The principal role of the left atrium (LA) is to modulate left ventricular filling and cardiovascular performance by functioning as (i) a reservoir for pulmonary venous return during ventricular systole, (ii) a conduit for pulmonary venous return during early ventricular diastole, and (iii) a booster pump that augments ventricular filling during late ventricular diastole. The interplay between these atrial functions and ventricular performance throughout the cardiac cycle is crucial in many pathophysiological conditions. However, in clinical practice, we do not really assess all of the components of LA function. In fact, quantification of LA function remains challenging. Calculating ejection fraction or atrial ejection force has occasionally been proposed as methods for quantifying LA function, but they are neither routinely used nor recommended in the literature.

Standard recommendations in the literature propose using LA volume calculated from trans-thoracic 2D echocardiography orthogonal views. LA size correlates with both LA and left ventricular (LV) function and is a strong predictor of cardiovascular morbidity and death. The antero-posterior diameter, calculated with M-mode or 2D echocardiography, is no longer considered to adequately represent the true LA size. For these reasons, the ASE/EACVI joined paper recommends the measurement of LA volumes with either the area-length method or, ultimately, the Simpson’s method in four- and two-chamber apical views. Nevertheless, it is clearly evident that a great deal of work has focused on the LA anteroposterior diameter. Consequently, the most recent ESC guidelines for evaluating hypertrophic cardiomyopathy recommend its measurement. Current ESC guidelines for predicting the risk of rhythmical events still recommend including the LA diameter in scores.

From another perspective, the paper by Morris et al. is important because it provides normal values and presents evidence supporting the future value of LA strain as the best way to characterize our patients’ atrial function. This especially applies to individuals with depressed left ventricular diastolic function, though its usefulness is not limited to this group of patients. In collaboration with Dr. Morris, a number of Japanese investigators are participating in a prospective study that includes 706 patients in order to further advance this important effort. The methodology and the results are likely to influence the direction of research studies in the near future.

Until recently, it must be remembered that investigators relied on a single software provided by one company. To date, there has clearly been no consensus and no real interchangeability between companies on how to process data for the measurement of LA strain. This is why the effort, such as that put forth by Morris, to collect a large amount of data from many centres is important. This is also one of the goals of a large prospective study (NORRE) by the EACVI and Lancellotti et al. who have already provided some normal values. The report on strain data are up-coming using imaging acquired with two types of echo-machines, though a single software is being used for quantifying the data. Prior to routine clinical application, companies providing software for strain quantification will have to develop some degree of standardization in order to ensure that at least the global systolic LA strain measurement is ‘identical’ across software packages.

Evaluation of LA deformation parameters is a new promising approach for analysing LA mechanics and perhaps electromechanical coupling (Figure 1). Early detection of LA dysfunction can be anticipated with strain measurement; it can also provide new insights into pathophysiology and perhaps guide clinical management. Towards that aim, Morris et al. have reported an LA strain and a strain rate feasibility of 95.1%. They are also reporting important physiological information. For instance, there were no differences in the LA pump function (LA-SRa) among different age groups, while there were some differences in the LA reservoir function. LA-Strain and LA-SRa were significantly lower in patients with NYHA class II than in those with NYHA class <2. Thus, it seems that if LA volume serves as the HbA1c of diastolic function, LA strain is most likely more related to LV diastolic function and filling pressures. In normal subjects, the reservoir, passive conduit, and pumping phases account for 40, 35, and 25%, of the atrial contribution to stroke volume, respectively. The LA reservoir (Figure 1a: first positive peak of strain) phase is essential for LV filling because the energy stored by the LA during ventricular systole is released after mitral valve opening, greatly contributing to LV stroke volume. The LA conduit phase (Figure 1b: plateau) spans early LV...
filling and diastasis. LA contractile (Figure 1c: return to the zero line) phase performance depends on preload, afterload, intrinsic contractility, and electromechanical coupling. The early peak (a) largely reflects LA-compliance but also represents LA-reservoir function. A significant positive correlation has been found between peak LA strain (a) and LV systolic longitudinal strain. LA conduit function is dependent on LV relaxation and preload. The transfer of blood to the LV is accompanied by LA myocardial shortening, resulting in negative SR values (c).13

Based on this theoretical background and the findings of Morris et al.4 and those of other studies of pathological conditions,5,12 adding the LA strain measurement to the algorithm for the assessment of LV diastolic function is a realistic goal. Some have proposed a ratio similar to E/e’ using LA strain data,13 while others have proposed using LA strain in addition to the CHADS score for predicting the embolic risk in atrial fibrillation.14 The work of Morris et al.4 as well as on-going investigations such as the NORRE study5 is needed to further validate the feasibility, reproducibility, and clinical value of LA strain and strain rate. We can expect from the Euro-Filling15 ongoing study that new data will encourage the addition of LA strain in the next recommendations and guidelines for evaluating diastole, filling pressures, and perhaps even heart failure with preserved ejection fraction. Nevertheless, the far-field location of the LA, the reduced signal-to-noise ratio, the thin atrial wall and the presence of the appendage and pulmonary veins all make strain imaging of the LA more difficult and more time consuming than for the LV, especially in light of the fact that the LV global longitudinal strain is becoming a standard in routine clinical care.5

References