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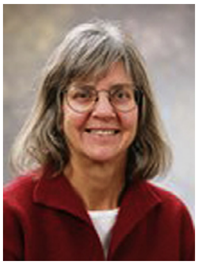
MY APPROACH

MY APPROACH to the athlete with hypertrophic cardiomyopathy[☆]



Rachel Lampert, MD

Shared decision-making is the cornerstone of my approach to the athlete with hypertrophic cardiomyopathy (HCM) in the discussion of returning to play. This means full discussion with the patient and often the family—what are the risks, what data do we have, how does this patient compare with the patients in the studies, what data are lacking? What do the professional society guidelines recommend? What does this patient/family think about risk in general?

For the athlete diagnosed with HCM who has clinical features indicative of high risk for sudden cardiac death (either a history of life-threatening ventricular arrhythmia, or known risk markers) and has thus received an ICD, this conversation is relatively straightforward. Data from the ICD sports registry, which included 75 patients with HCM, found that, although some athletes did receive appropriate shocks during sports, the ICD worked in all cases. We can say the risk of failure to convert an arrhythmia, or injury due to arrhythmia or shock, is low, although the study was not large enough to say the risks are zero. Based on these data, professional society recommendations now describe that participation in competitive sports "can be considered" for the athlete with an ICD. The possibility of being shocked during sports, or at other times, also needs to be discussed, as do the varying reactions of patients who receive shocks—for some, this will be an important consideration; for others, the potential risk of pain during sports is already an acceptable trade-off of the sport itself.

The conversation with the athlete diagnosed with HCM who does not show high-risk features—often diagnosed during screening, such as an athlete ECG screening program, or through family cascade screening after diagnosis of a relative—is paradoxically much more difficult at this time, as data are currently lacking. It is important to describe that current professional society recommendations recommend against competitive sports participation for patients with HCM. I then discuss with the patient the rationale—that many athletes who die suddenly, die from HCM. I also discuss the limitations of the data we have—that these were patients who had not been evaluated prior to death, and other studies show that most sudden cardiac death in HCM occurs at rest. The risk of sudden death in an HCM patient without recognized high-risk markers is not zero; however, whether sports increase that risk has not yet been described. Our ongoing study, "Lifestyle and Exercise in HCM" ("LIVE-HCM") may help determine whether vigorous exercise increases risk. For many patients, talking about approaches to risk in general can be helpful. For example, many sports (football) and activities (mountain climbing) carry intrinsic risk. Some patients and families choose to live in ways that avoid any avoidable risk, whereas others do not.

This shared decision-making approach requires a combination of knowledge of the data and willingness to engage the patient (and often family) as partners in the decision-making process. Most importantly, we need to stress that we do not have all the answers while providing a framework for decision-making.

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