

Introduction

Mitral valve prolapse (MVP) has been described as the most frequently diagnosed valvular cardiac abnormality with a reported prevalence between 5% to 15% in the general population. It is a heterogeneous condition with varied clinical presentations. Mitral valve prolapse (MVP) has been given many names including the systolic click murmur syndrome, Barlow syndrome, Billowing MVP syndrome, Ballooning mitral cusp syndrome, Floppy valve syndrome and redundant cusp syndrome. Mitral valve prolapse (MVP) is defined as mitral leaflets displacement beyond the normal range of leaflet motion relative to some reference structure, usually taken to be the mitral annulus {1}.

In the late 1980s, Levine et al. elegantly redefined the anatomy of the normal mitral valve. Using 3-dimensional echo imaging reconstruction, they showed that the mitral ring was actually shaped like a saddle, so that a false-positive diagnosis of MVP could be made especially in the apical 4-chamber view images showing displacement of valve leaflets above the mitral annulus, when actually the anatomy of the valve was completely normal {2}.

A major problem is the reliability and security of diagnostic criteria that attempt to distinguish between mild to moderate systolic displacement in persons literally normal and similar. Currently used echocardiographic criteria include an unknown but not small number of persons who are either normal or indistinguishable from normal {3}.

Partially to circumvent inappropriate, if not inaccurate diagnostic interferences based upon isolated echocardiographic interpretation, it has

been recommended that the clinical diagnosis of primary MVP weight information from the history, physical signs either auscultatory or non auscultatory, electrocardiogram, chest roentgenogram and echocardiogram with Doppler interrogation and color flow imaging {3}.

The benign clinical course of mitral valve prolapse is not only a reflection of low risks inherent in the mild form but is also a reflection of the inclusion of normal persons based on currently used diagnostic criteria. The price of applying a disease label to normal persons is clear-medical costs of continued care, psychological costs stemming from the implications of heart disease in healthy young persons, insurability, and employability {4}.