analysis. Among these, fresh materials for 30 tumors were suitable for microarray gene expression analysis (18 were previously examined [13] and 12 were newly enrolled in this study), and for the remaining 15 cases, only paraffin blocks were available. Because for 2 cases among the 30, only fresh materials were available, no paraffin tissues from surgical materials being left for this study, tissues of 43 cases were used for immunohistochemical studies. In addition to the surgical cases, 51 patients who were inoperable and had undergone a biopsy between 1996 and 2006 were enrolled.

All tumors were pathologically staged according to the TNM classification system of the International Union Against Cancer [14] using resected materials. The clinical stages, serum level of markers (NSE, ProGRP, CEA, SCC, and CYFRA), and response rates to chemotherapy were investigated using medical records. Cumulative smoking was carefully surveyed and described with reference to the *smoking index* (SI), defined as the product of the number of cigarettes per day and duration in years. Cause of death was surveyed thoroughly using death certificates, and lung cancer–specific survival or overall survival was analyzed as appropriate. All tissues were collected with informed consent from patients, and the study protocol was approved by the Japanese Foundation for Cancer Research institutional review board.

2.2. RNA isolation and gene expression profiling

Fresh samples of 30 SCLCs were obtained at surgery. The tissues of resected tumors were grossly dissected and snap-frozen in liquid nitrogen typically within 15 minutes of removal. We always confirmed that fresh tumor tissues for RNA extraction actually contained viable SCLC cells, using frozen section diagnosis. Total RNA was extracted using an RNeasy Mini kit (Qiagen, Hilden, Germany) according to the manufacturer's instructions. A 3-μg aliquot was used to generate ds-cDNA using a T7-Oligo (dT) primer, and the cDNA was transcribed into biotin-labeled cRNA using a GeneChip 3′ IVT Express Kit (Affymetrix, Santa Clara, CA, USA). Quality control of RNA and cRNA was performed using a bioanalyzer (Agilent Technologies, Santa Clara, CA, USA). After fragmentation, each sample was hybridized to Affymetrix HG U133 plus 2.0, which covers 38 500 genes, 47 400 transcripts, and more than 54 000 probe sets, and was stained according to the manufacturer's instructions (Affymetrix). We used GeneChip Scanner 3000 for scanning and GeneChip Operating Software (GCOS; Affymetrix) for data output.

2.3. Array data analysis

Data were analyzed and visualized by use of R software (version 2.9.2; www.t-project.org). Before analysis, all data were log transformed and subjected to Robust Multichip Average normalization [15].

Unsupervised hierarchical clustering analysis was accomplished with standard Pearson correlations and the Ward method using 15 530 probe sets expressed above the background in at least 20% of the 30 samples and 100 or more expression signals. To identify genes that represent the most informative markers between 2 groups obtained from clustering analysis about SCLC, we focused on those with $P < .01$ by the Welch t test and log fold-change above 2.0 or below −2.0.

2.4. Procedures for tumor tissue arrays

Surgical specimens were fixed with 15% buffered formalin and embedded in paraffin. They were sectioned at 4-μm thickness and stained with H&E for histologic diagnosis. Tissue arrays were made from paraffin specimens as follows: 2 spots of the most representative tumor area were selected considering heterogeneity and cored in 2-mm diameter with a tissue-arraying instrument (Azumaya, Tokyo, Japan). In cases of combined SCLC, only SCLC components were chosen for coring. Core samples were retrieved from donor tissues and arrayed in a new paraffin block.

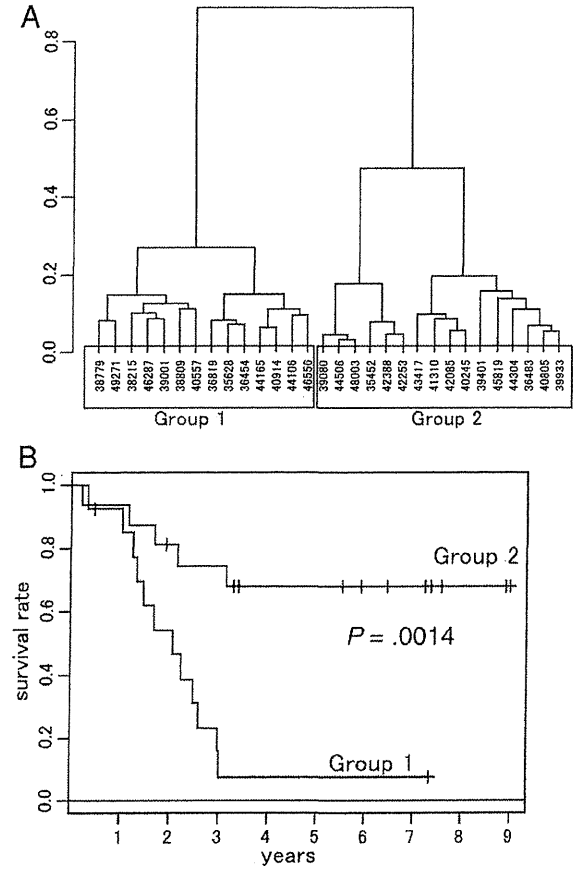

Fig. 1 A, Results of unsupervised hierarchical clustering of 30 SCLCs. B, SCLC-specific survival of groups 1 and 2. Note the better survival of group 2 as compared with group 1 ($P = .0014$).

Table 1 Patients characteristics of resected SCLC and LCNEC

Cases	Ref. no.	Diagnosis	Age (y)	Sex	SI	cT	cN	cM	Preoperative diagnosis	Induction chemotherapy (reduction rate)		Operation	pT	pN
1	29635	SCLC	76	M	1500	2	2	0	SCLC	Yes	PR: 84%	Lobectomy	4	2
2	30017	SCLC	57	M	1050	4	2	0	SCLC	Yes	PR: 70%	Lobectomy	4	2
3	30156	SCLC	67	M	940	3	2	0	SCLC or LCC	None		Lobectomy	4	2
4	30323	SCLC	59	M	1435	2	1	0	SCLC	Yes	CR: scar+	Lobectomy	2	2
5	30865	SCLC	64	M	400	1	0	0	p/d ca	None		Lobectomy	1	2
6	31160	SCLC	68	M	1000	1	0	0	SCLC	None		Lobectomy	4	0
7	31401	SCLC	72	M	680	1	0	0	SCLC	None		Lobectomy	2	0
8	32658	SCLC	84	M	1200	1	0	0	Unconfirmed	None		Partial resection	1	1
9	33130	SCLC	46	M	940	1	0	0	SCLC or SQ	None		Lobectomy	2	0
10	33587	Combined SCLC + AD	59	M	1480	1	1	0	AD or LCC	None		Lobectomy	4	0
11	34802	SCLC	73	M	960	1	0	0	SQ	None		Lobectomy	1	0
12	34947	SCLC	54	M	680	1	0	0	SCLC	Yes	PR: 74%	Lobectomy	1	0
13	35452	Combined SCLC + AD		F	0	2	0	0	AD	None		Lobectomy	2	0
14	35628	SCLC	73	M	800	1	2	0	AD or SCLC	Yes	PR: 77%	Lobectomy	1	0
15	35996	SCLC	61	M	375	1	2	0	SCLC	Yes	PR: 79%	Lobectomy	4	2
16	36454	SCLC	66	M	300	1	1	0	SCLC	Yes	SD: 24%	Lobectomy	1	1
17	36483	Combined SCLC + Spindle	64	M	1470	3	0	0	SCLC	Yes	PR: 67%	Lobectomy	4	0
18	36819	SCLC	67	M	920	2	2	0	SCLC	Yes	CR: regrowth+	Lobectomy	1	2
19	38779	SCLC	57	M	1110	1	0	0	SCLC	Yes	SD: 26%	Lobectomy	1	1
20	38809	SCLC	79	M	1180	2	0	0	SCLC	None		Lobectomy	4	0
21	39001	Combined SCLC + AD	59	M	675	1	0	0	SCLC	None		Lobectomy	1	0
22	39080	SCLC	76	M	600	1	0	0	AD or SCLC	None		Segmentectomy	1	0
23	39401	SCLC[c]	67	M	2000	1	2	0	Unconfirmed	None		Partial resection	1	0
24	39933	SCLC	53	M	1050	2	1	0	SCLC	None		Pneumonectomy	4	2
25	40557	Combined SCLC + AS	74	F	0	2	1	0	NSCLC	None		Lobectomy	2	2
26	40805	SCLC	68	M	1440	2	0	0	p/d ca	None		Lobectomy	2	0
27	40914	SCLC	68	F	380	2	0	0	AD or SCLC	None		Lobectomy	4	1
28	41179	SCLC	65	M	2400	2	1	0	SCLC	Yes	PR: 51.3%	Lobectomy	4	1
29	41310	SCLC	64	F	700	1	0	0	carcinoma	None		Lobectomy	1	0
30	42085	SCLC	71	M	1060	1	0	0	SCLC or p/d ca	None		Lobectomy	1	1
31	42253	Combined SCLC+ LCNEC	63	F	1880	3	0	0	SQ or SCLC	None		Lobectomy	4	0
32	43417	SCLC	74	M	200	2	1	0	NEC	None		Lobectomy	2	0
33	44106	SCLC	62	M	1175	1	0	0	SCLC	Yes	PR: 69.5%	Lobectomy	1	1
34	44165	Combined SCLC + LCC	70	M	1000	1	0	0	SCLC or LCC	None		Lobectomy	2	0
35	44304	Combined SCLC + LCC	63	M	3760	2	0	0	SCLC	None		Lobectomy	4	0
36	45819	SCLC	70	F	1000	2	0	0	SCLC	Yes	SD: 25.2%	Lobectomy	2	0
37	46287	SCLC	68	F	160	2	0	0	SCLC	Yes	PR: 73%	Lobectomy	4	0
38	49271	Combined SCLC + AD	80	M	840	2	0	0	AD	None		Lobectomy	2	2
39	50455	SCLC	70	M	1000	1	0	0	SCLC	None		Lobectomy	1	0
40	40245	SCLC	63	M	1660	2	0	0	SCLC	Yes	PR: 52.6%	Lobectomy	2	0
41	42388	Combined SCLC + AD	74	F	0	1	0	0	AD	No		Lobectomy	1	1
42	44506	SCLC	56	M	780	1	0	0	SCLC	Yes	PR: 50%	Lobectomy	1	0
43	48003	SCLC	68	F	270	1	0	0	SCLC	Yes	PR: 47%	Lobectomy	1	0

Table 1 (*continued*)

pM	p-Stage	Size (mm)	p	pm	v	ly	Adj-CTx	Reccurence	Treatment for recurrence: Regimen	Reduction status	Prognosis	Final follow-up (d)	Cause of death	Group
0	IIIB	22	1	1	1	1	Yes	Yes	CTx	PR	Dead	296	Pneumonia	N+B−
1	IV	50	0	2	1	0	Yes	Yes	CRTx	SD	Dead	737	Lung cancer	N+B+
0	IIIB	70	3	0	1	1	Yes	Yes	CTx	SD	Dead	568	Lung cancer	N+B+
0	IIIA	32	0	0	1	1	Yes	Yes	CRTx	CR	Dead	616	Lung cancer	N+B−
0	IIIA	16	0	0	0	1	Yes	None			Dead	732	Unknown	N+B−
0	IIIB	18	0	1	1	1	Yes	None			Alive	5825		N−B−
0	IB	33	0	0	1	0	Yes	Yes	Unknown[a]		Dead	617	Lung cancer	N+B+
0	IIA	20	2	0	1	1	None	Yes	Unknown[a]		Dead	209	Lung cancer	N+B−
0	IB	33	0	0	1	0	Yes	None			Alive	4103		N+B−
0	IIIB	26	0	1	1	1	None	None			Alive	4029		N+B−
0	IA	24	0	0	1	0	None	None			Dead	495	Mesentric embolism	N+B+
0	IA	22	0	0	1	0	Yes	Yes	CRTx + Op	PD	Dead	747	Lung cancer	N+B−
0	IB	45	0	0	1	0	Yes	None			Dead	2691	Unknown	N+B−
0	IA	20	1	0	1	0	None	None			Dead	174	Pneumonia	N+B−
0	IIIB	13	0	0	1	1	Yes	None			Alive	4072		N+B+
0	IIA	16	0	0	1	1	Yes	Yes	CTx	PD	Dead	373	Lung cancer	N+B−
0	IIIB	42	3	0	1	0	Yes	Yes	Unknown[a]		Dead	616	Lung cancer	N+B−
0	IIIA	25	0	0	1	1	Yes	Yes	CTx	PD	Dead	465	Lung cancer	N+B+
0	IIA	22	0	0	1	0	Yes	Yes	RTx	PR	Dead	948	Lung cancer	N+B−
0	IIIB	40	1-3[b]	1	1	1	None	Yes	RTx	CR	Dead	1098	Lung cancer	N+B−
0	IA	20	0	0	1	1	Yes	None			Alive	2682		N+B−
0	IA	19	0	0	1	0	None	Yes	CTx	SD	Dead	1157	Lung cancer	N+B−
0	IA	15	0	0	0	0	Yes	None			Alive	2167		N−B−
0	IIIB	58	3 (interlobe)	0	1	1	None	Yes	None[d]		Dead	77	Lung cancer	N−B−
0	IIIA	54	0	0	1	1	None	Yes	RTx	PD	Dead	120	Lung cancer	N+B+
0	IB	49	0	0	1	1	Yes	None			Alive	2623		N−B−
0	IIIB	48	1	1	1	1	Yes	Yes	RTx	CR	Dead	815	Lung cancer	N+B−
0	IIIB	11	0	1	1	1	None	None			Dead	312	Lung cancer	N+B−
0	IA	30	0	0	0	0	Yes	None			Dead	702	Respiratory failure	N−B−
0	IIA	20	0	0	1	1	Yes	None			Alive	3077		N−B−
0	IIIB	80	3	0	1	0	Yes	None			Alive	3037		N−B−
0	IB	80	1	0	1	0	Yes	None			Alive	2772		N−B−
0	IIA	15	2	0	1	1	Yes	Yes	CRTx	PR	Dead	1094	Lung cancer	N+B−
0	IIB	23	2	0	1	0	None	Yes	None[c]		Dead	620	Lung cancer	N+B−
0	IIIB	21	0	1	1	1	Yes	None			Alive	2363		N+B+
0	IB	32	1-3[b]	0	1	1	Yes	None			Dead	1203	Unknown	N+B−
0	IIIB	53	3	0	1	1	None	Yes	CRTx	PR	Dead	538	Lung cancer	N+B−
0	IIIA	31	0	0	1	0	Yes	Yes	Unknown[a]		Dead	760	Lung cancer	N+B−
0	IA	22	0	0	1	0	Yes	None			Alive	1330		N+B−
0	IB	32	1	0	0	1	Yes	None			Dead	1239	Other cancer	N−B−
0	IIA	30	0	0	1	1	No	Yes	RTx	SD	Dead	432	Lung cancer	N−B−
0	IA	9	0	0	0	0	No	Yes	RTx	PR	Dead	792	Lung cancer	N+B−
0	IA	11	0	0	0	0	No	None			Alive	2025		N+B−

2.5. Immunohistochemical analysis

Although histologic diagnosis was made based on H&E staining, immunohistochemical analyses were performed to characterize cells. Four-micrometer-thick tissue sections were mounted on silane-coated slides, routinely deparaffinized in xylene, and rehydrated through graded ethanol. For antigen retrieval, the slides were heated at 97°C for 40 minutes in citrate buffer at pH 6.0 or in EDTA buffer at pH 9.0. Immunohistochemical staining was performed using the EnVision+ DAB system with an autostainer (Dako, Glostrup, Denmark). Endogenous peroxidase activity was blocked with 3% hydrogen peroxide in methanol, and then each antibody was applied (Supplementary Table 1). We used antibodies for synaptophysin (SYP), chromogranin A (CGA), and CD56 as NE markers, as well as antibodies for p63 and high-molecular-weight cytokeratin (clone 34βE12 or K903) as basal cell markers (BA). Particular attention was paid to judgment of immunoreactivity in surgical materials because we intended to make a comparison between surgical and biopsy materials. Specifically, to avoid false-negative judgments in surgical materials, we always confirmed that positive control cells were correctly stained. Immunoreactivity was scored based on the percentage of cells that stained positively: negative, 0; less than 10%, 1+; 10% to 50%, 2+; and more than 50%, 3+. Only foci with SCLC morphology were evaluated if the case was diagnosed as combined with non-SCLC. The expression of each antibody in a tumor was defined as positive when 10% of the tumor cells or greater were stained (scores 2+ and 3+) and negative when less than 10% were stained (scores 0 and 1+). We defined cases with either positive p63 or CK34βE12 as belonging to the BA+ group and cases with any one of positive SYP, CGA, or CD56 as the NE+ group. Accordingly, all cases were divided into 4 groups: NE+BA−, NE+BA+, NE−BA+, and NE−BA−. Two independent observers (W. H. and Y. I.) pathologically reviewed all slides without any prior knowledge of patients, and discrepancies were resolved by joint discussion of the slides viewed with a multiheaded microscope.

2.6. Analysis of clinicopathological parameters

All analyses were performed using GraphPad PRISM software (ver 5.0b for Macintosh; GraphPad Software, San Diego, CA, USA) and SPSS software (ver 15.0; SPSS, Chicago, IL). We analyzed statistical correlations for clinicopathological features using the χ^2 test with Yate correction. Survival curves were delineated by Kaplan-Meier method, and survival difference was tested by the log-rank test using overall survival or cancer-specific survival, as appropriate. We also conducted univariate and multivariate analyses of the prognostic factors using the Cox proportional hazards model. All differences were considered statistically significant if $P < .05$.

3. Results

3.1. Gene expression analysis by microarray

To validate the results of the previous study with our cDNA microarray, 30 SCLCs were enrolled for the current study. The clinical characteristics of the enrolled cases were as follows: 21 men and 9 women; average age, 67 years; 27 (90%) were smokers; the median tumor size was 31 mm; and 14 (47%) were at p-stage I.

Unsupervised hierarchical clustering was performed with 15 431 of 54 000 probe sets on oligonucleotide array chips (Affymetrix HG U133 plus 2.0) expressed stably among all samples. The result of this clustering is shown in Fig. 1A. We obtained again 2 clusters, groups 1 and 2, and cases in group 2 had significantly better survival ($P = .0014$; Fig. 1B). We compared which genes were differently expressed in these 2 groups (Supplementary Table 2). Cases in group 2 highly expressed genes related to cell growth (G protein-coupled receptor, cyclin D1, *MYC*, etc), but many genes related to NE differentiation (*ASCL1*, *GRP*, *NCAM* [*CD56*], *CHGA*) were down-regulated.

3.2. Clinical characteristics of SCLC surgical patients and inoperable patients

As detailed in Table 1, for the surgical patients, the male/female ratio was 34:9, with a median age of 67 years (range, 46-84 years). Forty patients (95%) were smokers, with an average SI of 987. The median duration of follow-up was 24 months (range, 1-191 months). Among these, only 23 cases (53%) were definitely diagnosed as having an SCLC

Notes to Table 1

Abbreviations: p, pleural invasion; pm, intrapulmonary metastasis; v, vascular invasion; ly, lymphatic involvement; Adj-CTx, adjuvant chemotherapy; PR, partial response; CTx, chemotherapy; CRTx, chemoradiotherapy; RTx, radiotherapy; Op, Operation; LCC, large cell carcinoma; SD, stable disease; CR, complete response; p/d, poorly differentiated; ca, carcinoma; SQ, squamous cell carcinoma; AD, adenocarcinoma; NSCLC, non-small cell carcinoma; AS, adenosquamous cell carcinoma; NEC, NE carcinoma.

[a] Unknown means that the patient had treatment at another hospital.

[b] Invasion of visceral pleura was graded according to the report of Satoh et al [16]; p1-3 implies that a tumor extends to connective tissues between visceral and parietal pleural membranes.

[c] Double-synchronous primary carcinoma, SQ, and SCLC.

[d] Patients had best supportive care because of poor performance status.

[e] Patients had best supportive care because of his own decision.

Table 2 Immunoreactivity score and serum markers

Cases	Ref. no.	Immunoreactivity score								Serum markers					Group
		NE	SYN	CGA	NCAM	BA	p63	K903	Ki-67 (%)	CEA	SCC	CYFRA	NSE	ProGRP	
1	29635	1	3	3	3	0	1	0	90	3.9	1.1	–	–	–	N+B−
2	30017	1	3	3	3	1	3	0	90	6.4	0.5	–	–	–	N+B+
3	30156	1	3	1	1	1	3	1	100	4	1.1	–	–	+	N+B+
4	30323	1	3	3	3	0	0	0	80	3.1	0.3	–	9.6	–	N+B−
5	30865	1	3	3	3	0	0	0	70	2.3	–	–	–	–	N+B−
6	31160	0	1	0	1	0	0	1	80	7.1	0.5	–	6.7	–	N−B−
7	31401	1	3	0	3	1	1	2	80	4.2	0.7	–	4	–	N+B+
8	32658	1	3	3	3	0	1	1	100	3.9	2.1	–	–	–	N+B−
9	33130	1	3	1	3	0	0	0	60	11.2	–	–	–	–	N+B−
10	33587	1	3	0	3	0	1	0	70	23.9	–	–	–	–	N+B−
11	34802	1	3	1	3	1	3	3	80	4.1	0.9	–	–	–	N+B+
12	34947	1	3	2	3	0	1	0	70	0.8	0.7	–	8.8	–	N+B−
13	35452	1	3	3	3	0	0	1	80	5.5	–	–	4.6	–	N+B−
14	35628	1	3	3	3	0	1	1	100	1.3	4	–	3.2	–	N+B−
15	35996	1	3	3	3	1	2	0	80	1.1	–	–	1.9	–	N+B+
16	36454	1	3	3	3	0	0	0	100	3.2	1.2	–	7.2	–	N+B−
17	36483	1	0	1	3	0	1	0	80	3.2	1.4	–	5.1	–	N+B−
18	36819	1	3	3	3	1	2	0	80	5.4	0.2	–	14.3	–	N+B+
19	38779	1	3	3	3	0	0	1	90	2.1	0.2	–	7.6	70	N+B−
20	38809	1	3	3	3	0	0	0	90	6.7	0.4	–	8.6	–	N+B−
21	39001	1	3	3	3	0	0	1	100	2.3	–	1.3	6.4	29.9	N+B−
22	39080	1	3	3	3	0	1	1	70	8.4	–	–	–	–	N+B−
23	39401	0	0	1	1	0	0	1	90	3.6	2	–	–	–	N−B−
24	39933	0	0	0	1	0	0	1	70	5.7	0.4	4.5	6.7	17.2	N−B−
25	40557	1	3	3	3	1	3	3	100	2.1	0.4	3.5	7.5	20.5	N+B+
26	40805	0	0	0	1	0	0	0	100	3.5	0.7	1.8	6.5	25.5	N−B−
27	40914	1	3	1	3	0	1	0	100	15.1	0.7	2.4	6.6	72.5	N+B−
28	41179	1	3	3	3	0	1	1	70	3.1	1	–	3.8	151	N+B−
29	41310	0	0	1	1	0	1	0	70	6.3	0.3	1.8	4.9	35.3	N−B−
30	42085	0	1	0	0	0	1	1	80	3	0.6	1.3	2.1	20.8	N−B−
31	42253	0	0	1	0	0	0	0	90	5.2	0.4	4.7	13	26.4	N−B−
32	43417	0	1	0	1	0	0	1	90	1.7	–	2.3	10	26.6	N−B−
33	44106	1	3	3	3	0	1	0	100	2.3	0.7	–	–	78.3	N+B−
34	44165	1	3	3	3	0	1	1	90	5.4	1	–	–	–	N+B−
35	44304	1	0	1	2	1	0	3	80	3	0.4	–	–	18.6	N+B+
36	45819	1	3	2	1	0	1	1	100	3.9	–	–	–	49.6	N+B−
37	46287	1	3	3	3	0	0	0	90	5.3	–	–	23	638	N+B−
38	49271	1	3	3	3	0	1	1	100	18.8	0.7	–	6.9	56.2	N+B−
39	50455	1	3	3	3	0	0	0	90	2.6	0.6	–	–	32.4	N+B−
40	40245	0	0	0	0	0	0	0	80	3	0.2	–	12	24.7	N−B−
41	42388	0	0	0	0	0	0	0	70	4.2	–	–	–	–	N−B−
42	44506	1	3	3	3	0	0	0	90	1.9	–	1.2	2.8	16.4	N+B−
43	48003	1	2	3	3	0	0	0	70	0.8	0.9	1.4	–	267	N+B−
Positive ratio (%)		77	72	58	72	19	14	9	70-100	35	10	27	15	40	
N+: positive ratio (%)		100	94	75	94	24	18	12	86.1	33	9	20	11	62	
N−: positive ratio (%)		0	0	0	0	0	0	0	82	40	12	33	25	0	

NOTE. Reference values: CEA, 5.0 ng/mL; SCC, 1.5 ng/mL; CYFRA, 3.5 ng/mL; NSE, 10 ng/mL; ProGRP, 45.9 pg/mL.

before surgery. Most patients received a lobectomy and N2 lymph node dissection, except for 1 segmentectomy for a stage IA case, 1 pneumonectomy for stage IIB, and 2 partial resections. These 2 patients underwent partial resection because one was at a high risk (an advanced age and poor respiratory function) and the other had synchronous double-lung cancer with lobectomy performed for a larger tumor diagnosed as squamous cell carcinoma. Postoperatively, 25

cases were up-staged after identification of N or T factors. All information about the surgical patients is shown in Table 1, including invasion of visceral pleura, as graded for a previous study [16], and prognosis.

The characteristics of the biopsy group (n = 51) were as follows: median age, 67 years (range, 54-85 years); male/female ratio, 44:7; and 96% (43/45) having smoking history (average SI was 1152). One-year and 3-year survival rates were 57% and 2%, respectively. The serum level of ProGRP was higher than the reference value in 49 (96%) of 51 patients, and that of NSE was also higher in 27 (82%) of 33 patients.

Histologic review of resected materials confirmed that all cases were SCLCs according to the WHO classification, including 9 combined types as follows: 4 cases combined with adenocarcinomas, 1 with adenosquamous carcinoma, 1 with spindle cell carcinoma, 2 with large cell carcinoma, and 1 with LCNEC. Atypical cases were reviewed and agreed also by the pathology panel members of the Ministry of Health, Labour and Welfare study group as well as by some of the International Association for the Study of Lung Cancer pathology committee members. Tumors resembling SCLC such as Ewing sarcoma, poorly differentiated synovial sarcoma, lymphoma, squamous cell carcinoma composed of small-sized cells, and BA carcinoma were excluded, based on IHC results and/or close histopathologic observation.

3.3. NE and BA phenotypes in surgical and biopsied cases

Of the surgical patients, 31 (72%) were positive for SYN, 25 (58%) for CGA, 31 (72%) for CD56, 6 (14%) for p63, and 4 (9%) for CK34βE12. Percentages of NE marker positivity (58%-72%) were similar to the previous study based on surgery (57%-58% for SYN and CGA [7]). Immunoreactivity of BA markers might be explained by combined components with SCLC [12], although some cells were positive for both NE and BA markers. Interestingly, there were 8 patients (19%) positive for at least 1 BA marker, and 10 (23%) were negative for all NE markers (Table 2). According to these results, all cases could be classified into 4 subgroups: NE+BA− (n = 25; 58%), NE+BA+ (n = 8; 19%), NE−BA+ (n = 0), and NE−BA− (n = 10; 23%). Histologically, or using the Ki-67 index, it was difficult to distinguish among the 3 groups (Fig. 2; Table 2). When we compared immunoreactivity with several serum markers, the ProGRP value was significantly higher in the NE+ group, and no patients had an abnormal value in the NE− group (P = .023; Table 2), implying a good correlation of the NE phenotype between serum and tumors.

We examined concordance of classification by gene expression profiling and IHC phenotyping. Of 30 SCLC cases analyzed by gene expression profiling, 28 were successfully examined by IHC. All 12 cases classified to group 1 (poor prognosis group) by gene expression profiling fell into the NE+ group by IHC. Of the 16 cases classified to group

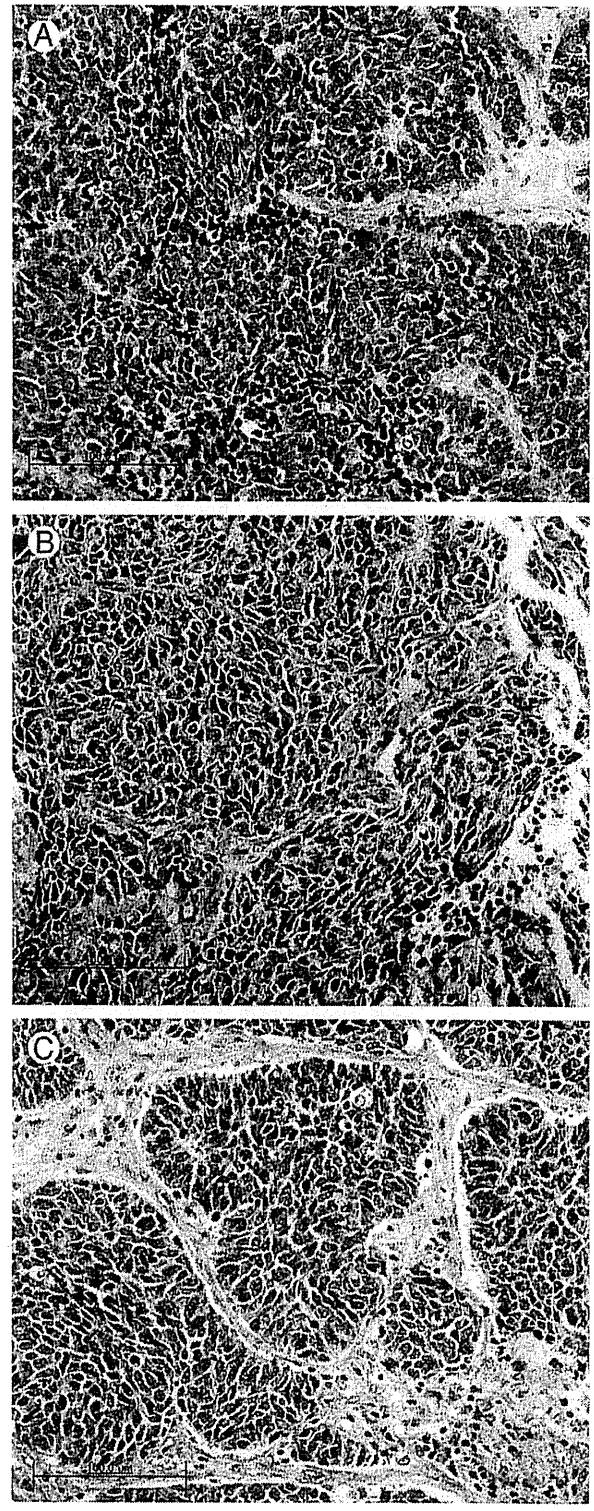

Fig. 2 Representative histologic pictures of SCLC subsets by NE differentiation and BA phenotypes (H&E, original magnification ×40). A, NE+BA−. B, NE+BA+. C, NE−BA−. Notably, there are almost no histopathologic differences among the 3 tumors, including mitosis counts.

Table 3 Comparison of clinicopathological features in the SCLC subgroups with/without NE and BA natures

Variable	No. of cases (n = 43)	NE markers		P	BA markers		P
		Negative (n = 10)	Positive (n = 33)		Negative (n = 35)	Positive (n = 8)	
Age (y)				.481			.7381
<60	10	1	9		9	1	
>61	33	9	24		26	7	
Sex				.718			.8666
Male	34	7	27		27	7	
Female	9	3	6		8	1	
Smoking status				.779			.9287
Never	3	1	2		2	1	
Smoker	40	9	31		33	7	
Tumor size (mm)				.818			.9044
≦30	25	5	20		21	4	
>30	18	5	13		14	4	
Lymph node metastasis				.616			.3605
Negative	25	7	18		22	3	
Positive	18	3	15		13	5	
Pathological stage				.687			.5953
I	17	5	12		15	2	
II-IV	26	5	21		20	6	
Combined subtypes	10	2	8		8	2	
AD	5	1	4		5	0	
SQ	0	0	0		0	0	
AS	1	0	1		0	1	
Spindle	1	0	1		1	0	
LCC	2	0	2		1	1	
LCNEC	1	1	0		1	0	
Induction CTx				.049			.9044
Negative	25	9	16		20	5	
Positive	18	1	17		15	3	
Adjuvant CTx				.56			.9303
Negative	14	2	12		12	2	
Positive	29	8	21		23	6	

Abbreviations: AD, adenocarcinoma; SQ, squamous cell carcinoma; AS, adenosquamous cell carcinoma; LCC, large cell carcinoma; CTx, chemotherapy.
NOTE. All were analyzed by χ^2 test with Yate correction.

2 (good prognosis group), 9 fell in the NE− group and the other 7 in the NE+ group. The concordance rates for groups 1 and 2 were 100% (12/12) and 56% (9/16), respectively.

For biopsy cases, all but 1 were positive for all the 3 NE markers and all were negative for the 2 BA markers. Only 1 patient was negative for CD56 and positive for SYN and CGA. As compared with surgical cases, therefore, the tumors of biopsy cases had a marked NE nature and lacked BA phenotypes.

3.4. Clinicopathological comparison between NE or BA expression and prognosis

We evaluated clinicopathological characteristics according to immunoreactivity for NE and BA markers (Table 3). Unfortunately, only 1 patient in the NE− group underwent induction chemotherapy, so we could not evaluate if the NE− tumors were chemosensitive or not. Rather, this indicated that tumors of the NE− group had almost no influence of chemotherapy and that their characteristics identified by IHC were innate, implying that the results of low NE expression were reliable. No factors showed any significant difference between the BA+ and BA− groups.

SCLC-specific survival curves of NE+/− and BA+/− groups are shown in Fig. 3. There was no difference based on the presence of BA phenotypes ($P = .28$; Fig. 3A), but NE phenotypes were critical for patient survival. In fact, the NE− group had a significantly better prognosis than did the NE+ group ($P = .03$; Fig. 3B). Among the 3 groups (NE+BA+, NE+BA−, NE−BA−), the NE−BA− group also showed a significant tendency toward a better outcome ($P = .036$; Fig. 3C).

3.5. Univariate and multivariate analyses of factors influencing prognosis

Thirty-three surgically treated patients underwent both lobectomy (single or bilobectomy) and platinum-based double chemotherapy (induction and/or adjuvant, ≥4 courses). We used this group with the same treatment condition to evaluate the factors influencing prognosis. Univariate analyses for

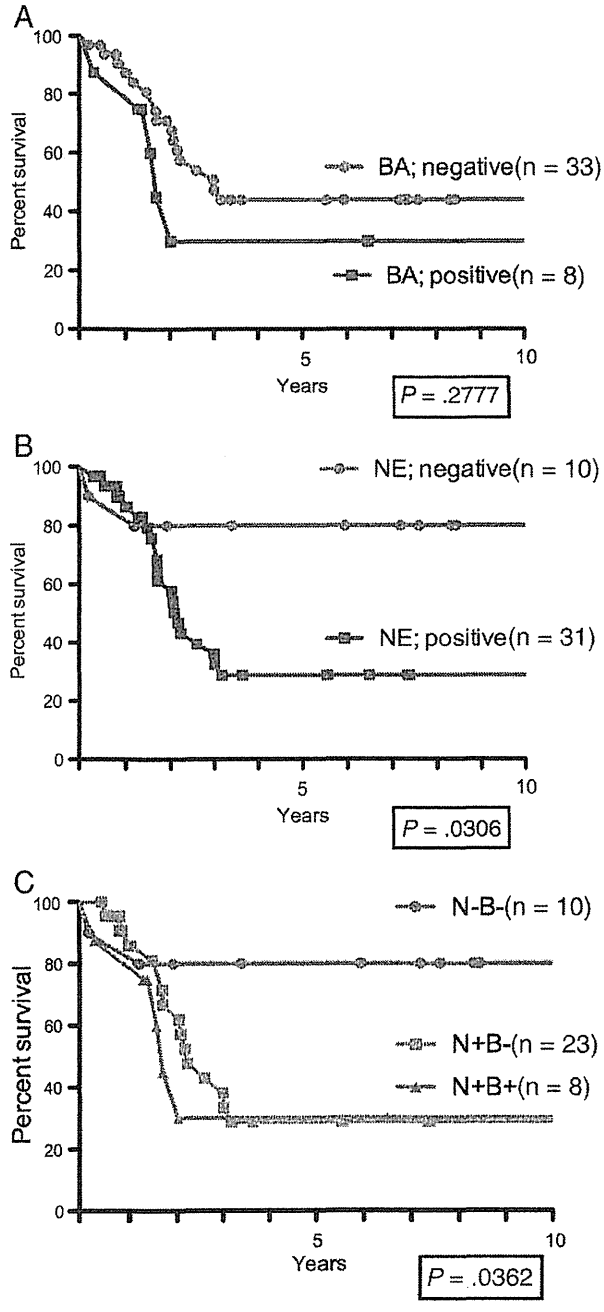

Fig. 3 SCLC-specific survival for patients with or without BA markers (A), $P = .278$, and NE markers (B), $P = .0306$. C, the NE− BA− group features a significantly better prognosis than the others.

overall survival showed that patients negative for NE markers tended to have good prognosis ($P = .047$; Table 4A). When using SCLC-specific survival, univariate analysis showed that both pathological stages ($P = .016$) and NE marker reactivity ($P = .012$) were significant markers for good prognosis. Age, SI, lymphovascular invasion, and BA marker immunoreactivity had no prognostic value. Multivariate analyses revealed that NE marker expression was the only independent factor influencing prognosis (Table 4B; risk ratio, 5.577; 95% confidence interval [CI], 1.172-26.524; $P = .031$). Multivariate analysis for SCLC-specific survival did not produce any significant results probably because the NE− group included no SCLC-specific deaths.

3.6. Induction chemotherapy and its effects on survival

Of the 43 surgical patients analyzed here, 17 (40%) underwent induction chemotherapy, and the reduction rate ranged from 24% to complete response, as detailed in Table 1. Because pretreatment might have some effect on prognosis, we performed survival analyses using 26 cases without pretreatment by comparing SCLC-specific survival between N+ (n = 17) and N− (n = 9) subgroups. As shown in Supplementary Fig. 1A, the survival of NE− subgroup was 3 times better than the NE+ subgroup. Although the difference was not significant ($P = .148$), this was probably due to the small number of cases. Furthermore, we compared SCLC death rates and survival difference of NE+ cases (n = 33) between those with induction chemotherapy (n = 16) and without (n = 17). They were 11 (69%) of 16 for cases with the pretreatment and 9 (53%) of 17 for cases without and were not significantly different. Also, as Supplementary Fig. 1B indicates, survival was not different between the 2 subgroups ($P = .19$), although the number of cases was larger than the analysis using non-pretreated cases. Based on these findings, we used all the cases including cases both with and without pretreatments for survival analysis.

4. Discussion

To our knowledge, this is the first report describing a hitherto unmarked SCLC subtype with a good prognosis, using substantial numbers of surgically resected cases. Here we demonstrated that the subtype can be detected by IHC alone using NE markers such as SYP, CGA and CD56. Previously, we identified the subtype by global gene expression profiling using cDNA microarrays. The current study, using oligonucleotide arrays (by Affymetrix), duplicated fairly well the subset with additional new cases. Also in this study, we focused on characterizing the SCLC subset by hypothesizing that low expression of NE-related proteins and/or a BA nature of tumor cells might explain differences from standard SCLCs.

In fact, BA carcinoma histologically resembles SCLC, and the BA pattern is a marker for worse prognosis for non-SCLC [17]. Our univariate and multivariate analyses reveal, however, that expression of NE markers is a prognostic factor, but the BA phenotype in terms of CK34βE12 and p63 protein expression has no effect on survival. The immunohistochemically defined obvious subtype of SCLC with a good prognosis comprised 23% of the surgically resected SCLC. Because there were no such cases in

Table 4 Univariate and multivariate analyses on factors influencing overall survival, based on all cases (n=96, surgery [n=45] and biopsy [n=51]). (A) analyses for SCLC-specific survival (B)

Parameters	A					B
	Univariate	Multivariate				Univariate
	P	*P*	Exp (coefficient)	Lower (95% CI)	Upper (95% CI)	*P*
Age (>60 y)	.900	.666	1.256	0.447	3.525	.618
Sex	.777					.303
Pathological stage (>I)	.135	.095	2.381	0.860	6.592	.016
Vascular invasion	.886					.174
Lymphatic invasion	.827					.534
NE marker	.047	.031	5.577	1.172	26.524	.012
BA marker	.777	.331	0.559	0.173	1.804	.208

inoperable patients, we could not perform a study using only biopsy materials.

According to the current WHO criteria for NE tumors, it is necessary to prove NE phenotypes for LCNEC diagnosis, but not for SCLCs. In the present study, approximately 80% of surgical tumors had NE phenotypes, largely consistent with the previous studies [7,18,20], and all the biopsy cases had obvious NE phenotypes proven by IHC. Although this fact suggests that the current WHO criteria work quite well, they are insufficient to distinguish the atypical SCLC subtype with a good prognosis, particularly for surgical cases.

Serum tumor markers including NSE, ProGRP, and CD56 are useful for clinical diagnosis of SCLC, and their immunohistochemical staining has been used for discrimination of NE tumors from others. However, their prognostic value has proved controversial [21,23]. In this study, we demonstrated immunohistochemical use for outcome prediction. Also, the NE marker levels in serum tended to be higher in the group with a poor prognosis. In fact, almost all the cases with elevated serum markers belonged to the poor prognosis group, as shown in Table 2. Because the number of cases with measured serum NE markers in the good prognosis group is limited, we should continue comparing the prognosis between groups with and without elevated values.

Chemosensitivity and radiosensitivity is crucial for SCLC treatment. Unfortunately, we were unable to determine if our NE− (negative) group was chemosensitive or not because none of the cases underwent induction chemotherapy or treatment of a recurrent tumor. We should further investigate sensitivity by accumulating more cases of this particular SCLC subtype.

Although it is difficult to distinguish histologically an SCLC subtype with a good prognosis, such a subtype may exist, which has distinct cellular and genetic characteristics. In our previous study [13], we performed an integrated analysis using clinical SCLC tumors and established SCLC cell lines. As a matter of fact, there were no cell lines that clustered together with the good prognosis subtype. Therefore, further studies may include establishing cell lines of this particular SCLC subtype.

Supplementary data

Supplementary data to this article can be found online at http://dx.doi.org/10.1016/j.humpath.2014.01.001.

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ORIGINAL ARTICLE

FHL1 on chromosome X is a single-hit gastrointestinal tumor-suppressor gene and contributes to the formation of an epigenetic field defect

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Tumor-suppressor genes on chromosome X can be inactivated by a single hit, any of the point mutations, chromosomal loss and aberrant DNA methylation. As aberrant DNA methylation can be induced frequently, we here aimed to identify a tumor-suppressor gene on chromosome X inactivated by promoter DNA methylation. Of 69 genes on chromosome X upregulated by treatment of a gastric cancer cell line with a DNA-demethylating agent, 5-aza-2′-deoxycytidine, 11 genes had low or no expression in the cell line and abundant expression in normal gastric mucosae. Among them, *FHL1* was frequently methylation-silenced in gastric and colon cancer cell lines, and methylated in primary gastric (21/80) and colon (5/50) cancers. Knockdown of the endogenous *FHL1* in two cell lines by two kinds of shRNAs significantly increased cell growth *in vitro* and sizes of xenografts in nude mice. Expression of exogenous *FHL1* in a non-expressing cell line significantly reduced its migration, invasion and growth. Notably, a somatic mutation (G642T, Lys214Asn) was identified in one of 144 colon cancer specimens, and the mutant *FHL1* was shown to lack its inhibitory effects on migration, invasion and growth. *FHL1* methylation was associated with *Helicobacter pylori* infection and accumulated in normal-appearing gastric mucosae of gastric cancer patients. These data showed that *FHL1* is a methylation-silenced tumor-suppressor gene on chromosome X in gastrointestinal cancers, and that its silencing contributes to the formation of an epigenetic field for cancerization.

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Keywords: field for cancerization; chromosome X; DNA methylation; gastrointestinal cancer; *Helicobacter pylori*

INTRODUCTION

Inactivation of tumor-suppressor genes is deeply involved in cancer development and progression.[1] The vast majority of tumor-suppressor genes are somatically inactivated by two hits of both alleles by genetic and/or epigenetic mechanisms, such as point mutations, chromosomal deletions and aberrant DNA methylation of promoter CpG islands (CGIs).[2,3] The two-hit theory makes tumor-suppressor genes on chromosome X unique because they can be inactivated by a single hit, and thus are 'risky' genes. So far, three examples have been identified, including *WTX* in Wilms tumors,[4] *FOXP3* in breast and prostate cancers[5,6] and *PHF6* in T-cell acute lymphoblastic leukemia (T-ALL),[7] all of which are inactivated by a point mutation or chromosomal loss.

Among the mechanisms of tumor-suppressor gene inactivation, aberrant DNA methylation can be present not only in tumor tissues but also in normal-appearing tissues, such as non-cancerous tissues of gastric,[8,9] colon,[10] liver,[11] esophageal,[12–14] breast[15] and renal cancer patients.[16] Levels of aberrant DNA methylation in non-cancerous tissues correlate with cancer risk clearly for gastric cancers[8,17] and other cancers, and accumulation of aberrant DNA methylation in a tissue is considered to form an epigenetic field for cancerization (epigenetic field defect).[18] Such association has been analyzed using methylation levels of marker genes, which are methylated in association with various tumor-suppressor genes and show much higher levels, and only a limited number of genes that functionally contribute to the field defect have been identified.

To identify risky genes that contribute to the formation of an epigenetic field defect, we here searched for genes on chromosome X from the 495 genes whose expression was upregulated fourfold or more after treatment with a DNA-demethylating agent, 5-aza-2′-deoxycytidine (5-aza-dC)[19] of a gastric cancer cell line (AGS), which is known to have very frequent methylation of CGIs.[20]

RESULTS

Screening of methylation-silenced genes on chromosome X

Among the 495 genes whose expression was upregulated fourfold or more by treatment of the AGS gastric cancer cell line with 5-aza-dC, 69 genes were located on chromosome X. Among the 69 genes, 11 genes had low expression (signal intensity <200) in non-treated AGS cells and had high expression (signal intensity >500) in a pool of gastric mucosae of three healthy volunteers.

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Genomic structures were analyzed for these 11 genes, and eight of them had CGIs in their promoter regions (Supplementary Table 1). Their mRNA expression levels were confirmed by quantitative reverse transcription–PCR (qRT–PCR) in non-treated AGS cells and gastric epithelial cells obtained by the gland isolation technique, and five (*MAOA, CXorf26, FHL1, SMARCA1* and *MAOB*) had consistent expression in gastric epithelial cells (Supplementary Table 1). Among the five genes, we focused on the *FHL1* gene, because it was reported to be able to inhibit growth, migration, invasion and metastasis of multiple types of cancer cells.[21–26] The other four genes were not reported to be involved in cancer development in the literature.

Promoter methylation and silencing of *FHL1* in gastrointestinal cancer cell lines

DNA methylation status of the *FHL1* promoter region was analyzed using two sets of methylation-specific PCR (MSP) primers designed to cover a region from the transcription start site to 220 bp upstream (Figure 1a). Among the 73 cancer cell lines analyzed (11 gastric, 7 colon, 12 lung, 12 skin, 7 pancreas, 4 esophageal, 4 prostate, 6 breast and 10 ovary cancer cell lines; Supplementary Table 2), *FHL1* was completely methylated (no unmethylated DNA molecules detected) in seven gastric, three colon (Figure 1b) and one lung cancer cell lines. In normal-appearing gastric and colonic mucosae, and peripheral leukocytes of healthy volunteers, *FHL1* was completely unmethylated in males, and partially methylated in females (Figure 1c). The partial methylation in females was considered to reflect methylation of the inactive chromosome X, which is shown later.

The role of the promoter methylation in downregulation of *FHL1* expression was analyzed. First, an association between the methylation and loss of expression was confirmed among the 11 gastric and 7 colon cancer cell lines. *FHL1* was consistently unexpressed in seven gastric and three colon cancer cell lines with its complete methylation (Figures 2a and b), but was expressed in most of the cancer cell lines without methylation, in normal colonic epithelial cells (CRL1790 and CRL1831) and in normal-appearing gastric and colonic mucosae. Second, when promoter methylation was removed by 5-aza-dC treatment of AGS and

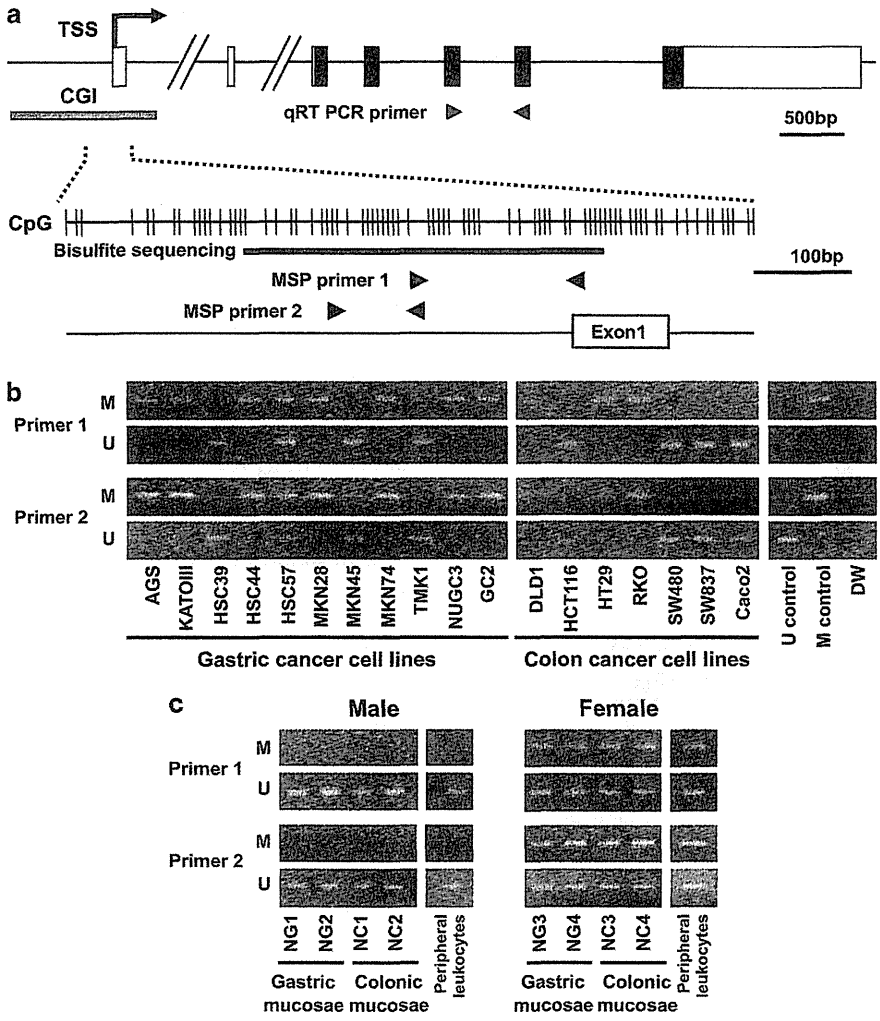

Figure 1. Genomic structure of *FHL1* and its methylation status in cancer cell lines, normal-appearing mucosae and peripheral leukocytes. (**a**) Genomic structure of *FHL1* and a CpG map of its promoter CGI. Open box, non-coding exon; closed box, coding exon; arrow, transcription start site (TSS); gray box, CGI region; vertical lines, individual CpG sites; arrowheads, primers for qRT–PCR and MSP; and bold line and number, the region and individual CpG sites analyzed by bisulfite sequencing. (**b**) Promoter methylation of *FHL1* in 11 gastric and seven colon cancer cell lines analyzed by MSP. M and U, primer sets specific to methylated and unmethylated DNA, respectively; U control, fully unmethylated genomic DNA; and M control, fully methylated genomic DNA. *FHL1* was frequently methylated in gastric and colon cancer cell lines. (**c**) Promoter methylation of *FHL1* in male and female normal-appearing gastric and colonic mucosae and peripheral leukocytes. *FHL1* was completely unmethylated in males and partially methylated in females.

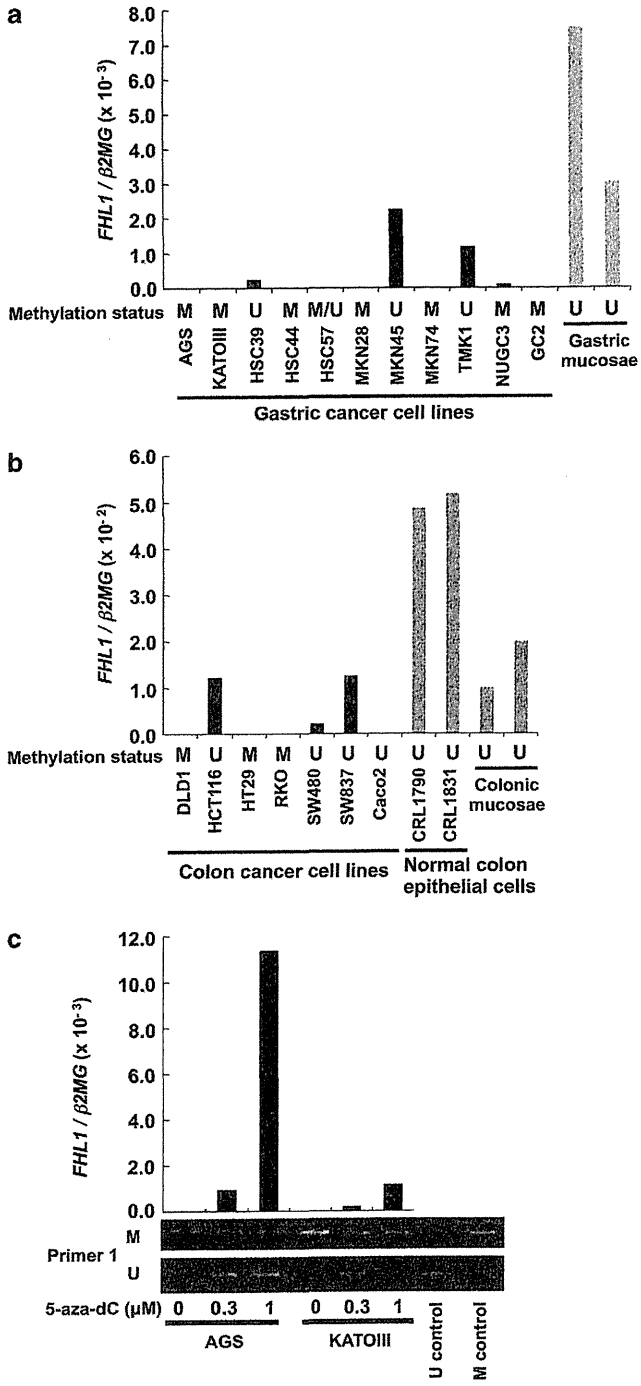

Figure 2. Methylation-silencing of *FHL1* in gastrointestinal cancer cell lines. (**a**) qRT–PCR of *FHL1* in gastric cancer cell lines and normal-appearing gastric mucosae. Results of MSP in Figure 1b are shown by M, M/U and U. M, only methylated DNA detected; M/U, both methylated and unmethylated DNA detected; and U, only unmethylated DNA detected. *FHL1* was not expressed in cell lines with complete methylation. (**b**) qRT–PCR of *FHL1* in colon cancer cell lines, normal colonic epithelial cells and normal-appearing colonic mucosae. *FHL1* was not expressed in cell lines with complete methylation. (**c**) Re-expression and demethylation of *FHL1* after 5-aza-dC treatment of AGS and KATOIII. *FHL1* expression was induced, along with its demethylation, after treatment with 5-aza-dC. U control, fully unmethylated genomic DNA; and M control, fully methylated genomic DNA.

KATOIII gastric cancer cell lines, *FHL1* expression was restored (Figure 2c). These data demonstrated that promoter methylation of *FHL1* caused its silencing.

Methylation of *FHL1* in surgical gastrointestinal cancer specimens

FHL1 methylation in surgical cancer specimens was analyzed by quantitative real-time MSP (qMSP) of 80 gastric and 50 colon cancers derived from male patients (Figure 3a). We adopted a cutoff value of 6%, which was previously determined based on the lowest methylation levels of tumor-suppressor genes in cancer samples,[9,27] and was also used in other researchers' report.[28] *FHL1* was methylated in 21 of the 80 (26%) gastric cancers and 5 of the 50 (10%) colon cancers. The presence of dense methylation of the promoter region was confirmed by bisulfite sequencing, and the fraction of densely methylated DNA molecules was in accordance with the methylation level obtained by qMSP (Figure 3b).

Association between promoter methylation and decreased expression was analyzed in 33 cancer specimens for which RNA was available. The mean *FHL1* expression level of 11 cancers with methylation was significantly lower than that of 22 cancers without methylation ($P=0.04$) (Figure 3c). Considering that surgical cancer specimens are contaminated with normal cells, the findings here supported that *FHL1* was methylation-silenced also in surgical cancer specimens.

Association between *FHL1* methylation and the CpG island methylator phenotype

Clinicopathological characteristics of cancers with *FHL1* methylation were analyzed in the 80 gastric cancers. *FHL1* methylation was not associated with tumor invasion, lymph node metastasis and histological type (Table 1). In contrast, *FHL1* methylation was associated with the presence of the CGI methylator phenotype (CIMP), 17 of 21 cancers with *FHL1* methylation (81%) and 13 of 59 without being CIMP-positive (22%; $P=2.9\times10^{-6}$). *FHL1* methylation was associated with the presence of Epstein–Barr virus (EBV) infection ($P=0.02$), but not with *hMLH1* methylation. This suggested that, between the two subtypes of CIMP-positive gastric cancers (those with EBV infection and those with *hMLH1* methylation),[29] *FLH1* methylation was associated with the former.

Growth-suppressive activity of *FHL1*

The effect of the *FHL1* expression loss on cell growth was analyzed by knocking down *FHL1* first *in vitro*. Two *FHL1*-specific shRNAs (sh1and sh2), along with a control shRNA (luciferase-specific shRNA; Luc-sh), were introduced into two cancer cell lines with *FHL1* expression (HCT116 and HSC39). *FHL1* expression was confirmed to be strongly suppressed by sh1 (11.7% of the control cells) and sh2 (14.8%) by qRT–PCR and also by western blot (Figure 4a). *FHL1* knockdown accelerated cell growth in HCT116 cells (sh1, 243% of control cells at 120 h, $P<0.001$, and sh2, 191%, $P<0.001$) and in HSC39 cells (sh1, 144% of control cells at 96 h, $P<0.01$, and sh2, 130%, $P<0.01$) (Supplementary Figure 1). Then, *in vivo* growth assay using a nude mouse xenograft model showed that HCT116 cells with *FHL1* knockdown formed 2.7-fold larger tumors than control cells (Luc-sh) ($P<0.001$) (Figure 4b), and that their mean weight was 2.8-fold heavier than that of control cells (Figure 4c). The maintenance of *FHL1* decrease by shRNA was confirmed (Supplementary Figure 2).

The growth-suppressive activity was further analyzed by expressing exogenous *FHL1* in two non-expressing cell lines (AGS and MKN28). By qRT–PCR and western blot, expression levels of the exogenous *FHL1* in AGS and MKN28 were shown to be ~10-and 40-fold, respectively, of those in non-cancerous gastric mucosae (Figures 4d and 5a, and Supplementary Figure 3a). *FHL1* expression reduced the cell growth in AGS (72.2% of control

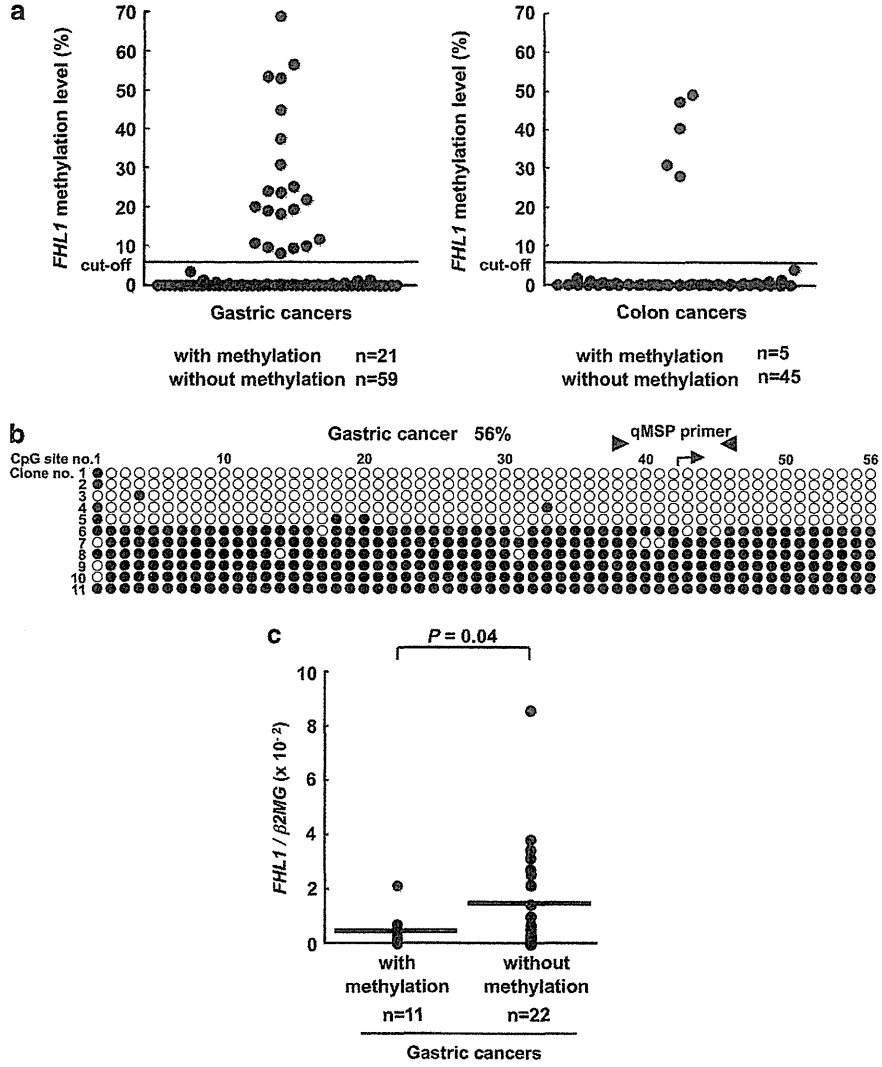

Figure 3. Methylation of *FHL1* in surgical gastrointestinal cancer specimens and its effect on expression. (**a**) Methylation levels in gastric (left) and colon (right) cancers derived from male patients. A horizontal line shows a cutoff value of 6%. *FHL1* was methylated in 21 of 80 primary gastric cancers and 5 of 50 colon cancers, respectively. (**b**) Confirmation of *FHL1* methylation by bisulfite sequencing. Fifty-six CpG sites were analyzed in a gastric cancer with a methylation level of 56%, and six of 11 DNA molecules were densely methylated. Closed circle, methylated CpG site; open circle, unmethylated CpG site; arrowheads, primers for qMSP; and arrow, transcription start site. (**c**) Decreased expression of *FHL1* in gastric cancers with methylation analyzed by qRT–PCR. A horizontal line represents the mean expression level in each group.

cells at 120 h, $P<0.05$; Figures 4d and 5b) but not in MKN28 (Supplementary Figure 3b).

Inhibitory effects of *FHL1* on migration and invasion

To clarify the mechanisms of how *FHL1* works as a tumor-suppressor gene, inhibitory effects of *FHL1* on cell migration and invasion were analyzed in two cell lines (AGS and MKN28). *FHL1* inhibited cell migration both in AGS (26.6% of control cells, $P<0.01$, Figure 5c) and in MKN28 (33.1% of control cells, $P<0.01$, Supplementary Figure 3c). In addition, *FHL1* inhibited cell invasion both in AGS ($P<0.05$, Figure 5d) and in MKN28 ($P<0.05$, Supplementary Figure 3d). In contrast, no induction of apoptosis was observed in AGS by terminal deoxynucleotidyl transferase dUTP nick end labeling assay (Supplementary Figure 4).

An *FHL1* mutation and its loss of function

FHL1 mutations were analyzed by sequencing its seven exons in 58 gastric and 144 colon cancer specimens derived from male patients. A somatic mutation (G642T; Lys214Asn) in exon 6 was identified in a colon cancer (Figure 5e). Also, a synonymous polymorphism (C450T) was observed in two gastric cancers. In the cancer with the G642T mutation, *FHL1* methylation was absent (data not shown), suggesting that either this mutation or promoter methylation was sufficient to inactivate *FHL1*. Further, the effects of the G642T mutation were analyzed by exogenously expressing the mutant and wild-type *FHL1* at similar levels (Figure 5a and Supplementary Figure 3a) in non-expressing AGS and MKN28 cells. The mutant *FHL1* lacked the inhibitory effects on migration and invasion both in AGS (Figures 5c and d) and in MKN28 (Supplementary Figures 3c and d). The mutant *FHL1* also lacked its inhibitory effect on cell growth in AGS (Figure 5b), whereas such effect could not be analyzed in MKN28, whose growth was not suppressed even by wild-type *FHL1*. These data indicated that the mutation was a loss-of-function mutation.

FHL1 methylation levels in non-cancerous gastric and colonic mucosae

To analyze the association between *FHL1* methylation and *Helicobacter pylori* (*H. pylori*) infection, and the contribution of

Table 1. Association between clinicopathological characteristics of patients and *FHL1* promoter methylation

Characteristics	*FLH1 methylation*		P
	Positive (N = 21)	*Negative (N = 59)*	
Tumor invasion			
⩽T2	13	33	0.80
>T2	8	26	
Lymph node metastasis			
Positive	15	50	0.20
Negative	6	9	
Histological type			
Intestinal	8	27	0.61
Diffuse	13	32	
CIMP			
Positive	17	13	2.9×10^{-6}
Negative	4	46	
EBV infection			
Positive	4	1	0.02
Negative	17	58	
hMLH1 *methylation*			
Positive	4	5	0.23
Negative	17	54	

Abbreviations: CIMP, CGI methylator phenotype; EBV, Epstein–Barr virus.

FHL1 methylation to the formation of an epigenetic field defect, *FHL1* methylation levels were quantified in gastric mucosae of male healthy volunteers (with and without *H. pylori* infection; 16 each) and non-cancerous mucosae of male gastric cancer patients (with and without *H. pylori* infection; 26 each) (Figure 6a). Among the healthy volunteers, *FHL1* methylation was elevated only in *H. pylori*-positive individuals (10 of 16, 62.5%; $P = 0.01$, *t*-test). As potent methylation induction by *H. pylori* can mask a difference in *H. pylori*-positive individuals,[8] *FHL1* methylation levels were compared between healthy volunteers and gastric cancer patients among the *H. pylori*-negative individuals. *FHL1* methylation level was shown to be elevated only in gastric cancer patients (5 of 26, 19.2%; $P = 0.09$, *t*-test). In the case of the colon, *FHL1* methylation was elevated in colonic mucosae of only 2 of 50 colon cancer patients (4%) (Supplementary Figure 5).

FHL1 methylation levels in female specimens

FHL1 methylation levels were analyzed in female specimens, including gastric mucosae of healthy volunteers (18 with *H. pylori* infection and 10 without), those of gastric cancer patients (7 with *H. pylori* infection and 11 without) and one specimen of peripheral leukocytes (Figure 6b). As in male specimens, among the healthy volunteers, *FHL1* methylation levels were significantly elevated in *H. pylori*-positive individuals ($P = 0.01$, *t*-test). Among the *H. pylori*-negative individuals, they tended to be higher in cancer patients than those in healthy volunteers ($P = 0.06$, *t*-test). *FHL1* methylation levels in *H. pylori*-negative female specimens were expected to be 50% because *FHL1* is located on chromosome X, but its actual distribution was between 20 and 40%. Bisulfite sequencing of the *FHL1* promoter region showed that female specimens contained DNA molecules with sparse methylation of CpG sites (Figure 6c), which was in contrast with the dense methylation in cancer specimens (Figure 3b). It was considered that the inactive chromosome X had sparse methylation of the *FHL1* promoter region not detected by qMSP.

DISCUSSION

The *FHL1* gene on chromosome X was shown to be a tumor-suppressor gene in gastrointestinal cancers by the presence of its methylation-silencing, its inhibitory effects on migration, invasion and growth, and the presence of a loss-of-function mutation. Notably, a loss-of-function mutation was identified for the first time in any type of cancers. This added *FHL1* as a new member of 'risky' tumor-suppressor genes on chromosome X, and the first tumor-suppressor gene on chromosome X that can be inactivated by methylation-silencing. *FHL1* methylation was associated with *H. pylori* infection and strongly accumulated in gastric mucosae of gastric cancer patients. Together with the fact that *FHL1* is a tumor-suppressor gene, the accumulation of *FHL1* methylation was considered to contribute to the formation of a field for cancerization as a driver.

Downregulation of *FHL1* in surgical specimens has been reported in breast, renal, prostate,[23] gastric,[25] liver,[21] and lung cancers.[22] The downregulation was associated with short patient survival and deep invasion in gastric cancers,[25] and with poor differentiation in lung cancers.[22] As a mechanism for the downregulation, methylation silencing was described in bladder cancers.[24] Functionally, *FHL1* has been reported to suppress growth of lung, liver and breast cancer cells and transformed fibroblasts,[21,22,26,30] and migration and invasion of bladder cancer cells and transformed fibroblasts.[24,26] The data obtained here were in line with previous reports, and demonstrated that *FHL1* inhibits migration and invasion in gastrointestinal cancer cells.[22]

Mechanistically, FHL1 is characterized by the presence of four and a half highly conserved LIM domains, which are involved in a wide range of protein–protein interactions, including actin cytoskeleton, cellular signaling proteins and transcriptional machinery.[31] In hepatocellular carcinomas, FHL1 was shown to interact with Smad2 and activate TGF-β pathway independently of TGF-β.[21] In breast cancers, FHL1 was shown to interact with estrogen receptor-α and estrogen receptor-β, and repress estrogen-responsive gene transcription.[30] Proteins that interact with FHL1 in gastric and colonic epithelial cells have not been clarified yet. However, inactivation of the TGF-β pathway is known to be involved in these cancers,[32] and is a strong candidate mechanism of how *FHL1* inactivation is involved in these gastrointestinal cancers.

FHL1 methylation was present not only in cancer tissues, but also in non-cancerous gastric mucosae of gastric cancer patients (5 of 26) and in non-cancerous colonic mucosae of colon cancer patients (2 of 50). This showed, for the first time in any types of cancers, that *FHL1* methylation silencing is involved in the formation of the epigenetic field defect as a driver. So far, only a limited number of driver genes, including *CDKN2A, CDH1* and *LOX*, are known to be involved in the formation of an epigenetic field defect.[18] For those genes on autosomes, it is difficult to estimate what fraction of cells has biallelic methylation. In contrast, in the case of *FHL1*, its methylation level linearly correlates with the fraction of cells with its inactivation, and, even if its methylation level is low, the presence of its methylation is expected to bring a significant impact. *H. pylori* infection is known to induce aberrant methylation that consists of temporary and permanent components,[8,33] and the high methylation levels in individuals with current *H. pylori* infection were in accordance with this previous finding.

In females, approximately half of the DNA molecules were methylated, densely or sparsely, in gastric mucosae and peripheral leukocytes of healthy volunteers without *H. pylori* infection by bisulfite sequencing. As no methylated DNA molecules were detected in a male specimen, both the densely and sparsely methylated DNA molecules in female specimens were considered to be derived from the inactive X allele.[34] However, we were not able to demonstrate it because a polymorphism that can

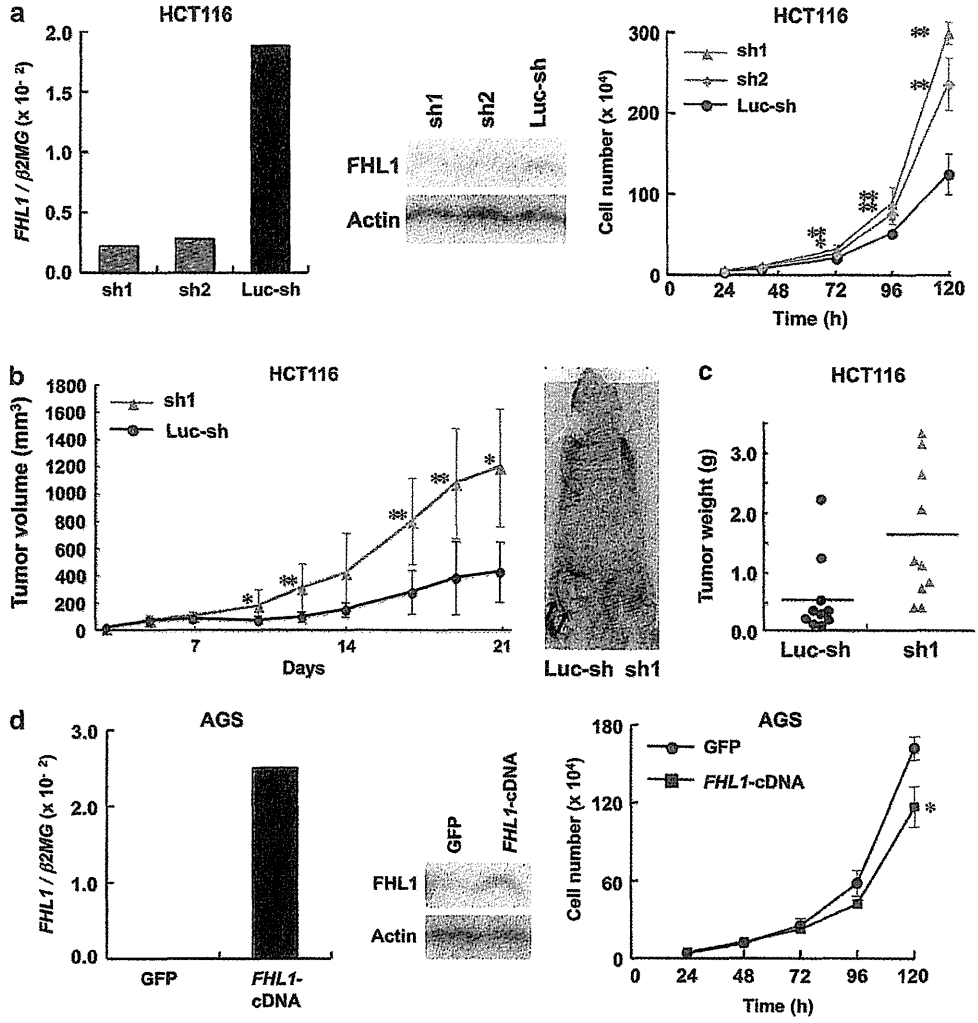

Figure 4. Growth-suppressive activity of *FHL1 in vitro* and *in vivo*. (**a**) *FHL1* knockdown and the resultant increased growth of HCT116 cells. Decreased expression of *FHL1* by its knockdown was confirmed by qRT–PCR (left) and western blot (middle). Growth rates of cells with *FHL1* knockdown were shown to be increased (*$P<0.01$, **$P<0.001$) (right). Data are shown as the mean of three independents ± s.d. (**b**) Increased *in vivo* growth of HCT116 cells with *FHL1* knockdown. Cells with *FHL1* knockdown (sh1) showed a 2.7-fold larger tumor volume compared with the control cells (Luc-sh) (*$P<0.01$, **$P<0.001$). Data are shown as the mean ± s.d. Arrows, tumors produced. (**c**) Increased tumor weight of cells with *FHL1* knockdown (sh1). Mean tumor weight of cells with knockdown (sh1) ($n=10$) was 2.8-fold heavier than that of controls (Luc-sh) ($n=10$). (**d**) Exogenous *FHL1* expression and the resultant decreased growth of AGS cells. Increased levels of *FHL1* expression were confirmed by qRT–PCR (left) and western blot (middle). Growth rates of cells with exogenous *FHL1* were shown to be significantly decreased (*$P<0.01$) (right).

distinguish the allelic origin of mRNA was not present. As qMSP detects only molecules that have dense methylation at primer sites, it was considered that it detected only densely methylated molecules, and methylation levels between 20 and 40% were observed in females.

In conclusion, we showed that *FHL1* on chromosome X is a methylation-silenced tumor-suppressor gene in gastrointestinal cancers, and its methylation in non-cancerous gastric mucosae contributes to the formation of an epigenetic field for cancerization.

MATERIALS AND METHODS

Cell lines and treatment with 5-aza-dC

Sixty-eight cancer cell lines (6 gastric, 7 colon, 12 lung, 12 skin, 7 pancreas, 4 esophageal, 4 prostate, 6 breast and 10 ovary cancer cell lines) and two normal colonic epithelial cells (CRL1790 and CRL1831) were obtained from the American Type Culture Collection (Manassas, VA, USA), Japanese Collection of Research Bioresources (Tokyo, Japan), RIKEN Cell Bank (Tsukuba, Japan) and Tohoku University Cell Resource Center for Biomedical Research (Sendai, Japan)(Supplementary Table 2). HSC39, HSC44 and HSC57 were gifted by Dr K Yanagihara; TMK1 was gifted by Dr W Yasui at Hiroshima University; and GC2 was established by MT For 5-aza-dC treatment. AGS and KATOIII cells were seeded on day 0; media containing freshly prepared 0.3 μM 5-aza-dC were added on days 1 and 3, and cells were harvested on day 5.[35]

Tissue specimens and analysis of *H. pylori* infection status

Cancer specimens were obtained from 80 male gastric cancer patients (average age = 60.4, range = 29–88) and 144 male colon cancer patients (average age = 70, range = 39–98) who underwent gastric and colon resection, respectively, with informed consent. All cancers were histologically diagnosed, and histological types of gastric cancers were classified according to the Lauren classification system (35 intestinal and 45 diffuse type).[36] EBV positivity was determined by *in situ* hybridization targeting *EBER1* using formalin-fixed and paraffin-embedded specimens.[37] The proportion of EBV-positive specimens (5 of 80, 6.3%) was close to EBV prevalence in a previous report (11 of 172, 6.4%).[38]

Normal-appearing gastric mucosae were obtained by endoscopic biopsy of the antral region from 60 healthy volunteers (32 male and 28 female; average age = 52, range = 25–91) and 70 gastric cancer patients

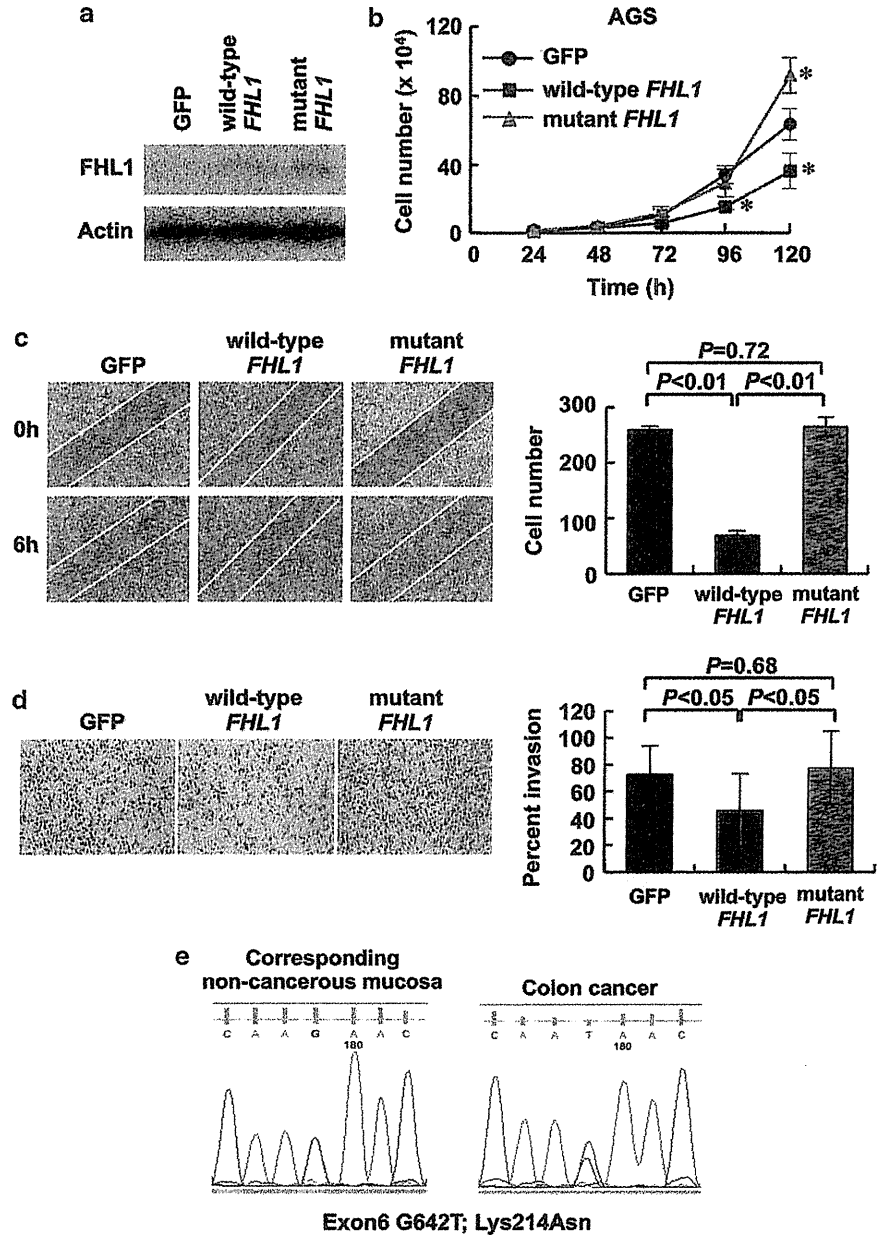

Figure 5. Inhibitory effects of *FHL1* on migration and invasion, and the lack of such functions in *FHL1* with the G642T mutation in AGS. (**a**) Expression levels of exogenous wild-type and mutant *FHL1* detected by western blot. (**b**) The growth-suppressive effect of the wild-type *FHL1*, and the lack of the effect in mutant *FHL1*. Whereas wild-type *FHL1* suppressed cell growth, mutant *FHL1* did not (*$P<0.01$). (**c**) Migration inhibition by wild-type *FHL1*, and the lack of the effect in the mutant *FHL1*. Whereas wild-type *FHL1* inhibited cell migration to 26.6% of the control cells, mutant *FHL1* did not. Photographs were taken at 0 and 6 h after scratching (left), and the number of cells that migrated into the scratched area was counted (mean ± s.d.; right). (**d**) Invasion inhibition by wild-type *FHL1*, and the lack of the effect in the mutant *FHL1*. Whereas wild-type *FHL1* inhibited cell invasion, mutant *FHL1* did not. Representative fields with invading cells on Matrigel-precoated membrane (left). Percent invasion is shown as the mean ± s.d. (right). (**e**) Sequence analysis of colon cancer specimens and corresponding non-cancerous colonic mucosae showed a somatic mutation (G642T; Lys214Asn) in exon 6 of *FHL1*.

(52 male and 18 female; average age = 65, range = 38–85). *H. pylori* infection status was analyzed by a serum anti-*H. pylori* IgG antibody test (SRL, Tokyo, Japan), rapid urease test (Otsuka, Tokushima, Japan) or culture test (Eiken, Tokyo, Japan). Gastric epithelial cells for qRT–PCR analysis were isolated by the gland isolation technique.[39] Normal-appearing colonic mucosae were obtained from a mucosal area distant from colon cancers of surgically resected specimens. Leukocytes were collected from one male (age = 47) and one female (age = 32) volunteer. Specimens were kept frozen at − 80 °C until DNA/RNA extraction. All the analyses using human-derived specimens were approved by the Institutional Review Boards.

Data processing of expression microarray analysis

Expression microarray analysis data in our previous report[19] were used. Signal intensities were scaled so that average signal intensity of all the 18 602 genes would become 500.

Sodium bisulfite modification, MSP, qMSP and bisulfite sequencing

Bisulfite modification was performed using 1 μg of *Bam*HI-digested genomic DNA as previously described.[40] MSP was performed with

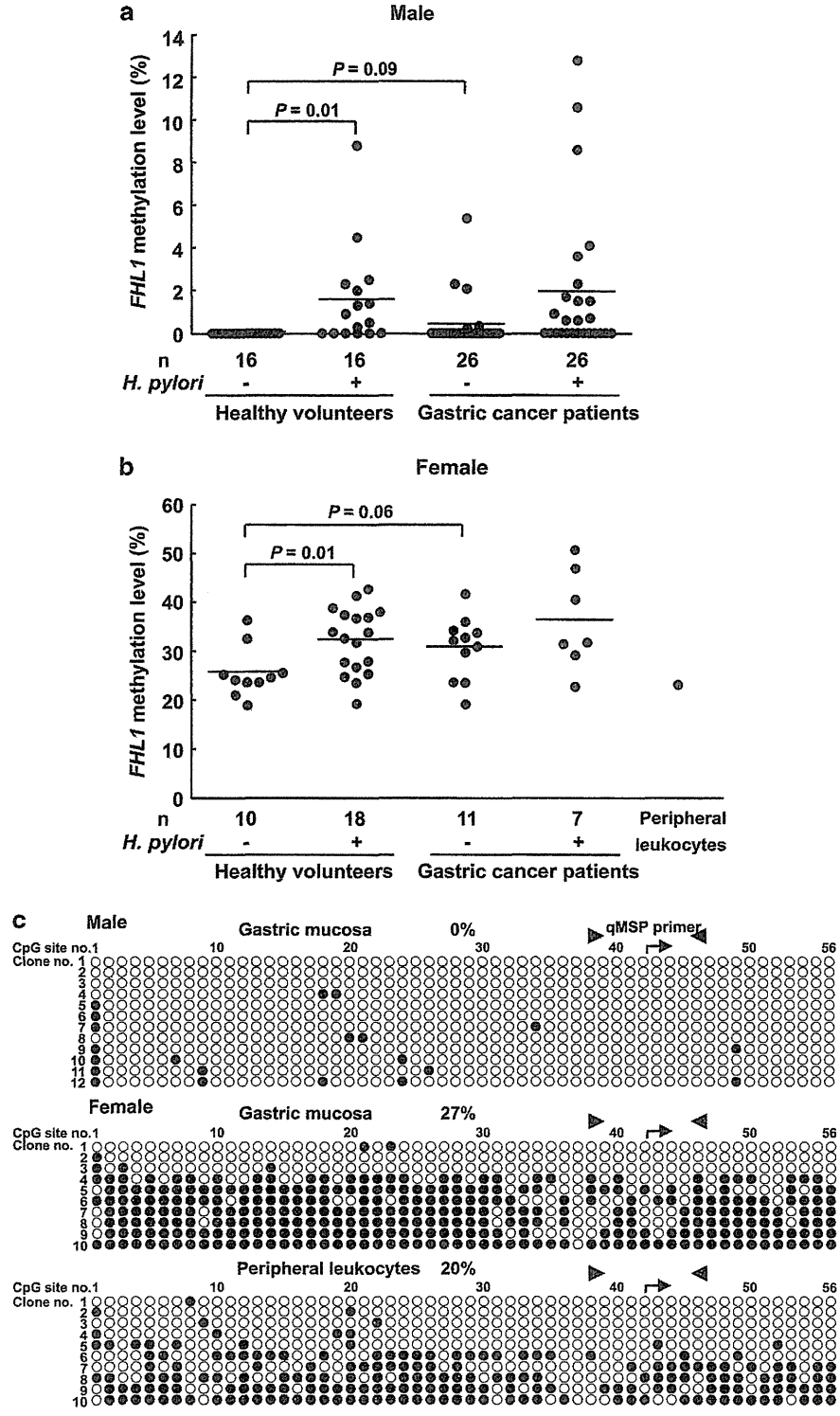

Figure 6. *FHL1* methylation levels in male and female gastric mucosae. (**a**) Methylation levels in male gastric mucosae of healthy volunteers and non-cancerous mucosae of gastric cancer patients. A horizontal line represents the mean methylation level for each group. Among healthy volunteers, *FHL1* methylation was present only in *H. pylori*-positive individuals ($P = 0.01$). Among individuals without *H. pylori* infection, *FHL1* methylation was present only in gastric cancer patients. (**b**) Methylation levels in female gastric mucosae and peripheral leukocytes. *FHL1* methylation levels distributed between 20 and 40%. Methylation levels were higher in *H. pylori*-positive healthy volunteers and gastric cancer patients also in female. (**c**) Bisulfite sequencing of male gastric mucosae, female gastric mucosae and female peripheral leukocytes. Female specimens contained both densely methylated and sparsely methylated DNA molecules, and it was considered that the inactive chromosome X can be densely and sparsely methylated. Closed circle, methylated CpG site; open circle, unmethylated CpG site; arrowheads, primers for qMSP; and arrow, transcription start site.

primer sets specific to methylated and unmethylated sequences (Supplementary Table 3). As controls, fully methylated and unmethylated DNA were prepared by methylating genomic DNA with *SssI* methylase (New England Biolabs, Beverly, MA, USA) and by amplifying genomic DNA with the GenomiPhi amplification system (GE Healthcare, Buckinghamshire, UK), respectively.

Quantitative real-time MSP was performed by real-time PCR using SYBR Green I (BioWhittaker Molecular Applications, Rockland, ME, USA) and an iCycler Thermal Cycler (Bio-Rad Laboratories, Hercules, CA, USA). Although a primer set for MSP was also used for qMSP, a specific annealing temperature in the presence of SYBR Green I was determined (Supplementary Table 3). The number of molecules in a specimen was determined by comparing its amplification with those of standard DNA that contained known numbers of molecules (10^1–10^6 molecules). Based on the numbers of methylated (M) and unmethylated (U) molecules, a methylation level was calculated as the fraction of M molecules in the total number of DNA molecules (no. of M molecules + no. of U molecules). Standard DNA was prepared by cloning PCR products of methylated and unmethylated sequences into a vector (pGEM-T Easy, Promega, Madison, WI, USA). The CIMP status in a gastric cancer was determined as described previously.[27]

Bisulfite sequencing was conducted with primers common to methylated and unmethylated DNA sequences (Supplementary Table 4). The PCR product was cloned into pGEM-T Easy, and 10–12 clones were cycle-sequenced for each specimen.

qRT–PCR

cDNA was synthesized from 1 μg of total RNA using a Superscript III (Invitrogen, Carlsbad, CA, USA). qRT–PCR was performed by real-time PCR using SYBR Green I and an iCycler Thermal Cycler. Standard DNA was prepared by serial dilution of PCR products quantified by the QIAxcel system (QIAGEN, Valencia, CA, USA) after purification using Zymo-Spin I Columns (Zymo Research, Orange, CA, USA).[41] The measured number of cDNA molecules was normalized to that of b2-microglobulin (*b2MG*). The primers and PCR conditions are shown in Supplementary Table 5.

Knockdown and cDNA introduction assays

For a knockdown assay, two pairs and one pair of oligonucleotides were designed against *FHL1* and *Luciferase* (control), respectively (Supplementary Table 6). After annealing of sense and antisense oligonucleotides, the fragment was cloned into a pGreenPuro lentiviral vector (System Biosciences, Mountain View, CA, USA). For cDNA cloning, the entire coding region of human *FHL1* was amplified by RT–PCR (Supplementary Table 7), and cloned into a pCDH-CMV-MCS-EF1-Puro lentiviral vector (System Biosciences). As a control, *copGFP* was cloned into the vector in the same manner. The mutant cDNA was synthesized using the site-directed mutagenesis technique.[42] Using complementary primers carrying mutated sequence (mutation site forward and reverse primers; Supplementary Table 7) and primers for each end of the entire coding region (entire region reverse and forward primers), RT–PCR was performed to generate two DNA fragments that had overlapping ends. These two PCR products were combined by a subsequent PCR with primers for each end of the entire coding region to obtain the mutant cDNA. The mutant cDNA was cloned into a pCDH-CMV-MCS-EF1-Puro lentiviral vector.

The viral vectors and packaging vectors (pPACKH1 HIV Lentivector Packaging Kit, System Biosciences) were cotransfected into 293TN packaging cells, and culture media-containing pseudoviral particles were retrieved. Infection of cancer cell lines with pseudoviral particles was performed according to the manufacturer's protocol (System Biosciences), and stably expressing cells were selected by puromycin without cloning.

Cell growth, migration, invasion and apoptosis analysis

Cell growth was analyzed by seeding cells in triplicate in a six-well plate (3×10^4 cells, AGS; 1×10^5 cells, HSC39) and in a 12-well plate (5×10^3 cells, HCT116). Their numbers were counted at 24, 48, 72, 96 and 120 h. Three independent cultures were performed for one experiment.

Cell migration was analyzed by a wound-healing assay.[43] Cells were seeded in triplicate in a 6-cm dish coated with type I collagen (1×10^6 cells, AGS; 4×10^6 cells, MKN28), and cultured in RPMI-1640 medium containing 1% fetal calf serum to form a monolayer. The cell monolayer was scraped in a straight line with a pipette tip. After incubation for 6 and 12 h, the migrating cells were observed under bright-field microscopy. Three independent cultures were performed for one experiment.

Cell invasion was analyzed by a Matrigel invasion assay, using a Boyden chamber with the Matrigel-precoated membrane or Matrigel-free membrane in the top chamber (BD Biosciences, Bedford, MA, USA). Cells were seeded in top chambers in serum-free RPMI1640 (5×10^4 cells, AGS; 1×10^5 cells, MKN28), and the bottom chambers were filled with RPMI1640 containing 10% fetal calf serum. After incubation for 24 and 48 h (AGS and MKN28, respectively), the area of cells invading through the top chambers was measured by ImageJ software (version 1.38, National Institutes of Health, Bethesda, MD, USA). Percent invasion was calculated as the area of cells invading through the Matrigel-precoated membrane relative to those through Matrigel-free membrane. Three independent cultures were performed for one experiment and the experiment was repeated three times.

The apoptosis of the cells was analyzed by terminal deoxynucleotidyl transferase dUTP nick end labeling assay, using an *in situ* cell death detection kit, TMRred (Roche, Basel, Switzerland).

Tumor formation assay in nude mice

Cells (8×10^6 cells, HCT116) were inoculated subcutaneously on both flanks of 7-week-old male athymic nude mice (BALB/cAJc1-nu/nu; CLEA, Tokyo, Japan). Tumor sizes were measured with calipers every 3 days and the volume was calculated as (length × width^2) × 0.5, and tumor weights were measured at their killing on day 22. All the animal experiments were approved by the Animal Experiment Ethical Committee at the National Cancer Center.

Mutation analysis

All seven exons of *FHL1* were amplified using 100 ng of genomic DNA with primers located in introns, except for one primer on exon 7 (Supplementary Table 8). The PCR products were directly cycle-sequenced with a BigDye Terminator kit (PE Biosystems, Foster City, CA, USA) and an ABI PRISM 310 automated DNA sequencer (PE Biosystems).

Statistical analysis

Differences in mean methylation levels, expression levels, cell numbers and tumor sizes were analyzed by the Welch *t*-test. Association between *FHL1* methylation and clinicopathological factors was analyzed by the χ^2 test. All the analyses were performed using SPSS (SPSS, Inc., Chicago, IL, USA), and the results were considered significant when a P value < 0.05 was obtained by two-sided tests.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ACKNOWLEDGEMENTS

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Supplementary Information accompanies the paper on the Oncogene website (http://www.nature.com/onc)