MR Diagnosis of Bone Metastases at 1.5 T and 3 T: Can STIR Imaging Be Omitted?

MRT-Diagnostik von Knochenmetastasen bei 1,5 T und 3 T: Kann auf die STIR-Bildgebung verzichtet werden?

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**Key words**
- skeletal-axial
- spine
- MR imaging
- metastases
- technical aspects
- staging

**Abstract**

**Objective:** To date, no prospective comparative study of the diagnostic value of STIR versus T1-weighted (T1w) sequences at both 1.5 T and 3 T has been performed with special focus on the detectability of bone metastases.

**Materials and Methods:** 212 oncological patients had a whole-body MRI at 1.5 T and/or at 3 T. The standard protocol comprised STIR and T1w sequences. All patients who showed typical signs of bone metastases were included in the study. Evaluation of the images was performed by the calculation of the number of metastases by three independent readers and by visual assessment on a 4-point scale.

**Results:** 86 patients fulfilled the inclusion criteria. The total number of metastases was significantly higher on T1w than on STIR images at both field strengths (p < 0.05). T1w revealed a sensitivity of 99.72% (3 T) and 100.00% (1.5 T) versus STIR with 70.99% (3 T) and 79.34% (1.5 T). In 53% (38/72) of all patients, STIR detected fewer bone metastases in comparison with T1w at 3 T. At 1.5 T, STIR showed inferior results in 37.5% (18/48) of all patients. Qualitative analysis indicated a significantly better lesion conspicuity, lesion delineation and an improved image quality on T1w compared to STIR imaging at both field strengths (p < 0.05) with similar results for T1w at 1.5 T and 3 T, but inferior results for STIR especially at 3 T.

**Conclusion:** The whole-body MRI protocol for the detection of bone metastases could safely be limited to the T1w sequence in adults, especially at 3 T. There is no need for an additional STIR sequence. These initial results will have a major impact on the department’s workflow if confirmed by larger studies as they will help reduce examination time and therefore save financial resources.

**Key points:**
- In a routine MRI protocol, T1w imaging is sufficient for the detection of bone metastases.
Introduction

Whole-body MRI has increasingly been used as the preferred method for oncological imaging. As an excellent imaging tool, it shows high sensitivity and specificity for the detection of bone marrow lesions, much more than other modalities such as bone scintigraphy or PET-CT [1–4]. Suggested and commonly used standard MRI protocols included a combination of T1-weighted (T1w) spin-echo and fat suppressed short-tau inversion recovery (STIR) imaging [3, 5]. This combination has been shown to be reliable in the detection of bone marrow disorders, e.g. metastases, with a high negative and a high positive predictive value, especially for STIR imaging [2, 5–8].

Bone metastases lead to a signal reduction on T1w imaging by a lengthened T1 relaxation time, which contrasts to the surrounding high signal of the bone marrow fat. On STIR imaging, most marrow disorders exhibit high signal intensity, whereas the fat of bone marrow is suppressed and shows a low signal. STIR has been used to improve lesion conspicuity, but in comparison with T1w, STIR has the disadvantage of a lower signal-to-noise ratio and less detailed anatomical information.

However, there has not yet been a definitive consensus as to which MR protocol is the best for evaluating bone marrow lesions. Furthermore, it is uncertain to what degree STIR actually improves lesion detection compared with T1w. Improving MR technology implies a state-of-the-art screening method with MR sequences which are of highest yield for the detection of bone metastases. Furthermore, rapid whole-body screening and a cost-saving work-up are warranted as well.

In view of the above, we conducted the present study to determine the current clinical use of T1w and STIR images for the detection of bone metastases. Over the past decades, the combined use of T1w and STIR for bone metastasis screening has become universally adapted, especially at 1.5 T MRI [1, 6, 9–14]. However, to date, no prospective study of the diagnostic importance of T1w compared to STIR imaging at conventional 1.5 T and high-end 3 T has been performed with special focus on the detectability of bone metastases as an indicator of diagnostic value.

Materials and Methods

Whole-body MRI scans of 212 patients with suspected or known bone metastases were reviewed. Patients underwent examinations at either 1.5 T, or 3 T or both MR systems between February 2010 and October 2014. MR images were obtained on a 1.5 T system until June 2012 (Philips Intera, Philips Healthcare, Eindhoven, The Netherlands) and, from July 2012 onwards, on a 3 T wide bore unit (Discovery MR750w, General Electric Healthcare, Milwaukee, USA). The exclusion criteria for the study group were: inconspicuous MR findings or bone lesions of uncertain malignancy, inhomogeneous bone marrow signal not allowing a differentiation between neoplastic process and bone marrow reversion, too many image artifacts or incomplete study protocol in case of early termination of scanning.

A routine MR scan was performed to image the whole spine, pelvis, femora, humeri, rib cage, shoulder girdle and sternum. The standardized MR protocol included T1w and STIR sequences of the spine. MR parameters for the spine at 1.5 T and 3 T are shown in Table 1.

The final study group consisted of 86 patients (79 females, 7 males, median age ± standard deviation 64 ± 12) with evident vertebral metastases from histologically proven cancer: 78 patients with metastases from breast cancer, 4 patients from lung cancer, 3 patients from plasmocytoma, 1 patient from prostate cancer and 1 patient from a leiomyosarcoma of the uterus.

Data analysis

A lesion-by-lesion analysis between sagittal T1w and STIR images of the spine was performed by three readers in order to ensure the best possible quality and to minimize the interreader variability. First-line reading was performed by a radiology resident (2–4 years of experience), followed by two senior radiologists. The three readers evaluated the studies independently from each other. Then the results were discussed in consensus. The evaluation of images was carried out by reviewing the reports and images of the patients. All the numbers of vertebral metastases were calculated and summarized separately in T1w and STIR sequences as well. Qualitative evaluation of images was performed by visual assessment on a 4-point scale with regard to lesion conspicuity, lesion delineation and overall image quality. A standard of reference was established by correlation with clinical outcome (minimum follow-up, 6 months), additional imaging (dedicated MR or CT and CT during the standard diagnostic evaluation of images).

Table 1

<table>
<thead>
<tr>
<th>1.5 T</th>
<th>3 T</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1w</td>
<td>STIR</td>
</tr>
<tr>
<td>TR (ms)</td>
<td>400</td>
</tr>
<tr>
<td>TE (ms)/TI (ms)</td>
<td>7.4</td>
</tr>
<tr>
<td>FOV (cm)</td>
<td>25</td>
</tr>
<tr>
<td>slice thickness/gap (mm)</td>
<td>5/0.5</td>
</tr>
<tr>
<td>matrix</td>
<td>336/252</td>
</tr>
<tr>
<td>NEX</td>
<td>2</td>
</tr>
<tr>
<td>scan time (min, s)</td>
<td>2.30</td>
</tr>
</tbody>
</table>

T1w = T1-weighted, STIR = short t2 inversion recovery, TR = repetition time, TE = echo time, FOV = field of view, TI = inversion time, NEX = number of excitations

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work-up including the spine or biopsy of the vertebra). In contrast to metastases, round-shaped skeletal lesions with complete signal loss in T1w and STIR images were defined as bone islands.

**Statistical analysis**

Number of metastases between T1w and STIR and qualitative data between both sequences were compared using a single-tailed paired Student’s t-test for each reader. The Wilcoxon signed-rank test was used to calculate the interobserver variability between two readers and Kendall’s W test was used among three readers. In addition, interobserver reliability was calculated also as intra-class correlations (ICC) or with Kappa statistic to determine consistency among raters (Cohen’s kappa). Sensitivity and specificity values were calculated for each sequence (with 95% confidence interval). All analyses were performed with SPSS Statistics 16.0 and Microsoft Excel. Significance was set at p < 0.05.

**Results**

MR images of 34 patients revealed disseminated, uncountable metastatic deposits to the spine or a diffuse vertebral infiltration. In these cases, an exact number of metastases could not be defined. Two of these patients had countable metastases on the 1.5 T examination and an uncountable status on the 3 T study after significant tumor progression in the time interval between both examinations.

In the group with disseminated infiltration, T1w and STIR subjectively showed the same amount of spine infiltration in 23 patients at 1.5 T and 3 T (Fig. 1). In 11 patients metastases were more evident on T1w than on STIR at 1.5 T and 3 T and they were depicted less well on STIR images (Fig. 2).

MR images of 54 patients revealed countable vertebral metastases in 1.5 T and/or 3 T. The number of bone metastases detected by each reader was significantly higher on images obtained with T1w than those obtained with STIR at 1.5 T and 3 T by all three readers (p < 0.05). The total number of confirmed lesions was 362 at 1.5 T and 363 at 1.5 T. The interobserver reliability was high (intraclass correlation ranging between 0.944 and 0.991, p = 0.000), indicating almost perfect agreement. Interobserver variability using the Wilcoxon test showed significant differences in case of some variables (with 95% confidence interval). All analyses were performed with SPSS Statistics 16.0 and Microsoft Excel. Significance was set at p < 0.05.

In 53% (38/72) of all patients, STIR detected fewer bone metastases in comparison with T1w at 3 T and in 37.5% (18/48) at 1.5 T (see also Fig. 4).

Qualitative assessment was performed in all patients with bone metastases. The mean ratings for the conspicuity, the delineation of the lesions and the overall image quality were significantly higher on images obtained with T1w compared to STIR (p < 0.05 for all). The interrater reliability ranged between kappa = 0.444 and kappa = 0.758 (all p < 0.05) indicating moderate to substantial agreement. A significant difference in case of image quality in STIR at 3 T indicates that readers 2 and 3 found it to be worse compared with reader 1 (Table 5).

**Discussion**

To the best of our knowledge, this is the first study to investigate the diagnostic usefulness of T1w compared to STIR at both 1.5 T and 3 T regarding the detectability of bone metastases. Concerning the results of the qualitative analysis including the detected number of metastases, T1w was more effective than STIR imaging. STIR showed a lower diagnostic yield in metastasis detection in comparison with T1w at both field strengths.

These results differ from those of former studies:

In the literature of the 90s and the turn of the millennium, a combination of T1w and STIR has been favored for the evaluation of bone marrow disorders. Studies reported STIR to be superior to T1w [2, 6–8] and STIR MRI has been recommended as a screening sequence, especially since it has been more accurate than other screening techniques such as bone scintigraphy [15]. As a consequence, STIR has been included in the appropriateness criteria published by the ACR in 2000 [16].

In more recent studies, the superiority of T1w compared to STIR has been emphasized: In a study in which fast Dixon-based multisequence WB MRI sequences were applied to evaluate the conspicuity of bone metastases, T1w sequence was superior to STIR [17]. In another study with breast cancer patients, T1w was of most value for the detection of bone metastases with a higher sensitivity (98%) in comparison with STIR, DWI and PET/CT on 3 T. However, the authors concluded that the low specificity of T1w (77%) could be increased to 95% with the addition of STIR and DWI [3].

The aforementioned results are supported by our findings.

In our study, the identified number of metastases and the mean rating of the qualitative data (subjective lesion conspicuity, lesion delineation and the overall image quality) revealed significantly better results by all readers using the T1w sequence as compared with STIR at both field strengths. Moreover, the results for T1w sequence were similar at 3 T and 1.5 T, whereas quantitative analysis indicated inferior results for STIR at 3 T compared with 1.5 T. Explanations for these findings might be: first, the higher influence of dielectric effects, pulsation artifacts and image inhomogeneity on STIR imaging at 3 T compared to 1.5 T, as has been reported in the literature [18]. Second, the higher signal-to-noise ratio (SNR) at 3 T with a higher spatial resolution [19–21] might particularly affect T1w showing comparable results at 3 T and 1.5 T, but much better results than STIR at both field strengths. In addition, STIR as a low-SNR sequence remains limited in its ability to provide anatomic detail.

Our study clearly indicates that a better performance by the additional use of STIR could not be achieved. In all cases, STIR neither...
provided a better differentiation of the lesions nor changed the diagnosis made by T1w imaging alone.
As an important point, in the past, STIR had an advantage as the edema-sensitive search sequence, but nowadays T1w imaging might be more useful for imaging bone metastases at higher field strengths because of a better image quality and higher metastases yield.
Fig. 2 A 73-year-old breast cancer patient with multiple vertebral lesions. The lesions are more clearly seen and more conspicuous on T1w than on STIR. Lesions were depicted to a lesser extent or not seen at all on STIR images (T1w a, STIR b at 3T; T1w c, STIR d at 1.5T).

Abb. 2 Eine 73-jährige Brustkrebspatientin mit multiplen Wirbelsäulenläsionen. Die Läsionen sind deutlicher zu sehen und auffälliger in der T1w als in der STIR. Die Läsionen wurden auf den STIR-Bildern in einem geringeren Ausmaß abgebildet oder waren überhaupt nicht sichtbar (T1w a, STIR b at 3T; T1w c, STIR d at 1.5T).

Table 2 Number of detected bone metastases by different readers on T1w and STIR at 3 T and 1.5 T.

<table>
<thead>
<tr>
<th></th>
<th>reader 1</th>
<th>reader 2</th>
<th>reader 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1w</td>
<td>STIR</td>
<td>p</td>
</tr>
<tr>
<td>3 T</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>number of metastases</td>
<td>361</td>
<td>264</td>
<td>0.00</td>
</tr>
<tr>
<td>(mean ± SD)</td>
<td>8.02 ± 9.12</td>
<td>5.80 ± 6.95</td>
<td>8.38 ± 9.31</td>
</tr>
<tr>
<td>1.5 T</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>number of metastases</td>
<td>363</td>
<td>300</td>
<td>0.00</td>
</tr>
<tr>
<td>(mean ± SD)</td>
<td>10.00 ± 11.94</td>
<td>7.77 ± 9.79</td>
<td>10.19 ± 11.9</td>
</tr>
</tbody>
</table>

SD indicates standard deviation, p <.05 was considered statistically significant.
In addition to the above-mentioned drawbacks of STIR, another disadvantage is its longer acquisition time compared to T1w. An optimal MR protocol should not only focus on high-yield MR sequences, but it should also been performed within an acceptable scan time to improve patient throughput and department productivity.

It should be noted that it is not clear to which degree post-therapeutic effects of irradiation or chemotherapy influenced the detectability of the lesions on T1w and STIR imaging. It is known that treatment induces edema, return of marrow fat, sclerosis or fibrosis [22], resulting in MR signal changes of the bone marrow which are time- and dose-dependent [23]. While T1w reflects marrow replacement and is rather independent of associated sclerosis, STIR reflects more the lesion composition (water content, fibrosis and sclerosis) and shows variable signal [24, 25].

Table 3 Interobserver variability in the detection of metastases on T1w and STIR at 3 T and 1.5 T.

<table>
<thead>
<tr>
<th>sequence</th>
<th>Z-score and p-value between raters (Wilcoxon) 1 and 2</th>
<th>Z-score and p-value between raters (Wilcoxon) 2 and 3</th>
<th>Z-score and p-value between raters (Wilcoxon) 1 and 3</th>
<th>Kendall’s W among 3 raters with p-value (Kendall’s W test)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1w</td>
<td>Z = -2.645 p = 0.008</td>
<td>Z = -1.265 p = 0.206</td>
<td>Z = -2.762 p = 0.006</td>
<td>W = 0.124 p = 0.004</td>
</tr>
<tr>
<td>STIR</td>
<td>Z = -2.200 p = 0.028</td>
<td>Z = -2.496 p = 0.013</td>
<td>Z = -1.213 p = 0.225</td>
<td>W = 0.060 p = 0.071</td>
</tr>
</tbody>
</table>

Interobserver variability at 1.5 T

<table>
<thead>
<tr>
<th>sequence</th>
<th>Z-score and p-value between raters (Wilcoxon) 1 and 2</th>
<th>Z-score and p-value between raters (Wilcoxon) 2 and 3</th>
<th>Z-score and p-value between raters (Wilcoxon) 1 and 3</th>
<th>Kendall’s W among 3 raters with p-value (Kendall’s W test)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1w</td>
<td>Z = -1.200 p = 0.230</td>
<td>Z = -1.300 p = 0.194</td>
<td>Z = -0.816 p = 0.414</td>
<td>W = 0.032 p = 0.353</td>
</tr>
<tr>
<td>STIR</td>
<td>Z = -0.226 p = 0.821</td>
<td>Z = -0.816 p = 0.414</td>
<td>Z = -0.241 p = 0.809</td>
<td>W = 0.004 p = 0.889</td>
</tr>
</tbody>
</table>

Table 4 Sensitivity and specificity of T1w and STIR for the detection of bone metastases of the spine at 3 T and 1.5 T.

<table>
<thead>
<tr>
<th>sequence</th>
<th>sensitivity (%)</th>
<th>specificity (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 T</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1w</td>
<td>99.72</td>
<td>100</td>
</tr>
<tr>
<td>STIR</td>
<td>70.99</td>
<td>89.55</td>
</tr>
<tr>
<td>1.5 T</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1w</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>STIR</td>
<td>79.34</td>
<td>74.47</td>
</tr>
</tbody>
</table>

In addition to the above-mentioned drawbacks of STIR, another disadvantage is its longer acquisition time compared to T1w. An optimal MR protocol should not only focus on high-yield MR sequences, but it should also been performed within an acceptable scan time to improve patient throughput and department productivity.

It should be noted that it is not clear to which degree post-therapeutic effects of irradiation or chemotherapy influenced the detectability of the lesions on T1w and STIR imaging. It is known that treatment induces edema, return of marrow fat, sclerosis or fibrosis [22], resulting in MR signal changes of the bone marrow which are time- and dose-dependent [23]. While T1w reflects marrow replacement and is rather independent of associated sclerosis, STIR reflects more the lesion composition (water content, fibrosis and sclerosis) and shows variable signal [24, 25].
Fig. 4 A 65-year-old woman with extensive metastatic breast cancer. At 3 T, T1w a shows an increased number of skeletal metastatic deposits and better image quality than STIR b. At 1.5 T, metastases are equal in extent on T1w c and STIR images d.

Abb. 4 Eine 65-jährige Frau mit ausgedehnter Brustkrebsmetastasierung. Bei 3 T zeigt T1w a eine größere Anzahl an Skelettmetastasen und eine bessere Bildqualität als die STIR b. Bei 1,5 T sind die Metastasen gleichermaßen auf den T1w- c und STIR-Bildern d vorhanden.
Furthermore, all cases without definite bone marrow changes and with unclear differential diagnosis (e.g. metastases versus hematopoietic red marrow) were excluded from the study. This may possibly affect our study results as well.

In conclusion, our data suggest that the exclusive use of T1w MRI, especially at 3 T, represents a safe and sufficient method for the detection of bone metastases in adults. The combination of T1w and STIR was not more accurate than T1w imaging alone. As a consequence, additional STIR imaging might be redundant in the assessment of skeletal metastases. If osseous lesions remain unclear, for example in case of very inhomogeneous bone marrow, additional pulse sequences, e.g. contrast-enhanced T1w, may still be added.

These initial results will have a major impact on the department’s workflow if confirmed by larger studies and help to save financial resources as well.

Clinical relevance of this study

1. As a rule, a new oncological state-of-the-art MR protocol limited to T1w is as effective as a combined T1w and STIR protocol, especially at the increasingly used higher magnetic field strengths (3 T).
2. By confining the MR protocol to T1w, examination and reporting times can be significantly reduced.
3. In times of economic constraints, cost-efficient MRI is warranted, without impairing the diagnostic accuracy.

References

19 Collins CM, Smith MB. Signal-to-noise ratio and absorbed power as functions of main magnetic field strength, and definition of “90 degrees” RF pulse for the head in the birdcage coil. Magn Reson Med 2001; 45: 684 – 691.