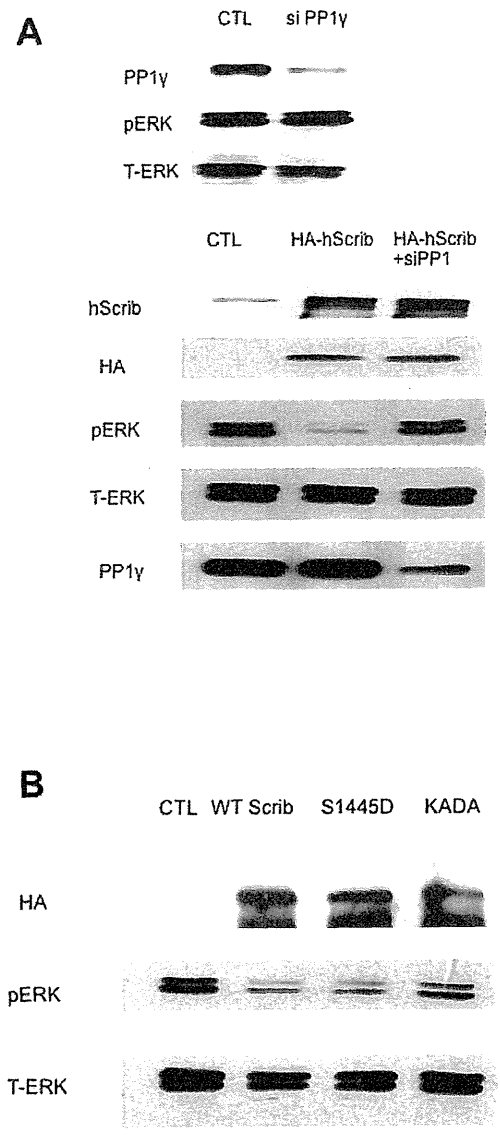

Figure 4. PP1γ is required for hScrib-induced de-phosphorylation of ERK. A) HEK 293 cells were transfected with PP1γ si RNA or si Luc RNA as control (CTL) and after 24 hours were then transfected with a plasmid expressing HA-tagged hScrib. After a further 24 hours the cells were extracted and levels of phospho and total ERK determined by western blot analysis. The upper three panels shows the changes in the ERK profiles when cells were transfected with siRNA PP1γ alone, whilst the lower set of five panels show the effects in the presence of ectopically expressed hScrib. B) HEK 293 cells were transfected with HA-tagged wild type hScrib, or the S1445D and KADA mutants. Total cell extracts were then made after 48 hours and the hScrib, phospho-ERK and total ERK were detected by western blotting.
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were performed using commercially purified PP1γ. The bound protein was then detected by western blotting using anti-PP1γ antibodies. The results in Figure 3A demonstrate a number of important features. In the absence of phosphorylation there is a strong interaction between hScrib and the purified PP1γ, demonstrating that the interaction between hScrib and PP1γ is indeed direct. However, there is also a clear increase in the association between hScrib and PP1γ when hScrib is phosphorylated by PKA, but not when it is phosphorylated by ERK1. We had previously shown that the major PKA phosphorylation site on hScrib was S1445 [19]. Therefore, to further confirm that phosphorylation of hScrib by PKA at S1445 can influence its capacity to interact with PP1γ, we repeated the pull down assays using the phospho-mimic mutation of hScrib, S1445D. As can be seen from Figure 3B, the S1445D mutant exhibits a significantly increased capacity to interact with PP1γ, which is similar to that seen following phosphorylation by PKA. These results demonstrate that phosphorylation of hScrib by PKA at S1445 can indeed increase the ability of hScrib to directly interact with PP1γ.

We then analysed whether hScrib was a potential substrate of PP1γ. Purified GST-hScrib fusion protein was subjected to in vitro phosphorylation with purified PKA and radiolabeled ATP. After extensive washing the radiolabeled hScrib fusion protein was incubated with purified PP1γ, and the amount of phosphorylated protein determined by SDS PAGE and autoradiography. The results obtained in Figure 3C demonstrate that the level of phosphorylated hScrib is decreased following incubation with PP1γ, demonstrating that hScrib is a potential substrate of the phosphatase and, furthermore, that hScrib can directly recruit active PP1γ. Also shown are the non-phosphorylatable mutants of hScrib, confirming the specificity of the phosphorylation reaction.

We then proceeded to determine whether the interaction of hScrib with PP1γ might be involved in the capacity of hScrib to downregulate ERK activation. Cells were transfected with control siRNA against luciferase or against PP1γ, and after 24 hours the cells were then transfected with an hScrib expression plasmid. After a further 24 hours the cells were extracted and the levels of activated phospho-ERK analysed by western blotting. The results obtained are shown in Figure 4A. As can be seen, in the absence of hScrib, siRNA PP1γ has minimal effect on the levels of phospho-ERK (Figure 4A upper three panels). In contrast, overexpression of hScrib significantly reduces the levels of phospho-ERK (Figure 4A lower five panels), and this is in agreement with previous studies [19]. However, the ability of hScrib to down-regulate the levels of phospho-ERK is largely abolished following treatment with siRNA PP1γ, suggesting that this activity of hScrib is in part PP1γ-dependent. To further investigate this, we repeated the assay using the PKA phospho-mimic mutant (S1445D) and the non-PP1γ binding mutant (KADA) of hScrib. After 24 hours the levels of phospho-ERK were analysed by western blotting and the results obtained are shown in Figure 4B. As can be seen the wild type and S1445D mutant of hScrib both strongly inhibit the levels of phospho-ERK, whilst the non-PP1γ binding mutant of hScrib is decreased in this activity. Taken together these results demonstrate that the ability of hScrib to interact with PP1γ correlates with its ability to down-regulate the levels of phospho-ERK.

Loss of hScrib enhances PP1γ nuclear localization

Having found that PP1γ plays a role in hScrib regulation of ERK signaling, we were next interested in determining whether hScrib could also potentially affect PP1γ localisation. Therefore, we first analysed the pattern of PP1γ expression in human keratinocytes after stably silencing hScrib expression in these cells. The distribution of PP1γ in control and shScrib HaCaT cells were analysed by immunofluorescence. The results in Figure 5A and Figure 5B, show that most of the PP1γ localises in the nucleus, although some also co-localises with hScrib at the plasma membrane and within the cytoplasm. More importantly, however, upon loss of hScrib expression there is a significant increase in the amount of nuclear PP1γ, with a corresponding decrease in the cytoplasmic pool. In order to verify these results we also performed

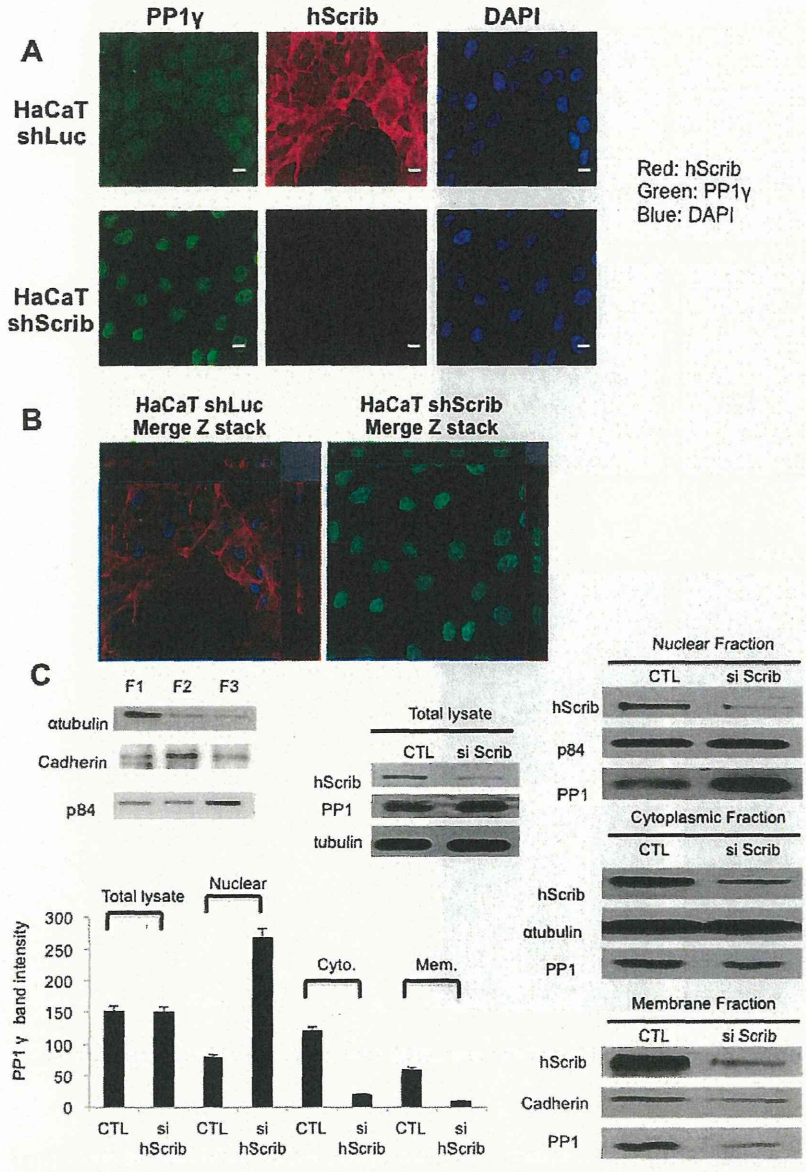

Figure 5. hScrib regulates PP1γ nuclear localization. A) Immunofluorescence analysis of hScrib and PP1γ expression in sh-Luc control HaCaT cells and sh-hScrib knockdown cells. The cells were grown on coverslips and then fixed and double-stained with the anti-hScrib antibody and the anti-PP1γ antibody. Note the significant increase in the levels of nuclear PP1γ in the absence of hScrib expression. B) Z-reconstruction (x-z direction) of a z-stack (15 planes, z-distance 0.2 μm), showing sh-hScrib knockdown cells have enhanced PP1γ localisation into the nucleus. C) HEK 293 cells were transfected with hScrib siRNA and si Luc RNA as control. Cells were either extracted in SDS PAGE sample buffer (Total lysate) or were fractionated into cytoplasmic (F1), membrane (F2) and nuclear (F3) pools (the example shows the integrity of a typical extraction procedure) and then PP1γ was detected by western blotting. p84 was used as a loading control for the nuclear fraction, cadherin was used as a loading control for the membrane fraction and α-tubulin was used as the loading control for the cytoplasmic fraction and total cell extracts. Note the relative increase in nuclear PP1γ following hScrib knockdown but no overall change in total PP1γ levels.
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a series of transient siRNA experiments, where hScrib levels were ablated in 293 cells, and the levels of PP1γ, both in total cell extracts or in the respective cellular fractions (Fig. 5C), were analysed by western blotting. As can be seen, loss of hScrib resulted in decreases in the cytoplasmic and membrane pools of PP1γ, but a corresponding increase in the amounts of the nuclear form of the protein.

To investigate the pattern of pERK expression following hScrib depletion we repeated the immunofluorescence assays staining for hScrib, PP1γ and pERK. The results obtained are shown in Figure 6. As can be seen, under conditions of hScrib depletion there is a marked increase in the levels of both nuclear and cytoplasmic pERK, consistent with previous observations [19]. This is also accompanied by an increase in the levels of nuclear PP1γ.

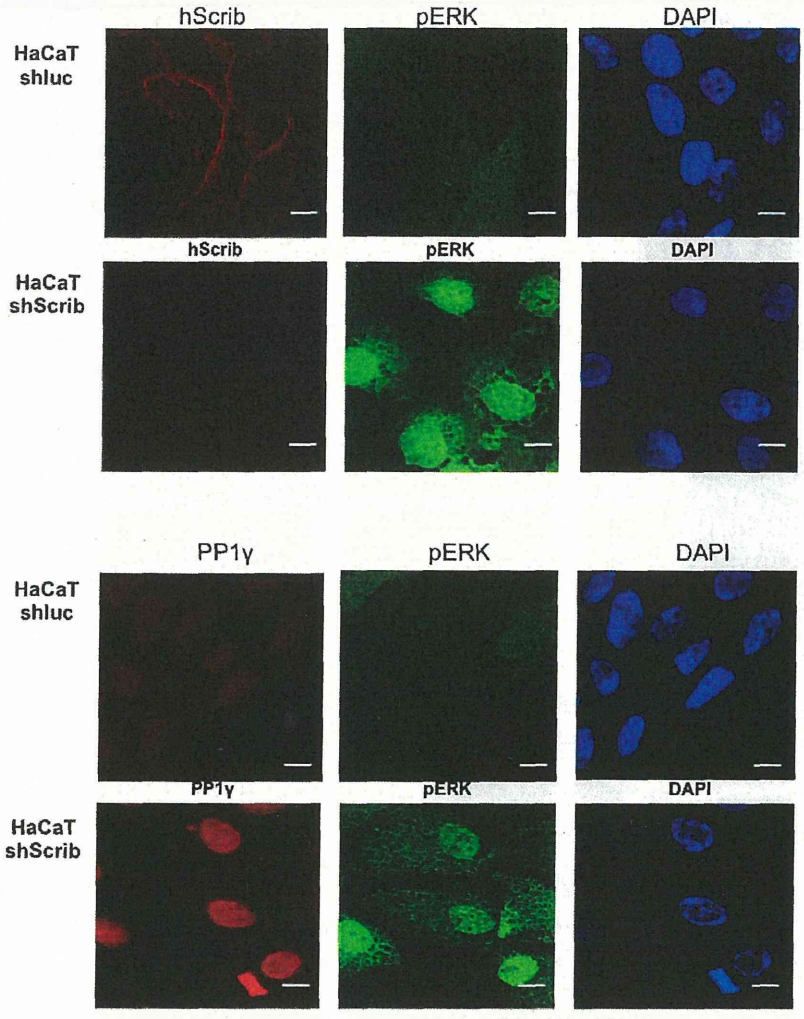

Figure 6. Loss of hScrib results in enhanced nuclear accumulation of both PP1γ and pERK. Control and shScrib HaCaT cells were stained for hScrib, phospho-ERK and PP1γ as indicated.
doi:10.1371/journal.pone.0053752.g006

hScrib tumour suppressor activity requires an intact PP1γ binding motif

We have previously shown that hScrib can suppress cell transformation induced by EJ-ras and Human Papillomavirus (HPV)-16 E7 [19]. To determine whether the interaction between hScrib and PP1γ was physiologically relevant in this context, primary BRK cells were transfected with HPV-16 E7 plus EJ-ras in the presence or absence of the hScrib wild type and KLDY/KADA mutant hScrib expressing plasmids, with or without the PP1γ expression plasmid. After 3 weeks the cells were fixed and stained and the numbers of colonies counted. As can be seen from Figure 7, co-expression of wild type hScrib and PP1γ strongly inhibits the oncogene cooperation between E7 and EJ-ras, whilst the KADA mutant of hScrib is compromised in this activity. These results demonstrate that the hScrib-PP1γ interaction is functionally relevant in an assay of oncogene cooperation.

Discussion

We have shown previously that hScrib can regulate ERK signaling in two ways. The first involves a direct protein interaction, which is mediated via two KIM binding sites located within hScrib. The second appears to involve the recruitment of a protein phosphatase [19]. In this study we provide evidence that a candidate phosphatase is PP1γ. We have also found that hScrib can control PP1γ sub-cellular localisation, with a loss of hScrib promoting PP1γ nuclear translocation.

Regulation of the ERK signaling cascade can occur at multiple levels and can involve Raf dephosphorylation, MEK1,2 phosphorylation, and also MEK1,2 dephosphorylation [24,43–44]. Furthermore, it has been reported that whilst the kinases in the pathway control signal amplitude, the phosphatase PP2A mediates both signal amplitude and signal duration [32–33]. Previous studies have also implicated PP1 in regulating ERK signaling through its ability to dephosphorylate Raf-1 at Ser 259 [45]. Since we have consistently observed that overexpressed hScrib results in a decrease in ERK phosphorylation, we initiated a series of studies to identify the potential phosphatases with which hScrib might interact. Using a proteomic approach we identified PP1γ as a direct interacting partner of hScrib, an interaction that we could confirm both in vitro and in vivo. Analysis of the hScrib amino

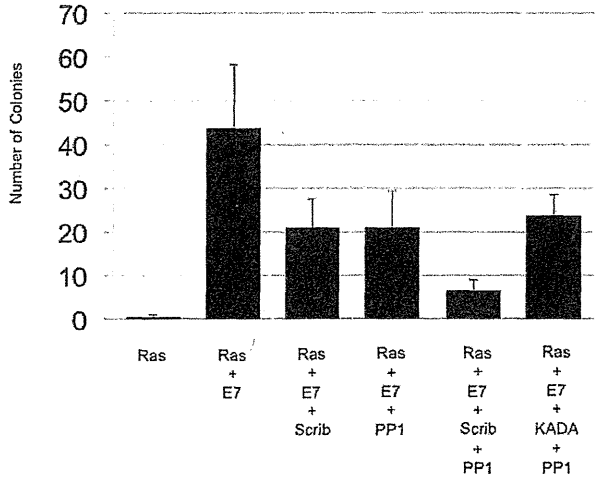

Figure 7. hScrib suppresses HPV-16 E7 and EJ-ras induced transformation in cooperation with PP1γ in a RVxF motif-dependent manner. BRK cells were transfected with EJ-ras alone, HPV-16 E7 plus EJ-ras, HPV-16 E7 plus EJ-ras and wild type hScrib, HPV-16 E7 plus EJ-ras and PP1γ, and HPV-16 E7 plus EJ-ras and wild type hScrib with PP1γ, and HPV-16 E7 plus EJ-ras and PP1γ plus the KADA non-PP1γ binding mutant of hScrib. After three weeks the dishes were fixed and stained and the colonies counted. Results represent the mean number of colonies from 3 independent assays and standard deviations are shown.
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acid sequence identified a potential site of interaction, KLDY, mutation of which abolished the ability of hScrib to bind PP1γ. Furthermore, this consensus PP1 recognition motif is conserved in mammalian forms of Scrib, but is absent in Drosophila.

We also analysed the effects of PP1γ ablation upon hScrib control of ERK phosphorylation, and found that loss of PP1γ greatly diminished the ability of hScrib to downregulate the levels of phospho-ERK in vivo. Furthermore, we also found that this activity of hScrib was in part dependent upon an intact PP1γ binding site motif. Interestingly, we also noted that the interaction between PP1γ and hScrib was increased following PKA phosphorylation of hScrib, one potential consequence of which is PP1γ-mediated de-phosphorylation of hScrib. Whether this has an important role with respect to other functions of hScrib remains to be determined and is worthy of further study. Taken together these studies demonstrate that hScrib can interact with PP1γ, an activity which appears to play a role in the ability of hScrib to downregulate the ERK signaling pathway. Interestingly, this regulation of ERK by hScrib has many parallels with a recent study showing that hScrib could also regulate Akt signaling [35]. This required hScrib interaction with the phosphatase, PHLPP1, resulting in the de-phosphorylation of Akt. In this case the interaction between hScrib and PHLPP1 requires sequences in the LRR region of hScrib. Thus hScrib could potentially interact simultaneously with multiple protein phosphatases to control diverse signaling pathways. It should also be emphasized that hScrib is a multifunctional protein, and loss of hScrib also results in increased levels of MEK activity, suggesting multiple mechanisms by which hScrib can control ERK signaling [46].

To investigate whether the capacity of hScrib to interact with PP1γ had any physiological relevance, we made use of an oncogene cooperation assay in primary rodent cells. Previous studies had shown that hScrib could suppress cell transformation induced by HPV-16 E7 and EJ-ras in these cells, and that this activity was dependent in part upon the ability of hScrib to interact with ERK [19]. We reasoned that this activity of hScrib might also be influenced by the ability of hScrib to interact with PP1γ. Indeed, both hScrib and PP1γ, either alone or in combination, could dramatically decrease the levels of HPV-16 E7 and EJ-ras induced cell transformation. However, the additive effects upon the levels of cell transformation, seen with the combination of hScrib and PP1γ, was abolished if a mutant hScrib defective in its ability to interact with PP1γ was included in the assay. This demonstrates that, in the context of an oncogene cooperation assay, the ability of hScrib to interact with PP1γ does play a role in the ability of hScrib to suppress cell transformation.

PP1γ has been linked to the regulation of a variety of different cellular processes, including the DNA damage response, nuclear function and diverse aspects of the cell cycle [47–52]. One of the important aspects of PP1γ regulation is believed to be related to the control of its nuclear expression, which can be mediated by proteins possessing the consensus RVxF PP1 binding motifs, and which can thereby control the correct cellular localization of PP1 [42,52]. We therefore investigated whether hScrib might have a similar potential regulatory function with respect to the pattern of PP1γ localization within the cell. This was indeed found to be the case; in two different assay systems we observed that loss of hScrib resulted in an increased nuclear accumulation of PP1γ, with a concomitant decrease in the levels found in membrane and cytoplasmic fractions. Thus hScrib would appear to contribute directly to the regulation of PP1γ expression patterns. Whether this is related to some of hScrib's previously reported pleiotropic effects upon cell proliferation and cell survival remains to be determined. Taken together, these studies have defined PP1γ as a novel interacting partner of hScrib, an interaction which correlates with hScrib downregulation of ERK signaling and suppression of oncogene-induced cell transformation.

Supporting Information

Figure S1 Schematic diagram showing the different hScrib expression constructs. The schematic shows the arrangement of the functional domains on the hScrib protein, highlighting the LRR, and PDZ domains. The putative PP1-binding site, KLDY is also shown in the carboxy terminal third of hScrib. Also summarized are the results on the interaction assays with PP1γ.
(TIF)

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Author Contributions

Conceived and designed the experiments: KN LB. Performed the experiments: KN TS AY VKS CK PM MT. Analyzed the data: KN LB. Contributed reagents/materials/analysis tools: KN KK SN TY YT TF SK. Wrote the paper: KN LB.

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Therapeutic Human Papillomavirus (HPV) Vaccines: A Novel Approach

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Abstract: Cervical cancer is the second largest cause of cancer-related death in women worldwide, and it occurs following persistent infection, sometimes for decades, with a specific subset of human papillomavirus (HPV) types; the approximately 13 oncogenic subtypes. Prophylactic vaccines against HPV infections hold promise for cost-effective reductions in the incidence of cervical cancer, but this may not be enough. Two prophylactic HPV vaccines are presently available and both contain L1 virus-like particles (VLPs) derived from the HPV subtypes most frequently associated with cervical cancer, HPV-16 and -18. Since the L1-VLP vaccines can only effectively prevent infection by the specific HPV subtype against which the vaccine was developed, cervical cancers caused by high-risk HPV subtypes other than HPV-16 and -18 may still occur in recipients of the current HPV vaccines. Furthermore, HPV vaccination coverage for adolescents is insufficient in most countries and therefore even HPV-16 and -18 infections are unlikely to be fully eradicated using the existing strategies. The development of HPV therapeutic vaccines remains essential. Many therapeutic vaccines aimed at clearing HPV-related cervical lesions have been developed and tested in patients with HPV16-positive cervical intraepithelial lesions (CIN) or cervical cancers. To date, definitive clinical efficacy and appropriate immunological responses have never been demonstrated for cervical neoplasia although promising results have been reported in patients with vulvar intraepithelial neoplasia. Here we discuss shortcomings of previous HPV therapeutic vaccine candidates and propose a novel vaccination strategy that leverages newly gained knowledge about mucosal immunity and the induction of mucosal immune responses.

Keywords: HPV therapeutic vaccine, mucosal vaccination, cervical mucosal immune system, E7-expressing lactobacillus-bases vaccine.

EPIDEMIOLOGY OF HPV INFECTION

At present, there are about 100 identified genotypes (types) of human papillomavirus (HPV) of which about 40 are genital HPV types that invade genital organs such as the uterine cervix, vaginal wall, vulva, and penis. Genital HPV types are classified into high-risk types commonly associated with cervical cancer and low-risk types known to cause condyloma acuminatum. This classification varies among researchers, but, in general, types 16/18/31/33/35/39/45/51/52/56/58/66/68 are classified as high-risk and 6/11/40/42/43/44/54/61/72 as low-risk [1]. Interestingly, the HPV type distribution varies depending on the stage of cervical neoplasia (Fig. **1**).

The HPV DNA detection rate in the genital organs of healthy adult females varies between advanced and developing countries but is approximately 20-40% collectively [2, 3]. In Japan, the HPV-positive rate in pregnant females aged 20-29 years has been reported to be 20-30%, which is similar to or higher than that among similarly aged females in the U.S [4]. The World Health Organization (WHO) has estimated an annual increase of 3 hundred million in the number of HPV carriers in the world [5, 6]. Overall HPV prevalence with normal cervical cytology was estimated to be 10.4 % [6]. Epidemiological data show HPV infection at least once during their lifespan in approximately 75 % of U.S. women [3]. Thus, HPV infection is common and can affect any female. Frequent sexual activity has been reported to increase the risk of HPV infection but this is not always the case [7].

NATURAL HISTORY OF CERVICAL INTRAEPITHELIAL NEOPLASIA

Natural history studies of CIN show that most infections and CIN lesions resolve spontaneously but some persist and progress to cervical cancer. The incidence of cervical intraepithelial neoplasia (corresponding to squamous intraepithelial lesion: SIL) is about 1 per 10 females with HPV infection [8]. The incidence of high grade SIL (corresponding to cervical intraepithelial neoplasia 2 and 3: CIN2-3) is about 3 per 10 females with low grade SIL, and that of CIN3 is about 1-2 per 10 females with low grade SIL [9]. Without treatment, the incidence of the progression of CIN3 to cervical cancer is about 30% [10]. Therefore, the incidence of the spontaneous development of cervical cancer is about 1 per 200-300 females with HPV infection. Factors associated with progression to cervical cancer in females with HPV infection have been extensively studied [1]. Many prospective studies have identified persistent HPV infection as the most important risk factor. They have also shown that persistent infection tends to occur in women with high risk HPV subtypes.

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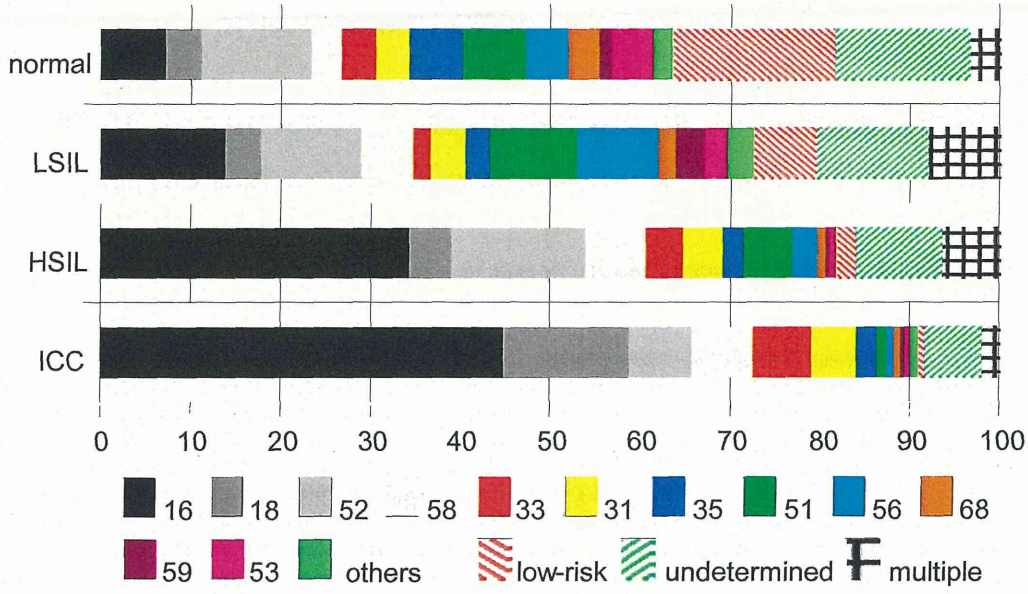

Fig. (1). HPV subtype distribution in cervical neoplastic lesions in Japan [18]. HPV16 and 18 are the most common subtypes found in invasive cervical cancer (ICC) but more than 40% of invasive lesions are associated with other oncogenic subtypes in Japan. HPV52 is the most common HPV subtype present among Japanese women with with normal cervical cytology [19].

Chronic virus proliferation induces the active proliferation/differentiation of infected epithelial cells, and some infected cells incidentally immortalize, which is the first step of carcinogenesis [1]. In contrast, transient infection involves short-term virus proliferation followed by the long-term latent presence of low copies of the viral genome in the basal cells of the genital epithelium [11]. Studies showing that HIV-infected women and patients who are under treatment with immunosuppressive agents have an increased incidence of CIN lesions [12, 13] suggest that cell-mediated immune response against HPV antigens is important in the control of HPV infection and progression to CIN. More controversial are the relative roles of systemic and local mucosal immune responses in HPV pathogenesis [14]. Trimble *et al.* reported that naturally occurring systemic immune responses to HPV antigens do not predict regression of CIN 2/3 lesions [15] but Nakagawa *et al.* demonstrated a positive association between systemic cell-mediated immune responses to HPV E6 and the regression of HPV/CIN [16].

SHORTCOMINGS OF THE CURRENT L1-VLP VACCINES

Theoretically, if HPV infection could be completely eradicated, HPV-associated cancers could be prevented. With this in mind, HPV vaccines began to be studied nearly 10 years ago. In 2002, Koutsky *et al.* were the first to show the clinical prophylactic effects of an HPV vaccine [17]. Soon thereafter, Merck in the United States and Glaxo Smith Kline (GSK) in Europe launched full-scale development of prophylactic vaccines against HPV. These products were approved and became commercially available just a few years ago. The vaccine antigens used by the two companies are virus-like particles (VLP) produced by overexpressing HPV16 L1 protein in yeast or insect cells. These particles have a 3-dimensional external structure similar to that of virus particles, but having no internal contents, they are not infective. The vaccine first reported by Koutsky *et al.* also used HPV16L1-VLP as an antigen.

One integral drawback of L1-VLP based vaccines is their negligible prophylactic effect on many HPV subtypes not specifically targeted by the vaccine [18]. For this reason, GSK and Merck developed cocktail vaccines composed of L1-VLPs corresponding to several HPV subtypes. The vaccine developed by Merck is a quadrivalent vaccine against HPV types 6, 11, 16, and 18 (Gardasil®) [19] and that developed by GSK is a bivalent vaccine against types 16 and 18 (Cervarix®) [20]. Unfortunately these L1-VLP vaccines are very specific and may not protect for long time against HPV types that exhibit very close genetic similarities to HPV-16 or -18, such as HPV-58 or -45 respectively. Ultimately, the most effective L1-VLP-based vaccines vaccines would be multivalent for the 13 described oncogenic HPV types. Such prophylactic vaccines would likely be much more expensive than their current counterparts.

HPV-16 or -18-related cervical cancers, which constitute less than 60% of all invasive cervical cancer cases in Japan [21], could be prevented if the appropriate subtype cocktail vaccine were available (Fig. **1**). However, the HPV subtype distribution in cervical cancer varies (60-70%) by worldwide location [22] and current vaccines are unable to address all oncogenic subtypes in even a single population. While current HPV vaccines are distributed without cost to the patient due to government subsidies or full coverage by insurance [23] these facile approaches will ultimately fail to eradicate the disease. Further, even with broad vaccination coverage, deficiencies in vaccine design mandate that even vaccinated females must continue cervical cancer screening.

The commercially available GSK and Merck HPV vaccines are indicated for uninfected females to prevent

HPV infection/spread. Due to the high prevalence of HPV infection, effective mass prophylactic vaccination strategies for uninfected females should include girls age 10 and above to predate the onset of sexual activity. Ph-III clinical studies in which females approximately 20 years of age were randomly inoculated with Gardasil® or Cervarix® revealed protective efficacy on the development of CIN2-3 associated with HPV-16 or -18 in 93-98% of vaccine-type naïve females who completed the vaccination protocol [24, 25]. However, intention-to-treat analysis revealed protective efficacy was only 19-30% for non-vaccine HPV subtypes [24, 25].

DEVELOPMENT OF HPV THERAPEUTIC VACCINES

The limitations of current prophylactic HPV vaccines demonstrate a pressing need for novel approaches to the eradication of HPV-related neoplasia and suggest that the development of therapeutic vaccines for the treatment of HPV-associated lesions will remain an important goal even if worldwide prophylactic vaccine programs are successfully implemented [26]. The past two decades has seen several inroads into the development of therapeutic HPV vaccines. The combined actions of the high-risk E6 and E7 oncoproteins are essential for the maintenance of the neoplastic phenotype and the evasion of apoptosis. Several functions have been described for E6 and E7. Initial observations revealed that E6 interacts with p53 and E7 interacts with Rb to block the activity of these tumour suppressors [1]. There are only two possible antigenic targets, E6 and E7, since these are the only viral proteins that will be expressed in all cancers and precursor lesions [1]. The approach of deliberate immunization with E6 and/or E7 of HPV 16 and 18 predominantly, and the generation of antigen-specific CTL as an immunotherapy for HPVassociated cancer has been tested with a wide array of potential vaccine delivery systems. Here we will summarize the results of the therapeutic vaccine clinical trials reported to (Table **1**) [14].

1. SGN-00101 (s.c.) is a fusion protein consisting of a heat shock protein (Hsp) from *Mycobacterium bovis* and HPV16 E7. The Ph-II study looking at the effects of SGN-00101 in women with CIN3 revealed histological regression to CIN1or less (complete remission: CR) in 13 (22.5%) of 58 cases, although immunological responses were not studied [27]. Another Ph-II study of the same agent administered to women with CIN showed the induction of cytotoxic T lymphocyte (CTL) against HPV16E7 in peripheral monocytes in 5 of 7 patients which obtained CR [28].
2. L1VLP-E7 (s.c.) is a vaccine using chimeric particles composed of HPV16 L1-VLP and E7. In the Ph-I/II study of women with CIN2-3, histological regression to CIN2 (partial remission; PR) was shown in 39% of vaccine recipients compared with 25 % of placebo recipients. This was not significant significant [29]. Clinical response was coupled with detectable cellular immune responses in some cases.
3. TA-HPV (i.m.) is a recombinant vaccinia virus expressing E6 and E7 of HPV-16 and -18. The Ph-II study of TA-HPV in women with vulvar intraepithelial neoplasia (VIN) revealed PR of lesions in 8 of 13 cases and responders also had an increase in lesion-infiltrating CD4 and CD8 positive cells [30].
4. TA-CIN (i.m.) is a fusion protein consisting of E6, E7 and L2 from HPV-16 and -18. The Ph-II study in women with VIN revealed CR or PR in only 6 of 29 cases. CTL against E6/E7 were induced in 4 of 29 cases [31]. Correlations between clinical efficacy and cellular immune responses to the vaccine remain unclear.
5. MVA-E2 (TGA4001) (intrauterine) is also a recombinant vaccinia virus expressing bovine papilloma virus (BPV) E2. A Ph-II study in subjects with CIN2-3 confirmed the down grade of CIN in some cases (19/34 cases) [32].
6. ZYC-101a (i.m.) is a DNA vaccine synthesized from proteins containing CTL epitopes against E6 and E7 of HPV-16 and -18. A Ph-III study was performed in subjects with CIN2-3. CR or PR was observed in 41% of vaccinated women and 27% of those receiving placebo. This was not a significant difference. Subset-analysis limited to those subjects aged 25 years or less revealed a statistically significant increase in the percentage of women with CR or PR in the vaccination group (72%) when compared to placebo controls (23%). However, no correlation was shown between CTL induction against E6/E7 and clinical effect [33].

Table 1. Clinical Trials of Therapeutic Vaccine for HPV-Associated Cervical Lesion

Trial Phase	Target Proteins	Vaccine Vectors	Inoculation	Target Types
Ph-I/II [27]	L1, E7	Chimera-VLP	S.C.	16
Ph-II [26]	E7	Hsp (SGN-00101]	S.C.	16
Ph-II [28]	E6, E7	Vaccinia virus (TA-HPV)	I.M.	16, 18
Ph-II [29]	L2, E6, E7	Fusion protein L2E6E7 (TA-CIN)	I.M.	16, 18
Ph-II [30]	BPV E2	Vaccinia virus (MVA-E2]	intrauteral	all
Ph-III [31]	E6, E7	plasmid vaccine (ZYC101a)	I.M.	16, 18
Ph-II [32]	E6, E7	Cocktailed Synthetic peptide	S.C.	16

S.C.: subcutaneous injection, I.M.: intramuscular injection, BPV: bovine papillomavirus.

7. Synthetic long-peptide vaccine (s.c.) is a peptide vaccine comprised of nine HPV16 E6 peptides and four HPV16 E7 peptides solubilized in incomplete Freund's adjuvant. A Ph-II study was performed in patients with VIN3. 5 of 20 patients demonstrated complete regression of their lesions [34].

In summary, no therapeutic HPV vaccines are presently available that exert significant clinical efficacy against CIN. Some of the tested therapeutic vaccines elicited systemic cellular immunity after intramuscular or subcutaneous injection, but none of the trials have assessed local cellular immune responses to vaccine antigen in the cervix.. The outcomes of vaccination strategies involving intramuscular or subcutaneous injection of E6/E7-based antigens for the treatment of VIN have been more promising [30, 31, 34]. We hypothesize that these findings are the direct result of the predicted poor response of cervical mucosal lesions to systemic cellular immune responses when compared to the effects of systemic immunity on epidermal lesions including those of VIN.

THE CERVICAL MUCOSAL IMMUNE SYSTEM AND HPV THERAPEUTIC VACCINES

Induction of adaptive cellular immune responses to HPV in the cervical mucosa is indispensable for treating cervical mucosal lesions such as CIN. Since precancerous lesion of the cervix develops essentially exclusively in the mucosal epithelium it would be predicted that intraepithelial lymphocytes (IELs) should be central to the elimination of CIN. To this poin, there are substantial differences between cellular and humoral immune responses in the female reproductive tract mucosa. It is well-known that intramuscular injection of L1-VLP based vaccines leads to systemic humoral immune responses characterized by the induction of anti-L1 IgG neutralizing antibody which leaks from the serum to protect the reproductive tract mucosa from HPV infection. However, the requirements for induction of mucosal cellular immune responses against microbial infected lesions differ from and are independent of those for systemic cellular immunity. Therefore, systemic intramuscular or subcutaneous vaccination strategies may be unsuitable for the induction of mucosal cellular immunity, at least in the reproductive tract mucosa.

In the uninduced state, the specific lymphocytes involved in mucosal immunity reside in the inductive sites of organized mucosa-associated lymphoid tissues (MALT); these are present in a variety of effector sites, including the mucosa of the intestine, respiratory tract and genital tract [35]. Efficient homing of lymphocytes to the gut is dependent on the homing receptors integrin $\alpha4\beta7$ and C-C chemokine receptor type 9 (CCR9). Lymphocyte-expressed integrin $\alpha4\beta7$ and CCR9 bind to their natural ligands, mucosal addressin cell adhesion molecule-1 (MAdCAM-1) and CCL25 (TECK), respectively, which are expressed on the cell surface of endothelial cells in submucosal post-capillary venules. In the intestine, mucosal dendritic cells (DCs) in gut-associated lymphoid tissues (GALT) regulate the expression of integrin $\alpha4\beta7$ on activated effector and regulatory lymphocytes in a retinoic acid-dependent manner [36]. Integrin $\alpha4\beta7$+ T cells reside the lamina propria in submucosa as lamina propria lymphocytes (LPL) and can differentiate into integrin $\alpha E\beta7$+ T cells upon exposure to TGF-β and expression of integrin $\alpha E\beta7$ facilitates retention of lymphocytes in the epithelium *via* interactions with E-cadherin [37] (Fig. **2**). Integrin $\alpha E\beta7$ is a specific marker of IELs residing in mucosal epithelia and those cells expressing this antigen on their surface were initially educated in the gut.

Several studies have demonstrated that human genital tract mucosa expresses MAdCAM-1 endogenously [38] and that GALT-derived integrin $\alpha4/E\beta7$+ T cells home to the genital mucosa [39-41]. This T cell homing and the expression of integrin αE increase in the presence of cervicitis and vaginitis [39, 40]. Although integrin $\beta7$+ mucosal T cells have been found in the cervical mucosa, a local inductive site (i.e., MALT) has never been demonstrated histologically [39, 40]. Taken together, GALT is thought to act as the inductive site for cervical IELs. GALT and the cervical mucosal connect through mucosa-specific T cells which express the homing receptors, integrin $\beta7$ and/or CCR9. Using flow cytometry, we have demonstrated that 25-30% of CD3-positive mucosal cervical lymphocytes are positive for the homing receptors integrin $\beta7$ and CCR9 and are thereby educated in GALT [41]. Approximately half of the integrin $\beta7$-positive T cells are CD45RO memory T cells while the other half are CD45RA effector T cells. Accumulation of integrin $\alpha E\beta7$+ IEL in CIN lesions varies markedly among patients and higher IEL numbers are associated with spontaneous regression of CIN [41]. These and related investigations have dramatically improved our understanding of cervical mucosal immunity which should hasten the development of a therapeutic HPV vaccine.

ORAL ADMINISTRATION OF HPV THERAPEUTIC VACCINES: A NOVEL APPROACH

Mucosal vaccination *via* oral administration of vaccine antigen is an effective method for the induction of mucosal immunity. Bermudez-Humaran *et al.* have evaluated the induction of CTL activity and the prevention/reduction of tumor formation following nasal or oral administration of live lactobacillus engineered to produce lactic acid-expressing HPV16E7 and IL-12, in tumor challenged murine models [42]. They found more marked induction of mucosal responses after nasal *vs* oral administration and a more effective induction of immunity when using *Lactobacillus plantarum vs Lactococcus lactis* [43]. Poo *et al.* have shown that oral immunization of C57BL/6 mice with *Lactobacillus casei* expressing HPV16 E7 reduces tumor formation induced by TC-1 cell administration. Immunization in these experiments elicited type 1 T cell immune responses to E7 in lymphocytes isolated from the spleen and from anogenital regional lymph nodes [44]. Although both studies used transmucosal immunization with Lactobacillus-based vaccines, they examined E7-specific systemic cellular immune response and regression of subcutaneous TC-1-induced tumors. These investigations provide no insight into mucosal cellular immune responses after immunization nor into the antigen specificity of mucosal lymphocytes. We have observed a marked induction of mucosal T cells possessing HPV16 E7-specific cellular immune recognition (E7-CMI) within intestinal mucosa after oral administration of *Lactobaccilus casei* expressing HPV16 E7 in mice [45].

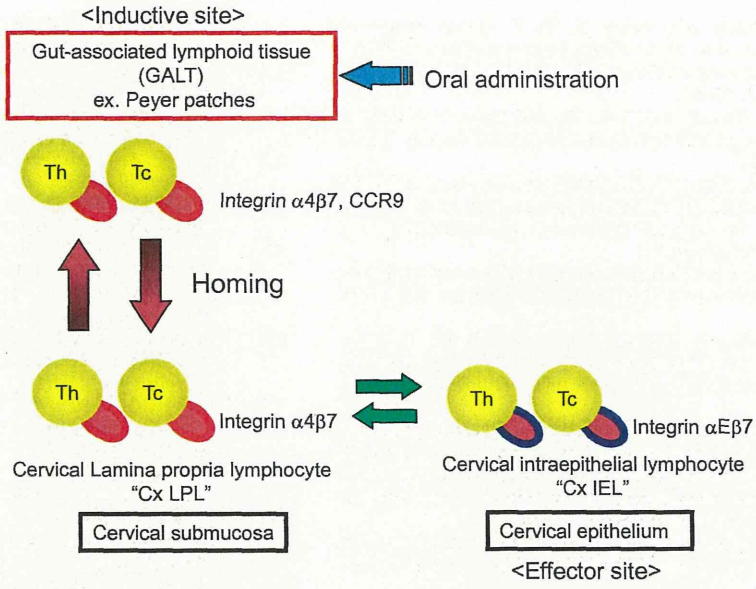

Fig. (2). Mucosal immune system in cervix. GALT is thought to act as the inductive site for cervical IELs. GALT and cervical mucosal connect through mucosa-specific T cells which express homing receptors, integrin α4β7 and/or CCR9. Integrin α4β7+ T cells can differentiate into αEβ7+ T cells upon exposure to TGF-β and expression of integrin αEβ7 facilitates retention of lymphocytes in the epithelium *via* interactions with E-cadherin. Integrin αEβ7 is a specific marker of IELs residing in mucosal epithelia and those cells expressing this antigen on their surface were initially educated in the gut. Oral administration of the therapeutic vaccine can stimulate directly to the inductive site. LPL: lamina propria lymphocytes.

In these studies, full-length mutated E7 was transduced into the *Lactobacillus casei* common to many lactic acid containing foods, and the bacterial cells were attenuated to the destroy exogenous plasmid gene. We compared mucosal vaccination *via* oral administration of the agent (GLBL101c) to systemic vaccination *via* intramuscular or subcutaneous injection of HPV16 E7 protein. Intramuscular and subcutaneous antigen administration induced small numbers of mucosal E7-CMI, but oral administration doubled these levels [45]. This implies that oral vaccination may surmount some of the deficiencies seen with systemic immunization that have been documented in previous clinical trials. Our preclinical data encouraged us to embark on a clinical trial using GLBL101c, which has now been advanced to the Ph-I/IIa stage. Patients with CIN3 who are positive for only for HPV16 alone are presently being enrolled in dose escalation study of the effects of orally administer GLBL101c on the progression or remission of their neoplastic lesions (unpublished data).

SUMMARY

The utility of the commercially-available HPV vaccines is great but incomplete. These vaccines are a valuable step toward the control of cervical cancer and should be advanced for worldwide distribution. However, cervical cancer and its precursor lesions cannot be eradicated extant vaccination strategies costly cervical cytology screening will remain essential until new, more broadly protective HPV vaccines are developed and vaccination coverage approaches 100 % among adolescents worldwide. Until then, strategies for the development of the next generation of HPV vaccines must include both prevenative and therapeutic products.

CONFLICT OF INTEREST

The authors confirm that this article content has no conflicts of interest.

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