Cardiac Player Health and Safety
The Role of Sports Cardiology

Matthew W. Martinez, MD FACC

Sports Cardiology Medical Director

HCM Medical Director

Team Cardiologist - New York Jets

Cardiologist – Major League Soccer, NFL Medical committee, NBPA, JETS

twitter @mmartinezheart

ATLANTIC HEALTH SYSTEM

The Changing Face of the American Athlete - Youth

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The Changing Face of the American Athlete – High School

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The Changing Face of the American Athlete - Collegiate

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Heat

Concussion

Nutrition

First Aid

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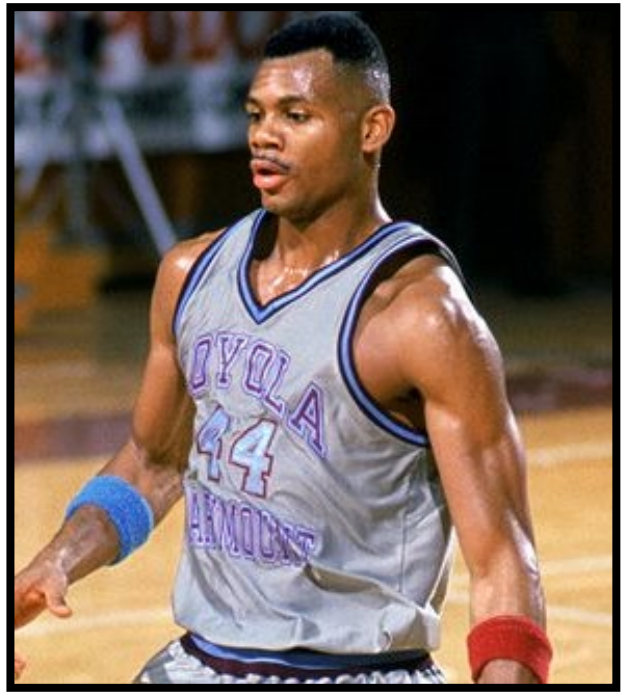

Hank Gathers
SCA March 4, 1990

Italian soccer captain found dead before game

By Associated Press March 4, 2018

Keyontae Johnson
2020 collapse

News › UK › Home News

London Marathon death: Matt Campbell, aged 29, dies after collapsing at mile 22

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PRO BASKETBALL

The N.B.A. Is the First League to Begin Standardized Cardiac Screening

By HOWARD BECK SEPT. 17, 2006

FIFA 2006 Pilot

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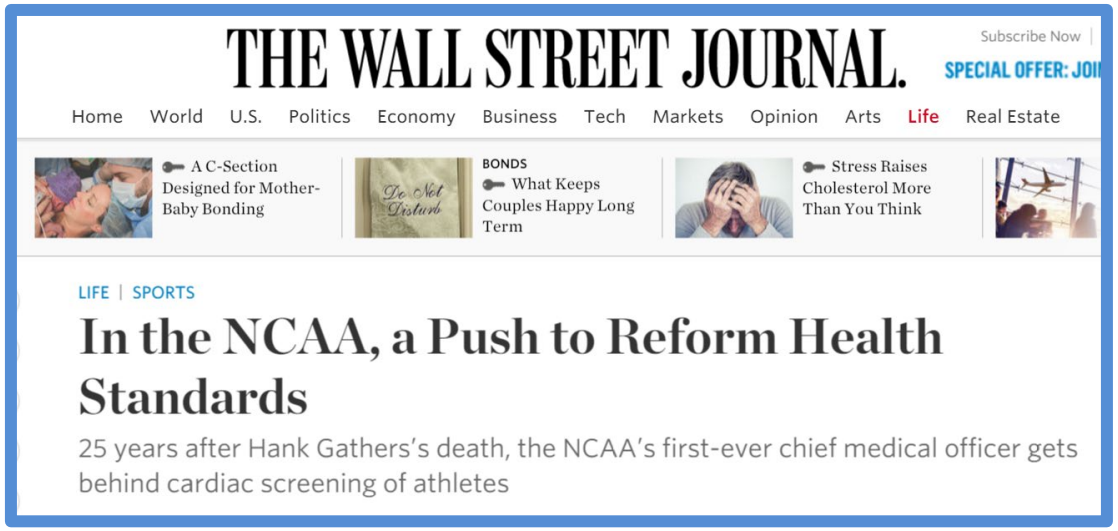
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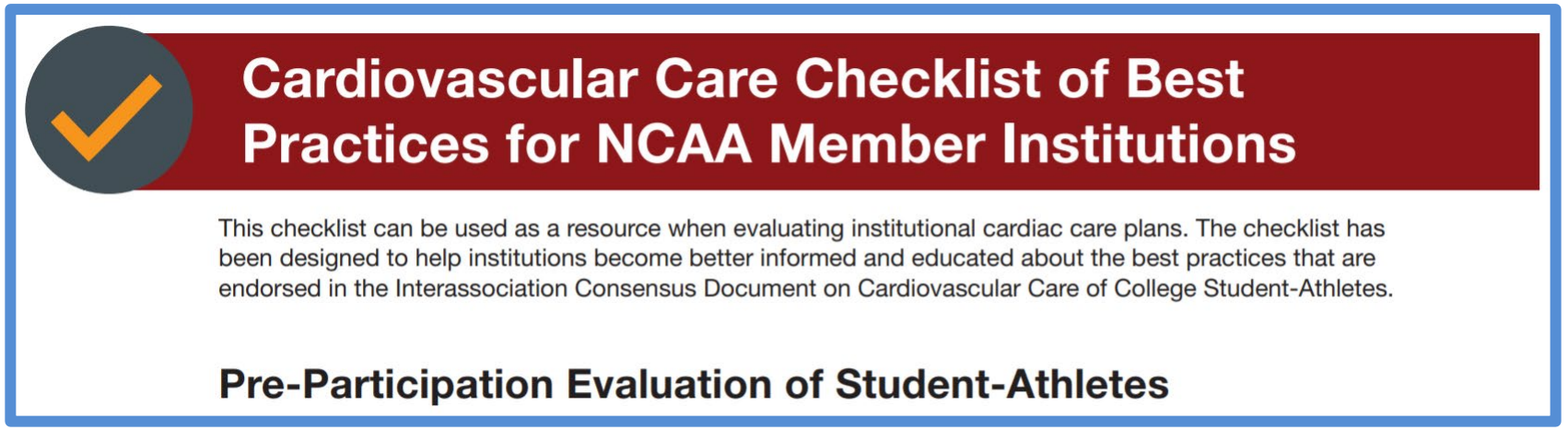
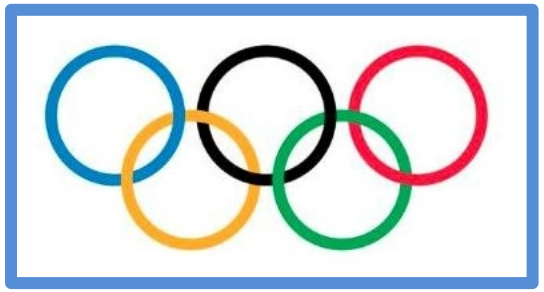
In the NCAA, a Push to Reform Health Standards

25 years after Hank Gathers's death, the NCAA's first-ever chief medical officer gets behind cardiac screening of athletes


Cardiovascular Care Checklist of Best Practices for NCAA Member Institutions

This checklist can be used as a resource when evaluating institutional cardiac care plans. The checklist has been designed to help institutions become better informed and educated about the best practices that are endorsed in the Interassociation Consensus Document on Cardiovascular Care of College Student-Athletes.

Pre-Participation Evaluation of Student-Athletes



ATLANTIC HEALTH SYSTEM

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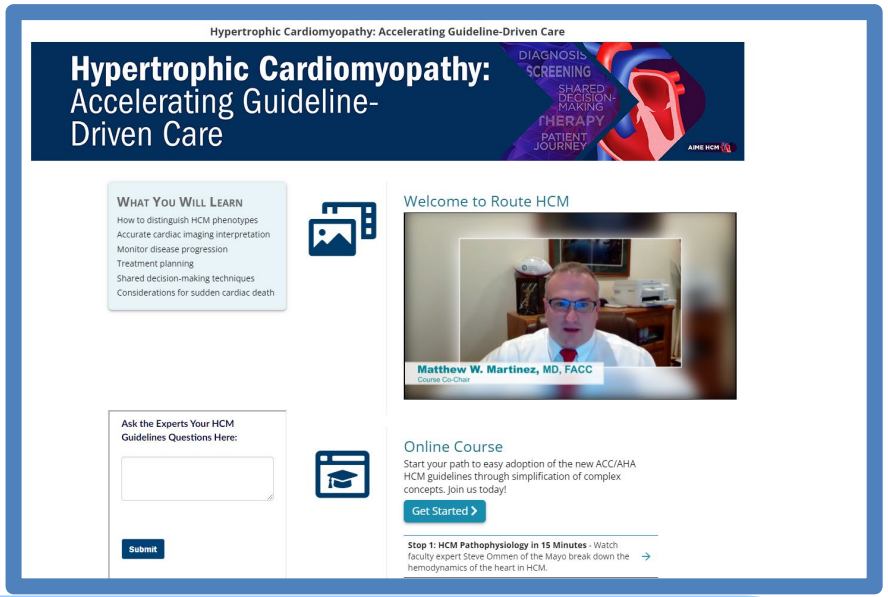
FELLOWS-IN-TRAINING & EARLY CAREER PAGE

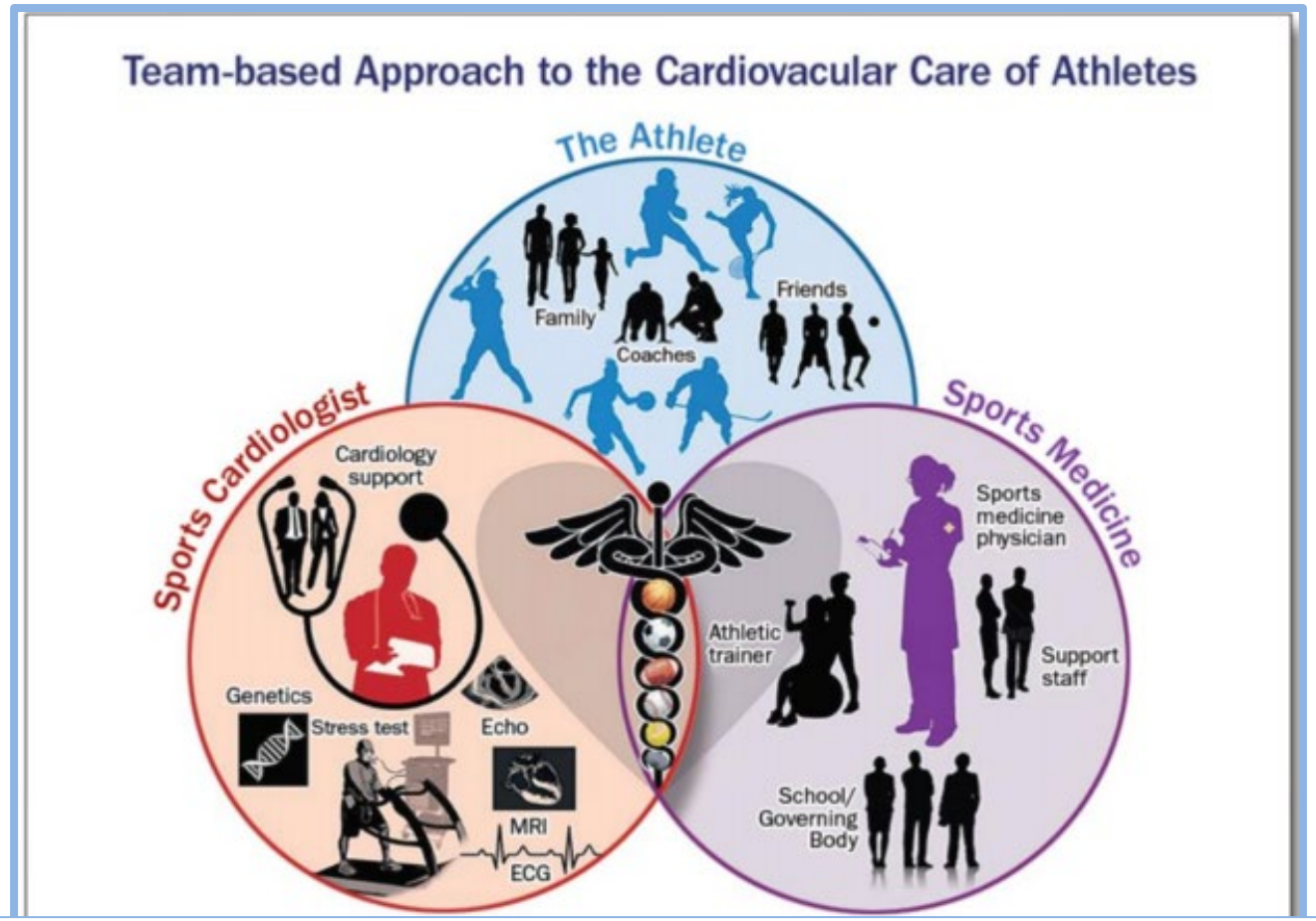
The Emergence of Sports Cardiology as a Specialty

Maxwell Eyram Afari, MD



HCM & Sports Cardiology Fellowship

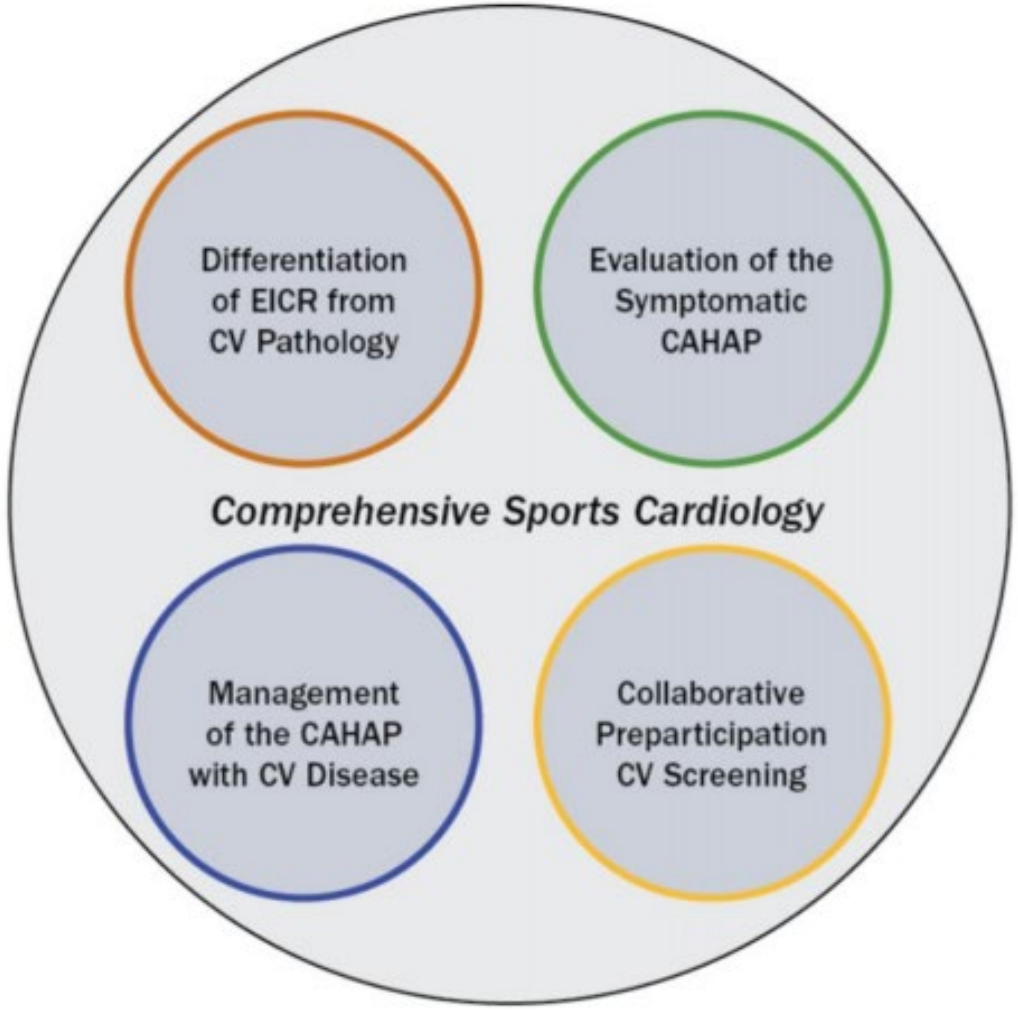
Care of the Athlete



Multidisciplinary Athlete-Centered Care ("Athlete Care Team") in Evaluating and Managing Athletes at Risk of SCD

Emery MS, Kovacs RJ. Sudden cardiac death in athletes. JACC Heart Fail 2018;6:30-40

Overview of Fundamental Core Competencies in Sports Cardiology



CAHAP = competitive athletes and highly active people; CV = cardiovascular; EICR = exercise-induced cardiac remodeling.

J Am Coll Cardiol 2017;70:1902-18

Which Athletes Are Highest Risk?

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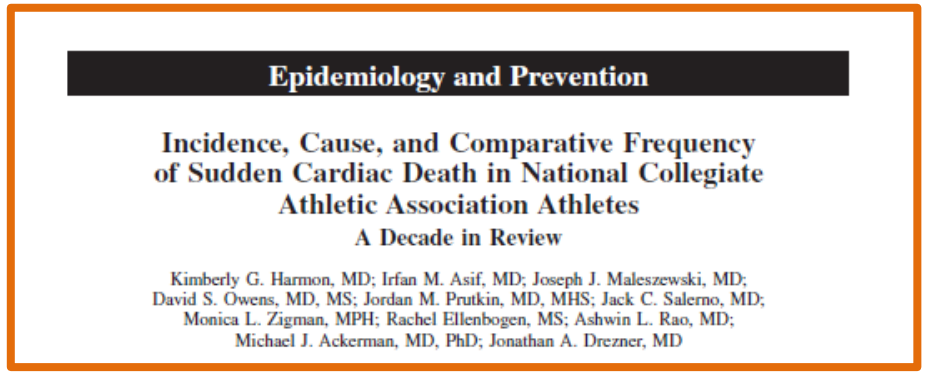
Incidence, Etiology and Comparative Frequency of NCAA Athletes: A Decade in Review



Epidemiology and Prevention

Incidence, Cause, and Comparative Frequency of Sudden Cardiac Death in National Collegiate Athletic Association Athletes

A Decade in Review

Kimberly G. Harmon, MD; Irfan M. Asif, MD; Joseph J. Maleszewski, MD; David S. Owens, MD, MS; Jordan M. Prutkin, MD, MHS; Jack C. Salerno, MD; Monica L. Zigman, MPH; Rachel Ellenbogen, MS; Ashwin L. Rao, MD; Michael J. Ackerman, MD, PhD; Jonathan A. Drezner, MD

Sport	Incidence
Men's basketball	1 in 8,978
Men's soccer	1 in 23,689
Men's Football	1 in 35,951
Men's Swimming	1 in 42,784
Men's Cross-country	1 in 42,857
Men's Lacrosse	1 in 45,850
Women's Cross-country	1 in 47,089
Women's Volleyball	1 in 49,217
Men's Baseball	1 in 50,023
NCAA Athletes	1 in 53,703
Women's Swimming	1 in 57,611
Women's basketball	1 in 77,061
Men's track	1 in 120,521

Harmon, Circulation, 2015

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Incidence of Male vs. Female SCA/D

Author	Year	Age of cohort	# Male SCA/D	Person-Years	Male Incidence	# Female SCA/D	# Female Person-years	Female Incidence
Corrado	2003	12-35	46	1,904,490	1:41,402	5	464,100	1:92,820
Toresdahl*	2014	high school	16	924,000	1:57,750	2	652,828	1:326,414
Harmon	2015	college	64	2,418,563	1:37,790	15	1,823,899	1: 121,593
Harmon	2016	high school	92	4,124,525	1:44,832	12	2,850,115	1:237,510
Peterson*	2020	high school	176	7,732,032	1:43,932	28	5,706,008	1: 203,786
		college	32	1,116,992	1:34,906	7	862,946	1:123,278
Total			**426**	**18,220,602**	**1:42,771**	**69**	**12,359,896**	**1:179,129**

- Males are at 4x the risk of Females

- 86% of deaths occurred in Males

*Included both SCA and SCD

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Comparison of Incidence Data in Male Sport

	Maron 2002-2011 (NCAA) SCD	Harmon 2003-2013 (NCAA) SCD	Peterson 2014-2018 (NCAA) SCA/D	Harmon 2007-2011 (high school) SCA/D	Peterson 2014-2018 (high school) SCA/D	Malhotra 1996-2016
American Football	1:39,000	1 :36,000			1:83,000	
Black			1:28,000			
White			1:20,000			
Male basketball		1:9,000		1:37,000	1:40,000	
Black		1:5,000	1:5,000			
White		1:15,000	1:15,000			
Male soccer		1:24,000			1:89,000	1:15,000

Incidence of SCD in Athletes by Race

Study	Year Published	Years Studied	Age	Black	White	Relative Risk
Maron	2014	2002 - 2011	17-26	1:26,000	1:143,000	5.50
Harmon	2015	2003 - 2013	18-26	1:21,000	1:68,000	3.23
Peterson	2020	2014 – 2018	College	1:18,000 (males)	1:39,000 (males)	2.10

- Looked at NCAA college athletes
- Used similar databases

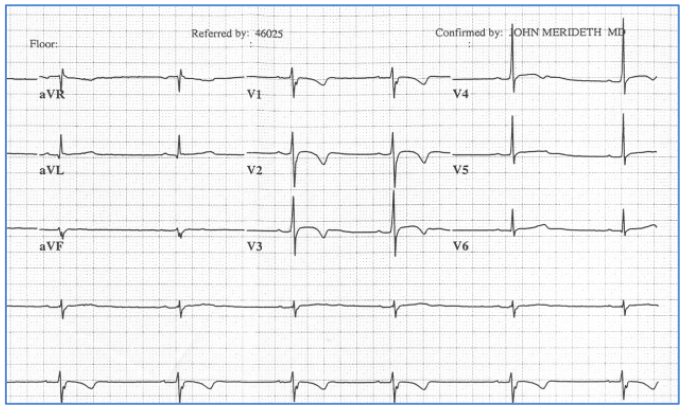
Which Athletes Are Highest Risk?

Male athletes

Black athletes

Basketball,
Soccer
&
American football

Sudden Cardiac Death in *Young* Athletes



Structural Abnormalities

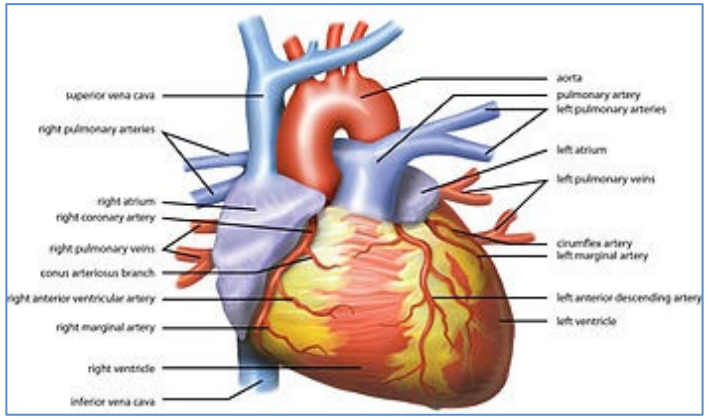
Hypertrophic cardiomyopathy
RV cardiomyopathy
Artery anomalies
Marfan syndrome
Valve disease

Electrical Abnormalities

Wolff Parkinson White syndrome
Long QT syndrome
Brugada syndrome
CPVT

Acquired Abnormalities

Infection (myocarditis)
Trauma (commotio cordis)
Drugs
Environment (heat/cold)



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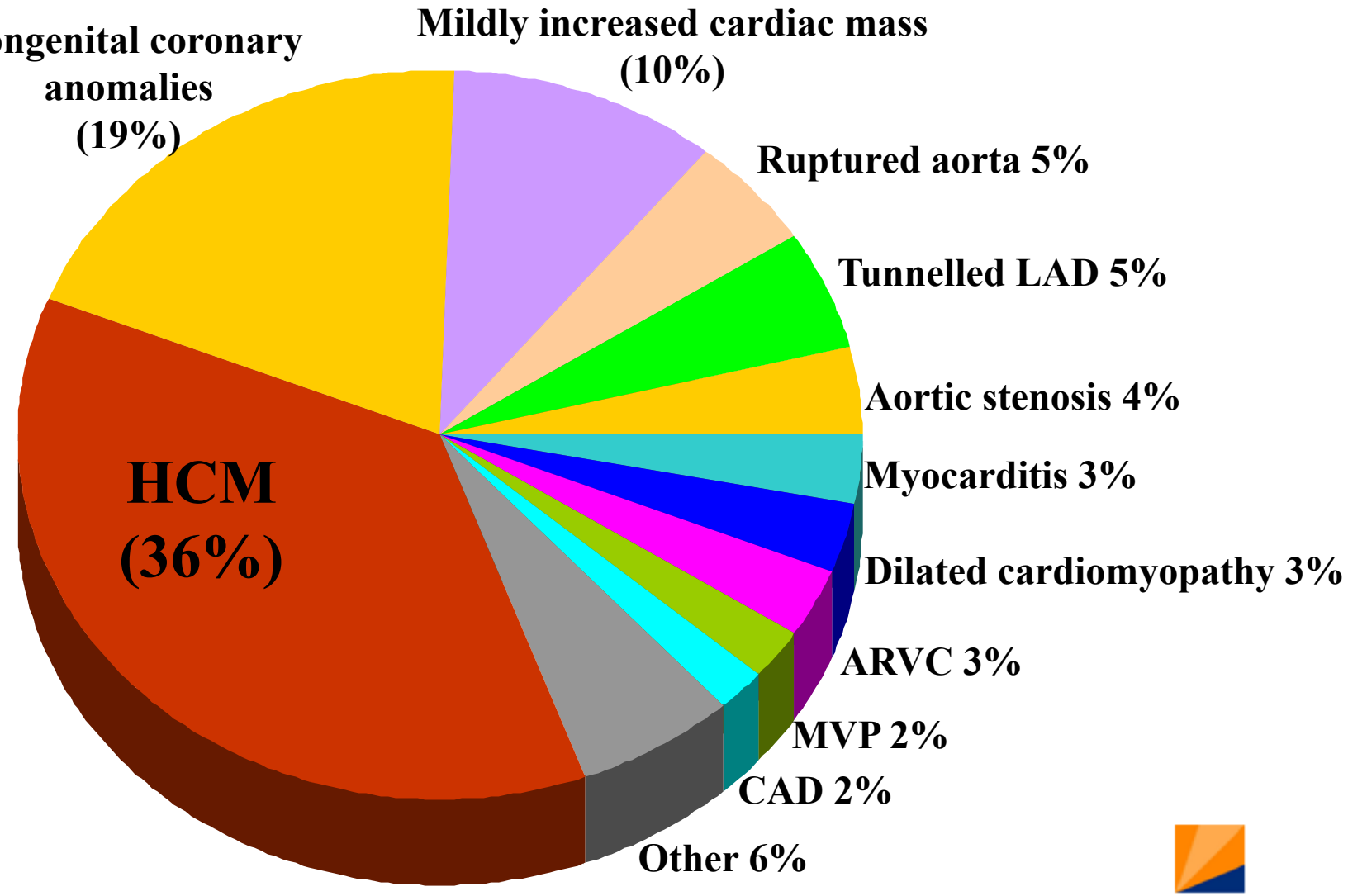
Traditional etiologies of SCD in Athletes (<40 years)

1980 - 2005

Multiple updates:
2007, 2009, 2016

N = 2406
Confirmed CV deaths = 840+

The data and message remains largely unchanged



Maron BJ et al. *Circulation.* 1996;94:850-56.

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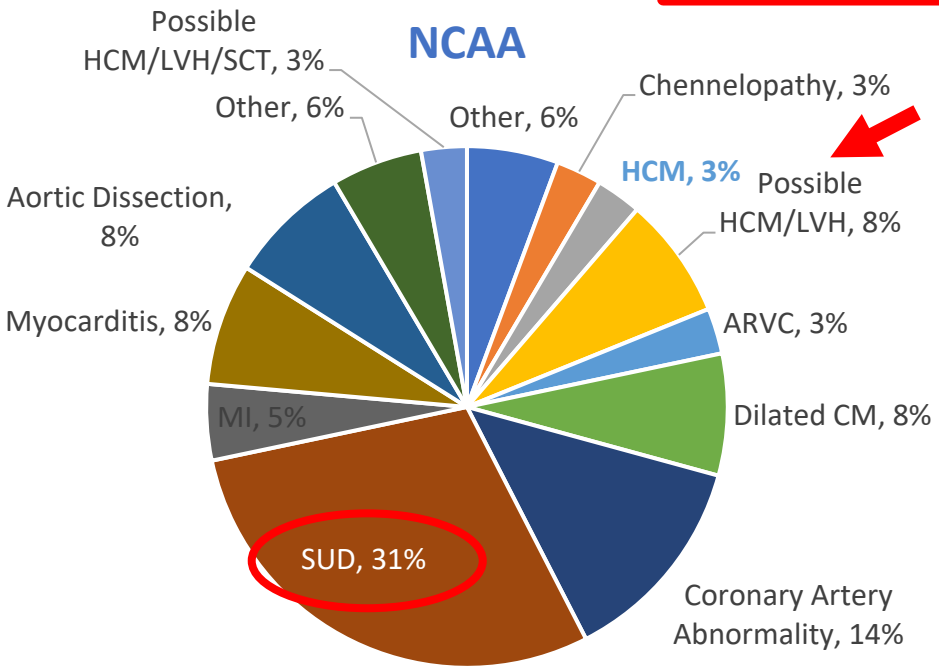
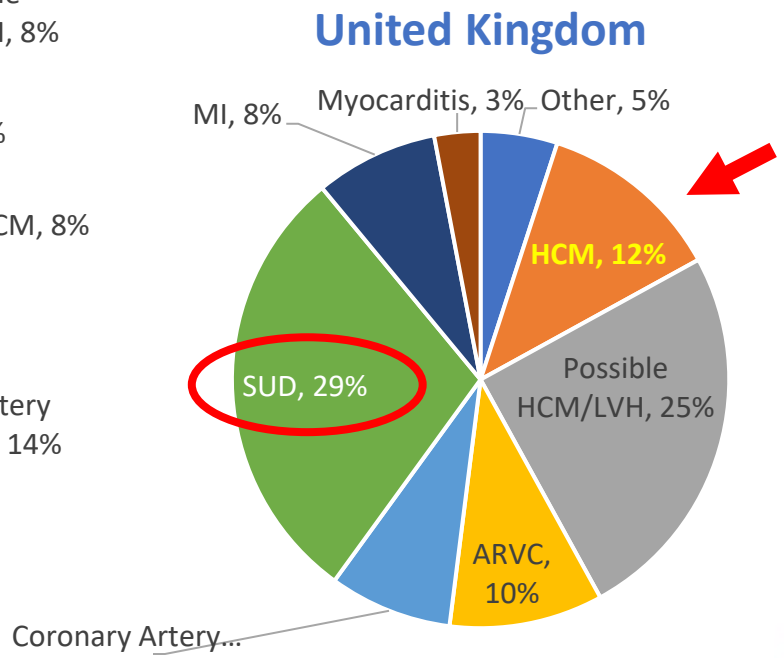
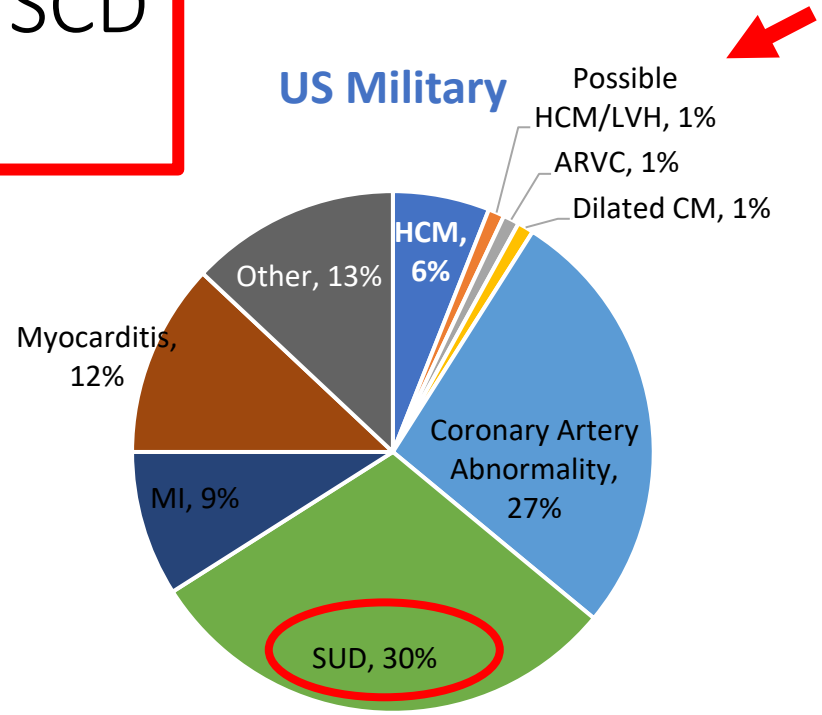
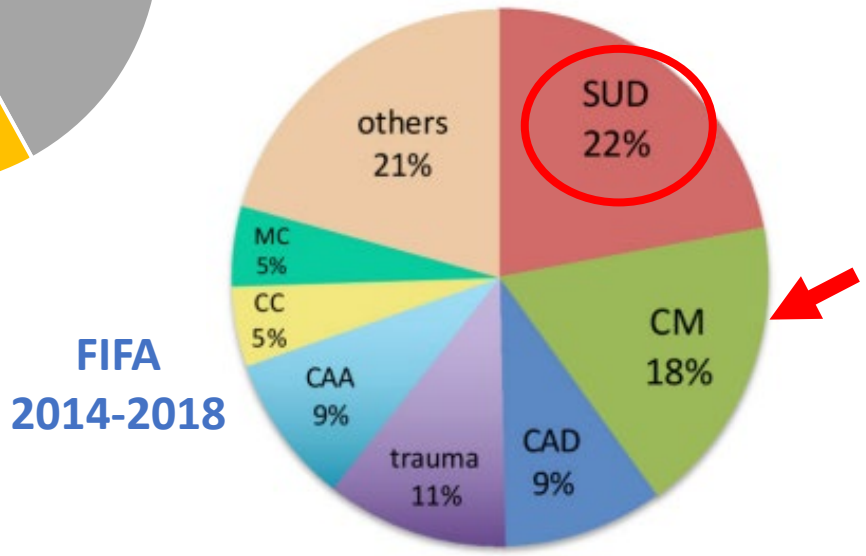
Contemporary Estimates of SCD - > challenge prior data









Eckart RE et al. Ann Intern Med. 2004;141:829-834.
Harmon KG et al. Circ Arrhythm Electrophysiol. 2014;7:198-204.
De Noronha SV et al. Heart. 2009;95:1409-1414.

How to identify those at highest risk?

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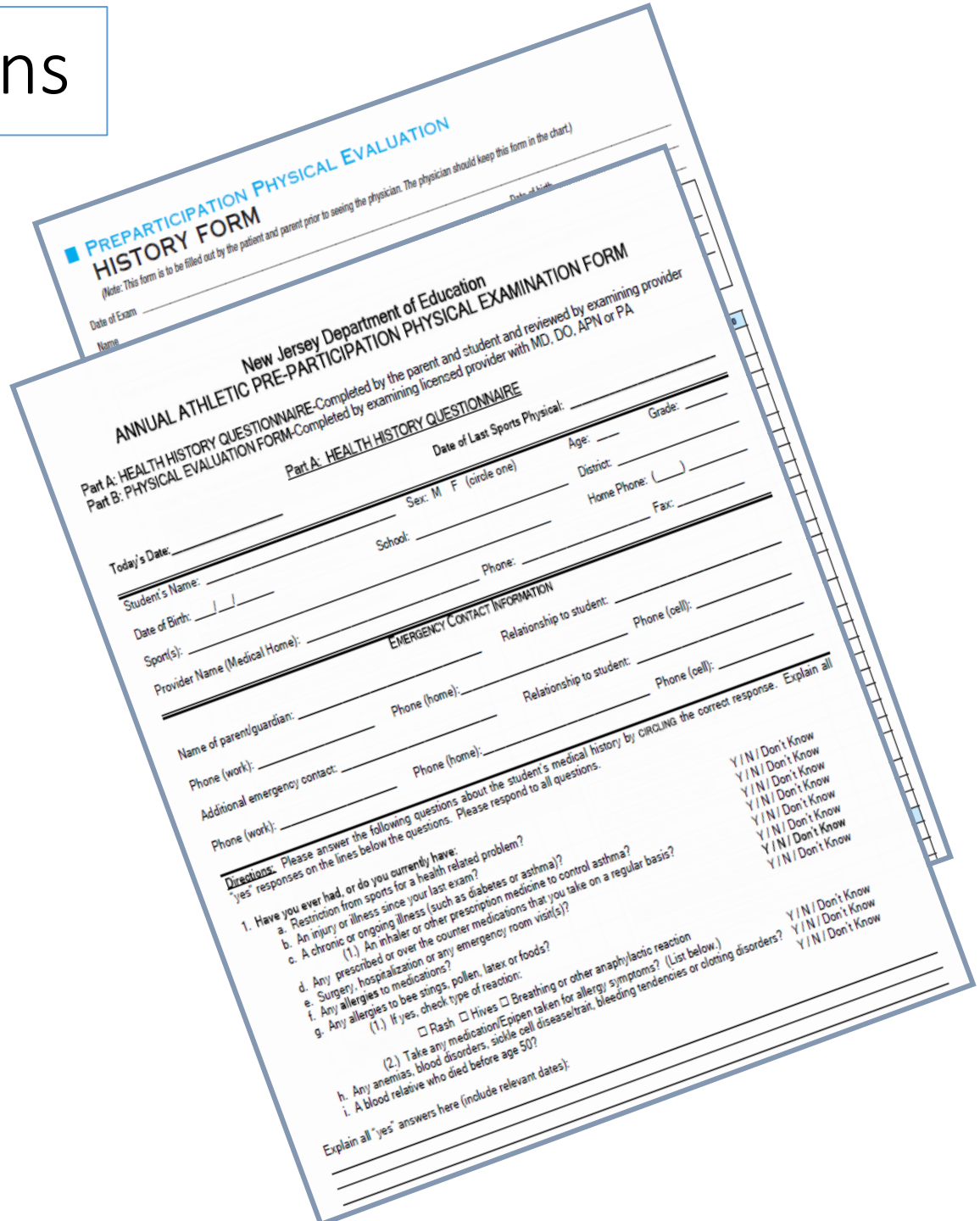
Preparticipation evaluations

- HS, Collegiate, Elite/Pro
- PPE CV screening
- Comprehensive personal, family history and physical exam
  - AHA 14-point
- Additional testing
  - ECG, Echocardiogram, Cardiac MRI



PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM
(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)
Date of Exam
Name

New Jersey Department of Education
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM
Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ Date of Last Sports Physical: _____
Student's Name: _____ Sex: M F (circle one) Age: ___ Grade: ___
Date of Birth: __/__/____ School: _____ District: _____
Sport(s): _____ Phone: _____ Home Phone: (___) _____
Provider Name (Medical Home): _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____
Phone (work): _____ Phone (home): _____ Phone (cell): _____
Additional emergency contact: _____ Relationship to student: _____
Phone (work): _____ Phone (home): _____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by CIRCLING the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had, or do you currently have:
   a. Restriction from sports for a health related problem? Y / N / Don't Know
   b. An injury or illness since your last exam? Y / N / Don't Know
   c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
      (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
   d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
   e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
   f. Any allergies to medications? Y / N / Don't Know
   g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
      (1.) If yes, check type of reaction:
      ☐ Rash ☐ Hives ☐ Breathing or other anaphylactic reaction
      (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
   h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
   i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

Cardiovascular Preparticipation Screening of Competitive Athletes

A Statement for Health Professionals From the Sudden Death Committee (Clinical Cardiology) and Congenital Cardiac Defects Committee (Cardiovascular Disease in the Young), American Heart Association

Barry J. Maron, Paul D. Thompson, James C. Puffer, Christopher A. McGrew, William B. Strong, Pamela S. Douglas, Luther T. Clark, Matthew J. Mitten, Michael H. Crawford, Dianne L. Atkins, David J. Driscoll, and Andrew E. Epstein

Originally published 15 Aug 1996 | Circulation. 1996;94:850–856

"The American Heart Association recommends that some form of preparticipation cardiovascular screening for high school and collegiate athletes

August 1996

Cardiovascular Preparticipation Screening of Competitive Athletes

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Originally published 15 Aug 1996 | Circulation. 1996;94:850–856

"The American Heart Association recommends that some form of preparticipation cardiovascular screening for high school and collegiate athletes

*"We conclude that a complete and careful personal and family history and physical examination . . . **is the best available and most practical approach to screening populations of competitive sports participants**"*

"The standard history and physical examination *intrinsically lack the capability to reliably identify many potentially lethal cardiovascular abnormalities*. Indeed, it is an unrealistic expectation that screening can reliably exclude most important cardiac lesions."

August 1996

Home » About » Resources » Media Center » News

New guidance on preventing sudden cardiac death in athletes published

NCAA, medical specialists recommend all universities have well-rehearsed emergency action plan for sudden cardiac arrest

April 15, 2

TABLE 1 **Cardiovascular Care Checklist of Best Practices for NCAA Member Institutions**

Pre-Participation Evaluation of Student-Athletes
❑ The purpose of the evaluation, as stated in the *2014-15 NCAA Sports Medicine Handbook* (19), is explained to the student-athlete.
❑ The cardiac evaluation includes, at minimum, a comprehensive personal and family history, and physical examination, such as the AHA 14-point evaluation or the Pre-participation Physical Evaluation Monograph, Fourth Edition.
❑ The pre-participation evaluation is either conducted on campus under the supervision of the institution's director of medical services or is reviewed by a process that is supervised by the institution's director of medical services.
❑ If an ECG is included in addition to history and physical screening, best practices include: ❑ Pre-ECG screening planning is performed with a multidisciplinary team. ❑ The student athlete is provided an in-depth explanation for the rationale of ECG screening and the possible risk vs. benefit of adding ECG screening. ❑ Modern athlete-specific ECG interpretation standards are used. ❑ Skilled cardiology oversight is available.

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New guidance on preventing sudden cardiac death in athletes published

NCAA, medical specialists recommend all universities have well-rehearsed emergency action plan for sudden cardiac arrest

April 15, 2

TABLE 1 **Cardiovascular Care Checklist of Best Practices for NCAA Member Institutions**

The field of sports cardiology is a highly specialized segment of cardiology and very few physicians and institutions across the country have the knowledge base, skill and experience in this discipline to accurately interpret an athlete's ECG. This could put smaller colleges and universities located in low-density population areas at a disadvantage when it comes to accessing expertise in sports cardiology. The task force recommended establishing regional referral centers that can provide pre-participation ECG interpretation, clarity on the cardiovascular status of athletes with irregular findings during their pre-participation screening, evaluations of new cardiovascular symptoms that develop during training or competition, and consultations on when a player with a cardiac issue is cleared to play.

rationale of ECG screening and the possible risk vs. benefit of adding ECG screening.

- ☐ Modern athlete-specific ECG interpretation standards are used.
- ☐ Skilled cardiology oversight is available.

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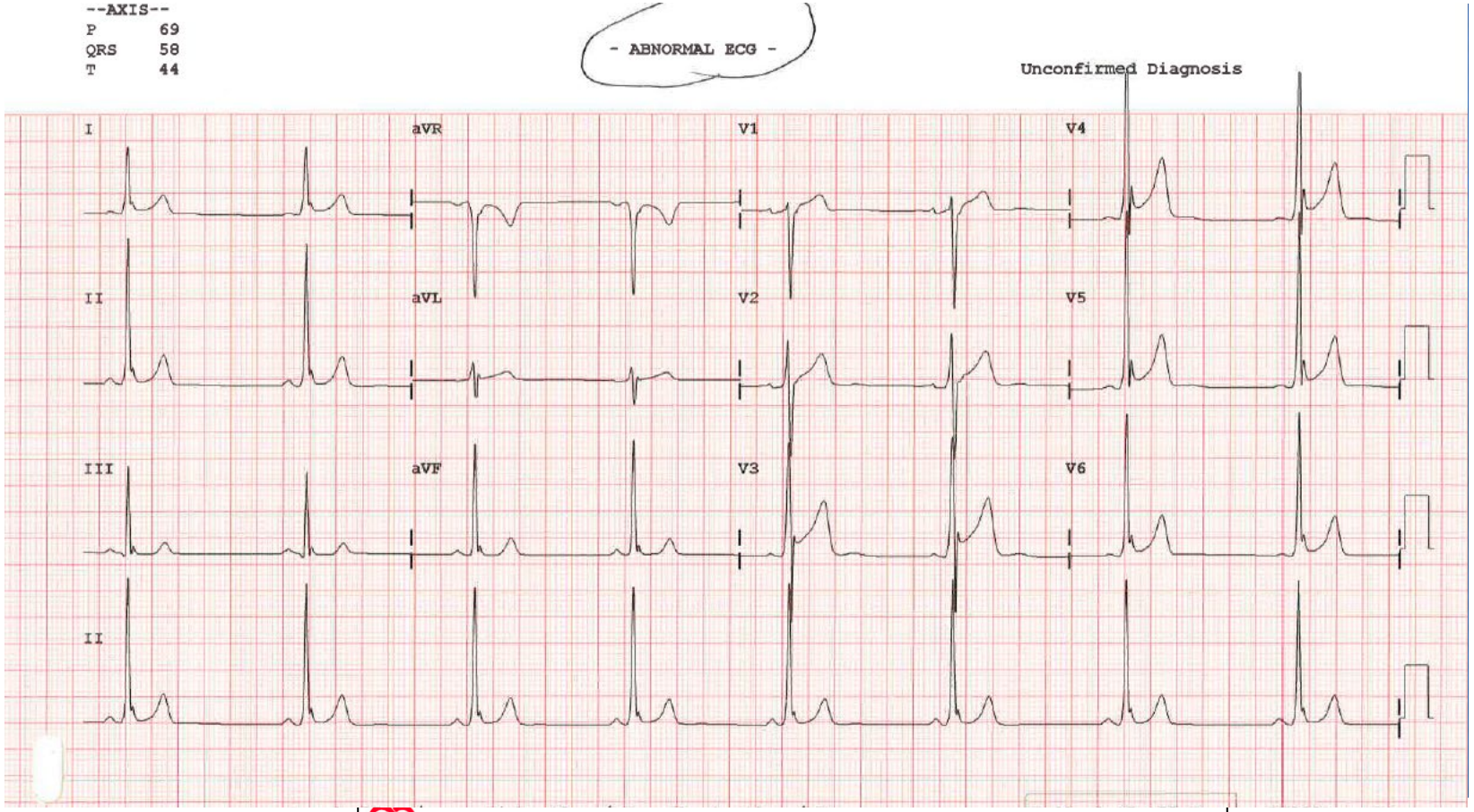


Accuracy
Sensitivity
Specificity

European Heart Journal (2017) **00**, 1–19
doi:10.1093/eurheartj/ehw631

CURRENT OPINION

International recommendations for electrocardiographic interpretation in athletes

Sanjay Sharma[1]*†, Jonathan A. Drezner[2]†, Aaron Baggish[3], Michael Papadakis[1], Mathew G. Wilson[4], Jordan M. Prutkin[5], Andre La Gerche[6], Michael J. Ackerman[7], Mats Borjesson[8], Jack C. Salerno[9], Irfan M. Asif[10], David S. Owens[5], Eugene H. Chung[11], Michael S. Emery[12], Victor F. Froelicher[13], Hein Heidbuchel[14,15], Carmen Adamuz[4], Chad A. Asplund[16], Gordon Cohen[17], Kimberly G. Harmon[2], Joseph C. Marek[18], Silvana Molossi[19], Josef Niebauer[20], Hank F. Pelto[2], Marco V. Perez[21], Nathan R. Riding[4], Tess Saarel[22], Christian M. Schmied[23], David M. Shipon[24], Ricardo Stein[25], Victoria L. Vetter[26], Antonio Pelliccia[27], and Domenico Corrado[28]

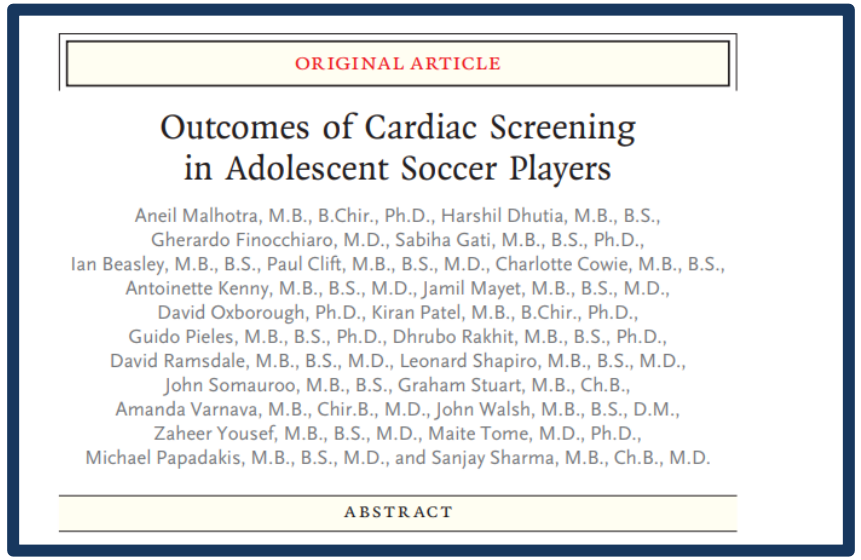
The Evolution of ECG Interpretation Criteria

	ESC 2005	ESC 2010	Seattle Criteria	International Criteria
False Positive Rate	15-20%	10-15%	3–6%	1–2%

Courtesy of K Harmon et al

The good, the bad and the uncertain

	Prevalence	Specificity	Utility
HCM	+++	+++	Good
LQTS	+	++/+++	OK
ARVC	+	+	Poor
Anomalous coronaries	++/+++	-	Poor
Brugada	+	++	Poor



ORIGINAL ARTICLE

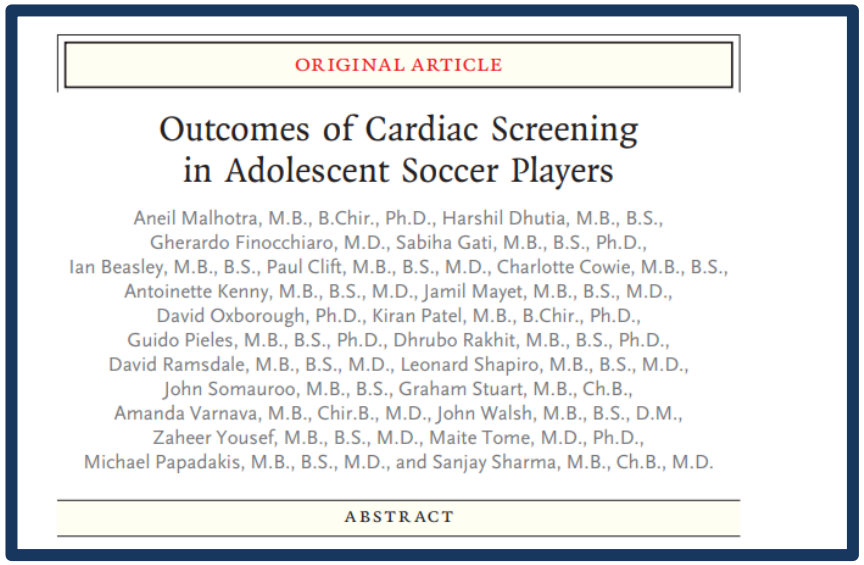
Outcomes of Cardiac Screening in Adolescent Soccer Players

Aneil Malhotra, M.B., B.Chir., Ph.D., Harshil Dhutia, M.B., B.S., Gherardo Finocchiaro, M.D., Sabiha Gati, M.B., B.S., Ph.D., Ian Beasley, M.B., B.S., Paul Clift, M.B., B.S., M.D., Charlotte Cowie, M.B., B.S., Antoinette Kenny, M.B., B.S., M.D., Jamil Mayet, M.B., B.S., M.D., David Oxborough, Ph.D., Kiran Patel, M.B., B.Chir., Ph.D., Guido Pieles, M.B., B.S., Ph.D., Dhrubo Rakhit, M.B., B.S., Ph.D., David Ramsdale, M.B., B.S., M.D., Leonard Shapiro, M.B., B.S., M.D., John Somauroo, M.B., B.S., Graham Stuart, M.B., Ch.B., Amanda Varnava, M.B., Chir.B., M.D., John Walsh, M.B., B.S., D.M., Zaheer Yousef, M.B., B.S., M.D., Maite Tome, M.D., Ph.D., Michael Papadakis, M.B., B.S., M.D., and Sanjay Sharma, M.B., Ch.B., M.D.

ABSTRACT

- 11,168 English 15-17yr old soccer player
- Mandatory H&P, ECG and Echo
- 20 yr study period
- 225 (2%) with congenital, valve disorders
- 42 (0.38%) with findings assoc with SCA

Malhotra A. *Br J Sports Med* 2019.



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ABSTRACT

23 died

8 deaths from cardiac causes

7 (88%) due to cardiomyopathy

6 were not identified by screening

Malhotra A. *Br J Sports Med* 2019.

Table 3. Characteristics of Athletes with Sudden Cardiac Death.

Athlete No.	Sex and Age	Race*	Years from Screening to Death	Diagnosis	Initial Screening Result	Blind Reading (Reviewer 1)	Blind Reading (Reviewer 2)
1	M, 16.8 yr	Black	0.1	Idiopathic left ventricular hypertrophy	Negative	Negative	Negative
2	M, 16.6 yr	Mixed	1.0	Hypertrophic cardiomyopathy	Abnormal ECG and echocardiogram	NA	NA
3	M, 16.6 yr	Black	3.3	Hypertrophic cardiomyopathy	Negative	Negative	Negative
4	M, 16.3 yr	Black	7.7	Dilated cardiomyopathy	Negative	Negative	Negative
5	M, 17.0 yr	White	7.9	Arrhythmogenic right ventricular cardiomyopathy	Negative	Negative	Negative
6	M, 17.2 yr	White	9.7	Arrhythmogenic right ventricular cardiomyopathy	Negative	Negative	Negative
7	M, 15.7 yr	White	11.5	Hypertrophic cardiomyopathy	Abnormal ECG and echocardiogram	NA	NA
8	M, 16.8 yr	White	13.2	Sudden arrhythmic death syndrome	Negative	Negative	Negative

* Race was reported by the athlete or the parent or guardian.

Improvement in diagnosis

- No improvement in survival –

Potential risk of harm

Malhotra A. *Br J Sports Med* 2019.

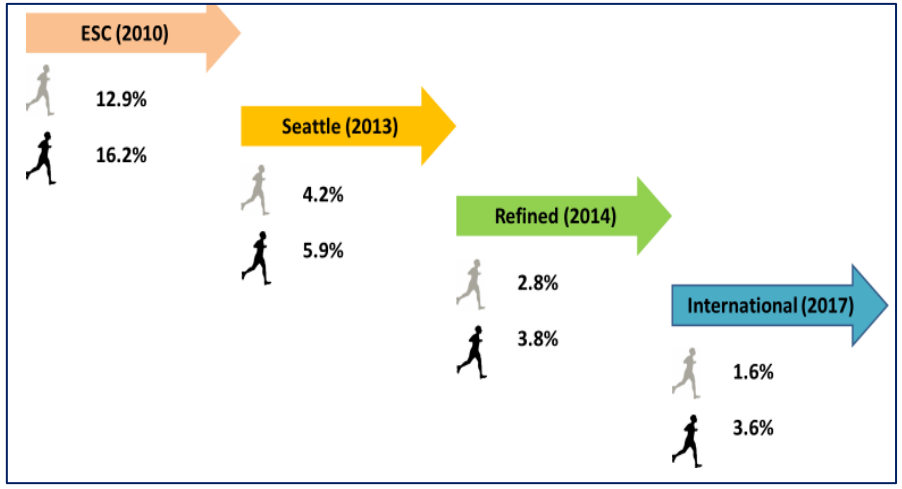
ATLANTIC HEALTH SYSTEM

- 5,258 NCAA athletes (73% White, 16% Black)
- 1.6% abnormal by International Criteria; 1.3% false positive (overall)

Hyde N. *J Electrocardiol* 2019.

- 11,168 soccer players
- 1.8% abnormal by International Criteria; 1.5% false positive (overall)

British Journal of Sports Medicine



- 1.4% White vs. 3.3% Black false positive
- 95% Male
- 91% White vs. 9% Black

Malhotra A. *Br J Sports Med* 2019.

ATLANTIC HEALTH SYSTEM

JAMA Cardiol. 2018;3(1):69-74.

Electrocardiographic Findings in National Basketball Association Athletes

Table 2. Abnormal Electrocardiographic (ECG) Findings

Abnormal ECG Classification	No. (%)			
	Total Athletes (n = 519)	Racial/Ethnic Subgroups		
		African American (n = 409)	White (n = 96)	P V
Seattle criteria	131 (25.2)	103 (25.2)	23 (24.0)	.90
Refined criteria	108 (20.8)	87 (21.2)	16 (16.6)	
International recommendations	81 (15.6)	65 (15.8)	11 (11.5)	.34
Abnormal ECG findings				
Short QT Interval (QTc <320 ms)	0	0	0	.99
Long QT Interval (QTc >470 ms)		(4.9)	4 (4.2)	.98
Left bundle branch block		0.2)	0	.99
Intraventricular conduction delay[a]		1.0)	0	.74
Q waves[b]		1.0)	2 (2.1)	.32
ST-segment depression[c]	9 (1.7)	9 (2.2)	0	.22
Abnormal T-wave inversion[d]	32 (6.2)	27 (6.6)	3 (3.1)	.24
Ventricular preexcitation[e]	1 (0.2)	1 (0.2)	0	.99
Frequent premature ventricular contraction (>2)	2 (0.4)	2 (0.5)	0	.99
≥2 Borderline findings	29 (5.6)	22 (5.4)	6 (6.3)	.91
Borderline ECG findings[f]				
Left atrial enlargement	69 (13.3)	53 (13.0)	13 (13.5)	.87
Right atrial enlargement	46 (8.9)	40 (9.8)	6 (6.3)	.33
QRS axis deviation	21 (4.0)	15 (3.7)	6 (6.3)	.26
Right bundle branch block	25 (4.8)	20 (4.9)	4 (4.2)	.99

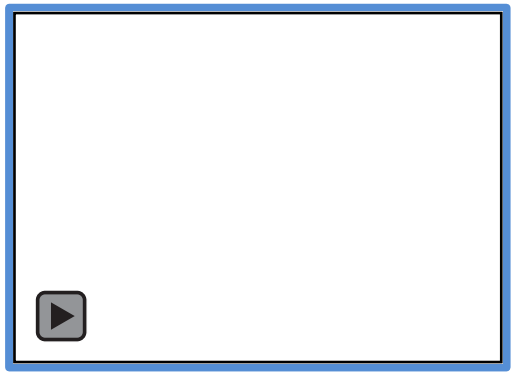
11/519 = 2%

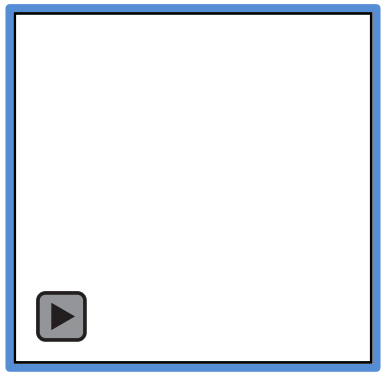
65/519 = 12.5%

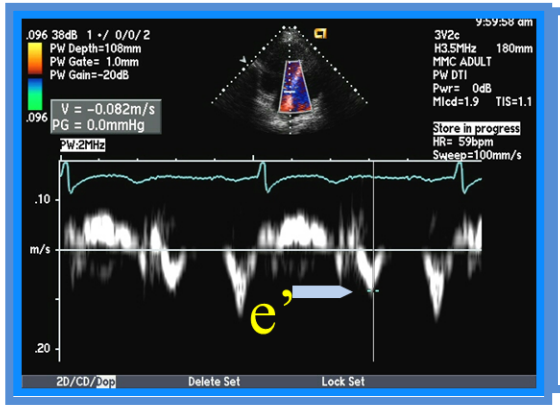
CONSIDER UNINTENDED CONSEQUENCES

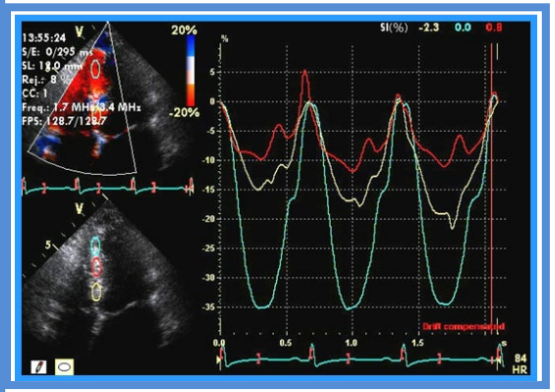
JAMA Cardiol. 2018;3(1):69-74.

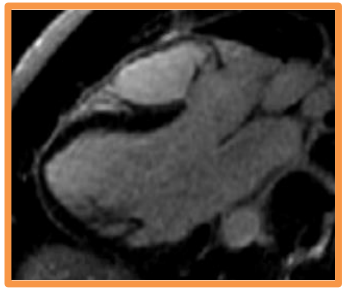
Cardiac Imaging

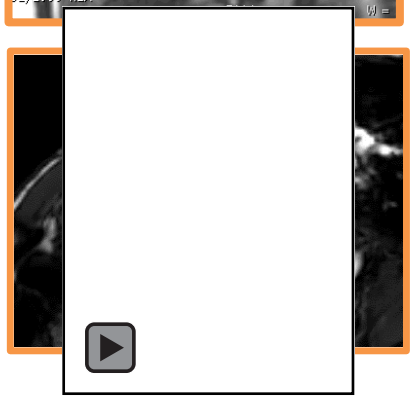






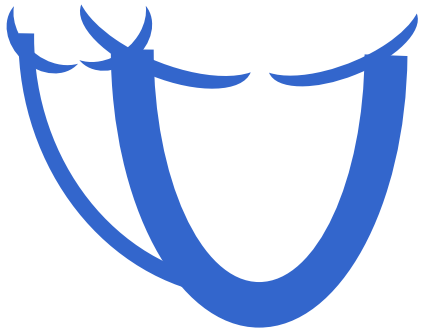






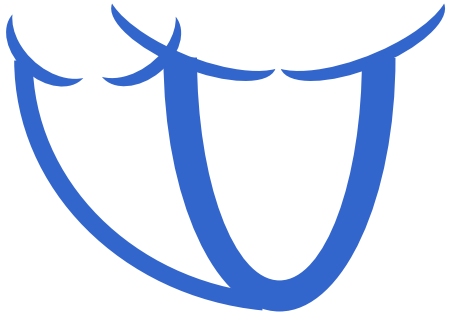
Athlete Structural Changes

Left Chamber Dilation



Myocardial Thickening

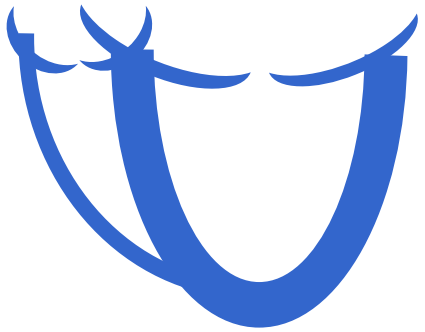
Right Chamber Dilation



ATLANTIC HEALTH SYSTEM

Athlete Structural Changes

Left Chamber Dilation

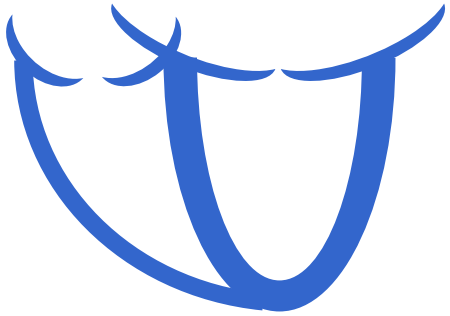


Physiologic LVH

Myocardial Thickening

Physiologic cLVH, eLVH

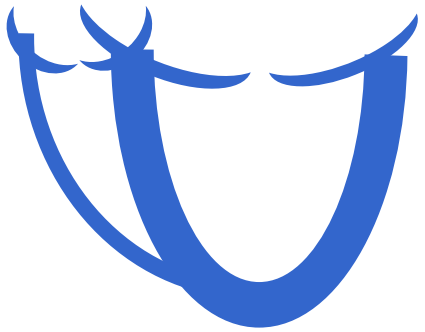
Right Chamber Dilation



Physiologic RV Dilation

Athlete Structural Changes

Left Chamber Dilation

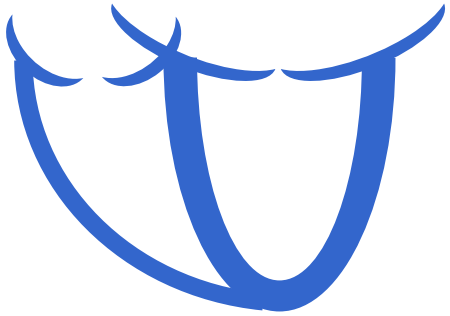


Physiologic LVH

Myocardial Thickening

Physiologic cLVH, eLVH

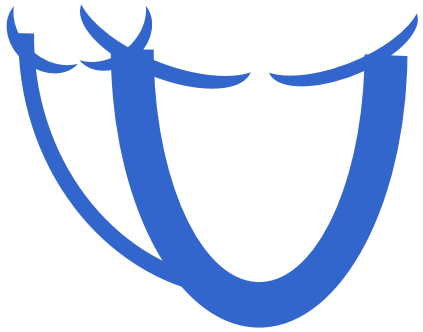
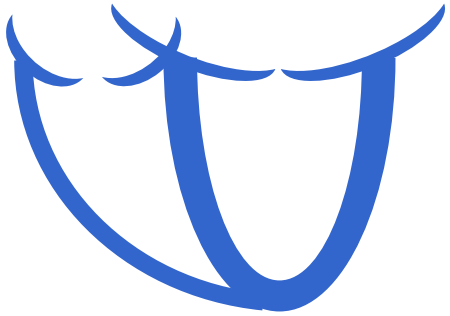
Right Chamber Dilation



Physiologic RV Dilation

Gray-Zone

Athlete Structural Changes

Left Chamber Dilation	Myocardial Thickening	Right Chamber Dilation
		
Physiologic LVH	***Physiologic cLVH, eLVH***	***Physiologic RV Dilation***
DCM Valvular Heart Disease	**HCM Hypertensive Infiltrative**	**ARVC**

ATLANTIC HEALTH SYSTEM

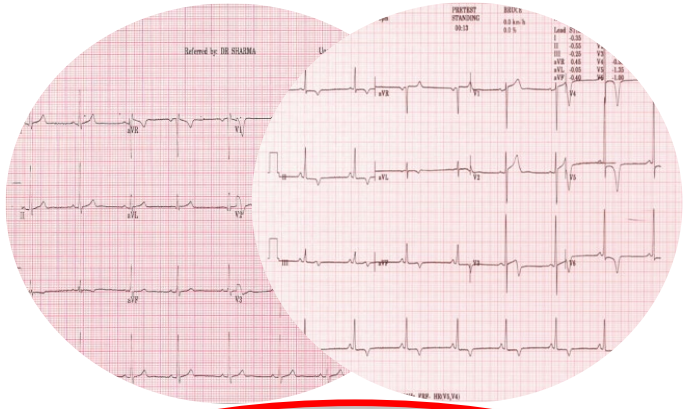
Comparison of Screening Strategies for Elite Athletes

	IOC/ USOC	FIFA	MLB	MLS	NBA/ WNBA	NFL	NHL	Premier League
Combine					X	X	X	
H&P	X[ι]	X[ι]	X	X	X	X	X[ι]	X
ECG	X	X	X	X^	X	X	X	X^
Echo		X		X	X	X		X^
Stress test ECG	X*	X*						
Stress Echo					X			
Additional Testing As needed	X	X	X	X	X	X	X	X

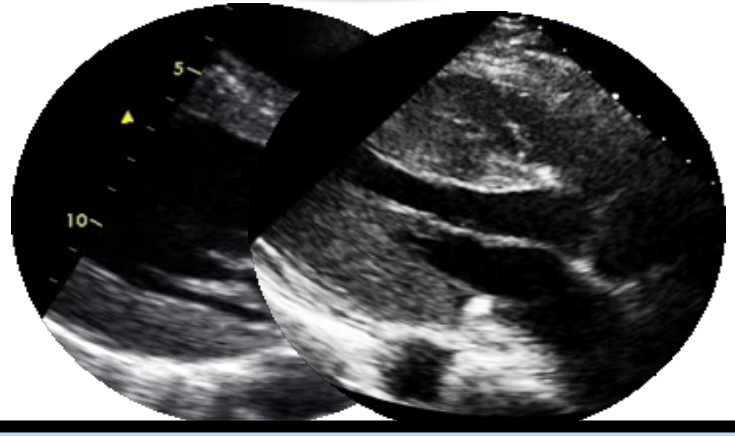
ι Unique H&P; others use AHA
^ Every 2 years
* Stress ECG if >35 years old

ATLANTIC HEALTH SYSTEM

Sports Cardiology



Physiology vs. Pathology



Knowing this is a MUST For Athlete Evaluations

ATLANTIC HEALTH SYSTEM

Athlete Screening

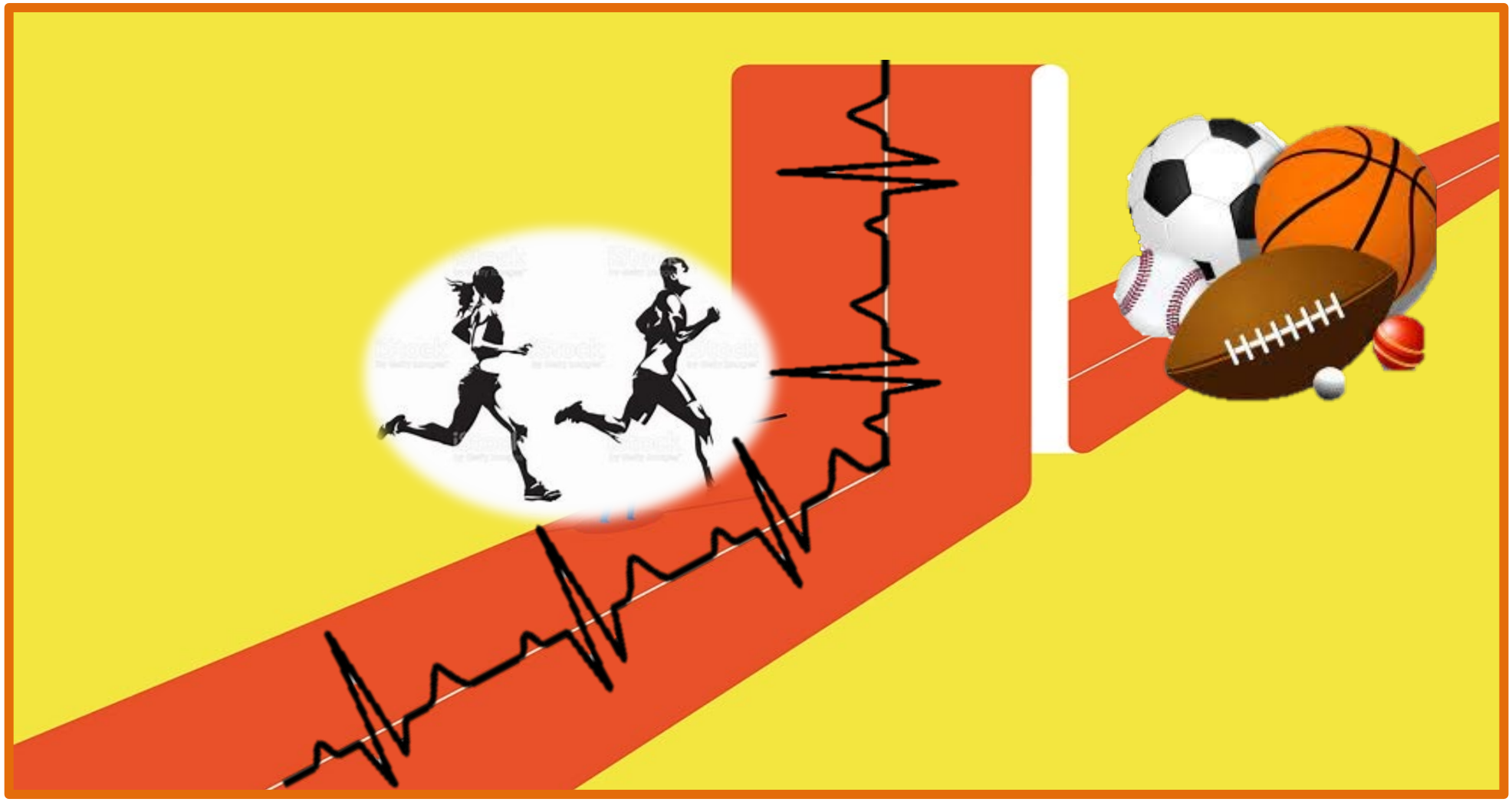
- Here to stay – ECG most often included.
- Echo imaging for higher risk groups
- Age to start? How often? Repeat?
- Expert review
  - –Who, When, How to handle any findings?
- Goals?
  - –Safety, disqualification, medical/legal?

Diagnosis →

Risk assessment →

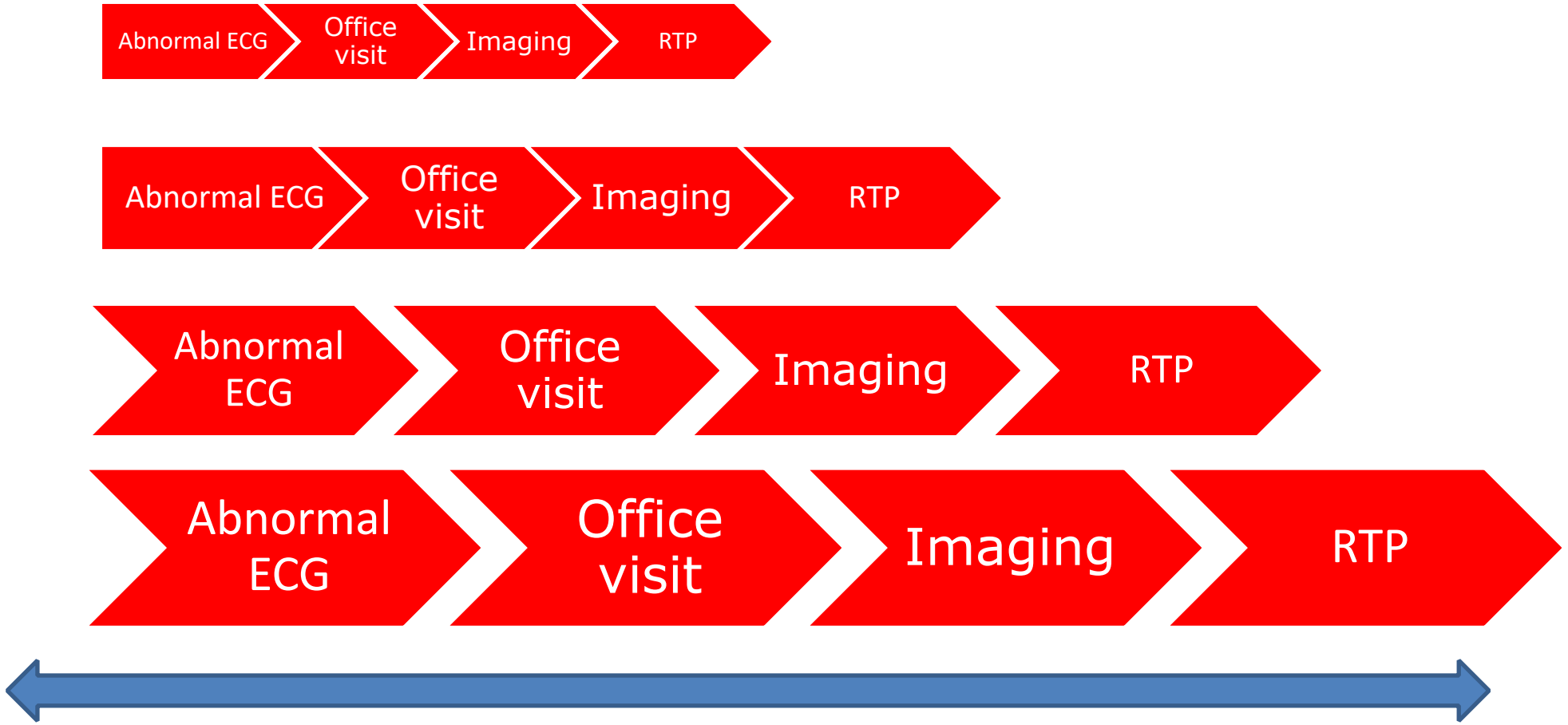
Develop a surveillance/safety plan

Barriers to Participation



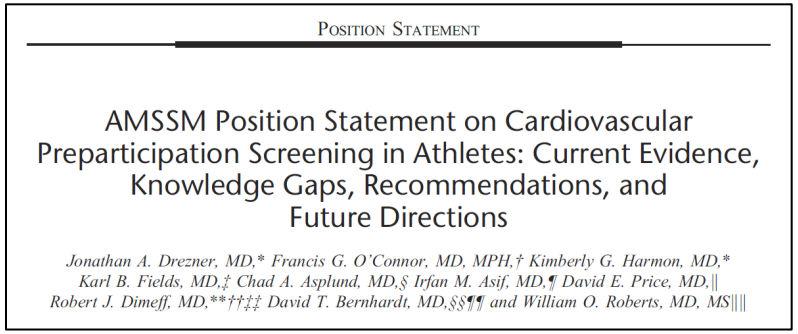
ATLANTIC HEALTH SYSTEM

Athlete assessment



ATLANTIC HEALTH SYSTEM

Purpose of CV Screening



POSITION STATEMENT

AMSSM Position Statement on Cardiovascular Preparticipation Screening in Athletes: Current Evidence, Knowledge Gaps, Recommendations, and Future Directions

Jonathan A. Drezner, MD, Francis G. O'Connor, MD, MPH,† Kimberly G. Harmon, MD,* Karl B. Fields, MD,‡ Chad A. Asplund, MD,§ Irfan M. Asif, MD,¶ David E. Price, MD,‖ Robert J. Dimeff, MD,**††‡‡ David T. Bernhardt, MD,§§¶¶ and William O. Roberts, MD, MS‖‖*

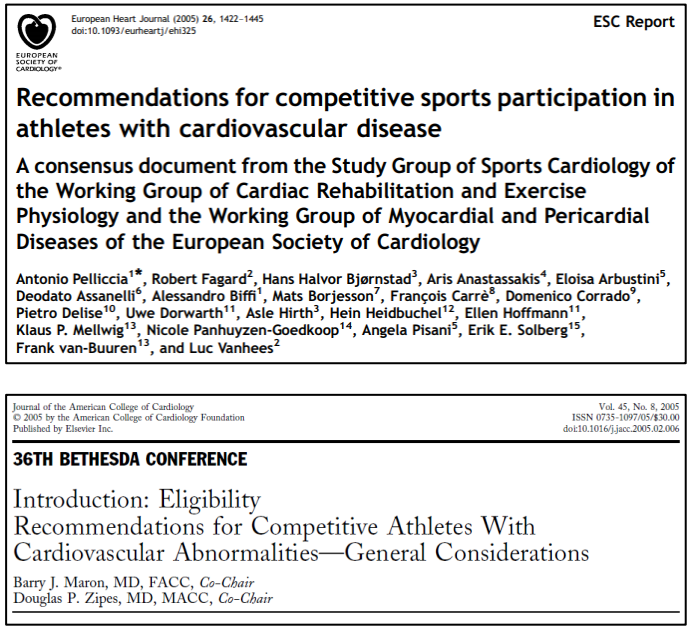
AMSSM
AMERICAN MEDICAL SOCIETY FOR SPORTS MEDICINE

- The primary goal of cardiovascular screening in competitive athletes is to identify cardiac disorders predisposing to SCA/D with the intent of **mitigating risk through individualized, patient-centered and disease-specific medical management**.

ATLANTIC HEALTH SYSTEM

Eligibility Recommendations

Playing with Cardiovascular Disease



European Heart Journal (2005) 26, 1422–1445
doi:10.1093/eurheartj/ehi325

ESC Report

Recommendations for competitive sports participation in athletes with cardiovascular disease

A consensus document from the Study Group of Sports Cardiology of the Working Group of Cardiac Rehabilitation and Exercise Physiology and the Working Group of Myocardial and Pericardial Diseases of the European Society of Cardiology

Antonio Pelliccia[1*], Robert Fagard[2], Hans Halvor Bjørnstad[3], Aris Anastassakis[4], Eloisa Arbustini[5], Deodato Assanelli[6], Alessandro Biffi[1], Mats Borjesson[7], François Carrè[8], Domenico Corrado[9], Pietro Delise[10], Uwe Dorwarth[11], Asle Hirth[3], Hein Heidbuchel[12], Ellen Hoffmann[11], Klaus P. Mellwig[13], Nicole Panhuyzen-Goedkoop[14], Angela Pisani[5], Erik E. Solberg[15], Frank van-Buuren[13], and Luc Vanhees[2]

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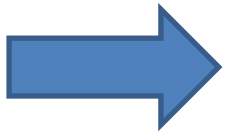
Vol. 45, No. 8, 2005
ISSN 0735-1097/05/$30.00
doi:10.1016/j.jacc.2005.02.006

36TH BETHESDA CONFERENCE

Introduction: Eligibility Recommendations for Competitive Athletes With Cardiovascular Abnormalities—General Considerations

Barry J. Maron, MD, FACC, *Co-Chair*
Douglas P. Zipes, MD, MACC, *Co-Chair*

2005



Moving away from:

"Disqualification"

"Ineligible"

"Not allowed"

ATLANTIC HEALTH SYSTEM

Eligibility Recommendations

Playing with Cardiovascular Disease

European Heart Journal (2005) 26, 1422–1445
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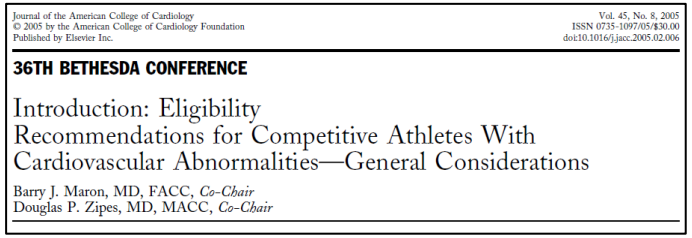

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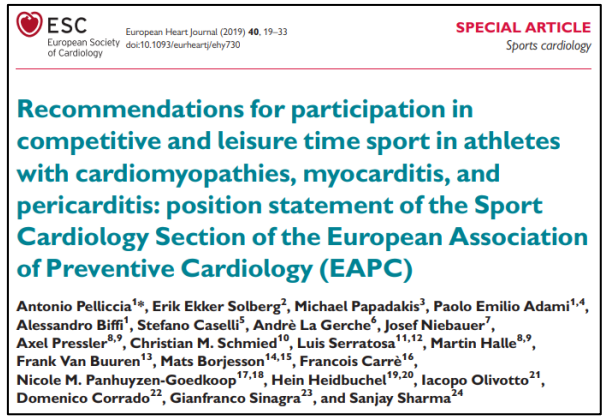


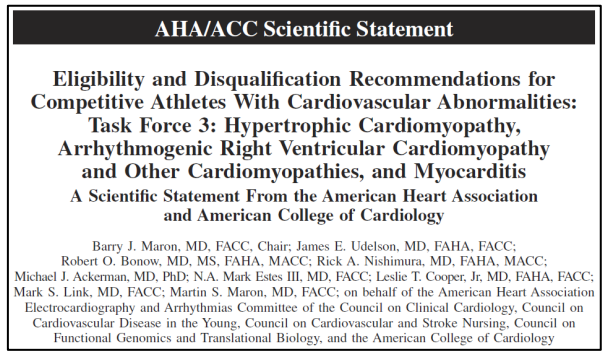
ESC European Society of Cardiology
European Heart Journal (2019) 40, 19–33
doi:10.1093/eurheartj/ehy730

SPECIAL ARTICLE
Sports cardiology

Recommendations for participation in competitive and leisure time sport in athletes with cardiomyopathies, myocarditis, and pericarditis: position statement of the Sport Cardiology Section of the European Association of Preventive Cardiology (EAPC)

Antonio Pelliccia[1*], Erik Ekker Solberg[2], Michael Papadakis[3], Paolo Emilio Adami[1,4], Alessandro Biffi[1], Stefano Caselli[5], Andrè La Gerche[6], Josef Niebauer[7], Axel Pressler[8,9], Christian M. Schmied[10], Luis Serratosa[11,12], Martin Halle[8,9], Frank Van Buuren[13], Mats Borjesson[14,15], Francois Carrè[16], Nicole M. Panhuyzen-Goedkoop[17,18], Hein Heidbuchel[19,20], Iacopo Olivotto[21], Domenico Corrado[22], Gianfranco Sinagra[23], and Sanjay Sharma[24]

2019



AHA/ACC Scientific Statement

Eligibility and Disqualification Recommendations for Competitive Athletes With Cardiovascular Abnormalities: Task Force 3: Hypertrophic Cardiomyopathy, Arrhythmogenic Right Ventricular Cardiomyopathy and Other Cardiomyopathies, and Myocarditis

A Scientific Statement From the American Heart Association and American College of Cardiology

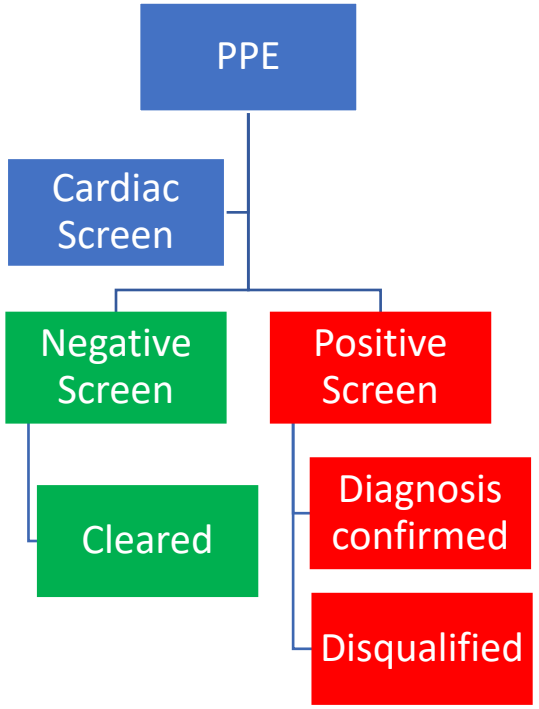
Barry J. Maron, MD, FACC, Chair; James E. Udelson, MD, FAHA, FACC; Robert O. Bonow, MD, MS, FAHA, MACC; Rick A. Nishimura, MD, FAHA, MACC; Michael J. Ackerman, MD, PhD; N.A. Mark Estes III, MD, FACC; Leslie T. Cooper, Jr, MD, FAHA, FACC; Mark S. Link, MD, FACC; Martin S. Maron, MD, FACC; on behalf of the American Heart Association Electrocardiography and Arrhythmias Committee of the Council on Clinical Cardiology, Council on Cardiovascular Disease in the Young, Council on Cardiovascular and Stroke Nursing, Council on Functional Genomics and Translational Biology, and the American College of Cardiology

2015

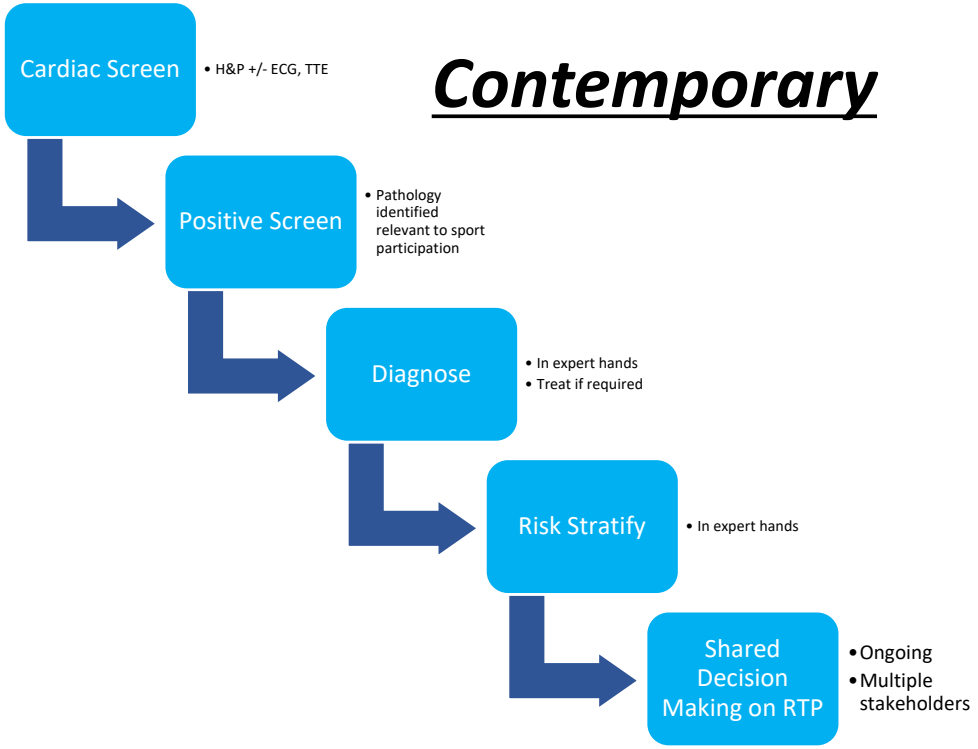
Guidelines now indicate we need more than yes or no.
-> Advocate risk assessment

ATLANTIC HEALTH SYSTEM

Paradigm Shift in Sports Cardiology



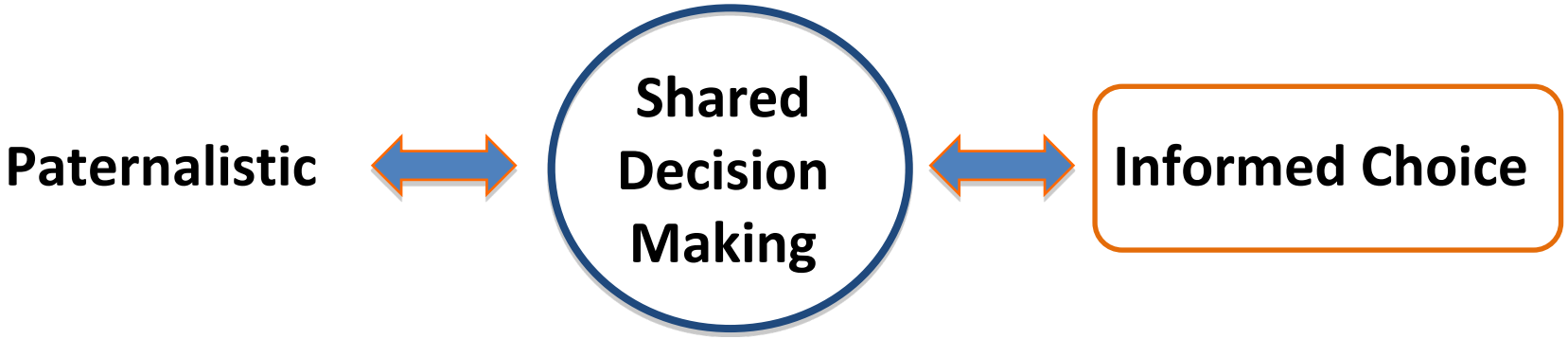
Traditional



Contemporary

Shared Decision Making

SDM is an approach where clinicians and patients make decisions together using the best available evidence.
(Elwyn et al. BMJ 2010)



Patient well informed (Knowledge)

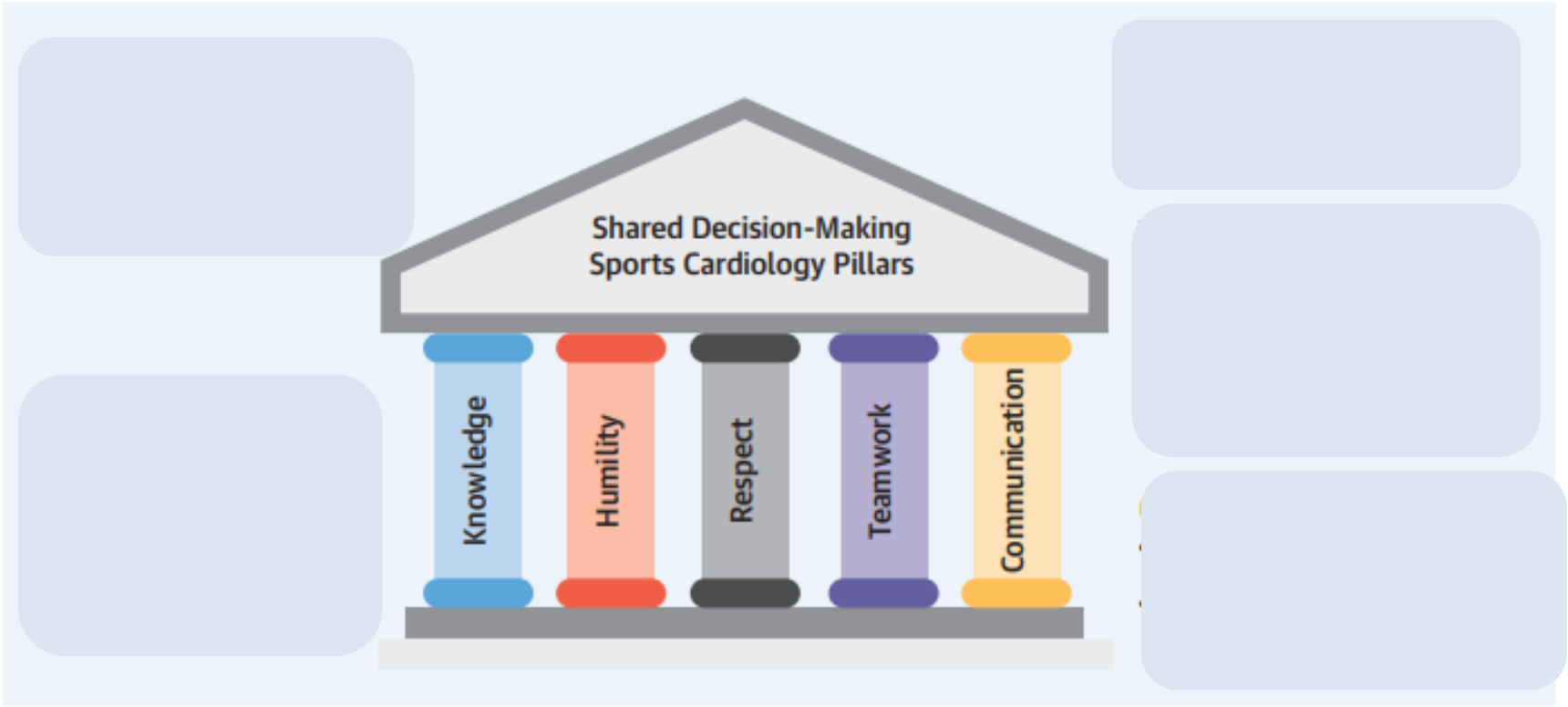
Knows what's important to them
(Patient values elicited)

Decision consistent with values

ATLANTIC HEALTH SYSTEM

SDM in Sports Cardiology

FIGURE 3 SDM Sports Cardiology Pillars



An illustration of the 5 pillars that make up a prescribed method of shared decision-making (SDM) that includes the required points to guide the patient-physician discussion.

Martinez, M.W. et al. J Am Coll Cardiol. 2021;78(14):1453-1470.

ATLANTIC HEALTH SYSTEM

CLINICAL SCIENCES

clinical commentary

The medical care of competitive athletes: the role of the physician and individual assumption of risk

BENJAMIN D. LEVINE and JAMES STRAY-GUNDERSEN

Institute for Exercise and Environmental Medicine,
Presbyterian Hospital of Dallas,
The Baylor/UT Southwestern Sports Science Laboratory, and
The University of Texas Southwestern Medical Center at Dallas

LEVINE, B. D. and J. STRAY-GUNDERSEN. The medical care of competitive athletes: the role of the physician and individual assumption of risk. *Med. Sci. Sports Exerc.*, Vol. 26, No. 10, pp. 1190–1192, 1994.

ATLANTIC HEALTH SYSTEM

Some young athletes with heart disease cleared to play under new recommendations

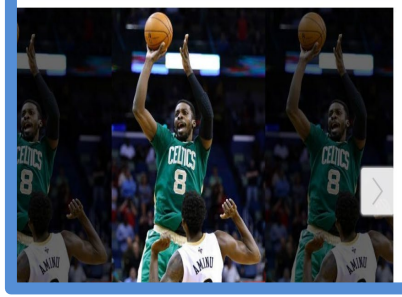
By AMERICAN HEART ASSOCIATION NEWS

Michigan DT Maurice Hurst, potential first-round pick, cleared to play after heart condition diagnosis

Frank Schwab
Shutdown Corner March 22, 2018

Follow

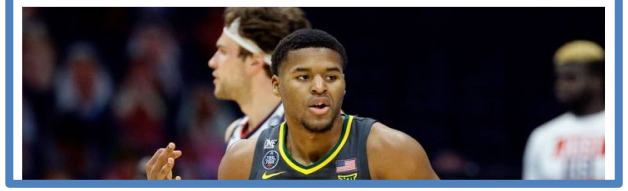
For 4 NBA players with serious heart ailments, a fraternity has helped get them through it



Baylor's Jared Butler medically cleared to play in NBA: Sources

By Shams Charania and The Athletic Staff
July 17, 2021 Updated 7:21 PM EDT

8 Comments



Soccer

Cleared by cardiologists, Sierra Leone's Alhaji Kamara joins D.C. United

By Steven Goff
May 10, 2016

D.C. United has acquired Alhaji Kamara, a forward from Sierra Leone whose career was jeopardized by a heart condition this winter.

In the past week, the MLS cardiology consultant and a heart specialist at MedStar Georgetown University Hospital examined Kamara and determined that he could resume playing soccer, United General Manager Dave Kasper said Tuesday.

With medical clearance, United finalized a deal with Kamara's previous employer, IFK Norrkoping of Sweden. D.C. did not pay a transfer fee but will compensate the Swedish team if Kamara, 22, meets performance incentives or is sold in the future.

Alhaji Kamara (Norrkoping)

NBA NHL

Clint Dempsey cleared to play again after heart problems

- Seattle Sounders striker missed end of last season with medical condition
- Dempsey says he hopes to make return to US national team soon

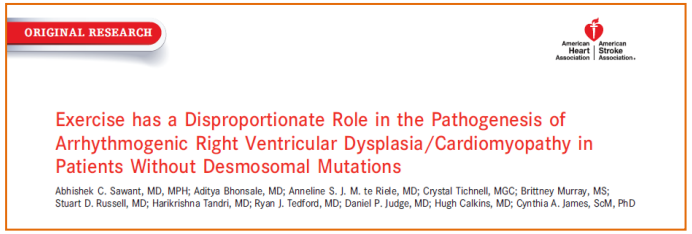
ESPN SCORES

Soccer | News Scores Schedule Transfers USMN

Christian Eriksen joins Brentford in remarkable return to football after cardiac arrest

Shared Decision-Making ≠ Low Risk for All

Exercise and Arrhythmogenic RV Cardiomyopathy

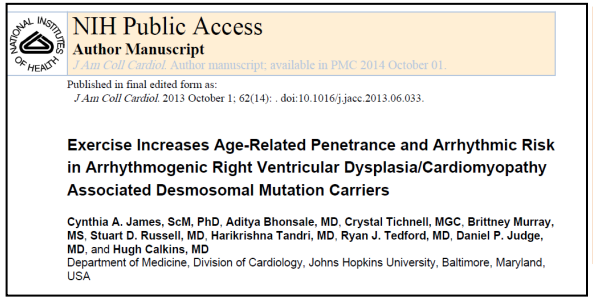


ORIGINAL RESEARCH

American Heart Association | American Stroke Association.

Exercise has a Disproportionate Role in the Pathogenesis of Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy in Patients Without Desmosomal Mutations

Abhishek C. Sawant, MD, MPH; Aditya Bhonsale, MD; Anneline S. J. M. te Riele, MD; Crystal Tichnell, MGC; Brittney Murray, MS; Stuart D. Russell, MD; Harikrishna Tandri, MD; Ryan J. Tedford, MD; Daniel P. Judge, MD; Hugh Calkins, MD; Cynthia A. James, ScM, PhD

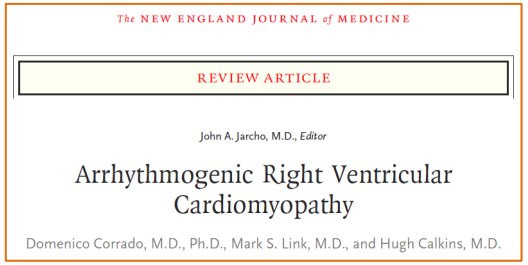


NIH Public Access
Author Manuscript
J Am Coll Cardiol. Author manuscript; available in PMC 2014 October 01.

Published in final edited form as:
J Am Coll Cardiol. 2013 October 1; 62(14): . doi:10.1016/j.jacc.2013.06.033.

Exercise Increases Age-Related Penetrance and Arrhythmic Risk in Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy Associated Desmosomal Mutation Carriers

Cynthia A. James, ScM, PhD, Aditya Bhonsale, MD, Crystal Tichnell, MGC, Brittney Murray, MS, Stuart D. Russell, MD, Harikrishna Tandri, MD, Ryan J. Tedford, MD, Daniel P. Judge, MD, and Hugh Calkins, MD
Department of Medicine, Division of Cardiology, Johns Hopkins University, Baltimore, Maryland, USA



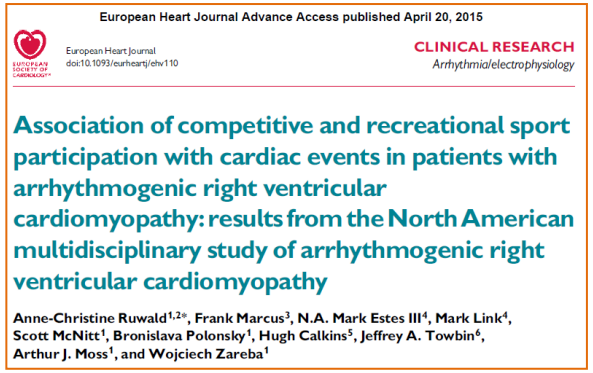
The NEW ENGLAND JOURNAL *of* MEDICINE

REVIEW ARTICLE

John A. Jarcho, M.D., *Editor*

Arrhythmogenic Right Ventricular Cardiomyopathy

Domenico Corrado, M.D., Ph.D., Mark S. Link, M.D., and Hugh Calkins, M.D.



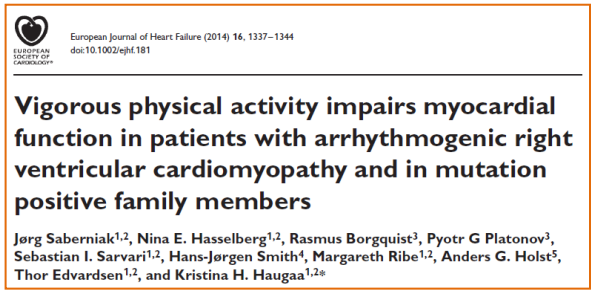
European Heart Journal Advance Access published April 20, 2015

European Heart Journal
doi:10.1093/eurheartj/ehv110

CLINICAL RESEARCH
Arrhythmia/electrophysiology

Association of competitive and recreational sport participation with cardiac events in patients with arrhythmogenic right ventricular cardiomyopathy: results from the North American multidisciplinary study of arrhythmogenic right ventricular cardiomyopathy

Anne-Christine Ruwald[1,2*], Frank Marcus[3], N.A. Mark Estes III[4], Mark Link[4], Scott McNitt[1], Bronislava Polonsky[1], Hugh Calkins[5], Jeffrey A. Towbin[6], Arthur J. Moss[1], and Wojciech Zareba[1]



European Journal of Heart Failure (2014) 16, 1337–1344
doi:10.1002/ejhf.181

Vigorous physical activity impairs myocardial function in patients with arrhythmogenic right ventricular cardiomyopathy and in mutation positive family members

Jørg Saberniak[1,2], Nina E. Hasselberg[1,2], Rasmus Borgquist[3], Pyotr G Platonov[3], Sebastian I. Sarvari[1,2], Hans-Jørgen Smith[4], Margareth Ribe[1,2], Anders G. Holst[5], Thor Edvardsen[1,2], and Kristina H. Haugaa[1,2*]

Exercise increases the risk of ventricular arrhythmias and worsens RV function

ATLANTIC HEALTH SYSTEM

LQTS

Return to play? Athletes with congenital long QT syndrome

Jonathan N Johnson,[1] Michael J Ackerman[1,2,3]

BJSM 2013

- Low rate of cardiac events and no deaths in over 650 athlete-years of follow-up

Sports Participation in Genotype Positive Children With Long QT Syndrome

Peter F. Aziz, MD,* Tammy Sweeten, MS,† Ramon L. Vogel, MD,† William J. Bonney, MD,† Jacqueline Henderson, RN,† Akash R. Patel, MD,‡ Maully J. Shah, MBBS†

JACC 2015

- No cardiac events and no deaths in **treatment-compliant** children with LQTS in 755 patient-years of follow-up

Shared Decision-Making in Cardiovascular Disease

ATLANTIC HEALTH SYSTEM

AHA/ACC CLINICAL PRACTICE GUIDELINE

2020 AHA/ACC Guideline for the Diagnosis and Treatment of Patients With Hypertrophic Cardiomyopathy

A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

COR	LOE	RECOMMENDATIONS
1	B-NR	1. For most patients with HCM, mild- to moderate-intensity recreational* exercise is beneficial to improve cardiorespiratory fitness, physical functioning, and quality of life, and for their overall health in keeping with physical activity guidelines for the general population (1-3).
1	C-EO	2. For athletes with HCM, a comprehensive evaluation and shared discussion of potential risks of sports participation by an expert provider is recommended (4).
2a	C-EO	3. For most patients with HCM, participation in low-intensity competitive sports is reasonable (5,6).

Ommen et al. Circulation. 2020;142:e558-e631.

Benefits of Exercise in HCM

- Improved exercise tolerance, increased V02 max.
- Potential for improved LV remodeling, increase in LV and RV end diastolic volume, improved diastolic function.
- Psycho-social benefits
- Overall health benefits (weight loss, improved metabolic profile

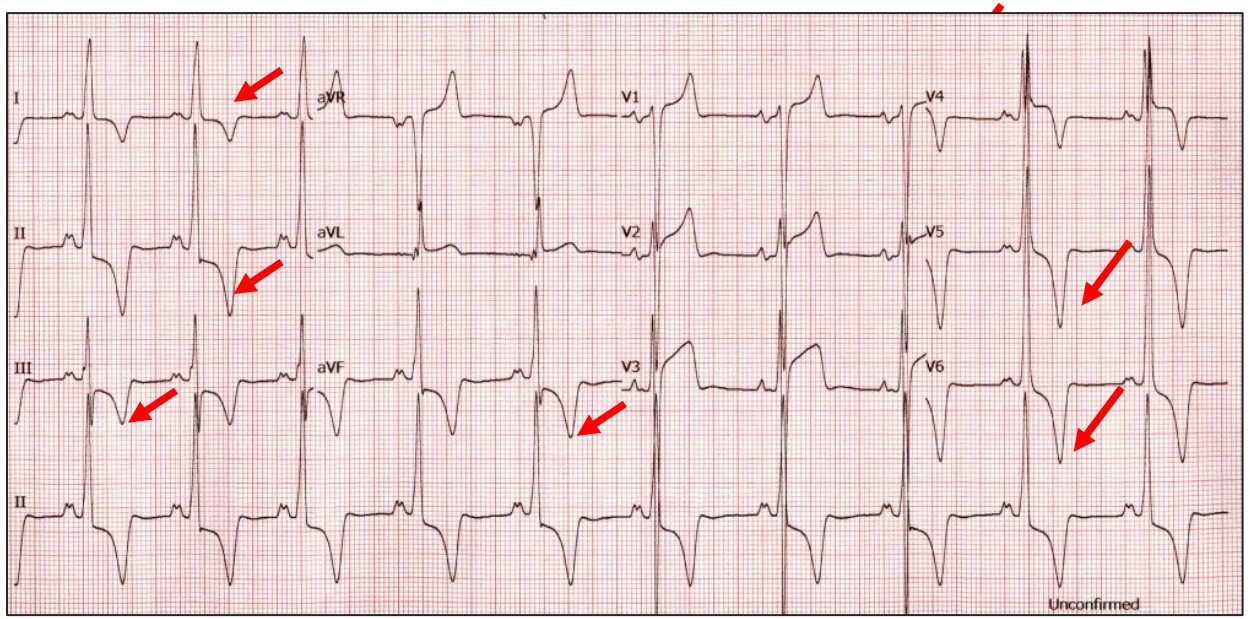
Case Presentation

17 y.o elite Caucasian Female
American Soccer midfielder

Asymptomatic.
No prior syncope, CV limitations.
No family hx of cardiomyopathy or sudden cardiac arrest.

Preparticipation screening evaluation including ECG.
ECG was abnormal.

Electrocardiogram



Sinus bradycardia
Normal QTc
TWI II, III, aVF, V3-V6

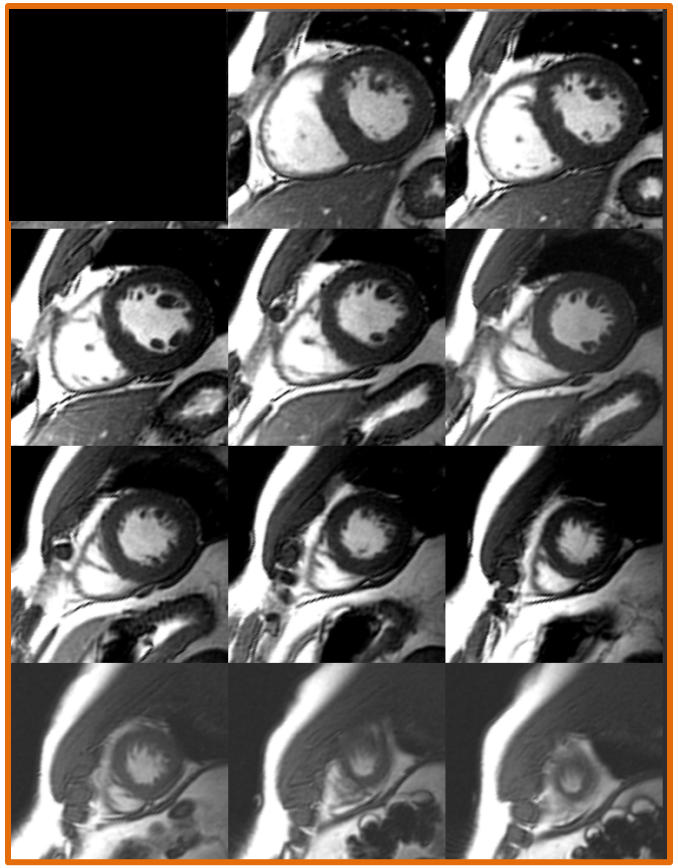
No prior ECG

Referred for ECHO

ATLANTIC HEALTH SYSTEM

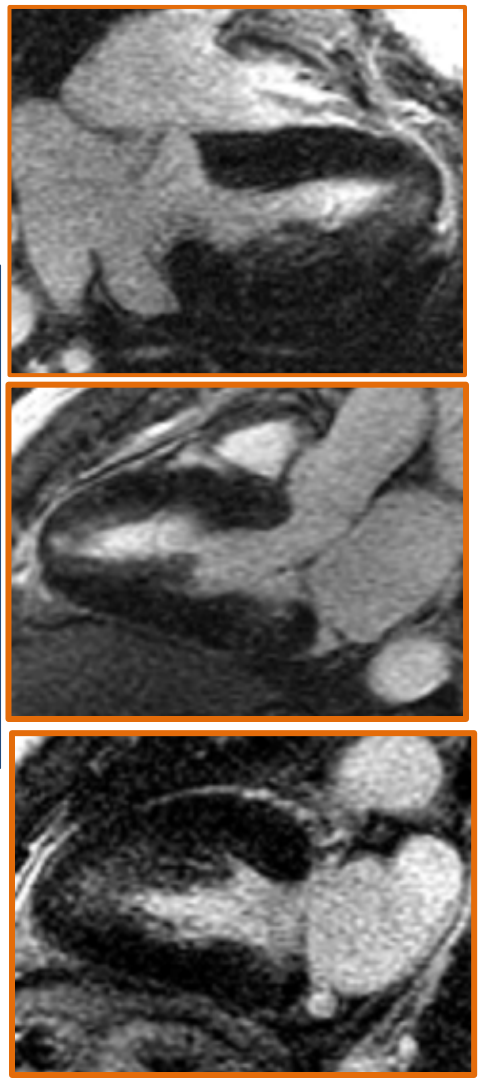
ECHO

- Normal biventricular size and function.
- LVEF = 65%.
- Normal wall motion. No valve disease: SAM or MVP. Abnormal diastolic function
- 17mm septal thickness.
- **Exercise Echo –** 16minutes + sprints; no arrythmias or obstruction, Normal HR and BP response
- **48hr Ambulatory monitor**: Rare PVCs



CMR

- LVEF = 75%.
- No SAM
- 18mm septum
- No LGE



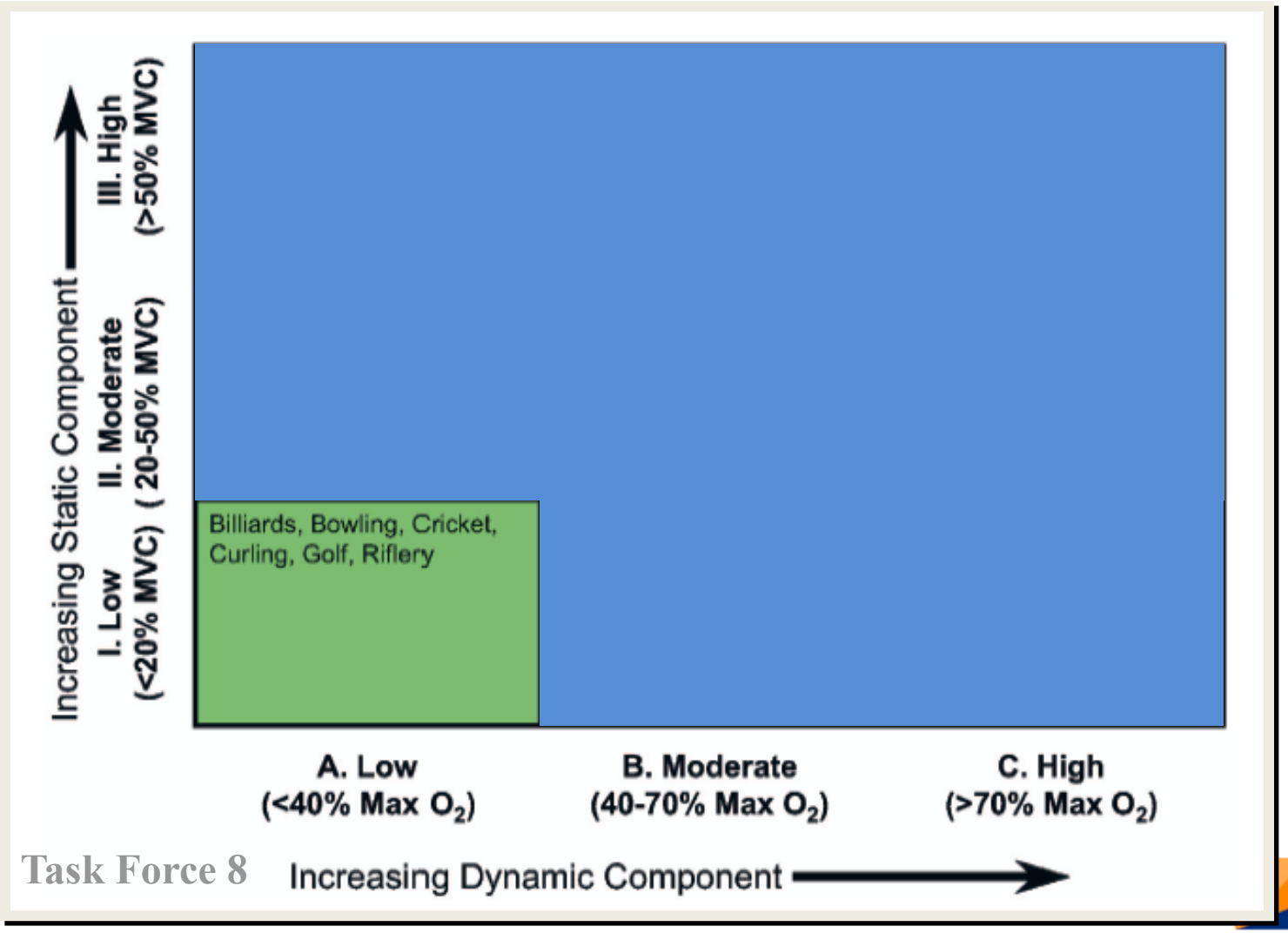
Athlete with SCA Risk

Would YOU allow this athlete with screening-based, incidentally detected HCM (asymptomatic) to continue with his/her competitive sport?

1. YES
2. NO
3. MAYBE

Physical Activity Among HCM Patients

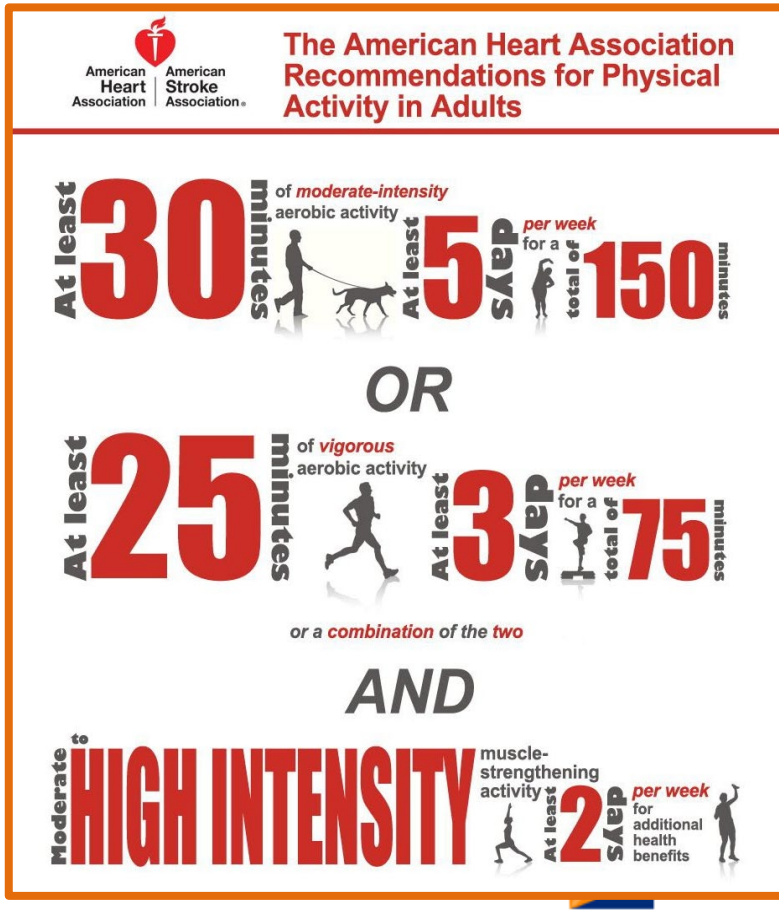
In clinical practice, the message of physical activity



Physical Activity Among HCM Patients

In clinical practice, the message of physical activity has been confusing

- Less active than the general U.S. population
- 60% believe exercise restrictions negatively impact emotional well-being
- Greater psychological morbidity overall but more so among:
  - Elite or competitive athletes
  - Those who decrease time spent exercising
- 55% do not meet minimum guidelines for physical activity



Reineck E. et al. Am J Cardiol. 2013;111:1034-39.
Luiten, R. et al. Open Heart 2016;3:e000488.
Sweeting J. et al. Open Heart 2016;3:000484.

Exercise in HCM

The Randomized Exploratory Study of Exercise Training in Hypertrophic Cardiomyopathy (RESET-HCM)

JAMA | Preliminary Communication

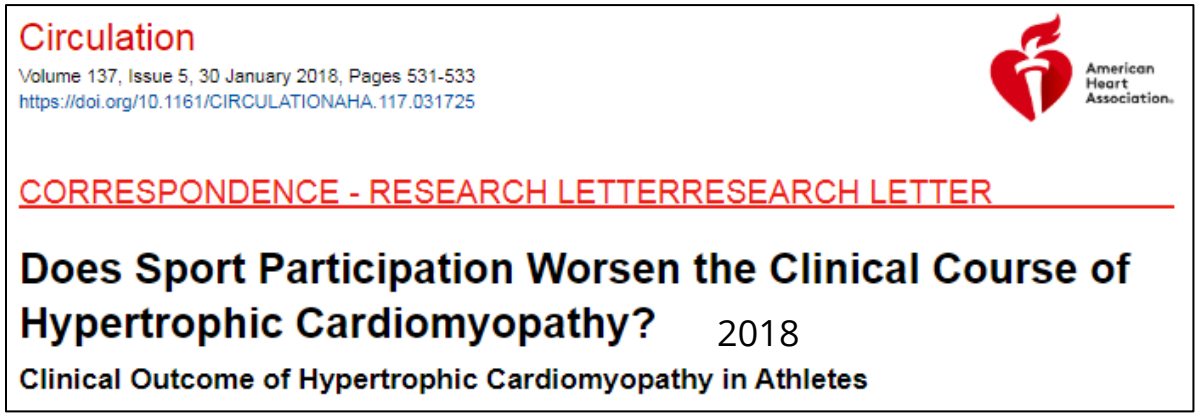
Effect of Moderate-Intensity Exercise Training on Peak Oxygen Consumption in Patients With Hypertrophic Cardiomyopathy

A Randomized Clinical Trial 2017

Sara Saberi, MD, MS; Matthew Wheeler, MD, PhD; Jennifer Bragg-Gresham, MS, PhD; Whitney Hornsby, PhD; Prachi P. Agarwal, MD, MS; Anil Attili, MD; Maryann Concannon, MSW; Annika M. Dries, BA; Yael Shmargad, BS; Heidi Salisbury, RN, MSN, CNS; Suwen Kumar, MBBS; Jonathan J. Herrera, MS; Jonathan Myers, PhD; Adam S. Helms, MD, MS; Euan A. Ashley, FRCP, DPhil; Sharlene M. Day, MD

- 136 patients with HCM; **mean age 50.4 years**
- Randomly assigned to **16 weeks of moderate-intensity exercise training** or usual activity
- Moderate-intensity exercise resulted in a significant but **small increase in exercise capacity** (+1.35 mL/kg/min)
- **No adverse events** (sustained ventricular arrhythmia, SCA, appropriate defibrillator shock, or death) in either group

Athletes with HCM



- 35 athletes with HCM; mean age 32
- 33 (94%) white
- 31 (88%) low risk by ESC risk score
- Mean observation 9 years
- 1 SCA occurred (amateur tennis player while walking)
- **No difference in the incidence of symptoms or events among patients who stopped or continued sport competitions**

CENTRAL ILLUSTRATION Athlete Assessment: Clinical Evaluation, Shared Decision-Making, and Athlete-Centered Decision

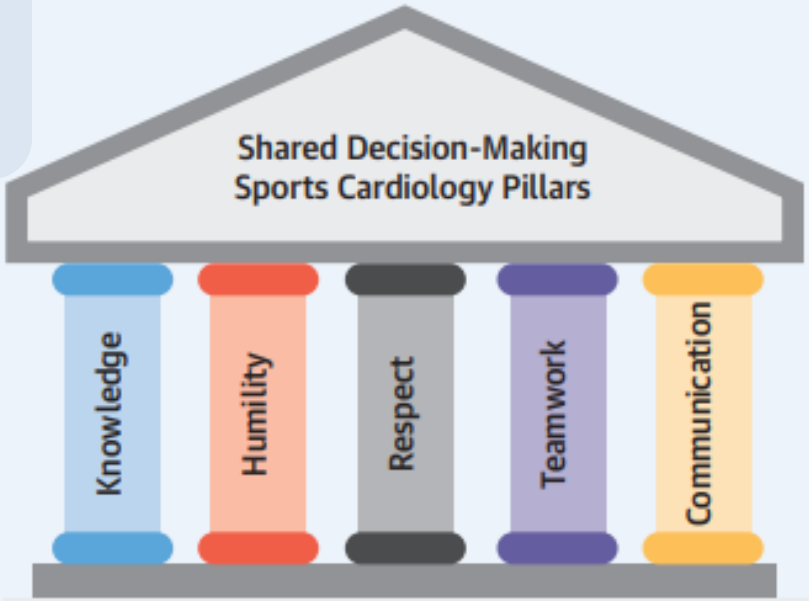
Athlete Evaluation

Athlete History (Sport Type, Intensity, Competition History)

Gender, Age, Ethnicity

Martinez, M.W. et al. J Am Coll Cardiol. 2021;78(14):1453-1470.

4. Document: Discussed risk and potential for harm even with an AED. Plan for surveillance → ?change in risk.



Who makes the final decision?

Martinez, M.W. et al. J Am Coll Cardiol. 2021;78(14):1453-1470.

Who makes the final decision?

All parties in agreement:
Expert Provider, Patient, Family and the University/Institution

FindLaw Caselaw United States US 7th Cir. KNAPP v. NORTHWESTERN UNIVERSITY

KNAPP v. NORTHWESTERN UNIVERSITY

Print 305 Font size: A A Reset

United States Court of Appeals,Seventh Circuit.

Nicholas KNAPP, Plaintiff-Appellee, v. NORTHWESTERN UNIVERSITY, an Illinois not-for-profit corporation, and Rick Taylor, Defendants-Appellants.

No. 96-3450.

Decided: November 22, 1996

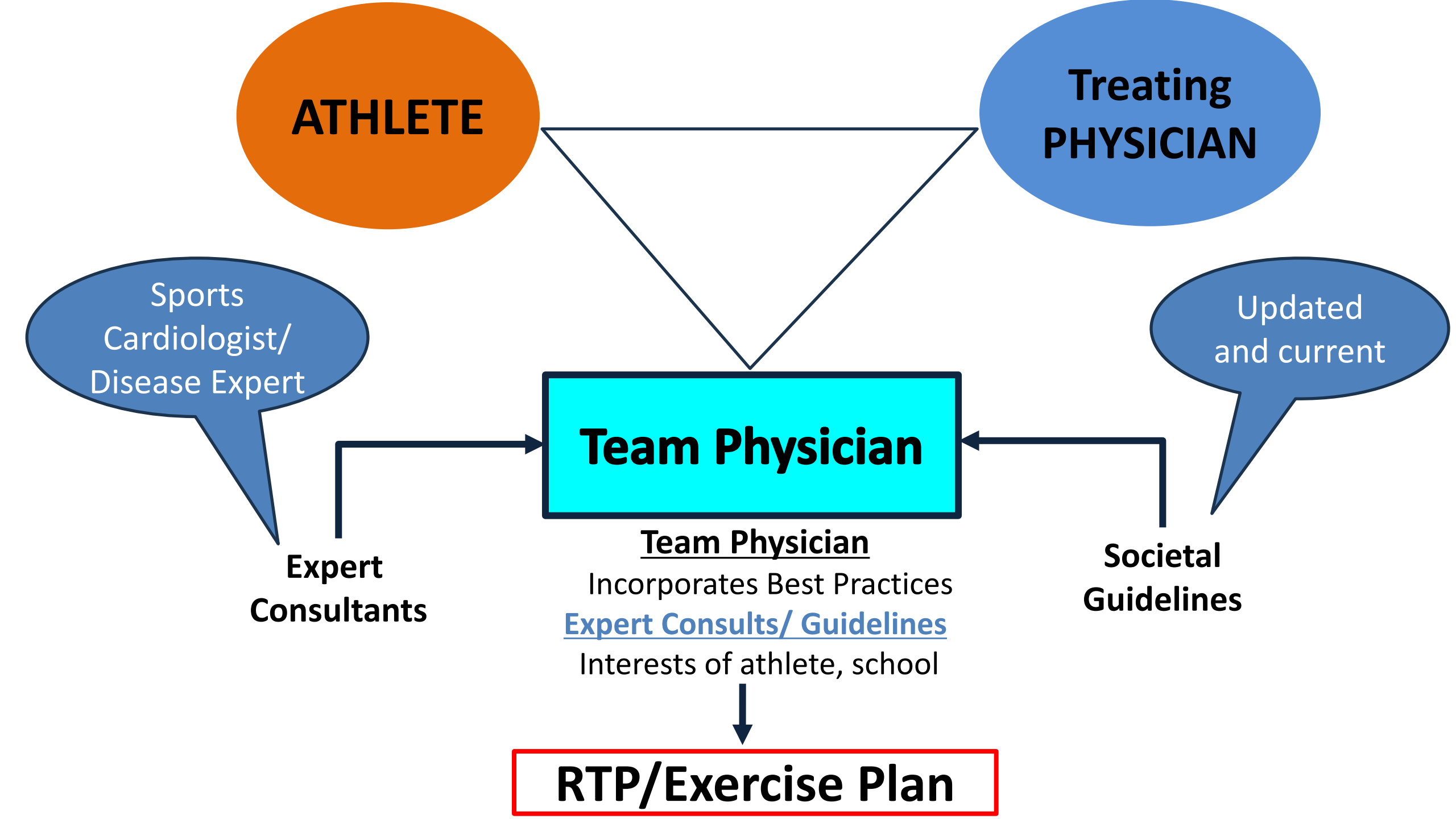
In closing, we wish to make clear that we are not saying Northwestern's decision necessarily is the right decision. We say only that it is not an illegal one under the Rehabilitation Act. On the same facts, another team physician at another university, reviewing the same medical history, physical evaluation, and medical recommendations, might reasonably decide that Knapp met the physical qualifications for playing on an intercollegiate basketball team. Simply put, all universities need not evaluate risk the same way. What we say in this case is that if substantial evidence supports the decision-mak[illegible] here Northwestern-that decision must be respected.

Shared Decision Making

cases involving risk of future injury, a school's perception of the threat of such injury cannot be based on unfounded fears or stereotypes; it must be based on objective evidence. Chiari, 920 F.2d at 317. But here, where Northwestern acted rationally and reasonably rather [illegible] paternalistically, no Rehabilitation Act violation has occurred. The Rehabilitation Act [illegible] replace, reflexive actions to actual or perceived handicaps with acti[illegible] Arline, 480 U.S. at 284-85, 107 S.Ct. at 1129.

Based on evidence, expert review. NOT – because I said so.

ATLANTIC HEALTH SYSTEM


ATHLETE
Treating PHYSICIAN
Sports Cardiologist/ Disease Expert
Updated and current
Team Physician
Expert Consultants
Team Physician
Incorporates Best Practices
Expert Consults/ Guidelines
Interests of athlete, school
Societal Guidelines
RTP/Exercise Plan

AHA/ACC CLINICAL PRACTICE GUIDELINE

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2a	C-EO	3. For most patients with HCM, participation in low-intensity competitive sports is reasonable (5,6).
2b	C-LD	5. For patients with HCM, participation in high-intensity recreational activities or moderate- to high-intensity competitive sports activities may be considered after a comprehensive evaluation and shared discussion, repeated annually with an expert provider who conveys that the risk of sudden death and ICD shocks may be increased, and with the understanding that eligibility decisions for competitive sports participation often involve third parties (e.g., team physicians, consultants, and other institutional leadership) acting on behalf of the schools or teams (4,7-11).

Ommen et al. Circulation. 2020;142:e558-e631.

Clinical Risk Factors for HCM Sudden Cardiac Arrest

Family history of sudden death from HCM
Massive LVH (>30mm)
Unexplained syncope
HCM w/ LV systolic dysfunction (EF <50%)
LV apical aneurysm
Extensive LGE on CMR
NSVT on ambulatory monitor

JAMA Cardiology | Original Investigation

Enhanced American College of Cardiology/American Heart Association Strategy for Prevention of Sudden Cardiac Death in High-Risk Patients With Hypertrophic Cardiomyopathy

Martin S. Maron, MD; Ethan J. Rowin, MD; Benjamin S. Wessler, MD; Paula J. Mooney, RN; Amber Fatima, MD; Parth Patel, MD; Benjamin C. Koethe, MPH; Mikhail Romashko, MD; Mark S. Link, MD; Barry J. Maron, MD

2019

- 2094 patients with HCM
- Mean follow-up 4.7 years
- 12 of 1567 (0.8%) had SCA
- 527 received primary prevention ICDs
- Very low annual mortality. 99% survival without ICD
- 20 patients w/ ICD interventions -> 85% had LGE

Risk stratification and prevention model averted nearly all SCD

Enhanced ACC/AHA clinical risk factor strategy for predicting SCD events was 95% sensitive

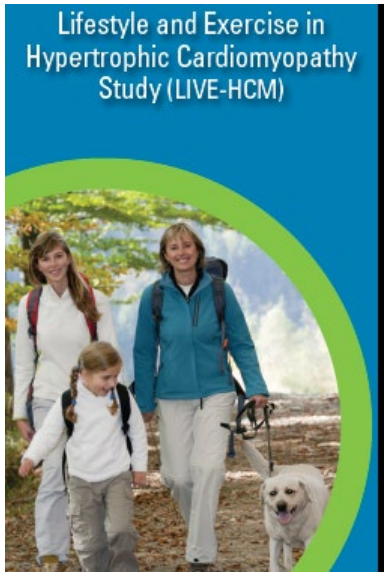
EXERCISE IN GENETIC CARDIOVASCULAR DISEASE
(LIVE-HCM)

Aim 1: Incidence **arrhythmic events** over 3 years
Comparison moderate or vigorous exercisers vs sedentary

Aim 2: **Quality of life**
Comparison moderate or vigorous exercisers vs sedentary

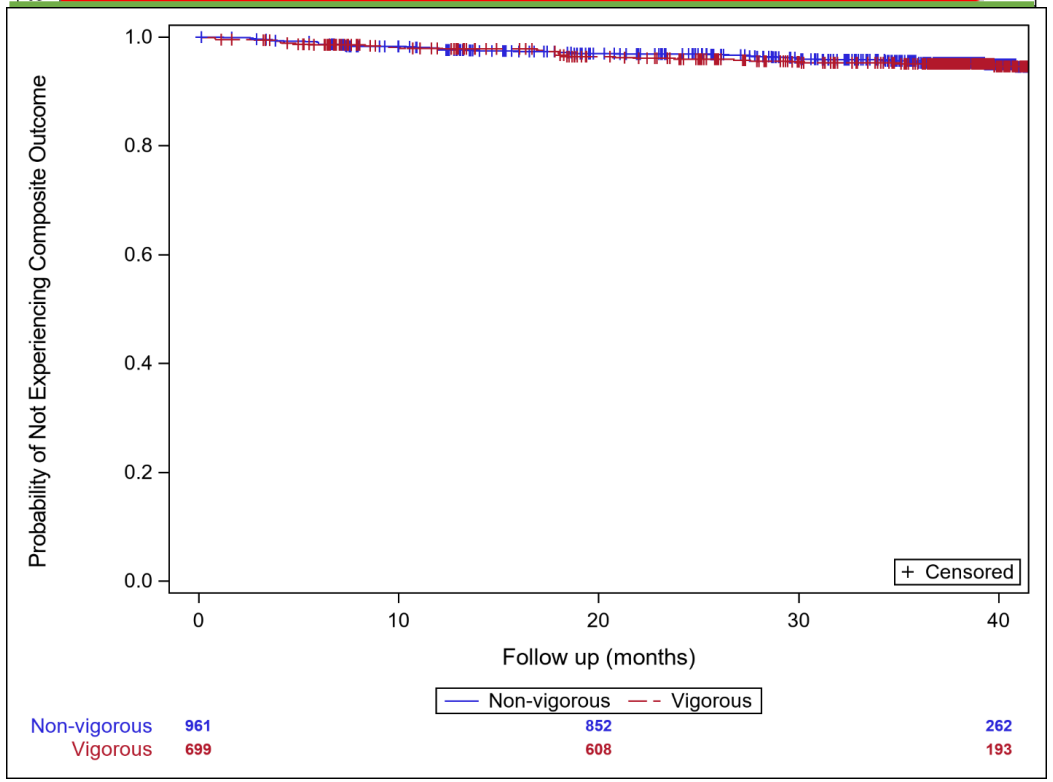
Age 8-60 years, with OR without ICD
Any level exercise

3 years of follow up



NIH R01 HL125918-01

	Non-Vigorous	Vigorous	Total
	N=961	N=699	N=1660
TOTAL composite endpoint			
N	44	33	77
Rate per 1,000 person-year	15.3	15.9	15.6
(95% CI)	(11.4, 20.5)	(11.3, 22.4)	(12.5, 19.6)



Return-to-Play for Elite Level Athletes With Sudden Cardiac Death Predisposing Heart Conditions

Katherine A. Martinez, J. Martijn Bos, MD, PhD, Darrel B. Newman, MD, Julie Haylett, Bradley Petek, MD, Dermot M. Phelan MD, PhD, Aaron Baggish, MD, Michael J. Ackerman, MD, PhD, and Matthew W Martinez, MD.

American College of Cardiology
New Orleans, LA
March 2023

Return-to-Play for Elite Athletes With Genetic Heart Diseases Predisposing to Sudden Cardiac Death

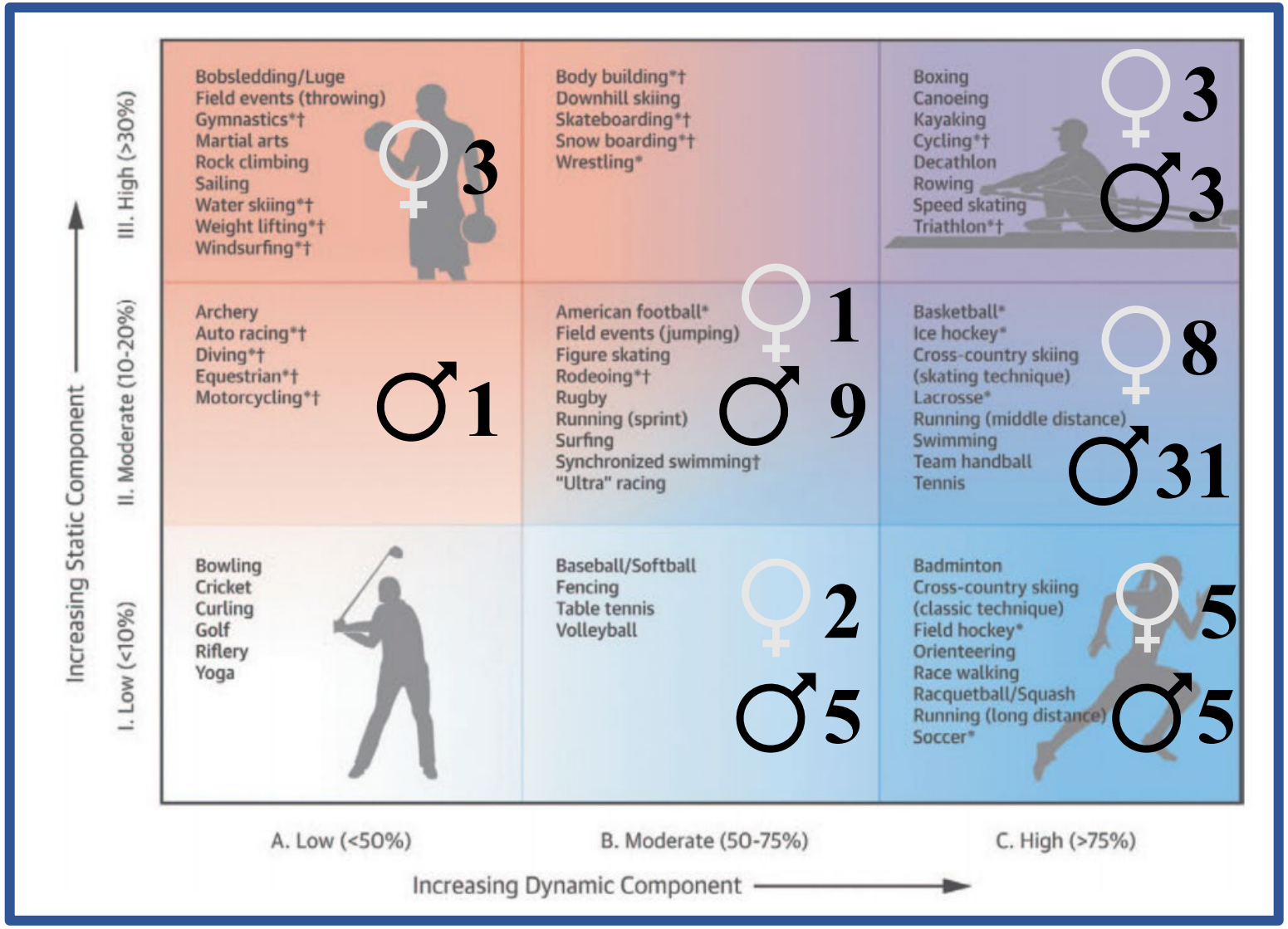
JACC VOL. 82, NO. 8, 2023
AUGUST 22, 2023:661-670

RTP for Elite Level Athletes With Sudden Cardiac Death Predisposing Heart Conditions

Demographics	Total Cohort
Total Number of Athletes	76
Mean Age at Return-to-Play (years)	19.9 ± 5.0
Female (%)	21 (28)
Race (%)	
White	38 (50)
Black	28 (37)
Not Disclosed/Unknown	4 (5)
Other	2 (3)
Asian	1 (1)
Hispanic	1 (1)
Indian	1 (1)
Pacific Islander	1 (1)
Diagnosis (%)	
HCM	40 (53)
LQTS	20 (26)
DCM	5 (7)
Other	5 (7)
ARVC	4 (5)
IVF	2 (3)
Symptomatic Prior to Diagnosis (%)	28 (37)
Syncope	10 (13)
Other	6 (8)
SCA	6 (8)
Irregular Heart Rate / Palpitations	4 (5)
Sustained VT	2 (3)

- 49 (64%) Division I and 27 (36%) professional athletes.
- 55 athletes (72%) were initially disqualified but opted to RTP after comprehensive clinical evaluation and SDM.
- 73 out of 76 athletes (96%) chose to RTP.
- 1 patients (1.3%) had ≥ 1 breakthrough cardiac event (BCE) with exercise, 2 (2.6%) without exercise.
- NO deaths.

K Martinez, JACC 2023



K Martinez, JACC 2023

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Irreg	

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Conclusion:

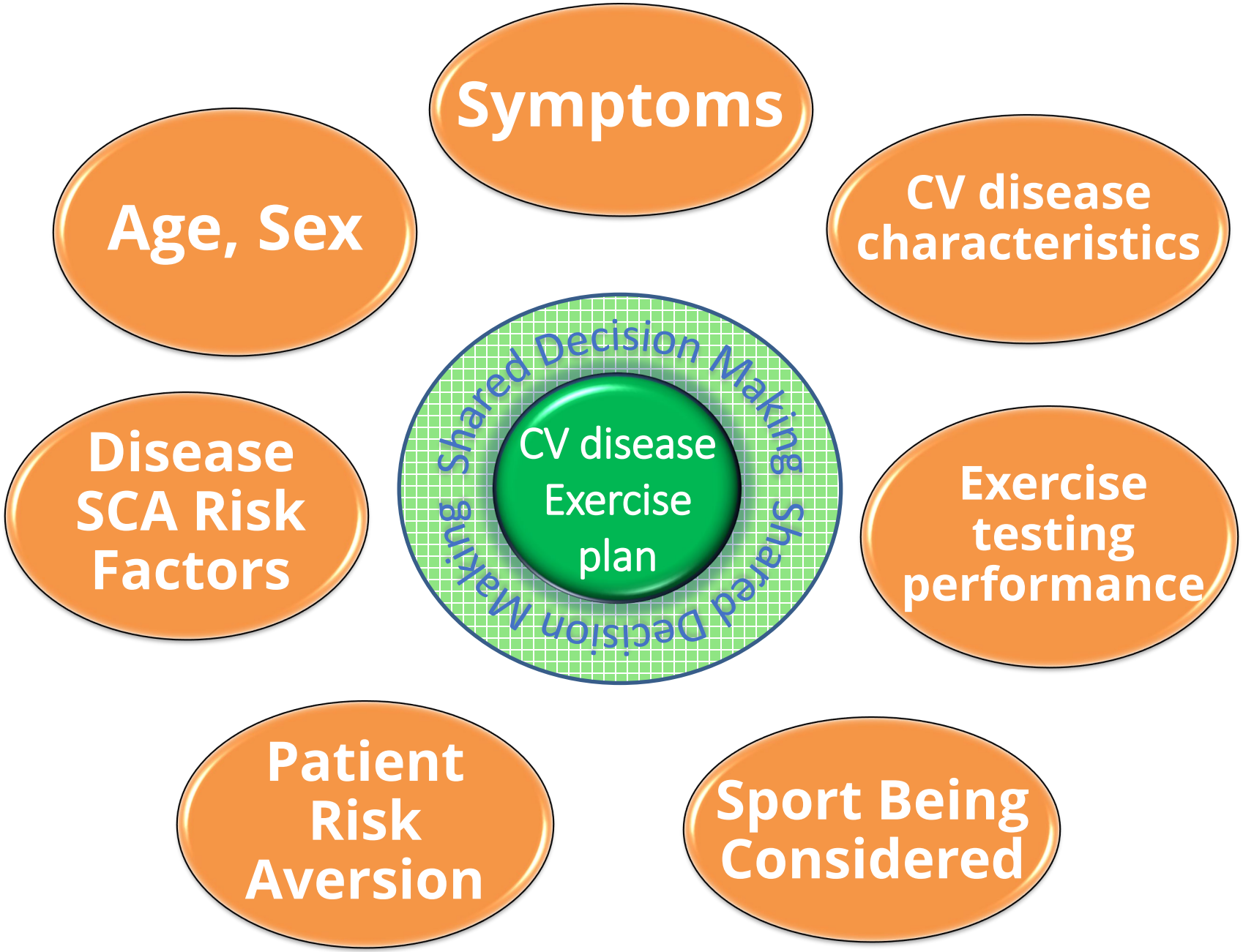
After careful evaluation by an expert, risk stratification, and SDM, an exercise plan can be put into place for Division I and professional athletes to RTP.

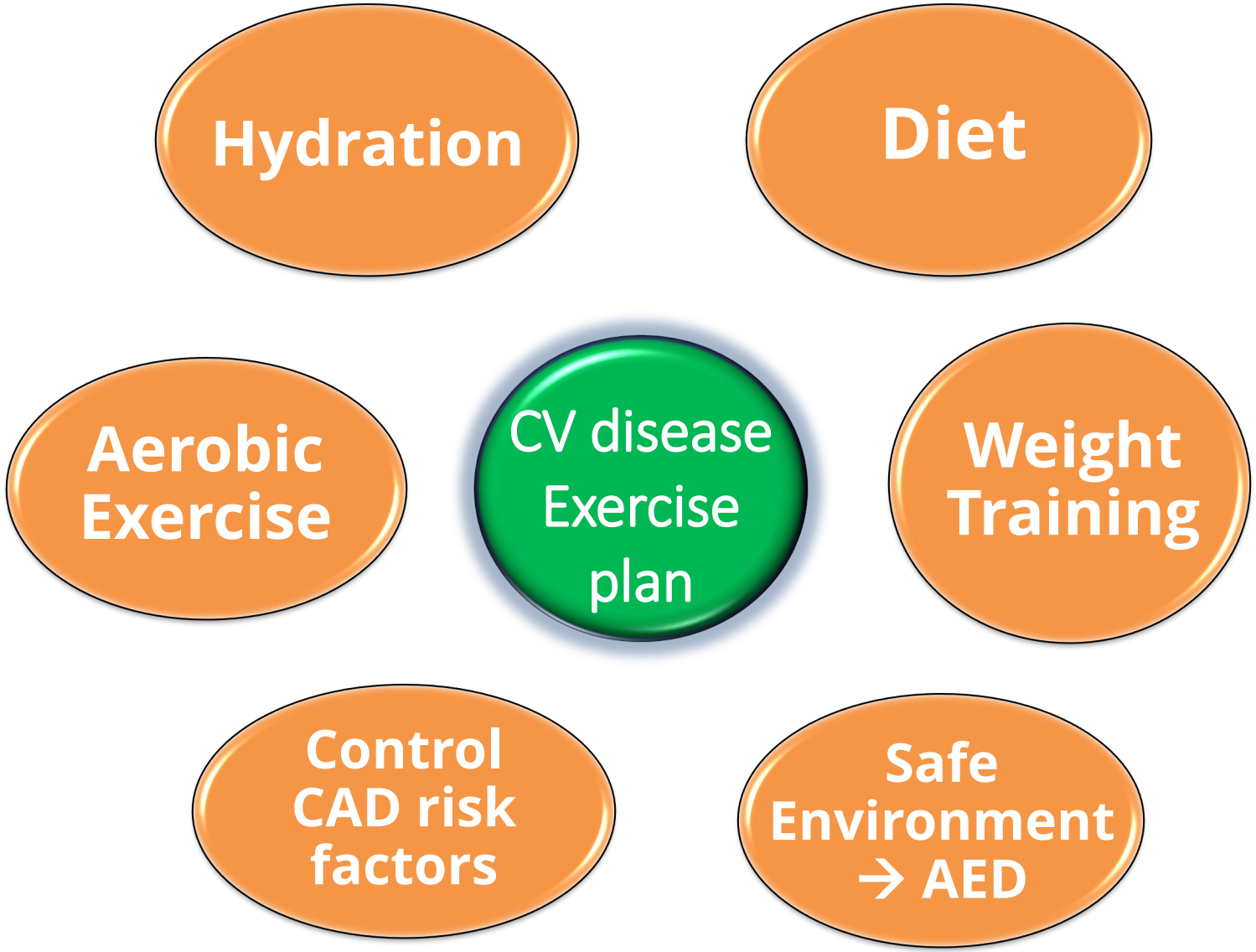
K Martinez, JACC 2023

Playing with HCM

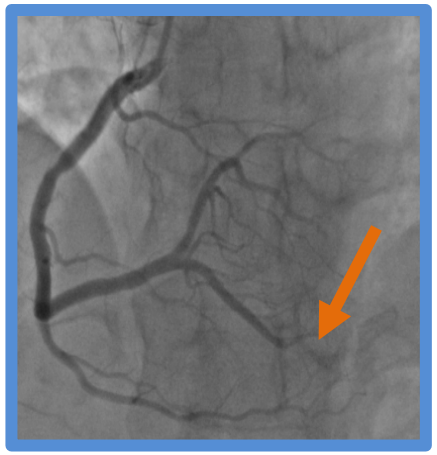
- Patient/player autonomy in health care decisions is important
- Absolute risk is difficult to quantify for all
- Risk avoidance/acceptance is individual decision

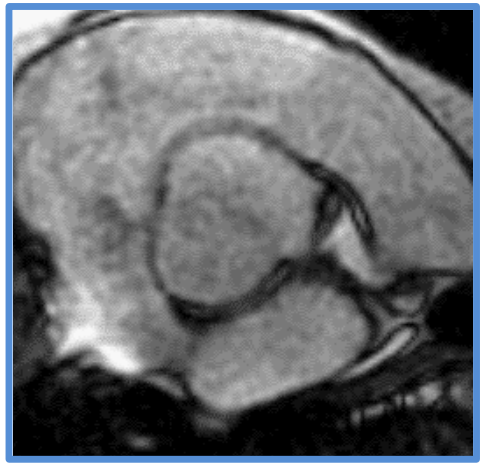
- **Potential harms of disqualification**:
  - Loss of self-identity
  - Loss of scholarship/education
  - Loss of income
  - Depression/mental health concerns

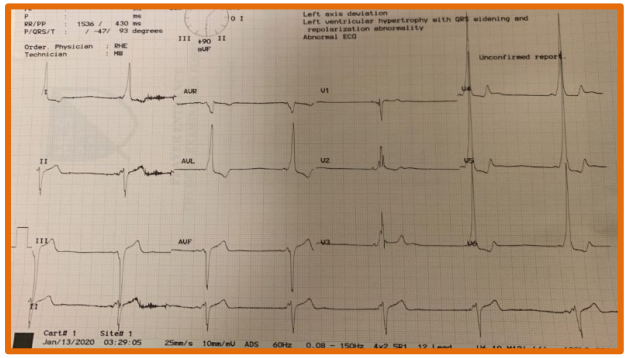


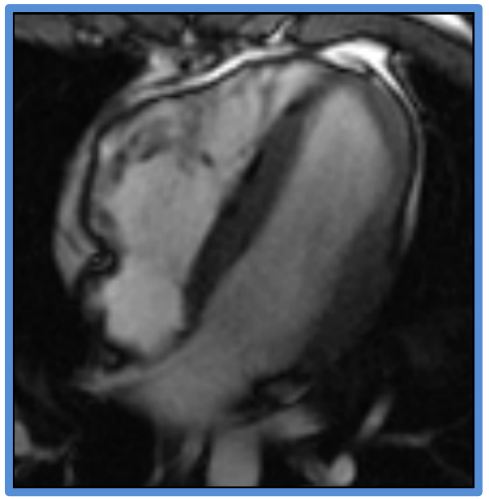


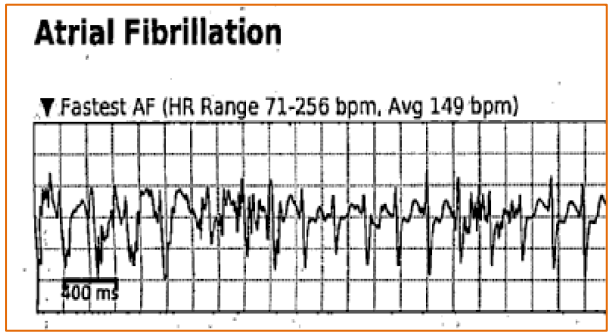
ATLANTIC HEALTH SYSTEM

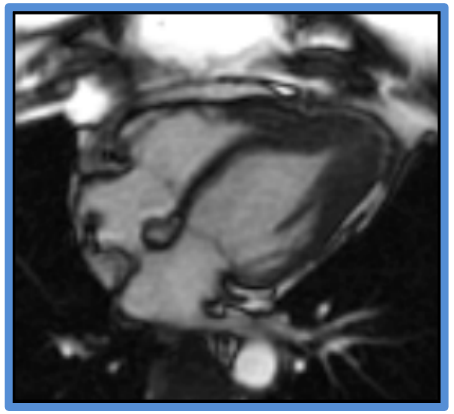












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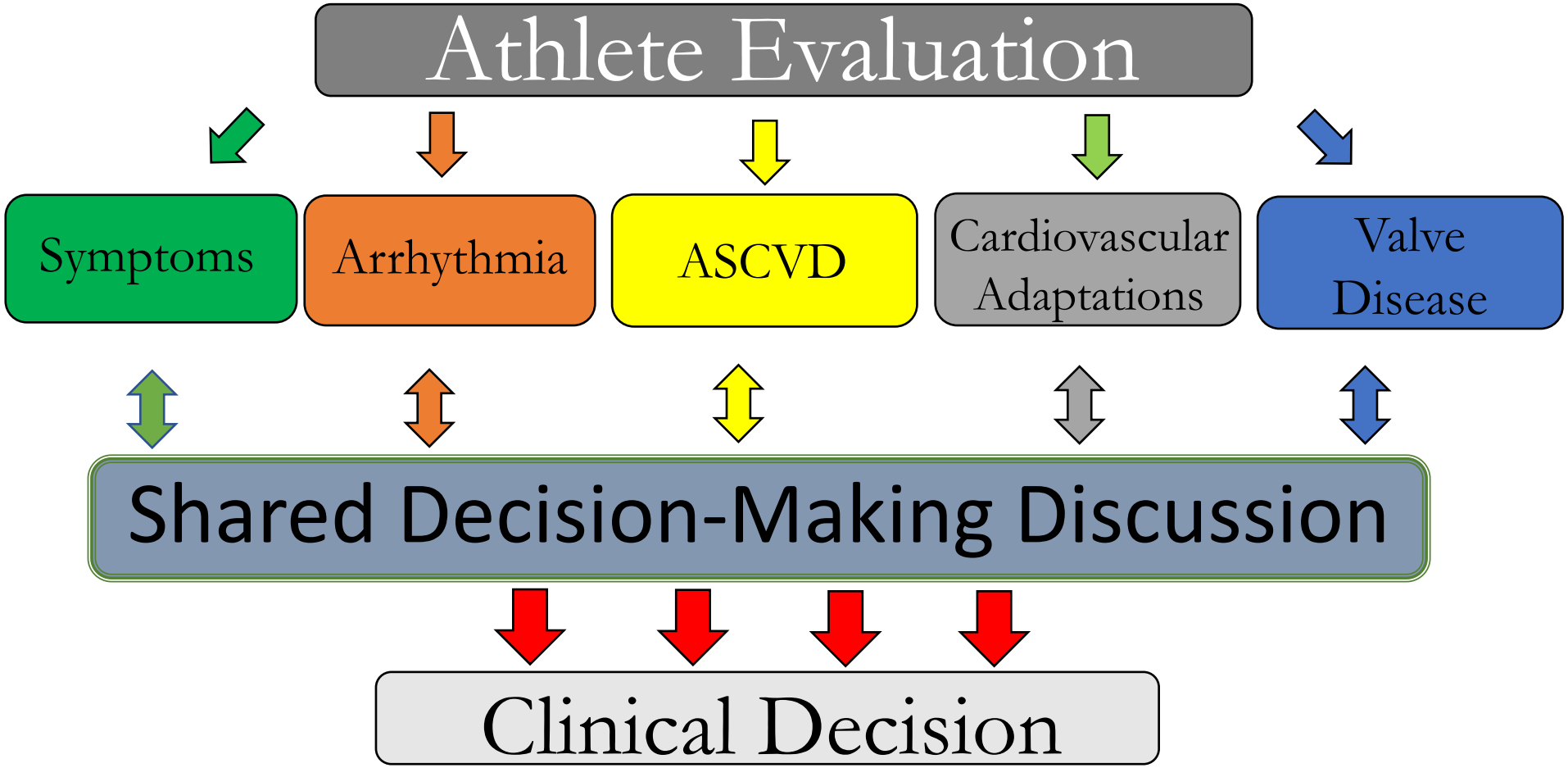
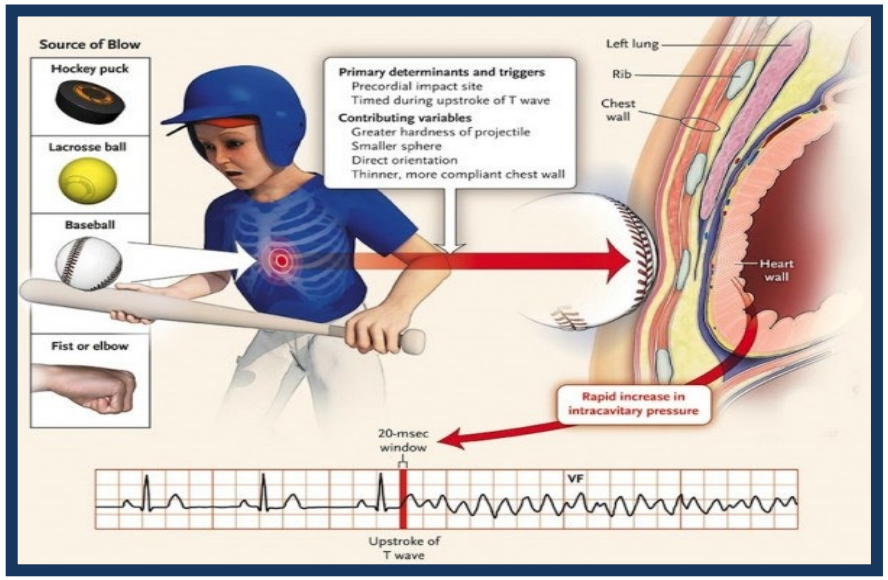

Athlete Evaluation
Symptoms
Arrhythmia
ASCVD
Cardiovascular Adaptations
Valve Disease
Shared Decision-Making Discussion
Clinical Decision

NO perfect evaluation process



Initial Arrhythmic Event

Low Risk

No Risk

ATLANTIC HEALTH SYSTEM

Christian Eriksen returns to Denmark squad for 1st time since collapse

Denmark plays a friendly away against the Netherlands on March 26 and hosts Serbia on March prepares for the World Cup in Qatar in November.

Keyontae Johnson
2020 collapse

All underwent cardiac screening

Bronny James

Damar Hamlin

ATLANTIC HEALTH SYSTEM

Sudden Cardiac Arrest Management

Pre-participation assessments are *never* perfect

EAP and AED are still important

Signs of cardiac arrest:

Sudden non-contact collapse, passed out athlete

ATLANTIC HEALTH SYSTEM

Care of the Athlete

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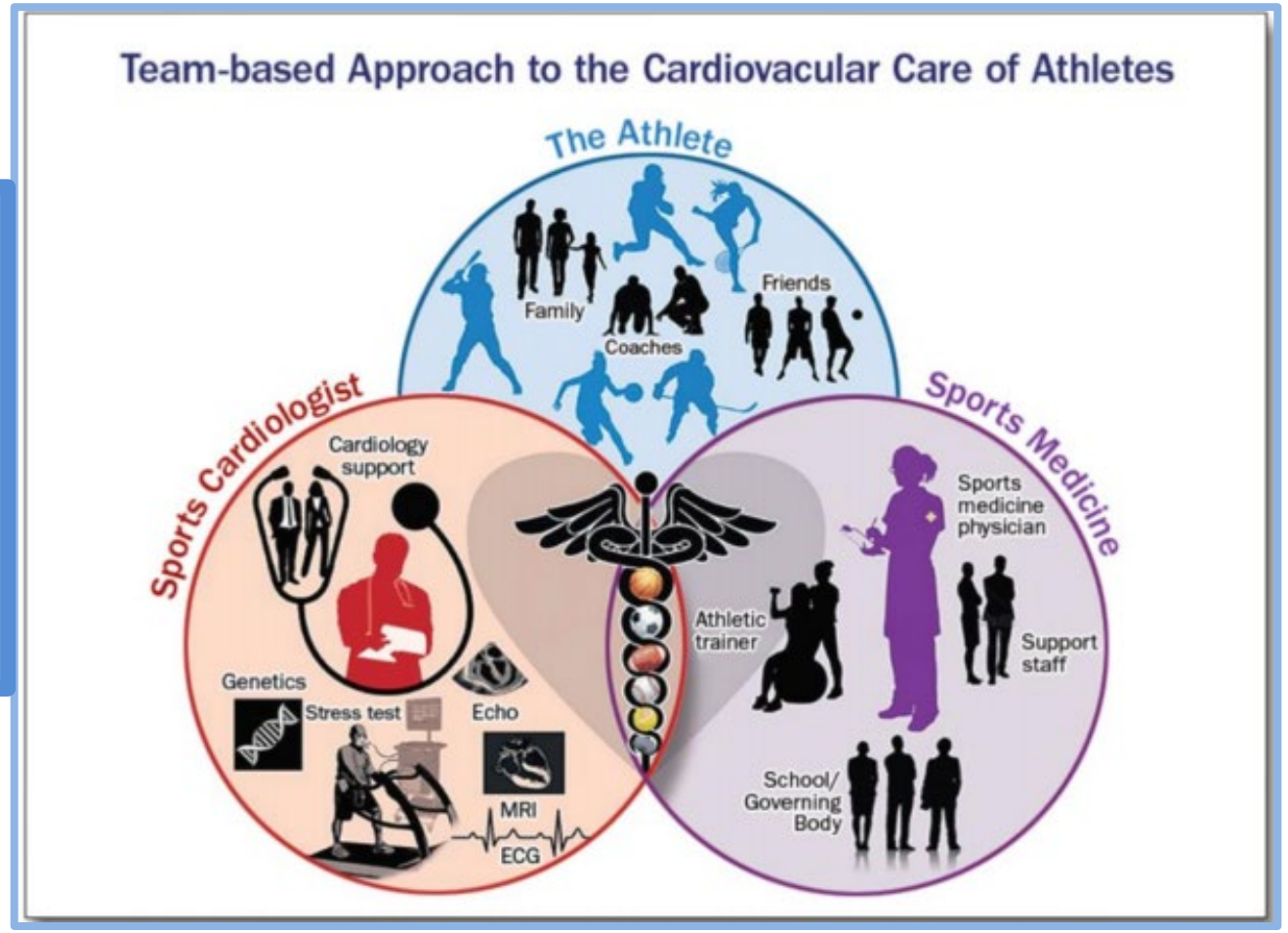
FELLOWS-IN-TRAINING & EARLY CAREER PAGE

~~The Emergence of~~ Sports Cardiology as a Specialty

Maxwell Eyram Afari, MD



Multidisciplinary Athlete-Centered Care ("Athlete Care Team") in Evaluating and Managing Athletes at Risk of SCD

Emery MS, Kovacs RJ. Sudden cardiac death in athletes. JACC Heart Fail 2018;6:30-40

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Sports Cardiology

- An important part of the Athlete Medical Team
- Understanding normal athlete adaptations is a must
  - –ECG
  - –Cardiac Imaging
- Sports Cardiology assessment
  - –Symptomatic or asymptomatic
  - –ASCVD, Valve
- Management of athletes should always include
  - –EAP and AEDs

Thank you

Matthew W. Martinez, MD FACC
Sports Cardiology Medical Director
HCM Director
Atlantic Health System/Morristown Med Center

twitter @mmartinezheart

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