# Introduction to Radiation Biology

Survey of Clinical Radiation Oncology

Lecture 2

## Outline

- Terminology
- Development of radiobiological damage
- Cell cycle
- Cell survival curves
- Radiobiological damage: oxygenation, fractionation, and 4 R's of radiobiology
- Cell and tissue radiosensitivity

## Radiation biology

- **Radiation biology** is the study of the action of ionizing radiation on living organisms
- The action is very complex, involving physics, chemistry, and biology
  - Different types of ionizing radiation
  - Energy absorption at the atomic and molecular level leads to biological damage
  - Repair of damage in living organisms
- Basic principles are used in radiation therapy with the objective to treat cancer with minimal damage to the normal tissues

## Types of ionizing radiations

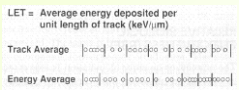
- Electromagnetic radiations
  - X-rays and Gamma-rays
- Particulate radiations
  - Electrons, protons, α-particles, heavy charged particles
  - Neutrons
- All charged particles: directly ionizing radiation
- X and γ-rays, as well as neutrons – indirectly ionizing radiation

## Types of ionizing radiations

- If radiation is absorbed in biologic material, ionizations and excitations occur in a pattern that depends on the type of radiation involved
- Depending on how far the primary ionization events are separated in space, radiation is characterized as *sparsely ionizing* (x-rays) or *densely ionizing* (α-particles)
- Heavier particles with larger charge produce higher ionization density
- For a given particle type, the density of ionization decreases as the energy (and velocity) goes up

## Linear Energy Transfer

- **Linear energy transfer** (LET) is the energy transferred per unit length of the track
- The special unit usually used for this quantity is keV/μm of unit density material
- It is an average quantity, typically *track* averaged




$$\mathrm{LET} = dE/dl$$

## Linear Energy Transfer

**Typical Linear Energy Transfer Values**

| Radiation | Linear Energy Transfer, keV/μm | |
|---|---|---|
| Cobalt-60 γ-rays | 0.2 | |
| 250-kV x-rays | 2.0 | |
| 10-MeV protons | 4.7 | |
| 150-MeV proton | 0.5 | |
| | Track Avg. | Energy Avg. |
| 14-MeV neutrons | 12 | 100 |
| 2.5-MeV α-particles | 166 | |
| 2-GeV Fe ions (space radiation) | 1,000 | |

- The method of averaging makes little difference for x-rays or for mono-energetic charged particles, but the track average and energy average are different for neutrons

## Relative Biological Effectiveness

- Equal doses of different types of radiation do not produce equal biologic effects
  - 1 Gy of neutrons produces a greater biologic effect than 1 Gy of x-rays due to the difference in the pattern of energy deposition at the microscopic level
- **The relative biologic effectiveness (RBE)** of some test radiation (r) compared with 250 kV x-rays is defined

$$RBE = \frac{D_{250kV}}{D_r}$$

- $D_{250kV}$ and $D_r$ are the doses of x-rays and the test radiation required for equal biological effect

## Relative Biological Effectiveness

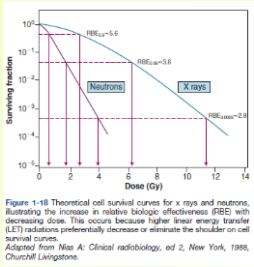
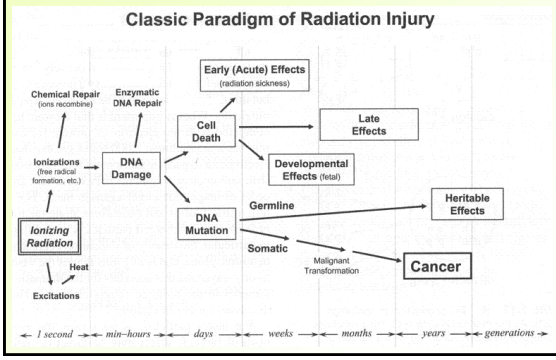



Figure 1-18 Theoretical cell survival curves for x rays and neutrons, illustrating the increase in relative biologic effectiveness (RBE) with decreasing dose. This occurs because higher linear energy transfer (LET) radiations preferentially decrease or eliminate the shoulder on cell survival curves.
*Adapted from Nias A: Clinical radiobiology, ed 2, New York, 1988, Churchill Livingstone.*

- Because the x-ray and neutron survival curves have different shapes the resultant RBE depends on the level of biologic damage chosen
- The RBE for a fractionated regimen with neutrons is greater than for a single exposure (because the RBE is larger for smaller doses)

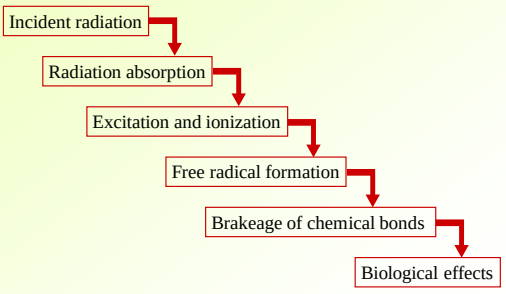
## Development of radiobiological damage




## Characteristic time scales

- The physical event of absorption occurs over about $10^{-15}$ seconds
- The biologic lifetime of the free radical is on the order of $10^{-10}$ - $10^{-9}$ seconds ($10^{-5}$ seconds in the presence of air)
- The expression of cell death may take up to days to months
- The expression of carcinogenesis may take years or generations

## Development of radiobiological damage



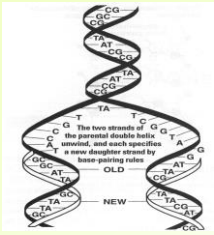
## Absorption of radiation

- Biological systems are very sensitive to radiation
- Absorption of 4 Gy in water produces the rise in temperature ~$10^{-3}$ $^{o}$C (~67 cal in 70-kg person)
- Whole body dose of 4 Gy given to human is lethal in 50% of cases (LD50)
- The potency of radiation is in its concentration and the damage done to the genetic material of each cell

## Biological effect

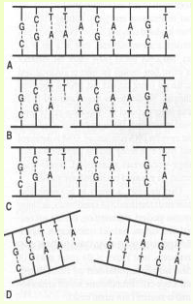
- The biological effect is expressed in cell killing, or cell transformation (carcinogenesis and mutations)
- The *primary target* of radiation is DNA molecule, suffering breaks in chemical bonds
- Depending on the extent of the damage, it can be repaired through several repair mechanisms in place in a living organism

## The structure of DNA



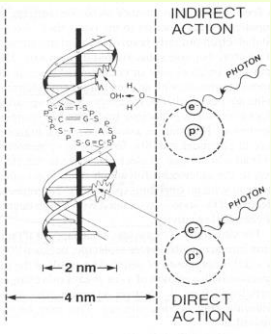

- DNA molecule has many deoxyribo-nucleotides (bases) linked in a chain-like arrangement
- Bases are held by hydrogen bonds and are paired complimentary (adenine with thymine; cytosine with guanine)
- Each half is a template for reconstruction of the other half
- During cell division each strand is self-replicated resulting in identical molecules

## DNA as a target




- **Single-strand breaks** are of little biologic consequence because they are repaired readily using the opposite strand as a template
- **Double-strand breaks** are believed to be the most important lesions produced in chromosomes by radiation; the interaction of two double-strand breaks may result in cell killing, carcinogenesis, or mutation

## Direct and indirect actions




- In direct action, a secondary electron resulting from absorption of an x-ray photon interacts with the DNA to produce an effect
- In indirect action, the secondary electron interacts with, for example, a water molecule to produce a hydroxyl radical (OH-), which in turn produces the damage to the DNA
- The DNA helix has a diameter of ~ 2 nm; free radicals produced in a cylinder with a diameter ~ 4 nm can affect the DNA
- Indirect action is dominant for sparsely ionizing radiation (x-rays)

## Free radicals

- **A free radical** is an atom or molecule carrying an unpaired orbital electron in the outer shell. This state is associated with a high degree of chemical reactivity
- Since 80% of a cell is composed of water, as a result of the interaction with a photon or a charged particle, the water molecule may become ionized:

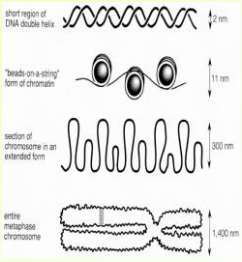
$$H_2O \rightarrow H_2O^+ + e^-$$

- $H_2O^+$ is an ion radical with a lifetime of ~$10^{-10}$ s; it decays to form highly reactive hydroxyl free radical $OH\bullet$

$$H_2O^+ + H_2O \rightarrow H_3O^+ + OH\bullet$$

- About 2/3 of the x-ray damage to DNA in mammalian cells is caused by the hydroxyl radical (lifetime of ~$10^{-3}$ s)

## Chromosomes

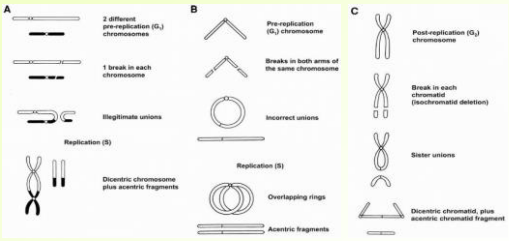



- DNA molecules carry the genetic information
- Chromosome is an organized structure of DNA and DNA-bound proteins (serve to package the DNA and control its functions)
- Chromosomes are located mostly in cell nucleus (some amount is in mitochondria)

## Chromosome aberrations

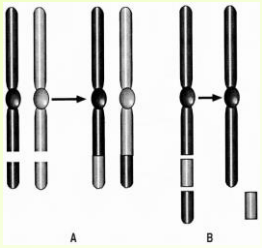
- Damage to DNA may result in *lethal damage* or repair efforts modulated by specific enzymes may result in *mutations* which can be perpetuated in subsequent cellular divisions
- Mutations are mostly characterized by deletions (where part of the genetic message is lost) or translocations where a segment of a chromosome is lost from its proper location and recombines with another chromosome

## Radiation-induced aberrations




Lethal aberrations include dicentrics (A), rings (B), and anaphase bridges (C)

## Radiation-induced aberrations




Symmetric translocations and small deletions are nonlethal

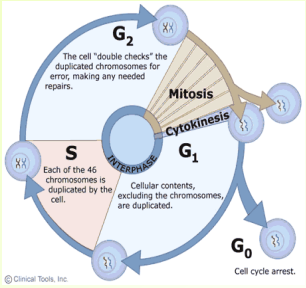
**A**: Symmetric translocation: radiation produces breaks in two different pre-replication chromosomes. The broken pieces are exchanged between the two chromosomes, and the "sticky" ends rejoin.

B: Deletion: radiation produces two breaks in the same arm of the same chromosome

## Mutations

- If occur in the germ cells (sperm and ova) they can be passed on as genetic abnormalities in offspring
- If they occur in the somatic cells (the cells that make up an organism) they can lead to the development of diseases including cancer - this is called carcinogenesis
- There are genes called oncogenes that affect cancer incidence
- If an inhibitory oncogene is lost due to a deletion the patient is at higher risk for cancer formation

## The cell cycle

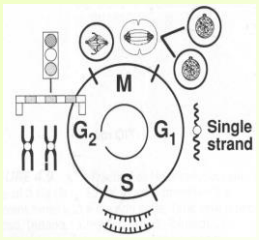



- **M** - mitosis, identifiable by light microscopy and the most constant time (~ 1 hr)
- **S** - DNA synthesis phase
- **$G_1$** - the first gap in activity, between mitosis and the S phase (most variable length)
- **$G_2$** - the second gap in activity, between S phase and the next mitosis
- If the cells stop progressing through the cycle (if they are arrested) they are in **$G_0$**

## Variation of radiosensitivity with cell age in the mitotic cycle

- Cells are most sensitive at or close to M (mitosis)
- G2 phase is usually as sensitive as M phase
- Resistance is usually greatest in the latter part of S phase due to repairs that are more likely to occur after the DNA has replicated
- If G1 phase has an appreciable length, a resistant period is evident early in G1, followed by a sensitive period toward the end of G1

## Molecular checkpoint genes

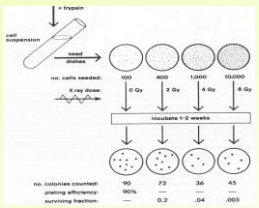


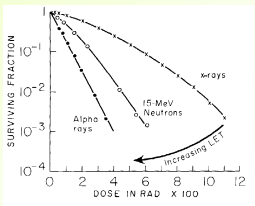

- Cell-cycle progression is controlled by a family of *molecular checkpoint genes*
- Their function is to ensure the correct order of cell-cycle events
- The genes involved in radiation effects halt cells in G2, so that an inventory of chromosome damage can be taken, and repair initiated and completed, before the mitosis is attempted
- Cells that lack checkpoint genes are sensitive to radiation-induced cell killing, and carcinogenesis

## Mechanisms of cell death after irradiation

- The main target of radiation is cell's DNA: single breaks are often reparable, double breaks lethal
- *Mitotic death* – cells die attempting to divide, primarily due to asymmetric chromosome aberrations; most common mechanism
- *Apoptosis* – programmed cell death; characterized by a predefined sequence of events resulting in cell separation in apoptotic bodies
- *Bystander effect* – cells directly affected by radiation release cytotoxic molecules inducing death in neighboring cells

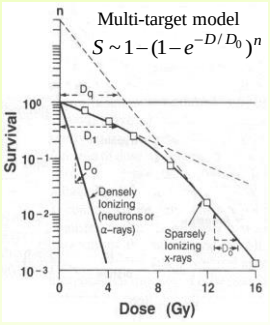
## Cell survival curves





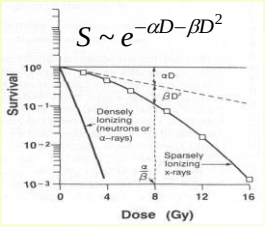

- A **cell survival curve** describes the relationship between the radiation dose and the proportion of cells that survive
- Usually presented in the form with dose plotted on a linear scale and surviving fraction on a log scale

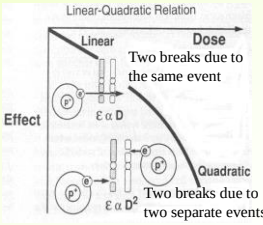
## Cell survival curve parameters




- $D_1$ – initial slope (the dose required to reduce the fraction of surviving cells to 37% of its previous value); $D_0$ – final slope
- $D_q$ – quasi-threshold, the dose at which the straight portion of the survival curve, extrapolated backward, cuts the dose axis drawn through a survival fraction of unity
- n – extrapolation number
- Radiosensitive cells are characterized by curves with steep slope $D_0$ and/or small shoulder (low n)

## Survival curves and LQ model



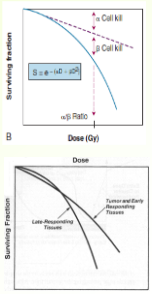

- Linear-quadratic model assumes there are two components to cell killing, only two adjustable parameters
- No final straight portion that is observed experimentally, but an adequate representation of the data up to doses used as daily fractions in clinical radiotherapy

## α/β ratios

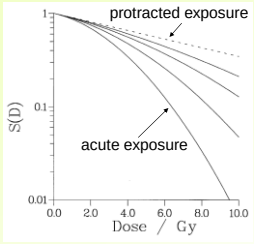
- If the dose-response relationship is represented by LQ-model:

$$S \sim e^{-\alpha D - \beta D^2}$$

- The dose at which $\alpha D = \beta D^2$, or $D = \alpha/\beta$
- The $\alpha/\beta$ ratios can be inferred from multi-fraction experiments
- The value of the ratio tends to be
  - larger (~10 Gy) for early-responding tissues and tumors
  - lower (~2 Gy) for late-responding tissues

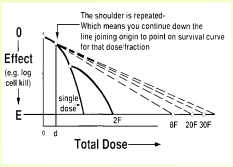


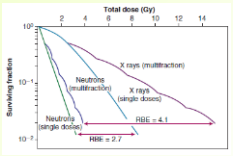

## Repair of sub-lethal damage




- In the presence of repair mechanisms sublesions may be eliminated *before* the next hit arrives - dose rate becomes relevant
- As the dose rate decreases the quadratic term ($\beta D^2$) becomes smaller
- At very low dose rates only the linear term, $\alpha D$, remains

## Fractionation




- Fractionation has a profound effect on cell survival curves for low LET radiation (some for high LET)
- The main objective clinically is sparing of the normal tissue by giving it time to repair sublethal damage
- Typically normal tissue repair mechanisms are much more effective than those of cancer cell's

## Equivalent treatment

- To find biologically equivalent treatments use LQ model:

$$S = \exp(\alpha D + \beta D^2)$$

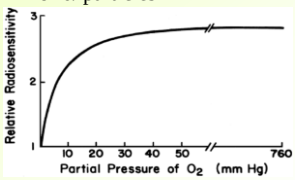
$$\alpha D + \beta D^2 = \alpha D_1 + \beta D_1^{\,2} = E$$

$$E/\alpha = nd\left(1 + \frac{d}{\alpha/\beta}\right)$$

- Here $d$ – dose per fraction, $n$ – number of fractions
- Should be evaluated separately for tumor and normal tissues

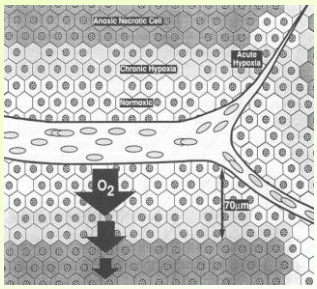
## Oxygen effect

- Oxygen makes the damage produced by free radicals permanent; the damage can be repaired in the absence of oxygen
- Oxygen enhancement ratio OER=3 can be achieved for x-rays; OER=1.6 for neutrons; only 1 for α-particles




Only 3 mm Hg, or about 0.5% of oxygen is required to achieve a relative radiosensitivity halfway between anoxia and full oxygenation

## Tumor oxygenation




- Oxygen can diffuse at only about 70 μm from the blood vessel
- Solid tumors often outgrow their blood supply and become hypoxic
- Cells not receiving oxygen and nutrients become necrotic

## The four Rs of radiobiology

- Fractionation of the radiation dose typically produces better tumor control for a given level of normal-tissue toxicity than a single large dose
- Radiobiological basis for fractionations (4 Rs):
  - *Repair* of sublethal damage in normal tissues
  - *Reassortment* of cells within the cell cycle move tumor cells to more sensitive phase
  - *Repopulation* of normal tissue cells; however too long treatment time can lead to cancer cell proliferation
  - *Reoxygenation* of tumor cells as tumor shrinks
- Prolongation of treatment spares early reactions

## Early and late responding tissues

- Rapidly dividing self-renewing tissues respond early to the effects of radiation; examples: skin, intestinal epithelium, bone-marrow
- Late-responding tissues: spinal cord, lung, kidney
- Early or late radiation response reflects different cell turnover rates

## Tissue response to radiation damage

- Cells of normal tissues are not independent
- For an tissue to function properly its organization and the number of cells have to be at a certain level
- Typically there is no effect after small doses
- The response to radiation damage is governed by:
  - The inherent cellular radiosensitivity and position in the cell cycle at the time of radiation
  - The kinetics of the tissue
  - The way cells are organized in that tissue

## Response to radiation damage

- In tissues with a rapid turnover rate, damage becomes evident quickly
- In tissues in which cells divide rarely, radiation damage to cells may remain latent for a long period of time and be expressed very slowly
- Radiation damage to cells that are already on the path to differentiation (and would not have divided many times anyway) is of little consequence - they appear more *radioresistant*
- Stem cells appear more *radiosensitive* since loss of their reproductive integrity results in loss of their potential descendants
- At a cell level survival curves may be identical, but tissue *radioresponse* may be very different

## Dose-response relationships

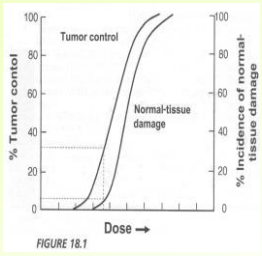


FIGURE 18.1

- Curves are typically sigmoid (S) -shaped for both tumor and normal cells
- Therapeutic ratio (index): tumor response for a fixed level of a normal tissue damage

## Therapeutic ratio

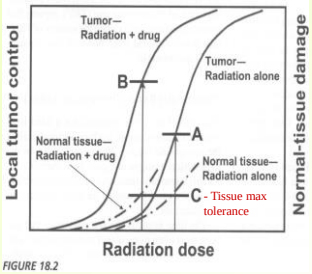


FIGURE 18.2

- The time factor is often employed to manipulate the TR (hyperfractionation for sparing of late-responding normal tissues)
- Addition of a drug, a chemotherapy agent, or a radio-sensitizer may improve the TR

## The volume effect in radiotherapy

- Generally, the total dose that can be tolerated depends on the volume of irradiated tissue
- However, the spatial arrangement of FSUs in the tissue is critical
  - FSUs are arranged in a series. Elimination of any unit is critical to the organ function
  - FSUs are arranged in parallel. Elimination of a single unit is not critical to the organ function

## Radiosensitivity of specific tissues and organs

- Each organ has established tolerance for whole and partial organ irradiation (volume fraction)
- Organs are classified as:
  - Class I - fatal or severe morbidity (bone marrow, heart, brain, spinal cord, kidneys, lungs)
  - Class II - moderate to mild morbidity (skin, esophagus, eye, bladder, rectum)
  - Class III - low morbidity (muscle, cartilage, breasts)

## Indications for radiation therapy

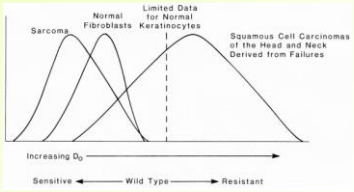
- Radiation therapy may be used to treat almost every type of solid tumor, including cancers of the brain, breast, cervix, larynx, lung, pancreas, prostate, skin, spine, stomach, uterus, or soft tissue sarcomas
- Radiation can also be used to treat leukemia and lymphoma (cancers of the blood-forming cells and lymphatic system, respectively)
- Radiation dose to each site depends on a number of factors: the type of cancer and whether there are tissues and organs nearby that may be damaged by radiation
- Palliative radiation therapy also can be given to help reduce symptoms such as pain from cancer that has spread to the bones or other parts of the body

## Radiosensitivity of cancer cells

- Highly radiosensitive cancer cells are rapidly killed by modest doses of radiation. These include leukemia, most lymphomas, and germ cell tumors
- The majority of epithelial cancers (carcinomas) have only moderate radiosensitivity
- Some types of cancer, such as renal cell cancer and melanoma, are notably radioresistant, with much higher doses required to produce a radical cure than may be safe in clinical practice

## Cell radiosensitivity

Summary of $D_0$ values for cells of human origin (in vitro studies)




- Cells from human tumors have a wide range of radiation sensitivities
- In general, squamous cell carcinoma cells are more resistant than sarcoma cells

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