

Role of Medical Internal Radiation Dose (MIRD) 2020 in evolving paradigms of use for internal emitters for radiotherapy of human cancers

Clinical radiotherapy is always a tradeoff between cure and toxicity, finding the acceptable therapeutic balance. Radiation oncologists, using external beam radiation to control primary tumors, have worked for decades to find this balance between cure of local tumor and normal tissue toxicity. In the last decade, based on advances in radiation dosimetry, and in instrumentation, they can now consistently achieve controlled radiation delivery that provides local tumor control while minimizing radiation toxicity to normal surrounding tissues. For targeted radionuclide therapy, key questions arise: *How can we accurately and practically measure tumor and normal tissue dosimetry of internal emitters? What are the radiation absorbed doses that are achievable by tumors and can be tolerated by normal radiosensitive tissues?* Now is the time to plan for a similar balance with targeted radiotherapy of internal emitters.

The new *Primer 2020* (S-1) “reflects the dramatic evolution of the field of nuclear medicine, more specifically, of molecular imaging and radiopharmaceutical therapy and of the complementary advances in technology, radiochemistry, and radiation biology” ...It also emphasizes the important distinction between dosimetry for risk assessment in diagnostic imaging (Primer 1) versus dosimetry for treatment efficacy and toxicity evaluation related to therapy (Primer 2020). Accordingly, guidance on treatment planning for radioimmunotherapy, radiopeptide therapy, and radiopharmaceutical therapy generally is provided. The MIRD schema (Primer 1) long the standard in the field for “guidance on internal dosimetry-related tasks that may be faced by nuclear medicine and other healthcare professionals, including the dosimetric requirements for regulatory

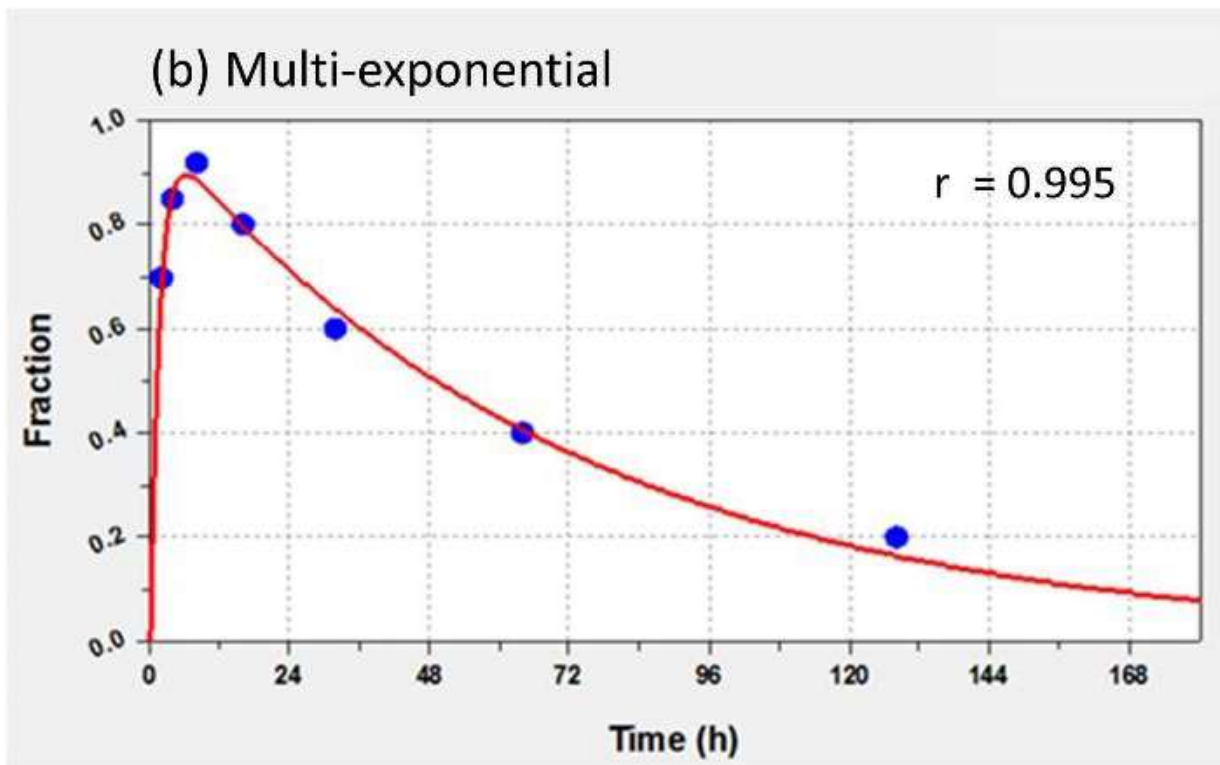
approval of new radiopharmaceuticals” has now expanded its applications to include details about how tumor specific radiopharmaceutical time-activity data can be acquired clinically and pre-clinically - for example, for patient-specific dosimetry in the context of radiopharmaceutical therapy - and how acquired data are analyzed to yield time-integrated activities (Chapter 5). For further details please consult *MIRD Primer 2020* (see Supplemental Figure 1 for an additional example).

As a metaphor for planning safe and efficacious targeted radiotherapies, we look for an “optimized treatment path,” in which we take the narrow road between guardrails of 1) efficacy: cGy to tumor sufficient for complete responses and even cures, and 2) safety: high enough TIs (therapeutic indices) for sensitive tissues like lung, kidney, and especially bone marrow, to avoid lasting radiation damage, whether deterministic or stochastic (see below). We remind the reader that that relative biologic effectiveness of external beam radiation, and  $\beta^-$  rays from internal emitters, is quite similar: around 1 (ICRP Publication 92).

S-1 *MIRD Primer 2020: A Complete Guide to Radiopharmaceutical Dosimetry*

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**Supplemental Figure 1.** From Figure 5.8b of the MIRD Primer 2020. Data points obtained from regions of interest using quantitative imaging of a hypothetical tumor metastasis showing an uptake followed by exponential clearance. Data were uncorrected for radioactive decay. Function fit by least squares regression to the data were a sum of 2 exponentials with 4 parameters (a, b, c, and d) of the form  $y = a \exp(-bt) + c \exp(-dt)$ . Analytic solution of the integral of the curve is  $a/b + c/d$ . Integral can be converted to  $\mu\text{C-hour/gram} \times \text{total mCi dose administered}$ . Radiation absorbed dose in cGy is obtained by simple multiplication of D decay constant in  $\text{gm-rad}/\mu\text{Ci-hr}$  for the radionuclide in question. In this case, the shape of the curve and kinetics would be typical for  $^{131}\text{I}$ -localization into a well differentiated thyroid cancer metastasis after oral administration during radioactive iodine therapy.



**SUPPLEMENTAL Table 1. Select milestones in PRID/PRIT development**

Year	Milestone	Preclinical or clinical?	Target	Radioisotope	References
1986-1988	Anti-chelate mAb radiopharmaceutical delivery (passive tumor targeting)	Preclinical	N/A	<sup>111</sup> In	(1,2)
1987	In vivo biotin-streptavidin PRID	Preclinical	N/A	<sup>111</sup> In	(3)
1988	Application of multivalent haptens during in vivo anti-tumor antigen/anti-hapten BsAb PRID	Preclinical	Murine Lyb8.2	<sup>125</sup> I <sup>111</sup> In	(4)
1990	First-in-human studies of biotin-streptavidin PRID	Clinical	CEA	<sup>111</sup> In	(5)
1991	First-in-human studies of BsAb PRID	Clinical	CEA	<sup>111</sup> In	(6)
1991	First-in-human studies of biotin-streptavidin PRIT	Clinical	CEA	<sup>90</sup> Y	(7)
mid-1990's	First-in-human studies of affinity enhancement system BsAb PRID	Clinical	CEA	<sup>111</sup> In	(8,9)
2010	First-in-human studies of dock-and-lock BsAb PRID	Clinical	CEA	<sup>111</sup> In	(10)
2010	In vivo bioorthogonal inverse electron demand Diels-Alder (IEDDA) PRID	Preclinical	TAG72	<sup>111</sup> In	(11)
2017-2018	In vivo bioorthogonal IEDDA PRIT	Preclinical Preclinical	CA19.9 CA19.9 gp72	<sup>177</sup> Lu <sup>225</sup> Ac <sup>212</sup> Pb	(12-14)
2019	Anti-tumor/anti-Pb-DOTAM BsAb PRIT	Preclinical	CEA	<sup>212</sup> Pb	(15)
2021	BsAb self-assembling and disassembling PRIT platform	Preclinical	GD2	<sup>177</sup> Lu <sup>225</sup> Ac	(16)

**SUPPLEMENTAL TABLE 2. Overview of select PRID/PRIT clinical trials**

Year	First Author(s)	Phase	Disease	PRIT method	Radiohaptent(s)	Target/Antibodies	References
1990	Kalofonos	?	lung	biotin-streptavidin	<sup>111</sup> In-biotin	CEA/HMfg1-St	(5)
1991	Stickney	?	colorectal	BsAb	<sup>111</sup> In-EOTUBE	CEA/ZCE-025	(6)
1991	Paganelli	?	multiple (GI, thyroid, lung, breast)	biotin-streptavidin	<sup>111</sup> In-biotin	CEA/FO23C5	(7)
1993	Le Doussal	?	colorectal	BsAb	<sup>111</sup> In-DPTA-TL, <sup>111</sup> In-DPTA	CEA/F6-734	(8)
1993	Peltier	I,II	thyroid	BsAb	<sup>111</sup> In-DPTA-TL	CEA/F6-734	(9)
1996, 1998	Bardies, Barbet	?	thyroid	BsAb	<sup>131</sup> I-, <sup>111</sup> In-DPTA-TL	CEA/F6-734	(17,18)
1999	Kraeber-Bodere	I,II	thyroid	BsAb	<sup>131</sup> I-DPTA-TL	CEA/F6-734	(19)
1999	Breitz	?	multiple (GI, lung, bladder, breast, ovarian)	biotin-streptavidin	<sup>90</sup> Y-biotin	EpCAM/NR-LU-10	(20)
2000	Knox	II	colorectal	biotin-streptavidin	<sup>90</sup> Y-biotin	EpCAM/NR-LU-10	(21)
2000	Weiden	I,II	lymphoma	biotin-streptavidin	<sup>186</sup> Re-, <sup>111</sup> In-, <sup>90</sup> Y-biotin	CD20/C2B8-StA (Rituximab StA)	(22)
2003	Kraeber-Bodere	I	lung	BsAb	<sup>131</sup> I-DTPA	CEA/hMN14-m734	(23)
2004	Forero	I	lymphoma	biotin-streptavidin	<sup>111</sup> In-, <sup>90</sup> Y-biotin	CD20/B939FP	(24)
2005	Shen	I	colorectal	biotin-streptavidin	<sup>111</sup> In-, <sup>90</sup> Y-biotin	TAG72/CC49	(25)
2006	Kraeber-Bodere	I	thyroid	BsAb	<sup>131</sup> I-DTPA	CEA/hMN14-m734	(26)
2006	Chatal	Two successive phase I studies	thyroid	BsAb	<sup>131</sup> I-DTPA	CEA/hMN14-m734 vs F6-734	(27)
2013, 2014	Schoffelen	I	colorectal	DNL BsAb	<sup>111</sup> In-, <sup>177</sup> Lu-IMP288	CEA/TF2	(28)
2015	Bodet-Milin	I	lung	DNL BsAb	<sup>111</sup> In-, <sup>177</sup> Lu-IMP288	CEA/TF2	(29)
2016	Bodet-Milin	I	thyroid	DNL BsAb	<sup>68</sup> Ga-IMP288	CEA/TF2	(30)
2020	Rousseau	?	breast	DNL BsAb	<sup>68</sup> Ga-IMP288	CEA/TF2	(31)
2021	Bodet-Milin	?	thyroid	DNL BsAb	<sup>68</sup> Ga-IMP288	CEA/TF2	(32)
2021	Touchefeu	?	colorectal	DNL BsAb	<sup>68</sup> Ga-IMP288	CEA/TF2	(33)

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