

Quality Control Worksheet – Report HAS BEEN sent out

Today's date: 5/15/2023

QC Received by Nera

Practice/Physician: Dr. Adria Rothfeld

Patient name: Michael Heitzner

Scan date: 1/30/2023

Response is made: _____

Scan/reading information:

Scan Date	1/30/2023
Sonographer	Rob A.
Reader	Diane Morgan

Concerns:

Scan Date	1/30/2023
CCA Mean IMT	0.66
CCA Max Region	0.81
Plaque Burden	NONE

05/10/2023 Todd: I told Dr. Rothfeld that I would ask Todd to look at the images back in early March. Please make this a priority so that I can get back to her sooner rather than later.

Thanks,
Ken Brigham

04/08/2023 Todd: Dr. Rothfeld had some questions about one of her patients. He had a CTA that showed some soft plaque, so she was surprised when he did not have any plaque in his carotid arterial beds. He has hypertrophic cardiomyopathy so that may be part or all the reason. She sent over the CTA notes, no images available. She asked if I would send you the report to look at it and check our images to make sure a plaque was not missing.

CardioRisk™ Scan Patient Results

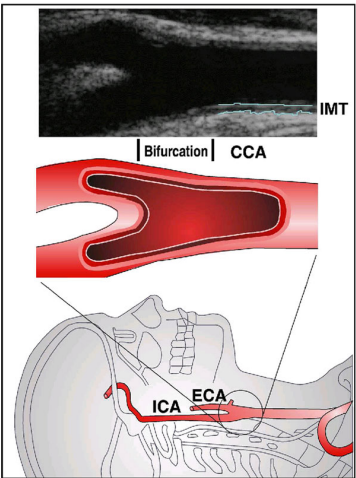
Patient Name: HEITZNER, MICHAEL
Gender: M
Date of Exam: 1/30/2023
Date of Birth: 2/18/1972
Referring Provider: ADRIA ROTHFELD

Patient Age	50	Patient IMT	0.66 mm
Arterial Age	51	Normal IMT	<.50 mm

CV Event Risk

All measurements in mm

Test Criteria:	Normal	Moderate	High	Last Visit ⁺	Alert Value [*]
Early Event Risk ⁺⁺	0.9				1.4
Average CCA Mean IMT	0.66				0.73
Average CCA Max Region		0.81			0.75
Plaque Burden ^{**}	NONE				



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 .9; Internal Carotid .8
Left CCA .8; Bulb .8; Internal Carotid .5
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)

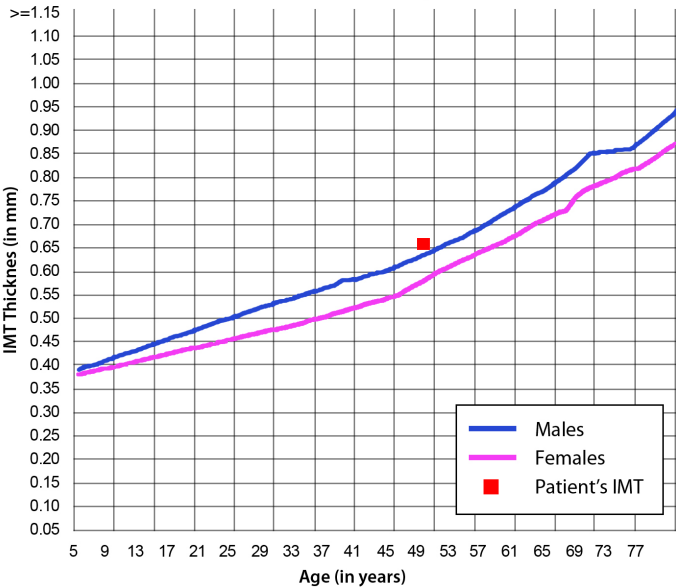
+ A progression rate of .034 mm or greater in the thickness of the mean IMT per year, increases the risk of future events significantly.
(Hodis HN, et al / Ann Intern Med 1998;128:262-9)

* 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.

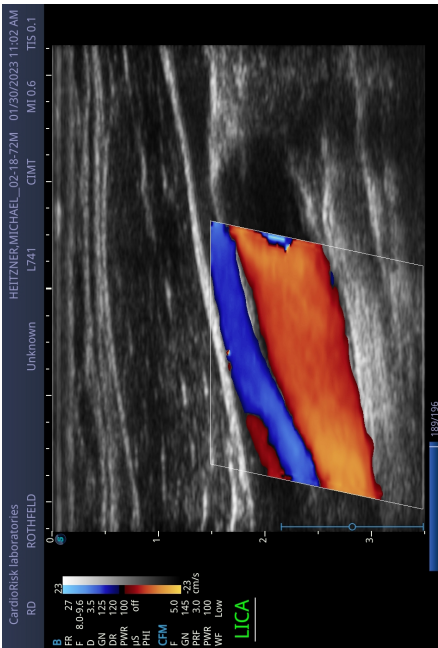
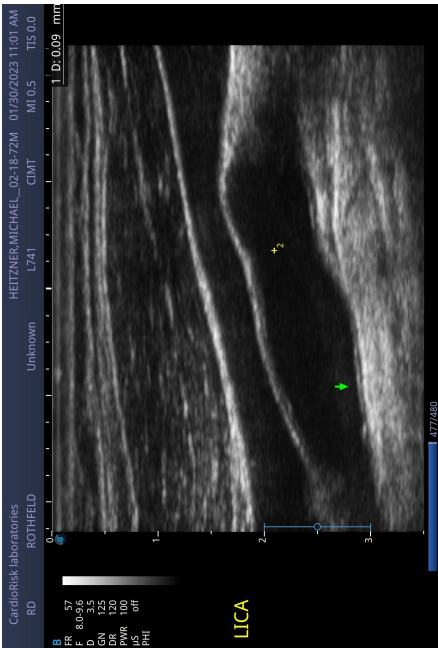
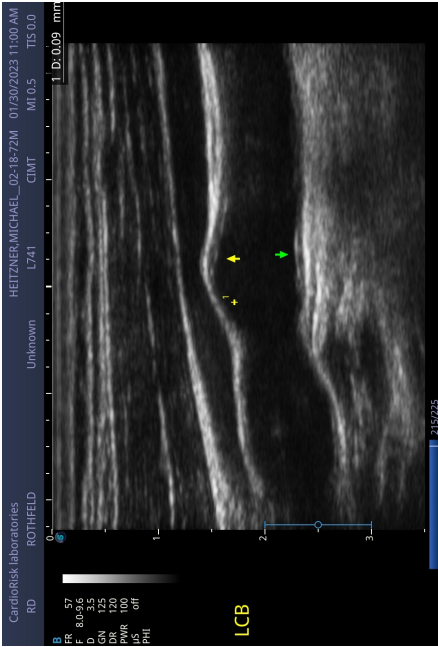
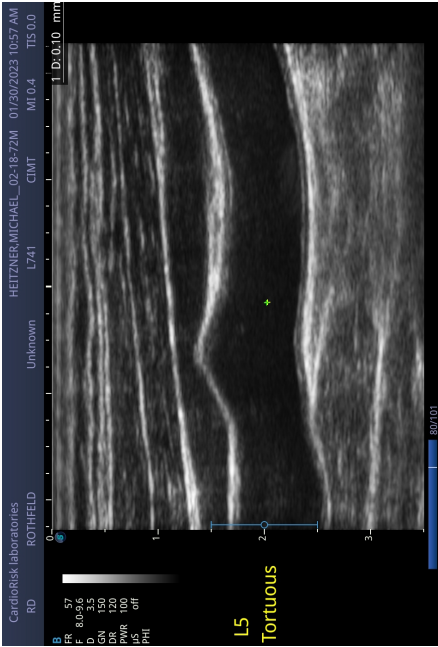
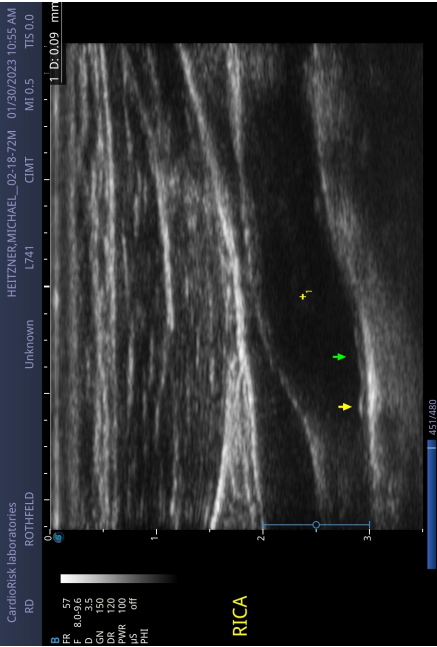
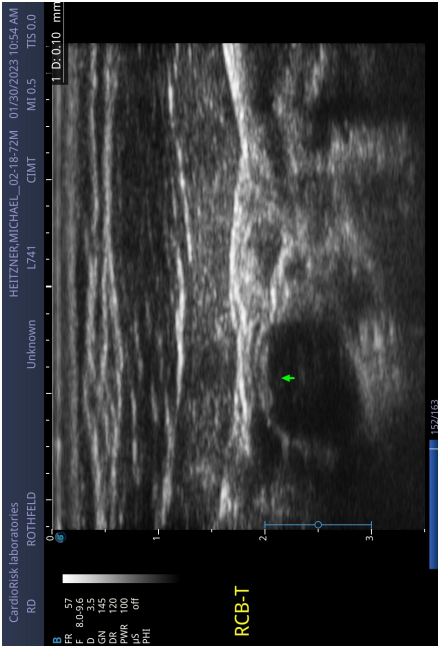
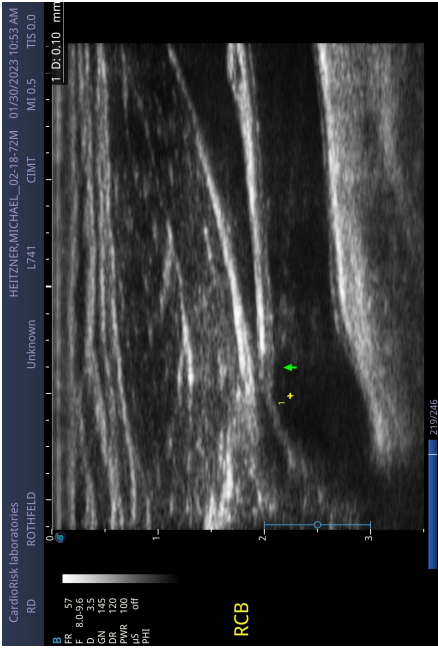
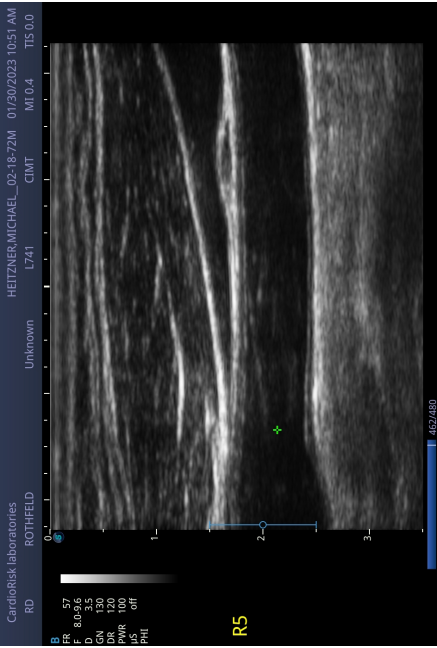
Patient Arterial Age Compared to U.S. Male/Female Populations



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.



CardioRisk Laboratories
At the Heart of Good Health



Heitzner, Michael W (MRN: 0833949) DOB: 2/18/1972



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530 1st Avenue, HCC 2nd floor
New York, NY 10016-6402
212-263-7294

Pt Name: Heitzner, Michael W
DOB: 2/18/1972
MRN: 0833949
Referring: Ronald W Galluccio
CC Recipient(s):
Pt Phone: 917-847-3537

<u>Procedure(s)</u>	<u>Accession Number(s)</u>	<u>Date of Service</u>
CT ANGIO CORONARY WITH IV CONTRAST AND CT CHEST WITHOUT IVC	21838835	3/23/21

IMPRESSION:

1. Total coronary artery calcium score: 7
2. Coronary artery atherosclerotic disease of the mid RCA (noncalcified plaque, moderate (50-55%) stenosis), LCx (calcified plaques, mild (maximum of 25%) stenosis), and LAD (noncalcified plaque resulting in 40-45% stenosis and other minimal calcified plaques resulting in no significant stenosis).
3. Small vascular connection between the LA appendage and the RV septal surface as described above.

FINDINGS:

CLINICAL INDICATION: 49 year old man presenting for evaluation of the coronary arteries.

COMPARISON: None.

TECHNIQUE: Non-contrast ECG synchronized CT of the heart was performed. Coronary artery calcification was analyzed using calcium scoring software with a threshold value of 130 Hounsfield Units.

Subsequently, a CT angiogram was performed of the heart from the level of the pulmonary artery bifurcation to the diaphragm in association with sequential ECG synchronization. A test bolus determined timing of the acquisition. In order to provide better visualization of the anatomy, advanced off-line 3D post-processing techniques, including curved reformatted images and volume rendering, were performed on an independent workstation. Multiplanar 3D rendered images were created from the source images. This confirms the presence of the described findings. Post-processing was performed with concurrent physician supervision.

MEDICATIONS:

Total contrast administered: 80 ml of Isovview-370 at 7 ml/s.

Bêta-blocker administered prior to injection: No.

Nitroglycerin administered prior to the examination: 0.4 mg SL.

FINDINGS:

CALCIUM SCORE:

LM: Number of lesions = 0; volume (mm³) = 0; calcium score = 0.

LAD: Number of lesions = 0; volume (mm³) = 0; calcium score = 0.

LCX: Number of lesions = 28; volume (mm³) = 0; calcium score = 7.

RCA: Number of lesions = 0; volume (mm³) = 0; calcium score = 0.

TOTAL: Number of lesions = 2; volume (mm³) = 8; calcium score = 7.

REFERENCE NORMS for CALCIUM SCORE (Following Mayo Clin Proc. 1999; 74(3): 243-52): No identifiable calcification = 0; Minimal identifiable calcification = 1 - 10, Mild calcification = 11 to 100; Moderate calcification = 101 to 400; Significant calcification = 401 or greater.

CORONARY ARTERY ANGIOGRAM FINDINGS:

Left main: No left main segment identified with separate origins of the LAD and LCx coronary arteries.

LAD: The LAD is a normal caliber vessel. Noncalcified plaque in the mid LAD (distal to the diagonal branch) resulting in mild stenosis (about 40-45%). Few scattered minimal noncalcified and calcified plaques seen in the proximal and mid LAD resulting in no significant stenosis (less than 10%).

LCX: The LCX is a normal caliber vessel. Small calcified plaque seen in the proximal and mid left circumflex coronary artery resulting in mild degree of stenosis (up to a maximum of 25%).

RCA: The right coronary artery is dominant. Noncalcified plaque seen in the mid RCA resulting in moderate degree of stenosis (50-55%).

DOMINANCE: Right coronary artery.

ADDITIONAL FINDINGS: Please note this is a cardiac focused examination and the chest is incompletely imaged. Small vascular connection seen arising from the medial aspect of the mouth of the LA appendage (series 7 image 88) that courses inferior to the left circumflex coronary artery and the anteriorly in close proximity to the aortic root and inserts into the septal surface of the RV (see series 7 image 121).

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by and Signed by Attending Puneet Bhatla MD 3/23/2021 11:39 AM