Impact of myocardial perfusion gated-SPECT on the decision to perform coronary angiography in patients with left ventricular dysfunction of ischemic origin

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ABSTRACT

Objectives: The aim of this study was to analyze how the myocardial perfusion gated-SPECT (Single Photon Emission Computed Tomography) influences the practice of a coronary angiography in patients with ischemic cardiomyopathy (IM).

Patients and methods: A total of 120 consecutive patients (mean age: 64.9±11.5 years, 25 female) with IM (left ventricular ejection fraction ≤40%) and without previous coronary angiography were evaluated by myocardial perfusion gated-SPECT (96 stress-rest and 24 only at rest). The ventricular ejection fraction (EF) was obtained at rest by gated-SPECT in all patients. The ischemic origin of the systolic dysfunction was established by means of coronary angiography in 64 patients and by previous myocardial infarction in the rest. Gated-SPECT results of these 64 patients were compared with those of 56 patients in whom coronary angiography had not been indicated.

Result: Scintigraphic myocardial ischemia (HR: 5.2; CI 95%: 2.68 to 10.35) in patients who were able to perform the stress-rest test and who had severely impaired EF (<30%) (HR: 0.9; CI 95%: 0.89 to 0.99) were the best independent predictors of coronary angiography. On the contrary, scintigraphic criteria of viability were not a determinant, from the statistical point of view, of coronary angiography in this series.

Conclusions: In patients with IM, demonstration of ischemia and severe reduction of the EF, but not detection of viable myocardium, prompted the performance of coronary angiography.

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Introduction

Ischemic cardiomyopathy (IC) is a disease with elevated morbidity and mortality.1-7 The principal motives to evaluate these patients with Gated myocardial perfusion SPECT (Single Photon Emission Computed Tomography) are the detection of myocardial viability, myocardial ischemia and quantification of left ventricular function.

In spite of all the existing literature, the impact of these findings on the management of patients with IC in the clinical practice has been analyzed in depth. Thus, the purpose of this study has been to evaluate in a single center the influence of the gated myocardial perfusion SPECT on decision-making to perform a coronary angiography (CA) in patients with coronary arterial disease and moderately to severely reduced left ventricular systolic function.

Methods

Patient screening

One hundred twenty patients (mean age: 64.9±11.5 years, 25 women), with IC (left ventricular ejection fraction ≤ 40%), and without previous CA, were studied with gated myocardial perfusion SPECT. The ejection fraction (EF) was always calculated at rest using the gated-SPECT. The ischemic origin was established by CA in the 64 patients in whom it was performed and by the background of myocardial infarction in the remaining 54 (anterior: 37, inferior: 17). Mean interval between the myocardial infarction and the gated-SPECT was 3.3 years.

Beginning with the 363 patients with EF ≤ 40% evaluated by gated myocardial perfusion SPECT, 243 were excluded due to heart valve diseases or idiopathic dilated cardiomyopathy (n: 61), cardiac pacemakers (n: 10), previous myocardial revascularization (n: 86) and previous CA (n: 86).

The images of the gated myocardial perfusion SPECT, the clinical data and performance of a CA during a 12-month follow-up of each patient were analyzed. The clinical variables and gated-SPECT variables were included prospectively and stored in a data bank of the Nuclear Cardiology Unit.

Gated myocardial perfusion SPECT

Of the 120 patients studied, 96 (80%) were evaluated with a short protocol (one day) of stress rest SPECT and 24 (20%) only rest gated-SPECT. In 56% of the patients, 99mTc-MIBI was used and in the remaining 44% 99mTc-Tetrofosmin was used.

In 86 patients, a stress test was performed with a cycloergometry test and in 10, dipyridamole was administered during the stress as they did not reach 80% of the tachycardization percentage calculated for their age without symptoms or electrocardiographic abnormalities.8

The first radiopharmaceutical dose, injected between 30 and 60 seconds prior to the completion of the maximum effort, was 24 mCi, with an interval of not less than 45 minutes between the injection of both doses.

Acquisition was obtained with an adjacent Siemens ECAM dual head gammacamera (at 90°) with a low energy high resolution collimator and performing a simicircular orbit initiated in the right anterior oblique view at 45° with detections every 3º until completing a 180° circle in left posterior oblique position. A 64 × 64 matrix and acquisition zoom factor of 1.45 were used. The number of images per cardiac cycle for the at rest gated-SPECT-1 and the at rest gated-SPECT-2 was 8. For the reconstruction, a filtered back projection was used with an order 5 Butterworth filter and 0.35 frequency for the stress test and an order 10 Butterworth filter and frequency of 0.45 for both at rest studies. Tomography slices were obtained on the short axis, horizontal long axis and vertical long axis slices. No attenuation and scatter correction was performed.

The left ventricle was divided into 17 segments and each one of them were allotted a score for uptake level of the myocardial perfusion of 0 to 4 (0=normal activity, 1=slightly decreased, 2=moderately decreased, 3=severely decreased, and 4=absence of activity), and for thickening (0=normal, 1=slightly decreased, 2=moderately decreased, 3=severely decreased and 4=absence of thickening). The perfusion summed rest score (SRS), perfusion summed stress score (SSS), perfusion summed difference score (SDS) and the summed thickening score at rest (STS) were analyzed.9,10 At 10 minutes of administering 10 mg of sublingual nitroglycerin, the myocardial viability was measured in gated-SPECT rest images in regions with severe hypokinesia and akinesia. It was considered that a patient had myocardial viability criteria when there was ≥ 3 myocardial segments (17% of all the left ventricle) with severe hypokinesia, akinesia or dyskinesia with a perfusion score of 0-2 plus systolic thickening.5,6,10

The percentage of myocardial viability was calculated using the following equation: (number of viable segments)/(total segments) × 100.

It was considered that there was myocardial ischemia when the summed perfusion difference score (SPD) between stress and rest was ≥ 2.5,6,10 The SDS was grouped into three categories: low SDS=0 to 2, intermediate SDS=3 to 7, and elevated SDS > 7.5,6

The percentage of ischemia was calculated with the following equation (number of ischemic segments)/(total segments) × 100.5,6 It was considered as distant ischemia when there was the presence of ischemia in the regions contralateral to the myocardial viability study.

Calculation of the EF and ventricular volumes was done using the automatic delimitation of endocardial and epicardial borders with the QGS5 quantitative program(Cedars-Sinai Medical Center, Los Angeles, CA) in the rest gated SPECT.11

Statistical analysis

All the continuous variables were expressed with the mean and standard deviation (SD) and all the categorial variables were expressed in percentages.

The comparison of quantitative variables was performed with Student’s T test for independent samples. To compare two independent categorial variables, the χ² test, and Fisher’s exact test was used.

To evaluate the decision to perform a CA, we studied the presence of myocardial viability in the rest gated-SPECT of 120 patients and the presence of myocardial ischemia in rest-stress SPECT of 96 patients.

For the identification of the independent predictor variable of a CA, the Cox regression multivariate analysis was used (FSTEP [LR], the threshold for the entry of the variables was p<0.05, and for the exit was p<0.10). The likelihood of a CA during the post-gated-SPECT follow-up was calculated with the Kaplan-Meier method and for comparison of the different groups, the log-rank test was used.

All the variables analyzed were introduced into a data base made in SPSS (Version 13.0, SPSS Inc., Chicago; and MedCalc® Version 9.5.2.0.). A statistical difference was considered as significant when p was <0.05.

Results

A CA was performed on 64 patients (53%) during the post gated-SPECT follow-up. The mean interval between the gated-SPECT and CA was 3 months (SD=2 months). In 43 out of the 64 patients, the CA was performed within the first 60 days post gated-SPECT.

Tables 1, 2 and 3 show the clinical characteristics and those of the gated-SPECT of the patients with and without CA. A total of 96
The predictive value of an intermediate score of SDS (3 to 7) was $\chi^2: 7.075; HR: 2.6 (95% CI: 1.3 to 5.3) \ p=0.008$, and of an elevated score of SDS ($>7$) was $\chi^2: 6.463; HR: 3.2 (95% CI: 1.3 to 7.7) \ p=0.01$ (adjusted by absence of history of myocardial infarction, angina, EF $\leq 30\%$ and gender) (fig. 2C). There were no significant differences in the clinical variables, of the gated-SPECT and of the stress test between patients with CA performed before and after 60 days post SPECT.

### Discussion

The myocardial perfusion SPECT studies with $^{201}$TI or technetium compounds are safe, easily available, relatively economical techniques with elevated sensitivity and accuracy for the diagnosis of ischemia and myocardial viability. The beneficial effect of coronary revascularization on the survival of patients with left ventricular dysfunction is related with the presence of ischemia and myocardial viability.

The combination of the perfusion data and left ventricular function offered by the gated- myocardial perfusion SPECT in patients with ischemic cardiomyopathy has an additional prognostic value, but the influence of this examination in the indication of a CA in these patients is little known in tertiary hospital centers having Nuclear Cardiology and Hemodynamic Units.

Therefore, the purpose of this study has been to analyze the predictive variables of CA in patients with IC in the gated-myocardial perfusion SPECT images.

The relationship of patients without and with scintigraphic criteria of myocardial viability studied with CA was not significantly different from those patients in whom this test was not performed.

### Table 3

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Without CA (n=49)</th>
<th>With CA (n=47)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dress</td>
<td>7.75 (SD=29.8)</td>
<td>76.5 (SD=24.2)</td>
<td>0.865</td>
</tr>
<tr>
<td>Duration (minutes)</td>
<td>6.7 (SD=2.7)</td>
<td>6.4 (SD=2.3)</td>
<td>0.521</td>
</tr>
<tr>
<td>max HR (beats/minute)</td>
<td>162.2 (SD=30.5)</td>
<td>159.1 (SD=27.1)</td>
<td>0.618</td>
</tr>
<tr>
<td>% of tachycardization</td>
<td>73.8 (SD=11.9)</td>
<td>78.2 (SD=15.5)</td>
<td>0.069</td>
</tr>
<tr>
<td>max SAP (mmHg)</td>
<td>162.3 (SD=29)</td>
<td>159.1 (SD=27.1)</td>
<td>0.618</td>
</tr>
<tr>
<td>max HR x max SAP</td>
<td>18,374 (SD=5381)</td>
<td>19,538 (SD=5564)</td>
<td>0.324</td>
</tr>
<tr>
<td>METs</td>
<td>5.7 (SD=2.2)</td>
<td>5.9 (SD=2.1)</td>
<td>0.641</td>
</tr>
<tr>
<td>ST $\geq 1$ mm</td>
<td>7 (14.3%)</td>
<td>16 (34%)</td>
<td>0.023</td>
</tr>
<tr>
<td>Angina</td>
<td>3 (61%)</td>
<td>6 (12.8%)</td>
<td>0.251</td>
</tr>
</tbody>
</table>

SD: standard deviation; max HR: maximum heart rate; METs: metabolic equivalent; max SAP: maximum systolic arterial pressure.
However, patients subjected to a CA were more symptomatic for angina, had a more advanced functional class, a lower EF and greater scintigraphic ischemia. The multivariant analysis showed that the myocardial ischemia and severe decrease of the EF (<30%) were predictors of the practice of the catheterism in these patients.

Bourque et al. analyzed the characteristics of the patients with left ventricular dysfunction and coronary artery disease who had undergone a CA without SPECT, a SPECT prior to the CA and a SPECT after the CA and observed that there were significant differences among the different groups according to the sequence of the tests. In the patients with a SPECT prior to the CA, previous coronary revascularization and the heart failure symptoms were less frequent when compared with the patients without SPECT. In addition, they had less likelihood of myocardial infarction. After the CA, patients with SPECT had more likelihood of heart failure, myocardial infarction, EF<30% and previous revascularization. However, the scintigraphic ischemia and viability were not specifically analyzed.

In another series, the relationship between left ventricular perfusion and the parameters of ventricular function and the indication of an early stress-rest myocardial perfusion post gated-SPECT CA in a population of 3,369 patients without backgrounds of myocardial infarction and without previous coronary revascularization was evaluated. A total of 445 coronary angiographies (13.2%) were performed in the first 60 days post-gated-SPECT and the likelihood of indicating a catheterism increased with the severity of the ischemia and decrease of the EF. For every 1% increase of myocardial ischemia, there was a 23% increase in likelihood of performing a CA. For every 1% decrease of the EF, there was a 6% increase in the likelihood of a CA. Our study provides additional information as it demonstrates that the scintigraphic criteria of myocardial viability did not significantly contribute in our setting to the decision of indicating a catheterism. The presence of ischemia in a certain myocardial territory already entails the presence of viability and from the scintigraphic point of view, the presence of ischemia is more predictive in the prediction of myocardial capacity of recovery than viability.

The fact that our results come from the experience of a single hospital, with patients referred specifically for the performance of a gated-SPECT, may limit the general application of these findings. Thus, these results should not necessarily be extrapolated to other centers where the evaluation of myocardial viability is performed in a priority way with other methodology such as the echo-dobutamine stress-rest Gated-SPECT.
or magnetic resonance. On the other hand, the population size is relatively small, so that future investigations on this study performed with a greater number of patients and with several techniques can contribute to improve these results.

Conclusions

Scintigraphic myocardial ischemia and severe decrease in the EF in the at rest gated-myocardial perfusion SPECT are more determining factors of the indication of a CA in patients with CI. In our series, the scintigraphic criteria of myocardial viability did not significantly contribute to the indication of cardiac catheterism.

Conflict of interest

The authors declare they have no conflict of interest.

References


