Gamma probe guided surgery for osteoid osteoma: Is there any additive value of quantitative bone scintigraphy?

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**Abstract**

**Objective:** The aim of this study is to evaluate the efficiency of gamma probe guided osteoid osteoma surgery and the applicability of quantitative analyses obtained from preoperative bone scan images. **Material and methods:** This study involved 12 osteoid osteoma patients who were treated with gamma probe guided surgery after preoperative bone scan. The calculated contrast ratios between nidus and adjacent healthy bone from preoperative bone scan and the calculated percentages of count reduction after resection of nidus during intraoperative gamma probe application were compared. Patients were followed up for any recurrence or complications. **Results:** The mean contrast ratio between nidus and adjacent healthy bone calculated from preoperative bone scan was 43.6% (range 33-53%). Following the nidus excision, an average of 55.8% (range 28-73%) count reduction was estimated with gamma probe in the tumor area. There was no correlation between preoperative scintigraphic contrast ratio and intraoperative gamma probe count reduction ratio ($r = 0.46$, $p = 0.13$). Complete cure was achieved in 11 (92%) patients with single operation, during the postoperative follow up period. None of the patients had any major or minor complications during or after the surgery. **Conclusions:** Due to high clinical success and low complication rate in osteoid osteoma surgery, gamma probe application is an effective and safe method that should be used more extensively in daily practice.

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**Cirugía del osteoma osteoide guiada por sonda gammadetectora: ¿existe un valor adicional de la gammagrafía ósea cuantitativa?**

**Resumen**

**Objetivo:** El objetivo de este estudio es evaluar la eficiencia de la sonda gammadetectora en la cirugía radioguidada por sonda gammadetectora y la aplicabilidad de análisis cuantitativo obtenido a partir de las imágenes de la gammagrafía ósea preoperatoria. **Material y métodos:** Este estudio incluye a 12 pacientes con osteoma osteoide quienes fueron tratados con cirugía radioguidada por sonda gammadetectora después de la gammagrafía ósea preoperatoria. Se compararon las relaciones de contraste calculadas entre el nido y el hueso sano adyacente en la gammagrafía ósea y los porcentajes de reducción de cuentas tras la exirpación quirúrgica del nido. Los pacientes fueron sometidos a seguimiento para detectar recurrencia o complicaciones postoperatorias. **Resultados:** La relación media de contraste entre el nido y el hueso sano adyacente fue de 43.6% (rango de 33-53%). Tras la extirpación del nido, se estimó mediante la sonda una reducción media de 55.8% (rango de 28-73%) en las cuentas detectadas en el área de tumor. No había ninguna correlación entre ambas relaciones ($r = 0.46$, $p = 0.13$). Se alcanzó una curación completa en 11 pacientes (92%) con una única operación, durante el período de observación postoperatorio. Ninguno de los pacientes tuvo alguna complicación menor o mayor durante o después de la cirugía. **Conclusions:** Debido a su elevada eficacia clínica y al bajo número de complicaciones quirúrgicas, la aplicación de la sonda gammadetectora en la cirugía del osteoma osteoide es un método efectivo y seguro, más extensivamente en la práctica diaria.

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Introduction

Osteoid osteoma is a benign bone tumor, which mainly affects long bones of children and young adults. This tumor consists of a central round or oval-shaped nidus and a sclerotic bone zone surrounding it.1,2

The diagnosis of osteoid osteoma is based on clinical, radiologic and scintigraphic findings. Bone scintigraphy is one of the best methods for the diagnosis of osteoid osteoma and for identifying the precise localization of the nidus.2,3

The treatment of osteoid osteoma is achieved with complete excision or destruction of the nidus. It is difficult to identify the nidus by direct visualization or palpation during operation, therefore intraoperative localization of the tumor is of high importance. Incomplete excision of the nidus may result in recurrence in the post-operation period. Wide resection applied to weight-bearing bones in order to minimize the risk of recurrence may also cause bone weakening and increase the risk of fracture as well.1,2,4,5

To prevent extensive resection and minimize mortality and morbidity, a precise intraoperative localization of the nidus and confirmation of complete resection is highly important. To serve this aim, several localization methods such as intraoperative nuclear medicine methods, tetracycline fluorescence and imaging-guided methods have been used in practice.1,2,6,7 Although not very common, gamma probe guided method has been used in patients with osteoid osteoma since 1980.8,9 Gamma probe is very successful in intraoperative localization of the nidus, which has the highest count measurement.6,7,10 Nidus localization is followed by the count measurement of the adjacent healthy bone in gamma probe guided osteoid osteoma surgery. This adjacent count value is used as the reference value to terminate the resection, and is regarded as proof of complete resection of the nidus. Nevertheless, the gamma probe counts of nidus and adjacent healthy bone, especially those obtained from lesions that are located in the bone localizations with complex geometric structures may vary widely. This may cause hesitation about the exact localization or about adequacy of excision.

Regarding these findings the aim of our study is to attract attention to gamma probe guided osteoid osteoma surgery, since it is not a widely applied or a well-known method, to find out the efficiency of gamma probe guided osteoid osteoma surgery, and evaluate the applicability of quantitative analyses obtained from preoperative scintigraphic images in order to determine the reference count value to finalize the gamma probe guided operation.

Materials and methods

Patients

Twelve patients with the diagnosis of osteoid osteoma who were treated with gamma probe guided surgery in Kocaeli University Hospital between 2009 and 2011 were analyzed in this prospective study. The study was approved by the institutional ethical committee, and written informed consent was obtained from all the participating patients.

Preoperative diagnostic imaging

Whole body bone scintigraphy was performed in all the patients in order to verify the diagnosis and determine the precise localization of the nidus. Adult patients received intravenous injection of 740 MBq $^{99m}$Tc-methylene diphosphonate ($^{99m}$Tc-MDP), and the children’s doses were adjusted according to their weights. Two-three hours following injections, a whole body scan and static images in anterior and posterior positions were obtained with a two-headed gamma camera system (Infinia, GE Medical Systems, Milwaukee, WI, USA) equipped with low energy, high resolution, and parallel-hole collimators. Thin-section computed tomography was performed in only 8 patients.

Quantification of $^{99m}$Tc-MDP uptake on diagnostic scintigraphy

In the preoperative period, diagnostic scintigraphic images obtained from the gamma camera (GC) were evaluated semi-quantitatively in the anterior or posterior views. Whether anterior or posterior; the image with the highest lesional activity accumulation was used.

On static scintigraphic images, elliptical regions of interest (ROI) of a median size of 2.7 cm² were drawn to the area where the nidus was located with the highest point of activity and to the adjacent healthy bone by semi-automatic method. Commercially available software was then used to quantify the maximum of counts within the nidus region (GC N) and the adjacent healthy bone region (GC Adj). In order to estimate the count reduction percentage during gamma probe application, the contrast ratio between the nidus and the adjacent healthy bone was calculated with the following formulation: $(\text{GC N} – \text{GC Adj}) / \text{GC N} \times 100$. However, these calculations obtained from bone scintigraphic images were not used during surgeries.

Gamma probe guided surgery

$^{99m}$Tc-MDP was injected intravenously at the doses used for diagnostic imaging to all the patients approximately 1 h before the surgical procedure. About 15 min after the injection, the skin overlying the nidus where the highest activity accumulation was observed, was marked with permanent ink with the help of a point cobalt–51 source under the gamma camera. Urinary catheterization was performed on the patients with lesions in or around the pelvic area in order to reduce the background activity which may come from the bladder.

All the patients were taken to the operating room for complete excision of osteoid osteoma under general anesthesia. All of the operations in our study were performed by the same surgeon. The surgeon was guided by a nuclear medicine specialist, who was experienced in using the gamma probe, during the operation. A hand-held gamma probe (Crystal Probe 2000, Berlin, Germany) with thallium-activated cesium iodide (CsI:Tl) crystal (diameter 15 mm) was used for the detection and excision of the osteoid osteoma intraoperatively (Fig. 1). The affected bone was reached
with an incision through the previously marked skin area. The nidus with the highest activity accumulation was determined by slowly moving the gamma probe along the surface of suspected bone area (GP N). Then, the counts were obtained from the adjacent healthy bone by the gamma probe (GP Adj). Counts of nidus and adjacent healthy bone were measured in counts per second and recorded. The nidus determined by the guidance of the gamma probe was excised intralesionally.

The surgical excision was completed when gamma probe counts obtained from excised nidus area (GP AE) became equal or lower to the counts obtained from the adjacent healthy bones. In most of the cases, the nidus was taken out in multiple small fragments; therefore ex vivo gamma probe counts were not evaluated. The histopathologic evaluations of the excised bones were performed. Following surgery, count decrease percentages of the tumor area after excision were calculated with a formulation \[ \text{GP N} - \text{GP AE} \times 100 \] in all the patients. During the follow-up period, the recurrence patterns or any complications were also evaluated.

**Analysis**

All the statistical analyses were performed by using SPSS version 16.0 for Windows (SPSS Inc., Chicago, USA). Demographic and clinical features of the patients were reported as mean ± standard deviation, median, and percent (%). Distribution of the data was determined to be normal with the Kolmogorov–Smirnov test. Correlation analysis between the contrast ratio values calculated from preoperative diagnostic scintigraphic images and the actual gamma probe count decrease percentage values were performed by using Pearson’s linear correlation test.  

**Results**

*Patient demographics*

Of 12 patients, eight patients were male and four patients were female. Half of the patients were in pediatric age. The ages of the patients varied from 8 to 43 years with a median age of 17 years.

*Preoperative imaging findings*

The nidus of the osteoid osteoma was successfully determined by focally increased uptake in preoperative bone scintigraphy in all of the patients. The localization of osteoid osteoma was in the proximal femur in 8 (67%) patients, in the diaphysis of femur in 2 (17%) patients, in acetabulum in 1 (8%) patient and in the diaphysis of tibia in 1 (8%) patient. The mean contrast ratio between nidus and adjacent healthy bone measured from preoperative scintigraphic images was 43.6% (range 33%–53%) (Table 1). Median time interval between preoperative whole body bone scintigraphies and gamma probe-guided surgeries were 14 days (range 5–19 days).

CT was used to localize the tumor in eight patients and successfully identified the nidus in all of these cases. The mean tumor size was 10 mm (range 5–15 mm).

**Gamma probe guided surgery findings and clinical outcome**

Following the nidus excision, a mean count reduction of 55.8% was estimated with gamma probe in the excised tumor area. Bone grafting or internal fixation was not required in any patient, and all the patients were mobilized in the early postoperative period (1–2 days). On histopathological examination, the nidus could be determined only in 7 of the patients’ specimens (58%). Neither nidus nor other pathological entity was histologically found in the remaining patients. None of the patients had major or minor complications during surgery and all of the patients were followed up for any recurrence and complications postoperatively.

During a median follow-up period of 20.5 months (range: 6–34 months), eleven of the patients (92%) had reported complete relief of pain. The recurrence was observed in only one patient who was 8 years old. The recurrent tumor was localized in the acetabular region (Fig. 2). Because of continuous and severe pain, she was re-operated with conventional surgery for osteoid osteoma following 6 months after the first operation and the cure was achieved (Table 1).

**Concordance of findings between gamma probe guided surgery and preoperative scintigraphic imaging**

There was no significant correlation between the calculated nidus/perinidal healthy bone contrast ratio obtained from preoperative diagnostic scintigraphic images and the count reduction ratio after resection obtained intraoperatively with gamma probe (\( r = 0.46, p = 0.13 \)).

**Discussion**

Osteoid osteoma is a benign bone tumor with a nidus of less than 2 cm, mostly located in long bones especially proximal parts of the femur and most of the cases are under 20 years of age with a significant male predominance.\(^2\,\text{11}\) Similar to these findings, most of the patients in our study were also children or young male adults, the tumors were most frequently located in the femur and the tumor sizes were ranging from 5 mm to 15 mm in whom CT was performed.

### Table 1

Demographic, preoperative scintigraphic and gamma probe guided surgical findings.

<table>
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<tr>
<th>Case no.</th>
<th>Age and genre</th>
<th>Loc</th>
<th>Gamma camera counts (maximum count)</th>
<th>Gamma probe counts (counts/s)</th>
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<th>FU</th>
<th>Cure</th>
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<tr>
<td></td>
<td></td>
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<td>Lesion</td>
<td>Adj</td>
<td>Ratio (%)</td>
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<td>Adj</td>
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Loc: nidus location; Adj: adjacent; Path: pathologically confirmed; FU: follow up (months); Fp: femur proximal; Fd: femur diaphysis; Td: tibia diaphysis; Ac: acetabulum.
Radiography, computed tomography, magnetic resonance imaging and bone scintigraphy are the methods to diagnose and determine the location of osteoid osteoma. The standard treatment for osteoid osteoma is surgery. The aim of the surgery is to excise the nidus completely by conserving the surrounding sclerotic bone. After the excision of the nidus, there is a permanent pain relief during the early recovery period and continuous pain is an indicator of an incomplete excision. Therefore, localization of the nidus is the key factor that determines the success of the surgery. In all of our cases, osteoid osteomas were diagnosed and localized successfully by bone scintigraphy.

Several surgical methods are used in osteoid osteoma surgery. The most favorable method used in the past was wide en bloc resection of the tumor. This traditional method, that includes the resection of both the nidus and the surrounding reactive tissue, is still used by many medical centers. Wide resection, made in order to reduce recurrence rate, also weakens the bone dramatically and causes a significant increase of morbidity. Bone grafting, internal fixation or long-term immobilization may be required to reduce the risk of pathological bone fracture after the application of this technique.

Since 1980, some new less invasive surgical techniques have initiated as an alternative to conventional surgery. Burr-down technique, intrallesional excision by gamma probe or portable gamma camera guidance, CT-guided percutaneous drill excision, laser photocoagulation, thermocoagulation, radiofrequency ablation are among these techniques. 

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\[ \text{Fig. 2. An 8-year-old female patient with osteoid osteoma. Posterior (a) and anterior (b) preoperative whole body bone scintigraphy images showing a focal increased uptake at the acetabular region (arrow) with a contrast ratio of 33%. After gamma probe guided surgery recurrence was observed (case no. 12).} \]
healthy bone contrast due to high epiphysis activity are believed to be the causes of the failure of the procedure. The gamma probe procedures in the literature reported increasing failure rates especially in sites showing complexity like acetabular region and in lesions of children located in the epiphysis where high physiological healthy bone activity accumulation is observed.\textsuperscript{14}

High and variable gamma probe counts around tumor site can be measured in tumors that are localized in sites with complex geometric structures and in the epiphyseal regions of pediatric patients. In those cases, it is difficult hard to localize the nidus with a gamma probe in the correct way. Different measures obtained from adjacent healthy bone area at the same time, may cause hesitation about the operation completion reference value and the sufficiency of excision as well. The researchers in this study aimed to find out the contrast rate of the nidus and the adjacent healthy bone area obtained from preoperative diagnostic scintigraphic images, the decline in the count rate by gamma probe during the operation and finally to find out the gamma probe reference value for the operation completion. However, no statistical correlation was found between the preoperative and intraoperative rates. Similar to our findings, Wioland and his colleagues were not able to find any correlation between gamma probe-guided operation analyses and nidus-to-healthy bone uptake ratio obtained from preoperative diagnostic scintigraphic images.\textsuperscript{14} The differences

structure, taking the low efficiency of gamma probe application into account.

Conflict of interest

The authors declare no conflict of interest.

References