Magnetic Resonance-Guided High-Intensity Focused Ultrasound (MR-HIFU): Technical Background and Overview of Current Clinical Applications (Part 1)

Magnetresonanz-gesteuerter hochintensiver fokussierter Ultraschall (MR-HIFU): Technische Aspekte und Überblick über die etablierten Applikationen (Teil 1)

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ZUSAMMENFASSUNG
Hintergrund Der extrakorporale hochintensive fokussierte Ultraschall (HIFU) ist ein vielversprechendes Verfahren zur nichtinvasiven Thermoablation gutartigen und bösartigen Gewebes. Derzeitige HIFU-Therapien nutzen Ultraschall (US-HIFU) oder MRT (MR-HIFU) zur Bildsteuerung mit der Möglichkeit zur integrierten Therapieplanung, Echtzeit-Therapiekontrolle (räumliche Orientierung und Temperatursteuerung) und Therapieevaluation.

Methode Dieser Übersichtsartikel basiert auf Publikationen aus Fachzeitschriften, die die thermale Ablation mittels HIFU thematisieren, und beinhaltet zudem eigene klinische Ergebnisse. Es wird ein kurzer Überblick über die häufigsten CE-zertifizierten klinischen Applikationen für MR-HIFU gegeben.

Ergebnisse Im Laufe des letzten Jahrzehnts erhielten zahlreiche HIFU-basierte Applikationen die Zulassung in diversen Ländern. Im Speziellen ist MR-HIFU nun zugelassen für die Therapie von Uterusmyomen, Linderung von Knochenschmerzen, der Ablation der Prostata und die Therapie des essentiellen Tremors als erste neurologische Applikationsform.

Schlussfolgerung MR-HIFU ist eine patientenfreundliche, nichtinvasive Methode zur Thermoablation, welche mittlerweile für mehrere klinische Applikationen zugelassen wurde. Insgesamt bestätigen die bisherigen klinischen Daten die Wirksamkeit und Sicherheit der Therapie sowie die Kosteneffizienz der Methode.

Kernaussagen:
- HIFU stellt eine vielversprechende Technik zur nichtinvasiven Thermoablation von Gewebe dar.
- HIFU wird üblicherweise unter Bildkontrolle mittels Ultraschall (US-HIFU) oder MRT (MR-HIFU) durchgeführt.
- Die bevorzugte Bildkontrolle (US-HIFU vs. MR-HIFU) hängt von der geplanten Applikation ab.
- MRT bietet einen höheren Weichteilkontrast zur Therapieplanung, eine nahezu in Echtzeit und nichtinvasiv erfolgende Temperaturkontrolle und eine postinterventionelle Therapieevaluation.

ABSTRACT
Background Extracorporeal high-intensity focused ultrasound (HIFU) is a promising method for the noninvasive thermal ablation of benign and malignant tissue. Current HIFU treatments are performed under ultrasound (US-HIFU) or magnetic resonance (MR-HIFU) image guidance offering integrated therapy planning, real-time control (spatial and temperature guidance) and evaluation.

Methods This review is based on publications in peer-reviewed journals addressing thermal ablation using HIFU and includes our own clinical results as well. The technical background of HIFU is explained with an emphasis on MR-HIFU.
Introduction

Over the past years, radiological imaging methods such as MRI, US and CT/X-ray have become an integral part of therapeutic interventions such as percutaneous and transarterial procedures to treat vascular and oncological diseases. Imaging allows treatment planning, provides spatial guidance to reach the targeted tissue and facilitates real-time monitoring of the intervention itself, thus ensuring increased safety and improved outcome. Furthermore, treatment can be evaluated in the same session using appropriate imaging protocols thereby providing a prognostic readout for efficacy.

Thermal ablation of tumors or metastases, for example, in the liver is currently performed with minimally invasive procedures under X-ray or CT guidance using percutaneous radiofrequency or microwave applicators that are inserted into the tumor. Yet, the above methods suffer from poor temperature control and insufficient target coverage especially for larger or irregular-shaped tumors. Furthermore, proximity to crucial structures sometimes prohibits insertion of the probe. A promising noninvasive alternative is high-intensity focused ultrasound (HIFU). Ultrasound presents a mechanical wave that can be focused inside the patient on one spot, where absorption and subsequent energy dissipation cause rapid and focal heating of the target tissue. Temperatures over 55°C basically induce coagulative necrosis instantaneously with sharp margins between treated and healthy tissue. HIFU can therefore be considered as a thermal knife, however without having to perform open surgery and to remove the tissue. Current HIFU treatments are performed under either ultrasound (US-HIFU) or magnetic resonance (MR-HIFU) imaging guidance, thus offering integrated therapy planning, real-time control (spatial and temperature guidance) and evaluation. The choice of imaging method depends on the exact application and treatment scheme. This review explains the underlying principles of HIFU therapy and presents an overview of the established clinical applications (part 1), while emerging applications that are in a translational or early clinical phase will be reviewed in a future second part (MR-Guided High-Intensity Focused Ultrasound (MR-HIFU): Overview of Emerging Applications (Part 2)).

Principles

The biological effect of ultrasound was first described by Wood et al. in 1927 upon noticing the detrimental effects of high-intensity ultrasound on animals [1]. Lynn et al. succeeded in focusing high-intensity ultrasound and recognized its thermodestructive potency when applied to an ex vivo tissue sample as well as in vivo when targeting the brain transcranially in cats and dogs [2]. Fry et al. were able to produce focal lesions within the central nervous system in several animal experiments after the skull was removed to avoid extensive heating of the bone surface [3]. Nonetheless, the clinical application of HIFU remained unsuccessful largely due to the lack of heating control and spatial targeting.

For the latter, HIFU was combined early on with diagnostic ultrasound B-mode imaging for improved spatial targeting. Combining HIFU with MR (MR-HIFU) imaging presented a challenge as the transducer needs to be MR-compatible and was first realized by Hynynen et al. [4]. The soft-tissue contrast of MRI and its ability for noninvasive temperature monitoring strongly improved procedure planning, and targeting of the focus spot, which contributed to the safety and efficacy of the procedure and paved the way to broader clinical application of MR-HIFU.

For HIFU ablation, typically frequencies in the range of 0.8 – 4 MHz are employed with intensities between 400 – 10 000 W/cm² (Iₜₐ – time-averaged intensity) and pressure amplitudes of up to 10 MPa [5], depending on the particular application. In contrast to HIFU, conventional diagnostic ultrasound usually uses a frequency spectrum between 2 and 15 MHz, intensities between 0.004 and 7.5 W/cm² (ISPTA – spatial peak temporal average intensity) and pressure amplitudes of up to 5.5 MPa depending on the mode being used with the lowest values in B-mode and the highest values in Doppler mode [6].
For this review we concentrated on the current status of MR-HIFU as well as a few selected potential future applications mostly related to oncology.

**Established applications**

**Uterine fibroids**

Symptomatic uterine fibroids are found in 20–40% of all women of childbearing age, causing dysfunctional uterine bleeding, infertility or mass effects on the bladder, intestines or nerves. Classical treatment schemes comprise medicamentous as well as operative (hysterectomy, myomectomy) or interventional therapies (UAE, HIFU). The noninvasive treatment of uterine fibroids using HIFU is increasingly used in equipped centers as it is an organ-preserving, partly outpatient method with low complication rates and fast recovery. A typical MR-HIFU treatment comprises three steps with an MRI prescan for delineation of the uterine fibroids and subsequent HIFU treatment planning (Fig. 2a), the HIFU treatment as such (Fig. 2b), and a contrast-enhanced MR post-treatment scan to evaluate the treated volume (Fig. 2c). The latter is typically congruent with the tissue in which a high enough thermal dose was achieved to induce thermal necrosis (Fig. 2b) and correlates to the non-perfused volume (NPV) observed in contrast-enhanced MR scans (Fig. 2c). HIFU allows fast treatment of even large fibroid volumes of up to 500 ml with approximately 240 ml being the average volume [8]. A high NPV is of clinical importance as the reduction of symptoms correlates with increasing NPV ratios [9]. Thus, the NPV is considered to be a measure of technical success with newer MR-HIFU studies achieving NPV ratios of 60–90% [10].

The indication for HIFU treatment must be well considered as a good selection of patients leads to a higher success rate with lower complication rates. In order to determine if a patient qualifies for a MR-HIFU therapy, T2-weighted and dynamic contrast-enhanced T1-weighted MR images are acquired to assess the size, quantity, location, signal intensity on T2-weighted images, and perfusion of the fibroids. The assessment of T2-weighted images is of clinical importance as fibroids with a higher signal intensity relative to skeletal muscle, also known as Funaki Type III fibroids, are more resistant to heating and generally excluded from MR-HIFU [11]. In addition, a recent study has shown that the presence of a peripheral rim with a high signal intensity around the fibroids on T2-weighted images, which could be associated with dilated veins, lymphatic vessels, and/or edema, significantly lowered the therapeutic response to MR-HIFU [12].

Exclusion criteria can include the presence of organs such as a voided bladder, intestines or nerves in the beam path. Preparations have to be made accordingly such as bladder-filling, manipulation of the intestines and the uterus, fasting or enema. Contraindications are suspicion of malignancy, pregnancy, an acute inflammatory process, pedunculated subserosal fibroids in addition to the general HIFU and MRI contraindications [13]. Uterine fibroids with a diameter greater than 10 cm, more than 5 myomas, large scars in the acoustic window, e.g. after a c-section, and myomas in the...
posterior wall or near the Os sacrum count as relative contraindications [13]. When patients have the wish to become pregnant, myomectomy should be the first choice. However, this does not count as a contraindication for HIFU therapy as previous documented cases (> 120) report pregnancies after HIFU, but patients need to be informed about possible complications and pregnancy should not be attempted for 6 months after therapy [13].

Many studies confirm MR-HIFU as a safer, feasible and effective alternative treatment option for myomas [8–16]. Also, from an economic healthcare point of view, MR-HIFU may reduce the
overall treatment costs and disease management thanks to fewer complications, shorter hospitalization and accelerated rehabilitation rates [17]. Complications may include pain, temporary vaginal discharge of necrotic material, cramps, skin burns and rarely nerve lesions [13].

**Bone-related applications**

Bone is the most common target site for the formation of distant metastases, which eventually occur in 70 – 80% of all patients suffering from solid tumors such as breast, lung and prostate cancer [18]. Bone metastases are often associated with strong pain and can lead to pathological fractures. At this stage, the disease is virtually incurable with a limited life expectancy, reduced mobility and strongly reduced quality of life. Treatment options in the management of bone metastases are palliative and directed at alleviating pain and comprise systemic therapies such as chemotherapy, hormonal therapy and bone-seeking bisphosphonates, as well as local treatments such as surgery, radiation therapy and thermal ablation using radiofrequency (RFA) or HIFU [19 – 21]. Radiotherapy, which is the current standard of care for the local treatment of painful metastases, achieves a response rate in ⅔ of all patients within 2 – 8 weeks, but in ⅓ of treated patients pain even-

**Table 1** Overview of currently most relevant applications for MR-HIFU and US-HIFU depending on their status of approval worldwide adapted from an overview of approved applications from the Focused Ultrasound Foundation (https://www.fusfoundation.org/diseases-and-conditions-all/overview).

<table>
<thead>
<tr>
<th>application</th>
<th>regulatory approval by region</th>
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<tbody>
<tr>
<td></td>
<td>MR-HIFU</td>
</tr>
<tr>
<td>oncolgical</td>
<td>NA, EU, Ru, Ch, In, Ja, ME, SA</td>
</tr>
<tr>
<td>° bone metastases</td>
<td>RU, Ko</td>
</tr>
<tr>
<td>° breast cancer</td>
<td>Ch, Ko</td>
</tr>
<tr>
<td>° liver cancer</td>
<td>Ch, Ko</td>
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<tr>
<td>° pancreatic cancer</td>
<td>Ch, Ko</td>
</tr>
<tr>
<td>° prostate diseases</td>
<td>NA, EU, Ru, SA</td>
</tr>
<tr>
<td>° soft tissue sarcoma</td>
<td>no approval</td>
</tr>
<tr>
<td>neurological</td>
<td>Ko</td>
</tr>
<tr>
<td>° depression</td>
<td>NA, EU, Ru, Ja, Ko, ME</td>
</tr>
<tr>
<td>° essential tremor</td>
<td>EU, Ru, Ko, ME</td>
</tr>
<tr>
<td>° neuropathic pain</td>
<td>Ko</td>
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<tr>
<td>° OCD</td>
<td>EU, Ru, Ko, ME</td>
</tr>
<tr>
<td>° parkinsonian tremor</td>
<td>EU, Ru, Ko, ME</td>
</tr>
<tr>
<td>women’s health</td>
<td>no approval</td>
</tr>
<tr>
<td>° breast fibroadenoma</td>
<td>EU</td>
</tr>
<tr>
<td>° uterine adenomyosis</td>
<td>EU</td>
</tr>
<tr>
<td>° uterine fibroids</td>
<td>NA, EU, Ru, Ch, In, Ja, Ko, ME, SA</td>
</tr>
<tr>
<td>musculoskeletal</td>
<td>EU</td>
</tr>
<tr>
<td>° back pain, facetogenic</td>
<td>EU</td>
</tr>
<tr>
<td>° osteoid osteoma</td>
<td>EU</td>
</tr>
<tr>
<td>cardiovascular</td>
<td>no approval</td>
</tr>
<tr>
<td>° hypertension</td>
<td>no approval</td>
</tr>
<tr>
<td>endocrine</td>
<td>no approval</td>
</tr>
<tr>
<td>° thyroid nodules</td>
<td>no approval</td>
</tr>
</tbody>
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NA = North America (USA + Canada), EU = Europe, Ru = Russia, Ch = China, In = India, Ja = Japan, Ko = Korea, ME = Middle East, SA = South America.

1 Obsessive-compulsive disorder.
sufficient heating to achieve pain relief. Instead, the focus spot
left in the tumor lesion. The near-field approach may not lead to
strategy for osteolytic lesions depends on the residual bone tissue
cessful heating of the bone surface (soft tissue is commonly monitored as a secondary readout for suc-
temperature mapping within the bone, heating of the adjacent
bone is still under discussion [30]. As MR thermometry based on
bone surface as well as the reached ablation depth within the
length of sonication on the ablation of soft tissue in front of the
ever, the effect of the interplay between sonication power and
protocol for these lesions is the near-field approach, where the
osteum adjacent to the bone. A commonly accepted treatment
as a secondary heat source which causes local ablation of the peri-
even at moderate ultrasound energy exposures. The latter acts
high absorption of ultrasound in bone causes rapid heating
morphology. In case an intact cortical bone surface is present,
more ultrasound energy than soft tissue, lower acoustic powers
are sufficient to adequately heat the bone surface and cause periost-
teal denervation [28]. Furthermore, as HIFU does not involve ioniz-
ingation and is virtually free of side effects, treatment can be
repeated if needed.

MR-HIFU treatment protocols depend on the specific lesion
morphology. In case an intact cortical bone surface is present,
the high absorption of ultrasound in bone causes rapid heating
even at moderate ultrasound energy exposures. The latter acts
as a secondary heat source which causes local ablation of the peri-
osteum adjacent to the bone. A commonly accepted treatment
protocol for these lesions is the near-field approach, where the
focus spot of HIFU is placed behind the cortical surface [29]. How-
ever, the effect of the interplay between sonication power and
length of sonication on the ablation of soft tissue in front of the
bone surface as well as the reached ablation depth within the
bone is still under discussion [30]. As MR thermometry based on
proton resonance frequency shift (PRFS) does not allow direct
temperature mapping within the bone, heating of the adjacent
soft tissue is commonly monitored as a secondary readout for suc-
cessful heating of the bone surface (Fig. 3a, b). The treatment
strategy for osteolytic lesions depends on the residual bone tissue
left in the tumor lesion. The near-field approach may not lead to
sufficient heating to achieve pain relief. Instead, the focus spot
should be directed at the tumor mass eroding the bone to achieve
soft tissue tumor ablation besides pain relief.

A phase 3 randomized trial including 112 patients showed pain
relief with average onset three days after MR-HIFU treatment with
a response rate of 64.3 % compared to 20 % in the placebo group
[31]. Pain relief after HIFU treatment was long lasting, i.e., up to
six months and longer. Furthermore, 27 % of all responding
patients could completely discontinue pain medication, while an
additional 17 % required less medication. Another prospective,
single-arm research study including 18 patients examined pain
relief from MR-HIFU in a first-line treatment setting. Here, 72.7 %
of all patients reported complete pain relief while omitting all pain
medication and 16.7 % of all patients reported partial pain relief
while keeping pain medication constant. Remarkably, local tumor
control was observed after MR-HIFU treatment in about 33.3 % of
all patients with restoration of bone integrity [32]. The clinical
outcome of pain relief is supported by current preclinical studies
pointing at thermal denervation of the bone and periosteum as
the most prominent mechanism for pain relief [25]. Despite ther-
mal ablation of the bone itself, there is no indication in clinical
and preclinical studies that HIFU treatment could lead to an additional
reduction of mechanical stability of weight-bearing bones or
increase the risk of fractures [33]. HIFU-related complications
may be comprised of skin burns or intramuscular edema with con-
secutive reduced mobility of the affected extremity directly after
treatment that usually resolves within days.

The bone application space has been broadened to include the
treatment of benign bone lesions such as osteoid osteomas or
sub-cortical desmoids [34–40]. In a recent study, Sharma et al.
demonstrated that MR-HIFU ablation of osteoid osteomas yields a
comparable clinical response to radiofrequency ablation with the
added benefit of being free of incisions and ionizing radiation [40].
Another interesting application is the treatment of pain related to facet joint arthritis [41], where HIFU offers a completely noninvasive alternative to standard treatments including minimally invasive RF ablation, medications (e.g., NSAIDs, topical analgesics), or local injections (e.g., steroids, analgesics).

Neurological diseases

Although the treatment of brain diseases was envisioned as one of the first clinical HIFU applications in the 1950s [3], FDA approval for the treatment of essential tremor was first given in 2016. While early HIFU studies required a craniotomy, a noninvasive therapy through the skull was finally made possible with a transducer covering the whole calvaria [42]. Corrections for scattering and refraction of ultrasound at the skull based on models derived from prior CT scans and using an improved HIFU transducer having 1024 beams (ExAblate Neuro, InSightec, Haifa, Israel) allow precise MR-guided focal ablation within the central part of the brain nowadays. To date, several non-oncological applications such as noninvasive ventriculostomy [43], thalamotomy to treat Parkinson’s disease [44] and therapy for refractory neuropathic pain [45] have been described with first successes in clinical studies. A first study showed convincing results of a noninvasive cerebellothalamic tractotomy for the treatment of 21 patients with therapy-refractory essential tremor [46] and describes transcrusial HIFU to be effective and safe. A randomized trial published by Elias et al. finally provided safety and efficacy data that led to the above-mentioned FDA approval of this method [47].

Ultrasound-induced cavitation in combination with intravenously administered microbubbles (i.e., ultrasound contrast agents) was also recognized for its potential to reversibly open the blood brain barrier [48]. That effect allows molecules to extravasate into the brain tissue that would normally be confined to the vascular system, though extent and time span depend on the size of the molecule and ultrasound parameters [49]. The approach was preclinically applied to improve drug delivery to brain cancer and also to treat neurological disorders such as Alzheimer disease. Recently, Lipsman et al. were able to demonstrate the safety and feasibility of opening the blood-brain barrier using MR-HIFU in a phase I safety trial which included five patients with Alzheimer’s disease [50].

Conclusion

Currently, the clinical use of MR-HIFU is restricted to the thermal ablation of tissues and is well established for the treatment of uterine fibroids and for pain alleviation in patients suffering from bone metastases. For the treatment of uterine fibroids, MR-HIFU has been shown to be a patient-friendly, safe and effective therapeutic option, with reduced overall healthcare spending thanks to fewer complications, shorter hospitalization and accelerated rehabilitation rates. The use of MR-HIFU for pain palliation caused by bone metastasis offers the advantage of fast treatment response and the possibility for repeated treatment as HIFU does not involve ionizing radiation. Local tumor control after HIFU treatment has been reported in a few cases using MR-HIFU for first-line treatment but needs broader statistical evidence. As a first application in neurological disorders, MR-HIFU recently gained approval for the treatment of essential tremor. Other neurological applications are currently being investigated.
Conflict of Interest

The authors declare that they have no conflict of interest.

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