Comprehensive confocal endomicroscopy of the esophagus \textit{in vivo}

Authors
Dongkyun Kang\textsuperscript{1}, Simon C. Schlachter\textsuperscript{1}, Robert W. Carruth\textsuperscript{1}, Minkyu Kim\textsuperscript{1,2}, Tao Wu\textsuperscript{1}, Nima Tabatabaei\textsuperscript{1}, Paulino Vacas-Jacques\textsuperscript{1}, Milen Shishkov\textsuperscript{1}, Kevin Woods\textsuperscript{2,3}, Jenny S. Sauk\textsuperscript{1}, John Leung\textsuperscript{3}, Norman S. Nishioka\textsuperscript{3}, Guillermo J. Tearney\textsuperscript{1,4,5}

Institutions
Institutions are listed at the end of article.

Bibliography
DOI http://dx.doi.org/10.1055/s-0034-1377177
Published online: 16.7.2014
Endoscopy International Open 2014; 02: E135–E140
© Georg Thieme Verlag KG Stuttgart · New York
E-ISSN 2196-9736

Corresponding author
Guillermo J. Tearney, MD, PhD
Massachusetts General Hospital – Wellman Center for Photomedicine
40 Blossom St. BHX 604 Boston, MA 02114 United States
Fax: 6177264103
gtearney@partners.org

Introduction

Standard of care endoscopic biopsy suffers from sampling error, which can limit the diagnosis of many esophageal diseases. Confocal laser endomicroscopy (CLE) is a recently introduced imaging technique where a microscopy probe is inserted into the gastrointestinal tract to obtain microscopic images of tissue without biopsy excision [1–5]. While CLE has the potential to improve tissue sampling [6], the speeds and modes of operation of CLE devices prohibit automatic and comprehensive acquisition of microscopic image data over large segments of luminal gastrointestinal organs.

Spectrally-encoded confocal microscopy (SECM) is a new reflectance CLE technology that uses a diffraction grating and a wavelength-swept laser to image tissues at very high speeds (> 10× video rate) [7]. Because of its high-speed capabilities, SECM has a potential to image the entire distal esophagus in an acceptable procedural time. Differences between CLE and SECM are summarized in Table 1. Previously, SECM, implemented using a bench top microscope, has been shown to be capable of visualizing key histomorphologic features associated with various esophageal diseases \textit{ex vivo} [8,9]. Recently, we have developed a miniature endoscopic SECM probe that contains high-resolution optics [10], can be placed into the gastrointestinal tract endoscopically over a guide wire, and automatically images large swatches of gastrointestinal tissues using a helical scan pattern. The aim of this study was to test this SECM endoscopic probe for imaging large areas of the esophagus \textit{in vivo}.

Materials and methods

SECM endoscopic imaging setup

We conducted comprehensive confocal microscopy using an SECM endoscopic imaging setup shown in Fig. 1. Near infrared light from the
gus was performed to conduct a comparative analysis. At necropsy, histological examination of the esophagus was performed. A guidewire was then introduced to the stomach through the auxiliary channel. The videoendoscope was then removed while the optics automatically rotated and pulled back within the transparent imaging tube. Light returned from the esophagus surrounding two papillae (shown as dark circular regions) surrounding two papillae (seen as circular features with low SECM signal (arrows)). Portions of the SECM image (~35%) are artifactual; in the top portion of the image, the imaging tube lost contact with the esophagus (NC) and the focal plane of the probe was not inside the tissue. At the bottom of the image, a segment of the image reveals high reflectance at the border between the liquid-air interface (LA).

**In vivo swine imaging**

SECM imaging of swine esophagus in vivo was conducted according to a study protocol approved by the Massachusetts General Hospital Subcommittee on Research Animal Care (Protocol# 2011N000115). Imaging was performed in a 45 kg female Yorkshire swine. After sedation and intubation, a videoendoscope (EPM-3300, Pentax) was advanced transorally to the gastroesophageal junction, and the initial evaluation of the esophagus was conducted. To increase the contrast of squamous nuclei, a low-concentration of acetic acid (6% concentration by volume) was topically applied to the esophagus using a spray catheter. A guidewire was then introduced to the stomach through the auxiliary channel. The videoendoscope was then removed while leaving the guidewire in place. The SECM endoscopic probe was introduced over the guidewire to approximately 5 cm proximal from the gastroesophageal junction. Once the probe was in place, the optics automatically rotated and pulled back within the transparent imaging tube. Light returned from the esophagus was detected and stitched together to form contiguous confocal microscopy images in 3 planes over a 5-cm-long esophageal segment. The animal was euthanized immediately following the procedure. At necropsy, histological examination of the esophagus was performed to conduct a comparative analysis.

**Results**

**Comprehensive confocal image of swine esophagus in vivo**

Contiguous 5 cm (length) by 2.2 cm (circumference) reflectance confocal microscopy images were acquired from three depth planes in 2.1 minutes. A large-area confocal image from the middle depth is shown in Fig. 2a. The horizontal axis of the image corresponds to the longitudinal direction of the esophagus, and the vertical axis is the circumferential axis. Approximately 22 cm² (65%) of the imaged area contains microscopic tissue information. At a low-magnification view (Fig. 2a), gross morphology of the esophagus can be seen. The epithelium (E) and lamina propria (LP) are visualized, and numerous papillae are seen as circular features with low SECM signal (arrows). Portions of the SECM image (~35%) are artifactual; in the top portion of the image, the imaging tube lost contact with the esophagus (NC) and the focal plane of the probe was not inside the tissue. At the bottom of the image, a segment of the image reveals high reflectance at the border between the liquid-air interface (LA).

As shown in Fig. 2b, the large-area image can be zoomed in to show a small region of interest at a higher magnification. The size of Fig. 2b is 2.0 mm by 1.3 mm, which is similar in size to a low-power microscopic field used in histologic analysis. At this magnification, cellular features of the tissue can be clearly seen, including numerous nuclei (seen as bright, highly reflecting dots) surrounding two papillae (shown as dark circular regions of low SECM signal marked by arrows). The image can be zoomed in further to produce a view (Fig. 2c) that is similar in size to a high-power field (40×). At this high magnification, numerous nuclei (N) can be seen encircling a papilla. Cellular features were visualized in SECM images at various depths within the epithelium. Fig. 3 shows high-magnification SECM images at three distinctive locations and en face histologic images of the swine esophagus. Fig. 3a, a SECM image taken from a superficial plane within the epithelium (box 1 in Fig. 2a), shows scattered nuclei (bright dots) similar to that seen in a histologic image of representative, nearby superficial squamous epithelium (Fig. 3d). Fig. 3b, a SECM image taken from a deeper region of the epithelium (box 2 in Fig. 2a), demonstrates numerous nuclei (bright dots) with a higher density than Fig. 3a and multiple papillae (dark circular regions) sur-
rounded by the nuclei. Similar cellular features are observed in a representative histologic image of the basal cell layer (Fig. 3e).

Fig. 3c, an SECM region from the LP (box 3 in Fig. 2a), enables the visualization of microstructures with high SECM signals that are similar in appearance to collagen seen in a representative histologic image of the LP (Fig. 3f).

Imaging multiple depths in a single scan

SECM images from multiple imaging depths were obtained through post-operation image processing of the volumetric data that was acquired in a single helical scan of the probe [11]. Fig. 4 shows SECM and en face histologic images obtained from the same respective transverse locations but at different imaging depths. The imaging depth changes from superficial (Fig. 4a and d) to deep (Fig. 4c and f) with a depth interval of 14µm between images. The SECM images were taken from the box 4 in Fig. 2a. In the SECM images, the papillae (dark circular regions) become bigger as the imaging depth increases from Fig. 4a to 4c, and a similar morphologic change is observed in the histologic images. Nuclear density increases with the imaging depth in the SECM images, and a similar trend is shown in the histologic images.

Discussion

We demonstrated the feasibility of conducting automatic, comprehensive confocal microscopy of the esophagus in vivo using SECM. Very large confocal images (11 cm²) of the swine esophagus from three imaging depths were obtained in about 2 minutes. Low-magnification views enabled the visualization of the gross morphology of the tissue, while high-magnification views revealed cellular features. This technology can also be modified to be used to image large portions of other gastrointestinal tract organs, including the stomach, small intestines, colon, and rectum. There were, however, areas where the technology needs to be improved further. Artifacts were present in portions of the SECM images. The first artifact was likely caused by peristalsis, where tissue motion relative to the SECM probe resulted in a zig-zag pattern in some regions (Fig. 2a, arrowheads). A second artifact was loss of contact between the probe and the tissue (Fig. 2a, NC). Adding a suction tube on the side of the probe increased and stabilized tissue contact [13], which will likely reduce these two artifacts. The processing time to generate a large-area image such as Fig. 2a (file size = 1.3 Gbytes) was around 4 minutes. This amount of processing time is acceptable for post-opera-
tion image analysis. However, a shorter processing time will be needed if we want to conduct intraprocedural visualization of the entire confocal microscopy dataset. Because of the current imaging depth of 100 µm, SECM was capable of visualizing the epithelium and LP but was unable to be used to image deeper tissue regions such as muscularis mucosa and submucosa. Optical coherence tomography (OCT) has been successfully used to visualize architectural features of these deeper tissue regions [14]. Because conditions such as Barrett’s esophagus (BE) and esophageal squamous dysplasia are primarily limited to the superficial mucosa, we expect that the cellular features visualized by SECM will provide comprehensive diagnostic information for most screening and surveillance cases.

As the next step of this research, we will utilize this probe to obtain comprehensive confocal microscopy images of the human esophagus in vivo. When imaging the human esophagus, we will use a lower concentration of acetic acid (1–3%) than the concentration used for the swine esophagus (6%), since our previous study of imaging human esophageal biopsy tissues showed that 0.6% acetic acid provides sufficient nuclear contrast in human tissues [8]. The transparent imaging tube will be disposed after each imaging session, while the internal SECM probe optics will be used for multiple imaging sessions. The costs of the imaging probe and disposable transparent imaging tube will likely be comparable to the costs of other imaging devices that are used in conjunction with endoscopy.

SECM images could enable targeted biopsy based on microscopic tissue assessment of the entire distal esophagus. During the imaging procedure, SECM images will be displayed in real time while the SECM probe automatically scans a long segment of the esophagus. An endoscopist or pathologist will review the SECM images and will determine regions that need further examination by histopathology. In conjunction with the laser marking functionality [15], the SECM probe can generate visible marks around the identified tissue regions and guide the endoscopist to biopsy tissues at these regions. The targeted biopsy enabled by SECM imaging could be helpful for improving the sampling yield of biopsy procedures such as those performed for Barrett’s surveillance. For endoscopists or pathologists to be able to read SECM images, we will develop and validate diagnostic criteria for SECM interpretation. Operators will undergo training sessions to gain expertise in reviewing and interpreting SECM videos and images.

Several challenges, however, are expected during SECM imaging of the human esophagus in vivo, including following four. First, certain shapes of the distal esophagus might pose difficulties for SECM imaging, including esophageal stricture or tortuositities. For these cases, it may be difficult to pass the probe as it would be for conventional endoscopy. These geometrical distortions can also bend the probe, which can bind the driveshaft, causing rotational artifacts. If the patient has an esophagus that is larger than normal, the SECM probe may not come into contact with a large portion of the esophagus. This situation may be mitigated by obtaining one pullback SECM scan and then repositioning the probe to acquire images from another region of the esophagus. Second, luminal contents, which are occasionally present in patients with gastroesophageal reflux disease (GERD) or BE, might make the SECM imaging difficult. The luminal contents could enter the space between the SECM probe and tissue, which can attenuate the light and change the focal plane so that it is no longer within the tissue itself. To mitigate this factor, we ensure that luminal contents are cleared during the initial endoscopic examination. As a result, we do not expect that luminal debris will interfere with SECM imaging. Third, the current SECM endoscopic probe always requires video endoscopy to introduce a guide wire. Conducting SECM imaging in conjunction with video endoscopy is beneficial since the esophagus can be cleaned during the endoscopy procedure, acetic acid can be applied in a controlled manner, and the location of the gastroesophageal junction (GEJ) can be determined, which guides SECM probe placement. Fourth, due to its current diameter of 7 mm, the SECM probe cannot be introduced through the accessory port of a standard video endoscope. Compared to the current over-the-guide wire introduction of the SECM probe, through-the-scope SECM could facilitate good spatial registration between SECM images and endoscopic observation. To utilize the SECM probe through the endoscopic accessory port, the diameter of the probe will need to be reduced.

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Fig. 4  SECM and representative, nearby en face histologic images taken at the same respective transverse locations but at different imaging depths. The imaging depth changes from superficial (a and d) to deep (c and f), with a depth difference of 14 µm between images. The SECM images were taken from the region marked by box 4 in Fig. 2a (scale bar = 100 µm).
Abbreviations

BE Barrett’s esophagus
CLE Confocal laser endomicroscopy
GEJ gastroesophageal junction
GERD gastroesophageal reflux disease
LP Lamina propria
OCT Optical coherence tomography
SECM Spectrally-encoded confocal microscopy


Institutions
1 Massachusetts General Hospital - Wellman Center for Photomedicine, Boston, MA
2 The University of Tokyo - School of Engineering, Tokyo, Japan
3 Massachusetts General Hospital - Department of Gastroenterology, Boston, MA
4 Harvard-MIT Division of Health Sciences and Technology, Cambridge, MA
5 Massachusetts General Hospital - Department of Pathology, Boston, MA

Acknowledgment

The authors thank William Puricelli, RN for his help during the animal study. This research has been sponsored by Nine Point Medical, Cambridge, MA. S. C. S is currently with Nine Point Medical. K. W. is currently with Emory University Hospital, Atlanta, GA. J. L. is currently with Tufts Medical Center, Boston, MA.

References