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Kinetic $^{18}$F-Fluoride of the Knee in Normal Volunteers

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Purpose: $^{18}$F-sodium fluoride ($^{18}$F[NaF]) is a well-established bone-seeking agent that has shown promise to assess bone turnover in a variety of disorders, but its distribution in healthy knee joints has not been explored. This study aimed to investigate parametric values for $^{18}$FNaF uptake in various bone tissue types (subchondral, cortical, and trabecular bone) and between regions of subchondral bone.

Methods: Twelve healthy subjects were hand-injected with 92.5 MBq of $^{18}$FNaF and scanned on a 3-T PET/MRI system. Listmode PET data for both knees were acquired for 50 minutes from injection simultaneously with MRI Dixon and angiography data. The image-derived input function was determined from the popliteal artery. Using the Hawkins model, Patlak analysis was performed to obtain $K_i$($K_{NR}$) values and nonlinear regression analysis to obtain $K_{NR}$, $K_i$, $k_3(k_2 + k_3)$, and blood volume. Comparisons for the measured kinetic parameters, SUV, and SUVmax were made between tissue types (subchondral, cortical, and trabecular bone) and between regional sections of subchondral bone.

Results: Cortical bone had the highest $^{18}$FNaF uptake differing significantly in all measured parameters when compared with trabecular bone and significantly higher SUVmax and $K_i$ than subchondral bone. Subchondral bone also had significantly higher SUV, SUVmax, and $K_i$ than trabecular bone tissue. Regional differences were observed in $K_i$ and $k_3(k_2 + k_3)$ values.

Conclusions: Quantitative $^{18}$FNaF PET is sensitive to variations in bone vascularization and metabolism in the knee joint.

Key Words: bone, fluoride, hybrid imaging, kinetics, knee, MRI, NaF, PET, PET/MRI

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Study Population

Twelve healthy subjects with no history of musculoskeletal complications (7 women, aged 22–44 years, body mass index 23 ± 3.3 kg/m²) and having abstained from exercise for 24 hours were hand-injected via an intravenous catheter with 92.5 MBq of

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The coils were used because of their lower attenuation effect on PET photons. Both knees were scanned using 1 flexible phased-array receive-only coil (NeoCoil, Pewaukee, Wis) around each knee. The coils were used because of their lower attenuation effect on PET photons. Both knees were scanned using 1 PET bed (field of view = 25 cm) in list mode starting with the injection of NaF for 50 minutes, and all MRI data were acquired simultaneously with PET imaging.

PET/MRI Scanning

Subjects were scanned on a 3-T whole-body time-of-flight PET-MR hybrid system (GE Healthcare, Milwaukee, Wis). Each subject was positioned feet first with a 16-channel flexible phased-array receive-only coil (NeoCoil, Pewaukee, Wis) around each knee. The coils were used because of their lower attenuation effect on PET photons. Both knees were scanned using 1 PET bed (field of view = 25 cm) in list mode starting with the injection of NaF for 50 minutes, and all MRI data were acquired simultaneously with PET imaging.

Magnetic resonance angiography data were acquired using a 3-dimensional gradient echo sequence with imaging parameters: repetition time/echo time (TE) = 21/2.1 milliseconds, slices = 18, slice thickness = 1.2 mm, and flip angle = 15°. A 2-point Dixon fat-water T1-weighted spoiled gradient echo MR sequence was acquired for MR-based attenuation correction of PET data with acquisition parameters: repetition time/TE1/TE2 = 4.1/1.1/2.2 milliseconds, field of view = 50 × 37.5 cm, matrix = 256 × 128, slice thickness/overlap = 5.2/2.6 mm, 120 images/slab, scan time = 18 seconds.

For calculation of the image-derived input function (IDIF), dynamic PET frame times of 40 × 1 seconds, 13 × 10 seconds, and 23 × 2 minutes were reconstructed using time of flight–ordered subset expectation maximization with 3 iterations and 21 subsets with corrections for decay, attenuation, scatter, random, and dead time. Time activity curves of bone PET uptake were determined using dynamic PET time frames of 8 × 2 seconds and 24 × 2 minutes with the same corrections. A 3-mL venous blood sample was taken 50 minutes after injection when arterial and venous blood concentrations have equilibrated and measured in a well counter.

IDIF Calculation

The IDIF was determined from [18F]NaF activity (kBq/mL) within the popliteal artery of each knee. The artery was segmented automatically from MR angiography images and a short time-frame PET angiogram during the arterial phase (0–16 seconds after injection) when the tracer is predominantly in the arteries. In order to minimize spillover artifacts, the voxels centered in the middle of the artery were determined for each dynamic PET frame and used for the IDIF. Central voxels were defined by including the voxels in each axial slice within the highest 10% of arterial NaF activity.

Bone Segmentation and Regions of Interest

Using the in-phase, out-of-phase, and water images from the Dixon scans, masks covering the femur, patella, and tibia were first created by manually drawing regions of interest (ROIs) (Fig. 2). The bone tissue was then segmented further to create subchondral/cortical bone masks using k-means clustering (4 cluster groups minimized to squared Euclidean distance repeated 4 times with different initial centroids). The long bone of the femur and tibia was identified as the cortical bone 6 to 8 cm from the center of the joint space. Trabecular bone ROIs in the tibia and distal end of the femoral bone were drawn for both legs maintaining a minimum of 3-mm distance from the edge of the bone to avoid partial voluming. Thereafter, the subchondral bone of the femur was manually subdivided into 5 regions: trochlea and central and posterior regions of the medial and lateral compartments. Similarly, tibial subchondral bone was further separated into lateral and medial regions. Lastly, cortical bone at the site of a patellar tendon insertion (tibial tuberosity) was identified and excluded from the analysis of cortical bone.

SUV and Kinetic Modeling

The time activity curves and IDIF data were fitted to the 2-tissue compartment model using the Patlak method and again using the non-linear regression (NLR) method. Patlak analysis is a graphical technique for estimating $K_i$, the total rate of plasma clearance of NaF to the bone matrix, which assumes that $^{18}$F is irreversibly bound to bone mineral ($k_4 = 0$). Data from 10 to 50 minutes were fit to allow for equilibration between tracer in plasma and the bone extracellular...
fluid. Nonlinear regression fitting included estimation of 3 rate 
parameters ($K_1$, $k_2$, and $k_3$) along with a partial volume fraction, 
a blood fraction, and an input dispersion estimate and was computed 
using COMKAT software. The rate constant $k_4$ was predefined as 
0. For both blood fraction and $K_1$, a parameter range from 0 to 1 
was applied, whereas a range of 0.015 to 0.8 was used for $k_2$ and $k_3$ 
and 0 to 2 seconds for the dispersion constant tau. To avoid local mini-
mums, fits were repeated with 3 starting conditions, and results with 
the lowest residuals were used. The rate of total plasma clearance 
using the NLR method ($K_{\text{NLR}}$) was calculated from the $K_1$, $k_2$, and 
$k_3$ values obtained by using the following formula:

$$K_{\text{NLR}} = K_1(1/ (k_2 + k_3))$$  

(1)

$K_{\text{NLR}}$, like $K_1$, has units of mL-min$^{-1}$-mL$^{-1}$, whereas $k_2$ and $k_3$ have 
units of min$^{-1}$.

The $K_{\text{NLR}}$ parameter can be separated into 2 parameters of 
physiological interest. One parameter is $K_1$, the rate of transit of the 
$[^{18}F]$ plasma concentration into the extravascular compartment, 
and reflects flow delivery of the tracer. Perfusion ($F$) estimates for 
each ROI were derived from $K_1$ values using least squares regres-
sion to the Renkin-Crone formula as

$$K_1 = F^* (1 - \exp(-PS/F))$$  

(2)

where the product of permeability and surface area (PS) was 
assumed to be 0.24, as reported by Piert et al. The second physiolog-
ical parameter is the extraction fraction, $k_s/(k_2 + k_3)$, which 
represents the fraction of $[^{18}F]$ entering the tissue that binds to the 
bone matrix as opposed to reentering the bloodstream.

Images for mean SUV and SUVmax were calculated from 
images obtained by averaging the last 2 frames of the dynamic 
study (46–50 minutes).

**Statistical Analysis**

Values across the entire patient cohort are reported as median 
with interquartile range, and $P$ values are from paired Student 
tailed $t$ tests using a threshold for significance of $P < 0.05$ after 
Bonferroni correction for multiple comparisons. Correlations be-
tween obtained parameters were analyzed using least products lin-
ear regression where goodness of fit was evaluated with a Pearson 
adjusted $R^2$ value. Reproducibility between IDIF blood activity 
and venous blood samples was analyzed by calculating the coeffi-
cient of variation, reported in percent. Image coregistration, ROI 
analysis, calculations, and statistical analysis were performed with 
software created in MATLAB 2013b (MathWorks, Natick, Mass).

**RESULTS**

Median parametric values along with interquartile range 
among all subjects are presented in Table 1. Variations in global 
$[^{18}F]$NaF uptake were observed between subjects (Fig. 3) with con-
sequently higher or lower SUV values across all 3 types of bone tissue. 
Comparisons between the 3 bone tissue types are shown in Figure 4. 
Cortical bone had highest $[^{18}F]$NaF uptake for all measured parameters 
compared with trabecular bone ($P < 0.01$), which had the lowest 
uptake. SUV and $K_1$ values for subchondral bone were lower than that 
of cortical bone, but these differences were not significant after cor-
rection for multiple comparisons. Subjects had significantly higher 
SUVmax and $K_1$ values and a significantly lower extraction fraction in 
cortical bone compared with subchondral bone. Subchondral bone had 
significantly higher $[^{18}F]$NaF uptake (SUV, SUVmax, and 
$K_{\text{NLR}}$; $P < 0.01$) than trabecular bone tissue.

There was a regional variance in distribution of $K_1$ and ex-
traction fraction values. The distribution ranged from cortical bone
of the shaft, which had the highest vascularization where $K_1 > K_i$ and $k_3/(k_3 + k_2) < 1$, to the trochlea and patella region of subchondral bone, where $k_3/(k_3 + k_2) \approx 1$ and $K_1 \approx K_i$ (Fig. 5). By visual analysis of $K_1$ and $k_3/(k_3 + k_2)$ maps, a negative gradient of $K_1$ values can be seen from the femoral and tibial shafts decreasing toward the joint space. A second gradient can be seen as $K_1$ is higher in subchondral bone and declines toward the center of the trabecular bone of the femur and tibial head (Fig. 6). In the subchondral bone of the femur, $K_1$ and blood volume values were higher in the posterior section, decreasing to the lowest in the trochlea ($P < 0.01$). The

![SUVmean](image1.png)

![K1](image2.png)

![SUVmax](image3.png)

![Blood volume](image4.png)

FIGURE 3. SUV of representative slice from 2 subjects. There was a wide intersubject range of $^{18}$FNaF uptake across the joint. The left image is a subject with low uptake in knee, whereas the right image is a subject with high uptake in all bone tissues. In addition to global variations in tracer uptake between subjects, some individual variations in the relative distribution of $^{18}$FNaF uptake across bone tissues regions were observed. In this example, the subject on the right has relatively low uptake in the subchondral bone of the femur compared with the subchondral bone of the patella and tibial head, whereas the subject on the left has equally low uptake in all subchondral regions.

of the shaft, which had the highest vascularization where $K_1 > K_i$ and $k_3/(k_3 + k_2) < 1$, to the trochlea and patella region of subchondral bone, where $k_3/(k_3 + k_2) \approx 1$ and $K_1 \approx K_i$ (Fig. 5). By visual analysis of $K_1$ and $k_3/(k_3 + k_2)$ maps, a negative gradient of $K_1$ values can be seen from the femoral and tibial shafts decreasing toward the joint space. A second gradient can be seen as $K_1$ is higher in subchondral bone and declines toward the center of the trabecular bone of the femur and tibial head (Fig. 6). In the subchondral bone of the femur, $K_1$ and blood volume values were higher in the posterior section, decreasing to the lowest in the trochlea ($P < 0.01$). The

![SUVmean](image1.png)

![K1](image2.png)

![SUVmax](image3.png)

![Blood volume](image4.png)

FIGURE 4. Parametric values of $^{18}$FNaF uptake for different bone tissue types of the knee. Cortical bone had the highest $^{18}$FNaF uptake in all measured parameters when compared with trabecular bone, which had the lowest uptake. Subchondral bone also had higher uptake than trabecular bone with significantly higher SUVmean, SUVmax, and $K_i^{NLR}$ values, yet only slightly elevated $K_1$ and $k_3/(k_3 + k_2)$ values. The relative distribution of $K_i^{NLR}$ values between bone tissues was almost identical to that of SUV. Note that despite having the highest uptake as expressed by SUV and $K_i^{NLR}$, cortical bone has the lowest extraction fraction. $P$ values were corrected for 18 comparisons using a Bonferroni correction ($\dagger P < 0.01$ difference compared with cortical bone, $\ddagger P < 0.01$ difference between trabecular bone and subchondral bone).
FIGURE 5. Components of $K_i$ for different bone tissue type. The SUV/$K_i^{NLR}$ relationship did not vary significantly between tissue types or between subjects. Linear regression analysis of SUV and $K_i^{NLR}$ gave SUV = 89 x $K_i^{NLR}$. The first column compares different ROI values from all subjects to this regression. Given that $K_i = K_1 \times (k_3/(k_3 + k_2))$, $K_i$ can be broken into a flow-related $K_1$ component, which is the rate of tracer entering the tissue, and an extraction fraction component, $k_3/(k_3 + k_2)$, which is the fraction of the tracer having entered the tissue that binds to the bone matrix. SUV of the cortical bone (shaft) is correlated to both $K_1$ and $k_3/(k_3 + k_2)$ values, whereas in trabecular bone and the patella, SUV is primarily determined by $K_1$ where $K_i = K_1$ and $k_3/(k_3 + k_2) = 1$ in all subjects.

DISCUSSION

Semiquantitative and quantitative values for $[^{18}F]$NaF uptake in the knee were obtained from healthy subjects using PET/MRI. A large intersubject variation in NaF uptake was observed as there were significant differences in uptake parameters between cortical bone and the subchondral/trabecular bone tissues. Trabecular bone was found to have significantly lower SUV, $K_i$, $K_1$, and blood volume values yet a significantly higher extraction fraction than the cortical bone tissue in the shaft of the femur and tibia. Blood volume was the parameter with the largest discrepancy between bone tissues being significantly higher in the shaft compared with subchondral or trabecular bone of the knee. Subjects had higher vascularization (larger blood volume and higher $K_1$) values in the shaft of the femur near the distal end. A similar regional discrepancy was also evident in SUV, SUVmax, and $K_i^{NLR}$ values, whereas in trabecular bone and the patella, SUV is primarily determined by $K_1$ where $K_i = K_1$ and $k_3/(k_3 + k_2) = 1$ in all subjects.
made between the spine and humeral bone tissues where low \( K_i \) values in the humeral bone were partially compensated by a higher \( k_3/(k_3 + k_i) \) to give a more comparable, yet still significantly lower, \( K_i \) value.\(^{23,25}\) Aside from the \( K_i \) and \( k_3/(k_3 + k_i) \) gradients, all other parametric values within the subchondral bone tissue ROIs of subjects were quite homogenous with no significant differences when comparing subchondral subregions across the patella, femur, and tibia.

\( K_i^{\text{Pat}} \) values from the Patlak method were 17% lower than those obtained by NLR, which is a larger bias than previously reported by Siddique et al.,\(^7\) where \( K_i^{\text{Pat}} \) was 10% lower than \( K_i^{\text{NLR}} \) in the lumbar vertebrae. Still, \( K_i^{\text{NLR}} \) values correlated highly with both \( K_i^{\text{Pat}} \) values \((R^2 = 0.97)\) and SUV \((R^2 = 0.90)\) with no regional variations in their correlation. Ultimately, this study gives no evidence of meaningful differences in using Patlak or NLR methods to determine \( K_i \) as they could be interchanged with a conversion factor. Studies including mean SUV, \( K_i^{\text{Pat}} \), and \( K_i^{\text{NLR}} \) have found these parameters to have similar reproducibility with coefficients of variation ranging between 9% and 15%\(^{19-20}\) although \( K_i^{\text{NLR}} \) had lower reproducibility when \( k_3 \) is not limited to 0 when fitting. In this study, SUV, \( K_i^{\text{Pat}} \), and \( K_i^{\text{NLR}} \) have comparable variance where intersubject SDs are between 43% and 46% of mean values. Despite similar reproducibility, \( K_i \) values have been reported to be a more sensitive measure of regional bone metabolism than SUV.\(^{17,18,27,42}\) In the limbs, where \( F^+ \) uptake is low, Brenner et al.\(^{43}\) and Apostolova and Brenner\(^{44}\) and concluded the minimal change of SUV in a patient must be greater than 50% to reliably detect disease or treatment-related changes, whereas the same diagnosis could be made from a change in \( K_i \) of 25%. \( K_i \) values have also shown to be more sensitive when analyzing alterations in subchondral bone of the femur adjacent to cartilage defects.\(^4\) SUVmax values in this study are similar to previously reported mean SUVmax values of 2.44 for the tibia\(^{43}\) and 2.22 in the femur shaft.\(^{44}\) SUVmax has been found to correlate well with adjacent cartilage alterations,\(^24\) and although it had the largest intraindividual variation in this study, it had a relatively lower variance between subjects and greater differentiation between bone tissues (Fig. 4). In this study, using NLR was advantageous as obtaining \( K_i \) and extraction fraction parameters provided useful information that could not be extracted from \( K_i \) alone.

The \( K_i \) values obtained in this study were within a flow-dominant regimen where it has, theoretically, a linear correlation to blood flow \((K_i \ll \text{PS})\). The flow values obtained in this study compare well with measured blood flow in the femoral shaft,\(^{45}\) but lack a criterion-standard measure to investigate \( K_i \) as a surrogate flow measure. To date, the most convincing studies to confirm the relationship between blood flow in bone tissue and \( K_i \) for \([\text{\textsuperscript{18}}\text{F}]\text{NaF} \) kinetics have been performed in swine vertebrae.\(^{15,21}\) Since then, authors have reported a poor correlation between \( K_i \) and bone perfusion in studies of the hip of human surgery patients\(^{46}\) and the forelimbs of healthy rats.\(^{47}\) Obtaining an estimate of flow would be of great clinical value. Bone perfusion is usually linked to metabolic activity and varies greatly between different bones and bone regions in the skeleton where the extremities are among the lowest.\(^{23,25,47}\)
Perfusion studies using microspheres have shown a reduction of blood flow in bones related to age, osteoporosis, and reduced endothelium-dependent vasodilation.

With regard to this study's aim to report key parametric values for $^{18}$FNaF uptake in the healthy knee, there are several limitations to be considered when interpreting the results. First, the number of subjects is small where results can be skewed by relatively few abnormalities. The range of ages (22–44 years) is a period of rather stable bone density in human adults, but factors such as body mass index, varus/valgus alignment, disease, or activity level could alter the kinetics in bone tissue. Second, despite the numerous advantages from combining PET imaging with MRI in knee examinations, there are disadvantages in foregoing the superior information on bone density, which CT provides. This information is valuable in both the attenuation correction of PET data and the segmentation of bone tissue. Dixon-based methods, as used by the scanner in this study, have been shown to underestimate bone $^{18}$FNaF mean SUV by 10%, ranging between 0% and 20% depending on location. The subchondral bone would be least affected being close to the bone surface, whereas the trabecular bone could have a more pronounced underestimation of SUV due to improper attenuation correction. Likewise, a similar underestimation of $K_i$ and $K_i$ would be expected, although it would be partially offset by a similar underestimation of activity in input function obtained from the popliteal artery. Lastly, the use of an IDIF would best be confirmed by using arterial sampling as a criterion standard. In this study, venous samples confirmed the activity of the later phase of the IDIF but not the earlier phase of high activity.

PET/MRI is an optimal dual-imaging combination offering the advantages of the high soft tissue contrast and resolution of MRI and the sensitivity of PET. In this study, MR angiography added the advantage of segmenting the popliteal artery, making an automated process to obtain the IDIF possible. The input functions obtained correspond well with literature values for $^{18}$FNaF from arterial sampling, and visual inspection of generated ROIs confirmed successful automated segmentation of the popliteal artery. Mean IDIF values 50 minutes after injection were 6% higher than venous blood samples taken on an equilibrium time point, whereas Cook et al found arterial blood samples to be 2% higher than venous blood samples after 24 minutes. With the increased use of NaF in nononcological studies of the skeleton, it has become even more relevant as moderate differences in NaF uptake may be an early indication of bone degradation in diseases such as osteoarthritis.

The combination of PET/MRI reduces the radiation dose significantly in 2 ways. First by eliminating CT and, second, because the PET data are acquired for the duration of the MRI protocol (which can be up

**FIGURE 7.** Comparison of $K_i^{\text{NLR}}$ with SUV values and $K_i^{\text{Pat}}$ Patlak. A, Scatterplot of $K_i^{\text{NLR}}$ results from all ROIs of all subjects plotted against ROI mean SUV ($R^2 = 0.90$). The Bland-Altman plot compares SUV values and $K_i^{\text{NLR}}$ values multiplied by the slope determined from the regression (slope = 0.90). B, A scatterplot with regression fit and Bland-Altman plot of the same ROIs comparing $K_i^{\text{NLR}}$ vs $K_i^{\text{Pat}}$ values ($R^2 = 0.97$). The Patlak method produced $K_i$ values that were 17% lower than those obtained by NLR and had a slightly poorer correlation to SUV ($R^2 = 0.87$).
Quantitative MRI techniques have been widely studied to develop robust and still retain the same signal-to-noise ratio in PET SUV maps. A standard clinical dose of 200 MBq to 90 MBq (used in this study) was good with an average coefficient of variation of 9% between 1 and 50 minutes.

to an hour), the injected dose of [18F] fluorid e can be decreased from a standard clinical dose of 200 MBq to 90 MBq (used in this study) and still retain the same signal-to-noise ratio in PET SUV maps. The effective dose of this study is estimated to be 2.16 mSv.

FIGURE 8. Image-derived input function of [18F]NaF repeated in 1 subject. One subject underwent injections on 3 separate days. Image-derived input functions for each scan are plotted from time of injection. Reproducibility across sessions was good with an average coefficient of variation of 9% between 1 and 50 minutes.

CONCLUSIONS

This study showed significant variations in regional bone perfusion and metabolism between skeletal tissue types in the knee joint. We have shown the feasibility of using PET/CT to create an accurate IDIF from the popliteal artery and to conduct a quantitative and semiquantitative evaluation of bone metabolism in the knee at a low radiation dosage. [18F]NaF PET/CT/MRI is a noninvasive technique that offers an attractive tool to simultaneously estimate bone perfusion and metabolism at clinically relevant sites of the knee.

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