Relationship between Late Gadolinium Enhancement Extent in Cardiac Magnetic Resonance Imaging and Severity of Coronary Artery Disease in Old Myocardial Infarction

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ABSTRACT

Purpose: To assess the relationship between the severity of coronary arteries involvement and the extent and pattern of myocardial scars in Cardiac Magnetic Resonance of patients with history of remote myocardial infarction.

Materials and Methods: The Cardiac Magnetic Resonance images of sixty patients with history of remote ST segment or non-ST segment elevation myocardial infarction were reviewed. The patients were candidates for selective coronary angiography and referred for Cardiac Magnetic Resonance imaging in order to evaluate the myocardial viability.

Results: The age of patients with history of old myocardial infarction (n = 60), among whom 78.3% were male, averaged 61.2 (SD = 11.5). There was no association between the severity of coronary artery stenosis in each territory and the presence of myocardial scar detected by late Gadolinium enhancement of Cardiac Magnetic Resonance (for all three vessel territories P = .05). However, there was a significant association between the coronary artery runoff and the presence of late Gadolinium enhancement in Cardiac Magnetic Resonance (P value for left anterior descending coronary artery [LAD], left circumflex [LCX] and right coronary artery [RCA] was = .002, = .001 and = .001, respectively). A significant relationship was found between the pattern of scar in terms of being transmural or non-transmural and the severity of coronary artery stenosis (P = .001), while the pattern of scar was not associated with the coronary artery runoff (P = .2).

Conclusion: The results of this study support the hypothesis contending that the time window for revascularization will increase in the presence of antegrade coronary flow in the jeopardized myocardium, which causes a limitation in the infarct progression and subsequent lesser extent of myocardial scar.

Keywords: magnetic resonance imaging, cine; methods; myocardial infarction; diagnosis; hysiopathology; prognosis; severity of illness index; time factors.

INTRODUCTION

Contrast enhanced Cardiac Magnetic Resonance (CMR) imaging is an accurate imaging modality for the non-invasive evaluation of coronary artery disease (CAD).1–4 The myocardial tissue characteristics can be directly visualized by CMR and late Gadolinium
Relationship Between IGE Extent in CMRI and Severity of CAD in Old MI—Faghih et al

**MATERIALS AND METHODS**

The CMR images of sixty patients with history of remote ST or non-ST segment elevation MI were reviewed. The patients were candidates for selective coronary angiography and referred for CMR imaging in order to evaluate the myocardial viability. The presence of MI was confirmed by reviewing the hospital records and considering American Heart Association (AHA) guidelines. Selective coronary angiograms were performed in all patients via femoral approach using Seldinger technique. The left and right anterior and posterior projections were obtained from left and right coronary arteries in all patients. The angiograms were interpreted by an expert cardiologist, also the number of coronary vessels were recorded. The study was approved by institutional research and ethics committee.

**Coronary Angiography Protocol**

The indication of coronary angiography was based on approved guidelines. Selective coronary angiography was performed in all patients via femoral approach using Seldinger technique. The left and right anterior and posterior projections were obtained from left and right coronary arteries in all patients. The angiograms were assessed by an expert cardiologist, also the number of vessels involvements, severity of lesions and runoffs of stenotic coronary arteries were recorded.

**CMR Protocol**

Cardiac MRI with 1.5-Tesla Avanto Siemens device (Siemens Healthcare, Erlangen, Germany) with gadolinium based contrast agent (Magnevist) was conducted. The steady-state free precession sequences for cine images were done. Consecutive breath-hold short axis of the heart was used to obtain functional assessment: Perfusion MRI was performed at rest using a “first-pass” technique with fast intravenous injection of a gadolinium-based contrast agent.

Myocardial edema in the acute phase of MI was shown as a bright signal on T2-weighted images. Late gadolinium enhancement (LGE) images as a T1-weighted inversion recovery sequences were acquired 10 minutes after intravenous administration of gadolinium. The inversion time was chosen in a way to null the myocardial signal using “inversion time scout”. The pattern of LGE was used to differentiate the two kinds of post-infarction necrosis (subendocardial and transmural LGE) based on the extent and pattern of myocardial scars in CMR of patients with history of remote MI.

**Statistical Analysis**

Statistical Package for the Social Science (SPSS Inc, Chicago, Illinois, USA) version 19.0 was used for all statistical analyses. One sample Kolmogorov-Smirnov test was used to assess normal distribution. Quantitative variables were expressed as mean (standard deviation) and categorical variables were expressed as number (percentage). To compare variables Chi square or Mann-Whitney tests were used if appropriate. To assess the sensitivity and specificity of CMR in prediction of coronary artery involvements 2*2 tables were used. $P$ values less than .05 were considered significant.

**RESULTS**

Among 60 subjects of the study population, 47 (78.3%) patients were male. The mean (SD) of age was 61.2 (11.5), which fluctuated between 35 and 86 years of age. The mean (SD) of left ventricular ejection fraction (LVEF) by echocardiography and CMR was 26.8 (10.3) and 27.6 (11.6), respectively. (Table 1 shows demographic and angiographic characteristics of the study population) Table 2) depicts detailed coronary angiographic findings of the study population. Left anterior descending (LAD), left
circumflex (LCX) and right coronary arteries (RCA) were involved in 93.3%, 78.3% and 83.3% of subjects, respectively. Severe stenosis and poor runoff were observed in minority of patients. Table 2. Table 3 depicts CMR findings of the study population. No association was found between the severities of coronary stenosis in each territory and the presence of myocardial scar detected by LGE of CMR (for all three vessel territories $P \geq .05$). However, there was a significant association between coronary artery runoff and the presence of LGE in CMR ($P$ value for LAD, LCX and RCA was $< .002, < .001$ and $< .001$, respectively). On the other hand, in patients who showed myocardial scar based on LGE in CMR, a significant association between the pattern of scar in terms of being transmural or non-transmural and the severity of coronary artery stenosis was seen ($P = .001$), while the pattern of scar was not associated with the coronary artery runoff ($P = .2$).

### Diagnostic Accuracy of CMR in Prediction of Coronary Artery Stenosis

We found a specificity of 100% for CMR in the prediction of coronary artery stenosis in all three territories. However, the sensitivity of CMR in prediction of coronary artery stenosis was 91%, 70% and 66% for LAD, LCX and RCA involvements, respectively (Table 4).

### DISCUSSION

In this study, a significant relationship was found between the coronary runoff and the presence of scar detected by LGE in CMR. We also showed an association between the severity of coronary stenosis and the pattern of scar in terms of being transmural or non-transmural. To the best of our knowledge, this is the first study which has investigated the relationship between severity of CAD and myocardial scar in CMR in patients with history of remote MI.

Among different studies about CMR in MI (5-7,9-11,20-22), Kim and colleagues investigated the CMR of 24 patients with acute MI in order to differentiate the chronic old myocardial scar from acute infarction. They also showed...
that distinctive features of old scar may exist in CMR and can be used in differentiating old and acute MI. However, they did not consider the pattern of coronary artery lesions in their study.

Bexell and colleagues, in a similar study, examined the relationship between the severity of proximal coronary stenosis, the amount of coronary collaterals and the myocardial scar extent in patients with history of chronic CAD. They demonstrated a significant relationship between coronary artery stenosis and the extent of myocardial scar in the absence of MI history. They showed that myocardial scarring can be observed even in the presence of non-significant coronary lesions and extent of coronary collaterals is an important factor in the development of myocardial scar.

In this study we found that the coronary artery runoff in patients with history of remote MI may be more important than the severity of coronary artery stenosis in myocardial scarring, also the importance of coronary stenosis severity is in transmurality of the scar.

Ortiz-Perez and colleagues examined acute MI patients treated by primary PCI by CMR and found that the TIMI flow and the presence of collaterals are two independent predictors of myocardial salvage index and transmurality. Therefore, it is reasonable to consider a relationship between the extent of scar and the coronary artery runoff, as well as the transmurality and the severity of coronary stenosis.

A good specificity (100) for CMR in detecting coronary artery stenosis in patients with history of MI was also shown in this study. However, the sensitivity and diagnostic accuracy was higher in LAD lesion detection than in LCX and RCA. The diagnostic accuracy of CMR has been examined by Bernhardt and colleagues. They investigated patients with history of CABG and PCI and showed that diagnostic accuracy of CMR in CABG patients is lower. In their study, the specificity of CMR for detecting coronary artery was between 85% and 87% for different coronary vessels, which is much lower than the specificity we found. On the other hand, in our study, the sensitivity of CMR for detecting stenosis in each coronary vessel was also different from Bernhardt and colleagues’ study, in which a higher sensitivity for RCA and LCX, but not LAD, was reported. Indeed, our study population has been chosen among patients with documented MI who had low ejection fractions and this dissimilarity in study population may explain the difference in specificity and sensitivity.

CONCLUSIONS

In conclusion, the results of this study support the hypothesis contending that the time window for revascularization will increase in the presence of antegrade coronary flow in the jeopardized myocardium, which causes a limitation in the infarct progression and subsequent lesser extent of myocardial scar. Therefore, the prognosis of patients who had early invasive strategies in the treatment of acute MI is better. CMR is a feasible method in the evaluation of patients with history of MI and has a good diagnostic accuracy in detecting coronary lesions particularly in LAD territory.

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CONFLICT OF INTEREST

None declared.

REFERENCES

3. Kwong RY, Schussheim AE, Rekhrad S, et al. Detecting acute coronary syndrome in the emergency department...
with cardiac magnetic resonance imaging. *CIRCULATION.* 2003;107:531-7.


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