A computed method for noninvasive MRI assessment of pulmonary arterial hypertension

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A VARIETY OF MEDICAL IMAGING methods have been proposed to noninvasively assess pulmonary arterial pressure (Ppa) values (3, 7–9, 17, 18, 20, 21). Among these, our laboratory (15) has recently proposed an MRI method based on the ratio of the pressure wave velocity to U max has been compared with the mean pressure value. The present method enables the noninvasive assessment of mean pulmonary arterial pressure wave velocity over the main mean pulmonary arterial pressure (Ppa Cat) in each patient. A significant correlation was found between the systolic and diastolic pressures in the same patient series. We conclude that this computed method, which combines physical and biophysical parameters, improves the accuracy of MRI to noninvasively estimate pulmonary arterial pressures.

pulmonary arterial hypertension; magnetic resonance phase mapping; computing; pulmonary arterial blood pressures

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Therefore, the present proposed method only involves $U_{\text{max}}$ and $S_{\text{max}}$. The principle of the method is based on an expression of Ppa as a combination of powers of $U_{\text{max}}$ and $S_{\text{max}}$. These combinations are determined by computing. Furthermore, the method also allows us to take into account biophysical parameters in a manner similar to that proposed by Du Bois and Du Bois (4) for the calculation of body surface area. When applied to the present issue, this manner is equivalent to normalize $U_{\text{max}}$ (Un) and $S_{\text{max}}$ (Sn):

$$\text{Un} = U_{\text{max}}^a \cdot \text{height}^b \cdot \text{weight}^c \cdot \text{HR}^d$$

$$\text{Sn} = S_{\text{max}}^a \cdot \text{height}^b \cdot \text{weight}^c \cdot \text{HR}^d$$

where HR is heart rate (10). Consequently, according to this normalization, the aim of the work was to compute polynomial series of Un and Sn.

**MATERIALS AND METHODS**

The procedures used in the present work have been described previously (14, 15).

*Patients.* MRI and right-side heart catheterization were performed in 31 patients, 14 women and 17 men, aged 24–83 yr (mean 63 yr). Right-side heart catheterization was performed for the following indications: lung transplantation ($n = 4$), primary PAH ($n = 5$), secondary PAH due to chronic thromboembolic disease ($n = 4$), cardiac valvular disease ($n = 7$), and myocardial disease ($n = 11$). The investigation conforms with the principles outlined in the Declaration of Helsinki. An institutional ethics committee approved the study, and informed consent was obtained for both the right catheterization and MRI, after the nature of the procedures had been explained. The time interval between the two techniques was usually 2 days, but anyway <1 wk. Patients’ height, weight, and heart rate ranged between 1.80 and 1.50 m, 113 and 54 kg, and 100 and 56 beats/min (mean 1.67 m, 77 kg, 77.5 beats/min), respectively. The catheterization provided the values of the $P_{\text{sys}}$, $P_{\text{dias}}$, and mean $P_{\text{pa}}$ in catheterization (Ppa Cat) vs. Ppa obtained by computing, respectively. The Bland and Altman method was used to compare the mean and maximal absolute differences between $P_{\text{sys}}$, $P_{\text{dias}}$, and Ppa obtained from catheterization and computing, respectively, were also calculated.

$P_{\text{paComp}}$ measurement uncertainty related to uncertainty ($\epsilon$) in any parameter used in the calculation (e.g., $U_{\text{max}}$, $S_{\text{max}}$, patient weight, height, or heart rate) was assessed by considering the mean absolute difference $P_{\text{paComp}} - P_{\text{paComp}}(\pm \epsilon)$, from the whole patient series.

**RESULTS**

Among the different tested combinations of parameters, the selected computed result for $P_{\text{paComp}}$ was as follows:

$$P_{\text{paComp}} = p_1(\text{Un}) + p_2(\text{Sn})$$

with

$$p_1(\text{Un}) = -0.0017 y^2 + 1.1534 y - 2.6239$$

and

$$y = 114.90 \text{ Un}^{-3} - 526.45 \text{ Un}^{-2} + 801.41 \text{ Un}^{-1} - 381.98$$

and

$$p_2(\text{Sn}) = 0.0104 z^2 + 0.9650 z - 0.0977$$

and

$$z = -0.0556 v^2 + 1.3475 v + 0.6691$$

and

$$v = 5 \times 10^{-12} \text{ Sn}^2 - 2 \times 10^{-6} \text{ Sn} - 2.33$$

$$\text{Un} = U_{\text{max}}^{0.50} \times \text{height}^{0.83} \times \text{weight}^{-0.30} \times \text{HR}^{0.14}$$

$$\text{Sn} = S_{\text{max}}^{1.50} \times \text{height}^{-4.30} \times \text{weight}^{2.30} \times \text{HR}^{0.60}$$

where $U_{\text{max}}$, $S_{\text{max}}$, height, weight, and HR are expressed in cm/s, cm$^2$, m, kg, and beats/min, respectively.

![Fig. 1. Phase-mapping sequence applied in 1 volunteer perpendicularly to the pulmonary artery axis. The magnitude (top) and the coupled-phase image (bottom) allowed us to measure variations in vessel cross-sectional area and blood flow velocity, respectively, with a 30-ms resolution time.](http://jap.physiology.org/Content\.....)}
The plot $P_{pa\, Cat}$ vs. $P_{pa\, Comp}$ is presented in Fig. 2. Equation of the linear regression was the identity line, i.e., $P_{pa\, Cat} = P_{pa\, Comp}$ ($r = 0.92$). The comparison between the two parameters by means of the Bland and Altman method leads to the following: $P_{pa\, Cat} - P_{pa\, Comp} = 0 \pm 2.37$ mmHg (95% reliability; graph not shown). When $P_{pa\, Comp}$ was calculated by using only $p_1$ (Un) or a computed polynomial series of $U_{max}$, the correlation coefficient of the linear regression was then 0.90 and 0.85, respectively (graphs not shown). We also examined the role of patient age as a possible fourth biophysical parameter after the normalization was done with patient height, weight, and heart rate and found that it did not improve the correlation coefficient. It should also be noted that no significant correlation was found between $P_{pa\, Cat}$ and patient’s height ($r = 0.15$), weight ($r = 0.13$), or heart rate ($r < 0.01$).

Intra- and interobserver variability for $U_{max}$ and $S_{max}$ are presented in Figs. 3, A and B, and 4, A and B, respectively. The range of values were 16.68–98.95 and 16.97–99.70 cm/s for $U_{max}$ and 3.74–13.17 and 3.80–13.26 cm$^2$ for $S_{max}$, respectively. This variability was not significantly different one from the other. In contrast, significant differences were found in the $S_{max}$ intra- and interobserver variability: the mean differences and 95% reliability domains were $-0.17 \pm 0.16$ and $-0.22 \pm 0.10$ cm$^2$, respectively (graphs not shown). The standard deviation of intra- and interobserver variability was 1.93 and 2.07 cm/s for $U_{max}$ and 0.48 and 0.38 cm$^2$ for $S_{max}$, respectively. Therefore, when $U_{max}$ and $S_{max}$ measurement uncertainties were taken equal to 1 SD from the intraobserver variability, $P_{pa\, Comp}$ uncertainty was found equal to 3.6 and 0.6 mmHg, respectively. Measurement uncertainty for patients’ height, weight, and heart rate was estimated to be 1 cm, 1 kg, and 10% of the patient heart rate value, respectively, leading to $P_{pa\, Comp}$ uncertainty equal to 0.6, 0.4, and 1.6 mmHg, respectively. The sum of all of the uncertainty was then equal to 6.8 mmHg. In addition, the $P_{pa\, Cat}$ measurement uncertainty was estimated to be 1 mmHg. These values should be compared with the mean and maximal absolute differences between $P_{pa\, Cat}$ and $P_{pa\, Comp}$, 5.4 and 11.9 mmHg, respectively.

The plots of the $P_{\text{dias}}$ and $P_{\text{sys}}$ measured by catheterization ($P_{\text{dias\, Cat}}$ and $P_{\text{sys\, Cat}}$, respectively) vs. that assessed from computing ($P_{\text{dias\, Comp}}$ and $P_{\text{sys\, Comp}}$, respectively) are presented in Fig. 5. The equation of the linear regression was again that of the identity line: $P_{\text{dias\, Cat}} = P_{\text{dias\, Comp}}$ ($r = 0.93$) and $P_{\text{sys\, Cat}} = P_{\text{sys\, Comp}}$ ($r = 0.86$), respectively. The mean and maximal absolute differences between $P_{\text{dias\, Cat}}$ and $P_{\text{dias\, Comp}}$ were 3.6 and 9.2 mmHg, respectively. The mean and maximal absolute differences between $P_{\text{sys\, Cat}}$ and $P_{\text{sys\, Comp}}$ were 10.6 and 28.7 mmHg, respectively.

**DISCUSSION**

The present study indicates that estimation of the mean blood pressure in the MPA using noninvasive MRI measurements of the maximal systolic blood velocity and vessel CSA
can be more accurate than previously reported (15). A first improvement is to select relevant physical parameters, with low intra- and interobserver variability (Eq. 1, Figs. 3 and 4) and to take into account biophysical parameters that may play a role in the pressure estimation. A second improvement is 1) to compute the best normalization of the physical parameters by means of the biophysical ones, in a manner similar to that used for body surface area calculations (4), and 2) to select the combination of polynomial series of the normalized physical parameters leading to the best correlation with the pressure value given by invasive right-side catheterization. Using this method in a series of 31 patients, over a wide range of pressure values, we found mean and maximal absolute differences in Ppa between values given by catheterization and the computation equal to 5.4 and 11.9 mmHg, respectively.

The present method is a development of the former one (15), which estimated maximal and minimal Ppa values to frame the actual Ppa value. The comparison with right-side catheterization showed that PpaCat was framed by the two values in 13 of 15 patients of the series (87% reliability). Moreover, the difference between the framing values ranged between 9 and 52 mmHg for the patient series. The present MRI method should also be compared with ultrasound methods. Stevenson (21) compared several echographic methods against catheterization in a selected pediatric series (50 patients), under nearly ideal circumstances and with an experienced physician. The best correlation coefficient and mean absolute difference between pressure estimates and values from catheterization for Ppa, P dias, and P sys were $r = 0.94$ and 7.7 mmHg, $r = 0.96$ and 4.5 mmHg, and $r = 0.97$ and 5.4 mmHg, respectively. However, it should be noted that 1) the best echographic method used in each of the above-mentioned assessment was successful in 98, 98, and 89% of patients, respectively; 2) the regression was not the identity line; and 3) in the particular case of Ppa assessment, the maximal difference between the estimate and the value from catheterization was 27 mmHg. Nevertheless these figures can be compared with ours: $r = 0.92$ and 5.4 mmHg (maximal difference = 11.9 mmHg), $r = 0.93$ and 3.6 mmHg.
mmHg, and \( r = 0.86 \) and 10.6 mmHg for Ppa, \( p_{\text{dias}} \), and \( P_{\text{sys}} \), respectively. In agreement with Stevenson’s work, we suggest that the availability of a variety of noninvasive methods to assess pulmonary pressure is of value and that these different methods should be considered complementary rather than competitive. A much larger study than the present one is, however, warranted to compare these MRI and ultrasound methods in adults.

An important limitation of the previous method was the broad variability of \( S_{\text{min}} \) measurements (Eq. 1), leading, now only, to the consideration of \( U_{\text{max}} \) and \( S_{\text{max}} \) as relevant physical parameters. The relative intra- and interobserver variability of \( U_{\text{max}} \) and \( S_{\text{max}} \) was found to be 0.8 and 1.5 and 0.4% and 1.8%, on average, respectively (Figs. 3 and 4, respectively). We previously observed (15) that the value of the vessel CSA is not significantly correlated with Ppa. The present study has confirmed this finding, because the contribution of \( U_{\text{max}} \) in the Ppa estimation was much greater than that of \( S_{\text{max}} \). This is supported by the high-correlation coefficient calculated when \( p_1 \) (Un) or a computed polynomial series of \( U_{\text{max}} \) is used to estimate Ppa, \( r = 0.90 \) and \( r = 0.85 \), respectively, compared with \( r = 0.92 \) when both Un and Sn are used. This also explains why Ppa measurement uncertainty is mainly related to that of \( U_{\text{max}} \), 6.8 and 3.6 mmHg, respectively. We suggest that the following hypothesis might explain the relevance of \( U_{\text{max}} \) to the assessment of Ppa: when pulmonary vascular resistance increases, Ppa also increases to maintain the pulmonary blood flow, but the greater the pulmonary vascular resistance, the less efficient this adaptation. Hence, under these conditions, the blood flow tends to diminish. This assumption is coherent with the strongly nonlinear relationship between \( 1/U_{\text{max}} \) and Ppa and the secondary role of the vessel CSA in the assessment.

Further improvement in the present method may be expected. First, the reliability of each physical parameter could benefit from forthcoming improvement in imaging, such as motion-adapted cine phase-contrast images (12) and use of an automatic delineation of the vessel (11, 13). Second, the principle of the method allows us to introduce additional parameters, both physical and biophysical, to improve its accuracy. Indeed, although the contribution to the final pressure estimate of such additional parameters may be relatively less and less important, they can, nevertheless, improve its accuracy. For example, if \( S_{\text{min}} \) measurement becomes more reliable due to improvement in imaging (see above), it will be possible to compute further combinations of polynomial series of \( U_{\text{max}} \), \( S_{\text{max}} \), and \( S_{\text{min}} \) (or \( \Delta S \) as well; Eq. 3). Also, it has been shown that respiratory motion produces periodic variations in the mean Ppa (6). Therefore, respiratory frequency could be introduced in the physical parameter normalization as an additional biophysical parameter along with patient height, weight, and heart rate (Eqs. 4 and 5). However, introduction of this parameter obviously requires a specific recording. Alternatively, lowering the image acquisition time could be considered to perform measurements within a breath hold, as done for pressure measurements during catheterization. Finally, it should be kept in mind that some phenomena occurring in Ppa assessment are difficult to avoid or measure. In particular, in patients with primary pulmonary hypertension, pulmonary vasomotor waves induce rhythmic oscillations in pulmonary arterial blood pressure (6). Also, the influence of the sedative prescription before the right-side catheterization that has been shown to be efficient (21) is difficult to assess.

We have also tested the method by the additional computed estimation of \( p_{\text{dias}} \) and \( P_{\text{sys}} \) in the same series of patients. The correlation coefficient for \( p_{\text{max}} \) \( (r = 0.93) \) was higher than that for \( P_{\text{sys}} \) assessment \( (r = 0.86) \) and close to that for Ppa assessment \( (r = 0.92) \).

In conclusion, we suggest that the present noninvasive method, with a mean and maximal absolute uncertainty of 5.4 and 11.9 mmHg, respectively, could be helpful to screen patients to decide whether the catheterization should be performed and for the follow-up of hemodynamic changes associated with medical therapies, such as long-term vasodilator treatment in patients with PAH (2, 5).

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