Lymphoscintigraphy in Chyluria, Chyloperitoneum and Chylothorax

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Lymphoscintigraphy allows functional assessment of lymphatic transport and depiction of regional lymph nodes, is fast and non-traumatic and has no known side effects. We retrospectively analyzed lymphoscintigraphic studies to determine their efficacy in the investigation of chyluria, chyloperitoneum and chylothorax. Methods: Twenty-one whole-body lymphoscintigrams using 99mTc-per-rectal lymphoscintigraphy were obtained from patients with chyluria, chyloperitoneum and/or chylothorax. The images were reviewed to assess the rate of tracer transport and number, size and distribution of lymph vessels and nodes as well as the presence of collateral, fistula or lymph reflux. Results: Lymphoscintigraphy was normal in 5 of 11 patients who showed lymphatic obstruction (6 of 11 patients) in chyluria associated with filariasis. Lymphatic obstruction was demonstrated in chyloperitoneum and/or chylothorax associated with liver cirrhosis (2 patients), postoperative (1 patient) or congenital (1 patient) lymphatic dysplasia, inferior vena cava obstruction (1 patient) and nephrotic syndrome (1 patient). Enhanced lymph flow was seen in systemic lupus erythematosus (1 patient). Follow-up lymphoscintigrams showed patent lymphovenous anastomosis (1 patient), improvement (1 patient) or no change (1 patient) in lymphatic drainage after treatment. Conclusions: Lymphoscintigraphy can demonstrate abnormal lymphatic drainage in chyluria, chyloperitoneum and chylothorax. It is useful for selecting patients for surgery and assessing the effect of treatment.

Key Words: chyluria; chyloperitoneum; chylothorax; lymphoscintigraphy


Lymphangiography has been the main imaging modality in investigating chyluria, chyloperitoneum and chylothorax. It is useful for detecting abnormal retroperitoneal lymph nodes, leakage from dilated lymphatics, lymphoepipelvic fistulization, skipping of lymphatic chain, patency of thoracic duct and abnormal leg lymphatics (1–3). However, it requires tedious cannulation of lymphatics, is invasive and is not readily reproducible. It also can result in local tissue necrosis, fat embolism to the lungs, hypersensitivity reaction and exacerbation of lymphedema by the contrast material (4). Lymphoscintigraphy using 99mTc-sulfur microcolloid, antimony sulfide colloid, stannous phytate, rhenium sulfur material (4). Lymphoscintigraphy allows functional assessment of lymphatic transport and depiction of regional lymph nodes, is fast and non-traumatic and has no known side effects. We retrospectively analyzed lymphoscintigraphic studies to determine their efficacy in the investigation of chyluria, chyloperitoneum and chylothorax. Methods: Twenty-one whole-body lymphoscintigrams using 99mTc-per-rectal lymphoscintigraphy were obtained from patients with chyluria, chyloperitoneum and/or chylothorax. The images were reviewed to assess the rate of tracer transport and number, size and distribution of lymph vessels and nodes as well as the presence of collateral, fistula or lymph reflux. Results: Lymphoscintigraphy was normal in 5 of 11 patients who showed lymphatic obstruction (6 of 11 patients) in chyluria associated with filariasis. Lymphatic obstruction was demonstrated in chyloperitoneum and/or chylothorax associated with liver cirrhosis (2 patients), postoperative (1 patient) or congenital (1 patient) lymphatic dysplasia, inferior vena cava obstruction (1 patient) and nephrotic syndrome (1 patient). Enhanced lymph flow was seen in systemic lupus erythematosus (1 patient). Follow-up lymphoscintigrams showed patent lymphovenous anastomosis (1 patient), improvement (1 patient) or no change (1 patient) in lymphatic drainage after treatment. Conclusions: Lymphoscintigraphy can demonstrate abnormal lymphatic drainage in chyluria, chyloperitoneum and chylothorax. It is useful for selecting patients for surgery and assessing the effect of treatment.

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Phaticopelvic fistulization, skipping of lymphatic chain, patency of thoracic duct and abnormal leg lymphatics (1–3). However, it requires tedious cannulation of lymphatics, is invasive and is not readily reproducible. It also can result in local tissue necrosis, fat embolism to the lungs, hypersensitivity reaction and exacerbation of lymphedema by the contrast material (4). Lymphoscintigraphy using 99mTc-sulfur microcolloid, antimony sulfide colloid, stannous phytate, rhenium sulfur microcolloid, anthimony sulfide colloid, stannous phytate, rhenium sulfur colloid, human serum albumin or dextran delineates the pattern of lymphatic drainage, is fast and non-traumatic and has no known side effects (5–6). Use of lymphoscintigraphy in investigating chyluria, chyloperitoneum and chylothorax has been limited to a few case reports (7–13). We retrospectively analyzed lymphoscintigraphic studies to determine their efficacy in the investigation of chyluria, chyloperitoneum and chylothorax.

MATERIALS AND METHODS

Between June 1989 and May 1996, lymphoscintigraphy was performed on 18 patients with chyluria (9 women, 2 men), chyloperitoneum (2 men), chyloperitoneum and chylothorax (3 women, 2 men). Follow-up scans were obtained on 3 patients, giving a total of 21 lymphoscintigraphic studies. The average patient age was 38.0 yr (range 25–57 yr), and average duration of symptoms was 4.7 yr (range 3 mo to 36 yr) for chyluria and 6.0 mo (range 10 days to 18 mo) for chyloperitoneum and chylothorax. Elephantiasis of the lower extremities was the most common associated symptom. Other associated symptoms and signs included hematuria, flank pain, dysuria, urinary frequency, oliguria, weight loss, fever, cough, anasarca, chest discomfort, dyspnea and enlarged inguinal lymph nodes. A previous history of filariasis was known in 7 of 13 patients with chyluria. Urine, peritoneal, pleural or pericardial fluid were positive for fat droplets after Sudan staining and negative for acid-fast bacilli, culture and cytology in all patients. Repeated thick-film night blood smears were also negative for microfilaria in all patients. Final diagnoses were made...
by correlating lymphoscintigraphic findings with laboratory and other imaging studies, including chest radiograph, barium meal, intravenous urogram, renogram, ultrasound, CT, MRI, lymphangiogram, venogram and aortogram. The diagnoses included filariasis (11 patients), liver cirrhosis (2 patients), postoperative (1 patient) or congenital (1 patient) lymphatic dysplasia, nephrotic syndrome (1 patient), inferior vena cava (IVC) obstruction (1 patient) and systemic lupus erythematosus (1 patient).

Lymphoscintigraphy was performed using a large-field-of-view gamma camera fitted with a low-energy, general-purpose collimator. Anterior whole-body scans were acquired 5–10 min and 20–30 min after subcutaneous injection of 37 MBq $^{99m}$Tc-antimony sulfide colloid (14 patients) or $^{99m}$Tc-dextran (4 patients) into the first and second interdigital spaces of both feet and/or hands at a scanning speed of 15 cm/min. Delayed scans of 1–6 hr were also obtained when the early images were abnormal. Images were reviewed by two nuclear medicine physicians. Delayed transport of the tracer and/or depiction of regional lymph nodes with or without collateral, fistula, tracer extravasation or reflux and crossover filling of lymph nodes were interpreted as incomplete lymphatic obstruction. No tracer transport and/or absent regional lymph nodes were considered to be complete lymphatic obstruction.

**RESULTS**

Lymphoscintigraphic findings, diagnoses and treatment are summarized in Table 1. Of the 11 patients with chyluria associated with filariasis, the lymphoscintigram was normal in 5 patients and showed complete obstruction of the right iliac lymphatics in 1 patient, incomplete right periaortic lymphatic obstruction in 3 patients and incomplete left iliac lymphatic obstruction in 1 patient with and 1 patient without right renal fistulization (Figs. 1–3). Enhanced lymph flow in the left arm and right leg was demonstrated in 1 patient (Patient 12) with chyluria, chyloperitoneum and lymphedema of the left arm and right leg associated with systemic lupus erythematosus (Fig. 4). The lymphoscintigram in 1 patient (Patient 13) with chyluria and chyloperitoneum from liver cirrhosis showed reflux of the tracer into the peritoneal cavity and attenuation of radioactivity

![FIGURE 1. Patient 4, a 32-yr-old woman with chyluria associated with filariasis. The anterior whole-body lymphoscintigram using $^{99m}$Tc-antimony sulfide colloid is normal with prompt and symmetrical appearance of radioactivity in the lymph vessels and nodes.](image-url)
FIGURE 4. Patient 12, a 29-yr-old man with chyluria, chyloperitoneum, and elephantiasis of the left arm and right leg associated with systemic lupus erythematosus. Technetium-99m-antimony sulfide colloid scans at (A) 10 min and (B) 60 min show enhanced lymph flow in the left arm and right leg.

Postoperative lymphoscintigram on 1 patient (Patient 5) showed patent left inguinal lymphovenous anastomosis (LVA) with prompt appearance of tracer in the kidneys, bladder, liver, and heart (Fig. 6). A follow-up scan showed no change in 1 patient on supportive treatment for liver cirrhosis (Patient 14) and improvement of lymph flow in another patient (Patient 11) after antifilarial drug therapy, renal pelvic lavage and LVA.

FIGURE 5. Patient 13, a 25-yr-old man with chyluria and chyloperitoneum associated with liver cirrhosis. The 60-mm delayed Technetium-99m-antimony sulfide colloid scan shows lymph reflux with an accumulation of tracer in the peritoneal fluid and attenuation of peritoneal and iliac lymphatics by ascites.

FIGURE 2. Patient 7, a 36-yr-old woman with chyluria and left leg lymphedema associated with filariasis. The Technetium-99m-antimony sulfide colloid scan obtained at 45-min shows incomplete left iliac lymphatic obstruction with collaterals in the left leg and delayed depiction of left iliac lymph nodes.

FIGURE 3. Patient 8, a 43-yr-old woman with chyluria associated with filariasis. The serial Technetium-99m-antimony sulfide colloid scan demonstrates incomplete obstruction with delayed tracer transport in the left iliac lymphatic vessel and delayed depiction of left inguinal nodes. Radioactivity in the right kidney at 150 min suggests lymphaticopelvic fistula (arrow).

in the bilateral iliac and periaortic lymphatics by peritoneal fluid (Fig. 5). One patient (Patient 18) with chylothorax, chylopericardium and elephantiasis of the left upper and lower extremities had congenital hypoplasia of left periaortic, iliac, leg and arm lymphatics. Of the remaining 4 patients with chyloperitoneum and chylothorax, the lymphoscintigram showed complete bilateral periaortic lymphatic obstruction.

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Pelvic lavage with 1% silver nitrate; inguinal LVA was performed in 5. One patient (Patient 13) with chyluria and massive lymph reflux into the peritoneal cavity on the lymphoscintigram did not respond to peritoneovenous shunt and LVA. Specific treatment of the primary disorder and/or supportive therapy with repeated therapeutic paracentesis and thoracentesis were given to the remaining 6 patients with chyloperitoneum and chylothorax.

**DISCUSSION**

Lymphoscintigraphy was first introduced in 1953 using Au-colloid. Because of its high absorbed radiation at the injection site, Au has been replaced by Tc-colloid, human serum albumin and dextran. Lymphoscintigraphy allows functional assessment of lymphatic transport and depiction of regional lymph nodes. After the interstitially administered tracer is taken up into the lymphatics, clearance and trapping of colloid in lymph nodes are dependent on particle size and functional status of the reticuloendothelial system. Less than 35% of colloidal particles are absorbed in 24 hr and a delay of several hours may be required to image draining nodes. Transport of dextran depends on diffusion, less on actual lymph flow and is accelerated by skeletal muscle and lymphatic contractions. Thus, total-body uptake of dextran is faster and greater than that of antimony sulfide colloid. In spite of rapid lymph node uptake rates, total popliteal lymph node sequestration of dextran has been shown to be significantly lower because of its higher uptake by lymphatic to venous system and increase background reticuloendothelial activity of ilioinguinal nodes. Dextranavidation may be difficult to distinguish from lymph reflux (16). We observed right renal lymph reflux in only one patient with chyluria. The initial diagnosis of filariasis is based on laboratory criteria using filaria-specific IgG and thick-film blood smear for microfilaremia. It has been shown that asymptomatic infected persons invariably have circulating microfilaremia, whereas patients who have clinical manifestations and active filarial infection frequently have no detectable microfilaremia (17). None of the patients with chyluria associated with filariasis in our study had microfilaremia. The diagnosis of filariasis in these patients was based on a history of previous exposure, exclusion of other causes of chyluria and response to antifilarial therapy.

Chyloperitoneum and chylothorax result from interference of lymph flow at the base of the mesentery, cisterna chyli or thoracic duct caused by primary lymphatic dysplasia; infection, especially filariasis and tuberculosis; peritoneal dialysis; or exposure, exclusion of other causes of chyluria and response to antifilarial therapy.
cirrhosis. A lymphoscintigram of one of the patients with chyloperitoneum from liver cirrhosis showed lymph reflux into the peritoneal cavity. IVC obstruction and postsinusoidal portal hypertension result in increased lymph flow through the thoracic duct from viscera due to venous stasis. Leakage of chyle from the disrupted lymph vessels and fistulas causes chyloperitoneum and chylothorax. Lymphatic drainage and transdiaphragmatic movement of chylous peritoneal fluid through the pleuroperitoneal canal have been proposed as mechanisms in the formation of chylothorax. Radioisotope migration speed may be a clue for differentiating these two mechanisms, which is more rapid in the presence of a diaphragmatic defect (18,19).

Chyloperitoneum occurs in 52% of nephrotic syndrome patients, possibly because of bowel ischemia with resultant lacteal leakage or malabsorption (20).

Treatment of chyluria, chyloperitoneum and chylothorax includes fat restriction or a medium-chain triglyceride diet because synthetic triglyceride is transported from the gut directly to the liver by the portal system and is not absorbed by the lymphatics. Thus, formation of intestinal lymph and lymph flow through the thoracic duct are decreased, allowing the fistulas to seal off and the collaterals to open up. In more severe cases of chyluria it may be necessary to (a) instill 0.5%–1% silver nitrate into the renal pelvis to induce chemical lymphangitis and fibrosis of the fistulas; (b) surgically disrupt lymphaticoureteral fistulas; and (c) perform renal decapsulation, LVA, renal autotransplant and nephrectomy (21). Lymphoscintigraphy can identify patent lymph vessels before surgery and determine the function of LVA after surgery. It is a suitable method of patient selection for surgery and follow-up (22). Paracentesis or peritoneovenous shunting may be effective in controlling chyloperitoneum (23). Intermittent thoracentesis, closed-chest drainage, pleurodesis and surgical ligation of the thoracic duct below the leakage may also be useful in treating chylothorax.

CONCLUSION

Lymphoscintigraphy can demonstrate abnormal lymphatic drainage in chyluria, chyloperitoneum and chylothorax. It is useful for selecting patients for surgery and assessing the effect of treatment.

REFERENCES


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