Amyloid in the cardiovascular system: a review

I Kholová, H W M Niessen

The cardiovascular system is a common target of amyloidosis. This review presents the current clinical and diagnostic approach to amyloidosis, with the emphasis on cardiovascular involvement. It summarises recent nomenclature, classification, and pathogenesis of amyloidosis. In addition, non-invasive possibilities are discussed, together with endomyocardial biopsies in the diagnosis of cardiac amyloidosis. Finally, recent advances in treatment and prognostic implications are presented.

Amyloidosis is a generic term that encompasses a large group of diverse diseases rather than a single disease entity. By definition, the only diagnosis of amyloidosis is morphological assessment of cytological/histological or postmortem material. Despite the fact that morphologically proteinaceous deposits are identical, these proteins are chemically different and can be identified and classified by immunohistochemical/biochemical analysis. The primary structure of these proteins is crucial to the formation of amyloid, its sites of deposition, and the clinical symptoms. Amyloid deposits may be found in any part of the body. Remarkably, amyloid may be found in the absence of clinical manifestations.

DEFINITION, NOMENCLATURE, AND CHEMICAL CHARACTERISTICS

Amyloidosis is characterised by the extracellular deposition and accumulation of insoluble fibrillar proteins, with concomitant destruction of normal tissue structure and function. Amyloid fibrils are arranged in an antiparallel conformation with a β pleated sheet structure. It is recommended that amyloid and amyloidosis should be classified by the fibrillar protein forming the amyloid deposits. The current nomenclature of amyloidosis is based on the nature of the major fibrillar protein, which is designated protein A, followed by an abbreviation of the protein name. Eighteen proteins, 19 if lactoferrin is included, have been identified to date. Table 1 summarises the main protein types causing amyloidosis.

“It is recommended that amyloid and amyloidosis should be classified by the fibrillar protein forming the amyloid deposits”

In addition to the fibrils, which characterise the material as amyloid, it contains other components, which are common to most types of amyloid. These include serum amyloid P component, amyloid enhancing factor, and glycosaminoglycans. Other basement membrane components, including fibronectin, laminin, and collagen IV, may also be found in amyloid deposits.

PATHOPHYSIOLOGY

Although at least 18 different amyloidogenic proteins have been recognised, identical processes are probably involved in the formation of the amyloid fibrils, which are remarkably similar to each other, despite the biochemical differences. Protein species with a conformation that allows ordered self assembly are needed for fibril formation. The process is performed either by partial unfolding of the native protein (for example, light chain immunoglobulin), by proteolytic cleavage (for example, lactadherin), or by adoption of a secondary structure in a peptide with a random coil. Many precursors of amyloid play a role as molecular carriers, others form multipeptide complexes.

The mechanism by which amyloid aggregation causes tissue damage and consequent organ dysfunction has been widely discussed and studied. Amyloid deposition can disturb the tissue architecture and lead to organ dysfunction. Local cytotoxicity and interactions with local receptors can also influence organ function. Free radical injury mechanisms have been suggested in amyloidogenesis in several types of amyloidosis. Recently, it has been shown that light chain proteins from patients with amyloid cardiomyopathy can alter the cellular redox state in cultured cardiomyocytes. In addition, both in vivo and in vitro evidence has shown that amyloid can induce apoptosis.

CLINICAL CLASSIFICATION

In clinical practice, amyloidosis is classified as primary, secondary, hereditary, and age related. Primary (idiopathic, systemic) amyloidosis appears with no antecedent or coexisting disease, it involves mesenchymal organs such as the cardiovascular system, gastrointestinal tract, and muscle tissue, and tends to form nodular deposits. Cardiac involvement is common. Secondary (reactive) amyloidosis is associated with chronic diseases, and has a tendency to deposit in parenchymal organs such as the liver, spleen, and kidneys. The heart is involved only rarely. The hereditary amyloidoses are usually inherited in an autosomal dominant fashion, with only a few autosomal recessive forms such

Abbreviations: ANF, atrial natriuretic factor; IAA, isolated atrial amyloidosis; SAA, serum amyloid A; SSA, systemic senile amyloidosis; TTR, transthyretin
The heart is the main target. Increases with aging and is not related to concurrent disease. Senile type. Age is the only risk factor. The incidence classified as either the isolated atrial form or the systemic form. Of note is the male and age preponderance: 60–65% of patients with amyloidosis are men and only 1% of patients are younger than 40 years of age. As familial Mediterranean fever and familial corneal amyloidosis. Cardiac involvement is rare and usually occurs late in the disease. Age related (elderly) amyloidosis is classified as either the isolated atrial form or the systemic senile type. Age is the only risk factor. The incidence increases with aging and is not related to concurrent disease. The heart is the main target.

**CARDIAC CLINICAL MANIFESTATIONS**

In general, the symptoms of amyloidosis are non-specific. Cardiac amyloid involvement may simulate cardiomyopathy, congestive heart failure, coronary heart disease, valvular heart disease, or arrhythmia. Table 2 lists the clinical features of cardiac amyloid involvement. Unusual features include spontaneous resolution of hypertension and hemi blocks.

Initial symptoms that might lead to the suspicion of cardiac amyloidosis include fatigue, dyspnoea, purpura, macroglossia, atypical chest pain, hepatomegaly, peripheral oedema, arhythmia, and systolic murmur. Predominantly right sided heart failure is the most common clinical feature. In addition, coronary heart disease is often incorrectly diagnosed.

Of note is the male and age preponderance: 60–65% of patients with amyloidosis are men and only 1% of patients are younger than 40 years of age.

**DIAGNOSIS**

The expanding number of amyloidogenic proteins causes difficulties in formulating a correct diagnosis. The identification of amyloidogenic proteins has paramount importance for treatment and prognosis. The diagnostic approach should be multidisciplinary and include clinical examination, biochemical tests, imaging, and genetic analysis to assess the extent of the disease and its complications.

**Misdiagnosis**

Unfortunately, because many of the clinical signs of amyloidosis are non-specific, they are often misinterpreted. Fatigue may be misdiagnosed as functional or stress related. Purpura may be misdiagnosed as senile purpura or purpura simplex. Involvement of submandibular salivary glands may be interpreted as submandibular lymphadenopathy and consequent xerostomia as Sjögren syndrome. Increased sedimentation often leads to a diagnosis of polymyalgia rheumatica.

**Non-invasive tests**

A diagnostic approach to patients with suspected cardiac amyloidosis might include the following non-invasive methods to help in establishing the diagnosis: electrocardiography, echocardiography including Doppler mode, chest radiography, magnetic resonance imaging, radionuclide imaging of radio-labelled amyloid P protein, protein electrophoresis to search for monoclonal immunoglobulins in serum and urine, abnormal transthyretin or amyloid A protein in serum, and genetic testing for suspected hereditary amyloid disorders.

Table 1: Main protein types causing amyloidosis with the emphasis on cardiovascular system involvement

<table>
<thead>
<tr>
<th>Amyloid protein</th>
<th>Precursor</th>
<th>Distribution</th>
<th>Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>Immunoglobulin light chain</td>
<td>Systemic/localised</td>
<td>Primary/myeloma associated</td>
</tr>
<tr>
<td>AH</td>
<td>Immunoglobulin heavy chain</td>
<td>Systemic/localised</td>
<td>Primary/myeloma associated</td>
</tr>
<tr>
<td>AA</td>
<td>Serum amyloid A</td>
<td>Systemic</td>
<td>Secondary</td>
</tr>
<tr>
<td>Aβ, Microglobulin</td>
<td>β Microglobulin</td>
<td>Systemic</td>
<td>Secondary</td>
</tr>
<tr>
<td>ATTR</td>
<td>Transthyretin</td>
<td>Systemic</td>
<td>Systemic/familial</td>
</tr>
<tr>
<td>AANF</td>
<td>Atrial natriuretic factor</td>
<td>Systemic</td>
<td>Atrial isolated</td>
</tr>
<tr>
<td>AApoA-I</td>
<td>Apolipoprotein A-I</td>
<td>Localised/systemic</td>
<td>Aortic/familial</td>
</tr>
<tr>
<td>AApoA-II</td>
<td>Apolipoprotein A-II</td>
<td>Systemic</td>
<td>Familial</td>
</tr>
<tr>
<td>Amed</td>
<td>Lactoferrin</td>
<td>Localised</td>
<td>Familial</td>
</tr>
<tr>
<td>Alys</td>
<td>Lysozyme</td>
<td>Systemic</td>
<td>Familial</td>
</tr>
<tr>
<td>Alβ</td>
<td>Fibrinogen α chain</td>
<td>Systemic</td>
<td>Familial</td>
</tr>
<tr>
<td>Acys</td>
<td>Cystatin C</td>
<td>Systemic</td>
<td>Familial</td>
</tr>
<tr>
<td>Aβ Protein precursor</td>
<td>Aβ Protein precursor</td>
<td>Localised</td>
<td>Familial</td>
</tr>
<tr>
<td>AcPr</td>
<td>Proin protein</td>
<td>Localised</td>
<td>Familial</td>
</tr>
<tr>
<td>Abri</td>
<td>Abri protein precursor</td>
<td>Localised</td>
<td>Familial</td>
</tr>
<tr>
<td>Acal</td>
<td>(Pro)calcitonin</td>
<td>Localised</td>
<td>Thyroid tumours derived from C cells</td>
</tr>
<tr>
<td>AAAPP</td>
<td>Islet amyloid polypeptide</td>
<td>Localised</td>
<td>Longerhans islets, insulinomas</td>
</tr>
<tr>
<td>Apro</td>
<td>Prolactin</td>
<td>Localised</td>
<td>Proactinomas, pituitary in elderly</td>
</tr>
<tr>
<td>Ains</td>
<td>Insulin</td>
<td>Localised</td>
<td>Iatrogenic</td>
</tr>
<tr>
<td>Akler</td>
<td>Kerato-epithelin</td>
<td>Localised</td>
<td>Familial, cornea</td>
</tr>
<tr>
<td>Alac</td>
<td>Lactoferrin</td>
<td>Localised</td>
<td>Familial, cornea</td>
</tr>
</tbody>
</table>

Proteins involved in the cardiovascular system are in bold.

Table 2: Cardiac clinical manifestations of amyloidosis

<table>
<thead>
<tr>
<th>Clinical characteristics of cardiac amyloid involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilated cardiomyopathy (cardiomegaly, predominant systolic dysfunction)</td>
</tr>
<tr>
<td>Restrictive cardiomyopathy (right cardiomegaly, predominant diastolic dysfunction, stiff heart syndrome)</td>
</tr>
<tr>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>Electrocardiographic disorders (rhythm abnormalities, low voltage QRS complexes, sick sinus syndrome, atrioventricular and ventricular conduction abnormalities)</td>
</tr>
<tr>
<td>Coronary insufficiency (myocardial infarction, angina pectoris)</td>
</tr>
<tr>
<td>Valvular dysfunction</td>
</tr>
<tr>
<td>Pericardial tamponade</td>
</tr>
<tr>
<td>Enhanced sensitivity to digitalis glycosides</td>
</tr>
<tr>
<td>Atrial thrombosis—embolisation</td>
</tr>
</tbody>
</table>

"The diagnostic approach should be multidisciplinary and include clinical examination, biochemical tests, imaging, and genetic analysis to assess the extent of the disease and its complications"
The serum hepatocyte growth factor concentration has been reported to be significantly higher in patients with both primary and secondary amyloidosis, but further multicentric studies are needed. Recently, the diagnostic potential of (trans,trans)-1-bromo-2,5-bis-(3-hydroxy carbonyl-4-hydroxy)-styrlybenzene has been considered. This Congo red nontoxic derivative can bind to amyloid both in vivo and in vitro and it can be evaluated in scintigraphic studies.

**Morphological diagnosis of amyloidosis in general**

Amyloid can be diagnosed and classified in any affected tissue specimen by means of special stains and biochemical analysis. The morphological diagnosis is of paramount importance and cannot be replaced by clinical, biochemical, or radiological procedures. Fat aspiration biopsy introduced by Westermark and Stenkvist in 1973 is the most common tool to diagnose systemic amyloidosis. Fat aspiration biopsy is simple, easy to perform and repeat, and bears a negligible risk of complications. However, fat aspiration biopsy is less sensitive than kidney and rectal biopsy. Moreover, the sample should not contain only fat droplets. Alternatively, if sufficient material is present, it can be used for further immunohistochemical, electron microscopical, and molecular analyses. Another standard procedure for the confirmation of the diagnosis of systemic amyloidosis is rectal biopsy and amyloid is commonly diagnosed by renal biopsy. Furthermore, sural nerve, skeletal muscle, and gastrointestinal biopsy samples other than rectal can also be used in the diagnosis of amyloidosis. If positive, Congo red fluorescence is recommended in all Congo red negative suspicious tissue samples. In such cases, electron microscopy is of paramount importance and positive results have been reported in Congo red negative cases.

**Biochemical analysis from biopsy material**

Both formalin fixed and fresh/frozen tissue samples can be used for the further biochemical analysis of amyloid. Reversed phase high performance liquid chromatography is the method of choice for the purification and analysis of amyloid proteins extracted from formalin fixed tissues. In contrast sodium dodecyl sulfate polyacrylamide gel electrophoresis based western blotting appears to be the better method for fresh tissue analysis. Furthermore, the determination of chemical composition through amino acid sequencing or mass spectroscopy from formalin fixed specimens is available.

**Diagnosis of cardiac amyloidosis**

Unfortunately, because of the diversity of symptoms, cardiac amyloidosis is diagnosed predominantly after death, although the tentative diagnosis of cardiac amyloidosis can easily be confirmed by myocardial biopsy.

**Endomyocardial biopsies**

Endomyocardial biopsy was found to be a safe and effective method for assessing cardiac amyloid involvement. According to American College of Cardiology/American Heart Association criteria, endomyocardial biopsy is recommended in patients with heart failure in whom an inflammatory or infiltrative disorder of the heart is suspected. Fat aspiration biopsy is a possible alternative to endomyocardial biopsy in cases of primary amyloidosis. Another alternative is rectal biopsy, although this approach has a lower positivity, ranging from 58% to 80%, and thus cannot substitute completely for endomyocardial biopsy. In cases with known amyloidosis, as demonstrated by a positive biopsy from extracardiac tissue with echocardiography and other signs indicating cardiac involvement, endomyocardial biopsy is not essential. However, endomyocardial biopsy remains the method of choice to diagnose cardiac amyloidosis when non-invasive tests give equivocal results. In addition, immunohistochemical analysis to characterise amyloid protein is feasible. In most cases, the tissue obtained is sufficient for such an analysis. Endomyocardial biopsy also enables the degree of myocardial damage and cellular changes to be assessed.

“Endomyocardial biopsy is recommended in patients with heart failure in whom an inflammatory or infiltrative disorder of the heart is suspected.”

In a series of 454 endomyocardial biopsies, systemic amyloid was found in 7%. The yield of endomyocardial biopsies is increased if at least four biopsy specimens are obtained. Importantly, cardiac involvement is interstitial, plentiful, and easily recognised compared with the almost exclusively vascular, mild, and focal pattern seen extracardially. Unfortunately, small amyloid deposits can be missed at light microscopy using Congo red staining. Congo red fluorescence is recommended in all Congo red negative suspicious tissue samples. In such cases, electron microscopy is of paramount importance and positive results have been reported in Congo red negative cases.

**Morphology**

**Macroscopy**

Amyloid is either indistinct or associated with a waxy cut surface. Localised forms can lead to organ enlargement and can imitate tumours. At necropsy, the reaction with Gram’s iodine followed by treatment with 10% sulfuric acid will show amyloid deposits as a blue/violet colour. Either fresh tissue or frozen sections can be used to demonstrate amyloid deposits.

**Heart macroscopy**

Hearts infiltrated by amyloid are usually only moderately enlarged, weighing 400–850 g, although giant hearts of over 1000 g have also been described. The mean cardiac weight in senile involvement was significantly higher than that seen in subjects with primary (even fatal) involvement. Most infiltrated hearts are firm, rubbery, and non-compliant, mimicking hypertrophic cardiomyopathy—that is, the walls of heart chambers are thickened, but the ventricular lumina are not dilated. About one third of hearts have dilated chambers imitating congestive cardiomyopathy. Importantly, about 15% of hearts show no macroscopically visible changes. In the senile form, atrial deposits are grossly discernible as bead-like, semitranslucent nodules (fig 1A).

**Light microscopy and special stains**

**General pattern and stains**

At light microscopy, all forms of amyloid deposits are amorphous and homogenous, with pale eosinophilic areas, when stained with haematoxylin and eosin (fig 1B, C). Since the 19th century, amyloid deposits have been known to stain metachromatically if aniline dyes such as methyl or

---

**Table 3** Diagnostic algorithm for biopsy samples to diagnose and classify amyloid

| (1) | Haematoxylin and eosin stain, Congo red polarisation |
| (2) | Congo red fluorescence |
| If negative: | |
| (3A) | Serial sections of the whole sample | (3B) Electron microscopy |
| (3AA) | Haematoxylin and eosin stain, Congo red polarisation |
| (3AB) | Congo red fluorescence |
| If positive: | |
| (4) | Immunohistochemical classification |
crystal violet are used. At present, Congo red is the standard staining method. Congo red stained amyloid has an orange or red colour on light microscopy and has apple green birefringence under polarised light (fig 1D–F). However, Congo red is not specific, because it also stains eosinophil granules, enterochromaffin granules, Paneth cell granules, elastic fibres, collagen, and foreign materials such as chitin, fungal constituents, and plant components. Certain pitfalls can be avoided by alkaline Congo red modification.66 71–76 Most of the other stains available are not recommended to be used alone and are listed with decreasing specificity and sensitivity: Sirius red, thioflavine T, toluidine blue, p-dimethylaminobenzaldehyde-nitrite, alcian blue, and crystal violet.67 74 75 Alternatively, a panel of special stains has been recommended to increase the sensitivity in certain cases because of possible staining variability.76 Importantly, prolonged formalin fixation of amyloid tissue may abolish or lessen its staining reactions. Some authors stated Sirius red

Figure 1  Example of a heart with amyloidosis. (A) Macroscopic view showing nodules with amyloid (arrows). (B) Microscopic view showing eosinophilic areas containing amyloid (asterisks); original magnification, ×100. (C) Microscopic view showing eosinophilic bands, containing amyloid, around individual cardiomyocytes (arrows); original magnification, ×100. (D) Microscopic view (same figure as C) showing apple green birefringence under polarised light; original magnification, ×100. (E) An intramyocardial artery showing Congo red stained amyloid (arrow); original magnification, ×400. (F) An intramyocardial artery (same figure as E) showing apple green birefringence under polarised light; original magnification, ×400. (G) Amyloidosis is characterised by the deposition of fine fibrillar material (asterisk) in and around cardiomyocytes (arrow); original magnification, ×10 000. (H) Amyloidosis is characterised by the deposition of fine fibrillar material (asterisk) around small vessels; arrow, endothelial cell; original magnification, ×15 000.
as superior in cardiac amyloidosis, particularly for identifying very small deposits in the isolated atrial form.

Cardiac involvement pattern
The degree of involvement of different parts of the heart—endocardium, myocardium, pericardium, valves, coronary arteries, and veins—is not uniform in the different forms of amyloidosis. However, amyloid patterns are of limited value in the diagnosis in individual patients. Perifibrous/pericellular is the most common pattern seen, and nodular and mixed patterns have also been described. Interestingly, atrophy of the surrounding myocytes and fibrosis of the conduction system have been noted in relation to amyloid deposition. The myocytes often reveal perinuclear vacuolation; although this is a non-specific feature also found in hypertrophy related to increased glycogen storage. Amyloid deposits in the vessel wall are predominantly segmentally distributed and cause luminal narrowing.

Immunohistochemistry
The immunohistochemical classification of amyloid deposits is a useful tool with increasing importance in amyloid diagnosis, and a large number of anti-amyloid fibril protein antibodies are commercially available. However, the increasing number of amyloid fibrillar proteins identified may be demanding in routine practice. The following spectrum of fibrillar proteins is recommended to test for the most common systemic amyloidosis: amyloid A, amyloid of apolipoprotein A-I, amyloid of fibrinogen α chain, amyloid of light chains, amyloid of lysozyme, amyloid of transthyretin, and amyloid of β2 microglobulin origin. Table 4 lists a differential diagnostic panel of antibodies to be used in heart and vessel amyloid assessment. Recently, an immunogold technique that enables typing of amyloid in difficult clinical cases was reported.

Table 4
Commerically available antibodies against amyloid protein fibrils in general/cardiovascular amyloidosis diagnostics

<table>
<thead>
<tr>
<th>Antibody</th>
<th>Clonality/clone</th>
<th>Distributor</th>
</tr>
</thead>
<tbody>
<tr>
<td>κ Light chain</td>
<td>Polyclonal</td>
<td>Dako, Glostrup, Denmark</td>
</tr>
<tr>
<td>λ Light chain</td>
<td>Polyclonal</td>
<td>Dako</td>
</tr>
<tr>
<td>AA Amyloid</td>
<td>Monoclonal/mc1</td>
<td>Dako</td>
</tr>
<tr>
<td>β2 Microglobulin</td>
<td>Polyclonal</td>
<td>Dako</td>
</tr>
<tr>
<td>Atrial natriuretic peptide</td>
<td>Polyclonal</td>
<td>Biogenesis, Poole, Dorset, UK</td>
</tr>
<tr>
<td>Transferritin</td>
<td>Polyclonal</td>
<td>Dako</td>
</tr>
</tbody>
</table>

Electron microscopy
General ultrastructure
Ultrastructurally, amyloid consists of a loose meshwork of 7–10 nm rigid, non-branching, hollow fibrils of indeterminate length. The fibrils measure from 30 to more than 1000 nm in length. These fibrils are usually found in extracellular spaces and aggregate in a crossed β pleated sheet conformation.

Cardiac ultrastructure
In the myocardium, pericellular encasement non-branching fibrils are found. Fibrils are adjacent to the basement membrane of myocytes, some of which can be completely surrounded by fibrillous material (fig 1G, H). The amyloid fibrils are in close proximity to the basement membrane of the myocytes. Furthermore, the deposition of amyloid is associated with a focal increase of mitochondria. Electron microscopy can detect amyloid when histochemical stains such as Congo red are still negative.

CARDIOVASCULAR AMYLOIDOSIS AS A PART OF PRIMARY AMYLOIDOSIS
In primary amyloidosis, clonal plasma cells secrete monoclonal immunoglobulin light chains, which are deposited predominantly in the kidney, heart, and nerves. Symptomatic cardiac involvement is present in a quarter to half of patients with primary amyloidosis and is the major prognostic factor. Importantly, a cardiac cause of death is the most common amyloid related death in primary amyloidosis, and is seen in 40% of patients in the form either of congestive heart failure or arrhythmia. Congestive heart failure is the most frequent cardiovascular manifestation. Conduction system abnormalities and heart blocks are the second most frequent complications. Stenoses and obstructions in the intramural coronary arteries by amyloid deposits can lead to ischaemic disease, which differs in prognosis. Interestingly, epicardial coronary artery involvement and interstitial myocardial involvement were absent or mild in these cases. In addition, non-sclerotic valves showed amyloid deposits in primary amyloidosis. Pericardial effusion is a common symptom. However, constrictive pericarditis and cardiac tamponade resulting from amyloid deposits are unique. Orthostatic hypotension caused by amyloid deposits in nerves and ganglia was also revealed. Uniquely, cardiac denervation was described in primary amyloidosis, with no other cardiac symptoms. In general, cardiac involvement in the absence of other organ deposits is rare.

Secondary amyloidosis
With the decrease of chronic infectious diseases, such as tuberculosis and osteomyelitis in the developed world, secondary amyloidosis has become rare and is found mainly in association with diseases such as rheumatoid arthritis and inflammatory bowel disease. A tumour related form is also diagnosed and recently haemodialysis related amyloidosis was described. Amyloid is formed from serum amyloid A (SAA), an acute phase protein produced in response to inflammation. Several forms of SAA have been identified in human plasma. SAA1 predominates in the formation of amyloid A deposits. The major constituent protein in haemodialysis related amyloidosis is β2 microglobulin.

SECONDARY AMYLOIDOSIS

www.jclinpath.com
Cardiac involvement may occur; however, significant deposition of amyloid in the heart is unusual and is rarely the cause of death. Thus, although myocardial infiltration is unusual, there have been case reports of extensive cardiac involvement, even with cardiac failure and arrhythmia, in secondary amyloidosis in such diseases as juvenile rheumatoid arthritis, sarcoid, psoriatic spondylarthropathy, and multifocal neurone neuropathy. Vascular involvement is less frequent, mostly involving intramyocardial small vessels. In contrast, in β2-microglobulin amyloidosis, only vascular and endocardial involvement was described.

Amyloid deposits were also found in post rheumatic sclerotic valves. Amyloid deposits in aortas and temporal arteries, whereas intimal amyloid is derived from apolipoprotein A-I. Serum amyloid A isotypes were detected in the aortic amyloid appears to be the most common form of localised amyloid. Occurring in nearly all people over 50 years of age, aortic amyloid appears to be the most common form of localised amyloid. Biochemically, aortic amyloid is distinct either from ANP present in IAA or from TTR in SSA. Interestingly, an association between valvular amyloid deposits and old thrombotic material was proposed. Furthermore, amyloid was found in porcine bioprosthetic cardiac valves after explantation following longterm implantation.

AMYLOID INVOLVEMENT OF VESSELS
Senile aortic amyloid
Occurring in nearly all people over 50 years of age, aortic amyloid appears to be the most common form of localised amyloid. Biochemically, aortic amyloid is distinct either from ANP present in IAA or from TTR in SSA. Recently, the lactadherin derived protein, medin, was purified from medial amyloid deposits in aortas and temporal arteries, whereas intimal amyloid is derived from apolipoprotein A-I. Serum amyloid A isotypes were detected in atherosclerotic lesions.

“Occurring in nearly all people over 50 years of age, aortic amyloid appears to be the most common form of localised amyloid”
Three different forms involving the media, intima, and adventitia have been described so far. The most common form is in the media, followed by intimal and adventitial deposition. The clinical relevance is not clear yet. No casual relation between aortic amyloid and hypertension or dissecting aneurysm was observed. The thoracic aorta is predominantly involved in the medial form: nodules and thin streaks in the inner half of the media are mostly in the proximity of elastin fibres. Intimal amyloid is associated with atheromatous lesions and appears as irregular lumps. Adventitial amyloid is either in the connective tissue or in the walls of the vasa vasorum.

**Other forms of vascular amyloidosis**

Senile amyloid angiopathy has been described in a variety of vessels. Its biochemical characteristics remain unknown, but similarities between aortic medial amyloid and medial amyloid of the common carotid and temporal arteries were reported. Senile vascular amyloidosis derived from the N-terminus of apolipoprotein A-I reported in dogs has yet to be documented in humans. Interestingly, amyloid involved in the N-terminus of apolipoprotein A-I reported in dogs has yet to be documented in humans.27 133 Senile vascular amyloidosis derived from the N-terminus of apolipoprotein A-I reported in dogs has yet to be documented in humans.27 129 131 Interestingly, amyloid involvement was greater in the veins than in the arteries in senescence accelerated mice.14

**TREATMENT**

The therapeutic approach depends on the type of amyloidosis and the stage of the disease, so the precise diagnosis is of principal importance. The treatment of amyloidosis is specifically directed at the amyloidogenic process, and supportive treatments directed to consequent organ dysfunctions.18

Supportive treatment of cardiac failure includes diuretics, whereas calcium channel blockers, β blockers, and digoxin are contraindicated in cardiac amyloidosis.14 Patients with arrhythmia may benefit from a pacemaker.16

In primary amyloidosis, chemotherapy regimens of melphalan and prednisone have been used for decades and are the most successful. Alternative drugs under consideration and in trials are 4'-iodo-4'-deoxydoxorubicin, vincristine, dexamethasone, and α interferon.16 18 135 Cardiac transplantation with supportive chemotherapy is under consideration,14 136 and stem cell transplantation is another treatment option.165 137

Secondary amyloidosis requires aggressive treatment of the underlying inflammatory or neoplastic process. Currently, no definitive treatment is available in non-hereditary, age related amyloidosis; however, patients may benefit from supportive treatment, including a pacemaker.16 64

To date, no effective treatment has been reported for the most common hereditary amyloidosis, TTR amyloidosis, apart from liver transplantation. However, the onset of cardiomyopathy can be prevented if liver transplantation is carried out before cardiac involvement.66 Successful combined heart–liver and liver–kidney transplantation was reported for hereditary TTR and apolipoprotein A-I amyloidosis, respectively.138 139

Future perspectives include treatments based on precursor stabilisation (transferrin), prevention of formation by crosslinking, elimination of the synthesising cells (light chains), and immunisation to induce host mediated reaction (light chains).27 140 141

**PROGNOSIS**

The prognosis varies according to the type of amyloidosis, the stage of the disease, and the age of the patient at the time of diagnosis. Primary amyloidosis has the worst prognosis, which is exacerbated by multisystem involvement and cardiac involvement in particular.142 Histologically, the worst prognosis is connected with the presence of nodular deposits, thick perimyocytic layers of amyloid, and small myocyte diameters in endomyocardial biopsy.141 The overall median survival after diagnosis is less than two years in most. In secondary amyloidosis, the underlying chronic disease affects the prognosis, and hereditary amyloidoses vary in prognosis according to the specific mutation.16 18 34 In addition, heart rate variability assessed by Holter monitoring was found to be a possible predictor of mortality in patients with both primary and secondary amyloidosis involving the heart.45 Echocardiography should be a routine part of the assessment of cardiac involvement and predicting prognosis.15

**CONCLUSIONS**

Amyloidosis often affects the cardiovascular system. The heart is usually infiltrated by amyloid fibrils in primary amyloidosis and age related forms of amyloidosis, less commonly in transferrin familial amyloidosis, and rarely in secondary amyloidosis. Cardiac infiltration results in cardiac symptoms dominated by congestive heart failure and arrhythmias. The diagnosis of amyloidosis requires tissue sample confirmation. Congo red staining in polarised light is the method of choice at the present. However, the pathologist should not only make the generic diagnosis of the presence of amyloid, but should also determine the protein fibril type by means of immunohistochemistry, because it is of diagnostic, prognostic, and therapeutic importance.

**ACKNOWLEDGEMENTS**

Dr Kholova was a PhD student of the Marie Curie Training Site of the European Community (No. HPMT-2000-114) at the IGAR-VU. Dr Niessen is a recipient of the Dr E Dekker program of the Netherlands Heart Foundation (D99025). The project was supported by grant IGA Ministry of Health CR No. 7992–3.

**Authors’ affiliations**

I Kholova,* H W M Niessen, Department of Pathology, Vrije Universiteit Medical Centre, De Boelelaan 1117, 1007 MB Amsterdam, The Netherlands

*Present address: A I Virtanen Institute for Molecular Sciences, University of Kuopio, Kuopio, Finland
REFERENCES


