THE STORY OF THE CYCLIST-PAINTER WITH HEART FAILURE AND ARRHYTHMIAS (INCLUDING ATRIAL FIBRILLATION). CASE REPORT OF THE *ABC STUDY ON HEART DISEASE ASSOCIATION*

(*ABC is acronym for Adria, Bassano, Conegliano, and Padova Hospitals)

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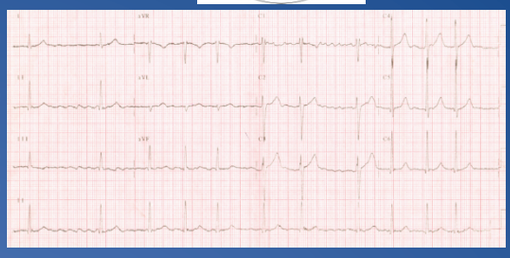
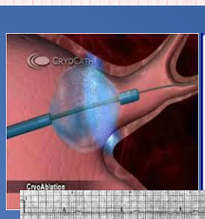
CLINICAL HISTORY

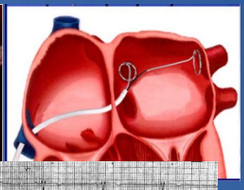
Our patient is a cyclist at a competitive level with regular sport idoneity from 37yr, with mild mitral valve prolapse, remote reumathic fever with pancarditis and family history of atrial fibrillation. His story begins with palpitation during intense physical activity at 43: isolated VEB were recognized, both at rest and on maximal effort, non inducible at electrophisiologic study. Against medical advice he continued high level cycling getting regularly fitness sport certificate up to 55yr. At this time AF was first documented. He was suggested to undergo AF ablation and started oral anticoagulant treatment.



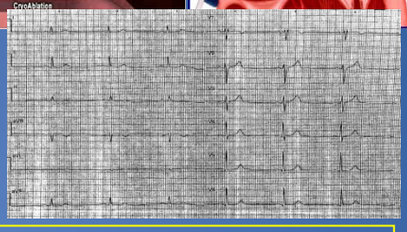
FIRST CLINICAL EVENT

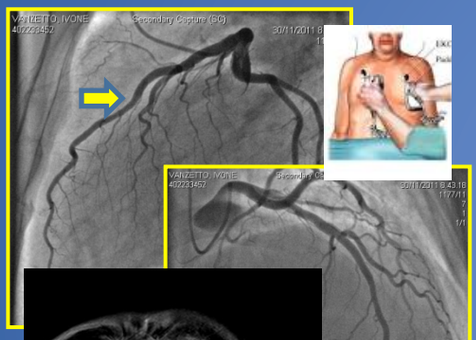
Few months later a **SYNCOPE** after exercise occured with severe politrauma. The admission ECG showed AF and a E**chocardiogram** revealed a sport-induced remodeling with normokinetic LV and mild mitral regurgitation. After long rehabilitation and virtually no sport activity he underwent **PV Crioablation**.

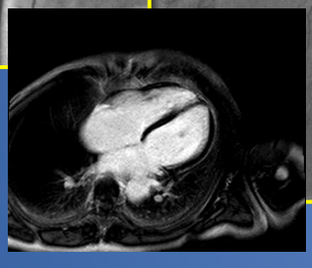


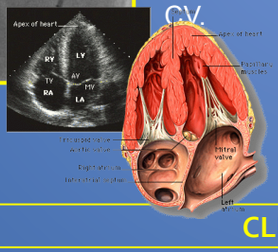


Then, cause of evidence of sinus rhythm on ECG, anticoagulation was interrupted. Regular rhythm monitoring, both with and without antiarrhythmic drugs demonstrating paroxistical AF, followed. However he started cycling again with competitions without problems.



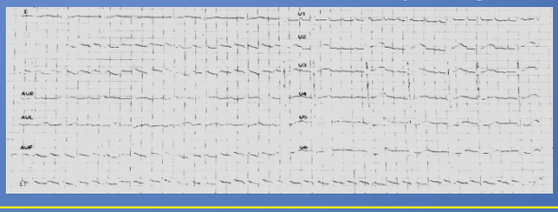


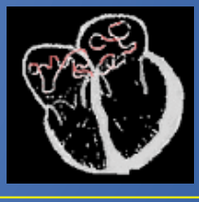




SECOND CLINICAL EVENT

At 58yr one more major clinical event (**DIPLOPIA** in relapse of persistent AF) occurred. Was performed an **Echocardiogram** (severe reduction in LVEF32%), a **coronary angiography** (no critical coronary lesions, short intramiocardial bridge on medium LAD) and an effective electrical cardioversion (ongoing Amiodarone treatment) with early relapse of AF and spontaneous restoration of SR two months later. A **cardiac MRI** confirmed dilated-ipokinetic cardiomiopathy (LVEF 40%) without myocardial fibrosis. After a period of sport restriction, he started cycling regularly. Few weeks later Atrial Flutter was detected, but he firmly disagreed one more electrical CV.

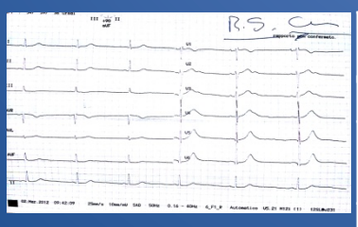




CLINICAL FOLLOW UP

The patient and his clinical cardiologist agreed on drug rhythm-control strategy (Amiodarone). Several ECG demonstrated SR manteinance.

Echocardiograms showed almost normalization of LVEF and the patient referred well-being (even better in cycling performance), despite some relapses of AF after emotive stress.



Now AF is persistent, but the patient is asymptomatic with a good rate-control, increased his cycling activity, Warfarine is well tolerated, and he feels comfortable in his usual life activities.

	At 48	At 49	At 55	At 56	At 57	At 58 (I)	At 58 (II)	At 61	At 63
Rhythm	SR	SR	SR	AF	AF	AF	AF	SR	AF
Aortic root Tubular aorta	- 42	- 42	43 42	46 41	-	-	- -	46 41	
Left atrium (mm)	36	36	36	36	-	-	-	46	46
LVEF %	68	65	68	60	46	32	45	50	50
EDD EDV	50 -	51 -	51	60	59 -	56 56	- 61	61 77	61 77
MR	1+	1 /2+	1+	1+		1+	1/ 2+	2/3+	2+
RV kinetic and dimension	-	-	Mild dilatation ,normal kinetic	Mild dilatation normal kinetic	-	-	-	normal	normal

CONCLUSION

This long and varied clinical case reminds us that often in medicine, major treatments and aggressive medical cares do not mean major patient's benefit