Magnesium in Cardiovascular Disease

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In cardiovascular medicine, magnesium is of major importance in the treatment of arrhythmias and coronary artery disease. Magnesium raises the ventricular fibrillation threshold and prolongs the sinus node recovery time and atrioventricular conduction time. Main indications for magnesium are torsade de pointes tachycardias, digitalis induced ventricular tachyarrhythmias and multifocal atrial tachycardias. Additionally, magnesium has been used successfully in ventricular ectopies after overdose of neuroleptics or tricyclic antidepressants. Potential benefits can be expected in monomorphic ventricular tachycardias and in ventricular arrhythmias that did not respond to class III antiarrhythmic drugs. Recent studies have shown positive effects of magnesium in perioperative patients, where the incidence of atrial and ventricular arrhythmias could be reduced.

Oral magnesium has been used for years in patients with premature ventricular beats (PVB). Several studies have shown that combined oral therapy with magnesium and potassium improves the endothelial function in these patients and reduces platelet-dependent thrombosis. These encouraging results from basic science studies have now been confirmed in a large clinical trial showing that oral magnesium therapy improves exercise duration and quality of life in patients with documented coronary artery disease [59].

Key words: magnesium, arrhythmia, coronary artery disease

Magnesium, an essential mineral, plays an important role in the regulation of transmembrane electrolyte transfer. Publications as early as the 1930s document that magnesium deficiency can precipitate ventricular arrhythmias and that treatment with magnesium has antiarrhythmic potency on the supraventricular as well as ventricular level [1–3]. These cardiac effects of magnesium are induced by activation of the Na/K-ATPase, which stabilizes the membrane potential. Magnesium raises the ventricular fibrillation threshold. Impulse initiation and propagation are altered by a decrease of sinus rate, and prolongation of sinus node recovery time and atrioventricular refractory period [4, 5]. These characteristic actions on sinus and atrioventricular node place magnesium in the group of physiologic calcium antagonists [6]. Additionally, magnesium influences the occurrence of arrhythmias by altering early and late afterpotentials. Within the myocardial cell, low magnesium concentrations are associated with membrane destabilization, while high magnesium concentrations are membrane stabilizing, and therefore antiarrhythmic. Table 1 shows the electrophysiological consequences of high and low magnesium concentrations.

Therapeutic strategies for life-threatening arrhythmias have mostly been studied in uncontrolled settings. Torsades de pointes, arrhythmias due to digitalis, multifocal atrial tachycardias, sustained ventricular tachycardias or ventricular tachyarrhythmias after class III antiarrhythmic drugs pose difficult methodological problems for controlled studies. The interaction between magnesium and coronary heart disease has been studied for four decades. There is ample evidence that a significant percentage of patients with coronary artery disease suffer from magnesium deficiency. Magnesium is a potent vasodilator [7, 8] and plays an important role in muscle contraction [9]. During ischaemia, it exerts cellular protective effects against calcium ion influx and reduces vascular resistance and systolic blood pressure [10]. In 2000 Shechter described a significant improvement of endothelial function in patients with stable coronary artery disease through magnesium therapy [11]. A recently completed study finally provides the link from basic science to clinically relevant parameters [12]. The investigators were able to show the effects of oral magnesium therapy on the exercise duration and quality of life in patients with documented coronary heart disease.

10 % of hospitalized patients can be presumed to be magnesium deficient, for patients in intensive care this figure might be as high as 50 % [13, 14]. The low magnesium levels are mainly due to renal magnesium losses through diuretics or digitalis treatment or to the secondary hyperaldosteronism of heart failure.

In general, serum magnesium levels do not adequately reflect a patient’s magnesium status and cannot be used to monitor therapeutic interventions. Only intracellular magnesium measurements can detect magnesium deficiency.

Table 1. Effects of magnesium on electrical features of myocardial cells

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<tr>
<th>Electrophysiological effects of low magnesium concentrations</th>
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<tr>
<td>• Reduced resting potential</td>
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<td>• Reinforced sinus automaticity</td>
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<tr>
<td>• More frequent early afterdepolarisations</td>
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<td>• Widening of the QRS complex</td>
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<td>• Prolonged QT-intervals</td>
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<tr>
<td>• T-wave abnormalities, occurrence of U-waves</td>
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<tr>
<td>• Lowered atrial fibrillation threshold</td>
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<td>• Lowered ventricular fibrillation threshold</td>
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<tr>
<td>• Prolonged sinu-atrial conduction time</td>
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<tr>
<td>• Prolonged refractory period of atrium and AV-node</td>
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<tr>
<td>• Raised ventricular fibrillation threshold</td>
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<tr>
<td>• Reduction of drug-induced triggered activity</td>
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<td>• Reduction of ischaemia-associated arrhythmias</td>
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Parenteral Magnesium in Arrhythmia

Overview

Proven indication:
- Torsades de pointes tachycardia
- Digitalis-induced ventricular tachyarrhythmias
- Multifocal atrial tachycardias
- Perioperative patients

Reasonable indication:
- Ventricular arrhythmias due to overdose of neuroleptics or tricyclic antidepressant drugs
- Rescue treatment of ventricular arrhythmias, after class III antiarrhythmic drugs
- Refractory ventricular fibrillation

Potential indication:
- Monomorphic ventricular tachycardias
- Supraventricular tachycardias not responding to adenosine
- Arrhythmias in heart failure and/or with diuretics

Not an indication:
- Atrial fibrillation
- Cardiac arrest

Torsades de Pointes Tachycardia

The term torsades de pointes characterizes a special form of polymorphic ventricular tachycardia with a baseline prolonged QT interval. The ECG shows a typical oscillating “sine wave” pattern and polarity switching from negative to positive. Major triggering events are bradycardias (sinus arrest, AV-block III), electrolyte disturbances (hypokalemia, hypomagnesemia), and drugs that prolong the repolarization phase (class Ia or III antiarrhythmics, tricyclic antidepressants) [15–17]. In most cases structural myocardial disease is present. The electrical mechanism is related to dispersion of repolarisation or to triggered activity with afterdepolarisation, which can be suppressed by magnesium [18]. The potency of magnesium in this indication has been documented in numerous studies [15, 19, 20]. Today, parenteral magnesium is the drug of choice in all torsades de pointes tachycardias [21–25]. Accordingly, the guidelines of the American Heart Association recommend magnesium in this indication [26].

Digitalis-Induced Ventricular Tachyarrhythmia

Various types of arrhythmias can be observed in patients with digitalis overdose. As early as 1935, Zwilling described the effects of magnesium on digitalis-induced arrhythmias [3]. Digitalis inactivates the Na/K-ATPase, inducing the classic hyperkalemia of severe digitalis overdose [27]. The positive influence of magnesium on the Na/K-ATPase antagonizes this effect [28]. Animal experiments documented a magnesium induced raise of the fibrillation threshold even in the presence of digoxin [29]. Due to methodological problems no controlled studies are available to date, however, for lack of safe alternatives, the use of parenteral magnesium in this indication is unchallenged [24, 30–33]. The electrical cardioversion of digitalis-induced tachyarrhythmias is problematic and the treatment with specific antibodies is costly and may not be available everywhere. Thus, magnesium is the preferred therapeutic option [21–23].

Multifocal Atrial Tachycardias (MAT)

This rare form of tachycardia is characterized by at least 3 different sites of atrial activity and P wave morphologies, a heart rate of more than 100 beats per minute, and variable PP and PQ intervals. Postoperative patients, those in intensive care and patients with decompensated chronic obstructive pulmonary disease are particularly prone to develop these arrhythmias. The proposed mechanism of MAT is an increased automaticity, which can usually be interrupted by magnesium [34, 35].

Perioperative Use

The efficacy of magnesium against peri- and postoperative arrhythmias in cardiac surgery is well documented. A controlled study by England in 1992 found a 50% reduction in the incidence of ventricular arrhythmias with perioperative administration of parenteral magnesium. Supraventricular arrhythmic events were reduced from 37% to 17% [36]. Recent publications have confirmed these results and underline the potentials of perioperative magnesium therapy [37–40]. All studies show a significant reduction in incidence and duration of atrial (ectopias, atrial fibrillation) and ventricular events.

Ventricular Arrhythmias Due to Intoxication With Neuroleptics or Tricyclic Antidepressant Drugs

Magenesium is successfully used for ventricular ectopias in intoxications with astemizole, neuroleptic drugs or tricyclic antidepressants [41–43]. Again, case reports and observational studies have to substitute for controlled settings, but clinical experience and pharmacological considerations support the use of parenteral magnesium in these indications [22, 23].

Rescue Treatment of Ventricular Arrhythmias Occurring After Class III Antiarrhythmic Drugs

A major argument for the use of magnesium in ventricular arrhythmias after class III antiarrhythmic drugs have failed is the lack of interaction of magnesium with conventional antiarrhythmics [44]. In patients who have received antiarrhythmic drugs, rapid recurrences of tachyarrhythmias that occur despite repeat defibrillation and widening QRS complexes pose a therapeutic dilemma. The interaction of multiple antiarrhythmics creates unpredictable and often proarrhythmogenic effects. In these situations magnesium provides a valuable therapeutic option [22, 24].

Refractory Ventricular Fibrillation

Despite the lack of controlled studies, magnesium provides a valuable therapeutic option in these dramatic clinical situations [45, 46]. According to the American Heart Association guidelines parenteral magnesium should be considered alternative treatment (class indeterminate) for ventricular fibrillation refractory to standard therapy [26].

Monomorphic Ventricular Tachycardias

The diversity of pathophysiological processes underlying ventricular tachycardias might in part explain the conflicting results that the mostly small studies on magnesium in monomorphic tachycardias have produced [47–49]. In a randomized, double blind study by North, magnesium successfully terminated ventricular tachycardia in one third of the patients [50]. Manz and coworkers showed similar cardioversion rates [51]. However, successful cardioversion seems to be dependent on the dose of magnesium. A bolus dose of 2 g magnesium sulphate has been recommended [25].

Supraventricular Tachycardias

In electrophysiological studies in humans, magnesium has been shown to prolong the refractory period [4, 5]. This fact provides the rationale for the use of magnesium in supraventricular tachycardias (SVT). However, existing results are inconsistent. While Wesley describes successful cardioversion of SVT in 70% of patients [52], only 29% of episodes of induced supraventricular reentry tachycardias converted to...
The use of magnesium in cardiovascular disease has been studied extensively. Low magnesium levels seem to play a role in the pathogenesis of coronary artery disease [85]. A controlled study by Shechter in 50 patients with coronary artery disease demonstrated a significant improvement of endothelial function with oral magnesium therapy [11]. Furthermore, 3 months of oral magnesium reduced the development of
platelet-dependent thrombosis in patients with coronary artery disease [86]. The latter finding is corroborated by data showing a promotion of platelet-dependent thrombosis by low intracellular magnesium concentrations [87].

The clinical significance of these magnesium effects were impressively documented in a study presented at the 2001 ACC in Orlando [12]. For the first time, a study in patients with coronary artery disease could show that not only surrogate parameter such as endothelial function and the incidence of platelet-dependent thrombosis but also hard clinical endpoints can be influenced by oral magnesium therapy. This prospective, double-blind, randomized, placebo-controlled study analyzed 187 patients from 5 international centers. After 6 months, the magnesium group showed a significant improvement in the primary study endpoint, functional capacity, as measured by exercise testing (Table 2). This improvement was significant versus baseline and versus the placebo group. Additionally, quality of life questionnaires analyzed at 1, 3 and 6 months showed a significant improvement in quality of life with magnesium. The positive effects of magnesium could be detected even though all patients received concurrent optimal treatment according to international guidelines (Aspirin 95 %, beta-blockers 48 %, ACE-inhibitors 40 %, lipoprotein-lowering drugs 66 %).

The importance of these findings is emphasized by the association between exercise duration and cardiovascular mortality as well as overall mortality in patients with coronary artery disease [88].

Multiple mechanisms could explain the benefits seen in the magnesium group. Magnesium acts as a systemic [8] and coronary vasodilator [7] and is integrated in many metabolic processes such as in muscle contraction [9]. It is a cofactor of ATPase [89] and acts as a physiological calcium antagonist [9, 89, 90], thereby preventing intracellular calcium overload in ischemia. Magnesium reduces the vascular resistance, which subsequently increases the cardiac index [10, 89, 91]. A high extracellular magnesium concentration not only reduces the vascular tone in systemic, coronary and pulmonary vasculature [89] but also lowers the systemic blood pressure [10].

**Recommendations for Dose and Administration**

For oral magnesium therapy in patients with coronary artery disease 15 to 30 mmol should be prescribed per day. According to the results of published studies concurrent potassium substitution is recommended. Patients should take their medication 2 hours apart from any meal.

**Conclusion**

The use of magnesium as an antiarrhythmic drug for supraventricular and ventricular arrhythmias has been a matter of increasing interest and controversy over recent years. In view of the influence of magnesium on electrical stability and function and modification of myocardial cells as well as the myocardium as a whole, the drug appears valuable in a wide array of arrhythmias. The physiological basis of the therapeutic concept and the wide margin of safety provide convincing arguments.

As studies have now transcended from basic science to evidence of clinical efficacy, coronary heart disease features prominently among the indications for oral magnesium therapy. It could be shown that magnesium improves exercise duration and general well being in these patients.

The easy and safe handling of the drug as well as the low treatment costs justifies the increasing interest in magnesium for clinical use and scientific research.

**References**


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**Table 2. Maximal exercise duration in patients with stable coronary artery disease in minutes** (Shechter et al. [12]).

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<th>Magnesium</th>
<th>Placebo</th>
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<tr>
<td>At baseline</td>
<td>8.1 ± 2.7</td>
<td>7.8 ± 2.9</td>
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<tr>
<td>After 6 months</td>
<td>8.7 ± 2.1</td>
<td>7.8 ± 2.9</td>
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<td>p = 0.01</td>
<td>p = 0.162</td>
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