RESEARCH ARTICLE

Coronary Computed Tomography Angiography Based Assessment of Endothelial Shear Stress and Its Association with Atherosclerotic Plaque Distribution In-Vivo

Holger Hetterich¹*, Ahmad Jaber², Moritz Gehring², Adrian Curta², Fabian Bamberg¹, Nenad Filipovic³, Johannes Rieber⁴

¹ Institute of Clinical Radiology, Ludwig-Maximilians-University Hospital, Munich, Germany, ² Department of Cardiology, Ludwig-Maximilians-University Hospital, Munich, Germany, ³ Faculty of Mechanical Engineering, University of Kragujevac, Kragujevac, Serbia, ⁴ Department of Cardiology and Intensive Care Medicine, Heart Center Munich-Bogenhausen, Munich, Germany

* Holger.Hetterich@med.uni-muenchen.de

Abstract

Purpose

The relationship between low endothelial shear stress (ESS) and coronary atherosclerosis is well established. ESS assessment so far depended on invasive procedures. The aim of this study was to demonstrate the relationship between ESS and coronary atherosclerosis by using non-invasive coronary computed tomography angiography (CTA) for computational fluid dynamics (CFD) simulations.

Methods

A total number of 7 consecutive patients with suspected coronary artery disease who received CTA and invasive angiography with IVUS analysis were included in this study. CTA examinations were performed using a dual-source scanner. These datasets were used to build a 3D mesh model. CFD calculations were performed using a validated CFD solver. The presence of plaque was assumed if the thickness of the intima-media complex exceeded 0.3 mm in IVUS. Plaque composition was derived by IVUS radiofrequency data analysis.

Results

Plaque was present in 32.1% of all analyzed cross-sections. Plaque prevalence was highest in areas of low ESS (49.6%) and high ESS (34.8%). In parts exposed to intermediate-low and intermediate-high ESS few plaques were found (20.0% and 24.0%) (p<0.001). Wall thickness was closely associated with local ESS. Intima-media thickness was 0.43±0.34mm in low and 0.38±0.32mm in high ESS segments. It was significantly lower
when the arterial wall was exposed to intermediate ESS (0.25±0.18mm and 0.28 ± 0.20mm) (p<0.001). Fibrofatty tissue was predominately found in areas exposed to low ESS (p≤0.023).

Conclusions
In this study a close association of atherosclerotic plaque distribution and ESS pattern could be demonstrated in vivo. Adding CFD analysis to coronary CTA offers the possibility to gather morphologic and physiologic data within one non-invasive examination.

Introduction
The localization of coronary atherosclerotic lesions is not randomly distributed but shows a characteristic pattern with preferred locations at branches or bends [1]. The complex geometry of the vessel causes a distortion of the laminar flow up to local flow stagnation or reversal. This results in locally different levels of endothelial shear stress (ESS). Especially low ESS has been linked with the initiation and progression of atherosclerosis [2–4].

Shear stress is difficult to measure directly in vivo. Using computational fluid dynamics (CFD) ESS and other flow dependent parameters can be calculated if an accurate description of the vessel geometry is available. In the coronary circulation most CFD studies so far relied on invasive procedures such as invasive angiography and intravascular ultrasound (IVUS), limiting the results to high risk patients with indication for cardiac catheterization [5–7].

Besides these invasive techniques, 3-dimensional (3D) models can today be obtained by non-invasive coronary computed tomography angiography (CTA). Several studies showed that CTA models are accurate and can be used for CFD calculations [8–10]. However, so far ESS pattern calculated based on CTA models has not been linked to atherosclerotic plaque distribution in patients in vivo.

The aim of this study was to calculate ESS based on the vessel geometry as obtained by CTA and compare these findings with the distribution and composition of coronary atherosclerotic plaques as assessed by IVUS and radiofrequency data analysis (RF) in patients without prior known coronary artery disease.

Methods
Study design and overview
This project was designed as a prospective in-vivo feasibility study. The protocol was approved by the ethics committee of the Ludwig-Maximilians University and written informed consent was obtained from all patients before entering the study. The study complies with the declaration of Helsinki of 1975, as revised in 2008. Consecutive patients underwent CTA and IVUS evaluation. CTA models were used for ESS calculations, IVUS data for plaque assessment only. Both were matched using multiple anatomical landmarks and the association of ESS level and plaque distribution was assessed.

Patients
Patients underwent coronary CTA if they had symptoms suggestive for coronary artery disease with a low to intermediate likelihood and stress testing was not possible or the results of stress testing were not conclusive or uninterpretable [11]. Patients with acute chest pain, recent acute
coronary syndromes, known coronary artery disease, impaired renal function (glomerular filtration rate <60 ml/min) allergy to contrast media, active cancer or a live expectancy of less than one year were not included in this study. If significant coronary artery disease could not be excluded by CTA, patients received coronary angiography and IVUS evaluation. Vessels with significant stenosis of more than 30% by quantitative coronary angiography were not included in the analysis.

**Coronary CTA**

The CTA examinations were performed on a dual source CT scanner (Somatom Definition, Siemens AG, Healthcare Sector, Forchheim, Germany) with the following parameters: gantry rotation time 0.33 s, temporal resolution 83 msec, pitch adapted to heart rate (0.2–0.43), tube voltage 120 kV, tube current 560 mA with electrocardiogram (ECG) triggered tube current modulation. All patients received 0.8 mg nitroglycerine sublingually 2 minutes before the scan. The contrast agent (Ultravist 370, Schering AG, Berlin, Germany) was continuously injected in the right or left antecubital vein at a volume and flow rate adapted to the patient’s body weight followed by a flush of 50 ml normal saline solution using an 18 gauge venous catheter. In a region of interest in the ascending aorta bolus tracking was performed and data acquisition was automatically started 4 sec after attenuation reached 100 Hounsfield units. CT data sets were retrospectively reconstructed at 20%, 40% and 80% of the R-R interval obtained by ECG with a slice thickness of 0.75 mm and an increment of 0.5 mm using a medium soft-tissue convolution kernel (B26f). The phase with the best image quality and the least motion artifacts was used for further processing.

**Invasive coronary angiography and IVUS**

The ostia of the coronary arteries were cannulated via femoral approach using standard Judkins technique. To achieve maximum dilatation of the coronary arteries 0.25 mg of nitroglycerin were injected intracoronarily. Angiographic images from different standardized angles were obtained to achieve an optimal visualization of the vessel without shortening or overlapping. Subsequently a guidewire was introduced into the vessel and the IVUS probe was advanced. The studies were performed using a commercially available imaging system (Si, Volcano Corp., Rancho Cordova, CA, USA), which allows ECG gated data acquisition. The ultrasound probe (Eagle Eye Gold, Volcano Corp., Rancho Cordova, CA, USA) had a diameter of 2.9 F. Using a carrier frequency of 20 MHz a penetration depth of about 8 mm can be achieved. The axial resolution is 80 μm, the lateral resolution 200 μm. Data for both grayscale IVUS and RF data were simultaneously acquired during a standardized motorized pullback at a speed of 0.5 mm/sec.

**Data processing**

**Geometric reconstruction**

The axial CTA data sets were digitally processed to extract the geometric contours of the coronary arteries. A software prototype (Siemens AG, Healthcare Sector, Forchheim, Germany) was used for semiautomatic segmentation and meshing of the vessel surface with triangles. This model was imported into an open-source software package (MeshLab V1.11). Structures other than the examined vessel were removed. Sidebranches were cut at a distance at least two vessel diameters apart from the bifurcation. The resulting surface mesh model was further processed in a commercially available software tool (Gambit 2.4.6, Ansys Inc., Southpointe, PA, USA). In a first step the previous mesh was removed and replaced by a triangular surface mesh with smaller element size. Inflow and outflow areas were defined. Subsequently an adaptive 3D
computational mesh was built consisting of 300,000 to 400,000 polyhedral elements for the entire model. One model per vessel was reconstructed. This model was further used for blood flow simulations (Fig. 1).

**Model assumptions and boundary conditions**

Blood flow was assumed to be constant with a velocity of 0.17 m/sec at the coronary ostium, 3D, incompressible and laminar, based on the low Reynolds number of about 300 for small vessels [12,13]. Blood was defined as Newtonian fluid with a dynamic viscosity of 3.7 mPas and a density of 1060 kg/m$^3$. Vessel walls were defined as solid, stiff and stationary. A no slip condition was used at the boundaries of the vessel wall.

**Computational fluid dynamics**

The Navier-Stokes equations for the individual elements were solved using the finite element method (Fluent 12.0.16, Ansys In., Southpointe, PA, USA). Calculations were performed until the solution fully converged. The results were displayed as a 3D model of the vessel with color coded ESS (Fig. 2). The elements on the surface mesh were divided into quartiles corresponding to different levels of ESS and representing 25% of the mesh surface area (quartile 1 = lowest ESS, quartile 2 = intermediate low ESS, quartile 3 = intermediate high ESS, quartile 4 = highest ESS). Models of the vessel surface for each quartile were reconstructed and exported for analysis (Fig. 3).

**CTA and IVUS matching**

The position of the IVUS probe was determined at the beginning and the end of the motorized pullback by fluoroscopy. Anatomic landmarks which could be detected by both CTA and...
IVUS were identified, including side branches, the left main coronary artery and atherosclerotic lesions with characteristic features such as calcifications, pronounced eccentric wall thickening or luminal narrowing. Based on the known pullback speed this information was used for manual correlation of the IVUS images and the 3D coronary model obtained by CTA.

**IVUS measurements**

The thickness of the intima-media complex as defined by the lumen border and the signal intense outer elastic lamina was measured in grayscale IVUS images using a dedicated software package (Medical Imaging Assistant, Version 4.2.10C, INDEC BioSystems Inc., Santa Clara, CA, USA). In each ESS quartile, measurements of intima-media thickness were obtained at 25 randomly selected points, resulting in 100 measurements per vessel. The measurements were performed by two experienced investigators who were blinded to the CFD results to avoid bias. To include early atherosclerotic changes the presence of plaque was assumed if the thickness of intima-media complex exceeded 0.3 mm (Fig. 3) [14].

**RF data plaque analysis**

Data on plaque composition were derived from IVUS RF data analysis (Virtual Histology, VH) using the S5i system (Volcano Corp., Rancho Cordova, CA, USA). For vessel wall definition the lumen-vessel border as well as external elastic membrane were automatically detected and

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**Figure 2. Color encoded illustration of endothelial shear stress (ESS) on a 3D model of a right coronary artery obtained by coronary computed tomography angiography.** After segmentation side branches were cut 1–2 cm from the branching point. The volume mesh consisted of about 400,000 polyhedral cells. The Navier-Stokes equations were solved by the finite element method. The level of ESS increases from blue to red as shown in the color map on the left.

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manually corrected in each selected cross-section. For each cross-section the relative amount of fibrofatty tissue, fibrous tissue, necrotic core and dense calcium is calculated by the software (Fig. 4) [15].

Statistical analysis
All numerical data are presented as mean ± standard deviation. A chi-square test was used for the comparison of plaque presence in the different quartiles. For the comparison of wall thickness and plaque composition an analysis of variance and post hoc Duncan’s multiple range tests were performed. To account for the clustered nature of the data a general estimation equation was applied. The level of significance was set at p<0.05. A commercially available software tool (SPSS Statistics 17.0, SPSS Inc., Chicago, IL, USA) was used for statistical analysis.

Results
Patients
Of the 14 patients who underwent coronary CTA, 7 (50%) had an indication for cardiac catheterization based on CTA findings and current guidelines [16]. IVUS was attempted in 18 of 21 (86%) vessels and was successfully performed in 14 of 21 (67%) arteries. The quality of coronary CTA was sufficient in 18 of 21 (86%) vessels but only 12 of 21 (57%) could be successfully segmented and meshed. In the remaining 6 of 21 (29%) arteries calcifications (3 vessels), strong enhancement of an adjacent coronary vein (1 vessel) or weak enhancement of major side branches (2 vessels) precluded adequate segmentation of the vessel lumen. Based on quantitative coronary angiography, no stenosis with > 30% luminal obstruction was detected. Hence a
total number of 10 vessels (1 right coronary artery, 5 left anterior descending arteries and 4 left circumflex arteries) from 7 patients (4 male) with matching coronary CTA and IVUS examinations were available for analysis. Patient characteristics are shown in Table 1.

**Endothelial shear stress**

Based on the previously defined conditions the mean ESS in the 10 vessels was $1.66 \pm 0.84$ Pa (range of $0.02–13.75$ Pa). The highest levels of ESS were observed at the inner side of proximal bifurcations whereas the lowest ESS occurred at the inner curvature of angulated segments. There was no significant difference in the average ESS between proximal and distal vessel segments ($1.70 \pm 1.51$ Pa, 95% CI 1.49–1.86 Pa vs. $1.62 \pm 0.53$, 95% CI 1.43–1.79 Pa, $p = 0.18$). However, there was a wider distribution of ESS values in the proximal than in the distal parts of the vessel (range $0.02–13.75$ Pa vs. $0.11–6.67$ Pa). Since the inflow velocity was set as a constant, there was no significant relation between the mean value of ESS and the respective vessel diameter observed. For all vessels the average ESS in quartile 1 was $0.73 \pm 0.30$ Pa (range $0.02–1.08$ Pa), in quartile 2 $1.44 \pm 0.71$ Pa (range $1.09–1.67$ Pa), in quartile 3 $2.13 \pm 1.03$ Pa (range $1.68–2.75$ Pa) and in quartile 4 $3.80 \pm 2.7$ Pa (range $2.76–13.75$ Pa).

**Wall thickness**

The average wall thickness for all vessels was $0.34 \pm 0.28$ mm (range $0.07–2.20$ mm). Wall thickness was higher in the proximal than in the distal parts of the vessel ($0.46 \pm 0.32$ mm, 95% CI $0.38–0.61$ mm vs. $0.28 \pm 0.14$ mm, 95% CI $0.18–0.32$ mm, $p < 0.001$). In areas where no plaque was present the average wall thickness was $0.21 \pm 0.07$ mm (range $0.07–0.30$ mm, 95% CI $0.20–0.22$ mm). In segments where plaque was found the average wall thickness was $0.69 \pm 0.39$ mm (range $0.31–2.20$ mm, 95% CI $0.62–0.75$ mm) ($p < 0.001$).
Plaque prevalence and composition

In total plaque was present in 321 (32.1%) of all measurements with very few calcified regions as defined by CTA (6 of 321 (1.8%)). IVUS RF data analysis for plaque composition was successful in 260 of 321 (81.0%) of all plaque cross-sections. In the remaining 61 (19%) cross-sections the software was not able to analyze tissue components due to very small plaque area. In total 56.3\% of plaque tissue consisted of fibrous, 24.7\% of fibro-fatty, 11.9\% of necrotic and 7.1\% of calcified tissue (all p < 0.012).

Association of ESS and wall thickness

The arterial wall was thickest in areas of low ESS (quartile 1) followed by areas of high ESS (quartile 4) (p < 0.001). In segments exposed to intermediate ESS (quartile 2 and 3) the wall was significantly thinner (p < 0.001). Average wall thickness in the different quartiles and 95% CI are shown in Table 2.

### Table 2. Wall thickness.

| Quartile | Mean Wall Thickness ± SD (mm) | Minimum (mm) | Maximum (mm) | 95% Confidence Interval (mm) |
|----------|-------------------------------|--------------|--------------|-------------------------------|
| 1        | 0.43 ± 0.34                   | 0.07         | 2.08         | 0.39–0.47                      |
| 2        | 0.25 ± 0.18                   | 0.01         | 1.30         | 0.23–0.27                      |
| 3        | 0.28 ± 0.20                   | 0.06         | 1.73         | 0.26–0.31                      |
| 4        | 0.38 ± 0.32                   | 0.06         | 2.20         | 0.32–0.35                      |

Mean wall thickness was highest in quartile 1 (low endothelial shear stress (ESS)) and lowest in quartiles 2 and 3 (intermediate ESS). Vessel wall thickness in quartile 4 (high ESS) was in between. Differences were not significant between quartile 2 and 3 (p = 0.15). All other differences were statistically significant (p < 0.001).

SD: standard deviation

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Association of ESS and plaque prevalence

Most of plaques were found in quartile 1 (124 of 321, 38.6%) followed by quartile 4 (87 of 321, 27.1%). In the second quartile 50 of 321 (15.6%) and in the third quartile 60 of 321 (18.7%) plaques were found. Atherosclerotic plaque prevalence is shown in Table 3. In short there was a significantly higher prevalence of plaques in areas with very low or very high ESS as compared to intermediate levels of ESS (p < 0.001). Also there were more plaques in areas of low than high ESS (p < 0.001).

Association of ESS and plaque composition

We observed a higher relative amount of fibrofatty tissue in regions exposed to the lowest level of ESS (p < 0.023). There was no significant difference in fibrous, necrotic, and calcified tissue among different ESS levels (all p < 0.061) as shown in Fig. 4.

Discussion

This pilot study shows that CFD calculations based on 3D models of coronary arteries obtained by non-invasive CTA are feasible and can demonstrate an association between ESS distribution and atherosclerotic plaque pattern in patients without prior known coronary artery disease.

In concordance with earlier experimental series we observed a high number of atherosclerotic lesions, increased wall thickness and higher amount of fibrofatty tissue in areas exposed to low ESS [6,7,17]. The pathophysiologic role of low ESS for the genesis of atherosclerosis has been extensively studied. Low ESS reduces the availability of nitric oxide and increases the production of endothelin leading to endothelial dysfunction [18–20]. Furthermore low ESS fosters the uptake of low-density lipoprotein-cholesterol, activation of apoptotic activity in endothelial cells and upregulation of adhesion molecules for inflammatory cells [21–23]. Increased wall thickness and high amount of fibrofatty tissue are characteristics of these early plaque formations [24,25]. After their initiation, the natural history of early fibroatheromas also depends on the level of ESS. High risk vulnerable plaques tend to occur in areas with the lowest values of ESS [17,26]. In the present study few lesions were found in segments with intermediate ESS. However, we found a high number of atherosclerotic lesions also in areas exposed to high ESS. Although in the past high ESS was considered the driving force for the development of atherosclerosis, it is today confirmed that plaques preferentially develop in regions of low ESS [17,27]. Nevertheless, large atheromas can cause obstruction of the vessel lumen. In segments with even mild luminal narrowing blood flow velocity can increase and ESS rises subsequently [28]. To minimize this effect, vessels with a significant lesion (> 30% by quantitative coronary angiography) have been excluded. We were unable to detect differences in the relative amount

Table 3. Plaque prevalence.

| Quartile | No plaque (n, %) | Plaque (n, %) |
|----------|----------------|--------------|
| 1        | 126 (50.4)     | 124 (49.6)   |
| 2        | 200 (80.0)     | 50 (20.0)    |
| 3        | 190 (76.0)     | 60 (24.0)    |
| 4        | 163 (65.2)     | 87 (34.8)    |

There was a significantly higher prevalence of atherosclerotic plaques in areas of very low (quartile 1) and very high (quartile 2) endothelial shear stress (ESS) as compared to areas of intermediate ESS (quartile 2 and 3) (p < 0.001). Furthermore plaque prevalence was higher in quartile 1 compared to quartile 4 (p < 0.001). Differences between quartile 2 and 3 were not significant (p = 0.56).

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of fibrous, necrotic and calcified tissue in areas exposed to low, intermediate or high levels of shear stress. Given the large standard deviations, the present study might be underpowered to detect these differences. This is especially true for the rather small amounts of calcifications and necrotic tissue that we found in this low risk population, which are typical features of advanced plaque types [29].

The importance of low ESS has recently been underscored by the PREDICTION study. In patients suffering from acute coronary syndrome low ESS was an independent predictor for progressive plaque enlargement and luminal narrowing despite good medical therapy for risk factor reduction [5]. This and other studies used techniques for ESS assessment that depend on invasive procedures like conventional angiography and IVUS, which are adequate in a high risk population [5,6,28]. However, invasive procedures are not adequate in low risk populations. Therefore these patients often undergo coronary CTA as part of the work-up for suspected coronary artery disease.

Data on ESS analysis based on non-invasive coronary CTA models is currently limited [8,9]. A recent study by Katranas et al. demonstrated an association of low ESS and expansive plaque remodeling [30]. In our study we found a relationship between ESS and plaque prevalence, wall thickness as well as plaque composition adding to the body of evidence for the feasibility of CTA derived ESS analysis. Furthermore our study confirms the association of low ESS and atherosclerotic plaque in a low to intermediate risk population without a history of coronary artery disease. Invasive angiography and IVUS examinations were not used for CFD analysis but were only performed for accurate plaque assessment, which allowed evaluation of even very early plaque stages. One major drawback of ESS assessment with coronary CTA without additional invasive procedures is its limited spatial resolution which would prevent detection of subtle atherosclerotic changes. However, in a natural-history study of atherosclerosis most lesions that caused subsequent cardiovascular events had a high plaque burden of about 70% and a small luminal area [31], features which can also be appreciated in coronary CTA [32,33]. If large, soft plaques are detected on coronary CTA, ESS analysis might allow for a better prediction of progression or subsequent events, a thesis which needs to be tested in further trials. Furthermore the use of CTA might facilitate the analysis of the relationship of high risk plaque features and ESS in large patient cohorts.

The absolute values for ESS were comparable to other studies [6,7,13,17]. Nevertheless absolute values of ESS highly depend on the lumen of the 3D vessel reconstruction and the boundary conditions of the CFD model. Automated or semi-automated vessel segmentation may affect the absolute dimensions of the vessel. Lumen area and diameter may be increased or decreased by segmentation procedures subsequently leading to lower or higher absolute numbers of ESS. A higher in-flow velocity in the CFD model results in higher absolute ESS values, whereas the pattern of ESS distribution remains similar over a broad range of inflow velocities. Therefore we did not use absolute but relative ESS values to analyze the association between ESS and atherosclerosis.

This study only shows the correlation between ESS and atherosclerotic plaque at one point in time. Therefore we cannot prove that ESS as calculated by our approach is the driving force behind the atherosclerotic wall changes, as suggested in other studies [5,6]. Serial examinations are necessary to address this question.

Limitations
Several limitations apply to this study. The study size was rather small with a total number of 7 patients and 10 vessels. Calcifications were the most important cause for inaccurate vessel segmentation precluding adequate CFD analysis in three arteries with diagnostic image quality.
Advanced segmentation algorithms will have to be implemented to reduce artefacts caused by calcified plaque and to allow CTA based CFD analysis in patient with extensive calcifications. Since this is an in-vivo study, we were unable to obtain histology data for the analysis of plaque composition but had to rely on IVUS RF data. For the flow simulations we made several simplifications. First of all, blood flow is not constant but changes during the cardiac cycle. Second, we assumed stiff, none moving vessel walls although the vessel is expanding and contracting and is bent while the heart is beating. It can be speculated that a more sophisticated model would find a closer correlation between ESS and atherosclerotic lesions. However, the same simplifications have been made in other studies by different workgroups [5,34,35]. Furthermore, calculations using pulsatile blood flow and deformable meshes require higher computational power and are more time consuming, which might hamper the practical implementation of this technique. Results of ESS calculations based on CTA were not validated against invasive ESS measurements. However, we are not aware of an approved system that allows a direct measurement of ESS in patients in-vivo. The correlation between IVUS and CTA was done manually which probably resulted in some inaccuracy, especially with regard to the rotational orientation of the IVUS images. Co-registration of IVUS and angiography and automated correlation with CTA could help to facilitate this procedure. Moreover, we did not use a patient specific flow profile but a constant, standardized flow, which could result in some inaccuracies for the ESS values compared to the real situation in-vivo. Nevertheless relative ESS quartiles were used to assess the association of ESS and atherosclerosis pattern to reduce the effect of absolute differences in ESS calculations.

Conclusion

Coronary CTA is an established tool for the non-invasive assessment of coronary morphology. As we were able to demonstrate, CFD analysis based on coronary CTA offers the possibility to gather also information about coronary physiology and functional data non-invasively within one examination. Further studies will evaluate whether ESS analysis based on CTA models can add significant information about plaque composition, progression and risk prediction, which might influence therapeutic decisions. Since coronary CTA is already available in most cardiac centers the potential future implementation of CFD would not depend on new costly hardware development but could be achieved by adding dedicated software packages to common CT-scanners.

Author Contributions

Conceived and designed the experiments: HH FB NF JR. Performed the experiments: HH AJ MG AC JR. Analyzed the data: HH AJ MG AC JR. Contributed reagents/materials/analysis tools: HH NF JR. Wrote the paper: HH AJ MG AC FB NF JR.

References

1. Krams R, Wentzel JJ, Oomen JA, Vinke R, Schuurbiers JC, et al. (1997) Evaluation of endothelial shear stress and 3D geometry as factors determining the development of atherosclerosis and remodeling in human coronary arteries in vivo. Combining 3D reconstruction from angiography and IVUS (ANGUS) with computational fluid dynamics. Arterioscler Thromb Vasc Biol 17: 2061–2065. doi: 10.1161/01.ATV.17.10.2061 PMID: 9351372

2. Gimbrone MA Jr (1999) Endothelial dysfunction, hemodynamic forces, and atherosclerosis. Thromb Haemost 82: 722–726. PMID: 10605774

3. Malek AM, Alper SL, Izumo S (1999) Hemodynamic shear stress and its role in atherosclerosis. JAMA 282: 2035–2042. doi: 10.1001/jama.282.21.2035 PMID: 10591386

4. Frangos SG, Gahtan V, Sumpio B (1999) Localization of atherosclerosis: role of hemodynamics. Arch Surg 134: 1142–1149. doi: 10.1001/archsurg.134.10.1142 PMID: 10522862
5. Stone PH, Saito S, Takahashi S, Makita Y, Nakamura S, et al. (2012) Prediction of progression of coronary artery disease and clinical outcomes using vascular profiling of endothelial shear stress and arterial plaque characteristics: the PREDICTION Study. Circulation 126: 172–181. doi: 10.1161/CIRCULATIONAHA.112.096438 PMID: 2272305

6. Stone PH, Coskun AU, Kinlay S, Popma JJ, Sonka M, et al. (2007) Regions of low endothelial shear stress are the sites where coronary plaque progresses and vascular remodelling occurs in humans: an in vivo serial study. Eur Heart J 28: 705–710. doi: 10.1093/eurheartj/ehl575 PMID: 17347172

7. Stone PH, Coskun AU, Kinlay S, Clark ME, Sonka M, et al. (2003) Effect of endothelial shear stress on the progression of coronary artery disease, vascular remodelling, and in-stent restenosis in humans: in vivo 6-month follow-up study. Circulation 108: 438–444. doi: 10.1161/01.CIR.0000080882.35274.AD PMID: 12860915

8. Frauenfelder T, Boutsianis E, Schertler T, Husmann L, Leschka S, et al. (2007) In-vivo flow simulation in coronary arteries based on computed tomography datasets: feasibility and initial results. Eur Radiol 17: 1291–1300. doi: 10.1007/s00330-006-0465-1 PMID: 17061068

9. Frauenfelder T, Boutsianis E, Schertler T, Husmann L, Leschka S, et al. (2007) Flow and wall shear stress in end-to-side and side-to-side anastomosis of venous coronary artery bypass grafts. Biomed Eng Online 6: 35. doi: 10.1186/1475-925X-6-35 PMID: 17897460

10. Goubergrits L, Kertzscher U, Schoneberg B, Wellnhofer E, Petz C, et al. (2008) CFD analysis in an anatomically realistic coronary artery model based on non-invasive 3D imaging: comparison of magnetic resonance imaging with computed tomography. Int J Cardiovasc Imaging 24: 411–421. doi: 10.1007/s10554-007-9275-z PMID: 17955344

11. Taylor AJ, Cerqueira M, Hodgson JM, Mark D, Min J, et al. (2010) ACCF/SCCT/ACR/AHA/ASE/ASNC/NASCI/SCAI/SCMR 2010 appropriate use criteria for cardiac computed tomography. A report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, the Society of Cardiovascular Computed Tomography, the American College of Radiology, the American Heart Association, the American Society of Echocardiography, the American Society of Nuclear Cardiology, the North American Society for Cardiovascular Imaging, the Society for Cardiovascular Angiography and Interventions, and the Society for Cardiovascular Magnetic Resonance. J Am Coll Cardiol 56: 1864–1894. doi: 10.1016/j.jacc.2010.07.005 PMID: 21087721

12. Santamaria A, Weydahl E, Siegel JM Jr, Moore JE Jr (1998) Computational analysis of flow in a curved tube model of the coronary arteries: effects of time-varying curvature. Ann Biomed Eng 26: 944–954. doi: 10.1114/1.113 PMID: 9846933

13. Wellnhofer E, Goubergrits L, Kertzscher U, Affeld K (2006) In-vivo coronary flow profiling based on biplane angiograms: influence of geometric simplifications on the three-dimensional reconstruction and wall shear stress calculation. Biomed Eng Online 5: 39. doi: 10.1186/1475-925X-5-39 PMID: 16774680

14. Nissen SE, Gruley JC, Grines CL, Booth DC, McClure R, et al. (1991) Intravascular ultrasound assessment of lumen size and wall morphology in normal subjects and patients with coronary artery disease. Circulation 84: 1087–1099. doi: 10.1161/01.CIR.84.3.1087 PMID: 1884441

15. Garcia-Garcia HM, Mintz GS, Lerman A, Vince DG, Margolis MP, et al. (2009) Tissue characterisation using intravascular radiofrequency data analysis: recommendations for acquisition, analysis, interpretation and reporting. EuroIntervention 5: 177–189. doi: 10.4244/EIJV5I2A29 PMID: 20449928

16. Taylor AJ, Cerqueira M, Hodgson JM, Mark D, Min J, et al. (2010) ACCF/SCCT/ACR/AHA/ASE/ASNC/NASCI/SCAI/SCMR 2010 Appropriate Use Criteria for Cardiac Computed Tomography. A Report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, the Society of Cardiovascular Computed Tomography, the American College of Radiology, the American Heart Association, the American Society of Echocardiography, the American Society of Nuclear Cardiology, the North American Society for Cardiovascular Imaging, the Society for Cardiovascular Angiography and Interventions, and the Society for Cardiovascular Magnetic Resonance. Circulation 122: e525–e555. doi: 10.1161/CIR.0b013e3181fcae66 PMID: 22723305

17. Chatzizisis YS, Jonas M, Coskun AU, Beigel R, Stone BV, et al. (2008) Prediction of the localization of high-risk coronary atherosclerotic plaques on the basis of low endothelial shear stress: an intravascular ultrasound and histopathology natural history study. Circulation 117: 993–1002. doi: 10.1161/CIRCULATIONAHA.107.695254 PMID: 18250270

18. Ziegler T, Bouzourene VJ, Harrison VJ, Brunner HR, Hayoz D (1998) Influence of oscillatory and unidirectional flow environments on the expression of endothelin and nitric oxide synthase in cultured endothelial cells. Arterioscler Thromb Vasc Biol 18: 686–692. doi: 10.1161/01.ATV.18.5.686 PMID: 9598825

19. Cheng C, van Haperen R, de Waard M, van Damme LC, Tempel D, et al. (2005) Shear stress affects the intracellular distribution of eNOS: direct demonstration by a novel in vivo technique. Blood 106: 3691–3698. doi: 10.1182/blood-2005-06-2326 PMID: 16105973
20. Gambillara V, Chambaz C, Montorzi G, Roy S, Stergiopulos N, et al. (2006) Plaque-prone hemodynamics impair endothelial function in pig carotid arteries. Am J Physiol Heart Circ Physiol 290: H2320–2328. doi:10.1152/ajpheart.00486.2005 PMID: 16415081

21. Tricot O, Mallat Z, Heymes C, Belmin J, Lesche G, et al. (2000) Relation between endothelial cell apoptosis and blood flow direction in human atherosclerotic plaques. Circulation 101: 2450–2453. doi:10.1161/01.CIR.101.21.2450 PMID: 10831515

22. Liu Y, Chen BP, Lu M, Zhu Y, Stermerman MB, et al. (2002) Shear stress activation of SREBP1 in endothelial cells is mediated by integrins. Arterioscler Thromb Vasc Biol 22: 76–81. doi: 10.1161/hq1012.101822 PMID: 11788464

23. Cheng C, Tempel D, van Haperen R, de Boer HC, Segers D, et al. (2007) Shear stress-induced changes in atherosclerotic plaque composition are modulated by chemokines. J Clin Invest 117: 616–626. doi: 10.1172/JCI28180 PMID: 17304353

24. Stary HC (2000) Natural history and histological classification of atherosclerotic lesions: an update. Arterioscler Thromb Vasc Biol 20: 1177–1178. doi:10.1161/01.ATV.20.5.1177 PMID: 10807728

25. Stary HC, Chandler AB, Glagov S, Guyton JR, Insull W Jr, et al. (1994) A definition of initial, fatty streak, and intermediate lesions of atherosclerosis. A report from the Committee on Vascular Lesions of the Council on Arteriosclerosis, American Heart Association. Circulation 89: 2462–2478. doi:10.1161/01.CIR.89.5.2462 PMID: 7648691

26. Chatzizisis YS, Coskun AU, Jonas M, Edelman ER, Stone PH, et al. (2007) Risk stratification of individual coronary lesions using local endothelial shear stress: a new paradigm for managing coronary artery disease. Curr Opin Cardiol 22: 552–564. doi:10.1097/HCO.0b013e3282f07548 PMID: 17921744

27. Caro CG (2009) Discovery of the role of wall shear in atherosclerosis. Arterioscler Thromb Vasc Biol 29: 158–161. doi: 10.1161/ATVBAHA.108.166736 PMID: 19038849

28. Wentzel JJ, Janssen E, Vos J, Schuurbiers JC, Krams R, et al. (2003) Extension of increased atherosclerotic wall thickness into high shear stress regions is associated with loss of compensatory remodeling. Circulation 108: 17–23. doi:10.1161/01.CIR.0000078637.21322.D3 PMID: 12821552

29. Stary HC, Chandler AB, Dinsmore RE, Fuster V, Glagov S, et al. (1995) A definition of advanced types of atherosclerotic lesions and a histological classification of atherosclerosis. A report from the Committee on Vascular Lesions of the Council on Arteriosclerosis, American Heart Association. Circulation 92: 1355–1374. doi:10.1161/01.CIR.92.5.1355 PMID: 7648691

30. Katranas SA, Kelekis AL, Antoniadis AP, Chatzizisis YS, Giannoglou GD (2014) Association of remodeling with endothelial shear stress, plaque elasticity, and volume in coronary arteries: a pilot coronary computed tomography angiography study. Angiology 65: 413–419. doi: 10.1177/0003319713483543 PMID: 23567480

31. Stone GW, Maehara A, Lansky AJ, de Bruyne B, Cristea E, et al. (2011) A prospective natural-history study of coronary atherosclerosis. N Engl J Med 364: 226–235. doi:10.1056/NEJMoa1002358 PMID: 21247313

32. Leber AW, Becker A, Knez A, von Ziegler F, Sirol M, et al. (2006) Accuracy of 64-slice computed tomography to classify and quantify plaque volumes in the proximal coronary system: a comparative study using intravascular ultrasound. J Am Coll Cardiol 47: 672–677. doi:10.1016/j.jacc.2005.10.056 PMID: 16458154

33. Johnson TR, Nikolaou K, Busch S, Leber AW, Becker A, et al. (2007) Diagnostic accuracy of dual-source computed tomography in the diagnosis of coronary artery disease. Invest Radiol 42: 684–691. doi:10.1097/RLI.0b013e318069076d PMID: 17884765

34. Politis AK, Stavropoulos GP, Christolis MN, Panagopoulos FG, Vlachos NS, et al. (2007) Numerical modeling of simulated blood flow in idealized composite arterial coronary grafts: steady state simulations. J Biomech 40: 1125–1136. doi: 10.1016/j.jbiomech.2006.05.006 PMID: 16828103

35. Goubergrits L, Wellinhofer E, Kertzsch U, Affeld K, Petz C, et al. (2009) Coronary artery WSS profiling using a geometry reconstruction based on biplane angiography. Ann Biomed Eng 37: 682–691. doi: 10.1007/s10439-009-9656-7 PMID: 19229618