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JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

Defucosylated Anti-CCR4 Monoclonal Antibody (KW-0761) for Relapsed Adult T-Cell Leukemia-Lymphoma: A Multicenter Phase II Study

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ABSTRACT

Purpose
Adult T-cell leukemia-lymphoma (ATL) is usually resistant to conventional chemotherapies, and there are few other treatment options. Because CC chemokine receptor 4 (CCR4) is expressed on tumor cells from most patients with ATL, KW-0761, a humanized anti-CCR4 monoclonal antibody, which markedly enhances antibody-dependent cellular cytotoxicity, was evaluated in the treatment of patients with relapsed ATL.

Patients and Methods
A multicenter phase II study of KW-0761 for patients with relapsed, aggressive CCR4-positive ATL was conducted to evaluate efficacy, pharmacokinetic profile, and safety. The primary end point was overall response rate, and secondary end points included progression-free and overall survival from the first dose of KW-0761. Patients received intravenous infusions of KW-0761 once per week for 8 weeks at a dose of 1.0 mg/kg.

Results
Of 28 patients enrolled onto the study, 27 received at least one infusion of KW-0761. Objective responses were noted in 13 of 26 evaluable patients, including eight complete responses, with an overall response rate of 50% (95% CI, 30% to 70%). Median progression-free and overall survival were 5.2 and 13.7 months, respectively. The mean half-life period after the eighth infusion was 422 ± 147 hours (± standard deviation). The most common adverse events were infusion reactions (89%) and skin rashes (63%), which were manageable and reversible in all cases.

Conclusion
KW-0761 demonstrated clinically meaningful antitumor activity in patients with relapsed ATL, with an acceptable toxicity profile. Further investigation of KW-0761 for treatment of ATL and other T-cell neoplasms is warranted.

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INTRODUCTION

Adult T-cell leukemia-lymphoma (ATL) is an aggressive peripheral T-cell neoplasm caused by human T-cell lymphotropic virus type I. The disease is resistant to conventional chemotherapeutic agents, and there currently exist limited treatment options; thus, it has a poor prognosis.[1-4] A recent phase III trial for previously untreated patients with aggressive ATL (acute, lymphoma, or unfavorable chronic type) age 33 to 69 years demonstrated that a dose-intensified multidrug regimen, VCAP-AMP-VECP (vincristine, cyclophosphamide, doxorubicin, and prednisone; doxorubicin, ranimustine, and prednisone; and vindesine, etoposide, carboplatin, and prednisone), resulted in median progression-free (PFS) and overall survival (OS) of 7.0 and 12.7 months, respectively.[5] This remains unsatisfactory compared with responses in other hematologic malignancies. Allogeneic hematopoietic stem-cell transplantation has evolved into a potential approach to treating patients with ATL over the last decade. However, only a small fraction of patients with ATL have the opportunity to benefit from transplantation, such as those who are younger, have achieved sufficient disease control, and have an appropriate stem-cell source.[6,7] Therefore, the development of alternative treatment strategies for patients with ATL is an urgent issue.

Because CC chemokine receptor 4 (CCR4) is expressed on tumor cells from most patients with ATL,[8,9] we postulated that it might represent a novel molecular target for immunotherapy. Accordingly, KW-0761, a next-generation humanized anti-CCR4 immunoglobulin G1 (IgG1) monoclonal antibody (mAb) with a defucosylated Fc region, which markedly enhances antibody-dependent cellular cytotoxicity (ADCC), was developed.[10,11] We demonstrated that robust ADCC by the defucosylated anti-CCR4 mAb against primary tumor cells from patients with ATL mediated by autologous effector cells was triggered both in vitro and in a humanized mouse model in vivo.[11-13] These promising preclinical results prompted us to conduct a phase I clinical trial of KW-0761 for patients with relapsed CCR4-positive peripheral T-cell lymphoma (PTCL), including ATL. This study demonstrated good tolerability, predictable pharmacokinetics, and preliminary evidence of potent antitumor activity and resulted in a recommended dose of 1.0 mg/kg for subsequent clinical trials.[14] Herein, we report the results of a multicenter phase II study designed to assess the efficacy, pharmacokinetic profile, and safety of KW-0761 monotherapy in patients with relapsed CCR4-positive aggressive ATL.

PATIENTS AND METHODS

Patients

Patients 20 years of age or older with CCR4-positive aggressive ATL (acute, lymphoma, or unfavorable chronic type)[1,4] who had relapsed after at least one prior chemotherapy regimen were eligible. The unfavorable chronic type of ATL was defined by the presence of at least one of the following three factors: low serum albumin, high lactate dehydrogenase, or high blood urea nitrogen concentration.[5] CCR4 expression was determined by immunohistochemistry or flow cytometry using a mouse anti-CCR4 mAb (KM2160)[8,14] and confirmed by a central review committee. All patients were required to have an Eastern Cooperative Oncology Group performance status of 0 to 2. Eligibility criteria also included the following laboratory values: absolute neutrophil count $\geq$ 1500/μL, platelet count $\geq$ 50,000/μL, hemoglobin $\geq$ 8.0 g/dL, AST $\leq$ 2.5 $\times$ the upper limit of the normal range (UNL), ALT [lteuq] 2.5 $\times$ UNL, total bilirubin $\leq$ 1.5 $\times$ UNL, serum creatinine $\leq$ 1.5 $\times$ UNL, corrected serum calcium $\leq$ 11.0 mg/dL, and arterial partial oxygen pressure $\geq$ 65 mmHg or arterial blood oxygen saturation $\geq$ 93%. Patients were excluded if they had an active infection, a history of organ transplantation, active concurrent cancers, CNS involvement, a bulky mass requiring emergent radiotherapy, or seropositivity for hepatitis B virus antigen, hepatitis C virus antibody, or HIV antibody.

Study Design

This study was a multicenter, single-arm, phase II trial. Objectives of the study were to evaluate the efficacy, pharmacokinetic profile, and safety of KW-0761 monotherapy. Patients received intravenous infusions of KW-0761 once per week for 8 weeks at a dose of 1.0 mg/kg.[14] Oral antihistamine and acetaminophen were administered before each KW-0761 infusion to prevent infusion reactions. The primary end point was overall response rate (ORR), and secondary end points included the best response by disease site, PFS, and OS. Objective responses were assessed after the fourth and eighth infusions of KW-0761 by an independent efficacy assessment committee according to the modified response criteria for ATL.[4] It was estimated that 25 patients would be required to detect a lower limit of the 95% CI exceeding the 5% threshold of ORR based on the assumptions that the minimum required ORR for a new drug for relapsed, aggressive ATL is 5%,[15] with an expected ORR for KW-0761 of 30%[14] with 90% power. Adverse events (AEs) were graded according to the National Cancer Institute Common Terminology Criteria for AEs, version 3.0. The presence of human anti-KW-0761 antibodies in the patients' plasma was examined using enzyme-linked immunosorbent assay. Blood samples collected at times strictly in accordance with the protocol were employed for the pharmacokinetic analysis. Samples were obtained from patients who had received at least one dose of KW-0761 up to all eight doses. When any event resulted in an alteration in the infusion protocol, only those samples taken before the alteration were used for the analysis. The following parameters were calculated for plasma KW-0761: maximum drug concentration and trough drug concentration of each KW-0761 administration, area under the blood concentration time curve from 0 to 7 days after the first and eighth doses, and half-life period ($t_{1/2}$) after the eighth dose. As an additional research parameter, we investigated blood T-cell subset distribution during and after KW-0761 treatment and compared these values with those of 10 healthy donors as controls (five men, five women; median age, 45 years; range, 41 to 57 years).

Statistical Analysis

Survival estimates were calculated using the Kaplan-Meier method. PFS was defined as the time from the first dose of KW-0761 to progression, relapse, or death resulting from any cause, whichever occurred first. OS was measured from the day of the first dose to death resulting from any cause. Regarding T-cell subset analysis, differences between the patients' values before KW-0761 treatment and those of the controls were examined using the Mann-Whitney U-test. Differences between KW-0761 pretreatment values and those at each time point after KW-0761 treatment were examined using the Wilcoxon signed-rank test. All analyses were performed with SPSS Statistics 17.0 (SPSS, Chicago, IL). In this study, $P < .05$ was considered significant.

Study Oversight

The study was sponsored by Kyowa Hakko Kirin Company (Tokyo, Japan). The academic investigators and the sponsor were jointly responsible for the study design. The protocol was approved by the institutional review board at each participating site, and all patients and controls provided written informed consent before enrollment according to the Declaration of Helsinki.

RESULTS

Patients

Of the 28 patients enrolled onto the study, 27 (12 men, 15 women) received at least one infusion of KW-0761. One patient was withdrawn for aggravation of the general condition before the administration of KW-0761. Demographics and clinical characteristics of the 27 patients are summarized in Table 1. Median age was 64 years (range, 49 to 83). The disease subtypes included 14 acute, six lymphoma, and seven unfavorable chronic type ATL. Of these 27 patients, 14 (52%) completed the schedule of eight planned infusions. Of the remaining 13 patients, 11 (41%) discontinued treatment because of disease progression, one (4%) because of skin rash, and another (4%) because of concurrent colon cancer, for which this patient was excluded from the efficacy evaluation.

Efficacy of KW-0761

Of 26 patients evaluable for efficacy, objective responses were noted in 13 patients (ORR, 50%; 95% CI, 30% to 70%), including eight complete responses (CRs). Responses according to disease site were 100% (13 of 13; all CRs) for blood, 63% (five of eight) for skin, and 25% (three of 12) for nodal and extranodal lesions. Responses according to disease subtype were 43% (six of 14) for acute, 33% (two of six) for lymphoma, and 83% (five of six) for unfavorable chronic type ATL. Responses according to number of prior chemotherapy regimens were 48% (10 of 21) in those who had one prior regimen and 60% (three of five) for those who had two or three prior regimens. Median PFS and OS were 5.2 and 13.7 months, respectively (Figs 1A, 1B).

Table 1. Patient Demographics and Clinical Characteristics (n = 27)*

Characteristic	No.	%
Age, years		
Median	64	
Range	49-83	
≥ 65	13	48
Sex		
Male	12	44
Female	15	56
ECOG performance status†		
0	15	56
1	7	26
2	5	19
Disease subtype		
Acute	14	52
Lymphoma	6	22
Chronic	7	26
Prior chemotherapy regimens, No.		
1	22	82
2	3	11
3	2	7

Abbreviation: ECOG, Eastern Cooperative Oncology Group.
*Of 28 patients enrolled, 27 received at least one infusion of KW-0761.
†ECOG performance status scores range from 0 (normal activity) to 5 (death), with higher scores indicating more severe disability.

Pharmacokinetics

KW-0761 plasma concentrations over eight infusions, once per week, at 1.0 mg/kg are shown in Figure 2. Mean maximum drug concentration and trough drug concentration (± standard deviation) of the eighth infusion were 42.9 ± 14.2 μg/mL and 33.6 ± 10.6 μg/mL, respectively. Mean area under the blood concentration time curve from 0 to 7 days after the eighth infusion was 6,297 ± 1,812 μg × hours/mL. The mean $t_{1/2}$ after the eighth infusion was 422 ± 147 hours.

AEs

Table 2 lists AEs that occurred in at least 15% of patients or at grades 3 to 4, which were determined as possibly, probably, or definitely KW-0761 related. The most common nonhematologic AE was an infusion reaction (89%). In addition, 80% or more of the following recorded AEs occurred along with an infusion reaction: fever, chills, tachycardia, hypertension, nausea, and hypoxemia (Table 2). These events occurred primarily at the first infusion, becoming less frequent with subsequent treatments. The infusion reactions and component events were transient, and all patients recovered, although some needed systemic steroids. Skin rashes were observed as another frequent nonhematologic AE (63%), mostly occurring after the fourth or subsequent infusions. Of the 14 patients who developed grade 2 or higher skin rashes, objective responses were noted in 13 patients (93%), including eight CRs. On the other hand, of the 12 patients who developed no or grade 1 skin rashes, no objective responses were observed. A typical clinical course of the rash is depicted in Appendix Figures A1A and A1B (online only). The skin rash observed in this patient appeared after the seventh infusion, and the corresponding skin biopsy revealed mild perivascular CD8-positive cells dominating an inflammatory reaction, with an absence of ATL cells. The skin rash recovered on application of topical steroid. Of the 17 patients who developed skin rashes, one developed Stevens-Johnson syndrome, which was determined as possibly KW-0761 related, although that patient also received trimethoprim/sulfamethoxazole, fluconazole, and acyclovir for prevention of infection according to the protocol. This patient stopped those preventive agents and was treated with

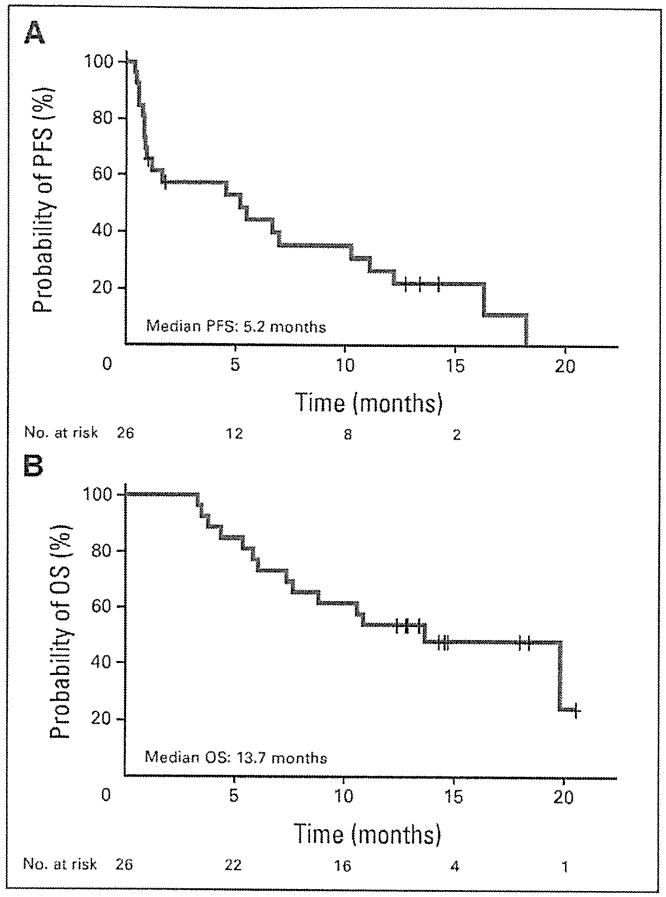

Fig 1. Kaplan-Meier curves of estimated (A) progression-free survival (PFS; median, 5.2 months) and (B) overall survival (OS; median, 13.7 months).

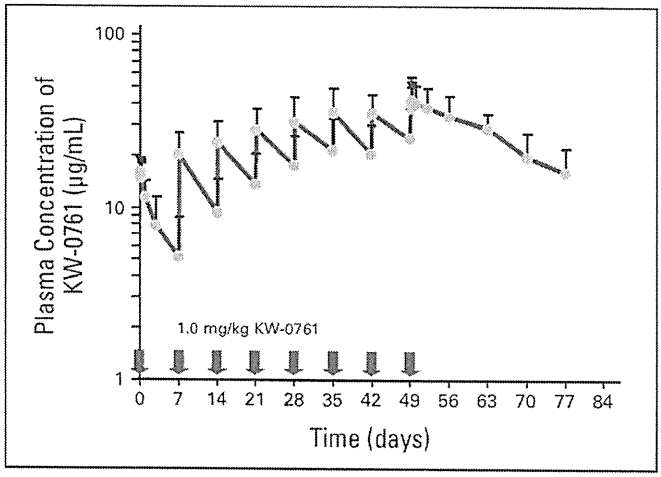

Fig 2. Pharmacokinetics of KW-0761. Mean KW-0761 plasma concentrations during and after 1.0 mg/kg KW-0761 infusions once per week for 8 weeks. Bar indicates upper limit of standard deviation.

Table 2. Adverse Events (n = 27)*

Adverse Event	Grade (No. of patients) 1	2	3	4	All Grades No. of Patients	%	Infusion Reaction Related (No. of patients) All Grades	≥ Grade 2
Nonhematologic								
Infusion reaction	1	22	1	0	24	89		
Fever	20	2	0	0	22	82	18	2
Rash	3	9	5	0	17	63	1	0
Chills	14	2	0	0	16	59	16	2
ALT	5	4	2	0	11	41		
AST	3	5	2	0	10	37		
Tachycardia	9	0	0	0	9	33	9	0
Hypertension	6	2	0	0	8	30	8	1
Albuminemia	7	1	0	0	8	30		
ALP	4	2	0	0	6	22		
Weight gain	5	0	0	0	5	19		
Nausea	4	1	0	0	5	19	5	1
Hyponatremia	5	0	0	0	5	19		
Hypoxemia	0	2	3	0	5	19	4	4
Hypotension	2	2	0	0	4	15	3	1
Pruritus	0	3	1	0	4	15		
γ-GTP	0	1	3	0	4	15		
Hypophosphatemia	0	4	0	0	4	15		
Hyperuricemia	4	0	0	0	4	15		
Hypercalcemia	1	1	0	1	3	11		
Hypokalemia	1	0	2	0	3	11		
Erythema multiforme†	0	0	1	0	1	4		
Hyperglycemia	0	0	1	0	1	4		
Tumor lysis syndrome	0	0	1	0	1	4		
Metabolic/laboratory, other‡	4	7	3	0	14	52		
Hematologic								
Lymphopenia§	0	6	9	11	26	96		
Leukocytopenia	3	7	8	0	18	67		
Thrombocytopenia	7	2	3	2	14	52		
Neutropenia	5	4	5	0	14	52		
Hemoglobin	4	3	1	0	8	30		

Abbreviations: ALP, alkaline phosphatase; BUN, blood urea nitrogen; CRP, C-reactive protein; GTP, glutamyl transpeptidase.

*Of 28 patients enrolled, 27 received at least one infusion of KW-0761. Listed are adverse events determined as possibly, probably, or definitely KW-0761 related that occurred in at least 15% of patients or were of grade 3 to 4 severity.

†One patient diagnosed as having Stevens-Johnson syndrome.

‡Other metabolic and laboratory test abnormalities included hypoproteinemia, BUN elevation, CRP, glycosuria, hypochloremia, and hyperammoniemia.

§Lymphopenia included decrease of abnormal lymphocytes.

systemic steroids, but improvement required the passage of 4 months. Lymphopenia, including a decrease in the number of ATL cells, occurred in 26 (96%) of the 27 patients. Grades 3 to 4 thrombocytopenia was observed in five patients (19%) but was not associated with bleeding, and grade 3 neutropenia also occurred in five patients but did not lead to a febrile episode. The latter two hematologic AEs improved in all patients. None of the patients developed detectable anti–KW-0761 antibody.

T-Cell Subset Analysis

The numbers of circulating blood CD4+ CCR4+, CD4+ CD25+ FOXP3+, CD4+ CCR4−, and CD4− CD8+ cells from KW-0761–treated patients and those from the 10 controls are presented as box and whisker plots in each graph (Appendix Figs A2A to A2D, online only). The numbers of CD4+ CCR4+ and CD4+ CD25+ FOXP3+ cells in patients with ATL before treatment were significantly higher than those in the controls but were significantly reduced after the first KW-0761 infusion. The reduction lasted for at least 4 months after the eighth infusion (Appendix Figs A2A, A2B; online only). The numbers of CD4+ CCR4−, and CD4− CD8+ cells in patients with untreated ATL were significantly lower than those in the controls. KW-0761 treatment led to a transient further reduction of those cells; however, recovery took place by the fifth infusion (Appendix Figs A2C, A2D; online only).

DISCUSSION

In the present multicenter phase II study, KW-0761 monotherapy demonstrated significant responses in patients with relapsed ATL with an acceptable toxicity profile. An ORR of 50% and median PFS and OS values of 5.2 and 13.7 months, respectively, were observed. Because the lower limit for an ORR with a 95% CI was 30%, this study met the primary end point. These results suggest an improvement over what has been achieved with other agents in relapsed ATL.[15] Cladribine was associated with an ORR of 7% (one of 15 patients),[16] and irinotecan hydrochloride treatment had an ORR of 38% (five of 13 patients) with a median duration of response of 31 days.[17] Antiviral therapy consisting of a combination of zidovudine and interferon, which has been proposed as a standard first-line therapy in leukemic subtypes of ATL,[18] was initially reported as having a median OS of 3.0 months in 19 patients with acute or lymphoma type ATL.[19] In addition, White et al[20] reported three objective responses lasting longer than 1 month with zidovudine plus interferon in 18 patients with ATL, of whom 15 had received prior therapy. Those observations collectively suggest that KW-0761 may offer an advantage over or provide an additional therapeutic option to the currently available therapy for relapsed ATL, although there were no direct comparisons.

On examining the results of ATL treatment according to disease site, disease in blood seemed to be more sensitive to KW-0761 than at other disease sites. Currently, we are unable to fully explain this difference; however, factors such as the KW-0761 delivery or the amount of ADCC effector cells such as natural killer (NK) cells and monocytes/macrophages in each disease site may be important.

Pharmacokinetic analyses demonstrated that the $t_{1/2}$ after the eighth administration of KW-0761 was nearly the same as that of circulating endogenous human IgG1, indicating good stability of this antibody in vivo. In addition, no anti-KW-0761 antibody was detected, suggesting that the antigenicity of this novel defucosylated mAb is not likely to be a problem clinically, consistent with findings in our preceding phase I study.[14]

The infusion reactions observed in the present study may also provide novel insights into problems associated with antibody therapy. It is generally recognized that complement plays a major role in infusion reactions,[21] but this mechanism cannot apply to KW-0761, because the agent is unable to mediate complement-dependent cytotoxicity.[11] Therefore, the infusion reactions observed here may have a different mechanism compared with those of other antibody therapies, such as rituximab. KW-0761 has a defucosylated Fc region, which markedly enhances ADCC because of increased binding affinity to the

Fcγ receptor on effector cells. Defucosylated IgG1 is a more potent activator of NK cells than nondefucosylated IgG1 during ADCC.[22] We surmise that the infusion reactions to KW-0761 were mainly induced by cytokines and related cytotoxic molecules released from highly activated NK cells.

The present study demonstrated that compared with the levels in the controls, KW-0761 led to a significant and lasting decrease in the number of CD4+ CCR4+ but not CD4+ CCR4− or CD4− CD8+ cells in patients with ATL. Consistent with the fact that CCR4 is expressed not only on T-helper type 2 cells but also on regulatory T (Treg) cells,[23-26] KW-0761 treatment also resulted in a significant and lasting decrease in CD4+ CD25+ FOXP3+ cells, including both ATL cells and endogenous non-ATL Treg cells.[27-29] Reduction or suppression of Treg cells is expected to be a potentially promising strategy for boosting antitumor immunity in patients with cancer, as observed in studies with ipilimumab,[30-33] although ipilimumab and KW-0761 have different targets; the former suppresses Treg cell function, and the latter decreases their number. Hence, KW-0761 could also lead to activation of antitumor immunity, which might also contribute to its potent anti-ATL response. Because ipilimumab causes immune-related AEs such as diarrhea and colitis, we were especially vigilant in monitoring for this type of AE. Because CCR4 contributes to lymphocyte skin-specific homing,[34] it was not surprising that skin rashes, which could be an immune-related AE, were frequently observed in the present KW-0761 study. Skin rashes, including the most severe case of Stevens-Johnson syndrome, the causal association of which with concomitant medications other than KW-0761 could not be excluded, proved to be manageable, and patients improved in all cases, although some needed systemic or topical steroid treatment. The observed better responses to KW-0761 in patients with grade 2 or higher skin rashes were highly impressive. However, the underlying mechanisms for this finding are not clear; thus, further detailed investigation is warranted. All of the 14 patients who developed grade 2 or higher skin rashes received five or more KW-0761 infusions according to the protocol, whereas only three of the 12 patients who developed no or grade 1 skin rashes received five or more KW-0761 infusions. This suggests the possibility that skin rashes were associated with the number of KW-0761 infusions. The Cochran-Mantel-Haenszel test stratified by the number of KW-0761 infusions ($\leq$ four v $\geq$ five) indicated a significant association between clinical response and skin rashes (no or grade 1 v grades 2 to 4; $P = .009$). However, the sample size is insufficient to draw such a conclusion.

Following on a phase III study (JCOG9801 [Japan Clinical Oncology Group 9801]) for untreated aggressive ATL,[5] the present promising results for KW-0761 monotherapy prompted us to conduct a subsequent randomized trial of VCAP-AMP-VECP chemotherapy with or without KW-0761 for previously untreated ATL (Clinicaltrials.gov: NCT01173887). CCR4 is also expressed on tumor cells from a subgroup of PTCL other than ATL, which also has an unfavorable prognosis.[2,35,36] Thus, we are currently conducting a phase II study of KW-0761 monotherapy for relapsed CCR4-positive PTCL (Clinicaltrials.gov:NCT01192984). In addition, Duvic et al[37] recently reported a phase I/II study of KW-0761 for refractory cutaneous T-cell lymphoma. They found that KW-0761 was well tolerated at doses of 0.1 to 1.0 mg/kg, and a promising ORR of 39% (15 of 38 patients) was achieved, although expression of CCR4 on lymphoma cells was not included as one of the eligibility criteria (Clinicaltrials.gov: NCT00888927). Furthermore, clinical trials of KW-0761 for patients with Hodgkin's lymphoma may be worth trying, because it has been reported that Hodgkin's lymphoma tumor cells produce CCR4 ligand molecules, and migratory CCR4-expressing Treg cells prevent a host immune attack on tumor cells, thereby creating an immunologically favorable environment for the tumor cells.[38]

Although this phase II study offers a novel promising treatment option (KW-0761) for patients with relapsed ATL, some limitations should be discussed. First, the present phase II study was relatively small, with consequent limitations on drawing definitive conclusions about the efficacy and safety profile of KW-0761. Second, patients received different prior systemic chemotherapy regimens, which could affect the results of the present study. Finally, the enrolled patients all had aggressive ATL, but three clinical subtypes (acute, lymphoma, and unfavorable chronic type) were included. Although there may be no significant differences in susceptibility to conventional chemotherapies between these subtypes, the heterogeneity of the enrolled patients might have affected the results.

In conclusion, this multicenter phase II study demonstrated that KW-0761 monotherapy showed clinically meaningful antitumor activity in patients with relapsed ATL, with an acceptable toxicity profile. Further investigation of KW-0761 for ATL and other T-cell neoplasms is warranted on the basis of the present results.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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Appendix

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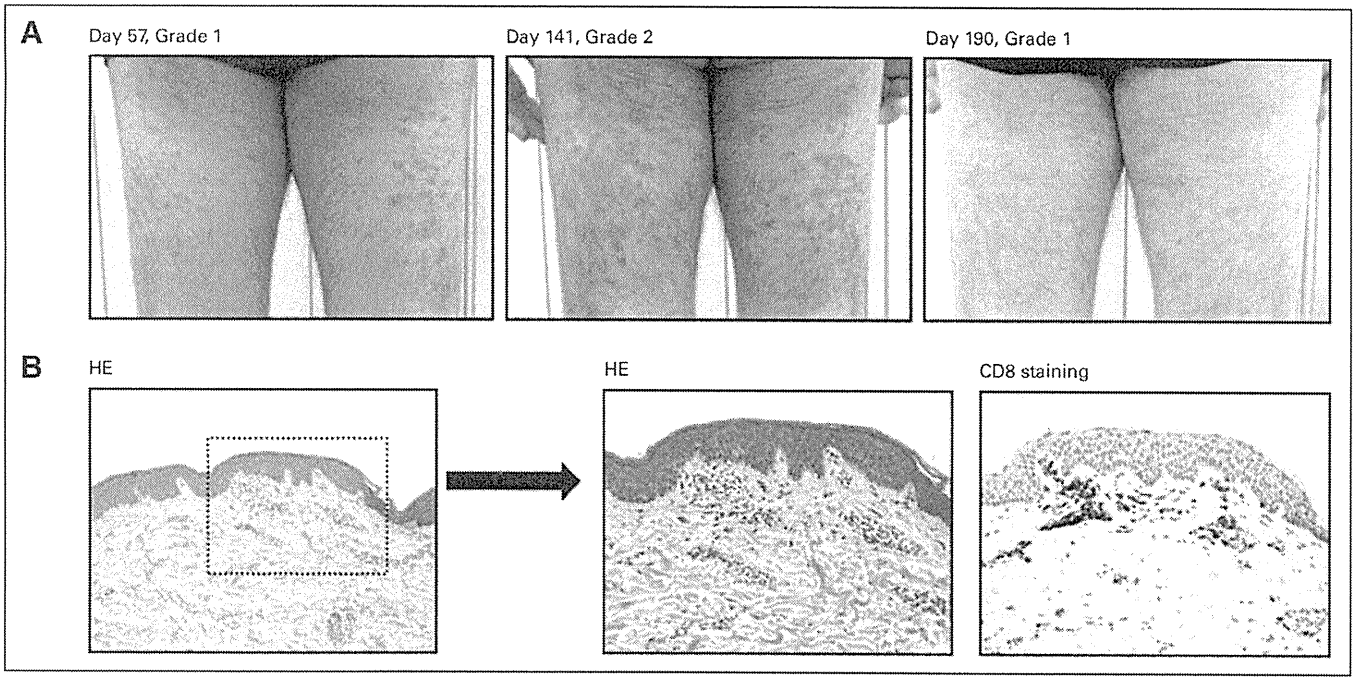

Fig A1. Example of typical clinical course of skin rash after KW-0761 treatment. (A) Macroscopic observations of patient whose skin eruptions appeared after the seventh infusion. (B) Corresponding skin biopsy at day 57 showing mild spongiosis and mild perivascular inflammation with dominant CD8-positive cells but absence of adult T-cell leukemia-lymphoma cells. The skin rash recovered on treatment with topical steroid. HE, hematoxylin and eosin.

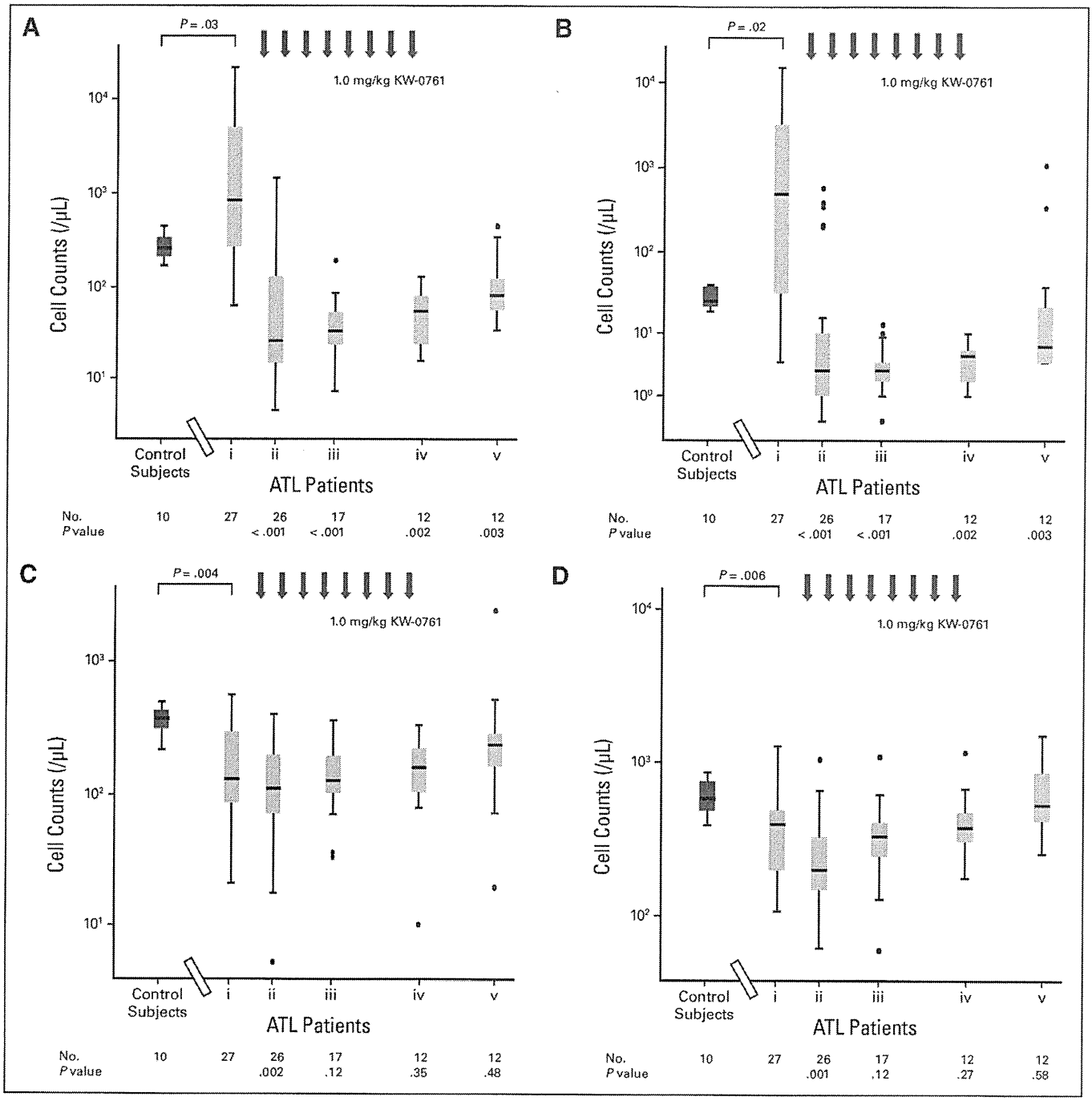

Fig A2. T-cell subset analysis. Blood samples collected at times in accordance with the protocol were employed. When any event resulted in a discontinuation of the infusion protocol, only those samples taken before this time were used for the T-cell subset analysis. (A) Numbers of CD4+ CCR4+ cells from KW-0761–treated patients with adult T-cell leukemia-lymphoma (ATL) in blood samples taken (i) just before the first KW-0761 infusion, (ii) just before the second infusion, (iii) just before the fifth infusion, (iv) 1 week after the eighth infusion, and (v) 4 months after the eighth infusion and those from 10 controls are shown as box and whisker plots indicating minimum, lower quartile, median, upper quartile, and maximum values. Differences between the patients' values before KW-0761 treatment and those of the controls are indicated as a *P* value (Mann-Whitney U-test) in the graph. The number of samples used for analysis at each point is indicated below the graph. The differences between before and each point after KW-0761 treatment [(i) *v* (ii), (iii), (iv), or (v)] are indicated as a *P* value (Wilcoxon signed-rank test) below the graph. CCR4 was detected by a monoclonal antibody (clone 1G1), where its binding to CCR4 was not affected by the presence of KW-0761. Numbers of (B) CD4+ CD25+ FOXP3+; (C) CD4+ CCR4−; and (D) CD4− CD8+ cells are presented in the same manner.

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ORIGINAL ARTICLE

Long-term outcomes after hematopoietic SCT for adult T-cell leukemia/lymphoma: results of prospective trials

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We have previously conducted clinical trials of allogeneic hematopoietic SCT with reduced-intensity conditioning regimen (RIC) for adult T-cell leukemia/lymphoma (ATLL)—a disease caused by human T-lymphotropic virus type 1 (HTLV-1) infection and having a dismal prognosis. Long-term follow-up studies of these trials revealed that 10 of the 29 patients have survived for a median of 82 months (range, 54–100 months) after RIC, indicating a possible curability of the disease by RIC. However, we have also observed that the patterns of post-RIC changes in HTLV-1 proviral load over time among the 10 survivors were classified into three patterns. This is the first report to clarify the long-term outcomes after RIC for ATLL patients.
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Keywords: adult T-cell leukemia/lymphoma; allogeneic hematopoietic SCT; reduced-intensity conditioning regimen; HTLV-1 proviral load

Introduction

Adult T-cell leukemia/lymphoma (ATLL) is a peripheral T-cell malignancy that is caused by human T-lymphotropic virus type 1 (HTLV-1) infection and commonly affects individuals at an average age of 60 years. It has been reported that the 4-year survival rate was only 10.3%; in particular, patients with an acute or lymphoma subtype showed a dismal prognosis with a 4-year survival rate of approximately 5.0%.[1] Several retrospective studies for ATLL patients younger than 50 years have suggested the possible usefulness of allogeneic hematopoietic SCT (allo-HSCT) with a conventional conditioning chemotherapy regimen. However, the treatment-related mortality by conventional allo-HSCT was high (40–60%), probably due to the disease-specific immune deficiency at diagnosis.[2–4] This unacceptable level of mortality, even in the case of young patients, critically deters the applicability of conventional allo-HSCT for the general population of ATLL.

To permit the application of allo-HSCT for ATLL in patients aged more than 50 years, we can consider allo-HSCT for ATLL conditioned with reduced-intensity regimen (hereafter, allo-HSCT conditioned with reduced-intensity regimen is referred to as 'RIC'). Few retrospective studies have reported the results of RIC for ATLL so far; Shiratori *et al.*[5] followed up 15 patients after allo-HSCT (including 10 who received RIC) whose median age was 57 years and reported that the OS rate at 3 years reached 73%. Kato *et al.*[6] investigated the results of 33 patients with allo-HSCT from unrelated donors but this study included only 6 patients receiving RIC. However, our study group had previously activated the first clinical trials of RIC in 2001. These were two trials to clarify the feasibility of RIC: one studied RIC administered with immunosuppressant antithymocyte globulin (ATG) and the other studied RIC without ATG. The results have been already published elsewhere[7,8] and the treatment-related mortality in both trials collectively decreased to the 20% level, showing that RIC is a promising procedure for ATLL patients more than 50 years of age. In this report, we present the results of long-term follow-up of the two trials and discuss the longitudinal patterns of changes in HTLV-1 proviral load in survivors.

Patients and methods

The patient characteristics have been described in the previous reports.[7,8] Briefly, patients were eligible if they had ATLL of acute or lymphoma type and were aged between

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50 and 70 years. The patients were required to be in either CR or PR at the time of trial registration, and to have a HLA-identical sibling donor. The conditioning regimen consisted of fludarabine (30 mg/m^2 per day) for 5 days and BU (1 mg/kg orally per day) for 2 days. The patients in the first study also received low-dose ATG (2.5 mg/kg per day) for 2 days, whereas those in the second study did not. On day 0, G-CSF-mobilized peripheral blood grafts from their HLA-identical sibling donors were transplanted. To prevent GVHD, we continuously infused CYA (3 mg/kg per day) starting on day −1. The degree of donor–recipient chimerism in peripheral blood mononuclear cells was examined according to the previously reported method.[9] The HTLV-1 proviral load was estimated using blood samples obtained before and at 1, 2, 3, 6, 12 months and every year after transplantation. HTLV-1 proviral DNA was measured by the quantitative PCR amplification of HTLV-1 pX DNA.[10] The detection limit of the HTLV-1 proviral load was 0.5 copies per 1000 cells. The OS curve was estimated by the Kaplan–Meier method.

Results and discussion

Long-term survivors after RIC

In all, 15 and 14 patients were registered in the first and second studies, respectively. Eleven (six and five in the first and second studies, respectively) and eight (four in each study) patients died because of ATLL and the treatment, respectively. The last treatment-related death occurred 26 months after RIC. Characteristics of the remaining 10 patients (5 in each study) are summarized in Table 1. They are currently alive with a median follow-up period of 82 months after RIC (range, 54–100 months). Of the surviving patients, six and four patients had the acute and lymphoma types of ATLL. Of 10 patients, 5 received the grafts from HTLV-1-positive sibling donors. The OS rate at 60 months (5 years) was 34% (95% confidence interval, 18–51). No death was reported beyond 36 months after RIC (Figure 1).

Of the 10 survivors, 3 developed nonhematological relapse in the skin and/or lymph nodes within a half year after RIC (Table 1). However, remission was achieved again in these patients after the discontinuation of CYA, immunosuppressive agent, and the administration of additional treatments. In one of these patients, remission was achieved with the cessation of CYA alone. Two other patients were treated with systemic chemotherapy as well as local irradiation or donor lymphocyte infusion after the discontinuation of CYA, and thereafter obtained remission. These three patients survived for 100, 88 and 54 months after RIC, respectively. Because disease recurrence is usually fatal, the clinical course for the three patients was unique. It is suggested that the newly established immunological environment after RIC might have contributed to the eradication of ATLL lesions after early relapse.

All the 10 survivors developed acute GVHD (9 grades I–II and 1 grade III). Chronic GVHD was observed in all but one patient. Although immunosuppressive treatment was discontinued in 9 of the 10 patients, 1 patient is still receiving treatment due to active chronic GVHD. The development of chronic GVHD may suggest the presence of the graft-vs-ATLL effect. Of note is that 8 of 10 survivors received RIC when they were in PR after induction chemotherapy.

Kinetic patterns of HTLV-1 proviral load in long-term survivors

Serial changes in the HTLV-1 proviral load after RIC in the 10 long-term survivors are shown in Figure 2. The changes in the proviral load are heterogeneous but can be roughly classified into three patterns. In the first pattern, the proviral load became undetectable after RIC and continued to remain so; this pattern was seen in three patients. In the second pattern, the proviral load had become undetectable but returned to detectable levels thereafter; this pattern was also seen in three patients, all of whom had received RIC from HTLV-1-negative donors. Finally, in the third pattern, the proviral load had remained at the carrier level in four patients; these patients received the grafts from donors who were HTLV-1 carriers. All the 10 survivors continue to show complete donor chimera during the observation period regardless of the HTLV-1 proviral load level.

We noted that one survivor who was donated graft from an HTLV-1 carrier showed a strikingly high proviral load (nearly 1000 copies) during the first year after RIC; this

Table 1 Characteristics of long-term survivors

Age (years)	*Gender*	*ATL subtype*	*Donor status of HTLV-1*	*Status at RIC*	*Acute GVHD*	*Chronic GVHD*	*Relapse*	*Treatment after relapse*	*Current Karnofsky PS score (%)*	*Survival after RIC (months)*
62	Male	Acute	(+)	PR	I	Yes	Lynd, skin (day 28)	d/c CsA	>90	100
66	Female	Acute	(+)	PR	II	Yes	No		>90	98
51	Male	Acute	(−)	PR	II	Yes	No		>90	98
53	Male	Lymph	(−)	PR	II	Yes	No		>90	91
54	Male	Lymph	(−)	CR	II	Yes	Lynd (day 171)	d/c CsA, Rx, Cx	>90	88
55	Male	Lymph	(+)	PR	II	Yes	No		>90	75
62	Male	Acute	(+)	CR	II	Yes	No		>90	74
50	Female	Lymph	(−)	PR	I	Yes	No		>90	62
56	Male	Acute	(−)	PR	II	Yes	Skin (day 29)	d/c CsA, DLI, steroid	>90	54
53	Female	Acute	(+)	PR	III	No	No		>90	54

Abbreviations: Cx = chemotherapy; d/c = discontinued; DLI = donor lymphocyte infusion; lynd = lymph node; PS = performance status; RIC = hematopoietic stem cell transplantation conditioned with reduced-intensity regimen; Rx = radiation therapy.

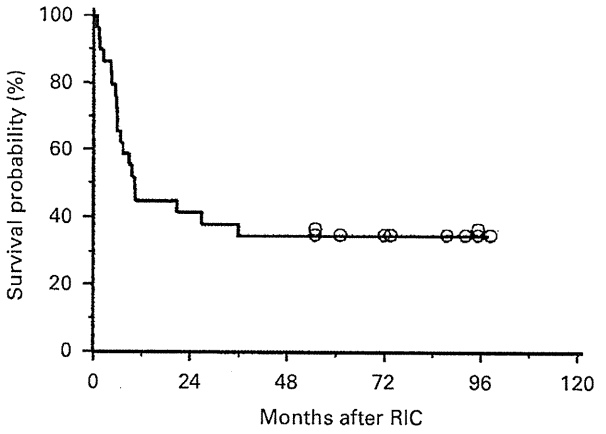

Figure 1 Kaplan–Meier curves for OS following RIC for ATLL. Circles show survivors (censored cases).

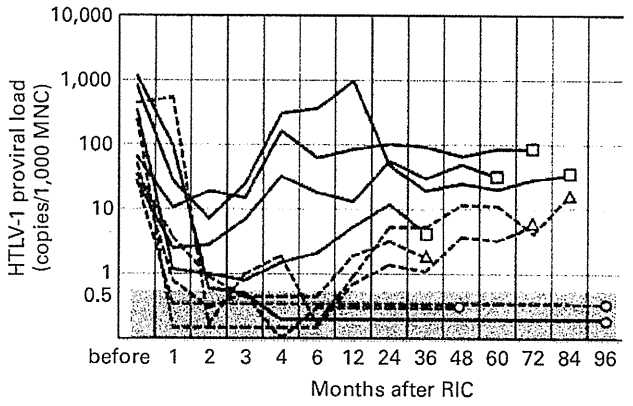

Figure 2 The longitudinal patterns of HTLV-1 proviral load after RIC in 10 long-term survivors. The HTLV-1 proviral load was measured by assaying serial blood samples after RIC by real-time PCR amplification of pX DNA and is expressed as copies per 1000 mononuclear cells (MNC). A load of less than 0.5 copies per 1000 MNC was considered undetectable, which is shown by the shaded area. A solid line indicates a patient who received a transplant from an HTLV-1 carrier donor whereas a dotted line indicates a patient from an HTLV-1-negative donor. Each circle, triangle or square indicates the latest measurement for the patient. Circle shows a pattern that the proviral load became undetectable after RIC and continued to remain so. Triangle shows a pattern that the proviral load had become undetectable but returned to detectable levels thereafter. Square shows a pattern that the proviral load had remained at the carrier level.

load then gradually decreased to the carrier level in the second year and the patient is currently surviving without any relapse. A temporary proliferation of HTLV-1-infected (nonleukemic) donor cells, as confirmed by a chimerism analysis, might have occurred due to some unknown etiology.

Conclusion

The long-term follow-up in our prospective studies has shown that one-third of the patients have survived and remain free of ATLL. We have also observed the different patterns of changes in proviral load; the pattern of changes in patients who received the grafts from HTLV-1-positive donors was different from that in patients who received the grafts from HTLV-1-negative donors. In conclusion, this is the first report on the long-term outcomes of ATLL patients who received allo-HSCT, and we have confirmed that RIC from matched sibling donors is a feasible treatment modality for ATLL, and that this treatment has a possible curative effect in patients with ATLL.

Conflict of interest

The authors declare no conflict of interest

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Polycomb-Mediated Loss of miR-31 Activates NIK-Dependent NF-κB Pathway in Adult T Cell Leukemia and Other Cancers

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SUMMARY

Constitutive NF-κB activation has causative roles in adult T cell leukemia (ATL) caused by HTLV-1 and other cancers. Here, we report a pathway involving Polycomb-mediated miRNA silencing and NF-κB activation. We determine the miRNA signatures and reveal miR-31 loss in primary ATL cells. MiR-31 negatively regulates the noncanonical NF-κB pathway by targeting NF-κB inducing kinase (NIK). Loss of miR-31 therefore triggers oncogenic signaling. In ATL cells, miR-31 level is epigenetically regulated, and aberrant upregulation of Polycomb proteins contribute to miR-31 downregulation in an epigenetic fashion, leading to activation of NF-κB and apoptosis resistance. Furthermore, this emerging circuit operates in other cancers and receptor-initiated NF-κB cascade. Our findings provide a perspective involving the epigenetic program, inflammatory responses, and oncogenic signaling.

INTRODUCTION

Adult T cell leukemia (ATL) is an aggressive T cell neoplasm with very poor prognosis (Yamaguchi and Watanabe, 2002). Human T cell leukemia virus type I (HTLV-I) is recognized as an etiological factor in T cell malignancy. Although mounting molecular evidence has contributed to our ability to cure several cancers and other diseases, the genetic background of ATL leukemogenesis is not yet fully understood. Thus, it is an urgent request to clarify the molecular mechanism of ATL development.

Constitutive activation of nuclear factor-κB (NF-κB) is observed in the ATL cell lines and primary isolated tumor cells from ATL patients, although the viral oncoprotein Tax, a powerful activator of NF-κB, is not expressed in these malignant cells (Hironaka et al., 2004; Watanabe et al., 2005). NF-κB activation aberrantly contributes to cell propagation and anti-apoptotic responses in ATL and other cancers (Prasad et al., 2010). In our previous study, inhibition of NF-κB activity with a specific inhibitor, DHMEQ, drastically impaired the levels of ATL cell growth and resistance to apoptosis (Watanabe et al., 2005), suggesting that the molecular background of aberrant NF-κB activation may give us potential therapeutic targets. A recent report provided a new readout that NF-κB-inducing kinase (NIK) has a causal role in tumor progression and the aggressive phenotypes of various cancers, including ATL (Saitoh et al., 2008). NIK plays a pivotal role in the noncanonical (alternative) NF-κB pathway as a crucial kinase in receptor-initiating signaling, including signaling from CD40, LTBR, and BAFFR.

Significance

Here, we propose a molecular perspective of the onset of oncogenic signaling. NIK overexpression is a major driving force for constitutive NF-κB activation in various types of cancers. Using ATL cells as a model of NF-κB-addiction, we identified miR-31 as a suppressor of NIK that is completely silenced in ATL cells. Furthermore, an oncogenic function of a subset of Polycomb is implicated in NF-κB signaling via miRNA regulation. This study introduces a fundamental link between the Polycomb-mediated epigenetic regulation and the NF-κB signaling, allowing us to attribute the constitutive activation of NF-κB to epigenetic reprogramming.

Several studies have recently implicated another functional significance of NIK protein in epithelial cell proliferation, inflammatory response, and oncogenic signaling (for review, see Thu and Richmond, 2010). Although the expression level of NIK is strictly maintained by proteasomal degradation in normal cells (Liao et al., 2004), increased level of NIK transcript are observed in some cancers, causing inappropriate accumulation of NIK protein without stimuli (Annunziata et al., 2007; Saitoh et al., 2008). Overexpression of NIK leads to aberrant phenotypes in several cell types; however, little is known about the abnormal accumulation of NIK in malignant cells.

Recent advances have led to deeper understanding of a new aspect of posttranscriptional gene regulation, i.e., regulation by a class of noncoding RNAs. MicroRNAs (miRNAs) are functional RNAs with 18–25 nt in length that contribute to a class of cellular functions by negatively controlling targeted gene expression via base-pairing to 3′ untranslated region (3′ UTR). A single miRNA regulates the expression of multiple genes, and the functions of miRNAs therefore need to be orchestrated for cellular homeostasis (Ventura and Jacks, 2009). In the context of cancer pathology, many studies have provided evidences that miRNAs can act as either oncogenes or tumor suppressors. Although the relationship between miRNA deregulation and oncogenes has been clarified in several cancer cells, there has been no integrated analysis of gene expression in ATL. Since miRNAs have important functions in living cells, miRNA expression needs to be tightly regulated. Our knowledge about the regulatory mechanisms of miRNA expression is very inadequate because research effort has focused mainly on the role of miRNAs, which remains one of the most intriguing questions. miRNA regulation involves multiple steps. miRNA maturation has been identified as an important step, and its deregulation leads to progression and development of cancer (Davis et al., 2008; Trabucchi et al., 2009). Genetic deletion in cancer cells has also been reported to account for specific miRNA defect (Varambally et al., 2008). In addition, miRNA expression seems to be epigenetically programmed. DNA methylation and histone modification are strong candidates for miRNA regulation and their abnormalities, therefore, have causal roles in cancer initiation, development, and progression. In particular, Polycomb group proteins have central functions in cellular development and regeneration by controlling histone methylation, especially at histone H3 Lys27 (H3K27), which induces chromatin compaction (Simon and Kingston, 2009). Recent studies have revealed that the amount of Polycomb family is closely associated with cancer phenotypes and malignancy in breast cancer, prostate cancer, and other neoplasms (Sparmann and van Lohuizen, 2006). However, the substantial status of Polycomb family and their epigenetic impact in ATL cells have not been documented. Furthermore, the general roles of Polycomb proteins in miRNA regulation are mostly unknown. As described above, since miRNAs are multifunctional molecules in gene regulation, it is of pivotal importance to clarify the miRNAs functions and their regulatory circuit in order to formulate therapeutic strategies.

In the present study, we first performed global miRNA and mRNA profilings of the ATL cells derived from patients to precisely define the significance of miRNA expressions and functions.

RESULTS

miRNA Expression Signature in Primary ATL Cells

To characterize the miRNA expression signature in the primary ATL cells, we first performed an miRNA expression microarray analysis. For results with physiological significance, we used total RNA prepared from clinical ATL samples (n = 40, Table S1 available online) and control CD4+ T cells from healthy donors (n = 22) aged 50–70 years. A strict threshold ($p < 1 \times 10^{-5}$) and two-dimensional hierarchical clustering analysis revealed 61 miRNAs that showed significantly altered levels of expression in ATL cells compared with those of control CD4+ T cells (Figure 1A). It is noteworthy that 59 miRNAs out of 61 (96.7%) showed decreased expression in the primary ATL cells. Among them, we identified miR-31 as one of the most profoundly repressed miRNAs in all ATL individuals (fold change, 0.00403; Figure 1B). miR-31 was recently reported as a tumor suppressor and/or metastasis-associated miRNA in metastatic breast cancer. However, the biological functions of miR-31 in lymphocytes have not been studied. We therefore focused on the biological significance and regulatory mechanisms of miR-31 expression in T cells as well as in solid cancers.

miR-31 Negatively Regulates NF-κB Signaling via NIK Expression

To study the functional significance of miR-31 loss, we attempted to identify the target genes of miR-31 using four computational algorithms. We also performed gene expression microarray analysis of the primary ATL cells (n = 52, Table S1) and normal CD4+ T cells (n = 21) in order to detect aberrations in gene expression. Selected putative target genes are known to be involved in cell-cycle regulation and T cell development (Table S2). To experimentally identify the target genes, we performed reporter-based screens as described below. Luciferase-3′ UTR reporter assays demonstrated a remarkable negative effect against upstream gene expression by the *MAP3K14* 3′ UTR sequence (Figure S1B), which is consistent with an initial cloning report (Malinin et al., 1997). MAP3K14, also known as NIK, has a central role in noncanonical NF-κB signaling by phosphorylation of IKKα. A previous report (Saitoh et al., 2008) and the present results (Table S2) show that NIK is overexpressed in ATL cells, leading to constitutive NF-κB activation. As shown in Figure 2A, treatment with a miR-31 inhibitor increased *NIK* 3′ UTR reporter activity, suggesting the involvement of endogenous miR-31 in NIK downregulation. A computational search predicted one site each of miR-31 and miR-31 antisense (miR-31*) binding sites in the *NIK* 3′ UTR (Figure 2B). To identify the regulatory sequence in 3′ UTR of *NIK*, we established additional two reporters with mutated sequence in each potential seed region (Figure 2C; Figure S1C). Mutant 1, which contains mutated sequence in the miR-31 seed region, partially canceled the negative effect of endogenous miR-31 (Figure S1D) and prevented the effect of Anti-miR-31 treatment (Figure 2D). On the contrary, our results suggest that miR-31* does not participate in NIK regulation. miR-31-mediated reporter regulation was also observed in T cell lines (Figure S1E). To confirm the results, we repeated the experiment to examine whether miR-31 could inhibit NIK expression through seed sequence. We made expression plasmid vectors carrying NIK, NIK-3′

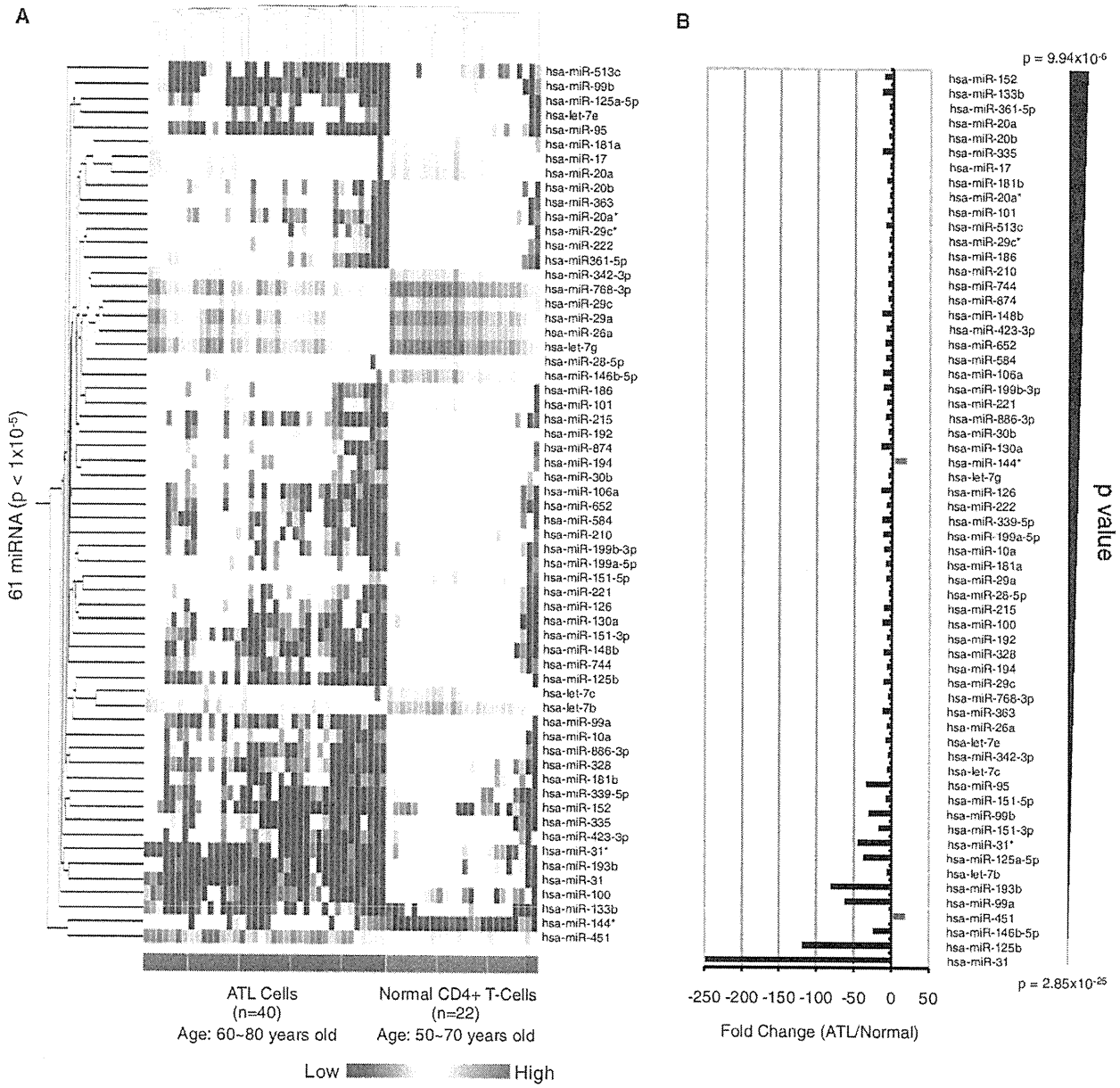

Figure 1. Global Profiling of Cellular miRNA on Primary ATL Cells

(A) Two-dimensional hierarchical clustering analysis and Pearson correlation as similarity measure on the miRNAs expressed at significantly different levels between the ATL (n = 40) and the control (n = 22) groups. Sixty-one miRNAs were identified ($p < 1 \times 10^{-5}$) and by filtering on more than 5-fold changes. A vertical branch shows the expression pattern of the selected miRNAs in each individual.

(B) Fold changes in the 61 miRNAs between ATL and Normal ($p < 10^{-5}$, fold change >5-fold). Selected miRNAs are arranged according to p values. See also Table S1.

UTRWT, or NIK-3′ UTRMu1 and tested their expressions in 293T cells. Results demonstrated that expression of NIK-3′ UTRWT was inhibited by simultaneous introduction of miR-31 (Figure 2E). miR-31 inhibition inversely rescued the NIK level, revealing that the cellular miR-31 level negatively affected that of the NIK protein through its 3′ UTR sequence. These lines of evidence collectively demonstrated that miR-31 recognizes and regulates *NIK* mRNA through specific binding to its 3′ UTR.

Transient introduction of the miR-31 precursor in TL-Om1 cells, which were established from an ATL patient, resulted in downregulation of NIK at the mRNA and protein levels, associated with downregulation of the phospho-IKKα/β level and NF-κB activity (Figures S1F and S1G). In contrast, miR-31 inhibition resulted in accumulation of NIK mRNA and protein in HeLa cells (Figure 2F). Manipulation of the miR-31 level clearly indicated that the miR-31 level negatively correlates with cellular

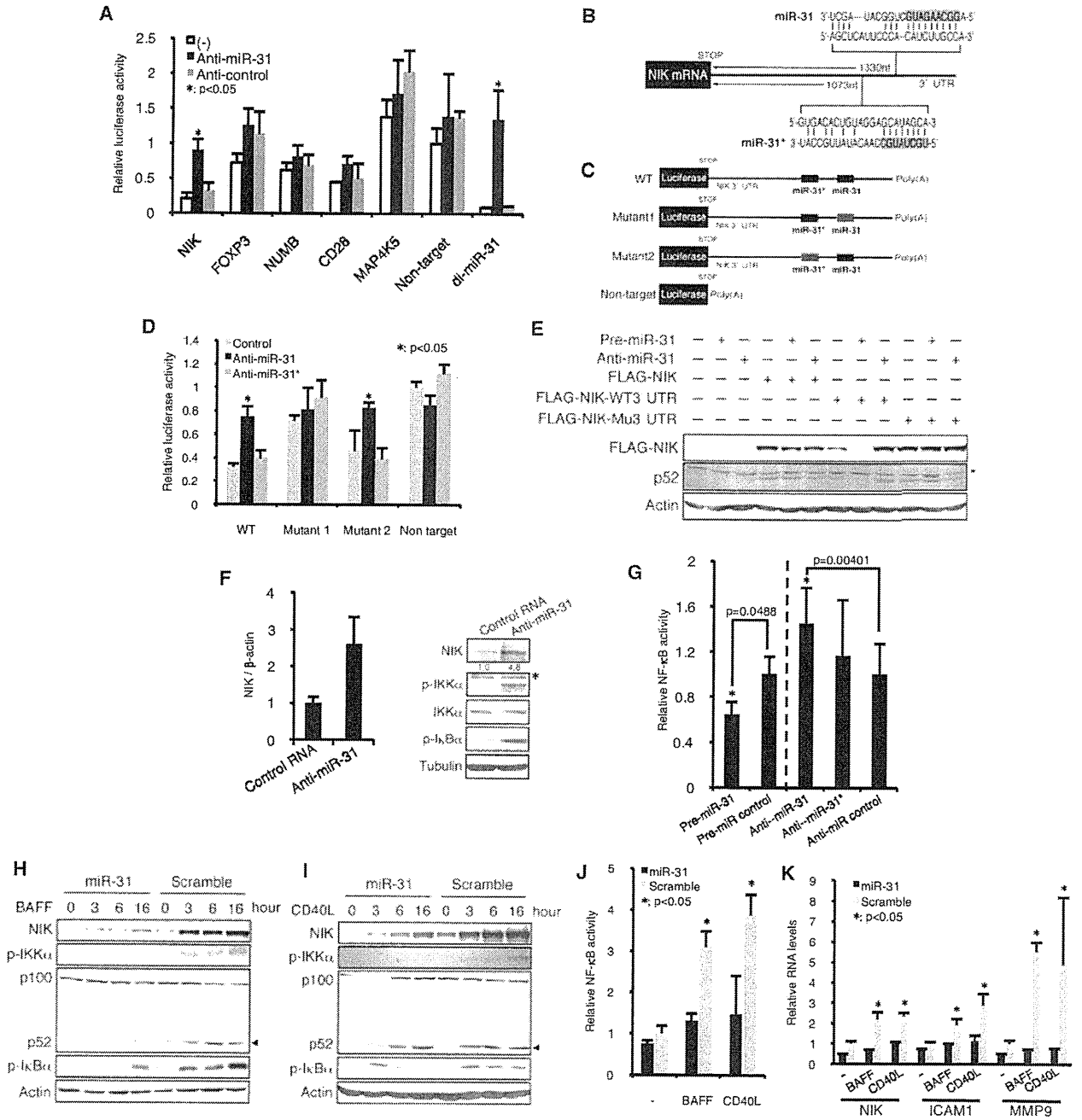

Figure 2. miR-31 Is a Negative Regulator of NF-κB Pathway by Inhibiting NIK Expression

(A) Reporter-based miR-31's target gene screening. A series of 3′ UTR-luciferase reporters was transfected in HeLa cells together with or without miR-31 specific inhibitory RNA (Anti-miR-31) or control RNA (Anti-control). Relative values of Dual-luciferase assay are presented. "Non-target" represents reporter without any 3′ UTR. "di-miR-31" reporter contains two perfect match sequences. The data are presented as mean ± SD of three independent experiments.

(B) Schematic of miR-31 target sites in the *NIK* 3′ UTR.

(C) Mutation-induced reporters. Red box stands for mutated target region (see Figure S1C).

(D) miR-31 negatively regulates *NIK* 3′ UTR analyzed by reporter assay (n = 4, mean ± SD). Luciferase activities of reporter series were tested in a presence or absence of miR-31 inhibitor.

(E) FLAG-tagged NIK protein is negatively regulated through its 3′ UTR and miR-31 binding. Plasmid vectors and miR-31 precursor or miR-31 inhibitor are cotransfected in 293T cells. Western blots showed levels of NIK and endogenous p52. Asterisk indicates nonspecific bands.

(F) NIK mRNA (left) and protein (right) levels in HeLa cells measured by quantitative RT-PCR (n = 3, mean ± SD) and western blotting, respectively. Treatment of miR-31 inhibitor resulted in NIK accumulation. Result of densitometry is shown in the bottom panel. Asterisk indicates nonspecific bands.

(G) Cellular NF-κB activity in HeLa cells (n = 5, mean ± SD) in a presence or absence of miR-31 precursor or inhibitor.

NF-κB activity (Figure 2G). Furthermore, enforced miR-31 expression in B cells attenuated both BAFF and CD40L-mediated NIK accumulation and the subsequent NF-κB signaling (Figures 2H–2K). Consistent with previous reports (Ramakrishnan et al., 2004; Zarnegar et al., 2008b), we also found decreased levels of IκBα phosphorylation. On the other hand, TNF-α-triggered canonical NF-κB activation was not affected by miR-31 in Jurkat cells (Figures S1H–S1K). These results collectively show that miR-31 inhibits the basal and receptor-initiated activities of noncanonical NF-κB pathway. With genetic evidence and an experimental approach, we further demonstrated that the function of miR-31 is well conserved among several classes of species (Figures S1L–S1O). Taking together all these results, miR-31, which is almost completely absent in primary ATL cells, appears to play a critical role in negative regulation of the NF-κB pathway by manipulating the expression of NIK.

miR-31 Suppresses ATL Cell Growth and Promotes Apoptosis by Inhibiting NF-κB

Although it was documented that abnormal NIK accumulation in ATL cells acts as a constitutive activator of the NF-κB pathway, the mechanism underlying overproduction of NIK remains to be elucidated. The results described in the previous section indicated that the amount of miR-31 is linked to the level of NIK, and we therefore speculated that downregulation of miR-31 expression is at least partially responsible for the constitutive activation of NF-κB in ATL cells. Quantitative RT-PCR revealed that *NIK* mRNA levels were negatively correlated with miR-31 levels in primary ATL cell samples (Figure 3A). To investigate the functional roles of NIK and miR-31, we established TL-Om1 cells stably expressing the miR-31 or NIK specific shRNA (shNIK) by retroviral vectors. RT-PCR and western blots showed that expression of miR-31 or shNIK reduced NIK at mRNA and protein levels as well as the levels of phospho-IKKα/β, p52, and IκBα (Figures 3B and 3C). Decreased levels of nuclear RelA and RelB are considered to represent repressed activities of the canonical and noncanonical NF-κB pathways, respectively (Figure 3D). EMSA and NF-κB reporter assays also revealed the repressive function of miR-31 and shNIK on the NF-κB activity (Figures 3E and 3F; Figures S2A, S2B, S5B, and S5C). Re-expression of NIK led to NF-κB activation that was inhibited by miR-31, suggesting a reciprocal relationship between the level of miR-31 and that of NIK.

We and others previously showed that constitutive NF-κB activation is a strong driver of ATL proliferation and prosurvival properties. Here, we examined the effects of miR-31 loss on ATL cell growth. We found that TL-Om1 cells expressing miR-31 or shNIK showed a significant attenuation of cell proliferation compared with control cells. In addition, serum starvation experiments showed greater sensitivity to induced cell death in NIK-repressed cells (Figure 3G). miR-31 expression showed the same phenotypic results in other ATL-derived cell lines (Figures S2C, S2D, and S5E). Jurkat cells do not have significant basal activity of NF-κB, and showed no significant difference in cell growth with or without induced expression of miR-31 (Figure S2E).

Next, we hypothesized that miR-31-mediated NF-κB modulation may affect cellular apoptosis, because numerous studies have demonstrated that NF-κB activation is a strong antiapoptotic factor in ATL and other cancer cells. We found that repression of NIK by miR-31 or shNIK resulted in downregulation of a subset of genes involved in resistance to apoptosis such as BCL-XL, XIAP, and FLIP (Figure 3H), suggesting that miR-31 has a role in proapoptosis through inhibition of NF-κB activity. To assess the biological function of miR-31 in apoptosis signals, we utilized a lentivirus gene transfer system for cell lines and freshly isolated tumor cells. The lentivirus vector is competent to infect nondividing cells and the infected cells can be monitored by the fluorescence of Venus. We found that lentivirus-mediated miR-31 expression promoted basal and Fas-directed apoptosis in TL-Om1 cells (Figure 3I). Venus-negative population showed no significant changes, demonstrating the specificity of miR-31 activity. To confirm the relationship among miR-31, NIK, and NF-κB signaling, we also prepared another retroviral vector encoding NIK without its 3′ UTR sequence. As results, re-expression of NIK reversed the miR-31-mediated apoptosis. In addition, miR-31 expression led to caspase 3 activation (Figure 3J). Collectively, these findings indicate that miR-31 mediates apoptosis through repression of NIK in ATL cell lines.

Tumor cells from ATL patients primarily represent the malignant characteristics. In fact, miR-31 loss is found from patient samples (Figures 1 and 3A). To demonstrate the responsibility of miR-31 for tumor cell survival, we tested whether lentivirus-mediated miR-31 expression has a killing effect against tumor cells. After establishment of lentivirus infection, the apoptotic cells were determined by flow cytometry. The results revealed that expression of miR-31 facilitated tumor cell death. Since NIK repression by shRNA lentivirus also showed a strong killing effect, NIK and NF-κB activity are suggested as crucial players for survival in ATL tumor cells (Figure 3K). Strong toxicities were not observed in normal resting lymphocytes that express low levels of NIK. Taken together, these lines of experimental evidence, including data from cell lines and primary ATL cells, definitively support two notions that (1) miR-31 acts as a tumor suppressor in T cells, and (2) NIK-regulated NF-κB has pivotal importance in cancer cell survival.

Loss of miR-31 Occurs in T Cells with Genetic and Epigenetic Abnormalities

The results described above together with previous publications indicate that regulation of miR-31 expression has profound impacts on multiple functions in human tumors as well as in normal cells. However, little is known about the regulatory mechanism of miR-31 expression. The human gene that encodes miR-31, *hsa-miR-31*, is located at 9p21.3, which is

(H–K) miR-31 attenuates signal-dependent NF-κB activation in B cells. (H and I) BJAB cells expressing miR-31 or control RNA were treated with BAFF (0.2 μg/ml) or CD40L (0.5 μg/ml) for indicated time periods. The protein levels of NIK, phospho-IKKα/β, p100/p52 (arrowheads indicate active p52), and phospho-IκBα were shown. Actin was detected as control. (J) NF-κB activity (n = 5, mean ± SD) evaluated by NF-κB-luciferase reporter assay at 24 hr after cytokine treatments. (K) NF-κB-dependent gene expressions were inhibited by miR-31 (n = 3, mean ± SD). See also Table S2 and Figure S1.

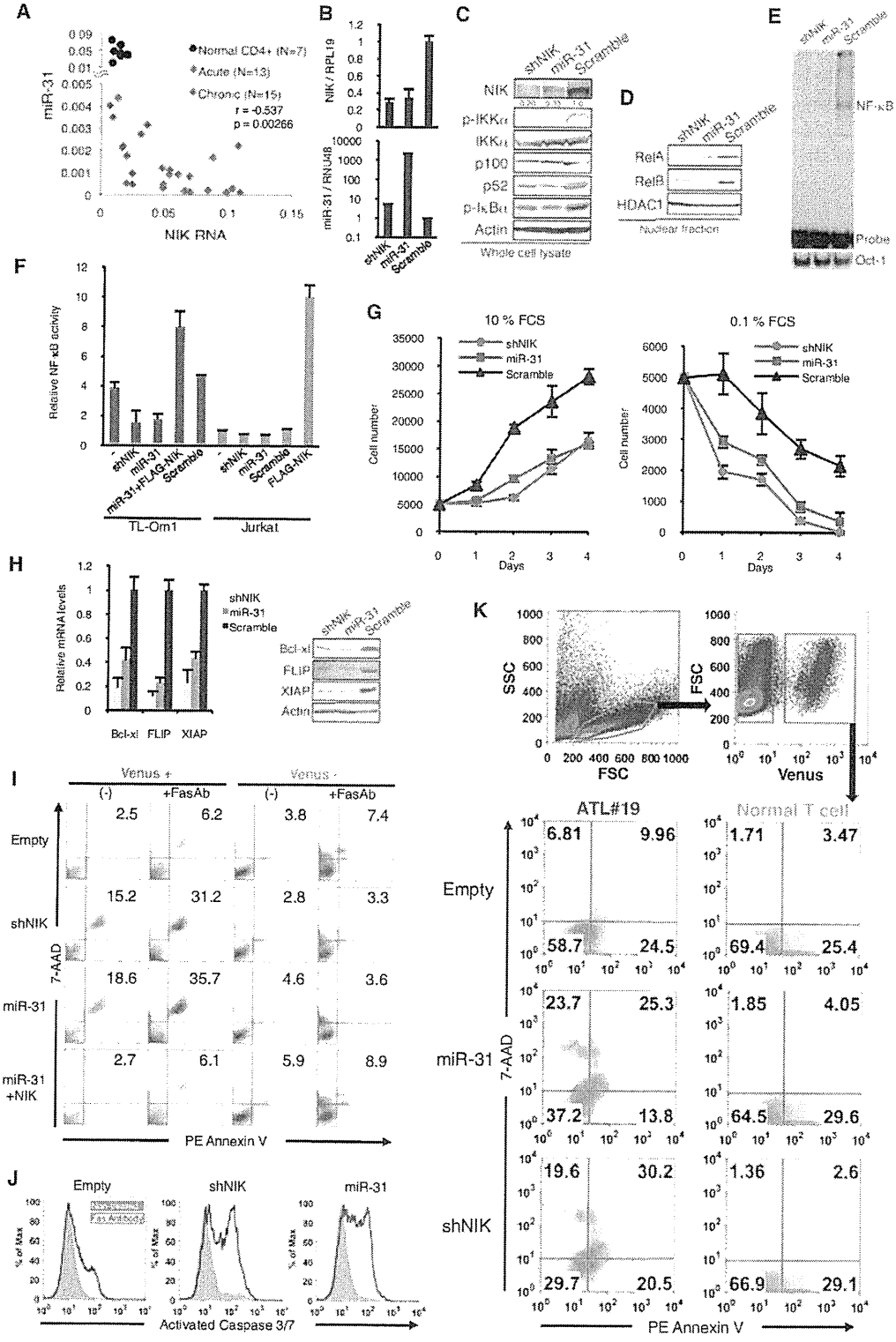

Figure 3. Loss of miR-31 Is Responsible for Constitutive NF-κB Activation, Abnormal Cell Growth, and Resistance to Apoptotic Cell Death in ATL Cells

(A) Expression levels of miR-31 and *NIK* in individual ATL patients and normal controls using data set obtained by quantitative RT-PCR. Pearson's correlation coefficient within ATL samples was described in the graph.

adjacent to clusters of the *CDKN2* and *IFNA* families, and is a well-known hotspot of genomic loss in several types of human cancers. We performed genome-wide scans of genetic lesions in 168 ATL samples and demonstrated that 21 ATL cases (12.5%) had genomic deletion of 9p21.3 containing the *hsa-miR-31* coding region (Figure 4A; Figure S3A). All of these cases also have genomic defect in *CDKN2A* region. A major proportion of ATL cases that are without genetic deletion and somatic mutation in the *hsa-miR-31* region showed remarkable loss of miR-31 expression (Figure 4B). Detailed expression profiling revealed drastic downregulation of *Pri-miR-31* transcription in the primary ATL cells (Figure 4C). There was a strong correlation between the levels of mature miR-31 and primary transcript ($r = 0.9414$, $p = 5.45 \times 10^{-8}$). *hsa-miR-31* is located in intronic region of *LOC554202* gene. However, *LOC554202* mRNA levels were very low in primary T cells and there was no significant difference between ATL and normal cells, strongly suggesting that loss of miR-31 expression is due to specific transcriptional suppression in ATL cells. Using computational analysis, we identified a putative TATA box and transcriptional start site (TSS) 2500 bp upstream of the miR-31 coding region (Figure 4D). Although no CpG islands were found in this region, we unexpectedly discovered an assembly of YY1-binding motifs upstream of the miR-31 region in human and mouse (Figure 4D; Figure S3C). YY1 is a pivotal transcription factor and a recruitor of the Polycomb repressive complex (PRC) (Simon and Kingston, 2009). Convergence of the YY1 binding sequence, especially the repressive motif (Figure S3D), seems to be evolutionarily conserved, suggesting that YY1 is important in the regulation of miR-31 transcription. We further performed chromatin immunoprecipitation (ChIP) to evaluate repressive histone hallmarks, including di- and trimethylated H3K9 (H3K9me2 and H3K9me3) and trimethylated H3K27 (H3K27me3). The results showed higher levels of methylation at H3K9 and H3K27 in a broad area containing the miR-31 coding region (Figure 4E). As shown in Figures S3E–S3G, there was an inverse correlation between the levels of miR-31 expression and repressive histone methylation. These data allowed us to hypothesize that histone methylation, especially that of Polycomb family-dependent H3K27me3, may contribute to miR-31 repression. To confirm our hypothesis, we performed a YY1 knockdown experiment using a specific shRNA (Figures 4F–4I). As expected, knockdown of YY1 led to an increase in the levels of *Pri-miR-31* and mature miR-31 (Figures 4F and 4G). Furthermore, ChIP assays showed that YY1 occupied the miR-31 region, especially in the upstream region of TSS, where there is an array of YY1 binding sites (Figures 4D and 4H). The results also demonstrated that decreased occupancy of YY1 and concomitant derecruitment of EZH2, a key component of PRC2, were induced by YY1 knockdown, indicating involvement of EZH2 in the repressive complex recruited to the miR-31 region (Figures 4H and 4I; Figure S3H). These results collectively suggest that YY1 regulates PRC2 localization and initiates miR-31 suppression. Indeed, we found significant escalation of methylated histone H3K9 and H3K27 at the miR-31 locus of peripheral blood lymphocytes of ATL patients (Figure 4J), indicating that aberrant abundance of suppressive histone methylation may be responsible for the loss of miR-31 in the primary ATL cells.

Overexpression of PRC2 Components Leads to miR-31 Repression

Given that Polycomb-mediated repressiveness affects miR-31 level, our findings imply that the amount of EZH2 is related to miR-31 expression (Figure 4I; Figures S3G and S4A). We found a significantly upregulated expression of PRC2 components, especially EZH2 and SUZ12, in the primary ATL cells (Figures 5A and 5B; Table S3). Quantitative RT-PCR revealed that miR-31 levels inversely correlated with both *EZH2* and *SUZ12*, respectively (Figure 5C). miR-101 and miR-26a, which are putative negative regulators of EZH2, seem to be associated with this relationship in ATL cells (Figures S4B–S4E). To further confirm our hypothetical mechanism linking the epigenetic machinery and miR-31 expression, we performed a "loss-of-PRC2-function" assay. Retroviral delivery of shSUZ12 and shEZH2 in the ATL cell lines resulted in a great increase in the levels of *Pri-miR-31* and its mature form (Figure 5D; Figure S4F). Knockdown of PRC2 induced histone demethylation at H3K27 in the miR-31 region, which is concomitant with the decrease in H3K9me3 levels, EZH2 occupancy, and HDAC1 recruitment (Figure 5E), suggesting that this multimeric complex leads to a completely closed chromatin architecture as a result of histone modifications in the miR-31 genomic region.

To further examine whether the proposed mechanism holds true in other human cancers, we analyzed a couple of carcinoma cell lines, including HeLa cells and nonmetastatic and metastatic breast carcinoma cell lines, MCF7 and MDA-MB-453 cells, respectively. qRT-PCR revealed that expression of *EZH2* and *SUZ12* inversely correlated with miR-31 levels (Figure S4G).

(B) miR-31 restoration by retroviral vector inhibits *NIK* RNA accumulation in TL-Om1 cells. The results of *NIK* and mature miR-31 quantifications are shown (n = 3, mean ± SD).
(C) miR-31 or shNIK expression downregulates NIK protein expression and inhibits downstream pathway of noncanonical NF-κB in TL-Om1 cells.
(D) Reduced nuclear translocation of RelA and RelB proteins in miR-31- or shNIK-expressing TL-Om1 cells.
(E) miR-31-dependent downregulation of NF-κB activity in TL-Om1 cells examined by EMSA.
(F) NF-κB-luciferase reporter assays (n = 5, mean ± SD). FLAG-NIK plasmid was transiently introduced 48 hr prior to the assay.
(G) miR-31 level is relevant to proliferation of ATL cells. Cell proliferation curve of TL-Om1 cells were evaluated in two FCS conditions (n = 3, mean ± SD).
(H) Apoptosis-related gene expression in TL-Om1 cells analyzed by qRT-PCR (n = 3, mean ± SD) and western blots.
(I) Lentivirus-mediated NIK depletion promotes basal and Fas antibody-mediated apoptosis. Venus-positive population represented lentivirus-infected cells. Apoptotic cells were determined by PE-Annexin V / 7-AAD stainings (n = 4). Representative FACS analyses are shown.
(J) miR-31 activates Caspase 3/7 determined by FACS (n = 3).
(K) miR-31 expression and NIK depletion induce tumor cell death. Primary tumor cell from ATL patient and healthy CD3+ T cells were infected with lentivirus and analyzed by FACS. The apoptotic cells were defined by sequential gating beginning with FSC-SSC to select intact lymphocytes, subgating on the Venus-positive population, and calculating the PE-Annexin V and 7-AAD profilings. Representative result is shown and summarized data are presented in Figure 6J. See also Figure S2.