We welcome the interest of Drs. Rapezzi and colleagues in our article (1). We did not discuss radionuclide imaging of amyloid with tracers developed for bone scintigraphy because few data are available and because of constraints of space. Bone scintigraphy in amyloidosis has been evaluated systematically only in very small series (2), and there is no evidence as yet for a specific molecular interaction between bone-seeking isotopes and amyloid deposits. We believe that the suggestions by Dr. Rapezzi and colleagues that bone scintigraphy can facilitate the differential diagnosis of transthyretin and AL cardiac amyloidosis is therefore unsubstantiated in light of present knowledge but that further investigation of this interesting phenomenon is warranted.

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REFERENCES


We thank Drs. Suhar, Hitchcock, Russo, and Topol for their interest in our recent report of the prognostic value of coronary computed tomographic angiography (CCTA) for the prediction of all-cause death (1). Suhar and colleagues raise the possibility that most patients in our study population with moderate to severe triple-vessel coronary artery disease may have undergone coronary revascularization that might have affected their mortality. In response to this important question, we have further evaluated data now available to us at the primary sites from which patients were referred. Among the 106 patients with CCTA-identified moderate to severe 3-vessel coronary artery disease (defined by severe plaque in the proximal or midportions of the left anterior descending artery/diagonal branch and left circumflex artery/obtuse marginal branch and right coronary artery, or moderate to severe plaque in the left main artery), 37 underwent subsequent invasive coronary angiography, with 6 undergoing percutaneous or surgical revascularization. No significant difference existed in all-cause mortality between the small groups of patients who underwent invasive angiography or coronary revascularization and the larger number who did not (both p > 0.20 in univariate analyses).

As Suhar and colleagues also correctly note, these results represent intermediate-term outcomes based upon CCTA findings from 16-slice CCTA scans, for which long-term mortality data is only just beginning to unfold (2). Our study represents the scaling of only the first of many hurdles to come. Future prognostic series examining the efficacy of current generation 64-slice CCTA plaque identification for the prediction of future adverse outcome, including major cardiovascular events other than death, are necessary at this early stage in the field. Furthermore, additional information that can be routinely gleaned from a typical CCTA examination, including plaque composition patterns (3); cardiac chamber function, volumes, and mass (4); and myocardial attenuation densities (5) should be