



# Ventilation/Perfusion SPECT Imaging— Diagnosing Other Cardiopulmonary Diseases Beyond Pulmonary Embolism

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Ventilation/perfusion single-photon emission computed tomography (V/P SPECT) is the scintigraphic technique recommended primarily for the diagnosis of acute pulmonary embolism (PE) and is golden standard for the diagnosis of chronic PE. Furthermore, interpreting ventilation and corresponding perfusion images enables pattern recognition of many other cardiopulmonary disorders that affect lung function and also allows quantification of their extent. Using Technegas for the ventilation imaging, grading of small airway disease in COPD is possible and the method is recommended for PE diagnosis in patients with severe COPD that is not possible with radiolabelled liquid aerosols. An optimal combination of nuclide activities, acquisition times for ventilation and perfusion, collimators, and imaging matrix yields an adequate V/P SPECT study in approximately 20 minutes of imaging time. The holistic interpretation strategy of V/P SPECT uses all relevant information about the patient and ventilation/perfusion patterns. PE is diagnosed when there is more than one subsegment showing a V/P mismatch representing an anatomic lung unit. Apart from PE, other pathologies should be identified and reported, such as obstructive lung disease, heart failure, and pneumonia according to the European Association of Nuclear Medicine guidelines.

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## Overview of Ventilation/ Perfusion SPECT<sup>1</sup>

Ventilation/Perfusion SPECT (V/P SPECT) is the recommended method for the diagnosis of pulmonary embolism (PE) and it should be used whenever possible.<sup>1</sup> Apart from PE, other changes can be identified and reported, such as the signs of chronic obstructive pulmonary disease (COPD), pneumonia, left heart failure, chronic PE, pulmonary hypertension and suspicion of other parenchymal processes like tumors.<sup>2-6</sup> Recent studies have shown that for the

ventilation study, Technegas particles have an advantage over radiolabeled liquid aerosols due to the better penetration to the periphery of the lung. Therefore, Technegas enables studies in patients with obstructive lung disease.<sup>7</sup> Radiolabeled macroaggregated human albumin is the imaging agent of choice for perfusion scintigraphy. An adequate V/P SPECT acquisition starting with ventilation and continuing with perfusion can be done in 20 minutes by using an optimal combination of radionuclide activities, collimators, and imaging matrix. It is recommended that the 1-day protocol starts with a ventilation examination, immediately followed by perfusion.<sup>8</sup> This allows for presentation of matching ventilation and perfusion slices in all projections. It also allows for rotating volume images based upon maximum intensity projections and quantification of V/P Quotient. V/P SPECT should be interpreted according to the European Association of Nuclear Medicine guidelines.

## V/P SPECT Acquisition

Administration of the ventilation and perfusion agents should always be performed in the same position, preferably supine.

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<sup>1</sup>Guest Editor's note: While most of the articles in this issue of *Seminars* uses the abbreviation "V/Q" when referring to ventilation and perfusion lung scanning, the term "V/P" is common in Sweden and some parts of Europe. "V/P" and "V/Q" lung scans are the same. The term "V/P" has been retained here to reflect the authors' preference.

Table 1 Optimization of Ventilation and Perfusion Examinations in V/P SPECT

	Ventilation	Perfusion
<b>Administration</b>	Inhalation	IV injection
<b>Radiopharmaceutical and administered activity</b>	$^{99m}\text{Tc}$ -Technegas 25-30 MBq to reach the lungs	$^{99m}\text{Tc}$ -MAA 120-160 MBq
<b>particle size</b>	0.09 $\mu\text{m}$	15-100 $\mu\text{m}$
<b>Time of Imaging</b>	Approx 11 minutes	Approx 5 minutes
<b>Acquisition protocol</b>	General purpose collimator: 64 $\times$ 64 matrix, 60-64 steps for each head, 10 sec/step	General purpose collimator: 64 $\times$ 64 matrix, 60-64 steps for each head, 5 sec/step
<b>Reconstruction</b>	Iterative reconstruction—eight subsets and four iterations	Iterative reconstruction—eight subsets and four iterations

During inhalation, activity over the lungs should be monitored to ensure adequacy of pulmonary activity deposition. The procedure starts with ventilation scintigraphy. Large particles ( $>2 \mu\text{m}$ ) are deposited mainly by impaction in large airways. Very fine particles,  $<1 \mu\text{m}$ , are mainly deposited in alveoli by diffusion. In comparison to radiolabeled liquid aerosols, Technegas shows significantly improved outcomes with deposition of radioaerosol in central airways and better penetration to the lung periphery, which is important for patients with obstructive airways disease. Thus, it enables a correct diagnosis of PE even in obstructive patients and its use is generally recommended.<sup>3,7,9</sup>

Perfusion tomography follows immediately after ventilation SPECT without changing the patient's position. After intravenous injection, the particles of size 15-100  $\mu\text{m}$  are lodged in the pulmonary capillaries and in the precapillary arterioles in proportion to the perfusion.

To achieve adequate imaging quality with low radiation exposure in a short time, relationships between radioactivities, acquisition times, collimators, and matrices for SPECT imaging must be optimized. This problem has been

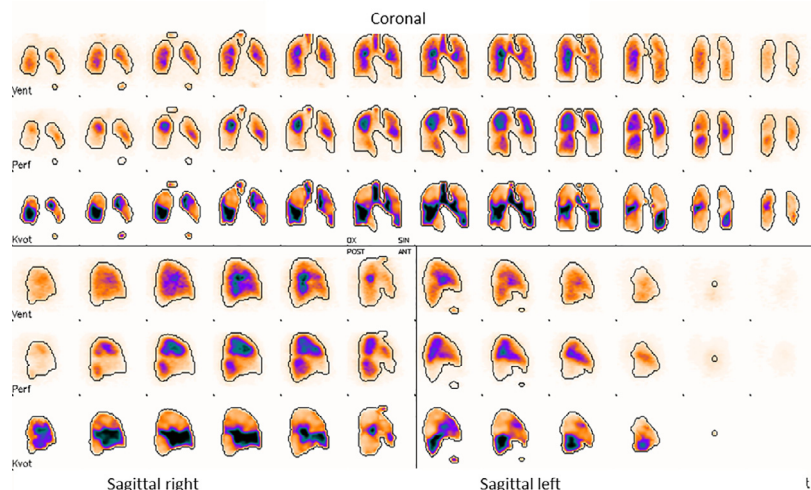
systematically analyzed.<sup>8</sup> Doses of 25-30 MBq for ventilation studies and 120-160 MBq for perfusion studies were found to be optimal by using a general purpose collimator and 64  $\times$  64 matrix. The total acquisition time is about 20 minutes. If a matrix of 128  $\times$  128 is used, higher doses and/or longer acquisition times are required. This is not promoted as it does not yield images of significantly higher quality. To follow the good medical practice, radiation exposure should be minimized to the lowest level consistent with satisfactory image quality (Table 1).

When low-activity doses are used for V/P SPECT, as in the case of the pregnant or young female, it is essential to use an optimized iterative reconstruction. It is recommended to use ordered-subset expectation maximization with four iterations and eight subsets. Standard software can be used for the image presentation in coronal, sagittal, and transversal projections as well as for the presentation of rotating 3D images.<sup>8</sup>

We have developed a program to calculate and to display ventilation/perfusion quotient images to facilitate the image interpretation. For this purpose, ventilation is normalized to perfusion counts, and then the V/P quotient images are calculated.

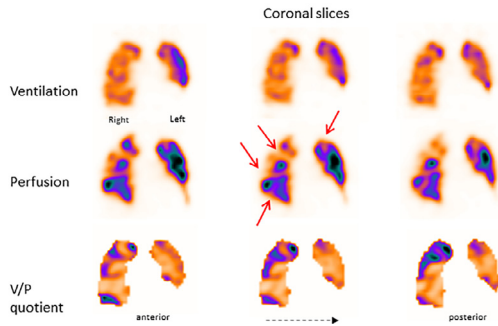
### Image presentation: Overview & quality control

The lung contour is automatically displayed in Ventilation, Perfusion and V/P images



**Figure 1** Overview of ventilation and perfusion SPECT images in coronal and sagittal slices. Ventilation and perfusion are carefully aligned to each other.

## COPD + PE (red arrows)



**Figure 2** Patient with severe COPD and PE. Coronal slices: uneven distribution of ventilation with deposition of aerosols in small airways. Multiple perfusion defects are seen bilaterally (red arrows). COPD, chronic obstructive pulmonary disease; PE, pulmonary embolism.

V/P quotient images facilitate also quantification of PE extent. Using this protocol, attenuation correction is not required.<sup>8,10</sup>

An overview of ventilation and perfusion in coronal and sagittal slices is useful for quality control and fast orientation regarding pulmonary pathology. It is important to present the matched images so that ventilation and perfusion are carefully aligned to each other (Fig. 1). This is greatly facilitated by the one session protocol with the patient in an unchanged position. The option to triangulate coronal, sagittal, and transverse slices is valuable for identification of matching and nonmatching ventilation and perfusion changes. Proper alignment is also a prerequisite for V/P quotient images. V/P quotient images facilitate recognition of mismatch and “reverse mismatch” patterns. This is important for the interpretation and quantification of the PE extent and for all ventilation and perfusion defects. However, quotient images are not a prerequisite for a high-quality V/P SPECT.

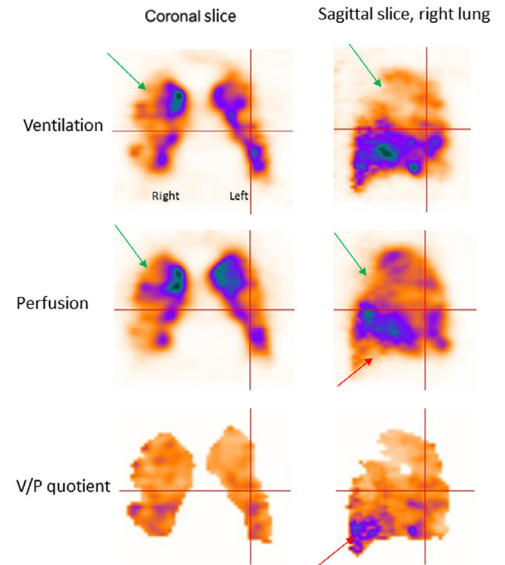
### Holistic Interpretation

For V/P SPECT, interpretation criteria are as important as the imaging technique itself. In the holistic interpretation, all patterns of ventilation and perfusion as well as numbers of defects are described and interpreted and clinical probability is considered. The holistic interpretation gives a clear answer; yes or no regarding PE. Large V/P SPECT studies have shown conclusive reports in 96%-99% of cases.<sup>11-15</sup> This goal was not achieved with previous probabilistic criteria (PIOPED 1 and modified PIOPED).<sup>16,17</sup>

PE is diagnosed when there is more than one segment or two subsegments, showing a ventilation/perfusion mismatch representing an anatomic lung unit. Apart from PE, other pathologies should be identified and reported, such as broncho-obstructive disease, left heart failure, pneumonia, and suspicion of other parenchymal processes like tumors. Pitfalls exist both with respect to the imaging technique and scan interpretation.<sup>1,18</sup>

### Chronic Obstructive Pulmonary Disease

COPD is frequently observed in patients suspected of PE, because COPD patients are at a higher risk of PE.<sup>2,9,11</sup> The

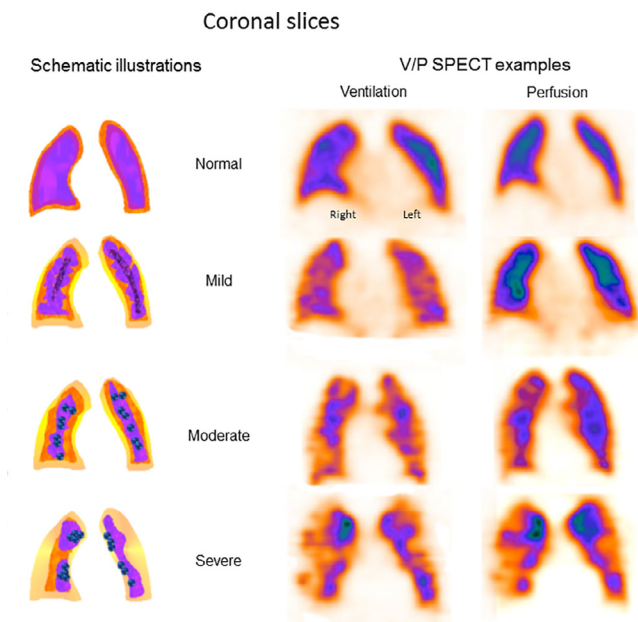
COPD + emphysema (green arrows)  
+PE (red arrows)

**Figure 3** Patient with severe COPD, emphysema, and PE. Coronal and sagittal slices: uneven distribution of ventilation with central deposition of aerosols indicating severe degree of airway obstruction. In the right upper lobe is area with absent ventilation (better preserved perfusion), emphysema (green arrow). Corresponding perfusion images (middle row) show segmental perfusion defects (red arrows), PE, in the ventilated areas, well delineated on V/P quotient image. COPD, chronic obstructive pulmonary disease; PE, pulmonary embolism.

rate of PE in patients hospitalized for acute exacerbation of COPD may be as high as 25%. PE accounts for up to 10% of deaths in stable COPD patients. Different to the PIOPED study, PE can be diagnosed even in the presence of COPD with V/P SPECT.

The characteristic of COPD is a general unevenness of ventilation. The degree of ventilation defect reflects varying severity of small airway disease and emphysema typical for COPD.<sup>2,3,9,11,19,20</sup> Emphysema is characterized by areas of absent/decreased ventilation with usually less pronounced perfusion defects (reverse mismatch).<sup>3,21</sup> Focal deposition of aerosol in central or peripheral airways may even locate sites of airway obstruction.<sup>19</sup> The degree of unevenness of aerosol distribution correlates with lung function tests.<sup>3,22,23</sup> The method gives the possibility to localize ventilation and perfusion impairment and also estimate total lung function.<sup>24</sup> It is noteworthy that there are no contraindications to V/P SPECT and that even very sick and breathless patients can be studied. Figure 2 shows coronal slices in a patient with a severe COPD and PE. Figure 3 shows coronal and sagittal slices in a patient with severe COPD, emphysema, and PE. The grading of obstruction in ventilation SPECT has been standardized (Fig. 4).

- Grade 1: Uneven radioaerosol distribution through the lung.
- Grade 2: Uneven radioaerosol distribution and reduced Technegas penetration to the periphery, with deposition of radioaerosols in small airways, seen as hot spots.



**Figure 4** Degree of airway obstruction. Coronal slices: ventilation and corresponding perfusion images; normal pattern, mild, moderate, and severe COPD. COPD, chronic obstructive pulmonary disease.

- Grade 3: Severely impaired Technegas penetration to the lung periphery and a central deposition of Technegas in large airways, usually with large areas of reduced/absent ventilation.

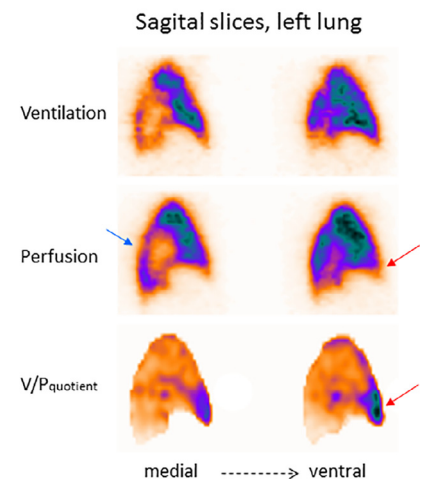
Moreover, V/P SPECT has a high sensitivity to showing an obstructive pattern in the lungs of many apparently healthy smokers<sup>2</sup>.

## Pneumonia

Pneumonia is also frequent finding in patients investigated for suspected PE. Figure 5 shows a patient with pneumonia and PE. Pneumonia is here a general term for conditions of lung inflammation often caused by a bacterial, viral, or fungal infection, where blood biomarkers are not sufficient in diagnosing pneumonia. Nonspecific clinical symptoms can lead to diagnostic problems.<sup>25,26</sup>

In pneumonia, V/P SPECT shows ventilation defects, which usually exceed perfusion defects known as reverse mismatch (reversed V/P mismatch).<sup>27,28</sup> Preserved perfusion along the pleural border peripheral to a central matched defect often termed a “stripe sign” is a specific characteristic of pneumonia (Fig. 5).<sup>29</sup> In a recent study that has followed patients with PE and pneumonia both clinically and with V/P SPECT, ventilation/perfusion changes typical for pneumonia and PE has normalized, confirming the diagnoses.<sup>2</sup> Dyspnoea was a common symptom in these patients. It can be

## Pneumonia (blue arrows) + PE (red arrows)



**Figure 5** Patient with pneumonia and PE in the right lung. Sagittal slices: reduced/absent ventilation posteriorly with reduced perfusion in the same area. Preserved perfusion adjacent to the pleura, “stripe sign” (blue arrow). In the middle lobe, perfusion defect is seen (red arrow) in the ventilated area.

caused by pneumonia as well as by PE or COPD. In some patients, V/P defects typical for pneumonia reduce the total lung function in the absence of any morphologic CT changes. Frequently, pneumonia is comorbid with PE. In these clinical scenarios, PE is frequently missed by CT.<sup>2,30</sup> This is important information because in general, current clinical and nuclear medicine practices do not recognize nor use V/P SPECT as a potential imaging method to diagnose or manage pneumonia.

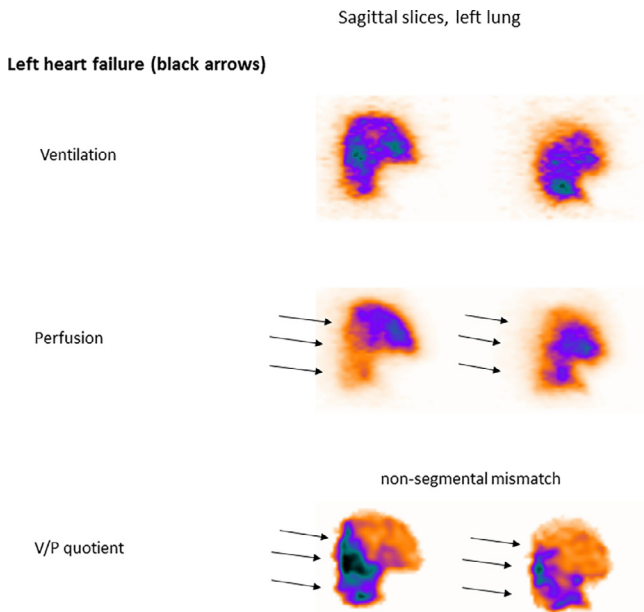
## Left Heart Failure

Antigravitational perfusion distribution from the posterior to anterior region indicates pulmonary congestion. The pattern was described already in 1966<sup>31</sup> and studied later.<sup>2,4,32-34</sup> As ventilation is usually less affected, the typical pattern is an antigravitational redistribution of perfusion and V/P mismatch in dorsal regions of the lung. This V/P mismatch has a nonsegmental pattern (does not conform to pulmonary vascular architecture) and should not be misinterpreted as PE. Figure 6 shows a patient with nonsegmental mismatch. The positive predictive value  $\geq 88\%$  for heart failure has been reported.<sup>4</sup> The power of V/P SPECT for diagnosis of heart failure was recently confirmed with regard to right heart catheterisation.<sup>34</sup>

## Chronic PE

Chronic PE represents a condition in which pulmonary emboli do not resolve and the clinical presentation is often insidious. Chronic PE may be a progressive disease that develops in about 1%-5% of patients after an acute episode of PE, even in patients who have been treated.<sup>35-38</sup> It might be a consequence of repeated frequently

<sup>2</sup>Work in progress by the authors, presented at Eur Respiratory Society Annual Congress 2018

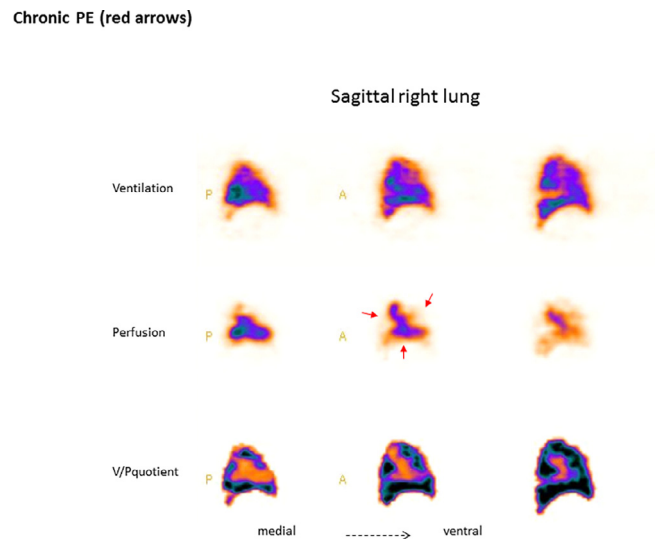


**Figure 6** Patient with left heart failure. Sagittal slices: Antigravitational distribution of ventilation and more so of perfusion, causing nonsegmental V/P mismatch in the dorsal regions (black arrows).

unrecognized small pulmonary emboli.<sup>39</sup> It may also lead to chronic thromboembolic pulmonary hypertension (CTEPH), right heart failure, and arrhythmia, which are frequent causes of death.

The value of V/P scintigraphy in this situation is well established but underutilized for this important diagnosis.<sup>40–41</sup> This has been confirmed in a head-to-head comparison between X-ray CT Pulmonary Angiography (CTPA) and planar scintigraphy with pulmonary angiography as a reference. Among patients with pulmonary hypertension, scintigraphy had a sensitivity of 96% and specificity of 90%, whereas CTPA had a sensitivity of 51%.<sup>42</sup> Soler et al confirmed that V/P SPECT had a higher sensitivity compared with CTPA.<sup>43</sup> For exclusion of CTEPH, V/P scintigraphy is the imaging test of choice.<sup>38</sup>

Pulmonary scintigraphy might also be able to differentiate among different types of CTEPH. A predominantly central subtype of CTEPH can be treated with a pulmonary endarterectomy. A predominantly peripheral subtype is not operable (Fig. 7). Sensitivity for detecting thromboembolic segments was significantly higher for V/P planar scintigraphy compared with CTPA: 96%–97.4% vs 51%, specificity 90%–95% vs 99%.<sup>42</sup> In central disease, the sensitivity of V/P SPECT was significantly higher than the sensitivity for V/P planar scintigraphy ( $63.5\% \pm 3.1\%$  vs  $42.7\% \pm 3.2\%$ ). The specificities of these two imaging modalities were not significantly different. In a similar setting, sensitivity of V/P SPECT was  $62.0\% \pm 4.1\%$  and that of CTPA  $47.8\% \pm 2.9\%$ .<sup>43</sup> Dual-energy CT perfusion and angiography, using a single acquisition, shows only moderate agreement ( $K = 0.44$ ) with scintigraphy on the segmental level. Agreement between CTPA and scintigraphy ranged from fair ( $K = 0.31$ ) to slight



**Figure 7** Patient with chronic pulmonary embolism. Sagittal slices: uneven ventilation. The corresponding perfusion images show hyperperfusion in the central part of the lung. Perfusion defects (red arrows) around the lung, clearly visible on V/P quotient images.

( $K = 0.09$ ).<sup>44</sup> In the treatment planning, even V/P SPECT under-represents the true extent of vascular obstruction from CTEPH.<sup>43</sup> Dual-energy CT is not able to supplement this information gap.

## Conclusion

To take full advantage of the V/P SPECT potential, it is crucial to apply an optimal protocol for a single-session imaging of both ventilation and perfusion. This should be done by using low nuclide activities and by making a holistic interpretation.

Ventilation SPECT can be used to classify small airway disease in COPD. Together with perfusion SPECT, it can be used to evaluate the parenchymal damage (emphysema) in COPD. Ventilation and perfusion SPECT can be used to diagnose pneumonia and pulmonary congestion. To quantify pulmonary function, it is essential to measure ventilation and perfusion.

It is important to underline that using V/P SPECT, PE can be diagnosed in the presence of COPD and other pulmonary comorbidities. These advantages of V/P SPECT make it a suitable and desirable technique for diagnosing and following up PE. It is also an ideal technique to diagnose and follow up cardiopulmonary diseases like COPD, pneumonia, and left heart failure, which often cause similar kind of symptoms as PE.

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