ROLE OF RADIO-FREQUENCY ABLATION IN MANAGEMENT OF LUNG TUMORS

An Essay

Submitted for the Partial Fulfillment of The Master Degree in **Radio diagnosis**

Presented by Ahmed Mohammed Abd elmagid TobarM.B. B. Ch

Supervised by

Prof. Dr. Mohammed Zaki Elhedk

Professor of Radio diagnosis
Faculty of Medicine
Ain Shams University

Dr. Togan Taha

Lecturer of Radio diagnosis Faculty of Medicine Ain Shams University

Faculty of Medicine Ain Shams University 2012

List of Contents

Title	Page No.
Introduction & Aim of the work	
Lung Anatomy	3
Pathology of lung tumors	
Physical Principles	80
Technique	93
Illustrative Cases	
Summary and Conclusion	145
References	147
Arabic Summary	

List of Figures

Figure No.	Title	age No.
Fig. (2-1):	Anatomy of the lung	3
Fig. (2-2):	Anatomical relationship of the extra-thoracic trachea	5
Fig. (2-3):	Anatomical relationship of the main bronchi	6
Fig. (2-4):	Illustration of the main, lobar and segmental bronchial	
	division	9
Fig. (2-5):	Topography of the right lung; medial view	
Fig. (2-6):	Topography of the left lung; medial view	
Fig. (2-7):	Diagram showing lung lobes and fissures	
Fig. (2-8):	Bronchopulmonary segments	
Fig. (2-9):	The major divisions of the mediastinum	
Fig. (2-10):	Diagram showing the components of the pleura	
Fig. (2-11):	Lymphatic drainage of the lungs.	
Fig. (2-12):	PA chest radiograph.	
Fig. (2-13):	lateral chest radiograph	34
Fig. (2-14):	Examination of the seated patient (a) Linear probe placed	
	longitudinally on the right parasternal line. (b) Corresponding	
	sonographic longitudinal panoramic image. K cartilage at the	
	point of insertion of the rib, ICR intercostal space, M muscle,	
Fig. (2.15).	P line of the pleura Examination of the seated patient. (a) Linear probe placed	
Fig. (2-15):	parallel to the ribs in the third intercostal space. (b)	
	Corresponding sonographic transverse panoramic image .M	
	muscle, P line of the pleura	37
Fig. (2-16):	Trans hepatic examination (a) Convex probe placed	
11g. (2-10).	subcostally from the right. Slight tilting in cranial direction.	
	(b) Corresponding sonographic image. L liver, LV liver vein,	
	ZF diaphragm, S reflection of the liver above the diaphragm.	
Fig. (2-17):	Examination from the lateral aspect (a) Convex probe placed	
g · ()·	longitudinally in the mid portion of the right axillary line. (b)	
	Corresponding sonographic image. D diaphragm. The	
	normal mobile lung is shifted during inspiration into the	
	phrenicocostal recess and covers the upper margin of the	
	liver	39
Fig. (2-18):	Chest wall with normal smooth visceral pleura (arrow1).On	
	the outside, the echo-poor pleural gap (arrow 2) and then the	
	echogenic (echo-rich) parietal pleura (arrow 3). The extra	
	pleural fatty lamella varies in strength. The seemingly	

	thicker visceral pleura is actually an artifact due to reflection of the air-containing lung	40
Fig. (2-19):	Clearly recognizable double contour in the area of the	40
g · (>)·	parietal pleura (arrow), corresponding with the actual parietal	
	pleura and endothoracic fascia. Note the disproportionally	
	thick visceral pleura (arrowheads) due to artifact	41
Fig. (2-20):	Numerous comet-trail artifacts on the diaphragmatic pleura	
	(white arrow). Given the existing pleural effusion, the comet-	
	trail artifacts are likely due to a partial collapse of the lung	
	and not an expression of an interstitial parenchymal pathology of the lung	12
Fig (2-21).	a)CT lung window. B) CT mediastinal window.	42 47
Fig. (2-22):	a. A-D: Segmental bronchi. (A): Aortic arch (and distal	
1 -gv (= -=)v	trachea) level. The apical segmental bronchus (arrow) of the	
	right upper lobe is seen. (B): Carinal level. The apical	
	posterior segmental bronchus is demonstrated (solid curved	
	arrow). Anterior segment of the right upper lobe (straight	
	arrow) and posterior segment branch (curved arrow) are also	
	seen. (C): Left pulmonary artery level .The cephalad of the	
	apicoposterior segmental bronchus (straight arrow) and	
	horizontal course of the anterior segment are depicted at this	
	level. (D): Right pulmonary artery level. The bronchus intermedius (small arrow) is seen, with its thin posterior wall	
	On the left, the bifurcation of the left upper lobe (curved	
	arrow) and lower lobe (straight arrow) are visible	51
Fig. (2-23):	a. (Cont) E-G: (E): Slightly lower level. On the left, the	
3 ()	lingular segment (black arrow) is seen. The origin of the	
	middle lobe bronchus is seen on the right (arrowhead). Note	
	the origins of the superior segment bronch bilaterally (white	
	arrows). (F): Left atrial level. The right middle lobe bronchus	
	(black arrow) is seen anterior to the right lower lobe	
	bronchus (white arrow). The left lower lobe bronchus is also	
	demonstrated (white arrow). (G): Segmental bronchi .Curved arrows demonstrate the lateral basal segments bilaterally.	
	Note the posterior basal segment bronchi (straightarrows)	52
Fig. (2-24):	Vascular anatomy of pulmonary hila. A: Contrast-enhanced	
gv ()v	computed tomography scan depicting the vascular	
	components of the pulmonary hila. AA, ascending aorta; PA,	
	main pulmonary artery. Arrow: right upper lobe vein. V, left	
	upper lobe pulmonary vein. Arrowhead: superior segment	
	right lower lobe pulmonary artery. B: At a slightly lower	
	level. L, left lower lobe pulmonary artery. arrow: right upper	

	lobe pulmonary vein. The right atrial appendage is visible	
	(A). R: right pulmonary artery. C: The superior vena cava is	
	seen sandwiched between the right atrial appendage and the	
	right upper lobe pulmonary vein (white arrow), and the black	
	arrow demonstrates the proximal left coronary artery. V, left	
	upper lobe vein; D: PV, left and right lower lobe pulmonary	
	veins. LAA, left atrial appendage; RA, right atrium	53
Fig. (3-1):	Adenocarcinoma: Peripheral mass located immediately under	
	visceral pleura, with pleural retraction. Tumor has spread	
	along lymphatics, causing widened interlobular septa	
	(Lymphangitis carcinomatosa)	64
Fig. (3-2):	Squamous cell carcinoma, note whitish endobronchial	
3 ()	obstructive mass	66
Fig. (3-3):	Large cell lung carcinoma in a 64-year-old man. Fused FDG	
B : ():	PET/CT images of the chest show extension of the lung mass	
	(white arrow) into the aortopulmonary window; this	
	extension caused paralysis of the left vocal cord due to	
	involvement of the left recurrent laryngeal nerve, thus	
	explaining the asymmetric metabolism of the vocal cords.	
	1 6 3	
	Also marked narrowing of the left pulmonary artery (black	
	arrows) by the mass, thus illustrating the detail seen with	67
 (2.4)	PET/CT. Arrowheads in aortic arch	67
Fig. (3-4):	Small cell carcinoma, large central mass unsheathes bronchi	60
	and blood	68
Fig. (3-5):	Typical carcinoid in a 35-year-old woman with recurrent	
	pneumonia. Chest CT scan (lung window) demonstrates	
	marked cystic bronchiectasis of the left lung. A carcinoid of	
	the left mainstem bronchus was treated with pneumonectomy	70
Fig. (4-1):	Ionic agitation from alternating current causes tissue	
	coagulation through frictional heating	80
Fig. (4-2):	Needle of RITA system (Christmas tree needle)	89
Fig. (4-3):	Needle of radiotheraputic system (umbrella needle	
Fig. (4-4):	Single and cluster needle	
Fig. (5-1):	CT and gross pathologic appearances of ablated metastasis.	
8 ()	(a) Preprocedure planning CT with lung windows shows 14-	
	mm left lower lobe nodule (arrow). (b) Axial image with 3.5-	
	cm electrode array (arrow) deployed eccentrically around	
	lesion (c) Postprocedure CT with lung window shows area of	
	hemorrhage around ablated lesion (white arrow), with small	
	C	
	pneumothorax (black arrow), which was asymptomatic and	
	resolved spontaneously. (d) Gross pathology of resected	
	specimen shows ablated lesion (black arrow) eccentrically	

	located within ablation zone (outlined by white arrows). No	
	viable cells were seen microscopically	104
Fig. (5-2):	Grounding pads properly attached to the patient's thighs, equidistant to the RF site	106
Fig (5 3).	CT suite during lung RFA. The electrode has been	100
Fig.(5-3):	percutaneously introduced into the lung tumor and the	
	position of the deployed tines is monitored in three planes	109
Fig. (5-4):	CT image of the ablated lesion of the patient shown in Fig	107
116. (3 1).	36, at mediastinal indow setting. The lesion is totally	
	necrotized immediately after the radiofrequency ablation	111
Fig. (5-5):	CT image obtained 6 months after radiofrequency ablation.	
8 ()	The ablated lesion of the patient shown in Fig.36 appears	
	hypo dense, unenhanced and decreased in size. These	
	findings indicate complete ablation	111
Fig. (5-6):	CT image obtained 6 months after radiofrequency ablation.	
	These findings indicate complete ablation	112
Fig. (5-7):	Contrast enhanced follow-up CT image at one year reveals	
7. (7.0)	local Recurrence of the lesion	112
Fig. (5-8):	(A) CT scan showing biopsy-proven left upper lobe metastasis	
	from colon cancer. (B) Radiofrequency ablation of the lesion	
	with adjacent parenchymal hemorrhage and ground glass	
	changes. (C) Follow-up CT scan 1 month post ablation demonstrates an enlarged ablation zone that gradually	
	regresses at the 6-month follow up CT scan (D) and at the 1-	
	year follow-up study (E)	115
Fig. (5-9):	Persistent symptomatic procedure-related pneumothorax in a	113
116. (0)).	78-year-old woman with a history of heavy cigarette	
	smoking and emphysema and biopsy-proven 2-cm NSCLC	
	in the right upper lobe who refused lobectomy (a) CT scan of	
	lung window demonstrates RF electrode within targeted	
	tumor during RF ablation. In addition to pneumothorax	
	(arrowheads), intraparenchymal hemorrhage (arrow) is	
	noted. (b) Intraprocedurally, an 8-F pigtail catheter was	
	placed to drain the pneumothorax. The patient had a	
	persistent air leak and incomplete reexpansion of the lung	
	with chest tube suction. A large-bore chest tube was placed	
	but the air leak persisted. The patient underwent a conversion	
	to a water seal and discharged home 13 days after RF	
	ablation. Anteroposterior chest radiograph (c) 40 days after RF ablation, immediately before removal of the surgically	
	placed large-bore chest tube, shows that the pneumothorax	
	remained stable; the patient remained asymptomatic.	119
	remained states, the patient remained asymptomatic.	

Fig. (5-10):	Fatal pulmonary abscess of bronchocavitary and cavitary-	
	cutaneous fistulas in a 44-year-old woman with stage IIIB	
	NSCLC of the right upper lobe previously treated with	
	chemotherapy and external-beam irradiation. RF ablation	
	was performed for relief of chest and shoulder pain and	
	possible prolongation of life by cytoreduction of the tumor.	
	(a) CT scan of soft-tissue windows with RF electrode located	
	in the deep portion of the tumor. Note the proximity of the	
	electrode tines to the anterior segment of the right upper-lobe	
	bronchus (arrow). Three weeks after RF ablation, the patient	
	experienced progressive dyspnea over several days. CT scans	
	of lung windows (b,c) demonstrate an air-containing necrotic	
	abscess in the region of RF ablation with fistulous	
	connection to the anterior segmental bronchus (arrow) and	
	skin via the previous RF electrode tract (arrowheads). The	
	patient died 7 weeks after RF ablation as a result of	
	progressive respiratory distress and airspace disease despite	
	aggressive antibiotic therapy, attempts to close the bronchial	
	fistula with an endoscopically placed covered stent, and	
	repeated transcavitary catheter-directed administration of	
	biologic adhesive (fibrin glue followed by bovine albumin)	
	<u> </u>	122
Fig. (5-11):	Cerebral gas microembolization during RF ablation in a 66-	
	year-old man with an isolated 6.6-cm 4.0-cm right middle-	
	lobe metastasis from squamous-cell carcinoma of the	
	esophagus. The patient had undergone an esophagectomy	
	with colonic pull-through 1 year earlier. (a) CT scan of lung	
	windows with the RF electrode positioned along the deep	
	aspect of the tumor. (b) Duplex US of right internal carotid	
	artery at baseline immediately before RF ablation shows no	
	microembolic Doppler signals. (c) On duplex US image at	
	the same location as b during RF ablation just before roll-off,	
	arrows denote multiple bidirectional discrete "blips" caused	
	by gas microemboli. (d) CT scan of lung windows at the	
	same level as a shows that the necrotic tumor has cavitated	
	with a residual thin wall. Note preservation of the large	
	adjacent pulmonary vessel, presumably as a result of the	105
F: (6.1)	heat-sink effect	
Fig. (6-1):	Case 1	131
Fig. (6-2):	A, CT scan of chest shows recurrent neoplasm (arrow) in	
	radiation field after initial complete response with	122
	chemoradiation therapy.	132

Fig. (6-3):	B, CT scan obtained during radiofrequency (RF) ablation	
	shows position of electrode in mass.	133
Fig. (6-4):	C, Supine CT scan obtained immediately after RF ablation and removal of electrode shows increased parenchymal density and peripheral ground-glass opacity around tumor corresponding to lesion induced by RF heat. Note absence of	122
	pneumothorax.	133
Fig. (6-5):	D, CT scan obtained at same level as C 6 weeks after C	
	shows mass has become smaller and retracted toward hilum	134
Fig. (6-6):	Case 3	135
Fig. (6-7):	Case 4	136
Fig. (6-8):	Case 5	137
Fig. (6-9):	Case 6	139
Fig. (6-10):	Case 7	141
Fig. (6-11):	Case 8	143
Fig. (6-12):	Case 9	

List of Tables

Table No.	Title	Page No.
Table (2-1):	Right lung.	15
Table (2-2):	Left lung	
Table (2-3):	Lower limits of the lung and pleura	20
Table (3-1):	Primary tumor (T) staging	
Table (3-2):	Regional lymph nodes (N) staging	74
Table (3-3):	Distant metastasis (M) staging	75
Table (3-4):	TNM-staging system	76
Table (3-5):	Signs and symptoms of pulmonary carcinoma: Pathologic	
	correlation	78
Table (5-1):	Selection Criteria to determine When to Use RFA	101
Table (5-2) :	Types of complications	117

LIST OF ABBREVIATIONS

NSCLC: NON SMALL CELL LUNG CANCER
LMSB: LEFT MAIN STEM BRONCHUS
RMSB: RIGHT MAIN STEM BRONCHUS
CT: COMPUTED TOMOGRAPHY
FDA: FOOD & DRUG ADMINSTRATION
GGO: GROUND GLASS OPACIFICATION

HU: HOUSEFIELD UNIT mA: MILLIAMBER

MHZ : MEGA HERTZ KHZ : KILO HERTZ

MRI : MAGNETIC RESONANCE IMAGING

RF : RADIOFREQUENCY

RF A : RADIOFREQUENCY ABLATION

PA : POSTERO-ANTERIOR

CXR : CHEST X-RAY

AP : ANTERO-POSTERIOR

MM : MILLI METER CM : CENTIMETER

IVC : INFERIOR VENA CAVA SVC : SUPERIOR VENA CAVA

TB : TUBERCLOSIS

DNA : DEOXYRIBONUCLAEC ACID

BAC : BRONCHIOLOALVEOLAR CARCINOMA

SCC : SQUAMOUS CELL CARCINOMA

PET : POSITRON EMMISON TOMOGRAPHY

LCNEC: LARGE CELL NEUROENDOCRINE CARCINOMA

SCLC : SMALL CELL LUNG CARCINOMA WHO : WORLD HEALTH ORGANIZATION

UICC : UNION INTERNATIONALE CONTRE LE CANCER AJCC : AMERICAN JOINT COMMITTEE ON CANCER

RML :RIGHT MIDDLE LOBE

HCC : HEPATO CELLULAR CARCINOMA

MIN : MINUTE W : WATT

FDG : FLURODEOXYGLUCOSE

DWI : DIFFUSION WEIGHTED IMAGING

GY : GRAY

CEA : CARCINOEMBRYONIC ANTIGEN

PT : PROTHROMBIN TIME

INR : INTERNATIONAL NORMALIZED RATIO

US : ULTRASONOGRAPHY

LUNG ANA TOMY

1-Gross Lung Anatomy

Overview

The anatomy of the respiratory system can be divided into 2 major parts, airway anatomy and lung anatomy.

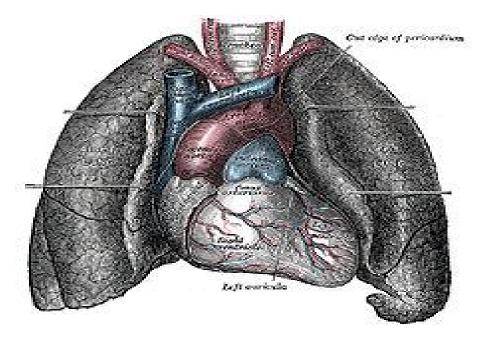


Fig.(2-1): Anatomy of the lung (Standring, 2005).

ANATOMY OF THE TRACHEOBRONCHIAL TREE

Trachea

A single tube represents the entrance to the lung's airways between the entrance and periphery lies a meticulously designed system of branching airways that serve to conduct the inspired air into those peripheral channels that carry alveoli in their walls and can thus contribute to the exchange of gases between air and blood (Fishman's et al., 2008).

The trachea extends from the larynx, which fixes it through the hyoid bone to the skull, down to its bifurcation in the mediastinum at the level of the fifth thoracic vertebra. Its length varies with movements of the head and respiration but averages about 10–12cm in the adult (Seaton et al., 2000).

Anatomical relation:

Its extra-thoracic portion extends down to the sixth cartilage and is closely related to the thyroid gland laterally and its isthmus anteriorly. The recurrent laryngeal nerves also run laterally, beneath the thyroid, while the oesophagus is directly behind, separating it from the vertebrae (*Seaton et al., 2000*).

As it enters the chest, the trachea is related anteriorly to the remains of the thymus, the left innominate vein, the right innominate artery and the left common carotid artery. To its right are the innominate vein, superior vena cava and azygos vein, while on its left

lies the aortic arch. The left recurrent laryngeal nerve runs up between the aortic arch and trachea and then in the ridge between the trachea and oesophagus (Seaton et al., 2000).

The trachea is oval in cross-section, being slightly longer in transverse than in sagittal diameter. The tracheal cartilages are semicircular, the gap being in the posterior part where the circle is completed by a 'membranous' portion. The cartilages are connected to each other by fibrous tissue extending from their perichondrium (Seaton et al., 2000).

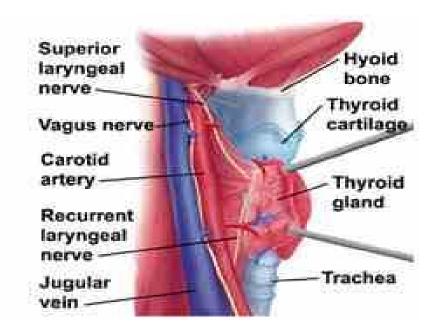


Fig. (2-2): Anatomical relationship of the extra-thoracic trachea (quoted from yoursurgery.com).

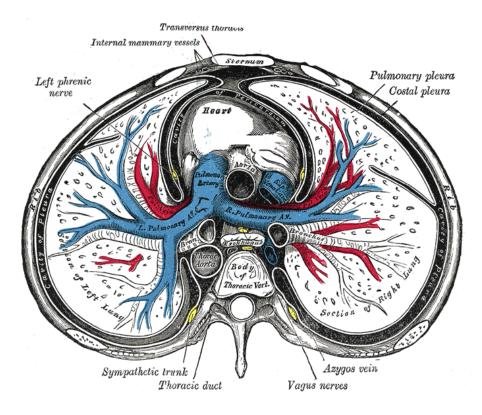


Fig.(2-3): Anatomical relationship of the main bronchi (quoted from Gray's Anatomy, education.yahoo.com)

Bronchi and their divisions:-

The trachea divides into right and left main bronchi at the carina. The carina resides approximately at the level of the fifth thoracic vertebral body (*Thompson*, 2003).