the detection of ischaemia than stress echo, this usually comes at the expense of reduced specificity.

An exciting new tool that has recently become clinically available is 64 slice/s cardiac CT. This new modality has the potential to become, in the near future, the method of choice in evaluating patients with chest pain at an intermediate risk, lack of ischaemic ECG changes, and negative Troponin. Already, at this early time, the comparison of the results with what is considered today as the true ‘gold standard’ for the assessment of coronary lumen, intravascular ultrasound, is favourable.8,9 There is, of course, a long way to go and we need to learn to overcome the pitfalls of this modality, in particular in patients with significant calcification and in those after stent(s) implantation. The issue of cost has also yet to be resolved, according to each country’s local specific economical environment. In the time being, based on the current study as well as previous ones, stress echo appears to be a simple and very useful initial non-invasive modality to assess patients with chest pain at an intermediate risk score. Clearly not ideal, perhaps even not best, but rather good indeed.

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References

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Evaluation of constrictive pericarditis by 64-slice multi-detector computed tomography

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A 71-year-old gentleman presented with a history of progressive right-sided heart failure. On 64-slice multi-detector computed tomography (MDCT), the patient was found to have a markedly thickened and calcified pericardium, with a maximal pericardial thickness of 14 mm over the inferior right and left ventricular surfaces (Panels A and B). Cine MDCT reconstructions demonstrated a conical-shaped deformity of both ventricles, enlargement of both atria, and an abnormal diastolic bounce of the interventricular septum consistent with constrictive pericarditis (Movie 1). Surgical pericardectomy was performed, during which bulging of the right ventricle through a resected portion of the pericardium was noted (Panel C). Pathological analysis of the resected pericardium found a thickened, calcified pericardium consistent with idiopathic constrictive pericarditis.

Supplementary movie is available at European Heart Journal online.

Panel A. Four-chamber MDCT image of the heart demonstrates marked thickening and calcification of the pericardium, which is most noticeable over the right ventricle (arrows). Note the abnormal conical deformity of the ventricles.

Panel B. Short-axis MDCT image of the heart. Note the fibrotic, thickened pericardium over the inferior border of both ventricles (arrows), as well as the extensive calcification of the pericardium over the right ventricle (arrow heads) and, to a lesser extent, the left ventricle.

Panel C. During surgical pericardectomy, the heart was found to be encased by a grossly thickened and calcified pericardium. Dissection of a portion of the pericardium over the right ventricle allowed the right ventricular free wall to bulge through the resected area (arrow).

Movie 1. Four-chamber cine CT reconstruction demonstrates the typical conical deformity of the ventricles, enlargement of the atria, a subtle bounce of the interventricular septum during diastole, and restraint of ventricular motion in diastole.