

Quality Control Worksheet – Report HAS BEEN sent out

Today's date: 2/28/2023

QC Received by Todd/Heidi

Practice/Physician: Dr. Wright

Patient name: Taylor Abernathy

Scan date: 11/15/2022

Response is made: _____

Scan/reading information:

Scan Date	11/15/2022
Sonographer	Marie
Reader	Diane Nielson

Concerns:

2/28/23 Dr. Wright: Trust you are doing well!!! Hope to see you in Spokane at the BDM preceptorship in April! My patient (Robert) Taylor Abernathy had a CIMT on 11.15.2022. The report showed echogenic plaque on the right. He had known high grade stenosis without history of TIA. A CTA in April showed 85% stenosis and no ulceration. We started BDM max therapy then. A few days ago, he had an atherothrombotic TIA and carotid US shows ulcerated plaque with thrombus. Here's my request. Can someone look at the right carotid images and see if there is any lipid-rich area? The only thing that makes sense to me is that he had a small lipid lake then that ruptured. Not that this changes anything--I'm just trying to understand what happened. His inflammatory markers have been great as recently as 30 days prior to his event. Unsettling to say the least. Fortunately, his stroke was small, and he will probably make a full recovery. Thankfully I had him on dual antiplatelet therapy which limited the clot size.... Thank you, sir!

CardioRisk™ Scan Patient Results

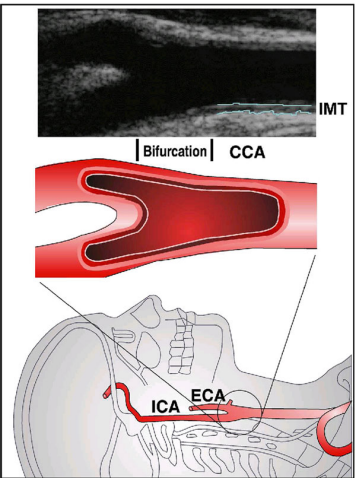
Patient Name: ABERNATHY, TAYLOR
Gender: M
Date of Exam: 11/15/2022
Date of Birth: 5/2/1955
Referring Provider: DAVID WRIGHT

Patient Age	67	Patient IMT	1.14 mm
Arterial Age	>80	Normal IMT	<.50 mm

CV Event Risk

All measurements in mm

Test Criteria:	Normal	Moderate	High	Last Visit ⁺	Alert Value [*]
Early Event Risk ⁺⁺			5.8		2.5
Average CCA Mean IMT			1.14		0.73
Average CCA Max Region			1.32		0.75
Plaque Burden ^{**}			18.4		



Comments: The following values are the largest intima-media thickness (IMT) measurements found in each carotid artery segment. Any measurement equal to or 1.3mm is defined as 'plaque' and is characterized as being: **S = Soft; H = Heterogeneous; or E = Echogenic** (includes mineral deposits like calcium). All measurements are in millimeters.

Right CCA 1.2; Bulb 5.8 E; Internal Carotid 4.5 E
Left CCA 1.7 H; Bulb 4.3 H.; Internal Carotid 2.1 H
Doppler was used bilaterally. Carotid Stenosis > 50% possible.
Complete Doppler Flow study may be considered if clinically indicated.

++ Early Event Risk refers to a patient's increased risk of having an event in the next 5.1 years \pm 2.3 years. It does not suggest the patient will have an event in that time frame, only that the hazard ratio significantly increases (from 1 to between 4.1 and 6.7 depending on the patient's Framingham risk score) (D Baldassare et al / Atherosclerosis xxx 2006 xxx-xxxx)

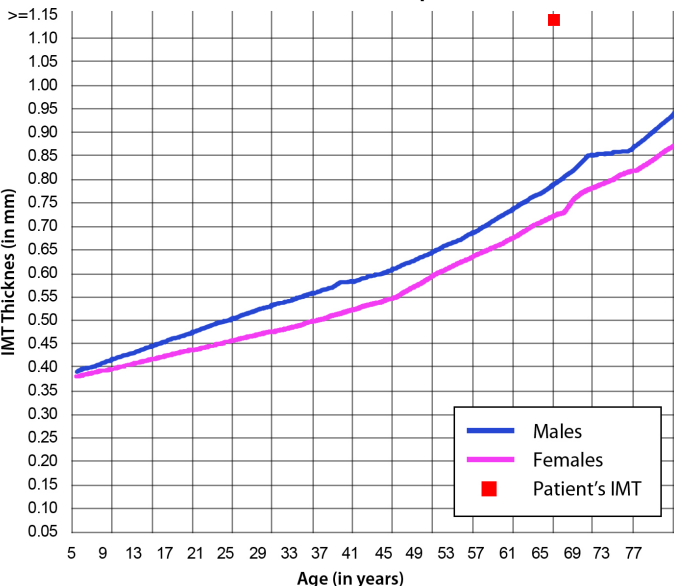
+ A progression rate of .034 mm or greater in the thickness of the mean IMT per year, increases the risk of future events significantly. (Hodis HN, et al / Ann Intern Med 1998;128:262-9)

* The Alert Value is the threshold measurement at which this patient's risk is inflated beyond a 'Normal' reading.

** Plaque Burden is the sum of the plaques found and measured. It does not have an Alert Value because plaques of any size are atherosclerotic and increase patient risk. The Plaque Burden score is intended to help physicians track progression of disease over time.

Patients with values in yellow or red on ANY risk test criteria have inflated risk.

Patient Arterial Age Compared to U.S. Male/Female Populations



Your Doctor should interpret the results from this report in conjunction with your other risk factors. Medical decision making takes a multitude of factors into account, and risk factor modification should be made in consultation with your Doctor. Arterial Age™: The mean distal 1 cm common carotid artery (CCA) IMT measured looks like the average same gender person in a general population which had no coronary heart history expressed as Arterial Age above. The risk assessment data provided above should be used with caution. Data from five different studies which used different criteria for participation, different training methods, and different scanning and reading protocols [A: Tonstad, S (1996) Arterioscler Thromb; B: Urbina, E (2002) Am J Cardiol; C: Oren, A. (2003) Arch Intern Med.; D: Tonstad, S. (1998) Eur J Clin Invest; E: Aminbakhsh, A (1999) Clin Invest Med] were used to create an approximate arterial age compared to normal populations found in these studies. Regression analyses was used to estimate population age over time based on the cited studies above. In a careful literature review, the data cited above is an approximation of the relationship between CIMT and age in epidemiologic studies. The above data relating age to CIMT is useful in comparing a single patient's result with a population mean, and takes on additional meaning when comparing a current CardioRisk CIMT score with a previous CardioRisk CIMT score on the same patient. It is important to note that these studies do not account for the highest risk patients, those who died from the disease.



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