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MICROBEAM RADIATION THERAPY (MRT)

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MICROBEAM RADIATION THERAPY (MRT)

Synopsis

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Microbeam Radiation Therapy (MRT) uses highly collimated, quasi-parallel arrays of X-ray microbeams of 50-600 keV, produced by 3rd generation synchrotron sources. The main features of highly brilliant Synchrotron sources are an extremely high dose rate and very small beam divergence. High dose rates are necessary to deliver therapeutic doses in microscopic volumes, to avoid spreading of the microbeams by cardiosynchronous movement of the tissues. The minimal beam divergence results in the obvious advantage of steeper dose gradients delivered to a tumour target, thus achieving a higher dose deposition in the target volume in fractions of seconds, with a sharper penumbra than that produced in conventional radiotherapy.

MRT research over the past 20 years has yielded many results from preclinical trials based on different animal models, including mice, rats, piglets and rabbits. Typically, MRT uses arrays of narrow (~25-75 micron-wide) microplanar beams separated by wider (100-400 microns centre to centre) microplanar spaces. Peak entrance doses of several hundreds of Gy are surprisingly well tolerated by normal tissues and at the same time show a preferential damage of malignant tumour tissues.

Comparisons between broad beam irradiations and MRT indicate a higher therapeutic index in the latter. A selective radiovulnerability of the tumour vasculature versus normal blood vessels by MRT and the involved cellular and molecular mechanisms are at the origin of these differential effects.

Materials and Methods

The production of such highly collimated, quasi-parallel arrays of X-ray microbeams ranging in energy from 50-600 keV is only feasible at a 3rd generation synchrotron source. The ESRF is currently among the most adequate sources for future clinical trials where the spreading of the microbeams due to cardiosynchronous movement of the tissues can be avoided by extremely rapid dose delivery. Because of the small beam divergence and the adequate photon spectrum (keV), a Multi Slit Collimator (MSC), inserted into the beam, produces and preserves steep dose gradients delivered to a tumour target within a fraction of seconds. The sharp dose gradients between peaks and valleys are preserved even after 15 cm of penetration of the microbeams in the depth of the tissue [1]. A 3D dose profile in a mouse head is presented in figure 1.

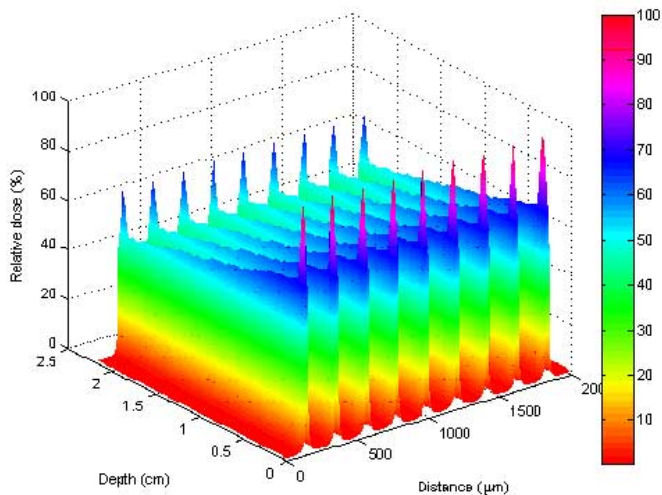


Figure 1: Monte Carlo simulated 3D dose profile of 9 parallel microbeams within a mouse head. The peaks at the entrance and at the exit show the increase in dose due to the presence of bone.

The wiggler source provides, at a distance of 40 m from the storage ring, a beam of about 40 mm in width and 1 mm in height. Thus, to irradiate a tumour volume of approximately 3 cm diameter, the target must be swept vertically through the beam in combination with a very fast shutter system [2] that defines exactly the upper and lower limit of the irradiated target zone.

The production of very regular microbeams is a crucial aspect for MRT. The development in instrumentation included the very first variable MSC (Archer collimator [3]), then the Tecomet MSC [4], and recently the advanced ESRF MSC (EMSC) produced from a solid tungsten carbide piece using new wire cutting techniques [5].

Historical overview in MRT and Summary of most important results

Spatial fractionation of ionizing radiation in the microscopic range was first reported in the sixties. A 25 μm -wide 22 MeV deuteron microbeam, used to simulate the effects of cosmic radiation (Curtis 1967)[6,7], failed to elicit cerebral damage in mice unless absorbed doses were over ~ 3000 Gy (Curtis 1963)[7,8]; the deuterons, however, reached only ~ 1.5 mm tissue depth.

Later, it appeared that "microbeam radiation therapy" (MRT), using arrays of microplanar, synchrotron-generated X-ray beams, safely delivered radiation doses to contiguous normal animal brains that were much higher than maximum doses tolerated by the same normal tissues of animals or patients from any standard millimetres-wide radiosurgical beam (Laissue et al, 1998[9]). Preclinical experiments began in 1995 at the ESRF and have been pursued until today: Schweizer et al. 2000 [10]; Laissue et al, 1999, 2001 [11,12]; Blattmann et al, 2002 [13]; Bräuer-Krisch et al, 2005 [14], P. Regnard et al, 2008[15,16], and by R. Serduc 2008,2009 [17-19].

MRT delivers peak radiation doses up to fifty times higher than other radiosurgeries and spares fast-growing, immature tissues such as the duck brain in ovo (Dilmanian et al, 2001[20]) and the chick chorio-allantoic membrane in vitro (Blattmann et al, 2005[13,21]). In vivo, the cerebella of normal suckling Sprague-Dawley rat pups and of normal weanling piglets were irradiated by arrays of parallel, synchrotron-wiggler-generated X-ray microbeams in doses covering the MRT-relevant range (~ 50 -600 Gy). Most animals developed normally over at least one year after irradiation (Laissue et al, 1999 [11,12], An example of a histological section of the hindbrain of the weaned piglets is shown in figure 2.



Figure 2: Microbeam irradiated normal CNS of weaned piglets (1.5cm x 1.5cm ~28 mm-wide beams ~210 mm on center, 625 Gy). The histological sections look normal, except for "stripes" due to the dropout of neuronal/astroglial nuclei. This sharp spatial fractionation is preserved throughout the cerebellum. No tissue necrosis, hemorrhage or demyelination was observed.

In preclinical trials, intracranial rat 9LGS and mouse EMT-6 carcinomas have been treated by variants of MRT; the growth of nearly every tumour was suppressed, at least temporarily, and many tumours were ablated (Laissue et al, 1998[9]; Dilmanian et al, 2002, 2003[22,23]; Smilowitz et al, 2006[24]). Even the extraordinarily radiation-resistant and fast-growing murine squamous cell carcinoma VII has been palliated by MRT (Miura et al, 2006[25]). For the intracerebral 9LGS, estimates of the therapeutic index of MRT versus broad-beam treatment indicate a ~5-fold advantage, with a normal tissue tolerance = 10-fold higher for peak microplanar versus seamless doses of radiation (Dilmanian et al, 2002[22]). In conventional radiotherapy, the effect of changing an irradiation parameter, e.g., the dose fractionation schedule, is predictable. Conversely, methods to predict the effect of varying MRT parameters such as array width and height, slit width, centre-to-centre spacing, number of ports, energy spectrum, dose microdistribution and schedules for temporal fractionation (Serduc et al, 2009[18]) or geometric adjustments (Bräuer-Krisch et al, 2005[14,26]) of multidirectional MRT are only beginning to be developed.

During the last 10 years, major progress has been made to better understand the underlying biological mechanisms, use the feature of MRT increasing the permeability of the tumour vasculature to inject additional drugs or dose enhancing agents as well as developments in Medical Physics to prepare clinical trials at the ESRF. Novel approaches for treating certain epilepsies show equally very promising results. Microbeams are used in fundamental research to create microscopic lesions to study mechanisms of certain neurological diseases.

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