Premature Ventricular Contractions

Underwriting Dialogue

Characteristics

Premature ventricular contractions, or PVCs, are heartbeats that occur earlier than usual and originate in a ventricle (a bottom chamber of the heart). Heartbeats normally originate in the sinoatrial node, also called the SA node, which is located in the right atrium (top right chamber of the heart). PVCs are commonly seen in insurance applicants, especially on ambulatory (Holter) monitoring.

PVCs that originate from only one ventricular focus are unifocal, while multifocal PVCs come from more than one ventricular location. A ventricular couplet is two successive PVCs, while a ventricular triplet is three PVCs in a row. Three or more successive PVCs is also termed ventricular tachycardia.

Ventricular bigeminy means that every other beat is a PVC, while ventricular trigeminy indicates that every third beat is a PVC. While often asymptomatic, PVCs can be associated with palpitations, dizziness/lightheadedness, a pounding sensation, a feeling that the heart has stopped, and other symptoms.

Diagnosis

When PVCs are present it is important to know whether there is any underlying cardiac disease or other conditions that may affect the heart. In general, a complete cardiac evaluation should include a stress test, echocardiogram, and ambulatory monitoring.

Further investigation may occasionally be ordered, such as cardiac magnetic resonance imaging (MRI) or evaluation by an electrophysiologist (a cardiologist who specializes in heart rhythms).

Besides cardiac conditions, PVCs may also be seen in a variety of other situations, such as electrolyte abnormalities, thyroid and other endocrine disorders, sleep apnea and other pulmonary diseases, stress, use of prescription or over the counter medications (such as stimulants), illicit drug use, and alcohol, caffeine, or tobacco use.

Recent studies have shown that the presence of frequent PVCS, in the range of 15% to 20% of total heart beats on 24 hour ambulatory (Holter) monitoring, increases the risk of developing a cardiomyopathy, which can reverse if the PVCs resolve.

Treatment

Treatment of PVCs needs to be individualized. If no underlying disease is present and if any symptoms present are tolerable then reassurance may suffice, perhaps with an attempt to avoid or minimize exposure to possible precipitants.

Medications that may be used to treat PVCs include beta blockers, calcium channel blockers, and antiarrhythmic agents, such as flecainide, propafenone, amiodarone, and sotalol.

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PVCs can also be treated with radiofrequency catheter ablation, a procedure which can be especially useful if cardiomyopathy due to frequent PVCs is present. If PVCs are present in conjunction with underlying disease then treatment would depend upon the specific condition present.

Underwriting PVCs: Case Studies

The underwriting of PVCs takes a number of issues into account, including pattern and frequency, the presence of underlying disease, symptoms, and the results of cardiac testing. While the presence of PVCs in the face of underlying disease may be of concern, some studies have also found PVCs in healthy people to be associated with increased mortality. However, some applicants who are considered to be low risk after a complete evaluation may not require a class limitation.

Applicant 1 is a 35 year old applicant with a history of palpitations who was found to have occasional PVCs, including bigeminy, on ambulatory monitoring. A stress test and echocardiogram were normal. The applicant was reassured by the cardiologist that the PVCs were benign and that no specific treatment was indicated. *This applicant would qualify for Preferred Plus.*

Applicant 2 is an asymptomatic 60 year old applicant who had PVCs noted on a routine electrocardiogram. Ambulatory monitoring revealed two episodes of ventricular tachycardia, each lasting three beats. Echocardiography and stress testing were normal. Specific treatment was felt to be unnecessary. *This applicant would qualify for Standard Plus.*

Applicant 3 is a 50 year old applicant who was evaluated for a syncope episode. Ambulatory monitoring revealed frequent PVCs, including frequent couplets and many episodes of ventricular tachycardia. Echocardiography revealed evidence of a severe cardiomyopathy. *This applicant would be declined.*

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