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# Detectability and structural stability of a liquid fiducial marker in fresh *ex vivo* pancreas cancer resection specimen on CT and 3T MRI

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## Abstract

### Objectives

The aim of this study was to test the visibility of a new liquid fiducial marker injected in *ex vivo* pancreas tissue on magnetic resonance imaging (MRI) and computed tomography (CT). Furthermore, its injection performance using different needle sizes was investigated as well as its structural stability after fixation in formaldehyde.

### Material and Methods

Liquid fiducial markers with a volume of 20-100  $\mu\text{L}$  were injected into the freshly resected pancreas of three patients (two males age 69 and 72, one female age 68) with suspected adenocarcinoma of the pancreatic head. Injection was performed under X-ray guidance using a high precision unit dose injector with different needle sizes (18G, 22G, 25G). While cooled on ice, the specimens were scanned on MRI and CT with routine clinical sequences. Signal threshold based segmentation was performed manually on CT. The marker volume visible on CT was compared to the actually injected volume as a measure of potential marker backflow. After rigid registration of the MR images to the CT data set, marker detectability was assessed by searching for the corresponding hypointense structure in the respective segmentation.

### Results

Markers with a volume of  $\geq 20 \mu\text{L}$  were easily detected as hyperintense structures on X-ray and CT. In clinically used  $T_1$ - and  $T_2$ -weighted 3T MRI sequences, all marker sizes ranging from 20 $\mu\text{L}$  – 100 $\mu\text{L}$  were visible as hypointensity. Since most markers were non-spherical however, MRI visibility was relatively poor and their differentiation from hypointensities caused by air cavities or surgical clips was challenging and only feasible with a reference CT. Marker backflow was observed when injected with an 18G needle, which was prevented by injection using a smaller 22G and 25G needle. The marker was stable after 24h fixation in formaldehyde where only small volume degradations were observed ( $6.6 \pm 13.0\%$ ) and with the exception of one instance no wash out occurred.

### Conclusion

The liquid fiducial marker with injected volumes of 20 $\mu\text{L}$  – 100 $\mu\text{L}$ , injected in an *ex vivo* pancreatic cancer resection specimen, was visible as hyperintensity on kV X-ray, CT and hypointensity on MRI and stable over a period of 24 hours in formaldehyde. Since most injected markers were non-spherical, a marker size of

55  $\geq 50\mu\text{L}$  is recommended for the clinically used MRI sequences. Most likely, *in vivo* marker injection will result in more spherical forms due to persisting metabolism, and this in turn will enhance MRI visibility in an hyper intense structure.

**Key Words**

Liquid fiducial marker, pancreatic adenocarcinoma, MRI visibility, ex vivo

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## 1. Introduction

In radiation therapy (RT) accurate and precise delineation and localisation of the target volume is mandatory for high-quality dose delivery avoiding geometrical misses caused by setup errors and/or anatomical variations (e.g. organ motion, deformation and filling). In particular for mobile tumours, inter-fractional position verification is frequently performed based on X-ray radiographic imaging, termed image-guided radiotherapy (IGRT). IGRT of pancreatic ductal adenocarcinoma (PDAC) is, however, challenging since it is one of the abdominal soft tissue organs not visualized under X-ray guidance and hence requires anatomical surrogates, e.g. bony landmarks, intratumoral or adjacent stents or surgical clips, or solid fiducial markers [Ref: van der Horst\_Int J Rad Onco\_2014, Packard\_Journ Med Imaging and Rad Onco, Chortogiannos\_Journ Med Imaging Rad Sciences\_2017]. For several primary tumours, e.g., prostate cancer, solid gold fiducial markers implanted endoscopically have replaced bony landmarks as standard of care due to the low complication rate of the procedure and the small residual setup errors [Ref: VanderHorst\_2013, Varadarajulu\_2009]. By reducing setup margins, highly conformal radiation techniques, such as stereotactic ablative radiotherapy (SABR), have been pioneered and were reported to reduce treatment-related toxicity [REF: Gkika\_2017, zu TOMO Chen\_Journal of Thoracic Disease\_2009, Drozds\_Strahlenther Onkol\_2016, van Baardijk Radiother Oncol 2012]. Conversely, solid gold markers not only deteriorate image quality in both computed tomography (CT) [Ref: Scherman Rydhög\_2015] and magnetic resonance imaging (MRI) [Ref: Gurney-Champion\_2015, Schneider\_2017], but may additionally cause significant dose perturbations in particle therapy, a treatment modality currently assessed for PDAC [Ref: Giebeler\_2010, Newhauser\_2007].

A new biocompatible liquid marker, BioXmark, has been developed, which forms a semisolid gel after injection into soft tissue, consists of low *Z*-elemental (non-ferrous and non-magnetic) composition and causes minimal proton dose perturbations [Ref: Scherman Rydhög\_2017; Jølcck\_2014]. Moreover, the marker remains chemically stable during normo-fractionated and high-dose single-fraction irradiation schemes [Ref: Troost\_2017]. Finally, a recent clinical study confirmed its applicability for use in patients

with locally advanced lung cancer and no significant positional and structural degradation was observed over a 7-weeks course of radiation treatment with photons [Ref: Scherman Rydhög\_2016].

90 Patients with PDAC scheduled for proton therapy might also benefit from this marker, since it can be endoscopically implanted using very thin ( $\leq 25$  G) needles, allowing for minimal invasive injection, and its size and visibility on MRI, kV X-ray and CT images can be accurately adjusted by altering the injected volume. A recent phantom study that quantitatively investigated the marker's MRI characteristics in terms of visibility and artefacts has shown that this marker is visible on MRI as a strong signal void in both T1 and T2  
95 weighted images at 3T and, in contrast to solid markers, its degree of visibility does not correlate to the degree of artefacts [Ref: Schneider\_2017]. In part contradictory, in a recent study the BioXmark marker was found to be iso-intense compared to prostatic tissue in T2 weighted images at 1.5T [Ref: De Roover 2018]. Since in MR guided radiotherapy target and organ at risk delineation is often performed on or supported by T2 weighted images, the visibility of fiducial markers in these sequences is particularly crucial.

100 Therefore, the aim of the present study was to assess the marker's visibility in real pancreatic tissue on CT and T1 and T2 weighted MRI, and to examine the marker's structural stability after injection using different needle sizes. However, at present this marker is still lacking CE-marking and has thus not been approved for *in vivo* clinical use in patients with PDAC. In order to prepare the clinical application of the injectable fiducial marker, the study was hence performed by injecting the marker into fresh *ex vivo* pancreas resection  
105 specimens.

## 2. Materials and Methods

### 2.1. Pancreatic resection specimen

Three patients (two males age 69 and 72, one female age 68) suspected to have an adenocarcinoma of the pancreatic head scheduled for primary pancreaticoduodenectomy provided informed written consent for *ex*  
110 *vivo* injection of the liquid fiducial marker into the obtained resection specimen and for subsequent X-ray, CT and MR imaging thereof. Immediately after resection, the resection specimen was stored in a container with ice at approximately 4°C to prevent enzymatic degradation, and was transported to the Department of Pathology for immediate biopsy selection for frozen section analysis. Thereafter, the injection of the markers and imaging of the resection specimen were performed within the next 2 hours, while being transported on

115 ice. Surgical clips or sutures placed into the resection specimen during the surgical resection were not removed and thus still present during marker injection and subsequent imaging. The study was approved by the local Ethics committee of the Faculty of Medicine and University Hospital Carl Gustav Carus of the Technische Universität Dresden (EK-534122015).

## 120 2.2. Fiducial marker injection

The liquid marker (BioXmark®, Nanovi Radiotherapy A/S) is a three-component fully biocompatible liquid soft-tissue marker. After injection into soft tissue, ethanol diffuses out of the marker, causing an increase of marker viscosity resulting in a gel-like structure within 30 min after injection. Several liquid markers (5-6) of various volumes (range 20–100 µL) were injected at a depth of 1-2cm directly adjacent to the tumour boundaries (~30 min after surgical resection). Moreover, three different needle sizes (18G, 22G, 25G) were used during the injection into the three specimens respectively. For this, the needles were attached to a unit dose injector (MicroDose™, Vlow Medical B.V., Eindhoven, The Netherlands) for accurate and reproducible injection. The injection was performed under kV-X-ray guidance to facilitate the subsequent differentiation of injected markers and surgical clips or sutures.

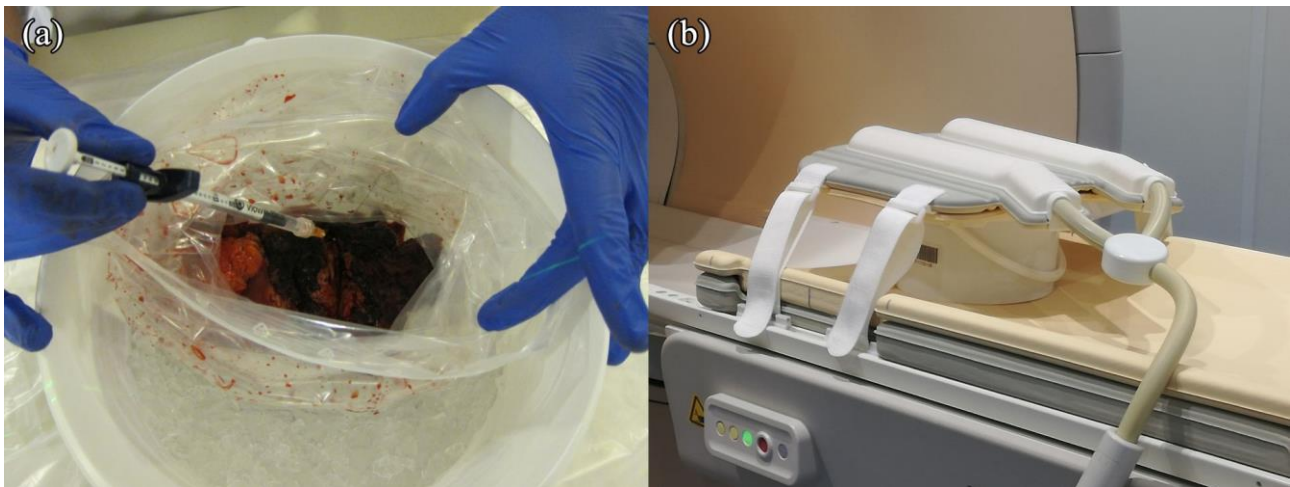
## 130 2.3. MR and CT image acquisition

Immediately after marker injection, the specimens were scanned with clinically used scan protocols for pancreatic cancer patients (see table 1) on CT (*Siemens SOMATOM Definition AS, Siemens Healthineers, Erlangen, Germany*) and MRI (3.0 T *Philips Ingenuity TF PET/MR scanner, Philips Healthcare, Eindhoven, The Netherlands*). MR images were acquired with a 32-channel SENSE Torso/Cardiac coil performing a T<sub>1</sub>-weighted spoiled gradient echo sequence (THRIVE) and a T<sub>2</sub>-weighted turbo spin echo sequence. The scan was performed with the specimen still placed on ice (see figure 1). To test the stability of the marker after fixation in formaldehyde for 24 hours, the complete scan protocol was repeated for one of the three resection specimens.

140 *Table 1: Scan protocols used on MRI and CT for imaging of the pancreatic resection specimens after marker injection.*

| Imaging modality | In-plane resolution [mm <sup>2</sup> ] | Slice thickness [mm] | FOV [mm <sup>3</sup> ] | TE/TR [ms] | BW [Hz] | FA [°] | SENSE Factor | X-Ray exposure [mAs] | X-Ray voltage [kVp] |
|------------------|----------------------------------------|----------------------|------------------------|------------|---------|--------|--------------|----------------------|---------------------|
| MRI – T1w        | 1.51×1.51                              | 3                    | 258×258×120            | 1.4/3.2    | 721     | 10     | 2            | -                    | -                   |
| MRI – T2w        | 0.76×0.76                              | 3                    | 254×254×79             | 80/800     | 290     | 90     | 2            | -                    | -                   |
| CT               | 0.98×0.98                              | 2.0                  | 500×500×242            | -          | -       | -      | -            | 12                   | 120                 |

Abbreviations: FOV = field of view; TE = echo time; TR = repetition time; BW = bandwidth; FA = flip angle.



145 *Figure 1. (a) Container with resection specimen on ice during marker injection. (b) Scan setup on the MR scanner with the anterior and posterior parts of 32-channel SENSE Torso/Cardiac coil encapsulating the ice-filled container with the resection specimen.*

#### 2.4. Analysis

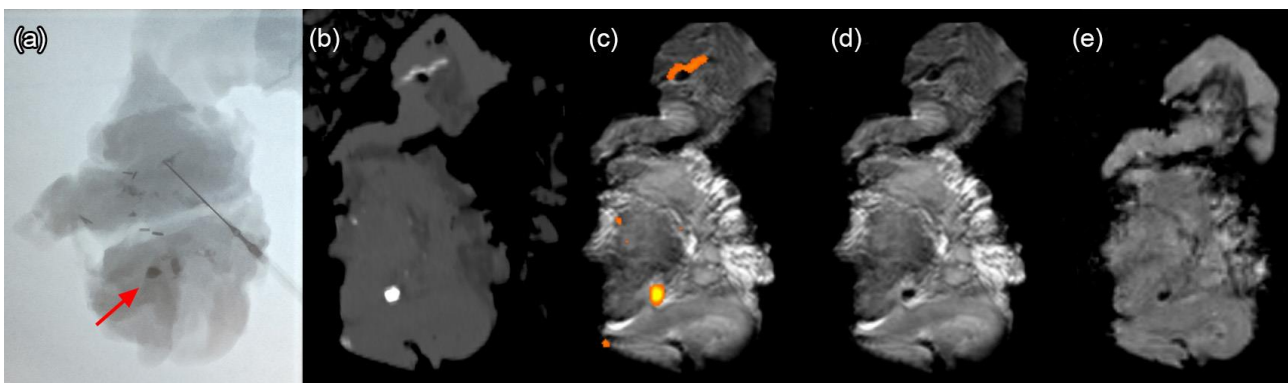
150 The markers were first segmented as hyperintense structures in the acquired CT images with the open source software 3D Slicer [Ref:Pieper 2004] by threshold segmentation such that the lower threshold was selected to be three standard deviations higher than the mean signal intensity of the pancreatic tissue (i.e.  $129.3 \pm 4.1$  HU) to ensure that with 99.7% confidence no tissue voxels were falsely segmented. In order to correctly assign the respective markers and to prevent erroneously segmenting surgical clips or sutures instead of liquid fiducial markers, the X-ray images taken during injection were used as a visual aid. The CT images  
 155 were then manually registered onto the MR images taking into account the specimen contour (Figure 2).



Within the pancreatic resection specimen defined by the CT segmentation, markers were expected to appear hypointense on the MR images [Ref: Schneider et al]. Marker visibility was thus approved when a hypointense structure was present in the respective segmentation.

160 In order to try to quantify a backflow of marker material during injection, the ratio of marker volume segmented on CT to the actually injected volume was assessed. While due to a marker size depending partial volume effect, the segmented volume was expected to be larger than the injected volume, the multiple of the respective marker size was expected to be smaller in case of marker backflow.

In order to assess the stability of the fiducial marker after fixation of the resection specimen in formaldehyde for 24 hours, for one resection specimen the segmentation procedure was repeated on the CT scan obtained  
165 after fixation. The segmented volumes of the respective markers on CT before and after fixation were finally compared to deduce a possible degradation.



170 *Figure 2. (a) kV X-ray of a resection specimen during marker injection in which the needle is visible on the right, as well as several surgical clips close to the marker injections of which a 100µL marker is marked with a red arrow. Coronal slice where this 100µL marker is visible on (a) CT and (b) T<sub>2</sub>-weighted Turbo Spin Echo (TSE) MRI superimposed with the threshold based orange-yellow CT segmentation (c) Native T<sub>2</sub>-weighted TSE MRI and (d) T<sub>1</sub>-weighted Gradient Echo (GRE) MRI. The injected 100µL fiducial marker is depicted as hyperintensity on CT and as signal void on T<sub>2</sub>- (c) and T<sub>1</sub>-weighted (d) MRI.*

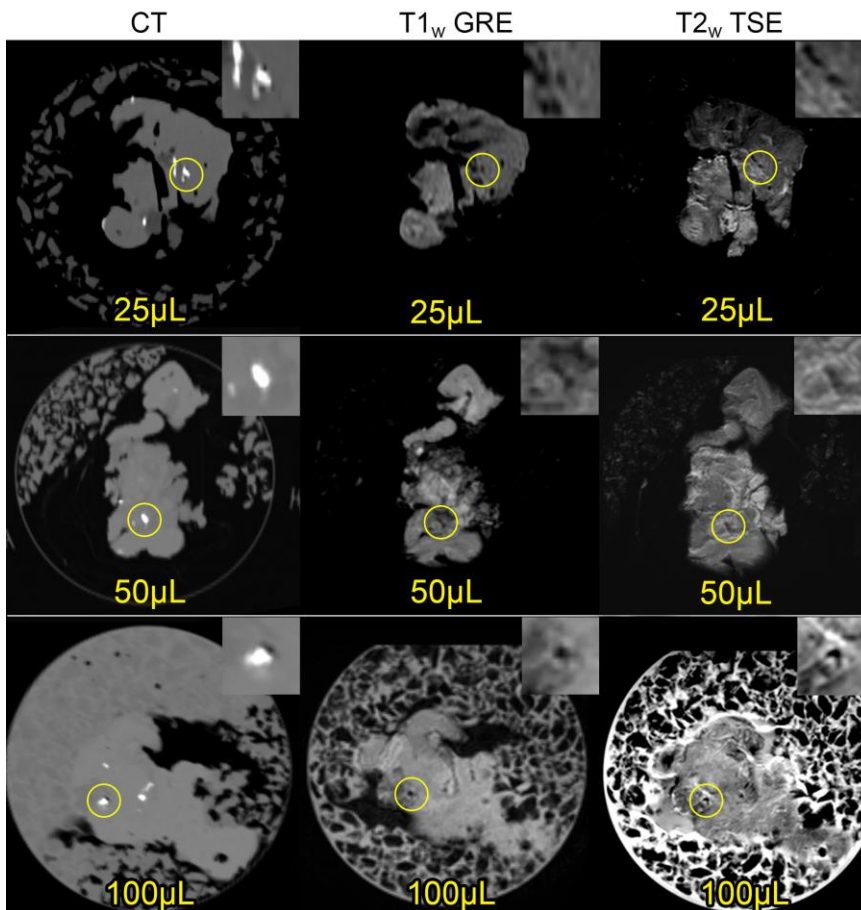
175

### 3. Results

While in two resection specimen 6 markers were injected, in one specimen only five markers were injected due to a relatively small size of the specimen. Furthermore, for two specimens a unit dose injector was used

180 which allowed smallest injections of 25 $\mu$ L steps while for the last specimen only a unit dose injector was available which allowed smallest injections in steps of 20 $\mu$ L. This lead to a slightly different size and number of injected markers throughout the used resection specimens.

### 3.1. Marker visibility on T1- and T2-weighted MRI



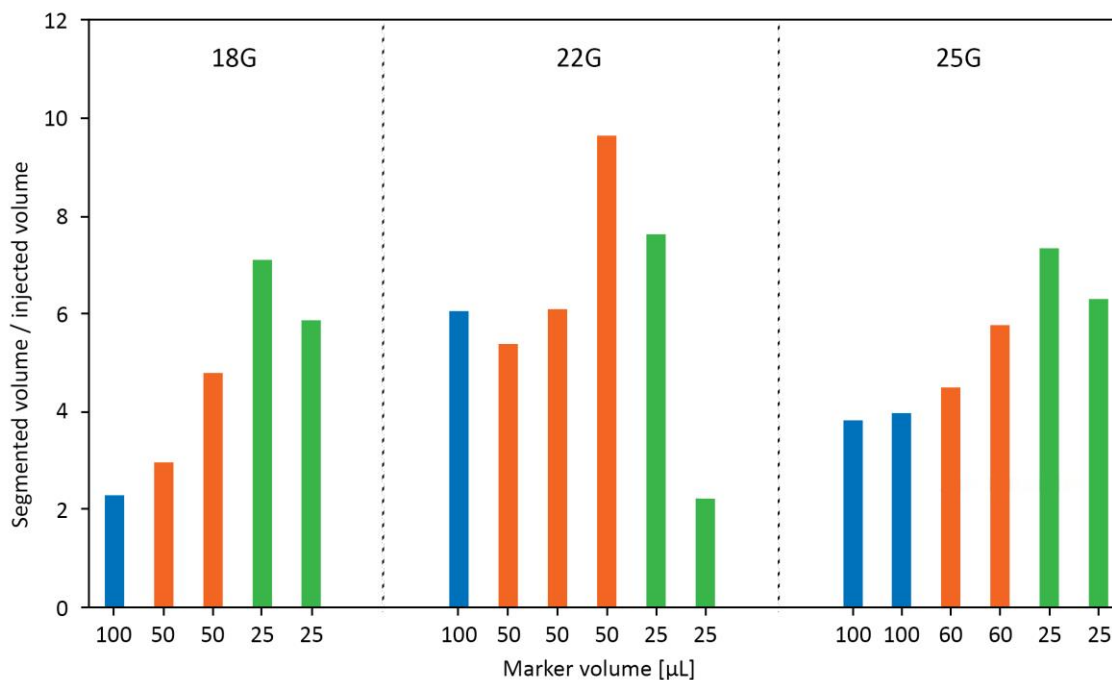
185 *Figure 3. Coronal view of all three resection specimens on CT [left], T<sub>1w</sub> gradient echo (GRE) MRI [middle] and T<sub>2w</sub> turbo spin echo (TSE) MRI [right]. Markers of different sizes (25-100  $\mu$ L) are visible as hyperintensity on CT and hypointensity on both T<sub>1w</sub> and T<sub>2w</sub> MRI. On the top right of each segment a close up of the yellow circled region of interest is shown for clear visualization of the marker.*

190 Figure 3 presents imaging slices of the resection specimen on CT, T<sub>1</sub>- and T<sub>2</sub>-weighted MRI from all three patients included in this study. As can be appreciated from Figure 3, the liquid fiducial marker is detectable on CT as hyperintense structure and on both T<sub>1</sub>- and T<sub>2</sub>-weighted MRI as hypointense structure, respectively. Marker of all sizes (20-100 $\mu$ L) tested in this study could be detected with the clinically used sequences. Noteworthy, on CT it was detected that injection generally resulted in a non-spherical marker, making MR

visibility strongly dependent on slice orientation and voxel size. Moreover, a diffuse injection or injection  
 195 too close to the surface hampered MR visibility leading to 4 of 17 markers which were non-detectable on  
 MRI. Images of all 17 markers visible or non-visible on CT and MRI can be found in the supplementary.

### 3.2. Fiducial marker injection performance as a function of needle size

The injection was performed with needle sizes of 18G, 22G and 25G. In the case of 18G needles, marker  
 200 backflow out of the injection site was observed. This was prevented by the use of smaller needle sizes of  
 22G or 25G. However no correlation was found between the needle size and the ratio of segmented volume  
 to injected volume as a measure of marker backflow due to the larger variance within the respective  
 specimens and marker sizes (Figure 4).



205 *Figure 4. Ratio of fiducial marker's segmented volume to the injected volume. The 17 markers with volumes between 20-100μL were injected into the three resection specimens using different needle sizes (18G-25G).*

### 3.3. Fiducial marker stability after 24h fixation in formaldehyde

After 24h fixation in formaldehyde all markers in the investigated resection specimen were still visible on  
 210 CT (see Figure 5 for a coronal maximum intensity projection) and MRI (Figure 6), and geometrically stable.

Overall, the volume degradation was  $6.6 \pm 13.0\%$ . One  $60\mu\text{L}$  marker was partially washed out of the specimen as was detected on the CT images.

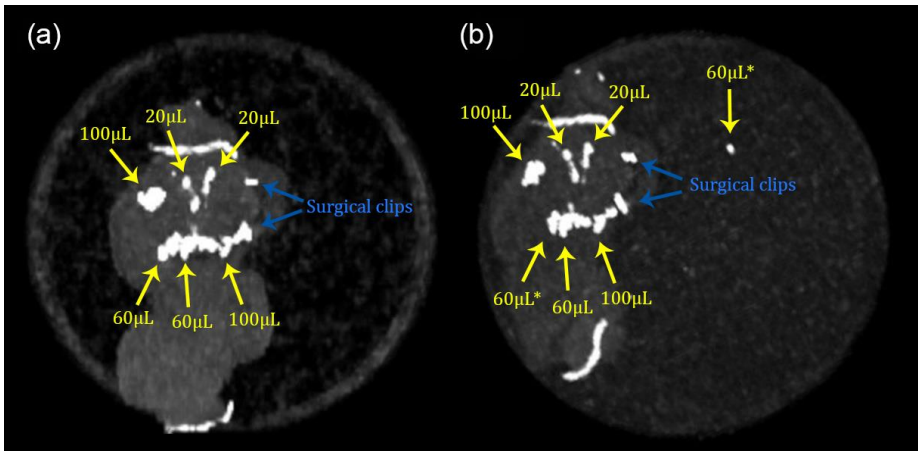


Figure 5. Maximum intensity projection of the CT from the resection specimen before (a) and after (b) fixation in formaldehyde. All 6 injected markers were stable in their size and position. It can be appreciated that one hyperintense structure, i.e. the partially washed out  $60\mu\text{L}$  marker (marked with an asterisk), was found in the top right corner of the container filled with formaldehyde.

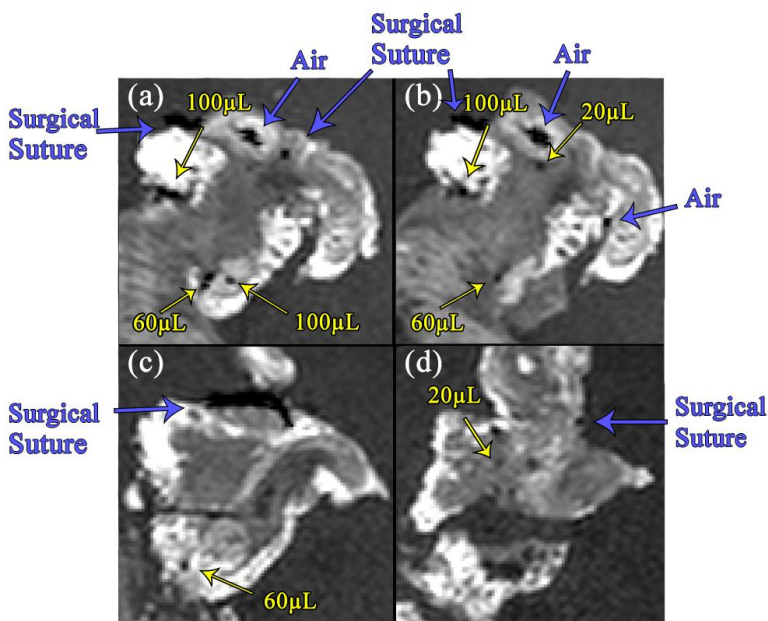


Figure 6. Four representative  $T1w$ -MRI slices of a pancreatic cancer resection specimen fixated in formaldehyde showing all six injected markers. Remaining hypointensities caused by a surgical suture and air cavities are also visible.

#### 4. Discussion

In this study the liquid fiducial marker BioXmark<sup>®</sup> was tested for the first time *ex vivo* in freshly resected  
225 pancreatic cancer specimen. Marker detectability on CT was satisfactory with markers clearly depicted as  
hyperintense structures. On MRI marker detectability was difficult due to signal voids from tissue  
heterogeneity, air cavities, surgical clips or sutures resembling the fiducial markers in MRI. To distinguish  
fiducial marker induced signal voids from the latter, a prior registration with the CT images was necessary.  
Moreover, marker backflow was reduced using smaller needle diameters, and the marker was found stable  
230 after 24h fixation in formaldehyde.

The detectability on MRI, at least *ex vivo*, may improve using a marker composition with gadolinium leading  
to a hyperintense marker. However, in the *in-vivo* situation, the marker performance is thought to improve  
since less or no hypointensities caused by air cavities and/or surgical clips are present. Conversely, since  
fiducial marker injection in case of PDAC is often performed into the adipose tissue in direct proximity of  
235 the tumour, marker visibility on fat-saturated MRI sequences will be hampered, as also found in clinical  
practice with fiducial gold markers in our institute (data not shown).

After registration with the CT images of the specimen, many markers were still only poorly visible or even  
not visible at all. When comparing these markers to the CT images, it appears that in these cases the injection  
was not sphere-like. Hence detectability was strongly depending on the injected shape and the distance to the  
240 specimen surface. Nevertheless, in particular larger markers  $\geq 50\mu\text{L}$ , which formed sphere-like volumes,  
were visible as strong signal void on both  $T_1$ - and  $T_2$ -weighted MRI. This is concordant to the results found  
in [Ref: Schneider2018], where the marker was found to be causing signal voids at 3T independent of the  
contrast mechanism due to an apparent lack of water protons. In [De Roover 2018] the marker was found to  
be isointense to prostatic tissue on  $T_2$ w-MR images at 1.5T. These different findings may resulted from the  
245 lower field strength used in their study. More likely however this effect could have resulted from a signal  
contamination caused by the phantom material in which the marker was injected into. Since the ellipsoid  
shaped  $300\mu\text{L}$  marker analysed in the study by De Roover et al. [De Roover 2018] showed a size in slice  
encoding dimension which was close to the slice thickness acquired in MRI (4 mm), a partial volume effect  
cannot be ruled out.

250 When introduced into clinical practice after successful CE marking, it is expected that the *in vivo* use will lead to more spherical and hence better detectable markers on MRI. This is caused by the persisting metabolism and fast efflux of ethanol after injection. Alongside, in the *in vivo* situation motion blurring will impede on the MR quality and will most likely require larger marker volumes of 50 $\mu$ L – 100 $\mu$ L to still be visible on MRI. These volumes should preferably be injected with a thin needle preventing marker backflow.

255 The marker's visibility on different anatomical imaging modalities is of great value to the community of radiation oncology. Besides its minimal proton dose perturbations [Ref: Scherman Rydhög\_2017; Jølcck\_2014], the stability during a prolonged course of fractionated, high-dose radiotherapy [Ref: Troost\_2017] and also after fixation in formaldehyde makes the marker promising for neoadjuvant and definitive treatment concepts involving photon or proton beam therapy.

260 In conclusion, the liquid fiducial marker with injected volumes of 20 $\mu$ L – 100 $\mu$ L, injected in an *ex vivo* pancreatic cancer resection specimen, was visible on kV X-ray, CT and MRI, and stable over a period of 24 hours in formaldehyde. Since most injected markers were non-spherical, a marker size of  $\geq$ 50 $\mu$ L is recommended for the clinically used MRI sequences. Most likely, *in vivo* marker injection will result in more spherical forms due to persisting metabolism, and this in turn will enhance MRI visibility.

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### **Disclosure of Conflicts of Interest**

None.

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