Appendix 2 (as supplied by the authors): Phenocopies of hypertrophic cardiomyopathy and distinguishing characteristics

HCM Phenocopies	Differences from hypertrophic cardiomyopathy
Athlete's Heart 1,2	Concentric LVH
	LVH regresses with cessation of exercise
	Cardiopulmonary exercise stress test, Echo parameters of diastolic function may help distinguish from HCM
Fabry's Disease ³	X-linked recessive multisystem disease
	 Cardiac manifestations include LVH, conduction defects, CAD, aortic and mitral regurgitation, aortic root dilatation
	o Renal failure
	o Stroke
	 Skin manifestations: telangiectasias, angiokeratomas (typical locations include groin, hip and periumbilical regions)
	Diagnosis can be achieved by measurement of low alpha-galactosidase activity, endomyocardial biopsy or genetic testing
	Enzyme replacement may alter the disease course
Amyloidosis ⁴	ECG is marked by low voltage; Echo may be characterized by LVH with increased echogenicity and decreased systolic function
	AL Amyloid
	o Multisystem disease caused by deposition of monoclonal light chains
	ATTR Amyloid; abnormal Tc pyrophosphate scan
	 Due to autosomal dominant mutations in transthyretin characterized by neuropathy, cardiomyopathy or both
	 Liver transplantation can be curative, however those with significant cardiac manifestations may require dual organ transplantation
Danon Disease ⁵	Characterized by deficiency of lysosomal-associated membrane protein 2 with severe cardiomyopathy and mild skeletal myopathy
	Other clinical features can include mental retardation and ophthomologic manifestations
	Elevated creatine kinase or muscle biopsy can aid diagnosis

	Limited treatment options; may progress to need for heart transplantation
Mitochondrial Cardiomyopathies ⁶	Characterized by multisystem disease with possible manifestations including:
	Optic atrophy; pigmental retinopathy
	• Cardiomyopathy
	• CNS features
	Peripheral Nervous System features including hypotonia, muscle weakness, neuropathy
Noonan Syndrome ⁷	Autosomal dominant disease
	Can be characterized by short stature, pectus excavatum, hypertelorism, low set ears, pulmonic valve stenosis amongst other features
	Abnormalities platelet function and clotting

References

- 1. Pelliccia A, Maron BJ, Spataro A, et al. The upper limit of physiologic cardiac hypertrophy in highly trained elite athletes. *N Engl J Med* 1991;324:295-301.
- 2. Basavarajaiah S, Boraita A, Whyte G, et al. Ethnic differences in left ventricular remodeling in highly-trained athletes relevance to differentiating physiologic left ventricular hypertrophy from hypertrophic cardiomyopathy. *J Am Coll Cardiol* 2008;51:2256-62.
- 3. Wu JC, Ho CY, Skali H, et al. Cardiovascular manifestations of Fabry disease: relationships between left ventricular hypertrophy, disease severity, and alphagalactosidase A activity. *Eur Heart J* 2010;31:1088-97.
- 4. Selvanayagam JB, Hawkins PN, Paul B, et al. Evaluation and management of cardiac amyloidosis. *J Am Coll Cardiol*. 2007;50:2101-10.
- 5. Maron BJ, Roberts WC, Arad M, et al. Outcome and phenotypic expression in LAMP2 cardiomyopathy. *JAMA*. 2009;301: 1253–1259.
- 6. DiMauro S, Schon EA. Mitochondrial respiratory-chain diseases. *N Engl J Med*. 2003; 348: 2656–68.
- 7. Romano AA, Allanson JE, Dahlgren J, et al. Noonan syndrome: clinical features, diagnosis, and management guidelines. *Pediatrics* 2010;126:746-59.