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**EFFECTS OF LOW INTENSITY BIO-RESONANCE FOCUSED
ULTRASOUND ON DESTROYING CANCEROUS CELLS: A
LITERATURE REVIEW**

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Abstract:

The literature describing low-intensity ultrasound in two significant areas of cancer therapy - sonodynamic therapy and ultrasound-mediated chemotherapy - was reviewed. Each technique consistently killed cancer cells, and the bioeffects of ultrasound were attributed primarily to thermal actions and inertial cavitation. Each therapeutic modality benefited from using theranostic contrast agents composed of microbubbles for both therapy and vascular imaging. The development of these agents is critical because it establishes a therapeutic-diagnostic platform for monitoring anti-cancer therapy success. However, little attention has been paid to either the direct examination of the underlying mechanisms underlying observed bioeffects or the viability of these therapies in naturally occurring cancers in larger mammals; if such investigations yielded encouraging results, a therapy technique could be rapidly applied in treating cancer patients.

Keywords: Ultrasound bioeffects, Cancer therapy, Low-intensity ultrasound, Sonodynamic therapy, Antivascular ultrasound, ultrasound-mediated chemotherapy.

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INTRODUCTION:

Ultrasound therapy with low intensity has been used to treat a variety of conditions. It has been used in conjunction with sensitizing molecules to affect cancer cells (sonodynamic therapy) directly; it has been used in conjunction with chemotherapeutic molecules to enhance their activity in cancer therapy (ultrasound-mediated chemotherapy); it has been used to affect cells and their components (sonoporation) directly; it has been used for gene delivery or transfection, as well as to promote cell growth (ultrasound-mediated cell growth). This review aims to shed light on the role of low-intensity ultrasound in cancer treatment. The published studies investigated in vitro cancer cell suspensions and cultures and the treatment of various implanted tumours in small laboratory animals. The following review discusses four of the most frequently used low-intensity ultrasound applications in cancer therapy research: sonodynamic therapy, ultrasound-mediated chemotherapy, ultrasound-mediated gene delivery, and anti-vascular ultrasound therapy.

Although no widely accepted definition of low-intensity ultrasound exists, this review focused on studies in which cancer cells or tumours were generally insonated at a power density less than 5.0 W.cm², which corresponds to a root-mean-square pressure amplitude of approximately 0.3 MPa. Numerous variables in the sonication conditions used in the literature complicate accurate comparisons between reports. Pressure-intensity conversions were performed in this review using the formula $I = p^2/c$, where I denote intensity, p denotes root mean square pressure amplitude, = density, and c denotes sound speed (Preston 1991).

In general, insonation of neoplasms with low-intensity ultrasound is a straightforward procedure because it does not require a focused beam (which must be precisely located), the apparatus is relatively inexpensive, the bioeffects on adjacent normal tissues are generally believed to be minimal, and it is possible to easily target sensitizing or chemotherapeutic molecules and microbubbles located within the neoplasm. Although treatment times are longer than with focused high-intensity ultrasound, repeated treatments or dose fractionation are straightforward to perform.

Sonodynamic Therapy

Sonodynamic therapy is derived from the term photodynamic therapy. Unlike photodynamic therapy, which uses light to stimulate photosensitizers to generate reactive oxygen species directly,

sonodynamic therapy uses ultrasound-induced cavitation and sonosensitizers to generate free radicals that kill nearby rapidly dividing cancer cells. An advantage of sonodynamic therapy is that it uses continuous, low-intensity ultrasound at diagnostic ultrasound frequencies to treat tumours located deep within the body. On the other hand, photodynamic therapy employs visible light, which rapidly attenuates in tissues and penetrates only superficially or intraoperatively. When Jin et al. (2000) treated a subcutaneously located murine squamous cell carcinoma, they discovered that sonodynamic therapy inhibited tumour growth by 77%, compared to 27% with photodynamic therapy. The latter was ineffective in the tumour's deeper regions.

Sonodynamic therapy was initially based on the same light-sensitive agents developed for photodynamic therapy, hematoporphyrin and its derivatives. A sensitizing agent should be taken up and retained preferentially by the tumour. The therapy kills cancer cells while having a negligible effect on normal tissues in the surrounding area; the agent should also be relatively non-toxic to normal mammalian tissues. To maximize the efficacy of treating solid tumours, the sonosensitizer must be injected intravenously before insonation, rather than directly into the tumour, to ensure that it is distributed more completely and uniformly throughout the neoplasm (Ninomiya et al. 2012).

There have been published overviews of the sonosensitizers used in the therapy (Kuroki et al., 2007; Feril et al., 2011; Shibaguchi et al., 2011; Chen et al., 2014). In sonodynamic therapy, the sonication parameters (typically 1.0-2.0 MHz at a power density of 0.5 to 3.0 W.cm²; Tables 1,2) are chosen to induce inertial cavitation in cell culture or tumour, a process in which a bubble in a liquid rapidly collapses, generating a shock wave that generates free radicals and initiates a cascade of molecular events that activate the sonosensitizer and damage the cancer cells (Misik and Riesz 2000; Rosenthal et al. 2004; Yu et al. 2004[c]). While it appears that the production of reactive oxygen species plays a role in the antitumor effect, Wang et al. 2011[a] state that thermal effects cannot be ruled out. Along with these direct cytotoxic effects on neoplastic cells, it is necessary to consider other possible effects on the growing tumour, such as its vascular supply. According to Gao et al. (2013), sonodynamic therapy also had an antivascular effect, inhibiting tumour neovascularization. Additionally, a chemotherapeutic agent has been used as the sonosensitizer. Adriamycin (Gao et al. 2010), cisplatin (Bernard et al. 2011; 2012 [0.4 0.02 MPa]), and

doxorubicin (Liang et al. 2013) were found to be cytostatic in vitro, and their apoptotic activity was

enhanced when combined with chlorine e6 (Gao et al. 2010) or a hematoporphyrin (Liang et al. 2013).

Table 1: Sonodynamic therapy of cell cultures and suspensions

Cancer cell culture/suspension	Sonosensitizer	Insonation parameters		Reference
		MHz	W.cm ⁻²	
(viii) non-neoplastic (endothelial cells)	5-aminolevulinic acid	1.0	1.0	Gao et al 2013
multiple cell lines	porphyrin derivative	1.0	1.0	Tsuru et al 2012
multiple cell lines	porphyrin derivative	1.0	0.5-2.0	Hachimine et al 2007
tongue	5-aminolevulinic acid	1.0	0.6, 0.8	Lv et al 2012
murine mammary	chlorine e6	1.0	0.36, 0.72	Li et al 2013
murine leukemia	protoporphyrin IX	1.1	0.64-2.1	Wang et al 2013[b]
histiocytic lymphoma	hematoporphyrin	1.1	1.0	Su et al 2013[a]
human melanoma	cisplatin	1.0	1.0	Bernard et al 2012
human leukemia	protoporphyrin IX	1.1	1.0	Su et al 2014
gastric	antibody/porphyrin	1.0	1.0	Abe et al 2002
Ehrlich ascites	protoporphyrin IX	1.34	1.0-5.0	Zhao et al 2009
acute myeloid leukemia	chlorine e6	1.1	1.0	Su et al 2013[b]
cholangiocarcinoma	Hematoporphyrin + doxorubicin	1.2	0.5-2.0	Liang et al 2013
ovarian	cisplatin	1.0	2.0	Bernard et al 2011
ovarian	methylene blue	1.7	0.46	Xiang et al 2011

human breast	protoporphyrin IX	1.1	1.0	Li et al 2012[a] Wang et al 2013[a] Gao et al 2010
	chlorin e6	1.0	0.36, 0.72	
	chlorin e6 + adriamycin	1.0	0.5-2.0	
glioma	ZnPcS2P2	1.0	0.5	Chen et al 2012[b] Li et al 2013 Xu et al 2012 Xu et al 2013 Yamaguchi et al 2011[b]
	HMME	1.0	0.5	
	photofrin	1.0	0.5	
	II	1.0	0.5	
	titanium nanoparticles	1.0	1.0	
nasopharyngeal	curcumin	1.7	0.46	Wang et al 2011[b] Wang et al 2011[c] Wang et al 2012[b]
	II	1.7	0.46	
	II	1.7	0.46	
hepatic	hematoporphyrin	1.92	1.27-3.18	Yumita et al 1989 Liu et al 2008[b] Ninomiya et al 2012 Ninomiya et al 2014 Wang et al 2012[a]
	II	1.43	1.0-4.0	
	titanium nanoparticles	1.0	0.1	
	II	0.5,1.0	0.8, 0.4	
	hypocrellin-B	1.7	0.46	

HMME = hematoporphyrin monomethyl ether

Table 2: Sonodynamic therapy of tumors

Tumor	Sonosensitizer	Insonation parameters		Reference
		MHz	W.cm ⁻²	
human MKN-45	DCPH-PNa(I)	1.0	2.0	Hachimine et al 2013
tongue	5-aminolevulinic acid	1.1	2.0	Gao et al 2013
small cell lung	chlorin e6	1.0	0.4-1.6	Chen et al 2013[b]
osteosarcoma (rats)	hematoporphyrin	10.5	0.8	Tian et al 2009
squamous cell	gallium-porphyrin/pheophorbide-a	1.0	0.51	Jin et al 2000
gastric	antibody / gallium-porphyrin	1.0	2.0	Abe et al 2002
	porphyrin derivative	1.0	2.0	Tsuru et al 2012
breast	photofrin	.015/1.0	0.2,2.0	Barati et al 2010
	no sensitizer	.015/1.0	0.2,2.0	Barati et al 2009
glioma (rats)	5-aminolevulinic acid	1.04	10.0	Ohmura et al 2011
	5-aminolevulinic acid	1.0	2.65	Jeong et al 2012
	chlorin e6/polyvinyl pyrrolidone	1.0	0.4-1.0	Tserkovsky et al 2012
hepatic	hematoporphyrin	1.43	2.0	Liu et al 2008[b]
	protoporphyrin IX	1.43	3.0	Wang et al 2011[a]
		1.0	1.0	Ninomiya et al 2012

	titanium oxide nanoparticles hematoporphyrin microbubbles Chlorin e6		1.0 2.0 1.56 4.0	Zheng et al 2012 Shi et al 2011
colon	ATX-S10 photofrin II protoporphyrin IX/nanoparticles protoporphyrin IX/nanoparticles NPe6 polyhydroxy fullerenes		2.0 3.0 1.92 1.0-5.0 1.1 2.0 1.1 2.0 2.0 3.0 2.0 3.0	Yumita et al 2000[a] Yumita et al 2000[b] Sazgarnia et al 2011 Shanei et al 2012 Yumita et al 2011 Yumita et al 2013
murine sarcoma 180	hematoporphyrin pheobromide a protoporphyrin IX sinoporphyrin sodium		1.92 1.7 1.92 3.0 2.2 5.0 1.9 2.0-6.0	Yumita et al 1990 Umemura et al 1996[b] Liu et al 2007[a,b] Li et al 2013

Unless otherwise stated all tumors were in mice. Key: ATX-S10 = 4-formyloxim ethylidene-3-hydroxy-2-vinyl-deutero-porphynyl(IX)-6,7-d'aspartic acid; NPe6 = mono-l-aspartyl chlorin e6

Following Yumita et al. (1989) .s and Umemura et al. (1990) .s initial descriptions of sonodynamic therapy, numerous confirming reports further demonstrated the therapy's bioeffects. In contrast to previous reviews, we have classified the research studies according to the type of cancer cell and the associated sensitizer that were insonated; this was done to serve as a guide for previous sonodynamic studies that place a premium on the type of cancer receiving therapy (Tables 1,2). Over the last 25 years, actual data have been published using various sensitizers and involving various types of cancer (Tables 1,2), and each report has consistently demonstrated the

significant bioeffects of sonodynamic therapy. However, determining the relative merits of each of these numerous sonodynamic agents is difficult because each agent was investigated in isolation without comparison to another's efficacy. Thus, critical questions remain unanswered, such as whether the newly developed nanoparticle sensitizers are more effective at killing cancer cells than the original porphyrins.

Sonodynamic therapy, as a gold standard, induced apoptosis in cancer cell suspensions and cultures and inhibited tumour growth in animal models of cancer.

The therapy's efficacy has also been demonstrated in tumours that are more deeply located, such as those of the central nervous system (Ohmura et al., 2011; Gao et al., 2013; Jeong et al., 2012). Histologic examinations of post-therapy cancer cells consistently revealed damage to their ultrastructure, including the destruction of cell membranes, mitochondrial swelling, and chromatin condensation (Liu et al. 2006[b], 2007[a, b], 2008; Wang et al. 2008[a], 2011[c], 2012[b]); it was assumed that these changes induced by the therapy mediated cancer cell death. Combining photodynamic and sonodynamic therapy had a synergistic effect in solid tumours, resulting in increased post-treatment tumour necrosis, tumour growth inhibition, and increased survival times (Jin et al. 2000; Tserkovsky et al. 2012).

Given that many of the intravenously injected sonosensitizers (Tables 1, 2) were initially developed for use in photodynamic therapy, those used in sonodynamic therapy in the future must be light insensitive or have no cutaneous side effects (Shibaguchi et al. 2011; Ninomiya et al. 2012; Tsuru et al. 2012; Gao et al. 2013). Preliminary data from solid tumours support the administration of a regimen of multiple therapies to enhance bioeffects and reduce tumour growth and size; fractionation will also help mitigate the thermal effects of therapy (Jeong et al., 2012).

Combining the sonosensitizer with a microbubble contrast agent could significantly enhance sonodynamic therapy in the future (Zheng et al., 2012). The combined agent is then a theranostic agent. Ultrasound imaging can be used to monitor the microbubbles' entry into the tumour vasculature and, once detected within the tumour via diagnostic ultrasound, sonodynamic therapy can be initiated. The establishment of a therapeutic-diagnostic platform capable of monitoring the efficacy of therapy (Lionetti and Paddeu 2010). Additionally, insonation of the microbubble may have significant local thermal bioeffects, including the destruction of endothelial cells lining the tumour vasculature and a reduction in tumour vascularity (Levenback et al. 2012).

To date, in vivo observations have been made on laboratory animals (mice and rats) implanted with subcutaneous tumours, indicating the need for future studies in a larger mammal, possibly using sonodynamic therapy to treat naturally occurring cancers. These additional studies, if successful, could result in the start of human clinical trials.

Ultrasound Along with Chemotherapy

There is interest in using low-intensity ultrasound to enhance the delivery of chemotherapeutic agents to solid tumours in cancer therapy. Agents may be non-specific in that they do not target only malignant cells, and thus high concentrations of the cytotoxic drug will be present in normal tissues, possibly causing adverse effects (Nomikou et al. 2010 [a]). Additionally, factors such as poor vascularity and defective lymphatic drainage can result in elevated interstitial fluid pressure within the tumour, preventing the drug from being absorbed in therapeutic levels (Nomikou et al. 2010 [a]). Insonation of a tumour in the presence of a chemotherapeutic agent has the potential to improve the agent's delivery to cancer cells while minimizing cytotoxicity in adjacent normal tissues. Chemotherapeutic agents have been delivered using ultrasound alone, ultrasound combined with microbubbles and drug-loaded microbubbles. Additional chemotherapeutic studies have been conducted with drug-loaded liposomes in the presence of microbubbles and ultrasound and drug-loaded liposomes attached to microbubbles.

Along with the role of microbubbles in chemotherapy delivery via these direct effects, other antivascular effects have been described, which will be discussed later (see Anti Vascular Ultrasound). Additionally, magnetic microbubbles have been developed in which the drug and iron oxide are combined into a microbubble that can be imaged using both ultrasound and magnetic resonance (MR) imaging. This review has concentrated on the findings of recent research studies; for a broader overview of the subject, the reader is referred to Nomikou and McHale's 2010[b] and Trendowski's 2010[c] papers (2013).

LIFU in the presence of chemotherapy

Low-intensity ultrasound has been investigated in vitro and in vivo for its potential to increase cancer cells' sensitivity to a chemotherapeutic agent.

In vitro studies

Insonation of tumour cell suspensions and cultures in the presence of a chemotherapeutic agent can facilitate the agent's cellular uptake; the inertial cavitation caused by the ultrasound beam results in the formation of microjets that carry the agent directly into the cell or disrupt the cell membranes, allowing extracellular agents to enter (Feril and Tachibana 2012).

Yoshida et al. (2008) observed a synergistic enhancement of cell killing and increased apoptosis in human myelomonocytic cells when they were insonated in the presence of doxorubicin. Few studies have compared the responses of chemosensitive and

chemoresistant cancer cells. Yu et al. (2004[a]) identified sub-strains of human ovarian cancer cell lines resistant to Adriamycin and Cisplatin. They discovered that chemosensitive and chemoreceptive cells exhibit distinct biochemical properties. Ultrasound inhibited cell proliferation and clone formation in chemoresistant cell populations, but not in chemosensitive cells. Hassan et al. (2012) examined human uterine carcinoma cells and a multidrug-resistant phenotype in another doxorubicin study. The order in which insonation and doxorubicin were applied revealed differences in the carcinoma cells' sensitivity. The authors observed that depending on the sonication time, the parent carcinoma cells could be desensitized, or the resistant cell could be sensitized to doxorubicin. On scanning electron microscopy, insonation of human tongue carcinoma cells in the presence of scutellarin significantly enhanced cell injury with irregularly shaped and fractured microvilli and the formation of apoptotic bodies; there was a decrease in cancer cell growth and an increase in cell apoptosis (Li et al. 2013).

***In vivo* studies**

Chemotherapy and ultrasound efficacy have also been studied in mouse tumour models. Tomizawa et al. (2001) discovered that combining intraperitoneal bleomycin with ultrasound results in tumour growth suppression in a murine lymphoma. When camptothecin was injected directly into a fibrosarcoma and then insonated, it was hypothesized that the resulting decrease in tumour growth was due to the chemotherapeutic drug being distributed throughout the tumour via ultrasound including the less vascularized regions (Nomikou et al. 2010[a]). Chemosensitive and chemoresistant ovarian cancers were implanted in the murine kidney and insonated 15 minutes after adriamycin was injected intraperitoneally (Yu et al. 2004[b]). Because ultrasound enhanced adriamycin in both types of cancer, it was hypothesized that ultrasound could reverse adriamycin resistance in ovarian cancer cells. Scutellarin was administered orally before tumour insonation in studies on a human tongue squamous cell carcinoma, and the combined therapy inhibited tumour growth, angiogenesis, and lymphangiogenesis (Li et al., 2013).

The RoyalVibe.Focused Ultrasound Device

Dr Raymond Venter is a scientist with an entrepreneurial spirit. He is the inventor and manufacturer of the CellQuicken device and the sole director of the CellQuicken company. Raymond invented the CellQuicken frequency generator, which instantly cured his father of cancer.

It is a natural sound frequency device that assists the body in cellular restoration. The device employs low-intensity ultrasound with a high frequency and energy levels at the cellular level. This therapy takes place while you sleep, work at a desk, or rest: there is no medication involved, and there are no side effects. Focused ultrasound is a development of modern technology that allows for the treatment of conditions without the side effects associated with conventional treatments. However, we have evolved only when we address the underlying cause of the condition rather than merely masking the symptoms.

CellQuicken's Focused Ultrasound product solutions determine the cell resonance frequency to stimulate or destroy the bioenergy contained within the cell or organism.

Focused ultrasound is a relatively new technology that directs acoustic energy to anatomical targets to minimise hidden pathologies. While conventional allopathic medicine is effective in treating various diseases, it is ineffective in treating several cancers.

Ultrasound technology's continued advancement should be closely monitored and considered a viable alternative to conventional treatment, which frequently involves severe side effects and invasive procedures.

CONCLUSION:

All of the therapies that used low-intensity ultrasound, including sonodynamic therapy, ultrasound-mediated chemotherapy and gene delivery, and anti vascular ultrasound therapy, consistently produced bioeffects that resulted in the death of cancer cells. Low-intensity ultrasound applications are thought to be safe and non-toxic, easy to apply to a tumour, and relatively inexpensive. Multiple bioeffects are likely responsible for a therapy's efficacy, although the importance of thermal and inertial cavitation bioeffects has been established in animal tumour models. In some cases, the tumour's accessibility to insonation is a constraint, as the cancer cells may be adjacent to a gas-containing structure or bone and thus difficult to reach by the ultrasound beam. This limitation can be overcome in such clinical situations by imaging and treating with intracavity transducers.

Additionally, the current generation of microbubbles has a limited capacity for therapeutic loading agents at the required dosages. These limitations could be overcome by optimizing the design of microbubbles to increase their payload carrying capacity. Co-administration of therapeutic agents and microbubbles could also be used to circumvent the payload issue.

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