should be discharged from further follow-up.

First-degree relatives of patients with other CM including ARVC, DCM, and RCM not known to be affected should undergo periodic TTE in those cases where genetic testing is not categorical and where late occurrence may arise. Screening every 5 years may be reasonable. LVNC should be present from birth and no late occurrence is to be expected.

### Cardiotoxic therapy

Evaluation by TTE of ventricular size and function is recommended before, during, and after cancer therapy. 3DE is the preferred

technique for monitoring LV function, although 2D TTE measurement of global longitudinal strain is recognized as a more sensitive means of detecting subclinical LV dysfunction during follow-up studies.<sup>49</sup> For low dose type I toxicity, for example doxorubicin, repeat TTE is recommended at the completion of therapy and 6 months later. For patients exposed to type II toxicity, for example trastuzumab, repeat TTE is recommended every 3 months during therapy and at 6 months following completion of therapy.

### Adult congenital heart disease

TTE is the primary imaging tool in the on-going management of the adult with congenital heart disease. It is used to measure and follow-up valve and ventricular function, ventricular mass, calculate pulmonary pressure, and monitor intracardiac shunts. Special competency in ACHD is important in TTE in this group of patients, particularly as imaging becomes complicated by the super-imposition of acquired disease with age. Frequency of repeat TTE should be decided on the basis of type of congenital abnormality, type and result of surgical correction, the individual's clinical condition and prognosis, and the availability of local medical services.<sup>67,68</sup> In general, annual TTE should be performed in any asymptomatic, clinically stable patient following incomplete or palliative repair, for example Tetralogy of Fallot. In any asymptomatic patient following complete repair without residual structural or haemodynamic abnormality, there is no clear evidence of benefit from regular repeat TTE. TTE should be performed in any patient with documented ACHD to investigate a change in clinical status or examination and to guide therapy.

### Following device therapy and intervention

There is increasing demand for TTE not only in the identification of patients suitable for device therapy and intervention but for following such patients after therapy. While it is common practice to monitor implantation or exclude immediate and early complications, there are very limited data however that demonstrate improved patient care directly as a result of regular, repeat echocardiography following device therapy and intervention.

### Pacing, resynchronization, and cardio-defibrillator therapy

The majority of complications from implantation of pacemakers, resynchronization devices and cardio-defibrillators occur in-hospital or within the first 6-weeks.<sup>87</sup> TTE should be performed in all patients soon following implantation to exclude mechanical complications, including PEff, and to check on lead placement. There is no evidence to support further echocardiography unless there is clinical concern regarding complications such as device-related infection.

### Transcatheter valve and device therapy

Early assessment with echocardiography within 24 hrs following transcatheter valve intervention is recommended, whether or not peri-procedural echocardiography is performed during the procedure itself. The aim is to confirm function of the valve, exclude complications including paravalvar regurgitation and pericardial effusion, and to act as a baseline for future comparison not only of the new device but also of ventricular and other valve function.<sup>88</sup> Thereafter, for

transcatheter aortic valve implantation, follow-up evaluation is recommended as for surgically-implanted bioprostheses but additional, repeat assessment of transcatheter mitral valve intervention is recommended at 6 months specifically to assess reverse ventricular remodelling.<sup>88</sup>

For transcatheter repair of paravalvar regurgitation, periprocedural echocardiography is required but early assessment by TTE within 24 hrs should also be performed to exclude complications and as a baseline for future reference. Additional repeat echocardiography thereafter may be performed as planned for the prosthetic valve itself with no additional imaging required without a clinical suspicion of complications.

Following transcatheter or device occlusion of the left atrial appendage, follow-up echocardiography is performed within the first month, at 6 months and then annually to ensure device stability, absence of leak and to exclude associated complications.<sup>89</sup>

### Revascularization for IHD

There is no evidence to support routine TTE following percutaneous revascularization.<sup>90</sup> The rationale for and timing of echocardiography in patients with stable angina and ACS has been discussed but repeat imaging following percutaneous revascularization is not necessary unless the patient has had a complicated course, for example suspected peri-procedural myocardial infarction, dissection or guidewire perforation. TTE should be performed as baseline prior to discharge following surgical revascularization.

## Conclusions

Indications for TTE in the adult continue to grow and activity in many departments across Europe increases inexorably. TTE is operator dependent and it is vital that the test is performed by qualified individuals within proficient departments that monitor quality.<sup>91,92</sup> Demand for TTE and the costs that arise from providing high quality imaging necessitates that there is a clear incremental benefit to the patient and the healthcare system from the performance of the test beyond history and examination, taking into account other imaging modalities. The degree of benefit will be subject to change and indications will need to be subject to regular review.

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