Impact of Magnetic Resonance Imaging on the Diagnosis of Abdominal Complications of Paroxysmal Nocturnal Hemoglobinuria

By Didier Mathieu, Alain Rahmouni, Patricia Villeneuve, Marie Christine Anglade, Henri Rochant, and Norbert Vasile

Magnetic resonance (MR) imaging is a method of choice for assessing vascular patency and parenchymal iron overload. During the course of paroxysmal nocturnal hemoglobinuria (PNH), it is clinically relevant to differentiate abdominal vein thrombosis from hemolytic attacks. Furthermore, the study of the parenchymal MR signal intensity adds information about the iron storage in kidneys, liver, and spleen. Twelve PNH patients had 14 MR examinations of the abdomen with spin-echo T1- and T2-weighted images and flow-sensitive gradient echo images. Vessels patency and parenchymal signal abnormalities—either focal or diffuse—were assessed. MR imaging showed acute complications including hepatic vein obstruction in five patients, portal vein thrombosis in two patients, splenic infarct in one patient. In one patient treated with androgens, hepatocellular adenomas were shown. Parenchymal iron overload was present in the renal cortex of eleven patients with previous hemolytic attacks. On the first MR study of the remaining patient with an acute abdominal pain showing PNH, no iron overload was present in the renal cortices. Follow-up MR imaging showed the onset of renal cortex iron overload related to multiple hemolytic attacks. Despite the fact that all our patients were transfused, normal signal intensity of both liver and spleen was observed in three of them. MR imaging is particularly helpful for the diagnosis of abdominal complications of PNH. 

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Table 1. Acute Abdominal Pain Occurring in Previously Diagnosed PNH Patients

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Age (yrs)/Sex</th>
<th>Duration of Disease (yrs)</th>
<th>Previous Complications</th>
<th>Acute Complications</th>
<th>Renal Cortex Signal Intensity</th>
<th>Liver Signal Intensity</th>
<th>Spleen Signal Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>19/F</td>
<td>1</td>
<td>Hemolytic attacks, infections, BCS</td>
<td>Acute BCS and cavernous transformation of the portal vein</td>
<td>Decreased</td>
<td>Heterogeneous</td>
<td>Decreased</td>
</tr>
<tr>
<td>2</td>
<td>51/M</td>
<td>6</td>
<td>Hemolytic attacks, infections BCS</td>
<td>Acute BCS and portal and mesenteric thrombosis</td>
<td>Decreased</td>
<td>Heterogeneous</td>
<td>Decreased</td>
</tr>
<tr>
<td>3</td>
<td>18/F</td>
<td>1</td>
<td>Hemolytic attacks, infections</td>
<td>Portal thrombosis</td>
<td>Decreased</td>
<td>Decreased</td>
<td>Decreased</td>
</tr>
<tr>
<td>4</td>
<td>19/M</td>
<td>2</td>
<td>Hemolytic attacks, infections, cerebral vein thrombosis</td>
<td>Splenic infarct</td>
<td>Decreased</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>5</td>
<td>20/M</td>
<td>3</td>
<td>Hemolytic attacks, infections</td>
<td>Acute BCS</td>
<td>Decreased</td>
<td>Heterogeneous</td>
<td>Normal</td>
</tr>
<tr>
<td>6</td>
<td>36/M</td>
<td>5</td>
<td>Hemolytic attacks, infections, cerebral vein thrombosis</td>
<td>Acute BCS</td>
<td>Decreased</td>
<td>Heterogeneous</td>
<td>Decreased</td>
</tr>
</tbody>
</table>

T1-weighted spin-echo (SE) images were obtained with a repetition time (TR) of 420 milliseconds and an echo time (TE) of 15 milliseconds (TR/TE = 420/15), a matrix of 192 × 256, three acquisitions, and an 8-mm thickness with a gap of 0.8 mm; (2) T2-weighted SE images were obtained with a TR of 2,200 milliseconds and a TE of 45 and 90 milliseconds (TR/TE = 2,200/45,90), a matrix of 160 × 256, two acquisitions, and an 8-mm thickness with a gap of 0.8 mm (additional coronal images were obtained in one patient); (3) flow-sensitive fast low angle shot (FLASH) gradient echo (GRE) images were obtained with TR of 30 milliseconds, TE of 8 milliseconds, a flip angle of 35°C during breathholding, and a matrix of 256 × 256 with contiguous 8-mm thickness sections (these axial GRE sequences were performed from the right atrium to the plane of the renal veins. Additional coronal images were obtained in six examinations).

All MR imaging studies were prospectively read by one of the authors (D.M. or A.R.) and retrospectively reviewed by both of these authors in conference. For the 14 MR examinations, different abdominal MR abnormalities were considered including (1) thrombosis of the abdominal vessels including inferior vena cava and hepatic, portal, splenic, mesenteric, and renal veins on GRE images (ie, in the absence of thrombosis, a vessel appears as a bright lumen on these images, and on the other hand, an obstructed vessel exhibits a lower signal than flowing blood); (2) presence of focal liver or splenic lesions; and (3) diffuse decreased signal intensity of the liver, the spleen, and the renal cortex for the assessment of iron overload (Fig 1); the signal intensity was considered decreased if it was less than the signal intensity of skeletal muscle—used as a reference tissue—on T2-weighted SE and, particularly, on GRE images.14

RESULTS

In five patients from the first group (Table 1), obstruction of the upper abdominal vessels without collateral pathways, indicating an acute episode, was shown including BCS in four patients (patients no. 1, 2, 5 and 6), associated in one case with thrombosis of the portal and the mesenteric veins (patient no. 2) and an isolated portal vein thrombosis in one

Table 2. Follow-up of Previously Diagnosed PNH Patients

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Age (yrs)/Sex</th>
<th>Duration of Disease (yrs)</th>
<th>Previous Complications</th>
<th>Renal Cortex Signal Intensity</th>
<th>Liver Signal Intensity</th>
<th>Spleen Signal Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>30/M</td>
<td>14</td>
<td>Hemolytic attacks, infections (no complication for 8 years)</td>
<td>Decreased (rim)</td>
<td>Decreased</td>
<td>Decreased</td>
</tr>
<tr>
<td>8</td>
<td>60/F</td>
<td>11</td>
<td>Hemolytic attacks, infections, BCS</td>
<td>Decreased</td>
<td>Decreased</td>
<td>Decreased</td>
</tr>
<tr>
<td>9</td>
<td>43/F</td>
<td>8</td>
<td>Hemolytic attacks, infections</td>
<td>Decreased</td>
<td>Decreased</td>
<td>Decreased</td>
</tr>
<tr>
<td>10</td>
<td>28/F</td>
<td>5</td>
<td>Hemolytic attacks, infections, renal vein thrombosis</td>
<td>Decreased</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>11</td>
<td>29/M</td>
<td>7</td>
<td>Hemolytic attacks, infections, cerebral vein thrombosis</td>
<td>Decreased</td>
<td>Decreased</td>
<td>Decreased</td>
</tr>
</tbody>
</table>
FIG 1. Normal and abnormal appearance of kidneys in PNH disease. (A) Normal appearance of the kidneys on axial GRE image. The signal intensity of the renal cortex was equal to the signal intensity of the skeletal muscles. The patency of the different abdominal vessels is marked by a bright signal (patient no. 12). (B) Iron overload of the renal cortex on axial GRE image. Diffuse low signal intensity of the renal cortex. This signal intensity is less than the signal intensity of the skeletal muscles (patient no. 9). (C) Localized low signal intensity of the corticomedullary junction on axial GRE image in a patient with PNH disease (patient no. 7). Notice the low signal intensity of both liver and spleen corresponding to iron overload.

The PNH syndrome encompasses pancytopenia, chronic intravascular hemolysis, and recurrent thrombotic epi-
Table 3. Acute Abdominal Pain Showing PNH

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Age (yrs)/Sex</th>
<th>MR Examination</th>
<th>Acute Complication</th>
<th>Blood Transfusions (U/mo)</th>
<th>Renal Cortex Signal Intensity</th>
<th>Liver Signal Intensity</th>
<th>Spleen Signal Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>18/F</td>
<td>Portal vein thrombosis</td>
<td>3 mo after Hemolytic attacks</td>
<td>10</td>
<td>Decreased</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8 mo after BCS</td>
<td>12</td>
<td>Decreased</td>
<td>Heterogeneous</td>
<td>Decreased</td>
</tr>
</tbody>
</table>

sodes.20,22 During the course of this disease, numerous severe hemolytic attacks may occur marked by malaise, fever, headache, abdominal, and lumbar pains. The same acute clinical symptoms may also be caused by vascular thromboses. To differentiate the etiologies of these acute symptoms, imaging studies are required for an adequate and prompt treatment.23 PNH is the condition associated with the highest risk of hepatic vein obstruction or BCS.5,22,24 Using flow-sensitive GRE sequences, without injection of contrast agent, MR imaging is a highly sensitive method of assessing vascular patency.11,12 In the five BCS patients of the present study, GRE images showed characteristic hepatic vein abnormalities, ie, irregular veins, absence of hepatic veins, intrahepatic venous collateral pathways associated with a liver enlargement, and a hypertrophic caudate lobe.25–28 A heterogeneous appearance of the liver parenchyma was also shown, ie, hypointense areas in the periphery of the liver contrasting with a normal signal intensity of the caudate lobe (Figs 4 and 5). These areas could represent different and progressive stages of the disease, ie, congestion, ischemia, necrosis, and subsequent fibrosis.25–28 In our series, it is noteworthy that these hypointense areas were peripheral supporting the theory of the progressive extension from small-sized hepatic vein involvement to obstruction of the large-sized hepatic veins, as described by Valla et al.6

MR imaging is also a sensitive method for the detection of iron overload leading to magnetic field inhomogeneities and, therefore, a loss of signal, particularly on GRE images.19,29,30 In the absence of hepatic vein obstruction, both liver and splenic iron overload were present in five patients treated by previous blood transfusions. Reticulo-endothelial cell iron in the liver and spleen is derived from the phagocytosis of intact red blood cells, occurring during the metabolism of transfused erythrocytes.17 However, normal signal intensity of both liver and spleen was observed in three of our patients: one patient with a newly diagnosed PNH disorder and two other patients treated by multiple blood transfusions during the year before the MR examination, respectively 50 and 80 U/yr. In these two latter patients, the intense intravascular hemolysis with important urinary iron loss could explain the absence of parenchymal iron overload of liver and spleen. Free hemoglobin is filtered by the kidneys and is both reabsorbed and stored by the epithelial cells of the proximal tubules. Marked hemosiderin deposits in the proximal renal tubule are a common feature in all autopsy and biopsy reports dealing with PNH.30,41,31,32 As shown in occasional case reports, low signal intensity of the renal cortex can be observed in PNH because of the iron overload represented by hemosiderin.14–17 Our study confirms that this

Fig 2. Portal vein thrombosis (patient no. 3). On this coronal GRE image, the portal vein is marked by a low signal intensity showing the obstruction (arrow). The hepatic artery is visualized as a thin bright vessel (arrowheads).

Fig 3. Pain in the left hypochondrium (patient no. 4). On this coronal T2-weighted image, a focal hyperintense lesion is obvious at the upper part of the spleen corresponding to a splenic infarct. Notice the low signal intensity of both renal cortex.
Fig 4. Budd-Chiari syndrome. Hypointense peripheral areas (*) in comparison to the normal signal intensity of the hypertrophic caudate lobe. Presence of multiple intrahepatic and peripheral collateral veins with a patent IVC. Notice the diffuse low signal of the renal cortex of the left kidney on this axial GRE image.

finding is always present when previous hemolytic attacks have occurred during the course of PNH. This low signal intensity was diffuse within the cortex in 10 patients with previous hemolytic attacks (Fig 1B). In one patient of our series, this low signal intensity was localized at the corticomедullary junction (Fig 1C). It is tempting to speculate that this peculiar feature was a residual hemosiderin deposition in a patient who did not experienced hemolytic attacks for many years. Finally, in one patient, MR appearance of the kidneys was normal (Fig 1A). This patient had no previous hemolytic attacks before the MR examination. The course of this patient was rapidly marked by multiple acute episodes of hemolysis, and then a decreased signal intensity of the renal cortex appeared on follow-up MR examinations (Fig 6, A and B). However, low signal intensity of the renal cortex is not pathognomonic of PNH because this appearance has otherwise been shown in the kidneys of patients with long-standing sickle cell anemia, treated by multiple blood transfusions, with hemosiderin deposition in glomerular epithelium.33,34 This MR finding may also be obtained in any patient with chronic hemoglobinuria.

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REFERENCES


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