Bone metastases of differentiated thyroid cancer: impact of early $^{131}$I-based detection on outcome

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Abstract

Bone is the second most frequent target of distant metastases in patients with differentiated thyroid cancer, and such forms carry a very poor prognosis. The impact of $^{131}$I therapy in this setting is controversial. We describe the diagnostic circumstances and outcome of patients with bone metastases recently managed in two institutions. Among 921 consecutive thyroid cancer patients who had total thyroidectomy and $^{131}$I ablation between January 2000 and December 2004 and who were subsequently monitored, bone metastases had been diagnosed in 16 patients. In three cases, the bone metastases were non-functioning (negative $^{131}$I uptake). These patients were treated with surgery and radiotherapy but progressed rapidly. The other 13 patients had functioning (positive $^{131}$I uptake) bone metastases. In five of them, thyroid cancer was revealed by signs of distant involvement (bone pain, $n=4$; dyspnea, $n=1$). The 131I uptake was found in more than two-thirds of patients with distant metastases and in roughly equal proportions of patients with lung or bone involvement (Durante et al. 2006). However, the impact of $^{131}$I therapy on bone metastases is controversial (Proye et al. 1992). $^{131}$I ablation can contribute to early detection of bone metastases at a time when the Tg level may be only moderately elevated, when other radiological studies are negative, and when the disease is potentially curable by $^{131}$I therapy.

Endocrine-Related Cancer (2007) 14 799–807

Introduction

About 3 to 5% of patients with differentiated thyroid cancer develop bone metastases (Bernier et al. 2001, Haq & Harmer 2005, Durante et al. 2006). Bone metastases are less frequent than pulmonary metastases but carry a far worse prognosis (Haq & Harmer 2005, Durante et al. 2006).

Iodine 131 ($^{131}$I) has been used since 1946 to treat patients with functioning metastases (Seidlin et al. 1946). $^{131}$I uptake is found in more than two-thirds of patients with distant metastases and in roughly equal proportions of patients with lung or bone involvement (Durante et al. 2006). However, the impact of $^{131}$I therapy on bone metastases is controversial (Proye et al. 1992).
In a historical report by Brown, only 1 (5%) out of 21 patients with bone metastases treated with \(^{131}\)I survived 5 years (Brown et al. 1984), but efficacy seems to have improved in recent years (Bernier et al. 2001, Petrich et al. 2001, Haq & Harmer 2005, Durante et al. 2006). Bernier et al. (2001) obtained a 15% survival rate at 10 years in patients with bone metastases. By comparison, more than 60% of patients with metastases confined to the lungs survive for 10 years (Casara et al. 1993, Hindie et al. 2003, Durante et al. 2006).

Bone metastases are rarely detected at an early stage. Here, we analyzed the diagnostic circumstances and outcome of patients with bone metastases in a series of patients with differentiated thyroid cancer recently managed in two institutions.

**Patients and methods**

From January 2000 to December 2004, a total of 921 patients with newly diagnosed differentiated thyroid cancer received total thyroidectomy and ablation therapy with 100 mCi (3.7 GBq) \(^{131}\)I, either at the Nuclear Medicine Department of Saint-Antoine Hospital or at Saint-Louis Hospital (Paris, France), and were subsequently monitored. The first follow-up examination, 6–12 months after ablation therapy, included Tg assay under thyroid-stimulating hormone stimulation. This analysis focuses on 16 patients (11 females and 5 males) in whom bone metastases were discovered either during the initial work-up or during follow-up. Their mean age was 57.2 years (16–77 years). No other case of bone metastases occurred during the follow-up period of this study (average 45 months).

**Non-functioning metastases**

Three patients had bone metastases that were non-functioning, i.e., did not take up \(^{131}\)I. These three patients were treated with surgery and/or external beam radiotherapy (Table 1).

**Functioning metastases**

In the other 13 patients, all the bone metastases were functioning (\(^{131}\)I-avid). Four of these patients also had functioning lung metastases (Table 2). When bone metastases were suspected on the basis of \(^{131}\)I whole-body scan, and in order to precisely locate \(^{131}\)I foci, \(^{131}\)I scanning was repeated and combined with \(^{99m}\)Tc-HMPD (\(^{99m}\)Tc-hydroxy-methylene-diphosphonate) bone scanning, using simultaneous dual-tracer planar imaging, and SPECT (single photon emission computerized tomography) imaging if necessary. In both the institutions, scanning was done with a double-head gamma camera (DST-XL, GEMS). Radiological studies were also performed in every case.

Patients with functioning metastases received repeated courses of \(^{131}\)I, consisting of 100 or 150 mCi every 6 months until uptake was no longer detected on the therapy scan. Repeat therapy was not preceded by diagnostic scanning. Additional therapy (surgery and/or external beam radiotherapy) was given in six cases (Table 2).

Before any \(^{131}\)I therapy, patients were instructed to avoid food and medication with high iodine content (a specific list is given). Moreover, urinary iodine was measured in all patients. All patients were thoroughly informed of \(^{131}\)I therapy and imaging studies.

This retrospective study was done in compliance with the ethical requirements at our Institution.

**Results**

**Discovery of non-functioning metastases**

In two patients (patients B and C), bone pain was the first symptom of thyroid cancer. In the third (patient A), non-functioning metastases of the cervical spine were discovered, together with neck soft tissue recurrence, 12 months after initial management, and were documented by FDG PET-CT (fluorine-18-deoxyglugose positron emission tomography/computerised tomography) and MRI (Table 1).

**Outcome of patients with non-functioning metastases**

The three patients concerned had a rapidly progressive disease, despite various treatments (Table 1), and survived for 5 to 34 months (mean 19.3 months; Table 1).

**Discovery of functioning metastases**

Thyroid cancer was revealed by signs linked to distant metastases in five cases. Back pain was the first symptom of thyroid cancer in four patients (nos 2, 6, 8, 11) and was associated with spinal cord compression in three cases. Dyspnea was the revealing symptom in one patient (no. 13); computerised tomography (CT) showed the presence of multiple lung and bone metastases and an enlarged thyroid. The distribution of bone metastases at initial \(^{131}\)I therapy in these five patients is shown in Table 2. Off-T4 Tg levels ranged between 31 and 86 960 ng/ml (Table 2).

In the other eight patients, bone metastases were revealed by \(^{131}\)I scanning during \(^{131}\)I remnant ablation in seven cases (nos 1, 3, 4, 5, 7, 9, 12), and, in the last case (patient no. 10), during a second course of \(^{131}\)I given because of a high initial Tg level (147 ng/ml) and because...
of the large size of the initial thyroid tumor (7 cm). The distribution of bone metastases at initial 131I therapy in these eight patients is shown in Table 2. The off-T4 Tg level at diagnosis of bone metastases ranged between 7.4 and 9020 ng/ml. In four cases, the stimulated Tg level was lower than 40 ng/ml (nos 3, 4, 5, 7). Complementary radiological studies were negative in seven patients. In the remaining one patient (no. 1), MRI showed a single metastasis (a 5 mm lesion of the right humerus).

Outcome of patients with functioning metastases

The five patients in whom thyroid cancer was revealed by distant metastases (patient nos 2, 6, 8, 11, 13) had a mean follow-up of 49 months. Two of them (nos 6, 8) died. Patient no. 6 received treatment with an anti-angiogenic drug (Nexavar Sorafenib, Bayer), during the last 3 months, which gave a temporary improvement of dyspnea, together with a transient reduction of the size of pulmonary nodules and Tg levels. Two others patients (nos 11, 13) have progressive disease despite multiple courses of 131I and additional local treatments (Table 2). The fifth patient (no. 2) had a single (spinal) metastasis for which she received surgery, external beam radiotherapy, and a total of 524 mCi 131I, but with an incomplete response (Table 2).

Among the eight patients (nos 1, 3, 4, 5, 7, 9, 10, 12) whose bone metastases were discovered by 131I scanning, five are in an apparent remission after an average cumulative 131I dose of 303 mCi and no additional therapy. 131I uptake has disappeared in these five patients (Figs 1–3). Tg level has fallen markedly in two patients (from 511 to 1.7 ng/ml in patient no. 1 (Fig. 1) and from 22 to 4 ng/ml in patient no. 5 (Fig. 2)), and is undetectable in the other three patients (nos 3, 4, and 7 (Fig. 3)). Another patient (no. 12) had an excellent response and is continuing 131I therapy. She has a slight residual 131I uptake at a single site, while the other bone and lung 131I foci have disappeared, and the off-T4 Tg level has fallen from 194 to 10.9 ng/ml. One of the other two patients (patient no. 9) has a progressive disease with new bone metastases despite 131I therapy and local treatments, and died 63 months after the discovery of bone metastases. The other patient (no. 10), who had focal 131I uptake in the left femur, refused additional therapy because MRI showed a normal femur. She finally accepted therapy 18 months later because of a rise in Tg levels on L-T4 therapy. At this time, the 131I scan showed multiple bone metastases which were also clearly visible on MRI, and the off-T4 Tg level which had increased from 180 to 2234 ng/ml. Disease is now progressing despite 131I therapy.
Table 2 Patients with functioning (131I avid) bone metastases

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Sex</th>
<th>Age</th>
<th>Histology</th>
<th>Tumor and node stage</th>
<th>Mode of discovery</th>
<th>Initial distant sites of 131I uptake</th>
<th>Radiological studies</th>
<th>Data at diagnosis of bone metastases</th>
<th>Management</th>
<th>Data from the last 131I therapy (off-LT4)</th>
<th>Patient state</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>16</td>
<td>Papillary</td>
<td>T2N1b</td>
<td></td>
<td>131I Post-surgery</td>
<td>MRI: positive only for humerus (5 mm lesion)</td>
<td>Tg (ng/ml) off-LT4: 519</td>
<td>Mode of discovery: Post-surgery</td>
<td>MRI: positive</td>
<td>Tg (ng/ml): 11.5</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>27</td>
<td>Follicular (Hurthle areas)</td>
<td>T2Nx</td>
<td>Pain; medullary compression</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>Partial response</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>34</td>
<td>Papillary</td>
<td>T3Nx</td>
<td>131I Post-surgery</td>
<td>MRI: negative. Bone scan: negative</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>Apparent remission</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>45</td>
<td>Papillary</td>
<td>T1N1b</td>
<td>131I Post-surgery</td>
<td>MRI: negative. Bone scan: negative</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>Apparent remission</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>48</td>
<td>Papillary</td>
<td>T1Nx</td>
<td>131I Post-surgery</td>
<td>MRI: positive. Bone scan: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>Apparent remission (detectable Tg)</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>53</td>
<td>Follicular (poorly differentiated)</td>
<td>T4aN1b</td>
<td>Bone pain</td>
<td>MRI: positive. Bone scan: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>Deceased</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>55</td>
<td>Papillary (Hurthle areas)</td>
<td>T1Nx</td>
<td>131I Post-surgery</td>
<td>MRI: negative. Bone scan: negative</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>Apparent remission</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>63</td>
<td>Follicular</td>
<td>T2N1x</td>
<td>Pain; medullary compression</td>
<td>MRI: positive. Bone scan: negative</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>Deceased</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>67</td>
<td>Papillary</td>
<td>T4aN1b</td>
<td>131I Post-surgery</td>
<td>MRI: negative. Bone scan: negative</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>MRI: positive</td>
<td>Deceased</td>
</tr>
</tbody>
</table>
Table 2 continued

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Sex</th>
<th>Age</th>
<th>Histology</th>
<th>Tumor and node stage</th>
<th>Tg (ng/ml)</th>
<th>Mode of discovery</th>
<th>Initial distant sites of $^{131}$I uptake</th>
<th>Radiological studies</th>
<th>Management</th>
<th>Cumulative $^{131}$I activity (mCi)</th>
<th>Other treatments</th>
<th>Follow-up</th>
<th>Residual $^{131}$I uptake</th>
<th>Tg (ng/ml)</th>
<th>Last Tg (under rhTSH)</th>
<th>Patient state</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>F</td>
<td>74</td>
<td>Papillary</td>
<td>T3Nx</td>
<td>180</td>
<td>2nd ablative $^{131}$I Post-surgery</td>
<td>Left femur (residual bed uptake)</td>
<td>MRI: negative, PET: negative, bone scan: negative</td>
<td>550</td>
<td>No</td>
<td>29 months</td>
<td>L femur; R 4th rib; skull</td>
<td>4926</td>
<td>Progressive disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>F</td>
<td>77</td>
<td>Follicular</td>
<td>T2N0</td>
<td>194</td>
<td>$^{131}$I Post-surgery</td>
<td>Skull, sternum, ribs + lung multiple</td>
<td>CT thorax, skull: negative, bone scan: negative</td>
<td>550</td>
<td>No</td>
<td>63 months</td>
<td>Sternum</td>
<td>10.9</td>
<td></td>
<td>Partial response</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>F</td>
<td>77</td>
<td>Follicular (poorly differentiated)</td>
<td>T3N0</td>
<td>22 600 (positive TgAb)</td>
<td>Dyspnea; CT showed lung and bone metastases</td>
<td>Skull, ribs, R. scapula, R. humerus, L. femur + Lung multiple</td>
<td>MRI: T12 (compression) CT: positive multiple PET: positive multiple</td>
<td>242</td>
<td>Spine: surgery + radiotherapy, skull: surgery</td>
<td>34 months</td>
<td>Lung, spine, ribs, L. femur</td>
<td>45 500</td>
<td>Progressive disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*aPatient age (in years) at thyroid surgery. (Patients are classified according to age at diagnosis).

*bFollow-up in months from diagnosis of bone metastases.

*cThis patient could not have further stimulation tests because she left France.

*dPatient no. 4: the only case where disappearance of $^{131}$I uptake was documented on a diagnostic scan (5 mCi) and not on a therapy scan. (Because it was decided to give local therapy for the sole bone lesion in the case of persistent uptake or detectable Tg.) The patient had a second diagnostic scan 1 year later, which also was negative with stimulated Tg < 1 ng/ml. A rhTSH stimulation test 3 years later was also negative.

*ePatient no. 9: new bone metastases appeared during follow-up. She also had cementoplasty of T11.

*fAlthough the first post-surgery scan was negative, a second dose was given because of the elevated Tg level at first ablation dose (147 ng/ml), and tumor size (7 cm).
Discussion

The poor prognosis associated with bone metastases of differentiated thyroid cancer (Brown et al. 1984, Niederle et al. 1986, Ruegemen et al. 1988, Marcocci et al. 1989, Proye et al. 1992, Pacini et al. 1994, Schlumberger et al. 1996, Pittas et al. 2000, Van Tol et al. 2000, Bernier et al. 2001, Petrich et al. 2001, Zetting et al. 2002, Eustatia-Rutten et al. 2003, Haq & Harmer 2005, Durante et al. 2006) might partly be due to the fact that they are rarely detected at an early stage. Among 109 patients with bone metastases described by Bernier et al. (2001), only 4 had both radioiodine uptake and a negative standard X-ray examination. Similarly, in the study by Durante et al. (2006), radiographs were negative at presentation in only 8 (7%) out of 115 patients. This series confirms the poor prognosis associated with bone macrometastases: no complete response was achieved in such patients, even in case of positive $^{131}$I uptake. The five patients with functioning macrometastases had a mean follow-up of 49 months. Despite intensive $^{131}$I therapy and additional local treatments (Table 2), two patients died, two had progressive disease, and one had a partial response. The average survival time of three other patients with non-functioning metastases was much shorter (19.3 months). There are at least two explanations for a better outcome in patients with $^{131}$I avid macrometastases, when compared with patients in whom bone metastases show no $^{131}$I trapping: the first is that $^{131}$I avidity probably implies a better differentiation of the tumor and the second is the impact of radiation delivered by $^{131}$I. Intensive multimodality treatment is clearly justified in patients with functioning
macrometastases as it may allow for better survival. Whenever possible, FDG-PET should be obtained in patients with non-functioning metastases or those with functioning macrometastases. We believe that FDG-PET is an important complementary imaging study in these patients.

Our main finding is that a substantial percentage of bone metastases can now be discovered early on the $^{131}$I scan, when tumor burden is still limited. A complete response to iodine therapy can be achieved at this early stage. In 8 out of the 16 cases in this series (50%), the bone metastases were first revealed by $^{131}$I scanning. Complementary radiological studies were performed in all eight patients (MRI in six, CT in two, bone scan in seven). These imaging studies were negative in seven (cf. Table 2). In the remaining patient (patient no. 1), MRI showed a single metastasis. FDG-PET scan was not ordered on a routine basis in these patients (performed only in patient no. 10, in whom it proved negative). A study by Ito et al. (2007) showed that the sensitivity of FDG-PET is similar to that of bone scanning, but with higher specificity.

At the time of $^{131}$I ablation, the off-T4 Tg level in four patients with radiologically undetectable metastases was below 40 ng/ml, a value that some authors have proposed as a sign of possible distant metastasis (Schlumberger et al. 1996, Schlumberger 1998). In the absence of ablation therapy, early detection of bone metastases in these patients would not have been possible.

Several factors may have contributed to early detection of bone metastases, including trends toward earlier discovery and management of thyroid cancer and more frequent use of total thyroidectomy and $^{131}$I ablation (Schlumberger 1998, Mazzaferri & Kloos 2001, Cooper et al. 2006, Pacini et al. 2006). Scanning made after a therapy dose of $^{131}$I is highly sensitive so that a scan should always be obtained when a therapy dose has been administered. Improved sensitivity of gamma cameras may also be a factor.

We used dual-isotope acquisition of $^{131}$I and $^{99m}$Tc-HMDP bone scanning as internal landmarks. The correlation with anatomy can now be rendered easier by combining single-photon emission computed tomography and the computed tomography ($^{131}$I-SPECT/CT) images were obtained with an integrated system ‘hybrid instruments’ (Krausz & Israel 2006).

Among the 13 patients with functioning bone metastases, 12 were diagnosed during initial management (clinical work-up or $^{131}$I scanning) and one was diagnosed 6 months later. None of the other patients developed functioning bone metastases, in keeping with our previous findings on functioning pulmonary metastases (Hindie et al. 2003). These results suggest that postsurgery adjuvant $^{131}$I therapy can be useful not only for early diagnosis of distant functioning metastases but possibly also for preventing late metastatic events.

Excellent responses to $^{131}$I therapy were obtained, without the need for additional treatment, in six of the eight patients in whom bone metastases were first discovered by $^{131}$I scanning. $^{131}$I uptake disappeared in five of these patients, while the other patient had slight residual $^{131}$I uptake at a single site (the other bone and lung metastases cleared). These results confirm the prognostic importance of early diagnosis of bone metastases of thyroid cancer (Marcocci et al. 1989, Pittas et al. 2000, Bernier et al. 2001, Petrich et al. 2001, Haq & Harmer 2005, Durante et al. 2006). The only patient who had delayed repeat $^{131}$I therapy progressed; MRI became positive and the Tg level increased tenfold. Therefore, when the whole-body $^{131}$I scan points to the presence of bone metastases – even if other imaging methods (MRI, CT, etc.) are negative...
and the Tg level is only moderately elevated – repeat 131I therapy should not be postponed; only at this early stage of tiny metastases is there a chance of cure.

In these patients with functional metastases that had no structural correlate on cross-sectional imaging, it is possible that the thyroid cancer metastases are actually bone marrow metastases rather than ‘bone’ metastases per se. Since 131I passes through the bone marrow and the blood stream, and since bone marrow metastases by definition must be quite small, it is likely that 131I treatment would be more effective in this setting. The 5 mm lesion seen on the MRI in the humerus of patient no.1 was actually in the bone marrow and not in the bone parenchyma.

Antiangiogenic drugs and other targeted treatments may constitute a new therapeutic approach in patients who progress despite 131I therapy. A number of molecules are under investigation (Baudin & Schlumberger 2007). Yet, none has emerged as providing a definite benefit on survival with acceptable toxicity.

This study suggests that post-surgical 131I ablation can contribute to early detection of bone metastases, at a time when the Tg level may be only moderately elevated, when other radiological studies are negative, and when the disease is potentially curable by 131I therapy.

Funding
A part of the costs for this work was supported by ‘Cisbio International’. There is no conflict of interest related to this study.

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