18F-sodium fluoride positron emission tomography assessed microcalcifications in culprit and non-culprit human carotid plaques

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Background. 18F-NaF positron emission tomography (PET) targets microcalcifications. We compared in vitro microPET assessed 18F-NaF uptake between culprit and non-culprit human carotid plaques. Furthermore, we compared 18F-NaF uptake with calcification visualized on microcomputed tomography (microCT).

Methods. Carotid plaques from stroke patients undergoing surgery were incubated in 18F-NaF and scanned using a microPET and a microCT scan. The average PET assessed 18F-NaF uptake was expressed as percentage of the incubation dose per gram (%Inc/g). 18F-NaF PET volume of interest (VOI) was compared with CT calcification VOI.

Results. 23 carotid plaques (17 culprit, 6 non-culprit) were included. The average 18F-NaF uptake in culprit carotid plaques was comparable with the uptake in non-culprit carotid plaques (median 2.32 %Inc/g [IQR 1.98 to 2.81] vs. median 2.35 %Inc/g [IQR 1.77 to 3.00], P=0.916).

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Only a median of 10% (IQR 4 to 25) of CT calcification VOI showed increased ¹⁸F-NaF uptake, while merely a median of 35% (IQR 6 to 42) of ¹⁸F-NaF PET VOI showed calcification on CT.

Conclusions. ¹⁸F-NaF PET represents a different stage in the calcification process than CT. We observed a similar PET assessed ¹⁸F-NaF uptake and pattern in culprit and non-culprit plaques of high-risk patients, indicating that this method may be of more value in early atherosclerotic stenosis development. (J Nucl Cardiol 2018)

Spanish Abstract

Antecedentes. La tomografía por emisión de positrones (PET) con ¹⁸F-flururo de sodio (¹⁸F-Fluor) demuestra microcalcificaciones. En este estudio, comparamos la captación de ¹⁸F-Fluor entre placas carotídeas culpables y no culpables valorada con microPET in vitro. Además, comparamos la captación de ¹⁸F-NaF con las calcificaciones detectadas por microtomografía computada (microCT).

Métodos. Placas carotídeas de pacientes postoperados que sufrieron de un evento vascular cerebral fueron incubadas en ¹⁸F-NaF y escaneadas usando microPET y microCT. El promedio de la captación fue expresado como porcentaje de la dosis de incubación por gramo (%Inc/gr).

Resultados. Se incluyeron 23 placas carotídeas (17 culpables y 6 no culpables). El promedio de la captación de ¹⁸F-NaF en placas carotídeas culpable fue comparable al de las placas no culpables. (mediana 2.32%Inc/gr [IQR1.98-2.81] vs. mediana 2.35%Inc/gr [IQR1.77-3], p=.916). Solo una mediana de 10% (IQR 4-25) del VOI en CT mostró un aumento en la captación de ¹⁸F-Fluor, mientras una mediana de 35% (IQR 6-42) del VOI de PET ¹⁸F-NaF mostró calcificación en CT.

Conclusiones. La tomografía por emisión de positrones con ¹⁸F-NaF evalúa una etapa distinta en el proceso de calcificación que la CT. El patrón de captación de ¹⁸F-NaF que observamos en este estudio fue similar entre placas culpables y no culpables de pacientes de alto riesgo, lo cual indica que este método puede ser de mayor valor en el desarrollo temprano de la estenosis ateroesclerótica. (J Nucl Cardiol 2018)

Chinese Abstract

背景。¹⁸F钠化钠正电子发射断层扫描（PET）可用于检测微钙化。我们使用微型PET来评估尸体外的¹⁸F钠化钠在颈动脉罪犯和非罪犯斑块之间的摄取区别。此外，我们还将¹⁸F钠化钠的微钙化与microCT扫描检测的钙化进行对比。

方法。将接受手术的中风患者的颈动脉斑块在¹⁸F钠化钠中培养并用microPET和microCT进行扫描。PET对¹⁸F钠化钠的平均摄取率为每克培养剂的百分比。¹⁸F钠化钠PET中的感兴趣区域（ROI）在CT和钙化图像中的感兴趣区域（VOI）中进行比较。

结果。一共有23个颈动脉斑块，其中17个罪犯斑块和6个非罪犯斑块。罪犯和非罪犯颈动脉斑块的¹⁸F钠化钠的平均摄取率无明显差异（中值2.32%Inc/g [IQR1.98-2.81] vs. 中值2.35%Inc/g [IQR1.77-3.00], p = 0.916）。仅中值为10% [IQR 4-25]的CT钙化VOI显示有¹⁸F钠化钠的摄取增加，中值为35%[IQR 6-42]的¹⁸F钠化钠PET VOI显示有CT上的钙化。

结论。相较于CT, ¹⁸F钠化钠PET展现了钙化过程中的一个不同阶段。在高危病人中,我们观察到罪犯和非罪犯斑块具有类似的PET ¹⁸F钠化钠摄取和模式，表明该方法可能在早期动脉粥样硬化狭窄发展中具有更高的价值。 (J Nucl Cardiol 2018)

French Abstract

Contexte. La tomographie par émission de positons (TEP) au ¹⁸F-NaF marque les microcalcifications. Nous avons comparé in vitro les plaques carotidiennes humaines responsable d’accident vasculaire cérébrales marquées au ¹⁸F-NaF avec une microTEP et leur calcification au moyen d’un microCT.

Méthodes. Les plaques carotidiennes de patients victimes d’un accident vasculaire cérébral qui ont bénéficié d’une intervention chirurgicale ont été incubées dans du ¹⁸F-NaF et imagées avec une microTEP et un microCT. Le pourcentage d’absorption moyen de ¹⁸F-NaF par gr de tissu (% Inc/g) ont été comparées au volume d’intérêt (VOI) des calcifications mesurées par CT.
Résultats. 23 plaques carotidiennes (17 responsables d’un AVC et 6 non responsables) ont été incluses. Le % moyen d’absorption de $^{18}$F-NaF dans les plaques carotidiennes responsables furent comparable à l’absorption dans les plaques non responsables (2,32% Inc/g vs 2,35% Inc/g, $p = 0,916$). Dix pourcent seulement des calcifications visualisées par CT démontrèrent une augmentation d’absorption de $^{18}$F-NaF et 35% des plaques montrèrent une absorption de $^{18}$F-NaF PET VOI démontrèrent des calcifications au CT.

Conclusions. L’imagerie de l’absorption de $^{18}$F-NaF par tomodographie à positrons représente un processus physiopathologique différent de l’imagerie des calcifications par CT. L’absorption du $^{18}$F-NaF par les plaques responsables et non responsables d’accidents vasculaire cérébraux pourrait s’avérer utile dans le diagnostic précoce des sténoses athéromateuses. (J Nucl Cardiol 2018)

Key Words: $^{18}$F-sodium fluoride ($^{18}$F-NaF) · Calcification · PET/CT imaging · Vulnerable atherosclerotic plaque · Carotid artery stenosis

INTRODUCTION

Surgical removal of atherosclerotic plaques from the carotid artery highly reduces the risk of future stroke in symptomatic patients with $\geq 70\%$ stenosis.1 However, most of these patients will not have a new event when treated with best medical therapy.2 Furthermore, the role of surgery in moderate symptomatic stenosis (50% to 69%) and asymptomatic stenosis is under debate.3–5 Therefore, taking into account the potential risk for surgical complications, the selection of patients who will benefit most from surgery is challenging.

In order to improve risk stratification, research has been focused on the identification of plaques at risk for rupture, so-called vulnerable plaques.6–8 Currently, plaque thickness and intraplaque processes, such as inflammation and microcalcification, are seen as important contributors to vulnerability. These processes have become targets of various molecular imaging techniques, as they potentially allow non-invasive risk stratification of individual patients with carotid artery stenosis.9,10 Recently, several studies have shown the feasibility of $^{18}$F-sodium fluoride ($^{18}$F-NaF) positron emission tomography (PET) for imaging of atherosclerotic plaques.11–13 $^{18}$F-NaF predominantly binds to areas of microcalcification within the plaque.14 Appearance of microcalcifications indicates the active formation of calcification and is associated with plaque vulnerability.15,16 In contrast, established calcifications are seen as atherosclerotic end stage products and are associated with plaque stability.17–20 It has been suggested that $^{18}$F-NaF may additionally be a useful marker for plaque vulnerability.21 Indeed, a clinical study by Joshi et al. showed that ruptured and high-risk coronary plaques have a significantly higher $^{18}$F-NaF uptake than non-culprit and low-risk coronary plaques.22 However, data on $^{18}$F-NaF uptake in carotid plaques are limited and their usefulness for the prediction of future stroke is unclear.23–25 Additionally, limited data have been published on the relation between active microcalcifications and established calcifications in human carotid plaques.26,27 The primary objective of this study is to compare in vitro microPET assessed $^{18}$F-NaF uptake between culprit and non-culprit carotid plaques from stroke patients, using non-macrocalcified renal arteries from healthy kidney donors as negative controls. The secondary objective is to compare the distribution of $^{18}$F-NaF uptake on microPET with calcification visualized on a high-resolution microcomputed tomography (microCT) in carotid plaques.

MATERIALS AND METHODS

Study Subjects

Carotid plaques were collected from stroke patients who underwent carotid endarterectomy (CEA) at the Department of Surgery (Division of Vascular Surgery) of the University Medical Center Groningen (UMCG), between July 2015 and March 2016. Indication for CEA was decided by a surgeon expert panel and was based on the presence of symptomatic (culprit) stenosis ($\geq 50\%$) or asymptomatic (non-culprit) stenosis ($\geq 70\%$) of the internal carotid artery, according to internal guidelines.28,29 One patient with $<50\%$ stenosis was selected for CEA because of an irregular aspect of the plaque surface.
In order to increase the reliability of our measurements, we used renal artery specimens from healthy kidney donors as negative controls. The specimens were obtained during living donor nephrectomy.

Clinical and demographic data from the included patients were collected from medical records. In the group with culprit plaques, medication use and history of cardiovascular diseases prior to the recent event were registered. The study was reviewed by the ethics committee of the UMCU (METc 2015/258). All patients gave written informed consent.

**Study Procedure**

Immediately after excision, carotid plaques and renal artery specimens were placed into phosphate buffered saline (PBS) and kept on ice. Both were incubated for one hour in 49.4 ± 7.2 MBq \(^{18}\text{F-}\text{NaF}\) in 20 mL. After incubation, the plaques and renal arteries were carefully rinsed 5 times with 10 mL PBS. Then, tissue samples were weighed and microPET and microCT scans were performed. After the imaging procedure, the carotid plaques were cut transversely into segments of 3 to 4 mL. The renal arteries had a maximum thickness of 5 mL and therefore no cross-sections were made. The segments were embedded in paraffin for histological analysis.

**Production of \(^{18}\text{F- NaF}\)**

\(^{18}\text{F-}\text{NaF}\) was produced by passing a solution of \(^{18}\text{F-fluoride}\) in water over a quaternary methyl ammonium (QMA) light anion exchange cartridge (Waters Chromatography B.V., Etten-Leur, The Netherlands). After washing the QMA with water, \([^{18}\text{F}]-\text{fluoride}\) was eluted with saline and passed over a sterile Millex GS 0.22 µm filter (Millipore B.V., Amsterdam, The Netherlands). The radiochemical purity for all runs was >95%.

**PET and CT Acquisition**

Carotid plaques and renal arteries were positioned into a microPET scanner (MicroPET Focus 220, Siemens Medical Solutions USA, Knoxville, TN, USA), and an emission scan of 30 minutes was performed. After the PET scan was finished, the bed of the PET scanner was transferred to a microCT scanner (Inveon CT, Siemens Medical Solutions USA, Knoxville, TN, USA) without moving or touching the tissue samples. The CT exposure settings were 50 keV and 500 µAs, and a 100-ms exposure time for 360 projections during one 360° rotation.

The PET scans were reconstructed into a single frame of 30 minutes, using OSEM2D (4 iterations and 16 subsets), after being normalized and corrected for attenuation and decay of radioactivity. The CT images were reconstructed with the Feldkamp algorithm. 30

**Data Analysis**

The PET and CT images were automatically registered using PMOD 3.7 (PMOD Technologies LLC, Zürich, Switzerland). The registration was visually inspected and manually corrected when necessary. For quantification of the average \(^{18}\text{F-}\text{NaF}\) uptake, three-dimensional volumes of interest (VOIs) were drawn around the whole tissue samples. The uptake (in kBq/cc) was corrected for weight of the specimen and the incubation dose, and expressed as percentage uptake of total incubation dose per gram of tissue (%Inc/g). It was assumed that 1 cubic centimeter equals 1 gram of tissue.

VOIs were also automatically drawn around \(^{18}\text{F-}\text{NaF}\) PET areas with a threshold of ≥50% of the maximum \(^{18}\text{F-}\text{NaF}\) uptake and assigned as \(^{18}\text{F-}\text{NaF}\) PET VOI. VOIs were automatically drawn around CT areas with a Hounsfield Unit (HU) ≥1000 and assigned as CT calcification VOI. The threshold of 50% of the maximum uptake value was chosen in order to select the volume with the highest \(^{18}\text{F-}\text{NaF}\) uptake, and thereby minimize the bias of a partial volume effect. 27 The HU of 1000 was based on the CT scan of a phantom with various known calcium hydroxyapatite densities, whereby a lower threshold was chosen in order to not miss any calcification. To determine the overlap between the \(^{18}\text{F-}\text{NaF}\) PET VOIs and CT calcification VOIs, an intersection VOI was automatically drawn. Then, the CT calcification area (HU ≥1000) within the \(^{18}\text{F-}\text{NaF}\) PET VOI was measured and expressed as a percentage of the \(^{18}\text{F-}\text{NaF}\) PET VOI; and the other way around: \(^{18}\text{F-}\text{NaF}\) PET uptake area (≥50% of maximum \(^{18}\text{F-}\text{NaF}\) uptake) within the CT calcification VOI was measured and expressed as a percentage of the CT calcification VOI.

**Histological Staining**

To validate our data, von Kossa and alizarin red stainings for calcification were performed on two plaque segments without any CT calcification, but with clear \(^{18}\text{F-}\text{NaF}\) uptake. The pattern of \(^{18}\text{F-}\text{NaF}\) uptake on PET images was compared with the results of histology. Furthermore, the two renal arteries with the highest \(^{18}\text{F-}\text{NaF}\) uptake were selected for staining (negative controls). Only negligible \(^{18}\text{F-}\text{NaF}\) uptake was expected and no calcification in the renal arteries, because only healthy kidney donors with a renal vasculature without any signs of atherosclerosis are eligible for transplantation.

To obtain further information on the vulnerability of included carotid plaques, segments of five culprit and three non-culprit plaques were assessed for histological features of vulnerability. The segments were stained with Martius Scarlet Blue (MSB) using histochemistry and for CD68- and CD34-expressing cells using immunohistochemistry. 31 With these markers, the presence of intraplaque thrombus and collagenous fibrous cap (MSB), inflammation (CD68-positive macrophages), and intraplaque microvessels (CD34-positive endothelial cells) could be identified. One observer, highly experienced in vascular pathology, visual inspected and interpreted the histological features, and compared the culprit and non-culprit plaques. For a detailed description of the staining procedures, see Online Resource 1.

**Statistical Analysis**

Descriptive data are presented as frequencies (percentage), median (interquartile range), or mean ± SD. Based on the distribution of data (tested by normal probability plots),
differences between data were analyzed with non-parametric tests. For continuous data the Mann–Whitney U test (two groups) or the Kruskal–Wallis test (≥two groups) was used. Categorical data were analyzed with the Chi Square test. A Spearman Correlation was used to test the association between continuous data. A two-sided P-value <0.05 was considered statistically significant. Statistical analyses were performed using SPSS for Windows (version 23.0).

RESULTS

Patient Characteristics

We included 23 carotid plaques (17 culprit and 6 non-culprit) from 23 patients (median age 72 years, interquartile range [IQR] 61 to 75, 85% male) who had undergone CEA, and 15 renal artery specimen from healthy kidney donors (Table 1). The demographic and clinical characteristics were comparable between stroke patients with culprit and non-culprit plaques (Table 2). Only BMI was higher in the non-culprit group (P=0.020). The mean time between the cerebrovascular event (stroke, TIA or amaurosis fugax) and CEA in the group with culprit plaques was 21±14 days. All patients in the non-culprit group had a history of stroke related to the contralateral carotid artery. The time range between that stroke and the recent non-culprit CEA was 2 to 23 months. The healthy kidney donors (from whom renal artery segments were obtained) were younger than CEA patients (P=0.001) and had no history of cardiovascular disease.

Visual Assessment of PET and CT Images

PET images of all 23 plaques, showed a heterogeneous 18F-NaF uptake distribution and clear hotspots (Figure 1). The registered PET and CT images (n=16) showed a discordant pattern between CT assessed calcification and 18F-NaF assessed calcification. In all plaques, 18F-NaF uptake was seen in regions without calcifications visualized on CT scan. In the largest CT calcification volumes 18F-NaF uptake was only seen at the outer surface (Figure 2). The 18F-NaF uptake in the renal arteries was only visible when a low 18F-NaF uptake threshold was chosen compared with the carotid plaques, and no calcification was visible on the CT (n=8).

Table 1. Included specimens

<table>
<thead>
<tr>
<th></th>
<th>Culprit plaque</th>
<th>Non-culprit plaque</th>
<th>Renal artery specimen</th>
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<tbody>
<tr>
<td>Number included</td>
<td>17</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Number PET performed</td>
<td>17</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Number CT performed</td>
<td>15</td>
<td>1</td>
<td>8</td>
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</table>
Histological Staining

The von Kossa and alizarin red stainings showed calcification deposits in the two selected 18F-NaF-positive, CT negative segments of the carotid plaques. The pattern of 18F-NaF uptake on PET images matched with the area of histologically proven calcification (Online Resource Figure 1). Areas with negligible 18F-NaF uptake did not show any histological evidence for calcification. As expected, no calcifications were identified in the segments of the renal arteries (Online Resource Figure 2).

The five culprit and three non-culprit plaques segments showed all at least one characteristic of vulnerability. Macrophage infiltration was clearly visible in all segments, as was the presence of intraplaque microvessels, without a visual difference in culprit or non-culprit segments. Two culprit plaques and one non-culprit plaque showed a clear thrombus indicative of intraplaque hemorrhage. One non-culprit plaque showed a very thin fibrous cap (Online Resource Figure 3).

DISCUSSION

The present study investigated in vitro microPET assessed 18F-NaF uptake, in culprit and non-culprit human carotid plaques. We hypothesized that 18F-NaF uptake in culprit plaques was higher than in non-culprit carotid plaques, based on previous results in coronary plaques, and the concept of microcalcification and plaque rupture.15,22 Our results, however, demonstrate...
comparable $^{18}$F-NaF uptake in culprit and non-culprit carotid plaques. Interestingly, we found that $^{18}$F-NaF uptake was present in regions without evidence of calcification on CT scan. Furthermore, most of the CT calcification VOIs had low $^{18}$F-NaF uptake, confirming that both techniques represent a different stage of calcification.\textsuperscript{14,23,32}

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**Figure 1.** $^{18}$F-NaF microPET and microCT images of human carotid plaque. (A, E) Human carotid plaque after carotid endarterectomy. (B, F) Sagittal view of ex vivo PET showing a heterogeneous distribution of $^{18}$F-NaF uptake with a clear hotspot (red/yellow). (C, G) Sagittal view of corresponding microCT images. On the background of example G are the contours of the CT bed visible. (D, H) Fused images showing different distributions of microcalcification ($^{18}$F-NaF PET) and established calcification (microCT). Scale PET images in %Inc/g, scale CT images in HU.

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**Figure 2.** Sagittal views of $^{18}$F-NaF microPET and microCT of human carotid plaques. (A, D, G) PET areas with $^{18}$F-NaF uptake. (B, E, H) CT images showing calcification. In image B only one small calcification can be seen in the areas of $^{18}$F-NaF uptake. (C, F, I) Fused images. Volumes of interest are drawn around CT calcification areas (white calcification, pink line). The relatively large calcifications (white arrows) show the most intense $^{18}$F-NaF uptake at their surface. In the smaller calcifications this cannot be observed due to the limited resolution. Scale PET images in %Inc/g, scale CT images in HU.
Recently, Vesey et al. showed that in vivo $^{18}$F-NaF uptake was higher in culprit carotid artery stenosis than in the contralateral non-culprit stenosis in 18 patients with recent CVA ($\log_{10}$ standardized uptake value, mean $0.29 \pm 0.10$ vs $0.23 \pm 0.11$ respectively, $P<0.001$). These findings are consistent with the results of a clinical study of Quirce et al., in nine patients, where $^{18}$F-NaF uptake reported as mean target-to-background ratio was higher in culprit plaques ($2.12 \pm 0.44$) than in contralateral non-culprit plaques ($1.85 \pm 0.46$, $P=0.220$). Age and sex distribution were comparable between these two studies and our study. Only Vesey et al. provided information about the cardiovascular history and other cardiovascular risk factors of the included patients. The prevalence of smoking and diabetes mellitus was similar. Furthermore, more than 50% of the patients had other manifestations of atherosclerosis, as in our study. Since the included patients in both studies were comparable, the remaining question is how these contradictory results can be explained.

Table 3. Comparison of $^{18}$F-NaF PET VOI with CT calcification VOI

<table>
<thead>
<tr>
<th>No.</th>
<th>Size (mm$^3$)</th>
<th>$^{18}$F-NaF PET VOI of total plaque volume (%)</th>
<th>CT calcification volume within $^{18}$F-NaF PET VOI (%)</th>
<th>CT calcification VOI of total plaque volume (%)</th>
<th>$^{18}$F-NaF PET volume within CT calcification VOI (%)</th>
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$^{18}$F-NaF PET VOI was defined as ≥50% of maximum $^{18}$F-NaF uptake; CT calcification VOI was defined as Hounsfield Units ≥1000 VOI, volume of interest; PET, positron emission tomography; $^{18}$F-NaF, $^{18}$F- Sodium Fluoride; CT, computed tomography; HU, Hounsfield Units.

*aIn this carotid plaque, no calcifications could be identified on CT scan

*bNon-culprit carotid plaque
First, although Vesey et al. did find a significant difference between 18F-NaF uptake in culprit and contralateral non-culprit plaques, the differences were small and a substantial overlap between the uptake values in both groups was present, as was in the study of Quirce et al. Furthermore, the 18F-NaF uptake between patients scheduled for CEA and control patients differed to a larger extent (delta 0.17 SUVmean) than the difference between culprit and non-culprit uptake (delta 0.07 SUV mean). Therefore, we believe that no absolute cut off value for the diagnosis of culprit plaques based on 18F-NaF uptake can be determined, only when compared with control patients there is a relevant difference. This is in line with the results of our study.

Although the sample size is small, our data show that 18F-NaF uptake between culprit and non-culprit carotid plaques was comparable while the uptake in plaques was significantly higher than in control renal arteries.

Table 4. 18F-NaF uptake and HU-values in PET VOI and in CT VOI

<table>
<thead>
<tr>
<th>No.</th>
<th>18F-NaF uptake in PET VOI</th>
<th>18F-NaF uptake in CT VOI</th>
<th>Averaged HU-value in PET VOI</th>
<th>Averaged HU-value in CT VOI</th>
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<tbody>
<tr>
<td>1</td>
<td>3.6</td>
<td>1.9</td>
<td>−295</td>
<td>2273</td>
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<tr>
<td>2</td>
<td>5.9</td>
<td>2.5</td>
<td>1367</td>
<td>3616</td>
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<td>3</td>
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<td>3.7</td>
<td>1293</td>
<td>3489</td>
</tr>
<tr>
<td>4</td>
<td>7.6</td>
<td>3.0</td>
<td>603</td>
<td>3085</td>
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<td>2769</td>
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<td>1512</td>
<td>3616</td>
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<tr>
<td>7</td>
<td>2.6</td>
<td>−</td>
<td>−361</td>
<td>−</td>
</tr>
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<td>1.5</td>
<td>−137</td>
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<tr>
<td>16</td>
<td>6.5</td>
<td>2.6</td>
<td>568</td>
<td>3289</td>
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</table>

18F-NaF uptake was expressed as percentage uptake of total incubation dose per gram. 18F-NaF, 18F- Sodium Fluoride; PET, positron emission tomography; CT, computed tomography; HU, hounsfield units; VOI, volume of interest. 
18F-NaF PET VOI was defined as ≥50% of maximum 18F-NaF uptake; CT calcification VOI was defined as Hounsfield Units ≥1000.

Figure 4. Relation between PET assessed 18F-NaF uptake and CT assessed calcification in human carotid plaques. CT assessed calcification VOI was defined as HU-value ≥1000. Data is expressed as percentage 18F-NaF uptake of the total incubation dose per gram of tissue (% Inc/g). Spearman Correlation was used to assess the relation between 18F-NaF uptake and CT assessed calcification.

Second, there may be differences in the degree of stenosis of the carotid arteries between patients in the aforementioned studies and our patients. Vesey et al. found that 18F-NaF uptake was related to the degree of stenosis on CT, but they did not report the stenosis degree in the separate groups, neither did Quirce et al. In our study, the stenosis degree in both, non-culprit and the culprit plaques, was high and all plaques showed high-risk features based on histology. This could explain the similar 18F-NaF uptake.
In contrast, Joshi et al. did find a difference between culprit and non-culprit coronary plaques of patients with myocardial infarction. This might be the consequence of local differences in the mechanical forces exerted to the artery wall and the endothelium of the coronary vascular bed, causing local differences in plaque initiation and progression. In contrast to the coronary arteries, both carotid arteries are exposed to similar blood flow patterns and mechanical stress. This might result in the same pattern of plaque development and progression.

$^{18}\text{F-NaF}$ activity was increased in areas without calcification on CT and most of the CT calcification VOI showed minimal $^{18}\text{F-NaF}$ uptake. This supports the idea that microcalcification, as visualized with $^{18}\text{F-NaF}$ PET, and established calcification visualized on CT may reflect different stages of the calcification processes in atherosclerotic plaques.

Established calcification is a well-known marker of total plaque burden and is strongly associated with the risk for cardiovascular events. However, the amount of established calcification, as detected by CT, only provides information about the processes in the past and not about the actual biological activity of the plaque. Moreover, larger and denser areas of calcification may even stabilize the plaque. This has, for example, been suggested by Shalaan et al., who found a higher CT assessed calcification volume in non-culprit than in culprit carotid plaques. The average percentage of plaque volume that was calcified was comparable with our study. Unfortunately, in our study CT assessed calcification volume could not be compared between culprit and non-culprit plaques, due to limited availability of CT images in the non-culprit group ($n=1$) because of image reconstruction failures.

Another important example can be derived from the work of Puri et al., who performed a post-hoc patient-level analysis of 8 prospective trials in which coronary atheroma was measured with intravascular ultrasound. They showed that although statins had a clear plaque-regressive effect, they also promoted coronary atheroma calcification, indicating stabilization.

In this study increased $^{18}\text{F-NaF}$ uptake was related to the calcium volume on CT in the majority of the carotid plaques. This is probably caused by binding of $^{18}\text{F-NaF}$ at only the surface of the calcifications. The binding of fluoride to hydroxyapatite is based on ion exchange, rather than incorporation by active transport. This probably also explains why $^{18}\text{F-NaF}$ uptake can still be found in vitro.

However, in our study a few plaques with low calcium volume had a high $^{18}\text{F-NaF}$ uptake and vice versa. This suggests $^{18}\text{F-NaF}$ accumulation in areas without any evidence of calcification, or at least no calcification with a size above the detection limit of the microCT scan. The presence of calcifications smaller than the CT detection limit, i.e. microcalcifications was indeed confirmed by histological staining of $^{18}\text{F-NaF}$ positive and CT negative segments. $^{18}\text{F-NaF}$ probably binds to the relatively large surface of microcalcifications, causing an intense signal on PET images.

These observations indicate that $^{18}\text{F-NaF}$ imaging can detect biologically active plaques, before they can be visualized on CT. This implies that $^{18}\text{F-NaF}$ imaging may be useful in evaluating disease progression, as was further shown in patients with aortic stenosis, where baseline $^{18}\text{F-NaF}$ uptake correlated well with the calcium progression after 1 year. Especially, $^{18}\text{F-NaF}$ uptake in areas without established calcification on CT was the best predictor of calcium progression.

Furthermore, Derlin et al. found a positive correlation between $^{18}\text{F-NaF}$ uptake in the carotid arteries and, age and various cardiovascular risk factors in 269 patients with no history of stroke. Derlin et al. included a heterogeneous population, consisting of patients with low or minimal cardiovascular risk as well. In contrast, we included only patients with already a history of cardiovascular disease and, therefore, at a high-risk for a cardiovascular event. These findings further highlight the possibility of $^{18}\text{F-NaF}$ imaging to identify patients at high-risk for cardiovascular disease in a low-risk population. In addition, the finding that $^{18}\text{F-NaF}$ uptake in carotid plaques exceeded that of controls (renal arteries) and no calcification was visible in renal arteries on microCT or with histological staining adds evidence to the hypothesis that the presence of microcalcification identified by $^{18}\text{F-NaF}$ is a feature of atherosclerosis. The relation between the extent of $^{18}\text{F-NaF}$ uptake in bilateral carotid plaques and features of vulnerability needs to be further investigated.

Strengths of our study are the inclusion of a control group, and the scanning of calcium phantoms in order to accurately determine the calcium threshold. Furthermore, by comparing calcification identified by $^{18}\text{F-NaF}$ PET imaging with calcification visualized on microCT, this study adds knowledge to the relatively new field of $^{18}\text{F-NaF}$ imaging in atherosclerosis. Our study has some limitations. First, it should be considered that the number of plaques, especially non-culprit plaques, is small and a type II statistical error might be introduced. However, given the similar distribution of $^{18}\text{F-NaF}$ uptake in both groups, a high number of plaques would need to be recruited to find a statistical significant difference if present. We believe that small differences in uptake will not have any clinical implication.

Second, the tracer uptake could be underestimated due to partial volume effects, as with every imaging study. Third, CT images of 16 plaques (one non-culprit)
out of 23 were available for analysis due to practical and technical issues. Fourth, we did not assess the plaque morphology of the right and left side in the same patient. Culprit and non-culprit plaques were derived from different patients.

**NEW KNOWLEDGE GAINED**

We have demonstrated that the calcification patterns on 18F-NaF PET images and CT images are different. Clearly, 18F-NaF PET visualizes a different stage of the calcification process than CT. 18F-NaF uptake in carotid plaques exceeded the uptake in non-calcified renal arteries, but was comparable between culprit and non-culprit carotid plaques, probably due to the advanced nature of atherosclerotic disease in our patients.

**CONCLUSION**

We conclude that 18F-NaF has the potential to identify carotid plaques with active calcification. Further prospective studies on 18F-NaF uptake and symptomatology are required to assess the predictive and diagnostic value of 18F-NaF imaging in patients with early stage atherosclerosis.

**Disclosure**

The authors declared they do not have anything to disclose regarding conflict of interest with respect to this manuscript.

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**References**


