The Hamster Cheek Pouch as a Model of Oral Cancer for Boron Neutron Capture Therapy Studies: Selective Delivery of Boron by Boronophenylalanine

Erica L. Kreimann, Maria E. Itoiz, Alejandra Dagrosa, Ricardo Garavaglia, Silvia Farías, Daniel Batistoni, and Amanda E. Schwint


ABSTRACT

Herein we propose and validate the hamster cheek pouch model of oral cancer for boron neutron capture therapy (BNCT) studies. This model serves to explore new applications of the technique, study the biology and radiobiology of BNCT, and assess the uptake of boron compounds and response of tumor, precancerous tissue, and clinically relevant normal tissues. These issues are central to evaluating and improving the therapeutic gain of BNCT. The success of BNCT is dependent on the absolute amount of boron in the tumor, and the tumor:blood and tumor:normal tissue boron concentration ratios. Within this context, biodistribution studies are pivotal. Tumors were induced in the hamsters with a carcinogenesis protocol that uses dimethyl-1,2-benzanthracene and mimics spontaneous tumor development in human oral mucosa. The animals were then used for biodistribution and pharmacokinetic studies of boronophenylalanine (BPA). Blood, tumor, precancerous pouch tissue surrounding tumor, normal pouch tissue, tongue, skin, cheek mucosa, palate mucosa, liver, and spleen, were sampled at 0–12 h after administration of 300 mg BPA/kg. The data reveal selective uptake of BPA by tumor tissue and, to a lesser degree, by precancerous tissue. Mean tumor boron concentration was 36.9 ± 17.5 ppm at 3.5 h and the mean boron ratios were 2.4:1 for tumor:normal pouch tissue and 3:2:1 for tumor:blood. Higher doses of BPA (600 and 1200 mg BPA/kg) increased tumor uptake. Potentially therapeutic absolute boron concentrations, and tumor:normal tissue and tumor:blood ratios can be achieved in the hamster oral cancer model using BPA as the delivery agent.

INTRODUCTION

BNCT is a binary treatment modality that involves the selective accumulation of $^{10}$B carriers in tumors followed by irradiation with a thermal or epithermal neutron beam. The high linear energy transfer $\alpha$ particles and recoiling $^7$Li nuclei emitted during the capture of a thermal neutron by a $^{10}$B nucleus (1, 2) have a range of approximately 5–9 μm in tissue and are known to have a high relative biological effectiveness (3). Thus, BNCT would potentially target neoplastic tissue selectively (4, 5). The basic requirements for a therapeutic advantage for BNCT are a high degree of selectivity for the accumulation of $^{10}$B in tumor relative to the surrounding normal tissues and a sufficiently high absolute concentration of $^{10}$B in tumor tissue (6). As during any radiation therapy, the therapeutic tumor dose is limited by the tolerance of the surrounding normal tissue within the treatment volume (7).

Clinical trials of BNCT for the treatment of glioblastoma multiforme and melanoma using BPA or BSH as the boron compounds are under way (5, 8–11). Trials for brain tumors are in the dose-escalation phase in Europe (Petten, Finland and, as of 2001, the Czech Republic and Sweden). In the United States, the initial Phase I clinical trials at Brookhaven National Laboratory and at Massachusetts Institute of Technology have been completed. The BNCT program at Brookhaven National Laboratory has ended, whereas there are plans to continue BNCT clinical trials at Massachusetts Institute of Technology. In Japan, intraoperative BNCT of brain tumors is performed using thermal beams and, more recently, the mixed thermal-epithermal beam of the JRR4 Reactor. Contributory experimental studies have been carried out using a variety of animal tumor models based on the implantation of tumor cells (5, 12–18).

The current status of experimental and clinical BNCT studies warrants research on experimental models to devise strategies to improve the therapeutic advantage of this therapeutic modality, explore new applications, understand the biology and radiobiology of BNCT and analyze the behavior of clinically relevant normal tissues. Within this context we herein propose and validate the use of the hamster cheek pouch carcinogenesis model for BNCT studies.

Hamster cheek pouch is the most widely accepted model of oral cancer (19–22). Carcinogenesis protocols induce premalignant changes and SCCs that closely resemble human lesions (23–26). The hamster cheek pouch anatomically resembles a pocket that is easily accessible to local tumor induction and can be readily everted for local treatment such as irradiation and macroscopic follow-up. A unique feature of this model lies in the possibility of undertaking macroscopic follow-up of the evolution of tumor, precancerous tissue, and normal tissue at different times after treatment by simply evertning the cheek pouch and recording the chosen end points. Macroscopic end points could eventually be correlated with histopathological studies of biopsy samples. Vascular studies in particular can be performed elegantly on normal and neoplastic cheek pouch tissue using a variety of techniques (27). Undoubtedly, the knowledge of the vascular changes involved in BNCT is critical to the effective application of this technique (28–30).

Within the context of the search for new applications of BNCT, head and neck cancer may potentially benefit from the therapeutic advantage afforded by this modality. SCC of the head and neck is the sixth most prevalent cancer. Patients are generally treated with surgery combined with radiation therapy and chemotherapy. Radical removal of a tumor and surrounding tissues results in large tissue defect (31–34). Thus, tissue and organ preservation would be an important aim of alternative therapeutic strategies. The 5-year survival rate for head and neck SCC has improved only marginally over the past 20 years, remaining at 52% (31). These data suggest the need for new therapeutic strategies (35, 36).

Here we must stress that the approach of the present study is contributory solely from the viewpoint of basic research but may pave the way for future studies that could address the rationale for clinical application.

In terms of the study of the biology of BNCT the hamster cheek pouch model poses an advantage in that tumors are induced by a process that mimics the spontaneous process of malignant transfor...

Received 7/6/01; accepted 10/30/01.

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3 The abbreviations used are: BNCT, boron neutron capture therapy; BPA, boronophenylalanine; BSH, sodium borocaptate; DMBA, dimethyl-1,2-benzanthracene; b.w., body weight; ICP-AES, Atomic Emission Spectroscopy with Inductively Coupled Plasma; SCC, squamous cell carcinoma.

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mation rather than by the growth of implanted tumor cells. Furthermore, this mode of tumor induction allows the study of precancerous tissue around a tumor (26). Precancerous tissue is not available in animal models based on tumor growth from transformed cells implanted in healthy tissue. Multiple primary tumors are a known phenomenon in head and neck cancer (37). Furthermore, local-regional recurrence is a common and challenging oncological problem in patients affected by this disease (31). As proposed initially by Slaughter et al. (38), carcinomas would arise from multifocal areas of precancerous change involved in the process of field cancerization (39–43). Thus the possibility of addressing the issue of precancerous tissue behavior would be contributory.

Furthermore, this model allows us to address the issue of accumulation of BPA in normal oral tissues and in the healthy tissue that gives rise to a tumor. Their clinical relevance lies in the fact that oral mucositis could be a potential dose-limiting consideration in BNCT of brain tumors or if BNCT is eventually applied to the treatment of head and neck tumors (7). Coderre et al. (7) addressed this issue in a study on dose-effect relationships related to BNC irradiation of oral mucosa using the model of rat ventral tongue mucosa. The study shows the sensitivity of tongue mucosa to BNC irradiation. Given that at present it is impossible to follow $^{10}B$ concentrations in tumors during BNCT, it would seem reasonable to adopt the maximum tolerable dose to normal tissue as a therapeutic dose (44). Thus, it is of paramount importance to estimate the boron concentration in the normal tissues that would actually be involved in the treatment with BNCT to calculate the upper limit of the neutron fluence. Furthermore, within the context of dose calculation, it is important to know if the concentration of boron in normal tissues can be extrapolated from the concurrent blood values that can be monitored during infusion and irradiation. Coderre et al. (7) reported that rat tongue and blood boron values were comparable. However, this issue must be addressed for each tumor site that may potentially benefit from BNCT and for the healthy tissues in the beam path. In this way it may be possible to establish the conditions to eradicate tumors within the tolerance limit of the surrounding normal tissues.

Pouch tumors occasionally undergo spontaneous partial necrosis. This fact allows us to explore, in selected pouch tumor samples containing variable amounts of viable tumor tissue and small areas of necrosis, the correlation between BPA uptake and cell viability, an issue addressed by Coderre et al. (6) in human glioblastoma multiforme.

Herein we propose the use of the hamster cheek pouch carcinogenesis model for BNCT studies and validate its adequacy by performing boron biodistribution and pharmacokinetic studies of BPA.

**MATERIALS AND METHODS**

**Tumor Induction.** The right cheek pouch of noninbred young (6 weeks old) Syrian hamsters was submitted to topical application of 0.5% DMBA in mineral oil three times a week for 14 weeks in keeping with a standard hamster cheek pouch carcinogenesis protocol (20). The protocol ensures humane practices. The treated pouch was periodically everted under light anesthesia and examined to monitor tumor development. Once the exophytic tumors (Fig. 1) had developed and reached a diameter of approximately 3–5 mm, the animals were used for biodistribution and pharmacokinetic studies of BPA.

**BPA Biodistribution Studies.** BPA (L-enantiomer, >98% $^{10}B$-enriched; Boron Biologicals, Inc., Raleigh, NC) containing 4.9% B by weight was used as the boron delivery agent. Injection solutions of the BPA-fructose complex were prepared in keeping with procedures published previously (45, 46). A 0.14 M solution was prepared for i.p. administration and a 0.24 M solution was prepared for i.v. administration. In this way, convenient injection volumes were available for each administration route. Briefly, BPA was converted to a more soluble fructose complex by mixing BPA and fructose in water at a 1:1 molar ratio. The pH was adjusted to 9.5–10.0 with NaOH, and the mixture was stirred until all of the solids dissolved, and the pH was then readjusted to 7.4 with HCl. The concentration was then adjusted with USP water for injection to the corresponding molarity. The solution was passed through a 0.22-μm pore sterilization filter (Nalge Company, Rochester, NY). BPA was administered i.p. at a dose of 300, 600, or 1200 mg/kg b.w. Blood and tissue samples were removed at different post-administration times: 0, 0.5 h, 1 h, 1.5 h, 2.5 h, 3.5 h, 6 h, and 12 h for the dose of 300 mg BPA/kg b.w. On the basis of these data, the optimum time point in terms of absolute and relative tumor boron values was shown to be 3.5 h. The time point of 3.5 h was selected to assess boron delivery by the higher doses of BPA. Blood samples were taken from the jugular vein with a heparinized syringe. The following tissues were sampled: tumor, precancerous pouch tissue surrounding tumor (pouch treated with DMB(A)), normal pouch tissue (nontreated pouch), tongue, cheek skin, cheek mucosa, palate mucosa, liver, and spleen. Noninjected animals were used as control. All of the samples were weighed immediately. Tissue samples were stored at −70°C, and blood samples were stored at 4°C until use.

A pharmacokinetic analysis was performed on the blood boron concentrations and time data after i.v. administration of 300 mg BPA/kg b.w. using a nonlinear regression program (WIN-NONLIN, professional 3.1). For this purpose we performed, in keeping with a technique developed previously by our laboratory (47), a bolus injection of the BPA solution in the surgically exposed jugular vein of animals anesthetized with an i.p. injection of ketamine (140 mg/kg) and xylazine (21 mg/kg) followed by skin suture. Survival from the surgical procedure was 100%.

**Boron Analysis.** Boron analysis was performed by ICP-AES. Tissue samples (≤50 mg) were digested at room temperature overnight (or at 60°C for 1 h) in 0.15 ml of a 1:1 mixture of concentrated sulfuric and nitric acids at a concentration of 50 mg tissue/ml acid solution; addition of 0.5 ml of a 10% solution of the detergent Triton X-100 and dilution to 1 ml with water resulted in a clear solution for ICP-AES analysis (6). Blood samples (200–300 μl) were prepared by adding 2.5% Triton X-100 at a final concentration of 0.1% in water (final volume 5 ml). Standard solutions of boric acid were used to prepare a calibration line during each day of operation. BPA biokinetics curves were obtained for blood and each of the tissues. The number of samples for each point ranged from 5 to 13. The statistical significance of the differences between boron content of the different tissues at a given after administration time was assessed by a one-way ANOVA. An overall level of significance was taken to be $\alpha = 0.05$. If the residuals were not normally distributed then logarithmic transformations of the data were performed to normalize the data.

**Histology and Tumor Viability.** In keeping with the concept proposed by Coderre et al. (6) that BPA uptake depends on tumor cell viability, we examined the histology of representative tumors with different proportions of viable tumor tissue and analyzed the correlation with boron concentration. For this purpose each fresh tumor specimen was described macroscopically and divided into two contiguous samples of similar macroscopic appearance 3.5 h after the administration of 300 mg BPA/kg b.w. One
sample was analyzed for average boron content by ICP-AES. The other was fixed in buffered formalin, dehydrated, and embedded in paraffin. H&E-stained sections were analyzed by light microscopy. Areas of viable tumor parenchyma, stroma, and necrotic tissue were defined. An image analyzer (IBAS-Kontron) was used to quantitatively evaluate the areas of viable tissue (tumor parenchyma and stroma), and necrotic tissue outlined on the image of the histological section. We then evaluated the percentage area of each section occupied by viable tissue and necrotic tissue. The full extension of each section was considered for evaluation. Furthermore, we evaluated differential boron uptake 3.5 h after i.p. administration of 300 mg BPA/kg b.w. in viable and necrotic zones of the tumors. For this purpose we dissected six areas of tumor that appeared to be characteristically necrotic on visual inspection and processed the tissues for boron analysis. Twelve viable tumor samples on visual inspection were processed for comparison purposes. Given the scarce amount of necrotic tissue that could be dissected from a single tumor, a correlation between boron analysis and histology was not attempted.

**RESULTS**

Mean boron concentration in blood for i.p. and i.v. bolus administration did not exhibit statistically significant differences over the 1–12 h post-administration time range (Table 1, Fig. 2) that would be relevant in terms of improving blood loading and clearance, except for a slight advantage for i.v. administration in terms of clearance at 6 h. The pharmacokinetic analysis showed that between 0 h and 12 h after administration of BPA, blood boron concentrations exhibited a decay that corresponds to the distribution (α) and elimination (β) phases in keeping with a model of two compartments. Calculation of the pharmacokinetic parameters afforded the following results: $t_{1/2α} = 0.21 ± 0.12$ h; $t_{1/2β} = 3.30 ± 2.20$ h; central compartment volume of distribution $V_c = 502.5 ± 37.1$ ml/kg; and apparent total body clearance $Cl_r = 365.4 ± 145.5$ ml/h.

For the dose of 300 mg BPA/kg b.w. administered i.p. (Table 1; Fig. 3), boron concentration in tumor was significantly higher than in normal pouch tissue (nontreated pouch) for 0.5 h ($P = 0.021$), 1 h

<table>
<thead>
<tr>
<th>Time Post-Administration (h)</th>
<th>Blood (i.v.)</th>
<th>Blood (i.p.)</th>
<th>Normal pouch tissue (i.p.)</th>
<th>Tissue around tumor (i.p.)</th>
<th>Cheek mucosa (i.p.)</th>
<th>Tongue (i.p.)</th>
<th>Palate mucosa (i.p.)</th>
<th>Cheek skin (i.p.)</th>
<th>Spleen (i.p.)</th>
<th>Liver (i.p.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control (noninjected)</td>
<td>0.7 ± 0.2a</td>
<td>0.4 ± 0.1</td>
<td>0.7 ± 0.1</td>
<td>1.2 ± 0.5</td>
<td>1.4 ± 2.0</td>
<td>0.4 ± 0.6</td>
<td>0.3 ± 0.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>5.97 ± 18.9</td>
<td>1.9 ± 1.7</td>
<td>3.4 ± 2.8</td>
<td>4.6 ± 5.1</td>
<td>2.7 ± 2.9</td>
<td>4.0 ± 2.4</td>
<td>5.7 ± 3.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5</td>
<td>23.5 ± 12.1</td>
<td>12.6 ± 4.2</td>
<td>29.0 ± 18.4</td>
<td>14.5 ± 5.0</td>
<td>11.0 ± 7.0</td>
<td>9.3 ± 2.2</td>
<td>10.1 ± 5.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>15.6 ± 2.8</td>
<td>14.6 ± 5.5</td>
<td>12.4 ± 4.8</td>
<td>12.0 ± 5.5</td>
<td>10.7 ± 3.0</td>
<td>10.3 ± 3.0</td>
<td>10.2 ± 3.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>12 ± 7.9</td>
<td>13.9 ± 2.5</td>
<td>19.0 ± 7.6</td>
<td>22.3 ± 7.8</td>
<td>14.4 ± 4.2</td>
<td>12.9 ± 3.4</td>
<td>15.4 ± 5.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>9.8 ± 1.5</td>
<td>10.7 ± 2.6</td>
<td>13.7 ± 6.5</td>
<td>18.8 ± 3.4</td>
<td>15.3 ± 4.5</td>
<td>13.4 ± 3.3</td>
<td>15.4 ± 4.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>7.6 ± 1.0</td>
<td>11.7 ± 4.9</td>
<td>15.6 ± 5.4</td>
<td>19.6 ± 5.8</td>
<td>18.2 ± 8.9</td>
<td>14.1 ± 6.9</td>
<td>13.0 ± 4.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>6.0 ± 2.3</td>
<td>10.7 ± 2.3</td>
<td>13.2 ± 3.1</td>
<td>13.2 ± 3.1</td>
<td>10.4 ± 2.8</td>
<td>11.2 ± 2.5</td>
<td>7.2 ± 4.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>16 ± 0.2</td>
<td>3.2 ± 2.1</td>
<td>4.5 ± 3.9</td>
<td>2.9 ± 0.8</td>
<td>2.0 ± 1.9</td>
<td>2.5 ± 1.0</td>
<td>1.8 ± 1.7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Results are expressed as mean ± S.D. The number of samples per condition is indicated in brackets.

In the case of tumors, the range of values has been added in brackets.
pouch tissue with time post-administration up to 3.5 h and began falling thereafter. In some cases, normal tissue boron values rose above concurrent blood values. This difference reached statistical significance for cheek mucosa at 2.5 h (P = 0.032; Table 1; Fig. 4). Liver and spleen boron concentration values were similar to those of normal pouch tissue and blood (Table 1). BPA accumulation in liver and spleen would, thus, not be a particular concern in this model.

The higher doses of 600 and 1200 mg BPA/kg b.w. administered i.p. delivered more boron to tumor tissue (Table 3). The normal tissue boron values for the dose of 600 mg BPA/kg b.w. were, overall, slightly higher than for the dose of 300 mg/kg b.w. The dose of 1200 mg delivered higher amounts of boron to normal tissues. Blood boron values for the two higher doses doubled the value for the 300 mg BPA/kg b.w. dose (Table 3; Fig. 5). The higher BPA doses may be therapeutically beneficial. Even if the tumor:blood boron concentration ratio remains fixed, the therapeutic ratio improves as more boron compound is administered, and higher absolute boron concentrations are produced in both tumor and normal tissues (5).

Boron concentration in tumor was markedly heterogeneous and ranged, on average, from 8.1 ppm in tumors composed of predominantly necrotic tissue to 32.0 ppm in tumors composed of mainly viable tissue in the set of tumor samples submitted to histological assessment and boron analysis (Fig. 6). Quantification of the proportion of viable tissue in 14 tumor sections showed a statistically significant (Student’s t test, P ≤ 0.01) difference in BPA uptake between moderately necrotic (18.5 ± 2.0 ppm) and mainly viable tumor tissue (32.0 ± 13.5 ppm). The only sample of mainly necrotic tissue large enough to perform a correlation between histology and ICP evaluation showed a markedly low boron uptake (8.1 ppm). The macroscopic description of the tumor closely agreed with the actual

Table 2 Boron concentration ratios at different times after i.p. administration of 300 mg BPA/kg b.w.

<table>
<thead>
<tr>
<th>Ratio</th>
<th>0.5 h</th>
<th>1 h</th>
<th>1.5 h</th>
<th>2.5 h</th>
<th>3.5 h</th>
<th>6 h</th>
<th>12 h</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumor/normal pouch</td>
<td>3.1</td>
<td>1.8</td>
<td>2.0</td>
<td>2.3</td>
<td>2.4</td>
<td>1.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Tumor/blood</td>
<td>2.3</td>
<td>1.5</td>
<td>2.8</td>
<td>2.9</td>
<td>3.2</td>
<td>1.8</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Fig. 4. Boron concentration (µg B/g) in blood, cheek mucosa, palate mucosa, cheek skin, tongue, and normal pouch tissue versus time after i.p. administration of BPA at a dose of 300 mg/kg b.w. Each point represents 5–13 samples; bars, ± SD.

(P = 0.004), 2.5 h (P = 0.001), and 3.5 h (P = 0.000) after administration of BPA. At 1.5 h this difference did not reach statistical significance, a finding that could be attributed to the spread in values for tumor tissue. Boron concentration in tumor was higher than in blood at times of 0.5 h to 6 h. This difference reached statistical significance for 0.5 h (P = 0.043), 1 h (P = 0.027), 2.5 h (P = 0.018), 3.5 h (P = 0.000), and 6 h (P = 0.008).

The average tumor:normal pouch and tumor:blood ratios showed selective accumulation of BPA in tumor for all of the time points evaluated. The tumor:blood ratio improved with time after administration as blood clearance progressed. Table 2 shows the mean tumor: normal pouch and tumor:blood boron ratios for each time point. At 3.5 h the absolute boron value was 36.9 ± 17.5 ppm, and mean tumor:normal pouch tissue and tumor:blood ratios were 2.4:1 and 3.2:1 respectively. This would be the time point with the best therapeutic potential in terms of tumor absolute and relative boron concentration values, and normal tissue and blood boron content.

Precancerous tissue surrounding tumor (pouch treated with DMBA) showed a tendency, albeit not statistically significant, to concentrate BPA more than normal pouch tissue (Table 1; Fig. 3). Uptake of BPA in cheek mucosa, palate mucosa, cheek skin, and tongue did not differ significantly and exhibited the same tendency as in normal pouch tissue. Boron concentration rose in skin, intraoral tissues, and normal

![Graph](image)

Fig. 5. Boron concentration (µg B/g) in blood, cheek mucosa, normal pouch tissue, and precancerous tissue around tumor versus dose 3.5 h after i.p. administration of BPA. Each point represents 5–11 samples; bars, ± SD.

Table 3 Boron concentration (ppm) in blood and tissue samples for different doses of BPA at 3.5 h after i.p. administration

<table>
<thead>
<tr>
<th>Dose of BPA</th>
<th>Blood</th>
<th>Tumor</th>
<th>Normal pouch tissue</th>
<th>Tissue around tumor</th>
<th>Cheek mucosa</th>
<th>Tongue</th>
<th>Palate mucosa</th>
<th>Cheek skin</th>
<th>Spleen</th>
<th>Liver</th>
</tr>
</thead>
</table>
| 300         | 11.7 ± 4.9  
(n = 11)  | 36.9 ± 17.3  
(15.2–75.8)  
(n = 12)  | 15.6 ± 5.4  
(n = 9)  | 19.6 ± 5.8  
(n = 9)  | 18.2 ± 8.9  
(n = 7)  | 14.2 ± 6.9  
(n = 6)  | 13.0 ± 4.3  
(n = 5)  | 14.2 ± 8.3  
(n = 7)  | 12.9 ± 6.3  
(n = 7)  | 11.4 ± 4.5  
(n = 6)  |
| 600         | 23.1 ± 3.8  
(n = 5)  | 64.3 ± 34.4  
(11.9–120.2)  
(n = 12)  | 20.9 ± 1.6  
(n = 5)  | 19.6 ± 5.9  
(n = 5)  | 18.7 ± 5.1  
(n = 5)  | 14.3 ± 2.8  
(n = 5)  | 24.2 ± 12.4  
(n = 5)  | 13.7 ± 5.4  
(n = 5)  | 14.8 ± 5.5  
(n = 5)  | 12.5 ± 5.4  
(n = 5)  |
| 1200        | 25.3 ± 5.3  
(n = 5)  | 194.3 ± 203.1  
(61.3–510)  
(n = 7)  | 44.1 ± 6.3  
(n = 5)  | 47.7 ± 17.6  
(n = 5)  | 44.9 ± 7.1  
(n = 5)  | 37.7 ± 9.3  
(n = 5)  | 46.6 ± 7.7  
(n = 5)  | 37.2 ± 10.6  
(n = 5)  | 33.2 ± 5.3  
(n = 5)  | 27.5 ± 4.4  
(n = 5)  |

* Results are expressed as mean ± S.D. The number of samples per condition is indicated in brackets.

† In the case of tumors, the range of values has been added in brackets.
Heterogeneous uptake of BPA (5) holds true for hamster cheek pouch tumors and is an issue of concern in BPA-mediated BNCT. The biochemical rationale for the preferential uptake of BPA in tumor would be related to an elevated rate of amino acid transport at the tumor cell membrane (5). Within this context, the metabolic status of the cells may condition uptake and lead to a large spread in values. Heterogeneous uptake of BPA (5) holds true for hamster cheek pouch tumors and is an issue of concern in BPA-mediated BNCT.

The boron uptake data for precancerous tissue surrounding the tumor would evidence a tendency of premalignant tissue to incorporate more boron than normal tissue. This finding would provide a rationale for treatment of “field cancerized” tissue surrounding tumor (38) to reduce the risk of development of additional tumors in the area. However, because this particular tissue may incorporate more boron than normal tissue, its dose-limiting nature in terms of acute effects must be explored. The fact that the hamster oral cancer model can be used to study precancerous tissue is an advantage over transplanted tumor models.

This model allows us to study skin and intraoral tissues in addition to actual pouch tissue. Furthermore, the fact that boron concentration is similar in all of these tissues confers an additional advantage on the normal pouch tissue as a model of normal intraoral tissues and skin in terms of boron uptake. Given that boron concentration may rise above...
blood values in some cases in these normal tissues, it would be of utmost importance to evaluate, or at least estimate, actual uptake of boron by oral mucosa rather than extrapolate from blood values in patients if the present findings on normal oral tissues hold true for human subjects. BNCT treatment protocols in Europe are in the dose escalation phase. Whereas these protocols do not yet entail acute radiation damage to the oral mucosa, it could become a potential dose-limiting tissue in future treatment protocols involving higher doses, larger target irradiation field sizes, or multiple fields (7). The study of clinically relevant, potentially dose-limiting normal tissues in an adequate animal model such as the model described herein may contribute to elucidating previously unpredictable side-effects.

Our observations regarding high boron uptake in mainly viable tumor tissue and low boron uptake in mainly necrotic tumor tissue are in keeping with other studies (6). Moreover, the data of Patel and Sedgewick, (51) show that BPA accumulates preferentially in viable cells with uptake capacity. Conversely, BSH that has no known uptake mechanisms and is thought to penetrate a tumor by diffusion and leakage through tumor blood vessels would accumulate more in necrotic areas. The data reported herein would allow us to assume that BPA uptake values for 100% viable tumor tissue will be closer to the maximum values than to the means. In this sense, actual tumor:nor mal tissue and tumor: blood ratios for viable cells may be higher than the mean ratios. Thus, we could speculate that the therapeutic advantage of BCNT would increase with tumor viability in this model. Heterogeneous uptake by heterogeneous tumor tissues (52, 53) precludes accurate treatment planning. The agreement between prescribed and actual dose depends largely on the agreement between intended and obtained 10B concentration during irradiation. A large spread in boron concentrations creates additional problems in the analysis of biological responses (54). Once again, the possibility of addressing these issues experimentally in a model such as the hamster cheek pouch may contribute to improving the therapeutic advantage of BNCT. In particular, studies currently underway will examine, in more detail, the correlation between compound uptake and tumor histology. Tumor viability is central to uptake as shown by Coderre et al. (6) for glioblastoma multiforme in human subjects and, as evidenced in the present study, for hamster cheek pouch tumors (Fig. 7). However, it would be informative to evaluate the effect on boron incorporation into viable tumor of other variables that have not been examined to date such as degree of differentiation of the tumor and degree of vascularization.

The present study would set a scenario for BNCT irradiation studies in this model. Coderre et al. (7) have reported a compound biological effectiveness factor of 4.9 for BPA in normal rat tongue. The compound biological effectiveness factor for hamster cheek pouch remains to be determined. This model would be particularly useful to evaluate the response of dose-limiting oral tissues and assess the sparing effects of split-dose or fractionated BNCT irradiation schedules. The hamster cheek pouch model would allow for definitive scoring of tumor, precancerous, and normal tissue reaction to BNCT. This model also allows for the study of the role of vascularization in the BNCT-induced effect. The effect of local x-irradiation on vascularization has been studied by other authors in this model (55–57).

Given that there is a rationale to search for new strategies to treat head and neck cancer (35), that exploring new applications for BNCT is of interest to a number of groups worldwide, and that a deeper understanding of the biology and radiobiology of BNCT will undoubtedly contribute to improving the therapeutic advantage of this treatment, the hamster cheek pouch model may provide a contributory, novel, experimental approach to BNCT studies.

ACKNOWLEDGMENTS

We thank Dr. Sara Liberman for her support and Dr. Beatriz Gonzalez (Department of Biostatistics, Faculty of Exact and Natural Sciences, University of Buenos Aires) for generous and knowledgeable assistance with the statistical analysis of the data. We also thank Dr. Nélida Monedel of the Department of Experimental Pharmacology of Gador, S.A. for expert assistance with the pharmacological study and Sara Orrea for expert technical assistance. The United States Department of Energy, within the collaborative agreement with the National Atomic Energy Commission for BNCT studies, made possible the interaction with experts worldwide in the different areas of BNCT, who generously shared their knowledge with us. The morphometric measurements were performed using the image analyzer of the National Laboratory of Research and Services within the agreement between the National Atomic Energy Commission and the National Research Council. We also thank Dr. Jeffrey A. Coderre for reading a draft of the manuscript and generously making valuable suggestions.

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