INTRODUCTION

Chronic liver disease resulting in fibrosis, and ultimately cirrhosis, is a significant cause of morbidity and mortality worldwide. None of the conventional imaging techniques are able to detect early fibrosis and compare its grade with the histopathologic scale. Liver biopsy, as the diagnostic standard for liver fibrosis, also has limitations and is not well accepted by patients. Magnetic resonance elastography is a well-established technique for evaluating liver stiffness and may replace invasive procedures. Detection of liver fibrosis in its early stages, however, requires a detailed knowledge of normal liver stiffness.

OBJECTIVES

This study aimed to determine normal liver stiffness values in healthy volunteers.

PATIENTS AND METHODS

A total of 102 volunteers (mean age, 21.6 years; range, 20–28 years) with no history of gastrointestinal, hepatobiliary, or cardiovascular disease were enrolled in the study. Liver stiffness was evaluated by magnetic resonance elastography with a 1.5T clinical magnetic resonance scanner. Images of the induced transverse wave propagation were obtained and converted to tissue stiffness maps (elastograms).

RESULTS

The mean (SD) liver stiffness for the entire group of volunteers was 2.14 (0.28) kPa (range, 1.37–2.66 kPa). For women, the mean (SD) stiffness value was 2.14 (0.30) kPa (range, 1.37–2.66 kPa), and for men, 2.14 (0.25) kPa (range, 1.54–2.54 kPa).

CONCLUSIONS

Liver stiffness in a healthy adult cohort did not exceed 2.7 kPa and is not influenced by sex, body mass index, or fat content.
PATIENTS AND METHODS  

Study population  

A total of 102 white healthy volunteers (mean [SD] age, 21.5 [1.66] years; range, 20–28; 66 women [64.7%] and 36 men [35.3%]) were included in the study. The inclusion criteria were as follows: no contraindications to magnetic resonance imaging (MRI), no history of liver disease, no family history of chronic liver disease, normal liver enzyme levels, and no medication. All participants were on a normal diet and declared an alcohol consumption of less than 140 g/wk (men) and 70 g/wk (women). All volunteers provided written informed consent to participate in the study.

Magnetic resonance elastography tests were performed in the MRI laboratory of the Centre for Innovative Research in Medical and Natural Sciences (Medical Faculty of the University of Rzeszów, Poland) from December 2017 to May 2018.

Magnetic resonance elastography  

A 1.5T whole-body magnetic resonance scanner (Optima, GE Healthcare, Milwaukee, Wisconsin, United States) was used to perform the MRE scans. Elastography examinations were performed on an empty stomach or 6 hours after the last meal. Volunteers were allowed to drink plain clean water up to 2 hours before the examination. The test was performed with patients in a supine position.

The MRE system includes special acquisition and processing software, as well as hardware consisting of an active and passive driver. The passive driver is a small plastic drum-like device that is placed against the body to transmit mechanical waves into the tissue. In this study, the passive driver was placed on the upper abdomen overlying the right lobe of the liver, with the center of the driver at the level of the xiphisternum. The passive driver was held in place with an elastic abdominal binder strap. The position of the passive driver was chosen so that the largest part of the liver was directly under the driver. Axial MRE slices were acquired (FIGURE 1A); slices were planned on the axial and coronal scout and T2-weighted images such that slices were obtained from the largest cross-section of the liver. For consistency, all sequences were acquired in breath-hold and in end-expiration. Volunteers were instructed to hold their breath in end-expiration for reproducibility of the position of the slice. No intravenous contrast was given.

The passive driver was connected via flexible tubing to the active driver unit, which was located outside the MRI room. The active driver unit generates pressure pulses (at a 60-Hz frequency in this study) that are conducted to the passive driver via flexible tubing.

The MRE images were acquired using a 16-channel abdominal phase array coil.

FIGURE 1  

Magnetic resonance elastography of the liver in a healthy white individual. Axial magnitude image (A), wave image (B), and stiffness map (C) of one slice from the magnetic resonance elastography sequence. The liver is outlined in the wave image and the stiffness map (B and C). Three regions of interest are located in the right lobe of the liver (white circles) (C).
Liver magnetic resonance elastography in a healthy population

**Ethics**
The aim of the study was explained to all volunteers, and written informed consent was obtained from every individual participating in the study. The study protocol was approved by the Ethics Committee at the Medical Faculty of the University of Rzeszów (No. 8/10/2016) and conformed to the ethical guidelines of the 1975 Declaration of Helsinki (6th revision, 2008).

**RESULTS**
All MRE exams were successfully completed. None of the volunteers reported any discomfort during the procedure. The liver stiffness value in healthy volunteers ranged from 1.37 to 2.66 kPa, with a mean (SD) of 2.14 (0.28) kPa (95% CI, 2.09–2.20) ([FIGURE 2](#fig2)).

Liver stiffness values were similar between female and male volunteers (mean [SD], 2.14 [0.3] kPa; 95% CI, 2.07–2.22 and mean [SD], 2.13 [0.25] kPa; 95% CI, 2.05–2.22; respectively; \( P = 0.22 \)) ([FIGURE 3](#fig3)).

Liver stiffness values did not correlate with age (\( r = –0.03, P = 0.76 \)) ([FIGURE 4](#fig4)). The estimated fat fraction in the population ranged from 1.5% to 6.5%, and there was no correlation between the estimated fat content in the liver and mean liver stiffness (\( r = –0.02; 95\% \text{ CI}, –0.21 \) to 0.18; \( P = 0.85 \)) ([FIGURE 5](#fig5)). Similarly, liver stiffness did not correlate with BMI (\( r = 0.001; 95\% \text{ CI}, –0.19 \) to 0.20; \( P = 0.99 \)) ([FIGURE 6](#fig6)).

**DISCUSSION**
In order to correctly interpret liver stiffness values in patients, it is important to determine the reference range in a healthy population, taking into account potential population differences. Ultrasound elastography studies have suggested that normal liver stiffness values may be slightly lower in Asian populations compared with white populations.20-23

Shear-wave imaging was conducted using a modified 2-dimensional gradient-recalled echo-based pulse sequence with the following parameters: matrix size, 256 × 256; slice thickness, 10 mm; repetition time, 33 ms; echo time, 20 ms; flip angle, 30°; and time steps, 4. The resulting wave images ([FIGURE 1B]) were then automatically processed by the scanner, using a manufacturer-provided 2-dimensional direct inversion algorithm to generate quantitative images depicting tissue stiffness (elastograms) ([FIGURE 1C]).14,19

Liver stiffness was measured by placing the regions of interest (on magnitude stiffness maps) at 4 anatomically different slices of the liver. Three regions of interest were placed in each slice, avoiding large vessels, gallbladder, liver edge, and motion artefacts areas, and the stiffness measurement was recorded ([FIGURE 1C]). The mean liver stiffness value was calculated automatically and given in kPa.

Fat fraction was measured using a special technique provided by the manufacturer, called “IDEAL-IQ”, which slices through the entire liver during a single breath-hold at 6 different echo times. The data are automatically processed to generate quantitative maps showing fat fraction.

**Statistical analysis**
Liver stiffness values were presented as mean (SD). The Pearson correlation test was performed to assess the correlation of liver stiffness with age, estimated fat fraction percent of the liver, and body mass index (BMI). The \( \chi^2 \) test was performed to identify significant differences between male and female volunteers. Statistical significance was assumed at a \( P \) value of less than 0.05. Statistical analysis was performed using the MedCalc software (version 18.9.1; Mariakerke, Belgium).

**FIGURE 2** A box-and-whisker plot showing the distribution of mean liver stiffness values in 102 healthy white volunteers. Dots represent the mean values of each volunteer.
Liver stiffness examinations in Asian volunteers were performed in small groups. In a study performed in 5 living liver transplant donors, the stiffness was 2.20 kPa. This value is comparable to that obtained in the present study. Venkatesh et al. reported a slightly lower mean liver stiffness value in Asians (2.09 kPa; range, 1.68–2.48 kPa). In another study, which included 10 Asian volunteers, no stiffness value was reported.

Corpechot et al. demonstrated lower ultrasound elastography liver stiffness in women. Lee et al. examined a group of 49 liver donors and found no correlation between liver stiffness and
sex. In our study, we found no significant differences in liver stiffness between men and women. We also found no correlation between liver stiffness and age, which is consistent with other reports.⁴⁴,⁵⁵,⁶¹

A limitation of our study is that the volunteers were within a narrow age range (20–28 years). Although we found no correlation between liver stiffness and age, future studies should include individuals within a wider age range to confirm the results.

The strength of the study is its objectivity. Normal liver enzyme values were part of the inclusion criteria, which significantly contributes to the reliability of our results. In addition, we included the largest study group compared with all other reports available in the literature.

In conclusion, liver stiffness in a healthy European population did not exceed 2.66 kPa and is not influenced by sex, BMI, or fat content. We believe that our results will contribute to the establishment of normative liver stiffness values, which will translate into a wider application of MRE in clinical practice.
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CONTRIBUTION STATEMENT MO initiated and conceived the concept of the study, co-collected the data, co-led the data analysis and interpreta-
tion, wrote the first draft of the paper, coordinated draft revisions and wrote the final manuscript. VA co-collected the data, led the statistical analysis, and cowrote the first draft of the paper. EO contributed to the data acquisi-
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tion and draft revisions. KG contributed to the study conception and design, data analysis and interpretation, and draft revisions. All authors read and ap-
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CONFLICT OF INTEREST RLE and Mayo Clinic have intellectual property rights and a financial interest in magnetic resonance elastography technol-
ogy. RLE serves as CEO of Resoundant, Inc. Other authors declare no con-
flict of interest.

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