
Doctor Honoris Causa

PETER
JOSEF
ELL



Universitat Autònoma de Barcelona

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Discurs llegit a la
cerimònia d'investidura
celebrada a l'aula magna
de Casa Convalescència
el dia 5 d'abril
de l'any 2005



Universitat Autònoma de Barcelona

Editat i imprès
pel Servei de Publicacions
de la Universitat Autònoma de Barcelona
08193 Bellaterra (Barcelona)

Imprès a Catalunya

PRESENTACIÓ
DE PETER JOSEF ELL
PER IGNASI CARRIÓ

Peter Josef Ell, el científic i l'home

Peter Josef Ell, nascut el 7 de maig de 1944, és professor de Medicina Nuclear a la Universitat de Londres des de 1987, director de l'Institute of Nuclear Medicine, UCL, des de 1986, *Honorary Consultant Physician* del Middlesex Hospital des de 1976, i *Clinical Director* de l'UCLH NHS Trust des de 2001.

El professor Ell és una de les figures més rellevants del món en l'àrea de la medicina nuclear i del diagnòstic per la imatge. La seva formació, variada i europeista, inclou una llicenciatura en Medicina per la Universitat de Lisboa, un màster en Ciències per la Universitat de Londres i un doctorat per la Universitat de Berna. No solament parla diverses llengües, sinó que ha integrat les cultures portuguesa, alemanya i anglesa. És director de l'Institute of Nuclear Medicine de l'UCL, un dels serveis més grans d'Anglaterra en l'especialitat, i catedràtic de Medicina Nuclear en aquest mateix centre. És autor de més de cinc-centes publicacions científiques, moltes d'elles en les revistes de més factor d'impacte (*Lancet*, *JCO*, *JACC*, etc.), i és editor/autor de dotze llibres de text, i de múltiples comunicacions i presentacions a congressos. Ha estat convidat a pronunciar nombroses conferències arreu del món. La seva multiculturalitat li ha permès de tenir un paper central en la creació i formació de la Societat Europea de Medicina Nuclear (EANM), de la qual va ser autor de molts dels documents fundacionals, i de la qual ha estat president entre 1994 i 1996. Ha estat quinze anys redactor en cap de l'*European Journal of Nuclear Medicine and Molecular Imaging*, revista que, sota la seva direcció, s'ha consolidat com una de les més importants del món en aquesta àrea científica.

Si repassem el seu currículum de publicacions, en sorprèn no solament el nombre (més de cinc-cents articles originals, nombroses col·laboracions, capítols de llibres, llibres i patents), sinó també la gran qualitat. Entre les seves contribucions científiques destaquen la introducció de l'HMPAO per a la mesura del flux sanguini cerebral i el desenvolupament de l'SPECT cerebral (tomografia d'emissió de fotons), tècnica que s'ha convertit en estàndard arreu del món, la introducció de l'ús d'IgG humana per a la detecció d'infeccions o la introducció de la IBZM per a l'avaluació de la densitat de receptors D2 de la dopamina.

Recentment, ha estat també un dels introductors del PET/CT en el diagnòstic per la imatge, tècnica que ràpidament s'està convertint en estàndard en el diagnòstic oncològic. De fet, les seves primeres publicacions que es poden trobar al *Medline* són de 1974, i corresponen al diagnòstic de patologia tiroïdal. Posteriorment, cal destacar les publicacions sobre perfusió miocàrdica (*Lancet* 1977), la descripció de la imatge gammagràfica preoperatòria (*Lancet* 1978), els estudis de flux cerebral en la isquèmia, en els gliomes i en l'epilèpsia (*Lancet* 1983) i l'estudi de les lesions cerebrals en la SIDA (*Lancet* 1987). És conegut arreu del món com un dels pioners de l'SPECT cerebral en l'àrea de les neurociències. Tots aquests exemples demostren la visió de Peter Ell pel que fa al desenvolupament i futur d'una àrea de la medicina que està en evolució constant. Ha publicat documents de referència sobre àrees tan diverses com l'os, el cervell, el cor, el fetge, l'oncologia o la psiquiatria, i ha mostrat una capacitat extraordinària per entendre les qüestions clínicament rellevants en totes aquestes àrees. També és remarcable el fet que la seva activitat i producció científica no han minvat al cap de trenta anys d'activitat científica de primer nivell mundial. Només cal veure que actualment té projectes de recerca finançats per un valor superior als sis milions de lliures. Peter Ell ha ajudat, doncs, a crear, com a científic, les bases per a la medicina nuclear i la imatge molecular europea.

Les principals qualitats humanes de Peter Ell són la intel·ligència, la cultura i la sensibilitat per apreciar la diversitat i la multiculturalitat. Això, juntament amb la tenacitat i la capacitat d'escoltar, n'han fet un líder indiscutible en la medicina nuclear arreu del món. Al seu entorn ha sorgit una escola de medicina nuclear, que ha produït *ex fellows* que avui estan escampats per tot el món. Dins d'aquesta línia, no és gens estrany que fos l'inspirador i un dels fundadors de l'European School of Nuclear Medicine, organització que ha esdevingut central per oferir educació i certificació professional als especialistes europeus.

Peter Ell té, doncs, el perfil científic i humà adient per esdevenir doctor *honoris causa* per la Universitat Autònoma de Barcelona.

DISCURS
DE
PETER JOSEF ELL

Targeting: blind without an image

It is my unique and distinct honor to deliver this lecture to your prestigious Autonomous University of Barcelona. Being a child of the Iberic Peninsula, I am specially attached and indebted to you, returning to my geographical origin, at this auspicious moment of singular significance.

The topic I am about to share with you, has occupied the best and indeed the better part of my adult being, namely the ability to extract from an intact human, accurate, valid but also useful information, relevant to the practice of medicine. I was never destined to become a surgeon.

When I exited the study of medicine at the University of Lisbon, Hounsfield had not discovered CT, Mansfield had not developed his Nottingham concepts in magnetic resonance and even Donald in Glasgow had not yet pioneered the emerging use of ultrasound in medicine. But Georg von Hevesy, returning from Manchester and his work with Rutherford, had several decades before published his seminal and Nobel recognized work in radiotracer based physiology – the distinct and indeed distinguished Marie and Pierre Curie had laid many of the modern foundations of the concepts of radioactivity and radioactive tracer methodology.

It was for me a unique fascination to see in the early 70's a rectilinear scanner and later a gamma camera at work, depicting the arrival, distribution and sometimes elimination of radiolabeled tracers in health and in disease. I shall not forget the arrival of labeled phosphonates, which changed the detection of macrometastasis in the skeleton, the emergence of myocardial perfusion imaging with tracer quantities of Thallium and later the unraveling of the first tomographic and human images of blood flow in my lab, initially with I-123 labeled amines and finally with a Tc99m labeled oxime!

This period spans approximately one decade, between the 70's and the early 80's. But medical imaging as we now often coin a huge diversity of modalities (excluding interestingly, medical photography, histopathology, electron microscopy, etc.) was also about to undergo a period of immense and momentous change. X-ray based computed tomography emerged, ultrasound applications to imaging advanced, and nuclear magnetic resonance, electron beam tomography and most recently optical imaging emerged as major diagnostic tools. Quantum dot imaging has emerged as a new methodology – limitations in tissue penetration and toxicology are aspects here which will require further development. Wisely but inaccurately, the word nuclear was removed from the medical vocabulary of MR practitioners (as if one could resonate without a nucleus).

The power of modern imaging in diagnostics is now widely recognized. It pertains to all major medical endeavor and it is vital to the understanding and indeed management of numerous medical disease entities. Probably the greater majority of admissions to hospital are diagnostically validated via an imaging methodology. Even the still valid gold standards of histopathological diagnostics are being interrogated – what do these methods tell us about live human tissue, to what degree can this information be gazed upon from a single frozen tissue sample at a single moment in time?

We can now image and obtain 3 dimensional CT data at 0.3-0.4 mm? Sampling, of the whole body, in less time that it takes to ask and record the name, address and date of birth of a patient. Other non invasive technology offers us in addition, picomolar (not millimolar) sensitivity in the detection process of minute tracer quantities of biologically active ligands. What avenues will open to us and where will these lead to? In what follows, we outline a few possible scenarios.

Modern therapeutics makes use of immensely powerful drugs. These cost well over half a billion of dollars to develop and the future of hundreds of thousand employed workers and millions of patients depend on their success. What do we really know of these compounds, how well have these been characterized in man, prior to wide scale introduction? What can imaging contribute to this scenario?

We begin to appreciate that the greater proportion of drugs in present use in man, miss the in vivo target which they have been designed to impact upon. Furthermore, and possibly as a significant consequence, only a minority of individuals appear to benefit from medications prescribed for the same entity, to a larger group of affected patients.

The concept of individual targeting emerges, and with it, the concept of personalized medicine. A seductive editorial in *The European Journal of Cancer* describes the big impact on the field of oncology of a molecular targeted therapy designed to treat a rare disease. George Demteri discusses the impact of the development of selective tyrosine kinase inhibiting agents, such as Imatinib/Gleevec and the role FDG PET scanning has played in the demonstration of early target effectiveness of the drug.

We have seen that it is not enough to identify the whole of the human genome, we need to identify the phenotypic expression of multiple gene sequences which preside over and are responsible for the expression of symptoms in the individual. Only then can drug design target the relevant abnormality for possible correction.

In the biological cascade which is unleashed in the altered cell, ultimately leading to disease manifestations, it is clearly understood that gene malfunction and protein dysfunctions precede the developing sequences of altered biological signaling, altered metabolism, impaired angiogenesis and flow and finally altered structure and often volume. And yet, despite the clarity of this evolution from health to disease, we continue to look for the latter event – the alteration of morphology and structure. The seduction of anatomical imaging via CT and MR is all too apparent.

Clearly these are the diagnostic and staging tools which most often we use at present, but will there be the tools for the future? One of the recent lessons learned from ultra fine resolution CT is that serial scanning demonstrates that even benign lesions grow in size... no surprise here, until one remembers the daily practice of determining malignancy from nodular growth in CT/MR... Tumor volumes are also late indicators of disease progression and lack not only sensitivity, but also specificity.

What neurotransmission can be investigated with CT or MR or optical imaging, which intracellular cascade can be investigated by these technologies? What use will these methods offer in the identification of the caspases relevant to the onset of apoptosis? How could the now known abundance of D2 receptors in the human brain predict the response to psycho stimulants in the absence of the critical novel radioligand for imaging? Many such modern examples could be offered, what relevant alternatives should be considered?

Indeed we will have to develop newer imaging technologies which have the sensitivity required to image ultimately single cell processes. In the mean time, PET and SPET allows us to investigate biological phenomena at the picomolar

or femtomolar levels and (!) permit the imaging of specific biological signals and targets. We will need to favor a strategy of imaging intracellular processes in preference to anatomy, we will need to further appreciate that intracellular and intercellular signaling is more relevant than alterations of flow. Upstream signal detection is more likely to offer us a specific insight of the disease process rather than the utilitarian downstream approach.

At the opposite end of the complex spectrum of imaging technologies and only from time to time, a most elegant and simple method appears which truly revolutionizes an entire field. This occurred in the 90's with the development of the sentinel lymph node biopsy approach to the management of solid tumors. A spectacular advance was made in surgical oncology, where nuclear medicine has altered an entire field of cancer staging and treatment.

Where are we at present?

Human Data

Modern multislice spiral CT can indeed image at sub millimeter spatial resolution and MRI has also made great strides. Detection sensitivities however remain at best at the millimolar level. PET and PETCT and SPET and SPETCT combine the resolution of CT with the picomolar detection sensitivity for PET and SPET. PET alone is unable to image much below 4 mm and SPET operates at approximately 8-10 mm. We expect the PETCT and SPETCT devices to become the routine tomographic imaging instruments in the next five years, specially in the cardiovascular and oncology fields. High field MRI and fMRI and indeed SQUIDD devices will have a significant role to play in the neurosciences but the area of neurotransmission and drug discovery will remain firmly in the field of vision of PET and SPET. The 9.4 Tesla MRI scanner at the University of Illinois can show concentrations of sodium, phosphorus and oxygen in the brain, an example of developments to watch. Bullmore in Cambridge is also using fMRI methods to investigate changes in neuroactivation prior to and following the administration of therapy in patients with depression. Whilst abnormal patterns of activation are shown, the downstream signal is not enlightening us on the direct pharmacological effect of these therapies in the organ of interest.

SPET work with I-123

In my lab we first demonstrated in 1992 that the antipsychotic effects of clozapine are achieved without potent blockade of striatal D2 receptors, despite excellent therapeutic effect. We showed in 1994 that schizophrenic patients do not show low cortical GABA-BZ density in vivo and we used in 1996, R-91150, a novel ligand for the 5HT2a receptor. Large scale clinical studies with epidepride (a ligand targeting D2/D3 receptors started in 1996, and in 1997 we showed that clozapine selectively targets limbic cortical D2/D3 dopamine receptors in vivo in man. In 1998 we showed the alcohol dependency responsible for aberrant GABA/BZ binding in vivo in females, in 1999 we showed cortical D2/D3 receptors identified as a common site of action of typical and atypical antipsychotic drugs. In 2002 we performed first quantitative studies of CNS 1261 – a novel ligand targeting the NMDA intrachannel MK-801/PCP site in humans in vivo. We also showed that clozapine markedly suppresses NMDA binding in vivo.

PET and PETCT

Our experience with PET commenced in 1999 and very recently we started our PET work with the 5th PETCT device in the world. A first patient was scanned on the 17th of January 2002. With F18 labeled FDG, a ligand targeting mainly GLUT 1 and GLUT 3 transporters at the cell membrane we demonstrated early on, rapid response to treatment in lymphoma, and also showed in 2004 that PETCT is able to detect target response to a single dose of carbaplatin within 72 hrs of administration to patients in germ cell cancer. Using F18 labeled thymidine, we showed good correlation with MIB-1 in studies of cellular proliferation in patients with colorectal cancer and recently have shown better correlates of this ligand with thymidine kinase 1 activity. FDG PET has rapidly become a major imaging tool for the investigation of cancer. FDG PET has demonstrated that the glycolytic phenotype is seen in most cancers. The upregulation of glucose has recently been described as an adaptive process of the cancer cells to hypoxia and is seen as necessary for the evolution of invasive human cancers.

In conclusion

It is becoming hugely apparent that targeting biological signals in vivo in man will immensely benefit from modern imaging technologies. Mechanism of drug action and drug discovery will be significantly enhanced by radiolabeled imaging ligands. A new field has just begun.

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Single Photon Emission Tomography. Ell, PJ. The Lancet II, 138, 1982

Cerebral Blood Flow with I-123 labeled amines. Ell et al. The Lancet I, 1348-1352, 1983

Imaging Cerebral Damage in HIV Infection. Ell et al. The Lancet II, 569-570, 1987

Tc99m HMPAO Washout from the Brain. Ell et al. The Lancet I, 665-666, 1989

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Lymbic selectivity of clozapine. Pilowsky L S; Acton, P; Ell, PJ et al. The Lancet 350, 490-491, 1997

Sentinel Lymph Node Biopsy in Breast Cancer. Keshtgar, M; Ell, PJ. The Lancet 352, 1471-1472, 1998

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Bright future for nuclear medicine. Ell, PJ. The Lancet 354, 616, 1999

False Negative Rates in Sentinel Lymph Node Biopsy. Keshtgar, M; Ell, PJ. The Lancet, 354, 773, 1999

Nuclear Medicine in Neurology and Psychiatry. Costa, DC; Pilowsky, L; Ell, PJ. The Lancet 354, 1007-1111, 1999

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Clinical Role of Sentinel Lymph Node Biopsy in Breast Cancer. Keshtgar, M; Ell, PJ. *Lancet Oncology* 3,105-110, 2002

The Future of Nuclear Medicine. Ell, PJ; Hoejgaard, C; Becker, W. *The Lancet* 359, 629-630, 2002

In Vivo Imaging of Cellular Proliferation in Colorectal Cancer using PET. Francis, DL; Ell, PJ. et al. *GUT* 52, 1602-1606, 2003

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Volkow, N et al. Dopamine in drug abuse and addiction: results from imaging studies and treatment implications. *Molecular Psychiatry*, 9, 557-569, 2004

Voura, EB et al. Tracking metastatic tumor cell extravasation with quantum dot nanocrystals and fluorescence emission scanning microscopy. *Nature Medicine* 10, 993-998, 2003,

Gatenby, RA; Gillies, RJ. Why do cancers have high aerobic glycolysis? *Nature Reviews Cancer* 4, 891-900, 2004

CURRICULUM VITAE
PETER JOSEF ELL

Peter Josef Ell, doctor en Medicina, màster en Ciències, PD, FRCR (Fellow of the Royal College of Radiologists), FRCP (Fellow of the Royal College of Physicians), FMedSci (Fellow of the Academy of Medical Sciences).

Universitat de Londres. Catedràtic de Medicina Nuclear

Institut de Medicina Nuclear

The Middlesex Hospital

Cronologia dels llocs de treball

Catedràtic de Medicina Nuclear a la Universitat de Londres: octubre de 1987

Professor de Medicina Nuclear a la Universitat de Londres: octubre de 1981

Privat Dozent University (Berna): 1981

Professor sènior al Middlesex Hospital Medical School: setembre de 1976

Director de l'Institut de Medicina Nuclear, UCL: gener de 1986

Metge assessor honorari de The Middlesex Hospital: agost de 1976

Director clínic d'UCLH NHS Trust: 2001

Títols

Llicenciat en Medicina (1969), màster en Ciències (1972), doctor en Medicina (Berna, 1981), MRCP 1984, FRCR (1984), FRCP (1990), FMedSci (2002) (Fellow of the Academy of Medical Sciences UK, Fellow of the Royal College of Physicians, Fellow of the Royal College of Radiologists)

GMC Specialist Register: 2473453

Distincions

Medalla de la Ciutat de Montpeller (1991)

Alpha Omega Alpha Honor Medical Society Fellow, EUA (2003)

Medalla d'Or de la Universitat de Ghent, 2004

Membre actiu de les Societats de Medicina Nuclear finlandesa, suïssa i alemanya

Membre fundador de l'Associació Europea de Medicina Nuclear, 1985

Membre honorari de la Societat Finlandesa de Medicina Nuclear, 2003

Publicacions

Més de 550 manuscrits publicats i avaluats per un grup d'experts

Autor de 12 llibres de text i de 26 capítols de llibres de text

Més de 560 presentacions/resums científics, la majoria en congressos/simposis internacionals

Activitat editorial

Editor/coeditor de 29 llibres

Editor – Murray i Ell: llibres de text bàsics sobre medicina nuclear, 2 vols., 1200 p. Royal Society of Medicine. Book Award, 2 edicions.

Tercera edició a Ell i Gambhir, Elsevier, 2 vols. 1924 p, juny de 2004

Editor en cap de l'*European Journal of Nuclear Medicine*: 1990-2003

Internacional

President de l'Associació Europea de Medicina Nuclear: 1994-1996

Secretari de l'Associació Europea de Medicina Nuclear: 1987-1993

Secretary Linking Committee ENMS/EANM: 1984-1987

Expert Assessor de l'Agència de l'Energia Atòmica Internacional, Ministeri de Ciències. França (INSERM Expert) 93, German Science Council (2001), etc.

Moltes càtedres de professor visitant des de 1982 a l'Àsia, els EUA i Europa.

President d'EANM i SNM (EUA) Strategy Committee.

Experiència com a docent i examinador

Examinador intern i extern de doctorat a les universitats del Regne Unit i a altres universitats europees: Amsterdam (1998, 1993); Lió (1991), Lovaina (1997), Nijmegen (1998), Groningen (1998), Gant (2000-2001).

Avaluador extern per a la col·locació de personal de rang superior: Sidney (1991), Colorado (1991), Vanderbilt (1991 i 2001), Ontario (1995), Southampton (1996), Kuopio (1999), Sidney (1999), Nova York MSK (2001).

Programa del Màster de Ciències del Departament de Medicina Nuclear de la Universitat de Londres: durant més de vint anys va supervisar més de setanta estudiants de postgrau.

Fundador (com a president de l'Associació Europea de Medicina Nuclear) de l'European School of Nuclear Medicine, actualment un organisme educatiu europeu de medicina nuclear reconegut arreu del món.

Conferències

The Highlights Lecture és la conferència de més prestigi en el camp de la medicina nuclear. Té lloc en els congressos internacionals anuals per analitzar els últims descobriments en recerca i identificar els buits de coneixement i les tendències futures.

The Highlights Lecture: First Joint European Societies Congress, Hèlsinki (1984) i Amsterdam (1990)

The Highlights Lecture: World Federation of Nuclear Medicine and Biology, Montreal (1990), Sidney (1994), Xile (2002)

The Highlights Lecture: British Nuclear Medicine Society (1986, 1991)

The BadGastein Lecture: 1998

The Norman Veall Lecture: Berlín (1998)

The Bertil Nosslin Lecture: Estocolm (1997)

The Henry Wagner Memorial Lecture: EUA Societat de Medicina Nuclear (2003)

The Highlights Lecture European Association of Nuclear Medicine, Hèlsinki (2004)

The Finsen Lecture: Copenhaguen (2004)

Cronologia de recerca

Tc-99m IDP per a escintigrafia de miocardi

La detecció precoç d'infarts de miocardi aguts (AMI) estalvia vides. Abans, els marcadors del sèrum eren poc sensibles i poc específics. A la Unitat de Cures Coronàries es va pensar en un nou lligand, el Tc-99m imidodiphosphonate (IDP), per a la imatge directa/positiva de l'AMI, ja que els fosfonats havien mostrat una acceptació positiva en les cèl·lules musculars danyades (observació clínica personal). Vam utilitzar un model animal, vam induir-li un infart agut, vam investigar el nou lligand i el vam aplicar amb càmeres gamma mòbils a la unitat de cures coronàries. La sensibilitat de la detecció en el cas d'infarts de miocardi aguts l'home en un període de 48 hores és del 95%. *British Heart Journal XL*, 3, 226-233, 1978.

Ja teníem experiència prèvia de la importància dels mapes tomogràfics del flux sanguini cerebral amb les amines marcades I-123 (*Lancet* 1, 1348-1352, 1983).

Necessitàvem una molècula amb un marcador universal com el Tc-99m per transformar realment els prometedors estudis en una eina clínica que atragués l'atenció de tothom. Era la Tc-99m hexametilpropilenaminoxima (HMPAO) per al flux sanguini cerebral: un nou lligand lipoquílic capaç de descriure el flux sanguini en l'home. Combinat amb la tomografia d'emissió de fotons, es van obtenir uns innovadors tomogrames del flux sanguini en persones sanes, en pacients que havien sofert accidents vasculars cerebrals, d'altres amb demències, i d'altres amb moltes altres patologies. Vam ser els primers a utilitzar aquest lligand en l'home: un traçador que va guanyar dos guardons de la Reina a l'Exportació per a Amersham, que va iniciar, i més tard ampliar, la utilització clínica dels estudis de flux sanguini cerebral (*Lancet* II, 50-51, 1985).

Absorciometria de raigs X energia dual

Abans d'aquesta tecnologia, per als estudis de transmissió s'utilitzaven fonts de gadolini, però la precisió i la sensibilitat eren molt pobres. Vam presentar al Regne Unit una tecnologia basada en raigs X que va donar lloc a un augment espectacular del flux de fotons i, per tant, de la sensibilitat i la precisió. Vam establir la primera base de dades europea a partir d'una població normal del Regne Unit. Això va servir de referència en molts estudis clínics posteriors sobre osteoporosi. Actualment s'ha convertit en una tecnologia estàndard de referència arreu del món. *British Journal of Radiology*, 62, 587-592 (1989) i *British Journal of Radiology*, 63, 266-269 (1990).

La ciència de la imatgeria per neurotransmissió va ser la primera a utilitzar traçadors marcats amb positrons. Atesa l'escassetat de lligands adequats i la necessitat d'estudis clínics en mostres més grans de pacients, era obligat desenvolupar estudis basats en la I-123. Es va utilitzar la I-123 iodometoxibenamida (IBZM) per a la imatgeria postsinàptica D2: un nou lligand i un estudi que determina la distribució dinàmica bàsica en el cervell humà en persones sanes, en quatre pacients esquizofrènics medicats a intervals i en un pacient amb una demència de tipus Alzheimer. Aquest estudi va ser el primer que es va aplicar a la investigació de pacients esquizofrènics medicats i va mostrar el camí de la recerca biològica de nous medicaments no invasius per a l'home. Va ser el precursor d'un esforç que va durar deu anys amb vista a desenvolupar els estudis d'imatgeria per neurotransmissors amb traçadors I-123 per a la investigació funcional i *in vivo* de malalties psiquiàtriques, així com de les formes en què actuen els medicaments. *European Journal of Nuclear Medicine*, 16, 813-817, 1990.

Primera utilització de dobutamina per als estudis de moviment de l'escintigrafia de perfusió i la ressonància magnètica (MR)

La prova de l'esforç cardíac és decisiva a l'hora de la detecció precoç de la malaltia. Aquest experiment és una demostració del principi que l'estrès induït

per la dobutamina també es pot utilitzar amb ressonància magnètica: actualment s'utilitza de forma rutinària en ressonància magnètica cardíaca i en imatge de perfusió de miocardi. *American Journal of Cardiology* 70, 34-40, 1992

Com a conseqüència de l'estudi amb IBZM (més amunt), vam provar la hipòtesi dopaminogènica de l'esquizofrènia, que va mostrar una relació complexa entre el bloqueig de D2 i l'eficàcia clínica. Aquest programa es va desenvolupar durant deu anys: dades recents de 2002 mostren, per exemple, la relació entre l'ocupació del receptor D2, els símptomes depressius i els pacients esquizofrènics medicats. *Lancet* 340, 199-202, 1992, *Schizophrenia Research* 56, 31-36, 2001.

El primer estudi internacional de Cost Benefit of Myocardial Perfusion Scintigraphy (quatre països, vuit hospitals i 396 pacients es van agrupar en quatre estratègies diagnòstiques) demostra que les estratègies de recerca que utilitzen la medicina nuclear i la imatge de perfusió del miocardi són menys cares i més efectives si es comparen amb les estratègies que només utilitzen electroencefalogrames i angiografies coronàries (l'enfocament tradicional). *European Heart Journal* 20 (2), 157-166, 1999.

Capdavanters en la utilització de la tomografia d'emissió de positrons/tomografia computada (PET/CT) i les primeres dades obtingudes al Regne Unit: el gener de 2002 es va encarregar el primer escàner que combinava les tècniques PET i CT i es va aplicar al seguiment del càncer. Ja hem mostrat l'important impacte de la tomografia clínica d'emissió de positrons amb glucosa marcada, que canvia l'estadificació del càncer en aproximadament un 40% de tots els pacients estudiats. *European Journal of Nuclear Medicine*, 29,719-720, 2002.

PUBLICACIONES

Articles

1972

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1973

2. BRITTON, K.E.; ELL, P.J. «Thyroid scanning». *British Medical Journal* 2.

1974

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