Dual-Energy Perfusion-CT in Recurrent Pancreatic Cancer – Preliminary Results

Dual-Energy Perfusion-CT bei Pankreaskarzinomrezidiven – Vorläufige Ergebnisse

Key words
- abdomen
- pancreas
- CT
- adenocarcinoma

Abstract

Purpose: To evaluate the diagnostic performance of dual energy (DE) perfusion-CT for the differentiation between postoperative soft-tissue formation and tumor recurrence in patients after potentially curative pancreatic cancer resection.

Material and methods: 24 patients with postoperative soft-tissue formation in the conventional regular follow-up CT acquisition after pancreatic cancer resection with curative intent were included prospectively. They were examined with a 64-row dual-source CT using a dynamic sequence of 34 DE acquisitions every 1.5 s (80 ml of iodinated contrast material, 370 mg/ml, flow rate 5 ml/s). Weighted average (linearly blended M0.5) 120kVp-equivalent dual-energy perfusion image data sets were evaluated with a body-perfusion CT tool (see above) for estimating blood flow, permeability, and blood volume. Diagnosis was confirmed by histological study (n = 4) and by regular follow-up.

Results: Final diagnosis was local recurrence of pancreatic cancer in 15 patients and unspecific postoperative tissue formation in 9 patients. The blood-flow values for recurrence tissue trended to be lower compared to postoperative tissue formation with 16.6 ml/100 ml/min and 24.7 ml/100 ml/min, respectively for weighted average 120kVp-equivalent image data, which was not significant (n.s.) (p = 0.06, significance level 0.05). Permeability- and blood-volume values were only slightly lower in recurrence tissue (n.s.).

Conclusion: DE perfusion-CT is feasible in patients after pancreatic cancer resection and a promising functional imaging technique. As only a trend for lower perfusion values in local recurrence was found, the perfusion differences are not yet sufficient to differentiate between malignancy and unspecific postoperative alterations for this new technique. Further studies and technical improve-
Pancreatic cancer is known to have poor prognosis since the majority of patients present with advanced tumor stages at the time of diagnosis, which allows a potentially curative resection in only approximately 20% of the patients [1]. Following potentially curative resection, isolated local recurrence occurs in one third of the patients [1, 2]. In cases of local recurrence without distant metastases, however, patients may benefit from surgery, which was shown to be associated with an additional 15 months median overall survival [3]. Therefore, it is essential to identify local tumor recurrence early as this offers the possibility of recurrence resection, which can be combined with radiotherapy to achieve best results [4, 5]. To achieve this goal, a close follow-up following pancreatic ductal adenocarcinoma (PDAC) resection is required [4, 6, 7]. The National Comprehensive Cancer Network (NCCN) guidelines recommend a close surveillance with clinical history, physical examination, CA 19–9 and CT every 3 to 6 months for the first two years and then annually [8].

The major problem in detecting pancreatic cancer recurrence by CT-based follow-up is caused by unspecific postoperative changes with soft-tissue formation that can often barely be differentiated from disease recurrence [9]. Local recurrence is suspected in contrast-enhanced (CE-) CT if there is a visible enlargement of preexisting soft-tissue formations or if new soft-tissue formations appear. Conventional CECT offers high-resolution imaging and is widely available, safe and fast, but is only a morphology-based imaging method. Using perfusion CT offers the opportunity to get additional functional imaging information of the examined parenchyma with the same high resolution as provided by conventional CT. This implies that quantitative parameters like blood flow of the examined tissue can be quantified. Additionally, perfusion CT can be performed in dual energy mode, which offers image data featuring the enhanced contrast at 80 kVp while having the noise characteristics of an acquisition at 140 kVp. Many studies have shown the feasibility and value of perfusion CT and DE perfusion-CT in pancreatic cancer [10 – 12], but to our knowledge there are so far no publications on the topic of perfusion CT in pancreatic cancer recurrence.

The purpose of our study was to evaluate the possibility of differentiating unspecific postoperative soft-tissue alterations from tumor recurrence in the follow-up of patients after pancreatic cancer resection using DE perfusion-CT.
(370 mg iodine/ml; Ultravist® 370, Schering, Berlin, Germany), including at least arterial and venous phases (table 1). After conventional CT-acquisition of the upper abdomen, there was a 15 minute break to allow for contrast material to wash-out from the pancreatic parenchyma. During this break the patients remained on the CT table without moving. In order to minimize breathing artefacts during the following dynamic CT-examination, patients were instructed to use a shallow breathing technique. During the waiting period we defined the localization of the suspicious soft-tissue formation based on the CECT acquisition. A single low-dose acquisition (scan-&-view) during shallow breathing was used to validate the correctness of the chosen acquisition region. For the perfusion sequence 80 ml of a non-ionic contrast material (370 mg iodine/ml; Ultravist® 370, Schering, Berlin, Germany) was injected through a 16- or 18-gauge catheter in an antecubital vein using a flow rate of 5 ml/s, followed by a chaser bolus of 40 ml saline solution. The perfusion sequence in dual-energy mode was started after a constant delay of 13 seconds with respect to contrast material injection. The dual-energy (DE) technique employed tube voltages of 80 kVp and 140 kVp using tin filtration with effective tube currents of 270 mAs and 104 mAs (CARE Dose 4D, Siemens Medical Solutions, Forchheim, Germany) respectively. The dynamic imaging sequence consisted of 34 acquisitions of 0.5 s duration (rotation time) every 1.5 s (cycle time) (total examination time of 51 s). The perfusion sequence covered a craniocaudal width of 19.2 mm (collimation of 32 × 0.6), from which three consecutive image slices of 5 mm slice thickness could be reconstructed for each of the 34 acquisitions (kernel B30f (n = 16), B31f (n = 8)).

**Data analysis**

Perfusion data were analyzed utilizing a Body-Perfusion CT-tool (CT Body Perfusion – Workflow Template, Siemens Medical Solutions, Erlangen, Germany) at a multimodality workplace with the syngo.via imaging software (Siemens Medical Solutions, Forchheim, Germany). The CT Body Perfusion application (pancreatic tumors) for appraisal of perfusion data is based inter alia on compartment models. For the estimation of the blood flow value a single-compartment-model (maximum slope) and for blood volume value and flow extraction value a two-compartment model the software calculated the following parameters, respectively:

- **perfusion [ml/100 ml/min]**
- **permeability [ml/100 ml/min and]**
- **blood volume [ml/100ml]**

**Radiation exposure**

Effective radiation dose ($D_{eff}$) was calculated for the DE-acquisition of the perfusion sequence including the contribution of both tubes operating at 80 kVp and 140 kVp, respectively, as well as for the acquisitions in the context of regular follow-up CT examination. For that purpose, each of the corresponding dose-length-products (DLP) were multiplied with the corresponding conversion factor for abdominal CT-examinations (0.015 mSv/mGy × cm based on ICRP 60 published in 2004) [16]: Thus, the total radiation exposure (RE) of the CT examination is the sum of the effective radiation doses $D_{eff}$ of the dynamic DE-perfusion sequence as well as of the single-energy acquisitions.

**Statistical analysis**

For quantitative analysis, the distribution of the patient age and CT-perfusion-parameters was given as mean value with standard deviation and range. The derived perfusion-parameters were tested for significant differences between pancreatic cancer recurrence and unspecfic soft tissue using an unpaired t-test, respectively. A significance level of $p < 0.05$ was considered statistically significant. Descriptive statistics as well as t-tests were performed using Microsoft® Excel® 2008 for Mac, Version 12.3.6. Box-plots were generated using R (R Foundation for Statistical Computing).

**Table 1** Protocol of the three-phasic CT-acquisition and the dynamic DECT-perfusion sequence.

<table>
<thead>
<tr>
<th>phase</th>
<th>tube potential [kVp]</th>
<th>tube current (eff.) [mAs]</th>
<th>primary collimation [mm]</th>
<th>slice thickness (recon.) [mm]</th>
<th>delay [s]</th>
<th>gantry rotation time [s]</th>
<th>number of acquisitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. native</td>
<td>120&lt;sup&gt;1&lt;/sup&gt;</td>
<td>210&lt;sup&gt;1&lt;/sup&gt;</td>
<td>2 × 64 × 0.6</td>
<td>3.0/1.5</td>
<td>4</td>
<td>0.5</td>
<td>helical</td>
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<tr>
<td>contrast medium: 80 ml (flow 5 ml/s); ROI: abdominal aorta at the level of the coeliac trunk; trigger threshold: 120 HU; cycle time: 1.5 s; monitor delay: 10 s</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. arterial</td>
<td>120&lt;sup&gt;1&lt;/sup&gt;</td>
<td>210&lt;sup&gt;1&lt;/sup&gt;</td>
<td>2 × 64 × 0.6</td>
<td>3.0/1.5</td>
<td>10</td>
<td>0.5</td>
<td>helical</td>
</tr>
<tr>
<td>3. venous</td>
<td>120&lt;sup&gt;1&lt;/sup&gt;</td>
<td>210&lt;sup&gt;1&lt;/sup&gt;</td>
<td>2 × 64 × 0.6</td>
<td>3.0/1.5</td>
<td>40</td>
<td>0.5</td>
<td>helical</td>
</tr>
<tr>
<td>15 minutes break: contrast medium clearance – patient remaining on the CT table</td>
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<td></td>
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</tr>
<tr>
<td>4. perfusion</td>
<td>5n140/80</td>
<td>104/270</td>
<td>32 × 0.6</td>
<td>3 × 5.0</td>
<td>13</td>
<td>0.5 (full rotation)</td>
<td>34 dynamic</td>
</tr>
<tr>
<td>contrast medium: 80 ml with 40 ml saline solution chaser (flow 5 ml/s)</td>
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</tbody>
</table>

<sup>1</sup> plus CARE Dose 4D and CARE kV, Siemens.
Results

The study population consisted of 24 patients (16 men, 8 women) (mean age 66.2 years; range: 48 – 83). The mean follow-up period in the group of postoperative soft tissue formation was 42.4 months. During this period no suspicious growth was detected in the regular follow-up CT. In the group with pancreatic cancer recurrence mean follow-up was 14.7 months.

DECT perfusion was feasible and could be evaluated in all 24 patients. The final diagnosis was local recurrence of pancreatic cancer in 15 patients. In nine patients postoperative soft-tissue formation without local recurrence was diagnosed. Out of the 15 patients with recurrence histological proof of local recurrence was available in four patients, while the remaining 11 patients showed typical symptoms of progressive disease in the further follow-up confirming the diagnosis. The mean diameter of the recurrent tissue formations was 1.9 × 2.5 cm, while the diameter of the non-tumorous postoperative tissue averaged 1.2 × 2.1 cm.

In Fig. 1 the box-plot exemplifies the data points of the blood flow in recurrence versus postoperative soft-tissue formations. The mean values with standard deviation for blood flow, permeability and blood volume in recurrence and unspecific postoperative tissue formations for weighted average 120kVp-equivalent DE image data are visualized in Fig. 2, 3 and summarized in Table 2. The blood-flow values for recurrence tissue were lower compared to postoperative soft tissue with a range from [8.4 – 29.9] ml/100 ml/min for weighted average 120 kVp-equivalent image data in recurrence and a range from [9.9 – 66.9] ml/100 ml/min for weighted average 120kVp-equivalent image data in postoperative soft-tissue formation. These differences did not reach statistical significance (p = 0.06).

Mean permeability values were lower in recurrence tissue compared to postoperative soft tissue with a range from [0.9 – 17.1] ml/100 ml/min and [1.6 – 29.7] ml/100 ml/min for weighted average 120 kVp-equivalent image data (n.s.). The blood volume values were nearly the same in recurrence and postoperative soft tissue (range: 0.1 – 6.2 ml/100 ml and 0.04 – 5.96 ml/100 ml) for weighted average 120 kVp-equivalent image data (n.s.; Table 2).

Radiation exposure

The mean total radiation exposure (DLP) for the entire CT examination (regular follow-up CT plus dynamic perfusion sequence) was 1248.9 mGy × cm (Deff (total) = 18.7 mSv) subdivided in 598.8 mGy × cm (Deff (DECT perfusion) = 9.0 mSv) for the perfusion sequence [range 258 – 761 mGy × cm (Deff = 3.9 – 11.4 mSv] and 650.1 mGy × cm (Deff (3-phase CT) = 9.7 mSv) for the regular follow-up CT [range 260 – 1362 mGy × cm (Deff = 3.9 – 20.4 mSv]. In line with the regular follow-up acquisitions all patients had ar-
Table 2  Mean values with standard deviation of blood flow, permeability and blood volume for recurrence and postoperative soft-tissue formation after pancreatic cancer resection at average weighted 120 kVp examinations.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Recurrence tissue (n = 15)</th>
<th>Postoperative soft tissue (n = 9)</th>
<th>p-value</th>
</tr>
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<tbody>
<tr>
<td>Blood flow [ml/100 ml/min]</td>
<td>16.6 ± 6.0</td>
<td>24.7 ± 18.1</td>
<td>0.06</td>
</tr>
<tr>
<td>Permeability [ml/100 ml/min]</td>
<td>8.7 ± 4.0</td>
<td>10.7 ± 9.3</td>
<td>0.23</td>
</tr>
<tr>
<td>Blood volume [ml/100mll]</td>
<td>2.3 ± 1.6</td>
<td>2.8 ± 1.8</td>
<td>0.25</td>
</tr>
</tbody>
</table>

Abb. 3 Arterielle Phase a und farbkodierte Parameterkarte der Werte für den Blutfluss, berechnet aus der Perfusionsssequenz b zeigen ein Beispiel für ein postoperatives Narbengewebe um die Arteria hepatica (Pfeil). In der farbkodierten Parameterkarte der Werte für den Blutfluss b stellen violette/blaue Farbtöne niedrige und gelbe/rote Farbtöne hohe Blutflüsse dar. Der entsprechende Wert des Blutflusses des Narbengewebes war 37.4 ml/100 ml/min (rote Ellipse).

**Discussion**

In the present study, dual source dual energy CT perfusion has been used for the first time to differentiate local disease recurrence from unspecific soft-tissue alterations in patients after pancreatic cancer resection. We found that while local disease recurrence shows lower blood flow than postoperative soft-tissue formation, there was a considerable overlap between both groups. Local recurrence of pancreatic cancer occurs in 80% of patients within 2 years after potentially curative resection [17]. Patients with isolated local recurrence of pancreatic cancer show a survival benefit when repeat resection [3] with or without radiotherapy can be performed [18], and should therefore be identified early during follow-up. One of the most difficult radiological challenges in this context is the differentiation between unspecific postoperative soft-tissue alterations and true recurrence at an early stage with conventional imaging modalities.

In some cancer centers, postoperative follow-up with PET-CT imaging after pancreatic cancer resection is performed under the assumption that this imaging method is superior in identifying pancreatic cancer relapse compared to CECT [19, 20]. This is, however, a costly and not widely available method. Consequently, a postoperative follow-up protocol including regular CECT and tumor marker measurement as a cost-effective standard is used in most centers, and PET-CT is performed only in cases of inconclusive CT and tumor marker clinical findings [4]. A new complementary CT technique providing additional functional information on the examined tissue, such as CT perfusion and dual-energy CT could overcome the disadvantage of CECT compared to PET-CT, with the benefit of greater availability and lower costs. Dual-energy CT and perfusion-CT as well as the combination thereof are expected to improve the diagnosis of pancreatic cancer [11, 21 – 23]. Using perfusion-CT, the analysis of temporal changes of attenuation (in Hounsfield units [HU]) allows assessing the vascular supply of tumors. The derived blood flow values correlate with the histopathologically determined microvessel density in pancreatic neuroendocrine tumors [24]. Dual-energy CT offers the possibility of a simultaneous data acquisition using different photon spectra (usually at 80/100 kVp and 140 kVp) of distinctly different mean energies during a single helical acquisition [25]. The thereby derived weighted average 120 kVp-equivalent image data combine the advantages of increased (iodine) contrast at 80 kVp with the low noise at 140 kVp, and could thus improve the delineation of perfusion differences between pancreatic cancer recurrence and postoperative soft-tissue alterations.

One previous dual-energy perfusion-CT study in pancreatic cancer showed the potential of dual-energy perfusion-CT in patients with pancreatic carcinoma by more accurate measurements compared to single-energy perfusion-CT [11].

Our findings of non-significantly reduced blood-flow values in pancreatic cancer recurrence tissue compared to non-tumorous postoperative soft tissue tend to match the results of CT perfusion studies evaluating primary pancreatic cancer. These studies reported reduced blood flow in pancreatic adenocarcinomas.
compared to healthy pancreatic tissue both in dual-energy perfusion-CT as well as single-energy perfusion-CT [12]. Our findings suggest that local pancreatic cancer regrowth induces changes leading to a reduced tissue-perfusion, similar to primary pancreatic cancer growing in healthy pancreatic tissue. Histopathologically confirmed pancreatic cancer recurrences show similar changes as primary pancreatic tumors with desmoplastic altered tissue with fibrous stroma and epithelioid tumor cells [26], which explain a reduced blood flow in these lesions. Compared to the reported blood-flow values of pancreatic cancer in previous dual-energy and single-energy studies, the blood-flow values of local recurrence of pancreatic cancer in our study were even lower, with mean values of 17 ± 6 "0.01 min⁻¹ vs. 27 ± 4 "0.01 min⁻¹ and 32 ± 28 "0.01 min⁻¹ [10, 11]. This can be explained by the perfusion characteristic of the underlying environmental tissue in which the respective lesions develop. As both postoperative soft tissue and pancreatic recurrence tissue have very low blood volume values we could not find significant differences between the two. The permeability values in pancreatic cancer recurrence compared to non-tumorous postoperative soft tissue were in the same range with a slight trend towards lower permeability values in cancer regrowth. This finding again matches the results of the comparison between pancreatic cancer and healthy pancreatic tissue. The values tended to be lower in pancreatic cancer, but without significant difference and a wide range in values [11, 12]. In earlier perfusion-CT studies, permeability values for local recurrence of pancreatic cancer compared to primary pancreatic cancer were clearly lower which is in line with the finding of the present study. We found a mean permeability of approximately one-fourth of the reported permeability-values in pancreatic cancer tissue [11, 12]. A limitation of the study is the small number of patients without local recurrence of pancreatic cancer. Further studies including more patients are needed to confirm the trend we found between recurrence and non-tumorous postoperative soft tissue. Secondly we did not obtain histological confirmation of the suspected recurrence in all patients. The local recurrences that were diagnosed by further signs of progression in the following examinations already showed a measurable progression in size compared to former CT at the time of examination with the perfusion-CT-protocol. Nevertheless, it is possible that the soft-tissue formation at the time of examination with the perfusion-protocol was not representative for recurrent malignant tissue in the perfusion-CT. Therefore an overestimation of local recurrence in this study is possible. Further studies with regular integration of dual-energy-/perfusion-imaging could solve this problem by recording functional parameters during the course of follow-up, but significant dose-reduction would thus be required. Furthermore, there was no histological confirmation in patients with unspecific postoperative soft-tissue formation due to the corresponding small alterations, which are not easily accessible for puncture, for example. However, we supposed a comparatively long period of follow-up without any signs of progression in these patients long enough to assume that these changes do not have primary malignant behaviour. In conclusion, dual-energy perfusion CT is feasible in patients after pancreatic cancer resection and is a promising functional imaging technique. As we only found a trend to lower perfusion values in local recurrence compared to unspecific postoperative tissue alterations, the perfusion differences between both tissues are not yet sufficient to allow a clear distinction. Further studies including larger patient collectives and technical improvements are needed to achieve reliable data for this differentiation.

Acknowledgements

This research was supported by the German Research Foundation (DFG) within project R02 entitled “Innovative Imaging of Tissue Perfusion” of the Transregional Collaborative Research Center SFB/TRR 125 “Cognition-guided Surgery”.

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