Incidental cardiac abnormalities on non-electrocardiogram-gated multi-detector computed tomography imaging of the thorax and abdomen

Lim K C, Chai P, Teo L S L

ABSTRACT
Little attention is usually paid to the heart on non-electrocardiogram (ECG)-gated multi-detector computed tomography (MDCT) imaging of the thorax and abdomen. The current MDCT systems have fast scanning capabilities that render non-ECG-gated images with reduced cardiac motion artefacts due to greater temporal and spatial resolution. This has allowed for better evaluation of the cardiac structures. We present a pictorial review of incidental cardiac abnormalities found on MDCT imaging of the thorax and abdomen performed in our institution. We systematically describe abnormalities involving the pericardium, myocardium, cardiac valves, cardiac chambers, coronary artery and congenital heart disease. Some of these images have echocardiographic and magnetic resonance imaging correlation. The purpose of this pictorial essay is to draw attention to cardiac abnormalities found incidentally on non-ECG-gated MDCT imaging of the thorax and abdomen, which may or may not be related to the patient’s symptoms.

Keywords: cardiac abnormalities, computed tomography, incidental

PERICARDIUM
Pericardial effusion
The common causes of pericardial effusion are heart failure, renal failure, infection, neoplasia and injury, including trauma and myocardial infarction. The CT attenuation value (Hounsfield units [HU]) reflects the characteristics of the pericardial fluid; a value closer to that of water (0 HU) is likely to be a simple effusion (Fig. 1), whereas a value greater than that of water density can be seen in conditions such as malignancy, haemopericardium and purulent exudate. Radiologists’ awareness of CT findings of pericardial tamponade allows early diagnosis and prompt life-saving intervention. These findings include a large pericardial effusion, compression of the cardiac chambers, bowing of the interventricular septum, enlargement of the vena cava and reflux of contrast material into the azygos vein and inferior vena cava.

Fig. 1 A 16-year-old female patient with known B-cell mediastinal lymphoma, presenting with shortness of breath. Contrast-enhanced axial CT thorax image shows an incidental large pericardial effusion (*), which is isodense to water and indicative of a simple effusion. A central venous catheter for chemotherapy is present (arrow). Aspirated sterile pericardial fluid was negative for malignancy.
Pericardial calcification

Pericardial calcification is an important sign, but not pathognomonic of constrictive pericarditis, in which it may be associated with a thickened pericardium. It is commonly seen within the atrioventricular grooves and in the diaphragmatic portions of the pericardium (Fig 2). Constrictive pericarditis is now more commonly secondary to cardiac surgery and therapeutic irradiation, rather than infection, collagen vascular disease and uraemia. Pericardial calcification occurs less frequently today. Ling et al from Mayo Clinic recently reported that pericardial calcification was seen in 27% of their patients with constrictive pericarditis, compared to the 40% incidence reported much earlier at the same institution. Most of the constrictive pericarditis cases in these studies were idiopathic in nature, whereas tuberculosis was seen in only one patient in the recent study. The occurrence of calcification despite the rarity of tuberculosis suggests that this is a nonspecific response to chronic inflammatory processes. This may also reflect disease chronicity, where tissue fibrosis and dystrophic calcification may obliterate evidence of previous infection.

Pericardial masses

A pericardial cyst is the most common cause of a primary pericardial mass. This is formed when a portion of the pericardium is pinched off during development. This benign lesion is usually well-defined with homogeneous low density, most commonly located in the right cardiophrenic angle (Fig. 3). Pericardial metastases
have a 40-fold increase in incidence compared to primary tumours, mainly arising from lung (Fig. 4) and breast cancers.

Pericardial tumours can manifest as pericardial effusions, pericardial thickening or nodular masses on CT.

**MYOCARDIUM**

**Myocardial infarction**

CT findings related to previous myocardial infarction include subendocardial fatty replacement (Fig. 5), delayed contrast enhancement, myocardial thinning and calcification in the infarcted area. Myocardial calcification is seen in 8% of myocardial infarctions that are more than six years old. It appears as a thin, curvilinear calcification on CT images, usually within the periphery of the infarct, in the distribution of the inter-ventricular septum and cardiac apex (Fig. 6).

Contrast-enhanced CT imaging usually allows the differentiation of ventricular chambers, evaluation of wall attenuation, and facilitates the assessment of regional myocardial thinning and focal dilatation. However, the thickness of normal left ventricular myocardium on non-gated CT imaging is variable, as it is scanned at variable phases of the cardiac cycle. Lee et al postulated from clinical experience that the left ventricular myocardium is thinned when the interventricular septum or posterior myocardium on axial CT image of mid-ventricular level is thinner than 10 mm, and the myocardium is thick when it is thicker than 25 mm.
Myocardial aneurysm

Left ventricular aneurysm can be subdivided into true and false aneurysms. True aneurysms have a continuous wall of thinned, scarred myocardium, whereas false aneurysms arise from interruption or rupture of the myocardium. Both can be complicated by thrombus formation. True aneurysms are most commonly located at the anterior wall of the left ventricle or cardiac apex, usually secondary to transmural myocardial infarction (Fig. 7). They are seen in 8%–12% of patients after acute myocardial infarction. Rarer causes include trauma, Chagas disease, sarcoidosis and congenital causes.

False left ventricular aneurysms are uncommon and potentially fatal, usually requiring prompt surgical repair due to a 30%–45% lifetime risk of rupture. They commonly arise from the inferior wall of the left ventricle, secondary to myocardial rupture 5–10 days post infarction. False aneurysms in a sub-mitral location following replacement of the mitral valve and resection of the mitral valve apparatus have also been reported. It is important to differentiate between true and false aneurysms due to the differences in management. In addition to the typical inferior locations, other CT features suggestive of a false aneurysm include narrow ostium (orifice to aneurysm diameter ratio < 0.5), discontinuity of the myocardium at the neck of the aneurysm and absence of coronary arteries overlying the aneurysm.

Myocardial masses

Metastases to the myocardium are more common than primary tumours. 12% of oncology patients are reported to suffer from cardiac or pericardial metastases, frequently through direct invasion from adjacent structures, haematogenous or lymphatic spread. They may manifest as filling defects within the cardiac chambers, multiple masses, nodules or diffuse infiltration of the myocardium on CT imaging (Figs. 8 & 9). Non-ECG-gated MDCT with intravenous contrast media usually provides adequate localisation and definition of the tumour extent.

CARDIAC VALVES

Valvular heart disease/calcification

The limited temporal resolution and complex orientation of cardiac valves are the limitations of non-gated CT imaging in demonstrating the morphologic abnormalities of each cardiac valve. However, the dilatation and hypertrophy of the cardiac chambers secondary to haemodynamic adaptations in valvular heart disease can sometimes be interpreted on routine CT images. Under normal circumstances, the ventricles appear roughly equal in size.
of the left atrium and appendage in the presence of a normal left ventricle. The resultant chronic left atrial hypertension results in pulmonary vein dilatation, leading to pulmonary hypertension. The right ventricular myocardium subsequently hypertrophies, and this is seen on CT imaging as thickened right ventricular free wall and septal myocardium. Further progression to right atrial hypertension follows, causing flattening and posterior bowing of the interatrial septum. Signs of right heart failure may be seen on non-gated CT, which include dilatation of the coronary sinus, vena cavae, hepatic and azygos veins.

In chronic mitral regurgitation, there is dilatation of the left atrium and ventricle secondary to volume overload, followed by thickening of the left ventricular myocardium. However, in acute mitral regurgitation, the cardiac chambers are usually not dilated in the presence of interstitial pulmonary oedema and signs of severe left atrial hypertension on CT imaging.\(^\text{19}\)

Aortic valve calcification seen on CT imaging (Fig. 10b) is proportionately related to the severity of aortic stenosis.\(^\text{20}\) but the reference ranges of the calcium scores are probably dependent on the imaging protocol and CT equipment used. The common causes of aortic valve calcification are congenital bicuspid valve before the fourth decade and acquired valve degeneration after the sixth decade.\(^\text{20}\) Cowell et al opined that poorly defined or diffuse segments of calcium on CT imaging usually represent a minor aortic valve gradient, while coalescent calcium centred on the aortic valve likely represents moderate stenosis, and very heavy calcification almost invariably represents significant valvular stenosis.\(^\text{20}\) Other CT findings of aortic stenosis include left ventricular hypertrophy and post-stenotic dilatation of the ascending aorta.
Aortic regurgitation may be suggested on CT imaging by the presence of left ventricular and aortic dilatation. However, a milder form of the disease may be overlooked.

**Papillary muscle calcification**

Left ventricular papillary muscles are vital to left ventricular and MV function. Papillary muscle calcification is most frequently seen at the apex of the muscle (Fig. 11). It is associated with coronary artery disease and dilated cardiomyopathy.

**CARDIAC CHAMBERS**

**Filling defects**

Filling defects within the cardiac chambers are more commonly due to thrombs than tumours. Thrombus typically occurs along the posterolateral wall of the left atrium or within the left atrial appendage, as a nonenhancing filling defect (Fig. 12). It is usually associated with cardiomyopathy and dysrhythmia. Thrombus in the left ventricular apex is associated with previous myocardial infarction and ventricular aneurysm (Fig. 13).

Left-sided cardiac thrombi are potential sources of systemic embolisation, whereas right-sided lesions are associated with deep vein thrombosis and pulmonary thromboembolism. Cardiac thrombus related to tumours, such as renal cell carcinoma with invasion of the inferior vena cava, shows relative good enhancement and are located in the right heart chambers. Cardiac myxoma, the most common primary cardiac tumour, is usually located within the atrium and more likely in the left atrium. It tends to arise from the fossa ovalis as a heterogeneously low attenuation filling defect.

**CORONARY ARTERIES**

**Coronary artery calcification**

Calified coronary arteries strongly correlate with coronary artery disease. The left anterior descending artery is most commonly involved (Fig. 14). Patients with calcified coronary arteries have a higher frequency of cardiac complications, including arrhythmia, ischaemia, hypotension and myocardial infarction.

**CONGENITAL HEART DISEASE**

Some cases of isolated congenital heart disease may be detected incidentally on CT imaging performed for non-cardiac-specific symptoms such as unexplained dyspnoea, or for evaluation of pulmonary hypertension or bilateral hilar enlargement on chest radiograph in adulthood.
Of all the congenital heart diseases, atrial septal defects (ASDs) account for about a third of cases in adults. As the interatrial septum in the region of the fossa ovalis may be too thin to be delineated on non-ECG-gated CT imaging, the diagnosis of ASD should be made cautiously (Fig. 15). However, in the presence of increased curvature of the right atrial cardiac border due to right atrial enlargement, intracardiac shunts should be suspected in addition to pulmonary arterial hypertension and tricuspid valve abnormalities.

**CONCLUSION**

Various cardiac abnormalities can be identified incidentally on MDCT images of the thorax and abdomen. Hence, it is important to review the cardiac findings, and if present, mention this in the radiology report, as some of these findings could be relevant to the patient’s presenting complaints. With greater awareness and by using a systemic approach to assess the heart in CT imaging of the thorax and abdomen, radiologists would be better able to identify cardiac lesions on non-ECG-gated MDCT images.

**ACKNOWLEDGEMENT**

We would like to acknowledge Dr Lee Yeong Shyan, Consultant Radiologist from Tan Tock Seng Hospital, Singapore for his kind permission to utilise Fig. 2a.

**REFERENCES**


Multiple Choice Questions (Code SMJ 201112B)

Question 1. The following are CT features of cardiac tamponade:
(a) Dilatation of the vena cavae.  
(b) Reflux of contrast into the inferior vena cava.  
(c) Right atrial dilatation.  
(d) Large pericardial effusion.

Question 2. The following are CT features of myocardial infarction:
(a) Subendocardial fatty replacement.  
(b) Early contrast enhancement.  
(c) Myocardial thinning.  
(d) Myocardial calcification.

Question 3. The following are characteristics of true left ventricular aneurysms:
(a) They are commonly located at the left ventricular apex.  
(b) They can be complicated by thrombus formation.  
(c) The cause is that of transmural myocardial infarction.  
(d) Prompt surgical intervention is required.

Question 4. Cardiac valvular calcification is associated with:
(a) Rheumatic fever.  
(b) Previous endocarditis.  
(c) Malignancy.  
(d) Congenital malformations.

Question 5. The following are characteristics of constrictive pericarditis:
(a) Pericardial calcification is pathognomonic for constrictive pericarditis.  
(b) Constrictive pericarditis is rarely secondary to radiotherapy.  
(c) Constrictive pericarditis is associated with a thickened pericardium.  
(d) Uraemia is a cause of constrictive pericarditis.

Doctor's particulars:
Name in full: ________________________________  
MCR number: ________________________________ Specialty: ________________________________  
Email address: ________________________________

SUBMISSION INSTRUCTIONS:
1. Log on at the SMJ website: http://www.sma.org.sg/cme/smj and select the appropriate set of questions.  
2. Select your answers and provide your name, email address and MCR number. Click on "Submit answers" to submit.

RESULTS:
1. Answers will be published in the SMJ February 2012 issue.  
2. The MCR numbers of successful candidates will be posted online at www.sma.org.sg/cme/smj by 13 January 2012.  
3. All online submissions will receive an automatic email acknowledgment.  
4. Passing mark is 60%. No mark will be deducted for incorrect answers.  
5. The SMJ editorial office will submit the list of successful candidates to the Singapore Medical Council.  
6. One CME point is awarded for successful candidates.

Deadline for submission: (December 2011 SMJ3B CME programme): 12 noon, 06 January 2012.