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Each practice guideline and technical standard, representing a policy statement by the College, has undergone a thorough consensus process in which it has been subjected to extensive review, requiring the approval of the Commission on Quality and Safety as well as the ACR Board of Chancellors, the ACR Council Steering Committee, and the ACR Council. The practice guidelines and technical standards recognize that the safe and effective use of diagnostic and therapeutic radiology requires specific training, skills, and techniques, as described in each document. Reproduction or modification of the published practice guideline and technical standard by those entities not providing these services is not authorized.

ACR–NASCI–SPR PRACTICE GUIDELINE FOR THE PERFORMANCE OF QUANTIFICATION OF CARDIOVASCULAR COMPUTED TOMOGRAPHY (CT) AND MAGNETIC RESONANCE IMAGING (MRI)

PREAMBLE

These guidelines are an educational tool designed to assist practitioners in providing appropriate radiologic and radiation oncology care for patients. They are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care. For these reasons and those set forth below, the American College of Radiology cautions against the use of these guidelines in litigation in which the clinical decisions of a practitioner are called into question.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the physician or medical physicist in light of all the circumstances presented. Thus, an approach that differs from the guidelines, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the guidelines when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of the guidelines. However, a practitioner who employs an approach substantially different from these guidelines is advised to document in the patient record information sufficient to explain the approach taken.

The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these guidelines will not assure an accurate diagnosis or a successful outcome. All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of these guidelines is to assist practitioners in achieving this objective.

I. INTRODUCTION

This guideline was developed collaboratively by the American College of Radiology (ACR), the North American Society for Cardiovascular Imaging (NASCI), and the Society for Pediatric Radiology (SPR).

Cardiac magnetic resonance imaging (MRI) and computed tomography (CT) are important noninvasive methods for the assessment of ischemic and nonischemic cardiomyopathies, pericardial disease, cardiac masses, and congenital heart disease. In addition, CT angiography (CTA) and MR angiography (MRA) are well-established noninvasive cross-sectional imaging methods for the detection and assessment of vascular anatomy and a variety of vascular pathologies.

Previous published guidelines from the ACR have provided practitioners with the educational tools to perform MRA, CTA and cardiac MR and CT imaging. However, with continued improvements in the fidelity of advanced CT and MRI scanners and increasingly available advanced imaging methods, there is a clear need for new guidelines on the quantitative aspects of CT and MRI for cardiovascular imaging.
This document is the first endeavor from the ACR that aims to provide an overview of practice guidelines for cardiovascular CT and MRI, aimed at quantitative indications. Given the rapid development of quantitative cardiovascular CT and MRI, it is anticipated that future versions of this document will evolve as advanced quantification methods are widely adopted into clinical practice.

II. INDICATIONS

Indications for quantification of CT and MRI include, but are not limited to, the following quantitative applications:

4. Evaluation of vascular morphology prior to surgical intervention.
5. Flow measurement with phase contrast MRI.
6. Flow characterization with contrast enhanced time-resolved MRA.
7. Characterization of myocardial morphology and function.
8. Assessment of pressure gradients across focal stenosis using phase contrast MRI.
10. Assessment of volume of hypoperfused myocardium with perfusion imaging.

III. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL

See the ACR Practice Guideline for Performing and Interpreting Magnetic Resonance Imaging (MRI) and the ACR Practice Guideline for Performance and Interpreting Computed Tomography (CT).

IV. GENERAL ASPECTS OF THE PROCEDURE

A. General Aspects of Quantitative Cardiovascular Imaging with CTA and MRA

1. Morphological evaluation
   a. Distance measurements
      For CTA and MRA, a widely used approach for morphological evaluation and measurement is to use curved planar images derived from the volumetric data set. This can be done by delineating the centerline of the vessel to create a curved planar reconstruction of the arterial segment in question. Vendor software allows deconvolution of the vessel, permitting a curved planar view that can be displayed in both cross-sectional and longitudinal projections. An accurate cross-sectional diameter and area measurement of the normal vessel can be obtained using this projection. Measurements of coronary artery diameter can be obtained within a precision of approximately 0.6 mm on CTA and to approximately 1 mm on MRA. Length measurements can be derived curved planar on multiplanar reformatted views.

   Pitfalls include inaccurate placement of the centerline by automated software. This most often occurs in small vessels such as the coronary arteries or calf vessels. A centerline that is eccentric or incorporates mural calcification or thrombus does not accurately represent the lumen of the vessel. Artifactual stenoses may be produced by an improper centerline. Thus, it is important that the centerline be verified by an experienced observer to avoid this pitfall. On MRA, gradient nonlinearity can cause in-plane and out of plane image distortion that leads to incorrect vessel measurements.

   Alternatively, many cardiovascular imagers use standard multiplanar imaging and assess the individual vessels using double oblique multiplanar reformats (MPR) perpendicular to the vessel axis. This is typically done in an interactive fashion with various segments of the arteries being evaluated sequentially for areas of plaque and stenosis.

   b. Cross sectional diameter measurements
      Cross sectional diameter measurements are performed using a double oblique MPR perpendicular to the vessel axis. If an area of dilatation or stenosis is suspected, the area can be quantified using reference measurements from adjacent normal vessel sections. A common practice is to compare luminal diameter that is deemed normal, is within 1 cm proximal, and is distal to the stenosis or dilatation on the longitudinal straightened curved planar images. The average diameter of these two measurements is used as the reference normal diameter of the vessel. The diameter of the abnormal segment is divided by the reference normal diameter to arrive at a percentage of stenosis or dilatation (% stenosis or dilation = abnormal segment [mm] referenced to the normal segment). Workstation software is available to make this calculation or it may
be calculated manually. In practice, it may be difficult to confidently identify one or more reference normal areas due to diffuse calcified and noncalcified plaque. If only one reference normal area can be defined (either proximal or distal), this area can be used as a single reference segment with the caveat that it may slightly overestimate or underestimate the true extent of the stenosis or dilatation.

Dilatation of the arteries is often due to positive remodeling and atherosclerosis, although multiple other causes exist including vasculitis and trauma. In general, an aneurysm is defined by dilatation of an artery to >1.5 times the diameter of the adjacent normal segment. Stenosis is far more common and is usually due to atherosclerosis. Because of the limited spatial resolution for 64 and higher [1,2] slice CTA of approximately 0.35mm², 9 to 10 voxels typically span the entire diameter of a proximal coronary artery lumen, for example. Each pixel represents approximately 10% of the luminal diameter. Thus, overly precise reporting of stenoses is often not appropriate. Generally, a percentage range is used. A typical spectrum might include a stenosis grading of <25%, 25% to 50%, 50% to 75%, or >75% [3]. Alternatively, more recent guidelines for coronary CTA suggest the following grading system: normal, <50%, 50% to 70%, >70%, occluded [4,5].

In evaluating stenoses on CTA, it is important to distinguish calcification from the opacified lumen to properly define the stenosis and minimize the effects of blooming artifacts. This can be particularly problematic in separating the anterior tibial artery from the anterior tibia. It is also a common problem in the interpretation of a coronary CTA. The most common, simple solution is to use a lower window center setting and wider window width. Most vendors provide software with preset window and level settings that optimize evaluation of calcified arteries. It may also be useful to assess the extent of calcification in both the longitudinal and transverse curved planar reconstructions. MRA is used less frequently to characterize dilation and stenosis because of its slightly lower spatial resolution. However, an approach similar to that described above can be used with MRA.

Calcification is not readily visible on MRI, and therefore blooming effects seen with CTA do not impact MRA. For this reason MRA is often used in peripheral vascular disease, particularly in the setting of severe vascular calcification.

c. Cross sectional area, volume and angle measurements

Measurements of an aneurysm’s cross-sectional area can be calculated from longitudinal straightened curve planar reconstructed images using the techniques described in section 1b above, and many vendors provide this software. Nevertheless, it is not commonly used because most studies of the accuracy of CTA have correlated it with quantitative catheter-based angiography which relies on unidimensional measurements. Volume and angle measurement are not commonly performed for CTA and MRA, but are very helpful for follow-up of thoracoabdominal aortic aneurysms and iliac artery aneurysm after endovascular repair [6], as well as for planning endovascular repair.

d. Region of interest characterization

(CT Only)

Attenuation measurements of the arterial wall can be obtained for plaque characterization. Generally, a region of interest (ROI) is placed on the wall and a Hounsfield Unit (HU) measurement is obtained that represents an average pixel value. This measurement can be performed on unenhanced gated CT study, often a calcium scoring examination, and it has also been attempted with CTA. Optimally, it should be possible to categorize plaques as primarily calcified, fibrous, or fatty in density. Although studies correlating CTA with intravascular ultrasound have shown some ability to distinguish among these three plaque densities, in clinical practice it is often difficult to confidently differentiate fibrous and fatty plaques. This limitation likely arises from partial volume averaging and variability of HU measurements among different vendors. Thus, plaque is generally characterized as calcified, non-calcified, or mixed. It is also important to quantify HU measurements in the aorta when they are elevated. Crescent-shaped high attenuation in the aortic wall is seen in intramural hematoma [7], but it is important to repeat the measurements after IV contrast is administered because intramural hematoma does not enhance, and an alternative
diagnosis (e.g., vasculitis) should be sought if there is enhancement [8].

2. Technical aspects of velocity and flow quantification
Velocity and flow quantification with MRI are achieved using phase contrast imaging [9,10]. Phase contrast MRI (PC-MRI) exploits the fact that moving tissue (i.e. blood) acquires a phase shift in the presence of velocity encoding gradients. This phase shift is directly proportional to the velocity of the blood as it moves through a magnetic field. With PC-MRI, two measurements are typically acquired: the first with a positive bipolar gradient, the second with a negative bipolar gradient. The resultant image is a subtracted phase image. Signal from stationary tissue is eliminated, while the only signal that remains originates from moving tissue and is directly proportional to its velocity.

There are two techniques for synchronizing the electrocardiogram (ECG) signal with the cardiac cycle: prospective and retrospective [11,12]. With prospective gating, the acquisition is triggered by the R wave and is paused at the end of the cardiac cycle for a short period until the next R wave arrives. This has the advantage of negating the effects of mild arrhythmia, although this occurs at the expense of excluding some data during end diastole. Retrospective gating acquires data throughout the cardiac cycle, such that no portion of the cardiac cycle is excluded. This technique is more sensitive to arrhythmia, although, with current arrhythmia rejection software, this effect can be minimized.

PC-MRI can be implemented as a breath-hold technique or with free breathing [13,14]. Breath-holding may be preferred within the thorax or abdomen due to the effects of respiratory motion. Prospective gating may be preferred with breath-hold PC-MRI due to its more consistent acquisition, although either gating approach is acceptable. The principal drawback of breath-holding is the restricted acquisition time, which may compromise temporal resolution. Free breathing PC-MRI permits a longer acquisition, which allows higher temporal resolution, although image quality may be reduced due to respiratory motion artifact.

The most important parameter for PC-MRI is the velocity encoding variable \( V_{\text{enc}} \). \( V_{\text{enc}} \) is generally given in cm/sec and is the highest and lowest detectable velocity measured by that PC-MRI pulse sequence. The closer the \( V_{\text{enc}} \) is to the actual velocity, the more accurate the measurement. If the \( V_{\text{enc}} \) is lower than the maximum velocity being measured, then aliasing will occur. If the \( V_{\text{enc}} \) is significantly higher than the actual velocity, then signal intensity is reduced, which may reduce the accuracy of the measurement. Since \( V_{\text{enc}} \) is inversely proportional to the amplitude of the magnetic gradient, the lower the velocity being measured, the higher the gradient strength.

\( V_{\text{enc}} \) is most commonly encoded in a single direction during a PC-MRI acquisition (i.e., unidirectional PC-MRI). The direction of the \( V_{\text{enc}} \) variable can be altered depending on what is being measured and this will determine slice prescription. In-plane PC-MRI is where the \( V_{\text{enc}} \) direction is encoded within the plane of the image either anterior-posterior direction, left-right direction, or cranial-caudal direction. In-plane PC-MRI is useful for determining flow direction such as when characterizing the eccentricity of an aortic regurgitant jet on a three chamber cardiac orientation. Through-plane PC-MRI is where the \( V_{\text{enc}} \) is encoded through the plane of the slice. This technique is commonly used for measuring velocity and flow, and it is important that the through plane imaging slice be directly orthogonal to the region of interest. \( V_{\text{enc}} \) can be also encoded in three directions (x, y, and z) during a single acquisition (i.e., tridirectional PC-MRI) [15]. Since more time is needed to acquire the additional directions, imaging times are long and therefore temporal resolution may be compromised with a breath-hold acquisition.

a. Direction
In its most basic application, PC-MRI can be used to visualize flow direction. This can be achieved with in-plane PC-MRI where the imaging slice is chosen to match the region of interest. Precise selection of \( V_{\text{enc}} \) is less important for this application, as long as the \( V_{\text{enc}} \) is above the velocity being measured. Accurate slice prescription is essential especially in regions where position may be affected by respiratory variations, (e.g., in a portal venous system [16].

b. Velocity
Through-plane PC-MRI is used for accurate measurement of velocity [17]. It is essential that the through plane slice be positioned directly orthogonal to the region of interest so that the true velocity is being measured and not a vector component of the true velocity. In-plane PC-MRI may be useful for planning the setup of the through plane slice. For example, a sagittal oblique in-plane PC-MRI of a thoracic aortic coarctation will depict the direction of the high velocity jet inferior to the stenosis so that the through plane slice can be prescribed directly orthogonal to the flow
jet. Preliminary in-plane PC-MRI has the added advantage of providing an assessment of actual velocity, so that the $V_{sec}$ can be increased on the through-plane slice if aliasing occurs. In order to ensure true orthogonal positioning, the through-plane slice should or must be set up from at least two different orientations. Velocity is measured by drawing a ROI that includes the entire lumen of the vessel being evaluated. Peak velocity is the pixel with the highest signal intensity within the ROI. Average velocity represents the average of all the pixels within the ROI. Pressure gradients (mmHg) across a focal stenosis can be estimated using the modified Bernoulli equation, $P=4V^2$, where $V$ is the peak velocity in m/sec. If the peak velocity is measured at multiple points along a vessel, such as above and below a coarctation, then the pressure gradient between those points can be estimated [18]. It is important to note that the modified Bernoulli equation does not apply for long segment stenoses. Finally, assessment of the shape of the velocity-time curve may be helpful in conditions where there is dampened flow, such as in pulmonary hypertension.

c. Flow
Blood flow can be calculated from the velocities measured by PC-MRI. It is optimal to acquire the velocity measurements directly orthogonal to the direction of flow; therefore using in-plane PC-MRI to set up the through-plane slice is very helpful. For correct calculation of flow, the ROI needs to be accurately drawn within the flow region, since the ROI area will determine the final flow value [19]. It is essential that spatial resolution is set to match the vessel of interest. If spatial resolution is too low, flow and velocity will be underestimated due to partial volume effects. Similarly, temporal resolution (i.e., time per frame) must be adequate for measuring flow in the vessel of interest. For example, high flow vessels such as the thoracic aorta require higher temporal resolution.

3. Time resolved angiography
a. Technical aspects
Time-resolved angiography refers to rapid frame rate angiography where images are acquired per unit of time such that sequential filling and draining of vascular structures can be assessed. Time-resolved angiography can be carried out using either MRI or CT. Time-resolved MRA (TR-MRA) refers to ultrafast MRA where 3 dimensional datasets are acquired every 1 to 3 seconds. In order to speed up the acquisition, conventional MRA is implemented with acceleration strategies such as parallel imaging or view sharing (i.e., TRICKS, TWIST) [20-25]. If TR-MRA is implemented as a 2D acquisition, then frame rates of several images per second can be achieved. Time-resolved angiography with CT usually involves acquiring a single slice or stack of slices (with multi-detector CT) every second as a contrast bolus is injected and is the preferred method for bolus timing with CT.

b. Applications
TR-MRA, in its most basic use, can be used as a bolus timing acquisition for measuring contrast transit times for conventional MRA. TR-MRA can also be used to visualize in real-time the passage of a bolus of contrast through different portions of the circulation. For example, TR-MRA may be the method of choice for imaging the pulmonary vasculature as it depicts sequential filling of pulmonary arteries, pulmonary veins and thoracic aorta, which has particular utility for assessing congenital heart disease or aortic dissection. The passage of a contrast bolus can also be quantified by placing ROIs in different vessels to measure its time to peak enhancement. For example, the absolute transit time between the pulmonary trunk and thoracic aorta is elevated in conditions such as pulmonary hypertension and congestive heart failure [26-28]. Similarly, relative contrast transit times between different vascular territories can be expressed as ratios. Contrast transit times between the left heart and right heart can be calculated in order to better characterize intracardiac and extra cardiac shunts.

4. Quantitative techniques specific to cardiac MRI and CT
Echocardiography, notably transthoracic echocardiography, remains the primary screening tool for evaluating cardiac morphology and function [29]. However, evaluation with echocardiography relies on operator skill, and variability in scanning technique may contribute to intraobserver and interobserver variation [30]. Such variation is notably higher with echocardiography than with MRI [31].

Cardiac-gated MRI and CT can provide images of the heart chambers throughout the entire cardiac cycle; thereby, enabling quantitative measurement of myocardial wall thickness and
mass, chamber sizes, and myocardial function that are similar and arguably more reproducible than that achieved by transthoracic echocardiography [32,33]. Moreover, the intravenous administration of contrast agents enables the determination of myocardial perfusion and the myocardial delayed enhancement on MRI and more recently on CT [34].

Many of the measurement standards used for clinical cardiac CT and MRI are derived from those of echocardiography [29]. It is important to note that specific thresholds of measurement for healthy individuals vary based on body habitus [35-37], race [35-37], gender [35-41], and age [40,42,43]. Moreover, imaging technique itself can result in differences in measurement. For example, the actual pulse sequence used for cardiac MRI (e.g., fast gradient echo vs. steady state free precession [44-46]) may affect left ventricular measurements, although field strength (1.5 T vs. 3T) does not appear to not have any significant influence [45].

a. Myocardium
i. Wall thickness
Myocardial wall thickness is traditionally measured on end-diastolic images. End diastole can be defined at the onset of the P-wave, but is preferably defined as the frame after mitral valve closure or the frame in the cardiac cycle in which the cardiac dimension is largest. In healthy adults, end-diastolic left ventricular thickness is typically between 6 to 12 mm [29,40]. To minimize volume averaging effects, image acquisition is typically performed in a plane perpendicular to the wall being measured. For the left ventricle this is typically performed on short axis images. Special regions such as the apex are better suited for evaluation on 2-chamber and 4-chamber long-axis views. The basal anteroseptal segment is best evaluated on a 3-chamber view.

ii. Myocardial mass (left ventricular mass)
The myocardial mass of the left ventricle (LV) can be determined by measuring end-diastolic LV myocardial volume and multiplying this by the specific gravity of myocardium (1.05 g/ml) [36]. The myocardial volume of the LV can be determined by summing the area of the myocardium from a stack of images that covers the entirety of the LV and multiplying this by the thickness of each slice (and slice gap if present). The difference between endocardial and epicardial tracings represents myocardium. The area of the myocardium can be calculated by subtracting the area of the LV's chamber (endocardial tracing) from the area of the LV (epicardial tracing). Note that the papillary muscles are typically excluded from the endocardial border (i.e., included within the volume of the chamber) as exclusion of the papillary muscles reduces postprocessing time requirements by obviating a separate trace of the papillary muscles [47]. However, in some specific cases such as in patients with hypertrophic cardiomyopathy, it may be useful to perform an additional trace of the papillary muscles and include their mass in the LV myocardial volume [47]. In hypertrophic cardiomyopathy, the papillary muscles are relatively larger, and their exclusion would underestimate overall myocardial mass as well as overestimate the LV diastolic volume and underestimate the LV ejection fraction [48].

b. Cardiac chamber
i. Ventricular volumes can be measured linearly using short and long axis dimensions but is more commonly measured in terms of volume. When quantifying the LV using 2-dimensional (2D) linear measurements, the LV’s internal diameters are measured from the endocardium of the anteroseptum to the endocardium of the inferolateral wall on the three chamber view. It is recommended that the LV internal dimension be measured at its minor dimension, at the mitral chordae level (approximately at the mitral valve leaflet tips when open). Left and right ventricular volumes can best measured using a modified Simpson’s method whereby the ventricular chamber volume is determined by the sum of the endocardial area multiplied by the slice distance using short axis images [49,50]. CT provides added flexibility for postprocessing in that ventricular volumes can be performed often more quickly using other views such as axial images [51] and often more advanced region growing post-processing software based on density for faster determination of chamber contours [52]. In some cases, it may be helpful to
calculate the ratio of right ventricle (RV) to LV size as an assessment of RV enlargement.

ii. Atria
There are few CT and MRI studies reporting normal left and right atrial measurements. Echocardiographic standards, however, suggest that the normal left atrial anterior-posterior dimension is less than 4.0 cm during end-systole and that the normal minor axis (i.e., transverse) right atrial dimension is less than 4.5 cm [29]. However, the atria, especially the right atrium, are often oblong or unusually shaped, making specific diameter measurements less useful as a determination of enlargement. However, atrioventricular valvular dysfunction (e.g., mitral or tricuspid insufficiency or stenosis) will often be present with atrial enlargement.

c. Myocardial function
i. Ventricular ejection fraction
Ventricular ejection fraction (EF) is defined by the following equation [36,49,50]: EF (%) = (EDV – ESV)/EDV in which EDV is end-diastolic volume and ESV is end-systolic volume. EDV and ESV are determined using the modified Simpson method described above by drawing endocardial tracings on short axis slices of the heart, from the atrioventricular valve plane (base of the heart) to the apex, at end-diastole and end-systole. Because the length of the ventricle is shorter at end-systole than in end-diastole, it is most often necessary to trace an endocardial contour on an additional end-diastolic slice.

There is variability in how endocardial contours are drawn. Whether one includes or excludes the papillary muscles and ventricular trabeculae from the blood pool volume is a matter of choice. An individual physician, or by consensus an imaging laboratory, should establish a convention by which epicardial contours will be drawn in all patients. By establishing this standard, one will have confidence in the accuracy, reproducibility, and stability of functional measurements versus interval changes in measures of cardiac function in patients returning for repeat examinations.

The ventricular chambers are bounded by the atrioventricular valves, mitral or tricuspid, and the ventriculoarterial valves, aortic or pulmonic. There is universal agreement that the atrioventricular valve plane defines the base of the ventricular chamber and is therefore a well-defined boundary of the ventricle. The decision of how much of the ventricular outflow tract to include, i.e., how close to the ventriculoarterial valve each endocardial contour tracing extends, varies. Some investigators include and others exclude the left and right ventricular outflow tracts, while others draw endocardial contours up to the aortic and pulmonic valve planes.

In normal patients or in those with coronary artery disease it has been shown that there is no significant difference in EDV or ESV [47]. Clinically relevant differences in EDV and ESV values may be found in patients with cardiomyopathy or other pathologies depending on inclusion or exclusion of the papillary muscles [53]. Volumetric and EF measurements by MRI and CT have been shown to be very comparable [52,54].

In addition to EDV and ESV the following functional parameters are easily calculated from the same short axis image data after drawing endocardial contours:
- Stroke volume (SV = EDV – ESV).
- Ejection fraction (EF[%] = 100 x [EDV – ESV]/EDV).
- Cardiac output (CO = SV • heart rate).
- Cardiac index (CI = CO / body surface area (BSA) = SV • heart rate / BSA.
- Myocardial mass (g) which is determined when epicardial borders are drawn on end-systolic slices in addition to the endocardial contours.
- End-diastolic volume index (EDVI = EDV/BSA).
- End-systolic volume index (ESVI = ESV/BSA).
ii. Wall motion
Although there are a variety of methods for quantitative assessment of wall motion, the visual assessment of cine images remains the standard for wall motion assessment [55]. Wall motion can be visually assessed during systole as normal, hypokinetic (decreased wall motion), akinetic (no wall motion), or dyskinetic (paradoxical motion or reversal of wall motion i.e., aneurysm). In some circumstances it may be helpful to further subdivide hypokinesis into mild, moderate, and severe hypokinesis.

Assessment of myocardial wall motion can be performed during rest. For the assessment of patients with suspected coronary artery disease, however, wall motion assessment during pharmacologic stress using an inotrope medication (e.g., dobutamine) is often more helpful as significant coronary disease may not be evident in the resting state. For stress wall motion assessments, regional wall motion during stress is compared with resting wall motion, typically on a segment by segment basis. A recent meta-analysis [56] of 37 studies with 2,191 patients revealed stress wall motion MRI to have a sensitivity of 83% and specificity of 86% for detecting significant coronary artery disease (≥50% arterial diameter stenosis). This compares very favorably with cardiac stress scintigraphy [57], which in another large review of 79 studies and nearly 8,964 patients reported scintigraphy to have an overall sensitivity of 86% and specificity of 74% for detecting significant coronary artery disease.

d. Myocardial perfusion
Myocardial perfusion imaging has most commonly been performed with MRI [56] but more recently CT has shown promise as well [58]. Myocardial perfusion imaging is most typically performed during administration of a pharmacologic vasodilator stress agent (e.g., adenosine or dipyridamole), and enhancement of myocardium using rapid T1 weighted images is evaluated over time. This assessment is typically performed using a series of rapidly acquired short axis T1-weighted images that enables visual assessment of regional differences in enhancement. Enhancement of each myocardial region reflects perfusion of specific coronary arterial vascular territories. Similar to stress wall motion evaluation, a meta-analysis has shown stress myocardial perfusion MRI to have a high sensitivity (90%) and specificity (81%) for detecting significant coronary artery disease (≥50% arterial diameter stenosis).

e. Myocardial delayed enhancement imaging
Myocardial delayed enhancement (MDE); – also called late gadolinium enhancement, delayed gadolinium enhancement, or delayed contrast enhancement imaging – is a useful tool for assessing myocardial tissue [59,60]. Imaging is typically performed using MRI 10 to 20 minutes following the intravenous injection of a gadolinium-chelate contrast agent (e.g., 0.2 mmol/kg cumulative dose) in short axis views and often in supplemental long-axis views. On delayed imaging, abnormal regions of myocardium appear brighter than adjacent normal myocardium and are therefore often termed “hyperenhancement.” The underlying mechanisms for hyperenhancement are varied and not fully understood but reflect the relative faster washout of contrast in normal myocardium and prolonged retention of contrast in the abnormal tissue.

Hyperenhancement on MDE imaging was initially reported in the setting of myocardial infarction in which infarcted or nonviable myocardium is hyperenhanced [59,60]. Hyperenhancement typically begins in the subendocardial region, as this is represents the end-vessel or “at risk” territory of the myocardium as coronary arteries originate from the epicardial surface of the heart and dive deep into the subepicardium, mesocardium, and ultimately into the subendocardium.

Hyperenhancement of myocardial infarction is seen in both acute and chronic myocardial infarction. The segmental transmurality of the hyperenhancement has been shown to correlate with the likelihood for functional improvement following a coronary revascularization procedure. Transmurality of hyperenhancement is best characterized in quartiles, as less than 0% to 25%, 26% to 50%, 51% to 75%, or 76% to 100%. The likelihood of benefit from a revascularization procedure is high if there is little or no hyperenhancement (i.e.,
entirely viable myocardium) and very low if there is transmural enhancement (100%). Generally, myocardial segments with <50% hyperenhancement on MDE will benefit from a coronary revascularization procedure since they retain sufficient viable myocardium to respond favorably to revascularization efforts [60].

g. Myocardial segmentation and nomenclature
In 2002, the American Heart Association [61] suggested a standard reporting nomenclature for cardiac imaging studies (nuclear medicine, echocardiography, MRI, and CT) that is based on a 17-segment heart model in which the myocardial segments are defined by their location relative to the long axis (basal, mid, or apical) and circumferential location at each location. There are 6 segments (anterior, anteroseptal, inferoseptal, inferior, inferolateral and anterolateral) at both the basal and midventricular levels, 4 segments (anterior, septal, inferior and lateral) at the apical level, and a single apex region to comprise the total 17 segments of the left ventricle.

This segmental nomenclature is intended for regional descriptions of cardiac wall motion, myocardial perfusion, and myocardial delayed enhancement.

Calcium scoring
Coronary calcium scores were first reported over 20 years ago by Agatston et al. [62] using electron-beam CT whereby coronary calcium lesions with >130 Hounsfield units (HU) were assessed using a region of interest. The area of each calcified coronary lesion was then multiplied by a weighting factor based on the peak HU measured within the lesion (weighting factor: 1, 130 to 199 HU; 2, 200 to 299 HU; 3, 300 to 399 HU; 4, ≥400 HU). The Agatston score is achieved by adding all the calcium scores for each region.

Two other methods for measuring coronary calcium are the volume score and the mass score [63]. The volume score reflects the volume of calcium above the threshold; the mass score uses a phantom to calibrate the mass (mg) of coronary calcium above the threshold. In a large cohort study of 11,490 individuals, the Agatston, volume, and mass scores were found to be equally accurate for calcium scoring, and no single method was deemed superior in terms of reproducibility of results from consecutive scans in a patient [63].
b. Surveillance  
i. Role of noncontrast CT and MRI for surveillance of aneurysmal disease  
In the surveillance of an aortic aneurysm, the diameter and rate of growth of the diameter should be reported. They can be evaluated on noncontrast or contrast enhanced imaging. An MR or CT can be used; however, CT’s spatial resolution and the standardization between different CT scanners have generally led to CT becoming the standard surveillance test, particularly in older patients. In younger patients or patients with small aneurysms, an ultrasound examination may be used with the understanding that if there is growth of the aneurysm a CT or MRI scan can be obtained in order to best assess the precise size and characteristics of an aneurysm prior to treatment. There is no consensus algorithm for the surveillance of patients with aortic aneurysms.

ii. In baseline and follow-up imaging studies it is helpful to make aortic measurement at conventional locations in order to facilitate comparison. It is typical to make measurements at the following locations:
- Aortic annulus.
- Sinuses of Valsalva; at the level of the left main coronary artery origin from the left sinus.
- Sinotubular junction.
- Ascending aorta; at the level of the right pulmonary artery.
- Aortic arch; between the left common carotid and subclavian artery origins.
- Aortic isthmus (site of the ductus ligament insertion).
- Descending aorta; at the level of the right pulmonary artery.
- Diaphragmatic hiatus.
- Celiac plexus and/or superior mesenteric artery origin.
- Renal artery origin.
- Infrarenal aorta; midway between renal artery origins and the aortic bifurcation.
- Aortic bifurcation.
- Common iliac artery diameters.

c. Presurgical planning  
i. Endostent and open repair  
An aortic aneurysm may be repaired either in an open surgical fashion where a graft replaces the aneurysm or in an endovascular fashion where an endostent is deployed to exclude the aneurysm lumen. A number of cases may require a hybrid technique where both techniques are used.

ii. Location, size, volume, angles, areas, access via femorals/iliacs, etc.  
The evaluation for and endovascular treatment of aortic aneurysms requires several important measurements and observations. The lengths of the nondilated aorta proximal and distal to the aneurysm are termed the proximal neck and distal neck of the aneurysm respectively. The diameter and length of the proximal and distal neck determine the possibility and long term success of an endovascular repair. The angulation, quality of the aneurysm neck (calcification, thrombus) and relationship to nearby branches from the aorta are also factors involved in an endovascular repair.

For a descending thoracic aortic aneurysm, the distance between the left subclavian artery or left common carotid artery to the beginning of the aneurysm determines the proximal neck length, while the distance between the distal aspect of the descending thoracic aortic aneurysm and the visceral vessels defines the distal neck. In an abdominal aortic aneurysm (AAA), the extent of the aneurysm into the iliac vessels determines the length and distal diameter of the bifurcated grafts used in endovascular abdominal aneurysm repair (EVAR). The length from the proximal neck to the aortic bifurcation is also important for stent placement planning. These lengths can be estimated on axial imaging using table position, but a centerline measurement is preferred and considered the most accurate method. The centerline measurement is based on the true perpendicular vessel center acquired from the double oblique MPR technique. Endovascular repair may require the delivery of large devices from the femoral approach into the aorta. The diameter, tortuosity, and degree of calcification of the iliac and femoral vessels will usually predict the successful delivery of the graft devices.
d. Postsurgical monitoring guidelines

In contrast to patients who undergo surgical repair of an aortic aneurysm which may receive a single follow-up scan; patients who have undergone endovascular aneurysm repair with endografts require lifelong monitoring. There are no established guidelines for surveillance imaging post endovascular repair. Most patients receive a CT examination with intravenous contrast media to assess the aorta and graft and the possibility for endoleaks within the first 3 months after the repair. Endoleaks represent arterial flow into the aneurysm sac [68]. If there is enlargement of the endosac (excluded aortic lumen) from an endoleak, the aneurysm remains at risk of rupture. Therefore, aneurysm diameter measurements and possible increase in sac diameter must be reported. Changes in endosac volume, however, may be a more sensitive measure of sac enlargement [6]. Sac volumes as well sac diameters may be reported on noncontrast imaging and may be helpful to identify an enlarging sac or shrunking sac before there are changes in sac diameter [6].

e. Other sites of aneurysmal disease

i. Popliteal

Popliteal artery aneurysms as well as a number of peripheral aneurysms may not only be a risk for rupture but may also serve as a source of thrombi and subsequent distal embolization. The description of popliteal artery aneurysm should include not only the diameter and length of the aneurysm but also the presence and amount of thrombus within the aneurysm, as well as the patency of the distal (i.e., tibial) vessels at risk of embolization.

ii. Renal, splenic, mesenteric, great vessels, upper extremities

The size and location of an aneurysm and number of inflow and outflow vessels, and the amount of tissue perfused by the vessel are important in the determination as to when and how the aneurysm should be repaired or excluded. Pseudoaneurysms are associated with a higher risk of rupture.

2. Dissection, intramural hematomas, penetrating ulcer (primarily aorta): CTA and MRA

Penetrating atherosclerotic ulcers, intramural hematomas, and aortic dissections are closely related diagnoses discussed with the term acute aortic syndromes. CTA is more commonly used in the acute setting due to its availability and faster image acquisition while MRA examinations are common particularly in surveillance and follow up of these patients. The use of noncontrast CT prior to a contrast enhanced study is essential for the diagnosis of intramural hematoma.

a. Initial diagnosis and description

i. Location, involved anatomy, size, volume ROI in IMH (CT)

The classification of aortic dissections into Stanford Type A (involving the thoracic aorta proximal to the left subclavian origin) or Type B (involving only the thoracic aorta distal to the left subclavian vessel origin) should be reported. Dilatation of the aortic diameter and further extension of the dissection flap is important to recognize and report. Additionally, the location and number of fenestrations as well as the relative size and density of the false and true lumen may be helpful in determining the possible need for treatment. The extent of a penetrating ulcer and possible involvement into nearby branches should be reported. Aortic size and size of true and false lumen should be reported.

The noncontrast acquisition allows depiction of the hyperdensity of the acute hemorrhage within the wall of the vessel. T1-weighted MRI sequences can also be used to depict methemoglobin in the acute and subacute intramural hematoma. With intramural hematoma and dissection the extent of hematoma (both length and width) and possible branch vessel involvement should be noted. Imaging will document the existence of vessel rupture. In aortic dissection, the diameter and flow within the true and false lumen should be reported.

ii. Involvement of end organs, e.g., renal, mesenteric

The patients should be evaluated for possible end organ malperfusion, as this finding may necessitate urgent therapy.

b. Surveillance

Surveillance of patients with known high risk conditions associated with thoracic aortic dilatation and dissection require meticulous evaluation with MRA and CTA. These patients require centerline diameter measurements at the aortic annulus, sinus of
Valsalva, sinotubular ridge, ascending aorta and other involved areas.

c. Presurgical planning

Vessel diameters and treatment length must be quantitated. These will help determine if an endovascular repair can be performed and the diameter of the grafts needed. The amount of angulation of the arch, length from the arch vessels (left subclavian and left carotid artery), from the visceral vessels and the status of the vertebral arteries should be reported. Possible sites of endovascular access, including subclavian arteries and common femoral and iliac arteries, should be assessed.

d. Postsurgical monitoring

Early after endovascular repair, CTA is most commonly used to determine the presence of endoleak as well as possible complications such as stent migration or fracture, post procedure. Generally, lifelong annual CTA scans are needed to assess changes in the aortic diameter after repair. MRA is less commonly used due to its limited direct visualization of stent grafts, but it is an excellent alternative in patients with contraindications to CTA.

3. Atherosclerotic stenotic disease: CTA and MRA

a. Location, extent (length), severity (stenosis grading)

Atherosclerosis is a progressive systemic disease characterized by accumulation of lipid, fibrous tissue, and occasionally hemorrhages in the large arteries. Clinical manifestations are primarily due to ischemia related to stenotic disease or from rupture of aneurysms or emboli from associated in situ thrombus. CT and MR accurately depict the location, severity, and length of arterial stenoses or aneurysms. Quantitative evaluation of the stenoses is heavily dependent on the spatial resolution of the CT or MR technique used. Spatial resolution determines the level of detail that can be evaluated and the accuracy of quantitative measurements.

When atherosclerotic plaque is present, its precise anatomic location should be described, and the severity and length of stenosis reported. The severity of stenosis is graded as a percentage of diameter reduction – the diameter of the stenotic segment is divided by an adjacent normal diameter to determine the percentage of stenosis (or dilatation). However in smaller vessels, limitations in spatial resolution may preclude accurate use of percentage reduction and qualitative analysis is used (mild, moderate or severe). In smaller vessels, such as the infrapopliteal arteries of the leg, calcified atherosclerotic plaque may also cause artifactual narrowing of the apparent residual lumen due to blooming and beam hardening on CT; this should be taken into account during stenosis determination in order to avoid overestimating the degree of diameter reduction. MRA may be the preferred imaging modality in such patients. The length from the beginning to the distal most aspect of a stenosis should be described; this will influence the choice of potential intervention.

b. Typical sites of disease

i. Renal, mesenteric, aorto-iliac-femoral, runoff

Renal artery atherosclerosis leads to renal failure and renovascular hypertension. Aortic or proximal renal artery plaques are the usual culprit when atherosclerosis causes renal failure while stenosis of the proximal or more distal main renal artery or its branches leads to hypertension [69]. Both CTA and MRA have high sensitivity and specificity for depicting atherosclerotic narrowing of the entire renal artery and often the segmental branches [70,71].

Mesenteric occlusive disease is frequently due to atherosclerosis of the celiac axis, superior mesenteric artery, and inferior mesenteric artery. Accurate detection of proximal mesenteric arterial stenosis is possible with both CTA and MRA, and precise description of the site, length, and diameter reduction should be reported.

The abdominal aorta is a common site of atherosclerosis. The infrarenal aorta is generally considered aneurysmal if it is ≥3 cm in diameter, “ectatic” if it is between 2 to 3 cm in diameter [72], and considered stenotic if the lumen is less than 1 cm. Imaging studies are important in determining the aneurysm size, detecting the involvement of branch vessels, and depicting any associated significant stenoses involving the abdominal visceral or extremities. Preoperative imaging for potential endovascular repair (EVAR) of AAA is based on aneurysm morphology and access vessel size and patency [73]. After stent placement, imaging is used to monitor aneurysm diameter and volume, detect and
classify endoleaks, and evaluate morphologic details of the stent graft [74].

In the iliac and lower extremity arteries, atherosclerosis may lead to claudication or limb threatening ischemia. Depiction of the anatomic location, length, and severity of stenosis is critical in determining if medical management, intervention, or surgery is best.

c. Other sites: great vessels, subclavian, carotids

The thoracic aorta may become aneurysmal secondary to extensive atherosclerosis, connective tissue disease, aortitis, dissection, or poststenotic changes. Accurate short-axis measurement of the aortic diameter is determined using multiplanar techniques as diameters determined on axial images may be inaccurate. The presence of aortic atheromata, ulceration, intramural hematoma, and dissection can all be accurately depicted and described using current cross-sectional techniques. Atherosclerosis of the proximal internal carotid artery leads to cerebrovascular ischemia and stroke. Ultrasound, CTA, and contrast-enhanced MRA (CE-MRA) are all highly sensitive for detecting internal carotid artery stenosis. Depiction of a stenosis with a diameter reduction of 70% to 99% is most commonly used for intervention.

d. Role of phase contrast MRI for:
   i. Visualization of flow reversal, waveforms (tardus-parvus), etc.

Most current CT and MR angiographic techniques rely solely on the morphologic assessment of the vasculature. Phase contrast (PC) MR angiography assesses the hemodynamic consequences of an arterial lesion. PC flow quantification is a valuable, versatile tool in the noninvasive evaluation of flow characteristics within almost any vascular bed. It accurately depicts quantitative flow profiles depicting velocity, volume, rate, and direction. PC imaging can depict a tardus-parvus phenomenon distal to a high-grade stenosis, often adding specificity to other MR angiographic methods.

   ii. Hemodynamic significant stenosis, e.g., renal artery MRA with signal dropout

The hemodynamic significance of a stenosis can be assessed using a phase contrast MR flow profile which may depict a delay or loss of the early systolic peak, or a signal void [75]. A signal dropout on PC MRA is seen when a stenosis is hemodynamically significant due to the presence of turbulent flow and intravoxel dephasing resulting from a broad spectrum of intravoxel velocities [76]. Cine phase-contrast MRI flow quantification techniques in combination with contrast-enhanced MRA can accurately detect and determine the degree of renal artery stenosis [75,77].

iii. Estimation of pressure gradients

Pressure gradients across a arterial stenosis are used to determine its hemodynamic significance and therapy. Peak flow velocity is determined on phase contrast MR imaging. Pressure gradients across short/focal stenosis can then be approximated using a modified Bernoulli equation, \( \Delta P = 4V^2 \), where \( \Delta P \) is the peak pressure gradient in millimeters of mercury and \( V \) is the peak blood flow velocity in meters per second.

4. Embolic disease: CTA and MRA
   a. Pulmonary embolus (acute)

Acute pulmonary embolism (PE) increases the pulmonary arterial pressure which may progress to right heart failure and circulatory collapse. Right ventricular dysfunction is a marker for adverse outcome in patients with acute PE [78,79]. The ratio of the right ventricle (RV) to left ventricle (LV) diameters is an accurate sign for RV dysfunction [80,81]. Other signs have been described, including bowing of the interventricular septum and reflux of contrast medium into the inferior vena cava (IVC). The sizes of the azygous vein, superior vena cava, and pulmonary artery are also indirect measures of right heart dysfunction and pulmonary hypertension [82].

   b. Pulmonary embolus (chronic) – see cardiac MRI/MRA

5. Vasculitides (infectious and inflammatory): MRA and CTA

MRA and CTA are excellent methods to evaluate for the presence, severity, and extent of vasculitides such as, but not limited to:
   - Takayasu arteritis.
   - Giant cell arteritis.
   - Infectious arteritis.
   - Kawasaki disease.
   - Autoimmune vasculitis (e.g., Lupus, Bechet’s).
   - Phakomatoses (e.g., neurofibromatosis), [83,84].
MRA and CTA are cross sectional methods that have the unique advantage of not only evaluating for luminal narrowing but also allowing direct visualization of the vessel wall. In general, direct visualization of vasculitis with CTA and MRA is limited to processes involving large vessels such as the aorta and its branches. Vasculitis of medium and small vessels may be more challenging related to the spatial resolution of these imaging methods, and evaluation of these entities may be indirect, related to tissue damage caused by the vasculitis.

a. Location, extent, severity of luminal narrowing and/or aneurysmal dilation
   i. Stenosis grading (stenotic disease)
      Luminal narrowing/stenoses is an important sequela of large vessel vasculitis and is responsible for a large percentage of morbidity related to vasculitis. Quantification of stenosis in vasculitis is identical to that performed for atherosclerotic disease, and details are described above. As with all stenotic disease, the location, severity, and length of the stenosis are important to report.
   ii. Diameter and/or cross sectional area (aneurysmal disease)
      Aneurysmal dilatation is another major complication of vasculitis, leading to potential rupture (e.g., luetic vasculitis of the ascending aorta in syphilis) or formation of thrombus with subsequent embolization (e.g., Kawasaki’s disease). Quantitative evaluation of aneurysmal dilatation associated with vasculitis is identical to that for aneurysmal disease, providing description of the location, length, cross-sectional diameter or area measured from double-oblique multiplanar reconstruction (MPR). In addition, it may be helpful in some situations to measure the volume of the aneurysm using 3D segmentation software, for longitudinal observation.
   iii. Wall thickness
      In addition to quantifying the luminal dimensions, CTA and MRA are uniquely positioned to visualize the vessel wall and therefore quantify the thickness. An abnormally thickened artery may indicate the presence of vasculitis. In general, the aorta should be no thicker than approximately 2 mm, although it can vary up to 4 mm [85]. Longitudinal tracking of wall thickening may be a useful marker of disease activity [86,87], although the definitions of abnormal wall thickness are not precise. When measuring the wall thickness, it is important to use double oblique MPR measurements to obtain a slice perpendicular to the vessel wall to ensure accurate measurements by minimizing partial volume effects that may cause wall thickness to be overestimated. Both MRI and CT are excellent methods to visualize vessel walls, MRI methods provide good soft-tissue contrast that can aid in more precise delineation of the vessel wall boundaries, although CTA generally has higher spatial resolution.

b. Role of phase contrast MRI for flow reversal (e.g., subclavian steal in great vessel disease)
   In stenotic disease, particularly Takayasu arteritis and giant cell arteritis, severe narrowing or occlusion of the great vessels result in altered flow patterns that can result in symptomatic conditions such as subclavian steal. Cardiac gated phase contrast MRI performed in the axial plane is a useful means to visual flow direction and also quantifies flow reversal in the vertebral arteries. In some cases, it may be helpful to perform maneuvers such as arm exercises of the affected side to elicit steal phenomenon.

6. Fibromuscular dysplasia
   Fibromuscular dysplasia (FMD) is a relatively common nonatherosclerotic vascular disease that affects the intima or media of large and medium arteries, including, but not limited to:
   - Renal arteries.
   - Internal carotid arteries.
   - Iliac arteries.
   - Vertebral arteries.
   - Mesenteric arteries.

a. Morphology
   The morphology of FMD is highly varied ranging from focal stenoses to long tubular stenoses to the classic “string of beads” appearance. FMD is associated with the development of aneurysms and dissections of the affected vessels. Quantification of stenosis can be performed just as with other forms of stenotic disease. In addition, the presence of webs, particularly in the string of beads configuration, may make identification and grading of hemodynamically significant stenoses challenging [88]. For these reasons, CTA
may be the preferable modality if FMD is suspected, as it has higher spatial resolution than MRA, although both methods provide an excellent noninvasive means for evaluating renal artery stenosis [89,90]. However, few direct comparisons in the setting of FMD have been made [90].

b. Phase contrast for turbulence / hemodynamically significant stenoses

3D phase contrast (PC) MRA is commonly used to evaluate stenoses for hemodynamic significance. As discussed above, Grist, et al. demonstrated that signal dropout on PC-MRA images at the site of a hemodynamically significant stenosis may be a useful method to distinguish mild to moderate narrowing from more severe disease, due to the dephasing of signal within a voxel that occurs in the presence of turbulent flow [76]. Further, Prince, et al. first demonstrated the ability of 3D PC MRA to predict functional recovery after revascularization [91].

c. Phase contrast for pressure gradients

2D phase contrast, like ultrasound Doppler, can be used to measure the peak velocity across a focal stenosis. Using the Bernoulli approximation (also known as the modified Bernoulli equation), the pressure gradient across a focal stenosis can be approximated as: \( \Delta P \text{ (mmHg)} \approx 4V^2 \), where \( V \) = maximum velocity (m/s). This approximation is not valid over long segment stenoses.

7. Vascular malformations: MRA and CTA

Vascular malformations are complex entities with a spectrum of abnormalities including parenchymal arteriovenous malformations (AVMs), venous angiomas, cavernous angiomas, and capillary telangiectasias. In addition to characterizing the qualitative features of vascular malformations (e.g., presence of nidus, draining, veins), MRA and CTA can be used for quantitative assessment of these entities.

a. Location, extent, size

The location with respect to adjacent anatomy and the extent and size of a vascular malformation should be reported.

b. Other quantitative aspects of morphology – size of feeding/draining vessels

In AVMs large draining veins are often identified. Their diameter (measured in double oblique MPRs) and potential length may be helpful information for the treating physician.

c. Use of time resolved imaging – bolus passage time

Time resolved contrast-enhanced MR imaging methods (e.g., TRICKS, TWIST, CENTRA) [25] may offer relative estimates of transit times of small boluses of injected gadolinium based contrast agents (GBCAs) to help characterize vascular malformations. Higher temporal resolution techniques are under development. The precise utility of transit time is not well defined at this time.

8. Venous disease: MRA and CTA

CTA and MRA in the delayed phase (for contrast enhanced imaging) or non-contrast enhanced MRA using time of flight methods are excellent methods to evaluate for the presence of deep venous thrombosis in the lower extremities and pelvis [92,93].

a. May-Thurner syndrome

May-Thurner syndrome typically occurs in young women presenting with left lower extremity deep vein thrombosis (DVT), and is caused by compression of the left common iliac vein as it passes between the lumbar spine posteriorly and (typically) the right iliac artery anteriorly.

i. Morphology of venous stenosis

In addition to the presence of clot, patients with left lower extremity DVT should undergo evaluation of the left common iliac vein with high resolution CTA or MRA, acquired in the delayed phase. Double oblique MPRs visualizing the iliac vein at the narrowest point should be performed. The area of narrowing is typically ribbon-like, and measurements of the major and minor axis of the vessel cross-section should be provided. In some cases the vein may be occluded.

ii. Time resolved MRA for venous collaterals, flow reversal, etc.

Time resolved contrast enhanced MRA (TRICKS, TWIST, CENTRA) [25] may be helpful for identifying venous collaterals and the presence of flow reversal. The use of phase contrast MRA for quantitative assessment of venous narrowing for measuring pressure gradients in May-Thurner syndrome is not well established, although it holds promise.
9. Acquired cardiac disease: MRI/MRA, CTA
   a. Ischemic disease
      i. Function and morphology (primarily LV, but also RV)
         The evaluation of cardiac function can provide valuable prognostic information on ischemic heart disease. The ejection fraction (EF) predicts outcome better than the number of vessels involved [94], and prognosis after myocardial infarction (MI) is closely related to the degree of LV contractile dysfunction [95]. Regional ventricular dysfunction (thinning of wall, decreased systolic wall thickening, abnormal wall motion, or the presence of LV thrombus) is also a good indicator of acute/chronic ischemia [96]. Based on these data, quantitative measures of ventricular function should be performed by short axes direct planimetry when ECG gating is used for image acquisition. For cardiac CT, imaging is often performed with prospective ECG gating to limit patient radiation exposure. When this acquisition strategy is used, quantitative measures will not be available. Myocardial perfusion imaging is another important method using myocardial blood flow (MBF) or coronary flow reserve (CFR), detecting multivessel disease that is sometimes not obvious in qualitative imaging [97]. While quantification has been studied, at present image interpretation is primarily subjective. The main target is LV in most IHD patients, but RV evaluation is also important especially in inferior wall ischemia/infarction. Later generation multidetector CT scanners with faster scan time and thinner slices are now used for research purposes in this field, with encouraging preliminary data.
   ii. Presence of and extent of scar/infarct, T2 signal in acute MI
      Myocardial delayed contrast enhancement (MDE) imaging using either gadolinium (MR) or iodine (CT) indicates irreversible injury [98]. At present, these metrics are used on a quartile basis with specific cutoffs of 50% delayed enhancement [60]. Ischemia-associated myocardial edema shows high signal on T2-weighted imaging. The extent of high-T2 signal reflects the area of risk [99], but reversible injury. Moreover, myocardial salvage area, namely the difference between the entire high T2 signal area and the MDE area, can be determined from MR images. This is routinely performed subjectively.
   iii. Complications, e.g., valvular related abnormalities
      Several complications are associated with acute myocardial infarction (MI), including papillary muscle injury, ventricular septal defect (VSD), contained rupture, and pericarditis or Dressler’s syndrome, which can be detected by CT or MR imaging [100]. Papillary muscle involvement is known to cause mitral valve regurgitation. Quantification of valve regurgitant volume/fraction by MR and evaluation of pericardium are discussed below.
   iv. Coronary artery calcium scoring (CT) for risk assessment
      Calcium scoring images are acquired with noncontrast ECG gated CT to optimally visualize and quantify calcified plaque [62]. High “calcium scores” are associated with an increased risk of MI [101], and a calcium score of 0 has a very low but nonzero risk of a major adverse cardiac event [102].
   b. Nonischemic cardiomyopathy and infiltrative disease
      i. Function and morphology
         There are several nonischemic cardiomyopathies: hypertrophic cardiomyopathy (HCM), dilated cardiomyopathy (DCM), and restrictive cardiomyopathy. Restrictive cardiomyopathy usually occurs secondary to infiltration of the myocardium, amyloidosis, myocardial fibrosis (after open heart surgery), radiation, sarcoidosis, or endomyocardial eosinophilia. Nonischemic cardiomyopathy usually has an alteration in the ventricular function, leading to heart failure. In addition to EF, the LV myocardial mass (myocardial volume x myocardial density) is a useful parameter to assess nonischemic cardiomyopathy; LV mass and myocardial wall thickening correlate independently with prognosis [96]. Generalized or regional wall-motion abnormalities also occur in DCM or HCM. The metrics for function and morphology follow those described in section IV.A.
ii. Extent of delayed enhancement for staging/prognosis
While MDE imaging is used more often in detecting MI, scar quantification on MDE images may also play an important role in determining prognosis and risk assessment for nonischemic cardiomyopathy patients. Hyper-enhancement is often detected in the myocardium of HCM patients [103] in a characteristically patchy midwall distribution in hypertrophied areas, while DCM patients often show linear midwall striae. A higher percentage of MDE on MR in HCM patients is known to be associated with ventricular tachycardia and fatal arrhythmias [104]. Subjective assessment is routine.

iii. Complications (valvular disease, subaortic stenosis)
HCM is known to cause subaortic stenosis outflow obstruction due to the septum hypertrophy and systolic anterior motion (SAM) of the anterior leaflet of the mitral valve. MR imaging can potentially quantify pressure gradients or valve area using a phase contrast acquisition, which is discussed in the valvular disease section below.

c. Valvular disease

i. Cross sectional area (CT and MRI)
Valve area measurements in patients with aortic stenosis greatly affect treatment strategies and predict prognosis. On MR images, the valve area is usually calculated “indirectly” by measuring the time-velocity integrals at the valve and at an adjacent site with an easily measurable diameter (for example the aortic outflow tract) and then assuming conservation of flow. Several studies have also tested the “direct” measurement of valve areas by MR cine or phase-contrast sequences through the valve plane [105,106]. However, when measuring valve planimetry directly, CT with cardiac ECG gating allows excellent visualization of valve structure and thus is frequently used in clinical settings. When using either MR or CT for measuring valve planimetry, at least 30 cardiac phases should be imaged or reconstructed in order to most accurately identify end systole, or the time at which the aortic valve orifice is most open.

ii. Detection of insufficiency and stenosis
MR enables quantitative analysis of valvular disease, consisting of calculation of regurgitant volume and fraction in patients with regurgitant valves and measurement of peak or time average velocities and pressure gradients in patients with stenotic valves [105]. CT usually detects valve stenosis itself or poststenotic dilatation with direct planimetry but does not greatly contribute to the diagnosis of valve insufficiency.

iii. Phase-contrast MR: pressure gradients, regurgitant fractions
Phase-contrast MR sequences can be used for both flow quantification for valvular insufficiency and peak and average velocities quantification for valvular stenosis. Aortic insufficiency is usually graded by regurgitant volume (volume of regurgitant flow across the valve per heartbeat) or regurgitant fraction (regurgitant volume divided by forward stroke volume). Quantification of stenotic valves measures peak and average velocities across the valve on phase-contrast images. These velocities are converted into pressure gradients with the modified Bernoulli equation: $\Delta P = 4V^2$ (as described above). A mean gradient >50 mmHg or peak velocity > 4.5 m/sec is defined as severe aortic stenosis.

iv. Effect on heart (chamber enlargement) or great vessels (poststenotic dilatation)
The pathophysiology of aortic stenosis involves obstruction of LV outflow, which leads to elevated LV pressures and LV hypertrophy. Arterial stenosis also causes poststenotic dilatation, a dilation of the vessel 1 to 3 cm distal to the area of stenosis. In contrast, aortic insufficiency involves volume overload of the left ventricle, resulting in LV dilatation. CT or MR imaging can directly demonstrate and measure LV hypertrophy, LV dilatation, and poststenotic dilatation of the ascending aorta.

d. Diastolic dysfunction/heart failure

i. Function/morphology
Heart failure is characterized by any structural or functional cardiac disorder which impairs the ability of ventricles to fill with or eject blood. Therefore, for a final diagnosis of heart failure, the
evaluation of systolic and/or diastolic dysfunction is required. As described above, MR imaging can quantify LV volume and ejection fraction (EF), or assess wall motion and be used for both diagnosis and monitoring. Myocardial perfusion imaging determines whether coronary artery disease contributes to the development of heart failure. Delayed enhancement (DE) imaging can also be used for heart failure assessment; the extent of DE predicts the response to beta-blocker therapy [107].

ii. Role of phase contrast (E/A reversal)
The E/A ratio is the ratio of early to late (“atrial”) diastolic filling velocity of the ventricle and can rapidly detect abnormal diastolic function. While the normal E/A ratio is greater than 1, impaired relaxation of ventricle decreases early diastolic filling and results in a reduced or reversed E/A ratio, e.g., E/A ratio less than 1. E/A ratio is usually measured by echocardiography but can also be acquired with phase-contrast MRI by calculating transmirtal (or transtricuspid) velocity.

e. Pericardial disease

i. Function and morphology
Many disease processes can affect the pericardium, including infection, neoplasm, trauma, primary myocardial disease, and congenital disease, but the imaging findings are somewhat similar: thickened/enhanced pericardium, retention of pericardial fluid, and the impaired ventricular dilatation. Imaging usually targets the direct visualization of thickened/enhanced pericardium or the analysis of ventricular function. In these patients, function and morphology can be assessed as described above.

ii. Pericardial thickness and enhancement
CT and MRI provide excellent visualization of the pericardium and can lend support to the diagnosis of pericardial disease. Regarding the constrictive pericarditis, the CT and MR images can be used to directly measure pericardial thickening greater than 4 mm. This metric can be used with a subjective assessment of narrow, tubular deformation of the ventricles with a straightened or sigmoid-shaped interventricular septum to support the diagnosis [108]. Contrast enhancement is an additional qualitative finding associated with abnormal pericardium.

iii. ROI analysis for hemopericardium, calcium (CT)
ROI CT attenuation measurements characterize pericardial fluid ~40 to 60 HU. A fluid collection with attenuation close to that of water is likely to be a simple effusion, but attenuation greater than that of water suggests malignancy, hemopericardium, purulent exudate, or effusion associated with hypothyroidism [109]. MR can also characterize pericardial fluid, though qualitatively, with use of multisequences; hemorrhagic effusion is characterized by high signal on T1-weighted SE images and low intensity on gradient echo (GRE) cine images [110]. Another important feature of CT is its ability to detect pericardial calcifications, a finding indicative of constrictive pericarditis. Assessment of constrictive physiology with MRI or CT requires ECG gating.

f. Pulmonary veins preablation, postablation for atrial fibrillation and pulmonary vein stenosis

i. Preprocedure measurements (cross sectional diameters, length, number of veins, anatomy (especially variants)). In atrial fibrillation (AF) patients, atrial myocardium tissue is more often present in the pulmonary veins (PVs) and the atrial myocardium in the PVs has more severe discontinuity, hypertrophy, and fibrosis [111]. Catheter ablation has been widely used to treat AF and usually ablates the atrial myocardium inside the PVs to disconnect an abnormal interaction with left atrium. Preprocedural CTA or MRA for cross-sectional measurement of PV ostia is beneficial for selecting the optimal circular catheter [112]. Furthermore, because 38% of AF patients have variant anatomy of PVs [113], evaluating the number and location of PVs is useful in ascertaining that all PV orifices are evaluated during the procedure [113].

ii. Postprocedure stenoses
A well-known complication of catheter ablation is PV stenosis. CT has been the most commonly used modality to detect post-procedure stenoses, but MRI can be used as well. Because the PV size varies throughout the cardiac cycle and
the difference between maximum and minimum diameter is 15%+/-8% [114], ECG-gated CTA acquisitions are preferred.

g. Pulmonary arterial hypertension
   i. Primary, secondary
   Pulmonary arterial hypertension (PAH) is a condition characterized by increased pulmonary arterial pressure. In the conventional classification, it is divided into two main categories: 1) primary PAH (not caused by any other disease or condition); and 2) secondary PAH (caused by another underlying condition), including lung diseases (e.g., COPD, interstitial lung diseases), heart diseases (e.g., congestive heart failure, congenital heart disease, mitral stenosis), chronic thromboembolic diseases (e.g., pulmonary embolism), HIV infection, or medications. Secondary PAH is much more common than primary PAH.

   ii. Right ventricle function
   Increased pulmonary arterial pressure causes an increased workload of the RV, leading to RV hypertrophy with subsequent dilatation and right heart failure. MR and CT have been increasingly used for imaging the RV, as well as for the LV, but protocol should be carefully adjusted to accurately visualize the more complex shape of the RV [96]. In case of acute pulmonary embolism (PE), the chest CT measures the RV/LV diameter ratio and uses >0.9 to predict 30-day mortality and major complications [78,79]. A ratio of main pulmonary artery diameter to the ascending aorta diameter of greater than 1 can be reliably used to detect pulmonary hypertension in patients with cardiopulmonary diseases if the ascending aorta is of normal size [115]. In addition to morphological assessment, MR imaging can easily measure EF of both ventricles and LV end-diastolic volume that are significantly decreased in patients with PAH [116].

   iii. Pulmonary artery morphology (diameters, cross sectional areas)
   Mean pulmonary artery (PA) pressure correlates linearly with main PA diameter [117], and a PA diameter greater than 30 mm indicates a PA pressure greater than 20 mm Hg [118]. However, several studies failed to demonstrate that main PA diameter predicts an increased mortality or indicate severity of acute PE [119,120].

   iv. Assessment of clot burden with chronic thromboembolic disease
   The presence, location, and degree of obstruction of arterial clots can be scored according to several different scoring systems. Qanadli and Mastora [121,122] use CT pulmonary angiography to quantify acute PE severity. However, PA clot load scores usually do not take into account clots located in small peripheral PAs and the current literature shows some discrepancies regarding the association between the clot burden and immediate outcome. For example, while reports of the score proposed by Qanadli suggest that it is a significant predictor of death [120], others reported the clot scores to be a poor predictor of mortality [119]. In general, clot burden in CTPA is not reported.

   v. Assessment of valve function in PAH (morphology, flow, pressure gradients)
   Mitral valve stenosis can cause PAH. On the other hand, PAH can cause dilatation of the pulmonic valve ring and then results in pulmonic valve regurgitation. Assessment of mitral valve stenosis or pulmonic valve regurgitation can be performed on phase-contrast sequences for quantitative velocity and flow measurement using the methods previously described.

10. Congenital cardiac disease (vascular and cardiac): MRI, CT
   a. Cardiac function
   Cardiac-gated CT [123-131] and MRI [127,131-135] are useful for the evaluation of patients with suspected or known congenital heart disease (CHD). As with other conditions, both cardiac-gated CT and MRI can provide quantitative measurements of the various chamber sizes and function, notably chamber volumes, myocardial mass, and ejection fractions for the left and right ventricles using standard quantitative tools outlined previously in section IV.A.4 Quantitative Techniques Specific to Cardiac MRI and CT. Valvular function can also be assessed as detailed previously in section IV.B.9.c Valvular disease. For example, CT and MRI are ideal for the postoperative
assessment of repaired tetralogy of Fallot [127,134]. In this case, CT and MRI can provide functional assessment of ventricular volumes and ejection fractions. Pulmonic insufficiency and pulmonic stenosis can also be assessed using cine phase contrast MRI performed perpendicular to the main pulmonary artery. These data provide essential functional information, especially of the RV, for determining proper timing for pulmonic valve replacement in patients with corrected or uncorrected tetralogy of Fallot.

b. Vessel assessment

Arterial (e.g., thoracic aorta) and venous structures (e.g., pulmonary veins) are also well evaluated using CT angiography [123,125-131] or MR angiography [131,136-140]. For example, both CT and MRI have been shown to provide comparable diagnostic evaluation of aortic narrowing in children with coarctation of the aorta [131]. MRI has the added benefit of allowing blood flow analysis using velocity-encoded cine phase contrast MRI that can measure peak velocity across a juxtaductal aortic narrowing to estimate the pressure gradient across the aortic coarctation using the modified Bernoulli equation [136]. Time-resolved MR angiography [141,142] can be particularly helpful when evaluating the presence of anomalous and/or postsurgical vascular connections in patients with CHD.

Non-gated CT angiography of the cardiopulmonary structures is often a very informative method of examination. Elimination of ECG-gating allows one to decrease the radiation dose to the patient. This is an especially important point to remember when examining children and younger adult patients with CHD. Retrospective ECG triggered studies can allow for anatomic imaging with reduced cardiac motion artifacts and with radiation dose comparable to non-gated studies.

c. Pulmonary-to-systemic shunt (Qp/Qs ratio)

A unique evaluation in patients with suspected or known CHD is the assessment for a left-to-right shunt using the pulmonary (Qp) to systemic (Qs) blood flow ratio (Qp/Qs ratio) [143,144]. This measures the volume of blood flow between the pulmonary (i.e., right heart) and systemic (i.e., left heart) circulations. In healthy individuals, the blood flow is equal and the resultant Qp/Qs ratio is 1. In patients with an underlying left-to-right shunt lesion (e.g., atrial septal defect, ventricular septal defect, or partial anomalous pulmonary venous return) there is shunting of blood from the left to the right heart and Qp/Qs ratio >1. When the Qp/Qs ratio is <1, this represents right to left shunting. Symptomatic patients often present when the shunting becomes moderate (i.e., Qp/Qs >1.5) or large (e.g., Qp/Qs >2.2). The Qp/Qs ratio is most commonly measured using MRI. It can be determined by measuring the flow over the cardiac cycle on cine phase-contrast MRI performed perpendicular to the main pulmonary artery (Qp) and the ascending thoracic aorta (Qs).

In younger patients who are more sensitive to ionizing radiation, MRI may be the preferred modality, particularly when functional assessment with CT would require retrospective ECG gating and markedly increased radiation doses. Further, the use of time-resolved MRA and phase contrast MRI methods offer significant advantages whose relative importance will depend on the specific application.

V. DOCUMENTATION

Reporting should be in accordance with the ACR Practice Guideline for Communication of Diagnostic Imaging Findings.

VI. EQUIPMENT SPECIFICATIONS

The MRI equipment specifications and performance must meet all state and federal requirements. The requirements include, but are not limited to, specifications of maximum static magnetic strength, maximum rate of change of the magnetic field strength (dB/dt), maximum radiofrequency power deposition (specific absorption rate), and maximum acoustic noise levels.

VII. QUALITY CONTROL AND IMPROVEMENT, SAFETY, INFECTION CONTROL, AND PATIENT EDUCATION

Policies and procedures related to quality, patient education, infection control, and safety should be developed and implemented in accordance with the ACR Policy on Quality Control and Improvement, Safety, Infection Control, and Patient Education appearing under the heading Position Statement on QC & Improvement, Safety, Infection Control, and Patient Education on the ACR web site (http://www.acr.org/guidelines).
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