

Auscultation of HCM

- *Left ventricular outflow tract (LVOT) obstruction*
 - Harsh systolic ejection murmur best heard at left sternal border
 - Does not radiate to carotid a. (vs. valvular aortic valve stenosis [AS])
 - Effects of maneuvers are different from valvular AS (see below)
- *Mitral valve regurgitation*
 - Caused by systolic anterior movement (SAM) of mitral valve
 - Holosystolic murmur best heard at apex
 - Murmur of MR caused by HCM acts differently than other MR murmurs
 - Increase in preload and afterload increases typical MR murmur
 - Increase in preload and afterload decreases HCM type of MR murmur

Maneuvers

- LVOT obstruction creates a **dynamic gradient** due to the drag of mitral valve during SAM.
- Maneuvers that **decrease LV volume** will **increase gradient** and therefore increase the intensity of the murmur. Conversely, an **increase of LV volume** will decrease the intensity of the murmur.
- **↑ murmur**
 - ↑ contractility
 1. Post-premature ventricular contraction beat (*Brockenbrough response*)
 2. Dopamine: Positive inotropic effect
 3. Digoxin: Positive inotropic effect
 - ↓ preload
 1. Straining phase of Valsalva: This maneuver produces a positive intrathoracic pressure → venous return ↓ → LVEDV ↓
 2. Standing: Blood pools in the capillary bed due to gravity → venous return ↓
 3. Nitroglycerin: Venodilation → venous capacitance ↑ → venous return ↓
 - ↓ afterload
 1. Amyl nitrite: Vasodilation of arterioles → Systemic vascular resistance ↓
- **↓ murmur**
 - ↓ contractility
 1. β-blockers: Negative inotropic effect
 2. Verapamil (CCB): Negative inotropic effect
 3. Disopyramide (Class I antiarrhythmic): Negative inotropic effect
 - ↑ preload
 1. Passive leg rising: Venous return ↑
 2. Pregnancy: Expansion of blood volume
 - ↑ afterload
 1. Squatting (also ↑ preload): Reverse of standing
 2. Handgrip: Compression of the arteries of the arm