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<td>NISHIMURA, Kazuo; HIDA, Shuichi; OKADA, Kenichiro; YOSHIDA, Osamu; NISHIMURA, Kazumasa</td>
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MRI OF THE PROSTATIC CANCER: IN VIVO AND IN VITRO MRI RESULTS COMPARED TO PATHOLOGICAL FINDINGS

Kazuo Nishimura, Shuichi Hida, Kenichiro Okada and Osamu Yoshida

From the Department of Urology, Faculty of Medicine, Kyoto University
(Director: Prof. O. Yoshida)

Kazumasa Nishimura

From the Department of Nuclear Medicine, Faculty of Medicine, Kyoto University
(Director: Prof. J. Konishi)

Magnetic resonance imaging (MRI) of the prostate was accomplished in 23 patients who had prostatic cancer histologically proved by needle biopsy. Five prostates resected out of 23 patients with prostatic cancer were available for in vitro MRI. The MRI findings of the normal peripheral zone of the prostate had a high signal intensity on T2 weighted image, and the cancer nests in the peripheral zone had lower signal intensity than the normal peripheral zone. A partial or total destruction of the border line between outer zone and inner zone was observed besides microscopic invasions. MRI also enabled us to differentiate the cancerous foci from the normal tissue at a different signal intensity of imaging in some selected cases in which the resected specimen was examined by in vitro MRI.

MRI thus appears to be of clinical value in local staging of the prostatic cancer.

Key words: MRI, Prostatic cancer, Pathological specimen, In vitro MRI, In vivo MRI

INTRODUCTION

Many imaging modalities have been applied for staging of prostatic cancer, but they have a limited role. Computed tomography (CT) can sometimes detect extracapsular extension of cancer, lymphadenopathy, and bone metastasis. However, it can detect neither cancer confined within the capsule nor subtle extracapsular invasion\(^1,2\). Ultrasonography, especially transrectal sonography, can often detect intragrandular changes but is nonspecific. It can show neither lymphadenopathy nor bone metastasis\(^3\).

The newly developed MRI has been reported to be useful for the evaluation of the prostate. The fact that no respiratory motion influences the pelvic anatomy and its ability to produce images in multiple planes make MRI very suitable for making exact images of the pelvic organs.

We have examined the correlation between in vitro MRI of the resected prostatic cancer, pathological specimen findings of each corresponding slice, including in vivo MRI, to determine whether it is possible to distinguish prostatic cancer from the normal prostate on MRI.

PATIENTS AND METHOD

Twenty-three males (age range 62–85) with pathologically proved prostatic cancer were examined by MRI. Six cases of prostatic cancer had radical prostatectomy and 5 out of 6 served for in vitro MRI. Gross sections of the resected specimens were made, and H.E. staining was done. They were examined microscopically. The microscopic findings, and T1 and T2 weighted images of in vitro MRI were compared with the findings of in vivo MRI and ultrasonography. These analyses were done at the most corresponding cut surface in each examination. MRI of the pelvis was performed using a supercon-
Table 1. Results of the comparative study between in vitro T2 weighted MRI and the surgical specimen.

<table>
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<th>case</th>
<th>findings of in vitro T2 weighted MRI</th>
<th>findings of surgical specimen</th>
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| case 1 | outer zone; 4 low intensity areas  
inner zone; 1 suspicious area  
partial destruction of the border line between the inner and the outer zone | 4 cancer foci  
1 cancer focus  
cancer invades into the inner zone |
| case 2 | outer zone; 3 low intensity areas  
inner zone; 1 suspicious area | 2 cancer foci  
1 cancer focus |
| case 3 | outer zone; 2 low intensity areas  
inner zone; no suspicious area | 2 cancer foci  
1 cancer focus |
| case 4 | diminishment of the border line between the inner and the outer zone | the entire prostate was replaced by cancer. |
| case 5 | outer zone; 2 low intensity areas | 1 cancer focus |

In vitro MRI of case 1, stage D1 (T4N2MO), was studied by using a surface coil. The T1 weighted image of in vitro MRI showed a nodular appearance in almost all parts (Fig. 1). The T2 weighted image of in vitro MRI (Fig. 2) clearly
Fig. 3. Gross section of case 1. The dark area (arrowhead) is the cancerous focus. Most tissues in the inner zone is BPH, and the area indicated by the large arrowhead corresponds to BPH nodule in Fig. 2.

depicted the inner and outer zones, and a part of the border line between the inner and outer zone was found to be destroyed. Several areas of the inner zone also had a slightly higher intensity than other parts of the inner zone, just like a BPH nodule. The area of pathologically revealed cancer in the outer zone (Fig. 3) had a low intensity on T2 weighted image but had almost the same intensity as the normal outer zone on T1 weighted image. However, the high intensity areas in the outer zone on T2 weighted image in vitro MRI were identified as nonmalignant conditions, and the low intensity areas were either cancer or fibrotic tissue. However, there was no significant difference in signal intensity in the internal zone between cancerous and nonmalignant conditions. The area where cancer invaded into the internal zone corresponded to the area of the destroyed border line.

In vitro MRI of a stage B2 (T2N0M0) case (case 2) was studied by using a head coil. The T1 weighted image did not show any nodular image but showed a heterogeneous image. Cancer was found in both the inner and outer zones (Fig. 4, 5). The inner zone of the specimen was mainly composed of cancer, and fibromuscular tissue, and the T2 weighted image (Fig. 6) clearly showed such a structure. Cancer in the outer zone had low intensity, and in the inner zone it showed only a slightly higher intensity than the muscle.

Fig. 4. Gross section of case 2.

Fig. 5. Schema of cancer distribution of Fig. 4. The black area corresponds to the cancerous focus, and the arrow indicates fibromuscular tissue. The remaining area is mostly occupied by normal prostate tissue.

Fig. 6. T2 weighted image of case 2. Three low intensity areas in the outer zone (arrow) are suggested to be cancer foci. and in the inner zone cancer has only a slightly higher intensity than the muscle.

Almost all of these findings were consistent with the in vivo MRI findings.

All patients who did not undergo radical operation and whose axial T2 weighted MRI were examined had either a low intensity area or partial or total destruction of the border line between the inner...
and the outer zone.

Judging from these in vitro and in vivo studies, we conclude that cancer in the outer zone can be observed as a lesion showing lower intensity than the rest of the outer zone, and does not appear so clear in the inner zone. The destroyed border line between the outer zone and the internal zone corresponded to the area where cancer invaded into the internal zone. These findings were also recognized on in vivo MRI.

The T1 and T2 values were measured in 4 specimens, but no significant differences could be demonstrated between cancer and other parts of the prostate.

**DISCUSSION**

MRI is a new imaging modality and it is hoped that the superior soft tissue contrast of MRI over CT allows more accurate delineation of neoplastic extension.

Zonal anatomy of the prostate was depicted by MRI at a high magnetic field. According to the published reports, the anterior fibromuscular tissue of the normal prostate, the glandular tissue comprising the central zone of the prostate, and the glandular tissue of the peripheral zone of the prostate can be differentiated in intensity on the T2 weighted image. However, recognition of the normal zonal anatomy of the prostate was impossible in the studies at a low magnetic field strength. The importance of recognition of the peripheral zone that might represent cancer in this region was also pointed out in these reports. We previously reported that the outer zone was differentiated from the inner zone and that the outer zone showed a high signal intensity. Phillips et al. suggested that the peripheral zone had a high intensity due to a higher water content, less protein content, and less fibromuscular stroma.

Although most investigators found it difficult to distinguish carcinoma from benign hyperplasia, Steyn et al. suggested that carcinoma showed an irregular outline and that its field was nonhomogeneous. Larkin pointed out that a focal nodule of prolonged T1 and T2 relaxation time is specific to the carcinoma. Herman et al. did a biopsy of a prostatic nodule which was hypointense in comparison with the surrounding parenchyma on spin echo 2000/28 scan only, and proved that it was poorly differentiated adenocarcinoma.

Ling and Buoncore have reported studies similar to ours, on in vitro MRI. Ling observed a signal of lower intensity from the cancerous left lobe of the prostate, but he concluded that MRI could not distinguish between BPH and cancer. Carroll et al. found that 8 of their 12 prostatic cancer cases (67%) were hypointense to the remainder of the peripheral zone. They were unable to identify tumor prospectively in four cases (33%), but in only one of these four cases were they unable to identify the tumor prospectively and retrospectively. Phillips et al. interpreted the presence of a low intensity area in the outer zone as a sign of extracapsular invasion. As mentioned above, some authors suggested some relation between low intensity areas in the outer zone and the prostatic cancer, but no one proved the direct relation between the low intensity areas and the cancer areas, pathologically.

Our comparative study between in vitro MRI and pathological specimens precisely suggested that the carcinoma in the peripheral zone showed a lower intensity signal than that in other parts of the outer zone. This difference may be due to the volume of glandular secretion between normal glands and cancer.

In our experience of in vitro and in vivo MRI on 6 patients who underwent total prostatectomy, cancer foci in the inner zone were not always detected, but those in the outer zone could be observed on the T2 weighted images. In addition, when cancer invaded into the inner zone, partial or total disappearance of the border line between the inner and the outer zones indicated the presence of the cancer. Although small prostatic cancer foci had a similar appearance on in vivo MRI, an enlarged lesion showed the destruction of the border line between the internal
and the outer zone. A lower intensity area in the outer zone or a partial or total disappearance of the border line was also noted on T2 weighted axial images in all other patients who did not undergo radical operations.

There was no significant difference in the T1 or T2 values of the 4 specimens between cancerous and noncancerous parts of the specimens. Increased T1 and T2 values are attributed to increased free water, and these characteristics may be seen in other medical disorders such as edema, infection, benign tumors, malignant tumors and so on. Therefore, T1 and T2 values are thought to be of little clinical importance.

In the internal zone, BPH nodules and cancer foci could not be distinguished by the difference in the image intensity, but considering the finding that most cancers originate in the peripheral zone\(^8\), minor changes in this zone should not be overlooked.

In conclusion, we propose the following criteria for diagnosing early localized prostatic cancer on MRI:

1) A focal area of low intensity signal image in the outer zone with high intensity on T2 weighted image, because carcinoma almost always occurs from the peripheral zone\(^8\), and

2) A partial or total destruction of the border line between the inner and outer zones\(^9\).

Our data suggest that MRI is a promising method not only for staging prostatic cancer but also for detecting early prostatic cancer, and that MRI should be used as a primary noninvasive imaging modality for preoperative local staging.

Carrol et al.\(^5\) also concluded that high field strength MR imaging may be of predictive value in the differential diagnosing of prostatic abnormality when their location can be demonstrated. Although MRI may not be practical for use as a screening procedure because of its high cost, it seems to be useful for detecting early prostatic cancer.

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