A&P Refresher- Heart

Note: Not all slides will be covered

- Goal is to provide quick background/review to hopefully begin to understand some of the pathologies on first 2 slides
### Diseases and Disorders

#### Heart

<table>
<thead>
<tr>
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<th>Description</th>
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<td><strong>Inflammation of Heart Tissue</strong></td>
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<td>Endocarditis</td>
<td>Inflammation of the endocardium; affects the valves more severely than other areas of the endocardium; may lead to scarring, causing stenosed or incompetent valves</td>
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<tr>
<td>Pericarditis</td>
<td>Inflammation of the pericardium; see Clinical Impact, “Pericarditis and Cardiac Tamponade”</td>
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<td>Cardiomyopathy</td>
<td>Disease of the myocardium of unknown cause or occurring secondarily to other disease; results in weakened cardiac muscle, causing all chambers of the heart to enlarge; may eventually lead to congestive heart failure</td>
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<td>Rheumatic heart disease</td>
<td>Results from a streptococcal infection in young people; toxin produced by the bacteria can cause rheumatic fever several weeks after the infection that can result in rheumatic endocarditis</td>
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<td><strong>Reduced Blood Flow to Cardiac Muscle</strong></td>
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<td>Coronary heart disease</td>
<td>Reduces the amount of blood the coronary arteries can deliver to the myocardium</td>
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<td>Coronary thrombosis</td>
<td>Formation of blood clot in a coronary artery</td>
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<td>Myocardial infarction</td>
<td>Damaged cardiac muscle tissue resulting from lack of blood flow to the myocardium; often referred to as a heart attack; see Clinical Impact, “Angina, Infarctions, and the Treatment of Blocked coronary Arteries”</td>
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<td><strong>Congenital Heart Diseases (occur at birth)</strong></td>
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<td>Septal defect</td>
<td>Hole in the septum between the left and right sides of the heart, allowing blood to flow from one side of the heart to the other and greatly reducing the heart’s pumping effectiveness</td>
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<td>Patent ductus arteriosus</td>
<td>Ductus arteriosus fails to close after birth, allowing blood to flow from the aorta to the pulmonary trunk under a higher pressure, which damages the lungs; also, the left ventricle must work harder to maintain adequate systemic pressure</td>
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<td>Stenosis of the heart valve</td>
<td>Narrowed opening through one or more of the heart valves; aortic or pulmonary semilunar stenosis increases the heart’s workload; bicuspid valve stenosis causes blood to back up in the left atria and lungs, resulting in edema of the lungs; tricuspid valve stenosis results in similar blood flow problems and edema in the peripheral tissues</td>
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<td>Incompetent heart valve</td>
<td>Heart valves do not close correctly, and blood flows through in the reverse direction; see Clinical Impact, “Abnormal Heart Sounds”</td>
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<td>Cyanosis (sí-a-no’sis; cyan, blue + osis, condition of)</td>
<td>Symptom of inadequate heart function in babies with congenital heart disease; the infant’s skin appears blue because of low oxygen levels in the blood in peripheral blood vessels</td>
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<td>Heart Failure</td>
<td>Progressive weakening of the heart muscle, reducing the heart’s pumping action; hypertension leading to heart failure due to increased afterload; advanced age, malnutrition, chronic infections, toxins, severe anemias, hyperthyroidism, and hereditary factors can lead to heart failure</td>
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### Major Cardiac Arrhythmias

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**Abbreviations:** SA = sinoatrial; AV = atrioventricular.
Functions of the Heart

1. Generating blood pressure
2. Routing blood: separates pulmonary and systemic circulations
3. Ensuring one-way blood flow: valves
4. Regulating blood supply
   - Changes in contraction rate and force match blood delivery to changing metabolic needs
Cardiovascular Overview

- **Pulmonary circulation (through lungs)**
  - Lung capillaries
  - Right side of heart

- **Systemic circulation (through body)**
  - Left side of heart
  - Circulation to tissues of thorax, abdomen, and lower limbs

- **Tissue capillaries**
  - CO₂
  - O₂

- **Circulation to tissues of head, neck, and upper limbs**
  - CO₂
  - O₂

- **Circulation to tissues of head, neck, and upper limbs**
  - CO₂
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Size, Shape, Location of the Heart

- **Size of a closed fist**
- **Shape**
  - **Apex**: Blunt rounded point of cone
  - **Base**: Flat part at opposite of end of cone
- **Located in thoracic cavity in mediastinum** (central core of the thoracic cavity; everything in the thoracic cavity except the lungs.)
  - Important clinically when using a stethoscope, performing an ECG, or performing CPR
Heart Cross Section

Esophagus
Right pleural cavity
Right pulmonary artery
Right pulmonary vein
Superior vena cava
Ascending aorta
Right atrium
Right ventricle

Descending aorta
Tissue of mediastinum
Bronchus of lung
Parietal pleura
Left pleural cavity
Visceral pleura
Left pulmonary artery
Left pulmonary vein
Pulmonary trunk
Left atrium
Left ventricle
Visceral pericardium
Pericardial cavity
Parietal pericardium
Fibrous pericardium

Superior view

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Anatomy of the Heart

- **Pericardium** or pericardial sac
  - **Fibrous pericardium**: tough fibrous outer layer. Prevents over distention; acts as anchor
  - **Serous pericardium**: thin, transparent, inner layer. Simple squamous epithelium
  - **Parietal pericardium**: lines the fibrous outer layer
  - **Visceral pericardium** (epicardium): covers heart surface
  - The two are continuous and have a pericardial cavity between them filled with pericardial fluid
Anatomy of the Heart

Pericardium
- Fibrous pericardium
- Serous pericardium
  - Parietal pericardium
  - Visceral pericardium (or epicardium)

Pericardial cavity filled with pericardial fluid

Anterior view
Heart Wall

- **Three layers of tissue**
  - **Epicardium**: Serous membrane; smooth outer surface of heart
  - **Myocardium**: Middle layer composed of cardiac muscle cell and responsibility for heart contracting
  - **Endocardium**: Smooth inner surface of heart chambers

- **Pectinate muscles**: muscular ridges in auricles and right atrial wall

- **Trabeculae carneae**: muscular ridges and columns on inside walls of ventricles
External Anatomy

(a) Anterior view

Superior vena cava
Aorta
Branches of right pulmonary artery
Right pulmonary veins

Right atrium
Coronary sulcus
Right coronary artery

Right ventricle
Inferior vena cava

(b) Anterior view

Superior vena cava
Aorta
Right auricle

Great cardiac vein (in interatrial septum)

Right ventricle

Left atrium
Great cardiac vein (in anterior interventricular sulcus)
Anterior interventricular artery (in anterior interventricular sulcus)

Left ventricle

Apex
External Anatomy

Aorta

Left pulmonary artery

Left pulmonary veins

Left atrium

Great cardiac vein (in coronary sulcus)

Coronary sinus

Left ventricle

Middle cardiac vein (in posterior interventricular sulcus)

Apex

Superior vena cava

Right pulmonary artery

Right pulmonary veins

Right atrium

Inferior vena cava

Right coronary artery

Small cardiac vein

Posterior interventricular artery (in posterior interventricular sulcus)

Right ventricle

(c) Posterior view
Coronary Circulation: Arteries

- **Right coronary artery** exits aorta just superior to point where aorta exits heart; lies in coronary sulcus. Smaller than left. Extends to posterior aspect of heart
  - **Right marginal artery** to lateral wall of right ventricle
  - **Posterior interventricular artery** lies in posterior interventricular sulcus, supplies posterior and inferior aspects of heart

- **Left coronary artery** exits aorta near right coronary. Branches
  - **Anterior interventricular artery** (left anterior descending artery) in anterior interventricular sulcus
  - **Left marginal artery** supplies lateral wall of left ventricle
  - **Circumflex artery** extends to posterior aspect
Coronary Circulation: Veins

- **Great cardiac vein** and small cardiac vein drain right margin of heart
- **Coronary sinus**: veins empty here then into the right atrium
- Number of small veins drain the rest of the heart
Heart Chambers

• Atria
  - **Right atrium**: three major openings to receive blood returning from the body (superior vena cava, inferior vena cava, coronary sinus)
  - **Left atrium**: four openings that receive blood from pulmonary veins
  - **Interatrial septum**: wall between the atria. Contains a depression, the foramen ovale, a remnant of the fetal opening between the atria

• Ventricles
  - **Atrioventricular canals**: openings between atria and respective ventricles
  - **Right ventricle** opens to pulmonary trunk
  - **Left ventricle** opens to aorta
  - **Interventricular septum** between the two.
Structure of the Heart Valves

- **Atrioventricular valves** (AV valves). Each valve has leaf-like cusps that are attached to cone-shaped papillary muscles by tendons (chordae tendineae). Right has three cusps (tricuspid). Left has two cusps (bicuspid, mitral). When valve is open, canal is atrioventricular canal.

- **Semilunar valves**. Right (pulmonary); left (atrial). Each cusp is shaped like a cup. When cusps are filled, valve is closed; when cusps are empty, valve is open.
Heart Chambers

Superior vena cava
Ascending aorta
Right atrium
Anterior cusp of tricuspid valve
Inferior vena cava

(a) Anterior view

Pulmonary trunk
Trabeculae on interventricular septum
Chordae tendineae
Papillary muscles

(b) Superior view

Pulmonary trunk
Ascending aorta
Opening of right coronary artery
Aortic semilunar valve
Superior vena cava
Right atrium
Left atrium (cut open)
Bicuspid valve

(b) Superior view

b. © McMinn & Hutchings, Color Atlas of Human Anatomy/Mosby
Function of Heart Valves

(a) Valve positions when blood is flowing into the left ventricle.

1. The bicuspid valve is open. The cusps of the valve are pushed by the blood into the ventricle.

2. The aortic semilunar valve is closed. The cusps of the valve overlap as they are pushed by the blood in the aorta toward the ventricle.

(b) Valve positions when blood is flowing out of the left ventricle.

1. The bicuspid valve is closed. The cusps of the valves overlap as they are pushed by the blood toward the left atrium.

2. The aortic semilunar valve is open. The cusps of the valve are pushed by the blood toward the aorta.
Histology

- **Heart Skeleton**
  - Consists of plate of fibrous connective tissue between atria and ventricles
  - Fibrous rings around valves to support
  - Serves as electrical insulation between atria and ventricles
  - Provides site for muscle attachment
Cardiac Muscle

- Elongated, branching cells containing 1-2 centrally located nuclei
- Contains actin and myosin myofilaments
- **Intercalated disks**: specialized cell-cell contacts.
  - Cell membranes interdigitate
  - Desmosomes hold cells together
  - Gap junctions allow action potentials to move from one cell to the next.
- Electrically, cardiac muscle of the atria and of the ventricles behaves as single unit
Action potentials originate in the sinoatrial (SA) node (the pacemaker) and travel across the wall of the atrium (arrows) from the SA node to the atrioventricular (AV) node.

Action potentials pass through the AV node and along the atrioventricular (AV) bundle, which extends from the AV node, through the fibrous skeleton, into the interventricular septum.

The AV bundle divides into right and left bundle branches, and action potentials descend to the apex of each ventricle along the bundle branches.

Action potentials are carried by the Purkinje fibers from the bundle branches to the ventricular walls and papillary muscles.
Conducting System

- **SA node**: sinoatrial node. Medial to opening of superior vena cava. The pacemaker. Specialized cardiac muscle cells. Generate spontaneous action potentials. Action potentials pass to atrial muscle cells and to the AV node.

- **AV node**: atrioventricular node. Medial to the right atrioventricular valve. Action potentials conducted more slowly here than in any other part of system. Ensures ventricles receive signal to contract after atria have contracted.

- **AV bundle**: passes through hole in cardiac skeleton to reach interventricular septum.

- **Right and left bundle branches**: extend beneath endocardium to apices of right and left ventricles.

- **Purkinje fibers**: Large diameter cardiac muscle cells with few myofibrils. Many gap junctions. Conduct action potential to ventricular muscle cells.
Permeability changes during an action potential in cardiac muscle:

1. **Depolarization phase**
   - Voltage-gated Na⁺ channels open.
   - Voltage-gated K⁺ channels begin to open.

2. **Repolarization phase**
   - Voltage-gated Na⁺ channels close.
   - Voltage-gated K⁺ channels continue to open.
   - Voltage-gated K⁺ channels close at the end of repolarization and return the membrane potential to its resting value.

Permeability changes during an action potential in skeletal muscle:

1. **Depolarization phase**
   - Voltage-gated Na⁺ channels open.
   - Voltage-gated K⁺ channels close.
   - Voltage-gated Ca²⁺ channels begin to open.

2. **Early repolarization and plateau phases**
   - Voltage-gated Na⁺ channels close.
   - Some voltage-gated K⁺ channels open, causing early repolarization.
   - Voltage-gated Ca²⁺ channels are open, producing the plateau by slowing further repolarization.

3. **Final repolarization phase**
   - Voltage-gated Ca²⁺ channels close.
   - Many voltage-gated K⁺ channels open.
Differences Between Skeletal and Cardiac Muscle Physiology

- Cardiac: action potentials conducted from cell to cell. In skeletal, action potential conducted along length of single fiber
- Cardiac: rate of action potential propagation is slow because of gap junctions and small diameter of fibers. In skeletal it is faster due to larger diameter fibers.
- Cardiac: calcium-induced calcium release (CICR). Movement of Ca\(^{2+}\) through plasma membrane and T tubules into sarcoplasm stimulates release of Ca\(^{2+}\) from sarcoplasmic reticulum
Autorhythmicity of Cardiac Muscle

Permeability changes in pacemaker cells

1. Pacemaker potential
   - A small number of Na\(^+\) channels are open.
   - Voltage-gated K\(^+\) channels that opened in the repolarization phase of the previous action potential are closing.
   - Voltage-gated Ca\(^{2+}\) channels begin to open.

2. Depolarization phase
   - Voltage-gated Ca\(^{2+}\) channels are open.
   - Voltage-gated K\(^+\) channels are closed.

3. Repolarization phase
   - Voltage-gated Ca\(^{2+}\) channels close.
   - Voltage-gated K\(^+\) channels open.
Refractory Period

- **Absolute**: Cardiac muscle cell completely insensitive to further stimulation
- **Relative**: Cell exhibits reduced sensitivity to additional stimulation
- Long refractory period prevents tetanic contractions
Electrocardiogram

- Record of electrical event in the myocardium that can be correlated with mechanical events
- **P wave**: depolarization of atrial myocardium and signals onset of atrial contraction. Repolarization of atria simultaneously.
- **QRS complex**: ventricular depolarization and signals onset of ventricular contraction. Repolarization of ventricles.
- **T wave**: repolarization of ventricles; precedes ventricular relaxation
- **PQ interval** or PR interval: 0.16 sec; atria contract and begin to relax, ventricles begin to contract
- **QT interval**: 0.36 sec; ventricles contract and begin to relax
Electrocardiogram

Complete heart block (P waves and QRS complexes are not coordinated)

Premature ventricular contraction (PVC) (no P waves precede PVCs)

Prolonged QRS complexes

Bundle branch block

Atrial fibrillation (no clear P waves and rapid QRS complexes)

Ventricular fibrillation (no P, QRS, or T waves)
### Major Cardiac Arrhythmias

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**Abbreviations:** SA = sinoatrial; AV = atrioventricular.
Cardiac Cycle

• Heart is two pumps that work together, right and left half
• Repetitive contraction (**systole**) and relaxation (**diastole**) of heart chambers
• Blood moves through circulatory system from areas of higher to lower pressure.
  – Contraction of heart produces the pressure
Period of Isovolumetric Contraction

- Begins at the completion of the QRS complex.
- Ventricular muscles start to contract, increasing the pressure inside the ventricles. This causes the AV valves to close, which is the beginning of ventricular systole. The semilunar valves were closed in the previous diastole and remain closed during this event.
- 120-130 mL of blood are in the ventricles, left from the last diastole when the atria emptied into the ventricles. This is referred to as the end diastolic volume.
Period of Ejection

- Pressure in the ventricle has increased to the point where it is greater than the pressure in the pulmonary trunk/aorta. This pushes the cusps of the semilunar valves against the walls of the vessels, opening the valve.
- Blood is ejected from the ventricles.
- The pressures in the two ventricles are different: 120 mm Hg in the left ventricle; 25 mm Hg in the right ventricle. Remember: blood in the left ventricle must be pumped to the whole body; blood in the right ventricle is pumped to the lungs.
- After the first initial spurt, pressure starts to drop.
- At the end of the period of ejection, 50-60 mL remain: end-systolic volume.
Period of Isovolumetric Relaxation

- Completion of T wave results in ventricular repolarization and relaxation.
- Ventricular pressure falls very rapidly.
- Pulmonary trunk/aorta pressure is higher than ventricular pressure.
- Elastic recoil of the arteries causes blood to flow back toward the relaxed ventricles: the semilunar valves close, which is the beginning of ventricular diastole.
- Note that the AV valves are also closed.
Passive Ventricular Filling

- While the ventricles were in systole, the atria were filling with blood.
- Atrial pressure rises above ventricular pressure and the AV valves open.
- Blood flows into the relaxed ventricles, accounting for most of the ventricular filling (70%).
Active Ventricular Filling

- Depolarization of the SA node generates action potentials that spread over the atria (P wave) and the atria contract. This completes ventricular filling.
- At rest, contraction of atria not necessary for heart function.
- During exercise, atrial contraction necessary for function as heart pumps 300-400%.
Cardiac Cycle

1. **Atrial systole: active ventricular filling.** The atria contract, increasing atrial pressure and completing ventricular filling while the ventricles are relaxed.

2. **Ventricular systole: period of isovolumetric contraction.** The atria are relaxed, and blood flows into them from the veins. Ventricular contraction causes ventricular pressure to increase and causes the AV valves to close, which is the beginning of ventricular systole. The semilunar valves were closed in the previous diastole and remain closed during this period.

3. **Ventricular systole: period of ejection.** Continued ventricular contraction causes a greater increase in intraventricular pressure, which pushes blood out of the ventricles, causing the semilunar valves to open.

4. **Ventricular diastole: period of isovolumetric relaxation.** As the ventricles begin to relax at the beginning of ventricular diastole, blood flowing back from the aorta and pulmonary trunk toward the relaxing ventricles causes the semilunar valves to close. Note that the AV valves are closed also.

5. **Ventricular diastole: passive ventricular filling.** As ventricular relaxation continues, the AV valves open, and blood flows from the atria into the relaxing ventricles, accounting for most of the ventricular filling.
Events Occurring During the Cardiac Cycle

Time periods:
- Passive ventricular filling
- Period of isovolumetric relaxation
- Period of ejection
- Period of isovolumetric contraction
- Active ventricular filling

Pressure (mm Hg)
- Semilunar valves open
- AV valves close
- Diastolic pressure
- AV valves open
- Systolic pressure
- AV valves close
- Semilunar valves close
- Diastolic pressure AV valves open

Left ventricular volume (mL)
- End-systolic volume
- End-diastolic volume
- Semilunar valves close
- AV valves open

"Sound" frequency (cycles/second)
- Atrial systole
- Ventricular systole
- Ventricular diastole

First heart sound
- Second heart sound
- Third heart sound
- Dicrotic notch
### TABLE 20.2 Summary of the Events of the Cardiac Cycle

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<tr>
<td><strong>Ventricular Diastole</strong></td>
<td><strong>Ventricular Systole</strong></td>
</tr>
<tr>
<td><strong>Active Ventricular Filling</strong></td>
<td><strong>Period of Isovolumetric Contraction</strong></td>
</tr>
<tr>
<td><strong>Time Period</strong></td>
<td>Contraction of the atria pumps blood into the ventricles.</td>
</tr>
<tr>
<td><strong>Condition of Valves</strong></td>
<td>The semilunar valves are closed; the AV valves are opened (figure 20.18, step 1).</td>
</tr>
<tr>
<td><strong>ECG</strong></td>
<td>The P wave is completed and the atria are stimulated to contract. Action potentials are delayed in the AV node for 0.11 second, allowing time for the atria to contract. The QRS complex begins as action potentials are propagated from the AV node to the ventricles.</td>
</tr>
<tr>
<td><strong>Atrial Pressure Graph</strong></td>
<td>Atrial contraction (systole) causes an increase in atrial pressure, and blood is forced to flow from the atria into the ventricles.</td>
</tr>
<tr>
<td><strong>Ventricular Pressure Graph</strong></td>
<td>Atrial contraction (systole) and the movement of blood into the ventricles cause a slight increase in ventricular pressure.</td>
</tr>
<tr>
<td><strong>Aortic Pressure Graph</strong></td>
<td>Aortic pressure gradually decreases as blood runs out of the aorta into other systemic blood vessels.</td>
</tr>
<tr>
<td><strong>Volume Graph</strong></td>
<td>Atrial contraction (systole) completes ventricular filling during the last one-third of diastole. The amount of blood in a ventricle at the end of ventricular diastole is called the end-diastolic volume.</td>
</tr>
<tr>
<td><strong>Sound Graph</strong></td>
<td>Blood flowing from the ventricles toward the atria closes the AV valves. Vibrations of the valves and the turbulent flow of blood produce the first heart sound, which marks the beginning of ventricular systole.</td>
</tr>
</tbody>
</table>

**Abbreviation:** AV = atrioventricular.
### TABLE 20.2

<table>
<thead>
<tr>
<th>Atrial Diastole</th>
<th>Ventricular Diastole</th>
<th>Passive Ventricular Filling</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Period of Ejection</strong></td>
<td><strong>Period of Isovolumetric Relaxation</strong></td>
<td><strong>Passive Ventricular Filling</strong></td>
</tr>
<tr>
<td>The ventricles continue to contract, and blood is pumped out of the ventricles.</td>
<td>The ventricles relax, but ventricular volume does not change.</td>
<td>Blood flows into the ventricles because blood pressure is higher in the veins and atria than in the relaxed ventricles.</td>
</tr>
<tr>
<td>The semilunar valves are opened; the AV valves are closed (figure 20.18, step 3).</td>
<td>The semilunar valves are closed; the AV valves are closed (figure 20.18, step 4).</td>
<td>The semilunar valves are closed; the AV valves are opened (see figure 20.18, step 5).</td>
</tr>
<tr>
<td>The T wave results from ventricular repolarization.</td>
<td>The T wave is completed, and the ventricles are repolarized. The ventricles relax.</td>
<td>The P wave is produced when the SA node generates action potentials and a wave of depolarization begins to propagate across the atria.</td>
</tr>
</tbody>
</table>

Atrial pressure increases gradually as blood flows from the veins into the relaxed atria.
Atrial pressure continues to increase gradually as blood flows from the veins into the relaxed atria.
After the AV valves open, atrial pressure decreases as blood flows out of the atria into the relaxed ventricles.

Ventricular pressure becomes greater than pressure in the aorta as the ventricles continue to contract. The semilunar valves are pushed open as blood flows out of the ventricles. Ventricular pressure peaks as the ventricles contract maximally; then pressure decreases as blood flow out of the ventricles decreases.
Elastic recoil of the aorta pushes blood back toward the heart, causing the semilunar valves to close.
After closure of the semilunar valves, the pressure in the relaxing ventricles rapidly decreases.
No significant change occurs in ventricular pressure during this time period.

As ventricular contraction forces blood into the aorta, pressure in the aorta increases to its highest value, called the **systolic pressure** (approximately 120 mm Hg).
After the semilunar valves close, elastic recoil of the aorta causes a slight increase in aortic pressure, producing the **dicrotic notch** and **dicrotic wave**.
Aortic pressure gradually decreases as blood runs out of the aorta into other systemic blood vessels.

After the semilunar valves open, blood volume decreases as blood flows out of the ventricles during the **period of ejection**.
The amount of blood left in a ventricle at the end of the period of ejection is called the **end-systolic volume**.
During the **period of isovolumetric relaxation**, ventricular volume does not change because the semilunar and AV valves are closed.
After the AV valves open, blood flows from the atria and veins into the ventricles because of pressure differences. Most ventricular filling occurs during the first one-third of diastole.
Little ventricular filling occurs during the middle one-third of diastole.

Blood flowing from the ventricles toward the aorta and pulmonary trunk closes the semilunar valves. Vibrations of the valves and the turbulent flow of blood produce the **second heart sound**, which marks the beginning of ventricular diastole.
Sometimes the turbulent flow of blood into the ventricles produces a **third heart sound**.
Heart Sounds

• **First heart sound** or “lubb”
  - Atrioventricular valves and surrounding fluid vibrations as valves close at beginning of ventricular systole

• **Second heart sound** or “dupp”
  - Results from closure of aortic and pulmonary semilunar valves at beginning of ventricular diastole, lasts longer

• **Third heart sound** (occasional)
  - Caused by turbulent blood flow into ventricles and detected near end of first one-third of diastole
Aortic Pressure Curve

- **Dicrotic notch** (incisura): when the aortic semilunar valve closes, pressure within the aorta increases slightly.
- Blood pressure measurement taken in the arm is a reflection of aortic pressures, not ventricular.
20.8 Mean Arterial Pressure

- Average blood pressure in aorta
- MAP = CO x PR
  - CO is amount of blood pumped by heart per minute
    - CO = SV x HR
      - SV: Stroke volume (blood pumped during each heart beat)
      - HR: Heart rate (number of times heart beats per minute)
    - Cardiac reserve: Difference between CO at rest and maximum CO
  - PR is total resistance against which blood must be pumped
Factors Affecting Cardiac Output

- Increased vasoconstriction
- Increased heart rate
- Increased cardiac output
- Increased blood volume, exercise, change from a standing to a lying down position
- Increased sympathetic stimulation, decreased parasympathetic stimulation, and increased epinephrine and norepinephrine secretion from the adrenal medulla

Factors Affecting Peripheral Resistance

- Increased blood pressure, decreased blood pH, increased blood carbon dioxide, decreased blood oxygen, exercise, and emotions
- Decreased blood pressure, decreased blood pH, increased blood carbon dioxide, and decreased blood oxygen (see chapter 21)
- Increased vasoconstriction
- Increased mean arterial pressure
- Increased force of contraction (Starling law of the heart) ejects increased end-diastolic volume.
- Increased stroke volume
- Increased venous return increases end-diastolic volume and preload.
20.9 Regulation of the Heart

- **Intrinsic regulation**: Results from normal functional characteristics, not on neural or hormonal regulation
  - **Preload**: Starling’s law of the heart
    - Preload is the amount of stretch of the ventricular walls. The greater the stretch (preload), the greater the force of contraction.
  - **Afterload**: pressure the contracting ventricles must produce to overcome the pressure in the aorta and move blood into the aorta. Heart not as sensitive to this as it is to changes in preload.
Regulation of the Heart

- **Extrinsic regulation**: Involves neural and hormonal control
  - Parasympathetic stimulation
    - Supplied by vagus nerve, decreases heart rate, acetylcholine is secreted and hyperpolarizes the heart
  - Sympathetic stimulation
    - Supplied by cardiac nerves. Innervate the SA and AV nodes, coronary vessels and the atrial and ventricular myocardium. Increases heart rate and force of contraction. Epinephrine and norepinephrine released.
    - Increased heart beat causes increased cardiac output. Increased force of contraction causes a lower end-systolic volume; heart empties to a greater extent. Limitations: heart has to have time to fill.
  - Hormonal Control. Epinephrine and norepinephrine from the adrenal medulla. Occurs in response to increased physical activity, emotional excitement, stress
Heart and Homeostasis

• Effect of blood pressure
  – Baroreceptors monitor blood pressure; in walls of internal carotids and aorta. This sensory information goes to centers in the medulla oblongata

• Effect of pH, carbon dioxide, oxygen
  – Receptors that measure pH and carbon dioxide levels found in hypothalamus
  – Chemoreceptors monitoring oxygen levels found in aorta and internal carotids. Prolonged lowered oxygen levels causes increased heart rate, which increases blood pressure and can thus deliver more oxygen to the tissues.

• Effect of extracellular ion concentration
  – Increase or decrease in extracellular K⁺ decreases heart rate

• Effect of body temperature
  – Heart rate increases when body temperature increases, heart rate decreases when body temperature decreases
Baroreceptor and Chemoreceptor Reflexes

1. Sensory neurons (green) carry action potentials from baroreceptors and carotid body chemoreceptors to the cardioregulatory center. Chemoreceptors in the medulla oblongata also influence the cardioregulatory center.

2. The cardioregulatory center controls the frequency of action potentials in the parasympathetic neurons (red) extending to the heart through the vagus nerves. The parasympathetic neurons decrease the heart rate.

3. The cardioregulatory center controls the frequency of action potentials in the sympathetic neurons (blue). The sympathetic neurons extend through the cardiac nerves and increase the heart rate and the stroke volume.

4. The cardioregulatory center influences the frequency of action potentials in the sympathetic neurons (blue) extending to the adrenal medulla. The sympathetic neurons increase the secretion of epinephrine and some norepinephrine into the systemic circulation. Epinephrine and Norepinephrine increase the heart rate and stroke volume.
Baroreceptor Reflex

Baroreceptors in the carotid arteries and aorta detect an increase in blood pressure.
The cardioregulatory center increases parasympathetic and decreases sympathetic stimulation of the heart.

Blood pressure increases: Homeostasis Disturbed

The effectors (SA node and cardiac muscle) respond:
Heart rate and stroke volume decrease.

Blood pressure decreases: Homeostasis Disturbed

Baroreceptors in the carotid arteries and aorta detect a decrease in blood pressure.
The cardioregulatory center decreases parasympathetic and increases sympathetic stimulation of the heart; adrenal medulla secretion of epinephrine and norepinephrine increases.

Blood pressure increases: Homeostasis Restored

The effectors (SA node and cardiac muscle) respond:
Heart rate and stroke volume increase.

Blood pressure decreases: Homeostasis Restored
Blood pH (normal range)

Chemoreceptors in the medulla oblongata detect an increase in blood pH (often caused by a decrease in blood CO₂). Cardioregulatory center increases parasympathetic and decreases sympathetic stimulation of the heart.

**Actions**

Chemoreceptors in the medulla oblongata detect a decrease in blood pH (often caused by an increase in blood CO₂). Cardioregulatory center decreases parasympathetic and increases sympathetic stimulation of the heart.

**Reactions**

The effectors (SA node and cardiac muscle) respond:

Heart rate and stroke volume decrease, reducing blood flow to the lungs. Blood CO₂ levels increase.

**Blood pH increases:**

Homeostasis Disturbed

**Blood pH decreases:**

Homeostasis Disturbed

**Blood pH increases:**

Homeostasis Restored

**Blood pH decreases:**

Homeostasis Restored

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## Heart Diseases and Disorders

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inflammation of Heart Tissue</strong></td>
<td></td>
</tr>
<tr>
<td>Endocarditis</td>
<td>Inflammation of the endocardium; affects the valves more severely than other areas of the endocardium; may lead to scarring, causing stenosed or incompetent valves</td>
</tr>
<tr>
<td>Pericarditis</td>
<td>Inflammation of the pericardium; see Clinical Impact, “Pericarditis and Cardiac Tamponade”</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>Disease of the myocardium of unknown cause or occurring secondarily to other disease; results in weakened cardiac muscle, causing all chambers of the heart to enlarge; may eventually lead to congestive heart failure</td>
</tr>
<tr>
<td>Rheumatic heart disease</td>
<td>Results from a streptococcal infection in young people; toxin produced by the bacteria can cause rheumatic fever several weeks after the infection that can result in rheumatic endocarditis</td>
</tr>
<tr>
<td><strong>Reduced Blood Flow to Cardiac Muscle</strong></td>
<td></td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>Reduces the amount of blood the coronary arteries can deliver to the myocardium</td>
</tr>
<tr>
<td>Coronary thrombosis</td>
<td>Formation of blood clot in a coronary artery</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>Damaged cardiac muscle tissue resulting from lack of blood flow to the myocardium; often referred to as a heart attack; see Clinical Impact, “Angina, Infarctions, and the Treatment of Blocked coronary Arteries”</td>
</tr>
<tr>
<td><strong>Congenital Heart Diseases (occur at birth)</strong></td>
<td></td>
</tr>
<tr>
<td>Septal defect</td>
<td>Hole in the septum between the left and right sides of the heart, allowing blood to flow from one side of the heart to the other and greatly reducing the heart’s pumping effectiveness</td>
</tr>
<tr>
<td>Patent ductus arteriosus</td>
<td>Ductus arteriosus fails to close after birth, allowing blood to flow from the aorta to the pulmonary trunk under a higher pressure, which damages the lungs; also, the left ventricle must work harder to maintain adequate systemic pressure</td>
</tr>
<tr>
<td>Stenosis of the heart valve</td>
<td>Narrowed opening through one or more of the heart valves; aortic or pulmonary semilunar stenosis increases the heart’s workload; bicuspid valve stenosis causes blood to back up in the left atria and lungs, resulting in edema of the lungs; tricuspid valve stenosis results in similar blood flow problems and edema in the peripheral tissues</td>
</tr>
<tr>
<td>Incompetent heart valve</td>
<td>Heart valves do not close correctly, and blood flows through in the reverse direction; see Clinical Impact, “Abnormal Heart Sounds”</td>
</tr>
<tr>
<td>Cyanosis (si-à-no’sis; cyan, blue + osis, condition of)</td>
<td>Symptom of inadequate heart function in babies with congenital heart disease; the infant’s skin appears blue because of low oxygen levels in the blood in peripheral blood vessels</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Progressive weakening of the heart muscle, reducing the heart’s pumping action; hypertension leading to heart failure due to increased afterload; advanced age, malnutrition, chronic infections, toxins, severe anemias, hyperthyroidism, and hereditary factors can lead to heart failure</td>
</tr>
</tbody>
</table>