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Rapid Imaging of Experimental Infection with Technetium-99m-DTPA After Anti-DTPA Monoclonal Antibody Priming

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Antibodies accumulate nonspecifically in infectious foci due to the locally increased vascular permeability. This study describes a method of infection imaging in which 99mTc-DTPA (diethylenetriaminepentaacetic acid) is trapped at the target by a previously administered anti-DTPA monoclonal antibody, DTIn1. Methods: Rats with Staphylococcus aureus-infected calf muscle were injected intravenously with DTIn1. Two to 24 hr after the DTIn1 injection, 99mTc-DTPA was injected intravenously. In separate experiments, excess DTIn1 was cleared from the circulation 2 hr after injection with bovine serum albumin (BSA)-DTPA-In, galactosylated BSA-DTPA-In, goat antimouse IgG or avidin. Additionally, the effect of DTIn1 dose on 99mTc-DTPA abscess uptake was determined in a three-step protocol. The distribution of the radiolabels was studied by γ counting of dissected tissue and gamma camera imaging.

Results: Priming with DTIn1 resulted in specific retention of 99mTc-DTPA in the abscess. Such 99mTc-DTPA abscess uptake was not dependent on the interval between the DTIn1 and the 99mTc-DTPA injection: Optimal 99mTc-DTPA abscess uptake was already achieved within a 2-hr time span between the DTIn1 and DTPA injections. However, relatively high 99mTc-DTPA background was observed due to slowly clearing DTIn1-99mTc-DTPA complexes. Background reduction with various agents had a prominent effect on DTIn1 as well as 99mTc-DTPA biodistribution. The best reduction was obtained using BSA-DTPA-In. Optimal 99mTc-DTPA abscess uptake in the three-step protocol was obtained at higher DTIn1 doses (>100 μg). Conclusion: Infectious foci in a rat model can be imaged earlier with extremely low background levels after priming with DTIn1, followed by BSA-DTPA-In and imaging with 99mTc-DTPA, as compared with directly labeled IgG.

Key Words: technetium-99m-DTPA; monoclonal antibody priming; infection imaging; pretargeting protocols

J Nucl Med 1997; 38:901–906

Scintigraphic imaging of focal infection is currently performed with various agents, such as 67Ga-citrate, radiolabeled leukocytes or 111In-labeled human IgG (1,2). Large proteins such as IgG and human serum albumin localize nonspecifically in infectious and inflammatory foci due to the locally enhanced vascular permeability (3,4). Although labeled IgG is a convenient radiopharmaceutical, its relatively slow blood clearance, which causes persistently high background activity, interferes with the early diagnosis of infection and inflammation (5).

Reduction of background activity may be accomplished by pretargeting protocols. In these methods, the infectious focus is pretargeted and the radionuclide is administered afterwards as a low molecular weight ligand. The small ligand is rapidly excreted when not targeted to the infectious focus. Streptavidin and biotin have been used in such multistep approaches (6–8). Rusckowski et al. pretargeted mice with Escherichia coli infection with cold streptavidin and injected 111In-biotin 3 hr later (8). Higher abscess-to-background ratios were obtained compared with 111In-streptavidin or 111In-IgG. Similar results were observed in tumor pretargeting studies using antichelate antibodies and radiometal labeled chelates (9–12).

In this study, we investigated a multistep strategy for rapid infection imaging using an anti-DTPA (diethylenetriaminepentaacetic acid) monoclonal antibody (MAb) as the pretargeting agent and 99mTc-DTPA as the targeting radiopharmaceutical.

MATERIALS AND METHODS

Radiopharmaceuticals

Technetium-99m-IgG. Human nonspecific IgG in kit form (Technoscan-HIG; Mallinckrodt Medical B.V., Petten, The Netherlands) was labeled with 750 MBq 99mTc eluate according to the manufacturer’s instructions.

Monoclonal Antibodies. The production of anti-DTPA MAb DTIn1 (IgG2a), reacting with DTPA loaded with different metals, has been described (13). The affinity constant for 99mTc-DTPA was approximately 0.2 nM−1, which is similar to that for 111In-DTPA (13). The IgG2a variant of MAb G250 (14) was used as a non-DTPA binding-control antibody. DTIn1 and G250 were labeled with 185Ir (Amersham International, Buckinghamshire, U.K.) using the iodogen method (15).

Biotinylated DTIn1. DTIn1 was conjugated with NHS-LC-biotin (Pierce, Rockford, IL). Briefly, 0.8 mg DTIn1 and 740 μg NHS-LC-biotin in 50 mM sodium phosphate (pH 7.5) were incubated for 16 hr at 4°C. Thereafter, unreacted biotin was removed by PD10 (Pharmacia LKB Technology, Uppsala, Sweden) chromatography. Each DTIn1 molecule contained 18

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Received Mar. 28, 1996; accepted Aug. 12, 1996.

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biotins as determined by the method of Green (16). In vivo, the 99mTc-DTPA binding capacity of biotinylated DTIn1 and DTIn1 were similar.

**Bovine Serum Albumin (BSA)-DTPA-In.** BSA (Sigma Chemical Co., St. Louis, MO) was conjugated with the cyclic anhydride of DTPA (Sigma) in a 1:20 molar ratio as described by Hnatochik et al. (17). After PD10 chromatography to remove unreacted DTPA, excess InCl₃ (Merck, Darmstadt, Germany) was added. Five DTPA molecules were conjugated per BSA molecule as determined by the ITLC method described by Hnatochik et al. (17).

Galactosylated BSA-DTPA-In. BSA-DTPA-In was galactosylated essentially as described by Marshall et al. (18). To 36.5 mg dry activated galactose 10 mg BSA-DTPA-In (5 mg/ml in 25 mM sodium borate, pH 8.5) were added and allowed to react for 2 hr. PD10 chromatography was used to remove unreacted galactose. Thirty-two galactose molecules were conjugated per BSA-DTPA-In molecule as determined by the method of Dubois et al. (19).

**Technetium-99m-DTPA.** A kit containing 1 mg DTPA, 0.6 mg calcium nitrate and 0.05 mg stannous sulfate (pH 5.0) was radiolabeled with a fresh 99mTc eluate.

**Animal Studies.**

**Animal Model.** A Staphylococcus aureus calf muscle abscess was induced in young, male Wistar rats according to the method of Oyen et al. (3). Experiments were initiated 24 hr after the S. aureus inoculation. All radiopharmaceuticals were intravenously injected.

**Biodistribution Studies.** Rats were injected intraperitoneally with a phenobarbital overdose, bled by cardiac puncture and killed. Tissues were dissected and weighed. The activity in tissues and injection standards was measured in a shielded well scintillation counter and expressed as the percentage of injected dose per gram (%ID/g). From these data absorb-to-blood ratios (ABR) and absorb-to-contralateral muscle ratios (AMR) were calculated. In all experiments, groups of five rats were used.

**Immunoscintigraphy.** Groups of four rats were anesthetized (nitrous oxide/oxygen/halothane) and placed prone on a gamma camera (Orbiter, Siemens, Hoffman Estates, IL) equipped with a low-energy, parallel hole collimator. Images (400,000 counts per image) were obtained up to 2 hr postinjection (p.i.) and stored in a 256 × 256 matrix. The images were analyzed by drawing regions of interest over the whole animal, the abscess and the contralateral calf muscle (background). The absorb-to-background ratios and absorb-to-whole body ratios were calculated.

**Targeting of Infections with Technetium-99m-IgG.** Each rat was injected with 25 μg 99mTc-IgG (750 MBq/mg). The rats were killed, and the biodistribution was determined 4, 8 and 24 hr after injection.

**Two-Phase Targeting of Infections.** Each rat was injected with 100 μg DTIn1 (3MBq/mg) or 100 μg 125I-G250 (4 MBq/mg). Twenty-four hours later, the rats received 7.5 MBq 99mTc-DTPA (0.2 μg), and 2 hr later biodistribution studies were performed.

**Optimization of Time Between DTIn1 and DTPA Injection.** DTIn1 (100 μg labeled with 300 kBq 125I) was injected into each rat. Technetium-99m-DTPA (0.2 μg labeled with 7.5 MBq) was injected at 2, 6 or 24 hr. Radiolabel biodistributions were determined 2 hr p.i.

**Three-Step Targeting of Infections.** Ten rats were injected with 100 μg DTIn1. Two hours later, 5 of the 10 rats received 500 μg BSA-DTPA-In. All rats received 15 MBq 99mTc-DTPA (1.4 μg) 30 min later, and images were obtained up to 120 min p.i. As control, a third group of rats received 7.5 MBq 99mTc-DTPA (0.7 μg) only. Images were obtained up to 20 min p.i.

The three-phase targeting protocol was also studied in a biodistribution experiment. Ten rats received 300 μg DTIn1 labeled with 370 kBq 125I. After 2 hr, 5 of the 10 rats received 650 μg BSA-DTPA-In. Rats in both groups received 4 MBq 99mTc-DTPA (4 μg) 2.5 hr after the first injection, and biodistribution was determined 1 hr later.

**Comparison of Background-Reducing Agents.** Four background-reducing agents were studied in the three-step protocol: BSA-DTPA-In, galactosylated BSA-DTPA-In (gal-BSA-DTPA-In), goat antimonie IgG (GAM-IgG; rat serum absorbed; Southern Biotechnology Associates Inc., Birmingham, AL) and avidin (Sigma). Rats were injected with 30 μg DTIn1 (labeled with 2 MBq 125I or 30 μg biotinylated DTIn1 (labeled with 3 MBq 125I). Two hours later, a 10-fold molar excess of background-reducing agents was injected [assuming an antibody blood level of 4%ID/g and a total blood volume of 12 ml (3)]. Thirty minutes later, 4 MBq 99mTc-DTPA (3.5 μg) were injected. The biodistribution was determined 30 min p.i.

**Antibody Dose Optimization.** Increasing amounts of 125I-DTIn1 (10–900 μg per rat, labeled with 370 kBq 125I) were injected. Two hours later, BSA-DTPA-In was injected into each rat at a calculated 10-fold molar excess. Thirty minutes later, each rat was injected with 4 MBq 99mTc-DTPA (3.3 μg), and 99mTc-DTPA biodistribution was determined 1 hr p.i.

**Statistical Analysis.** All mean values are ± s.d. Statistical analysis was performed using one-way analysis of variance, with Bonferroni post-test correction for multiple comparisons.

**RESULTS.**

**Two-Phase Targeting of Infections.** Priming rats with DTIn1 for 24 hr had a profound effect on the 99mTc-DTPA biodistribution (Fig. 1). Whereas almost no differences in the biodistribution between DTIn1 and G250 were observed (data not shown), 99mTc-DTPA activity was significantly higher in DTIn1 primed rats in all examined tissues with the exception of the kidneys (p < 0.0001).

**Optimization of the Time Between DTIn1 and DTPA Injection.**

In Table 1, biodistribution of 125I-DTIn1 is shown 4, 8 and 26 hr after injection. The %ID/g 125I-DTIn1 in the blood decreased with time. More importantly, the 125I-DTIn1 uptake in the abscess was similar up to 26 hr after injection. Neither the ABR nor the AMR of 125I-DTIn1 improved with time.

The %ID/g 99mTc-DTPA in blood decreased significantly with increasing intervals between the DTIn1 and DTPA injections (Table 1). The 99mTc-DTPA uptake in other organs and in the abscess was not significantly affected by the interval between the DTIn1 and 99mTc-DTPA injections. ABR slightly improved from 0.27 at the 6-hr interval to 0.46 at the 24-hr interval between the DTIn1 and 99mTc-DTPA injections. No significant differences were observed in 99mTc-DTPA AMRs. Optimal absorb uptake of 99mTc-DTPA had been achieved during the 2 hr between the DTIn1 and DTPA injections. However, due to the high DTIn1 blood levels, 99mTc-DTPA background levels remained high.

To clarify the role of the two-step strategy, biodistribution studies with 99mTc-IgG were performed (Table 2). High background levels were also observed with 99mTc-IgG. The AMR was significantly higher using 99mTc-IgG, but no significant differences were observed in ABRs when 99mTc-IgG 4 hr post-infection was compared with 99mTc-DTPA in the two-phase protocol with a 2-hr timespan. Early imaging of infectious foci, in terms of ABRs, was not improved using this two-step protocol.
Three-Step Targeting of Infectious Foci

The effect of BSA-DTPA-In on 99mTc-DTPA abscess uptake and whole-body distribution was studied scintigraphically. Administration of BSA-DTPA-In resulted in a marked change in whole-body distribution of 99mTc-DTPA (Fig. 2). With the two- and three-step protocols, the abscesses were clearly visualized. However, a notable decrease of circulating 99mTc-DTPA was observed in BSA-DTPA-In-treated rats. With the three-step protocol, the abscess-to-background ratio increased to 14.8 ± 3.1 hr after 99mTc-DTPA injection. Due to the rapid excretion of the nontargeted 99mTc-DTPA, the abscess uptake as a percentage of residual activity increased up to 16.3% 2 hr after 99mTc-DTPA injection. In contrast, rats receiving 99mTc-DTPA only showed minimal abscess uptake (2.3% ± 0.3% of whole-body activity 20 min p.i.), and the abscess-to-background ratio did not exceed 2.

In the biodistribution experiment, striking differences between two- and three-step protocols were observed. A decrease in 99mTc-DTPA uptake was seen in blood (17-fold reduction), abscess (1.9-fold decrease) and other organs of rats treated with BSA-DTPA-In (Fig. 3). More importantly, the 99mTc-DTPA ABR was significantly higher in three-phase protocol rats (1.97 ± 0.42 versus 0.22 ± 0.03; p < 0.001), whereas the AMR was not different. The %ID/g 125I-DTIn1 in blood, kidneys and lungs significantly decreased, whereas a significant increase was seen in the liver and spleen, indicating DTIn1-BSA-DTPA-In complexation and subsequent metabolization (Fig. 3 inset). The amount of 125I-DTIn1 in the abscess was similar in both pretargeting protocols.

The three-step approach resulted in significant improvement of the ABR for 99mTc-IgG 4 hr p.i. (1.97 ± 0.42 versus 0.35 ± 0.05; p < 0.0001).

Comparison of Different Background-Reducing Agents

All agents effectively reduced the %ID/g 99mTc-DTPA in the blood (Table 3). BSA-DTPA-In had the most prominent effect on 99mTc-DTPA blood levels, with a 5.6-fold reduction compared with the two-step protocol. Only slightly (but significantly) decreased 99mTc-DTPA abscess uptake was observed after injection of BSA-DTPA-In or gal-BSA-DTPA-In. Lower 99mTc-DTPA levels were observed in the liver and spleen using BSA-DTPA-In or in the liver using gal-BSA-DTPA-In.

### TABLE 1
Optimization of Time Between DTIn1 and DTPA Injection

<table>
<thead>
<tr>
<th>Organ</th>
<th>4 hr p.i.</th>
<th>8 hr p.i.</th>
<th>24 hr p.i.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>3.17 ± 0.17</td>
<td>2.45 ± 0.15</td>
<td>1.50 ± 0.21</td>
</tr>
<tr>
<td>Muscle</td>
<td>0.10 ± 0.02</td>
<td>0.08 ± 0.01</td>
<td>0.10 ± 0.01</td>
</tr>
<tr>
<td>Abscess</td>
<td>0.83 ± 0.22</td>
<td>0.88 ± 0.32</td>
<td>0.66 ± 0.10</td>
</tr>
<tr>
<td>Liver</td>
<td>0.67 ± 0.05</td>
<td>0.55 ± 0.13</td>
<td>0.28 ± 0.03</td>
</tr>
<tr>
<td>Kidney</td>
<td>0.82 ± 0.08</td>
<td>0.77 ± 0.12</td>
<td>0.43 ± 0.06</td>
</tr>
<tr>
<td>Spleen</td>
<td>0.48 ± 0.04</td>
<td>0.47 ± 0.08</td>
<td>0.23 ± 0.04</td>
</tr>
<tr>
<td>ABR</td>
<td>0.26 ± 0.06</td>
<td>0.36 ± 0.15</td>
<td>0.44 ± 0.07</td>
</tr>
<tr>
<td>AMR</td>
<td>8.96 ± 3.07</td>
<td>10.28 ± 2.10</td>
<td>6.44 ± 0.17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organ</th>
<th>2-hr interval</th>
<th>6-hr interval</th>
<th>24-hr interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>1.72 ± 0.04</td>
<td>1.42 ± 0.08</td>
<td>0.97 ± 0.16</td>
</tr>
<tr>
<td>Muscle</td>
<td>0.06 ± 0.01</td>
<td>0.08 ± 0.03</td>
<td>0.08 ± 0.01</td>
</tr>
<tr>
<td>Abscess</td>
<td>0.49 ± 0.12</td>
<td>0.48 ± 0.10</td>
<td>0.44 ± 0.06</td>
</tr>
<tr>
<td>Liver</td>
<td>0.39 ± 0.03</td>
<td>0.28 ± 0.12</td>
<td>0.22 ± 0.03</td>
</tr>
<tr>
<td>Kidney</td>
<td>1.04 ± 0.09</td>
<td>1.08 ± 0.23</td>
<td>0.88 ± 0.07</td>
</tr>
<tr>
<td>Spleen</td>
<td>0.28 ± 0.02</td>
<td>0.20 ± 0.09</td>
<td>0.16 ± 0.02</td>
</tr>
<tr>
<td>ABR</td>
<td>0.28 ± 0.07</td>
<td>0.27 ± 0.14</td>
<td>0.46 ± 0.06</td>
</tr>
<tr>
<td>AMR</td>
<td>7.73 ± 2.21</td>
<td>7.43 ± 2.27</td>
<td>5.83 ± 0.16</td>
</tr>
</tbody>
</table>

p.i. = postinjection.
Higher $^{99m}$Tc-DTPA levels were observed in the spleen after GAM-IgG injection and in the liver and spleen after avidin injection. The $^{99m}$Tc-DTPA ABR significantly improved using avidin (2.7-fold), BSA-DTPA-In (3.6-fold) or GAM-IgG (3.7-fold).

After injection of avidin, gal-BSA-DTPA-In or GAM-IgG, $^{125}$I-DTN1 blood levels significantly decreased compared with the two-phase protocol (Table 3). Injection of BSA-DTPA-In did not reduce $^{125}$I-DTN1 blood levels. Elevated levels of $^{125}$I-DTN1 in liver and spleen were observed after BSA-DTPA-In, avidin or GAM-IgG injection, indicating removal of complex DTN1 by cells of the mononuclear phagocyte system. After gal-BSA-DTPA-In injection, $^{125}$I-DTN1 was cleared through the liver, indicating that the galactose moiety directed the gal-BSA-DTPA-In-DTN1 complexes to the liver.

**Antibody Dose Escalation Studies**

The amount of DTN1 in all organs in terms of protein mass increased linearly with increasing amounts injected DTN1 (data not shown), indicating that saturation was not reached.

Biodistribution data for $^{99m}$Tc-DTPA after priming with various doses of DTN1 are shown in Figure 4. The %ID/g in the abscess was significantly higher at $\pm 300 \mu g$ compared with $100 \mu g$ (0.31 ± 0.05 versus 0.19 ± 0.01; p < 0.05). Consequently, the ABR and AMR significantly increased when increasing the DTN1 dose from 100–300 μg [ABR: 0.88 ± 0.03 versus 1.79 ± 0.30 (p < 0.05); AMR: 5.63 ± 1.71 versus 8.79 ± 2.25 (p < 0.05)], indicating that 300 μg per rat was the optimal dose.

**DISCUSSION**

The development of an imaging technique to localize acute infection within a few hours is of great clinical importance (20). Using radiopharmaceuticals such as $^{111}$In-IgG and $^{99m}$Tc-IgG a relatively long time (\(\approx 24\) hr) is needed before a final diagnosis can be made (3). This is mainly related to slow blood clearance, resulting in slower increase of target-to-background ratios (3). We investigated whether a pretargeting protocol could overcome this drawback.

We evaluated the potential of an anti-DTPA MAb combined with radiolabeled DTPA for multistep targeting of infectious foci. After pretargeting with DTN1, the abscess was visualized with $^{99m}$Tc-DTPA. DTPA abscess uptake was based on antibody–antigen interaction because priming with G250 did not result in any specific $^{99m}$Tc-DTPA uptake. Given the hyperemia and increased vascular permeability in acute infections, optimal abscess uptake of $^{99m}$Tc-DTPA was achieved within a 2-hr time interval between the DTN1 and DTPA injections, since accumulation of DTN1 in the abscess was very rapid.

However, relatively high background activity was seen due to slow clearance of $^{99m}$Tc-DTPA-DTN1 complexes formed in the circulation. The two-phase protocol revealed no significant improvement in comparison to directly labeled $^{99m}$Tc-IgG at early time points.

To reduce the complexation of $^{99m}$Tc-DTPA with circulating DTN1, BSA-DTPA-In was injected. This markedly changed the whole-body distribution of the subsequently injected $^{99m}$Tc-DTPA. The imaging studies showed only minor amounts of $^{99m}$Tc-DTPA in the circulation, whereas the abscess was clearly visualized.

Four different background-reducing agents were compared. Immune complexes formed between DTN1 and avidin, GAM-IgG or BSA-DTPA-In should be cleared through the liver and spleen (9,21–25). DTN1-Gal-BSA-DTPA-In complexes should be cleared through the hepatic asialoglycoprotein receptor (26). Avidin and GAM-IgG do not interfere with the antigen-binding site of DTN1, whereas BSA-DTPA-In and gal-BSA-DTPA-In do. Each of the background-reducing agents significantly reduced the amount of $^{99m}$Tc-DTPA in the blood. The enhanced $^{99m}$Tc-DTPA liver and spleen uptake seen with avidin and GAM-IgG most likely represents $^{99m}$Tc-DTPA entrapment by DTN1 complexes not yet metabolized. In contrast, reduced amounts of $^{99m}$Tc-DTPA were observed in the spleen and/or liver with gal-BSA-DTPA-In and BSA-DTPA-In, indicating efficient blocking of the DTPA-binding site. Significantly decreased $^{99m}$Tc-DTPA abscess uptake was observed with BSA-DTPA-In and gal-BSA-DTPA-In. This reduced abscess uptake resulted from blocking of DTN1 antibody in the abscess or blockage of circulating DTN1 (thereby reducing the number of circulating DTN1-DTPA complexes contributing to $^{99m}$Tc-DTPA abscess uptake). These data suggest that $^{99m}$Tc-DTPA binding to prelocalized DTN1 plays an important role in $^{99m}$Tc-DTPA abscess uptake, in view of the slight reduction in the amount of $^{99m}$Tc-DTPA in the abscess after BSA-DTPA-In injection.
The best reduction of \(^{99m}\text{Tc}-\text{DTPA}\) background was obtained with BSA-DTPA-In: A 5.6-fold reduction of \(^{99m}\text{Tc}-\text{DTPA}\) blood level was achieved with a concomitant 3.5-fold increase in the ABR. The use of a background-reducing agent that can block the DTIn1 antigen-binding site does not hamper the targeting of infectious foci with \(^{99m}\text{Tc}-\text{DTPA}\). Therefore, the behavior of BSA-DTPA-In in these studies was superior to the other background-reducing agents.

Goodwin et al. used a similar background reduction approach to image tumors in mice (9). A three-step protocol was designed using an anti-BLEDTA IV antibody, a human transferrin-chelate conjugate and \(^{111}\text{In}-\text{BLEDTA IV}\). Due to the background reduction step, decreased \(^{111}\text{In}-\text{BLEDTA IV}\) tumor uptake and increased tumor-to-blood ratios were observed similar to our observations. In their study of mice with \(E.\ coli\) infection, Rusckowski et al. demonstrated that infection imaging could be improved, in terms of ABR and AMR, using streptavidin pretargeting and radiolabeled biotin (8).

With our three-step strategy, rapid imaging of infectious foci was achieved: high abscess-to-background ratios were obtained within 30 min p.i. of DTPA and 3 hr after the first injection. The three-phase targeting protocol may potentially improve the infection imaging at earlier times after tracer injection in humans. A limitation to this approach might be the development of a HAMA response after administration of DTIn1. For clinical studies, a humanized DTIn1 antibody is preferable.

**TABLE 3**

Comparison of Different Background Reducing Agents

<table>
<thead>
<tr>
<th>Organ</th>
<th>DTIn1</th>
<th>BSA-DTPA-In</th>
<th>Galactosylated BSA-DTPA-In</th>
<th>Goat anti-mouse (gG)</th>
<th>Avidin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>3.81 ± 0.27</td>
<td>3.77 ± 0.32</td>
<td>1.90 ± 0.10</td>
<td>0.57 ± 0.06</td>
<td>0.82 ± 0.09</td>
</tr>
<tr>
<td>Muscle</td>
<td>0.08 ± 0.004</td>
<td>0.08 ± 0.01</td>
<td>0.07 ± 0.005</td>
<td>0.11 ± 0.01</td>
<td>0.11 ± 0.01</td>
</tr>
<tr>
<td>Abscess</td>
<td>1.00 ± 0.21</td>
<td>0.93 ± 0.22</td>
<td>0.54 ± 0.14</td>
<td>0.56 ± 0.05</td>
<td>0.59 ± 0.07</td>
</tr>
<tr>
<td>Liver</td>
<td>0.68 ± 0.10</td>
<td>1.07 ± 0.12</td>
<td>3.28 ± 0.19</td>
<td>2.67 ± 0.06</td>
<td>1.99 ± 0.19</td>
</tr>
<tr>
<td>Spleen</td>
<td>0.65 ± 0.08</td>
<td>1.25 ± 0.11</td>
<td>0.46 ± 0.03</td>
<td>2.63 ± 0.42</td>
<td>2.71 ± 0.54</td>
</tr>
</tbody>
</table>

| Blood | 2.25 ± 0.20 | 0.40 ± 0.04 | 1.16 ± 0.08 | 0.51 ± 0.04 | 0.72 ± 0.09 |
| Muscle | 0.08 ± 0.003 | 0.07 ± 0.01 | 0.08 ± 0.01 | 0.08 ± 0.01 | 0.08 ± 0.01 |
| Abscess | 0.56 ± 0.11 | 0.36 ± 0.09 | 0.39 ± 0.09 | 0.47 ± 0.05 | 0.48 ± 0.08 |
| Liver | 0.45 ± 0.06 | 0.15 ± 0.02 | 0.33 ± 0.03 | 0.50 ± 0.04 | 0.76 ± 0.06 |
| Spleen | 0.29 ± 0.17 | 0.11 ± 0.01 | 0.22 ± 0.01 | 1.78 ± 0.25 | 1.34 ± 0.30 |
| ABR | 0.25 ± 0.04 | 0.90 ± 0.28 | 0.34 ± 0.08 | 0.92 ± 0.09 | 0.67 ± 0.07 |
| AMR | 7.29 ± 1.49 | 5.17 ± 0.85 | 5.34 ± 1.57 | 6.06 ± 0.75 | 5.89 ± 1.01 |

*Significant difference as compared with two-phase protocol (i.e., DTIn1) at p < 0.001.

Significant difference as compared with two-phase protocol at p < 0.01.

Significant difference as compared with two-phase protocol at p < 0.001.

No significant differences were observed between DTIn1 and biotinylated DTIn1; only DTIn1 results are shown.
multivalent DTPA might facilitate the use of lower DTInl protein doses needed in humans. The use of a human serum protein as a carrier. The immunogenicity of avidin (6) might hamper the use of the avidin-biotin system for infection imaging in humans, especially since a human equivalent of avidin is not available.

A potential drawback to the three-step method is the relatively large DTInl protein dose needed in humans. The use of multivalent DTPA might facilitate the use of lower DTInl doses in view of the higher affinity of antichelate antibodies for multivalent chelates compared to monovalent chelates (11).

CONCLUSION

Three-phase targeting of infectious foci results in early imaging with low background levels as compared with two-phase targeting protocols or directly labeled nonspecific IgG.

ACKNOWLEDGMENTS

We thank Mrs. J.C. Oosterwijk-Wakk’a and Mrs. M.C.A. de Weijert (University of Nijmegen, Department of Urology), Mr. E. Koenders (University of Nijmegen, Department of Nuclear Medicine) and Mr. G. Grutters and Mr. H. Eijkholt (University of Nijmegen, Central Animal Laboratory) for technical assistance. This study was partially supported by Research Grant 93–539 from the Dutch Cancer Society.

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