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## Current Clinical Use of Speckle Tracking Strain Imaging: Insights from a Worldwide Survey from the European Association of Cardiovascular Imaging-EACVI

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1 **Current Clinical Use of Speckle Tracking Strain Imaging: Insights from a Worldwide Survey**  
2 **from the European Association of Cardiovascular Imaging-EACVI**

3  
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2 L E Sade : None

3 S S Joshi: None

4 M Camelli: Participated data safety monitoring or advisory board for Novo nordisk and Astra Zeneca,  
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6 B Cosyns: participated on a Data safety Monitoring Board or advisory board for AMGEN, BMS

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18

19

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25

## 1 2 **ABSTRACT**

3  
4 **Background:** Echocardiographic speckle-tracking strain imaging (STE) has been a major advance in  
5 myocardial function quantification. We aimed to explore current world-wide clinical application of  
6 STE.

7 **Methods:** Access, feasibility, access, and clinical implementation of STE were investigated with a  
8 worldwide open-access online survey of the European Association of Cardiovascular Imaging  
9 (EACVI).

10 **Results:** Participants (429 respondents, 77 countries) from tertiary centers (46%), private clinics or  
11 public hospitals (54%) using different vendors for data acquisition and analysis were represented.  
12 Despite almost universal access (98%) to STE, only 39% of the participants performed and reported  
13 STE results frequently (>50%). Incomplete training and time constraints were the main reasons for not  
14 using STE more regularly. STE was mainly used to assess the left ventricular (99%) and less  
15 frequently the right ventricular (57%) and the left atrial (46%) function. Cardiotoxicity (88%) and  
16 cardiac amyloidosis (87%) were the most frequent reasons for the clinical use of left ventricular STE.  
17 Left atrial STE was used most frequently for the diagnosis of diastolic dysfunction and right  
18 ventricular STE for the assessment of RV function in pulmonary hypertension (51%). Frequency of  
19 STE use, adherence to optimal techniques and clinical appropriateness of STE differed according to  
20 training experience and across vendors. Key suggestions outlined by respondents to increase the  
21 clinical use of STE included improved reproducibility (48%) and standardization of strain values  
22 across vendors (42%).

23 **Conclusions:** Although STE is now readily available, it is underutilized in the majority of centers.  
24 Structured training, improved reproducibility and inter-vendor standardization may increase its uptake.

25

1 **Keywords:** Speckle tracking strain, echocardiography, clinical, inter-vendor.

## 2 **Introduction**

3 Speckle tracking echocardiography (STE) has been shown to be an invaluable tool in detecting  
4 subclinical LV systolic dysfunction in different clinical scenarios, and to provide a favorable impact  
5 on the management of specific cardiac conditions by providing information which is not available  
6 with any of the currently used echocardiographic parameters. The exciting potential of this approach is  
7 reflected by the exponential increase in research and scientific publications over the last decade.  
8 Furthermore, STE is frequently highlighted by current recommendation documents from the European  
9 Association of Cardiovascular Imaging (EACVI) and American Society of Echocardiography (ASE)  
10 as a state of the art approach for patient evaluation.<sup>1-7</sup> Consequently, it is crucial to have a better  
11 understanding of how this imaging technique is used in current clinical practice, from both a technical  
12 and clinical perspective as well as the remaining barriers limiting its widespread clinical  
13 implementation.  
14 Therefore, this survey aims 1) to understand the implementation of recommendations on ST strain  
15 imaging in clinical practice worldwide and 2) to explore barriers and challenges in clinical  
16 applications. Ultimately the survey seeks to inform future strategies to optimize integration of STE  
17 into routine patient assessment.

## 18 19 **Methods**

20 The present survey was conducted by the EACVI Scientific Initiatives Committee from 15 September  
21 to 15 October 2022 according to published criteria (8). Participation in the survey was through an  
22 open access weblink for physicians, sonographers and technicians. The weblink of the survey was  
23 shared through the European Society of Cardiology (ESC) website, official bulletins of the ESC, and

1 the social media for inviting the participants. Participants from 250 EACVI registered units around the  
2 world were invited to complete an online survey comprising 27 questions. The first 10 questions of the  
3 survey were prepared to obtain information about the access to STE and the feasibility of the tool in  
4 different categories of health care providers, 9 questions aimed at obtaining information about the  
5 training and optimal technical use of STE software, and 8 questions aimed to obtain information about  
6 the clinical implementation of STE in current clinical practice and the expected improvements to  
7 increase its integration into daily practice.

8

## 9 **Statistics**

10 Data were transferred into SPSS (Version 28.0) for statistical analyses. Categorical evaluations were  
11 transformed into semiquantitative scores. Training extent was grouped from 0 to 3 as; 0: no training  
12 (n=61), 1: trained via 1 educational resource (n=261), 2: trained via 2 or 3 educational resources  
13 (n=133) and 3: trained through more than 3 (n=20) educational resources. *Technical adherence score*  
14 (TAS) was obtained from 5 questions about the technical use of STE in the questionnaire: A point of 1  
15 was assigned if the response complied with current EACVI recommendations, if not a point of 0 was  
16 assigned (TAS  $\leq 3$  indicated poor adherence and  $\leq 4$  indicated good adherence ). *Clinical*  
17 *use score* (CUS) was obtained by assigning a score of 1 to each evidence based clinical condition  
18 where strain was used. For this purpose we took into account EACVI consensus documents,  
19 recommendation papers, ESC guidelines, and meta-analyses.<sup>2-7,9-20</sup> According to the opted responses  
20 the maximum TAS would be 5, and the maximum CUS would be 15 (Table 1). Comparison between  
21 the groups was performed by Chi-Square for categorical variables. Scores were compared among  
22 groups by one-way ANOVA with Bonferroni post hoc comparisons if necessary.

23

## 1 **Results**

2  
3 In total, 429 voluntary participants responded to the survey from 77 countries across the globe. The  
4 participants were from, Algeria, Angola, Argentina, Armenia, Australia, Austria, Bahrain,  
5 Bangladesh, Belgium, Bosnia and Herzegovina, Brazil, Bulgaria, Canada, Chile, China, Columbia,  
6 Costa Rica, Croatia, Cyprus, Czechia, Denmark, Egypt, Estonia, Finland, France, Georgia, Germany,  
7 Greece, Hungary, India, Iran, Iran, Iraq, Ireland, Italy, Japan, Jordan, Korea, Kuwait, Lebanon,  
8 Lithuania, Malaysia, Mexico, Mongolia, Morocco, Myanmar, the Netherlands, New Zealand, Nigeria,  
9 North Macedonia, Norway, Oman, Pakistan, Palestine, Paraguay, Peru, Poland, Portugal, Romania,  
10 Russian Federation, Saudi Arabia, Senegal, Serbia, Slovenia, South Africa, Spain, Sweden,  
11 Switzerland, Syrian Arab Republic, Taiwan, Tunisia, Turkiye, Ukraine, United Arab Emirates, United  
12 Kingdom of Great Britain and Northern Ireland, United States of America, Uruguay, Uzbekistan.

13  
14 Participants worked in tertiary centers (45%), public hospitals (37%), private clinics (17%) and  
15 intensive care or emergency departments (1%). More than half of the survey participants were senior  
16 echocardiographers (58%) and the others were early career echocardiographers (22%), multimodality  
17 imagers (16%) or sonographers (5%). Almost 95% of the participants worked in either cardiology or  
18 cardiothoracic departments with the remainder working in internal medicine, intensive care unit or  
19 emergency department (Figure 1).

## 21 **Access to Speckle Tracking Echocardiography**

22 The majority of respondents had access to STE within their department (80%), 15% reported having  
23 access to STE within their hospital and 5% either had access to it within their region (via referral)  
24 (3%) or did not have access to STE (2%) (Figure 2A).



1  
2 Interestingly, nearly a quarter (23%) of the participants reported not using this technology despite  
3 having access to it. The commonest reasons of not using STE were time constraints (49.7%) and the  
4 need for more training (37.6%). Other reasons included lack of motivation to spend time learning the  
5 technology (3.9%), not seeing the value in STE (3.9%) or a dislike for the post processing algorithms  
6 available to them (4.9%).

## 8 **Clinical Usage and Training Resources**

9 In terms of clinical usage, whilst 39% of the participants performed or reported speckle tracking  
10 frequently (>50% of their studies), 28% of the respondents included strain in their report infrequently  
11 (25-50% of their studies), 22% very rarely (<25% of their studies) and 7% of the respondents used  
12 STE only for research purposes (Figure 2B).

13  
14 The majority of respondents (84%) were trained in STE. Training at an expert center (47%) or by  
15 performing research with the use of STE (43%) were the most common means of training. Other  
16 training resources included national teaching courses (34%), the EACVI e-learning platform (22%),  
17 and EACVI hands-on teaching courses (17%) (Figure 3). While 15% did not receive any training,  
18 54% were trained on STE by means of more than one resource. Interestingly, 18 out of 38 (47%) who  
19 mentioned a need for more training had previous training (32 from 1 resource, 6 from more than 1  
20 resources). Importantly, more extensive training in STE was associated with increasing CUS (CUS:  
21  $6.1 \pm 3.2$  in those who were not trained, CUS:  $7.6 \pm 3.3^*$  in those who were trained via 1 resource,  
22 CUS:  $8.8 \pm 3.0^{*\dagger}$  in those who were trained via 2-3 resources, CUS:  $9.2 \pm 3.4^{*\dagger}$  in those who were

1 trained via more than 3 resources; \* $p < 0.01$  vs not trained, †  $p < 0.01$  vs 1 resource) (Central  
2 illustration).

#### 4 **Offline versus during acquisition preferences of STE analyses**

5 The majority (63%) of respondents performed strain analyses during image acquisition while 37%  
6 performed offline analyses. EchoPAC was the most widely (69%) used workstation for offline  
7 analysis among the respondents. TomTec was used by 10%, Xcelera by 7%. Other postprocessing  
8 systems were used less frequently. Users from emergency departments and intensive care performed  
9 STE exclusively during image acquisition. Offline strain analyses were least frequent among private  
10 clinic practitioners (24%) whereas offline systems were used by 35% of public hospital practitioners  
11 and 44% of tertiary center practitioners ( $p < 0.001$ ). More extensive STE training was associated with  
12 more frequent use of offline analysis workstations and offline strain analysis was performed by the  
13 majority of researchers (58%). Importantly, offline strain quantification was associated with higher  
14 CUS and TAS (Table 2).

15  
16 In the majority of the countries, STE provided no revenue as an add-on to the regular transthoracic  
17 echocardiography (56 out of 79 countries (71%), and according to 85% of the respondents). On the  
18 other hand, revenue for STE was declared by 88% of respondents from the United States of America,  
19 else, in 22 countries reimbursement or a fee was applied only occasionally.

#### 21 **Appropriate use of the technique**

22 Among the users almost all (99%) performed STE for the left ventricle (LV). For this purpose, 85%  
23 used global longitudinal strain (GLS) obtained from 3 apical views. However, 8% quantified LV

1 longitudinal strain from the apical 4- and 2- chamber views whilst 6% quantified STE from only the  
2 apical 4-chamber. Automated algorithm analysis with manual correction of the region of interest was  
3 the most widely adopted approach (88%). Only 6% used fully automated algorithms and 5% manual-  
4 only tracings.

5  
6 For clinical purposes, GLS was the most frequently used strain assessment tool (97%) followed by  
7 bull's eye plots (76%), the segmental strain curve pattern (33%), segmental peak systolic strain (28%)  
8 and time to peak strain (22%). In patients with atrial fibrillation, almost half the responders (49%)  
9 reported obtaining GLS using the automated algorithm only if the cardiac cycles were similar and  
10 within physiological limits. The others reported either taking an average of longitudinal strain  
11 measured manually from the 3 apical views regardless of cycle length variation (16%) or by assessing  
12 only the apical 4 chamber average longitudinal strain (4%). Meanwhile, 30% did not quantify LV  
13 longitudinal strain in patients with atrial fibrillation.

14  
15 Just under half (46%) of the survey participants quantified left atrial (LA) strain. The majority (59%)  
16 calculated LA longitudinal strain by taking an average of the apical 4- and 2-chamber views. Others  
17 used either the apical 4-chamber or 2-chamber views.

18 For the right ventricle (RV), STE was used by 57% of the respondents: 35% measured STE in the RV  
19 free wall, 27% took the average of STE measurements from the septum and free wall whilst 16% used  
20 the automated function imaging algorithm. Only 8% of respondents measured strain in the right  
21 atrium.

22

1 Training experience of the operator was associated with greater adherence to the technical  
2 recommendations provided by the EACVI / ASE standardization taskforce as shown in function of  
3 TAS in Central illustration (TAS:  $2.6 \pm 1.4$  in those who were not trained, TAS:  $3.0 \pm 1.1$  in those  
4 who were trained via 1 resource, TAS:  $3.3 \pm 1.2^*$  in those who were trained via 2-3 resources, TAS:  
5  $3.6 \pm 1.0^*$  in those who were trained via more than 3 resources;  $*p < 0.01$  versus no training) .  
6

### 7 **Characteristics of the Usage of STE by Vendors**

8 Among respondents, General Electric (GE) was the most frequently used cardiac ultrasound vendor  
9 for STE (59%), followed by Philips (32%), Siemens (3%), other brands (6%, including Canon,  
10 Toshiba, Esaote, Mindray). Differences in the technical approach to LV strain assessment were  
11 observed among users of different vendors (Table 3). LV GLS assessment from 3 apical views was  
12 performed most frequently by GE and Philips users as well as RV and LA strain assessments. Strain  
13 pattern recognition with the bull's eye plot was most frequently adopted by GE users. Importantly, the  
14 clinical frequency of STE utilization also differed among users of different vendors. Strain analysis  
15 during the acquisition was performed more frequently than offline analysis across all vendors, but this  
16 trend was most prominent among Siemens users. Forty-seven percent of GE users performed STE  
17 frequently (in  $>50\%$  of the studies), in comparison to 26% of Philips, 25% of Siemens and 21% of  
18 other brand users in their studies ( $p=0.001$ ). The majority (58%) of Siemens users performed STE in  
19 less than a quarter of their studies. Of note, the technical adherence score was highest among GE  
20 followed by Philips users. The evidence based clinical use score was also highest among GE users  
21 followed by other brand users and Philips users. Regarding STE vendor distribution across different  
22 institutions represented in the survey, GE and Philips were mostly used in tertiary centers, Siemens,

1 mostly in public hospitals and other brands mostly in private clinics (Central illustration). Training  
2 intensity did not differ between users of different vendors.

#### 4 **Applications of STE in Clinical Practice**

5 The survey investigated the conditions where LV strain was considered most helpful in clinical  
6 decision making. Diagnosis of cardiotoxicity (88%) and cardiac amyloidosis (87%) were highlighted  
7 as the most common conditions for the clinical use of STE. The other conditions stated by survey  
8 respondents are included in Figure 4.

9  
10 Whilst 62% of the participants envisaged using an impaired LV GLS as a trigger to optimizing  
11 medical treatment in patients with heart failure with preserved ejection fraction, 38% did not.  
12 Similarly, when asked regarding the use of LV GLS in heart failure with reduced ejection fraction  
13 (EF) (<50%), 35% reported always taking it into account as they considered GLS to be more  
14 reproducible than EF, 31% used it for monitoring response to medical therapy, 7% used it to monitor  
15 response to treatment in patients receiving cardiac resynchronization therapy and 27% did not use  
16 GLS in this scenario. Interestingly, the majority (71%) reported never using LV strain with  
17 dobutamine stress, while 25% reported using strain for the assessment of viability and 4% for the  
18 study of LV dyssynchrony.

19  
20 Clinical scenarios where RV strain was assessed by the participants included pulmonary hypertension  
21 (51%), arrhythmogenic cardiomyopathy (33%), routine echocardiographic exams to assess RV  
22 function (24%), suspicion of RV infarction (23%) and to aid selection of candidates for cardiac  
23 resynchronization therapy (7%).

1  
2 The survey also investigated indications for performing LA strain, with the most common being the  
3 diagnosis of diastolic dysfunction (48%), followed by prediction of the risk of developing atrial  
4 fibrillation (30%), the routine assessment of LA function (19%), as well as the prediction of embolic  
5 stroke risk in both sinus rhythm (14%) and atrial fibrillation (10%).

### 7 **Suggestions for Future Developments**

8 Finally, the survey gathered suggestions for solutions to increase the clinical use of STE. Improved  
9 measurement reproducibility was the most frequent answer provided (47%), followed by  
10 standardization of STE results to improve cross-interpretation across different vendors (42%). Faster  
11 algorithms (32%), increasing the revenue associated with performing STE (30%), the development of  
12 vendor neutral solutions (23%) and methods to apply STE to 3-dimensional data sets (18%) as well as  
13 higher frame rates (17%) were other important suggestions (Figure 5).

### 15 **Discussion**

16 The present survey is unique in providing real world data about the clinical use of STE from 77  
17 countries, focusing on access, application, training, and vendors. The main findings are as follows: 1)  
18 Despite near universal access, the performance of STE remains relatively low in clinical practice. 2)  
19 The extent of operator training in STE is associated with the frequency of clinical usage, adherence to  
20 optimal technique defined by the strain standardization task force and evidence based clinical use. 3)  
21 A non-negligible percentage of echocardiographers did not have training on STE or did not feel self-  
22 confident enough despite having some training. 4) There is also important vendor related variation in  
23 clinical use of STE.

1  
2 Overall, the current clinical application of STE was lower in this survey than expected. Despite almost  
3 universal access, only 39% performed and reported STE frequently (>50%) in their reports. When  
4 used, the clinical conditions where STE was applied were compliant with the scientific evidence and  
5 recommendations of the EACVI, most commonly being utilized in the left ventricle in patients with  
6 suspicion for cardiac amyloidosis and chemotherapy induced cardiotoxicity. Disease oriented  
7 evidence-based consensus documents are also eagerly awaited as well as further scientific evidence  
8 demonstrating the clinical benefits of using STE in routine practice across different medical  
9 conditions. Time constraints and lack of training were the 2 most important reasons for not using STE  
10 in daily practice despite having access to it. Time constraints may explain partly the preference of  
11 performing STE analysis during acquisition rather than offline. Even though the performance of STE  
12 is rarely reimbursed this was not described as a impeditive factor for its use, although it was described  
13 as a method of increasing the uptake and application of strain imaging in the future. The responses  
14 showed that most of the echocardiographers were trained at an expert center or using educational  
15 resources provided by their national societies. Approximately, a third of the respondents had received  
16 training from the EACVI driven resources, underpinning the importance of the efforts to expand the  
17 exposure to EACVI training platforms. The survey showed that respondents with more extensive  
18 training (training from more than 1 resource) in STE, demonstrated more frequent usage of this  
19 approach, greater adherence to optimal imaging techniques and more appropriate implementation of  
20 STE into clinical practice. The association between STE training experience and the frequency and  
21 quality of STE use in clinical practice suggests the need for a greater focus on structured training  
22 programs including at least 2 steps in order to achieve the necessary level of expertise and confidence  
23 for the use of STE in patient management.

1  
2 We observed prominent vendor related differences in the frequency of STE use, as well as adherence  
3 to optimal techniques and appropriate clinical application.<sup>21,22</sup> Furthermore, there was variation  
4 observed in vendor use according to place of work, with differences seen between tertiary centers,  
5 public hospitals and private clinics. The explanation for these vendor related differences requires  
6 further exploration but might include differences in processing algorithms and user-friendliness of the  
7 navigation platform among others. These differences might also present an opportunity for greater  
8 inter-vendor standardization efforts that might ultimately expand the clinical implementation of STE.  
9 Indeed, respondents felt that improved reproducibility and standardization of strain values across  
10 vendors were the key measures to improve uptake of STE in clinical practice.

11  
12

### 13 **Limitations**

14 The survey reflects the answers of voluntary respondents and may suffer from sampling bias.  
15 Confirmatory data from a larger number of more diverse centers would be welcome. The responses  
16 may be biased based on the potential different perceptions or interpretations of the questions by the  
17 respondents. We used arbitrary scoring systems when attempting to quantify the responses regarding  
18 technical adherence and clinical appropriateness factors. The negative contribution of poor image  
19 quality as a reason of not using the STE was not evaluated.

20

### 21 **Conclusions**

22 In conclusion, STE is now a widely accessible clinical tool, yet it is only routinely used in the minority  
23 of echocardiographic centers. Extensive training in STE appears important in determining a high



1 frequency of STE use and is associated with improved adherence to optimal imaging techniques and  
2 clinical appropriateness. Improving exposure of the echocardiographers to training resources as well  
3 as increasing measurement reproducibility and inter-vendor standardization may all contribute to  
4 accelerate the routine clinical adoption of STE.

## 6 **Data Availability**

7 The data underlying this article are provided by European Association of Cardiovascular Imaging  
8 (EACVI) by permission. Data will be shared on request to the corresponding author with permission  
9 of the EACVI.

## 11 **References**

- 12 1- Lang RM, Badano LP, Mor-Avi V, Afilalo J, Armstrong A, Ernande L, et al. Recommendations for  
13 cardiac chamber quantification by echocardiography in adults: an update from the American  
14 Society of Echocardiography and the European Association of Cardiovascular Imaging. *Eur Heart*  
15 *J Cardiovasc Imaging*. 2015;16:233-70.
- 16 2- Badano LP, Koliass TJ, Muraru D, Abraham TP, Aurigemma G, Edvardsen T, et al.  
17 Standardization of left atrial, right ventricular, and right atrial deformation imaging using two-  
18 dimensional speckle tracking echocardiography: a consensus document of the  
19 EACVI/ASE/Industry Task Force to standardize deformation imaging. *Eur Heart J Cardiovasc*  
20 *Imaging* 2018;19:591-600.
- 21 3- Galderisi M, Cosyns B, Edvardsen T, Cardim N, Delgado V, Di Salvo G, et al. Standardization of  
22 adult transthoracic echocardiography reporting in agreement with recent chamber quantification,  
23 diastolic function, and heart valve disease recommendations: an expert consensus document of the  
24 European Association of Cardiovascular Imaging. *Eur Heart J Cardiovasc Imaging*. 2017;18:1301-  
25 10.
- 26 4- Edvardsen T, Asch FM, Davidson B, Delgado V, DeMaria A, Dilsizian V, et al. Non-invasive  
27 imaging in coronary syndromes: recommendations of the European Association of Cardiovascular  
28 Imaging and the American Society of Echocardiography. *Eur Heart J Cardiovasc Imaging*.  
29 2022;23:e6-e33
- 30 5- Smiseth OA, Morris DA, Cardim N, Cikes M, Delgado V, Donal E et al. Multimodality imaging in  
31 patients with heart failure and preserved ejection fraction: an expert consensus document of the  
32 European Association of Cardiovascular Imaging. *Eur Heart J Cardiovasc Imaging*. 2022;23:e34-  
33 e61.
- 34 6- Marwick TH, Gimelli A, Plein S, Bax JJ, Charron P, Delgado V, et al. Multimodality imaging  
35 approach to left ventricular dysfunction in diabetes: an expert consensus document from the

- 1 European Association of Cardiovascular Imaging. *Eur Heart J Cardiovasc Imaging*. 2022;23:e62-  
2 e84
- 3 7- Haugaa KH, Basso C, Badano LP, Bucciarelli-Ducci C, Cardim N, et al. EACVI Scientific  
4 Documents Committee, EACVI Board members and external reviewers. Comprehensive multi-  
5 modality imaging approach in arrhythmogenic cardiomyopathy-an expert consensus document of  
6 the European Association of Cardiovascular Imaging. *Eur Heart J Cardiovasc Imaging*.  
7 2017;18:237-53
- 8 8- Haugaa KH, Marsan NA, Cameli M, D'Andrea A, Dweck MR, Carvalho RF, et al. Criteria for  
9 surveys: from the European Association of Cardiovascular Imaging Scientific Initiatives  
10 Committee. *Eur Heart J Cardiovasc Imaging*. 2019;20:963-6.
- 11 9- Magne J, Cosyns B, Popescu BA, Carstensen HG, Dahl J, Desai MY, et al. Distribution and  
12 Prognostic Significance of Left Ventricular Global Longitudinal Strain in Asymptomatic  
13 Significant Aortic Stenosis: An Individual Participant Data Meta-Analysis. *JACC Cardiovasc*  
14 *Imaging*. 2019;12:84-92
- 15 10- Westin O, Fosbøl EL, Maurer MS, Leicht BP, Hasbak P, Mylin AK. Screening for Cardiac  
16 Amyloidosis 5 to 15 Years After Surgery for Bilateral Carpal Tunnel Syndrome. *J Am Coll*  
17 *Cardiol*. 2022;80:967-77
- 18 11- Sharma S, Lassen MCH, Nielsen AB, Skaarup KG, Biering-Sørensen T. The clinical application  
19 of longitudinal layer specific strain as a diagnostic and prognostic instrument in ischemic heart  
20 diseases: A systematic review and meta-analysis. *Front Cardiovasc Med*. 2023;10:980626, doi:  
21 10.3389/fcvm.2023.980626, PMID: 37051064
- 22 12- Georgiopoulos G, Figliozzi S, Pateras K, Nicoli F, Bampatsias D, Beltrami M, et al. Comparison  
23 of Demographic, Clinical, Biochemical, and Imaging Findings in Hypertrophic Cardiomyopathy  
24 Prognosis: A Network Meta-Analysis. *JACC Heart Fail*. 2023;11:30-41.
- 25 13- Habib G, Bucciarelli-Ducci C, Caforio ALP, Cardim N, Charron P, Cosyns B, et al. Multimodality  
26 Imaging in Restrictive Cardiomyopathies: An EACVI expert consensus document In collaboration  
27 with the "Working Group on myocardial and pericardial diseases" of the European Society of  
28 Cardiology Endorsed by The Indian Academy of Echocardiography. *Eur Heart J Cardiovasc*  
29 *Imaging*. 2017;18:1090-21.
- 30 14- Maréchaux S, Guiot A, Castel AL, Guyomar Y, Semichon M, Delelis F, et al. Relationship  
31 between two-dimensional speckle-tracking septal strain and response to cardiac resynchronization  
32 therapy in patients with left ventricular dysfunction and left bundle branch block: a prospective  
33 pilot study. *J Am Soc Echocardiogr*. 2014;27:501-11.
- 34 15- Fine NM, Chen L, Bastiansen PM, Frantz RP, Pellikka PA, Oh JK, et al. Reference values for right  
35 ventricular strain in patients without cardiopulmonary disease: a prospective evaluation and Meta-  
36 analysis. *Echocardiography*. 2015;32:787-96.
- 37 16- Vitarelli A, Barilla F, Capotosto L, D'Angeli I, Truscetti G, de Maio M, et al. Right ventricular  
38 function in acute pulmonary embolism: a combined assessment by three-dimensional and speckle-  
39 tracking echocardiography. *J Am Soc Echocardiogr*. 2014;27:329-38.
- 40 17- Lyon AR, López-Fernández T, Couch LS, Asteggiano R, Aznar MC, Bergler-Klein J, 2022 ESC  
41 Guidelines on cardio-oncology developed in collaboration with the European Hematology  
42 Association (EHA), the European Society for Therapeutic Radiology and Oncology (ESTRO) and  
43 the International Cardio-Oncology Society (IC-OS). *Eur Heart J Cardiovasc Imaging*.  
44 2022;23:e333-e465

- 1 18- Pathan F, D'Elia N, Nolan MT, Marwick TH, Negishi K. Normal ranges of left atrial strain by  
 2 speckle-tracking echocardiography: A systematic review and meta-analysis. *J Am Soc*  
 3 *Echocardiogr*, 2017;30:59–70.
- 4 19- Fine NM, Shah AA, Han IY, Yu Y, Hsiao JF, Koshino Y, et al. Left and right ventricular strain  
 5 and strain rate measurement in normal adults using velocity vector imaging: an assessment of  
 6 reference values and intersystem agreement. *Int J Cardiovasc Imaging*.2013;29:571–80.
- 7 20- Morris DA, Takeuchi M, Krisper M, Kohncke C, Bekfani T, Carstensen T, et al. Normal values  
 8 and clinical relevance of left atrial myocardial function analysed by speckle-tracking  
 9 echocardiography: multicentre study. *Eur Heart J Cardiovasc Imaging*. 2015;16:364–72.
- 10 21- Ünlü S, Mirea O, Bézy S, Duchenne J, Pagourelas ED, Bogaert J, Thomas JD, Badano LP, Voigt  
 11 JU; EACVI-ASE-Industry Standardization Task Force. Inter-vendor variability in strain  
 12 measurements depends on software rather than image characteristics. *Int J Cardiovasc Imaging*.  
 13 2021;37:1689-97.
- 14 22- Farsalinos KE, Daraban AM, Ünlü S, Thomas JD, Badano LP, Voigt JU. Head-to-Head  
 15 Comparison of Global Longitudinal Strain Measurements among Nine Different Vendors: The  
 16 EACVI/ASE Inter-Vendor Comparison Study. *J Am Soc Echocardiogr*. 2015 ;28:1171-81  
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## 20 **Figure legends**

21 **Central illustration:** Frequent reporting, technical adherence and evidence based clinical use of STE  
 22 by training intensity, health care facility and vendors

23 **Figure 1:** Distribution of the participants by country (A), by work environment (B), by career position  
 24 (C).

25 **Figure 2:** Access to speckle tracking strain imaging (A) and usage frequency in clinical practice (B).

26 **Figure 3:** Resources used for training on STE.

27 **Figure 4:** The use of STE for specific clinical purposes (presented as percentage of respondents)  
 28 (\*denotes the diseases that were not included in the calculation of CUS)

29 **Figure 5:** Answers to “Which improvement would increase your clinical use of speckle tracking  
 30 imaging?”.

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**Tables:**

**Table 1:** Calculation of technical adherence and clinical use scores

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**Responses to questions showing technical adherence that were assigned a score of 1**

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1. How do you assess left ventricular global longitudinal strain? From 3 apical views.
2. How do you assess left atrial longitudinal strain? From the average of apical 4- and 2-chamber.
3. How do you quantify right ventricular strain? From both septum and free wall or by using the automated function imaging for the right ventricle.
4. How do you assess left ventricular longitudinal strain in atrial fibrillation? I obtain global longitudinal strain only if the cardiac cycles are similar and within physiological limits.
5. Which algorithm do you use to define the region of interest? Automated algorithm with manual correction.

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**Evidence based clinical use for specific diseases that were assigned a score of 1**

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1. Heart failure with preserved ejection fraction
  2. Chemotherapy induced cardiomyopathy
  3. Amyloidosis
  4. Hypertrophic cardiomyopathy
  5. Ischemic heart disease
  6. Fabry's disease
  7. Dilated cardiomyopathy (subclinical phase / early diagnosis)
  8. Aortic stenosis
  9. Adjunct to the diagnosis of arrhythmogenic cardiomyopathy
  10. Adjunct to patient selection for cardiac resynchronization therapy
  11. Adjunct for predicting the risk of developing atrial fibrillation
  12. Adjunct for predicting the risk of embolic stroke
  13. Adjunct for the diagnosis of diastolic dysfunction
  14. Pulmonary hypertension (right ventricle)
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 15. Suspected right ventricular infarction
 

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4 **Table 2:** Relation of real time versus offline strain analysis performance with training, health care  
5 provider, clinical usage and technical adherence.

		During image acquisition	Offline	P value
	Without training	43(78%)	12 (22%)	0.014
Training	Training from 1 resource	134 (63%)	79 (37%)	
	Training from >1 resource	84 (55%)	68 (45%)	
Health care provider	Private Clinic	53 (75%)	18 (25%)	0.014
	Public hospitals	99 (64%)	56 (36%)	
	Tertiary centers	106 (56%)	84 (44%)	
Clinical usage frequency	Frequent use >50%	96 (58%)	69 (42%)	0.02
	Infrequent use 25-50%	71 (59%)	49 (41%)	
	Rare use <25%	75 (79%)	20 (21%)	
	For research	13 (42%)	18 (58%)	
Clinical use score		7.7 ± 3.6	8.9 ± 3.2	<0.001
Technical adherence score		3.03 ± 1.2	3.3 ± 1.1	0.02

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2 **Table 3:** Vendor related usage characteristics

	General Electric n=261	Philips n=141	Siemens n= 13	Other n=14	P
<b>LV strain assessment</b>	98.1	98.6	100	93	
From 3 apical views	89	82	42	71	<0.001
Only from apical 4- chamber view	4	7	42	7	
From apical-4, and -2 chamber views	6	10	17	21	
<b>RV strain assessment</b>	61	57	21	42	0.008
<b>LA strain assessment</b>	45	49	33	21	NS
<b>Bull's Eye pattern use</b>	82	65	58	79	0.001
<b>Analyze performance</b>					
During acquisition	55	68	92	79	0.001
Offline	43	31	8	14	
<b>Frequency of use</b>					
>50% of studies	47	26	25	21	0.001
25-50% of studies	27	29	17	36	
<25% of studies	26	45	58	43	
<b>Technical adherence score</b>	3.3±1.1	3.0±1.2	2.3±1.6*	2.2±1.4†	0.001
<b>Clinical use score</b>	8.4±3.2	7.0 ±3.4†	6.8±2.5*	7.6±2.4	0.001
<b>Health care provider</b>					
Private clinic	13.4	19.1	33.3	57.1	0.001
Public hospital	38.2	36.2	50.0	21.4	

Tertiary center

47.3

44.7

8.3

21.4

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- 1 LA; left atrial, LV; left ventricular, RV; right ventricular. Values are presented as percentages or mean  
2  $\pm$  standard deviation. \*p<0.05 vs General Electric, †p<0.001 vs General Electric

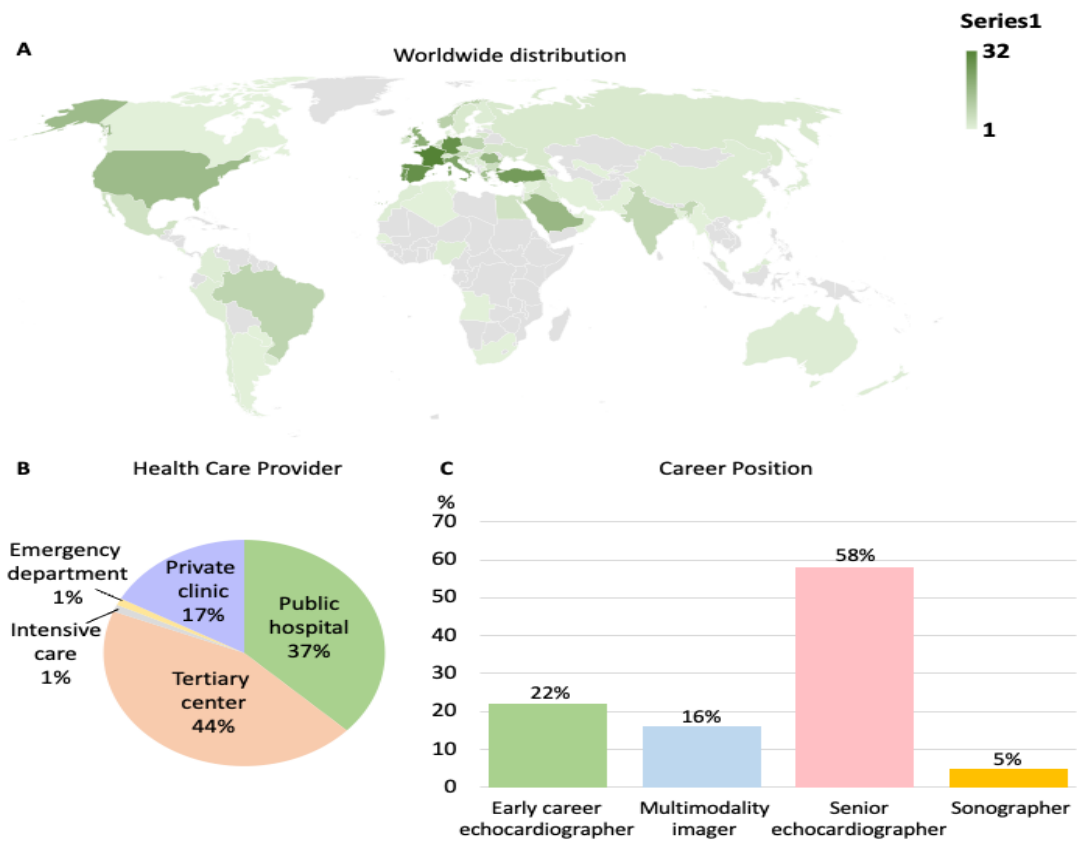


Figure 1



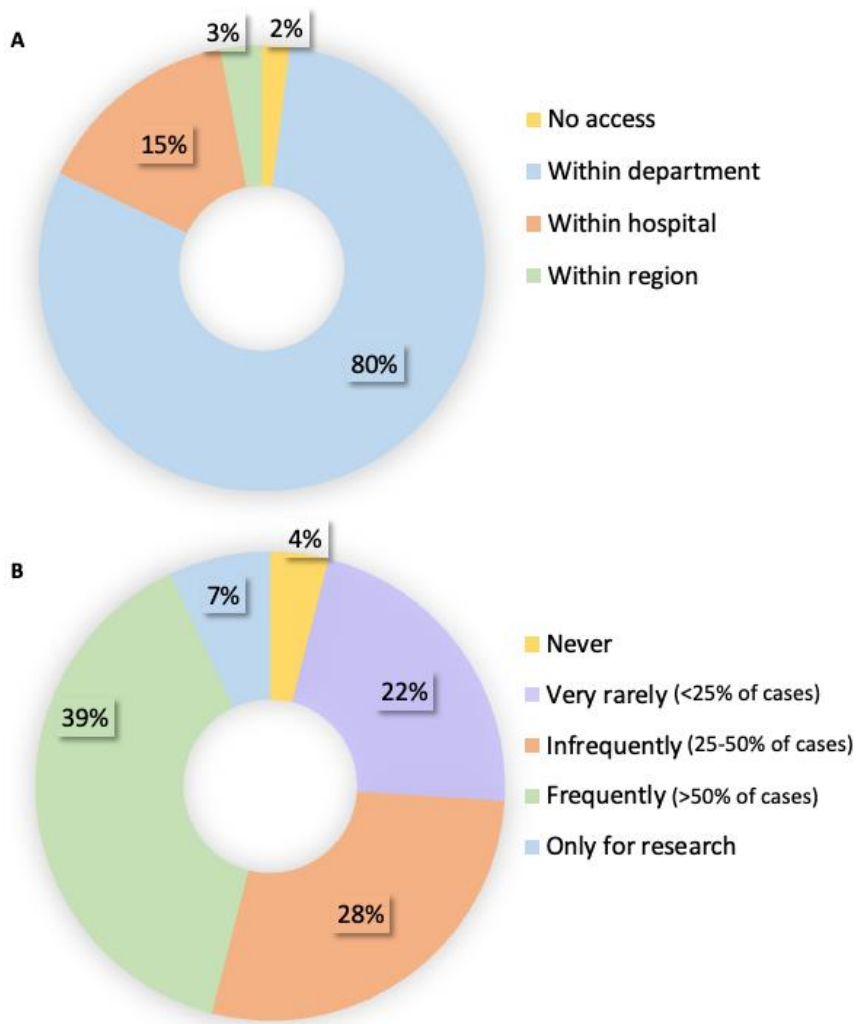


Figure 2

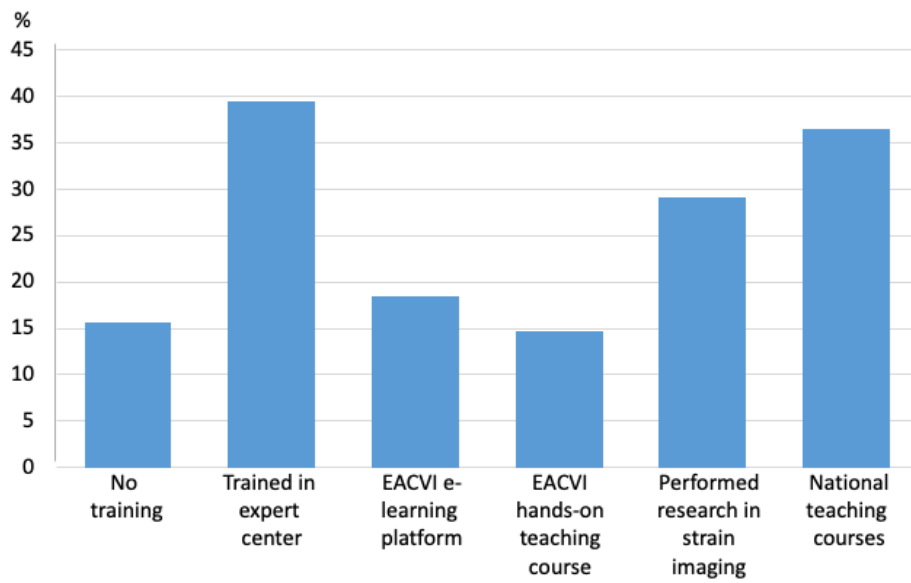


Figure 3

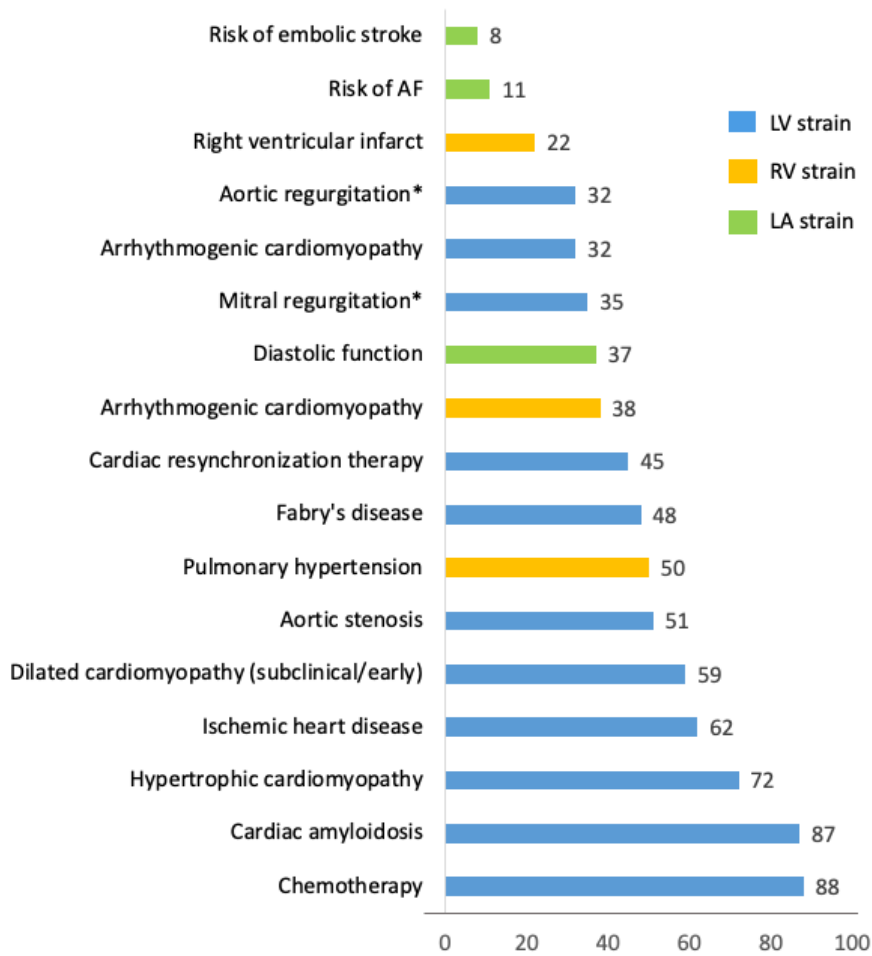


Figure 4

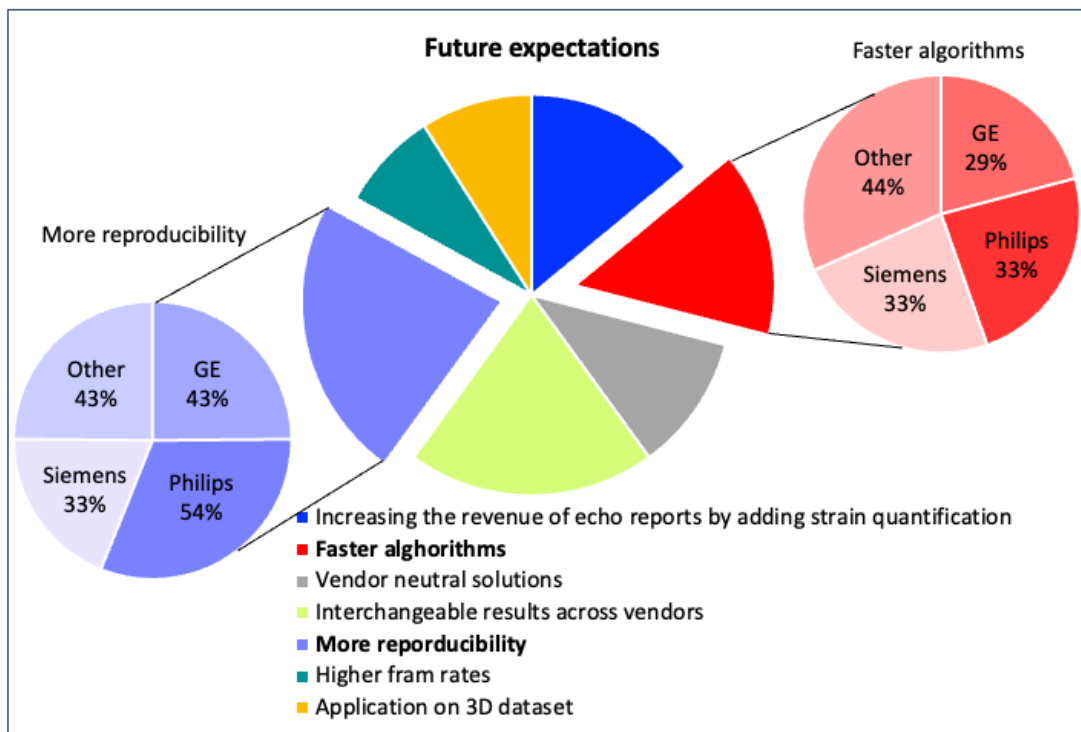


Figure 5