Tumor Microcirculation Evaluated by Dynamic Magnetic Resonance Imaging Predicts Therapy Outcome for Primary Rectal Carcinoma

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ABSTRACT

Contrast enhanced dynamic studies of malignant tumors performed by computed tomography or magnetic resonance imaging (MRI) are increasingly applied to characterize tumor microcirculation for the prediction of therapy outcome. The aim of our study was to correlate perfusion index (PI) values determined in primary rectal carcinoma before chemoradiation with therapy outcome.

In 17 patients with clinically staged T3 primary rectal carcinoma, dynamic MRI was performed before the onset of therapy using an ultrafast T1-mapping sequence. On the basis of the acquired data sets, PI values were calculated on a pixel-by-pixel basis. To characterize the heterogeneity of tumor microcirculation, relative cumulative frequency histograms of PI values within the tumors were computed. Subsequent resection of the tumors allowed correlating PI with histopathological classification.

In 12 of 17 patients, T-downstaging as a response to therapy was found, whereas in the remaining 5 patients no therapy response was observed after chemoradiation. A statistically significant difference between both groups was found for the mean PI (P < 0.001; \(8.5 \pm 1.7\) ml/min/100 g versus \(11.4 \pm 0.7\) ml/min/100 g). Analyzing the cumulative frequency histograms for both groups revealed an optimal discrimination for a PI value of 12.6 ml/min/100 g. The fraction of pixels in the tumor with PI values larger than 12.6 ml/min/100 g was significantly different (P < 0.001) between therapy-responding (3 ± 3.6%) and therapy-nonresponding tumors (21 ± 4.3%).

The results indicate either a reduced supply of nutrients as well as chemotherapeutic agents attributable to increased shunt flow or highly aggressive tumor cell clusters characterized by increased angiogenic activity. Noninvasive PI measurements by dynamic MRI in rectal carcinoma before therapy seem to be of predictive value for therapy outcome in patients scheduled for preoperative chemoradiation.

INTRODUCTION

Commonly used prognostic factors, such as clinical staging and histology, do not always predict therapy outcome effectively. To optimize therapy outcome, the clinical investigation of tumors should be performed in patient groups having the same tumor entity and stage and should concentrate on individual tumor biology. In combined chemoradiation therapy, therapy outcome is influenced (a) by the presence of hypoxic areas inside the tumor (1–3) and (b) by the uptake and retention of chemotherapeutic agents within the tumor tissue (4, 5). Both factors depend on parameters such as tumor perfusion and the ability of agents to extravasate through the vessel wall (6, 7).

To evaluate these microcirculatory parameters, contrast enhanced dMRI or dCT has been applied in recent studies, and the results were used as a predictor of radiotherapy response (8–11). The results indicate considerable clinical relevance but also demonstrate that inhomogeneity regarding tumor entity, stage, and treatment schemes has to be a point of major concern in the design of clinical studies. These studies, moreover, usually focus on areas with high contrast media uptake within the tumor, so called “hot spots,” to evaluate prognostic factors (8, 9), whereas intratumoral variation of microcirculatory parameters is disregarded.

Therefore, it was the aim of the present study to evaluate the predictive value of intratumoral frequency histograms of the PI, a microcirculatory parameter estimated from dMRI examinations, for therapy outcome in a homogenous group of patients regarding tumor entity (rectal carcinoma; G2), stage (cT3), and treatment scheme (standardized preoperative combined chemoradiation).

MATERIALS AND METHODS

Patients. From October 1997 to July 2000, 17 patients with rectal cancer were examined in this ongoing study. Included were all of the patients (mean age, 53.9; range, 38–71 years) with primary, histologically proven adenocarcinoma G2 of the rectum without metastatic spread who were scheduled for preoperative chemoradiation. In each patient, tumor staging, assessed by intrarectal ultrasound examination, showed infiltration into the perirectal fat and confirmed the diagnosis of a cT3 tumor (12). Excluded from the study were patients with tumor invasion of the sphincter, previous surgical operation or radiation in the area of the abdomen, previous chemotherapy, acute or previous second malignancies, contraindications for the MRI examination, or premature discontinuation of therapy including delayed or cancelled operation. The postoperative pathological classification was performed by an experienced pathologist (A. K.) in accordance with the T-classification of the American Joint Committee on Cancer 1998 (12). For each tumor, therapy outcome was classified either as “response,” if the pathological observation revealed no invasion into the perirectal fat (ypT0–2), or as “nonresponse,” if the observation yielded invasion (ypT3). Detailed patient data are summarized in Table 1.

The trial was approved by the Local Institutional Review Board. Written informed consent was obtained from all of the patients, after the nature of the procedure had been fully explained to them.

Treatment Technique. Each patient received preoperative, combined chemoradiation. A total radiation dose between 38.3 Gy and 45 Gy was administered at a single dose of 1.1 Gy twice a day. The radiation fields included the rectal canal and adjacent lymph nodes. Parallel to this, 350 mg/m² 5-fluorouracil (5-fluorouracil “Ebewe”; EBWE WE Ltd., Co., Austria) was administered continuously through an implanted central venous catheter (Port-A-Cath Deltec CADD-1 system; SIMS Deltec, Inc.) on each treatment day. Each combined chemoradiation started on Monday and was interrupted on weekends. After 4 weeks of treatment, all of the patients were allowed a therapy-free recovery interval of 2 weeks and subsequently scheduled for surgery in the following week.

MRI and Estimation of Perfusion Parameters. MRI examinations were performed with a 1.5-T whole-body MRI system (Magnemot VISION Plus; 3 The abbreviations used are: dMRI, dynamic contrast enhanced magnetic resonance imaging; dCT, dynamic contrast enhanced computed tomography; T-stage, extent of the tumor; G2, histopathological grade 2; CT, clinical classification of the tumor extent; PI, perfusion-index; ypT, pathological classification after initial multimodality treatment; PS, permeability-surface area.
To quantify tumor microcirculation, the PI was calculated for each pixel inside the defined tumor region according to:

\[ PI = \frac{1}{\sigma_{tumor}} \left[ \frac{dC_{tumor}/dt}{dC_{artery}/dt} \right] \]

where \( dC_{tumor}/dt \) is the maximum slope of the concentration-time curve as measured in the tumor, and \( C_{artery} \) is the maximum of the arterial input curve.

As described by Peters et al. (18) and Miles (19), the fraction of pixels with PI values lower than or equal to the specified PI value in the 17 patients (70.6%) showed a positive downstaging (ypT0–2; therapy responder), whereas the others (29.4%) showed no change in T-stage (ypT3; therapy nonresponder; Table 1).

Classifying the patients in two groups according to treatment outcome, therapy responders showed a lower mean PI of 8.5 ± 1.7 ml/min/100 g (95% confidence interval, 7.4–9.6 ml/min/100 g), whereas therapy nonresponders showed a higher mean PI of 11.4 ± 0.7 ml/min/100 g (95% confidence interval, 10.6–12.3 ml/min/100 g). The difference between both groups was highly significant (\( P < 0.001 \)).

Cumulative frequency histograms of the PI values are presented in Fig. 1 for all of the 17 patients. Significant differences between the therapy responder and the nonresponder group were found for all of the PI intervals between 8.4 ml/min/100 g and 14.7 ml/min/100 g (\( P < 0.01 \)). The best discrimination between both groups was found for a PI value of 12.6 ml/min/100 g (\( P < 0.001 \)). For this value, a mean fraction of 3.2 ± 3.6% (95% confidence interval, 0.9–5.5%) of the tumor pixels showed PI values greater than 12.6 ml/min/100 g in the responder group, as compared with a mean fraction of 21.3 ± 4.3% (95% confidence interval, 16–26.6%) in the nonresponder group. Again, the difference between both values was statistically significant (\( P < 0.001 \)).

DISCUSSION

In this study, tumor microcirculation was evaluated before the onset of fractionated combined chemoradiation. In contrast to previous
reports, a homogenous patient group was examined with respect to tumor entity (primary rectal carcinoma), stage (cT3, G2), and treatment schedule (standardized preoperative combined chemoradiation) to minimize the influence of these factors on therapy outcome. The subsequent resection of the tumors makes it possible to compare the pretherapeutic clinical findings with the histopathological classification after chemoradiation. Post-therapeutic T-stage was used as a clinical end point because it is proven to be an independent prognostic factor on therapy outcome in rectal carcinoma, whereas the relevance of other factors such as tumor volume are currently unknown (12).

The noninvasive imaging approach applied in this study has been described in detail in a previous publication (14, 15) and has been proven to be a robust and practical tool for monitoring tumor microcirculation. Thus far, only one slice through the tumor could be examined with our technique. This is certainly a limitation because it necessitates the assumption that the tumor region evaluated is a representative sample of the total tumor. But the same limitation exists with other measurement techniques such as polarographic oxygen measurements or tumor biopsies.

An additional point of consideration in our study is the interpretation of the microcirculatory parameter PI. Because of limitations in the temporal resolution of the imaging technique used, PI is a measure of both perfusion and capillary PS product. Both parameters together control the accumulation of nutrients as well as therapeutic agents in the interstitial environment of the tumor cells (21). However, this kind of ambiguity is inevitably connected to all of the commonly used approaches, even when standardized quantities and techniques are applied (22). A problem of earlier studies using descriptive curve parameters has been the neglect of the arterial input function (8, 10). The advantage of our approach is that information about the individual arterial input function is taken into account for the calculation of PI, as described in Eq. A.

There are few studies in literature comparing contrast enhancement with tumor areas showing increased angiogenic activity (28). In this study, a significant difference in the intratumoral PI values between patients responding to chemoradiation and those not responding. The nonresponding tumors were characterized by a high fraction of pixels with PI values greater than 12.6 ml/min/100 g, whereas responding tumors typically showed a significantly lower fraction. Defining a fraction of 15% as a threshold provided a complete discrimination between responders and nonresponders. This means that in any tumor where the fraction of pixels with PI values higher than 12.6 ml/min/100 g was smaller than 15%, preoperative combined chemoradiation resulted in a therapy response, whereas in tumors with a fraction greater than 15%, no therapy effect regarding T-stage was observed.

As discussed above, because microcirculatory tumor parameters such as the PI combine information about perfusion as well as PS product, the interpretation of our findings is difficult and strongly dependent on the question of which physiological parameter, perfusion or PS product, dominates the uptake of the contrast agent. If PI is a strong indicator of perfusion, the negative predictive value of a high mean PI on therapy response as observed in our study is contradictory to the well-established assumption that high perfusion values in tumors are associated with sufficiently high supply of nutrients such as oxygen or chemotherapeutic agents to the tumor cell and, as a consequence, with an increased effectiveness of therapeutic regimes such as chemotherapy and/or radiotherapy. To understand this controversial point, it may be speculated that areas with high PI in nonresponding tumors are caused by histopathologically established arteriovenous shunts that facilitate the direct passage of blood from arterial supply to the venous drainage without passage through the capillary bed, resulting in a high perfusion rate with no or only low exchange of nutrients (e.g., oxygen) or chemotherapeutic agents. Flow through these arteriovenous shunts has been estimated to be up to 30% of total tumor flow (25–27). If, on the other hand, PI is a strong indicator of PS product, then it can be speculated that the high PS products found in our study for nonresponding tumors are associated with tumor areas showing increased angiogenic activity (28). In this case, our findings are in good agreement with various studies, in which the correlation between tumor angiogenesis and tumor aggressiveness has been assessed by more or less invasive techniques in different types of cancers (29, 30). To decide which physiological parameter, perfusion or PS product, is dominating, both microcirculatory parameters must be evaluated separately. Unfortunately, apart
from some promising approaches (31, 32), there is no established method available presently for dMRI and dCT that allows differentiating between perfusion and PS product.

Nevertheless, with respect to the prediction of therapeutic outcome, the findings in this study underline the importance of assessing the heterogeneity and variability of microcirculation within the tumor before therapy. By applying a method that allows this kind of evaluation, our results indicate that prognostic information can be obtained even for the individual patient.

In summary, our findings allow the formulation of three hypotheses for advanced primary rectal carcinoma: (a) aside from known factors (e.g., TNM-stage), the response to chemoradiation is determined by some promising approaches (31, 32), there is no established method available presently for dMRI and dCT that allows differentiating between perfusion and PS product.

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REFERENCES

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