Persistent Iron Within the Infarct Core After ST-Segment Elevation Myocardial Infarction
Implications for Left Ventricular Remodeling and Health Outcomes

Jaclyn Carberry, BMESc, MBCiB, David Carrick, MBCiB, PhD,a,b Caroline Haig, PhD,c
Nadeem Ahmed, BMESc, MBCiB, Ify Mordi, MBCiB, Margaret McEntegart, MBCiB, PhD,a
Mark C. Petrie, MBCiB, MD,a Hany Eteiba, MBCiB, MD,a Stuart Hood, MBCiB, MD,a Stuart Watkins, MBCiB, MD,a,b
Mitchell Lindsay, MBCiB, MD,a Andrew Davie, MBCiB, MD,a Ahmed Mahrous, MBCiB,a Ian Ford, PhD,c Naveed Sattar, MBCiB, PhD,a Paul Welsh, PhD,a Aleksandra Radjenovic, PhD,a Keith G. Oldroyd, MBCiB, MD,a Colin Berry, MBCiB, PhD,a,b

ABSTRACT

OBJECTIVES This study sought to determine the incidence and prognostic significance of persistent iron in patients post-ST-segment elevation myocardial infarction (STEMI).

BACKGROUND The clinical significance of persistent iron within the infarct core after STEMI complicated by acute myocardial hemorrhage is poorly understood.

METHODS Patients who sustained an acute STEMI were enrolled in a cohort study (BHF MR-MI [Detection and Significance of Heart Injury in ST Elevation Myocardial Infarction]). Cardiac magnetic resonance imaging including T2* (observed time constant for the decay of transverse magnetization seen with gradient-echo sequences) mapping was performed at 2 days and 6 months post-STEMI. Myocardial hemorrhage or iron was defined as a hypointense infarct core with T2* signal < 20 ms.

RESULTS A total of 203 patients (age 57 ± 11 years, n = 158 [78%] male) had evaluable T2* maps at 2 days and 6 months post-STEMI; 74 (36%) patients had myocardial hemorrhage at baseline, and 44 (59%) of these patients had persistent iron at 6 months. Clinical associates of persistent iron included heart rate (p = 0.009), the absence of a history of hypertension (p = 0.017), and infarct size (p = 0.028). The presence of persistent iron was associated with worsening left ventricular (LV) end-diastolic volume (regression coefficient: 21.10; 95% confidence interval [CI]: 10.92 to 31.27; p < 0.001) and worsening LV ejection fraction (regression coefficient: -6.47; 95% CI: -9.22 to -3.72; p < 0.001). Persistent iron was associated with the subsequent occurrence of all-cause death or heart failure (hazard ratio: 3.91; 95% CI: 1.37 to 11.14; p = 0.011) and major adverse cardiac events (hazard ratio: 3.24; 95% CI: 1.09 to 9.64; p = 0.035) (median follow-up duration 1,457 days [range 233 to 1,734 days]).

CONCLUSIONS Persistent iron at 6 months post-STEMI is associated with worse LV and longer-term health outcomes.

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From the "British Heart Foundation Glasgow Cardiovascular Research Centre, Institute of Cardiovascular and Medical Sciences, University of Glasgow, Glasgow, Scotland; "West of Scotland Heart and Lung Centre, Golden Jubilee National Hospital, Clydebank, Scotland; and the "Robertson Centre for Biostatistics, University of Glasgow, Glasgow, Scotland. Funding was provided by a British Heart Foundation (BHF) grant (RE/13/5/30177; PG/11/2/28474) and the Chief Scientist Office. This project was also supported by a research agreement with Siemens Healthcare. Professor Berry was supported by a Senior Fellowship from the Scottish Funding Council. Dr. Welsh is supported by BHF Fellowship FS/12/62/29889. All other authors have reported that they have no relationships relevant to the contents of this paper to disclose. Drs. Carberry and Carrick contributed equally to this work.

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Myocardial hemorrhage (1) and microvascular obstruction (2) are common and prognostically important complications of reperfused ST-segment elevation myocardial infarction (STEMI), and they are independently associated with adverse remodeling and heart failure in the longer term (2). The improvements in survival after acute STEMI in recent decades translate to more surviving patients with injured hearts who are at risk of developing longer-term complications (3,4). Because there are no evidence-based treatments for microvascular obstruction and myocardial hemorrhage, more research is needed to understand the pathophysiology of these disorders more fully.

Myocardial hemorrhage is a result of severe microvascular injury, with extravasation of erythrocytes secondary to loss of endothelial integrity (1,5–8). Hemoglobin degradation products are toxic (9–11), and their persistence is evidenced by immunohistochemical staining of iron within macrophages reflecting sustained inflammation within the infarct zone (10). Information relating to the clinical significance of persistent iron within the infarct core in patients with acute STEMI complicated by myocardial hemorrhage has been limited (e.g., sample size of n ≤ 40 [11–13]), and prognostic data on health outcomes are lacking.

We aimed to determine the incidence of persistent iron in a large cohort of STEMI survivors using contemporary \( T_2^* \) (observed time constant for the decay of transverse magnetization seen with gradient-echo sequences) mapping (14,15). Additionally, we aimed to identify which clinical characteristics would be associated with persistent iron and whether persistent iron may be associated with adverse clinical outcomes.

We hypothesized that persisting iron would: 1) be associated with markers of the initial severity of STEMI; 2) present with distinct clinical characteristics when compared with resolved iron; 3) be associated with adverse myocardial remodeling; and 4) be associated with a worse prognosis in the longer term.

METHODS

The full methodology has been reported previously (16–19) and is detailed in the Online Methods.

CARDIAC MAGNETIC RESONANCE IMAGE ANALYSIS. Cardiac magnetic resonance (CMR) imaging analysis was performed on a Siemens workstation (Siemens Healthcare, Erlangen, Germany). Left ventricular (LV) volumes and ejection fraction were assessed using computer-assisted planimetry (syngo.MR, Siemens Healthcare).

\( T_2^* \) measurement and myocardial hemorrhage. LV contours were delineated with computer-assisted planimetry on the raw \( T_2^* \) image and then copied onto color-coded spatially co-registered maps (Online Methods). Regions of interest were drawn in the infarct area surrounding core, core, and remote zones. Myocardial hemorrhage at 2 days and iron at 6 months were defined as regions of signal intensity <20 ms within the infarcted area and were measured as a percentage of LV mass and as a percentage of infarct size (20–22). Each \( T_2^* \) map was assessed by 2 independent CMR analysts for the presence of myocardial hemorrhage or iron.

\( T_2 \) measurement and myocardial edema. LV contours on the last corresponding \( T_2 \) (the transverse relaxation time)-weighted raw image with an echo time of 55 ms were planimetered and then copied to the map (23). Regions of interest were drawn in the surrounding infarct and remote zones. The extent of myocardial edema was defined as LV myocardium with pixel values (\( T_2 \)) >2 SD from remote myocardium (23,24).

Infarct definition and size. The territory of infarction was quantified using computer-assisted planimetry and was expressed as a percentage of LV mass (25).

Myocardial salvage. Myocardial salvage was calculated by subtraction of percentage of infarct size from percentage of myocardial edema (7,26,27). The myocardial salvage index was calculated by dividing the myocardial salvage area by the initial percentage of myocardial edema.

Adverse remodeling. Adverse remodeling was defined as an increase in LV end-diastolic volume at 6 months from baseline by 20% or more (17).

HEALTH OUTCOMES. We pre-specified adverse health outcomes that are implicated in the pathophysiology and natural history of STEMI. The primary composite outcome was all-cause death or first heart failure event (hospitalization for heart failure or defibrillator implantation) following the 6-month CMR scan. The secondary composite outcome was major adverse cardiac events (MACE).

STATISTICAL ANALYSIS. The full statistical methods are reported in the Online Methods. All p values were 2-sided. A p value >0.050 indicated the absence of a statistically significant effect. Analyses were performed using SPSS version 22 for Windows (SPSS, Inc., Chicago, Illinois), or R version 3.3.0 (R Foundation for Statistical Computing, Vienna, Austria).
The characteristics of patients with paired evaluable $T_2^*$ data ($n = 203$) are shown in Table 1 and Online Table 1. The mean ± SD age was $57 ± 11$ years, and $78\%$ were male.

A total of $74 (36\%)$ patients had acute myocardial hemorrhage, and $44 (59\%)$ of these patients had evidence of persistent iron at $6$ months. No patients had de novo myocardial hemorrhage between the 2-day and 6-month scans.

Compared with patients with resolved hemorrhage from baseline, patients with persistent iron were less likely to have a history of hypertension, and they had higher heart rates at presentation (Table 1). The culprit artery was more likely to be the left anterior descending coronary artery, and these patients had higher peak troponin levels post-STEMI (Table 1).

CMR findings are summarized in Table 2 and Online Table 2.

CMR findings during the index hospitalization. The mean size of hemorrhage at baseline was $26.9 ± 15.2\%$ of infarct size. All patients with acute myocardial hemorrhage had microvascular obstruction.

At 2-day CMR, patients with persisting iron had lower LV ejection fractions, larger LV end-systolic volumes, larger infarctions, a greater burden of microvascular obstruction, and a larger area of myocardial edema at baseline, compared with patients with resolved iron (Table 2). There was no difference in $T_2$ signal in the infarct zone at baseline (Table 2).

CMR findings at 6 months. In patients with persistent iron, the extent of hemorrhage or iron (percentage of infarct size) reduced in size from baseline to follow-up ($26.2 ± 12.8\%$ vs. $10.6 ± 9.4\%$; $p < 0.001$) (Table 2). $T_2^*$ values within the infarct zone were lower at 6 months in patients with persisting iron (Table 2, Online Figure 2). Compared with patients without hemorrhage at baseline, patients with hemorrhage at baseline had higher $T_2$ values within the infarct zone at 6 months ($58.7 ± 4.9$ ms vs. $55.9 ± 3.7$ ms; $p < 0.001$). Additionally, patients with persisting iron had higher infarct zone $T_2$ values than patients without hemorrhage at baseline.
without acute hemorrhage and patients with resolved iron collectively (59.5 ± 5.5 ms vs. 56.2 ± 3.8 ms; p = 0.001). There was no difference in T2 values within the infarct zone in patients with persisting iron compared with patients with resolved iron (Figures 1A and 1B, Online Table 2, Online Figure 2).

**CLINICAL ASSOCIATES OF PERSISTENT IRON.** The multivariable associates of infarct core iron status at 6 months are shown in Table 3 and Online Table 3. The main predictors of persisting iron in patients with acute hemorrhage were a higher heart rate at presentation, the absence of a history of hypertension, and infarct size (Table 3).

**PERSISTENT IRON AND LV REMODELING.** In multivariable linear regression, persistent iron at 6 months was associated with worsening LV end-diastolic volume and worsening LV ejection fraction (Online Table 4, Online Figure 3). The multivariable association between persistent iron and adverse remodeling (odds ratio: 2.89; 95% confidence interval: 0.80 to 10.48; p = 0.106) was not statistically significant.

**PERSISTENT IRON AND HEALTH OUTCOME.** Health outcome data were available in 203 (100%) patients. The median duration of follow-up was 1,457 days (post-discharge censor duration range 233 to 1,734 days). All-cause death or heart failure following the 6-month assessment occurred in 14 (7%) patients, including 3 cardiovascular deaths (n = 2 sudden deaths), 1 unknown cause of death, and 5 heart failure episodes (hospitalization for heart failure [n = 1] and defibrillator implantation [n = 4]). Persistent iron was associated with the occurrence of all-cause death or heart failure (hazard ratio: 3.91; 95% confidence interval: 1.37 to 11.14; p = 0.011) (Figure 2).

MACE following the 6-month assessment occurred in 13 (6%) patients, including 3 cardiovascular deaths (n = 2 sudden deaths), 5 heart failure episodes (hospitalization for heart failure...
[n = 1] and defibrillator implantation [n = 4]), 4 non-STEMIs, and 1 STEMI.

Persistent iron was associated with the occurrence of MACE (hazard ratio: 3.24; 95% confidence interval: 1.09 to 9.64; p = 0.035) (Figure 2).

Associations with persistent iron and health outcome were not independent of the initial size of the infarct.

DISCUSSION

We present a large investigation of persistent iron within the infarct core, as revealed by T2* mapping, after acute myocardial hemorrhage in a cohort of unselected patients with STEMI.

The main findings are as follows: 1) 36% patients had myocardial hemorrhage at baseline, and 59% of these patients had evidence of persistent iron at 6 months; 2) de novo myocardial hemorrhage did not occur after the 2-day CMR scan; 3) clinical associates of persistent iron included patients’ characteristics (male sex, smoking status), hemodynamic features at presentation (heart rate), neutrophil count, and electrocardiographic, angiographic and imaging measures of STEMI severity (ST-segment resolution, Thrombus In Myocardial Infarction flow, infarct size, myocardial edema); 4) higher heart rate, absence of hypertension, and larger initial infarct size differentiated patients who had persisting iron from patients with resolution of iron; 5) persisting iron was associated with increasing LV end-diastolic volume and decreasing LV ejection fraction at 6 months; and 6) persisting iron was associated with an approximately 4-fold increase in the likelihood of all-cause death or heart failure and a 3-fold increase in the likelihood of MACE. Taken together, these findings identify persistent iron residues as a mechanistic explanation of LV remodeling and worsening function (Figures 1A and 1B). Potentially, persistent iron represents a therapeutic target, and further research seems warranted.

Our analysis builds on the results of other studies (11,12,18), and it helps to clarify some conflicting results (13). In a time-course study of myocardial edema and hemorrhage by Zia et al. (13), the mean T2* relaxation time returned to normal by 6 months...
TABLE 3  Multivariable Associations With 6-Month Iron Status (Resolved or Persisting) (n = 74) at 6 Months Post-STEMI in Logistic Regression Analysis*  

<table>
<thead>
<tr>
<th>Multivariable Associations</th>
<th>Odds Ratio (95% CI)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients’ characteristics and angiographic data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart rate, beats/min</td>
<td>1.08 (1.02-1.14)</td>
<td>0.009</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.12 (0.02-0.68)</td>
<td>0.017</td>
</tr>
<tr>
<td>Infarct size, % LV mass</td>
<td>1.10 (1.01-1.20)</td>
<td>0.028</td>
</tr>
<tr>
<td>Patients’ characteristics, angiographic data, and infarct size</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart rate, beats/min</td>
<td>1.08 (1.01-1.16)</td>
<td>0.020</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.10 (0.01-0.67)</td>
<td>0.018</td>
</tr>
<tr>
<td>Infarct size, % LV mass</td>
<td>1.10 (1.01-1.20)</td>
<td>0.028</td>
</tr>
</tbody>
</table>

*Only statistically significant variables are reported. All variables included in the model are described in the Online Appendix. The odds ratio (95% confidence intervals) indicates odds of persisting iron at 6 months given exposure to the independent variable. Similar results were obtained when myocardial edema was included instead of infarct size.

In Table 3, we report the multivariable associations with 6-month iron status (resolved or persisting) at 6 months post-STEMI. The table includes the odds ratio (95% confidence intervals) for various variables, such as heart rate, systolic blood pressure, and infarct size, which are associated with persistence of iron residues. The analysis is conducted using logistic regression. Our results reveal that a history of hypertension may have a protective effect on the persistence of iron. In addition, a diagnosis of hypertension was associated with increasing LV ejection fraction. This is an unexpected finding, given that previous studies showed that hypertension is associated with myocardial hemorrhage acutely (28,29). A history of hypertension reflects an established diagnosis and the presence of concomitant antihypertensive drug therapy initiated before the STEMI event. Further, persisting iron and acute myocardial hemorrhage reflect different but related processes. Persisting iron at 6 months reflects all factors from after reperfusion to follow-up, whereas myocardial hemorrhage early post-STEMI is related to acute reperfusion injury. We also observed no association between the time from symptom onset to reperfusion and the persistence of iron. Evidence suggests that ischemic time is associated with myocardial hemorrhage (6,28,30); however, studies in the present cohort (18,19) and others (5,11) have suggested that there is no association. Our results add to our idea that acute myocardial hemorrhage and persisting iron result from distinct pathological processes.

Bulluck et al. [12] pooled the results from all current studies of residual iron (11,12,18) and calculated the prevalence of myocardial hemorrhage as 39 of 73 (53%) patients, with 28 of 39 (72%) patients having persisting iron. Adding in our results (which include 30 patients from the serial imaging substudy by Carrick et al. [18]), the up-to-date values are 100 of 246 (41%) patients with myocardial hemorrhage (Kali et al. [11], 11 of 15; Bulluck et al. [12], 15 of 28; our study, 74 of 203) and 68 of 100 (68%) with persisting iron (Kali et al. [11], 11 of 11; Bulluck et al. [12], 13 of 15; our study, 44 of 74). The comparatively low incidence of persisting iron in our study may be a reflection of an unselected, consecutively recruited, large cohort of patients with STEMI, with a wide heterogeneity in the severity of infarcts. For example, in the population studied by Bulluck et al. [12], the acute infarct size was larger than in our study (27 ± 15% vs. 18 ± 14%), and the left anterior descending coronary culprit artery was predominant (60% vs. 40%). We have found that both these features are associated with persistence of iron residues.

Bulluck et al. [12] reported high T2 infarct zone signal in patients with persisting iron; however, the number of patients with resolved iron in their cohort was small (n = 2). Further, none of the patients in the study by Kali et al. [11] had resolved iron. The conclusion, therefore, that the persistence of iron causes edema has not been resolved. In the present study, myocardial T2 in the infarct zone at 6 months was higher in patients with acute myocardial hemorrhage, but no differences were observed in those patients with persistent iron compared with those with resolution (Figures 1A and 1B, Online Table 2). Other factors may be relevant, including the confounding problem that STEMI severity is linked with myocardial hemorrhage. Nonetheless, patients with persisting iron had higher infarct zone T2 signal than patients without hemorrhage and those with resolved iron collectively, a finding that supports a mechanistic basis for the association between persisting iron and worsening LV volumes and function. Persistent iron may represent a nidus to drive local and systemic inflammation, consistent with our observation of higher neutrophil counts in patients with persisting iron. This theory is further supported by a recent canine study by Kali et al. [10], which demonstrated the presence of proinflammatory cells in areas of iron deposition post-myocardial infarction.

Our research has important clinical implications. The persistence of iron defines a high-risk group of patients post-STEMI. Intramyocardial hemorrhage is proarrhythmic (31-33), and this feature may contribute in part to a higher mortality rate in patients with persisting iron at 6 months. The relationship between persistent iron and worsening health outcome further highlights the need for therapeutic interventions to prevent the occurrence of myocardial hemorrhage acutely. We have shown that patients with a more severe STEMI initially are at higher risk of persistent iron; therefore novel treatments may be stratified at-at-risk patients very early after reperfusion. Our results also support the case for...
CMR-based risk assessment at 6 months in those patients with acute myocardial hemorrhage early post-myocardial infarction to detect persistent infarct zone iron. Affected patients may benefit from more intensive therapy. We are uncertain about the justification for systemic iron chelation therapy as suggested by Bulluck et al. (34), given that iron deficiency is an adverse prognostic factor in patients with LV dysfunction (35). The possibility that patients with acute STEMI could benefit from targeted therapy to prevent myocardial hemorrhage is currently being investigated. T-TIME (A Trial of Low-dose Adjunctive alteplase During priMary PCI) (36) is a randomized, double-blind, placebo-controlled phase II trial of low-dose intracoronary alteplase in patients with acute STEMI who present <6 h from symptom onset with risk factors for microvascular obstruction (e.g., proximal culprit lesion location). T-TIME tests the efficacy hypothesis that intracoronary thrombolysis will reduce coronary thrombus burden, restore microvascular perfusion, reduce infarct zone hemorrhage, and improve surrogate clinical outcomes. The alternate safety hypothesis that intracoronary lysis will increase infarct zone hemorrhage and persistent myocardial iron, and thereby have an adverse effect on surrogate outcomes, will also be assessed.

**STUDY LIMITATIONS.** Our study lacks pathological correlation of the imaging results. Further, our results do not permit mechanistic interpretation regarding whether inflammation is the primary driver of persistent iron, or alternatively, persistent iron may reflect a defect in macrophage-mediated clearance of hemoglobin degradation products. As a result of time constraints imposed on the CMR examination, the T2* imaging protocol involved 3 short-axis slices (base, mid, apical) rather than a full LV stack, and therefore minor degrees of hemorrhage could have been missed. However, imaging positions were prescribed on anatomic landmarks, and scans were undertaken in the same laboratory, thus improving our ability to select the same matched slice positions between scans. The T2* acquisition was associated with imaging artifacts that limited the quantification of hemorrhage and iron in some patients. Future improvements to T2* mapping could include the use of high-pass filtered processing (37) and the use of an automated truncation method (38). Because the

**FIGURE 2 Persistent Iron and Adverse Outcomes After STEMI**

Kaplan-Meier survival curve for the relationship between infarct core iron status at 6 months and (A) all-cause death or heart failure and (B) major adverse cardiac events (censor time 1,457 days [range 233 to 1,734 days]). Persisting iron at 6 months post-ST-segment elevation myocardial infarction (STEMI) was associated with all-cause death or heart failure and major adverse cardiac events.
survival analyses included 14 events, we were limited in the number of confounders we could account for in the statistical models. These results are preliminary, and further research is warranted.

CONCLUSIONS

Persistent iron within the infarct core is common (about 3 in 5) in patients with myocardial hemorrhage early post-STEMI. Persistent iron is predictive of worsening LV function and volumes, as well as all-cause death or heart failure and MACE in the longer term.

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ADDRESS FOR CORRESPONDENCE: Professor Colin Berry, British Heart Foundation, Glasgow Cardiovascular Research Centre, Institute of Cardiovascular and Medical Sciences, 126 University Place, University of Glasgow, Glasgow, G12 8TA, Scotland, United Kingdom. E-mail: colin.berry@glasgow.ac.uk.

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KEY WORDS magnetic resonance imaging, myocardial infarction, remodeling

APPENDIX For a supplemental Methods section, supplemental Results section, and supplemental tables, figures, and references, please see the online version of this paper.