

Evaluation of specificity of CT angiography compared to conventional angiography for 16-Row Scanner

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Abstract: Herein, authors have evaluated the specificity of CT angiography (CTA) in comparison with conventional invasive angiography (CIA) in the diagnosis of coronary stenosis. For this purpose, 8 patients suspected to stenosis was used. They were undertaken CIA procedure after CTA using 16-multidetector-row machine. Result reveals that for patient-base analysis, the specificity of CTA was 25%. The values of specificity reveal a unacceptable performance of CTA. However, due to low number of patients, the obtained results cannot be used for final decision. [Ameneh Langari, Maryam Keivani. **Evaluation of specifict of CT Angiography Compared to Conventional Invasive Angiography for 16-Row Scanner.** *Life Sci J* 2014;11(9):450-453]. (ISSN: 1097-8135). <http://www.lifesciencesite.com>. 74

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1. Introduction

Conventional invasive angiography (CIA) is known as an effective protocol for diagnosis of coronary artery disease [1-3]. While CIA is highly reliable compared to other indirect evaluation methods such as stress testing, it is not an appropriate approach in many cases due to its invasive and complications such as myocardial infarction, stroke, etc. In this regards, a non-invasive alternative method for diagnosing coronary artery disease is desirable.

In order to overcome the complications of CIA, multi-slice computed tomography angiography (CTA) has been proposed in recent years as an alternative procedure for determining the presence of coronary obstructions. With the recent development in hardware with multiple detectors, the spatial resolution of the images has been significantly improved and consequently CTA has become the center of interest for clinicians. The imaging machines facilitated the rapid identification and assessment of atherosclerosis within the moving coronary arteries and potentially reduced the necessity of CIA. In Ref. [4] one can find another comprehensive systematic review and meta-analysis of the clinical effectiveness and cost-effectiveness of 64-slice or higher CTA as an alternative to CIA for detecting coronary artery disease. Other systematic reviews on evaluation 64-Slice CTA in the diagnosis and assessment of coronary artery disease has been conducted in refs. [2, 5,6]. Stein et al. [7] preformed a systematic review on 64-slice CTA for diagnosis of coronary artery disease. They concluded that negative CTA reliably excluded significant coronary artery disease. However, the data suggest that stenosis shown on CTA need confirmation. Combining the results of 64-slice CTA with a pretest clinical

probability assessment would strengthen the diagnosis [7]. Further useful findings can be found in other works that examined the accuracy of 64-row CTA in comparison with CIA for detecting coronary artery diseases [8-15].

Considering the abovementioned issues, this investigation is conducted scanner to evaluate the specificity of CTA in identifying significant stenosis using a 16-row-detector CT. The accuracy of CTA is compared with that of CIA method in diagnose of coronary arteries.

2. Methods

2.1. Population

The population was chosen from patients referred to hospitals with suspected coronary artery disease. In this study 8 patients asked to participate. According to cardiologist diagnoses, all these patients underwent CIA after CTA performed. Exclusion criteria for CTA were based on technical factors that made the patient unsuitable for the procedure. These included known allergic reaction to iodinated contrast agents, high baseline heart rate (>70 beats/min) with contraindication to beta-blockade, atrial fibrillation, inability to perform a 15-s breath hold, inability to lie flat, abnormal renal function (serum creatinine level >1.5 mg/dL).

2.2. CTA and CIA

All patients were scanned with a 16-slice CT scanner. A dose of 15 ml contrast material was used during the bolus timing scan calculated (by the apparatus software) at the level of the descending aorta. All data sets acquired were reconstructed from the axial images using retrospective electrocardiogram gating.

The reconstructed images were visually evaluated for estimation of coronary artery narrowing. The judgment about the absence/presence of desises was made after viewing the various images and checking stenosis of main coronary vessels.

2.3. CIA procedure and analysis

Routine CIA was performed via the femoral or radial artery. All evaluated vessels were classified as normal as having non-significant disease, or as having significant stenosis. Accordingly, patients were classified as positive for the presence of significant coronary artery disease if there was a significant stenosis in any artery.

2.4. Statistical Analysis

The CTA accuracy for detecting vessel stenosis was evaluated via an indicative statistical parameter i.e. specificity. These parameters were calculated for patient and presented as percentage.

3. Results

The characteristics of the 8 patients were analyzed and the result is presented in Table 1. The obtained result reveals that patients were diagnose as normal by both CIA and CTA.

Table 1: Diagnostic performance of CTA for the detection of >50% stenosis for patient-based analysis.

Analysis	Specificity %
Patient based	25

Many progresses have been accomplished to provide the time-saving accurate diagnostic protocols for suspected patients. The advent of 16-slice CT scanners accelerated this evolution. CTA is recommended useful especially for patients due to the higher complications of CIA. However, a crucial issue is to understand how much the CTA findings are close to those of CIA. According to the patient-based data presented in Table 1, CTA have a specificity of 25% when compared to CIA procedure.

Comparison between the obtained result and those presented in other review papers [5, 6], show that the patient-based specificity of presented study are less than the values reported by previous researchers for 64-slice CTA. Comparing the present study with other investigations reveals that the computed specificity is less than those reported in literature [5,6]. This reveals a not accepted performance.

3.2 Limitations

It should be remarked that the present study is conducted on a very limited works, hence, obtained results might not be generalized. The following

limitations to the present study should be considered. First, note that patients exposed to higher dose of radiation in CTA procedure in comparison with CIA [25]. Therefore, concerns should be raised about applying conservative radiation dose, and careful patient selection especially in the cases of young people and women of childbearing age [26]. Therefore, the present diagnostic performance may not be directly applicable to patients with a lower prevalence of diseases.

Moreover, it is expected that new generation of scanning machines with higher number of slice per rotation (rows) and higher temporal resolution can diminish some inaccuracy of the present 16-slice CT scanners. Previous research on different generation of multi-detector CT machines (4-slice, 16-slice and 64-slice scanners) revealed that increasing in number of slice per rotation result in more accurate results [21]. This trend is expected to be continued for the forthcoming multi section scanners with further number of detectors. For example new generated 320-row scanners improved image acquisition as well as reduced radiation dose compared with retrospectively gated 64-row CTA [15]. Moreover, in recent years, several modified techniques i.e. dose modulation [22], eliminating helical oversampling [23], prospectively gated approach with electrocardiogram triggering [24], etc. have been developed to decrease CTA radiation dose. These technological advances reveal that the reliability of CTA can approach to CIA in future.

Finally, it should be noted that heavy coronary calcification and consequent beam hardening is the major limitations to reliable evaluation of all coronary arteries [27-29]. In these cases CIA might be more useful than CTA to obtain completely reliable diagnoses.

4. Conclusions

The paper have considered the specificity of the CTA in comparison with CIA. It have clinical implications for the detection of significant coronary artery stenosis. The obtained results demonstrated not acceptable diagnostic accuracy for the assessment of obstructive disease using 16-row CTA. CTA had the positive predictive value of 25%. The value of PPV reveals a moderate performance of CTA. However, due to the low number of patients, further investigations is required to determine whether 16-row scanning technology has sufficient resolution to delineate coronary artery diseases. Hence the presented results are not accepted and requires to more investigations with a higher population.

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