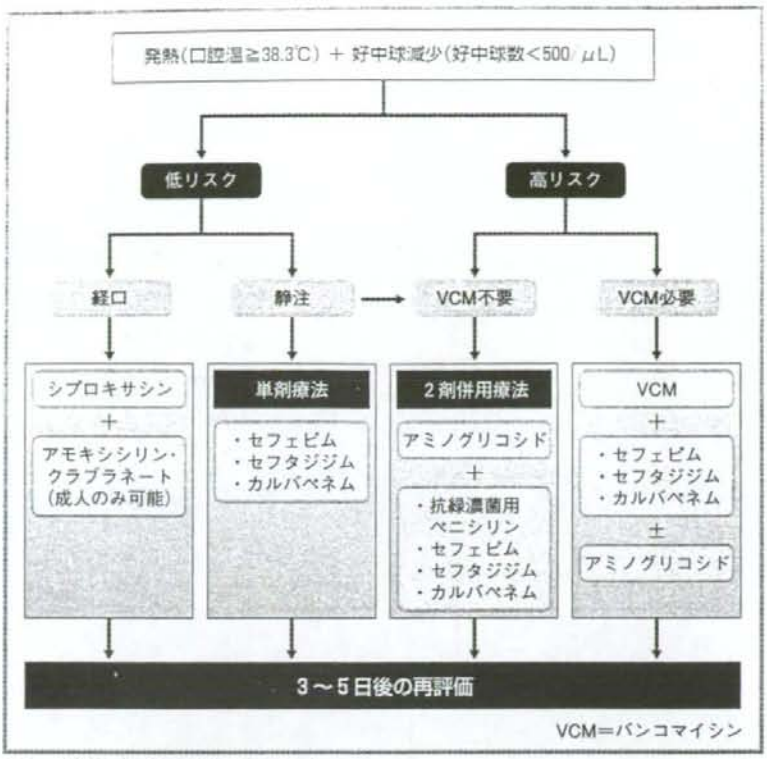

図1　はじめに使う抗菌薬の決め方

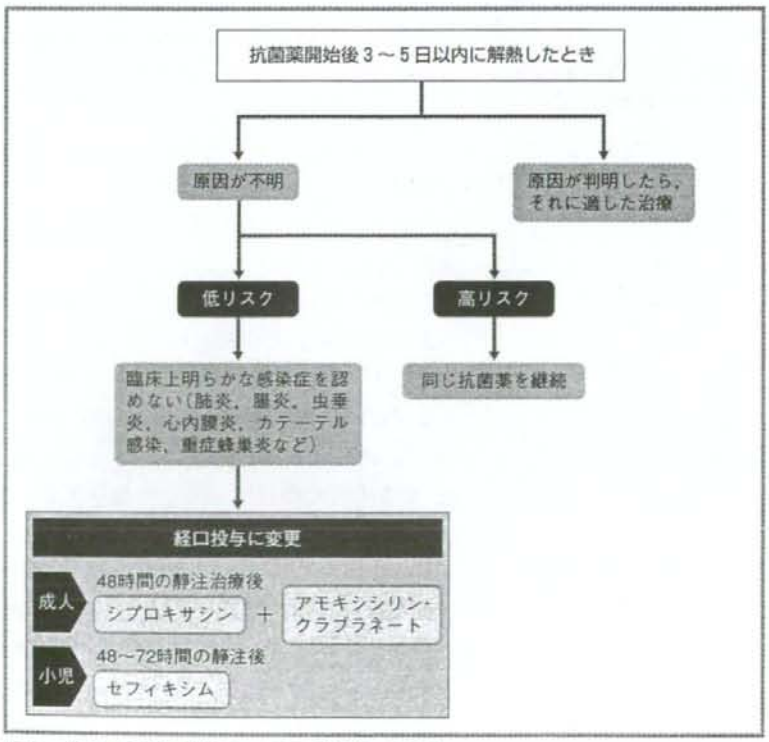

図2　抗菌薬投与開始後3～5日で解熱したとき

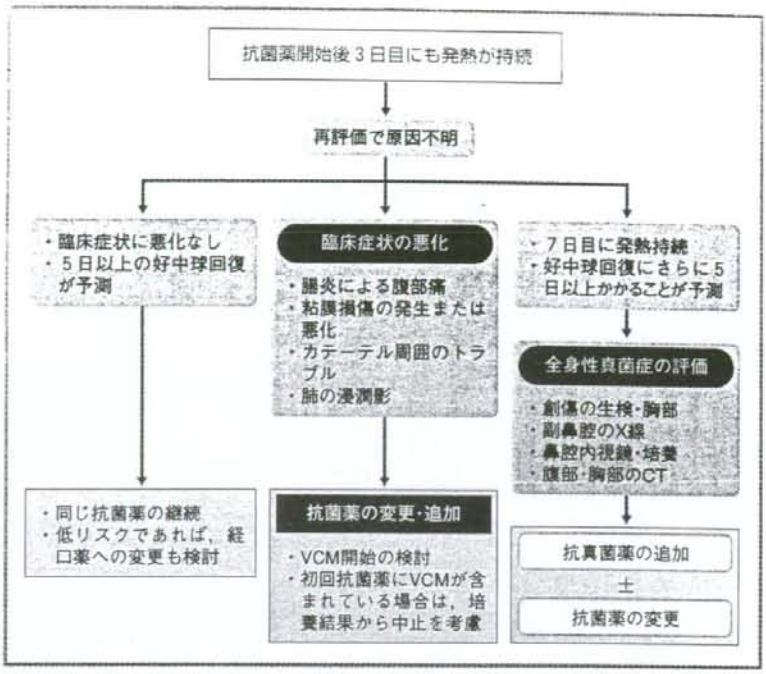

図3　抗菌薬開始後3～5日目にも発熱が持続しているとき

ともある．

●早発性下痢と遅発性下痢

がん化学療法に伴う下痢として早発性下痢と遅発性下痢がある．抗がん薬投与当日に起こる早発性下痢は，消化管の副交感神経が刺激されることによるコリン作動性の下痢であり，抗コリン薬であるブチルスコポラミン「ブスコパン」が有効である．

抗コリン薬：副交感神経遮断作用のある鎮痙薬のこと

数日から2週間たって発症する遅発性下痢は，抗がん薬により消化管粘膜が障害されるために起こる．また，腸管粘膜が障害される時期と好中球数が減少する時期とが重なった場合，腸管からの感染リスクが非常に高くなる．

●遅発性下痢の治療

婦人科領域では，イリノテカンやドセタキセルによる遅発性下痢が問題となり，重症度に応じた対応が必要である．

まず初めに問診を行い，発症時期，持続期間，下痢の性状，随伴症状（発熱，めまい，急激な腹痛，脱力），下痢の原因となるような薬物の内服・食事内容について十分な情報を得る．治療前に比し排便回数の増加が7回未満の場合は，ロペラミド「ロペミン」の内服（初回4 mg，下痢が止まるまで2～4時間ごとに2 mgずつ内服）と脱水の予防を行う．改善がみられない場合や，脱水や随伴症状を伴う重症の下痢の場合は，オクトレオチド「サンドスタチン」100～150（～500）μgを1日3回皮下注射し，抗生物質（フルオロキノロンなど）を開始，輸液による脱水・電解質の補正を行う．

（関好孝，温泉川真由，勝俣範之）

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A synthetic retinoid, TAC-101 (4-[3,5-bis (trimethylsilyl) benzamido] benzoic acid), plus cisplatin: Potential new therapy for ovarian clear cell adenocarcinoma

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Abstract

Objective. A novel retinoid, TAC-101 (4-[3,5-bis (trimethylsilyl) benzamido] benzoic acid), induces apoptosis of ovarian clear cell adenocarcinoma. The antitumor effect of TAC-101 alone or combined with cisplatin was tested using human ovarian carcinoma.

Methods. Induction of genes related to apoptosis by TAC-101 or cisplatin was assessed by DNA microarray analysis. TAC-101 (8 mg/kg/day orally for 21 days), cisplatin (7 mg/kg intravenously on day 1), or a combination of both drugs at the same dosages was administered to nude mice implanted subcutaneously with RMG-I or RMG-II clear cell adenocarcinoma cells. The antitumor effect was evaluated by calculating the treated/control tumor volume ratio at 21 days after implantation. The histoculture drug response assay was also performed using fresh surgical specimens of human ovarian cancer to determine the 50% inhibitory concentration (IC_{50}).

Results. Different apoptosis-related genes were induced by TAC-101 and cisplatin. Compared with control mice, the volume of both RMG-I and RMG-II tumors was significantly reduced ($p<0.05$) by either drug. The IC_{50} values of cisplatin and TAC-101 showed a significant correlation ($p<0.01$).

Conclusion. These *in vitro* findings suggest that a combination of TAC-101 and cisplatin may be a potential new treatment for ovarian clear cell adenocarcinoma.

Keywords: Ovarian carcinoma; Clear cell adenocarcinoma; TAC-101; Cisplatin; Histoculture drug response assay

Introduction

Clear cell adenocarcinoma accounts for more than 10% of ovarian cancer [1] and its incidence has recently been increasing in Japan [2]. Up to 60% of patients with this tumor have stage I disease according to the International Federation of Gynecology and Obstetrics (FIGO) classification [3]. However, patients with clear cell adenocarcinoma have a poor prognosis even when it is diagnosed at an early stage and treated by complete resection [2,4]. Since clear cell adenocarcinoma seems to show resistance to platinum-based chemotherapy, unlike the other types of ovarian carcinoma [5], more effective chemotherapy is needed for this tumor.

Retinoids have great potential in the fields of cancer therapy and chemoprevention [6,7]. While some tumor cells are sensitive to the growth inhibitory effects of natural retinoids, such as all-*trans*-retinoic acid (ATRA), many ovarian tumor cells are not [8]. We previously found that a new synthetic retinoid, 4-[3,5-bis (trimethylsilyl) benzamido] benzoic acid (TAC-101) was more effective at inducing apoptosis of clear cell adenocarcinoma cell lines than it was for other histological types of ovarian carcinoma [9]. TAC-

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101 also inhibits the growth of xenografts of a human ovarian clear cell adenocarcinoma cells (RMG-II), similar to paclitaxel, and has a stronger effect than *cis*-diammine dichloroplatinum (cisplatin) [9]. In the present study, we assessed the antitumor effect of cisplatin combined with TAC-101, as well as that of each drug alone. We analyzed the induction of genes related to apoptosis by each drug because TAC-101 might have different antitumor activity from cisplatin due to differences in their influence on gene expression. We also used an *in vivo* assay to determine the effect of TAC-101 or cisplatin on clear cell adenocarcinoma in mice, as well as the response to both agents combined. Finally, the histoculture drug response assay (HDRA) was performed to compare the activity of TAC-101 and cisplatin against human ovarian cancer specimens.

The results of these investigations were used to assess the potential clinical value of combined therapy with TAC-101 and cisplatin for ovarian clear cell adenocarcinoma, which has a poor prognosis due to resistance to standard platinum-based chemotherapy [5].

Materials and methods

Chemicals

TAC-101 was provided by Taiho Pharmaceutical Co., Ltd. (Saitama, Japan), cisplatin was purchased from Nippon Kayaku Co., Ltd. (Tokyo, Japan), and ATRA was purchased from Sigma Chemical Co. (MO, USA). For *in vitro* experiments, TAC-101 and ATRA were dissolved in dimethyl sulfoxide at concentrations of 20 mM and 10 mM to make stock solutions, which were stored at −20 °C until use. For *in vivo* experiments, TAC-101 was suspended in 0.5% hydroxyl propylmethylcellulose (Shin-Etsu Chemical Co., Ltd., Tokyo, Japan).

Cell culture

Two human ovarian clear cell adenocarcinoma cell lines (RMG-I and RMG-II), which we previously established [10,11], were cultured in a Ham's F 12 medium (Gibco Laboratories, NY, USA) supplemented with 10% fetal calf serum (FCS) (Mitsubishi Chemical Co., Tokyo, Japan) and 80 μg/ml of kanamycin sulfate (Meiji Seika Kaisha Ltd., Tokyo, Japan) at 37 °C under an atmosphere of 5% CO_2.

Microarray analysis

RMG-I and RMG-II cells (1×10^6 cells) were seeded into 10-cm flasks (BD Bioscience, MA, USA) and incubated for 3–5 days, after which the medium was replaced with fresh medium containing cisplatin (7.5 μg/ml),or TAC-101 (25 μM), and 2% FCS (control). Cultured cells were harvested after 24 h later.

Total RNA was extracted from these flasks using an RNeasy column (Quagen, CA, USA). Then microarray gene analysis was performed using a human apoptosis GEArray Q series kit (Super Array Co., MD, USA) consisting of 96 apoptosis-related genes and 4 housekeeping genes printed on a membrane. Total RNA (0.5 μg) was used as a template for the synthesis of biotin/dUTP-labeled cDNA probes according to the manufacturer's protocol. Membranes were hybridized with the labeled probes, washed, treated with 1.0 ml of CDP-Star chemiluminescence solution, and exposed to X-ray film (Eastman Kodak Company, NY, USA). Image analysis software (Scananalyze and GEArray Analyzer, Super Array Co., MD, USA) was employed to assess gene expression, and the increase in expression of apoptosis-related genes relative to the control (culture with FCS alone) was analyzed by Student's *t*-test. Expression of GAPDH was also assessed as a house-keeping gene. Anti-sense cDNAs for each gene were placed on the same GEArray chip from two to four times and average values were calculated. The expression of each gene was normalized by subtracting the background value and dividing by the level of GAPDH expression. Expression of each gene was measured twice by the same method and data were analyzed by the paired *t*-test with regard to the differences of population mean values between two related groups. For genes that showed significant differences of expression, their ratio relative to control expression was calculated. A ratio ≥1.5 was defined as up-regulation and a ratio ≤2/3 was defined as down-regulation.

Activity against RMG-I and RMG-II tumors in nude mice

RMG-I or RMG-II cells were implanted subcutaneously into the backs of nude mice, and the tumors that developed were measured after 3 weeks. Mice that had tumors with an estimated volume ([largest diameter (mm) × smallest diameter (mm)]^2/2) of approximately 100 mm^3 were selected and assigned to groups of 8 animals each by stratified random allocation based on the individual tumor volumes, so that each group had a almost equal mean tumor volume on day 1. Changes in the body weight of the mice were measured to determine the nontoxic dose of each drug, and inhibition of tumor growth was examined at that dose.

TAC-101 (8 mg/kg/day) was administered daily for 21 days by oral gavage using a 1-ml tuberculin syringe (SS-01T, Terumo Co., Tokyo, Japan) and needle, while cisplatin was injected into the tail vein at a dose of 7 mg/kg on day 1. Combination therapy was given with TAC-101 and cisplatin at these doses. The dose of TAC-101 was set on the basis of its antiproliferative activity and effect on body weight in a previous dose-finding study [12], while the dose of cisplatin was equivalent to that used clinically [13]. An untreated control group was also included. Body weight was measured twice a week in order to monitor toxicity. Animals were handled in accordance with the protocol established by the Animal Care Committee of Taiho Pharmaceutical Co., Ltd. (Tokyo, Japan).

The tumor volume (TV) was measured daily over time in each animal and the ratio of the volume on day 21 to that at the start of treatment was calculated. Welch's *t*-test (two-tailed) was performed to compare TV values and the effect of combined treatment was determined by the intersection union test [14].

Histoculture drug response assay (HDRA)

Among patients who underwent surgery for ovarian cancer at Keio University Hospital, the HDRA was performed in those who consented to enrollment in the present study. The study protocol was approved by our IRB (institutional review board), and informed consent was obtained from all participating patients. We performed the HDRA (TAC-101 32 cases, ATRA 27 cases, cisplatin 33 cases) according to a modification of the method of Ohie et al. [15]. Briefly, collagen gel sponge (Gel Foam, Pharmacia & Upjohn Co., Tokyo, Japan) was cut into cubes of about 1 mm^3, and a cube was placed into each well of a 24-well plate (Sumilon, Sumitomo Bakelite Co., Ltd., Tokyo, Japan). The culture medium (1 ml/well) was F-12 medium (Gibco Laboratories, NY, USA) containing 20% fetal bovine serum (Mitsubishi Chemical, Co., Tokyo, Japan) and 80 μg/ml of kanamycin (Meiji Seika Kaisha, Ltd., Tokyo, Japan). The concentration of cisplatin (Nippon Kayaku, Co. Ltd., Tokyo, Japan) in the culture medium was set at 6.25, 12.5, 25, 50, or 100 μg/ml, and each concentration was tested in 4 wells. The same concentrations of TAC-101 (Taiho Pharmaceutical Co., Ltd., Tokyo, Japan) and ATRA (Sigma Chemical Co., MO, USA) were also tested in 4 wells each. During surgery, tumor specimens were harvested aseptically and cut into cubes of approximately 1 mm^3 with scissors. Then a tumor tissue cube was placed onto the collagen sponge in each well of the 24-well plate. After incubation at 37 °C under an atmosphere of 5% CO_2 for 7 days, viable cells were detected by the methylthiazoletetrazolium (MTT) assay. In brief, MTT (Sigma Chemical Co., MO, USA) was dissolved in phosphate-buffered saline (5 mg/ml) containing 100 mM succinic acid (Wako Pure Chemical Industries, Ltd., Tokyo, Japan). Then 100 μl of MTT solution was added to each well, and incubation was done for 4 h at 37 °C under an atmosphere of 5% CO_2. The stained tumor tissue cubes were subsequently transferred into new 24-well plates, after which 1 ml of dimethyl sulfoxide (Wako Pure Chemical Industries, Ltd., Tokyo, Japan) was added to extract the MTT-formazan product. Next, 100 μl of the extract from each well was transferred into the wells of a 96-well microplate (Sumilon, Sumitomo Bakelite Co., Ltd., Tokyo, Japan), and the absorbance was measured at 540 nm using a microplate reader (Model 450, Bio-Rad Laboratories, CA, USA). After

Table 1
Up-regulated genes

	TAC-101			Cisplatin		
	Gene name	Ratio	p-value	Gene name	Ratio	p-value
RMG-I	RIP	14.51	<0.05	Bcl-10	1.91	0.06
	Cardiac/RIP2	7.17	0.08	IAP-2	1.67	<0.05
	CHK2	6.98	0.06			
	Caspase 5	5.05	<0.05			
	CIDE-A	4.03	<0.05			
	LTBR	2.11	<0.05			
	LTB	2.09	<0.05			
	p63	2.00	0.08			
	NAIP/BIRC1	1.94	0.10			
	TNFB	1.72	0.06			
	PYCARD	1.52	0.08			
RMG-II	Caspase 5	2.17	<0.05	Bcl-2	2.82	0.08
				Caspase 5	1.65	<0.05

RIP: receptor-interacting protein.
Cardiac/RIP2: cardiac/receptor-interacting protein-2.
CHK2: checkpoint kinase 2.
CIDE-a: cell death-inducing DFFA-like effector-A.
LTBR: lymphotoxin-beta receptor.
LTB: lymphotoxin-beta.
TNFB: tumor necrosis factor-beta.
PYCARD: PYD and CARD domain-containing protein.
IAP-2: inhibitor of apoptosis protein-2.

extraction of the formazan product, the wet weight of the tumor tissue was also measured and the absorbance per gram of tissue was calculated. The percent inhibition of tumor growth by each drug was calculated by comparison with the growth in untreated control wells using the following formula: Percent inhibition of tumor growth (%) = [1 − (absorbance per gram of tumor tissue in treated wells/absorbance per gram of tumor tissue in control wells)] × 100.

To determine whether TAC-101, cisplatin, and ATRA showed activity against a tumor, the 50% inhibitory concentration (IC_{50}) of each drug was calculated. Spearman's correlation coefficient analysis was used to examine correlations between the IC_{50} values for TAC-101 or ATRA and the values for cisplatin.

Results

Effect of TAC-101 and cisplatin on clear cell adenocarcinoma cell lines

As shown in Tables 1 and 2, microarray analysis of RMG-I and II cells revealed differences in the expression of apoptosis-related genes between TAC-101 and cisplatin treatment. RMG-I and -II cells were both tested twice under the same conditions to select genes that showed significant changes of expression compared with control culture (no agents).

Table 2
Down-regulated genes

	TAC-101			Cisplatin		
	Gene name	ratio	p-value	Gene name	ratio	p-value
RMG-II	TRAIL-R4	0.59	0.07	PYCARD	0.66	<0.05
	IAP-2	0.58	<0.05	Caspase 14	0.55	0.07
	Hus1	0.35	0.07	Caspase 9	0.16	<0.05
	CHK1	0.31	0.08			
	TNF-alpha	0.06	<0.05			
	TRAF6	0.04	0.09			

TRAIL-R4: tumor necrosis factor receptor superfamily.
Hus1: hydroxyurea-sensitive (check point homolog).
CHK1: checkpoint.
TNF-alpha: tumor necrosis factor-alpha.
TRAF6: TNF receptor-associated factor 6.

In RMG-I cells, the apoptosis-related molecules up-regulated by addition of TAC-101 were receptor-interacting protein (RIP), caspase 5, cell death-inducing DFFA-like effector A (CIDE-A), lymphotoxin-beta receptor (LTBR), and lymphotoxin receptor (LTB). In contrast, the only apoptosis-related molecule up-regulated by addition of cisplatin was inhibitor of apoptosis protein-2 (IAP-2). In RMG-I cells, no apoptosis-related molecules were significantly down-regulated by either of the two drugs.

In RMG-II cells, the apoptosis-related molecule up-regulated by addition of either TAC-101 or cisplatin was CAS5. In RMG-II cells, the apoptosis-related molecules down-regulated by addition of TAC-101 were IAP-2 and TNF-alpha, while the molecules down-regulated by addition of cisplatin were PYD and CARD domain-containing protein (PYCARD) as well as caspase 9.

Table 3
Activity against RMG-I tumors in nude mice (n=8)

	TV on day21 (Mean±2SD)(mm^3)	RTV (%)
C	6.26±2.05	100
T	4.55±1.60	73
P	4.55±1.76	73
T/P	2.98±0.88	48

*p<0.05, **p<0.01, by Welch's test.

Effect of TAC-101 and cisplatin on xenografts in mice

On day 21, that TAC-101 suppressed the tumor growth the most, after implantation of RMG-I cells, the treated/control ratio of the relative tumor volume (RTV = mean TV in the treated group/mean TV in the control group) × 100) was 73%, 73%, and 48% in the TAC-101 monotherapy group, cisplatin monotherapy group, and combined therapy group, respectively (Table 3). Compared with the control group and combination therapy, the RTV was significantly smaller in the combined therapy group (p<0.01, Welch's t-test). When the effect of each drug treated group was assessed (the intersection union test), RTV was found to be significantly decreased by TAC-101 monotherapy (p<0.05) and also by cisplatin monotherapy (p<0.05) compared with combination therapy. For RMG-II cells, the treated/control RTV ratio on day 21 was 68%, 80%, and 60% in the

Table 4
Activity against RMG-II tumors in nude mice (n=8)

	TV on day21 (Mean±2SD)(mm^3)	RTV (%)
C	3.54±1.21	100
T	2.41±0.47	68
P	2.85±0.59	80
T/P	2.13±0.57	60

*p<0.05, **p<0.01, by Welch's test.

Table 5
Results of Spearman's rank correlation coefficient analysis of HDRA data

	TAC-101 vs. cisplatin ($n=31$)	TAC-101 vs. ATRA ($n=24$)	Cisplatin vs. ATRA ($n=25$)
Results of the test	Positive correlation	No correlation	No correlation
Sum of square of rank difference	2626	2202	1732
Correlation coefficient rs	0.47	0.04	0.33
Z value	2.58	0.20	1.64
p-value (two-sided probability)	$p<0.01$	$p=0.84$	$p=0.10$

TAC-101 monotherapy group, the cisplatin monotherapy group, and the combination therapy group, respectively (Table 4). Compared with the control group, RTV was significantly decreased in both the TAC-101 monotherapy group and the combined therapy group (Welch's t-test: $p<0.05$ and $p<0.01$, respectively). When compared between groups which the drug used (the intersection union test) to assess the effect of those, only the cisplatin monotherapy group showed a significant decrease of RTV ($p<0.05$) compared with the combination therapy group. Body weight was monitored by measuring the average weight and the average change of weight in each group of mice. Weight loss of 15% or more indicating severe drug toxicity which is out of evaluation of antitumor activity was not detected in this study.

Effect of TAC-101 and cisplatin on surgical specimens of ovarian cancer

The IC_{50} values of TAC-101, cisplatin, and ATRA (control) were determined, and correlations were investigated by Spearman's correlation coefficient analysis.

As a result, the IC_{50} of TAC-101 showed a significant correlation with that of cisplatin ($rs=0.47$, $p<0.01$), but the IC_{50} of ATRA was not correlated with that of cisplatin ($rs=0.33$, $p=0.10$) (Table 5).

Discussion

Clear cell adenocarcinoma accounts for slightly more than 10% of all epithelial ovarian carcinoma according to FIGO [1]. In recent years, however, an increase of this type of tumor has occurred in Japan and it now accounts for about 20% of ovarian carcinoma [2]. The combination of paclitaxel and carboplatin which is a standard chemotherapy so far only achieves a low response rate of 18% and most tumors show resistance to currently available chemotherapy, resulting in a poor prognosis, thus there is an urgent need for more effective treatment [2].

We previously found that TAC-101 induces the apoptosis of various ovarian cancer cells [9], particularly RMG-I and RMG-II cells derived from clear cell adenocarcinoma. TAC-101 has also demonstrated antitumor effect comparable to that of paclitaxel and cisplatin against clear cell adenocarcinoma xenografts in nude mice [9]. Furthermore, TAC-101 shows antitumor activity against colon cancer cells [16], but its mechanism of action has not yet been elucidated for either type of cancer. Because TAC-101 induces apoptosis, we focused on apoptosis-related genes in the present study to investigate the potential mechanism of its antitumor effect. When DNA microarray analysis was performed, up-regulation of caspase 5 was found as an effect of TAC-101 and cisplatin, but was not seen with ATRA. These results are in agreement with our previous *in vitro* findings that cisplatin and TAC induce apoptosis, but ATRA does not [9], suggesting that the anticancer effect of TAC-101 and cisplatin is based on induction of apoptosis.

Although Sako et al. [17] found that TAC-101 caused up-regulation of FAS in colon cancer cells, there was no relationship between this change and induction of apoptosis by TAC-101 in ovarian clear cell adenocarcinoma based on our results obtained using RMG-I and RMG-II cells.

Microarray analysis of RMG-I and RMG-II cells revealed differences in the expression of apoptosis-related genes between TAC-101 and cisplatin. TAC-101 induced the expression of pro-apoptotic molecules such as RIP, caspase 5, CIDE-A, and TNF-alpha, while it inhibited the expression of IAP-2, an anti-apoptotic molecule, suggesting possible induction of apoptosis in ovarian clear cell adenocarcinoma cells.

In contrast, cisplatin up-regulated some anti-apoptotic factors, such as IAP and Bcl family genes, and it down-regulated pro-apoptotic factors like caspase 9. Such changes of gene expression may be related to the resistance of clear cell adenocarcinoma to cisplatin and platinum-based chemotherapy, unlike the other types of epithelial ovarian carcinoma [5]. The possibility of enhanced efficacy by concomitant administration of TAC-101 with cisplatin could also be suggested because these two drugs have different mechanisms for the induction of apoptosis. To make matters clearer and pursue the issue, further discussion is needed on the apoptotic genes and their significance on the findings as related to apoptosis; particularly, how the findings of TAC-101 suggest induction of apoptosis.

The present study also demonstrated that TAC-101 was able to inhibit the growth of clear cell adenocarcinoma tumors in mice, with the RTV being reduced to 73% and 68% of the control value for RMG-I and RMG-II tumors, respectively, while the respective values were 73% and 80% in the case of cisplatin monotherapy. Thus, TAC-101 demonstrated a similar effect to cisplatin, which is recognized as a key chemotherapy agent for ovarian carcinoma. When the combined effect of these drugs was evaluated, there was a significant decrease of tumor volume, suggesting that the combination of cisplatin and TAC-101 may be a potential new treatment for clear cell adenocarcinoma.

Although a clinical study of TAC-101 is currently underway [18], its activity against human ovarian carcinoma is still unknown. Therefore, we performed the HDRA to investigate the antitumor activity of TAC-101 against human ovarian carcinoma specimens. We previously used the HDRA to assess the response of cisplatin for ovarian carcinoma, and we found a true positive rate, true negative rate, and accuracy of 88%, 86%, and 87%, respectively [19]. We have also found that the clinical efficacy of cisplatin therapy for ovarian carcinoma can be predicted by the HDRA [19]. When patients were classified into high-sensitivity and low-sensitivity groups based on the cut-off IC_{50} value for cisplatin and the 5-year overall survival rate was

compared by the Kaplan–Meier method, it was significantly higher in the high-sensitivity group than in the low-sensitivity group [19]. Because it is not currently possible to obtain such clinical data of ovarian cancer patients for TAC-101, its effect on ovarian specimen was indirectly evaluated by comparing IC_{50} values with those for cisplatin. We found that the IC_{50} values for TAC-101 and cisplatin determined in the HDRA showed a significant positive correlation ($p<0.01$). Accordingly, the two drugs may demonstrate a synergistic effect on tumors showing a high sensitivity to cisplatin in the HDRA, because of the difference in their apoptosis-inducing effect (microarray analysis) and the stronger activity demonstrated against implanted RMG-I and RMG-II tumors by a combination of these two drugs. Further investigation is still necessary, but clinical activity of TAC-101 against ovarian carcinoma is possible based on the results of the HDRA.

In conclusion, our findings suggest that the combination of TAC-101, an orally active synthetic retinoid, and cisplatin may be a potential new treatment for clear cell adenocarcinoma.

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Establishment of an ovarian metastasis model and possible involvement of E-cadherin down-regulation in the metastasis

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Clinical observations of cases of ovarian metastasis suggest that there may be a unique mechanism underlying ovarian-specific metastasis. This study was undertaken to establish an *in vivo* model of metastasis to the ovary, and to investigate the mechanism of ovarian-specific metastasis. We examined the capacity for ovarian metastasis in eight different human carcinoma cell lines by implantation in female NOD/SCID mice transvenously and intraperitoneally. By transvenous inoculation, only RERF-LC-AI, a poorly differentiated carcinoma cell line, frequently demonstrated ovarian metastasis. By intraperitoneal inoculation, four of the eight cell lines (HGC27, MKN-45, KATO-III, and RERF-LC-AI) metastasized to the ovary. We compared E-cadherin expression among ovarian metastatic cell lines and others. All of these four ovarian metastatic cell lines and HSKTC, a Krukenberg tumor cell line, showed E-cadherin down-regulation and others did not. E-cadherin was then forcibly expressed in RERF-LC-AI, and inhibited ovarian metastasis completely. The capacity for metastasizing to the other organs was not affected by E-cadherin expression. We also performed histological investigation of clinical ovarian-metastatic tumor cases. About half of all ovarian-metastatic tumor cases showed loss or reduction of E-cadherin expression. These data suggest that E-cadherin down-regulation may be involved in ovarian-specific metastasis. (*Cancer Sci* 2008; 99: 1933–1939)

Metastasis is the major cause of death from cancer, despite significant progress in the diagnosis and clinical management of the diseases. It is urgent and essential to elucidate the mechanisms of cancer metastasis in order to improve the prognosis of cancer patients. Generally, metastasis consists of multiple events initiating invasion to the basement membrane and connective tissue, followed by migration into an adjacent blood or lymphatic vessels and the reaching of distant organs. The last step in metastasis is the arrest of circulating cancer cells and formation of tumor foci at the target organ.[1–4] Two mechanisms have been proposed underlying the multiple steps of metastasis.[5,6] One theory, that floating cancer cells in the blood or lymphatic stream are trapped in capillary vessels by mechanical constraints and grow to form secondary foci, simply correlates with the blood or lymphatic flow pattern. Metastasis of colon cancer to the liver may follow this anatomical theory, for instance; however, the other is a more complicated hypothesis based on molecular interactions between cancer cells (seeds) and the microenvironment of the target organ (soil). This 'seed and soil' theory can explain organ-specific metastasis such as the bone metastasis of prostate cancer,[7] brain metastasis of breast cancer,[8] and so on.

The incidence of metastatic ovarian tumors has been reported to comprise 7–10% of all ovarian cancer.[9,10] The common sources of ovarian metastatic tumors are the stomach, colon and rectum, appendix, breast, uterus, lung, and skin (melanoma).[11–14] Interestingly, bilateral lesions are found in 50–70% of patients,[10–12] and there are several reports of cases of intramucosal gastric cancers with ovarian metastasis.[15,16] These clinical data, which indicate the propensity of some tumor subsets for metastasis to the ovary, suggest the existence of unknown mechanisms underlying ovarian-specific metastasis.

Among metastatic tumors in the ovary, there is an interesting and controversial subset of tumors named Krukenberg tumors. The term 'Krukenberg tumor' has sometimes been loosely applied to any adenocarcinoma metastasizing to the ovary; however, most investigators used the classical criteria for the diagnosis of Krukenberg tumor as follows: (1) cancer in the ovary; (2) intracellular mucin production by neoplastic signet-ring cells; and (3) diffuse sarcomatoid proliferation of ovarian stroma.[17,18] The mechanisms that develop these morphologic alterations are not clear, but the significant stromal proliferation suggests that some tumor–stroma interactions may be involved in ovarian-specific metastasis.

To elucidate the mechanisms underlying ovarian-specific metastasis, an *in vivo* model of ovarian metastasis is definitely needed. To date, however, such a model has never been established. In our experiments, eight different human carcinoma cell lines were implanted in immune-deficient mice by transvenously and intraperitoneally. We examined the capacity for ovarian metastasis of these cell lines, and succeeded in establishing an *in vivo* ovarian-metastasis model with stromal reaction in the ovarian tumor. We further investigated whether E-cadherin down-regulation might be involved in ovarian-specific metastasis, because all cell lines revealing some capacity for metastasis to the ovary showed loss or reduction of E-cadherin expression.

Materials and Methods

Cell cultures. We used eight human carcinoma cell lines, as shown in Table 1. The characteristics and origins of MKN-28, MKN-45, MKN-74, TMK-1, and KATO-III are described elsewhere.[19,20] HGC27, HSKTC,[21] and RERF-LC-AI were purchased from RIKEN BioResource Center, Japan. HGC27 and RERF-LC-AI were maintained in MEM (Gibco/Invitrogen, Carlsbad, CA, USA) with 10% fetal bovine serum (FBS; PAA Laboratories, Ontario, Canada). HSKTC were maintained in F-12 HAM (Sigma-Aldrich, St. Louis, MO, USA) with 15% FBS and 2-mM L-glutamine. The other cell lines were maintained in RPMI-1640 (Sigma-Aldrich) with 10% FBS. All media were also supplemented with 100-μg/mL ampicillin and 100-μg/mL streptomycin. All cells were incubated at 37°C under 5% CO_2 and harvested from subconfluent cultures.

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Table 1. Human carcinoma cell lines inoculated into mice

Cell line	Origin
HGC27	Poorly differentiated gastric carcinoma
TMK-1	Poorly differentiated gastric carcinoma
MKN-45	Poorly differentiated gastric carcinoma
MKN-28	Moderately differentiated gastric carcinoma
MKN-74	Moderately differentiated gastric carcinoma
KATO-III	Gastric signet ring cell carcinoma
HSKTC	Krukenberg tumor
RERF-LC-AI	Poorly differentiated lung carcinoma

Animals. NOD/SCID (NOD/LtSz-scid) mice were maintained in a specific pathogen-free environment. Six- to 8-week-old mice were used in this experiment. Studies were conducted in accordance with the National Institutes of Health Guide for the Care and Use of Laboratory Animals.

Metastatic screening assays. Cells were suspended in the corresponding medium and inoculated into mice by injection into the tail vein (1×10^6 cells in 100 μL per mouse) and peritoneal cavity (1×10^7 cells in 100 μL per mouse). Mice were sacrificed when they became moribund and were evaluated for the organ distribution of established tumors. All experiments were performed under appropriate anesthesia. The resected tissues were fixed in 10% formalin, cut into 2- to 3-mm-thick slices, and embedded in paraffin for subsequent histological examination.

Immunoblotting. Cells were lysed in a buffer consisting of 25 mmol/L Tris-HCl (pH 8.0), 5 mmol/L ethylenediaminetetraacetic acid (EDTA), 125 mmol/L NaCl, 0.5% Triton X-100, 0.5% NP-40 (Sigma-Aldrich), and protease inhibitor mixture (Roche Diagnostics). After centrifugation at 20400g for 15 min, the supernatant was obtained. All 30-μg cell lysates were subjected to sodium dodecyl sulfate–polyacrylamide gel electrophoresis and then separated proteins were transferred to Hybond-P (Amersham Biosciences, Buckinghamshire, UK). After blocking, an anti-E-cadherin mouse monoclonal antibody (dilution 1:2500; Becton Dickinson, NJ, USA) or anti-β-actin mouse monoclonal antibody (dilution 1:1000; Sigma-Aldrich) was incubated for 1 h at room temperature. The membrane was incubated with a horseradish peroxidase–conjugated secondary antibody (Dako, Glostrup, Denmark) and visualized using an enhanced chemiluminescence kit (Amersham Biosciences).

Transfection. A PEF1/Myc-His vector plasmid containing the murine E-cadherin gene or an empty vector plasmid (kindly provided by Dr Shibata at the National Cancer Center Research Institute, Tokyo, Japan) was transfected into RERF-LC-AI using the Lipofectamine LTX Reagent (Invitrogen) according to the manufacturer's protocol. A neomycin resistance gene on the vectors was used to create geneticin-resistant stable clones.

Immunofluorescence. RERF-LC-AI and its transfectant clones were grown on collagen type I-coated culture slides (Becton Dickinson) and fixed in 4% formalin for 10 min. They were permealized with 0.1% Triton-X-100, blocked in 5% normal rabbit serum, and incubated with an anti-E-cadherin mouse monoclonal antibody overnight at 4°C, followed by an fluorescein-isothiocyanate–labeled secondary antibody (Dako) for 30 min at room temperature. The primary antibody was used at 1:100 and the secondary antibody at 1:50 dilution in 5% normal rabbit serum. Texas Red-X phalloidin (Molecule Probes, Eugene, OR, USA) and Hoechst (Molecule Probes) were used to visualize filamentous actin and the nucleus, respectively. Slides were examined using a Zeiss confocal laser scanning microscope (Axiovert 200 M LSM510-Software; Carl Zeiss, Göttingen, Germany).

Patients and tissue samples. To investigate clinical ovarian metastatic tumor cases, 25 operated cases and five autopsies were analyzed. In all cases, macroscopic enlargement of the ovary was observed. Sections were prepared from formalin-fixed, paraffin-embedded tissues of samples resected surgically between 1989 and 2005. This study was conducted under the approval of the Ethics Committee of Keio University, School of Medicine.

Immunohistochemistry. Each section was deparaffinized, rehydrated, and incubated with fresh 0.3% hydrogen peroxide in methanol for 30 min at room temperature. For antigen retrieval, sections were boiled in pH 6 (E-cadherin staining of mouse samples) or pH 7 (smooth muscle actin [SMA] staining and human-specific cytokeratin; CAM 5.2) citrate buffer for 10 min, or autoclaved in pH 7 citrate buffer (E-cadherin staining of human samples), or incubated in 0.1% tripsin at 37°C for 20 min (pankeratin staining). The sections were then incubated with primary antibodies for 1 h at room temperature. The primary antibodies and dilutions were as follows: anti-E-cadherin monoclonal antibody (1:5000; BD Transduction Laboratory) for mouse samples, anti-E-cadherin monoclonal antibody (1:500; HECD1[22]) for human samples, anti-AE1/AE3 monoclonal antibody (1:200; Dako), anti-SMA monoclonal antibody (1:200; Dako), and anti-CAM 5.2 monoclonal antibody (1:20; BD Transduction Laboratory). The sections were washed three times in phosphate-buffered saline, and incubated with the secondary antibody, Immpress Reagent (Vector Laboratories), for 30 min at room temperature.

Statistical analysis. The ages of the patients with clinical ovarian metastatic tumor were compared using the Mann–Whitney *U*-test. Other correlations were analyzed by the χ^2-test. All calculations were performed with ystat2000 (Igaku Tosho Shuppan, Tokyo, Japan).

Results

Examination of the capacity for ovarian metastasis in the eight cell lines and establishment of an ovarian-metastasis model. Using transvenous inoculation to NOD/SCID mice, the tumorigenicity of the eight human cancer cell lines was extremely low in our examination. Almost all cell lines did not show any tumorigenicity, including in the lung or liver. Only RERF-LC-AI, however, formed tumors in several organs (Table 2). RERF-LC-AI metastasized to the lung at 100%, which was considered to be a natural result because this cell line was originally derived from a lung cancer, and also because the lung should generally be the first organ that cells reach after injection into the tail vein. RERF-LC-AI most frequently metastasized to the ovary (67%) after the lung, and bilateral lesions were observed in one-third of ovarian metastatic cases (Table 2, Fig. 1a). Therefore, it was considered that RERF-LC-AI had a high propensity for ovarian metastasis, and that the experimental system of transvenous inoculation of this cell line to NOD/SCID mice could be used

Table 2. Organ distribution of experimental metastasis after transvenous inoculation of RERF-LC-AI

Organ							Days after inoculation
Ovary (unilateral/bilateral)	Peritoneal dissemination	Ascites	Pancreas	Liver	Lung	Bone/bone marrow	
3/5 (60%) (2/1)	1/5 (20%)	0/5 (0%)	1/5 (20%)	0/5 (0%)	5/5 (100%)	1/3 (33%)	53–94

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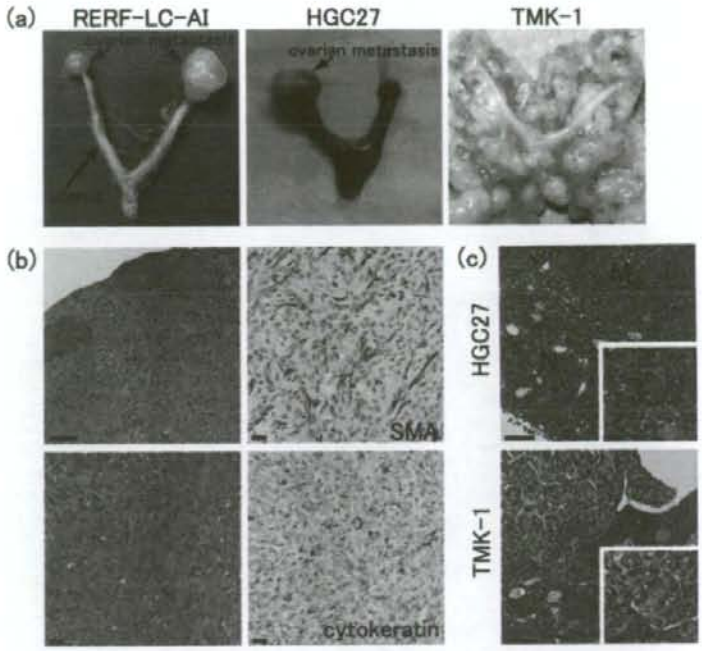

Fig. 1. Experimental metastasis by inoculation of human carcinoma cell lines. (a) Macroscopic findings of mouse ovarian tumors. Transevenous inoculation of RERF-LC-AI and intraperitoneal inoculation (i.p.) of HGC27 caused bilateral and unilateral enlargement of the ovaries, respectively. In the i.p. experiment of TMK-1, the ovaries were entirely buried in the disseminated tumor. (b) Histology and immunohistochemistry (smooth muscle actin [SMA] and human specific cytokeratin) of mouse ovarian tumors of RERF-LC-AI. Bar = 100 μm (left upper), 20 μm (the others). RERF-LC-AI cells diffusely infiltrated the ovary, and there remained only little normal ovarian tissue. In metastatic tissue, stromal reaction of ovarian fibroblasts was observed. (c) Histology of ovarian tumors established by i.p. of HGC27 and TMK-1. Insets show larger magnification of the tumor (HGC27) and the border region of tumor and normal ovarian tissue (TMK-1). HGC27 cells proliferated in the ovary (M), and normal ovarian tissue (N) remained in lower part of the figure, surrounding the metastatic tumor. This finding indicates metastasis to the ovaries, not invasion. With TMK-1, we observed the invasion of cancer cells from the surface of the ovary. Bar = 100 μm, 10 μm (insets).

Table 3. Organ distribution of experimental metastasis after intraperitoneal inoculation of the different cell lines

Cell line	Organ						Days after inoculation
	Ovary (unilateral/bilateral)		Peritoneal dissemination	Ascites	Liver	Lung	
	Metastasis	Invasion					
TMK-1	0/10 (0%)	5/10 (50%) (5/0)	10/10 (100%)	10/10 (100%)	6/10 (60%)	0/10 (0%)	21–24
HGC-27	1/9 (11%) (1/0)	0/9 (0%)	9/9 (100%)	0/9 (0%)	3/9 (33%)	3/9 (33%)	49–72
MKN-45	1/5 (20%) (0/1)	0/5 (0%)	5/5 (100%)	2/5 (40%)	1/5 (20%)	2/5 (40%)	45–86
MKN-28	0/8 (0%)	2/8 (25%) (2/0)	8/8 (100%)	6/8 (75%)	5/8 (63%)	2/8 (25%)	30–45
MKN-74	0/5 (0%)	0/5 (0%)	4/5 (80%)	0/5 (0%)	2/5 (40%)	0/5 (0%)	33–104
KATO-III	1/4 (25%) (1/0)	0/4 (0%)	2/4 (50%)	0/4 (0%)	2/4 (50%)	0/4 (0%)	101–164
HSKTC	0/12 (0%)	0/12 (0%)	1/12 (8%)	0/12 (0%)	0/12 (0%)	0/12 (0%)	119–264
RERF-LC-AI	1/4 (25%) (1/0)	0/4 (0%)	4/4 (100%)	4/4 (100%)	1/4 (25%)	1/4 (25%)	37

as an *in vivo* model of ovarian metastasis. Histologically, three-quarters of the ovarian tumors in this model demonstrated a stromal reaction, mimicking the sarcomatoid proliferation of ovarian fibroblasts in Krukenberg tumor (Fig. 1b).

Because the formation of tumor foci after transvenous inoculation of the examined cell lines was extremely rare, we also inoculated each cell line intraperitoneally. In this experiment, peritoneal dissemination was observed most often in six of the eight cell lines (Table 3). Ovarian involvement was also observed in these six cell lines; however, in the cases of TMK-1 and MKN-28, the ovaries were buried in the disseminated tumors, and the cancer cells were considered to invade the ovaries directly from predominant adjacently disseminated tumors. On the other hand, by inoculation with HGC27, MKN-45, KATO-III, and RERF-LC-AI, significant enlargement of the ovary without adjacent dissemination was observed (Fig. 1a,c). These four cell lines are considered to have some capacity for metastasizing to the ovary, but even in RERF-LC-AI, ovarian metastasis occurred at only a low percentage by intraperitoneal inoculation (i.p.). After i.p. of RERF-LC-AI, mice became moribund and were sacrificed earlier than after transvenous inoculation (37 days *vs* 53–94 days) (Tables 2 and 3). It can be speculated that in i.p. cases, peritoneal dissemination might debilitate mice so rapidly that ovarian metastasis could hardly be observed when they were sacrificed.

HSKTC, a rare cell line derived from Krukenberg tumor,[21] was also used in our examination. Unfortunately, its tumorigenicity was extremely low, even by intraperitoneal inoculation, and we could not evaluate its affinity for the ovary in *in vivo* experiments.

Down-regulation of E-cadherin in ovarian-metastatic carcinoma cell lines. To characterize the four metastatic cell lines, we searched the common features concerning gene expression. Although we examined the expression of some chemokines and their receptors, these molecules were not commonly expressed in the four cell lines. Then we focused on another molecule,

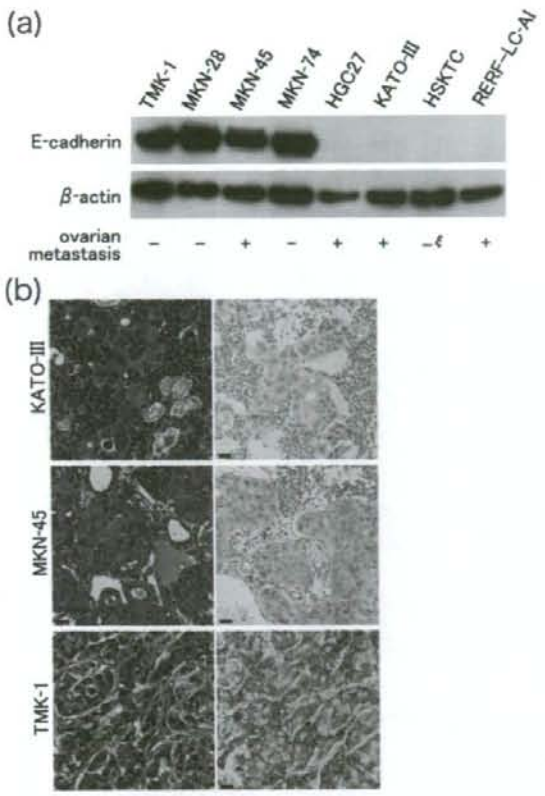

Fig. 2. E-cadherin expression in different carcinoma cell lines. (a) Immunoblot analysis of eight human carcinoma cell lines. Of the four cell lines which clearly metastasized to the ovary, all but MKN-45 demonstrated loss of E-cadherin expression. A Krukenberg tumor cell line, named HSKTC, was also negative for E-cadherin, although it showed extremely poor tumorigenicity in NOD/SCID mice (§). All non-'ovarian-metastatic' cell lines expressed E-cadherin strongly. (b) Hematoxylin–eosin staining and E-cadherin immunohistochemical staining of ovarian lesions of KATOIII and MKN-45, and disseminated tumor of TMK-1. KATO-III was negative for E-cadherin, and MKN-45 showed only weak staining of the cytoplasm. TMK-1 demonstrated positive staining of the cell membranes. Bar = 20 μm.

E-cadherin, whose down-regulation and inactivation in these cells have been reported previously.[23,24] We examined E-cadherin expression of the eight carcinoma cell lines by immunoblot analysis and immunohistochemical staining of mouse tumors. The three of four 'ovarian-metastatic' cell lines and HSKTC showed loss of E-cadherin expression in immunoblot analysis and immunohistochemistry (Fig. 2a,b). Although MKN-45, an 'ovarian-metastatic' cell line, was E-cadherin-positive in immunoblot analysis, its metastatic tumor demonstrated only weak cytoplasmic staining by E-cadherin immunohistochemistry (Fig. 2b). Dysfunctional E-cadherin by an in-frame deletion mutation of the gene in MKN-45 cells[23] seems to be involved in the cytoplasmic localization. On the other hand, non-'ovarian-metastatic' cell lines TMK-1, MKN-28, and MKN-74, were positive on E-cadherin immunoblotting and also showed strong membranous staining in immunohistochemistry.

Inhibition of ovarian metastasis by E-cadherin expression. To investigate whether E-cadherin down-regulation has any effect on ovarian metastasis, the murine E-cadherin gene was transfected into RERF-LC-AI, which showed a high propensity for metastasis to the ovary by transvenous inoculation. Transfectant clones were confirmed to express E-cadherin by immunoblot analysis (Fig. 3a), and immunocytochemistry proved the localization of E-cadherin on cell membranes (Fig. 3b). Three high-expressing clones (LC CDH1-1, -6, -8) and two empty vector-expressing clones (LC vector-3, -4) were inoculated into immune-deficient mice by intravenous injection. None of the E-cadherin transfectants showed tumorigenicity in the ovaries, while mock cells metastasized to the ovaries at high frequency (Table 4). The capacity for metastasis to other organs, such as the pancreas and lung, was maintained in all of the transfectants examined. E-cadherin expression of mouse metastatic tumors of LC CDH1-1, -6, and -8 was confirmed by immunohistochemistry (Fig. 3c). These data indicate that E-cadherin expression specifically inhibited ovarian metastasis in our model.

Classification of clinical ovarian-metastatic tumors by E-cadherin expression. In order to identify whether E-cadherin down-regulation is also observed in clinical cases, we classified 30 cases of ovarian-metastatic tumor by E-cadherin expression examined by immunohistochemistry (Table 5 and Fig. 4). Loss or reduction of E-cadherin expression was observed in 14 cases, and this subset of tumors showed significant associations with a younger population, stomach origin, bilateral involvement of the ovaries, poor differentiation, and stromal proliferation. The other 16 cases demonstrated a strong expression of E-cadherin. Most of these tumors were of colonic origin and well differentiated. Stromal proliferation was rarely observed in E-cadherin-positive cases.

Discussion

Organ-specific metastasis has been investigated intensively and the underlying mechanism has been partly elucidated in several types of carcinoma.[5] The findings of diverse molecules, such as chemokines, growth factors and so on, signal pathways, and new genes have enabled new developments in this field;[1,5] however, there has been no basic research on ovarian-specific metastasis. In the present study, we examined the capacity for metastasis to the ovary in different human carcinoma cell lines. Implantations of the cell lines into NOD/SCID mice were performed

Table 4. Organ distribution of experimental metastasis after transvenous inoculation of RERF-LC-AI transfectants

Transfectant	Organ							Days after inoculation
	Ovary (unilateral/bilateral)	Peritoneal dissemination	Ascites	Pancreas	Liver	Lung	Bone/bone marrow	
LC/CDH1-1	0/5 (0%)	1/5 (20%)	0/5 (0%)	1/5 (20%)	0/5 (0%)	5/5 (100%)	0/5 (0%)	68–163
LC/CDH1-6	0/5 (0%)	3/5 (60%)	0/5 (0%)	0/5 (0%)	0/5 (0%)	3/5 (60%)	0/5 (0%)	70–91
LC/CDH1-8	0/5 (0%)	2/5 (40%)	0/5 (0%)	5/5 (100%)	0/5 (0%)	5/5 (100%)	1/5 (20%)	53–72
LC/vector-3	4/5 (80%) (2/2)	1/5 (20%)	1/5 (20%)	3/5 (60%)	1/5 (20%)	4/5 (80%)	1/5 (20%)	31–66
LC/vector-4	3/4 (75%) (1/2)	4/4 (100%)	2/4 (50%)	3/4 (75%)	1/4 (25%)	4/4 (100%)	0/4 (0%)	66–86

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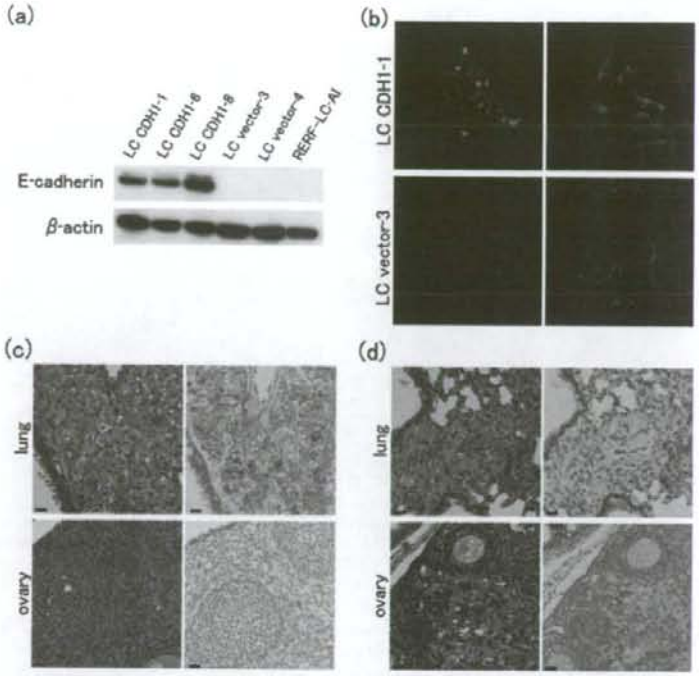

Fig. 3. Expression of E-cadherin in RERF-LC-AI transfectants (a,b) and representative findings of mouse tumors of the transfectants ([c] LC CDH-1 [d] LC vector-3). (a) Immunoblot analysis. E-cadherin transfectants were positive for E-cadherin, while mock clones and the parent cell line were negative. (b) Immunocytochemistry of LC CDH1-1, LC vector-3. Staining of E-cadherin (fluorescein-isothiocyanate–green), filamentous actin (phalloidin-red). LC CDH1-1 cells expressed E-cadherin, and merged staining of E-cadherin, actin, and nucleus (Hoechst-blue) showed membranous colocalization at the cell junction. (c,d) Hematoxylin–eosin staining and E-cadherin immunohistochemistry of the tumors. All clones tested showed tumorigenicity in the lung, and the lung tumors of E-cadherin transfectants showed E-cadherin expression in immunohistochemical staining. None of the E-cadherin transfectants metastasized to the ovary, while the mock clones showed high capacity for ovarian metastasis. Bar = 20 μm.

Table 5. Classification of clinical ovarian metastatic tumors by E-cadherin expression

Variables	E-cadherin expression		*P*-values
	Negative or weakly positive	Positive	
Number of cases	14	16	
Median age	48.6 (29–77)	59.2 (46–78)	0.014*
Primary organ			0.028**
Stomach	10	3	
Colon	2	13	
Breast	1	0	
Unclear	1	0	
Ovarian involvement			0.043*
Bilateral	11	8	
Unilateral	1	7	
Unclear	2	1	
Peritoneal dessemination			0.14
Positive	11	8	
Negative	3	8	
Histological findings of ovarian metastatic tumor			
Differentiation			0.00002**
Well or Moderate	0	12	
Poor	14	4	
Stromal proliferation			0.0002**
Positive	11	2	
Negative	3	14	

*$P < 0.05$; **$P < 0.01$.

transvenously and intraperitoneally. By clinical descriptions,[16,25,26] systemic circulation, peritoneal dissemination, and the lymphatic pathway are thought to be potential anatomical routes for metastasizing to the ovary. In our present model, hematogenous spread as well as the lymphatic pathway may be involved in the ovarian-specific metastasis by both transvenous and intraperitoneal inoculation. Transvenous inoculation of RERF-LC-AI and its transfectants of empty vector caused ovarian metastasis with remarkably high frequency, although the cells also metastasized to the other several organs. It could be considered that there

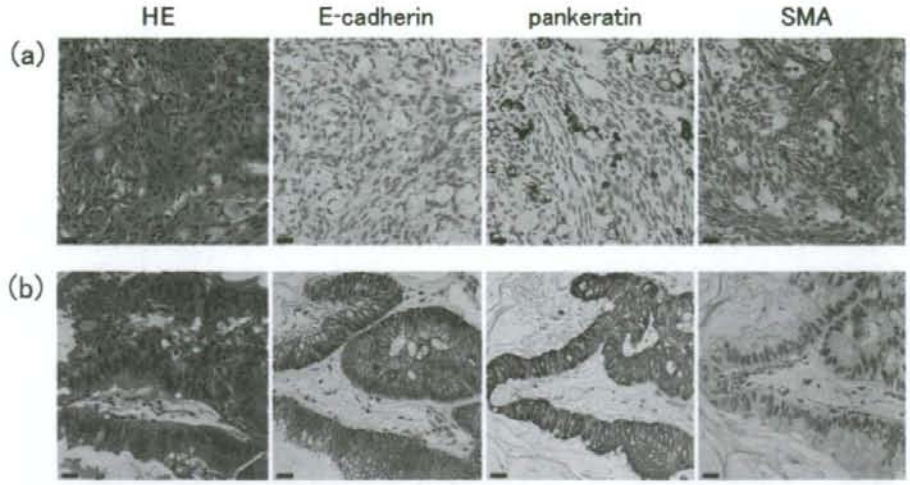

Fig. 4. Representative findings of ovarian metastatic tumors in clinical cases, hematoxylin–eosin (HE) and immunohistochemical staining. E-cadherin-negative or weakly positive case (a) and E-cadherin-positive case (b). HE staining and immunohistochemistry of E-cadherin, pankeratin (AE1/AE3), and smooth muscle actin (SMA). In (a), loss of E-cadherin expression and stromal proliferation were observed. In (b), metastatic tumor of well-differentiated adenocarcinoma showed E-cadherin positivity and relatively poor proliferation of stroma. Bar = 20 μm.

established an *in vivo* model of 'preferential' metastasis to the ovary, and then we utilized this model for investigation of molecular mechanisms of ovarian-specific metastasis.

Because all of the cell lines which metastasized to the ovary by intraperitoneal inoculation showed loss or reduction of E-cadherin expression on immunoblotting and/or immunohistochemistry, we hypothesized that E-cadherin down-regulation might be involved in the mechanism of ovarian-specific metastasis. To examine this hypothesis, RERF-LC-AI was transfected with the murine E-cadherin gene and inoculated into NOD/SCID mice transvenously. Forced expression of E-cadherin in RERF-LC-AI inhibited ovarian metastasis entirely and specifically, as it hardly affected metastasis to the other organs. E-cadherin is a transmembrane glycoprotein localized in the adherens junctions of epithelial cells and acts as a calcium-dependent adhesion molecule.[27] The reduction of E-cadherin expression increases mitotic activity of cancer cells, and promotes invasion and metastasis in general;[28,29] however, the results of our experiments indicate that loss or reduction of E-cadherin expression may promote, in particular, ovarian-specific metastasis. It has been shown that the germ line inactivating mutations in the E-cadherin gene causes hereditary diffuse gastric cancer syndrome, which is characterized by a high risk for diffuse gastric cancer and lobular breast cancer,[30,31] tumors that are associated with increased incidence of ovarian metastasis.[16,32] These data also support the hypothesis that E-cadherin down-regulation might be involved in ovarian-specific metastasis. Because it is hard to explain such involvement by only the function of E-cadherin as an adhesion molecule, there may be other unknown regulatory functions of E-cadherin, which can inhibit metastasis to the ovary.

Especially in organ-specific metastasis, the final step in metastatic events, where circulating cancer cells arrest and form tumor foci at distant sites, is considered to be an essential factor in specificity.[5,6] Those factors depend on the association of the characters of cancer cells and the microenvironment of the distant organ. For instance, osteoblastic bone metastasis of prostate carcinoma is closely associated with a series of biological interactions between tumor cells and bone cells where metastatic tumor cells release growth factors that in turn activate osteoblasts.[7] In classical Krukenberg tumor, ovarian stroma proliferates sarcomatously.[25,26] It can be hypothesized that there may be significant interaction between some types of cancer cells and ovarian stromal cells. Such tumor–stroma interaction may cause unique stromal proliferation and, perhaps as a result, help ovarian-specific metastasis. In our histological examination of clinical ovarian metastatic tumors, loss or reduction of E-cadherin expression was observed in about half of the cases. Interestingly, significant stromal proliferation and E-cadherin down-regulation emerged almost synchronously. Our *in vivo* model also demonstrated both E-cadherin down-regulation in RERF-LC-AI cells and stromal reaction in the ovary. Reduction of E-cadherin may be necessary for possible tumor–stroma interaction in ovarian-metastatic tumors.

In our clinical examination, most primary organs of E-cadherin down-regulated tumors were the stomach or breast, which are anatomically distant from the ovary. On the other hand, the majority of E-cadherin-positive tumors metastasized from the colon, which is relatively close to the ovary. This type of ovarian metastasis is considered to simply depend on anatomical proximity. Therefore, it is speculated that there are multiple types of metastasis to the ovary. The metastasis from relatively distant organs, which could be due to some propensity of cancer cells for ovarian metastasis and be regarded as ovarian-specific metastasis, may require E-cadherin down-regulation. In such type of metastasis, the interaction of carcinoma cells and ovarian stromal cells may help the metastasis.

In conclusion, we established an *in vivo* model of transvenous metastasis to the ovary. Our experiments using this model and investigation of clinical cases suggest the involvement of E-cadherin down-regulation in ovarian-specific metastasis.

Acknowledgments

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【子宮体癌 2】

再発に対するレジメンとその有効性

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はじめに

本邦における子宮体癌の発症頻度は欧米と比較して低く，ほかの婦人科がんと比較して比較的予後良好な疾患とされてきた．しかし，最近では罹患数の著しい増加に伴い，臨床の現場では再発の症例に遭遇することも少なくない状況となってきている．National Comprehensive Cancer Network (NCCN) の子宮体癌ガイドラインにおいても再発子宮体癌の治療法は多岐にわたり，明確な指針がないのが現状である．当然ながら，治療法の選択は臨床試験により集積されたエビデンスに基づいてなされるべきであり，臨床試験のデザインが比較的容易であることから再発子宮体癌の化学療法を対象とした大規模な臨床試験がすでに行われ，新しいエビデンスが得られつつある．また，再発子宮体癌に対するprogesterone製剤をはじめとする内分泌療法についてもさまざまな報告がなされている．

本稿では，再発・進行子宮体癌を対象としたランダム化比較試験におけるレジメンの変遷とその有効性を概説するとともに，内分泌療法についても触れることによって再発子宮体癌の化学療法を考察し，今後の展望について紹介する．

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単剤化学療法

現在までに報告されている子宮体癌に対する各種抗癌剤のなかで，単剤で20％を超える奏効率を認めるものとして，anthracycline系薬剤のadriamycin (ADM)，epirubicin (EPI)，platinum系薬剤のcisplatin (CDDP)，carboplatin (CBDCA)，taxane系薬剤のpaclitaxel (PTX)，docetaxel (DOC) が挙げられる（表1[1〜7]）．

ADMはGynecologic Oncology Group (GOG) studyにより37％の奏効率が報告され[1]，現在に至るまで子宮体癌のkey drugとされている．Platinum系薬剤はCDDPで20〜42％，CBDCAで27〜33％の奏効率が報告されており[3,4]，anthracycline系薬剤と同様にkey drugの1つと考えられている．ADMの作用機序としては，DNAと複合体を形成することによりDNA polymerase反応，RNA polymerase反応を阻害し，DNAとRNA双方の生合成を抑制する．一方，DNA鎖とinterstrand crosslinkを形成して結合し，DNA合成およびそれに引き続く癌細胞分裂の阻害がCDDPの作用機序である．

また，比較的最近導入されたtaxane系薬剤の奏効も報告されており，作用機序としてはtubulinの重合を促進し，微小管を過剰形成させるとともに，脱重合抑制により形成された微小管の安定化であることが知られている．PTXは，本邦で施行された第Ⅱ相試験によると，再発・進行癌23例に対して30.4％の奏効率が報告されている[6]．

表1　単剤化学療法第Ⅱ相試験

	症例数	奏効率（%）	PFS中央値（月）	文献
Doxorubicin (60 mg m^2・every 3 weeks)	43	37	5	1)
Epirubicin (80 mg m^2・every 3 weeks)	27	26	9.5	2)
Cisplatin (50 mg m^2・every 3 weeks)	49	20	2.9	3)
Carboplatin (400 mg/m^2・every 4 weeks)	64	17	—	4)
Paclitaxel (24h) (250 mg/m^2/24h・every 3 weeks)	28	36	7	5)
Paclitaxel (3h) (210 mg/m^2/3h・every 3 weeks)	23	30	4.3	6)
Docetaxel (70 mg/m^2・every 3 weeks)	32	31	3.9	7)

PFS : progressive free survival

またDOCは，同じく本邦で施行された第Ⅱ相試験の結果から31.3％の奏効率が得られている[7]．これらの成績をもとに，本邦では2005年より子宮体癌に対してtaxane系製剤が保険適用とされた．

以上のように，anthracycline系，platinum系，taxane系薬剤などは単剤で20～37％と比較的高い奏効率を認めているが，complete responseが得られるものは少なく，その効果としても奏効期間は2.9～5か月，生存期間の中央値は1年未満である．

多剤併用化学療法

多剤併用化学療法は，単独で有効とされ，かつ異なる機序の抗癌剤を組み合わせ，その相加・相乗効果でより高い奏効率を得ることを目的としている．しかしながら，各施設間での個々の結果を比較することは，背景も異なっており，またselection biasも存在することから正確な評価とはなりえない．そこで，より高いエビデンスを追求するにはランダム化比較試験（RCT）が必要となる．以下に再発・進行子宮体癌を対象とした，特にGOGでのランダム化第Ⅲ相試験の変遷について，比較したレジメンとその結果を述べていく（**表2**[1,8～11]，**図1**）．

1994年に報告されたGOG48試験（ランダム化第Ⅲ相試験）の対象は，前治療として化学療法の行われていない再発・進行子宮体癌である．ただし，前治療として放射線療法とprogestin製剤は許容されている．比較レジメンはADM 60 mg/m^2 3週ごとv.s. AC（ADM 60 mg/m^2 + CPA 500 mg/m^2）療法3週ごとであり，結果としては，ADM単剤とAC療法の奏効率はそれぞれ22％と30％でAC療法が有意に優れていたが，無増悪生存期間および全生存期間では明らかな有意差は認められず，CPAの併用効果は否定された．

次いで，2004年に報告されたGOG107試験（ランダム化第Ⅲ相試験）は，対象を化学療法治療歴のない，stageⅢ，Ⅳの進行子宮体癌と初回治療で手術療法および/もしくは放射線療法が施行された再発子宮体癌とし，比較レジメンはADM 60 mg/m^2 3週ごとv.s. AP（ADM 60 mg/m^2 + CDDP 50 mg/m^2）療法3週ごとであった．結果は，奏効率においてはADM単剤の25％に対しAP療法が42％と有意に優れており（p = 0.004），加えて無増悪生存期間も中央値でそれぞれ3.8か月と5.7か月（p = 0.014）とAP療法はADM単剤治療よりも有意に優れていた．全生存期間の中央値で

表2　多剤併用化学療法第Ⅲ相試験

	レジメン	症例数	奏効率（%）	PFS中央値（月）	生存期間中央値（月）	文献
GOG 48	A	132	22	3.2	6.9	1)
	AC	144	30	3.9	7.3	
			(NS)	(NS)	(p＝0.048)	
GOG 107	A	150	25	3.8	9.2	8)
	AP	131	42	5.7	9.0	
			(p＝0.004)	(p＝0.014)	(NS)	
EORTC 55872	A	87	17	7	7.0	9)
	AP	90	43	8	9.0	
			(p＜0.001)	(NS)	(NS)	
GOG 163	AP	157	40	7.2	12.6	10)
	AT	160	43	6	13.6	
			(NS)	(NS)	(NS)	
GOG 177	AP	129	34	5.3	12.3	11)
	TAP	134	57	8.3	15.3	
			(p＜0.01)	(p＜0.01)	(p＝0.037)	
GOG 209	TAP			on going		
	TC					
JGOG 2043	AP					
	TC			on going		
	DP					

A : adriamycin, AC : adriamycin＋cyclophosphamide, AP : adriamycin＋cisplatin, AT : adriamycin＋paclitaxel, TAP : paclitaxel＋adriamycin＋cisplatin, TC : paclitaxel＋carboplatin, DP : docetaxel＋cisplatin
PFS : progressive free survival, NS : no significance

は9.0か月と9.2か月と有意差は認められなかったものの，AP療法は毒性も許容できると考えられたことから，ADM単剤と並んでAP療法も進行・再発子宮体癌に対する有用な化学療法レジメンの1つと考えられるようになり，GOGのこれ以降のランダム化第Ⅲ相試験ではAP療法が再発・進行子宮体癌の標準治療群とされるようになった．

この結果を追証する形で2003年に報告されたEORTC55872試験（ランダム化第Ⅱ/Ⅲ相試験）は，対象を化学療法治療歴のない再発・進行子宮体癌とし，比較レジメンはADM 60 mg/m² 4週ごとvs. AP（ADM 60 mg/m²＋CDDP 50 mg/m²）療法4週ごとであった．結果は，AP療法が，ADM単剤治療に対し，奏効率がそれぞれ43％と17％（p＜0.001）と有意に優れていた．毒性もGOG107試験の結果とほとんど差がなく，有効性・安全性ともにGOG107試験が検証された形となり，AP療法は進行・再発子宮体癌の標準的化学療法と考えられるようになった．しかし，全生存期間に関してはGOG107試験と同様，有意差は認められなかった．

続いて，taxane系製剤の単剤投与での高い奏効率を認めた報告[5]を背景に2004年にはGOG163試験（ランダム化第Ⅲ相試験）が報告された．この試験の対象は化学療法治療歴のない，stage Ⅲ，Ⅳの進行子宮体癌，再発子宮体癌とされ，比較レジメンはAP療法v.s. AT療法（ADM 50 mg/m²＋PTX 150 mg/m² 24時間投与＋G-CSF併用3週ごと）であった．結果は，AP療法とAT療法間で，奏効率がそれぞれ40％，43％，無増悪生存期間中央値がそれぞれ7.2か月，6か月，全生存期間中央値がそれぞれ12.6か月，13.6か月と有意差を認めず，血液毒性と上部消化管障害でも有意差を認めなかった．この試験ではPTXの24時間投与とG-CSFサポートを必要とするAT療法についてADMと併用する薬剤をCDDPからPTXに変

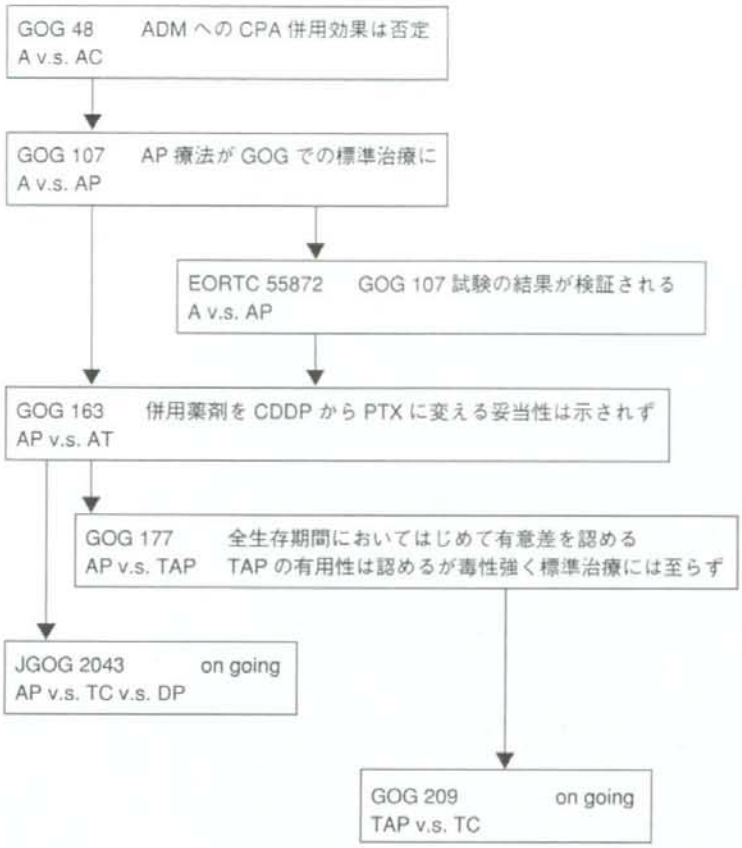

図1　再発子宮体癌に対するRCTの変遷

A : adriamycin, AC : adriamycin + cyclophosphamide, AP : adriamycin + cisplatin, AT : adriamycin + paclitaxel, TAP : paclitaxel + adriamycin + cisplatin, TC : paclitaxel + carboplatin, DP : docetaxel + cisplatin

える妥当性は示されなかった.

そこで次にAP療法にPTXの上乗せ効果を検証するために2004年に行われたGOG177試験（ランダム化第Ⅲ相試験）では，対象を化学療法治療歴のない，stageⅢ，Ⅳの進行子宮体癌，再発子宮体癌とし，比較レジメンはAP療法v.s. TAP療法（PTX 160 mg/m² + ADM 45 mg/m² + CDDP 50 mg/m² + G-CSF併用3週ごと）であった．結果は，TAP療法がAP療法に対し，奏効率がそれぞれ57％と34％（p＜0.01），無増悪生存期間中央値が，それぞれ8.3か月と5.3か月（p＜0.01）と有意に優れていただけでなく，全生存期間中央値においても15.3か月と12.3か月（p＝0.037）と有意に優れていた．子宮体癌のRCTで全生存期間において初めて有意差を認めたが，grade 2の末梢神経障害がそれぞれ27％と4％，grade 3の末梢神経障害は12％と1％の頻度で認められるなどTAP療法の毒性はAP療法よりも強く，有症状のうっ血性心不全をTAP群131例中3例に認め，治療関連死も5例に認めたことなどから毒性の点で問題があり，TAP療法がにわかに標準治療と結論されるには至らなかった．

以上のように，単剤で比較的高い奏効率を認めていたanthracycline系薬剤のADMを出発点とし，platinum系薬剤のCDDPを加えたAP療法が標準治療となり，GOG177試験では初めてPTXのAP療法に対する上乗せ効果を確認するに至った．しかし，TAP療法は生存期間延長を認める

もののG-CSF投与を必要とするうえに毒性は強く，末梢神経障害の有意な増加や心不全，治療関連死を認めている点が問題であり，現在EORTC（European Organization for Research and Treatment of Cancer）において追試（EORTC55984）が行われている．一方，PTXが単剤としてはADMに匹敵する奏効率を示すことが明らかとなり[5,6~12]，CDDPもしくはBDCAとの併用療法においては50～56％と高い奏効率が報告されている[13~15]．また，本邦の婦人科悪性腫瘍化学療法研究機構（JGOG）が2005年に行った全国調査では，過半数の施設がエビデンスが不十分にもかかわらずTC（PTX＋CBDCA）療法を第一選択としている現状が報告されている．AP療法とTC療法（PTX 175 mg/m^2 3時間投与＋CBDCA AUC5 3週ごと）の第Ⅱ相試験も行われており[16]，AP療法群34例とTC療法36例で，奏効率はそれぞれ27.6％と35.3％，無増悪期間の中央値は3.9か月と5.1か月，15か月全生存率は31％と45％でTC療法が良好な結果を示し，感染や嘔気・嘔吐といった毒性についてはAP療法で多い傾向を示した．

このようにTC療法の有用性を示唆する結果が報告されているが，第Ⅲ相試験で検討されておらず，今後検証する必要がある．このように，現時点での再発子宮体癌に対する標準的化学療法はAP療法であると考えられている．

しかし，GOGおよびEORTCでの臨床試験の対象は，放射線療法や内分泌療法の治療歴については制約がないものの，化学療法については前治療歴のない再発・進行子宮体癌としているため，化学療法施行後の再発子宮体癌に対するレジメンの選択に関しては判断に迷うところであるが，PTXは前化学療法に無効あるいは再発の子宮体癌19例に対しても36.8％の奏効率が報告されていることから[12]，前治療としてPTXが用いられていなければtaxane製剤を中心とした併用療法も試みるに値すると考えられる．

内分泌療法

子宮体癌の発がん機序にestrogenが関係していることから，progesteroneには子宮体癌に対する抗腫瘍効果が認められる．その作用機序としては，estrogen receptorのdown regulationを惹起する，progesterone receptorを介して腫瘍細胞のapoptosisを誘導する，estradiolからestroneへ変換させることでestrogen活性を下げる，などと考えられている．Progesterone製剤としてはmedroxyprogesterone acetate（MPA）やmegestrol acetate（MA），hydroxyprogesterone caproateが用いられ，progesterone単剤としての再発・進行子宮体癌に対する奏効率は9～16％と報告されている[17]．また，選択的estrogene受容体作動薬（SERM）であるtamoxifenも子宮体癌に対する抗腫瘍効果が期待され，GOGではMAとtamoxifenとの交代療法やMPAもしくはMAとtamoxifenとの併用試験などが行われているが，現時点においてはprogesterone単剤と比較して有意差は認められず，tamoxifen追加投与の有用性は報告されていない[18,19]．その他のSERMとしてarzoxifeneやtoremifene, raloxifeneがあるが，その効果は未知数である．

内分泌療法は欧米では再発子宮体癌に対しても積極的に用いられているのに対し，本邦では化学療法や放射線療法の補助療法として用いられているのが現状である．GOGによって再発・進行子宮体癌を対象にTAP療法v.s. tamoxifen＋MA療法の比較試験（GOG 189試験）が試みられたが，症例登録が少なく中止となっている．現時点では，化学療法と内分泌療法のどちらを選択するかについて妥当性のあるエビデンスはないが，今後QOLを重視する点で内分泌療法は注目される治療法であり，今後のエビデンスの集積が期待される．

おわりに

本稿では，再発子宮体癌を対象とした臨床試験におけるレジメンの変遷とその有効性を概説した．再発子宮体癌に対する化学療法としては，platinum製剤を中心としてanthracycline系またはtaxane系薬剤を組み合わせたレジメンが代表的であると思われる．しかし，子宮体癌の化学療法