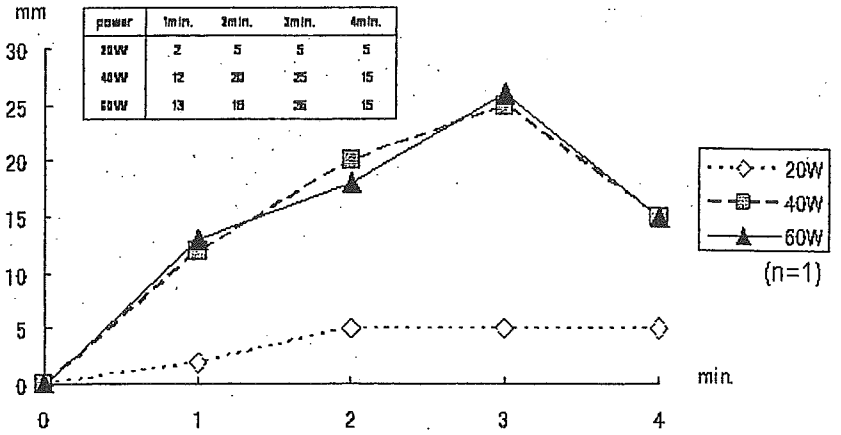

power	1min.	2min.	3min.	4min.
20W	2	5	5	5
40W	12	20	25	15
60W	13	18	25	15

FIG. 5. The diameter of the maximum coagulation area was 25 mm at 40 W and 60 W for 3 min. There was no difference between 40 and 60 W for each time. The diameter of the maximum coagulation area shrank to 15 mm at 40 and 60 W for 4 min.

no lymph node metastasis and had the best 5-year survival rate (100%) [6]. Meanwhile, according to a pathological study on lymph node metastasis of primary lung carcinoma after surgery, the rate of metastasis (N1 and N2) was 0% with a tumor 1.0 cm or less, 17% with a tumor 1.1 to 2.0 cm, and 37% with a tumor 2.1 to 3.0 cm in diameter [7]. As a result, it seems to be possible to control 83% of lung carcinomas smaller than 2.0 cm in size by local treatment. Also, the rate of local lymph node metastasis of metastatic lung tumor is known to be low.

We usually perform surgery for such patients as a possible cure, but this may lead to considerable lung damage with significant loss of function. Although VATS has widened the indication of surgery recently, some patients are unable to undergo even VATS due to poor cardiopulmonary function, severe adhesion, or advanced age, etc. Radical radiotherapy or chemotherapy or both may be offered with curative intent to such patients, but the prospect of cure is substantially worse than with surgical options, while it may also lead to considerable lung damage with significant loss of function caused by radiation fibrosis, systemic toxicity due to the anticancer agent. Therefore, new modalities for local treatment that effectively destroy tumor but are less invasive and less damaging to normal lung tissue are required. Recently, several investigators tried to use radiofrequency ablation (RFA) [8–10] or photodynamic therapy (PDT) for peripheral lung tumors [11, 12].

We are interested in microwave coagulation therapy (MCT), which has been successfully used to perform coagulation of hepatic tumors. In 1978, hepatic surgery with MCT was introduced by Tabuse [1], and recently the effectiveness of percutaneous microwave coagulation therapy (PMCT) under ultrasonography or CT scan guidance for small hepatocellular carcinoma was demonstrated [3, 4]. We considered this modality to be applicable for patients with lung tumors who are poor surgical candidates, as well as patients with hepatic tumors, and evaluated the efficacy and safety of MCT for lung tissue experimentally.

The microwave generator emits a higher frequency wavelength than electrocautery and generates dielectric heat energy due to friction of water molecules when irradiating living tissue. MCT applies this mechanism to achieve tumor necrosis. Because the dielectric heat energy cannot be generated in the presence of air, selective tumor damage may be achieved, with limited damage to the surrounding normal air-filled lung tissue. We considered it essential to know how MCT affects normal lung tissue before performing PMCT clinically for peripheral lung malignancies. An experimental study was deemed necessary to evaluate the thermal response, coagulation extent, and histological changes in the air-filled normal lung.

With regard to thermal response, the temperatures of normal canine lung tissue rose with increased microwave power and coagulation time. The temperatures in normal lung tissue rose to 90-100°C at 5 mm from the electrode after 60 s and 70-80°C at 10 mm after 90 s, thereafter reaching a plateau. A power of 20 W was not sufficient to coagulate lung tissue. These data suggested that the same thermal response could be obtained at 40 and 60 W. The coagulation area in normal canine lung tissue increased to 18 mm and 22 mm at 40 W and 60 W for 4 min, respectively. Therefore, it may be possible to coagulate a diameter of approximately 20 mm. In solid tumors, there is a possibility to achieve more extensive coagulation. In human resected normal lung with central-type lung carcinoma, the coagulation area increased to 25 mm at 40 and 60 W for 3 min and shrank to 15 mm for 4 min. This phenomenon may be explained by shrinking of lung tissue due to rapid elevation of the temperature in the tissue, because there is no radiator effect in the resected lung due to the lack of blood supply. From the current study, we concluded the optimal condition in clinical PMCT to be 40-60 W for 3–4 min of coagulation.

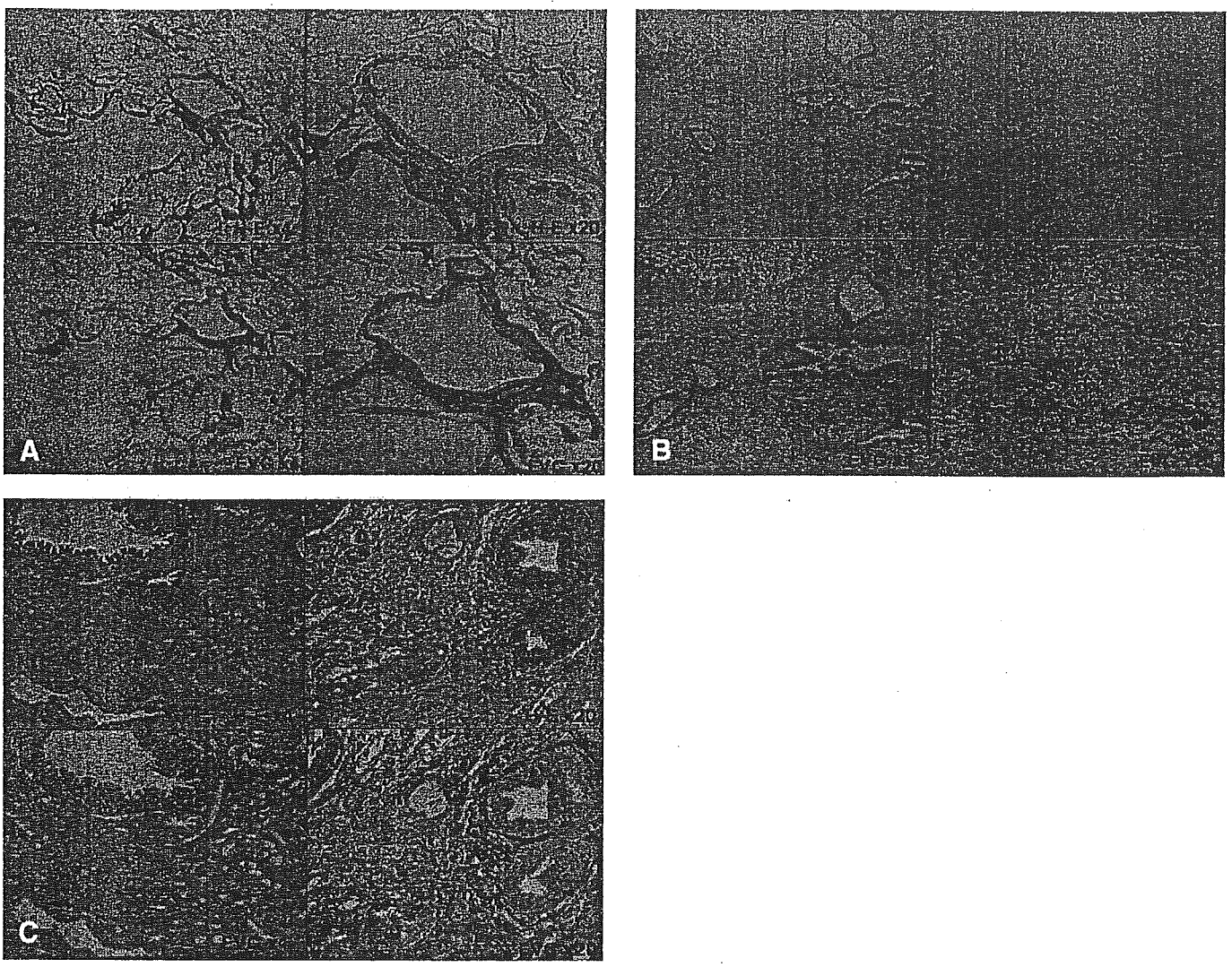

FIG. 6. (A) Histological findings shortly after microwave coagulation showed degeneration and thickening of collagen fiber and exfoliation and ulceration of bronchial epithelium surrounding the electrode. Surrounding bronchial and veins were not destroyed. (B) After 3 months, histological findings showed stromal edema and loose collagen fiber, immature neoangiogenesis, progression of bronchiolus epithelial hyperplasia, infiltration of inflammatory cells at the boundary zone between the central coagulation area and normal tissue. (C) After 6 months, coagulated tissue became scar tissue that showed disappearance of stromal edema, tight collagen fiber, mature capillaries, disappearance of inflammatory cells and completion of epithelial hyperplasia. (Color version of figure is available online.)

Histological analysis following MCT for normal canine lung tissue demonstrated exfoliation and ulcer formation of the epithelium in the bronchioli and degeneration and thickening of collagen fiber in the parenchyma by heat coagulation shortly after MCT. The coagulated lesions were gradually repaired by progression of epithelial hyperplasia and infiltration of inflammatory cells, showing stromal edema and granulation tissue after 3 months and finally becoming scar tissue after 6 months. We concluded MCT to be a safe modality for lung tissue because no destruction of bronchioles or veins was seen in the specimens during 6 months.

The present studies of MCT for peripheral lung tissue demonstrated that this new modality had no serious adverse effects and could be performed safely. However, the incidence of pneumothorax by CT-guided RFA was demonstrated to be 38.5% (3/8) in a rabbit model [8] and 33.3% (1/3) and 53.8% (7/13) in clinical cases [9, 10], which seems to be relatively high. Therefore, the development of a fine electrode with a cooling system will be necessary to prevent complications such as pneumothorax and heat sensation for clinical use.

From our experimental studies, the advantages of PMCT are the fact that this modality is minimally invasive, may be performed by local anesthesia, and is applicable for patients with poor cardiopulmonary function. In addition, the microwave generator is a very simple device, maintenance free, easy to handle, and portable, and the procedure is easy compared with RFA and PDT. The possibility of pneumothorax, heat

sensation or pain, or both during treatment and the limited coagulation area are considered the disadvantages for clinical use at present. Nevertheless, our results demonstrated the possibility of MCT for patients with small peripheral lung tumors with the intent of curative treatment. Although MCT is considered to be a useful modality as minimally invasive therapy for small peripheral lung tumors, further comparative research is necessary with other modalities such as RFA and PDT for peripheral lung tumors.

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Frequent loss of E-cadherin and/or catenins in intrabronchial lesions during carcinogenesis of the bronchial epithelium

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Early-stage bronchial squamous cell carcinoma;
Immunohistochemistry

Summary Inactivation of the cadherin-mediated cell–cell adhesion system is believed to play a role in the initial steps of cancer invasion and metastasis. Expression of E-cadherin and its intracytoplasmic binding molecules (α-catenin, β-catenin, and plakoglobin) was examined immunohistochemically in 84 cases of intrabronchial precancerous lesions (bronchial squamous metaplasia (BSM) without atypia, BSM with atypia, dysplasia), and 21 cases of carcinoma in situ, and 4 cases of microinvasion to the bronchial wall, and 32 cases of stage I well differentiated squamous cell carcinoma (squamous cell carcinoma) to investigate the association between expression of E-cadherin and/or catenins and cancer progression. Reduced expression of E-cadherin and/or catenins was closely correlated with an atypical grade of dysplasia in the basal layer ($p < 0.05$). In particular, downregulation of E-cadherin and/or catenins was associated with an atypical grade of BSM with atypia in intrabronchial lesions ($p < 0.01$). We conclude that downregulation of α-catenin and/or β-catenin, which may reflect dysfunction of the cadherin-mediated cell–cell adhesion system, is an important marker for atypical grade during carcinogenesis of the bronchial epithelium.

1. Introduction

Cadherins are a family of cell–cell adhesion molecules that are essential for tight junctions

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between cells [1,2], and E-cadherin is the form most strongly expressed in epithelial cells. Cadherins form a complex with cytoplasmic proteins, known collectively as catenins. This molecular complex, together with other cytoskeletal components such as actin, constitutes the intercellular adherence junction [2–4]. The catenins are classified into two groups, α-catenins and β-catenins, and the latter group includes plakoglobin and *Drosophila* Armadillo protein as well as β-catenin itself [5,6]. Plakoglobin is isolated from the desmosomal fraction [7] and is present in both desmosomes and adherence junctions [8], and may therefore be a common regulatory molecule in cell junctions.

Cadherin-mediated cell adhesion acts as a suppressor of the invasion of cancer cells in vitro [9–11], and dysfunction of the E-cadherin system correlates with cancer cell invasion in human cancers [12,13]. The role of α-catenin in the cadherin adhesion system has been revealed by studies with cancer cells. The human lung cancer cell line PC9 expresses an aberrant α-catenin mRNA and shows very loose cell–cell association [14,15]. PC9 cells become much more closely associated and acquire an epithelioid arrangement after transfection with cDNA for a subtype of α-catenin and αN-catenin [16]. These results suggest that α-catenin is indispensable for cadherin-mediated cell–cell adhesion.

Previous immunohistochemical studies have revealed many examples of reduced and/or heterogeneous expression of E-cadherin [17–19] and α-catenin [20] in undifferentiated invasive cancers, and impaired expression of E-cadherin or α-catenin has been reported to be associated with high incidences of lymph node metastasis of human breast [21], esophageal [22], and head and neck [23] cancers. However, there have been few studies on the relationship between reduced E-cadherin expression and the prognosis of cancer patients [24–28].

The role of β-catenin and plakoglobin in determining the fate of cells has been suggested by work on a *Drosophila* homologue of this protein, Armadillo [29,30]. Moreover, it has been revealed that the association between E-cadherin and α-catenin is mediated by β-catenin [31], and that β-catenin in turn mediates the interactions of the cadherin–catenin complex with the c-erbB-2 gene product and epidermal growth factor receptor (EGF-R) [32–34]. A tumor suppressor gene product, APC protein, has been shown to interact with β-catenin and plakoglobin and to play important roles in the E-cadherin-mediated cell adhesion system and to participate in tumor invasion and metastasis.

In a previous study, we divided primary lung cancers into two groups on the basis of their expression of E-cadherin and catenins, as detected by immunohistochemistry [35]. In addition, we demonstrated a close relationship between E-cadherin-associated cell–cell adhesion, catenins, and cytologic features, in particular the formation of cellular clusters and the frequency of solitary cells. Preoperative evaluation of both cytologic features and E-cadherin-associated cell–cell adhesion may be useful for predicting the malignant characteristics of lung cancer [36].

E-cadherin and α-catenin, and also β-catenin and plakoglobin, play important roles in the cadherin-mediated cell adhesion system in various cancers. However, in the context of carcinogenesis of the bronchial epithelium, expression of E-cadherin, α-catenin, β-catenin, and plakoglobin in intrabronchial precancerous lesions has not yet been reported. In order to investigate a possible dysfunction of the E-cadherin-mediated cell adhesion system in intrabronchial lesions, we used immunohistochemistry to examine the expression of E-cadherin, α-catenin, β-catenin, and plakoglobin in biopsy specimens.

2. Materials and methods

2.1. Biopsy specimens

The biopsy samples were obtained from 109 patients with intrabronchial lesions resected between 1991 and 2000 at the Department of Surgery of Tokyo Medical University Hospital. These lesions were diagnosed pathologically as BSM without atypia in 32 cases, BSM with atypia in 25 cases, dysplasia in 5 cases, carcinoma in situ in 21 cases, microinvasion to the bronchial wall in 4 cases, and stage I well differentiated squamous cell carcinoma in 32 cases. The specimens were fixed with 10% formalin and embedded in paraffin.

2.2. Immunohistochemistry

Mouse monoclonal antibodies against human E-cadherin (HECD-1; Takara, Kyoto, Japan), α-catenin and β-catenin (anti-α-catenin and anti-β-catenin; Transduction Laboratories, Lexington, KY), and plakoglobin (CBL175; Cymbus Bioscience, Southampton, UK) were used for immunohistochemical staining. Four-micrometer-thick tissue sections were prepared from all paraffin-embedded specimens and collected on silane-coated glass slides. After deparaffinization, the formalin-fixed paraffin-embedded sections were treated with

0.01% trypsin and subjected to microwave antigen retrieval [37].

The immunohistochemical method using the avidin-biotin-peroxidase complex was described previously [35]. The reaction products were visualized with diaminobenzidine and the sections were counterstained with hematoxylin.

Negative control staining, which was performed with the same class of immunoglobulin instead of the first antibody, yielded negative results in all cases. The intensity and pattern of immunostaining with HECD-1, anti-α-catenin, anti-β-catenin, and CBL175 in intrabronchial lesions were compared with those of normal bronchial epithelium, and the immunohistochemical staining results were evaluated as described previously [35]. Levels of immunostaining were evaluated in separate compartments of the bronchial epithelium: the basal layer (the first two-fifths of the distance between the basement membrane and the free surface), the intermediate layer, and the superficial layer (the upper one-fifth of this distance). Expression of E-cadherin, α-catenin, β-catenin, and plakoglobin in each layer was judged to be normal if more than 90% of the intrabronchial lesion cells were positively stained by the appropriate antibodies. If staining was distinctly weaker than that of normal epithelium, or if less than 90% of the intrabronchial lesion cells were positively stained, the expression was judged to be reduced. Immunohistochemical staining was scored independently by two observers (Y.K., Y.E.).

2.3. Statistical analysis

The data were analyzed using the Cochran–Armitage test [38], which was conducted by a stepwise method excluding E-cadherin, α-catenin, β-catenin, and plakoglobin, since these four variables are the variables of interest. Differences at $p < 0.05$ were considered to be statistically significant.

3. Results

In bronchial epithelium, E-cadherin and all catenins were expressed at a high level. Immunohistochem-

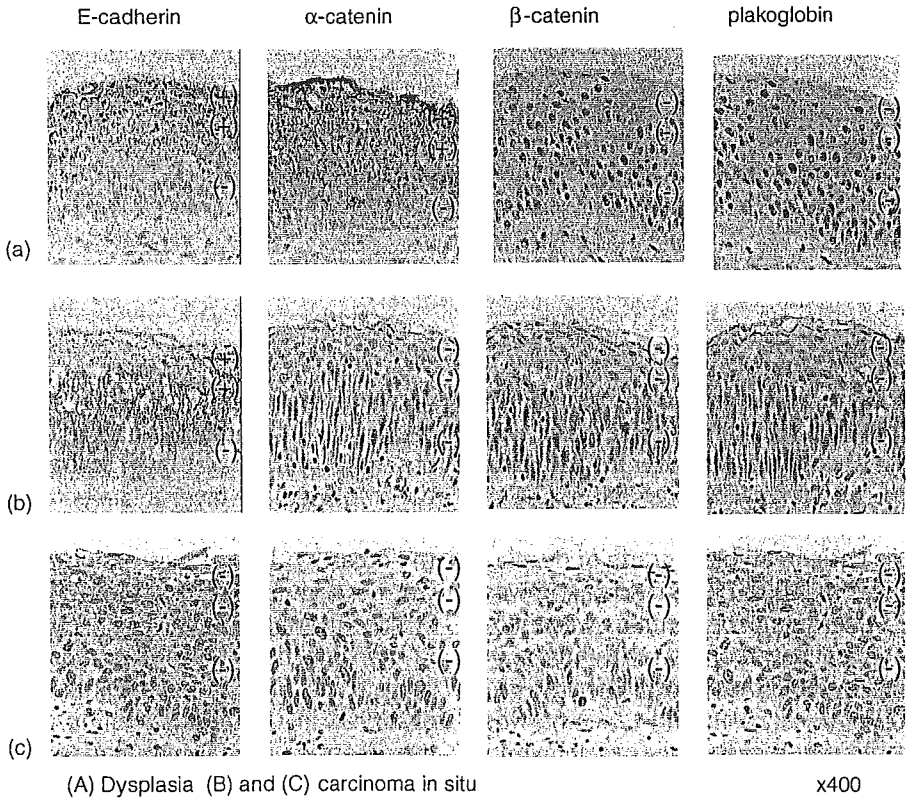

Fig. 1 (A) Representative immunohistochemical staining for E-cadherin, α-catenin, β-catenin, and plakoglobin in biopsy specimens of dysplasia (a) and carcinoma in situ (b and c). Evaluation for each layer of the intrabronchial lesions is shown at the right side of each picture ×400. (B) A borderline area between carcinoma in situ and dysplasia. Evaluation for each layer of the carcinoma in situ area is shown at the left side of each picture, and that for each layer of the dysplasia area at the right side of each picture.

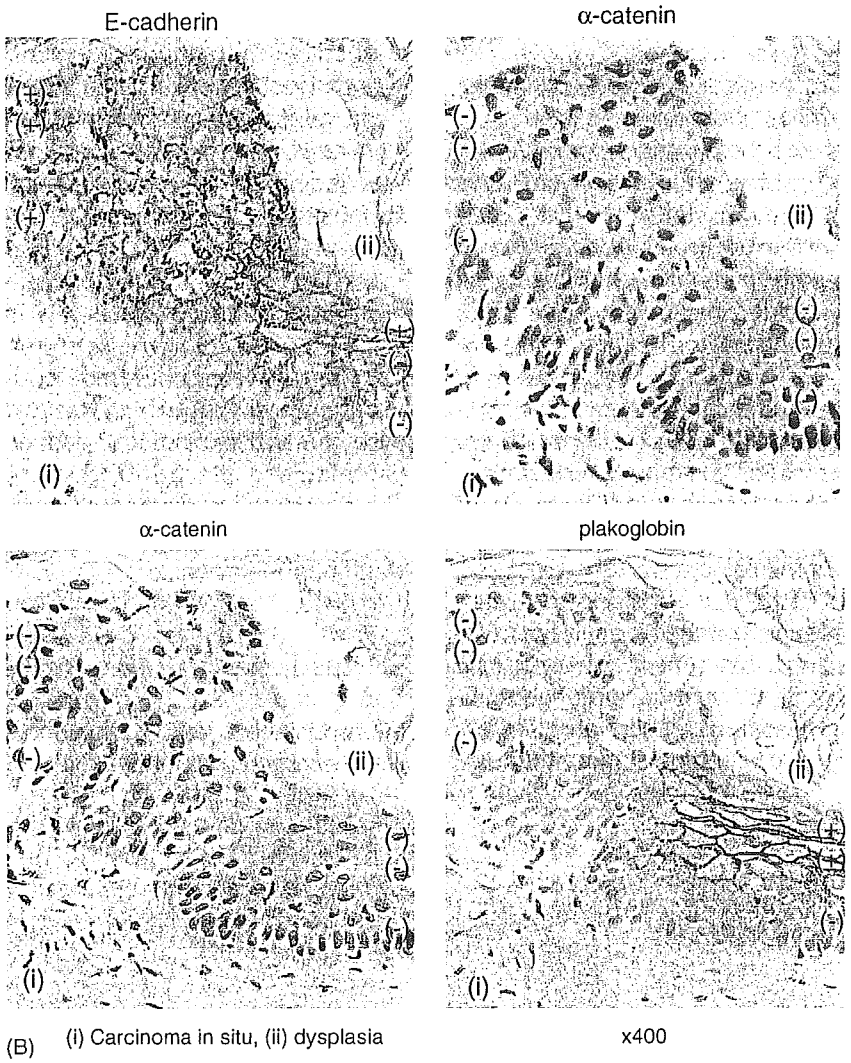

Fig. 1 (*Continued*).

ical findings for representative intrabronchial lesions are shown in Fig. 1. Cases with reduced expression of either E-cadherin or catenins in intrabronchial lesions are summarized in Table 1. Reduced expression of E-cadherin and/or catenins was closely correlated with an atypical grade of dysplasia in the basal layer ($p < 0.05$). In particular, down-regulation of E-cadherin and/or catenins was associated with an atypical grade of BSM with atypia in intrabronchial lesions ($p < 0.01$). Additionally, reduced expression of E-cadherin and catenins was observed in squamous cell carcinoma, as shown in Table 2.

In BMS without atypia ($n = 32$ cases), loss of expression of α-catenin, β-catenin or plakoglobin was observed in the basal layer in six cases (18%), in the intermediate layer in two cases (6%), and in the superficial layer in three cases (9%). In BSM with atypia ($n = 25$ cases), loss of expression of E-cadherin, α-catenin, β-catenin or plakoglobin was observed in the basal layer in seven cases (28%), in the intermediate layer in seven cases (28%), and in the superficial layer in five cases (20%). In dysplasia ($n = 5$ cases), loss of expression of these molecules was observed in the basal layer in two cases (40%), in the intermediate layer in one case (20%), and in the superficial layer in one case (20%). In carcinoma in situ ($n = 21$ cases), loss of expression was observed in the basal layer in 10 cases (48%), in the intermediate layer in 9 cases (43%), and in the superficial layer in 8 cases (38%). In microinvasion to bronchial wall ($n = 4$), loss of expression was observed in the basal layer in four cases (100%), in the intermediate layer in three cases (75%), and in the superficial layer in two cases (50%). These results are presented in Fig. 2 and Table 3.

Table 1 Aberrant expression of E-cadherin and catenins in intrabrounchial lesions

	E-cadherin			α-Catenin			β-Catenin			Plakoglobin			Rate[a] (%)
	B	I	S	B	I	S	B	I	S	B	I	S	
BSM without atypia $n=32$	+	+	+	−	−	+	+	+	+	−	−	−	21
	+	+	+	+	+	+	−	+	+	+	+	+	
	+	+	+	+	+	+	−	+	+	+	+	+	
	+	+	+	+	+	+	+	+	−	+	+	+	
	+	+	+	+	+	+	+	+	+	−	+	+	
	+	+	+	+	+	+	+	+	+	−	−	−	
	−	−	+	+	+	+	+	+	+	+	+	+	
BSM with atypia $n=25$	+	+	+	−	+	+	−	−	−	+	+	+	28
	+	+	+	−	−	−	−	−	−	+	+	+	
	+	+	+	+	+	+	−	−	−	+	+	+	
	+	+	+	+	+	+	−	−	+	−	−	+	
	−	−	−	−	−	−	−	−	−	−	−	−	
Dysplasia $n=540\%$	−	+	+	−	+	+	−	−	−	−	−	−	40
	−	+	+	−	+	+	+	+	+	+	+	+	
	+	+	+	+	+	+	−	−	+	+	+	+	
	+	+	+	+	+	+	−	+	+	−	+	+	
	+	+	+	−	−	−	−	−	−	−	−	−	
	+	−	+	−	−	+	−	−	−	+	+	+	
Carcinoma in situ $n=21$	−	+	+	−	−	−	−	−	−	−	−	−	48
	−	−	+	−	−	−	+	+	+	+	+	+	
	−	−	−	−	−	+	−	−	−	−	−	+	
	−	−	−	−	−	−	−	−	−	+	+	+	
	−	−	−	−	−	−	−	−	−	−	−	−	
	−	−	−	−	−	−	−	−	−	−	−	−	
Microinvasion to bronchial wall $n=4$	+	+	+	−	−	+	−	−	−	+	+	+	100
	+	+	+	−	−	+	−	−	+	+	+	+	
	+	+	+	+	+	+	−	−	−	−	−	−	
	+	+	+	+	+	+	+	+	+	−	+	+	

Variable	Contrast	p-Value
BSM without atypia	BSM with atypia	0.097
BSM without atypia	Dysplasia	0.043
BSM without atypia	Carcinoma in situ	0.003
BSM without atypia	Microinvasive to bronchial wall	0.001

B: basal layer; I: intermedtate layer; S: superficial layer.
[a] Reduced expession rate of either E-cadherin or catenins in intrabronchial lesions.

Table 2 Reduced expression rate of E-cadherin and catenins in advanced stage of squamous cell carcinoma

	Squamous cell carcionoma, $n=32$
E-cadherin	21 (67%)
α-Catenin	26 (81%)
β-Catenin	27 (84%)
Plakoglobin	14 (44%)
Rate[a]	100%

[a] Reduced expression rate of either E-cadherin or catenins in squamous cell carcinoma.

4. Discussion

It has been established that malignant transformation can arise from an accumulation of genetic alterations. This stepwise transformation is known as multistep carcinogenesis. In general, it is known that primary lung carcinoma is one of the most malignant solid tumors, and that it has a wide range of invasive and metastatic behavior. There is a high possibility that alterations in genotype are reflected in the morphological phenotype of the bronchial epithelium. In this context, bronchial

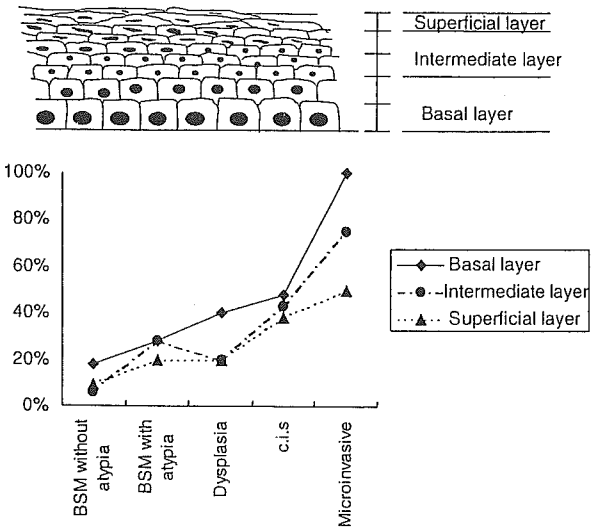

Fig. 2 Proportion of cases with reduced expression of either E-cadherin or catenins within the basal layer (♦), the intermediate layer (●) or the superficial layer (▲) of the intrabronchial lesions. The relative distribution of the different layers is shown in the upper part of the figure.

squamous metaplasia and dysplasia can be considered as precancerous lesions, mutation of the p53 tumor suppressor gene, and deletion of chromosome 17p have been reported in such lesions [39–42]. We have reported sequential changes in cell proliferation, DNA aneuploidy and accumulation of mutant p53 protein during carcinogenesis in the bronchial epithelium, and that these histochemical changes initially occurred in the basal layer [43]. We believe that the ability of cancerous cells to invade the bronchial wall will be acquired in a sequential manner during carcinogenesis. Therefore, we investigated the reduction of expression of E-cadherin and/or catenins in intrabronchial precancerous lesions and the early stages of bronchial squamous cell carcinoma. In intrabronchial lesions and squamous cell carcinoma, expression of either E-cadherin or catenins was reduced in 21% of BSM without atypia, 28% of BSM with atypia, 40% of dysplasia, 48% of carcinoma in situ, 100% of carcinoma microinvasive to the bronchial wall, and 100% of squamous cell carcinoma. We also demonstrated a positive correlation between the expression of these molecules and the grade of atypia of intrabronchial lesions. Our previous studies showed that reduced expression of E-cadherin and catenins occurs frequently in non-small cell lung carcinoma [35]. Hence, our present findings indicate that downregulation of E-cadherin and catenins may play an important role in the progression of human intrabronchial lesions and squamous cell carcinoma.

Studies on cell–cell adhesion molecules may help to clarify the mechanisms of local invasion and metastasis. Investigations of the cadherin–catenin complex have been carried out at the cellular and molecular levels [14,22,44]. It has already been reported that reduction of E-cadherin expression is caused by mutation and by inactivation of the E-cadherin gene by hypermethylation in the promoter region [45]. Dysfunction of the cadherin–catenin complex caused by reduction of the expression of these molecules implies an increased ability of cancer cells to disperse, which is the probable early step of local invasion and metastasis. Reduction of expression of E-cadherin and α-catenin is associated with local invasion and metastasis of scirrhous carcinoma in gastric cancer, breast cancer, and esophageal cancer [20,22].

In BSM with atypia and dysplasia, cells showing reduction of E-cadherin and/or catenin expression were localized mainly in the basal layer. As histological atypia increased, reduced expression of each molecule also became evident in the intermediate and superficial layers. This observation parallels the finding that proliferating cells and cells with accumulation of mutant p53 protein appeared from the basal layer to the superficial layer during carcinogenesis in the bronchus [43]. Therefore, we hypothesize that these cellular changes indicate an increased risk of eventual malignant transformation, and also that cells in the basal layer are the first to acquire the capacity for local invasion.

Our present study suggests that reduction of expression of E-cadherin and/or catenins is a rela-

Table 3 Aberrant expression rate of E-cadherin and/or catenins in intrabronchial lesions

	BSM without atypia	BSM with atypia	Dysplasia	c.i.s	Microinvasion to bronchial wall	Sq.c.ca.
Basal layer	6 (18%)	7 (28%)	2 (40%)	10 (48%)	4 (100%)	100%
Intermediate layer	2 (6%)	7 (28%)	1 (20%)	9 (43%)	3 (75%)	
Superficial layer	3 (9%)	5 (20%)	1 (20%)	8 (38%)	2 (50%)	
Whole layer	7 (21%)	7 (28%)	2 (40%)	10 (48%)	4 (100%)	
Total (cases)	32	25	5	21	4	32

tively early event in the genesis of bronchial squamous cell carcinoma, and that increasing histological atypia is accompanied by further diminution in the expression of these molecules. Finally, reduced levels of E-cadherin and/or catenins might play a critical role in local invasion beyond the basement membrane and the development of the advanced stage of squamous cell lung carcinoma.

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Phase II trial of postoperative adjuvant cisplatin and etoposide in patients with completely resected stage I-IIIa small cell lung cancer: The Japan Clinical Oncology Lung Cancer Study Group Trial (JCOG9101)

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Objective: Indications for surgical intervention for very limited small cell lung cancer have not yet been determined. The objective of this study is to determine whether resection followed by cisplatin and etoposide is feasible.

Methods: From September 1991 through December 1996, 62 patients with completely resected small cell lung cancer who were less than 76 years of age from 17 centers were entered in the trial. Of 62 patients, 61 were eligible, with a median follow-up of 65 months. Chemotherapy consisted of 4 cycles of cisplatin (100 mg/m^2, day 1) and etoposide (100 mg/m^2, days 1-3). There were 49 (80%) male patients, 44 with clinical stage I disease, 10 with stage II disease, and 6 with stage IIIa disease.

Results: Forty-two (69%) patients received 4 cycles of cisplatin and etoposide. No treatment-associated mortality was noted. Median survival time was not reached in patients with pathologic stage I disease, was 449 days in patients with stage II disease, and was 712 days in patients with stage IIIa disease. Three-year survival was 61% overall, 68% in patients with clinical stage I disease, 56% in patients with stage II disease, and 13% in patients with stage IIIa disease ($P = .02$). Recurrence was noted in 26 (43%) patients overall. Local failure was noted in 6 (10%) patients. Locoregional recurrence tends to be found more frequently in patients with stage IIIA disease. Distant failure was found in 21 (34%) patients overall. Brain metastasis was found in 15% of the patients.

Conclusion: Major lung resection followed by postoperative cisplatin and etoposide is feasible, with a favorable survival profile. Because nodal metastasis appears to be a major prognostic factor, preoperative evaluation of nodal status remains a major concern.

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The prognosis of lung cancer remains poor, and this disease is the leading cause of cancer mortality worldwide. Small cell lung cancer (SCLC) comprises approximately 20% of lung cancer cases. Without treatment, SCLC has the most aggressive clinical course of any other type of lung cancer, resulting in a very short median survival time of approximately 2 to 4 months. Although surgical resection is generally indicated for early stage non–small cell lung cancer, this is not always the case with SCLC. This can be explained by the fact that

dissemination to regional lymph nodes or distant organs would be found in most patients with SCLC at the time of initial presentation.[1] Therefore, localized forms of treatment, such as surgical resection or radiation therapy, rarely produce long-term survival, and systemic treatment with current chemotherapy regimens is usually incorporated into the treatment program.

Indications for surgical resection for SCLC have not yet been determined, although several authors have reported that a small minority of patients with limited-stage disease and adequate lung function might benefit from surgical resection.[1-9] According to these reports, the prognosis of resected SCLC was not so poor, especially when no pathologic nodal involvement was observed. The 5-year survival ranged from 26% to 61% in these trials if the tumor was stage I. Because SCLC tends to be disseminated and the results of surgical intervention alone for this disease have been reported to be poor,[1,10] postoperative chemotherapy has been used in most studies. However, the chemotherapy was not standardized, and various chemotherapy protocols were often used. Furthermore, most previous studies were retrospective and thus suffered from the inherent weakness of any retrospective assessment of a given treatment.

Because the combination of cisplatin and etoposide has been considered to be standard in the treatment of SCLC,[11] this combination was selected as a postoperative adjuvant regimen. We conducted a prospective study of surgical resection plus adjuvant chemotherapy for stage I through IIIA SCLC to investigate the efficacy of this treatment strategy.

Patients and Methods

Eligibility

Patients who were given postoperative diagnoses of SCLC histologically or cytologically were eligible for enrollment in the study. The patients had to have completely resected pathologic stage I, II, or IIIA disease according to the TNM classification of the International Union Against Cancer.[12] Histologic typing was determined according to the World Health Organization classification.[13] Inclusion criteria included an Eastern Cooperative Oncology Group performance score of 0 or 1, age between 20 and 75 years, no prior treatment for lung cancer, no other concurrent or previous malignancies, a leukocyte count of greater than 3500/μL, a platelet count of greater than 100,000/μL, a hemoglobin level of greater than 9.5 g/dL, a serum creatinine level of less than 1.5 mg/dL, and aspartate aminotransferase–alanine aminotransferase values of less than twice the institutional upper limit of normal. Exclusion criteria included a history of myocardial infarction within the past 3 months, hepatic cirrhosis, and/or severe cardiopulmonary dysfunction that required oxygen therapy. The following preoperative investigations were performed before entry into the study: computed tomographic (CT) scanning of the chest, upper abdomen, and brain; bronchoscopy; chest plain film; radionuclide bone scanning; complete blood cell count and serum chemistry; and physical examination. Preoperative mediastinoscopy was performed in some cases. All patients provided written informed consent before entering the study.

Treatment Schedule

Major lung resection, such as pulmonary lobectomy or pneumonectomy, was required as a surgical procedure for SCLC. Complete hilar and mediastinal lymph node dissections were recommended on the basis of the lymph node map defined by Naruke and colleagues.[14] After confirming complete resection and histologic typing of SCLC histologically, eligible patients were registered in the study.

Chemotherapy consisted of cisplatin (100 mg/m^2 on day 1) and etoposide (100 mg/m^2 on days 1-3; PE regimen). This regimen was repeated every 4 weeks and was administered in 4 courses. The dose was modified according to the blood cell count and renal function on the day of chemotherapy. Chemotherapy was administered unless the leukocyte count was less than 3000/μL or the platelet count was less than 75,000/μL. Chemotherapy was withheld until the counts recovered. If grade 4 hematologic toxicity, according to World Health Organization (WHO) criteria,[15] was seen, the dose of etoposide was reduced to 75%. Chemotherapy was permanently discontinued at any time when the serum creatinine level was 2.0 mg/dL or greater or the blood urea nitrogen level was 30 mg/dL or greater. To assess toxicity, we subjected all patients to complete blood cell counts and blood chemistry evaluations, such as for aspartate aminotransferase–alanine aminotransferase, blood urea nitrogen, and serum creatinine, as well as chest plain film and urinalyses at least once per week during treatment. Toxicity criteria were evaluated on the basis of the WHO criteria.[15]

Patients were followed up at the outpatient department every 3 months postoperatively and underwent CT scans of the chest, upper abdomen, and brain, as well as radionuclide bone scanning every 6 months, even when they were asymptomatic. No postoperative radiotherapy was applied until relapse was apparent.

Sites of relapse were determined by clinical, radiologic, or histologic criteria at initial recurrence. Local failure was defined as recurrence at the primary lung site or hilar-mediastinal lymph nodes. Distant failure was defined as recurrence in the contralateral lung, bone, brain, liver, or other extrathoracic regions.

Statistical Analysis

The trial was designed as a prospective phase II trial. The primary goal of the study was to estimate the survival. A sample size of 30 was considered to provide a power of 90% for detecting a significant improvement in the 3-year survival (from 20% to 50%) in a 1-sided test with an α value of .025 and a β value of .10. The median follow-up period for 35 surviving patients was 65 months. The length of survival was defined as the interval in months between the day of surgical resection of lung cancer and the date of death from any cause or the last follow-up. The survival curves were constructed by using the Kaplan-Meier method,[16] and curves were compared with the log-rank test.

Results

Patient Characteristics

Between September 1991 and December 1996, 62 patients were entered in this phase II trial at the 16 institutions that

TABLE 1. Patient characteristics

Total	61
Sex	
Male	49
Female	12
Age (y)	
Range	22-74
Median	64
Histologic subtype defined by WHO*	
Oat cell type	9
Intermediate type	45
Combined type	7
Clinical stage	
I	44
II	9
IIIA	8
Side of primary tumor	
Right	32
Left	29
Operative procedure	
Lobectomy	57
Pneumonectomy	4
Extent of lymph node dissection†	
Complete hilar and mediastinum	59
Only hilar	2
Pathologic stage	
I	35
II	8
IIIA	18
Performance status	
0	32
1	29

*Histologic subtyping was determined on the basis of the World Health Organization (WHO) classification. †The extent of lymph node dissection was defined by Naruke and associates.[14]

participated in the study. One patient was excluded because his final histologic category was changed from SCLC to large cell carcinoma. Thus, 61 patients were eligible for assessment of survival data, and their characteristics are shown in Table 1. The median age was 64 years (range, 22-74 years). According to histologic typing defined by the WHO, oat cell, intermediate, and combined types were found in 9, 45, and 7 patients, respectively. Forty-four patients had clinical stage I disease, 9 had stage II disease, and 8 had stage IIIA disease. Pathologically, stage I, II, and IIIA disease was found in 35, 8, and 18 patients, respectively.

Treatment Administration

As a surgical procedure, pulmonary lobectomy was performed in 57 (93%) patients, and pneumonectomy was performed in the other 4 patients. Among 4 pneumonectomies, 3 were on the left side, and 1 was on the right side. Complete hilar and mediastinal lymph node dissection was performed in 59 (97%) patients.

TABLE 2. Treatment delivery

Total no. of patients	61
No. of chemotherapy courses	
0	1 (2%)
1	5 (8%)
2	8 (13%)
3	5 (8%)
4	42 (69%)

A total of 204 courses were administered (Table 2). Forty-two (69%) patients underwent a full course of chemotherapy. The other 19 patients did not complete postoperative chemotherapy because of progressive disease in 3 patients, adverse effects in 7 patients, refusal of chemotherapy in 8 patients, and death from pneumonia in 1 patient.

Treatment-Related Toxicity

No treatment-associated deaths were found. Postoperative bronchopulmonary fistula was found in 1 (2%) patient who underwent pulmonary lobectomy after completion of the first cycle of chemotherapy. Chemotherapy-related toxicity is shown in Table 3. Grade 4 toxicity was found in 9 (15%) patients: leukopenia in 4 patients, thrombocytopenia in 2 patients, nausea in 2 patients, and cardiac failure in 1 patient. One patient died of pneumonia 2 months after the first course of chemotherapy, but this was not considered to be chemotherapy related.

Survival

Survival data are shown in Table 4. Among the 61 eligible patients, 35 were still alive after a median follow-up of 65

TABLE 3. Chemotherapy-related toxicity in 60 eligible patients treated for resected stage I to IIIA SCLC

	WHO grade				
Toxicity	1	2	3	4	4 (%)
Anemia	9	29	16	0	0
Leukocytopenia	7	17	26	4	6.5
Thrombocytopenia	11	8	14	2	3.2
Infection	2	1	0	0	0
Nausea	24	13	13	2	3.3
Diarrhea	8	2	2	0	0
Azotemia	35	0	0	0	0
Renal failure	18	0	0	0	0
Stomatitis	14	1	1	0	0
Dyspnea	5	0	0	0	0
Fever	10	7	0	0	0
Skin	4	2	0	0	0
Alopecia	13	23	11	0	0
Cardiac dysfunction	5	2	1	1	1.7
CNS	1	1	1	0	0
Peripheral neuropathy	5	1	0	0	0

WHO, World Health Organization; *CNS,* central nervous system.

TABLE 4. Survival in patients with resected SCLC who underwent postoperative chemotherapy

	Median survival time (d)	Survival 3 y	Survival 5 y
Clinical stage			
IA	Not reached	70%	66%
IB	Not reached	65%	65%
II	Not reached	56%	56%
IIIA	530	13%	13%
Pathologic stage			
IA	Not reached	78%	73%
IB	Not reached	67%	67%
II	449	38%	38%
IIIA	712	39%	39%

months. The overall estimated 3- and 5-year survivals were 61% and 57%, respectively (Figure 1). The 5-year survival was 66%, 56%, and 13% in patients with clinical stage I, II, and IIIA disease, respectively (Figure 2). Among the 44 patients with clinical stage I disease, 27 were classified as having clinical stage IA disease, and the other 17 were classified as having clinical stage IB disease. There was no significant difference in prognosis between clinical stage IA and IB disease. Similar results were obtained regarding the pathologic stage. Pathologic stage I disease showed a significantly better prognosis (Figure 3). The 5-year survivals in the 23 patients with pathologic stage IA disease and the 12 patients with stage IB disease were 73% and 67%, respectively. No significant differences in survival were observed between patients with pathologic stage IA and IB disease.

Patterns of failure. Recurrence was noted in 26 (43%) patients, and the sites of initial relapse at a median follow-up time of 65 months are shown according to the pathologic stage in Table 5. Recurrence was found in 30% of patients with stage IA disease, 25% of patients with stage IB disease, 50% of patients with stage II disease, and 67% of patients with stage IIIA disease.

Local failure was noted in 6 (10%) patients: 4 in the mediastinal lymph nodes and 2 in the bronchial stump. Locoregional recurrence tended to be found more frequently in patients with stage IIIA disease (22%) than in patients with stage I or II disease. Relapse at the bronchial stump was only seen in patients with stage IIIA disease.

Distant failure was found in 22 (36%) patients overall: 6 (26%) with stage IA disease, 2 (17%) with stage IB disease, 4 (50%) with stage II disease, and 9 (50%) with stage IIIA disease. Distant failure was most frequently noted in the brain, followed by the liver. The incidence of brain metastasis was 15% overall, 17% in patients with stage IA disease, and 11% in patients with stage IIIA disease. Bone metastasis was noted exclusively in patients with stage IIIA disease.

Discrepancy between clinical and pathologic stages. Table 6 shows the relationship between the clinical stage and the pathologic stage. Among 44 patients with clinical stage I disease, only 33 (75%) had pathologic stage I disease, and

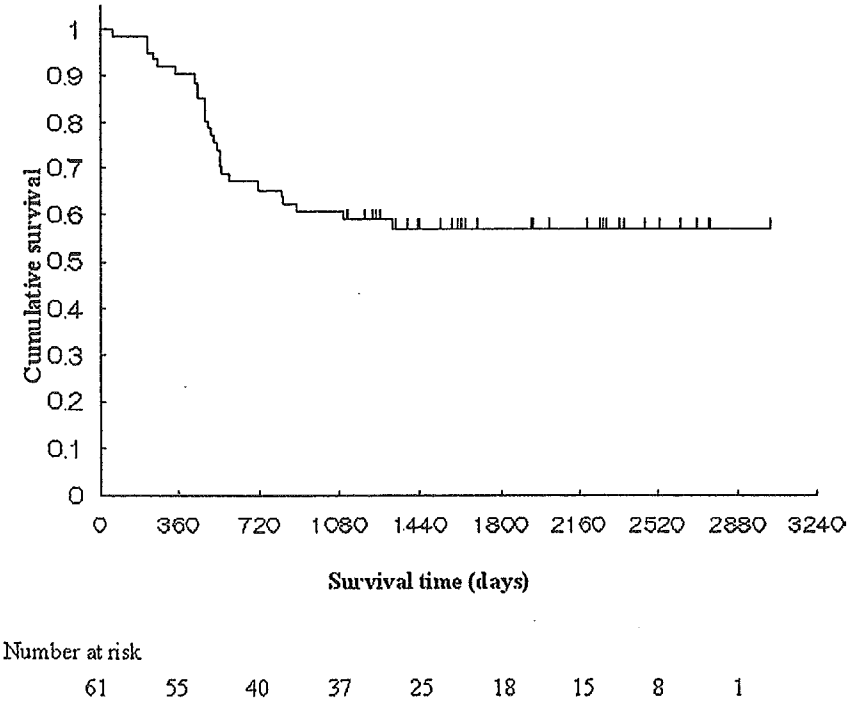

Figure 1. Survival curve for overall patients with resected SCLC.

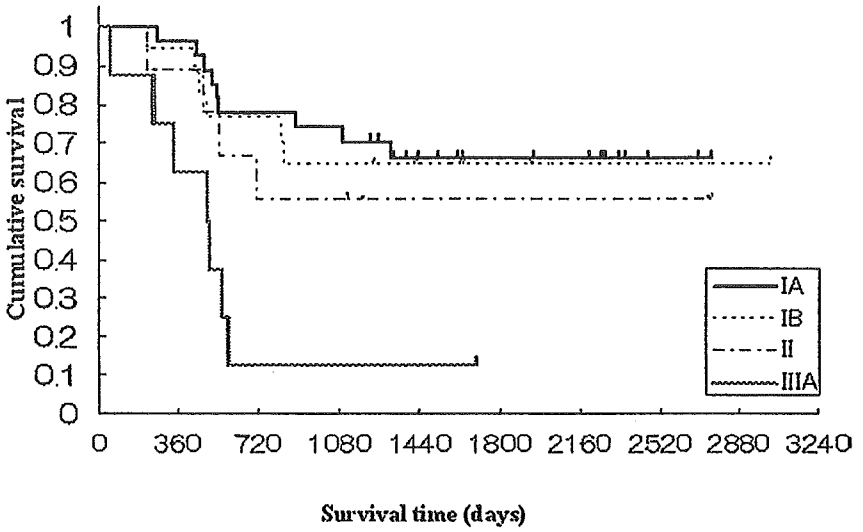

Figure 2. Survival curves for patients with resected SCLC by clinical stages.

6 had stage IIIA disease. Five patients with clinical stage IA disease had mediastinal lymph node metastasis. According to the Bowker test of symmetry, these differences were statistically significant.

Discussion

This phase II trial showed that postoperative PE for patients who underwent surgical resection of stage I to IIIA SCLC was feasible, and the outcome was acceptable. Survival was excellent in patients with stage I disease and did not appear to be inferior to that with chemoradiotherapy in patients with stage II or IIIa disease.

On the basis of the results of the British Medical Research Council, radical radiotherapy has been preferable to surgical intervention for SCLC,[17,18] and the indications for surgical resection for SCLC are still controversial. An operation would be indicated for limited SCLC because the most common relapse site after radiotherapy was locoregional, and surgical intervention might improve local control.[19] Several authors have reported that a small minority of

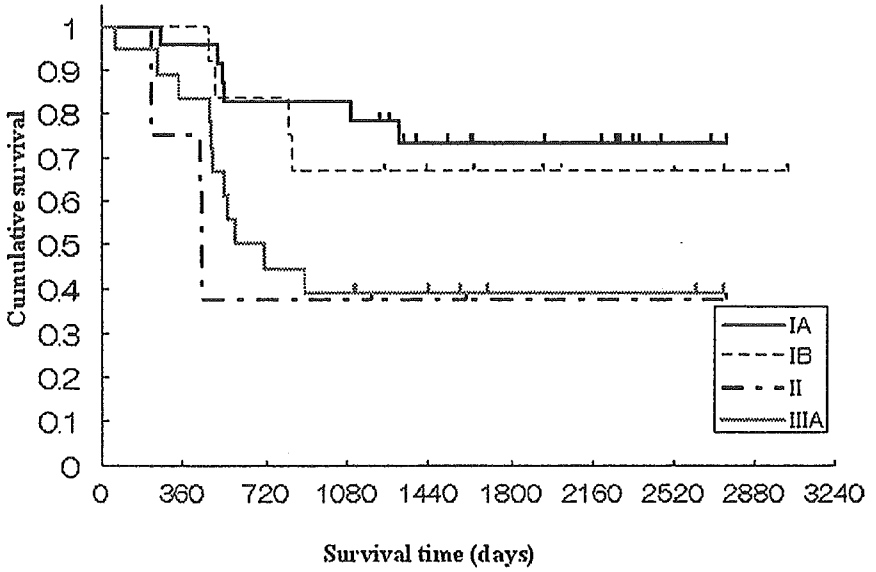

Figure 3. Survival curves for patients with resected SCLC by pathologic stage.

TABLE 5. Site of the first relapse by pathologic stages*

Variables	Overall	Stage IA	Stage IB	Stage II	Stage IIIA
No. of patients	61	23	12	8	18
No. of recurrence	26 (43%)	7 (30%)	3 (25%)	4 (50%)	12 (67%)
Recurrence					
Local					
Overall	6 (10%)	1 (4%)	1 (8%)	0 (0%)	4 (22%)
Mediastinum	4	1	1	0	2
Bronchial stump	2	0	0	0	2
Distant					
Overall	22 (36%)	6 (26%)	2 (17%)	4 (50%)	9 (50%)
Brain	9 (15%)	4 (17%)	0 (0%)	3 (38%)	2 (11%)
Bone	3	0	0	0	3
Liver	7	1	1	1	4
Lung	2	0	1	0	1
Small intestine	2	1	0	0	1

limited-stage SCLCs could be managed with an operation and postoperative chemotherapy.[1-9] According to those reports, the 5-year survivals were 28% to 36% overall and 26% to 61% in patients with stage I disease. However, most of those reports were retrospective and used various combinations of chemotherapy. Therefore, a prospective trial of adjuvant chemotherapy for patients with resected SCLC using standardized chemotherapy has been needed. Our survival data suggest that postoperative PE after major lung resection and hilar and mediastinal lymph node dissection is a feasible and promising treatment, especially for patients with stage I SCLC. The 3- and 5-year survivals for patients with stage I disease were 78% and 73%, respectively, and the median survival time was not reached. As for patients with stage II or IIIA disease, the results were not definitive, and a further prospective study is needed. This study dealt with postoperatively proved SCLC. As to the indication for surgical intervention for preoperatively diagnosed SCLC, controversies still remain. Our recommendation is as follows. When a patient has SCLC of clinical N1 or N2 status, chemoradiotherapy should be considered because a survival after an operation alone would not be good enough. Surgical intervention should be considered, however, for patients with clinical stage I disease because an operation followed by chemotherapy offers a good prognosis, as shown in this study, and because such SCLC sometimes turns out to be non-SCLC postoperatively. A phase III trial comparing chemoradiotherapy with surgical intervention followed by chemotherapy is interesting. However, the number of patients with SCLC with clinical stage I or II disease is very small, and we do not think it is possible to perform the phase III trial in this population.

TABLE 6. Relationship between clinical and pathologic stages

	Pathologic stage			
Clinical stage	I	II	IIIA	*P* value*
I	33	5	6	.011
II	1	3	5	
IIIA	1	0	7	

*P value in Bowker's test of symmetry.

Because clinical stage and pathologic stage were significant prognostic factors in our trial, preoperative staging, intraoperative staging, or both should be a major concern for the treatment of very limited SCLC. Actually, the following preoperative investigations were performed before entry into the study in this cohort: CT scans of the chest, upper abdomen, and brain; bronchoscopy; chest plain film; radionuclide bone scans; complete blood cell count and serum chemistry; and physical examination. If the diagnosis of SCLC was made preoperatively, we recommend the same preoperative workup as done by us in this study. Furthermore, if swollen lymph nodes are detected on thoracic CT scans, we absolutely recommend mediastinoscopy for such cases. As for positron emission tomography, we have no recommendation thus far because this modality has recently begun to be evaluated, although it could be useful for staging N1 disease. Intraoperatively, hilar and mediastinal lymph node sampling or dissection was performed in 59 (97%) patients. This intraoperative staging is also important for deciding on the treatment strategy.

The site of the first relapse was another fruit of our study. This clinical trial did not use postoperative mediastinal irradiation or prophylactic cranial irradiation (PCI). We should discuss the importance of these strategies for very limited SCLC. As to locoregional recurrence, approximately 10% of the patients showed relapse in the mediastinal lymph nodes, bronchial stump, or both. Five percent of patients with stage I or II disease eventually have locore-

gional recurrence, whereas this is seen in 22% of patients with stage IIIA disease. These results suggest that patients with stage IIIA disease, at least, could benefit from postoperative mediastinal irradiation, whereas those with stage I or II disease might not need to undergo radiotherapy. Thus, postoperative chemoradiotherapy might be used in a future trial for stage IIIA disease.

Auperin and associates[20] reported that PCI improved both overall survival and disease-free survival among patients with SCLC in complete remission. Surgically resected SCLC would be considered SCLC in complete remission, and PCI would be indicated. Overall, 15% of the patients in our study showed brain metastasis. Even among patients with stage IA disease, more than 10% of the patients had brain metastasis. Therefore, PCI might be necessary for all patients with completely resected SCLC, whereas some authors have insisted that patients with pathologic stage IA SCLC can be cured without any adjuvant treatment.[19]

Noda and coworkers[21] reported that combination chemotherapy consisting of irinotecan (CPT-11) and cisplatin was superior to PE for extensive SCLC. Although concurrent radiotherapy with CPT-11 would be harmful, we would use the new regimen for very limited SCLC, especially for stage II or IIIA SCLC.

Major lung resection with complete hilar and mediastinal lymph node dissection followed by postoperative PE is a feasible treatment and results in a favorable survival profile. Survival was especially good for patients with stage I disease. Our strategy could be used as a standard treatment arm in a future trial for very limited SCLC.

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REGULAR ARTICLE

Clinical-scale high-throughput human plasma proteome analysis: Lung adenocarcinoma

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Clinical proteomics requires the stable and reproducible analysis of a large number of human samples. We report a high-throughput comprehensive protein profiling system comprising a fully automated, on-line, two-dimensional microflow liquid chromatography/tandem mass spectrometry (2-D μLC-MS/MS) system for use in clinical proteomics. A linear ion-trap mass spectrometer (ITMS) also known as a 2-D ITMS instrument, which is characterized by high scan speed, was incorporated into the μLC-MS/MS system in order to obtain highly improved sensitivity and resolution in MS/MS acquisition. This system was used to evaluate bovine serum albumin and human 26S proteasome. Application of these high-throughput μLC conditions and the 2-D ITMS resulted in a 10-fold increase in sensitivity in protein identification. Additionally, peptide fragments from the 26S proteasome were identified three-fold more efficiently than by the conventional 3-D ITMS instrument. In this study, the 2-D μLC-MS/MS system that uses linear 2-D ITMS has been applied for the plasma proteome analysis of a few samples from healthy individuals and lung adenocarcinoma patients. Using the 2-D and 1-D μLC-MS/MS analyses, approximately 250 and 100 different proteins were detected, respectively, in each HSA- and IgG-depleted sample, which corresponds to only 0.4 μL of blood plasma. Automatic operation enabled the completion of a single run of the entire 1-D and 2-D μLC-MS/MS analyses within 11 h. Investigation of the data extracted from the protein identification datasets of both healthy and adenocarcinoma groups revealed that several of the group-specific proteins could be candidate protein disease markers expressed in the human blood plasma. Consequently, it was demonstrated that this high-throughput μLC-MS/MS protein profiling system would be practically applicable to the discovery of protein disease markers, which is the primary objective in clinical plasma proteome projects.

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Abbreviations: ABC, ammonium bicarbonate; **AID-HP**, albumin-and-IgG-depleted human plasma; **IAM**, iodoacetamide; **Ig**, immunoglobulin; **ITMS**, ion-trap mass spectrometry; **μLC**, microflow liquid chromatography; **NSI**, nanoelectrospray ionization; **SCX**, strong cation exchange; **TCEP**, tris[2-carboxyethyl]phosphine; **TPX**, methylpentene polymer

1 Introduction

Human blood plasma is generally the most informative proteome from a medical viewpoint, because it is the primary clinical specimen and it also represents the largest and deepest version of human proteome present in any sample [1–3]. Almost all body cells communicate with the plasma either directly or through tissues/biological fluids, and many of these cells release at least a part of their contents into the plasma upon damage or death. A comprehensive, systematic characterization of the plasma proteome in the healthy and

diseased states will greatly facilitate the development of biomarkers for early disease detection, clinical diagnosis, and therapy of cancer and other diseases. However, broad characterization of the human plasma proteome may pose one of the greatest challenges. This is because it can contain low-level proteins, which are secreted by solid tissues, as well as other important proteins (tissue leakage proteins at pg/mL levels) in the presence of several relatively dominant, high-abundance proteins (particularly HSA at 35–50 mg/mL). The dynamic range of plasma protein concentrations minimally spans nine orders of magnitude. For clinical and diagnostic proteomics using human plasma, it is essential to develop a comprehensive system, which has a high resolution and a wide dynamic range, for large-scale proteome analysis.

Recently, multi-dimensional LC-MS/MS has been developed as a powerful tool, particularly for comprehensive identification of highly complex proteins. This method can achieve a resolving power that is equal to or higher than 2-DE [4–6]. Broad protein identification techniques can detect specific proteins present in low concentrations in a highly complex protein matrix. To characterize the human plasma proteome, Smith *et al.* have achieved a protein identification dynamic range of more than eight orders of magnitude using 2-D LC combined with conventional ion-trap MS/MS instrumentation [6]. This approach has resulted in the identification of >800 plasma proteins from 5 μL plasma without the depletion of highly abundant HSA and/or immunoglobulins (Ig). The multi-dimensional LC-MS/MS techniques reported thus far indicate the potential usefulness of broad protein identification with high resolution and wide dynamic range for cataloging the plasma contents. However, these approaches require further improvement in terms of both ease of use and industrial applicability to routine clinical use, because their application to clinical research requires stable and reproducible analyses of a large number of human samples.

The establishment of a simple, robust, and high-throughput protein profiling system as a global platform is extremely important from the viewpoint of clinical proteomics. This is because a large number of human tissue/biological fluid samples could then be quantitatively analyzed, in a routine and reproducible manner, for expressed proteins. Such a system would help discover any protein that is significantly associated with a specific disease status. We have constructed a technically well integrated and high-throughput LC-MS/MS system with RP microflow LC (μLC) and a conventional ion-trap MS/MS equipped with a nanoelectrospray ionization (NSI) interface to detect lung cancer biomarkers and to analyze apoptotic mechanisms [7, 8]. Additionally, the system has been combined with on- or off-line strong cation-exchange (SCX) chromatography to result in a multi-dimensional protein profiling system. This protein profiling system using off-line 2-D SCX/RP μLC-MS/MS was successfully applied to broad protein identification of human plasma proteins [9]. We have also established protein depletion, in-solution digestion, and data-integrating/mining systems with an automated operation for large-scale human plasma proteome analysis.

The dynamic range and sequence coverage that results from protein identification by LC-MS/MS analysis depends on both the quality of the separation(s) applied and the MS platform [6]. When resolution performance is not considered, the quality of the 2-D LC is substantially related to the number of fractionation steps for the first dimension chromatography and the analytical running time for the second dimension chromatography. Since the dynamic range of the MS platform is based on the performance of the instrument used, the number of the MS/MS acquisition in one run strictly depends on both the scan speed and the analytical time required by the LC-MS/MS analysis. Recently, linear ion-trap MS/MS (2-D ITMS) instruments with a higher scan speed and sensitivity than conventional 3-D ITMS instruments have emerged as new generation instruments. Therefore, we applied the new 2-D ITMS instrument to the fully automated on-line 2-D μLC-MS/MS system developed by us [10].

In this study, we evaluated the performance of the μLC-MS/MS system using the 2-D ITMS instrument for extending the sensitivity, dynamic range, and coverage for comprehensive protein identification. BSA and human 26S proteasome were used as the authentic protein sample and the protein complex sample, respectively. The system, together with the on-line 2-D μLC-MS/MS system, was then applied to proteome analysis of human plasma; HSA- and IgG-depleted samples were obtained from a few healthy individuals and lung adenocarcinoma cases.

2 Materials and methods

2.1 Materials

HPLC-grade ACN, formic acid, and TFA were purchased from Wako Pure Chemical Industries, Ltd. (Osaka, Japan). Milli-Q grade water (Millipore, Bedford, MA, USA) was used. BSA, ammonium formate, ammonium bicarbonate (ABC), and iodoacetamide (IAM) were purchased from Sigma (St. Louis, MO, USA). Human 26S proteasome (PW9310) was obtained from Affiniti Research Products (Devon, UK). Tris[2-carboxyethyl]phosphine (TCEP) was purchased from Pierce (Rockford, IL, USA). Sequencing grade-modified trypsin was purchased from Promega (Madison, WI, USA).

2.2 Preparation of the digested BSA and human 26S proteasome samples

BSA (1 nmol) was diluted with 225 μL ABC (aq., 100 mM); then, 12.5 μL TCEP (10 mM) was added for reduction and the solution mixture was kept at 37°C for 45 min. Further, 12.5 μL IAM (50 mM) was added, and the solution mixture was alkylated in the dark at 24°C for 1 h. The resulting solution was digested with trypsin (trypsin:protein = 1:50, w/w),

