Diagnostic Value of Echocardiography Combined with Residual Cholesterol for Asymptomatic Myocardial Ischaemia in Coronary Artery Disease

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ABSTRACT
This study aimed to investigate the diagnostic value of combined echocardiography and residual cholesterol in asymptomatic myocardial ischaemia. One hundred and fifty-seven patients were seen at Hefei BOE Hospital from 2019 to 2022. The patients were divided into two groups, the observation group (n=90, confirmed asymptomatic myocardial ischaemia) and the control group (n=67, negative diagnosis), based on coronary angiography. The observation group had significantly higher residual cholesterol levels (p=0.001). A combined approach of echocardiography and serum residual cholesterol values showed statistically higher accuracy (p<0.05), with ROC curve analysis supporting the superiority of this method [AUC 0.788 (0.711-0.865), Yoden index 0.576]. It also demonstrated higher sensitivity (88.9%) and specificity (68.7%). The study concluded that combined echocardiography and serum residual cholesterol testing offer superior diagnostic efficacy and practicality for asymptomatic myocardial ischaemia, recommending it for the clinical use.

Key Words: Echocardiography, Residual cholesterol, Asymptomatic myocardial ischaemia, Diagnosis.

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This study assessed 157 patients (100 males, 57 females, average age 59.64 ± 7.19 years) suspected of this condition at Hefei BOE Hospital. Coronary angiography confirmed 90 cases forming the observation group, with the remaining 67 as controls.

Morning fasting venous blood was collected and analysed for biochemical parameters, including triglycerides, total cholesterol, HDL-C, and LDL-C levels. Residual cholesterol referred to the amount of cholesterol within the body that is aside from LDL-C and HDL-C. This encompasses elements such as triglycerides and intermediate-density lipoprotein cholesterol (IDL-C). Echocardiography was performed to assess heart structure and function, specifically focusing on abnormal ventricular wall motion. A residual cholesterol threshold of >0.51 mmol/L and presence of abnormal wall motion served as the two diagnostic criteria. In a combined diagnosis, a positive diagnosis was made if either of the two tests produced a positive result indicating the presence of myocardial ischaemia.

The comparison of the general conditions of the two groups showed that there were no statistical differences in age, gender composition, history of hypertension, history of smoking, history of diabetes, BMI level, TC, LDL-C, and HDL-C levels; the TG levels in the observation group were higher than those in the control group, and the differences were statistically significant (p<0.05). Comparison of residual cholesterol levels in the observation group and control group showed that the observation group had significantly higher levels (1.12 ± 0.91 mmol/L vs. 0.66±0.36 mmol/L), a difference that was statistically significant (t=3.895, p=0.001).
Table I: Positive predictive value and accuracy of three testing methods for asymptomatic myocardial ischaemia, n (%).

<table>
<thead>
<tr>
<th>Testing Method</th>
<th>Gold Standard</th>
<th>Positive Predictive Value</th>
<th>Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Observation Group (n=90)</td>
<td>Control Group (n=67)</td>
<td></td>
</tr>
<tr>
<td>Echocardiography</td>
<td>Positive</td>
<td>61/83 (73.49)</td>
<td>106/157 (67.52)</td>
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<tr>
<td></td>
<td>Negative</td>
<td>29/45 (64.29)</td>
<td>98/157 (62.42)</td>
</tr>
<tr>
<td>Residual cholesterol</td>
<td>Positive</td>
<td>54/77 (70.13)</td>
<td>98/157 (62.42)</td>
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<tr>
<td></td>
<td>Negative</td>
<td>36/44 (81.82)</td>
<td>126/157 (80.25)</td>
</tr>
<tr>
<td>Combined detection method</td>
<td>Positive</td>
<td>80/101 (79.21)</td>
<td>126/157 (80.25)</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>10/46 (21.74)</td>
<td>126/157 (80.25)</td>
</tr>
</tbody>
</table>

χ² 2.001  p 0.368

Figure 1: ROC curves of the predictive value of three testing methods for asymptomatic myocardial ischaemia.

When comparing the accuracy of the three testing methods, the combined detection method showed more accuracy than either echocardiography or residual cholesterol testing alone. The difference was statistically significant (p < 0.05, Table I).

![ROC curves](image)

The ROC curves for the diagnosis of asymptomatic myocardial ischaemia by the 3 methods were constructed separately, in which the area under the curve (AUC) value for the diagnosis of asymptomatic myocardial ischaemia using residual cholesterol alone was 0.628 (95% CI: 0.540-0.717, p=0.006, Yorden index = 0.257, sensitivity = 60.0%, specificity = 65.7%). Similar values for asymptomatic myocardial ischaemia using echocardiography alone were 0.680, 0.595-0.766, <0.001, 0.350, 67.8%, and 67.2%, respectively. The combined predictive efficacy of these two methods was found to be the highest: the AUC value was 0.788 (with a 95% CI of 0.711, AUC=0.865, p=0.001), the Youden index was 0.576, the sensitivity was 88.9%, and the specificity was 68.7% (Figure 1).

Residual cholesterol is a hot topic of research in recent years in relation to coronary atherosclerotic heart disease, calculated from total cholesterol, HDL-C and LDL-C in serum, which can be obtained during the routine examination of patients and is easy to operate. Previous studies had shown that every 1 mmol/L increase in residual cholesterol levels was associated with a 2.8-fold increase in the risk of ischaemic heart disease.³ Langsted et al. confirmed the association of high levels of residual cholesterol with major cardiovascular and cerebrovascular events in a cohort study of 109,574 patients recruited from the Copenhagen General Population Study (CGPS).⁶

In a precedent controlled study with 12,563 participants, a subset analysis revealed a notable relationship between residual cholesterol ≥0.51 mmol/L and coronary heart disease (OR=1.952, 95% CI=1.276-2.988, p=0.002).⁴ Adopting the same cut-off in the present study, residual cholesterol above 0.51 mmol/L accurately predicted asymptomatic myocardial ischaemia (AUC=0.628), affirming the prognostic potential of residual cholesterol for coronary atherosclerotic disease. Its inclusion in routine clinical diagnostics warrants further exploration. When combined with echocardiography, residual cholesterol yielded a significantly improved AUC of 0.788, highlighting its superior sensitivity and specificity compared to stand-alone testing.

This study, being a unicentric, retrospective analysis with a non-randomised sample, posed limitations to the generalisability of the results. Residual cholesterol, calculated from multiple data points and not-yet-a-routine clinical measures, may involve potential error. Furthermore, interactions between residual cholesterol and variables like age, sex, blood pressure, and diabetes are not fully clarified, warranting further investigation. In conclusion, combining echocardiography and residual cholesterol testing can enhance the diagnosis of asymptomatic myocardial ischaemia, demonstrating high sensitivity and specificity. Its implementability due to ease of use and accessibility makes it beneficial in clinical settings.

ETHICAL APPROVAL:
This study was approved by the Ethics Committee of the Hebei BOE Hospital, China.

COMPETING INTEREST:
The authors declared no competing interest.

AUTHORS’ CONTRIBUTION:
FL: Disease diagnosis, statistical analysis, and manuscript writing.
XH: Research design and writing.
QL: Disease diagnosis, personnel coordination, and case follow-up.
All authors approved the final version of the manuscript.

REFERENCES


