Intimal thickness determines the detection of non-calcified plaques by computed tomography angiography

Alina van der Giessen, Frank Gijsen, Udo Hoffmann

Aim
To study the ability of computed tomography angiography (CTA) to detect atherosclerotic plaque as compared to intravascular ultrasound (IVUS) in an ex vivo setting and determine a size threshold for non-calcified plaques.

Methods
Ten ex-vivo human atherosclerotic coronary arteries were imaged in a moving phantom by Dual Source CT (Siemens Medical Solutions) (DSCT) and IVUS (Boston Scientific). Cross-sectional images were reconstructed and co-registered every 0.4 mm and assessed qualitatively for the presence and composition of atherosclerotic plaque (non-calcified, mixed and calcified plaques) on DSCT and IVUS. In addition, lumen area, plaque area, plaque eccentricity and intimal thickness was measured on the IVUS images.

Results
All plaque types: 1002 cross-sections were assessed by IVUS containing 58% non-calcified, 16% mixed, and 3% calcified plaque (fig. 1). The cross-table 1 and table 2 show higher accuracies for mixed and calcified plaques (82% and 92%) than for non-calcified plaques (69%, p<0.05) for the detection by CTA. An example of the IVUS and CTA assessment of one artery is shown in figure 2.

Non-calcified: Table 3 shows the influence of IVUS measures on the detection of non-calcified plaques by CTA. Multivariate regression analysis showed that intimal thickness was the strongest independent predictor for the detection of non-calcified plaque by CTA (OR 1.55/0.1 mm). The thicker the plaque, the better the detection by CTA (fig. 3).

Conclusion
We established intimal thickness as an independent predictor of the ability of CTA to detect non-calcified plaque as compared to IVUS in an ex vivo setting. A reasonable detection rate (80%) was found for plaques with an intimal thickness of > 0.78 mm.

Relevance
Given knowledge from IVUS studies about the prevalence of plaques in various patient populations, these results provide a perspective for the ability of CTA to assist risk prediction and to assess plaque progression over time.