18F-fluoro-deoxy-glucose positron emission tomography (18F-FDG-PET) for assessment of enteropathy-type T cell lymphoma

M Hoffmann, H Vogelsang, K Kletter, G Zettinig, A Chott, M Raderer

**Background and aims:** Enteropathy-type T cell lymphoma (ETCL) represents a relatively rare disease, accounting for less than 1% of non-Hodgkin’s lymphomas. ETCL is an aggressive lymphoma which may either present de novo or arise in the context of longstanding or untreated coeliac disease (CD). The aim of this study was to evaluate the potential of 18F-fluoro-deoxy-glucose positron emission tomography (18F-FDG-PET) for imaging of ETCL. Furthermore, we wished to evaluate whether the presence of CD might provide a potential diagnostic obstacle to imaging of lymphoma due to unspecific 18F-FDG uptake and whether accumulation of 18F-FDG within the gut correlates with activity of CD.

**Patients and methods:** We retrospectively analysed patients with ETCL and individuals suffering from CD undergoing 18F-FDG-imaging at our PET unit. Material for histological reassessment by a reference pathologist had to be available for inclusion of patients in the analysis. Whole body 18F-FDG-PET scans were performed 40 minutes following injection of 300–380 MBq of 18F-FDG. Images were reconstructed iteratively. In areas with focally elevated FDG uptake and in case of diffusely elevated intestinal 18F-FDG accumulation, standard uptake values (SUVs) were calculated.

**Results:** During a period of two years, five patients (one male, four female) with a mean age of 56.4 years (range 44–62) with a diagnosis of ETCL underwent 18F-FDG-PET. Four of these patients were imaged before application of cytotoxic treatment while one patient had regular PET scans for follow up. All four patients undergoing pre-therapeutic imaging showed markedly elevated intestinal 18F-FDG uptake, with a maximal SUV of 6.4–8.0 (mean 7.15 (SD 0.82)). The patient imaged following surgery and cytotoxic therapy had no pathologic 18F-FDG uptake which was found to correlate with normal duodenal mucosa, as evidenced by repeated biopsies and conventional imaging methods. During the same time span, 12 patients (five male, seven female) with a mean age of 63.8 years (range 42–82) suffering from CD were imaged. Four of these patients showed no elevated intestinal 18F-FDG uptake while five had minor diffuse intestinal 18F-FDG accumulation with SUVs ranging between 2.2 and 4.6 (mean 3.4 (SD 0.89)). In the remaining three patients with diffuse intestinal 18F-FDG uptake, no SUV could be calculated. SUVs in patients with ETCL were remarkably higher than in patients suffering from CD (p=0.011), irrespective of the activity of CD at the time of imaging.

**Conclusion:** In spite of the relatively small number of patients, our results clearly indicate the potential value of 18F-FDG-PET for diagnosing and imaging ETCL. In addition, the data also suggest that 18F-FDG-PET may lead to early diagnosis in individuals developing ETCL in the context of longstanding CD. This is due to the fact that 18F-FDG does not appear to significantly accumulate in the gut of patients with CD, irrespective of disease activity.

ETCL is an aggressive disease which may either present de novo or arise in the context of longstanding or untreated coeliac disease (CD). The occurrence of refractory sprue—that is, clinical and histological worsening of CD in spite of a gluten free diet—or the development of ulcerative jejunitis may herald the progression of CD to overt lymphoma, as monoclonal T cell populations have been demonstrated in refractory sprue, ulcerative jejunitis, and ETCL.

According to recent data, patients diagnosed with ETCL face a poor prognosis. This is largely due to complications arising from peritonitis and malnutrition and later from progressive disease typically characterised by intestinal recurrences. Therefore, only approximately 50% of patients are amenable to chemotherapy and only a small proportion can finish the therapy.
treatment as scheduled. While occurrence of an aberrant pheno-
type of intraepithelial T cells and a monoclonal TCR
rearrangement are suggestive of ETCL,10–11 the final diagno-
sis might be difficult to establish from duodenal biopsies. In
addition, conventional radiological imaging appears to be of
rather limited value in patients with ETCL as the neoplastic
changes may be restricted to the epithelial layer of the small
bowel even when the lymphoma diffusely affects the whole
small intestine. Thus methods with the potential to delineate
the transition from CD to overt lymphoma and to assess the
tumour load in affected patients are strongly warranted to
facilitate early diagnosis and avoid delayed institution of
treatment.

Fluorine-18-2-fluoro-2-deoxy-D-glucose (18F-FDG) is one of
the most widely applied positron emission tomography
(PET) tracers used to survey cell metabolism. As the metabolic
turnover of tumour cells usually exceeds physiological
metabolic activity, excessive 18F-FDG uptake has conse-
quently been demonstrated in most cancers in vivo, rendering
whole body 18F-FDG-PET an excellent staging method in
various malignancies.7,12–16 Especially in the field of malignant
lymphomas, 18F-FDG-PET has become a well accepted method
for diagnosis and staging.12–18 One exception however appears
to be extranodal marginal zone B cell lymphoma of the
mucosa associated lymphoid tissue (MALT lymphoma),
which cannot be imaged by means of 18F-FDG-PET.11 As 18F-
FDG-PET has been used successfully for imaging of aggressive
lymphomas, it appears to be an attractive tool for clinical use
in ETCL, as it can image the whole body, including the small
intestine. Unspecific uptake of 18F-FDG however has also
been reported in various inflammatory conditions, and one
cannot rule out the fact that the inflammatory background in
intestinal mucosa affected by CD may constitute a potential
drawback for successful imaging of early stage ETCL.

The objective of this study therefore was to evaluate the
potential of 18F-FDG-PET for imaging of ETCL. Apart from
this proof-of-principle approach, we have compared the
results obtained in ETCL with 18F-FDG-PET findings in
individuals with CD in order to evaluate intestinal 18F-FDG
uptake in this cohort of patients.

PATIENTS AND METHODS

A retrospective analysis of patients with ETCL and individuals
suffering from CD undergoing imaging at our PET unit was
performed. Data of patients identified from our archives were
reassessed with respect to histological diagnosis and clinical
data, including history of enteropathy, gluten free diet, pre-

cence of endomysial antibodies (EMAs), and availability of
histological samples for re-evaluation. Histological diagnosis
of ETCL was established by a reference pathologist (AC)
according to the recent WHO Classification of Tumours of
Haematopoietic and Lymphoid Tissues. Biopsies from pa-

tients with CD were graded according to the criteria
defined by Marsh and modified by Oberhuber and colleagues.24 Only patients with histological samples available
at our institution were included in this analysis. EMAs were
determined in serum by immune fluorescence microscopy on
slides of distal monkey oesophagus (Bios, Barcelona, Spain)
using rabbit anti-IgA.

Whole body 18F-FDG-PET scans were performed on a GE
Advance PET scanner (GE Medical Systems, Waukesha,
Wisconsin, USA) with a whole body mode implemented as
standard software. All patients were asked to fast for at least
four hours prior to the 18F- FDG-PET scan. All patients
received an intravenous injection of 20 mg N-butylbromide
(Buscophan; Boehringer Ingelheim, Germany) for smooth
muscle relaxation. Blood glucose levels were normal in all
patients at the time of 18F-FDG application. PET emission
scanning was started 40 minutes following an intravenous
bolus injection of 300–380 MBq of 18F- FDG and was

Mean time span on a gluten free diet prior to PET scan was 67
months (range 4–212) but four patients were non-compliant
at the time of the PET scan (table 2).

RESULTS

During a period of two years, five patients (four female, one
male), mean age 56.4 years (range 44–62), diagnosed with
ETCL were referred to our PET unit (table 1). Diagnosis had
been established on duodenal biopsies in three patients and
on surgical resection specimens in two patients (fig 1). Four
of these patients had enteropathic changes in non-
tumoral mucosa which were classified according to Oberhuber
and colleagues2 as type 1 (increased number of intraepithelial
lymphocytes in an otherwise normal mucosa, n=1), type 3a
(increased number of intraepithelial lymphocytes and mild
villous atrophy, n=2), and type 3c (increased number of
intraepithelial lymphocytes and flat mucosa, n=1). In two of
these patients the small bowel mucosa distant from the inva-
sive ETCL showed a striking intraepithelial lymphocytosis
suggestive of an intraepithelial “low grade” component. In
one of these two cases immunophenotypic analysis and
molecular studies indeed confirmed intraepithelial lympho-

cytosis by demonstrating the same aberrant immunopheno-
type and the same monoclonal TCR gamma chain rearrange-
ment in sections from intraepithelial and invasive lymphoma.

Only two of these patients were known to have a history of
documented CD. Both patients were on a gluten free diet, and
had shown clinical deterioration in spite of strict adherence to
dietary measures before diagnosis of ETCL. One patient had
an eight month history of intestinal ulceration before the
diagnosis of T cell lymphoma involving the intestine and peri-


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In four ETCL patients the PET scan was performed prior to initiation of cytotoxic therapy. All of these patients showed significantly elevated abdominal focal or multifocal 18F-FDG uptake (fig 2A) at the site of bioptically verified lymphoma. In three cases, additional intestinal sites were also seen and one of these patients had an additional hot spot in the lung. While a CT scan of the thorax was suggestive of an inflammatory lesion, the PET result of lymphomatous involvement of both the intestine and lung was confirmed by autopsy four months later.

SUV in the cohort of patients with ETCL was 7.15 (0.82) (range 6.4–8.0). In one of these patients a control 18F-FDG-PET was acquired after six cycles of chemotherapy and disclosed no pathological 18F-FDG uptake. Currently, the patient is alive without evidence of disease 14 months after the initial diagnosis.

One of these patients was imaged following surgery and chemotherapy. Both 18F-FDG- PET and CT scanning were normal, and multiple duodenal biopsies and follow up CT scans obtained over a time span of 32 months showed no evidence of lymphoma recurrence. Thus the 18F-FDG-PET result was rated as true negative.

Of 12 patients with CD (for patient characteristics see table 2), four patients showed no elevated intestinal 18F-FDG uptake and thus no SUV was calculated in these patients. Five patients showed minor diffuse intestinal 18F-FDG accumulation with SUVs ranging from 2.2 to 4.6 (mean 3.4 (0.89)) (fig 2B). In an additional three patients with intestinal 18F-FDG uptake, no transmission scan had been obtained and thus SUV could not be calculated. SUVs in patients with ETCL were significantly higher than in patients suffering from CD (p=0.011). In patients with CD, intestinal 18F-FDG uptake did not correlate with disease activity (see table 2), as assessed according to the modified Marsh criteria.22 In four of 12 patients, a follow up 18F-FDG-PET was obtained. Three underwent imaging after initiation of dietary measures, resulting in clinical and histological improvement, while one patient was scanned due to clinical deterioration in spite of adherence to a gluten free diet (as also reflected by negative EMA levels). In spite of pronounced changes in disease status, 18F- FDG accumulation was not significantly altered in these four individuals. None of these patients with CD in our series

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**Table 1** Characteristics of patients with enteropathy-type intestinal T cell lymphoma (ETCL)

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Sex/Age</th>
<th>Clinical signs of entheropathy</th>
<th>Histology</th>
<th>PET result</th>
<th>SUV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F/60</td>
<td>CD (20*)</td>
<td>ETCL</td>
<td>Focal intestinal FDG uptake</td>
<td>7.7</td>
</tr>
<tr>
<td>2</td>
<td>F/58</td>
<td>Intestinal ulceration</td>
<td>ETCL</td>
<td>Focal intestinal FDG uptake</td>
<td>6.4</td>
</tr>
<tr>
<td>3</td>
<td>M/62</td>
<td>No clinical signs</td>
<td>ETCL</td>
<td>Focal intestinal and intrapulmonary FDG uptake (confirmed by autopsy)</td>
<td>6.5</td>
</tr>
<tr>
<td>4</td>
<td>F/58</td>
<td>CD (12*)</td>
<td>ETCL (after chemotherapy)</td>
<td>4×follow up PET, 4×negative</td>
<td>Neg</td>
</tr>
<tr>
<td>5</td>
<td>F/44</td>
<td>No clinical signs</td>
<td>ETCL</td>
<td>1st PET: focal intestinal FDG uptake; 2nd PET (after chemotherapy): negative</td>
<td>2nd PET: neg</td>
</tr>
</tbody>
</table>

PET, positron emission tomograph; CD, coeliac disease; SUV, standard uptake value.

*Onset of gluten free diet prior to (first) PET scan.

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**Table 2** Characteristics of patients with coeliac disease (CD)

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Sex/Age</th>
<th>Diagn</th>
<th>Histo†</th>
<th>EMA*</th>
<th>PET result</th>
<th>SUV</th>
<th>Onset of gluten free diet prior to PET (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F/58</td>
<td>CD</td>
<td>0</td>
<td>0</td>
<td>Negative</td>
<td>3.0</td>
<td>75</td>
</tr>
<tr>
<td>2</td>
<td>F/42</td>
<td>CD</td>
<td>0</td>
<td>0</td>
<td>Negative</td>
<td>Negative</td>
<td>35</td>
</tr>
<tr>
<td>3</td>
<td>F/59</td>
<td>CD</td>
<td>3c</td>
<td>3+</td>
<td>Negative negative</td>
<td>Negative negative</td>
<td>212‡</td>
</tr>
<tr>
<td>4</td>
<td>F/74</td>
<td>RS</td>
<td>3a</td>
<td>0</td>
<td>Negative</td>
<td>Negative</td>
<td>140</td>
</tr>
<tr>
<td>5</td>
<td>F/76</td>
<td>CD</td>
<td>3a</td>
<td>3+</td>
<td>Both PET scans: diffuse intestinal FDG uptake</td>
<td>1st PET: 2.9; 2nd PET 2.2</td>
<td>154</td>
</tr>
<tr>
<td>6</td>
<td>F/60</td>
<td>CD</td>
<td>3c</td>
<td>0</td>
<td>Negative</td>
<td>Diffuse intestinal FDG uptake</td>
<td>170‡</td>
</tr>
<tr>
<td>7</td>
<td>M/55</td>
<td>CD</td>
<td>3c</td>
<td>0</td>
<td>Negative</td>
<td>Diffuse intestinal FDG uptake</td>
<td>173</td>
</tr>
<tr>
<td>8</td>
<td>M/56</td>
<td>RS</td>
<td>3c</td>
<td>0</td>
<td>Negative</td>
<td>Intestinal FDG uptake</td>
<td>60</td>
</tr>
<tr>
<td>9</td>
<td>M/58</td>
<td>CD</td>
<td>3b-c</td>
<td>1</td>
<td>Negative</td>
<td>Intestinal FDG uptake</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>M/63</td>
<td>CD†</td>
<td>3b</td>
<td>3</td>
<td>Negative</td>
<td>Minimal diffuse intestinal FDG uptake</td>
<td>48</td>
</tr>
<tr>
<td>11</td>
<td>F/67</td>
<td>CD†</td>
<td>3b</td>
<td>3+</td>
<td>Negative</td>
<td>Minimal diffuse intestinal FDG uptake</td>
<td>12</td>
</tr>
<tr>
<td>12</td>
<td>M/82</td>
<td>RS</td>
<td>3a</td>
<td>0</td>
<td>Negative</td>
<td>Intestinal FDG uptake without dynamics</td>
<td>12</td>
</tr>
</tbody>
</table>

RS, refractory sprue; SUV, standard uptake value; FDG, fluoro-deoxy-glucose; PET, positron emission tomography

*EMA, endomysial antibodies semiquantitatively classified from 0 to 3.
†Histoology according to modified Marsh criteria.
‡Non-compliant.

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**Figure 1** Jejunal infiltration by enteropathy-type T cell lymphoma (ETCL). Haematoxylin and eosin stained section showing jejunal mucosa largely replaced by ETCL composed of large atypical lymphoid cells.
developed ETCL within the mean observation period of 22 months (range 4–32 months after the first 18F-FDG-PET scan).

**DISCUSSION**

ETCL is a rare disease, characterised by a dismal prognosis due to delayed diagnosis in most patients. The impaired performance status in afflicted individuals usually leads to poor tolerance of aggressive cytotoxic treatment, rendering current therapeutic approaches ineffective. While correct histological diagnosis is usually not a problem on resection specimens obtained from patients undergoing surgery because of intestinal perforation, it might be more difficult to establish on duodenal biopsies in patients with longstanding CD.

PET using 18F-FDG has become an established standard imaging modality in patients with lymphoma. We therefore hypothesised that 18F-FDG-PET might also be a potential diagnostic tool in patients with ETCL. 18F-FDG however accumulates in rapidly proliferating tissues as a reflection of enhanced glucose metabolism in cells and is therefore not specific for tumour cells. Various benign processes have been reported to result in 18F-FDG uptake, including inflammation or even muscle contractions. In these cases, calculation of SUV usually helps to distinguish neoplastic from benign processes.

The objective of our analysis was therefore to evaluate the efficacy of 18F-FDG-PET for imaging of ETCL with special emphasis on its potential enteropathic background caused by CD.

Our results demonstrated that 18F-FDG-PET can correctly visualise sites affected by ETCL. In addition, the 18F-FDG-PET results in patients with ETCL differed significantly from those obtained in patients suffering from CD. Visual analysis and particularly calculation of SUV revealed enhanced 18F-FDG uptake in involved intestinal areas, as confirmed on biopsy. In three patients, additional intestinal sites were found, and in one of these patients 18F-FDG-PET disclosed additional pulmonary involvement not evident before scanning. In terms of SUV, values were significantly higher in patients with ETCL compared with those with CD (p=0.011). Eight of our patients with CD showed tracer uptake but none had an SUV higher than 5, while all patients with ETCL demonstrating enhanced 18F-FDG accumulation had an SUV >6. In patients with a normal gut mucosa—that is, absence of malignancy or inflammation—usually no accumulation of 18F-FDG within the gut was seen. However, in some patients smooth muscle contractions can result in diffuse intestinal 18F-FDG uptake. To exclude this, all of our patients received N-butylbromide for smooth muscle relaxation.

Interestingly, there was no distinctive PET feature to differentiate active from inactive CD. In our patients, accumulation of 18F-FDG within the intestinal tract did not correlate with overall disease activity, and did not significantly change in patients imaged at different time points, in spite of altered clinical symptoms and histological findings. Rather than resulting in a gradual increase in 18F-FDG uptake from active to CD and refractory sprue, our results suggest that 18F-FDG-PET draws a precise threshold between CD and ETCL in terms of SUVs. As ETCL is a rare condition, the patient number in our retrospective study was rather small. While our limited data do not allow exact conclusions on whether or not 18F-FDG-PET is helpful in the follow up of patients with CD in diagnosing ETCL prior to other methods (biopsy, conventional

Figure 2  | (A) Coronal 18F-fluoro-deoxy-glucose positron emission tomography (18F-FDG-PET) image of a 60 year old female patient suffering from enteropathy-type T cell lymphoma (ETCL) showing two lesions with elevated FDG uptake (standard uptake value (SUV) 7.7). (B) Coronal 18F-FDG-PET image of a 74 year old female patient suffering from refractory sprue showing diffuse intestinal FDG uptake (SUV 2.2).

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imaging), our data suggest that individuals with an SUV >6 should be investigated further for ETCL. More prospective studies are needed to define the value of 18F-FDG-PET as a diagnostic tool in patients suffering from longstanding CD with suspected ETCL.

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REFERENCES