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A theranostic approach based on the use of a dual *boron*/Gd agent to improve the efficacy of Boron Neutron Capture Therapy in the lung cancer treatment.

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ABSTRACT.

This study aims at developing an innovative theranostic approach for lung tumour and metastases treatment, based on Boron Neutron Capture Therapy (BNCT). It relies on to the use of Low Density Lipoproteins (LDL) as carriers able to maximize the selective uptake of boron atoms in tumor cells and, at the same time, to quantify the in vivo boron distribution by Magnetic Resonance Imaging (MRI). Tumour cells uptake was initially assessed by ICP-MS and MRI on four types of tumour (TUBO, B16-F10, MCF-7, A549) and one healthy (N-MUG) cell lines. Lung metastases were generated by intravenous injection of a Her2+ breast cancer cell line (i.e. TUBO) in BALB/c mice and transgenic EML4-ALK mice were used as primary tumour model. After neutron irradiation, tumour growth was followed for 30-40 days by MRI. Tumour masses of boron treated mice increased markedly slowly than the control group.

Keywords:

Low Density Lipoproteins (LDL), Boron Neutron Capture Therapy (BNCT), MRI, theranostic agents, carboranes.

Background

Lung cancer remains the leading cause of cancer-related mortality (www.who.int/cancer/en) causing 1.59 million death worldwide per year. Lungs are the most common sites of metastatic disease and tumour relapse after the treatment of the primary mass. Since lung tumours are largely disseminated in the pulmonary parenchyma, their excision is often difficult and not resolving causing a median survival time of less than one year. For these reasons it is important to develop less invasive treatments able to discriminate between healthy and pathological tissues at cellular level. Boron neutron capture therapy (BNCT) is an experimental binary radiation therapy currently under intense scrutiny for the treatment of cancer, especially head and neck recurrent tumours[1], skin melanomas[2], liver metastatic diseases[3] and brain tumours[4]. It is based on thermal neutron capture by ^{10}B nuclei previously delivered to tumour cells. The neutron capture event results in the formation of excited ^{11}B that decay emitting highly ionising $^{4}He^{2+}$ and $^{7}Li^{3+}$ ions. Cell death is triggered by the release of the energy of these charged particles which create ionisation tracks along their trajectories in a range of approximately 5–9 μm. Thus it is possible to destroy tumour cells without affecting adjacent healthy cells if ^{10}B atoms are selectively accumulated in the intracellular space. It has been estimated that approximately 10-30 μg of *boron* per gram of tumour mass is needed to attain an acceptable therapeutic advantage, provided the availability of a suitable neutron source and considering an acceptable irradiation time[5,6]. This fact makes BNCT a promising option for the treatment of disseminated tumours, such as pulmonary metastases that cannot be treated by methods requiring a precise localization of the pathological tissue, like surgery, conventional photon-therapies or heavy ion-therapy. The selective delivery to tumour cells is crucial to increase the amount of internalized boron maintaining, at the same time, a low concentration in surrounding healthy tissues and in blood to minimize damage. Currently, two BNCT drugs are available for clinical investigation namely: i)L-para-boronophenylalanine (BPA), structurally related to the amino acid phenylalanine, that has been used in clinical trials to treat glioblastoma, head and neck recurrent cancer and melanoma[7] and ii) sodium mercaptoundecahydro-closo-dodecaborate (BSH) that has been investigated for the

treatment of malignant glioma[8]. Despite their clinical use, both BPA and BSH show low selectivity and great efforts have been made by several research groups to develop new and more selective *boron* delivery agents. To this purpose, polynuclear boron derivatives, especially carboranes, have been extensively investigated[9]. Carboranes are icosahedral cages containing 10 *boron* atoms and they have been used to design boron delivery vehicles due to their high *boron* content, chemical versatility and in vivo stability[10-11]. Carborane based agents may be functionalized with small targeting moieties including amino acids, vitamins, carbohydrates, porphyrinates, ect.[12] to achieve tumour selectivity. A different strategic concept for selectively introducing *boron* into tumour cells is based on the covalent binding of multiple carborane cages to monoclonal antibodies[13] or their incorporation into large entities such as, liposomes[14-15], low-density lipoproteins[16-18] (LDL) or other nanoparticles. Despite the current availability of many carborane derivatives that have given significant results in preclinical studies, none has been translated to the clinical setting. A crucial issue to reach this goal is the assessment of the *boron* amount in the tumour tissue. This is important in order to proceed with the neutron irradiation, because successful results can only be expected if the boron concentration threshold has been reached, and if a proper dose prescription is performed according to the therapeutic goal and the sparing of the normal tissue. Currently, *boron* concentrations in tumour are estimated in clinical trials using empirical data models that depend on tumour-to-blood, tumour-to-brain and brain-to-blood boron concentration ratios. One of the problems is that the uptake and distribution of boron varies among patients and that large uncertainties exist in the tumour-to-blood boron concentration ratio[19]. Only proper Neutron Capture Therapy (NCT) agent design, based on an improved knowledge of how molecules enter healthy and cancer cells, could allow the optimal intracellular concentration, needed to make NCT an effective therapy to cure cancer, to be reached. Furthermore, the access to not invasive and highly sensitive imaging techniques can allow the detection of tumour *boron* concentration in real time before neutron treatment. Some of these methodologies require the functionalization of the NCT agent with a proper imaging reporter, such as ^{18}F atoms for Positron Emission Tomography (PET), a Gd/Fe containing agent for Magnetic Resonance

Imaging (MRI) or ^{19}F atoms for ^{19}F-NMR. Both PET and MRI detection limits are below the boron threshold necessary to perform the therapy[20]. PET is more sensitive but it has the disadvantage of the administration of further radioactivity, while MRI appears to be a suitable technique to achieve the goal of the quantitative assessment of the NCT agent in tissues. Although its sensitivity is lower in comparison to nuclear and optical modalities, the high spatial resolution (<100um) of MRI provides detailed morphological and functional information, and the absence of ionizing radiation makes it safer than techniques based on the use of radioisotopes. MRI signal is dependent on the longitudinal (T_1) and transverse (T_2) proton relaxation times of water and in both clinical and experimental settings the endogenous contrast can be altered by the use of contrast agents (CA) that decrease T_1 and T_2 of water protons in the tissues where they distribute.[21] In a proton MR image there is a direct proportionality between the observed signal intensity (SI) enhancement and the concentration of the CA. Thus these agents can be used to carry out indirect *boron* quantification upon their linking to the neutron capture compound. Interestingly, a given cell can be visualised by MRI when the number of Gd^{3+} complexes is of the order of 10^8-10^9 per cell, i.e. a threshold close to the number of *boron* atoms necessary to provide an effective NCT treatment[22].

This study is aimed at testing the efficiency of a MRI theranostic agent for BNCT treatment of lung tumours and metastases. Lung metastases have been generated by intravenous injection of a $Her2^+$ breast cancer cell line (TUBO)[23]. The Her2 overexpression has been detected in approximately 20% of human breast cancers and is associated with an aggressive course and with early development of metastases. Several anti-Her2 strategies has been approved revolutionizing the clinical outcome of $Her2^+$ breast cancer, but in most cases, the succeeding onset of pharmacological resistance renders this treatments completely ineffective. In this context, the set-up of new strategies is urgently needed. As a model of primary tumour in the lung, we used a transgenic (Tg) mouse line model that ectopically expresses the oncogenic EML4-ALK fusion protein under a lung-specific SP-C promoter[24] specifically in lung alveolar epithelial cells. In all Tg mice, the EML4-ALK protein was expressed specifically in lung epithelial cells. All of the EML4-ALK transgenic mice developed many

adenocarcinoma nodules in both lungs with a 100% penetrance within a few weeks after birth, as a consequence of the potent oncogenic activity of the fusion kinase EML4-ALK. The dual MRI/BNCT agent used in this study is able to maximize the selective uptake of *boron* in tumor cells by targeting LDL receptors (LDLRs), and, at the same time, to quantify *boron* distribution in tumour and in other tissues by MRI[17]. LDLs have been identified as good carriers of *boron* cluster since the expression of LDLRs is up-regulated in many tumours[25,26]. Furthermore these nanoparticles can carry a high number of boron atoms without losing the specific internalization pathway. For NCT treatment, the AT101 ligand was chelated using $GdCl_3$ enriched in the isotope 157 to exploit its high thermal neutron cross-sections of around 255000 barns[27]. This cross-section provides a roughly 65-fold improvement upon the one of ^{10}B neutron capture. The nuclear reaction of ^{157}Gd generates prompt γ-rays of broad energy spectrum in competition with Auger electrons and X-rays. Due to their very short ranges (less than 0.5 nm up to 1.4 μm), ^{157}Gd atoms would have to be localized at the nuclei of target cells, in contact with DNA, in order to induce sufficient damage to cause apoptosis and to obtain an effective treatment.

Methods. The ^{10}B enriched ligand-*C*-[*N*-(DOTAMA-C_6)carbamoylmethyl]C'-palmitamidomethyl-*o*-carborane (^{10}B enriched AT101) was synthesized following the previously reported procedure[17] described in Supplementary Material.

Cell and animal irradiation were performed in the thermal column of the TRIGA Mark II reactor at University of Pavia (Italy). The experimental protocol is described in the supplementary materials. The irradiation facility was previously designed for TAOrMINA treatment[28]. TRIGA maximum power is 250 kW and has a cross section of 40 × 20 cm^2, a length of 1 m and it starts at about 1.3 m from the centre of the reactor core. The irradiation time has been fixed at 15 minutes at a reactor power of 30 kW, corresponding to a thermal neutron fluence of $1.26 \cdot 10^{12}$ cm^{-2} Animal studies were performed according to the national regulations and were approved by the local ethical committee. The preparation of the animal model is described in the Supplementary Materials. *Boron* concentration in tumour, tissues and organs was calculated using the equations[29] reported in Supplementary Material.

Mice models were prepared by injecting 50000 TUBO cells into the tail vein three weeks before the treatment. The first mice group (n=15) received AT101/LDL (0.1 mmol/kg Gd dose) 6h before irradiation. Group two (irradiated control group, n=15) received at the same time, the same volume of PBS. A third group of non-irradiated mice (n=10) was used as a reference to assess tumour growth in the absence of any treatment. The neutron field of the TRIGA Mark II is not collimated and this implies that during the lung irradiation, the whole body of the animal is indirectly exposed to the neutron field. In order to protect the healthy organs of the animal body a shield made of 95% ^6Li-enriched Li_2CO_3 powder was used as neutron absorber, due to the absence of secondary gamma radiation after ^6Li neutron capture[30].

The simulation code Monte Carlo N-Particles (MCNP) was used to design the treatment plan. The simulation was validated with neutron flux measurements by the activation of Cu wires using the Westcott formalism[31]. In the adopted experimental set-up 5 mice are irradiated at the same time, each one protected by two units of Li_2CO_3 neutron shield to cover the head and the abdomen

regions. The units are kept separated of about 1 cm to guarantee the direct exposure of the tumours to the neutron flux.

Results.

LDL adduct preparation and characterization. The dual *boron*/Gd agent (AT101) used in this work (Figure 1A) and its LDL adducts have been prepared following the already published procedures[17]. Briefly, since AT101 forms stable, large sized micelles in aqueous solution, it was necessary to de-assemble them by adding β-cyclodextrin (β-CD) before the incubation with LDL to yield the molecular dispersion of the amphiphilic complexes. The experimental work up consists of the step-wise addition of aliquots of the β-CD/AT101 adduct to the aqueous solution of LDL particles in order to transfer AT101 complexes to LDLs (Figure 1B). The thermodynamic association constant (Ka) of AT101/LDL adducts was of $1.7x10^4$ M^{-1} with an estimated number of 300 binding sites available to AT101 per protein[17]. The r_{1p} (the observed relaxation rate of a water solution containing 1mM of a paramagnetic species) of the AT101/LDL adduct was 15.5 $mM^{-1}s^{-1}$ and the dynamic light scattering (DLS) measurements indicated that their size was almost the same (24±2 nm) as that found on the native LDL particles (23±1 nm).

"In vitro" cellular uptake experiments and MRI analysis. Using the above reported method, an AT101/LDL adduct containing ca. 230 Gd complexes per protein was prepared. TUBO is a $Her2^+$ established cell line derived from a spontaneous mammary tumor arising in a virgin transgenic BALB-*neu*T female mouse. In these mice, the mammary carcinogenesis displays a histopathological course that closely recapitulates the one observed in human breast tumors[32], making this mouse model, and the TUBO cells derived from it, an ideal tool to test anti-cancer therapies. As already reported, many tumor cells are characterized by an up-regulation of LDL transporters[33]. In order to evaluate the uptake capacity of LDLRs, TUBO cells have been incubated in the presence of increasing amounts of

the AT101/LDL theranostic agent for 16h at 37°C. After washing with cold PBS, cells have been collected and analyzed by ICP-MS to measure the Gd content. In order to consider the different number of cells present in each sample, the amount of Gd was normalized to the total protein concentration. The results obtained with TUBO cells (Figure 2A) have been compared with those obtained with murine melanoma (B16-F10), human breast cancer (MCF-7), human lung adenocarcinoma (A549) and with healthy mouse mammary gland cells (N-MUG) using the same incubation protocol. Figure 2A shows that the internalization of AT101/LDL by tumour cells (TUBO, B16-F10, MCF-7, A549) is significantly more efficient in the range of the concentrations considered than that observed with healthy N-MUG cells. Cell viability after AT101/LDL incubation have been assessed by MTT test. (Figure S1 Supplementary Materials) A LDL concentration of 25 μg/ml in the culture medium was enough to internalize into the target cells a sufficient amount of *boron* to perform BNCT. In fact a Gd concentration of 1.7×10^{-9} moles/mg corresponds to an intracellular *boron* concentration of 28 ppm (by considering that 1 g of tissue contains 1×10^{9} cells and that 1 mg of proteins correspond to 6×10^{6} TUBO cells). This concentration is sufficient to attain a successful treatment if the *boron* concentration in the surrounding tissue is at least three times lower and if a sufficient neutron fluence can be delivered to patients in an acceptable irradiation time. To demonstrate that the uptake of the AT101/LDL adduct by TUBO cells involves LDLRs, a competition assay with native LDL was carried out. After 16h of cell incubation in the presence of the AT101/LDL adduct (20 μg/mL), the uptake decreased by about 50% when the concentration of native LDL added to the culture medium was 200 μg/mL. Furthermore, in order to exclude that the AT101/LDL uptake is the consequence of a difference in the endocytosis rates of these cell lines, a comparison of non-targeted, Gd-DOTAMA(C18)$^{34}_{2}$ containing stealth liposomes[35] (LIPO) uptake has been carried out. Figure 2B shows that the amount of internalised Gd is significantly lower than that measured upon AT101/LDL incubation in all considered tumour cells ($p<0.0006$). On the contrary, the healthy N-MUG cells not showed a significant difference between LDL and LIPO ($p= 0.1$) indicating the not-specific endocytic uptake of both particles. In order to assess whether the amount of Gd internalized in

target cells is enough to permit MRI visualization, T_1 weighted images of glass capillaries containing cellular pellets obtained by incubating TUBO cells with increasing amounts of LDL/AT101 were acquired at 7 T (Figure 2C). The T_1 weighted image shows clearly that the SI of cells incubated in the presence of LDL/AT101 is hyperintense in comparison with the control. As expected the SI is directly proportional to the LDL concentration.

Evaluation of the AT101/LDL particle uptake "in vivo" in pulmonary metastasis.

In order to generate the lung metastasis mice model, 50000 TUBO cells have been injected intravenously (iv) 3 weeks before MRI analysis and BNCT treatment. At this time all mice develop many pulmonary metastasis of 0.5-2 mm diameter. Tumour bearing mice (n=4) received (iv) a bolus of AT101/LDL at a dose of 0.1 mmolkg^{-1} as expressed in terms of Gd content. T_1-weighted spin-echo MR-images were acquired before and 3, 6, and 24h after the CA administration. Representative examples of axial T_1-images of lung metastases acquired before and 3h after LDL/AT101 injection are reported in Figure 3 A and B, respectively. Figure 3C reports the mean SI enhancement (%) at the different time intervals. As expected, high % SI enhancement are observed in the tumor region and in the liver due to the high LDLRs expression on both tumor cells and normal hepatocytes. On this basis, the liver has to be protected with a neutron shield during BNCT treatment.

The *boron* concentrations calculated at 3, 6 and 24h post-injection, using the method reported above, in the tumour, muscle (surrounding lungs), and liver are reported in Table 1. The intra-tumour *boron* concentration was significantly above the established threshold of 20/30 ppm, which is suitable for efficient BNCT treatment. The ratio of the concentration of *boron* atoms derives from the comparison between the concentrations in the tumour and surrounding muscle. On the basis of these results 6h POST i.v. has been selected as the best time to perform BNCT. In fact, at this time, the high *boron* concentration in tumour (48 ppm) is combined with a high tumour/muscle *boron* ratio that is fundamental to avoid healthy tissues damage.

BNCT treatment of TUBO cells "in vitro".

For the BNCT studies the AT101 ligand has been chelated to Gd^{3+} enriched in the isotope 157. Seven T75 flasks, four with TUBO cells previously incubated for 16h in the presence of AT101/LDL (50μg/ml protein concentration), and three with non-treated control cells were irradiated in the thermal column of the TRIGA Mark II reactor for 15 minutes. *Boron* concentration inside TUBO cells during the irradiation was of 36 ppm. At the end of irradiation the medium was removed and replaced with fresh DMEM and flasks were placed at 37 °C in a humidified atmosphere of 5% CO_2. After 24h cells were detached, counted and re-plated to follow their proliferation. Two cell controls have been used in this experiment. The first did not receive any neutron irradiation and any *boron* containing compound and the second control was irradiated without the administration of the *boron* containing compound. The proliferation rate of the *boron* treated cells survived to the irradiation is significantly lower than the rates measured for both control cells. (Figure 4). On this basis one can conclude that the intracellular *boron* amount is sufficient to induce a dramatic toxic effect upon neutron flux exposure.

Irradiation set-up and radiation dose calculations.

Mice neutron irradiation was carried out using the same irradiation facility used for cells. To limit the neutrons dose absorbed by the liver and spleen, as AT101/LDL accumulate in these organs and to limit the neutron-induced radioactivity in the whole animal, neutron-absorbing shields made of 95% ^{6}Li-enriched Li_2CO_3 powder have been used leaving only the thorax region, in correspondence of lungs, exposed to the neutron flux. (Figure S2 supplementary materials). To know the radiation doses delivered in the tumour and in the healthy tissues/organs, a simulation program dedicated to neutron and photon transport in complex geometries (MCNP) was used. The radiation/material interaction is carefully reproduced thanks to point-wise nuclear cross data. Using B concentrations measured by MRI and MCNP simulation, the total dose (Dtot) absorbed by the tissues was calculated as well as the various dose components arising from: i) high Linear Energy Transfer (LET) protons emitted by neutron capture reaction on ^{14}N and by elastic scattering on ^{1}H (% protons); ii)secondary

radiations emitted by neutron capture reaction on ^{10}B (therapeutic fraction; % ^{10}B NCT); iii) γ-rays, including the photon contamination of the incident neutron beam (facility background) iv) 2.2 MeV γ-ray of thermal neutron capture reaction on ^{1}H (% γ-rays) (Table 2 and 3).

To carry out a safe treatment, preliminary irradiations of wild type BALB/c mice (n=15) were performed using the described shielding without the administration of the *boron* containing compound. The irradiation time was increased from 10 up to 20 minutes, while the reactor power was kept at 250 kW. From these results (reported as supplementary materials in Figure S3), the time for the NCT irradiation was fixed to 15 minutes, taking into account the toxicity just described and the presence, during a real NCT, of the enhancement capture agents in the tissues. To assess the safety of this treatment plan, the doses were compared to a tolerance limit of about 7 Gy delivered in a total body X- or γ-ray irradiation of the mouse[36]. The dose contribution due to the 92.3% enrichment in ^{157}Gd was calculated as well. As anticipate, the biological effect was mainly expected from the Auger electrons which transport a very little fraction of the total energy emitted by ^{157}Gd capture reaction. As consequence, the contribution of this radiation in term of absorbed dose is pretty low. The MCNP simulations reported an enhancement of the total doses showed in Table 2 of about 5-6% in the lung metastases, while the same increment can be as high as around 10% in healthy tissues, depending on Gd concentration and organ position and shielding.

BNCT treatment of pulmonary metastasis.

BALB/c mice (n=40) received an i.v. injection of 50000 TUBO cells 3 weeks before BNCT treatment. This led to the formation of several pulmonary metastasis that have been visualized by MRI using a T_2-weighted RARE sequence. The number of metastasis varied markedly from mouse to mouse (from 5 to 20). The intratumour *boron* concentration has been determined by MRI 3h after the AT101/LDL administration and was of 43±10 ppm whereas 16±5 *boron* ppm have been found in the surrounding healthy muscle. Two groups of animals (n=15 for each group) underwent the irradiation treatment. The first group received AT101/LDL at a Gd dose of 0.1 mmol/Kg corresponding to a *boron* dose of

10mg/Kg, 6h before neutron exposure. The second group (irradiated control group) received the same volume of PBS to assess the effect of neutron irradiation in the absence of AT101/LDL. A third group of non-irradiated mice (n=10) was used as a reference to assess tumour growth in the absence of any treatment and irradiation. Tumour size has been monitored by MRI using a T_2-weighted RARE sequence. (Figure 5A-D) No growth of the tumour size was detected for irradiated and treated animals in the first 25 days after BNCT (Figure 5E). Only at longer times the tumour lesions slowly restarted their growth.

BNCT treatment of EML4-ALK transgenic mice.

EML4-ALK transgenic mice received the same treatment described above. At the day of irradiation, the tumour volumes of 6 weeks old EML4-ALK mice were between 0.5-15 mm^3 (Figure 6A). *Boron* concentrations were calculated 3h before BCNT treatment by MRI measuring the SI enhancement in the tumour regions in the T_1 weighted images before and after the AT101/LDL administration and they were of 52±12 and 16±5 ppm in the tumour and surrounding muscle, respectively. On this basis it is possible to conclude that also in this model the intratumour amount of *boron* was enough to expect a significant regression of the tumour mass upon the neutron exposure. A limited toxic effect on the surrounding muscle is expected thanks to the three times lower *boron* concentration detected in these healthy tissues. Two groups of mice have been considered in this study. The first group (n=5) received AT101/LDL in a Gd dose of 0.1 mmol/Kg, 6h before neutron exposure. The second group (irradiated control group; n=5) received the same volume of PBS in order to assess the effect of neutron irradiation in the absence of AT101/LDL. Figure 6B shows that the tumour growth of mice irradiated after *boron* treatment was negligible for the first 30 days.

Discussion.

The proposed procedure, based on the destruction of the tumour bulk by BNCT using a *boron*/Gd dual nanosized delivery agent, opens a promising therapeutic opportunity for lung cancer treatments in particular in the presence of disseminated tumours. This approach has been tested on mammary metastases (obtained by injecting i.v. mammary carcinoma TUBO cells) and ALK-EML4 transgenic mouse models of lung carcinogenesis, that develop highly aggressive tumours with modality similar to that of human cancer. In this contest, the possibility to measure *boron* concentration indirectly by MRI exploiting the presence of the conjugated Gd CA, was fundamental to proceed with the best treatment duration, at the most advantageous time after boron administration and with a proper neutron fluence. In fact, successful results can only be expected if a sufficient dose is delivered to tumour while the dose absorbed to normal tissues is kept under the tolerance dose. In order to achieve this result, a combination of three factors is necessary: a suitable boron concentration in the tumour, a high tumour to normal tissue ratio and a sufficient neutron flux to irradiate animals in acceptable times. The observed tumour re-growth observed on both mice models about 25-30 days after the treatment may be accounted in terms of two possible explanations: i) it might be associated to the presence in the tumour mass of quiescent cells, for which a greater capacity to recover from radiation and chemotherapeutic agent-induced damage has been demonstrated [37,38]. In addition, the higher resistance observed for these cells to targeted therapies could be the consequence of a lower expression of target receptors with respect to highly proliferating cells; ii) the neutron dose delivered to the lung tumour is not sufficient to kill all the cells. This may be due to the fact that the shielding set-up is a compromise between the need to protect the animal and the therapeutic effect gained by neutron irradiation. Actually, due to the proximity of lungs and liver, organs where AT101/LDL accumulates, it is difficult to design and locate the Lithium carbonate shield in a way that the healthy tissue is preserved while leaving the tumour exposed to neutron irradiation. This problem is essentially related to the small size of the animal and can be overcome in clinical applications where a collimated and selective neutron beam is used. Furthermore, as a consequence of the genetic

origin of the ALK-EML4 mice model, one week after neutron irradiation, a formation of new tumour masses was observed. At the time of irradiation these small tumour masses were completely absent and therefore not affected by the neutron treatment, or their diameter was < 0.2 mm and not detectable by MRI. The uptake of AT101/LDL administered intravascularly is reduced in the case of small lesions because they have not yet formed a distributed vascular system through which *boron* delivery takes place.

Finally, from these results one can surmise that it may be a worth to seek for the combination of BNCT with the administration of chemotherapic agents as well as with a different therapeutic strategy such us photodynamic therapy. These treatments should be administered 30-40 days after neutron irradiation when the bulk tumour mass is significantly reduced.

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Figure legends.

Figure 1. **A)** Schematic representation of the dual *boron*/Gd agent (AT101). **B)** Schematic depiction of the formation of AT101/β-CD and AT101/LDL adducts.

Figure 2. **A)** "In vitro" uptake experiments onTUBO, B16-F10, MCF-7, A549 and N-MUG cell lines. Cells were incubated for 16 h at 37°C in the presence of increasing amounts of AT101/LDL (expressed as protein concentration μg/ml). The amount of Gd taken-up by cells has been determined by ICP-MS and it was normalized to the protein content determined by the Bradford assay. Errors bars report the standard deviation (SD) of the data. **B)** Student two-tailed t test comparison of AT101/LDL and Gd-liposome (LIPO) cell uptake: TUBO ($p = 0.0002$); B16-F10 ($p = 0.00004$); MCF7 ($p = 0.0006$); A549 ($p=0.0001$); N-MUG ($p=0.1$). Cells were incubated for 16 h at 37°C in the presence of 20 μM Gd concentration in both LDL and LIPO conditions. A p value less than 0.05 was considered statistically significant. Data are expressed as means ± SD. **C)** T_1-weighted spin-echo MR image of an agar phantom with glass capillaries containing unlabeled cells (1) and cells incubated with 10, 20, 30 and 50 μg/mL of AT101/LDL (2–5, respectively) for 16 h at 37°C.

Figure 3. MRI "in vivo" in BALB/c mice with pulmonary metastases after administration of the AT101/LDL nanoparticles. Representative T_1-weighted MR images of BALB/c lungs acquired before **(A)** and 3 h after **(B)** the administration of AT101/LDL particles. **C)** A plot of MRI SI enhancements (%) measured in different organs vs time after the administration of the AT101/LDL adduct. Errors bars report the SD.

Figure 4. Proliferation curve of: not irradiated (○), irradiated (▲) TUBO control cells, and irradiated (■) TUBO cells after B treatment. Cells were re-plated 24h after the BNCT treatment.

Figure 5. Tumour-growth evaluation performed after neutron irradiation. T_2-weighted RARE images acquired on lung metastases irradiated with neutrons without (A,B) or after (C,D) administration of AT101/LDL. A) and C) images were acquired at time 0 and B) and D) 25 days after neutron irradiation.

In all images the arrows indicate tumour regions. E) Tumour volumes increase measured by MRI on untreated control mice (Δ), irradiated control mice (■) and irradiated and AT101/LDL treated mice (●). Error bars indicate the SD.

Figure 6. A) T_2-weighted RARE coronal image of a representative 6 weeks old EML4-ALK mouse. Disseminated tumours are clearly visible in both lungs and they are indicated with arrows. B) Tumour volumes increase measured by MRI on irradiated control mice (●) and irradiated and AT101/LDL treated mice (■). Error bars indicate the SD.

Table legends.

Table 1. Biodistribution of *boron* atoms in lung metastases bearing mice

Table 2. MCNP-simulated total absorbed dose (Dtot) and its components when animals are irradiated and treated with AT101/LDL adduct (mean neutron fluence of about $1.3 \cdot 10^{12}$ cm^{-2})

Table 3. MCNP-simulated total absorbed dose (Dtot) and its components when the animal undergoes neutron irradiation only (mean neutron fluence of about $1.3 \cdot 10^{12}$ cm^{-2})