Inhibition of IGF1R activity enhances response to trastuzumab in HER-2-positive breast cancer cells

B. C. Browne1, J. Crown1,2, N. Venkatesan3, M. J. Duffy4, M. Clynes1, D. Slamon3 & N. O'Donovan1*

1National Institute for Cellular Biotechnology, Dublin City University, Dublin 9; 2Department of Medical Oncology, St. Vincent’s University Hospital, Dublin 4, Ireland; 3Division of Hematology and Oncology, University of California, Los Angeles, CA, USA; *Department of Pathology and Laboratory Medicine, St Vincent’s University Hospital, and UCD School of Medicine and Medical Science, Conway Institute, University College Dublin, Dublin 4, Ireland

Received 5 May 2010; accepted 7 May 2010

Background: Although trastuzumab has improved the prognosis for HER-2-positive breast cancer patients, not all HER-2-positive breast tumours respond to trastuzumab treatment and those that initially respond frequently develop resistance. Insulin-like growth factor-1 receptor (IGF1R) signalling has been previously implicated in trastuzumab resistance. We tested IGF1R inhibition to determine if dual targeting of HER-2 and IGF1R improves response in cell line models of acquired trastuzumab resistance.

Materials and methods: HER-2, IGF1R, phospho-HER-2, and phospho-IGF1R levels were measured by enzyme-linked immunosorbent assays in parental and trastuzumab-resistant SKBR3 and BT474 cells. IGF1R signalling was targeted in these cells using both small interfering RNA (siRNA) and the tyrosine kinase inhibitor, NVP-AEW541.

Results: IGF1R levels were significantly increased in the trastuzumab-resistant model, SKBR3/Tr, compared with the parental SKBR3 cell line. In both the SKBR3/Tr and BT474/Tr cell lines, inhibition of IGF1R expression with siRNA or inhibition of tyrosine kinase activity by NVP-AEW541 significantly increased response to trastuzumab. The dual targeting approach also improved response in the parental SKBR3 cells but not in the BT474 parental cells.

Conclusions: Our results confirm that IGF1R inhibition improves response to trastuzumab in HER-2-positive breast cancer cells and suggest that dual targeting of IGF1R and HER-2 may improve response in HER-2-positive tumours.

Key words: breast cancer, HER-2, Herceptin, IGF1R, NVP-AEW541, trastuzumab

Introduction

HER-2 gene amplification or overexpression occurs in ~20 to 25% of human breast cancers and is associated with poor prognosis [1, 2]. Trastuzumab (Herceptin™, Genentech), a humanised monoclonal antibody directed against the extracellular domain of HER-2 [3], has shown activity both as a single agent and in combination with chemotherapy in HER-2-overexpressing breast cancer [4, 5]. However, not all HER-2 positive patients benefit from trastuzumab and those that initially respond can develop resistance [6].

Several mechanisms of resistance to trastuzumab have been proposed (for review, see [6, 7]), including reduced receptor antibody binding, increased cellular signalling through alternative receptor tyrosine kinases, and altered intracellular signalling involving loss of PTEN, reduced p27kip1, or increased Akt activity.

Increased signalling via the insulin-like growth factor-1 receptor (IGF1R) has been implicated in reduced response to trastuzumab in breast cancer cells in vitro. Lu et al. [8] reported that transfection of IGF1R into trastuzumab-sensitive SKBR3 cells conferred almost complete resistance to trastuzumab. Sensitivity to trastuzumab was restored by reducing IGF1R signalling with recombinant IGF binding protein 3 (rhIGFBP3) [9]. Jerome et al. [10] also reported that combined treatment with rhIGFBP3 and trastuzumab had significant growth inhibitory effects in trastuzumab-resistant BT474/HerR cells, which had acquired resistance following long-term exposure to trastuzumab. This combined treatment also had significant anti-tumour effects on MCF7/HER-2-18 xenografts. Furthermore, inhibition of IGF1R signalling with an anti-IGF1R antibody d1R or a specific IGF1R tyrosine kinase inhibitor (TKI) also sensitised trastuzumab-resistant SKBR3/HerR cells to trastuzumab [11].

To further elucidate the role of IGF1R in the development of trastuzumab resistance, we examined two in vitro models of acquired resistance to trastuzumab and tested the effects of
IGF1R inhibition on response to trastuzumab using both small interfering RNA (siRNA) molecules targeting IGF1R and an IGF1R TKI (NVP-AEW541).

**materials and methods**

**cells and reagents**

BT474 and SKBR3 cell lines were obtained from the American Tissue Culture Collection (Manassas, VA). Cells were maintained in RPMI-1640 medium with 10% fetal calf serum. Trastuzumab-conditioned cell lines BT474/Tr and SKBR3/Tr were established by continuous exposure to 1.4 μM trastuzumab for 9 months [12]. Trastuzumab (Herceptin™, Roche) was obtained from the Department of Pharmacy, St Vincent’s University Hospital. The IGF1R TKI NVP-AEW541 was obtained from Novartis Pharma (Basel, Switzerland).

**proliferation assays**

Cells (2.5–3.75 × 10⁶) were plated in wells of 96-well plates. After 24 h, cells were treated with or without trastuzumab (10 or 100 nM) and NVP-AEW541 (1 μM). Proliferation was measured after 5 days by cell counting or acid phosphatase assays. Prior to cell counting, cells were resuspended in RPMI-1640 containing Guava Viacount reagent (Guava Technologies, Hayward, CA) and counted using a Guava EasyCyte (Guava Technologies). For acid phosphatase assays, media was removed and cells were rinsed with phosphate-buffered saline (PBS), 100 μl of acid phosphatase substrate [7.25 mM p-nitrophenol phosphate (Sigma-Aldrich, Dublin, Ireland) in sodium acetate buffer] was then added to each well followed by incubation at 37°C for 45 min. Fifty microliters of 1 M NaOH was added to each well and the absorbance was read at 405 nm with 620 nm as a reference. Proliferation or inhibition of proliferation was calculated relative to untreated controls. Each assay was carried out in triplicate.

**protein extraction**

Cells were washed twice with ice-cold PBS and 100–500 μl RIPA buffer [50 mM Tris–HCl (pH 7.4), 1% Nonidet P-40, 0.1% sodium dodecyl sulfate, 150 mM NaCl, 1% Triton X-100] containing 1X protease inhibitor cocktail (Merck, Darmstadt, Germany), 2 mM phenylmethylsulfonyl fluoride (Sigma-Aldrich), and 1 mM sodium orthovanadate (Sigma-Aldrich) was added and cells were incubated on ice for 10 min. Lysates were centrifuged at 16 000x g, 20°C for 30 min. Fifty to one hundred micrograms of protein was used for IGF1R and 30 μg was used for EGFR measurement. Protein levels were calculated as nanogram/milligram of total protein. Seven micrograms, 140 μg, and 30 μg were used for phosphorylated HER-2, phosphorylated IGF1R, and phosphorylated EGFR measurements, respectively. Arbitrary values were calculated relative to levels in positive control cell lines.

**siRNA transfection**

A validated siRNA molecule targeting exon 2 and two pre-designed siRNA molecules targeting exons 2 and 4 of the IGF1R gene were obtained from Applied Biosystems (Foster City, CA). A kinesin siRNA and a scrambled sequence siRNA molecule (Applied Biosystems) were used as controls. Each siRNA molecule was transfected at a final concentration of 30 nM. Cells (6.5–8 × 10⁵) were resuspended in 10% RPMI for 96-well and 6-well plates, respectively. Each siRNA and NeoFX™ transfection agent (Applied Biosystems) was diluted in Gibco™ Opti-MEM reduced serum medium (Invitrogen, Carlsbad, CA) and incubated at room temperature (RT) for 10 min. Diluted NeoFX™ was then added to each siRNA and incubated for a further 10 min at RT. The transfection mix was added to the wells followed by the cell suspension. After 24 h, the transfection media was replaced with 10% RPMI with or without 10 nM trastuzumab. Six-well plates were used to prepare lysates after 72 h. Cells in 96-well plates were harvested after 4 days and counted using the Guava EasyCyte as described above.

**results**

**characterisation of trastuzumab-resistant cell lines**

Trastuzumab-conditioned SKBR3/Tr and BT474/TR cells displayed significantly reduced response to trastuzumab compared with the parental cells in proliferation assays (Table 1). The reduced response to trastuzumab was stable for at least 12 weeks, in the absence of trastuzumab (supplemental Figure 1, available at Annals of Oncology online). HER-2 and phospho-HER-2 levels, determined by ELISA, were not significantly altered in the SKBR3/Tr cells but were significantly increased in the BT474/TR cells compared with the parental BT474 cells (HER-2, P = 0.016; phospho-HER-2, P = 0.043) (Table 1). IGF1R levels were significantly higher in the SKBR3/Tr cells than in the parental SKBR3 cells (P = 0.012), while they were unchanged in BT474/TR cells. No significant difference in
produced similar results (data not shown). Combined targeting different exons of IGF1R, were also tested and determined by ELISA. Decreased IGF1R levels caused up to 20% growth inhibition (Figure 2). Two additional siRNAs, determined by ELISA. Decreased IGF1R levels caused up to 20% growth inhibition (Figure 2).

IGF1R/HER-2 heterodimerization

We examined the formation of IGF1R/HER-2 heterodimers by performing IP for HER-2 and immunoblotting for IGF1R and vice versa (Figure 1). Following IGF1R IP, HER-2 was detected in both parental and resistant SKBR3 and BT474 cells that were treated with trastuzumab. To determine if trastuzumab treatment induced heterodimer formation or if trastuzumab in the medium (and subsequent lysate) was responsible for immunoprecipitating HER-2, the same IP experiment was carried out in the absence of the IGF1R antibody. HER-2 was detected in all cell lysates prepared from trastuzumab-treated cells (Figure 1), suggesting that the HER-2 observed in the IGF1R IP experiment was due to direct IP by trastuzumab. SKBR3 and BT474 parental cells and SKBR3/Tr and BT474/Tr cells grown in the absence of trastuzumab were immunoblotted separately to facilitate detection of HER-2, in the absence of the high levels of HER-2 observed in samples from cells treated with trastuzumab (Figure 1). Low levels of HER-2 were detected, suggesting that low levels of HER-2/IGF1R heterodimers are present in both parental and resistant cells. The presence of the heterodimers was confirmed by IP for HER-2, followed by immunoblotting for IGF1R (Figure 1). Interestingly, HER-2 immunoprecipitated samples showed higher levels of IGF1R in both the parental and resistant cells after treatment with trastuzumab. This may be due to more efficient IP of HER-2/IGF1R heterodimers due to the presence of trastuzumab or may suggest that trastuzumab treatment increases HER-2/IGF1R heterodimer formation.

IGF1R siRNA

IGF-IR siRNA treatment reduced IGF1R levels by 34 (± 6) % in SKBR3 cells, 11 (± 7) % in SKBR3/Tr cells, 24 (± 4) % in BT474 cells, and by 21 (± 9) % in BT474/Tr cells, as determined by ELISA. Decreased IGF1R levels caused up to 20% growth inhibition (Figure 2). Two additional siRNAs, targeting different exons of IGF1R, were also tested and produced similar results (data not shown). Combined treatment with IGF1R siRNA and trastuzumab showed improved response compared with either trastuzumab or IGF1R siRNA alone, in both SKBR3 and SKBR3/Tr cells (Figure 2). In BT474 cells, combined treatment with IGF1R siRNA and trastuzumab did not improve response compared with treatment with trastuzumab alone. However, in the BT474/Tr cells, the combination of IGF1R siRNA with trastuzumab resulted in significantly improved response compared with either agent alone (Figure 2).

IGF1R tyrosine kinase inhibition

SKBR3 and SKBR3/Tr cells showed similar growth inhibition when treated with the IGF1R TKI NVP-AEW541 (1 µM)

Table 1. Expression and phosphorylation levels of HER-2 and IGF1R and sensitivity to trastuzumab in SKBR3 and BT474 parental and trastuzumab-resistant cell lines

<table>
<thead>
<tr>
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<th>% Growth in trastuzumab (100 nM)</th>
<th>HER-2, ng/mg</th>
<th>pHER-2*</th>
<th>IGF1R, ng/mg</th>
<th>pIGF1R§</th>
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<tbody>
<tr>
<td>SKBR3</td>
<td>57.4 ± 0.9</td>
<td>228.1 ± 37.6</td>
<td>0.34 ± 0.02</td>
<td>0.7 ± 0.1</td>
<td>0.34 ± 0.03</td>
</tr>
<tr>
<td>SKBR3/Tr</td>
<td>75.9 ± 4.0*</td>
<td>184.7 ± 16.8</td>
<td>0.34 ± 0.06</td>
<td>1.8 ± 0.3*</td>
<td>0.34 ± 0.03</td>
</tr>
<tr>
<td>BT474</td>
<td>38.1 ± 7.6</td>
<td>147.9 ± 13.3</td>
<td>0.44 ± 0.05</td>
<td>3.7 ± 0.5</td>
<td>0.50 ± 0.03</td>
</tr>
<tr>
<td>BT474/Tr</td>
<td>73.6 ± 4.4*</td>
<td>411.4 ± 78.2</td>
<td>0.62 ± 0.05*</td>
<td>3.1 ± 0.4</td>
<td>0.57 ± 0.09</td>
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*aPhospho-HER-2 and phospho-IGF1R levels are expressed relative to a positive control cell line (HCC1419).

Table 1. Expression and phosphorylation levels of HER-2 and IGF1R and sensitivity to trastuzumab in SKBR3 and BT474 parental and trastuzumab-resistant cell lines

*indicates P <0.05 for comparisons of resistant cell lines with respective parental cell lines, as determined by the Student’s t-test.

IGF1R, insulin-like growth factor-1 receptor.

IGF1R/HER-2 heterodimerization

We examined the formation of IGF1R/HER-2 heterodimers by performing IP for HER-2 and immunoblotting for IGF1R and vice versa (Figure 1). Following IGF1R IP, HER-2 was detected in both parental and resistant SKBR3 and BT474 cells that were treated with trastuzumab. To determine if trastuzumab treatment induced heterodimer formation or if trastuzumab in the medium (and subsequent lysate) was responsible for immunoprecipitating HER-2, the same IP experiment was carried out in the absence of the IGF1R antibody. HER-2 was detected in all cell lysates prepared from trastuzumab-treated cells (Figure 1), suggesting that the HER-2 observed in the IGF1R IP experiment was due to direct IP by trastuzumab. SKBR3 and BT474 parental cells and SKBR3/Tr and BT474/Tr cells grown in the absence of trastuzumab were immunoblotted separately to facilitate detection of HER-2, in the absence of the high levels of HER-2 observed in samples from cells treated with trastuzumab (Figure 1). Low levels of HER-2 were detected, suggesting that low levels of HER-2/IGF1R heterodimers are present in both parental and resistant cells. The presence of the heterodimers was confirmed by IP for HER-2, followed by immunoblotting for IGF1R (Figure 1). Interestingly, HER-2 immunoprecipitated samples showed higher levels of IGF1R in both the parental and resistant cells after treatment with trastuzumab. This may be due to more efficient IP of HER-2/IGF1R heterodimers due to the presence of trastuzumab or may suggest that trastuzumab treatment increases HER-2/IGF1R heterodimer formation.

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IGF1R tyrosine kinase inhibition

SKBR3 and SKBR3/Tr cells showed similar growth inhibition when treated with the IGF1R TKI NVP-AEW541 (1 µM)
NVP-AEW541 treatment decreased pIGF1R levels by 12 (±5)% and 11 (±5)% in SKBR3 and SKBR3/Tr cells, respectively, and by 29 (±6)% and 10 (±6)% in BT474 and BT474/Tr cells, respectively, as measured by ELISA. Addition of NVP-AEW541 to trastuzumab had a greater inhibitory effect on cell growth than either treatment alone in both SKBR3 and SKBR3/Tr cells (Figure 3). NVP-AEW541 was not as effective in BT474 and BT474/Tr cells, achieving only 10% growth inhibition at 1 μM (Figure 3). However, the combination of NVP-AEW541 and trastuzumab showed a significantly greater effect on growth than trastuzumab alone in the BT474/Tr cells (P = 0.021).

**Discussion**

Not all patients with HER-2-overexpressing breast cancer benefit from trastuzumab therapy, and those that initially respond frequently develop resistance [6]. Previous studies suggest that alternative receptor tyrosine kinase (RTK) signalling, such as IGF1R or EGFR signalling, may play a role in trastuzumab resistance [8, 10, 13, 14]. Our studies of two models of acquired trastuzumab resistance suggest that different mechanisms of resistance can develop in HER-2-positive breast cancer cells. In the SKBR3/Tr model of acquired trastuzumab resistance, we observed an increase in IGF1R levels, which suggests that the development of trastuzumab resistance in these cells is associated with increased expression of IGF1R, with no significant change in HER-2 levels. In the BT474/Tr model, no change in IGF1R levels was detected but both the levels and phosphorylation of HER-2 were increased and may play a role in acquired trastuzumab resistance in this model. EGFR and phosphorylated EGFR levels are also significantly increased in BT474/Tr cells compared with BT474 cells [15]. Heterodimerization between the EGFR/HER-2 and the subsequent signalling from this complex may be responsible for the trastuzumab resistance in this model. This hypothesis is consistent with previous reports of increased EGFR/HER-2 signalling in BT474 cells selected for resistance to trastuzumab in vivo [14].

IGF1R has been shown to heterodimerize with HER-2 in MCF-7-HER2 cells [16] and in trastuzumab-resistant cells [11, 17]. In contrast to previous findings [11, 17], we detected HER-2/IGF1R heterodimers in both the parental and trastuzumab-resistant cells, suggesting that heterodimerization is not unique to trastuzumab-resistant cells and does not appear to play a causative role in the development of acquired trastuzumab resistance in the SKBR3 and BT474 models. However, blocking this interaction may improve response to trastuzumab treatment both in sensitive and resistant cells.
While the SKBR3/Tr cells showed reduced response to trastuzumab compared with parental cells, combined treatment with trastuzumab and IGF1R siRNA enhanced growth inhibition in both SKBR3 parental and SKBR3/Tr cells. The combination of trastuzumab and the IGF1R inhibitor, NVP-AEW541, also achieved similar growth inhibition in both cell lines. The improved response seen in both the SKBR3 parental cell line and the trastuzumab conditioned SKBR3/Tr cell line suggest that IGF1R inhibition may be beneficial in HER-2-positive tumours that express IGF1R, regardless of sensitivity to trastuzumab.

Although the levels of IGF1R are higher in BT474 than in SKBR3 cells, neither the IGF1R siRNA nor the TKI enhanced response to trastuzumab in these cells. Esparis-Ogando et al. [18] tested NVP-AEW541 with trastuzumab in BT474 cells and showed that the combination was synergistic in these cells, using concentrations of 2.5 and 5 μM NVP-AEW541. Therefore, the concentration used in our study (1 μM) may have been too low to observe an enhanced response to trastuzumab in the BT474 cells. However, while NVP-AEW541 is selective for IGF1R, with a concentration that causes 50% inhibition of growth (IC50) of 0.086 μM in cellular activity assays, the IC50 for its effect on the insulin receptor is 2.3 μM [19], suggesting that use of the inhibitor at higher concentrations may result in non-specific effects.

While targeting IGF1R in ineffective in BT474 cells, the combination of either IGF1R siRNA or NVP-AEW541 with trastuzumab achieved significantly enhanced growth inhibition in the BT474/Tr cells compared with trastuzumab alone. Therefore, although IGF1R expression and phosphorylation was not significantly altered in this model of acquired trastuzumab resistance, co-targeting HER-2 and IGF1R enhances response to trastuzumab. Similar results were obtained with the IGF1R siRNA and the TKI in combination with trastuzumab, suggesting that the enhanced response was due to targeting IGF1R and not due to non-specific effects.

Two immunohistochemical studies have reported that IGF1R is expressed in 48.5% (33/68) and 54.0% (39/72) of HER-2-positive tumours [20, 21]. Phosphorylated IGF1R has been detected in ~64% of HER-2-positive breast tumours [22]. Targeting IGF1R may be a rational approach to improve response to trastuzumab in the sub-group of HER-2-positive breast tumours that express IGF1R. A number of IGF1R monoclonal antibodies are currently being tested in breast cancer, and more recently, a number of IGF1R TKIs have entered phase I trials [23]. A phase I/II trial of trastuzumab in combination with the IGF1R TKI, BMS-754807, is currently recruiting patients with advanced or metastatic HER-2-positive breast cancer.

In conclusion, our results provide further evidence that IGF1R inhibition may enhance response to trastuzumab in HER-2-positive tumour cells that also express IGF1R and in tumour cells that have developed resistance following trastuzumab treatment. Clinical trials of HER-2 and IGF1R inhibitors should also include analysis of potential predictive biomarkers to identify HER-2-positive tumours that may respond to the dual targeting approach.

funding
Cancer Clinical Research Trust, Ireland, the Health Research Board Clinician Scientist Award (CSA/2007/11) to JC and the Science Foundation Ireland Strategic Research Cluster (08/SRC/B1410).

disclosure
JC has received research funding and speaker’s fees from Roche and Novartis. DS has received speaker’s fees from Genentech and Novartis.

references


