Convection-enhanced Drug Delivery for Glioblastoma: A Systematic Review Focused on Methodological Differences in the Use of the Convection-enhanced Delivery Method

Abstract
Glioblastoma (GBM) is a leading cause of brain cancer-related death. The blood–brain barrier (BBB) prevents the transport of most systemic delivered molecules to the brain. This constitutes a major problem in the therapy of brain tumors. In the last decade, numerous different drug-delivery approaches have been developed to overcome the BBB. The objective of this study is to provide an overview of the methodological aspects used in all preclinical and clinical studies published from 2011 to 2016 where convection-enhanced delivery (CED) was used for drug delivery in the treatment of GBM. A systematic review of English articles published in the past 5 years was undertaken using PubMed and Embase. The search terms (brain tumor [MeSH Terms]) AND (CED OR convection enhanced delivery) were used in PubMed and a similar search was carried out in Embase using their “multi-field search.” All studies using CED on an intracranial GBM model were included. The search resulted in 151 hits after duplicates were removed. In total, 30 studies were included in the review. Of these, two publications studied the technical aspects of the CED method. Furthermore, only one study was a clinical study. The research field is focused on preclinical drug development trials and less emphasis is placed on the CED technique itself. However, it is important that future studies focus on establishing optimal protocols for the use of CED in rodents as well as for big brain models to be able to use the CED method in patients with GBM.

Keywords: Blood–brain barrier, brain tumor, convection-enhanced delivery, glioblastoma, oncology

Introduction
Glioblastoma (GBM) is one of the most malignant brain tumors and increases in frequency with age. GBM remains incurable, and despite trimodal therapy, the median survival is only 14–20 months. Combining surgical resection, external radiation, and chemotherapy has little effect.[1,2]

Two important factors account for the lack of effectiveness: the inherent ability of the GBM tumor to infiltrate deep into surrounding tissue, which makes complete resection impossible,[3] and the ineffectiveness of systemic drug-delivery due to the blood–brain barrier (BBB). Furthermore, the molecular characteristics of available chemotherapeutic agents (polar and with a high molecular weight) make penetration across the BBB even more challenging.[4]

To overcome the challenges of the BBB, Bobo et al.[4] proposed the use of convection-enhanced delivery (CED). CED creates fluid convection by maintaining the pressure gradient throughout the infusion. This greatly enhances the distribution of the desired molecule.[4] Convection through CED differs from simple diffusion. Simple diffusion is the passive movement of solute from a high concentration to a lower concentration, whereas the movement created by CED is due to the positive pressure created by the pump.

Despite the fact that CED was already described back in 1994[4] and has been used in numerous clinical trials since,[5‑13] no drugs have yet been approved for administration by CED. Moreover, only one Phase III trial has been completed,[12] and this failed probably due to insufficient drug distribution.[14] This clearly shows that CED is not a simple technique to apply and that not all drugs convect just because they are infused into the brain parenchyma. Essential aspects to consider are catheter design, number of catheters used and their

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placement, infusion rate and start-up infusion protocol, duration of infusion, type of drug infused (cell affinity, drug size and charge, lipo-/hydrophilic), potential drug encapsulation, and importantly, which method to use to evaluate drug distribution.

In this systematic review, our objective was to provide an overview of the methodological aspects listed above in all preclinical and clinical studies published from 2011 to 2016 where CED was used for drug administration in the treatment of GBM.

Materials and Methods

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses was used. The ethical committee at our department approved the study.

Articles in English published in the period from October 30, 2011, to October 30, 2016, registered in Embase or PubMed were included in this review. In addition, the reference lists were read to ensure that all relevant studies were included.

The search term (brain tumor [MeSH Terms]) AND (CED OR convection enhanced delivery) was used in PubMed. A similar search was carried out for Embase using their multi-field search tool.

No limits were applied to the search on PubMed and Embase. The last search was carried out on October 30, 2016.

Data relating to the CED methodology used in each of the publications were extracted and the following data were registered: What type of agent was infused? What tumor cell line was used? What type and how many catheters were used for the infusion? How much was infused and at what flow rate? Did the subjects experience any adverse effects? Did the researchers evaluate drug distribution and if so what method was used? What type of pump was used? Where was the tip of the catheter placed?

Results

The search in PubMed and Embase resulted in 202 publications. After removing duplicates, 151 articles remained. Of the 151 articles, 97 articles were not experimental studies or were irrelevant to the subject of this review.

After assessing the 54 remaining articles, 22 were excluded because they did not use a GBM tumor model. One publication was excluded because it was only in Chinese. One article was not accessible and the author was contacted to get the full-text article. However, the author never responded. Accordingly, 30 articles were included as displayed in Figure 1, 29 were experimental animal studies and the last was a clinical, nonrandomized, and nonblinded study. The level of evidence in this review is thus level 5.

Preclinical data concerning mice and rats are listed in Table 1 and 2, respectively. Clinical data are listed in Table 3.

Some of the studies in the present review included several experimental animal groups exposed to a variety of experimental conditions. Only data from intracranial GBM models in these studies were used.

The studies all infused different agents except for carboplatin, irinotecan and cetuximab-IONP. Each of these were used in two studies.

The noninvasive human U87-MG GBM cell line was used in 12/30 (40%) of the studies, seven of which were mice studies. The syngeneic F98 rat tumor cell line was used in 7/30 (23%) studies, followed by the human U251 GBM cell line, which was used in 3/30 (10%) studies.

Of 30 studies, 9 (30%) studies used simple cannulas with sizes varying from 22-gauge to 33-gauge. Whether these were blunt or sharp-tipped and which point style was used in the case of the latter were not disclosed. Of 30 studies, 7 (23%) studies used stepped catheters. Of 30 studies, 7 (23%) studies did not mention what type of catheter was used.

In 28/30 (93%) of the studies, only one catheter was used. Of 30 studies, 2 (7%) studies included experimental groups where up to four catheters were used.[42,44]

In 27/30 (90%) studies, the catheter was placed intratumorally. Of 30 studies, 1 (3.5%) study used both intratumoral and peritumoral catheter placement on different animal groups.[42] Of 30 studies, 2 (7%) studies did not specify where the catheter was placed.[30,37]

The infusion parameters varied between studies. Flow rate in mice ranged between 0.11 and 60 µl/h (mean 22.3 µl/h) and in rats ranged between 1 and 120 µl/h (mean 33.6 µl/h). In the human clinical trial, the flow rate was 400 µl/h (200 µl/h/catheter).

The total volume infused ranged between 5 and 126 µl (mean 43 µl) in mice and 5–1574 µl (mean 187.5 µl) in rats. In the clinical trial, a total volume of 40,000 µl was infused.

The duration of the infusions ranged between 5 min to 28 days (mean 5.4 days) in mice and 12.5 min to 31 days (mean 16 h) in rats. In the human clinical trial, the infusion lasted 100 h. All studies opted to use one infusion.

Of 30 studies, 8 (27%) studies used an internal pump. Of those, six were osmotic devices and two were iPRECIO micro-infusion pumps. The remaining 22 (73%) studies used an external pump.

Of 30 studies, 3 (10%) studies used magnetic resonance imaging (MRI) to evaluate drug distribution in the brain tissue. This was done by attaching iron oxide nanoparticles to the drug. On T2-weighted images, the particles are
| Author and year | Agent infused | Type of drug | Type of tumor | Adverse effects | Flow rate | Total volume infused | Duration | Number of catheters | Cannula/catheter placement | Number of infusions | Pump | Catheter placement | Evaluation of convection |
|-----------------|---------------|--------------|---------------|-----------------|-----------|---------------------|----------|------------------|--------------------------|---------------------|------|------------------|----------------------|
| Bouras et al., 2015[15] | Cetuximab-IONP | Nanoparticles | U87MG | No adverse effects observed | 30 µL/h | 10 µL | 20 min | 1 | Not mentioned | External | Intratumoral | MRI and histology |
| Kaluzova et al., 2015[16] | Cetuximab-IONP | Nanoparticles | N08-30, U87MG, LN229 | No adverse effects observed | 30 µL/h | 10 µL | 20 min | 1 | 22-gauge cannula | 1 | External | Intratumoral | MRI |
| Wang et al., 2015[17] | Bevacizumab | No coating | U87MG, LN229 | No adverse effects observed | 0.11 µL/h | 74 µL | 28 days | 1 | Brain infusion kit | 1 | Internal | Intratumoral | No evaluation |
| Danhier et al., 2015[18] | SiRNA/chitosan-LNC | Liposomal | U87MG | Not mentioned for CED | 30 µL/h | 60 µL | 120 min | 1 | 26-gauge cannula | 1 | External | Intratumoral | No evaluation |
| Bernal et al., 2014[19] | Temozolomide-PMNP | Nanoparticles | U87MG | Local edema | * | 10 µL | * | 1 | Stepped | 1 | External | Intratumoral | MRI and histology |
| Chen et al., 2013[20] | Nanoliposomal irinotecan | Liposomal | GBM43/SF7A9 | No adverse effects observed | 60 µL/h | 5-10 µL | 5-10 min | 1 | Stepped | 1 | External | Intratumoral | Histology |
| Sonabend et al., 2014[21] | Etoposide | No coating | Murine proneural GBM | Focal tissue damage limited the site of catheter placement | 0.5 µL/h | 84 µL | 7 days | 1 | Alzet brain infusion kit 3 | 1 | Internal | Intratumoral | No evaluation |
| Stephen et al., 2014[22] | NPCP-BG-CTX | Nanoparticles | GBM6 | Not mentioned for CED | 60 µL/h | 5 µL | 5 min | 1 | Not mentioned | 1 | External | Intratumoral | Ex vivo NIRF |
| Zamykal et al., 2014[23] | IMC-A12 | IGFR target | U87MG, GS-12 | No adverse effects observed | 0.25 µL/h | 126 µL | 21 days | 1 | Alzet brain infusion kit II | 1 | Internal | Intratumoral | No evaluation |
| Suzuki et al., 2014[24] | Interleukin-13 Pseudomonas exotoxin | IL-13 target | U251 | Not mentioned for CED | 1.4 µL/h | 101 µL | 3 days | 1 | Not mentioned | 1 | Internal | Intratumoral | SPECT/CT |
| Shultz et al., 2011[25] | 17Llu-DOTA-f-Gd3N@C80 | Metallofulleren coated | U87MG | Not mentioned for CED | 12 µL/h | 18 µL | 90 min | 1 | 28-gauge cannula | 1 | External | Intratumoral | No evaluation |
| Weng et al., 2013[26] | QD-IL, QD-L | Liposomal | U87MG, GBM37 | Not mentioned | Ramped: 6>12>30>48 µL/h | 10 µL | 22.5 min | 1 | Stepped | 1 | External | Intratumoral | MRI and histology |

MRI – Magnetic resonance imaging; SPECT – Single-photon emission computed tomography; CT – Computed tomography; NIRF – Near-infrared fluorescence; CED – Convection enhanced delivery; IGFR – Insulin-like growth factor 1 receptor; IL – Interleukin; BG – O6-benzylguanine; GBM – Glioblastoma; IONP – Iron oxide nanoparticles; LNC – Lipid-core nanocapsules; PMNP – Polymeric nanoparticle; NPCP-BG-CTX – Nanoparticle chitosan-PEG copolymer-O6-benzylguanine-chlorotoxin; IMC – A12 – cixutumumab; QD-L – Quantum dot-immunoliposome; * - Not disclosed
| Author and year | Agent infused                              | Type of drug | Type of tumor | Adverse effects | Flow rate | Total volume infused | Duration | Number of catheters | Cannula/catheter | Number of infusions | Pump | Catheter placement | Evaluation of convection |
|-----------------|--------------------------------------------|--------------|---------------|-----------------|------------|----------------------|----------|----------------------|-----------------|---------------------|------|---------------------|--------------------------|
| Halle et al., 2016<sup>[27]</sup> | Anti-let-7a                               | No coating   | T87 GSC       | No adverse effects observed | 2 µL/h     | 1411-1574 µL         | 31 days  | 1                    | Plastics One       | 1                  | Internal (iPRECIO infusion pump) | Intratumoral No evaluation |
| Mendiburu-Eliçabe and Gil-Ranedo, 2015<sup>[28]</sup> | Nanoliposomal irinotecan | Liposomal    | U87MG         | No adverse effects observed | 30 µL/h    | 20 µL                | 40 min   | 1                    | Stepped           | 1                  | External              | Intratumoral No evaluation |
| Cooper et al., 2015<sup>[29]</sup> | EA-human serum albumin BBB targeting | BBB targeting | Rat CNS-1     | No adverse effects observed | 120 µL/h   | 40 µL                | 20 min   | 1                    | 33-gauge cannula   | 1                  | External              | Intratumoral No evaluation |
| Yang et al., 2014<sup>[30]</sup> | Carboplatin                               | No coating   | F98 Gliosis   |                 | 20/1 µL/h  | 10/168 µL            | 30 min/7 days | 1                    | Not mentioned      | 1                  | External and internal | Not mentioned ICP-OES |
| Xi et al., 2014<sup>[31]</sup> | Nanodiamond-doxorubicin | Nanodiamonds | U251          | No adverse effects observed | Incremental: 6>12>15 µL/h | 5 µL | (10/10/8) 28 min | Not mentioned | 1                  | External              | Intratumoral Fluorescent microscope |
| Yin et al., 2013<sup>[32]</sup> | Retroviral-replicating-vector expressing cytosine deaminase | Tumor-selective RRV | U87MG Gliosis | No adverse effects observed | 60 µL/h | 20 µL | 20 min | 1 | Stepped | 1 | External | Intratumoral Histology |
| Huo et al., 2012<sup>[33]</sup> | Liposomal lipoplatin                     | Liposomal    | F98 Necrosis and oedema |                 | 20 µL/h | 10 µL | 30 min | 1 | 28 gauge cannula | 1 | External | Intratumoral ICP-OES |
| Phillips et al., 2012<sup>[34]</sup> | Rhenium-186 liposomes                    | Liposomal    | U87MG Gliosis |                 | 120 µL/h | 25 µL | 12,5 min | 1 | 27-gauge cannula | 1 | External | Intratumoral SPECT/CT |
| Xi et al., 2012<sup>[35]</sup> | Vincristine                               | No coating   | C6 rat Minor trauma at the site of the infusion cannula | Incremental: 6>12>15 µL/h | 5 µL | (10/10/8) 28 min | 1 | 26-gauge cannula | 1 | External | Intratumoral No evaluation |
| Shi et al., 2015<sup>[36]</sup> | Cisplatin, carboplatin, and lipoplatin   | Liposomal    | F98 Not mentioned | Not mentioned for CED | 30 µL/h | 10 µL | 20 min | 1 | 33-gauge cannula | 1 | External | Intratumoral No evaluation Histology |
| Zhang et al., 2016<sup>[37]</sup> | SN-38-loaded polymeric micelles          | Liposomal    | U87MG Not mentioned | Not mentioned for CED | Incremental: 12>30>48 µL/h | 20 µL | (15/10/15) 40 min | Stepped | 1 | External | Not mentioned Histology |

Contd...
### Table 2: Contd...

| Author and year | Agent infused | Type of drug | Type of tumor | Adverse effects | Flow rate | Total volume infused | Duration | Number of catheters | Cannula/catheter | Number of infusions | Pump | Catheter placement | Evaluation of convection |
|-----------------|--------------|--------------|---------------|-----------------|-----------|----------------------|---------|---------------------|-----------------|---------------------|------|------------------|-------------------------|
| Hiramatsu et al., 2015[38] | Tetrakis chlorin | No coating | F98 | Not mentioned | 8 µL/h | 192 µL | 24 h | 1 | ALZET Brain Infusion Kit 2 | 1 | Internal (osmotic) | Intratumoral | Histology |
| Shi et al., 2016[39] | Oxaliplatin | Liposomal | F98 | Not mentioned for CED | 30 µL/h | 10 µL | 20 min | 1 | 33-gauge cannula | 1 | External | Intratumoral | Plasma mass spectrometry |
| Barth et al., 2016[40] | Cisplatin-containing EGFR-targeting bioconjugates | EGFR targeting | F98 | Not mentioned for CED | 20 µL/h | 10 µL | 30 min | 1 | Not mentioned | 1 | External | Intratumoral | No evaluation |
| Saucier-Sawyer et al., 2016[41] | PLGA BPNP Nanoparticles | U87MG, RG2 | F98 | Not mentioned for CED | 40 µL/h | 20 µL | 30 min | 1 | Stepped | 1 | External | Intratumoral | Histology |
| Yang et al., 2014[42] | Pegylated liposomal doxorubicin | Liposomal | F98 | Not mentioned | Incremental: 12>30>48 µL/h | 20 µL | (15/10/15) 40 min | 1-4 | Not mentioned | 1 | External | Intratumoral and peritumoral | Histology |
| Thysgaard et al., 2016[43] | Methotrexate 125I-UdR | No coating | T87 | No adverse effects observed | 5 µL/h | 1200 µL | 10 days | 1 | PlasticsOne | 1 | Internal (iPRECIO infusion pump) | Intratumoral | SPECT/CT |

EGFR – Epidermal growth factor receptor; BBB – Blood–brain barrier; RRV – Retroviral replicating vector; CED – Convection-enhanced delivery; SPECT – Single-photon emission computed tomography; CT – Computed tomography; EA – Ethylamine; PLGA BPNP – poly(lactic-co-glycolic acid) brain-penetrating nanoparticles; ICP-OES – inductively coupled plasma optical emission spectrometry

### Table 3: Summary of clinical trial

| Author and year | Agent infused | Type of drug | Type of tumor | Adverse effects | Flow rate | Total volume infused | Duration | Number of catheters | Cannula/catheter | Number of infusions | Pump | Catheter placement | Evaluation of convection |
|-----------------|--------------|--------------|---------------|-----------------|-----------|----------------------|---------|---------------------|-----------------|---------------------|------|------------------|-------------------------|
| Surapaneni et al., 2015[44] | Topotecan | No coating | 10 patients with GBM | No adverse effect | 400 µL/h (2 catheters) | 40,000 µL | 100 h | 1 or 2 | Tunneled infusion catheters | 1 | External | Intratumoral | No evaluation |
| Bruce et al., 2011[45] | | | | | | | | | |

*Both publications used data generated from the same experiment. GBM – Glioblastoma
shown as areas with hypointensity. Of 30 studies, 9 (30%) studies used histology. Only 7/30 (23%) studies reported volume of distribution (Vd). Of 30 studies, 10 (33%) studies did not use a procedure to evaluate how the drug had been distributed.

Of 30 studies, 6 (20%) studies mentioned side effects due to the CED method. These were local edema and tissue damage along the cannula/catheter tract, gliosis, and necrosis. Side effects due to the different infused molecules were also mentioned but are not addressed in this review. Of 30 studies, 12 (40%) studies did not mention whether side effects due to the CED procedure occurred.

Discussion

The aim of this review was to provide an overview of the methodological aspects used in all preclinical and clinical studies published within the last 5 years where CED was used for drug delivery in the treatment of GBM. Based on this overview, we evaluated the catheter systems used, placement of catheters, infusion protocols applied, duration of infusions, number of infusions, the drugs infused, and how drug distribution was estimated.

The search resulted in 202 articles, of which 51 were duplicates. Of the remaining 151 studies, 64% were excluded (97 studies) because the studies were either nonexperimental or used another delivery method than CED. Among the remaining 54 studies, only 30 used GBM models. Altogether, only 30 studies focusing on CED for GBM therapy have been published over the course of the last 5 years. Since we only evaluated the methodological aspects of CED and not outcomes of survival or other outcome measures, one can argue that the risk of bias is low.

Of the 30 studies, only one study was a clinical study and the remaining 29 studies were conducted on rodents. This indicates that despite CED being known for over 20 years, it is still mainly used in preclinical studies. Moreover, we find it interesting that no data were generated in large brain nonrodent studies. It is surprising that such important information influencing CED was left out so often.

The technical aspects of the CED method deserve to be studied because optimizing the parameters of the CED method might also influence the results of preclinical drug development studies.

Of the 30 studies included in this review, only two studies done by Yang et al. [42] and Weng et al. [26] studied the technical aspects of the CED method.

Agent infused

In nearly all the 30 studies, different therapeutic agents were infused. The objective of most studies was to investigate the effect of drug coating with nanoparticles or liposomes to better control the release of a drug into the brain parenchyma or increase the area of drug distribution. Several studies investigated specific receptor targeting such as insulin-like growth factor receptor and epidermal growth factor receptor. [25,40] Only a few of the studies mentioned specific properties of the molecules they used, such as drug charge, hydrophilicity, or tissue affinity, although these properties influence the effective distribution of drugs in the brain by CED. [48]

Type of tumor

The type of tumor (i.e., the characteristics of the tissue in which the drug is to be distributed) is relevant to consider when applying the CED method.

A model should, as closely as possible, reflect the complexity of the human brain so that preclinical effect, toxicity, and safety can be determined before initiating a human clinical trial.

Twelve of the studies in this review have used the cell line U87-MG. Allen et al. [49] concluded that the origin of the widely used U87MG line is different from that of the original U87-MG from Uppsala. [49] Saucier-Sawyer et al. [41] described that their U87-MG cell line produces a tumor with circumscribed infiltration and limited necrosis. [41] making it a poor model of the human GBM tumor that is characterized by its extensive infiltration and necrosis. Eleven studies using U87-MG thus seem to have used a cell line that does not really mimic the properties of human GBM tumor tissue.

Catheter design

Seven studies used a stepped catheter for infusion. Of the remaining studies, nine used simple canulas with sizes varying from 22-gauge to 33-gauge. Seven of the studies did not mention which type of cannula or catheter they used. It is surprising that such important information influencing CED was left out so often.

Most of the studies did not discuss their choice of catheter even though the design of the catheter plays an important
role in limiting the amount of backflow occurring along the catheter. Several studies mention that catheters were slowly withdrawn or left in place for a short period after infusion. However, the effect on drug backflow using these procedures is not mentioned in the studies. The 32-gauge cannula, one of the smallest metal cannulas commercially available, must be used at a flow rate of 0.5 µl/min (30 µl/h) to avoid reflux, a rate surpassed by many studies in this review.

A so-called step-design catheter has been proposed by Krauze et al. It is a promising design that could enhance drug delivery by reducing both the infusion time and the volume of drug required to cover the targeted structure in the brain. Since the stepped catheters prevent reflux, they seem preferable compared to the often-used simple cannula or nonstepped designed catheters.

From the wide array of catheters and cannulas used in the reviewed articles, one can only encourage that additional focus is given to catheter choice in future preclinical CED studies.

**Catheter placement**

The rationale behind peritumoral placement of catheters is to target the part of the GBM that is infiltrating healthy brain tissue. Yang et al. investigated the effect of CED on four different experimental groups. The four groups were intratumoral infusion, peritumoral infusion after tumor removal, peritumoral infusion before tumor removal, and peritumoral infusion before tumor removal with prior use of steroids. They concluded that peritumoral infusion without prior tumor removal resulted in maximum Vd. The efficacy of the infusion was further enhanced by treatment with steroids before CED. These are interesting findings, but in the clinical setting, the majority of GBM patients will have their tumor resected followed by adjuvant therapy. Moreover, the human brain is very large, and therefore, multiple catheters are probably needed.

Some articles mentioned that the tip of the catheter was placed at the center of the bulk tumor. However, the authors did not explain how this was achieved. It might be a difficult task when working with mice and rat brains because of their small size and without the help of a guiding system.

**Flow rate and duration of infusion**

In CED, the crucial aspect is to optimize flow by applying a pressure that forces penetration of the drug into the tissue. Although the precise mechanism is still not clear, interstitial fluid pressure is elevated in tumors. This might be beneficial when treating highly invasive tumors, since the infused drug will spread further away from the bulk tumor. However, drug distribution inside the tumor mass might become compromised. It has been shown that the use of steroids before CED can reduce the interstitial pressure inside the tumor and can therefore reduce tumoral leakage.

As seen in Tables 1-3, flow parameters vary between studies. It is unclear in most of the studies, why a particular flow rate or infusion time was chosen.

In the majority of studies, the infusion was kept at the same rate throughout the experiment. Interestingly, only five studies chose to use an incremental flow rate. Bobo et al. used an incremental flow rate to increase the distribution of the infused agent. The logic behind using an incremental flow rate is to keep a constant positive pressure during the whole infusion period and avoid the pressure plateauing, ensuring that the infusion liquid penetrates the targeted area of tissue.

Excessive flow pressure can, however, result in tissue fracturing, and once this occurs, the fracture will tend to propagate preventing the liquid from being properly distributed through the extracellular space.

Schomberg et al. concluded that ramping CED infusion protocols could potentially minimize backflow and produce more spherical infusion clouds, but further research is required to determine the strength of this correlation, especially in relation to maximum infusion rates.

**Evaluation of drug distribution**

One lesson learned from the only Phase III trial published to date (the PRECISE trial) was that evaluation of drug distribution is crucial. However, proper evaluation is not easily achieved.

In the reviewed articles, most studies used histology and only a few used computed tomography [CT] or MRI. However, eleven studies did not evaluate how their drugs were distributed at all. Although histological evaluation in preclinical studies might be relevant, it is not suitable for clinical use.

One method used for the evaluation of distribution is to coadminister a contrast agent with the drug and then presume that the distribution of the contrast agent, as shown on CT or MRI, equals that of the drug’s distribution. However, from our own experience (unpublished data), this is not the case, which makes sense since a drug convects differently according to its size, charge, and tissue affinity. Another method, used by the three studies in this review using MRI, was to conjugate iron oxide particles to the drug infused. The distribution of the conjugates was then evaluated. A limitation of this approach is that conjugation (e.g., with iron oxide) alters the size and potentially the charge and tissue affinity. Weng et al. used a so-called quantum dot attached to a nanocarrier. The quantum dot emits an infrared light that can be measured with a charge-coupled device camera. However, this technique only works on thin skulls such as mice.
In one of our own studies also included in this review, we infused a radiopharmaceutical (125Iodo-deoxyuridine).\textsuperscript{[43]} This is a single photon emitter that can be visualized directly using single-photon emission CT imaging without any need for drug modification such as conjugation.

**Conclusion**

From 2011 to 2016, 30 studies have used CED for GBM therapy. Only one study was clinical, indicating that CED is still mostly explored preclinically. Since the first description of CED in 1994, it has become evident that the technical aspects of the infusion are important for the distribution of drugs and that there might be an important gain of therapeutic effect if good protocols can be developed.

This review shows that most researchers invested little interest in the methodological set-up of CED. This was true for catheter design, number of catheters used and their placement, infusion rate and start-up infusion protocol, and duration of infusion, indicating that the CED methodology was viewed as having only a small influence on the results of the drug studies. In general, the reporting on adverse effects was also severely lacking and even sometimes completely missing from the studies reviewed. It can also be added that endpoint measures are lacking in most of the studies: valid measures of the area of distribution of a given molecule with the given CED protocol using imaging such as MRI or CT combined with histology.

In our opinion, these aspects should be included in the future preclinical CED studies. Moreover, we find it crucial that the same CED protocols as those intended for use in humans are studied in large animals, such as tumor-bearing pigs, to overcome the challenges we face with translation of promising preclinical CED trials into successful clinical trials.

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**Conflicts of interest**

There are no conflicts of interest.

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