A role for $^{11}$C-methionine PET imaging in ACTH-dependent Cushing’s syndrome

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Abstract

Objective: We report our experience of functional imaging with $^{11}$C-methionine positron emission tomography–computed tomography (PET–CT) co-registered with 3D gradient echo (spoiled gradient recalled (SPGR)) magnetic resonance imaging (MRI) in the investigation of ACTH-dependent Cushing’s syndrome.

Design: Twenty patients with i) de novo Cushing’s disease (CD, n = 10), ii) residual or recurrent hypercortisolism following first pituitary surgery (± radiotherapy; n = 8) or iii) ectopic Cushing’s syndrome (n = 2) were referred to our centre for functional imaging studies between 2010 and 2015. Six of the patients with de novo CD and five of those with persistent/relapsed disease had a suspected abnormality on conventional MRI.

Methods: All patients underwent $^{11}$C-methionine PET–CT. For pituitary imaging, co-registration of PET–CT images with contemporaneous SPGR MRI (1 mm slice thickness) was performed, followed by detailed mapping of $^{11}$C-methionine uptake across the sella in three planes (coronal, sagittal and axial). This allowed us to determine whether suspected adenomas seen on structural imaging exhibited focal tracer uptake on functional imaging.

Results: In seven of ten patients with de novo CD, asymmetric $^{11}$C-methionine uptake was observed within the sella, which co-localized with the suspected site of a corticotroph microadenoma visualised on SPGR MRI (and which was subsequently confirmed histologically following successful transphenoidal surgery (TSS)). Focal $^{11}$C-methionine uptake that correlated with a suspected abnormality on pituitary MRI was seen in five of eight patients with residual or recurrent Cushing’s syndrome following first TSS (and pituitary radiotherapy in two cases). Two patients elected to undergo repeat TSS with histology confirming a corticotroph tumour in each case. In two patients with the ectopic ACTH syndrome, $^{11}$C-methionine was concentrated in sites of distant metastases, with minimal uptake in the sellar region.

Conclusions: $^{11}$C-methionine PET–CT can aid the detection of ACTH-secreting tumours in Cushing’s syndrome and facilitate targeted therapy.

Invited Author’s profile

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**Introduction**

Despite recent advances in imaging and surgical techniques, both immediate and long-term remission rates following transsphenoidal surgery (TSS) for Cushing’s disease (CD) remain suboptimal for a condition that is associated with significant excess morbidity and mortality (1, 2, 3). This lack of success can be attributed in part to the challenge associated with reliably identifying the site of a corticotroph adenoma, which may be only a few millimetres in maximum diameter, coupled with the high rate of pituitary incidentalomas (10–15%) in the general population (4, 5). Accordingly, reliance on cross-sectional imaging alone (e.g., magnetic resonance imaging (MRI) or computed tomography (CT)) may fail to deliver a surgical target in up to 40% of CD patients (6), or erroneously implicate an incidentaloma as the source of adrenocorticotrophic hormone (ACTH) excess (7). Bilateral inferior petrosal sinus sampling (BIPSS) remains an important tool for discriminating central (pituitary) Cushing’s from the ectopic ACTH syndrome (EAS), but its utility in lateralising a corticotroph adenoma is limited (findings at surgery correspond with BIPSS lateralisation in approximately two-thirds of cases, a rate only marginally better than chance alone) (8, 9, 10). Functional nuclear medicine imaging (e.g. octreotide scintigraphy, 18F-fluorodeoxyglucose positron emission tomography (18F-FDG–PET)) has been employed by some workers, but with variable success, which in part reflects the limited spatial resolution of traditional scintigraphy and pituitary CT and the relatively high background uptake of 18F-FDG by normal brain tissue.

11C-methionine has been proposed as an alternative PET tracer for the localisation of pituitary adenomas (11, 12). In contrast to 18F-FDG, it is preferentially taken up by the normal pituitary gland, with relatively low uptake by the surrounding brain. Early studies confirmed that most types of pituitary adenoma exhibit enhanced 11C-methionine uptake, thus offering potential advantages over both somatostatin receptor (SSTR) ligand and 18F-FDG tracers (11, 13). Although experience to date with 11C-methionine in Cushing’s syndrome is limited, preliminary findings appear promising. In a study of 12 patients with CD, Ikeda et al. (14) noted that 11C-methionine was superior to 18F-FDG, detecting all microadenomas (100% sensitivity vs 67% for FDG). Moreover, co-registration of 11C-methionine PET–CT with 3.0T MRI was reported to offer greater accuracy in localising an adenoma within the sella. Here, we expand these findings and present our experience in 20 patients with ACTH-dependent Cushing’s syndrome. In addition, we highlight a novel approach to image analysis that permits co-registration of 11C-methionine PET–CT with spoiled gradient recalled (SPGR) acquisition MRI (Met-PET/MRI), and subsequent detailed profiling of tracer uptake across the sella. This technique has two important advantages: i) it allows the site of maximal 11C-methionine uptake to be more accurately defined and ii) it addresses the important question of whether a lesion seen on structural imaging exhibits functional activity. Accordingly, we show how it can help confirm or reveal the site of autonomous ACTH secretion in patients with ACTH-dependent Cushing’s syndrome.

**Patients and methods**

**Patients**

11C-methionine PET–CT was performed in 20 patients (16 women, four men; mean age 43 years (range 17–77 years)) with ACTH-dependent Cushing’s syndrome referred to our University Teaching Hospital between 2010 and 2015. Ten patients had newly diagnosed CD (confirmed biochemically by the demonstration of ≥2 of: raised 24-h urinary free cortisol excretion; failure of serum cortisol to suppress to <50 nmol/l following dexamethasone 0.5 mg 6 h for eight doses; raised sleeping midnight serum (>100 nmol/l) or late-night salivary (>4.3 nmol/l) cortisol; with unsuppressed ACTH levels and with a clear central to peripheral gradient on BIPSS), with conventional MRI (see below) identifying a possible microadenoma in six cases. Seven patients had residual or recurrent disease following TSS, two of whom had also received adjunctive radiotherapy (fractionated in one case and stereotactic radiosurgery in the other). All were referred because of equivocal post-treatment MRI appearances. One patient had undergone TSS for presumed CD, but with resection of an incidental Rathke’s cleft cyst; subsequent review of the case revealed inconclusive initial investigations with respect to the source of autonomous ACTH secretion. Two patients were referred for further investigation of possible EAS (one with a structural lesion on MRI, but no demonstrable gradient on BIPSS; the second with acute onset of florid Cushing’s syndrome). All patients were managed in accordance with local clinical guidelines and all patients provided informed consent for 11C-methionine PET–CT imaging. The decision to offer further treatment was undertaken on a case-by-case basis.
following discussion by a specialist pituitary multidisciplinary team comprising pituitary neurosurgeons, endocrinologists, radiation oncologist, neuropathologist and neuroradiologist, who had full access to the MetPET/MRI scans to aid decision-making.

**Synthesis of \(^{11}\text{C}\)-methionine**

The PET tracer, \(\text{L-}[\text{methyl-}^{11}\text{C}]-\text{methionine}\), was synthesised in compliance with good manufacturing practice using a captive solvent in loop methylation method without preparative HPLC, adapted from methods published previously (15, 16, 17). Briefly, \(^{11}\text{C}\)CO\(_2\) was produced using a PETtrace cyclotron (GE Medical Systems, Milwaukee, WI, USA) via the \(^{14}\text{N}(p,\alpha)^{11}\text{C}\) reaction before conversion to \(^{11}\text{C}\)MeI in the Mel MicroLab (GE Medical Systems). This was then transferred to the HPLC loop of a modified TracerLabFXC (GE Medical Systems) synthesiser containing an \(\text{l-homocysteine}\) precursor solution (0.5 M aqueous NaOH solution in ethanol). \(^{11}\text{C}\)-methionine was produced in yields up to 15 GBq with a radiochemical purity of \(>96\%\) and specific activity between 32.2 and 1564 GBq/\(\mu\)mol (average 205.5 GBq/\(\mu\)mol).

**\(^{11}\text{C}\)-methionine PET–CT imaging**

PET scans were acquired on a GE Discovery 690 PET–CT scanner (GE Medical Systems). Twenty minutes prior to each study, 300–400 MBq of \(\text{L-}[\text{methyl-}^{11}\text{C}]-\text{methionine}\) was administered intravenously. Attenuation correction was achieved using a low dose CT (140 kV, 220 mA, 0.5 s rotation, and 0.984 mm pitch). This was followed with a single bed position PET study of the head. Time-of-flight (ToF) PET data were acquired for a total acquisition time of 20 min. PET images were reconstructed with CT attenuation correction using cubic interpolation. The PET uptake of one image set was normalised to the corresponding (background) cerebellar uptake. The registered MR and PET images were read into the profiling software, which overlays the PET onto the MRI, and produces a two-dimensional profile of the pituitary uptake on a selected orientation (axial, coronal or sagittal) and slice. The reference position was established as follows: using the coronal slices, the midpoint of the profile was centred on the hypothalamic origin of the pituitary stalk with left and right limits set as equidistant (10 mm) from the centre of the profile. The software outputs three-dimensional surface plots of the pituitary uptake and PET/MRI overlays to allow correlation of site(s) of tracer uptake with site(s) of possible structural abnormalities.

**Results**

**Patients with \(\text{de novo}\) CD**

Ten patients with newly diagnosed CD underwent \(^{11}\text{C}\)-methionine PET–CT, and in seven of these profiling revealed an asymmetric peak in tracer uptake within the sella, which co-localized with a possible adenoma identified on SPGR MRI (illustrative cases 1–3; Table 1; Figs 1, 2 and 3). In four patients initial conventional SE MRI failed to identify a structural lesion, which was subsequently visualised on SPGR sequences. No abnormal pattern or focus of tracer uptake was seen in three patients, all of whom subsequently underwent transphenoidal exploration, but only one attained post-operative remission.

**Case 1**

A 47-year-old woman with typical symptoms and signs of hypercortisolism was found to have ACTH-dependent Cushing’s syndrome (Table 1). Conventional T1W SE coronal MRI pre- (Fig. 1a) and post-gadolinium injection of 0.1 mmol/kg gadopentetate dimeglumine. A SPGR acquisition sequence was also performed to optimise co-registration with the PET/CT dataset. In brief, sagittal T1-weighted fast spoiled gradient echo images (TR (repetition time) 11.5 ms, TE (echo time) 4.2 ms, slice thickness 1 mm, 0 mm gap, 256\times 256 matrix) of the whole head were obtained after i.v. injection of 0.1 mmol/kg gadopentetate dimeglumine.

**Image processing and analysis**

Image processing was performed in the commercial software package MATLAB (version R2013a, the MathWorks, Inc., Natick, MA, USA, 2013). PET data sets (ToF or SharpIR reconstruction) were co-registered with the SPGR MR images using cubic interpolation. The PET uptake of one image set was normalised to the corresponding (background) cerebellar uptake. The registered MR and PET images were read into the profiling software, which overlays the PET onto the MRI, and produces a two-dimensional profile of the pituitary uptake on a selected orientation (axial, coronal or sagittal) and slice. The reference position was established as follows: using the coronal slices, the midpoint of the profile was centred on the hypothalamic origin of the pituitary stalk with left and right limits set as equidistant (10 mm) from the centre of the profile. The software outputs three-dimensional surface plots of the pituitary uptake and PET/MRI overlays to allow correlation of site(s) of tracer uptake with site(s) of possible structural abnormalities.
(Fig. 1b) identified an 8 mm right-sided lesion, which was confirmed on SPGR sequences (Fig. 1c). Profiling of \(^{11}\)C-methionine uptake across the sella revealed a clear right-sided peak (Fig. 1d), which co-localised with the suspected adenoma (Fig. 1e; PET overlaid onto coronal SPGR MRI sequence shown in Fig. 1c). Surgical and histological findings confirmed a corticotroph adenoma, and 0900 h serum cortisol on day 1 postoperatively was undetectable (<25 nmol/l).

**Case 2** A 48-year-old woman with intermittent symptoms of hypercortisolism was diagnosed with periodic/cyclical Cushing’s syndrome. BIPSS performed during an active phase confirmed a pituitary origin with a right-sided gradient (Table 1). Conventional T1W SE coronal MRI pre- (Fig. 2a) and post-gadolinium (Fig. 2b) raised the possibility of an inferior right-sided microadenoma, which was visualised more easily on coronal (Fig. 2c) and axial (Fig. 2d) SPGR sequences. \(^{11}\)C-methionine profiling revealed an asymmetric right-sided peak of tracer uptake within the sella (Fig. 2e) corresponding to the abnormality identified on MRI (Fig. 2f; PET overlaid onto axial SPGR MRI sequence shown in Fig. 2d). At surgery a right-sided corticotroph adenoma was resected from the site of the suspected lesion. The patient remains in remission 4 years later.

**Case 3** A 31-year-old woman was diagnosed with ACTH-dependent Cushing’s syndrome. Conventional T1W SE coronal MRI pre- (Fig. 3a) and post-gadolinium (Fig. 3b) was unremarkable, but axial SPGR sequences identified a possible left-sided microadenoma (Fig. 3c). BIPPS confirmed a pituitary origin, but with a strongly positive right-sided gradient (Table 1). Profiling of \(^{11}\)C-methionine uptake across the sella revealed asymmetric tracer uptake skewed to the left (Fig. 3d) and concordant with the site of the suspected lesion on SPGR MRI (Fig. 3e; PET overlaid onto axial SPGR MRI sequence shown in panel Fig. 3c). Surgery confirmed a corticotroph adenoma adjacent to the left cavernous sinus. The patient remains in remission 1 year later.

**Patients with recurrent/persistent ACTH-dependent Cushing’s syndrome following previous pituitary surgery (± radiotherapy)**

Eight patients with recurrent or persistent ACTH-dependent Cushing’s syndrome underwent \(^{11}\)C-methionine PET–CT. In five cases \(^{11}\)C-methionine profiling demonstrated tracer uptake which co-localized with an
area identified on SE and/or SPGR MRI as the most likely site of residual or recurrent adenoma (illustrative cases 4 and 5; Table 1; Figs 4 and 5). In three patients no clear abnormal focus of \(^{11}\text{C}\)-methionine uptake was seen, and none of these had an abnormality on SE or SPGR MRI.

**Case 4** A 43-year-old woman who had previously undergone successful TSS for CD caused by a pituitary macroadenoma presented with features suggestive of recurrence 2 years after her initial operation. Conventional T1W SE coronal MRI pre- (Fig. 4a) and post-gadolinium (Fig. 4b) revealed no change compared to earlier post-operative scans, showing an area of low signal intensity on the left side of the fossa, extending in to the cavernous sinus, which was confirmed on SPGR sequences (Fig. 4c). This had previously been interpreted as consistent with postoperative change/scar tissue as the patient

**Figure 1**

Case 1: \(^{11}\text{C}\)-methionine PET–CT co-registered with SPGR MRI confirms functionality within an easily visualised right-sided corticotroph microadenoma. (a and b) T1-weighted coronal SE MRI pre- and post-gadolinium. (c) Coronal SPGR MRI following gadolinium. (d) Sella profiling of \(^{11}\text{C}\)-methionine uptake in the coronal plane. (e) PET profile overlaid onto coronal SPGR MRI shown in c. L, left; M, midline (based on the origin of the pituitary stalk at the level of the hypothalamus); R, right. Arrows denote the site of the adenoma. The ratio of \(^{11}\text{C}\)-methionine pituitary uptake relative to background cerebellar uptake is shown using a scale of 0 (blue) to maximum 5 (red).
was in full clinical and biochemical remission and glucocorticoid-dependent. Profiling of 11C-methionine uptake across the sella revealed the expected concentration of tracer within the normal gland (Fig. 4d and e – right sella), but a second discrete focus of tracer uptake on the left (Fig. 4d and e – left sella/parasellar region). At surgery, ACTH-staining tumour was resected from the site of the suspected recurrence on the left, and the patient went back in to remission.

Case 5

A 42-year-old woman had persistent CD after a ‘failed’ TSS, during which a central (4 mm) microadenoma was identified and resected, but proved to be an incidental (non-secretory) prolactinoma. She was treated with metyrapone and hydrocortisone (‘block and replace regimen’) and followed up with serial imaging. One year later, T1W SE MRI (Fig. 5a and b) identified a suspicious area on the post-gadolinium images adjacent to the left cavernous sinus (Fig. 5b), which was confirmed on SPGR MRI (Fig. 5c). This lesion had not been noted previously. Profiling of 11C-methionine uptake across the sella revealed the expected concentration of tracer within the remaining normal gland (Fig. 5d and e – right sella), but a second, subtle, focus of low level tracer uptake on the left corresponding to the hypointense lesion seen on MRI (Fig. 5d and e – left sella). The patient underwent a second TSS targeting the left-sided lesion, which was subsequently confirmed to be a corticotroph microadenoma.
Postoperatively, the patient is in full remission and remains glucocorticoid-dependent.

Patients with EAS

11C-methionine PET–CT was performed in two patients with presumed EAS. In both cases very little tracer uptake was seen within the pituitary fossa, but distant sites of metastasis were detected, with subsequent histology confirming ACTH-staining neuroendocrine tumours (NETs): small bowel primary tumour in one patient (illustrative case 6; Table 1; Fig. 6) and primary breast tumour in the other.

Case 6 ▶ A 42-year-old woman was diagnosed with ACTH-dependent Cushing’s syndrome. Although conventional T1W SE MRI was considered unremarkable (Fig. 6a and b), dynamic sequences raised the possibility of a right-sided

Figure 3

Case 3: 11C-methionine PET–CT co-registered with SPGR MRI identifies a left-sided microadenoma that is not readily visualised on initial MRI, in a patient with clear BIPPS lateralisation to the right. (a and b) T1-weighted coronal SE MRI pre- and post-gadolinium. (c) Axial SPGR MRI following gadolinium. (d) Sella profiling of 11C-methionine uptake in the axial plane. (e) PET profile overlaid onto axial SPGR MRI shown in c. L, left; M, midline; R, right. Arrows denote the site of the adenoma. The ratio of 11C-methionine pituitary uptake relative to background cerebellar uptake is shown using a scale of 0 (blue) to maximum 3 (red).
However, BIPSS failed to show a central:peripheral ACTH gradient, suggesting EAS (Table 1). In light of these discordant findings, the patient underwent whole body ¹¹C-methionine PET–CT. ¹¹C-methionine pituitary profiling revealed minimal tracer uptake throughout the sella, with no focus at the site of the suspected right-sided microadenoma (Fig. 6d and e). However, a left supraclavicular lymph node exhibited ¹¹C-methionine uptake (Fig. 6f), and biopsy demonstrated features in keeping with a NET. Further investigation revealed a small bowel primary NET with liver metastases.

**Discussion**

We have shown that ¹¹C-methionine PET–CT co-registered with SPGR MRI is a potentially important addition to
the clinician’s armamentarium for the investigation of ACTH-dependent Cushing’s syndrome. Using a novel approach to image analysis, which allows for more accurate mapping of tracer uptake within the sella, it appears to have particular utility when a structural lesion is identified/queried on MRI, either in a patient with de novo Cushing’s syndrome or when previous pituitary surgery has failed to achieve sustained remission from hypercortisolism (Figs 1, 2, 3, 4 and 5). It may also identify sites of ectopic ACTH secretion (Fig. 6).

In many centres, pituitary MRI is performed early in the diagnostic algorithm for ACTH-dependent Cushing’s syndrome, because demonstration of an obvious macroadenoma simplifies management; however, macroadenomas account for <10% of all corticotroph adenomas (18, 19). In contrast, many microadenomas are not reliably visualised using...
conventional (SE) MRI sequences, with several case series suggesting that 40% or more of patients with CD have ‘negative scans’ (6, 10). Accordingly, more detailed sequences (e.g., dynamic and/or SPGR MRI) are often employed, leading to a reported improvement in sensitivity from 50–55% (SE) to 70–75% (dynamic) and 70–90% (SPGR), but with the important caveat of a high detection rate of incidental pituitary lesions (6, 20, 21, 22). This presents a significant challenge, with the risk that a coincidental pituitary lesion will be erroneously identified as the source of excess ACTH, either in a patient with genuine CD due to a non-visualised microadenoma (illustrative case 5, Fig. 5c) or in a patient with EAS (illustrative case 6, Fig. 6c). In one series of 65 patients with proven ectopic disease, 17 (26%) were shown to have subtle abnormalities on pituitary MRI (23).

BIPSS remains the gold standard for distinguishing pituitary and ectopic sources of ACTH secretion (8, 24). However, it does not reliably lateralize the side of an adenoma in up to a third of patients with CD. Indeed, over-reliance on BIPSS to define lateralization is fraught with challenges that have been described in several reports including a large series of patients (n=501) from the National Institute of Health (10). The strict dichotomy of right vs left does not hold true in all cases, as up to 20% of adenomas are central or bilateral. In addition, interpretation can be difficult or impossible when lateralization varies at

Figure 6
Case 6: ¹¹C-methionine PET–CT co-registered with SPGR MRI shows minimal tracer uptake in the sella in a patient with a possible lesion on dynamic MRI, but BIPSS suggestive of ectopic Cushing’s syndrome. (a and b) T1-weighted coronal SE MRI pre- and post-gadolinium. (c) Dynamic MRI. (d) Sella profiling of ¹¹C-methionine uptake in the coronal plane. (e) PET profile overlaid onto coronal SPGR MRI (Note the absence of tracer uptake at the site of the suspected focal lesion seen on dynamic and SPGR MRI). (f) Coronal and axial PET–CT of the upper thorax. L, left; M, midline; R, right. Dashed arrow denotes the site of a pituitary incidentaloma. Solid arrows show ¹¹C-methionine uptake within a supraclavicular lymph node. The ratio of ¹¹C-methionine pituitary uptake relative to background cerebellar uptake is shown using a scale of 0 (blue) to maximum 3 (red).
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FDG–PET (PET/CT) (28). Indeed, 18F-FDG–PET/CT has sensitivity reported to be of the order of 40–70% (27). The heterogeneity of SSTR2 and SSTR5 expression with scan limited use in CD. Even in EAS there is considerable very small lesions, explains why they have found only this, coupled with the difficulties inherent in visualising expression of SSTRs (especially SSTR subtypes 2 and 5) and offer superior anatomical definition of sites of tracer acquisition. However, PET/CT is generally considered to be employed to detect ACTH-secreting tumours at any site, it is predominantly in EAS that their role has been established (27). While conventional SSTR scintigraphy lacks spatial resolution (especially for lesions <2 cm), this can be partly overcome through the use of SPECT (single-photon emission computerised tomography) for image acquisition. However, PET/CT is generally considered to offer superior anatomical definition of sites of tracer uptake. Crucially, both techniques depend on tumoral expression of SSTRs (especially SSTR subtypes 2 and 5) and this, coupled with the difficulties inherent in visualising very small lesions, explains why they have found only limited use in CD. Even in EAS there is considerable heterogeneity of SSTR2 and SSTR5 expression with scan sensitivity reported to be of the order of 40–70% (27).

18F-FDG uptake is linked to tumour glucose metabolism, as opposed to receptor binding, and hence lesions that do not express SSTRs, and are not visualized with octreotide scans, may theoretically be detected with 18F-FDG–PET (PET/CT) (28). Indeed, 18F-FDG–PET/CT has been shown to detect thymomas, thymic and bronchial carcinoids and pancreatic NETs causing EAS, although some clinicians argue that its use is limited when cross-sectional imaging is truly negative (29). However, as with SSTR imaging, reports exist of the detection of lesions not previously visualised on CT (30, 31, 32, 33).

In pituitary Cushing’s 18F-FDG–PET/CT has found limited use to date, potentially reflecting the relatively low metabolic rate of most corticotroph adenomas. In a recent prospective study of ten consecutive patients with subsequently confirmed CD, high resolution 18F-FDG–PET/CT (18F-FDG–hrPET) was performed together with SE and SPGR MRI (34). 18F-FDG–hrPET revealed increased tracer uptake in four patients, two of whom had no demonstrable lesion on SE MRI. However, SPGR proved more sensitive than 18F-FDG–hrPET, identifying a pituitary adenoma in seven cases and, importantly, no adenomas were detected by 18F-FDG–hrPET that were not visualised on SPGR MRI. Indices of adenoma metabolic activity (ACTH concentration and ACTH response to CRH stimulation), rather than adenoma size, were proposed as potential predictors of 18F-FDG–hrPET positivity (34). Adenoma location on 18F-FDG–hrPET was reported to correspond with surgical findings in the four patients with positive PET scans, although the lack of co-registration of PET images with CT or MRI makes it difficult to be certain that the foci of increased 18F-FDG uptake corresponded with the lesions seen on MRI. A comparable detection rate (58%) was reported by Alzahrani et al. (35) in their retrospective study of 12 patients who underwent conventional 18F-FDG–PET/CT.

11C-methionine has been employed as an alternative PET tracer for the localisation of pituitary adenomas by several groups (11, 12). Methionine, as the first amino acid incorporated into all peptides, is an ideal substrate for 11C-labelling to allow identification of sites of increased peptide/protein synthesis. In contrast to 18F-FDG, it is preferentially taken up by the normal pituitary gland compared to surrounding brain [the ratio of standardized uptake values (SUVmax) in normal pituitary gland compared to background brain has been reported to be as high 2.0 in some studies (11)]. Physiological uptake is also seen in the nasopharynx, salivary and lacrimal glands, bone marrow, liver and pancreas.

Early studies have confirmed that most pituitary adenomas exhibit enhanced 11C-methionine uptake, thus offering potential advantages over both SSTR ligand and 18F-FDG tracers (11, 13). It is perhaps somewhat surprising then that experience with 11C-methionine imaging in CD is limited to a small number of cases. Ikeda et al., describing their findings in 12 patients with CD who underwent 1.5T and 3.0T MRI, 11C-methionine PET/CT (in 11 cases) and 18F-FDG–PET/CT, concluded that methionine was superior to FDG as a tracer, detecting all eleven microadenomas (100% sensitivity vs 67% (eight of 12) for FDG) (14). Moreover, co-registration of 11C-methionine PET/CT with 3.0T MRI SE sequences was reported to offer greater accuracy in localising adenoma...
within the sella. However, findings from this study must be interpreted with caution as the authors provided only limited information on how the localization of adenomas was defined (particularly with reference to background tracer uptake by remaining normal pituitary tissue), and little data was provided to allow correlation of imaging appearances with intraoperative findings and postoperative endocrine/clinical outcomes (14).

We have performed 11C-methionine PET/CT in 20 patients with ACTH-dependent Cushing’s syndrome who fall in to one of three subgroups: i) de novo CD (n = 10), (ii) residual or recurrent hypercortisolism following first pituitary surgery (+radiotherapy; n = 8) or iii) ectopic Cushing’s syndrome (n = 2). In all but one case, images obtained from PET/CT were co-registered to the contemporaneous SPGR MRI (1 mm slices) using mutual information between the high resolution CT and MRI scans. In this way, CT acts as a bridge to allow registration of the PET and MR images (Met-PET/MRI). In addition, we have developed image analysis software that allows the detailed profiling of tracer uptake across the sella and adjacent structures to be profiled in three planes (axial, coronal and sagittal), thereby helping to confirm whether tracer uptake and, where evident, a structural abnormality are colocalized.

Our preliminary findings suggest that Met-PET/MRI may help inform decision-making in the following situations:

i) in patients with de novo CD and:
   a) a suspected lesion on SE MRI (Figs 1 and 2).
   b) Normal SE MRI, but a suspected lesion on dynamic or SPGR MRI (Fig. 3).

In both of these situations PET confirms functionality within the visualised lesion;

ii) following non-curable TSS, or in patients with recurrent disease (including Nelson’s syndrome), when further surgery or radiotherapy is being considered – here, it can help distinguish residual/recurrent disease from post-treatment change/scar tissue (Figs 4 and 5) and

iii) in EAS with an incidental non-functioning pituitary lesion (Fig. 6).

In addition, the source of ectopic ACTH secretion (including metastases) may be identified (Fig. 6).

In contrast to the findings of Ikeda et al., Met-PET/MRI did not identify a focus of abnormal tracer uptake in all cases: six (30%) had non-diagnostic scans. However, it is important to note that the majority of the 20 patients studied were selected for Met-PET/MRI on the basis of indeterminate MRI appearances. It is likely therefore that the true sensitivity for detecting functioning corticotroph adenoma in an unselected cohort lies somewhere in between, but further studies are required to confirm these findings.

Several factors may contribute to the failure to localise a microadenoma or to identify the site(s) of residual/recurrent disease in a previously treated patient. These include relatively low levels of tracer uptake by corticotroph tumours – in our experience they accumulate less 11C-methionine than their somatotroph, lactotroph or thyrotroph counterparts – which, particularly when combined with a central location within the sella, may result in tumour uptake merging with physiological uptake into the remaining normal gland. Consistent with this, lesions that are more laterally situated are relatively easily visualised by virtue of producing a skewed pattern of tracer uptake across the sella (Figs 1, 2 and 3). Failure to recognise or acknowledge cyclical/periodic CD may also theoretically yield a false negative result if the scan is performed during an inactive phase.

The application of image analysis techniques with detailed profiling of tracer uptake across the sella allows subtle patterns of abnormal tracer uptake to be identified, and this may have particular application in CD where low-level 11C-methionine uptake by a small microadenoma may otherwise not be easily distinguished from background uptake by remaining normal pituitary tissue. We speculate therefore that a multi-modal pituitary imaging approach using SE and/or SPGR pituitary MRI and 11C-methionine PET/CT could be adopted for ‘difficult’ pituitary Cushing’s cases, in order to maximize the chance of adenoma detection and localization.

Declaration of interest
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

Funding
This research did not receive any specific grant from any funding agency in the public, commercial or not-for-profit sector.

Acknowledgements
We are grateful to our colleagues S Heard, H Simpson, V K Chatterjee, R Smith and F Algibirho for their support and helpful discussion of cases. We also thank the clinicians who have referred patients to our centre for further investigation. O Koulouri, A S Powlson, N G Burnet, J D Pickard and M Gurnell are supported by the NIHR Cambridge Biomedical Research Centre, and J D Pickard is an NIHR senior investigator.
This paper forms part of a special issue of European Journal of Endocrinology on Cushing’s syndrome. This article is adapted from work presented at the IMPROCUUSH-1: Improving Outcome of Cushing’s Syndrome symposium, 12–14 October 2014. The meeting was supported by the European Science Foundation, Deutsche Forschungsgemeinschaft, Carl Friedrich von Siemens Stiftung, European Neuroendocrine Association and the Deutsche Gesellschaft für Endokrinologie. The opinions or views expressed in this special issue are those of the authors, and do not necessarily reflect the opinions or recommendations of the European Science Foundation, Deutsche Forschungsgemeinschaft, Carl Friedrich von Siemens Stiftung, European Neuroendocrine Association and the Deutsche Gesellschaft für Endokrinologie.

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