Radiation Induced DNA Damage in Operators Performing Endovascular Aortic Repair

Running Title: El-Sayed and Patel et al.; Radiation Induced DNA Damage in EVAR

Tamer El-Sayed, MRCS1*; Ashish S. Patel, PhD1*; Jun S. Cho, MRCS1;
James A. Kelly, MRCS1; Francesca E. Ludwinski, PhD1; Prakash Saha, PhD1;
Oliver T. Lyons, PhD1; Alberto Smith, PhD1; Bijan Modarai, PhD1

and Guy’s and St Thomas’ Research Collaborative

1The Academic Department of Vascular Surgery, School of Cardiovascular Medicine and Sciences, King’s College London, BHF Centre of Excellence at Guy’s & St Thomas’ NHS Foundation Trust, London, United Kingdom

*Joint first authors

Address for Correspondence:
Bijan Modarai, PhD
Academic Department of Vascular Surgery
School of Cardiovascular Medicine and Science
King’s College London
First Floor, North Wing, St Thomas’ Hospital
Westminster Bridge Road, London
SE1 7EH, United Kingdom
Tel: 020 7188 0216
Fax: 020 7188 1094
Email: Bijan.Modarai@kcl.ac.uk
Abstract

Background—Radiation exposure during fluoroscopically-guided interventions such as endovascular aortic repair (EVAR) is a growing concern for operators. This study aimed to measure DNA damage/repair markers in operators performing EVAR.

Methods—Expression of the DNA damage/repair marker, gamma-H2AX (γ-H2AX) and DNA damage response (DDR) marker, phosphorylated ataxia telangiectasia mutated (pATM), were quantified in circulating lymphocytes in operators during the peri-operative period of endovascular (infra-renal [IEVAR], branched [BEVAR] and fenestrated [FEVAR]) and open aortic repair using flow cytometry. These markers were separately measured in the same operators but this time wearing leg lead shielding in addition to upper body protection and compared with those operating with unprotected legs. Susceptibility to radiation damage was determined by irradiating operators’ blood in vitro.

Results—γ-H2AX and pATM levels increased significantly in operators immediately after BEVAR/FEVAR (P<0.0003 for both). Only pATM levels increased after IEVAR (P<0.04). Expression of both markers fell to baseline in operators after 24hrs (P<0.003 for both). There was no change in γ-H2AX or pATM expression after open repair. Leg protection abrogated γ-H2AX and pATM response after BEVAR/FEVAR. The expression of γ-H2AX varied significantly when operators’ blood was exposed to the same radiation dose in vitro (P<0.0001).

Conclusions—This is the first study to detect an acute DNA damage response in operators performing fluoroscopically-guided aortic procedures and highlights the protective effect of leg shielding. Defining the relationship between this response and cancer risk may better inform safe levels of chronic low dose radiation exposure.

Key Words: radiation; aneurysm; occupational exposure, pATM, γH2AX
Clinical Perspective

What is new?

- This is the first study to detect acute radiation induced DNA damage in operators who carried out endovascular aortic repair by demonstrating an increase in the expression of DNA damage/repair markers, γ-H2AX and pATM, in their circulating lymphocytes immediately after procedures.
- *In vitro* irradiation studies demonstrated that operators had a variable susceptibility to radiation induced DNA damage.
- The use of leg lead shielding abrogated the DNA damage response in operators.

What are the clinical implications?

- Conventional dosimetry fails to account for the biological consequences of radiation exposure to operators during fluoroscopically guided procedures.
- Safe radiation exposure limits have been set without considering any inter-individual differences in susceptibility to deleterious effects.
- Wearing lower leg protective lead shielding is essential for reducing scatter radiation induced DNA damage.
- The use of cellular markers, including γ-H2AX and pATM, which readily lend themselves to high throughput sampling may facilitate individual risk-profiling, improve our understanding of the mechanisms involved in occupational radiation induced mutagensis and define optimal protection strategies.
Recent years have seen an exponential increase in the number of fluoroscopically guided cardiovascular interventions carried out by interventional cardiologists, electrophysiologists and vascular surgeons, with many of these for pathologies previously treated by open surgery. Endovascular aortic repair (EVAR), for example, has become the mainstay of treatment in many institutions and is increasingly used for patients that would have been turned down for intervention 10 years ago.\textsuperscript{1,2} The growing number and complexity of procedures means that interventionists are exposed to higher amounts of radiation, a subject that is becoming increasingly topical.\textsuperscript{3-7} A recently published 15 year follow up study of the EVAR trial, comparing endovascular and open aortic repair, reported an increased incidence of malignancy in patients treated by EVAR.\textsuperscript{8} There is, rightly so, a significant focus currently on reducing the patients’ exposure to radiation but mounting evidence suggests that recurrent low dose exposure to the practitioner is equally as important. Robust data collection to assess the risks posed to the interventionist is in its infancy, but a number of studies suggest a link to adverse health effects, including a higher risk of posterior subcapsular lens changes and malignancy.\textsuperscript{9-11} One recent study found a higher incidence of malignancy, including brain cancer, breast cancer and melanoma in interventionists who performed fluoroscopically guided procedures compared with those who had never performed these.\textsuperscript{12} A better understanding of the hazards of occupational radiation exposure requires sensitive tools to measure exposure at an individual level and clarification of the biological effects of exposure.

Circulating lymphocytes are particularly sensitive to radiation and may, therefore, offer the opportunity to study the acute biological consequences of low dose exposure.\textsuperscript{13,14} Double stranded DNA breaks (DSBs) induced by ionising radiation lead to phosphorylation of the histone protein H2AX to form $\gamma$-H2AX, with the levels of $\gamma$-H2AX in the cell peaking half an
hour after exposure to radiation. During the acute phase of exposure, DNA damage in lymphocytes also results in induction of a damage sensor known as the Mre11-Rad50-Nbs1 (MRN) complex, which causes rapid phosphorylation of ataxia telangiectasia mutated (ATM) protein. This, in turn, leads to phosphorylation of downstream targets that act as cell cycle checkpoints, resulting in DNA damage-induced arrest at G1/S, S, and G2/M as part of the DNA repair process. Expression of phosphorylated ATM (pATM), a DNA damage response (DDR) marker, and γ-H2AX, a marker of DNA repair, in circulating lymphocytes may, therefore, be a sensitive biomarker of radiation-induced DNA damage. The use of such biomarkers could facilitate a biological assessment of the effects related to radiation exposure.

The current safe limits for low dose occupational radiation exposure have been extrapolated from data obtained from individuals exposed to high doses (e.g. atomic bomb survivors) and assume a linear, no-threshold relationship between exposure and cancer risk. Emerging data suggest, however, that there is variability in tissue response to radiation, that the safe threshold may vary between individuals and the risk relationship is not linear.

The aims of the present study were to: (i) study the biological effect of radiation exposure in operators by measuring pATM and γ-H2AX expression in circulating lymphocytes following EVAR; (ii) to examine individual operator sensitivity to radiation exposure using γ-H2AX levels as a biomarker; and (iii) to evaluate the protective effect of wearing lower leg lead shielding.

**Methods**

**Study participants**

Blood samples were collected from vascular surgeons and interventional radiologists before, immediately after and 24hrs after they performed endovascular and open aortic repairs. All
operators had experience of endovascular aortic repair procedures and beyond their learning curve. The BEVAR/FEVAR procedures were performed by one of four operators, all of whom had experience of >100 of these procedures. Endovascular procedures consisted of standard infra-renal aortic repairs (IEVAR) and complex thoracoabdominal, branched (BEVAR) and fenestrated (FEVAR) repairs. This study was approved by the London - City & East Research Ethics Committee (16/LO/1111) following the principles of the Declaration of Helsinki and written informed consent was obtained from each participant.

**Procedural details**

All endovascular aortic repair procedures were carried out in a hybrid operating theatre equipped with the Philips Allura Xper FD20 fixed X-ray imaging system (Philips Healthcare, Eindhoven, Netherlands). Default settings used were a pulse rate of 7.5 pulses/second for background fluoroscopy and two frames/second for digital subtraction angiography (DSA) acquisitions. For both fluoroscopy and cineangiography an x-ray beam filtration of 1.5 mmAl combined with 0.4 mm Cu was used. The equipment set-up and operating staff positioning was similar for IEVAR and BEVAR/FEVAR procedures and has been described previously. The fluoroscopy equipment was controlled by a senior radiographer for each procedure. At the start of each case, the under table lead shielding was specifically checked to ensure it was in the optimal position. A ceiling-mounted lead shield was available and was positioned at the operators’ discretion for each procedure. Mobile lead shields for the radiographer and anaesthetist, lead garments (0.35 mm thickness), leaded thyroid collars, and leaded goggles were used for all endovascular cases. Leg lead shields were not routinely worn. A cohort of 6 operators (selected from the first cohort of 15 studied) were asked to wear lower leg lead shielding (0.5mm thickness, XENOLITE–TB,
DuPont Technology, Lite Tech, Inc. Norristown, PA, USA) as additional protection to separately study the effect of radiation exposure on operators when legs were protected.

**Standard dosimetry**

Electronic dosimeters (Hitachi-Aloka Medical PDM-127; Hitachi Aloka Medical Ltd, Tokyo, Japan) were used to measure direct radiation exposure. These devices recorded cumulative measurements of the “dose equivalent” of absorbed radiation in micro Sieverts (μSv) for each case. Dosimeters were attached to three different areas on the operator: (i) left breast pocket under the protective lead garment; (ii) left breast pocket over the protective lead garment; and (iii) left mid leg. The dose-area product (DAP), fluoroscopy time, and air kerma dose were recorded for all procedures.

**Flow cytometry**

Venous blood samples were collected from operators in EDTA tubes (BD Biosciences, UK). Red blood cells were lysed using Pharmlyse (BD Biosciences, UK) for 10mins and then washed in 0.5% BSA/PBS for 5mins at 4°C. Cells were fixed (Inside Fix, Miltenyi Biotec, UK) for 10mins at room temperature followed by staining with FITC-conjugated mouse anti-human CD3 antibody (Miltenyi Biotec, UK) for 30mins on ice in the dark. Cells were then permeabilised on ice (Permeabilisation Buffer A, Miltenyi Biotec, UK) and washed twice prior to staining for γ-H2AX and pATM using anti-human APC- and PE-conjugated antibodies respectively (BD Biosciences and BioLegend, UK). APC and PE conjugated IgG isotype control antibodies (BD Biosciences and BioLegend) were used in fluorescence minus one (FMO) samples for appropriate gating of γ-H2AX and pATM respectively. Samples were processed on a MACSQuant flow cytometer (Miltenyi Biotec, UK) and analysed using FlowJo software.
A more detailed analysis of γ-H2AX and pATM expression in subpopulations of CD3+ lymphocytes was also carried out (Supplemental Methods). Samples from operators performing IEVAR were also analysed for the expression of 8-oxoguanine DNA glycosylase-1 (OGG1), a dedicated DNA repair enzyme, with its expression directly correlating with DNA damage caused by base oxidation as opposed to double stranded DNA breaks (Supplemental Methods and Supplemental Table 1 for a list of all antibodies used). For each procedure, the opportunity was taken to collect blood samples from the patient to study γ-H2AX and pATM expression in their circulating CD3+ lymphocytes using the same methodology as outlined for operators above.

**Immunocytochemistry**

Blood samples were collected, lysed and fixed as described above. Samples were incubated with mouse anti-human CD3 immunomagnetic microbeads for 30mins following by positive selection of labelled lymphocytes using LS Columns (Miltenyi Biotec, UK). Isolated CD3+ cells were permeabilised (0.5% Triton X-100 in PBS for 20mins), washed and stained with mouse anti-human γ-H2AX (5μg/ml; BioLegend, UK), followed by secondary staining with donkey Cy3-conjugated anti-mouse (5μg/ml, Jackson ImmunoResearch Laboratories). Cells were washed and mounted using DAPI gel mount (Sigma-Aldrich, UK).

**Irradiation of blood samples in vitro**

Blood from 6 operators, randomly selected from the entire cohort of 15 operators studied, was collected in EDTA tubes and exposed to radiation doses between 100 and 1000mGy using a Darpac 2000 (Gulmay Medical, UK) x-ray unit (energy: 80kVp [half-value layer, 2.0mmAL], 6.9mA, applicator: 8cm diameter) positioned approximately 25cm from the x-ray source. Following red blood cells lysis, γ-H2AX and pATM staining and analysis by flow cytometry (as
described above) was carried out within 30mins of irradiation. Blood was collected and irradiated on 3 separate occasions from each operator, ensuring that they had not performed any intervention involving exposure to radiation in the 48hrs prior to sampling.

**Statistical Analysis**

Data were analysed using GraphPad Prism 7.0a (GraphPad Software Inc., San Diego, CA, USA) and SPSS-22 (SPSS Inc., Chicago, IL, USA). Where appropriate, non-parametric Wilcoxon signed rank, Mann Whitney U and two-way ANOVA tests were used. A $P$ value <0.05 was considered to be statistically significant.

**Results**

**Peri-operative changes in $\gamma$-H2AX and pATM**

Fifteen operators (13 males, 40years [34-49], Table 1) carried out a total of 45 procedures, including 15 IEVAR, 16 BEVAR/FEVAR and 14 open AAA repairs. BEVAR/FEVAR was associated with longer screening time and higher DAP ($P<0.0001$ for both) compared with IEVAR (Figure 1). Personal dosimetry showed minimal exposure under the operators’ protective lead garment, but higher exposure over the lead ($P<0.0001$), particularly at the lower leg level ($P<0.0001$, Figure 1). An optimised flow cytometric strategy was used to quantify both $\gamma$-H2AX and pATM expression in circulating lymphocytes (Figure 2). Immunohistochemistry confirmed that $\gamma$-H2AX foci, absent in both operator and patient blood samples pre-operatively, appeared in post-operative lymphocyte films (Figure 2C).

There was a significant increase in the levels of both $\gamma$-H2AX and pATM in circulating lymphocytes of operators immediately after BEVAR/FEVAR ($P<0.0003$ for both, Figure 3). The expression of pATM increased in operators who carried out IEVAR ($P<0.04$), but $\gamma$-H2AX did
not show significant changes in this cohort. The expression of both markers fell to baseline levels in all operators after 24hrs ($P<0.003$ for both, Figure 3). There was no change in $\gamma$-H2AX or pATM expression at any time point during the peri-operative period of open AAA repair.

A significant post-operative rise in $\gamma$-H2AX and pATM in both T helper and cytotoxic T cell sub-populations of CD3$^+$ lymphocytes was detected after EVAR, with the relative expression of $\gamma$-H2AX higher in T helpers compared with cytotoxic T cells ($P<0.05$ for all, Supplemental Figures 1, 2).

The deeper phenotyping strategy used to compare the relative post-operative levels of $\gamma$-H2AX and pATM in CD4$^+$ and CD8$^+$ T lymphocytes showed that the increases in levels of $\gamma$-H2AX levels were significantly higher in CD4$^+$ Naïve and Central memory cells (Supplemental Figures 1, 2).

After IEVAR, there was a significant increase in OGG1 expression in the CD3$^+$ lymphocytes that expressed elevated levels of pATM but not $\gamma$-H2AX ($P<0.03$, Supplemental Figure 3).

Changes in $\gamma$-H2AX and pATM in operators after BEVAR/FEVAR and IEVAR did not correlate with either DAP or screening time in either cohort (Figure 3).

In patients, increased expression of both $\gamma$-H2AX and pATM levels were detected in CD3$^+$ lymphocytes immediately after BEVAR/FEVAR and IEVAR procedures ($P<0.004$, for both, Supplemental Figure 4)

**Factors affecting $\gamma$-H2AX expression in operators**

A variable response ($P<0.0001$) was apparent when $\gamma$-H2AX expression in lymphocytes, sampled from six operators, was studied in vitro after controlled irradiation using doses ranging between 100-1000mGy (Figure 4A). At any given dose some operators mounted a consistently
exaggerated response whilst others demonstrated far lower expression of γ-H2AX on their lymphocytes.

The same six operators were asked to wear lower leg shielding during BEVAR/FEVAR procedures (n=9 cases) and blood samples were obtained prior to and after they had performed each procedure. Wearing lower leg lead protection significantly abrogated the lymphocyte γ-H2AX and pATM response in operators after BEVAR/FEVAR, with no change in the expression of either marker immediately after the procedure (Figure 4C). Comparable DAP, over the leg exposure measurements and screening times suggested that the radiation exposure associated with procedures during which the operators wore lower leg lead shielding was comparable with those carried out without leg protection (Figure 4D).

Discussion

Ionising radiation can induce different forms of DNA damage such as base pair damage, single stranded breaks (SSBs), and double stranded breaks (DSB), the latter is considered the most deleterious as these are more difficult to repair than other forms of DNA damage.30,31 Left unrepaired, DSBs can cause chromosomal instability and cell apoptosis. Incomplete repair leads to deletions and chromosomal rearrangements such as translocations and inversions that can ultimately lead to mutations.20 These types of chromosomal abnormalities have been detected in lymphocytes of both patients and hospital staff after chronic exposure to low dose radiation.13,16,17

Circulating lymphocytes are particularly sensitive to radiation exposure, mounting an acute response to radiation induced DNA damage which includes raised expression of pATM and γ-H2AX. Elevated levels of the latter marker have been demonstrated in patients’
lymphocytes after paediatric cardiac catheterisation and as a consequence of radiation exposure during diagnostic CT scanning.\textsuperscript{17,32} The present study demonstrates an upregulation of both $\gamma$-H2AX and pATM expression in interventionists’ and patients’ lymphocytes after endovascular aortic repair.

Neither $\gamma$-H2AX nor pATM have previously been studied in interventionists performing fluoroscopically guided aortic procedures. To our knowledge the present study is the first to demonstrate elevated expression of these markers of DNA damage/repair in operators exposed to radiation. This is of importance to the entire community of workers exposed to low dose radiation. A more profound effect was seen in operators peforming BEVAR and FEVAR, complex and lengthy repairs that were associated with higher radiation exposure compared with standard infra-renal endovascular repairs. We, and other groups, have previously reported that DAP, flouroscopy and radiation exposure are higher for these complex procedures compared with standard IEVAR.\textsuperscript{4,33} In our experience, BEVAR/FEVAR was associated with a two-fold increase in DAP and three-fold longer flouroscopy time.\textsuperscript{5} The present study confirmed, by personal dosimetry, an almost two-fold higher exposure at leg level for the operator performing BEVAR/FEVAR as opposed to IEVAR.

Changes in $\gamma$-H2AX and pATM were not detected in operators after open repair, highlighting the fact that this is an effect directly related to radiation exposure. This effect was absent in operators who wore lower leg lead shielding during complex aneurysm repair, indicating that the majority of DNA damage occurs in lymphocytes irradiated in the lower leg tissues and long bones.

Our data also demonstrate inter-individual variability in the induction of $\gamma$-H2AX in operators’ lymphocytes when irradiated \textit{in vitro}, suggesting that susceptibility to DNA damage
may vary and that “safe” exposure limits may not apply universally. A range of doses, including some far higher than that those recorded for occupational exposure, were used to provoke an exaggerated response and help ummask differences between individuals. Although increased expression of both of these markers were detected immediately after endovascular intervention, levels fell back to normal 24hrs after the procedure in operators, a finding that has previously been reported in patients exposed to radiation. A greater understanding of this reparative response to DNA damage is needed in order to determine the influence of factors such as age, sex, co-morbidities and chronicity of exposure and whether a complete repair is achieved in damaged cells. Estimates of cancer risk from exposure to ionising radiation are based on epidemiological studies of exposed human populations, especially the atomic bomb survivors of Hiroshima and Nagasaki. These studies have provided relatively reliable estimates of risk for moderate to high radiation doses. However, risk estimates for repeated exposures to low dose radiation, are based on linear extrapolation using epidemiological data from high dose exposures, making these estimates less reliable. Traditional methods to quantify radiation risk associated with fluoroscopically guided procedures is through absorbed radiation dose or exposure indices such as DAP that estimate absorbed radiation dose. These provide theoretical risk estimate that does not factor in individual variations in susceptibility to radiation damage. Measurement of biological markers, such as γ-H2AX and pATM, provides the opportunity for individual risk profiling, but at this stage, a better understanding of the long term consequences of the raised levels of γ-H2AX and pATM during endovascular interventions is required.

We found a post-operative rise in γ-H2AX and pATM in both T helper and cytotoxic cell populations, with the relative expression of post-operative γ-H2AX higher in T helper (CD4+) compared with cytotoxic T cells (CD8+). Using this deeper phenotyping strategy to compare
relative expression levels in CD4\(^+\) and CD8\(^+\) cells, we found post-operative γ-H2AX levels are significantly higher in CD4\(^+\) naïve and central memory cells. It appears that γ-H2AX did not rise in CD8\(^+\) central memory cells post-operatively.

Expanding on the biological significance of the differential expressions that we have found in T-cell subsets is beyond the scope of the present study. The effects of chronic radiation exposure on the overall health of surgical operators may only be revealed through long term investigations. Other groups have found that CD8\(^+\) cells are more sensitive to radiation-induced apoptosis than CD4\(^+\) cells.\(^{39}\) It is possible that CD8\(^+\) cells are less likely to persist after being irradiated and be registered as γ-H2AX expressing cells.

After IEVAR there is a significant increase in OGG1 expression, a dedicated DNA repair enzyme that specifically excises 7,8-dihydro-8-oxoguanine (8-Oxo-G), with its expression directly correlating with DNA damage caused by base oxidation.\(^{29}\) Our finding of higher OGG1 expression in CD3\(^+\) lymphocytes that demonstrate elevated levels of pATM, but not γ-H2AX, suggests that the DNA damage response marker, pATM, is activated in the lymphocytes of operators in response to DNA damage caused by base oxidation as well as DNA breaks caused by direct energy transfer.

Protective equipment available to the operator include lead aprons, thyroid shields, lead eye protection, ceiling-suspended leaded shields, rolling leaded shields, radiation-attenuating sterile surgical gloves and sterile lead-equivalent patient-mounted drapes.\(^{40}\) Below table lead shielding is particularly important for minimising scatter radiation.\(^{41}\) The stark findings of the present study specifically highlight the importance of using leg leaded pads, by demonstrating that the markers of DNA damage detected in operators’ circulating lymphocytes were absent when the operator wore additional lower leg lead shielding. The electronic dosimeters placed
over the leg confirmed a significant amount of scatter radiation absorbed at that level - in fact, higher than the dose at chest level. The capability of modern fixed imaging systems to produce higher quality images compared with mobile c-arms is associated with a significantly higher amount of scatter radiation produced by the radiation source under the operating table. Operators often neglect to wear lower leg lead shielding, viewing its use as cumbersome and unnecessary, but the present data highlight the importance of protecting the legs.

Dose awareness and training in radiation protection are fundamental for minimising occupational radiation exposure. There is currently no mandatory requirement for training in fluoroscopic operation or mandatory radiation protection certification for vascular operators in the UK. Radiation exposed workers are encouraged, however, to attend Ionising Radiation (Medical Exposure) Regulations (IRMER) training courses. Vascular surgery was granted speciality status in the UK in 2013 and with this a new curriculum and training programme was developed. The first cohort of trainees have had instruction on radiation protection practices as part of their induction into the programme. The first sitting of the examination for these trainees will take place in 2018 and should include questions on radiation safety, reflecting the content of the new curriculum.

The current endovascular case mix exposes the vascular operator to relatively high radiation doses compared with, for example, interventional cardiologists performing percutaneous coronary intervention (PCI). In our experience the per case dose to the vascular operator is almost 6-fold higher during IEVAR compared with PCI but it should be noted that interventional cardiologists perform cases more frequently (Supplemental Table 2).

It is essential that operators adhere to “As Low As Reasonably Achievable” (ALARA) principles to minimise exposure to themselves, their team and the patient. These include wearing a
dosimeter at all times, with cumulative doses monitored regularly and leveraged use of real time dosimetry where possible.\textsuperscript{44,45} Other principles include lowering the rate of fluoroscopy where applicable, minimising use of cinefluorography (which produces 10 times more radiation compared with standard fluoroscopy), using collimation and maximising the distance between the operator and x-ray source, remembering that as distance doubles, exposure is reduced by a factor of four.\textsuperscript{46} Finally, closely monitoring the orientation and angulation of the x-ray source, particularly avoiding left anterio oblique (LAO) projection, which exposes the operating team to the highest amount of scatter radiation, is key for minimising absorbed dose.

Limitations of this study

The present study does not relate the effective radiation doses absorbed during each procedure, calculated by taking into account the radiosensitivity of different body tissues, to the expression of DNA damage/repair markers. We have also not established the relationship between the acute response (\(\gamma\)-H2AX and pATM levels) and cytogenetic markers of chronic low dose radiation damage and DNA misrepair, such as micronuclei and dicentric chromosomes. Finally, it is important to stress that the biomarkers of radiation exposure measured in this study demonstrate an acute cellular response, but we do not yet know how this gives rise to increased cancer risk. Relating one to the other would require longitudinal measurements in a much larger cohort of operators with long term, prospective follow up.

Acknowledgements

The authors would like to acknowledge the members of the Guy’s and St Thomas’ Vascular Research Collaborative
Sources of Funding

Bijan Modarai is funded by a British Heart Foundation Senior Clinical Research Fellowship (FS/17/24/32596)

Disclosures

None

References


Table 1. Details of operators participating in the study

<table>
<thead>
<tr>
<th>Operator</th>
<th>Age (years)</th>
<th>Gender</th>
<th>Years Performing Interventions</th>
<th>Interventional sessions/month</th>
<th>Sampled For IEVAR/BEVAR/FEVAR</th>
<th>Sampled for open AAA repair</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>As Trainee</td>
<td>As Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>42</td>
<td>M</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>36</td>
<td>M</td>
<td>7</td>
<td>0</td>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>43</td>
<td>M</td>
<td>5</td>
<td>7</td>
<td>1.5</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>39</td>
<td>M</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>48</td>
<td>M</td>
<td>4</td>
<td>10</td>
<td>24</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>40</td>
<td>M</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>34</td>
<td>M</td>
<td>4</td>
<td>0</td>
<td>12</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>45</td>
<td>M</td>
<td>10</td>
<td>8</td>
<td>6-8</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>39</td>
<td>F</td>
<td>13</td>
<td>1</td>
<td>2-4</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>37</td>
<td>M</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>11</td>
<td>36</td>
<td>M</td>
<td>7</td>
<td>0</td>
<td>6</td>
<td>Yes</td>
</tr>
<tr>
<td>12</td>
<td>49</td>
<td>M</td>
<td>5</td>
<td>14</td>
<td>20</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>41</td>
<td>M</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>Yes</td>
</tr>
<tr>
<td>14</td>
<td>40</td>
<td>F</td>
<td>10</td>
<td>0</td>
<td>5</td>
<td>Yes</td>
</tr>
<tr>
<td>15</td>
<td>42</td>
<td>M</td>
<td>7</td>
<td>0</td>
<td>12</td>
<td>Yes</td>
</tr>
</tbody>
</table>

IEVAR indicates infra-renal endovascular aortic repair; BEVAR, branched endovascular aortic repair; FEVAR, fenestrated endovascular aortic repair; AAA, abdominal aortic aneurysm.
Figure Legends

Figure 1. Radiation exposure to operators during EVAR procedures
A, Screening time during BEVAR/FEVAR was significantly longer than IEVAR (P<0.0001).
B, DAP during BEVAR/FEVAR was higher than IEVAR (P<0.0001). C, Readings from personal dosimeters placed over operators’ chest under the lead, over the lead and at the left leg. Leg doses were significantly higher during BEVAR/FEVAR compared with IEVAR (P<0.05). EVAR indicates endovascular aortic repair; IEVAR, infra-renal endovascular aortic repair; BEVAR, branched endovascular aortic repair; FEVAR, fenestrated endovascular aortic repair; DAP, dose area product (mGy.cm²); Horizontal line, median.

Figure 2. Flow cytometric and immunohistochemistry analysis of γ-H2AX and pATM expression in operators’ lymphocytes during the peri-operative period of EVAR
Flow cytometric dot plots of lysed, fixed and permeabilised cells from whole blood collected from an operator pre, immediately after and 24hrs post FEVAR. A, Lymphocytes are identified according to forward and side scatter profile and gated according to expression of CD3. B, Example flow cytometric dot plots showing that γ-H2AX expression in CD3⁺ lymphocytes increases in an operator immediately after a complex (fenestrated) endovascular aortic repair, and falls to pre-operative levels after 24 hours. This response is also seen with lymphocyte expression of pATM. C, Immunohistochemical staining of lymphocytes (DAPI, blue) isolated from an operator shows, compared with the pre-operative sample, an increase in γ-H2AX expression (purple foci) on these cells immediately after FEVAR. γ-H2AX indicates gamma H2AX; pATM, phosphorylated ataxia telangiectasia mutated protein; EVAR, endovascular
aortic repair, FEVAR, fenestrated endovascular aortic repair; DAPI, 4',6-Diamidino-2-Phenylindole Dihydrochloride, scale bar =10μm.

Figure 3. Changes in expression of γ-H2AX and pATM in operators’ lymphocytes in response to radiation exposure during EVAR

A, Expression of γ-H2AX in operators’ lymphocytes prior to, immediately after and 24 hours after open aortic repair (n=14) and EVAR (all IEVAR and BEVAR/FEVAR procedures grouped together, n=31). B, Expression of pATM in operators’ lymphocytes prior to, immediately after and 24 hours after open aortic repair (n=14) and EVAR (n=31).

C, γ-H2AX expression during the peri-operative period of BEVAR/FEVAR (n=16) compared with IEVAR (n=15). D, pATM expression during the peri-operative period of BEVAR/FEVAR (n=16) compared with IEVAR (n=15). E, Correlation between fold change increase in γ-H2AX expression and DAP (n=31). F, Correlation between fold change increase in pATM levels and DAP (n=31). G, Correlation between fold change increase in γ-H2AX levels and fluoroscopy time (n=31). H, Correlation between fold change increase in pATM levels and fluoroscopy time (n=31). None of the operators studied wore leg shielding during these procedures. γ-H2AX indicates gamma H2AX; pATM, phosphorylated ataxia telangiectasia mutated protein, EVAR, endovascular aortic repair; IEVAR, infra-renal endovascular aortic repair; BEVAR, branched endovascular aortic repair; FEVAR, fenestrated endovascular aortic repair, *P<0.05.

Figure 4. Factors affecting γ-H2AX expression in operators

A, Variation in γ-H2AX levels in operators’ lymphocytes following in vitro irradiation of their blood samples on 3 separate occasions (bars represent standard error of means, n=6, P<0.0001).
B, An operator wearing lower leg shielding (red arrows). C, γ-H2AX and pATM expression in operators’ lymphocytes with (black bars, n=9) and without (red bars, n=16) the use of leg protection during BEVAR/FEVAR procedures (P<0.05). D, Radiation exposure, measured by DAP and personal dosimeters worn at leg levels during procedures with (n=9) and without (n=16) leg shielding. γ-H2AX indicates gamma H2AX; pATM, phosphorylated ataxia telangiectasia mutated protein; BEVAR, branched endovascular aortic repair; FEVAR, fenestrated endovascular aortic repair; DAP, dose area product; *P<0.05.
A  Fixed, lysed whole blood  T-lymphocyte gating  T-lymphocytes backgated

B  γ-H2AX  pATM

C  Pre  Post
Radiation Induced DNA Damage in Operators Performing Endovascular Aortic Repair
Tamer El-Sayed, Ashish S. Patel, Jun S. Cho, James A. Kelly, Francesca E. Ludwinski, Prakash Saha, Oliver T. Lyons, Alberto Smith and Bijan Modarai
Guy's and St Thomas' Research Collaborative

Circulation. published online October 20, 2017;
Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2017 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/early/2017/10/10/CIRCULATIONAHA.117.029550
Free via Open Access

Data Supplement (unedited) at:
http://circ.ahajournals.org/content/suppl/2017/10/10/CIRCULATIONAHA.117.029550.DC1

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation is online at:
http://circ.ahajournals.org/subscriptions/
SUPPLEMENTAL MATERIAL
Supplemental Methods

**Flow cytometric analysis of $\gamma$-H2AX, pATM and OGG1 expression in lymphocytes**

Venous blood samples were collected from operators in EDTA tubes (BD Biosciences, UK). Red blood cells were lysed using Pharmlyse (BD Biosciences, UK) for 10mins and then washed in 0.5% BSA/PBS for 5mins at 4°C. Cells were stained with FITC-conjugated mouse anti-human CD3 antibody (Miltenyi Biotec, UK), Viogreen-conjugated mouse anti-human CD4 antibody, APC/Cy7-conjugated mouse anti-human CD8 antibody, PE/Cy7-conjugated mouse anti-human CD45RO antibody (BD Biosciences, UK) and PerCP-conjugated mouse anti-human CCR7 antibody (BioLegend, UK). Cells were fixed (Inside Fix, Miltenyi Biotec, UK) for 10mins at room temperature followed by permeabilisation on ice (Permeabilisation Buffer A, Miltenyi Biotec, UK) and washed twice prior to staining for $\gamma$-H2AX and phosphorylated ATM (pATM) using anti-human APC- and PE-conjugated antibodies respectively (BD Biosciences and BioLegend, UK). T cell subsets were divided into T Helper (CD3$^+$CD4$^+$) and cytotoxic (CD3$^+$CD8$^+$) cells. These were further phenotyped into Naïve (CD3$^+$CD4$^+$CD45RO$^-$ and CD3$^+$CD8$^+$CD45RO$^-$), central memory (CD3$^+$CD4$^+$CD45RO$^+$CCR7$^+$ and CD3$^+$CD8$^+$CD45RO$^+$CCR7$^+$) and effector memory (CD3$^+$CD4$^+$CD45RO$^+$CCR7$^+$ and CD3$^+$CD8$^+$CD45RO$^+$CCR7$^+$) helper and cytotoxic T lymphocytes respectively for further analysis of $\gamma$-H2AX and pATM expression. Samples from operators performing IEVAR were also analysed for the expression of PerCP-conjugated mouse anti-human OGG1 (Novus Biologicals, UK) in addition to $\gamma$-H2AX and pATM expression as previously described.
Appendix

Guy's and St Thomas' Cardiovascular Research Collaborative

From Guy’s & St Thomas’ NHS Foundation Trust, London, UK.

Tyrrell M, Gkoutzios P, Abisi S, Black S, Zayed H, Bell RE, Sallam M, Biasi L, Patel SD,
Supplemental Tables

Supplemental Table 1. Antibodies used for flow cytometry

<table>
<thead>
<tr>
<th>Antibody</th>
<th>Source</th>
<th>Conjugate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD3</td>
<td>Miltenyi Biotec</td>
<td>FITC</td>
</tr>
<tr>
<td>CD4</td>
<td>BD Biosciences</td>
<td>Viogreen</td>
</tr>
<tr>
<td>CD8</td>
<td>BD Biosciences</td>
<td>APC/Cy7</td>
</tr>
<tr>
<td>CD45RO</td>
<td>BD Biosciences</td>
<td>PE/Cy7</td>
</tr>
<tr>
<td>CCR7</td>
<td>BioLegend</td>
<td>PerCP</td>
</tr>
<tr>
<td>CD14</td>
<td>BD Biosciences</td>
<td>Vioblue</td>
</tr>
<tr>
<td>CD45</td>
<td>BD Biosciences</td>
<td>Vioblue</td>
</tr>
<tr>
<td>pATM</td>
<td>BioLegend</td>
<td>PE</td>
</tr>
<tr>
<td>γ-H2AX</td>
<td>BD Biosciences</td>
<td>APC</td>
</tr>
<tr>
<td>OGG1</td>
<td>Novus Biologicals</td>
<td>PerCP</td>
</tr>
</tbody>
</table>
Supplemental Table 2. Radiation exposure during PCI and IEVAR

**A**

<table>
<thead>
<tr>
<th>Radiation Exposure</th>
<th>PCI</th>
<th>IEVAR</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAP (mGy.cm²)</td>
<td>9940 (4440-170170)</td>
<td>82786 (53611-144257)</td>
<td>0.01</td>
</tr>
<tr>
<td>Screening Time (mins)</td>
<td>11.2 (5.21-28.57)</td>
<td>24.78 (14.06-49.39)</td>
<td>0.007</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operator personal dosimetry (µSv)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under lead</td>
<td>0 (0-4)</td>
<td>0 (0-3)</td>
<td></td>
</tr>
<tr>
<td>Over lead</td>
<td>6 (2-11)</td>
<td>11 (4-74)</td>
<td></td>
</tr>
<tr>
<td>Leg</td>
<td>16 (2-48)</td>
<td>92 (43-202)</td>
<td>0.002</td>
</tr>
</tbody>
</table>

**B**

<table>
<thead>
<tr>
<th>Operator</th>
<th>Age</th>
<th>Years Performing Interventions</th>
<th>Interventional sessions/week</th>
<th>Interventional cases / session</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>As Trainee</td>
<td>As Consultant</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>46</td>
<td>8</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>62</td>
<td>8</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>53</td>
<td>5</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>36</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>52</td>
<td>5</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>42</td>
<td>8</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

A. Direct and indirect measurement of radiation exposure during PCI and IEVAR using DAP, fluoroscopy time and personal dosimetry (n=6). B. Details of age and caseload for interventional cardiologists that were performing the monitored procedures. PCI indicates percutaneous coronary intervention; IEVAR, infrarenal endovascular aortic repair; DAP, dose area product (mGy.cm²).
Supplemental Figures
Supplemental Figure 1

A

Lymphocytes

CD4 & CD8 T cells

CD8 T cells

CD4 T cells

B

CD4 Lymphocytes

γ-H2AX

pATM

Pre

Post

T(N)

T(CM)

T(EM)

C

CD8 Lymphocytes

γ-H2AX

pATM

Pre

Post

T(N)

T(CM)

T(EM)
**Supplemental Figure 1. Flow cytometric analysis of γ-H2AX and pATM expression in subpopulations of T lymphocytes in operators during the peri-operative period of FEVAR**

**A**, Representative flow cytometric dot plots showing CD3<sup>+</sup> lymphocytes subdivided into CD8<sup>+</sup> (cytotoxic) and CD4<sup>+</sup> (T helper) cells. These two cell subsets are further phenotyped into CD45RO<sup>-</sup>CCR7<sup>+</sup> (Naïve), CD45RO<sup>+</sup>CCR7<sup>+</sup> (Central Memory, T<sub>CM</sub>) and CD45RO<sup>-</sup>CCR7<sup>-</sup> (Effector Memory, T<sub>EM</sub>) cells. **B**, Example flow cytometric dot plots show increased γ-H2AX and pATM expression in CD3<sup>+</sup>CD4<sup>+</sup> T helper cells and their naïve, T<sub>CM</sub> and T<sub>EM</sub> subpopulations from the blood of an operator immediately after FEVAR. **C**, Example flow cytometric dot plots show an increase in γ-H2AX and pATM expression in CD3<sup>+</sup>CD8<sup>+</sup> cytotoxic T cells and their naïve, T<sub>CM</sub> and T<sub>EM</sub> subpopulations from the blood of an operator immediately after FEVAR. γ-H2AX indicates gamma H2AX; pATM, phosphorylated ataxia telangiectasia mutated protein; FEVAR, fenestrated endovascular aortic repair.
Supplemental Figure 2

A

(i) CD4

% γ-H2A.X

Pre Post

(ii) CD8

% γ-H2A.X

Pre Post

(iii) CD4

% pATM

Pre Post

(iv) CD8

% pATM

Pre Post

B

% γ-H2A.X

CD4 CD8

C

% pATM

CD4 CD8

D

% γ-H2A.X

Naive Central memory Effector memory

E

% pATM

Naive Central memory Effector memory
Supplemental Figure 2. Comparison of changes in γ-H2AX and pATM in T helper and cytotoxic T cell subsets during the peri-operative period of FEVAR

A, The post-operative expression of γ-H2AX was significantly higher in (i) CD4+ T helper cells (n=6, P<0.02) and (ii) CD8+ T cytotoxic cells (n=6, P<0.02) of operators performing BEVAR/FEVAR. The expression of pATM was similarly raised in (iii) CD4+ T helper (n=6, P<0.04) and (iv) CD8+ T cytotoxic cells (n=6, P<0.04). B, The post-operative γ-H2AX expression was higher in CD4+ T helper cells compared with CD8+ cytotoxic T cells in operators after FEVAR (n=6, P<0.04). C, The post-operative expression of pATM in CD4+ T helper cells and CD8+ cytotoxic T cells was comparable (n=6). D, The post-operative expression of γ-H2AX was significantly higher in CD4+ Naïve and Central memory cells compared with their CD8+ counterparts (n=6, P<0.05). E, The post-operative expression of pATM in Naïve, Central Memory and Effector memory cells was comparable in CD4+ T helper cells and CD8+ cytotoxic T cells. *P<0.05. γ-H2AX indicates gamma H2AX; pATM, phosphorylated ataxia telangiectasia mutated protein; FEVAR, fenestrated endovascular aortic repair.
Supplemental Figure 3

A

\[\begin{array}{c|c|c}
\gamma\text{-H2AX} & \text{Pre} & \text{Post} \\
\hline
\gamma\text{-H2AX} & 0.28\% & 0.10\% \\
p\text{ATM} & 0.51\% & 1.95\% \\
\text{OGG1} & 0.18\% & 2.80\% \\
\end{array}\]

\[\text{CD3} \rightarrow \text{OGG1}\]

B

![Bar chart showing lymphocyte percentages for γ-H2AX, pATM, and OGG1 before and after treatment.](chart.png)

Legend:
- Red: γ-H2AX
- Blue: pATM
- Brown: OGG1

* indicates a significant difference.
Supplemental Figure 3. Expression of OGG1 on γ-H2AX and pATM expressing CD3+ T lymphocytes during the peri-operative period of IEVAR

A, Flow cytometric analysis of blood taken from an operator before and after IEVAR showing an increase in lymphocyte expression of pATM and OGG1, but not γ-H2AX in CD3+ lymphocytes. Selective gating of γ-H2AX and pATM positive cells indicates a greater increase in OGG1 expression in the pATM positive population. B, Analysis of CD3+ lymphocytes, isolated from 6 operators after IEVAR, co-stained for γ-H2AX, pATM and OGG1 shows a significant increase in pATM and OGG1 ($P<0.03$, both), but not γ-H2AX. IEVAR indicates infrarenal endovascular aortic repair; γ-H2AX, gamma H2AX; OGG1, 8-oxoguanine glycosylase; pATM, phosphorylated ataxia telangiectasia mutated protein.
Supplemental Figure 4

A, Expression of γ-H2AX in lymphocytes prior to, immediately and 24 hours after open aortic repair (n=14) and EVAR (all IEVAR and BEVAR/FEVAR procedures grouped together, n=72). B, Expression of pATM in lymphocytes prior to, immediately and 24 hours after open aortic repair (n=14) and EVAR (n=72). C, γ-H2AX expression during the peri-

Supplemental Figure 4. Patient response to radiation exposure during EVAR

A, Expression of γ-H2AX in lymphocytes prior to, immediately and 24 hours after open aortic repair (n=14) and EVAR (all IEVAR and BEVAR/FEVAR procedures grouped together, n=72). B, Expression of pATM in lymphocytes prior to, immediately and 24 hours after open aortic repair (n=14) and EVAR (n=72). C, γ-H2AX expression during the peri-
operative period of BEVAR/FEVAR (n=42) compared with IEVAR (n=30). D, pATM expression during the peri-operative period of BEVAR/FEVAR (n=42) compared with IEVAR (n=30). E, Immunohistochemical staining of lymphocytes (DAPI, blue) isolated from a patient shows, compared with the pre-operative sample, an increase in γ-H2AX expression (purple foci) in these cells immediately after EVAR. *P<0.05. γ-H2AX indicates gamma H2AX; pATM, EVAR, endovascular aortic repair; IEVAR, infra-renal endovascular aortic repair; BEVAR, branched endovascular aortic repair; FEVAR, fenestrated endovascular aortic repair; phosphorylated ataxia telangiectasia mutated protein. DAPI, 4’,6-Diamidino-2-Phenylindole Dihydrochloride, scale bar =10µm.