
Using double dose Tl-201 myocardial scintigraphy (DMSC), we reported previously that the increase of blood flow distribution (BFD) in exercise to whole myocardium was less in the patients with ischemic heart disease (IHD) than in control subjects. This time, we studied BFD in exercise not only to whole but to regional myocardium, and compared with the findings in coronary angiography. In the patients with more than 75% coronary stenosis, scintigraphy and computer analysis was performed with administration of two Tl doses each at the submaximal peak of exercise and control state. The rate of change in BFD was calculated from the ratio of Tl dosage and of the radioactivity in myocardium. The increase of BFD to whole myocardium was less in multi vessel disease than in single vessel disease, and regionally this increase was less in the perfused by stenotic artery than in normal area. And the change in regional BFD was well visualized in the subtraction image. No significant correlation was shown between the rate of change in regional BFD and the number of stenotic vessels. Thus, coronary blood flow reserve is smaller in multi vessel disease, and regionally in the area perfused by stenotic coronary artery. We concluded that the severity of IHD can be evaluated quantitatively from the rate of change in BFD to whole and regional myocardium, and besides the regional change can be visualized in the subtraction image.


The degree of myocardial ischemia due to Kawasaki disease was evaluated by Tl-201 myocardial scintigraphy at rest and with administration of dipyridamole. The material included 131 patients with a history of Kawasaki disease whose coronary arterial lesions had been confirmed by selective coronary arteriography (SAG) and was divided into three groups on the findings of SAG: 40 cases with obstruction, 29 cases with localized stenosis and 62 cases with aneurysm. All of them had resting myocardial imaging and 40 patients were studied with intravenous dipyridamole.

Perfusion defects were detected in 14 cases in the coronary obstructive group at rest (35%). Five of them were studied with dipyridamole load and demonstrated clearer and larger perfusion defects than at rest. 35 patients with normal images at rest were studied with dipyridamole load. In 17 cases newly appeared in the perfusion defects were noted and sensitivity in coronary obstructive group was 81%.

Tl-201 myocardial imaging using dipyridamole was found to be a useful method to evaluate the myocardial ischemic lesions associated with Kawasaki disease.


Thallium-201 myocardial scintigraphy was performed in 17 patients with dilated cardiomyopathy (DCM). LV area (LVA) was number of LV image. LV uptake index (LVI) was percentage of radioactivity on LV myocardial area to total injected activity. Wall uptake ratio (WUR) was radioactivity ratio on IVS and LV free wall to total injected activity. DCM was classified by morphological findings on scintigram. The three groups were classified in D group (only dilated LV wall), RV group (visualization of RV wall) and PD group (perfusion defect on LV wall). LVA and LVI were greater than those in valvular disease with volume overload, and WUR was not greater than that. LVI and WUR in RV and PD groups also was lower than those in D group. ECG, CTR, LVPS and Carlig Index for estimation of cardiac function in DCM were examined. These parameters in RV and PD groups showed more abnormality than those in D group. Therefore, we estimated that cardiac function in RV and PD groups was lower than that in D group. We concluded that LVA, LVI and WUR as quantitative indices of the Thallium-201 scintigram were valuable for the evaluation of DCM.


To determine the clinical usefulness of Tl-201 myocardial scintigraphy (Tl-MCS) in the acute phase of myocardial infarction (MI), we compared Tl-MCS with electrocardiographic site of MI, Killip classification, Forrest hemodynamic substent (PHS), maxCPK, ECPK, maxLDH, ILDH, maxGOT and left ventriculogram (LVG). Method: Tl-MCS was performed within 72 hours after onset of MI (26.4±16.1 hours). Tl-MCS were divided into 6 projections. Each image was divided into 5 segments. Tl-MCS activity was visually assessed for each segment by a four-point system; 4=normal, 3=slightly decreased, 2=definitely decreased, 1=severely decreased. Tl-MCS score was calculated by summing up of each segment point. Results: Tl-MCS score of the patients with one site of MI was significantly higher than that of ITH with more than two sites of MI. There were significant correlations between Tl-MCS score and maxCPK, ECPK, maxLDH, ILDH and maxGOT. Tl-MCS score of the patients with PHS significantly lower than that of the patients with FHS I or II. Tl-MCS score of the patients with aneurysm or dyskinesis on LVG was significantly lower than that of the patients with akinesia, hypokinesis or normal wall motion. Conclusion: Tl-MCS findings in the acute phase of MI might reflect infarct size and cardiac function.