PET Imaging During Radiotherapy of Head and Neck Cancer

The worldwide incidence of head and neck cancer is estimated at approximately 643,000 (1). In the United States, approximately 53,640 new head and neck cancers will be diagnosed in 2013, with 11,520 deaths expected (2). The treatment choice for head and neck cancer depends on the primary site and surgical resectability; however, with an increasing effort of preservation of organ function the use of definitive radiation therapy alone or in combination with chemotherapy has been increasing, particularly in oropharyngeal cancers. Radiation therapy alone or in combination with an increasing effort of preservation site and surgical resectability; however, neck cancer depends on the primary 2013, with 11,520 deaths expected (2). The treatment choice for head and neck cancers will be diagnosed in approximately 643,000 (1). In the United States, approximately 53,640 new head and neck cancer patients with 18F-FDG PET at baseline and after a median of 24 Gy of radiation therapy and another group after 20, 40, and 60 Gy of a total of 72 Gy (5). Patients with a rapid drop in 18F-FDG uptake in tumors showed significantly better disease-free survival. Imaging at 10–20 Gy (1–2 wk into radiation therapy) was found to be the best time point for using 18F-FDG PET to monitor patients during therapy (5). The performance of 18F-FDG PET was, however, significantly lower in predicting disease-free survival in 2 additional studies when 18F-FDG PET was performed later, after 40 or 47 Gy of radiation, and images were analyzed only visually for the presence or absence of residual uptake in tumors (6,7). It has also been questioned whether the changes in standardized uptake value (SUV) early after radiation therapy fully reflect the changes in the biology of head and neck cancer. In a preclinical study that used autoradiography and PET imaging 11 d after radiation therapy, the maximum SUV (SUVmax) remained constant, although the tumor 18F-FDG accumulation on autoradiography decreased in viable tumor areas (8).

Because both radiation therapy and chemotherapy decrease proliferation rates in responding tumors, imaging the changes in cell proliferation may provide a more accurate evaluation of the treatment effects. Among several radiolabeled nucleoside analogs developed for imaging cell proliferation, 3'-deoxy-3'-18F-fluorothymidine (18F-FLT), a thymidine analog that is not incorporated into DNA, is most widely studied. The intracellular trapping of 18F-FLT is a function of the enzymatic activity of thymidine kinase 1, a key enzyme in DNA synthesis with high activity during the proliferative S phase of the cell cycle and low activity in the quiescent G0/G1 phase (9). Untreated head and neck squamous cell cancers are readily detectable with 18F-FLT PET, with high tumor-to-background ratios, although the SUV with 18F-FLT tends to be generally lower than with 18F-FDG (10–14). Comparison studies of 18F-FLT and 18F-FDG by Hoshikawa et al. showed similar detectability and false-positive rates in primary tumors and cervical nodal metastases for 18F-FLT and 18F-FDG (11,12). The pretherapy staging of head and neck cancer with 18F-FLT PET appears limited by the nontumoral uptake in reactive cervical nodal areas due to proliferation of reactive B-lymphocytes (15).

Previous studies have shown a significant drop in 18F-FLT uptake in squamous cell head and neck cancer early after initiation of radiotherapy (14,16). However, the correlation between the change in 18F-FLT uptake in head and neck cancer and disease-free survival was only recently reported in 2 studies published in The Journal of Nuclear Medicine (6,17). Hoeben et al. imaged 48 patients with stage III or IV head and neck cancer at 3 time points, first at baseline (pretherapy), after 5–12 daily fractions of radiotherapy (corresponding to 10–24 Gy), and in a subgroup of 29 patients also after 15–19 daily fractions (corresponding to 30–38 Gy) (17). Although 98% of patients had complete clinical response at the end of treatment, the 3-y disease-free survival was only 79%. There was a significantly better disease-free survival in patients who showed a 45% or more
drop in SUVmax (and ≥41% on gross tumor volume delineated with 18F-FLT) on the early mid-therapy scan. However, the change in SUVmax between the baseline and late mid-therapy scan was not predictive of treatment outcome. Patients undergoing radiotherapy alone had a better outcome if the baseline SUVmax in the primary tumor was lower (<6.6), whereas in the combined chemoradiation therapy group a higher baseline SUV tended to correlate with better outcome, possibly reflecting the better efficacy of chemotherapy in tumor tissue with a higher rate of cellular proliferation. The other recent study on the utility of 18F-FLT PET during radiation therapy was reported by Kishino et al. in the October 2012 issue of The Journal of Nuclear Medicine (6). Different from the study by Hoeben et al., the follow-up 18F-FLT PET scans in the study by Kishino et al. (6) were obtained at a later time point during treatment (median of 40 Gy of radiotherapy). The image analysis also differed in the study by Kishino et al., which dichotomized the results as positive or negative based on visual assessment of residual uptake rather than the change in SUV. This study found that during radiotherapy, 18F-FLT uptake in the tumor disappeared faster than 18F-FDG; however, the residual 18F-FLT uptake after 40 Gy of therapy still only showed a positive predictive value of 35% (17% for 18F-FDG). The negative predictive value of absence of uptake was similar for 18F-FLT and 18F-FDG (97% and 100%, respectively), although many more lesions showed visual disappearance of 18F-FLT accumulation at 40 Gy. The presence of residual 18F-FLT or 18F-FDG uptake after 40 Gy of radiation did not correlate with local control of disease over a median follow-up of 39 mo.

Several preliminary conclusions can be drawn from these studies. (1) Head and neck cancer treatment monitoring during radiotherapy with PET, either with 18F-FDG or 18F-FLT, is more effective if done earlier during therapy rather than later, probably at around 20 Gy (~2 wk with the conventional fractionation of 2 Gy/d). This may be at least partly explained by the inability of PET scans obtained later during the course of therapy to identify microscopic residual disease that is ultimately responsible for tumor recurrence. As shown by Kasamon et al. in lymphoma, the late PET scan may not be able to differentiate the tumors with the higher rate of cell kill from tumors with slower cell kill (18), leading to a false-negative late PET scan because microscopic residual disease will be below the detectability of the PET imaging system. In early responding tumors on the other hand, the rapid cell kill will lead to a rapid and significant drop in uptake of 18F-FLT and 18F-FDG early after initiation of radiotherapy. Another potential issue is the development of postradiation inflammatory changes, which will become more profound later in the therapy and may confound the interpretation of PET images. (2) Accurate quantitation of uptake in addition to visual assessment appears to improve the predictive value of PET in monitoring response to radiation therapy in head and neck cancer. This requires careful standardization of PET acquisition and image analysis for larger multicenter studies that can validate the utility of PET in monitoring response to radiation therapy in head and neck cancers. (3) Comparison data of 18F-FLT and 18F-FDG PET imaging during radiotherapy of head and neck cancer is limited. Compared with 18F-FDG, the more rapid change in 18F-FLT uptake during therapy may suggest that 18F-FLT better reflects the change in tumor biology with radiation; however, outcome data demonstrating the superiority of 18F-FLT to 18F-FDG in this setting are still lacking. It may be prudent to incorporate 18F-FLT PET in future clinical trials evaluating the utility of 18F-FLT PET during radiotherapy to monitor treatment response in head and neck cancers.

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REFERENCES

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