Radionuclide Imaging of Musculoskeletal Infection: A Review

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Learning Objectives: On successful completion of this activity, participants should be able to describe (1) the principle of combined labeled leukocyte/marrow imaging; (2) at least one advantage of 18F-FDG PET or PET/CT over MRI for diagnosing spondylodiskitis; and (3) at least one advantage of SPECT/CT over planar imaging in the diagnosis of pedal osteomyelitis in diabetic patients.

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There are numerous imaging tests for diagnosing musculoskeletal infection. Radiographs are routinely performed, because even when not diagnostic, they provide an anatomic overview of the region of interest that could influence subsequent procedure selection and interpretation. MRI is sensitive and provides superb anatomic detail. Bone scintigraphy accurately diagnoses osteomyelitis in bones not affected by underlying conditions. 67Ga is used primarily for spondylodiskitis. Although in vitro labeled leukocyte imaging is the radionuclide test of choice for complicating osteomyelitis such as diabetic pedal osteomyelitis and prosthetic joint infection, it is not useful for spondylodiskitis. Antigranulocyte antibodies and antibody fragments have limitations and are not widely available. 111In-biotin is useful for spondylodiskitis. Radiolabeled synthetic fragments of the antimicrobial peptide ubiquicidin are promising infection-specific agents. 18F-FDG is the radiopharmaceutical of choice for spondylodiskitis. Its role in diabetic pedal osteomyelitis and prosthetic joint infection is not established. Preliminary data suggest 68Ga may be useful in musculoskeletal infection. 124I-fialuridine initially showed promise as an infection-specific radiopharmaceutical, but subsequent investigations were disappointing. The development of PET/CT and SPECT/CT imaging systems, which combine anatomic and functional imaging, has revolutionized diagnostic imaging. These hybrid systems are redefining the diagnostic workup of patients with suspected or known infection and inflammation by improving diagnostic accuracy and influencing patient management.

Key Words: FDG; gallium; labeled leukocytes; osteomyelitis; PET/CT; SPECT/CT

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Acute osteomyelitis arises hematogenously or via direct inoculation. Local risk factors include open fractures, recent surgery, and orthopedic hardware. Systemic risk factors include diabetes, immunosuppression, and substance abuse (I). The diagnosis is not always obvious, and imaging procedures are part of the diagnostic workup. There are numerous imaging tests from which to choose, none of which is optimal for every situation. This article reviews the various radiopharmaceuticals used in the diagnostic workup of patients suspected of having musculoskeletal infection.

MORPHOLOGIC IMAGING

Radiography

Radiographs are the initial imaging study performed for suspected osteomyelitis. Early findings include soft-tissue swelling and blurring of adjacent fat planes. Medullary trabecular lysis, cortical destruction, and periosteal reaction may not appear for more than a week (Supplemental Fig. 1; supplemental materials are available at http://jnmt.snmjournals.org). Although sensitivity and specificity only range from about 50% to 75% and from 75% to 83%, respectively, radiographs provide an anatomic overview of the areas of interest potentially guiding selection and interpretation of subsequent procedures (2).

MRI

The earliest findings, which can appear within 2 d after onset of infection, are a decrease in signal intensity on T1-weighted MRI sequences and an increase in signal intensity on fat-suppressed T2-weighted sequences caused by inflammatory marrow edema (Supplemental Fig. 2). Periosteal reaction and adjacent soft-tissue edema appear later. Intravenous contrast material is useful for evaluating abscesses and differentiating synovial fluid from synovial thickening. The test has a very high negative predictive value for excluding osteomyelitis. Its positive predictive value, the ability to differentiate osteomyelitis from noninfectious causes of abnormal marrow signal intensity, is lower (2).

CT and Ultrasonography

CT and ultrasonography are not primary imaging modalities for osteomyelitis. On CT, acute osteomyelitis appears as an area of increased density in the medullary cavity, accompanied by blurring of fat planes, periosteael reaction, and cortical loss (2).

Ultrasoundography is useful in regions complicated by orthopedic instrumentation and in patients for whom MRI is contraindicated. The diagnosis of acute osteomyelitis is made by identification of a subperiosteal abscess. Before the formation of a subperiosteal abscess, the diagnosis may be missed. Soft-tissue abscesses adjacent to bone may be misinterpreted as subperiosteal abscesses (2).
RADIONUCLIDE IMAGING

Bone Scintigraphy

Bone scintigraphy is performed with $^{99m}$Tc-labeled diphosphonates. Uptake depends on blood flow and rate of new bone formation. Three-phase bone scintigraphy usually is performed for osteomyelitis and consists of the perfusion phase, followed immediately by the soft-tissue phase. The skeletal phase is performed 2–4 h later. Focal hyperperfusion, focal hyperemia, and focally increased bony uptake is the classic appearance of osteomyelitis. The test is sensitive and specific in otherwise normal bone. Pre-existing conditions such as fracture, orthopedic hardware, and adjacent soft-tissue infection decrease specificity (3).

$^{67}$Ga Scintigraphy

$^{67}$Ga uptake in infection is multifactorial. Approximately 90% of the injected $^{67}$Ga is in plasma, nearly all of which initially is transferrin-bound. Increased blood flow and vascular membrane permeability result in increased delivery and accumulation of $^{67}$Ga at foci of infection. $^{67}$Ga binds to lactoferrin, which is present in most infections. Direct bacterial $^{67}$Ga uptake has been reported. Siderophores, chelates produced by bacteria, are $^{67}$Ga-avid. The siderophore–gallium complex presumably is transported into the bacterium and phagocytized by macrophages. Some $^{67}$Ga may be transported by circulating leukocytes. Imaging usually is performed 18–72 h after injection. Currently, $^{67}$Ga imaging is used primarily for spondylodiskitis (Fig. 1) (3).

Labeled Leukocyte Scintigraphy

In Vitro Labeled Leukocytes. $^{111}$In-oxyquinoline ($^{111}$In) and $^{99m}$Tc-exametazime ($^{99m}$Tc) are most often used to label leukocytes in vitro. Leukocyte uptake depends on intact chemotaxis, number and types of cells labeled, and cellular response to a particular stimulus. The circulating leukocyte count should be 2,000 or more per microliter for diagnostically acceptable images. Because most leukocytes labeled are neutrophils, labeled leukocyte imaging is most sensitive for neutrophil-mediated infections. Intense pulmonary activity on images obtained soon after labeled leukocyte infusion is caused by cellular activation during labeling, which impedes passage of labeled leukocytes through the pulmonary vasculature (4).

Advantages of the $^{111}$In radiolabel include stability; a normal distribution at 24 h after infusion limited to liver, spleen, and bone marrow; and ability to perform delayed imaging. Complementary bone marrow imaging can be performed before, simultaneously with, or after $^{111}$In-labeled leukocyte imaging. Disadvantages include limited resolution and the 18- to 30-h delay between injection and imaging (4).

$^{99m}$Tc-labeled leukocyte distribution is more variable because some of the technetium elutes from the leukocytes and is excreted via the kidneys and hepatobiliary system. Therefore, in addition to reticuloendothelial system visualization, the urinary tract, bowel, and gallbladder often are seen. Higher-resolution images and ability to detect abnormalities shortly after injection are advantages of $^{99m}$Tc-labeled leukocytes. Disadvantages include label instability and the short half-life of $^{99m}$Tc, which limits delayed imaging. There should be 2–3 d between $^{99m}$Tc-labeled leukocyte imaging and marrow imaging (4).

Leukocytes accumulate in infection and marrow, and it is not always possible to differentiate between them on labeled leukocyte images. $^{99m}$Tc-sulfur colloid bone marrow imaging facilitates this differentiation. Both radiopharmaceuticals accumulate in marrow; only labeled leukocytes accumulate in infection. Labeled leukocyte/marrow imaging is positive for osteomyelitis when activity is present on the labeled leukocyte image without corresponding activity on the marrow image (Figs. 2 and 3). The accuracy of labeled leukocyte/marrow imaging is approximately 90% (5). Dual-time-point imaging at 3–4 h and 20–24 h after labeled leukocyte infusion has been suggested as an alternative to labeled leukocyte/marrow imaging (6).

In Vivo Labeled Leukocytes. Besilesomab, a murine monoclonal IgG1 antibody, binds to cross-reacting antigen-95 on granulocyte and granulocyte precursor cell membranes. About 10% of $^{99m}$Tc-besilesomab is neutrophil-bound. Twenty percent circulates freely, localizing in infection through nonspecific mechanisms. The incidence of human antimurine antibody response, which occurs in more than 30% of patients receiving repeated injections, is a disadvantage (7).

Sulesomab is a 50-kDa fragment antigen binding (Fab`) portion of an IgG1 class murine monoclonal antibody that binds to normal cross-reactive antigen-90 on leukocytes. Approximately 3%–6% of the $^{99m}$Tc-sulesomab injected is associated with circulating neutrophils; by 24 h, about 35% is in the marrow. Initial investigations suggested that uptake in infection includes binding to circulating neutrophils and to leukocytes present at the site of infection. Subsequent data suggested that accumulation in infection is nonspecific (7).

Interleukin 8, a chemotactic cytokine that binds to α-chemokine receptor types 1 and 2 on leukocytes, rapidly accumulates in infection. Limited investigations suggest that this agent accurately diagnoses musculoskeletal infection (7).

$^{111}$In-Biotin

Biotin, or vitamin B7, which is important in glucose metabolism, is a bacterial growth factor (8). $^{111}$In-biotin, alone and combined with streptavidin, has been used for imaging infection. Advantages include same-day imaging and little or no bone marrow uptake. Antibiotic therapy does not affect sensitivity (7).

Radiolabeled Antibiotics

Radiolabeled antibiotics were an attempt at developing infection-specific agents. The most extensively investigated radiolabeled antibiotic is $^{99m}$Tc-ciprofloxacin. Initial investigations reported high sensitivity and specificity. Subsequent investigations raised serious questions about specificity, and enthusiasm for radiolabeled antibiotics has faded (7).

FIGURE 1. Osteomyelitis cervical spine. (A and B) Sagittal CT image (A) shows destructive changes at C6–C7 level (arrow) corresponding to area of intense radiopharmaceutical uptake on sagittal $^{67}$Ga SPECT image (B). (Reprinted with permission of (3).)
Radiolabeled Antimicrobial Peptides

Antimicrobial peptides, part of the natural defenses of most living organisms, are small, cationic, and amphipathic (hydrophilic and hydrophobic). Their expression may be constant or induced on contact with microbes. They may be transported by circulating leukocytes. Antimicrobial peptides kill microbes but are not harmful to mammalian cells, and their therapeutic and diagnostic potential is being investigated (7,9,10). Radiolabeled synthetic fragments of ubiquicidin, which is present in murine macrophages, have been the most extensively studied antimicrobial peptides (7,10,11).99mTc-ubiquicidin 29-41 appears to be sensitive and specific for musculoskeletal infection and has shown promise for monitoring treatment response (7). 68Ga-labeled ubiquicidin 29-41 successfully detects bacterial infection (11).

18F-FDG

18F-FDG is transported into cells via glucose transporters and is phosphorylated by hexokinase to 18F-2'-18F-FDG-6 phosphate but not metabolized further. Uptake by leukocytes depends on cellular metabolic rate and number of glucose transporters. There is an increased number and expression of glucose transporters by activated inflammatory cells and an increased affinity of these transporters for 18F-FDG (3).

18F-FDG PET is a relatively high-resolution imaging test that provides precise radiopharmaceutical localization. The small 18F-FDG molecule enters poorly perfused areas rapidly. Imaging typically is performed about 1 h after injection. Uptake usually normalizes within 3–4 mo after trauma or surgery, and degenerative bone changes ordinarily show only mildly increased uptake (3).

68Ga-Citrate

Although the imaging characteristics of 68Ga-citrate are superior to those of 67Ga, uptake mechanisms are the same. Disadvantages of 68Ga, including uptake in inflammation, trauma, and tumor, also apply to 68Ga-citrate. Another potential disadvantage is its short half-life (68 min). Complexing 68Ga-citrate with peptides may overcome these problems (12).

124I-Fialuridine

124I-fialuridine is a specific substrate of bacterial thymidine kinase. In a pilot study, all 8 patients with musculoskeletal infection demonstrated 124I-fialuridine accumulation in the infection. There was no abnormal uptake in the control (13). Results of subsequent investigations, however, have been disappointing (14,15).

INDICATIONS

No one agent is equally efficacious throughout the skeleton. Selecting the most appropriate study depends on the clinical situation. In adults, it is useful to divide musculoskeletal infections into 3 categories: spine, diabetic foot, and prosthetic joint.

Spondylodiskitis

Spondylodiskitis arises hematogenously, through direct external inoculation, or through spread from contiguous tissues and can extend into adjacent soft tissues. Hematogenous pyogenic spondylodiskitis most often involves the lumbar spine. Tuberculous infection more commonly affects the thoracic spine and is more likely to involve more than two vertebrae (16).

Radionuclide imaging is a valuable adjunct to MRI for spondylodiskitis. Although bone scintigraphy is used for screening, false-negative results occur. It is not sensitive for detecting soft-tissue infections that accompany, or mimic, spinal infections. Scan findings may remain abnormal for some time after infection has resolved. 67Ga imaging improves the specificity of, and may detect infection sooner than, bone scintigraphy and identifies accompanying soft-tissue infections (3,17,18). 67Ga SPECT/CT reduces false-positive and false-negative results and identifies soft-tissue infection (3).

67Ga has disadvantages. Its physical characteristics and normal distribution can confound image interpretation. Although the test may become positive shortly after injection, imaging typically is performed 18–72 h after injection. 67Ga accumulates in inflammation, tumor, and trauma, which can coexist with, or mimic, infection.

Labeled leukocyte imaging is not useful for diagnosing spondylodiskitis. Approximately 50% of cases present as areas of non-specific decreased activity (4).
111In-biotin accurately diagnoses spondylodiskitis. Performing SPECT/CT accurately differentiates bone from soft-tissue infection and helps guide therapy (19,20).

18F-FDG imaging consistently outperforms bone, 67Ga, and anti-granulocyte antibody imaging and compares favorably with MRI (21–30). Gratzi et al. (22) reported that 18F-FDG PET was superior to MRI for low-grade spondylodiskitis. Stumpe et al. (25) reported that, in patients with lumbar spine vertebral end-plate abnormalities, 18F-FDG PET was 100% sensitive and specific. MRI was 50% sensitive and 96% specific. In an investigation of patients with inconclusive conventional imaging results, the sensitivity, specificity, and accuracy of 18F-FDG PET/CT were 81.8%, 100%, and 89.5%, respectively, versus 75%, 71.4%, and 74.1%, respectively, for MRI (26). Fuster et al. (27) compared 18F-FDG PET/CT and MRI. Sensitivity and specificity for 18F-FDG PET/CT were 83% and 88%, respectively, versus 94% and 38%, respectively, for MRI. In patients with brucellar spondylodiskitis, 18F-FDG PET/CT identified all foci of infection seen on MRI and revealed additional spinal lesions in 3 patients, as well as new paravertebral soft-tissue involvement and epidural masses. This additional information influenced patient management (29). Nakahara et al. (30) reported that 18F-FDG PET/CT was superior to MRI for localizing sites of infection and guiding minimally invasive therapy.

18F-FDG appears useful for monitoring treatment response in spondylodiskitis. Riccio et al. (31) reported that patients with poor treatment response had persistent bone and soft-tissue 18F-FDG uptake. 18F-FDG uptake confined to the margins of a destroyed disk after treatment did not indicate infection. Successful treatment of brucellar spondylodiskitis was associated with a significant decrease in 18F-FDG uptake (29). Skanje et al. (28) reported that 18F-FDG PET/CT was more accurate than MRI (90% vs. 61.5%) for assessing treatment response.

There are some circumstances in which 18F-FDG may be less useful. Differentiating infection from tumor and infection superimposed on tumor may be problematic. Significant focal 18F-FDG uptake in degenerative spine disease occasionally occurs (3). Foreign body reaction around uninfected spinal implants may also cause increased uptake (Fig. 4) (32). Regardless, published data support 18F-FDG imaging as the nuclear medicine test of choice for diagnosing spondylodiskitis, although more data are needed before one can conclude that it should be the initial imaging test for this entity.

Data about 68Ga-citrate in spondylodiskitis are limited. Nanni et al. (33) reported that the test was 100% sensitive and 76% specific. False-positive results were associated with tumor.

**Diabetic Pedal Osteomyelitis**

Diabetic patients can have a significant foot infection without a systemic response, and the diagnosis of osteomyelitis often is overlooked (34). Labeled leukocyte imaging is the radionuclide gold standard for diagnosing diabetic pedal osteomyelitis. The sensitivity and specificity of planar 111In-labeled leukocyte imaging range from 72% to 100% and from 67% to 100%, respectively. The sensitivity and specificity of planar 99mTc-labeled leukocyte imaging range from 86% to 93% and from 80% to 98%, respectively (3). Results using radiolabeled antigranulocyte antibodies and antibody fragments are similar (35–37).

SPECT/CT is useful in suspected pedal osteomyelitis (38–42). Heiba et al. (39) found that simultaneous dual-isotope 111In-labeled leukocyte/99mTc-methyl diphosphonate SPECT/CT and marrow imaging were significantly more accurate than planar imaging and single-isotope SPECT/CT, facilitating precise labeled leukocyte localization and improving interpreter confidence. In another investigation, dual-isotope SPECT/CT was more accurate than conventional imaging for diagnosing and localizing infection, helped guide patient management, and was associated with a shorter hospital stay (40).

Filippi et al. (41) reported that 99mTc-labeled leukocyte SPECT/CT changed study interpretation in more than half the cases, confirming or excluding osteomyelitis and precisely defining the extent of infection (Fig. 5). Erdman et al. (42) developed the Composite Severity Index for 99mTc-labeled leukocyte SPECT/CT. The likelihood of a favorable outcome varied inversely with the Composite Severity Index score, which predicted outcome more accurately than did classifying studies as positive or negative for osteomyelitis.

Vouillarmet et al. (43) used 99mTc-labeled leukocyte SPECT/CT to monitor the treatment response in diabetics with pedal osteomyelitis. The test was negative in 22 patients and positive in 7 patients, including 5 who subsequently relapsed. Sensitivity, specificity, positive predictive value, and negative predictive value for osteomyelitis relapse were 100%, 91.5%, 71.5%, and 100%. Lazaga et al. (44) reported that 99mTc-labeled leukocyte SPECT/CT was 90% sensitive and 56% specific for determining treatment response.

Although most investigations involve labeled leukocyte imaging, Aslangul et al. (45) reported that 67Ga SPECT/CT was 88% sensitive and 93.6% specific for diabetic pedal osteomyelitis.

Several groups have investigated 111In-FDG in diabetic foot infections (46–53). Basu et al. (46) reported that 18F-FDG PET was 94% accurate for differentiating osteomyelitis and soft-tissue infection from the neuropathic joint. Nawaz et al. (47) reported that 18F-FDG PET was 81% accurate for pedal osteomyelitis. Kagna et al. (49) reported that 18F-FDG PET/CT was 96% accurate for pedal osteomyelitis.

Yang et al. (50) reported that 18F-FDG PET was 93.8% accurate for pedal osteomyelitis. Sensitivity was nearly identical for patients with serum glucose levels above and below 150 mg/dL: 88.9% and 88.3%, respectively. The investigators concluded that mildly to moderately elevated serum glucose levels do not adversely affect sensitivity.

Shagos et al. (51) reported that 18F-FDG PET was more specific than bone scintigraphy for osteomyelitis, whereas bone scintigraphy was more sensitive than 18F-FDG PET for the neuropathic joint. Schwegler et al. (52), reported that 18F-FDG PET detected 2 of 7 cases (29% sensitivity) of osteomyelitis. They speculated that low sensitivity may have been related to decreased inflammatory response in the study population or impaired bony uptake of 18F-FDG, because of insulin resistance. Motion artifacts and limited spatial resolution also may have contributed to low sensitivity.

Familiari et al. (53) compared 18F-FDG PET/CT with planar 99mTc-labeled leukocyte imaging. 18F-FDG PET/CT accuracy was

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**FIGURE 4.** Uninfected spinal hardware. (A) 18F-FDG PET/CT scout radiograph demonstrates lumbar spine hardware. (B) Coronal 18F-FDG image reveals normal lumbar spine activity. Normal 18F-FDG findings effectively exclude infection.
of infection may be absent. Abnormal laboratory values are suggestive, but not diagnostic, of infection. Joint aspiration with culture is specific; sensitivity, however, is variable. Plain radiographs lack specificity. Hardware-induced artifacts limit, to some degree, cross-sectional imaging.

Radionuclide imaging has a preeminent position in the evaluation of joint arthroplasty infection. The bone scan has an accuracy of 50%–70%, which does not improve when performed as a 3-phase study. Combined bone 67Ga scintigraphy, with an accuracy of 60%–80%, offers only a modest improvement over bone scintigraphy alone. Labeled leukocyte/marrow imaging, with an accuracy of about 90%, currently is the best imaging test available. All the published studies confirm high specificity; nearly all also indicate high sensitivity.

The sensitivity and specificity of 99mTc-besilesomab for joint replacement infection range from 67% to 91% and from 57% to 75%, respectively. Complementary bone imaging and semiquantitative analysis improve accuracy.

The sensitivity and specificity of 99mTc-sulesomab range from 75% to 93% and from 65% to 86%, respectively. Dual-time-point imaging, time–activity curve analysis, and complementary marrow imaging improve accuracy.

Data on SPECT/CT in prosthetic joint infection are encouraging. The CT component of bone SPECT/CT identifies morphologic abnormalities that correspond to areas of increased activity on radionuclide images. Joint distension, fluid-filled bursa, and intramuscular fluid collections, findings that are sensitive and specific for infection, can be identified on the CT component of the examination. Al-Nabhani et al. (58) reported that bone SPECT/CT contributed useful information in more than 80% of patients with a painful knee arthroplasty. Filippi et al. (59) reported that the accuracy of 99mTc-labeled leukocyte imaging improved from 64% for scintigraphy with SPECT to 100% for SPECT/CT. SPECT/CT precisely localized labeled leukocyte accumulation, facilitating the differentiation of soft-tissue from bone infection. Kim et al. (60) reported sensitivity, specificity, and accuracy of 82.0%, 88.0%, and 84.8%, respectively, for planar imaging. Sensitivity, specificity, and accuracy increased to 93.3% with SPECT/CT. SPECT/CT precisely localized the site, and accurately delineated the extent, of infection (Fig. 6).

Graute et al. (62) reported sensitivity, specificity, and accuracy of 66%, 60%, and 61%, respectively, for 99mTc-besilesomab planar imaging. By adding SPECT/CT, sensitivity, specificity, and accuracy improved to 77%, 89%, and 73%, respectively.

The results of 18F-FDG for diagnosing prosthetic joint infection have varied. Good results have been reported by some investigators. Zhuang et al. (63) reported that 18F-FDG PET was 89.5% and 77.8% accurate for hip and knee arthroplasty infection, respectively. Correct diagnosis depended on location, not intensity, of uptake. Reimartz et al. (64) reported that 18F-FDG PET was 95% accurate for hip arthroplasty infection. Basu et al. (65) reported sensitivity and specificity of 81.8% and 93.1%, respectively, for hip

Prosthetic Joint Infection

Aseptic loosening, the most common cause of prosthetic joint failure, frequently results from an immune response by the patient’s body against one or more of the prosthetic components. The immune response can be accompanied by an intense inflammatory response involving large numbers of leukocytes. Aseptic loosening usually is managed with a single-stage exchange arthroplasty requiring one hospital admission and surgical intervention.

Infection occurs in 1%–2% of primary implants and up to 5% of revision implants. Approximately one third of these infections develop within 3 mo (early), another third within 1 y (delayed), and the remainder more than 1 y (late) after surgery. The inflammatory reaction accompanying infection can be similar to that in aseptic loosening, except that neutrophils, usually absent in aseptic loosening, invariably are present in large numbers in infection. Treatment consists of excisional arthroplasty followed by antibiotics and, eventually, revision arthroplasty.

Differentiating aseptic loosening from infection, important because their treatments are very different, can be difficult. Signs

FIGURE 6. Infected left-hip arthroplasty. (A and B) There is intense activity along lateral aspect of femoral component of prosthesis (arrow) on anterior 111In-labeled leukocyte image (A), with no corresponding activity on 99mTc-sulfur colloid bone marrow image (B). Study confirms infection but provides little information about extent. (C) On sagittal SPECT/CT image, infection extends anteriorly and posteriorly into soft tissues surrounding prosthesis (arrows). This information is useful for surgical planning.
arthroplasty infection and 94.7% and 88.2%, respectively, for knee arthroplasty infection. Other investigators reported similar results (66–68). Some investigators reported that 18F-FDG uptake around the femoral head and neck is not specific for infection; others reported that this pattern indicates synovitis plus infection (56,69,70).

The results of other investigations have been less satisfactory (71–77). Van Acker et al. reported 100% sensitivity and 73% specificity for prosthetic knee infection (71). Stumpe et al. reported that 18F-FDG PET was 69% accurate for prosthetic hip infection (73) and that periprosthetic 18F-FDG accumulation around a knee arthroplasty was not specific for infection (74). Delank et al. (75) concluded that 18F-FDG PET was not specific for lower-extremity joint arthroplasty infection. Another group of investigators found that the test was neither sensitive (64%) nor specific (67%) for prosthetic hip infection (76). Love et al. (77) reported that 18F-FDG was 71% accurate for lower-extremity prosthetic joint infection.

Comparative investigations of 18F-FDG and bone or labeled leukocyte imaging have been contradictory. Some investigations indicated that 18F-FDG is more accurate than bone scintigraphy; others suggested the opposite (64,71,73). Pill et al. (78) reported that 18F-FDG PET was 95% sensitive and 93% specific for infection. In a subgroup, the sensitivity and specificity of labeled leukocyte/marrow imaging were 50% and 95.1%, respectively. Love et al. (77) found that labeled leukocyte/marrow imaging was more accurate than 18F-FDG (95% vs. 71%). Basu et al. (65) compared 18F-FDG PET to labeled leukocyte/marrow imaging in 88 lower-extremity arthroplasties (59 hips, 29 knees). Although their specificities were very similar, 18F-FDG PET was significantly more sensitive than labeled leukocyte/marrow imaging (76.9% vs. 38.5%) for hip prosthesis infection. All 3 infected knee arthroplasties were positive on 18F-FDG PET, versus only 1 of 3 on labeled leukocyte/marrow imaging.

In a recent metaanalysis, the pooled sensitivity and specificity of 18F-FDG PET and PET/CT for lower-extremity prosthetic joint infection both were 86% (79).

The development of an infection-specific imaging agent would be a substantial improvement over currently available radiopharmaceuticals. Aryana et al. (80) reported that 99mTc-ubiquidin 29–41 was 100% accurate for hip arthroplasty infection. Though encouraging, these results must be confirmed in larger series.

CONCLUSION

Radionuclide imaging continues to play a vital role in the diagnostic workup of patients suspected of having musculoskeletal infection. The roles of bone and 68Ga imaging have decreased over time because they have been replaced by more appropriate procedures such as labeled leukocyte imaging and, in the case of spinal infections, 18F-FDG imaging. The hybrid imaging techniques SPECT/CT and PET/CT are redefining the role of radionuclide imaging in the management of patients with suspected or known musculoskeletal infection not only by improving diagnostic accuracy but also by demonstrating the potential of radiopharmaceuticals to monitor response to treatment.

Although the currently available agents reflect host response, infection-specific radiopharmaceuticals, such as radiolabeled peptides, show promise both for diagnosis and for monitoring response to treatment.

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