Imaging cardiac fat

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Ectopic fat deposition has been associated with lipotoxicity and derangement in local and systemic metabolism, insulin resistance, cardiac dysfunction, atherosclerosis, local, and systemic inflammation. The mechanisms and potentially detrimental effects of such an accumulation should be fully investigated in order to establish preventive strategies. The aim of this review is to provide an overview of current knowledge regarding imaging techniques to measure cardiac fat deposition and its potential clinical relevance, if any.

Keywords
Pericardial fat • Imaging biomarkers • Cardiovascular risk • Echocardiography

Introduction

Risk profiling remains a challenge in clinical cardiology. There is a need to define individual vs. population risk assessment obtained with conventional risk factors. Cardiac fat may play a role in this setting once its multifaceted action as an endocrine organ is thoroughly established and investigated. Nowadays, cardiac fat can be imaged with several modalities offering a quantitative assessment. However, when, how and why to measure cardiac fat remains a challenging clinical question that should be addressed in properly designed studies. Imaging techniques can play a role, not only as surrogate biomarkers, but also to assess cardiac fat modulation with therapeutic interventions.

Methods for quantification of cardiac fat

There is no consensus regarding the upper limit of normality for cardiac fat, either epicardial adipose tissue (EAT) or pericardial adipose tissue (PAT), and the reported volumes are highly variable among different patient populations, with some reporting a range of 4–52% of the total heart mass at autopsy and no significant change with age, whereas others document a trend towards an increase or decrease in the amount of tissue found in older patients. Ultrasound, cardiac tomography (CT), and cardiac magnetic resonance (CMR) have been used to quantify cardiac fat. Currently, there is no consensus on the ‘gold standard’ for an in vivo quantification of EAT and PAT.

Echocardiography

Ultrasound is the most widely available technique for estimating the amount of cardiac fat; it is also the fastest and the least expensive. However, echocardiography cannot directly quantify the volume of cardiac fat, although it has been shown to be correlated with volume assessed at CMR. Moreover, it is sometimes difficult to distinguish between EAT and PAT by echocardiography and it is likely that in many instances, PAT rather than EAT thickness is reported. In fact, ultrasound tends to overestimate the EAT volume and to underestimate the PAT volume when compared with MRI. This indicates that pericardial and epicardial fat in echocardiography can be lumped together, given the fact that the pericardium itself and its borders cannot always be clearly visualized. To standardize ultrasound measurements, Iacobellis and Willens proposed measuring EAT in the parasternal long-axis view at end-systole, placing the caliper at the level of the free wall of the right ventricle and averaging the measurement during three cardiac cycles, and in the mid-ventricular parasternal short-axis view on the right ventricular free wall along the mid-line of the ultrasound beam perpendicular to the interventricular septum at mid-chordal and tip of the papillary muscle level.

Cardiac tomography

CT provides a true volumetric visualization and quantification of EAT and PAT. In comparison with other imaging modalities, however, CT may provide a more accurate evaluation of fat tissue due to its higher spatial resolution compared with ultrasound and MRI.

CT offers the advantages of submillimeter collimation, high temporal and spatial resolution, and 3D views of the heart and its epicardial surface. Based on the reconstructed cross-sectional images, or preferably volumetric measurements can be performed. Hence, EAT and PAT can be separately quantified in CT images. Fox et al. proposed the following methodology:
the heart is imaged on average with 48 contiguous 2.5 mm slices with a prospectively ECG-triggered scanning protocol. There is no need to use contrast to assess pericardial fat. The method uses a pre-processing step to remove all other structures apart from the heart, using a region growing segmentation strategy. Then, an experienced user is required to scroll through the slices between upper and lower heart limit and, if the pericardium is visible, he is required to place from 5 to 7 control points. Catmull-Rom cubic spline functions are then automatically generated to obtain a smooth closed pericardial contour. Identification of the fat inside the contour is finally achieved by thresholding. The total thoracic fat volume included adipose tissue located in the pericardium and in the thorax from the level of the right pulmonary artery to the diaphragm and the chest wall to the descending aorta (Figure 2).

Magnetic resonance

For MRI acquisition of the heart a standardized protocol is used. Cardiac coil and ECG triggering is used for the sequences; during the acquisition time, patients are in breath-hold (10–12 s). Cardiac adipose tissue scans are obtained by fast-spin echo T1-weighted sequences with oblique axial orientation, for a correct study of horizontal long axes of the heart, in diastole (TE 42 ms; Echo Train Length 23; Bandwidth 62.50; slice thickness 8 mm; slice gap 0 mm; FOV 38 cm; matrix 288 × 224; Phase FOV 0.75; NEX 1; Trigger delay = minimum mm-thick section with 0 mm intersection gap, field of view, and a 256 × 256 matrix). Epicardial fat is defined as any adipose tissue located within the pericardial sac (Figure 3). The analysis of fat volumes is often manual and time-consuming. Images are also acquired in the short-axis view that covers the heart from the apex of the ventricles to the top of the atria. For each slice, area is quantified and volume is calculated by multiplying each area by the thickness, i.e. 8 mm, with no gap between images. Weight of cardiac fat can be obtained by multiplying the volume (cm³) by 0.92, which corresponds to cardiac fat density in gram per kilogram. We have recently demonstrated that fat volume is highly correlated with the fat area (r² = 0.87, P < 0.0001) measured in a four-chamber view, the average fat area was 2656 mm²; the average fat volume was 234 cm³, corresponding to the total cardiac fat mass of 215 g (EAT + PAT). This was confirmed in an animal-based model that studied MRI images of cardiac fat and found a strongly positive correlation with an ex vivo pericardial adipose mass at necropsy, validating it as an adequate technique for measuring fatty tissue around the heart. Unfortunately, due to the technical difficulty entailed in dissecting EAT from the myocardium, this observation could only be made on total pericardial fatty tissue and not on each one of its components as a different compartment.

Association of cardiac fat with cardiovascular risk factors

A growing body of evidence shows that epicardial fat may play a relevant role as a biomarker for cardiovascular risk assessment. PAT and EAT amounts increase with the body mass index (BMI) and decrease after weight loss and lifestyle interventions. PAT and EAT are strongly correlated to each other, while the correlation with intra-abdominal visceral adipose tissue (VAT), waist circumference, and BMI is greater for PAT than...
EAT. It has been shown that fat accumulation is proportional to the degree of obesity, with body fat ranging from 14 to 33 kg, visceral fat from 0.8 to 1.8 kg and cardiac fat from 134 to 236 g. In male subjects with primary untreated hypertension, blood pressure increased proportionally to the amount of visceral and total cardiac fat, while epicardial and subcutaneous fat were similar to that of healthy subjects. Nelson et al. found a weak correlation between the Framingham risk score and EAT thickness at echo.

Multiple metabolic risk factors, such as blood pressure, low-density lipoprotein cholesterol, glucose, and high-density lipoprotein cholesterol, were found to be associated with PAT in a subgroup of patients from the Framingham Heart study. Regarding classic anthropometric measures, both PAT and EAT measured with echo have been found to correlate with waist circumference and visceral adiposity. In a recent study of obese men, following an exercise training programme [(12 weeks) 60–70% of the maximal heart rate; 60 min/day, 3 days/week], epicardial fat thickness significantly decreased.

**Association of cardiac fat with other imaging biomarkers of cardiovascular disease**

A significant positive correlation was observed between pericardial fat and carotid intima media thickness (CCA-IMT). In an unadjusted sex-specific linear regression analysis, there was a significant association between pericardial fat and CCA-IMT in both women and men, an association that persisted after further adjusting for age and ethnicity. In the general population, pericardial fat is associated with carotid IMT, an association that may not be independent from markers of overall adiposity or common atherosclerosis risk factors. Pericardial fat measured by computed tomography assessed in 5770 participants in the MESA study was correlated with carotid distensibility; higher pericardial fat is associated with higher carotid stiffness, independent of traditional cardiovascular disease (CVD) risk factors and obesity. Epicardial fat tissue thickness is correlated negatively with flow mediated dilation and positively with age, diastolic blood pressure, hsCRP, fibrinogen, HOMA-IR, and lipid parameters. Multiple regression analyses showed epicardial fat tissue thickness to be an independent factor influencing endothelial function in patients with metabolic syndrome.

**Correlation with severity and outcome of cardiovascular disease**

Several studies have linked cardiac fat accumulation to the presence and severity of coronary artery disease (CAD).

The MESA study was able to determine an association between PAT and CAD after correcting for known risk factors in a community-based population with a prospective study design. It
also found a positive correlation between PAT and waist circumference; however, there was no association with the BMI. Others have also measured pericoronary fat when measuring EAT, and there is evidence that, in patients with the BMI <27, the two measurements correlate well with the extent of CAD and calcium score.

Sade et al. studied microvascular dysfunction in women with angina and normal coronary arteries, and documented PAT to be an independent predictor with a cut-off value of >0.45 cm, whereas traditional risk factors were not predictive of microvascular dysfunction.

In a study of obese and non-obese Japanese men, pericardial fat measured by CT scan was a significant variable for the presence of CAD and its severity based on coronary angiography; it also correlated well with age, triglycerides, and systolic blood pressure in non-obese patients. Tonbul et al. studied a patient population with end-stage renal disease (ESRD) and found a statistically significant relationship between the EAT and CAC score in ESRD patients, which was even higher in diabetic than in non-diabetic ESRD patients.

Using a cardiac 64 multi-slice CT protocol, Harada et al. described significantly larger EAT volumes in patients with acute coronary syndrome (ACS) than those with normal coronary arteries. PAT has also been documented to correlate well with multiple measures of metabolic risk factors and CAC in a community-based setting when measured with CT even after adjusting for several possible confounders. When indexed by the body surface area, the EAT volume was a strong independent determinant of the presence of total coronary occlusions and was associated with advanced age, male sex, degree of metabolic alterations, atheromatosis, and the history of ACS. EAT thickness over the free right ventricle wall measured using transthoracic echo has also been positively correlated with CAD severity and was found to independently predict significant coronary artery stenosis.

In a sample of 1000 subjects in the Framingham Heart Study undergoing contemporaneous CMR and CT examinations, the pericardial fat volume was associated with LV mass, LVEDV, and LA size in women and with the LV mass and the LA size in men. These associations persist after multivariable adjustment but not after accounting for body weight or VAT, with the exception of the LA size in men. These findings do not suggest that pericardial fat is a better correlate of cardiac structure and function than VAT or other more easily conducted anthropometric measures of adiposity. Based on these results, it is likely that systemic effects of generalized adiposity may overwhelm the local effects of pericardial fat. From the Framingham Heart Study Offspring cohort,

Figure 3 CMR image: the four-chamber view of the heart of a subject with high total cardiac fat. Adipose tissue surrounding the entire heart can be visualized and measured to achieve a complete assessment of epicardial, pericardial, and intra-thoracic fat.
abdominal and chest multidetector computed tomography to quantify volumes of pericardial fat, intra-thoracic fat, and VAT was performed. The analysis of 1267 participants demonstrated that pericardial fat and VAT, but not intra-thoracic fat, were significantly associated with prevalent CVD in age/sex-adjusted models and after adjustment for the BMI and waist circumference. After multivariable adjustment, associations were attenuated. Only pericardial fat was associated with prevalent myocardial infarction after adjusting for conventional measures of adiposity. Iozzo et al. showed that CAD is accompanied by augmented fat deposits surrounding the heart, which are negatively related to coronary flow hyperaemia. Among fat deposits, intra-pericardial fat was the only independent predictor of the hyperaemic myocardial blood flow, supporting the hypothesis of a direct paracrine/vasocrine effect. Janik et al. investigated the association between EAT and myocardial perfusion and showed that EAT volume assessed by CT was an independent predictor of ischaemia on PET, and outperformed CAC score in a CAD naive population at intermediate pre-test probability of disease. Similar results were obtained with SPECT, showing that pericardial fat was significantly correlated with myocardial ischaemia in patients without known CAD.

A few studies showing the impact on the progression of CAD and outcome are available. In a series of 375 consecutive asymptomatic subjects with an intermediate risk of developing CAD, who underwent serial non-contrast CT at least 3–5 years apart, epicardial fat volume increase ≥15% and hypertension were independent predictors of the number of new calcified plaques on follow-up.

In a dual-cohort study, the upper threshold of the epicardial fat volume from non-contrast-enhanced cardiac computed tomography in a healthy population was obtained and applied in a separate population assessed for major adverse cardiovascular events. The epicardial fat volume exceeding the newly defined upper normal threshold (median, range, and 25 and 75th percentiles of the non-normally distributed EFV indexed on the body surface normal threshold (median, range, and 25 and 75th percentiles of the newly defined upper normal limit of EFVi) was significantly and independently associated with prevalent myocardial infarction after multivariable adjustment, associations were attenuated. Only pericardial fat as an imaging biomarker is still in the promising phase of the health technology assessment pathway and more studies are needed for it to become an established imaging biomarker. Unfortunately, available evidence was not built in appropriately designed studies to assess the role of cardiac fat and most of the information that we have is a surrogate one coming from studies aimed at assessing other risk factors.

### Conclusions

There is still a long way to go before obtaining a complete description of how cardiac fat in all its components affects the myocardium and the coronary arteries, and what can be done to modulate its mechanical, metabolic, and endocrine activities in different clinical contexts. However, current literature appears to support this link, and future uses for this fatty tissue depot are already being postulated from an experimental standpoint. Cardiac fat appears to be an endocrine organ able to modulate cardiomyocyte and vascular function due to its proximity to these structures. Its potential clinical uses range from risk profiling in metabolic- and CVDs to outcome and follow-up studies and the assessment of therapeutic interventions through pharmacological and dietary modulation. Moreover, it is important to understand the relationship of cardiac fat and all its components with the distribution of visceral fat to other organs and vascular districts. Of the available imaging techniques, if one were to be used as a large-scale screening method, the most likely candidate would be cardiac fat thickness measured by echo given its affordability, availability, and shorter testing time. Areas of uncertainty to be covered are standardization of measurement, fat depot to be measured, site of fat accumulation, function, and altered conditions. The use of epicardial fat as an imaging biomarker is still in the promising phase of the health technology assessment pathway and more studies are needed for it to become an established imaging biomarker. Unfortunately, available evidence was not built in appropriately designed studies to assess the role of cardiac fat and most of the information that we have is a surrogate one coming from studies aimed at assessing other risk factors.

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### References


