Endocardial fibroelastosis in children with special reference to the lesions of cardiac ganglia

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SYNOPSIS In all cases of primary endocardial fibroelastosis investigated diffuse degenerative changes in the ganglion cells were detected. Thickened endocardium was formed by the proliferation of mesenchymal cells located under the endothelial endocardium and of the mesenchyme surrounding the necrobiotic muscle cells. In some cases ‘axial’ vacuolar degeneration, necrobiosis, and necrosis of muscle cells, interstitial oedema, and dilatation of capillaries and lymphatic spaces were found in the whole myocardium. In all cases these changes were in the subendocardial layer.

In the cases discussed morphological changes in the endocardium were seen to be secondary to lesions in myocardial and possibly in neural structures.

Morphological changes in cardiomyopathy with endocardial fibroelastosis have been the subject of many studies (Andersen and Kelly, 1956; Kelly and Andersen, 1956; Black-Schafer, 1957; Boj and Pikiel, 1964). The pathogenesis of this syndrome, however, has not as yet been explained. Some authors have recently stressed the role of the parasympathetic nervous cardiac system in the pathogenesis of certain heart diseases (Kgeberle, 1959; James and Reynolds, 1963; James, 1967). In this study changes in cardiac neural structures in cardiomyopathy with endocardial fibroelastosis were studied.

Material and Method

The material was from 17 children, aged from 4 months to 2 years, who had died of cardiomyopathy with endocardial fibroelastosis. The control group comprised seven children of the same age who had died from other causes. Postmortem examinations were performed eight to 36 hours after death.

For microscopic examination single sections from both ventricles were taken, while the complete atria were examined. The walls of the right and left atrium, including a part of the cardiac base, were cut horizontally into 0-3 cm sections which were fixed in 10% aqueous formalin solution, processed routinely, and embedded in paraaffin wax.

The sections were stained with haematoxylin and eosin, Mallory’s phosphotungstic acid haematoxylin (PTAH), Verhoeff’s elastic stain, MacManus periodic-acid-Schiff (PAS), Masson’s trichrome, Gomori’s reticulum stain, and cresyl echt violet for Nissl substance.

Clinical Data

As can be seen in Table I the age span of the patients was from 4 to 24 months. There were two cases of sudden death, two cases of clinically diagnosed myocarditis, three of pneumonia, and one case of leptomeningitis. In three cases death was preceded by respiratory and in the remaining cases by circulatory insufficiency.

Results

GROSS APPEARANCE OF THE HEART

The macroscopic outline of the heart in all cases of cardiomyopathy with endocardial fibroelastosis was similar. The heart was enlarged in all its dimensions, a ball-like, rounded apex formed by the left ventricle. The left ventricle was wide, the septum protruding toward the right, the heart muscle hypertrophic. The endocardium of the left ventricle was porcelain white, thick, and in two cases the endocardium of the right ventricle was also thickened.

In three cases the endocardium was greyish-yellow and only focally greyish-white, and on cross-
section it was a homogeneous, damp, greyish-yellow layer from 0.1 to 0.2 cm thick, spreading under the entire endocardium of the left ventricle and of the septum of the right ventricle sharply contrasting from the rest of the greyish-pink myocardial layer. The trabecular and papillary muscles in the entire cross section or only subendocardially were greyish yellow.

MICROSCOPIC APPEARANCE OF ENDOCARDIUM AND HEART MUSCLE

In sections stained with haematoxylin and eosin in all cases of investigated cardiomyopathy the thickened endocardium in the surface layer of the subendocardium contained for the most part slightly elongated cells with oval nuclei and granularly distributed chromatin. In the deeper layer, however, spindle-shaped cells with cylindrical nuclei and evenly distributed chromatin were found. These cells were often wavy (Figs. 2 and 3). They were stained by the PTAH method a dark blue. Along these cells numerous thin and thick fibres, stained pink by eosin, were seen. Both the thin and thick fibres as well as the long axes of the observed cells usually ran parallel to the subendocardial layer (Figs. 3 and 4). All the fibres were stained deep violet-red in the PAS reaction. In sections stained by the classical Verhoeff method the thin fibres were stained red, while the thick ones turned brown. The whole of the thickened endocardium showed a network of argyrophilic fibres (Fig. 5).

Also in the altered endocardium single myocardial cells were PAS positive and appeared well preserved (Fig. 6). In the subendocardial layer, particularly between the trabeculae, were found spindle-shaped cells and homogeneous membranes around the necrotic myocardial cells. In this layer the myocardial cells were swollen, the sarcoplasm around the nucleus was rarefied, and the remaining myofibrils on the perimeter had a distinct outline. Some of the cells had no nuclei and no sarcoplasm, and there were remnants of sarcolemma on their perimeter (Fig. 7). In other cases swollen myocardial cells staining poorly and completely blurred myofibrils predominated. These cells lacked cross striations (Fig. 8). Such changes could be found focally in various microscopical fields. Around the changed cells of the myocardium there were cells with cylindrical nuclei (Figs. 7 and 8), and amorphous PAS-positive substance. In some cases throughout the heart foci predominated in which the myocardial cells were thin, if empty of sarcoplasm, and spread out because of oedema and proliferation of interstitial tissue. This tissue showed widening of capillaries and tissue spaces lined with endothelium corresponding to lymphatic spaces. In some cases the outline of the muscle layers of the coronary arterioles was blurred and the endothelial cells protruded towards the lumen of the vessel. The veins and lymphatic spaces around the arteries were noticeably widened.

MICROSCOPIC APPEARANCE OF GANGLION CELLS OF THE ATRIUM

In the hearts with endocardial fibroelastosis ganglion cells of both large and small ganglia were degenerated. They were swollen with nuclei pressed to the side (Fig. 9), either vacuolated or pyknotic (Fig. 10). In many of the cells the greatly thickened cell membrane surrounded the granular degenerated cytoplasm (Fig. 11). Some ganglia had only cell shadows or empty spaces left where the cells had vanished, surrounded by a wreath of excessively proliferating amphocytes and fibroblasts (Fig. 12). Such cells were PAS negative and lacked tygroid.

In three cases there was a complete lack of nerve
Fig. 1  Normal ganglia in atrium of 6-month-old infant. H.E. × 120.

Fig. 2  Case 1. Fibres and cell structures laying parallel to the subendocardial layer of myocardium. H.E. × 380.

Fig. 3  Case 6. Wavy cells in thickened endocardium. H.E. × 400.

Fig. 4  Case 3. Spindle-shaped cells with cylindrical nuclei in thickened endocardium. H.E. × 480.
Fig. 5  Case 3. Thin fibres in the surface layer and thick fibres in the paramuscular layer. Axial vacuolar degeneration in the subendocardial layer. Verhoeff ×120.

Fig. 6  Case 8. Single myocardial cells preserved in the thickened endocardium. H.E. ×480.

Fig. 7  Case 7. Muscle cells without nuclei and with rarefied sarcoplasm and vacuolar degeneration. H.E. ×300.

Fig. 8  Case 17. Heart muscle cells in subendocardial oedematous layer. The outline of the myofibrils is blurred. Spindle-shaped cells around degenerated myocardial cells. H.E. ×120.
Fig. 9  Case 3. Ganglion cells with neuroplasm not uniformly stained and the nucleus is pressed to the side. H.E. ×320.

Fig. 10  Case 13. Vacuolated ganglion cells with pyknosis of nucleus. H.E. ×480.

Fig. 11  Case 2. Ganglion cell with greatly thickened membrane surrounds granular degenerated cytoplasm. H.E. ×320.

Fig. 12  Case 11. Cell shadows and empty spaces of vanished ganglion cells surrounded by wreath of excessively proliferating amphotocytes and fibroblasts. H.E. ×160.
cells in the large ganglia, while hypertrophic amphi-
cytes formed descending nodes (Fig. 13). The
changed ganglia showed mononuclear cells and
increased numbers of fibroblasts (Fig. 14).

Discussion

The microscopically thickened endocardium con-
tained mesenchymal and other cells which, because
of their morphological appearance and affinity to
certain stains, resembled smooth muscle cells. The
development of argyrophilic and elastic membranes
was connected with the presence of these two types
of cell. The results of our previous investigations
(Zółtowska, 1964) suggest that elastic elements
forming subendocardial membranes most probably
develop from smooth myocytes. They are formed
from a substance with an initial collagen-like staining
property created possibly by the smooth muscle
cells perhaps at the beginning of their existence, i.e.,
at the time when they possessed the properties of
young mesenchymal cells. Elastoplasia is conditioned
by the dynamic factor responsible for rebuilding the
internal layer and possibly by the work of contractile
elements of the already mature myocyte.

The proliferation of cellular elements which play
a role in thickening the endocardium comes from
the mesenchyme found under the endothelial endo-
cardium and has a pathology similar to that of
the thickening of the internal membrane of the
coronary arteries in children (Dock, 1946;
Schornagel, 1956; Robertson, 1960; Zółtowska,
1964), as well as from the mesenchyme proliferating
around the necrobiotic cells of the heart muscle.
This suggests that dynamic factors play a decisive
role in its creation.

In congenital heart defects in infants endocardial
thickening is a consequence of haemodynamic dis-
turbances resulting from the fundamental features
of the defect and from abnormal development of the
muscle. In congenital defects with arterial stenosis,
in addition to the haemodynamic factor connected
with much greater pressure in the left ventricle than
in the aorta, there is also anoxia (Ganong, 1967).
Similar factors play a decisive role in such other
aetiological changes as inflammation, infarcts, or
various forms of myocardial degeneration (Hudson,
1965).

Primary endocardial fibroelastosis in children is
diagnosed when there are no valvular heart lesions,
no inflammation, or no exactly defined myocardial
degeneration (Mitchell, Froehlich, Banas, and Gilkes-
on, 1966). The results of our own investigations, as
also those of other authors (Andersen and Kelly, 1956;
Kelly and Andersen, 1956; Boj and Pikel, 1964),
show that even in the so-called primary endocardial
fibroelastosis the endocardial changes are secondary
to the myocardial damage. The process of cardiac
cell necrosis is most intensive in the subendocardial
layer, which is very rich in a special type of receptor
(Coleridge, Coleridge, and Kidd, 1964), and changes
in the ganglia may point to a neurological cause of
the disease.

Normally in the atrial walls of an infant where
death was due to pneumonia, for example, ganglion
cells occur in large or small bunches or singly
included in the nerve pathway. These are large cells
with uniformly staining cytoplasm and a vesicular
nucleus with a distinct nucleolus. Each cell is sur-
rounded by a layer of satellite cells, no more than
three or four in a single section. The nerve fibres
with Schwann cells and thin collagen fibres with
single fibroblasts in their environment form a fine,
loose network (Fig. 1).

Hearts of children who had died of cardiomyo-
pathy with endocardial fibroelastosis showed de-
generation of ganglion cells or their atrophy with a
proliferation of amphiocytes and the formation of
descending nodes. These changes were accompanied
by hyperplasia of fibroblasts and the appearance of
a scanty number of mononuclear cells.

Fig. 13 Case 4. Ganglia lacking ganglion cells with
descending nodes formed by proliferating amphi-
cytes. H.E. ×120.
The problem of the nervous control of the heart action is an open matter. Morphological (Hirsch and Borghard-Erde, 1961; James, 1967) as well as biochemical (Burn and Rand, 1965; James, 1966; Malmfors, 1967) studies show the importance of this system to the work of the heart. Electron micrographs of cardiac neural structures show the existence of vesicular structures, most probably morphological exponents of mediator transportation of the autonomic system. Indirect evidence of cholinergic innervation of the cardiac pacemaker may be obtained with stains for cholinesterase (James and Sherf, 1968). Although it is now assumed that the formation and conduction of impulses in the heart occur within specialized myocardial cells the function of these cells is under the control of the cardiac nervous system. All this shows that the optional activity of the heart depends on the synchronization of the pacemaker and the cardiac nervous system (James, 1967).

Morphological changes in the heart in the form of cardiomegaly may possibly depend on the degree of damage to the parasympathetic nervous system and are evidence of inefficient cardiac activity. Reconstruction of the endocardium, on the other hand, may be a consequence of the dynamic factor also connected with high frequency of impulses in this layer, particularly in the case of dilatation (Coleridge et al, 1964). The problem of whether changes in the nerve elements precede the cardiac hypertrophy and endocardial thickening found later can be solved only by further experiments on animals.

References


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