The Heart of Trained Athletes
Cardiac Remodeling and the Risks of Sports, Including Sudden Death

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Young competitive athletes are widely regarded as a special subgroup of healthy individuals with a unique lifestyle who are seemingly invulnerable and often capable of extraordinary physical achievement.1–3 For more than 100 years, there has been considerable interest in the effects of intense athletic conditioning on the cardiovascular system.4–27 The advent of echocardiography more than 30 years ago provided a noninvasive quantitative assessment of cardiac remodeling associated with systematic training, and consequently, a vast body of literature has been assembled that is focused on the constellation of alterations known as “athlete’s heart.”4–27

Athlete’s heart is generally regarded as a benign increase in cardiac mass, with specific circulatory and cardiac morphological alterations, that represents a physiological adaptation to systematic training.1,6–27 However, the clinical profile of athlete’s heart has expanded considerably over the last several years as a result of greater accessibility to large populations of trained athletes studied systematically with echocardiography, ECG, cardiac magnetic resonance, and ambulatory Holter ECG monitoring. As a consequence, there is increasing recognition of the impact that prolonged conditioning has on cardiac remodeling, which may eventually mimic certain pathological conditions with the potential for sudden death or disease progression.

Over the last several years, sudden deaths of trained athletes, usually associated with exercise, have become highly visible events fueled by news media reports and with substantial impact on both the physician and lay communities.1,28–36 Interest in these tragic events has accelerated owing to their increased recognition; awareness that underlying, clinically identifiable cardiovascular diseases are often responsible; and the availability of treatments to prevent sudden death for high-risk athlete-patients. In the present review, we offer a comprehensive assessment of many issues that target the interrelation of intense physical exertion with cardiac structure and function, as well as the rare, potentially adverse consequences of sports.

Athlete’s Heart

Historical Perspectives
The concept that the cardiovascular system of trained athletes differs structurally and functionally from others in the normal general population remarkably extends over a century.4 During that time, there has also been periodic controversy about the true nature of athlete’s heart, ie, whether the findings are physiologically adapted, benign, and related only to training, or alternatively are potentially pathological and the harbinger of disease and disability.

The clinical entity of athlete’s heart has been defined with increasing precision using a variety of techniques. Henschen is credited with the first description in 1899, using only a basic physical examination with careful percussion to recognize enlargement of the heart caused by athletic activity in cross-country skiers.5 Henschen concluded that both dilatation and hypertrophy were present, involving both the left and right sides of the heart, and that these changes were normal and favorable: “Skiing causes an enlargement of the heart which can perform more work than a normal heart.”5 Subsequent investigators used quantitative chest radiography to show that heart size was increased in athletes, particularly those engaged in endurance sports with large aerobic requirements. Some early observers even regarded the heart of the trained athlete to be weakened owing to the “strain” created by continuous and excessively strenuous training and believed that athletes were subject to deteriorating cardiac function and heart failure.4

Physiology
Cardiovascular adaptations to exercise have been systematically defined and differ with respect to the type of conditioning: endurance training (sometimes also described as dynamic, isotonic, or aerobic) such as long-distance running and swimming; and strength training (also referred to as static, isometric, power, or anaerobic) such as wrestling, weightlifting, or throwing heavy objects.37 Sports such as cycling and rowing are examples of combined endurance and strength exercise. Most athletic disciplines to some extent combine endurance and strength modes of physical conditioning, and training-related physiological alterations represent a complex set of central and peripheral mechanisms operating at structural, metabolic, and regulatory levels.

Acute responses to endurance exercise training include substantial increases in maximum oxygen consumption, cardiac output, stroke volume, and systolic blood pressure,
associated with decreased peripheral vascular resistance. The immediate results of strength conditioning include only mildly increased oxygen consumption and cardiac output but substantial increases in blood pressure, peripheral vascular resistance, and heart rate.

Long-term cardiovascular adaptation to dynamic training produces increased maximal oxygen uptake due to increased cardiac output and arteriovenous oxygen difference. Strength exercise results in little or no increase in oxygen uptake. Thus, endurance exercise predominantly produces volume
load on the left ventricle (LV), and strength exercise causes largely a pressure load.

**Chamber Morphology**

Cardiac dimensional alterations associated with athletic training have been defined over the past 35 years in a number of cross-sectional echocardiographic (or cardiac magnetic resonance) studies, usually performed in highly trained individuals.1,6,9–26,38–42 The responses of individual athletes to systematic conditioning are not uniform. Training induces in approximately 50% of trained athletes some evidence of cardiac remodeling, which consists of alterations in ventricular chamber dimensions, including increased left and right ventricular and left atrial cavity size (and volume), associated with normal systolic and diastolic function (Figure 1). For example, marked enlargement of the LV chamber (≥60 mm) occurs in approximately 15% of highly trained athletes.10 This chamber enlargement may very occasionally be accompanied by a relatively mild increase in absolute LV wall thickness that exceeds upper normal limits (range 13 to 15 mm).9 LV remodeling with changes in mass is dynamic in nature and may appear to develop relatively rapidly, or more gradually, after the initiation of vigorous conditioning. Such changes, which are reversible with cessation of training, are most impressive in endurance athletes.18–20,27 However, there is considerable overlap in cardiac dimensions between a trained athlete population and age- and sex-matched sedentary controls.42 Athletes show relatively small (but statistically significant) increases of approximately 10% to 20% for wall thickness or cavity size, and these values in most individual athletes remain within accepted normal limits.42

The pattern and magnitude of physiologically increased LV mass may vary with respect to the nature of sports training13,27,41 (Figure 2). One metaanalysis15 and also the large database assembled at the Institute of Sports Medicine and Science (Rome, Italy)9–11,20–22,39,41 support in part an earlier hypothesis8 that specific morphological adaptations and changes in LV mass result from systematic training in different sports disciplines. The most extreme increases in cavity dimension or wall thickness have been observed in those elite athletes training in rowing, cross-country skiing, cycling, and swimming,9–11,20–22,26,39,41 whereas limited data in athletes participating in ultraendurance sports (such as triathlons) paradoxically show more modest alterations in cardiac dimensions.1,12 Of note, some misunderstanding persists as to whether strength training alone results in LV hypertrophy. Such sports are associated with only mildly increased wall thicknesses (often disproportionate relative to cavity size), whereas absolute values uncorrected for body surface area usually remain within the accepted normal range (≤12 mm; Figure 2).1,15,38,39,41,42

Increases in LV cavity size and calculated mass associated with athletic training are determined in part by body surface area (or lean body mass).9–11,13 Larger athletes (particularly men) will generally demonstrate greater absolute LV cavity and wall thickness dimensions. However, the relative contributions of demographic and environmental or genetic determinants to LV remodeling in trained athletes has long been a subject of controversy.43 Data assembled in large athlete populations assessed with multivariate analysis show that 75% of variability in LV cavity size is attributable to nongenetic factors, such as body size, type of sport, gender, and age, with body surface area the largest of these components10 (Figure 3). The remaining 25% of cavity size variability is otherwise unexplained40,43 and possibly caused in small part by genetic factors. Indeed, recent investigations in trained athletes have demonstrated an association between LV remodeling (and increased LV mass in response to training) and the angiotensin-converting enzyme gene I/D (ACE I/D) and/or angiotensinogen (AGT M/T) polymorphisms.33,44 There is no compelling evidence linking the magnitude of training-related cardiac dimensional changes in athletes with the level of performance during competition.

Left atrial remodeling is an additional physiological adaptation frequently present in highly trained athletes, most commonly those in combined static and dynamic sports (ie, cycling and rowing), and is largely explained by associated LV cavity enlargement and volume overload.22 Increased transverse left atrial dimensions (≥40 mm) are present in 20% of athletes and more substantially enlarged dimensions (≥45 mm) are evident in 2%. These latter dimensions overlap

**Figure 2.** Effect of specific sports training on LV cavity dimension or wall thickness in elite athletes, representing 27 different sporting disciplines. X-Country indicates cross-country; L.D. Running, long-distance running.

**Figure 3.** Impact of different clinical variables on LV end-diastolic cavity dimensions in a large population of male and female elite athletes. The relative impact of the examined variables (body size, gender, age, and type of sport) are shown here as a proportion of overall variability in LV cavity size.
with those observed in patients with cardiac disease (Figure 1). Nevertheless, left atrial enlargement in athletes appears to be benign and largely confined to training in endurance sports, and is only rarely associated with atrial fibrillation (<1% of cases).22,45

12-Lead ECGs
In cross-sectional analysis, a spectrum of abnormal ECG patterns is present in ~40% of trained athletes, occurring 2-fold more commonly in men than women, and particularly in those participating in endurance sports25 (Figure 4). Therefore, most athletes have ECGs that are within normal limits or that show only minimal alterations. However, the frequency with which these ECG patterns occur is highly dependent on the type, intensity, level of training, and precise criteria used to define normality (Figure 4). The most commonly reported alterations are early repolarization patterns, increased QRS voltages, diffuse T-wave inversion, and deep Q waves.8,25,46,47 Distinctly abnormal and bizarre ECGs, intuitively suggestive of cardiac disease, are encountered in an important minority of elite athletes (~15%).25 The vast majority of such ECGs represent only extreme manifestations of physiological athlete’s heart.

Arrhythmias
Because of the heightened vagal tone that accompanies physical conditioning, trained athletes are known to commonly incur innocent arrhythmias and conduction alterations, such as sinus bradycardia, junctional rhythm, and first-degree or Wenckebach AV block (Mobitz type I).1,26,46,47 However, the application of ambulatory (Holter) ECG monitoring to trained athletes unexpectedly documented substantial ectopy with frequent premature beats and complex ventricular tachyarrhythmias (including couplets and bursts of nonsustained ventricular tachycardia) in many such individuals.48,49 These findings suggest that a variety of arrhythmias are part of the athlete’s heart spectrum (Figure 5). Indeed, such rhythm disturbances have not been associated with adverse clinical events and are usually abolished or substantially reduced after relatively brief periods of deconditioning (as well as during physical training sessions and exercise testing). Even in athletes with heart disease, resolution of ventricular tachyarrhythmias with deconditioning is common and may represent a potential mechanism by which sudden death risk is reduced by withdrawal of these individuals from training and competition,49,50 in accord with consensus panel recommendations.2

A few observational studies have reported mild-to-moderate postrace elevations in biochemical cardiac-specific markers (plasma cardiac troponin T and I) suggestive of transient myocardial injury in some participants after prolonged and strenuous endurance athletic events, such as triathlons and marathons.51,52 At present, there is no evidence that these subclinical findings are associated with permanent

Figure 4. Relation of ECG patterns to sporting disciplines in 1005 highly trained athletes. ECGs that were distinctly abnormal (black bars), mildly abnormal (gray bars), and normal or with minor alterations (white bars) are depicted as proportions of all the athletes participating in each sporting discipline. X-C indicates cross-country. Reproduced from Pelliccia et al25 with permission of the American Heart Association. Copyright 2000.
clinical consequences. Some studies have also identified transient and reversible systolic and diastolic dysfunction after extreme athletic events.51,52 Although data defining the physiological and morphological adaptations of systematic training are considerable, it nevertheless remains unresolved whether the current profile of athlete’s heart can be extrapolated to all subgroups within this physically active and diverse population: those of different ages, sports disciplines, and racial or ethnic origin.9–18 Much of the available cardiac dimensional data have been assembled from white European athletes, particularly the large cohort at the Institute of Sports Medicine and Science comprising elite Italian national and international level competitors.9-11,20-22,25,39,48,49,51 Indeed, there are limited data defining the adaptations of athlete’s heart in females, in modestly trained individuals in youth sports programs, and in blacks and other minorities.

Sudden Death in Young Athletes

Background and Frequency

Sudden death occurring in young athletic individuals was once regarded as a mysterious and undefined syndrome; however, a voluminous body of literature defining the cardiovascular and other causes of these catastrophes has been assembled over the last several years.1,28–36,50,53–57 Nevertheless, the perception persists in the community that it is counterintuitive for young and highly trained high school, college, or professional athletes to unknowingly harbor potentially lethal cardiovascular disease susceptible to sudden and unexpected death.

These events convey a devastating emotional impact to families and the community at large.1,28,29 Once regarded as rare personal and family tragedies, sudden deaths in young athletes have been increasingly integrated into the public discourse. Although initially reported in the United States in the early 1980s,55 the causes of sudden death in young athletes and related issues (eg, preparticipation screening and disqualification criteria)1–3,57,58 have more recently become the focus of increasing concern in other parts of the world, including Europe, where a cluster of 7 recent deaths in elite athletes competing in soccer, hockey, and skating has occurred.58

Data establishing the prevalence of sudden death in athletes with precision are quite limited, although it is evident...
that the overall risk in this population is low. A 12-year
survey from Minnesota reported a frequency of sudden death
caused by undiagnosed cardiovascular disease in high school
athletes of 1:200 000/year (based on only 3 deaths among 1.4
million student-athlete sports participations in 27 sports).34

Mechanisms and Causes
Sudden death in young athletes usually occurs on the athletic
field and is related to physical activity, in the absence of prior
symptoms.1,28–36,50,53–56,59 Indeed, the incremental risk for
sudden death in adolescents and young adults is significantly
higher (ie, 2.8-fold greater) when associated with vigorous
physical exertion during competitive sports.36 Exercise acts as
a trigger for lethal ventricular tachyarrhythmias, given the
susceptibility imposed by underlying (and usually unsus-
pected) cardiac disease.33,36

A number of largely congenital and often clinically silent
cardiovascular diseases have been causally linked to sudden
deaths in young trained athletes in autopsy surveys (Figures 6
and 7). In the United States, hypertrophic cardiomyopathy
(HCM)1,32,33,35 has been consistently reported to be the single
most common cardiovascular cause, accounting for approxi-
mately one third of the deaths. Indeed, 3 recent and highly
visible sudden deaths or cardiac arrests that occurred in US
professional athletes were each caused by HCM (Jason
Collier [sudden death], Thomas Herrion [sudden death], and
Jiri Fischer [cardiac arrest]), as was 1 notable sudden death in
a Cameroon soccer player with previously diagnosed HCM
that occurred during a televised international match.58

Approximately 2% of young athletes who die suddenly are
reported to show normal cardiac structure on standard au-
topsy examination.1,33 Many of these deaths are likely caused
by ion-channel disorders (long-QT and Brugada syndromes
and catecholaminergic polymorphic tachycardia), Wolff-
Parkinson-White syndrome, coronary artery vasospasm, or
abnormalities of the conducting system and microvascula-
ture.33 Occasionally, a tunneled segment of the left anterior
descending coronary artery is the only structural abnormality
evident at autopsy to explain sudden death33; however, it is
unresolved whether this malformation can be regarded as the
sole cause of sudden death.1 In contrast, sudden deaths in
older athletes (>35 or 40 years) are caused predominantly by
atherosclerotic coronary artery disease.1 Primary ventricular
tachyarrhythmias are the mechanism of the vast majority of
sudden deaths in athletes, with Marfan syndrome and aortic
dissection the exceptions.

An alternative demographic profile has emerged from the
Veneto region of northeastern Italy in which ARVC61 is
reported to be the most common cause of athletic field
deaths.36 Such a predisposition to ARVC, which contrasts
sharply with the US experience, could be based on a unique
genetic substrate or the consequence of the long-standing
Italian national preparticipation screening program,62 or both.
Such systematic screening is less likely to identify and
disqualify from competition athletes with ARVC than those
with diseases more readily identified by screening, such as
HCM.63

Demographics
Sudden cardiovascular death may occur in a wide variety of
more than 30 competitive athletic disciplines, most com-

Figure 6. Causes of sudden death in
young competitive athletes, as reported
to the Minneapolis Heart Institute Foun-
dation national registry. Ao indicates
aorta; art., artery; AS, aortic stenosis;
CAD, coronary artery disease; DCM,
dilated cardiomyopathy; LQTS, long-QT
syndrome; LVH, LV hypertrophy; MV,
mitrval valve; and pts, patients.
These deaths are caused by severe blunt head, spine, and other bodily trauma (eg, during football or pole vaulting), heat stroke, uncontrolled bronchial asthma, ruptured cerebral artery aneurysm, and possibly sickle cell trait. Stroke, myocardial infarction, and sudden death have been linked to substance abuse with cocaine, anabolic steroids, or nutritional supplements (including ephedrine).

Two other circumstances in which trauma-related sudden death occurs during sports involve blunt, nonpenetrating, and often innocent-appearing blows to the precordium or neck (Figures 8 and 9). Virtually instantaneous death has been reported during ice hockey in which high-velocity blows to the neck by the puck trigger arterial rupture and subarachnoid hemorrhage (Figure 9). The likely mechanism is reflex.

Figure 7. Causes of sudden cardiac death in young competitive athletes. A, HCM. Gross heart specimen showing asymmetrical ventricular septal (VS) thickening. B, Idiopathic dilated cardiomyopathy showing greatly enlarged LV cavity. C, HCM. Histopathology showing substrate of disorganized cardiac muscle cells and chaotic architectural pattern. D, ARVC. Histological section of right ventricle showing extensive fatty replacement adjacent to small area of residual myocytes. E, Myocarditis. LV myocardium with clusters of inflammatory mononuclear cells. F, Premature coronary artery disease. Portion of right coronary artery with atherosclerotic narrowing and ruptured plaque. Adapted from Maron1 with permission of the Massachusetts Medical Society. Copyright 2003.

Blacks account for a disproportionate number of sports-related sudden deaths owing to previously undiagnosed HCM.1,32,33,35 This observation contrasts sharply with the striking underrepresentation of blacks in clinically identified HCM populations, suggesting that socioeconomic status and ethnicity may play an important role in determining access to echocardiography and consequently the clinical diagnosis of HCM.

Other Risks of Sports
A substantial number of other sudden deaths in athletes occur in the absence of cardiac disease and under diverse circumstances.1,34,56 These deaths are caused by severe blunt head, spine, and other bodily trauma (eg, during football or pole vaulting), heat stroke, uncontrolled bronchial asthma, ruptured cerebral artery aneurysm, and possibly sickle cell trait. Stroke, myocardial infarction, and sudden death have been linked to substance abuse with cocaine, anabolic steroids, or nutritional supplements (including ephedrine).64

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Figure 8. Blow to an unprotected area of the upper neck by a hockey puck (accompanied by abrupt reflex hyperextension) can result in sudden death (upper panel). Mechanism involves arterial dissection and rupture at the anatomic point where the vertebral artery courses through the bony canal of the foramina transversarium and penetrates the posterior atlanto-occipital membrane or dura mater (lower panel). Vertebral artery is rigidly anchored at this point (as it enters the transverse process of the first cervical vertebra) and becomes the point of rupture leading to massive hemorrhage into the subarachnoid space and instantaneous death. Lt. indicates left; Rt., right.
hyperextension of the head that causes vertebral artery dissection at its fixed anchor point within the foramina transversarium.

More commonly, precordial blows may trigger ventricular fibrillation without structural injury to ribs, sternum, or the heart itself (commotio cordis56,65; Figure 10). These events are more common causes of athletic field deaths than most of the aforementioned cardiovascular diseases (Figure 6). Commotio cordis is most frequently caused by projectiles that are implements of the game and strike the chest at a broad range of velocities (eg, hockey pucks or lacrosse balls [up to 90 mph]), but more frequently result from blows with only modest force (eg, a pitched Little League baseball striking a batter at 30 to 40 mph) or by virtue of bodily contact (eg, a karate blow or when 2 outfielders tracking a baseball collide).56

On the basis of clinical observations and an experimental animal model (which replicates commotio cordis), the mechanism by which ventricular fibrillation and sudden death occur requires a blow directly over the heart, exquisitely timed to within a narrow 10- to 30-ms window just before the T-wave peak during the vulnerable phase of repolarization.65 Basic electrophysiological mechanisms of commotio cordis are largely unresolved, although selective K⁺ ATP channel activation appears to play a role.1

Only ≈15% of commotio cordis victims survive, usually in association with timely cardiopulmonary resuscitation and defibrillation.56 However, there are reports of both successful66 and unsuccessful resuscitation with automated external defibrillators.57 Strategies for primary prevention of commotio cordis include innovations in sports equipment design. However, although softer-than-normal (“safety”) baseballs reduce the frequency of ventricular fibrillation under exper-

Figure 9. Stop-frame images of an aborted commotio cordis event during a televised professional hockey game. A, Flight of the puck from a slap shot (arrowheads and arrow) toward the victim (*). B through F, After precordial blow, victim (*) is seen progressively falling toward the surface of the ice. E and F, Enlarged stop frames showing final collapse.

Figure 10. Differential diagnosis between athlete’s heart and cardiac disease. Gray zone of overlap between physiological hypertrophy and pathological cardiomyopathies (including myocarditis, HCM, and ARVC). Adapted from Maron1 with permission of the Massachusetts Medical Society. Copyright 2003.
Athlete’s Heart and Cardiovascular Disease

Because of the potentially adverse consequences of underlying cardiovascular disease in young athletes, considerable attention has been focused on clinically distinguishing physiologically based athlete’s heart from a variety of structural heart diseases (Figure 10).1,7,19,20,22,24,71,72 This differential diagnosis has critical implications for dedicated athletes (and their physicians) because cardiovascular disease may represent the basis for disqualification from competitive sports to reduce the risk of sudden death.2,57 Furthermore, some athletes with cardiac disease judged to be at high risk may subsequently become candidates for an implantable defibrillator and prophylactic prevention of sudden death.1,73

Diagnostic dilemmas arise when the remodeling adaptations of athlete’s heart mimic certain pathological conditions, such as hypertrophic and dilated cardiomyopathies and ARVC (Figure 10). This circumstance may arise in athletes because of distinctly abnormal ECGs, or when absolute cardiac dimensions fall outside clinically accepted partition values (eg, >12 mm for LV wall thickness and ≥55 to 60 mm for LV cavity size at end diastole; somewhat lower cut points apply to female and adolescent athletes).11,24 For example, ≈2% of elite adult male athletes have been reported to show modestly increased LV wall thickness of 13 to 15 mm, which defines a “gray zone” of overlap between the extreme expressions of athlete’s heart and a mild HCM phenotype (without marked hypertrophy or outflow obstruction; Figure 11).7,9 This ambiguity can be resolved by the application of a number of noninvasive parameters, such as reduced cardiac mass with short deconditioning periods (best assessed with serial magnetic resonance imaging) or absolute LV diastolic dimension >55 mm, both of which suggest athlete’s heart.7 In contrast, an HCM diagnosis would be favored by abnormal Doppler-derived LV diastolic filling or relaxation indices or by the existence of a family member with HCM. Magnetic resonance imaging has value in resolving the HCM-versus–athlete’s heart differential diagnosis in selected athletes by virtue of its superiority over echocardiography in identifying segmental LV hypertrophy in the anterolateral free wall or apex.74

Rapid commercial laboratory testing is now available for both HCM75 and cardiac ion channel mutations,76 with the potential for achieving a DNA-based diagnosis. If a proband is positive for one of the known disease-causing mutant genes in the panel, the result is definitive. On the other hand, genetic testing has certain potential limitations. For example, negative tests are common but nondiagnostic because they may represent false-negative results. In addition, such commercial testing is costly (in the range of $5000), and it is uncertain whether that expense will be covered by insurance carriers. However, if the family gene defect is known, then all other relatives can be tested definitively and inexpensively.

Marked LV cavity enlargement in an athlete, even in the absence of cardiac symptoms, may intuitively raise the differential diagnosis between physiological hypertrophy and pathological cardiomyopathies,1,10,21 particularly when ejection fraction is judged to be at the lower range of normal or mildly depressed. This difficult clinical situation can often be resolved by surveillance with serial testing of ejection fraction at rest and with exercise, after disqualification from sports.

Complex and frequent ventricular tachyarrhythmias evident on ambulatory Holter ECG in trained athletes without cardiovascular abnormalities48,49 can raise the possibility of disease states such as myocarditis, for which a high index of clinical suspicion is required.7,48 Periods of forced deconditioning may not be useful in resolving such differential diagnoses, because detraining is associated with reduction (and even abolition) of ventricular tachyarrhythmias in athletes both without and with underlying pathological substrates (Figure 5).49
Long-Term Consequences of Athlete’s Heart

Extreme LV remodeling evident in some highly trained athletes has intuitively raised a concern of whether such exercise-related morphological adaptations are always innocent. For example, ≈15% of highly trained athletes show striking LV cavity enlargement, with end-diastolic dimensions ≥60 mm, similar in magnitude to that evident in pathological forms of dilated cardiomyopathy.1,10,21 One longitudinal echocardiographic study reported incomplete reversal of extreme LV cavity dilatation with deconditioning; substantial chamber enlargement persisted in 20% of retired and deconditioned former elite athletes after 5 years (Figure 12).21 There is no evidence at present showing that athlete’s heart remodeling leads to long-term disease progression, cardiovascular disability, or sudden cardiac death. The possibility that persistence of extreme remodeling after prolonged and intensive conditioning will ultimately convey deleterious cardiovascular consequences to some athletes is perhaps unlikely but at this time cannot be excluded with certainty.

Cardiovascular Criteria for Disqualification From Sports

The devastating impact of even relatively infrequent sudden deaths in young athletes offers justification for restriction from competition to reduce the risk related to silent and unsuspected cardiac disease. For athletes in whom cardiovascular disease has been identified (either by preparticipation screening3,63 or under other circumstances), important considerations arise with respect to the appropriate formulation of eligibility and disqualification decisions for competitive sports. The 2005 American College of Cardiology 36th Bethesda Conference2 and European Society of Cardiology (ESC)57 consensus documents offer expert panel recommendations and clear benchmarks for clinical practice, largely focused on amateur competitive athletes. Panel recommendations for athletic eligibility are based on the premise that intense sports training and competition increase risk for sudden death or disease progression in susceptible athletes with heart disease1,28–33,36,50 and that this risk can be reduced or minimized by either temporary or permanent withdrawal from sports.2,49,57 Indeed, the US appellate court decision in Knapp v Northwestern30 supports the use of national association medical guidelines (such as those of the Bethesda Conference) in justifying disqualification decisions in athletes. Therefore, team physicians would be prudent to rely on Bethesda Conference No. 36 in making difficult disqualification decisions, because it will likely play an important role as precedent in resolving future medical-legal disputes.

The recent ESC consensus report57 assessing eligibility criteria for competitive athletes with cardiovascular disease is modeled after the Bethesda Conference.2 Although the 2 guidelines are very similar, the European recommendations are selectively more restrictive in advising disqualification for certain cardiac conditions, including long-QT syndrome, HCM, and Marfan syndrome, particularly when diagnostic cardiac findings are borderline.

The assumptions with regard to sports, cardiovascular disease, and sudden death in these consensus guidelines are intuitive and justified, although the precise risks for sports participants with cardiac disease are not easily quantifiable, nor can this problem be subjected to formally controlled and evidence-based study designs. Nevertheless, there is preliminary evidence that the disqualification strategies of the Bethesda Conference2 and the ESC57 may minimize risk and thereby reduce the number of sudden deaths in young athletes.

Italian investigators attribute a decline in the rate of sudden cardiac death during sports to their long-standing systematic national preparticipation screening program, which routinely includes a 12-lead ECG.19 They report an almost 90% decline in the annual incidence of sudden cardiovascular death in competitive athletes (largely owing to reduced mortality from cardiomyopathy) from the Veneto region of northeastern Italy.19 This positive change occurred in parallel with progressive implementation of nationwide mass screening and the increasing identification of affected athletes who were then disqualified from competitive sports.

However, decisions to withdraw elite athletes from sports because of heart disease may be confounded by complex societal considerations and can prove difficult to implement, particularly when elite sports careers are involved.28–30 Many such athletes are highly motivated to remain in the competitive arena, may not fully appreciate the implications of the relevant medical information, or are willing to accept risks while resisting prudent recommendations to withdraw.

Figure 12. Cardiac remodeling caused by long-term deconditioning. Serial LV end-diastolic cavity dimensions and maximum LV wall thicknesses at peak training compared with measurements after an average detraining period of 5.6 years. Reproduced from Pelliccia et al21 with permission of the American Heart Association. Copyright 2002.
contrast to countries such as Italy, national standards linked to mandatory disqualification are not part of the US healthcare system. Improper overdiagnosis of cardiac disease may lead to unnecessary disqualification from athletics, thereby depriving some individuals of the psychological and economic benefits of competitive sports. As a cautionary note, physician judgment in making these medical eligibility/disqualification decisions can be impaired impossibly by extrinsic pressures imposed by relatives, fans, alumni, coaching staff, administrators, and other interested parties, particularly when athletes “shop” for multiple medical opinions.

The relationship between sports medicine and the law is complex and involves tenuous relationships between physicians, athlete-patients, teams, and institutions. Indeed, liability issues relevant to the management of competitive athletes with cardiovascular disease have become of increasing concern to the practicing medical community, given that several athlete deaths have triggered attempts in court to hold physicians accountable for alleged grievances. An evolving US medicolegal framework is clarifying the standard of care associated with this clinical practice while upholding the wisdom of withholding selected student-athletes with cardiovascular abnormalities from access to competitive sports programs in an effort to prevent their exposure to medically unacceptable risks.

Disclosures

None.

References


