Physiological characterization of human ovarian cancer cells in a rat model of intraperitoneal antineoplastic therapy

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Flessner, Michael F., Jaehwa Choi, Zhi He, and Kimberly Credit. Physiological characterization of human ovarian cancer cells in a rat model of intraperitoneal antineoplastic therapy. J Appl Physiol 97: 1518–1526, 2004. First published June 4, 2004; 10.1152/japplphysiol.00305.2004.—Destruction of cancer cells by therapies directed against new molecular targets requires their effective delivery to the tumor. To study diffusion and convection of intraperitoneal (ip) therapy to ip tumors, we established a new athymic rat (RNU) model with ovarian tumor cells (SKOV3 and OVCAR3) implanted in the abdominal wall. The model simulates metastatic tumor and facilitates the measurement of physiological parameters that govern transport forces. CD31 immunohistochemistry revealed unique patterns of angiogenesis, with a tissue-averaged vascular volume of ~0.01 ml/g for each tumor. The extracellular volume (SKOV3: 0.54 ± 0.11 ml/g, n = 5; OVCAR3: 0.61 ± 0.03, n = 5) was over twice that of the adjacent normal muscle (0.22 ± 0.06 ml/g, n = 5). Intravenous-injected antibody tumor clearance was two to three times that of muscle. Interstitial pressures were higher than normal tissue with a median of 10–15 mmHg. Quantitative autoradiography of frozen tissue slices from rats exposed to ip solutions containing [14C]mannitol or [125I]-immunoglobulin G (trastuzumab) was performed to determine transport of small and large molecules. With ip pressure of 0–6 mmHg, both mannitol and immunoglobulin G displayed steep concentration profiles close to the tumor surface with limited penetration deeper within the tumor tissue; antibody penetration was significantly affected by ip pressure. These results demonstrated effects of molecular size, ip pressure, the limited but highly permeable tumor vasculature, and the expanded interstitium on drug penetration from the peritoneal cavity. In conclusion, we have characterized physical and chemical parameters that determine transport of therapeutic agents in our unique tumor-bearing rat model.

Tumor Cells

Initial batches of the SKOV3 tumor cells were a kind gift from Dr. Joseph Rosenblatt and Dr. Pia Challita-Eid (University of Rochester, Rochester, NY). SKOV3 cell had been shown to overexpress HER2 receptors on their surface and would present a good target for the clinically relevant MAb Trastuzumab (Dr. P. Challita-Eid, personal communication). Later experiments were performed with SKOV3 or OVCAR3 cells purchased from ATCC (Rockville, MD). The SKOV3 cells were grown at 37°C with the following media: 90% McCoy’s 5A medium with 1.5 mM L-glutamine and 2.2 g/l sodium bicarbonate.

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(Invitrogen, Carlsbad, CA) supplemented with 10% fetal bovine serum (Sigma Chemical, St. Louis, MO). The cells multiplied quickly to provide ~10^6 cells in 3 wk. NIH:OVCAR-3 cells were grown in modified RPMI 1640 medium from ATCC and supplemented with 10 μg/ml bovine insulin and 20% fetal bovine serum (Sigma Chemical). The second tumor cell line was pursued as a possible variant to the SKOV3 tumor in terms of transport characteristics (macroscopic structure, microscopic structure, physiological variables). The establishment of a second xenograft in athymic rats also confirms the usefulness of the animal model in other applications.

Implantation of other cell lines was attempted but failed to grow in the athymic rats: MDA-MB-231 and MDA-MB-453.

Isotopic Tracers and Solutions

The solution used as a vehicle to introduce test molecules into the peritoneal cavity or intravenously (iv) was Krebs-Ringer bicarbonate (290 mosM/kg, pH = 7.4) solution (containing as follows (in mM): 120 NaCl, 10 KCl, 2 CaCl2, 25 NaHCO3, 0.28 KH2PO4, 1.2 MgSO4]. The solution was filtered with a 0.45-μm pore size membrane (Nalgene) and stored at 4°C. Bovine serum albumin (5%) was added to all solutions to be used in the peritoneal cavity; this prevents loss of protein (and oncotic pressure) from the plasma to the fluid in the cavity (8).

\[^{[\text{14C}]}\text{mannitol}\] was purchased from Moravek Biochemicals (Brea, CA) and used directly in experiments designed to measure extravascular space. Isotope detection was performed with a Beckman liquid scintillation counter (LS 6000IC, Beckman Instrument, or Tricarb 2500-TR, Packard Instrument, Meriden, CT).

Trastuzumab, the IgG MAb to the HER2 receptor, was used as a macromolecular marker because it was known to bind receptors on SKOV3 cells. It also acts as a general macromolecular marker. It was macroimmunoprecipitated with 10% tricarboxylic acid (13). Gamma counting was measured with Packard Cobra II auto-gamma counter or Beckman 8000 gamma counter.

Surgical Procedures

Tumor implantation. Animals were allowed to have full access to water and food and acclimatized after arrival in the Atymic Facility for at least 1 wk before any surgical manipulations. Tumor cells were harvested on the day of implantation. Implantation was carried out within 3 h of harvesting; the viability of postimplantation harvested cells was tested with Trypan blue and demonstrated that >85% of the total were viable 4 h after harvest.

Each animal was anesthetized with 1–5% halothane or isoflurane, 95% oxygen within a laminar airflow hood. With the use of sterile technique, the skin over the midline of the abdominal wall was opened, and a 2-cm vertical incision along the linea alba was made in the abdominal wall muscle to expose the peritoneum. With a syringe and 22-gauge needle, cells (30–40 × 10^6 per site of injection; typical injection volume was 0.2–0.3 ml) were injected into the muscle of the abdominal wall so as to form a subperitoneal nodule. As illustrated in Fig. 1, the location of implantation was selected because the hydrostatic pressure gradient, used to induce the convection of protein into the tumor, could be easily controlled by manipulating the ip pressure. With the ip pressure at zero, pure diffusive transport could be studied. The abdominal wall wound was carefully closed with interrupted simple sutures. The skin was closed with sterile wound clips. The animal was observed to recover and to move around its cage within 15 min after surgery. With the use of this procedure, <1% of the animals experienced postoperative complications that required termination before their use in an experiment.

The tumor cell nodule could be initially palpated through the skin; however, within 24 h, the nodule would disappear. If the tumor cells formed a solid tumor nodule, it would typically be palpable under the skin within 7–10 days. With both cell lines, ~50% of tumor implantations were successful. This success rate was improved to 75% by further immunosuppression of the animal with daily cyclosporine injections (3 mg sc each day); there were no apparent complications from the use of cyclosporine in this dose. Once the tumor had an apparent diameter of >5 mm, it was ready for one of several experimental protocols.

![Fig. 1. Design of experimental model. Tumor cells are implanted in the abdominal wall and allowed to grow into a nodule that protrudes into the peritoneal cavity. This position facilitates examination of growth of the tumor, the control of pressure forces across the tumor, and pressure measurements within the tumor during the experiment. P, pressure; P_{ip}, intraperitoneal pressure.](http://jap.physiology.org/)
Surgical procedure in preparation for a transport experiment. Because these experiments were typically 4–6 h in length, the tumor-bearing animals were initially anesthetized with intramuscular pentobarbital sodium (60 mg/kg). After the initial injection and placement of an iv catheter, subsequent injections of anesthetic were made iv. A tracheostomy was performed, and catheters were placed intra-arterially to monitor blood pressure (maintained mean arterial pressure of >80 mmHg) and to sample blood. An ip catheter was placed through the abdominal wall for instillation and sampling of the ip solution. Temperature was maintained at 36.5 ± 1.5°C by a warming blanket and heat lamp.

Tissue Histopathology and Immunohistochemistry

All frozen tumor sections were stained with standard hematoxylin and eosin and were examined for evidence of necrosis, as evidenced by the lack of nucleated cells or cellular material. Care was taken to ensure that all analyses were carried out on nonnecrotic tumors.

Immunohistochemistry of CD31, a vascular endothelial cell marker (19), was performed to determine the pattern of angiogenesis in each tumor and to assess total vascular space in the tumor tissue. This stain also permits the comparison of drug penetration profiles into the tumor with the location of the vasculature. Excess tumors were immediately fixed in neutral pH-buffered 4% formalin solution. They were then divided into three to four cross sections, embedded in paraffin wax, and cut into 4-μm sections for CD31 staining. The sections were deparaffinized with xylene and rehydrated with graded alcohols and treated with 0.01 M citrate buffer, pH 6.0, for antigen retrieval. Endogenous peroxidase activity was quenched with 3% hydrogen peroxide for 10 min. Staining was performed at room temperature throughout. Nonspecific binding sites were blocked with 1.5% donkey serum in PBS for 1 h. Sections were treated for 30 min with anti-CD31 antibody diluted 1:350 in blocking solution. The slides were washed three times in PBS, treated for 60 min with the biotinylated horseradish peroxidase complex (30-min incubation) and 3,3′-diaminobenzidine tetrahydrochloride (10 min) were used for detection. The sections were counter stained with Gill’s hematoxylin. No significant staining was observed in negative control sections (without primary antibody) run in parallel for each staining. Slides were independently examined by two investigators with a graticule in 10 different locations on each tumor. Any CD31-positive cell cluster that was distinguishable from adjacent tumor cells and connective tissue elements was counted as a single vessel.

Experimental Protocols

Determination of tumor vascular space and microvascular permeability. The purpose of these experiments is the determination of the rate of IgG transport from the plasma to the tumor interstitium and the degree of tissue-averaged vascular density. These parameters are important if the animal model is used for iv-delivered therapy or for the drug absorption of iv-delivered small MW drugs. In the experiments in SKOV3 tumor-bearing animals, we utilized dual-label quantitative autoradiography (QAR) to measure the total amount of 125I-labeled IgG in the tumor 3–4 h after iv injection and simultaneously to measure the microvascular space within the tumor with a second IgG marker labeled with 131I injected 1 min before death of the animal. Samples of plasma are taken every 30 min and counted with a gamma counter to measure the concentration of tracers in the plasma $C_{\text{plasma}}(t)$. After the final plasma samples, the animal was killed by decapitation to rapidly halt blood flow, and the tumor and adjacent normal abdominal wall muscle were quickly frozen in −70°C isopen- tane. The frozen tissue was sliced in a cryomicrotome, and dual-label QAR was carried out as in our laboratory’s previous publication (11) to determine the average concentration of each tracer in the tissue parenchyma $C_{\text{tissue}}(t)$ at the time of death. From the 131I-IgG, the relative vascular space (θIV; μl/mg tissue) is calculated from:

$$\theta_{\text{IV}} = \frac{C_{\text{tissue}}(t)}{C_{\text{plasma}}(t)}$$  (1)

where $C_{\text{plasma}}$ is the plasma concentration (cpm/μl) of the second antibody tracer labeled with 131I and presumed to occupy the vascular space only, and $t_I$ is the time of death. In the case of OVCAR3, the tissue-averaged vascular density was determined by QAR and found to be reasonably uniform among different tumors. Therefore, we used separate sets of animals to determine the vascular space and the IgG clearance.

The time-averaged clearance of IgG from the tissue vasculature ($R_{\text{tissue}}$, μl·mg⁻¹·s⁻¹) is found from:

$$R_{\text{tissue}} = \frac{C_{\text{plasma}}(t_I) - C_{\text{plasma}}(t_f)}{\theta_{\text{IV}} \int_0^{t_f} C_{\text{plasma}}(t) \, dt}$$  (2)

The average plasma loss rate of antibody mass per unit mass of tissue for a given tumor can be estimated from $R_{\text{tissue}} C_{\text{plasma}}$ tracer specific activity, where $C_{\text{plasma}}$ is equal to the time-averaged plasma concentration. Equation 2 assumes that all tracer leaving the microvasculature remained bound within the tumor or muscle or was located in the tumor interstitium. In our laboratory’s previous study (11), the nonspecific binding of the tumor stroma provided a significant trap for IgG; however, we cannot rule out some transfer to adjacent normal tissue. The rate of efflux for the tumor will be compared with that of the normal muscle. The vascular space within the tumor and within the normal muscle should be averaged and compared.

Extracellular space. The purpose of these experiments was to measure the relative extracellular volume in normal tissue and tumor. The relative extracellular space is a major determinant of drug transport through the tissue, and it is important to quantify when studying drug diffusion and convection through the tumor. To do this, a bolus of [14C]mannitol was injected iv into an anesthetized, tumor-bearing rat. The tracer was then continuously infused at a rate to maintain the plasma concentration at a constant value. The plasma was sampled every 15 min for 1 h to verify the concentration. At the end of the hour, the animal was killed by decapitation to rapidly halt blood flow, and the tissue was rapidly frozen. The tissue was sliced and processed for QAR to determine the tracer concentration in the tissue at the time of death $C_{\text{tissue}}(t_I)$; cpm/mg. The plasma samples were counted to determine the tracer concentration ($C_{\text{plasma}}$; cpm/μl). The extracellular volume relative to the tissue weight (θECV; μl/mg tissue) was calculated as follows:

$$\theta_{\text{ECV}} = \frac{C_{\text{tissue}}(t_I)}{C_{\text{plasma}}}$$  (3)

where $C_{\text{plasma}}$ is the time-averaged tracer concentration in the plasma. An estimate of the relative interstitial volume (θISV; μl/mg tissue) was calculated as:

$$\theta_{\text{ISV}} = \theta_{\text{ECV}} - \theta_{\text{IV}}$$  (4)

Penetration studies. The purpose of this procedure was to assess whether ip pressures of 0–8 mmHg influenced the penetration of ip-administered macromolecules (IgG) into the tissue surrounding the cavity and to compare the macromolecular transport with that of a small molecule (mannitol).

In the experiment, 50–100 μCi of 125I-labeled herceptin was mixed in 100 ml of the Krebs solution, containing 5% BSA and 0.5% Evans blue dye (to mark the contact area and penetration of tissue); this was warmed to 37–39°C. In experiments with [14C]mannitol,
25 μCi were mixed with 100 ml of the Krebs solution, containing 5% BSA.

To begin a low-pressure study, the cavity was opened and a small plastic chamber was affixed to the peritoneal side of the tumor with cyanoacrylate glue and filled with 2–3 ml of fluid. We have used these chambers for transport studies of the normal peritoneum and have shown that the transport across the tissue within the chamber is unaffected by the presence of the chamber (10). The height of this fluid was maintained at <1 cm to ensure a low hydrostatic pressure. The chamber ensured fluid contact with the tumor and minimal pressure. Samples were collected hourly, and at the end of 3 h, the fluid was removed, and after euthanasia the tumor was rapidly frozen. It was subsequently processed for autoradiography.

To initiate a high-pressure penetration study, a sufficient amount of the warm solution was injected ip to raise the pressure to 3 mmHg, and the remainder of the solution was placed in a reservoir connected to the ip catheter via tubing. The reservoir was raised to a level above the right heart to exert 4–8 mmHg of hydrostatic pressure in the cavity. The ip pressure rose to the desired pressure over 15 min and then became steady thereafter; the pressure was verified by glass manometer connected through a three-way valve to the ip catheter. Occasionally, an animal developed respiratory distress, and the pressure (volume) in the cavity had to be reduced by ~1 mmHg. Blood and intracavity fluid were sampled each hour for 1–3 h. Vital signs were carefully monitored throughout the experiment. Tissue pressure measurements were attempted throughout the experiment. At the end of the experiment, the animal was given an overdose of pentobarbital sodium, the cavity was opened by laparotomy, and the fluid was removed. The animal was then frozen rapidly with isopentane cooled in dry ice (~70°C). The exposed tumor and adjacent normal tissue were cut from the frozen carcass and maintained at ~70°C until processed for autoradiography.

Analytical Techniques

Measurement of interstitial pressure. The hydrostatic pressure profile within normal abdominal wall and within tumor tissue was measured with the technique of Wiig et al. (34) and Boucher and colleagues (4), as later modified by Flessner and Schwab (9, 14). The technique employs a micropipette mounted on a precision micromanipulator, which is used to penetrate the tissue in precise increments of 100–200 μm from the subcutaneous side inward toward the cavity. The micropipette is connected via a hydraulic system to a servo-null micropressure system (IPM 5A, Institute for Physiology and Medicine, Los Angeles, CA) to determine the actual pressure (in mmHg). Details of the procedure are found in our laboratory’s previous publication (14). The stroma of the tumors was difficult to penetrate 3–4 mm with the glass pipettes, which often broke before the measurement was completed; this limited the number of pressure profiles to one to three, which were obtained in any one tumor. In some cases, the “wick-in-needle” technique (WIN) was used as documented in Fadnes et al. (7), Boucher and Jain (5), and Wiig et al. (34) to verify the mean pressure at a depth of 1–3 mm.

QAR. Sections (10–20 μm) were cut from frozen specimens with a Hacker-Bright Cryomicrotome and were heat-dried to prevent further transport of the labeled trastuzumab. The sections were placed with standards (tissues with known isotope concentration) against X-ray film (Kodak Biomax MR) to produce autoradiograms. After development, the films were analyzed with a computerized densitometer (MCID, Imaging Research, St. Catherines, Ontario, Canada), which measures optical density vs. position in the tissue. The isotopic standards were used to construct a calibration curve [concentration vs. optical density (OD)] to convert the unknown ODs from the tissue samples to concentration. After exposure to film, the tissue slides were stained with hematoxylin and eosin. The device has the capability to superimpose the histological image and the autoradiographic image; the concentration profile was then measured by superimposing a computational grid over the tissue as illustrated in Fig. 2. The average OD within each box of the grid or the average OD within a larger area was determined and automatically converted to concentration. By careful superposition, the concentration vs. position curve or mean concentration of a large area was obtained (see Ref. 11).

In the case of two isotopes, a blocking layer of plastic was placed between the film and the radioactive tissue. This allowed the separation of the high-energy isotope 131I from the lower-energy 125I. After the high-energy autoradiogram was developed, the tissues were stored for 10 half-lives of the high-energy isotope and then reapplied to the film to obtain the autoradiograms of the lower-energy isotope. Each film was then analyzed as in the paragraph above.

Calculations and Statistics

Calculations were performed with Microsoft Excel (version 97 or 2000). Statistical calculations were performed with NCSS (Provo, UT). Data are presented as means ± SE. Tissue concentrations were typically normalized by dividing by the concentration in the peritoneal cavity or by the plasma concentration in accordance with formulas given above.

Quantities were judged to be significantly different if the probability of a type I error was of ≤0.05 (P ≤ 0.05).

RESULTS

Tumor Implantation: Observations of Metastases

The tumor cell nodule size could be estimated by palpating the tumor through the skin and approximating the limits of the raised tissue. However, the tumors often developed in various shapes with irregular penetrations through the boundaries of the normal abdominal wall muscle, including the interior boundary, the peritoneum. The true size of the tumor was often not apparent until the peritoneal cavity had been opened. Some of the SKOV3 implantations were allowed to grow beyond 4 wk and were observed to produce small white nodules or plaques on the liver, spleen, omentum, and the periaortic lymph nodes. This form of metastasis is consistent with the
spread of ovarian cancer. None of the OVCAR3 tumors were observed to form metastases, but their growth period was limited to 4 wk.

**Tumor Physiological Properties**

The tumor properties are summarized in Table 1.

**SKOV3 tumors.** The relative vascular space determined by QAR was averaged over 5–10 sections of each of five different tumors and was found to be 0.0087 ± 0.00030 μl/mg tissue, whereas it was 0.0094 ± 0.0021 μl/mg tissue in normal abdominal wall muscle (P > 0.5). Because QAR is performed on the entire tumor and therefore averages the results for all regions of the tumor, a second method of estimation was used. Figure 3A demonstrates a typical anti-CD31 stain of an SKOV3 tumor. Because the CD31 receptor marks all endothelial cells in the tissue, perfused as well as nonperfused vessels will be stained. The staining was concentrated around the edge of the tumor, with very little staining in the center of the nodule. The vessel density of the “hot” (increased vascular density) areas of the tumor averaged (n = 10) was 617 ± 66 vessels/mm². In the less dense center areas of the tumors, the vessel density averaged 23.7 ± 1.6 vessels/mm².

To compare the CD31 measurements with the QAR results, an assumption of the vessel cross-sectional area must be made and then multiplied by the number of vessels and the relative contribution of the hot areas to the total tumor. If each vessel is assumed to have an average radius of 6–12 μm or 6 × 10⁻³ to 12 × 10⁻³ mm (19), the areas for each vessel range from 0.000113 to 0.000452 mm² (πr²). From the product of vessel density times the area of a single microvessel, the area-density of the vessels in the hot areas is calculated to be 0.070 ± 0.01 to 0.28 ± 0.04 mm²/mm², whereas that of the less dense areas is 0.003 ± 0.000 to 0.012 ± 0.001 mm²/mm².

The relative extracellular space was found to be (n = 5) 0.54 ± 0.11 μl/mg tissue for the tumor, whereas it was 0.22 ± 0.06 μl/mg tissue in the adjacent normal muscle of the abdominal wall. These would correspond to approximate interstitial spaces (extracellular space – vascular space) of 0.53 and 0.21 in tumor and muscle, respectively.

Vascular permeability to IgG was estimated by measuring the total deposition in tissue vs. time and subtracting that portion of the antibody, which was contained within the vasculature (see Eq. 2). The average clearance was estimated to be (n = 6) 0.0085 ± 0.00057 μl·h⁻¹·mg⁻¹, whereas that of adjacent muscle (n = 6) was 0.00477 ± 0.00223 μl·h⁻¹·mg⁻¹ (P < 0.05).

**OVCAR3 tumors.** The relative vascular space determined by QAR was averaged over 5–10 sections of each of five different tumors and was found to be 0.0109 ± 0.0010 μl/mg tissue and was not significantly different from previous measurements in muscle (P > 0.5). As in the case of the SKOV3 tumor, a

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**Table 1. Anatomic and physiological characteristics of tumors**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Normal Muscle</th>
<th>SKOV3 Tumor</th>
<th>OVCAR3 Tumor</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD-31 staining, vessels/mm²</td>
<td>Not measured</td>
<td>617±66 (n = 10)</td>
<td>225±10 (n = 17)</td>
</tr>
<tr>
<td>High-density area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-density area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative vascular space, μl/mg tissue</td>
<td>0.00113 to 0.000452</td>
<td>0.0087±0.00030 (n = 5)</td>
<td>0.0109±0.0010 (n = 5)</td>
</tr>
<tr>
<td>Relative extracellular space, μl/mg tissue</td>
<td>0.22±0.06</td>
<td>0.54±0.11† (n = 5)</td>
<td>0.61±0.03† (n = 6)</td>
</tr>
<tr>
<td>IgG clearance, μl·h⁻¹·mg tissue</td>
<td>0.00477±0.00223</td>
<td>0.00885±0.00057 (n = 6)</td>
<td>0.0147±0.00241 (n = 5)</td>
</tr>
<tr>
<td></td>
<td>0.00595±0.00219 (n = 6, each)</td>
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</tbody>
</table>

*Comparison of tumor characteristics with normal muscle were evaluated for P < 0.05. †Significantly different from normal muscle (P < 0.05).
second method of estimation was used. Figure 3B demonstrates a typical anti-CD31 stain of an OVCAR3 tumor. The staining is concentrated around multiple, distinct nodules within the tumor, which present a distinctly different pattern from the SKOV3 tumors. The vessel density of the hot areas of the tumor averaged \( (n = 17) \) 225 \( \pm \) 10 vessels/mm\(^2\). In the less dense center areas of the tumor nodules, the vessel density averaged 15.5 \( \pm \) 2.1 vessels/mm\(^2\). If we make the same assumptions and calculations as with the SKOV3 results, the area density of the vessels in the hot areas is 0.026 \( \pm \) 0.011 to 0.102 \( \pm \) 0.046 mm\(^2\)/mm\(^2\), whereas that of the less dense areas is 0.0018 \( \pm \) 0.0002 to 0.007 \( \pm \) 0.001 mm\(^2\)/mm\(^2\). Because the hot area is 22% of the total, the overall average equals 0.007–0.028 (0.22 \( \times \) 0.026 + 0.78 \( \times \) 0.0018 = 0.0071). As with the SKOV3 tumors, the QAR results falls within the calculated range of areas resulting from the CD31 determinations.

The relative extracellular space \( (n = 6) \) was found to be 0.61 \( \pm \) 0.03 \( \mu \)l/mg tissue for the tumor, which is significantly different from the adjacent normal muscle of the abdominal wall (0.22 \( \pm \) 0.06 \( \mu \)l/mg tissue). The tumor interstitial spaces (extracellular space – vascular space) would be \( \sim \)0.60 \( \mu \)l/mg tissue.

Vascular permeability \( (n = 5) \) was found to be 0.0147 \( \pm \) 0.0024 \( \mu \)l-h\(^{-1}\)-mg tissue\(^{-1}\), whereas that of adjacent muscle \( (n = 6) \) was 0.00595 \( \pm \) 0.00219 \( \mu \)l-h\(^{-1}\)-mg tissue\(^{-1}\) \( (P < 0.05)\).

**Tumor Interstitial Pressures**

Figure 4 illustrates the peak and mean pressures for SKOV3 and OVCAR3 tumors, as determined with the micropipette servo-null system. The peak pressure is defined as the highest pressure recorded as the glass pipette is advanced 3–4 mm through the tumor; the mean pressure is the average of all readings within the tumor parenchyma. The range of pressure for both tumors was 0–32 mmHg, whereas the median pressures were 10–15 mmHg. The tumor pressures are quite variable within individual tumors and between xenografts from the same cell line. Peak pressures sometimes occurred at 300–400 \( \mu \)m from the surface but typically were higher at 1,500–2,000 \( \mu \)m. The typical size of these tumors was on the order of 3–10 mm in diameter, with some oval or cylindrical in shape and others with more spherical shape. As shown in the figures, peak pressures and mean pressures do not appear to correlate with tumor size; however, most of the tumors sampled were relatively small because of the design of the study.

**Tumor Penetration of MAb: Low vs. High ip Pressure**

Small molecules: \([^{14}C]\)mannitol. The average concentration profile of mannitol \( (n = 5) \) after 60 min \( [\text{tissue concentration normalized to the average peritoneal fluid concentration (C PF)}] \) into SKOV3 tumors from solution at low pressure (<1 mmHg) and at high pressure (6–8 mmHg). Open symbols refer to the low-pressure experiments \( (n = 6) \), whereas solid symbols refer to higher pressure experiments \( (n = 18) \). This figure demonstrates very low IgG concentrations with low pressure forces in the cavity. Higher pressures result in higher IgG concentrations in the tumor. The transport of the smaller molecular weight mannitol is diffusion dominated, and its penetration is blunted by rapid absorption in the tumor periphery. The concentration profile levels off in the central region of the tumor nodules where there are few vessels. \( C_{\text{tumor}} \), tumor concentration.

**Fig. 5. Penetration of \([^{14}C]\)mannitol after 60 min and \([^{125}I]\)-IgG after 180 min**

[Image: J Appl Physiol • VOL 97 • OCTOBER 2004 • www.jap.org]
min in Fig. 5 demonstrate little penetration with very low tumor levels of labeled IgG. Tissue concentration profiles in SKOV3 tumor-bearing animals after 180 min at an ip hydrostatic pressure of 6–8 mmHg are also shown in Fig. 5 for comparison and demonstrate a significant effect of higher ip pressure, which aids in the penetration of the antibody. This observation supports our hypothesis that increased ip pressure will deliver more antibody into the tumor.

**DISCUSSION**

**Animal Model**

We have successfully implanted SKOV-3 and OVCAR-3 human ovarian tumor cells into the abdominal wall muscle of athymic rats. This has permitted us to simulate a metastatic tumor nodule in the parietal peritoneum and to control the chemical and physical forces of transport for drugs administered in the peritoneal cavity. The novel tumor location permits the measurement and manipulation of forces and the determination of the transport outcome. If sufficient time is allowed for tumor growth, further metastasis occurs in the peritoneal cavity. In our laboratory’s prior rat model of ip carcinoma (11), we used a human melanoma cell line (FEMX-II) to create an analogous model, but the FEMX-II did not metastasize from the primary site of implantation. Other models in rats differ from ours because of the goal to create ascites (1) or bulky pelvic tumors (20, 28), which do not readily permit manipulation of force pressures necessary for ip-injected macromolecules.

Other models of ip cancer have been created in mice. Ozols et al. (28) treated a murine ovarian tumor with Adriamycin; administration of equivalent doses of the drug demonstrated nearly two orders of magnitude higher tumor drug levels after ip injection vs. iv, which supports the later findings of efficacy in humans (2). Ong and Mattes (27) set up an ascitic ovarian model in nude mice and studied routes of treatment with MAb to cell surface receptors; they did not study specific maneuvers to improve ip delivery. Wahl et al. (33) studied distribution of ip-injected antibodies in tumor-bearing mice and showed that, during the first 48 h of treatment, there was a significant therapeutic advantage compared with iv injection. Ito et al. (21) implanted LS174T human colon cancer in the peritoneal cavities of mice; when they compared IgG tumor profiles after iv injection with those from a small-volume ip injection of IgG, they observed a less uniform IgG concentration profile but higher concentrations in the tumor periphery. The major differences between these studies and our study are the positioning of the tumor and the use of the athymic rat as the tumor host, which permits specific physiological maneuvers and measurements that are difficult in mice.

**In Vivo Physiological Measurements of Tumor**

**Tumor vascular space.** The location and density of the tumor vascular space is important in understanding of drug transport within the tumor. The lack of uniformity leads to perturbations of how rapidly the concentration is dissipated within the parenchyma of the target. This is illustrated by a comparison of the [14C]mannitol profile in Fig. 5 with the vascular pattern in Fig. 3A. The lack of blood vessels resulted in a marked decrease in the removal rate of mannitol from the central portion of the tumor. On the other hand, the variation in vasculature has little effect on the transport of macromolecules, since they are removed from tissue by lymphatics, which are typically not functional in tumors (29).

The tumor vascular space in each tumor implant was estimated by QAR to be \(~0.009–0.01\) ml/g tumor 1 min after injection of a labeled protein. This was essentially the same as that of the adjacent normal tissue, and these values are similar to our previous measurement of 0.01 ml/g abdominal wall muscle of a different rat species (36). The fact that the tissue-averaged relative tumor vascular space is the same as that of normal muscle is a serendipitous finding, because tumor vasculature is highly variable, as illustrated by Fig. 3, A and B.

There are few comparable measurements of the tumor vascular space. In chambers mounted on the back of mice, relatively thin, transparent tumors have been grown for study (25). However, capillary densities were measured as microvascular length divided by the area of observation. Unfortunately, the numbers are not easily transformed into volume per gram tissue units. In a subsequent study of this tumor, the vascular volume averaged 0.092 ± 0.029 (vol vessels/vol tumor) (35).

In an earlier study that employed intravascular tracers, Gullino and Grantham (17) found that the vascular space varied from 1% for a fibrosarcoma to 12.4% for hepatoma HC. Thus the SKOV-3 and OVCAR-3 tumors are at the lower end of range of vascular volumes within tumors.

To verify the relatively low fraction of tissue that is occupied by blood vessels, we have performed immunohistochemistry to detect the relative number of potential vessels in the tumor tissue. We discovered two distinctive patterns in the two tumor types. OVCAR-3 appeared to form smaller nodules with areas of high density of staining in the connective tissue surrounding each small tumor nodule. SKOV3, on the other hand, formed larger nodules that, if left to grow beyond 8–10 mm in diameter, became necrotic in the center. The areas of increased angiogenesis were chiefly in the periphery of the tumor or tumor nodule. CD31 staining does not permit differentiation between perfused and nonperfused vessels. However, by assuming a range of average vessel diameters and calculating the potential contribution of each region to the overall vascular density, there appears to be good agreement between the CD31 staining and the tissue-averaged values from QAR.

**Tumor extracellular space.** The transport of a water-soluble substance through tissue is directly proportional to the degree of “porosity” or extracellular space in the tissue (13). Under the condition of no fluid in the peritoneal cavity, the extracellular spaces in the SKOV-3 and OVCAR-3 tumors were 0.54 ± 0.11 and 0.61 ± 0.03 ml/g tissue, respectively. With the assumption of a vascular volume of ~0.01 ml/g tissue, these would translate into approximate values for the interstitial space of 53 and 60 ml/100 g tissue, respectively. The interstitial space of normal abdominal wall muscle in Sprague-Dawley rats was previously determined to be 16 ml/100 g of tissue (36), comparable to that found in the muscle of athymics (0.22 ± 0.06).

Early work by Gullino and colleagues (18) demonstrated similar values for normal muscle in rats, whereas tumor interstitial spaces varied from 50–74 ml/100 g for hepatomas to nearly 80% for fibrosarcoma transplanted into rodents. This large interstitial space is thought to result from the lack of lymphatics and the high interstitial pressure (25–30 mmHg in Walker 256 carcinoma) (15). Thus the finding of an interstitial space in
tumors that is 2.5 times that of normal tissue is consistent with the measurements by other groups. The expanded interstitium should promote penetration of the drug into the tumor.

**Tumor vascular permeability.** The whole tumor technique we used to determine the clearance of the antibody from the tumor provides a tissue-averaged value and is limited in that it does not provide measurements of the intrinsic permeability of the capillaries. Taking into account that the areas containing the vasculature make up 10% of the vasculature do not provide measurements of the intrinsic permeability of the tumor provides a tissue-averaged value and is limited in that it does not provide measurements of the intrinsic permeability of the tumor.

Yuan (15) demonstrated the VX2 carcinoma growing in a rabbit ear chamber had a permeability to dextran 150 (nominal MW of 150) of $5.72 \times 10^{-8}$ cm/s, whereas granulation tissue was $7.3 \times 10^{-8}$ (ratio of $\sim 8$). These values are not easily transposed to whole tissue values, which we have calculated. Yuan et al. (35) studied the permeability of adenocarcinoma LS174T using the dorsal chamber in SCID mice. They found the PS/V (ml·min$^{-1}$·ml tissue$^{-1}$) for labeled albumin to be $7.56 \times 10^{-3}$ in the tumor, which is appropriately larger than the permeability of the SKOV-3 to the larger IgG molecule used in our study. That these tumors had limited vascular space and were slightly leakier than normal vessels favors the efficacy of regional delivery rather than systemic delivery.

**Tumor interstitial pressures.** Figure 4 displays the interstitial pressures of both types of tumors. The high tumor pressures in SKOV-3 and OVCAR3 tumors are similar to measurements in human melanoma (6) and in cervical cancer (31). These pressures differ from the normal pressure of the abdominal wall muscle, which is slightly negative (34, 36). These high pressures present a significant challenge to the delivery of antibodies from the periphery of the tumor or from the circulation (5).

**Penetration of Antibody into SKOV-3 Tumors**

Figure 5 clearly demonstrates the effect of pressure on the transport of an IgG antibody into SKOV-3 tumors. However, the relatively high interstitial pressures of Fig. 4 are likely a major factor in the lower concentration within tumor compared to normal tissue (14). The mannitol, which transports chiefly via diffusion, demonstrates rapid dissipation in the tumor interstitium due to the presence of highly permeable blood vessels, but the concentration of agent delivered is significantly higher than the macromolecule. If the high pressure could be maintained in the cavity for long periods of time, the IgG tumor concentration profiles would be expected to increase in magnitude with a greater duration of the experiment due to binding and the relative lack of functional lymphatics in the tumor (29). Further studies on the characteristics of the interaction between the Trastuzumab molecule and SKOV3 tumor cells are required to elucidate these mechanisms.

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