

## Quality Control Worksheet – Report HAS BEEN sent out

Today's date: 4/27/2023

Practice/Physician: Dr. McNamara

Patient name: Elizabeth Moffat

Scan date: 3/15/21

Response is made: \_\_\_\_\_

### Scan/reading information:

<b>Scan Date</b>	<b>3/15/21</b>	<b>3/11/20</b>
<b>Sonographer</b>	Dana	Dana
<b>Reader</b>	Diane N	Diane N

### Concerns:

<b>Scan Date</b>	<b>3/15/21</b>	<b>3/11/20</b>
<b>LICA</b>	0.8	1.4
<b>RICA</b>	0.9	1.4

Discrepancy for patient first name year to year.  
I'm sorry we missed this.

3/16/2023 Dr. McNamara: Her plaque appeared to regress too- is this another plaque straddle situation? Bc this was 2020/2021 - not a long time ago.

3/17/2023 Ken: Can you look at the images of Elizabeth Moffat from 2020 and 2021. It appears the heterogenous plaques in her RIC and LIC have regressed to non-plaques.

# CardioRisk™ Scan Patient Results

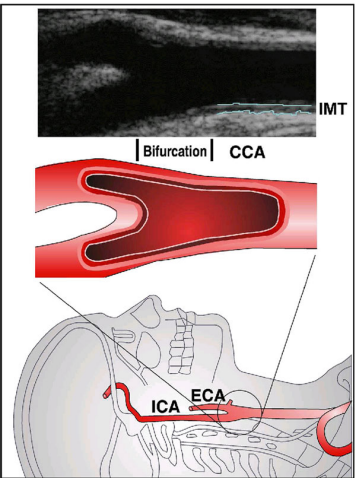
Patient Name: MOFFAT, ELIZABETH  
Gender: F  
Date of Exam: 3/15/2021  
Date of Birth: 7/4/1946  
Referring Provider: CAREY MCNAMARA

Patient Age	74	Patient IMT	0.71 mm
Arterial Age	63	Normal IMT	<.50 mm

## CV Event Risk

All measurements in mm

Test Criteria:	Normal	Moderate	High	Last Visit (2020) <sup>+</sup>	Alert Value*
Early Event Risk <sup>++</sup>	1.7			1.5	3
Average CCA Mean IMT	0.71			0.78	0.73
Average CCA Max Region		0.83		0.92	0.75
Plaque Burden <sup>**</sup>			1.7	4.2	



**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 .9; Bulb 1.2; Internal Carotid .9**  
**Left CCA .7; Bulb 1.7 H; Internal Carotid .8**  
**Doppler was used bilaterally.**

### Comments from 3/11/2020 Scan

Right CCA 1.0; Bulb 1.2; Internal Carotid 1.3 H  
Left CCA .9; Bulb 1.5 H; Internal Carotid 1.4 H  
Doppler was used bilaterally.

<sup>++</sup> 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)

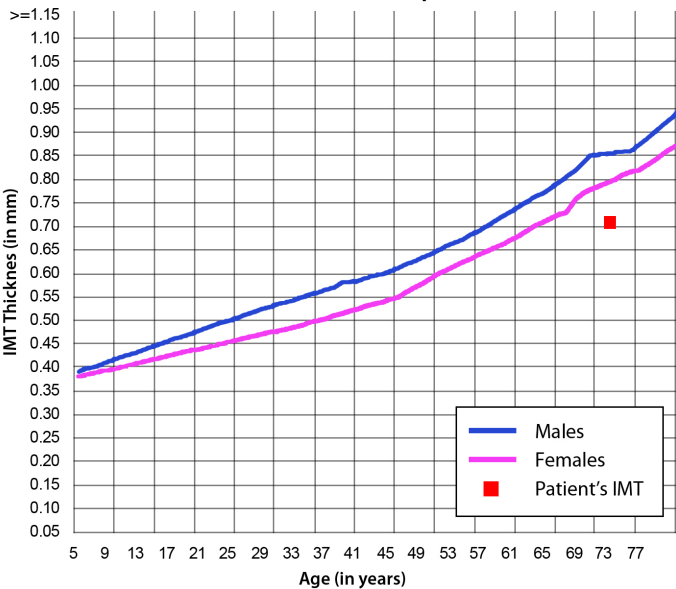
<sup>+</sup> A progression rate of .034 mm or greater in the thickness of the mean IMT per year, increases the risk of future events significantly.  
(Hodis HN, et al / Ann Intern Med 1998;128:262-9)

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

<sup>\*\*</sup> 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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