**Supplemental Online Table 1. CMR study protocol for ACM**

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| **CMR SEQUENCES** | | **IMAGING PARAMETERS** | **MODE OF ACQUISITION** |
| Localizers |  |  | * Sagittal, coronal, transaxial |
| Cine CMR | Balanced steady-state free precession | Slice thickness 8 mm; TR/TE minimum, interslice gap 20%, flip angle 70°, parallel imaging 2. | * Long axis 4-ch, 3-ch, 2-ch view * Short axis stack (8-10 slices) |
| Cine CMR | Balanced steady-state free precession | Slice thickness 5 mm; TR/TE minimum, interslice gap 20%, flip angle 70°, parallel imaging 2. | * Right ventricular inflow (3-5 slices) * Sagittal RVOT (3-5 slices) |
| Black-blood CMR | T1- or proton-density weighted fast spin-echo | Slice thickness 8 mm;  TR = 2RR; TE 25 ms  parallel imaging 2. | * Long axis 4-ch, 3-ch, 2-ch view * Short axis stack (8-10 slices) * Right ventricular inflow\* * Sagittal RVOT\* |
| Edema CMR | Turbo-inversion recovery magnitude | Slice thickness 8 mm;  TR = 2RR; TE 76 ms; TI 160 ms  parallel imaging 2. | * Long axis 4-ch, 3-ch, 2-ch view * Short axis stack (8-10 slices) * Right ventricular inflow \* * Sagittal RVOT\* |
| *GBCA administration* | | | |
| Cine CMR | Balanced steady-state free precession | Slice thickness 5 mm; TR/TE minimum, interslice gap 20%, flip angle 70°, parallel imaging 2. | * Right ventricular transaxial stack  (8-10 slices) |
| Flow CMR  *(optional. Recommended in case of RV dilatation*). | Through-plane motion-encoded phase-sensitive spoiled gradient echo | Slice thickness 6 mm; TR/TE 39/2.68; flip angle 20° | * Pulmonary artery * Aorta |
| Time inversion scout (about 8 minutes after GBCA administration) | Time-inversion scout gradient echo |  | * Mid short-axis view   (or long-axis 4-ch view) |
| LGE CMR\* | Phase-sensitive inversion recovery gradient echo | TR/TE per manufacturer recommendations; slice thickness 8 mm; interslice gap 20%; Flip angle 25°; no parallel imaging. Phase sensitive inversion recovery recommended. | * Long axis 4-ch, 3-ch, 2-ch view * Short axis stack (8-10 slices) * Right ventricular inflow (3-5 slices) * Sagittal RVOT (3-5 slices) |

\* On post contrast sequences the diagnosis of LV scar relies on demonstration of nonischemic LGE/fibrosis that affects the subepicardial (less often the midmyocardial) layers of the LV free wall, mostly the inferolateral region, with or without septal involvement, in the form of a stria (or band) pattern affecting ≥1 segment on the traditional “Bull’s Eye” system; the circumferential involvement by subepicardial LGE of the LV free wall and septum in short axis view (“ring pattern”) has been consistently reported as highly specific for ALVC.

LV LGE needs to be confirmed in 2 orthogonal views. Patchy, focal or septal junctional LGE are excluded from the diagnosis.

CMR, cardiac magnetic resonance; LGE, late gadolinium enhancement; RV, right ventricle; RVOT, right ventricular outflow tract; GBCA, gadolinium-based contrast agent.