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Aspects of photodetection in cervical and ovarian neoplasia

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Chapter 3

White light toxicity, resulting from systemically administered 5-ALA, under normal operating conditions

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Abstract

This study investigated damage to the intraperitoneal organs of the rat after systemic (intra-peritoneal and intra-venous) administration of low doses of 5-Aminolevulinic acid (ALA) and illumination with a standard white light operating-room (o.r.) lamp. This study was done within the framework of a larger study in which the possibility of using ALA for localization of small volume macroscopically non-visible peritoneal metastases of ovarian tumors is being investigated. Fluorescence diagnostics will be done in addition to the standard staging and localization procedures, either through a laparoscope or during laparotomy. In these circumstances, fluorescence diagnostics involves some risk of photosensitization of critical organs since a broad band (o.r.) light source is used during the surgical procedures for illumination of the operating area. The drug dose and the time interval between administration of ALA and illumination were varied and normal tissues were examined both macroscopically and microscopically for damage. A relationship was demonstrated between the maximum tolerable dose (MTD) of ALA (defined as the dose which did not cause any tissue damage) and the time interval between administration and illumination. White light which is used for illumination of the operating area was sufficient to induce damage to the peritoneal organs at relatively low ALA doses. The MDT's for a two, six and sixteen hour interval were found to be 1, 10 and 100 mg/kg respectively. The results were similar for both intra-peritoneal and intra-venous administration.

Introduction

In the majority of patients with ovarian cancer the diagnosis is established at an advanced stage, when spread has already occurred into the abdominal cavity. Standard staging procedure in ovarian cancer without overt spread is done by taking multiple blind biopsies at random from peritoneal surfaces for microscopical examination. The risk of understaging and subsequent undertreatment with this non-directed staging procedure is high.

The problem of possible understaging may be solved by using a fluorescence diagnostic technique as a tool for tumor localization. In this technique, a fluorescent dye is administered and distributed in the body, resulting in concentration gradients which can be used to discriminate normal from tumor tissue. 5-Aminolevulinic acid (ALA) induced Protoporphyrin IX (PpIX) is an effective fluorescent agent, which has been successfully used for the detection of malignancies¹⁻⁶. Hornung *et al.*¹ showed that in ovarian cancer ALA may improve detection of superficial malignant lesions in the abdominal cavity during staging and second look surgery by enabling directed non-blind biopsies.

ALA is metabolized to PpIX, a precursor of haem, which will selectively accumulate in tumor tissue. Apart from being fluorescent, PpIX is also a potent photosensitizer. For diagnostic applications the photosensitizing effect is unwanted as this may cause damage to healthy tissue. The extent of photosensitization depends on the dosage of ALA and the interval between administration of ALA and exposure to light, and is highly dependent on the excitation light source properties. Fluorescence diagnostics in ovarian cancer will be carried out during staging laparotomy or laparoscopy. Photosensitized tissue will then be exposed to broad band white light from the operating room lamp or endoscopic light source. Concern arises as to whether ALA will induce damage to critical abdominal organs when exposed to white light. Hornung *et al.*¹ did not report on this aspect.

In the present study we investigated the macro- and microscopic damage caused by ALA induced protoporphyrin IX to the abdominal organs of the rat when exposed during laparotomy to a white light operating room lamp. Several ALA doses and time intervals between ALA administration and light exposure were tested and intraperitoneal (i.p.) administration of ALA was compared with intravenous (i.v.) administration. The aim of our study was to establish a range of doses of ALA in combination with different time intervals which can be used safely in staging procedures for ovarian cancer without the appearance of photosensitization effects to abdominal tissues.

Materials and methods

Animals, drug dose and illumination properties

Adult female Wistar rats (i.p. injections; n=41) or Wag/Rij rats (i.v. injections; n=22) of approximately 200 grams body-weight were used. The animals received ALA dissolved in PBS by an intra-peritoneal or intra-venous injection. The dose of i.p. ALA varied from 1 to 200 mg/kg and the time interval between ALA administration and illumination during laparotomy was 2, 6, 16 or 24 hours. For the i.v. administration route, drug doses of 1 to 100 mg/kg and time intervals between ALA administration and the procedure of 2, 6 or 16 hours were used. The experiments were started at an i.p. ALA dose of 200 mg/kg and a time of 2 hours. These conditions were expected to induce evident macroscopic and microscopic damage to intra-abdominal organs^{7,19,20} thus giving an insight into the kind of tissue/cellular damage to be expected. The dose of i.p. ALA was subsequently decreased (100, 25, 20, 15, 10, 5, 1 mg/kg) until no more signs of macroscopic and microscopic damage to healthy tissue were found. This dose was considered to be the Maximum Tolerable Dose (MTD) of i.p. ALA for a 2 hrs interval between administration and the surgical procedure. Based on the information gained from the 2 hrs interval series, experiments at the other time intervals (6, 16 and 24 hours) were performed in the opposite way by starting at a low, probably non toxic dose of ALA, and increasing this dose until signs of macro-and/or microscopic damage were found and the MTD could be established. The MTD estimated from the i.p. experiments were used as starting doses for the i.v. dose finding experiments. Two rats were used at each dose level, and the MTD for each time interval was confirmed by an additional 2 rats. Control groups were also included which received no ALA but otherwise received the same treatment.

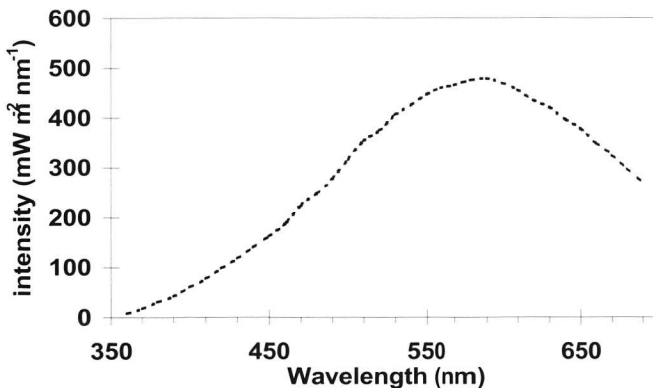


Figure 1 : Power spectrum of the Hanau operating lamp used. Total output 100 W/m² in focal plane.

All experiments were performed under the same illumination conditions using a standard operating room light source (Original Hanau, model 3120). The power spectrum of this lamp, depicted in Figure 1, was measured with a calibrated Optical Multichannel Analyzer (Oriol, model

77702, spectrograph MS125, calibrated with a model 63355 calibration lamp). We calculated the effective power spectrum, defined as the product of the (normalized) excitation spectrum of the photosensitizer and the power spectrum of the light source²³. The effective power spectrum expresses the effectiveness of a certain light source for the excitation of a certain photosensitizer. Using this expression, extrapolation of our results to other clinical settings is possible. For future purposes we also calculated the effective power spectrum of an endoscope light source.

Experiments

Prior to the surgical procedure the rats which received i.v. ALA were anesthetized with Ketamine (90 mg/kg body weight, i.m.), Xylazine (10 mg/kg body weight, i.m.), and Atropine (0.05 mg/kg body weight, i.m.). The rats which received i.p. ALA were anesthetized by Dormicum (1 mg/kg body weight i.p.) and Hypnorm (1 mg/kg body weight i.p.). A midline incision was made from xiphoid to symphysis. A surgical retractor was placed *in situ* which kept the internal abdominal wall folded outside and the intra-abdominal organs exposed to the light source. This situation was maintained for two hours with the light source at a working distance of 90 cm. Two animals were treated simultaneously. The intra-abdominal organs were kept moist during the procedure with Ringers solution at 37 °C. To maintain body temperature, an electrical temperature controlled underlay (37 °C) was used. During the procedure, liver, small and large intestines, peritoneum, skin and bladder were macroscopically observed for changes and signs of damage according to a standard list. After two hours the surgical procedure was ended and the abdominal skin was sutured. The rats were housed in dimmed lighting. Post-operative pain was suppressed with Buprenorphin (0.2 ml/kg i.m). The rats were sacrificed after 72 hours. At re-laparotomy the above mentioned organs were observed for macroscopic changes. Samples were taken from the liver, small and large intestines, peritoneum, skin and bladder in a standardized way and stored in formalin before being sectioned (5 µm sections) and stained (hematoxylin and eosin) for histological examination.

Results

General observations

In the period between administration of ALA and the start of surgery, the rats showed no sign of discomfort, although the ALA solution was acidic (pH 2.5-5). In one rat, a small amount of ALA solution was accidentally injected into subcutis and muscle. Necrosis of the muscle was only seen at 16 hours after administration of ALA. I.v. injection in the tail vein sometimes resulted in a local hemorrhage.

Macroscopic observations during the procedure

In the control group, which received no ALA and/or saline solution, no changes to intra abdominal organs could be observed during and after two hours of illumination.

Two animals (200 mg/kg i.p. 2 hour interval) died almost immediately after the procedure. The macroscopic observations during the illumination procedure are summarized in Table 1 for the various combinations of ALA dose (mg/kg) and time interval (hours) between administration and illumination.

In the exposed (illuminated) part of the liver, we observed a change in color during illumination, either reddening or blanching and edema, after administration of 5 mg/kg for a time interval of two hours, 10 mg/kg for a time interval of 6 hours and 100 mg/kg for a time interval of 16 and 24 hours. In all cases, the surface remained intact. A change in appearance of the small and large intestines was observed after administration of 20 mg/kg ALA for intervals of two and six hours and 200 mg/kg at 16 hours. A swelling of the intestinal wall was typically seen, together with focal hemorrhages on the outer surface. The visual appearance of the other intra-abdominal organs and the abdominal wall including the skin was not macroscopically changed during the procedure.

The macroscopic observations during illumination after i.v. administration of ALA were comparable to those obtained in the i.p. group (see table 2).

Table 1: The combinations of ALA doses (mg/kg) and time intervals (hours) between i.p. administration and treatment at which damage is observed (macroscopic damage, during illumination). The organs that were judged as damaged are named in the boxes.

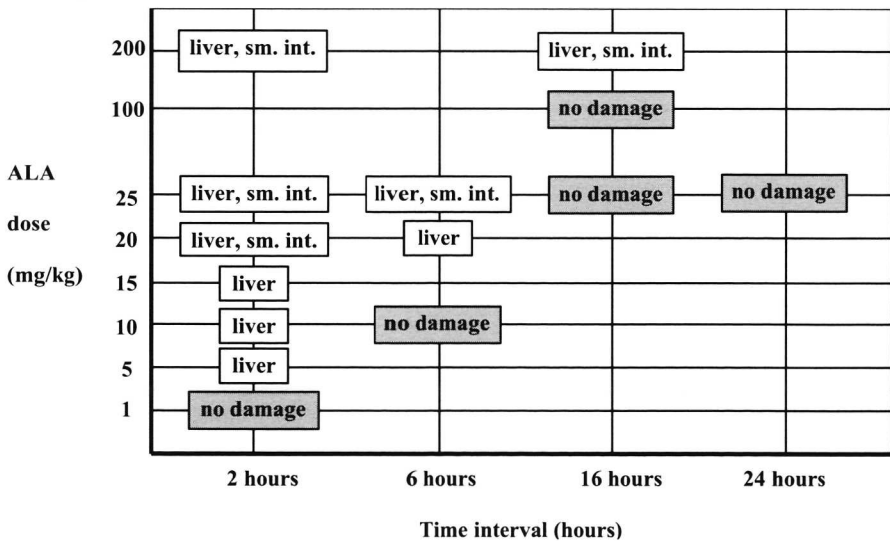
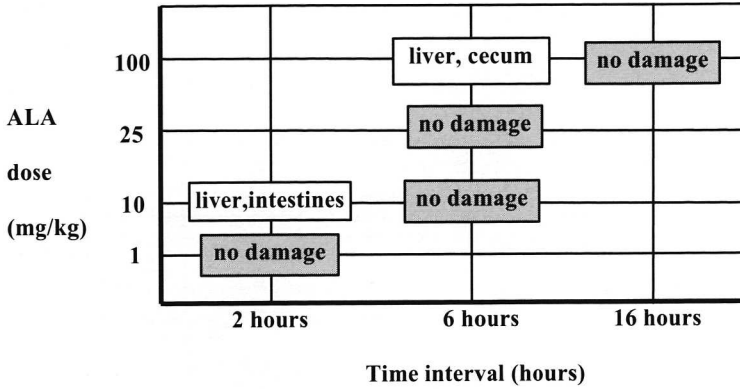


Table 2: The combinations of ALA doses (mg/kg) and time intervals (hours) between i.v. administration and treatment at which damage is observed (macroscopic damage, during illumination). The organs that were judged as damaged are named in the boxes.



Macroscopic observations after 72 hours

In the control group, which received no ALA and/or saline solution, no changes to intra-abdominal organs were observed. During the three days after the procedure, the animals showed no change in behavior and weight loss was limited to a maximum of 15% which was not different to the weight loss seen after surgery alone.

The macroscopic observations after 72 hrs are summarized in tables 3 and 4. Findings were comparable to those found during the surgical procedure. The discoloration of the

Table 3: The combinations of ALA doses (mg/kg) and time intervals (hours) between i.p. administration and treatment at which damage is observed (macroscopic damage, 72 hours after illumination). The organs that were judged as damaged are named in the boxes.

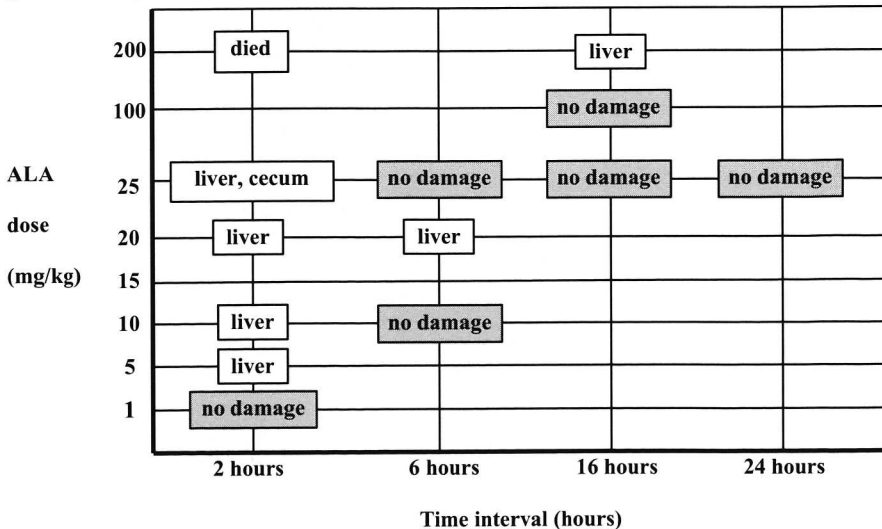
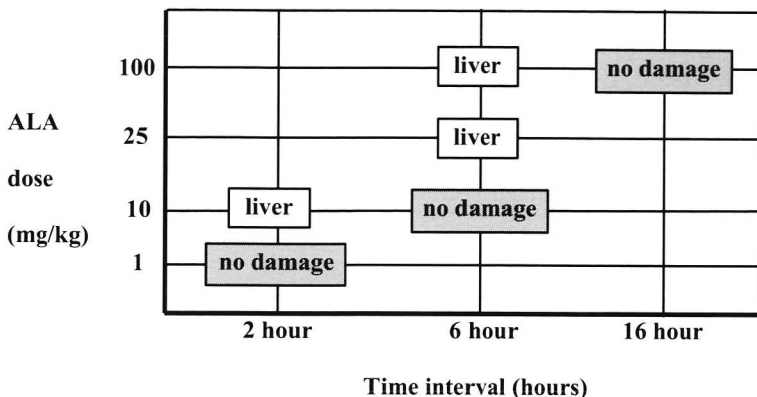


Table 4: The combinations of ALA doses (mg/kg) and time intervals (hours) between i.v. administration and treatment at which damage is observed (macroscopic damage, 72 hours after illumination). The organs that were judged as damaged are named in the boxes.



liver observed during the illumination was, in most cases still noticeable after 72 hours. Additionally, in these cases a white line was observed which delineated the illuminated area. The swelling of the intestines had disappeared in all cases. In a few cases a faint reddish discoloration was still present. No macroscopic changes to the other intra-abdominal organs could be observed. Findings were similar for both i.v. and i.p. treated rats.

Microscopic observations

Microscopic damage was limited to the liver and the intestine (wall). A typical example of the changes due to white light illumination of the small intestine is shown in Figure 2 (i.p., 25 mg/kg, 2 hrs interval). The outer layers, muscularis and submucosa, were intact while the mucosa on the side of the bowel exposed to light (A) has completely disappeared. The opposite mucosa, shielded by feces from light, remained intact. Figure 3 shows the damage to the liver of the same rat. A clearly demarcated area with cell damage is seen at the illuminated side. The thickness of this damaged layer is approximately 0.4 mm. The damage of both the liver and intestines was focal. In one rat (i.v., 25 mg/kg, 6 hrs interval) a necrotic superficial vessel wall was observed in the liver. We have not seen any abnormalities in other abdominal organs. In the control group no damage was seen to illuminated organs.

Maximum tolerable dose (MTD)

To obtain the MTD (no sign of macroscopic or microscopic damage) for the tandem dose of ALA and time interval, we combined the results from tables 1 and 2 (macro-

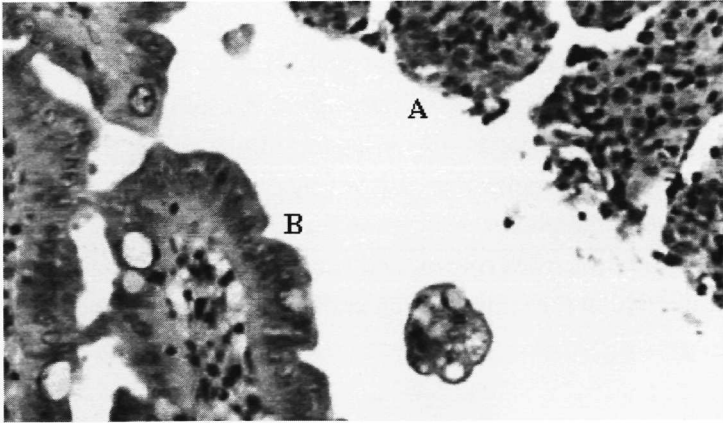


Figure 2: Small intestine wall. (dose i.p. 25 mg/kg, interval 2 hours) A; On the illuminated side the mucosa has disappeared, while at the dark side (B, shielded from the light by feces) the mucosa is still intact. The other layers remained intact.

scopic observations during the procedure), Tables 3 and 4 (macroscopic observations after 72 hours) and the microscopic observations. For the 2 hrs interval the MTD was established at 1 mg/kg; for the 6 hrs interval the MTD was established at 10 mg/kg and for the 16 hours interval the MTD was established at 100 mg/kg.

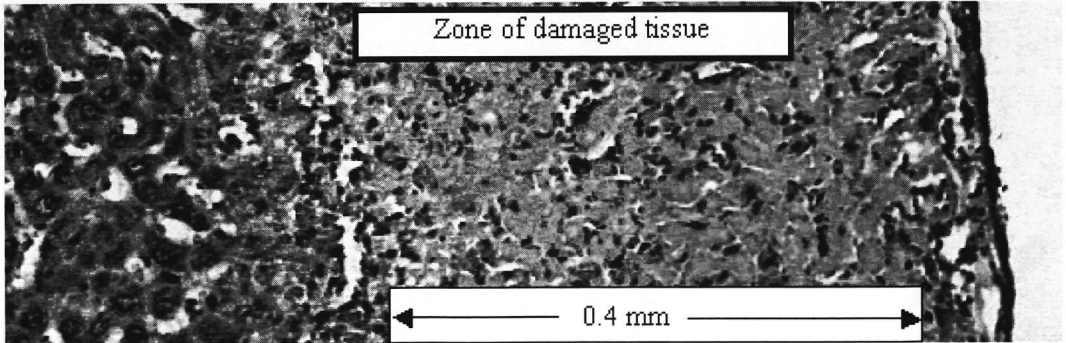


Figure 3: zone of cell damage at the illuminated side of the liver (dose i.p. 25 mg/kg, interval 2 hours)

Effective power spectrum

The effective power spectrum of the operating room light used in these studies and the relative excitation spectrum of PpIX are depicted in Figure 4. For comparison, Figure 5 shows the effective power spectrum of an endoscope white light source (100 W Xenon) with the absolute power spectrum measured 5 cm from the distal end.

Discussion

Photodetection using ALA (induced porphyrin IX) may be an attractive new diagnostic development in ovarian cancer diagnostic strategies. Photodetection can be added to current staging procedures like laparoscopy or laparotomy enabling the localization of macroscopically non-visible metastases. However, fluorescent diagnostics carry a risk of damage to tissue due to the photosensitization properties of PpIX. This risk is determined by illumination properties (power and wavelength) of the light source, the dose of photosensitizer, interval before illumination and the type of tissue/organ. During the

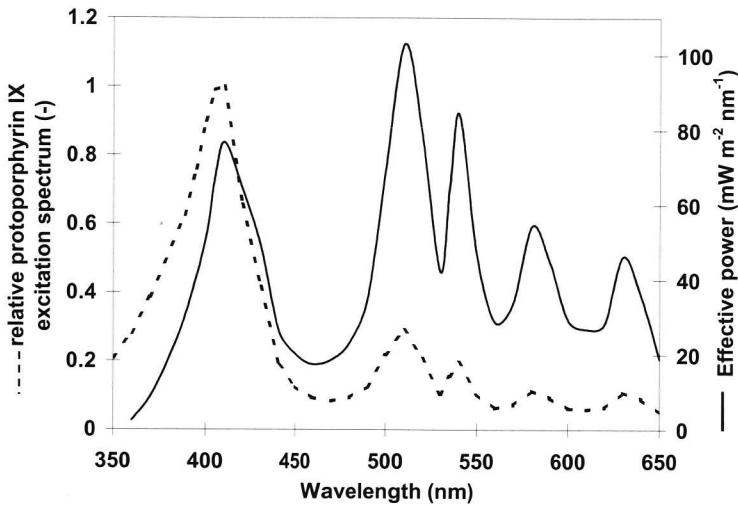


Figure 4: the relative absorption spectrum of protoporphyrin IX (dashed line) that we used to calculate the effective power spectrum of the OR lamp (full line)

photodetection assisted staging procedures, which can last several hours, the abdominal cavity will be exposed not only to blue light from the excitation source but also to intense white light from the endoscopic light sources or OR room lamps. In order to minimize the risk of phototoxic damage in future photodetection assisted staging procedures, we established safe ALA dose/time intervals when using white light sources in a rat model.

Safe doses (MTD's) were established at 1, 10, and 100 mg/kg for intervals of 2, 6 and 16 hours respectively for both i.v and i.p. routes of administration. As can be expected the shorter the time interval, the lower the MTD for ALA. Low dosages of ALA may not be very useful in photodetection. The success of photodetection diagnostics is based on differences in concentrations of photosensitizer between normal and tumor tissue and low

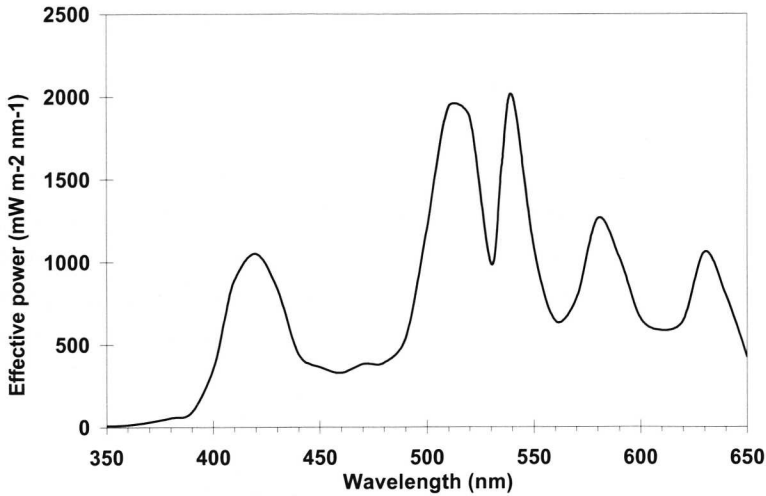


Figure 5: The effective powerspectrum of a white light endoscope (Xenon)

ALA doses may not give enough contrast. In that case, a higher ALA dose at a longer time interval should be used for clinical applications. Recently Hornung published on photodetection diagnostics of carcinomatosis in the (rat) abdominal cavity using ALA in combination with a blue excitation light source¹. He observed the best contrast between tumor-fluorescence and normal (peritoneum) fluorescence in the abdominal cavity 3 hours after administration of 100 mg/kg ALA. The combination of this relatively high drug dose and short time interval (between administration of ALA and illumination) would result in considerable tissue damage when exposed to the illumination conditions that we used in our experiments.

When evaluating the safety of photodetection diagnostics, both the severity and the (ir)reversibility of any induced damage of healthy tissue have to be taken into account. In this study we considered any macroscopic or microscopic change in organs as phototoxic damage. Phototoxic damage appeared to be restricted to the liver and small bowel. The observed damage would probably have little impact on the functionality of the organs involved, particularly in the liver where damage was limited to a superficial layer (0.4mm). Damage to the intestinal wall was limited to the mucosa whereas the muscular wall remained intact. Our study was limited to an evaluation of damage at 72 hours after illumination. Longer follow-up would, presumably, indicate regeneration of the damaged mucosa from unaffected areas. The chance of severe complications, like bowel perforation, therefore seems to be limited. Nevertheless our results in rats indicate that caution should be taken when applying photodetection diagnostics using intense light sources.

So far no clinical studies mention any phototoxic damage as a possible side effect of photodetection diagnostic procedures, even if white light sources are used. The discrepancy between our rat data and these clinical observations could be related to the larger mass of human organs with any damage being restricted to superficial layers without functional consequences. However, this has not been systematically evaluated and the impression remains that possible damage might be overlooked in clinical studies. Our intention was not to give absolute safe doses for humans but rather to demonstrate the potential for toxic side effects during photodetection procedures with high doses (and short intervals) of ALA. The study also indicates conservative safe doses where no damage is to be expected.

Suggestions of Precautions

To avoid phototoxicity in normal tissues during photodetection procedures the following should be considered: phototoxicity is determined by the light source properties, the dose of ALA and the interval between application and surgical procedure. In photodetection diagnostics via laparoscopy and laparotomy the use of white light can not be avoided. Modifications to the light source by using filters for blocking the blue part of the light source spectrum is not very effective as only a small influence on the effective power is obtained. In contrast to a common misunderstanding, the white light source of an endoscope is about 20 times more effective in causing damage to sensitized tissue than an OR lamp (as demonstrated in Figure 5). This leaves the time of exposure and the drug dose as potential variables in diminishing damage. In a clinical setting a time interval has to be used where the ALA dose is below MTD but sufficient to enable discrimination between normal and tumor tissue.

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