failure due to left ventricular systolic dysfunction who fulfil the criteria in section 1 of the guidance for the implantation of a CRT-P device, and also have additional risk factors for sudden cardiac death that separately fulfil the criteria for the use of an ICD device (as detailed in NICE technology appraisal guidance 95).²

The decision as to whether a CRT-P, CRT-D or ICD device is most appropriate should be made for each patient individually. It will depend on the relative importance of the risks associated with the underlying left ventricular dysfunction, ventricular dyssynchrony and symptomatic heart failure, as well as other factors that might contribute to the risk of sudden cardiac death.

The guidance on CRT should therefore be seen as complementing the earlier NICE guidance on "Implantable cardioverter-defibrillators for arrhythmias" (NICE technology appraisal guidance 95),² because it provides additional treatment options for some of the groups of people covered in that guidance.

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IMAGES IN CARDIOLOGY

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"Dynamic imaging" (systolic compression) of myocardial bridge visualised by electronic beam computed tomography

A 59-year-old man with history of hypertension and heavy smoking presented with recurrent dizziness, palpitation and chest pain during exertion. At admittance, an ECG recording showed rapidly conducting atrial fibrillation (mean heart rate 140 bpm) and otherwise normal findings. Blood pressure and a laboratory examination were normal. Within a few minutes after admission, atrial fibrillation spontaneously converted to sinus rhythm. To exclude coronary artery disease, the patient underwent 64-slice electronic beam computed tomography (EBCT). No calcification or coronary plaque was

detected. However, a myocardial bridge of the mid-segment of the left anterior descending coronary artery (LAD) was found (panels). Selection of different phases of the scanning cycle showed systo-diastolic diameter change of the vessel.

A myocardial bridge occurs when the myocardium covers a discrete portion of an epicardial coronary artery. A myocardial bridge is most commonly localised in the middle segment of the LAD. Systolic vessel compression and delayed diastolic relaxation may impair coronary blood flow, resulting in angina-like chest pain. Usually, myocardial bridging is a benign,

congenital condition with a favourable long-term outcome; infrequently, it may be associated with myocardial infarction, conduction disturbances and even sudden death.

When a diastolic "cuff-like" picture is noticed at EBCT, analysis of both diastolic and systolic images helps to confirm the systolic compression of the artery. This "dynamic" imaging such as provided by EBCT may be particularly helpful in linking clinical history to the anatomical finding.

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(A) Curved multiplanar reconstruction showing the mid-portion of the left anterior descending coronary artery (LAD). Note the course of the vessel within the myocardium. Arrows indicate entry and exit point of the vessel. (B) Volume rendering modality taken in diastole (60% of the R-R cycle), showing the uncompressed portion of the LAD. (C) Same as in B but taken in systole (40% of the R-R cycle), showing full compression of the LAD.