Phase Analysis of Gated Myocardial Perfusion Single-Photon Emission Computed Tomography Compared With Tissue Doppler Imaging for the Assessment of Left Ventricular Dyssynchrony

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Objectives

The purpose of this study was to compare left ventricular (LV) dyssynchrony assessment by gated myocardial perfusion single-photon emission computed tomography (SPECT) (GMPS) and tissue Doppler imaging (TDI).

Background

Recently, it has been suggested that LV dyssynchrony is an important predictor of response to cardiac resynchronization therapy (CRT); dyssynchrony is predominantly assessed by TDI with echocardiography. Information on LV dyssynchrony can also be provided by GMPS with phase analysis of regional LV maximal count changes throughout the cardiac cycle, which tracks the onset of LV thickening.

Methods

In 75 patients with heart failure, depressed LV function, and wide QRS complex, GMPS and 2-dimensional echocardiography, including TDI, were performed as part of clinical screening for eligibility for CRT. Clinical status was evaluated with New York Heart Association functional classification, 6-min walk distance, and quality-of-life score. Different parameters (histogram bandwidth, phase SD, histogram skewness, and histogram kurtosis) of LV dyssynchrony were assessed from GMPS and compared with LV dyssynchrony on TDI with Pearson’s correlation analyses.

Results

Histogram bandwidth and phase SD correlated well with LV dyssynchrony assessed with TDI ($r = 0.89, p < 0.0001$ and $r = 0.80, p < 0.0001$, respectively). Histogram skewness and kurtosis correlated less well with LV dyssynchrony on TDI ($r = -0.52, p < 0.0001$ and $r = -0.45, p < 0.0001$, respectively).

Conclusions

The LV dyssynchrony assessed from GMPS correlated well with dyssynchrony assessed by TDI; histogram bandwidth and phase SD showed the best correlation with LV dyssynchrony on TDI. These parameters seem most optimal for assessment of LV dyssynchrony with gated SPECT. Outcome studies after CRT are needed to further validate the use of GMPS for assessment of LV dyssynchrony. (J Am Coll Cardiol 2007;49:1708–14) © 2007 by the American College of Cardiology Foundation

Several studies have demonstrated the potential benefit of cardiac resynchronization therapy (CRT) in the treatment of end-stage heart failure (1–3). Recently, it has been suggested that left ventricular (LV) dyssynchrony is an important predictor of response to CRT, which can be assessed with echocardiography, in particular with tissue Doppler imaging (TDI) (4). Tissue Doppler imaging permits assessment of segmental myocardial velocities, and comparison of the timing of these different segmental velocities allows assessment of LV synchrony or dyssynchrony (4–6). Specifically, the presence of LV dyssynchrony of 65 ms or more has been demonstrated to adequately predict response to CRT (4).

Gated single-photon emission computed tomography (SPECT) is used for assessment of myocardial perfusion but also provides information on regional wall thickening (7–9). A count-based method has been developed to extract the sale of the Emory Cardiac Toolbox. The terms of this arrangement have been reviewed and approved by Emory University in accordance with its conflict-of-interest practice. Dr. Gabe B. Bleeker is supported by the Dutch Heart Foundation, grant no. 2002B109. Juhani Knuuti, MD, PhD, acted as Guest Editor for this article.

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amplitude (systolic wall thickening) and phase from the regional LV count changes throughout the cardiac cycle. The phase information is related to the time interval when a region in the 3-dimensional LV myocardial wall starts to contract. It provides information as to how uniform or inhomogeneous is the distribution of these time intervals for the entire LV (i.e., a measure of LV (dys)synchrony). Recently, this technique has been implemented to the Emory Cardiac Toolbox as a diagnostic tool for assessment of the LV mechanical (dys)synchrony (10).

The purpose of the present study was to compare the degree of LV dyssynchrony as assessed with phase analysis from gated myocardial perfusion SPECT (GMPS) and the degree of LV dyssynchrony as assessed with TDI in patients with heart failure, depressed left ventricular ejection fraction (LVEF), and wide QRS complex.

Methods

Patients and study protocol. The study population consisted of 75 consecutive patients with heart failure who were clinically referred for evaluation of potential eligibility for CRT. Selection criteria for CRT included severe heart failure (New York Heart Association [NYHA] functional class III or IV), LVEF <35%, and prolonged QRS duration (>120 ms). Medication included diuretics in 92% of patients, angiotensin-converting enzyme inhibitors in 91%, and beta-blockers in 71%. The clinical status of the patients was evaluated, with the NYHA functional class, 6-min walk distance (11), and quality-of-life score (with the Minnesota Quality of Life Questionnaire) (12).

Resting GMPS with technetium-99m tetrofosmin was clinically performed to exclude extensive ischemia and/or viability, in order to refer patients to revascularization if indicated (7,8). Extensive echocardiographic analysis, including TDI, was performed to evaluate LV function, size, and LV dyssynchrony, as previously described (4). The potential to derive LV dyssynchrony from GMPS was then evaluated. Various parameters (see details in the subsequent text) were obtained from phase analysis with the Emory Cardiac Toolbox software (10), aiming to evaluate LV dyssynchrony. Echocardiographic data obtained with TDI, assessing LV dyssynchrony, were used for comparison (4).

Gated myocardial perfusion SPECT. Resting GMPS with technetium-99m tetrofosmin (500 MBq, injected at rest) was performed with a triple-head SPECT camera system (GCA 9300/HG, Toshiba Corp., Tokyo, Japan) equipped with low-energy, high-resolution collimators. Around the 140-KeV energy peak of technetium-99m tetrofosmin, a 20% window was used. A total of 90 projections (step and shoot mode, 35 s/projection, imaging time 23 min) were obtained over a 360° circular orbit. The GMPS acquisition involved 16 frames/cardiac cycle. Data were stored in a 64 × 64 matrix. Data were reconstructed by filtered backprojection and then reoriented to yield gated short-axis images. The reconstruction was performed over 360°. These images were then submitted to the Emory Cardiac Toolbox for phase analysis. All SPECT images were analyzed at the department of radiology of Emory University School of Medicine by investigators (J.C. and E.V.G.) who were blinded to the echocardiographic and clinical data. A phase distribution was extracted from a GMPS study to represent the regional onset of mechanical contraction of the LV. It can be displayed in a polar map or in 3 dimensions and used to generate a phase histogram. Examples are shown in Figure 1.

The following 4 quantitative indexes were obtained from the phase analysis of all patients: 1) histogram bandwidth, which includes 95% of the elements of the phase distribution; 2) phase SD, which is the SD of the phase distribution; 3) phase histogram skewness, which indicates the symmetry of the histogram; and 4) histogram kurtosis, which indicates the degree to which the histogram is peaked (10). Preliminary normal databases for these quantitative indexes have been created (10). From the phase polar maps, the site of latest activation was identified (4 regions were evaluated, including anterior, inferior, lateral, septal). The region with the latest activation had larger phases and appeared in the phase polar map as a brighter region. In a healthy individual, the LV contracts in a coordinated manner and most of the myocardial segments have the same or similar phases. Thus, the phase distribution is nearly uniform and the phase histogram is a highly peaked, narrow distribution (Fig. 1A). As the LV mechanical synchrony worsens (becoming dysynchronous), the phase SD and histogram bandwidth are expected to increase (Fig. 1B).

Two-dimensional echocardiography and TDI. Patients were imaged in the left lateral decubitus position with a commercially available system (Vingmed Vivid Seven, GE-Vingmed, Milwaukee, Wisconsin). In all patients, the acoustic window was adequate, yielding good image quality.

Images were acquired with 3.5-MHz transducer at a depth of 16 cm in the parasternal view and apical 2- and 4-chamber views. Standard 2-dimensional and color Doppler data, triggered to the QRS complex, were saved in cineloop format. All echocardiographic examinations were performed by the same experienced echocardiographer, and all examinations were evaluated by consensus by 2 experienced cardiologists, blinded to the SPECT and clinical data at Leiden University Medical Center. The LV volumes (end-systolic and end-diastolic) were derived from the conventional apical 2- and 4-chamber views, and LVEF was calculated with the biplane Simpson’s rule (13). In addition
Figure 1 Phase Analysis With GMPS

(A) Example of a patient without left ventricular (LV) dyssynchrony on gated myocardial perfusion single-photon emission computed tomography (GMPS). The non-normalized (upper panel) and normalized (lower panel) phase distributions are nearly uniform, and the corresponding phase histograms are highly peaked, narrow distributions.

(B) Example of a patient with LV dyssynchrony derived from GMPS. The non-normalized (upper panel) and normalized (lower panel) phase distributions show significant non-uniformity and the corresponding phase histograms are widely spread distributions.
to the conventional 2-dimensional echocardiographic examination, TDI was performed to assess LV dyssynchrony. For TDI, color Doppler frame rates varied from 80 to 115 frames/s, depending on the sector width of the region of interest. Pulse repetition frequencies ranged from 500 Hz to 1 kHz, resulting in aliasing velocities of 16 to 32 cm/s. The TDI parameters were measured from color-coded images from 3 consecutive heartbeats by off-line analysis. Data were analyzed with commercially available software (Echopac 6.1, GE-Vingmed).

To determine LV dyssynchrony, the sample volume was placed in the basal portions of the septum, inferior, anterior, and lateral wall (with the 2- and 4-chamber images); peak systolic velocities and time-to-peak systolic velocities were obtained. The delay in peak velocity between the earliest and latest activated segments was calculated as indicator of LV dyssynchrony (4).

**Statistical analysis.** Continuous data are expressed as mean ± SD. Pearson’s correlation analysis was performed to evaluate the relation between histogram bandwidth, phase SD, histogram skewness, and histogram kurtosis by the phase analysis of GMPS and LV dyssynchrony by TDI. Multivariable linear regression analysis was performed to determine the relation between LV dyssynchrony assessed with TDI as dependent variable and histogram bandwidth, phase SD, histogram skewness, histogram kurtosis, etiology of heart failure, gender, age, LVEF, LV end-diastolic volume, LV end-systolic volume, and NYHA functional class as independent variables. A p value <0.05 was considered statistically significant.

**Results**

The study population consisted of 54 men and 21 women, with a mean age of 66 ± 9 years. Patient characteristics are summarized in Table 1. Mean NYHA functional class was 2.9 ± 0.3, and mean LVEF was 25 ± 8%. In all patients, histogram bandwidth, phase SD, histogram skewness, and histogram kurtosis were assessed with the phase analysis of GMPS and compared with the LV dyssynchrony as evaluated with TDI.

**Histogram bandwidth.** The mean histogram bandwidth was 149° ± 70° (range 31° to 304°), whereas the normal value of histogram bandwidth is 38.7° ± 11.8° for men and 30.6° ± 9.6° for women (10). Pearson’s correlation showed a good correlation with LV dyssynchrony as assessed with TDI (r = 0.89, p < 0.0001) (Fig. 2).

**Phase SD.** The mean phase SD was 48.6° ± 21.3° (range 10.2° to 98.8°), whereas the normal value of phase SD is 14.2° ± 5.1° for men and 11.8° ± 5.2° for women (10). Pearson’s correlation demonstrated a good correlation with LV dyssynchrony as measured with TDI (r = 0.80, p < 0.0001) (Fig. 3).

**Histogram skewness.** The mean skewness was 2.24 ± 0.71 (range 1.15 to 4.57), whereas the normal value of histogram skewness is 4.19 ± 0.68 for men and 4.60 ± 0.72 for women (10). A fair correlation with LV dyssynchrony as assessed with TDI was demonstrated by Pearson’s correlation, with a correlation coefficient r = −0.52, p < 0.0001 (Fig. 4).

**Histogram kurtosis.** The mean kurtosis was 5.81 ± 4.31 (range 0.53 to 23.08), whereas the normal value of histogram kurtosis is 19.72 ± 7.68 for men and 23.21 ± 8.16 for women (10). A fair correlation with LV dyssynchrony as evaluated with TDI was shown by Pearson’s correlation, with correlation coefficient r = −0.45, p < 0.0001 (Fig. 5).

**Idiopathic dilated cardiomyopathy versus ischemic cardiomyopathy.** In total, 26 patients had idiopathic dilated cardiomyopathy, whereas 49 patients had ischemic cardiomyopathy. Correlation coefficients for histogram bandwidth, phase SD, and histogram skewness were higher in patients with idiopathic dilated cardiomyopathy, whereas

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**Table 1 Clinical Characteristics of the Study Population (n = 75)**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value (Mean ± SD or n, %)</th>
</tr>
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<tbody>
<tr>
<td>Age (yrs)</td>
<td>66 ± 9</td>
</tr>
<tr>
<td>Men</td>
<td>54 (72%)</td>
</tr>
<tr>
<td>Ischemic cardiomyopathy</td>
<td>49 (65%)</td>
</tr>
<tr>
<td>Idiopathic dilated cardiomyopathy</td>
<td>26 (35%)</td>
</tr>
<tr>
<td>Previous infarction</td>
<td>41 (55%)</td>
</tr>
<tr>
<td>Q-wave on electrocardiogram</td>
<td>24 (32%)</td>
</tr>
<tr>
<td>2D echo parameters</td>
<td></td>
</tr>
<tr>
<td>LVEDV (ml)</td>
<td>241 ± 84</td>
</tr>
<tr>
<td>LVESV (ml)</td>
<td>185 ± 79</td>
</tr>
<tr>
<td>LVEF (%)</td>
<td>25 ± 8</td>
</tr>
<tr>
<td>6-MWT (m)</td>
<td>320 ± 107</td>
</tr>
<tr>
<td>QoL</td>
<td>35 ± 17</td>
</tr>
<tr>
<td>NYHA functional class</td>
<td>2.9 ± 0.3</td>
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</tbody>
</table>

Data are represented as mean ± SD or as n (%). 2D = 2-dimensional; 6-MWT = 6-minute walk test; LVEDV = left ventricular end-diastolic volume; LVEF = left ventricular ejection fraction; LVESV = left ventricular end-systolic volume; NYHA = New York Heart Association; QoL = quality-of-life score according to the Minnesota Living With Heart Failure questionnaire.
the correlation coefficient for histogram kurtosis was lower (Table 2). This difference was statistically significant for phase SD ($p = 0.03$).

**Impact of histogram bandwidth and other variables on LV dyssynchrony assessed with TDI.** Histogram bandwidth and phase SD showed strongest correlation with LV dyssynchrony assessed with TDI (Table 3).

**Discussion**

With the introduction of CRT, a new therapeutic option for patients with end-stage heart failure has emerged. Long-term benefit from CRT has been shown in large trials, demonstrating an improvement in NYHA functional class, 6-min walk distance, and quality-of-life score (1,2). In addition, echocardiographic studies have shown improvement in LVEF with a reduction in LV volumes (reverse remodeling) (14,15).

Because not all patients respond equally well to CRT, selection criteria have been defined in the American College of Cardiology/American Heart Association/North American Society for Pacing and Electrophysiology guidelines; these selection criteria include end-stage, drug-refractory heart failure, severe LV dysfunction, and wide QRS complex (16). Still, 20% to 30% of the selected patients do not benefit from CRT (2,17). Better identification of these patients is needed, and echocardiographic studies have shown that so-called responders and nonresponders can be distinguished on the basis of the presence or absence of LV dyssynchrony (5,18,19). In particular, TDI has been shown useful for detecting LV dyssynchrony and predict response to CRT (4).

In the current study, the value of phase analysis derived from GMPS to assess LV dyssynchrony was evaluated. The phase analysis tool in the Emory Cardiac Toolbox extracts a
phase distribution from a VMPS study representing the regional LV onset of mechanical contraction. Quantitative indexes such as phase SD and histogram bandwidth are then calculated from the phase distribution to assess the LV mechanical (dys)synchrony. In the present study, this technique was compared with TDI for assessment of LV dyssynchrony. Good correlations were noted for histogram bandwidth and phase SD assessed with TDI and for phase SD and LV dyssynchrony assessed with TDI (r = 0.89 and r = 0.80, respectively). These correlations support the hypothesis that the phase analysis of GMPS can be used to assess LV dyssynchrony. Furthermore, histogram bandwidth and phase SD best correlated with LV dyssynchrony assessed with TDI. In total, 49 patients had ischemic cardiomyopathy, whereas 26 patients had idiopathic dilated cardiomyopathy. Correlation coefficients for histogram bandwidth, phase SD, and histogram skewness were higher in patients with idiopathic dilated cardiomyopathy, whereas the correlation coefficient for histogram kurtosis was lower. This difference was statistically significant for phase SD (p = 0.03). This observation could imply that LV dyssynchrony as assessed with GMPS relates better with LV dyssynchrony as evaluated with TDI in patients with idiopathic dilated cardiomyopathy. However, considering the relatively small patient population in the present study, this conclusion would be premature.

Recently, a cutoff value of ≥65 ms for LV dyssynchrony has been proposed for the prediction of response to CRT. With this cutoff value, the sensitivity as well as the specificity for predicting clinical improvement was 80%, whereas the sensitivity and specificity for reverse LV remodeling were both 92% (4). For the usefulness of the phase analysis of GMPS in daily clinical practice, it would be desirable to determine cutoff values for the parameters given by the phase analysis. However, in the current study only the correlations between the different parameters derived from GMPS and LV dyssynchrony derived from TDI were evaluated. Future studies comparing TDI and GMPS in patients undergoing CRT are needed to determine the potential cutoff values from GMPS.

Several limitations need to be acknowledged. First, follow-up data after CRT implantation were not available; therefore, it remains to be determined what the value of GMPS is for prediction of response to CRT. Another limitation of GMPS, in general, is that GMPS is less suitable than echocardiography for follow-up after CRT implantation, due to the radiation burden.

In conclusion, the current findings demonstrate the feasibility of evaluating LV dyssynchrony with GMPS and its applicability in a clinical setting. The phase analysis from GMPS was compared with TDI for assessment of LV dyssynchrony, and the results demonstrate that the histogram bandwidth and phase SD might be the preferred parameters from GMPS to assess LV dyssynchrony, because these parameters correlated best with LV dyssynchrony as derived from TDI. Outcome studies after CRT are needed to further validate the use of GMPS for assessment of LV dyssynchrony.

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