

Quality Control Worksheet – Report HAS BEEN sent out

Today's date: 5/5/2023

QC Received by Nera

Practice/Physician: Heritage Medical Associates

Patient name: Sonal Gupta

Scan date: 4/25/2023

Response is made: _____

Scan/reading information:

Scan Date	4/25/2023	8/27/2022
Sonographer	Dana J.	Rob
Reader	Diane Morgan	Diane Nielson

Concerns:

Scan Date	4/25/2023	8/27/2022
RCB	1.5 H	.7
RICA	1.5 H	.6

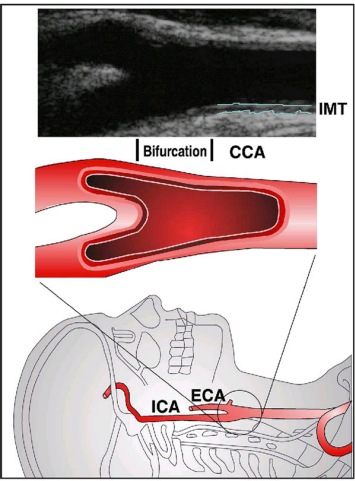
05/4/2023 Ken: Please look at the scans from 2022 and 2023 for Sonal Gupta. She has a low IMT now and a year ago, but she now has 2 heterogenous plaques that she did not have a year ago. Not quite sure how the two plaques formed when there was not enough time for the inflammation to have gotten severe and then resolved. Told her I would ask you to look at the images to see if we missed plaque in 2022 or what other answer there might be.

CardioRisk™ Scan Patient Results

Patient Name: GUPTA, SONAL
Gender: F
Date of Exam: 4/25/2023
Date of Birth: 10/6/1976
Referring Provider: SONAL GUPTA

Patient Age	46	Patient IMT	0.63 mm
Arterial Age	54	Normal IMT	<.50 mm

CV Event Risk				All measurements in mm	
Test Criteria:	Normal	Moderate	High	Last Visit (2022)*	Alert Value*
Early Event Risk**	1.5			0.8	1.7
Average CCA Mean IMT	0.63			0.64	0.73
Average CCA Max Region		0.79		0.76	0.75
Plaque Burden**			3.0		



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

Comments from 8/27/2022 Scan

Right CCA .6; Bulb .7; Internal Carotid .6
Left CCA .8; Bulb .8; Internal Carotid .6
Doppler was used bilaterally.

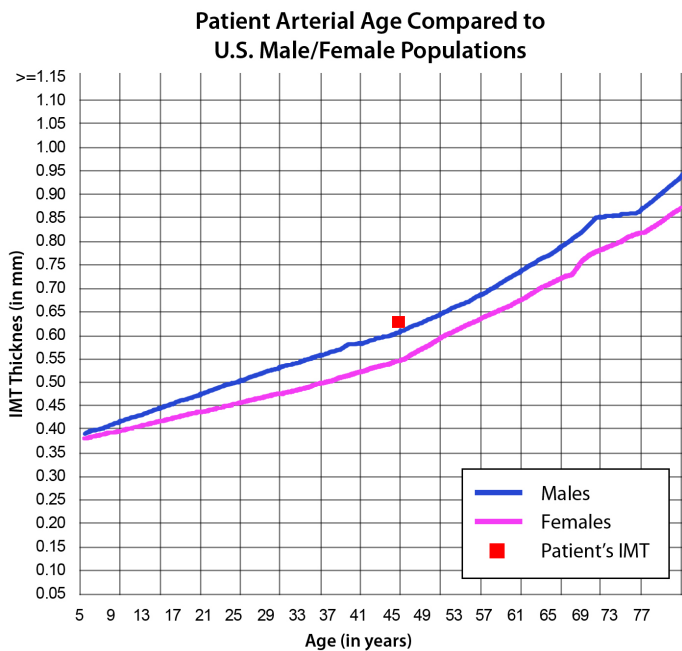
++ Early Event Risk refers to a patient's increased risk of having an event in the next 5.1 years \pm 2.3 years. It does not suggest the patient will have an event in that time frame, only that the hazard ratio significantly increases (from 1 to between 4.1 and 6.7 depending on the patient's Framingham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



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 disease 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.



