The usefulness of $^{99m}$Tc-SestaMIBI scan in the diagnostic evaluation of thyroid nodules with oncocytic cytology

F Boi, M L Lai, C Deias, M Piga, A Serra, A Uccheddu, G Faa and S Mariotti

Endocrinology and Nuclear Medicine, Department of Medical Sciences 'M. Aresu', Department of Cytomorphology and Department of Surgery and Imaging, University of Cagliari, Cagliari, Italy

(Correspondence should be addressed to S Mariotti, Endocrinology, Department of Medical Sciences, Presidio di Monserrato, University of Cagliari, Strada Statale 554-bivio Sestu, I-09042 Monserrato, Cagliari, Italy; Email: mariotti@pacs.unica.it)

Abstract

Objective: To assess the relevance of $^{99m}$Tc-SestaMIBI (MIBI) scan in the diagnostic evaluation of thyroid nodules with oncocytic cytology.

Subjects and methods: Twenty-four patients with a single (or prevalent) ‘cold’ solid nodule with Hurthle cells (HC) at fine needle aspiration cytology (FNAC) were studied. Cytological diagnosis of oncocytic metaplasia (OM) or HC tumor (HCT) was made when HC on the smear were comprised 10–75%, or >75%. Nodules concentrating MIBI at early and late (2 h after washout) stages were considered MIBI-positive. In all cases histological findings were obtained after total thyroidectomy.

Results: FNAC was malignant or suspect for malignancy in 16 cases (six HCT and 10 OM) and not suspect in eight (two HCT and six OM). Histological examination revealed 14 malignant tumors (11 HCT and three OM), and 10 benign thyroid lesions (three HCT and seven OM). Sensitivity of FNAC for malignancy was 92.8% and specificity was 70.0%; HCT were identified by FNAC in only 35.7% and OM in 70.0% of cases. No significant difference in MIBI positivity was found between malignant and benign thyroid nodules. The highest percentage of MIBI positivity was found in HCT (78.5%), but MIBI-positive nodules were also observed in thyroid lesions with HC metaplasia (40.0%).

Conclusions: MIBI scintiscan has no value in differentiating malignant from benign HC neoplasias. Most HCT are MIBI-positive, but this scan is not sufficiently specific to differentiate true HC neoplasias from other thyroid lesions showing HC at FNAC, although an MIBI-negative scan strongly supports the absence of true HCT.

European Journal of Endocrinology 149 493–498

Introduction

Hurthle cells (HC) or oncocytes are polygonal thyroid follicular cells with abundant granular eosinophilic cytoplasm, containing numerous mitochondria (1, 2). The term ‘oncocytic tumors’ or HC tumors (HCT) is reserved for thyroid neoplasms composed exclusively or predominantly (over 75%) of follicular cells exhibiting oncocytic features (3–5). The term oncocytic metaplasia (OM) indicates the presence of a variable (<75%) number of HC, often mixed with follicular monomorphic and intermediate cells, in other benign or malignant thyroid lesions. OM is a non-neoplastic hyperplasia of HC and appears to be particularly frequent in Hashimoto’s thyroiditis and nontoxic goiter (3–6). Classically, HCT are considered a variant of follicular neoplasms and may be classified as carcinomas or adenomas, based primarily on the architectural features of capsular or vascular invasion (2–4, 7). More recently, an HC variant of papillary thyroid carcinoma (HC-PTC) has also been recognized (8, 9).

Fine-needle aspiration cytology (FNAC) is considered the best procedure in the diagnostic evaluation of thyroid nodules (10), since in most cases it allows one to define the precise histotype in a simple and non-invasive fashion (10, 11). With particular regard to oncocytic nodules, FNAC does not appear to be a very reliable technique to distinguish HC adenomas from carcinomas (1, 4, 5). As observed with other histotypes, thyroid ultrasound (12) may help to identify thyroid nodules with a high risk of malignancy, while conventional $^{99m}$Tc-pertechnetate ($^{99m}$TcO$_4$) thyroid scintiscan has presently only an ancillary role in distinguishing malignant from benign lesions (13). During the last decade, $^{99m}$Tc-SestaMIBI (MIBI), a lipophilic cationic molecule, was introduced as a myocardial perfusion and viability imaging agent (14–17). MIBI has been reported to accumulate in benign and malignant lesions, such as lung, brain, parathyroid tumors and bone lesions (14–17). Recently, a positive MIBI scan has been reported in different thyroid tumors (22–27), but, when applied to unselected...
thyroid nodules, this procedure is not able to differentiate benign from malignant lesions (24, 27). Interestingly, however, MIBI scan has been found to be more frequently positive in HCT when compared with other thyroid neoplasias (27); however the relevance of this observation in the diagnostic evaluation of thyroid nodules is unclear, due to the very limited number of cases reported.

The aim of the present study was to evaluate the role of combined MIBI scintiscan and FNAC in the diagnostic evaluation of thyroid nodules with oxyphilic cytology, with particular regard to the differentiation of HCT from OM and the correct identification of malignant nodules.

Materials, methods and patients

Patients

A total of 24 euthyroid patients (20 women, age range 23 –70 years, and four men, age range 42 –72 years) with a single (or prevalent) thyroid nodule with HC at FNAC were included in this study. All patients were submitted to total thyroidectomy on the basis of clinical, echographic and/or cytological criteria independent from MIBI scan (see below). A summary of the main features of these patients, together with the final histology is reported in Table 1.

Conventional and color flow Doppler sonography

Thyroid ultrasonography (US) and color flow Doppler sonography (CFDS) using an Acuson 128 XP 10 color doppler system (Acuson Co., Mountain View, CA, USA) with a 7.5 mHz linear electronic transducer, were performed. The examination included first a conventional gray scale US, followed by CFDS; all thyroid nodules were identified, localized, counted and their diameters measured. The images were obtained by transverse and longitudinal planes scanning. All nodules were solid iso-hypoechoic, often heterogeneous due to the presence of calcifications and fluid areas, with a maximum diameter ranging from 10 to 60 mm. The CFDS patterns were classified (pattern 0 –III) as previously reported (28). As shown in Table 1, most of the patients presented intense intranodular vascularity, while the remaining nodules showed only peripheral blood flow.

Thyroid function assays

All hormonal and antibody assays were carried out by commercial kits. Serum free thyroxine (FT4) and free tri-iodothyronine (FT3) were assayed by RIA (Technogenetics, Milan, Italy); thyrotropin (TSH) by an ultra-sensitive chemioluminescent assay (Ortho Clinical Diagnostic SpA, Milan, Italy); and anti-thyroperoxidase antibody (TPOAb) by RIA (Biocode, Liège, Belgium). Normal values were as follows: FT4, 8.4 –20.4 pmol/l; FT3, 4.3 –8.6 pmol/l; TSH, 0.2 –3.0 mU/l; anti-TPOAb, < 20 U/ml. All patients had normal thyroid function; as detailed in Table 1, 6/24 showed increased titers of TPOAb.

Thyroid 99mTc-pertechnetate scintiscan

Thyroid scintigraphy was performed by means of a computerized gamma-camera equipped with a pinhole collimator (Elscint, SP4; Haifa, Israel) 30 min after i.v. injection of 110 MBq of 99mTcO4. Scans were performed in anterior, left-anterior oblique and right-anterior oblique projections. All patients showed a scintigraphic pattern characterized by a reduced uptake corresponding to a US position of prevalent thyroid nodules that often appeared typically ‘cold’.

Thyroid 99mTc-SestaMIBI scintiscan

This was performed by means of the same gamma-camera used for 99mTc thyroid scan after i.v. injection of 740 –1000 MBq of MIBI without any specific preparation. Two images were acquired: an early image with an acquisition time of 5 –10 min at 15 min and a late image with an acquisition time of 10 –15 min, 2 –3 h after tracer administration. Visual inspection of the images was performed following the MIBI deposition in nodular and extranodular thyroidal tissue in both images. The nodules were described as ‘hot’ or MIBI-positive when the scintigraphic pattern showed increased localized uptake in both early and late images, and the extranodular tissue did not concentrate MIBI at a late stage.

Fine needle aspiration cytology (FNAC) and histology

US-guided FNAC was performed using 22 –25-gauge needles and a 10 ml syringe. The smears (4 –12 for each nodule) were immediately fixed with Cytofix Bio-Optica, Milan, Italy and stained with hematoxylin-eosin (HE). In all cases a variable number (10 –100%) of follicular cells showed typical oncocytic changes. The criteria used for cytological evaluation were as follows: (a) For the evaluation of malignancy, monomorphic thyroid follicular cells with abundant colloid and without nuclear changes were considered non suspect. The presence of atypias such as nuclear enlargement, nuclear pleomorphism, binucleation and prominent nucleoli or cellular nests loosely cohesive with marked overlap, were considered suspect. A cytological diagnosis of PTC was made on the basis of classical features (papillae and/or characteristic nuclear changes such as grooves and pseudo-inclusions). (b) With regard to differentiation between true HCT and OM, the cytology specimens were considered as suggestive of HCT when...
Table 1 Main clinical features of the study group.

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Age (years)</th>
<th>Sex</th>
<th>TPOAb</th>
<th>Nodule (mm) US</th>
<th>CFDS* pattern</th>
<th>FNAC</th>
<th>Suspect for malignancy</th>
<th>MIBI scans</th>
<th>Histology</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>37</td>
<td>F</td>
<td>Pos</td>
<td>(37) hypo</td>
<td>III</td>
<td>OM</td>
<td>No</td>
<td>Pos</td>
<td>Foll A with OM in HT</td>
</tr>
<tr>
<td>2</td>
<td>61</td>
<td>F</td>
<td>Neg</td>
<td>(10) hypo</td>
<td>II</td>
<td>PTC with OM</td>
<td>Yes</td>
<td>Neg</td>
<td>PTC with OM in MNG</td>
</tr>
<tr>
<td>3</td>
<td>55</td>
<td>M</td>
<td>Neg</td>
<td>(60) iso</td>
<td>III</td>
<td>OM</td>
<td>Yes</td>
<td>Pos</td>
<td>MNG with OM</td>
</tr>
<tr>
<td>4</td>
<td>56</td>
<td>F</td>
<td>Neg</td>
<td>(22) iso</td>
<td>II</td>
<td>OM</td>
<td>No</td>
<td>Neg</td>
<td>HC-A</td>
</tr>
<tr>
<td>5</td>
<td>50</td>
<td>M</td>
<td>Neg</td>
<td>(16) iso</td>
<td>III</td>
<td>OM</td>
<td>Yes</td>
<td>Pos</td>
<td>Fol A with OM</td>
</tr>
<tr>
<td>6</td>
<td>44</td>
<td>F</td>
<td>Pos</td>
<td>(30) hypo</td>
<td>II</td>
<td>OM</td>
<td>No</td>
<td>Yes</td>
<td>Warthin’s-like PTC in HT</td>
</tr>
<tr>
<td>7</td>
<td>23</td>
<td>F</td>
<td>Pos</td>
<td>(27) hypo</td>
<td>III</td>
<td>PTC with OM</td>
<td>Yes</td>
<td>Pos</td>
<td>Warthin’s-like PTC in GD</td>
</tr>
<tr>
<td>8</td>
<td>45</td>
<td>F</td>
<td>Neg</td>
<td>(31) hypo</td>
<td>III</td>
<td>HC-N</td>
<td>Yes</td>
<td>Pos</td>
<td>HC-A</td>
</tr>
<tr>
<td>9</td>
<td>29</td>
<td>F</td>
<td>Neg</td>
<td>(25) iso</td>
<td>III</td>
<td>OM</td>
<td>No</td>
<td>Neg</td>
<td>Foll A with OM and occult PTC</td>
</tr>
<tr>
<td>10</td>
<td>69</td>
<td>F</td>
<td>Neg</td>
<td>(15) hypo</td>
<td>III</td>
<td>OM</td>
<td>Yes</td>
<td>Pos</td>
<td>Fol HC-C in HT</td>
</tr>
<tr>
<td>11</td>
<td>42</td>
<td>F</td>
<td>Pos</td>
<td>(18) hypo</td>
<td>II</td>
<td>HC-PTC</td>
<td>Yes</td>
<td>Neg</td>
<td>Warthin’s-like PTC in HT</td>
</tr>
<tr>
<td>12</td>
<td>42</td>
<td>M</td>
<td>Neg</td>
<td>(15) hypo</td>
<td>II</td>
<td>HC-N</td>
<td>Yes</td>
<td>Pos</td>
<td>Foll HC-C</td>
</tr>
<tr>
<td>13</td>
<td>47</td>
<td>F</td>
<td>Neg</td>
<td>(17) hypo</td>
<td>III</td>
<td>OM</td>
<td>Yes</td>
<td>Pos</td>
<td>Foll HC-C in focal HT</td>
</tr>
<tr>
<td>14</td>
<td>65</td>
<td>F</td>
<td>Pos</td>
<td>(15) hypo</td>
<td>II</td>
<td>HC-N</td>
<td>Yes</td>
<td>Pos</td>
<td>PTC with OM in HT</td>
</tr>
<tr>
<td>15</td>
<td>53</td>
<td>F</td>
<td>Neg</td>
<td>(25) hypo</td>
<td>III</td>
<td>OM</td>
<td>Yes</td>
<td>Pos</td>
<td>Foll HC-C in HT</td>
</tr>
<tr>
<td>16</td>
<td>50</td>
<td>F</td>
<td>Neg</td>
<td>(20) hypo</td>
<td>III</td>
<td>HC-N</td>
<td>No</td>
<td>Pos</td>
<td>HC-A</td>
</tr>
<tr>
<td>17</td>
<td>72</td>
<td>M</td>
<td>Neg</td>
<td>(11) iso</td>
<td>II</td>
<td>OM</td>
<td>No</td>
<td>Neg</td>
<td>Nodular HT and occult PTC</td>
</tr>
<tr>
<td>18</td>
<td>51</td>
<td>F</td>
<td>Neg</td>
<td>(27) iso</td>
<td>III</td>
<td>OM</td>
<td>Yes</td>
<td>Pos</td>
<td>Foll HC-C</td>
</tr>
<tr>
<td>19</td>
<td>52</td>
<td>F</td>
<td>Neg</td>
<td>(30) iso</td>
<td>II</td>
<td>HC-N</td>
<td>No</td>
<td>Neg</td>
<td>OM in MNG</td>
</tr>
<tr>
<td>20</td>
<td>70</td>
<td>F</td>
<td>Neg</td>
<td>(25) hypo</td>
<td>III</td>
<td>OM</td>
<td>No</td>
<td>Pos</td>
<td>Foll HC-C</td>
</tr>
<tr>
<td>21</td>
<td>57</td>
<td>F</td>
<td>Pos</td>
<td>(12) iso</td>
<td>II</td>
<td>PTC with OM</td>
<td>Yes</td>
<td>Neg</td>
<td>PTC with OM in HT</td>
</tr>
<tr>
<td>22</td>
<td>60</td>
<td>F</td>
<td>Neg</td>
<td>(26) iso</td>
<td>II</td>
<td>OM</td>
<td>Yes</td>
<td>Pos</td>
<td>Foll HC-C</td>
</tr>
<tr>
<td>23</td>
<td>53</td>
<td>F</td>
<td>Neg</td>
<td>(14) hypo</td>
<td>II</td>
<td>HC-PTC</td>
<td>Yes</td>
<td>Neg</td>
<td>HC-PTC</td>
</tr>
<tr>
<td>24</td>
<td>64</td>
<td>F</td>
<td>Neg</td>
<td>(19) hypo</td>
<td>III</td>
<td>HC-N</td>
<td>Yes</td>
<td>Pos</td>
<td>OM in MNG</td>
</tr>
</tbody>
</table>

M = male; F = female; hypo = hypoechoic; iso = isoechoic; N = neoplasia; C = carcinoma; A = adenoma; Foll = follicular; PTC = papillary thyroid carcinoma; HC = Hürthle cells; OM = oncocytic metaplasia; GD = Graves’ disease; HT = Hashimoto’s thyroiditis; MNG = multinodular goiter.

*CFDS pattern was classified 0—III as reported in (28).
HC represented > 75% of the total follicular cells present on the smear. HCT were classified as follicular unless typical nuclear features of PTC were detected within the oxyphilic cells - in this case a cytological diagnosis of papillary variant of HCT (or Warthin’s-like PTC) was performed. A lower number of HC was considered as evidence of OM (focal: 10–20% HC; moderate: 21–50% HC; marked: 51–75% HC), which was associated with various patterns of other benign, suspect or malignant cytological features (see Table 1).

Surgical specimens were fixed with 10% tamponated formalin. Each nodule was totally or subtotally sampled (with at least 10 sections including the capsule) and included in paraffin. Serial slides stained with HE were observed. The presence of benign or malignant neoplasias, as well as non-neoplastic lesions was identified by common criteria. With regard to the oxyphilic cells, the final histotype was classified as HCT when HC were > 75% and as OM (associated with various different benign or malignant thyroid lesions) when 10–75% of HC were detected.

**Statistical analysis**

The sensitivity and specificity for the correct identification of malignant nodules were calculated for the diagnostic procedures (single or in combination) by the Galen & Gambino formula (29).

**Results**

**Cytological and histological findings**

As shown in Table 1, 16 (66.7%) nodules were considered malignant or suspect for malignancy by FNAC criteria, while the remaining eight (33.3%) were not suspect. Histological examination showed 14 malignant and 10 benign lesions; in two of the latter cases a small occult PTC was also detected (Table 1), but this result was not considered when the sensitivity and specificity of FNAC was calculated (see below). As shown in Table 2, the sensitivity of FNAC for malignancy was 92.8% and the specificity was 70.0%.

With regard to the oncocytic changes, histological examination revealed the following: (a) 14 cases of HCT: 11 malignant (seven follicular carcinomas, three Warthin’s-like PTC and one HC-PTC) and three benign HC adenomas; (b) 10 cases displayed OM associated with three PTC and seven benign lesions (three follicular adenomas, three nontoxic multinodular goiters and one nodular Hashimoto’s thyroiditis). Two cases of occult PTC were detected in benign thyroid lesions (one follicular adenoma and one nodular Hashimoto’s thyroiditis).

The ability of FNAC to differentiate true HCT from OM is reported in Table 3. True HCT were correctly identified by FNAC in only 5/14 nodules, providing a sensitivity of 35.7%; on the other hand, FNAC correctly identified OM in 7/10 cases, corresponding to a specificity of 70%.

**Results of MIBI scan**

As reported in Table 4, 15/24 (62.5%) nodules displayed early and late MIBI uptake. No significant difference in MIBI positivity was found between malignant (10/15 = 66.7%) and benign (5/9 = 55.5%) nodules. The ability of MIBI to distinguish true HCT from OM is also reported in Table 4: most (11/14 = 78.5%) of the true HCT were MIBI-positive, while a few (4/10 = 40%) thyroid lesions with OM displayed significant MIBI uptake. This corresponded to a sensitivity of 78.5% and a specificity of 60% in correctly identifying true HCT.

**Combination of FNAC and MIBI scan in the diagnostic evaluation of HC nodules**

Finally, we evaluated the potential value of a combined approach by MIBI scan and FNAC to thyroid nodules with HC cytology. As reported in Table 5, the sensitivity...
observed in HC tumors, a surgical approach is generally advised.

Acknowledgements

This work was partially supported by M.U.R.S.T. (Rome, Italy) and by funds from the Regione Autonoma Sardegna to the Centro Studio per la Prevenzione e Terapia delle Malattie della Tiroide.

References


