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F18-FDG PET imaging as a diagnostic tool for immune checkpoint inhibitor-associated acute kidney injury

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Immune checkpoint inhibitors (ICIs), anti-cancer agents that enhance anti-tumor response, can cause autoimmune toxicities, including ICI-associated acute kidney injury (ICI-AKI). The most common histopathologic lesion in patients with ICI-AKI is acute tubulointerstitial nephritis (ATIN); however, a definitive diagnosis of ATIN requires a kidney biopsy (1). This represents a frequently encountered clinical challenge for providers, as AKI is very common among cancer patients, many of whom have contraindications to kidney biopsy (e.g., solitary kidney, therapeutic anticoagulation). Accordingly, non-invasive methods of diagnosing ICI-AKI are urgently needed, as treatment involves glucocorticoids and discontinuation of potentially life-saving immunotherapy.

Case reports and one case series explored the utility of 2-deoxy-2-[\(^{18}\)F]fluoro-D-glucose positron emission tomography-computed tomography (F\(^{18}\)-FDG PET-CT) for diagnosing ICI-AKI and reported mixed findings (2,3); however, these studies did not have clear inclusion and exclusion criteria to carefully phenotype the patients, did not use rigorous techniques to minimize sampling error, and, most importantly, in some cases did not include a control group. We sought to address these key knowledge gaps and define the role of F\(^{18}\)-FDG PET-CT in diagnosing ICI-AKI.
We used data from a retrospective, multicenter cohort study of 429 patients with ICI-AKI treated at 30 sites across 10 countries (1). Patients were diagnosed with ICI-AKI between 2012-2023 and had either biopsy-proven or clinically adjudicated ICI-AKI (Table S1), specifically ICI-ATIN.

We also assembled two control groups, each consisting of patients with cancer treated at Mass General Brigham (MGB). The first was comprised of patients with AKI from non-ICI etiologies, and the second was comprised of patients treated with ICIs who did not have AKI at the time of a follow-up F\textsuperscript{18}-FDG PET-CT.

For all three groups, patients were included if they had F\textsuperscript{18}-FDG PET-CT scans at baseline and within 14 days of AKI onset (or, for the second control group, a follow-up scan between 90-365 days following ICI initiation). Patients were excluded from all three groups if they had genitourinary cancer, lymphomatous infiltration of the kidneys, or received ≥7 days of glucocorticoids prior to the follow-up scan.

Radiologists at each site reviewed the F\textsuperscript{18}-FDG PET-CTs. They were unaware of group assignment at the time of review. Five 0.5 cm diameter regions of interest (ROIs) were drawn in the cortex of each kidney, avoiding the collecting system and space-occupying lesions such as cysts. The ROIs were selected to represent each kidney’s upper, mid, and lower poles. The mean standardized uptake value (SUV\textsubscript{mean}) for each ROI was recorded.
53 patients were included (9 with ICI-AKI, 24 with AKI from non-ICI causes, and 20 ICI-treated without AKI; **Figure S1**). Baseline characteristics were largely similar among the three groups (**Table S2**), as were F$^{18}$-FDG PET-CT scan technical parameters (**Table S3**).

Detailed characteristics of the 9 ICI-AKI patients are shown in **Table S4**. Three had biopsy-proven ATIN, whereas the remaining 6 had clinically-adjudicated ICI-ATIN. All had clinical features supporting a diagnosis of ATIN (**Table S5**). Those with AKI from non-ICI causes had prerenal AKI (n=10), ischemic or septic acute tubular necrosis (n=10), or other AKI etiologies (n=4) (**Table S6**).

Representative images from baseline and follow-up F$^{18}$-FDG PET-CTs from an ICI-AKI patient (#1) are shown in **Figure 1A**. Among those with ICI-AKI, the SUV$_{\text{mean}}$ increased by a median of 57.4% (IQR, 40.3 to 119.8) from baseline to follow-up. In contrast, it increased by 8.5% (IQR, 1.4 to 19.9) among patients with AKI from non-ICI causes and decreased by 0.8% (IQR, -16.6 to 5.1) among patients receiving ICIs without AKI (P<0.001; **Figure 1B**). The increase in SUV$_{\text{mean}}$ in patients with ICI-AKI was also greater compared to that of patients with AKI from non-ICI causes when stratified by AKI etiology (**Figure S2**). The AUC for the differentiation of ICI-AKI from the two control groups according to percent change in SUV$_{\text{mean}}$ was 0.97 (95% CI, 0.93 to 1.00) (**Figure 1C**). In a sensitivity analysis (described in the supplemental methods), the AUC was unchanged at 0.97 (95% CI, 0.92 to 1.00).

In the ICI-AKI cohort, there was little intra-individual variability in the ROIs at each time point (**Figure S3**), though overall precision improved monotonically with a greater number of ROIs (**Figure S4**).
We found that patients with ICI-AKI had a considerable increase in $SUV_{\text{mean}}$ on $^{18}$F-FDG PET-CT from baseline to the time of AKI compared to two groups of control patients. These findings suggest that, when a baseline $^{18}$F-FDG PET-CT is available, these scans have diagnostic utility in differentiating ICI-AKI from AKI caused by other etiologies and could offer a noninvasive alternative to kidney biopsy.

Though predominantly used for cancer staging and assessing treatment response, $^{18}$F-FDG PET-CTs have also been used to examine autoimmune toxicity resulting from ICIs. Patients with suspected ICI-associated colitis had increased radiotracer uptake in the colon, whereas uptake decreased with treatment with glucocorticoids (4). Another study found that patients with positive $^{18}$F-FDG PET-CTs of the thyroid were more likely to develop ICI-associated hypothyroidism (5).

Fewer data are available on the role of $^{18}$F-FDG PET-CT imaging for ICI-AKI (2,3). A single-center study examined $^{18}$F-FDG PET-CT scans in 14 patients with ICI-AKI and reported an increase in FDG activity in the renal parenchyma and a decrease in the collecting system (2). However, the study did not exclude patients with genitourinary cancer or those who had received prolonged courses of glucocorticoids prior to the follow-up $^{18}$F-FDG PET-CT scan, nor did they compare their findings to controls without ICI-AKI. Further, only a single ROI in the renal cortex was obtained in each patient, which could have resulted in sampling error.

In our study, we compared changes in FDG uptake from baseline to the time of AKI among patients with and without ICI-AKI while also incorporating rigorous inclusion and exclusion criteria. We acknowledge as a limitation that not all patients had biopsy-proven ICI-AKI; however, this reflects clinical practice, where a diagnosis is often made based on established risk factors, clinical features, and an absence of alternative etiologies (1).
In summary, we found that F\textsuperscript{18}-FDG PET-CT may be a useful adjunctive test for diagnosing ICI-AKI in patients with baseline imaging available. Larger prospective studies are needed to validate these findings.
REFERENCES


Figure 1
Figure 1. $^{18}$FDG PET-CT and ICI-AKI. A) Representative $^{18}$FDG PET-CT images at baseline (top panels) and at the time of ICI-AKI (lower panels). B) Percent change in $\text{SUV}_{\text{mean}}$ from baseline to the time AKI among patients with ICI-AKI (red), AKI from other causes (blue), and patients receiving ICI therapy without AKI (green). Biopsy-proven patients are represented by squares, and clinically-adjudicated patients with circles. C) ROC curve of percent change in $\text{SUV}_{\text{mean}}$ for differentiation of ICI-AKI from AKI from other causes.