A Concise Review of the Emerging Applications of Synchrotron-Generated Microbeams in the Treatment of Brain Disorders

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Abstract

Synchrotron-generated X-ray microplanar beams (microbeams) are characterized by the ability to avoid widespread tissue damage following delivery of doses ranging from hundreds to over a thousand Gray. The preservation of tissue architecture following high-dose microbeam irradiation is known as ‘tissue-sparing effect’ and is strictly related to the ability of microbeams to restrict spatially these exceedingly high doses to the beam path with minimal doses spreading outside to the adjacent tissue. Image-guided microbeam radiosurgery has been recently used to generate cortical transections or to induce deep-seated lesions in the rat brain. The ability to generate focal lesions or microscopic transections over the eloquent and non-eloquent cortex in experimental animals is of great interest for the development of experimental models in neurobiology, opening new treatment avenues for a variety of neuropsychiatric disorders originating from focal brain dysfunction. This paper reviews the current state of research on the radiobiological properties of synchrotron-generated microscopic X-ray beams and their emerging microradiosurgical application, with special reference to the treatment of a variety of brain disorders.

Categories: Neurosurgery
Keywords: spine, radiosurgery, cortex, movement disorders, transections, microbeams, synchrotron, brain, epilepsy

Introduction And Background

Stereotactic radiosurgery aims to attain growth-control through the ablation of a neoplastic lesion, to induce the obliteration of vascular malformations or to restore the correct functioning of a neural circuitry by modulating or ablating selected brain nuclei or fiber bundles. The ablation of the tissue contained within a well-defined target is achieved through the precise delivery of several hundreds of ionizing radiation beams sized 4 to 60 mm sent from a wide array of directions and intersecting over the volume selected for ablation with 3 to 5 mm 80% to 20% dose fall-out from the volumetric boundaries of the target. There is growing evidence that synchrotron-generated microscopic beams (microbeams) beams can carry much higher doses to the target as compared to conventional high-energy photons or gamma irradiation. Microbeams beams are characterized by the ability to carry extremely high doses without inducing damage to surrounding tissue. This paper aims to offer a concise review of the state of microbeam research applied to the CNS with special reference to the potential new clinical applications that can be explored.

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Review

Synchrotron-generated X-ray beams are tangentially emitted by relativistic electron bunches circulating in the storage ring of a synchrotron radiation facility. The X-ray source is a wiggler (a magnetic structure of alternating poles positioned on a straight section of the storage ring) producing a wide spectrum of photons with an energy range up to several hundreds of kilo electronvolts (keV). The quasi-laminar beam can be spatially fractionated into an array of rectangular microbeams of variable size by means of a multislit collimator [1]. The X-ray fluence is thousands of times higher than that of standard linear accelerators used in conventional radiotherapy. At the European Synchrotron Radiation Facility (ESRF, Grenoble, France), shown in Figure 1, the dose rate is around 16,000 Gy per second. This dose output is much higher than those available using conventional linear accelerators delivering up to 6 Gy per second. The minimal beam divergence of synchrotron X-rays allows the delivery of extremely high doses to the cells along the penetration path with minimal dose dispersion over the adjacent cells. Depending on the microbeam size, typically between 25 to 75 microns, a quasi-surgical cut involving a width comprising up to 3-4 neuronal cell bodies can be generated along the tissue penetration path (see figure 2). The delivery of an array of parallel beams generates alternating volumes receiving peak doses of several hundreds of Grays and valley doses of a few Grays (see figure 3). The beam distance center-to-center is variable from 100 to 400 gm, depending on the collimator choice and settings. The biological properties of larger beams measuring up to 0.7 mm (also known as minibeam) have been investigated lately. Minibeam could be generated without a synchrotron and can facilitate clinical use [2, 3]. For an overall description of the dosimetric methods, definitions, and calculations, please refer to the references [4, 5].
FIGURE 2: Haematoxylin-Eosin staining showing a quasi-surgical cut through the rat cortex 3 months after the delivery of a microbeam array (incident dose of 600 Gy, beam thickness: 75 µm, spacing: 400 µm).

Scale bars (placed at the bottom of the microbeam paths): 75 µm
Radiobiology of central nervous system microbeam irradiation

The Central Nervous System (CNS) radiobiology of microplanar beams was first studied about 50 years ago at the Brookhaven National Laboratory (BNL) by Curtis and coworkers. This group was the first to describe the preservation of CNS architecture after incredibly high radiation doses delivered by microscopic deuterium beams. An incident dose of 4000 Gy delivered to the mouse brain by a 25 gm-thin cylindrical microbeam failed to induce radionecrosis, which instead appeared after an incident dose of 140 Gy delivered as a 1-mm thick cylindrical beam [6, 7, 8]. Further work performed in the late nineteen at the National Synchrotron Light Source (NSLS) of the BNL using synchrotron-generated X-ray microbeams, and, later on, at the ESRF, investigated further the tissue tolerance to microscopic beams at doses tens to hundreds time larger than those allowed by conventional macroscopic beams [9, 10, 11, 12].

Unidirectional irradiation using microbeam arrays has been delivered to adult rat brain [11, 13, 15, 16], suckling rats cerebellum [16], piglets cerebellum [1], duckling embryo brain [18], skin and muscle of the mouse leg [19, 20], rat leg [21] and rat spinal cord [12]. The exceptional resistance of the normal-tissue to high dose microbeam irradiation with no evidence of late tissue effects [12, 22, 23, 24] lead to the development of a new concept in radiobiology, the tissue sparing
effect, described in the next paragraph.

**The tissue-sparing effect**

Microbeam irradiation is characterized by minimal side effects on normal tissue adjacent to the irradiated volume. While the cells along the path of penetration of the beams are completely destroyed, the nearby cell bodies remain unaffected with substantial preservation of the tissue architecture. In essence, microbeam irradiation acts like a surgical cut, leaving a scar extending up to the size of the penetrating beams. The lack of normal tissue damage following high dose unidirectional irradiation using arrays of microbeams is referred to as 'tissue sparing effect'. The tissue sparing effect is bound to the microbeams size: very high doses (up to 4000 Gy) can be delivered through microscopic beams sized 25 to 60 gm with no histological evidence of widespread radionecrosis outside the penetration path. Immunohistochemical studies using pH2AX show clearly that the neurons hit by the microbeam along his penetration path die almost immediately while the adjacent cells separated by a few microns but outside the high dose volume remain viable (unpublished personal data). Progressively lower doses (but still much higher than conventional radiosurgical or radiotherapeutic doses) are required to avoid tissue damage if ticker beams (100 to 600 gm) are used. Submillimetric beams (sized 0.6 to 0.7 mm) appear to retain the tissue sparing effect allowing to deliver incident doses of 400 Gy to the spinal cord of rats without inducing neurological damage: irradiation of rat spinal cord with four parallel 0.68-mm thick microbeams at 400 Gy in-depth beam dose did not induce paralysis after 7 months in three out of four rats [12]. This study showed not only that a highly radiosensitive structure such as the spinal cord can receive high dose irradiation through a microbeam array without neurologic sequelae but also that a beam width up to 0.68 mm is well tolerated, substantially maintaining the tissue sparing properties of thinner beams.

**Microbeam radiosurgery**

The ability of microbeam arrays to avoid radionecrosis and to preserve the architecture of the irradiated tissue is mainly attributed to the rapid regeneration of normal microvessels. Only a short segment of the microvascular bed receives ablating doses while the adjacent endothelial cells fall into the valley dose region receiving just a few Gy and can restore quickly the continuity of vascular supply [24]. The wide spatial interface between the unhindered tissue placed in the valleys and the tissue irradiated with peak doses within the microbeam paths facilitates a widespread vascular recolonization of the tissue receiving necrotic doses preventing the dissolution of the architecture of the irradiated tissues [3]. The self-repair of the normal microvasculature through the migration of unaffected cells surrounding the paths of microbeam penetration is considered by most as the basis for this ability of normal tissue to tolerate high dose microbeam irradiation [25, 26]. The tolerance of the vascular bed to high dose microbeam irradiation has been clearly demonstrated by the lack of extravasation of dyes administered to the experimental animals, which remained confined in the vessels after irradiation from 12h until three months following 1000 Gy [27]. This radioresistance phenomenon was not observed in 9L glioma microvessels, confirming the presence of a differential response to between normal and tumour brain tissues in rodents, an effect that can have significant clinical applications [19]. The neoplastic vasculature appears to be unable to replicate the fast repair of the segments hit by the peak dose, facilitating the development of radionecrosis over the irradiated tumor [12, 20, 28].

The unidirectional delivery of microbeam arrays to parts of the body harbouring neoplastic tissue is known as Microbeam Radiation Therapy (MRT). MRT irradiation has been carried out to deliver very high radiation doses into tumours in a single fraction through an unidirectional approach [11, 15]. Most of the experimental activity performed until now has been focused on the study of the effects of arrays of parallel microbeams [4, 5, 9-24, 28-30]. MRT has been applied to several tumor models including intracerebral gliosarcoma (9LGS) in rats [11, 15, 50], murine mammary carcinoma (EMT-6) [19] and human squamous-cell carcinoma (SCCVII) in mouse and rat [9, 20].
Rats bearing the intracranial 9L gliosarcoma irradiated anteroposteriorly with arrays composed of 27 gm thick microbeams spaced 100 gm on-center showed a clear survival advantage after MRT: 4 out of 14 rats irradiated at 625 Gy incident doses were long-term survivors with little brain damage revealed in histopathology [11]. The introduction of stereotactic techniques to deliver arrays of microbeams that interlace over a selected target volume [31, 12] has recently opened a new field of research that is by most considered as an extension of MRT but is much closer to the stereotactic radiosurgery experience.

The authors prefer to name this technique characterized by the stereotactic delivery of microbeams to a selected target volume as Microbeam RadioSurgery (MRS). MRS is currently performed at the ESRF biomedical beamline by: 1) directing beams to the target in a convergent isocentric fashion (creating a hot spot where the dose is enhanced by the overlapping of the beams) or 2) by interlacing 2 to 4 microbeam arrays over the target. MRS has been used at ESRF to ablate selected volumes (such as the subthalamic nucleus, the substantia nigra and the caudate nucleus) into the rat brain using both approaches. The ability to induce precise lesions in the rat brain using an image-guided non-invasive approach opens new ways to create experimental models of disease. For example MRS nigrotomies could offer a novel experimental model to study Parkinson’s disease (PD): experiments are underway to assess if MRS can replace or complement other PD experimental models of PD based on the induction of chemical lesioning of the Substantia nigra. A novel way to use microbeam arrays in a quasi-surgical way is currently being developed at ESRF: convergent or parallel arrays of microbeams carrying high doses are placed over selected cortical areas in order to hit tangentially and cut the horizontal axons connecting adjacent cortical columns. Cortical transections are a surgical procedure to parcellize an epileptic focus located in eloquent cortex [32, 33]. Cutting the horizontal axons required for the spreading of epileptic activity is an effective way to control the seizures without inducing neurologic dysfunction. Synchrotron-generated microbeams can be used to create cortical transections in rats offering a chance to study the tolerance of CNS to this technique.

This novel experimental application of microbeams provides a new and attractive tool to modulate cortical function by transecting the fibers connecting the cortical columns. Aside from the tight dosimetry, the relative low energy of the microbeams (continuous X-ray spectrum ranging from 50 to —350 keV, mean energy —100 keV) makes them well suited to treat superficial targets within the cortex. Microbeam transections, either placed over neocortical seizure foci or through the hippocampus, could prove to be an excellent tool to be added to the current radiosurgical techniques used to control seizures. A series of experiments are currently planned at ESRF aiming at the development of an experimental model of microbeam cortical transections in epileptic rats with the goal of verifying the ability of microbeam cortical transections to control seizures without damage to the eloquent cortex irradiated. Figures 4, 5 illustrate the irradiation room and stereotactic set-up at ESRF.
FIGURE 4: Irradiation room at ESRF, located at about 45 meters from the synchrotron radiation wiggler source. The sample positioning system is a Kappa-goniometer, that combined with an X-ray on-line X-ray detection system, allows for a submillimetric identification of the target. On the picture, a water tank for dosimetry is positioned on the Kappa goniometer.

FIGURE 5: Stereotactic set-up used for rat brain irradiation. For the prepositioning of the target, based on external markers, 3 high resolution video-cameras are installed. Bottom right: the X-ray radiography, taken just before the irradiation, allows for the submillimetric identification of the target.

Conclusions
The irradiation of normal brain and spinal cord with microbeam arrays is characterized by a distinct tissue-sparing effect. Peak doses between 300 and 600 Gy are in most cases well tolerated by the CNS with little or no histological evidence of brain damage. Fast sprouting and recovery of the microvascular bed has been observed in normal CNS tissue while the inability of neoplastic vascular network to repair itself exposes neoplastic tissue to an enhanced tumoricidal effect. Microbeam radiosurgery is able to induce non-invasively microradiosurgical lesions in the rat brain, thus offering a new way to develop experimental models to study PD, Huntington’s disease and many other CNS disorders. A recent development of microbeam research is the use of arrays of microbeams to induce cortical transections aiming to modulate cortical function through the selective cutting of horizontal axons connecting adjacent columns.

Additional Information

Disclosures

Conflicts of interest: The authors have declared that no conflicts of interest exist.

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