Dynamic optical projection of acquired luminescence for aiding oncologic surgery

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Abstract. Optical imaging enables real-time visualization of intrinsic and exogenous contrast within biological tissues. Applications in human medicine have demonstrated the power of fluorescence imaging to enhance visualization in dermatology, endoscopic procedures, and open surgery. Although few optical contrast agents are available for human medicine at this time, fluorescence imaging is proving to be a powerful tool in guiding medical procedures. Recently, intraoperative detection of fluorescent molecular probes that target cell-surface receptors has been reported for improvement in oncologic surgery in humans. We have developed a novel system, optical projection of acquired luminescence (OPAL), to further enhance real-time guidance of open oncologic surgery. In this method, collected fluorescence intensity maps are projected onto the image surface rather than via wall-mounted display monitor. To demonstrate proof-of-principle for OPAL applications in oncologic surgery, lymphatic transport of indocyanine green was visualized in live mice for intraoperative identification of sentinel lymph nodes. Subsequently, peritoneal tumors in a murine model of breast cancer metastasis were identified using OPAL after systemic administration of a tumor-selective fluorescent molecular probe. These initial results clearly show that OPAL can enhance adoption and ease-of-use of fluorescence imaging in oncologic procedures relative to existing state-of-the-art intraoperative imaging systems. © The Authors. Published by SPIE under a Creative Commons Attribution 3.0 Unported License. Distribution or reproduction in any medium, without permission, is prohibited.

Keywords: fluorescence-guided surgery; near-infrared dye; digital light processing technology; sentinel lymph node; peritoneal metastases.

Biomedical imaging continues to advance our capability to detect cancer and investigate associated biological events. Anatomical imaging with computed tomography (CT), magnetic resonance imaging (MRI), and ultrasound remain the primary imaging modalities in oncologic imaging. Functional and molecular imaging with radioactive contrast agents can provide whole-body information about tumor metabolism, proliferation, and hypoxia relative to healthy tissues. These modalities use noninvasive imaging to guide treatment selection along with diagnostic pathology of biopsy. However, relatively low sensitivity of anatomic modalities and poor spatial resolution of molecular imaging limit the ability of noninvasive imaging modalities for guiding surgery, which is the primary treatment option in many cancers. Optical imaging with colored or fluorescent contrast agents complements noninvasive imaging by providing high resolution and real-time visualization during endoscopic and surgical procedures.

Intraoperative fluorescence imaging provides real-time visualization of signal from fluorescent reporters over a large field of view (FOV) with exceptional sensitivity and resolution. Fluorescence imaging is used during surgery to assess patency of blood vessels and ureters. Near-infrared (NIR) fluorescence (700 to 900 nm) is often preferred for deep tissue imaging due to its higher depth of penetration and lower background fluorescence. However, NIR fluorescence is invisible to the human eye, and emitted light levels are typically low for the human eye to see, requiring camera-based detection. Clinical optical imaging systems typically consist of highly sensitive, scientific digital cameras with appropriate illumination source and optical filters for fluorescence detection. Fluorescence image information is acquired via attached computer, processed to reduce background signal and enhance contrast, then displayed on an adjacent digital monitor alongside or overlaying the reference brightfield image [Fig. 1]. We hypothesized that surface projection of fluorescence information on the surgical field [Fig. 1(b)] will improve the detection and removal of tumor tissue.

Digital light processing (DLP) technology enables fast, high resolution, and high contrast digital image projection. DLP systems utilize digital micromirror arrays to project bright and high resolution color images over large areas. Due to the increase in computer speed and economies of scale, DLP technology has been adapted for use during medical procedures. Herein we report a novel DLP-based strategy, optical projection of acquired luminescence (OPAL), for automated fluorescence imaging and direct super-imposition onto the surgical field.

We constructed a small prototype system to demonstrate proof-of-principle for OPAL applications in oncologic procedures. A white light-emitting diode (LED) light source (KL200 LED, Leica, Buffalo Grove, Illinois) provided illumination continuously during all procedures. Excitation light for fluorescence was provided by high power 760-nm LED (M780L2 and LEDD1B, Thorlabs, Maryland) with 769 ± 20.5 nm band-pass filter (FF01-769/41, Semrock, Rochester, New York). A 0.33-MP monochrome complementary metal-oxide semiconductor (CMOS) camera (Firefly MV FVMU-03MTM-CS, Point Grey Research, Canada) with 16-mm fixed focal lens [17HD (2/3” 16 mm F/1.4 C-Mount, Tamron, Japan)] and 785-nm long-pass edge filter (BLP01-785R, Semrock) was used for fluorescence detection. A 20 lumen, 608 x 684 pixel resolution pico projector kit (DLP Lightcrafter™, Texas Instruments, Dallas, Texas) was used to project images.

The OPAL system was positioned vertically, 30 cm above the operating field. This position gave a 3.5 x 5 cm² camera FOV for the camera (about 13 pixels/mm) and 7.5 x 5.5 cm² (about 10 pixels/mm) for the projector. Image acquisition, processing, and projection were controlled using MATLAB.
The mouse was anesthetized with isoflurane. The hair covering its left front limb was removed by gentle clipping and cream depilatory. The mouse was then positioned on its right side in dorsal recumbency. To perform dynamic projection using the OPAL system, the captured image was denoised using a 5 × 5 pixel (0.5 × 0.5 mm) median filter and thresholded to give optimal visual contrast between tumor (high intensity) and nontumor (low intensity) regions.

Prior to surgery, two large areas of fluorescence signal were observed as projected green light on the abdomen and projected onto the operating field as green color, easily visualized concurrent with white LED epi-illumination (Fig. 2). A midline incision was made to expose the internal organs. A relatively large 3 × 5 mm tumor was first illuminated and removed. The second fluorescence region was identified as a nodular mass extending from the pylorus of the stomach posteriorly along the duodenum that was not evident on visual inspection alone. Further exploration of the abdomen revealed high fluorescence from the bifurcation of the uterus and cervix. No other suspicious areas were identified by OPAL or by visual inspection. Identification of the first and second excised tissues as tumor was confirmed by histology. Tumor cells were not identified in the uterus, but integrin expression can be upregulated in these tissues due to cyclic hormonal changes.

The OPAL system provided visual contrast from NIR fluorescent contrast agent accumulation in regional lymph node and tumor tissue with minimal alteration of the normal surgical environment. Bleed-through of projected light was not detected during our testing of this prototype, but this may become a concern with use of a higher power projector.

The OPAL strategy will be best used in open surgeries that provide a relatively flat FOV and do not require significant magnification. These procedures include sentinel lymph node biopsy and cytoreduction in breast and ovarian cancer. Fluorescence imaging during endoscopic procedures, including robotic surgeries, requires attention to a digital display and would not benefit from direct image projection. Although NIR imaging has the potential for greater depth detection relative to visible wavelengths, fluorescence imaging systems based on a planar reflectance geometry have maximum reported depth of penetration of 4 cm and typically <2 cm. Our system leverages these advantages and combines them with DLP technology to achieve real-time reprojection of NIR fluorescence images correctly aligned with anatomical structures.

Further work is in progress to improve the sensitivity of fluorescence detection and optimize the contrast enhancement.
Fluorescence molecular imaging methods and targeted contrast agents are progressing steadily toward use in oncologic surgical procedures. Clinical imaging systems are already in place for detection of fluorescence contrast during endoscopy and open surgery. The fluorescence image projection method demonstrated through this prototype OPAL system represents a promising method for utilizing fluorescence molecular imaging to improve outcomes in oncologic surgery.

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References