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A Phase I clinical study of cisplatin-incorporated polymeric micelles (NC-6004) in patients with solid tumours

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BACKGROUND: On the basis of preclinical studies of NC-6004, a cisplatin-incorporated micellar formulation, we hypothesised that NC-6004 could show lower toxicity than cisplatin and show greater anti-tumour activity in phase I study.

METHODS: A total of 17 patients were recruited in a range of advanced solid tumour types. NC-6004 was administered intravenously (i.v.) every 3 weeks. The dose escalation started at 10 mg m^{-2} and was increased up to 120 mg m^{-2} according to the accelerated titration method and modified Fibonacci method.

RESULTS: One dose-limiting toxicity (DLT) occurred in a patient who was given 90 mg m^{-2} of NC-6004, otherwise any significant cisplatin-related toxicity was not observed or generally mild toxicity was observed. Despite the implementation of post-hydration and pre-medication regimen, renal impairment and hypersensitivity reactions still developed at 120 mg m^{-2}, which led to the conclusion that the maximum tolerated dose was 120 mg m^{-2}, and the recommended dose was 90 mg m^{-2}, although DLT was not defined as per protocol. Stable disease was observed in seven patients. The maximum concentration and area under the concentration–time curve of ultrafilterable platinum at 120 mg m^{-2} NC-6004 were 34-fold smaller and 8.5-fold larger, respectively, than those for cisplatin.

CONCLUSION: The delayed and sustained release of cisplatin after i.v. administration contributes to the low toxicity of NC-6004.

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Cisplatin, *cis*-diamminedichloroplatinum (II), is a platinum (Pt)-based chemotherapy drug used to treat various types of cancers. Clinical use of cisplatin is, however, associated with irreversible renal toxicity, which necessitates the use of pre- and post-hydration regimens, and excludes its use in patients with less than normal renal function (Pinzani *et al*, 1994). Cisplatin therapy also causes neurotoxicity, gastrointestinal toxicity (nausea and vomiting), haematological toxicity, and irreversible ototoxicity (Hartmann and Lipp, 2003). Furthermore, its anti-tumour efficacy continues to be limited by either intrinsic or acquired resistance (Kartalou and Essigmann, 2001). To overcome these cisplatin-related disadvantages, various types of Pt analogues, including carboplatin, oxaliplatin, satraplatin, and picoplatin have been developed (Kelland and Sharp, 1999; Judson and Kelland, 2000; Sharp *et al*, 2002). Another potential method for improving the therapeutic indices of cisplatin is the incorporation of cisplatin into polymeric micelles of varying size in the range of 20–100 nm composed of polyethylene glycol (PEG)-poly (amino acid) block co-polymers, in which PEG constitutes the hydrophilic outer shell of the micelle and cisplatin is incorporated into hydrophobic inner core of the micelle (Yokoyama *et al*, 1996; Nishiyama *et al*, 1999, 2001b, 2003; Nishiyama and Kataoka, 2001a).

Preclinical studies carried out on NC-6004, cisplatin-incorporated polymeric micelles composed of PEG-poly (glutamic acid) block co-polymers via polymer–metal complex formation (Figures 1 and 2), have indicated that it is preferentially distributed to tumours by enhanced permeability and retention effect (Matsumura and Maeda, 1986; Maeda and Matsumura, 1989; Maeda *et al*, 2000; Maeda, 2001), and demonstrates significantly lower toxicity than cisplatin and greater anti-tumour activity (Uchino *et al*, 2005). On the basis of these results, a phase I clinical trial of NC-6004 in patients with advanced solid tumours has been carried out. The objectives of the study were to determine the maximum-tolerated dose (MTD), the recommended dose (RD) for the phase II, the dose-limiting toxicities (DLTs), the safety and tolerability profile, and to explore evidence of anti-tumour activity, and the pharmacokinetics of NC-6004.

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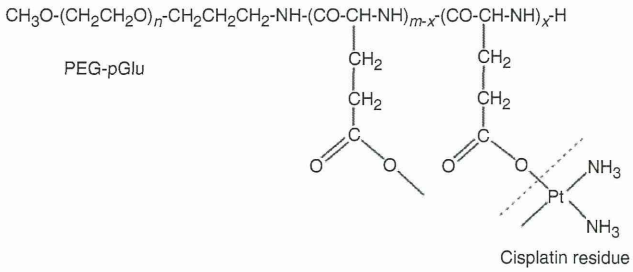

Figure 1 Structure of cisplatin-PEG-poly(glutamic acid) block co-polymer conjugate. PEG-pGlu, PEG-poly(glutamic acid); *n*, approximately 268; *m*, approximately 40; *x*, approximately 24.

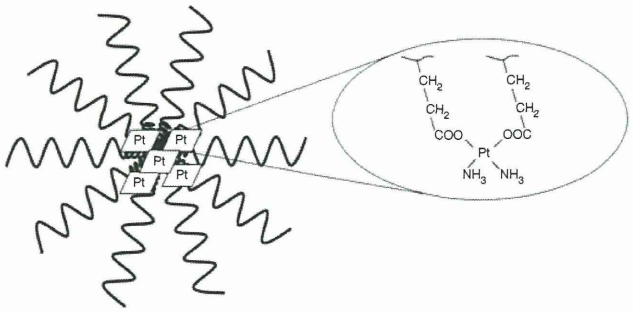

Figure 2 Structure of cisplatin-incorporated polymeric micelle, NC-6004. Core part, cisplatin residue bound to poly-L-glutamic acid. Exterior part, PEG.

PATIENTS AND METHODS

Ethics

The trial was an open-label, dose-escalating, phase I study conducted at two sites in the United Kingdom; Newcastle General Hospital and Belfast City Hospital. All procedures were reviewed by Independent Ethics Committees, and were in accordance with the protocol, the Helsinki Declaration (October 2000, and clarified 2002 and 2004), the Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) approved in July 1996, and the applicable regulatory requirements.

Administration of therapeutic agent

NC-6004 (NanoCarrier Co., Ltd Chiba, Japan) was a sterile solution containing the equivalent of 2.5 mg ml^{-1} cisplatin and could be diluted in 5% dextrose before administration.

Dosing was performed by intravenous (i.v.) infusion of 500 ml over 60 min, once every 3 weeks. Following the observation of renal toxicities, hydration using 1000 to 1500 ml of fluid, immediately after NC-6004 infusion, was implemented for the rest of the study. Later in the study, after the occurrence of four events of hypersensitivity reactions, the following prophylactic treatment was implemented at each cycle for all patients; 30 min before infusion – dexamethasone 20 mg i.v., chlorphenamine 10 mg i.v., and ranitidine 50 mg i.v. Oral dexamethasone 4 mg (twice a day), ranitidine 150 mg (twice a day), and chlorphenamine 4 mg (three times a day) could also be given if necessary on a per-patient individualised basis for 48 h after infusion.

Patients' eligibility and dose escalation

Patients with histologically confirmed advanced solid tumours, for which no standard therapy exists or has failed therapy, were eligible for enrolment in this study, provided that the following criteria were met: Eastern Cooperative Oncology Group performance status of $\leqslant 2$; age of $\geqslant 18$ years; life expectancy of at least 12 weeks; a normal haematological profile, renal function, hepatic function, and serum calcium level, no more than one previous course of Pt therapy, with maximum cumulative doses of 480 mg m^{-2} of cisplatin, 1040 mg m^{-2} of oxaliplatin, or 42 mg ml^{-1} min^{-1} (min = minutes) cumulative area under the concentration-time curve (AUC) of carboplatin, and no chemotherapy, no radiotherapy (except palliative radiation delivered to <20% of bone marrow), no immunotherapy, or no corticosteroids (greater than 10 mg per day of prednisone or equivalent) within 4 weeks before entering the study or patients who have not recovered from adverse events because of agents administered more than 4 weeks earlier. Patients who had severe hypersensitivity to Pt compounds, ototoxicity assessed by audiometry (except senile hearing loss at high frequency) or other neurotoxicity $\geqslant$ grade 2 were ineligible for enrolment in the study. Patients were excluded if they were pregnant or lactating.

Table 1 Dose modification for changes in estimated creatinine clearance or ^{51}Cr-EDTA clearance

Estimated creatinine clearance/GFR	NC-6004 dose	^{51}Cr-EDTA clearance (in ml min^{-1})	NC-6004 dose
>60 ml min^{-1}	100% of dose	>60	100% of dose
50–60 ml min^{-1}	80% of dose	40–60	50% of dose
<50 ml min^{-1} or any drop from baseline by >10% calculated GFR	^{51}Cr-EDTA clearance measurement	<40	Discontinue

Abbreviations: ^{51}Cr-EDTA clearance = chromium-51-ethylenediaminetetraacetic acid clearance; GFR = glomerular filtration rate.

The dose of NC-6004 is, hereafter, always expressed as cisplatin equivalent mg m^{-2} of body surface area per injection. The starting dose of NC-6004 was 10 mg m^{-2}, one-tenth of the lethal dose in 10% in rat or one-third of the toxic dose low in dog. In stage 1, (accelerated titration method), each dose was escalated at twice the previous dose level until drug-related toxicity $\geqslant$grade 2 was seen in cycle 1. Once the first drug-related toxicity $\geqslant$grade 2 in cycle 1 was seen, a minimum cohort of three patients was recruited, and each dose was defined as 150% of the previous one in stage 2 (modified Fibonacci method) until MTD was reached. The dose was modified according to the estimated creatinine clearance (Cl)/GFR measured before each administration of NC-6004 as detailed in Table 1. Intra-patient dose escalation was not permitted.

Toxicity was graded by the Common Terminology Criteria for Adverse Events version 3.0. MTD was defined as the dose at which one-third of patients experience DLT, and RD was the highest dose, which gave rise to no more than one DLT out of a cohort of six patients. DLTs were defined as grade 4 neutropenia associated with fever ($\geqslant$38.5°C) or diarrhoea $\geqslant$ grade 2, grade 4 neutropenia lasting $\geqslant$5 days without fever, grade 4 thrombocytopenia for $\geqslant$5 days, grade 3 or higher non-haematological toxicity (except liver transaminase elevation, or nausea or vomiting treatable by anti-emetic), and treatment delay >2 weeks before start of next cycle of treatment because of unresolved toxicity.

Pretreatment assessment and follow-up studies

Assessment of medical history was completed during the 21 days before the start of NC-6004 dosing. Safety was monitored throughout the trial until the end of trial visit. In the treatment phase, physical assessment, routine laboratory analysis, estimated creatinine Cl, and concurrent illness/therapy were reviewed on day 1 of cycle 1, then every week until week 7 and then every 3 weeks thereafter, and at withdrawal from the trial. Adverse events were reviewed during the first 4 days of cycle 1, then every week from

weeks 2 to 7 and then every 3 weeks from week 7 onwards, and at withdrawal. The CT/MRI scans of all target and non-target lesions were performed every 6 weeks and at withdrawal, and tumour markers, if applicable, were assessed every 3 weeks. The Response Evaluation Criteria in Solid Tumour (RECIST) was used to define lesions and the criteria for objective tumour response. For pharmacokinetic analysis, blood samples were taken at 0, 2, 4 and 8 h after administration on days 1, 2, 3, 4, 8, 15, and 22 and before cycle 2.

Pharmacokinetic analysis

Blood samples were centrifuged and separated plasma was processed to produce three different forms of sample: total plasma, gel filtrate and ultrafiltrate. Plasma (1 ml) was stored for total-plasma Pt analysis. Plasma (1 ml) was centrifuged with a molecular weight cutoff of 200 000 Da, and the eluant was analysed for micellar Pt. Finally, a further 1 ml of plasma was centrifuged with a molecular weight cutoff of 30 000 Da to give an ultrafiltrate for the determination of low-molecular weight Pt species, including cisplatin. Concentration of total plasma Pt and micellar Pt (gel filtrate) were measured using atomic absorption spectrometry on Analyst 600 (Perkin-Elmer, Waltham, MA, USA) against standards prepared in plasma. Ultrafiltrate samples were analysed by inductively coupled plasma mass spectrometry on Element 2 (Thermo Scientific Inc., Waltham, MA, USA) against centrifuged Pt standards at Durham University. Pharmacokinetic analysis was performed using WinNonlin version 1.3 (Pharsight Corporation, Mountain View, CA, USA) to calculate the maximum concentration (C_{max}), the time to the maximum concentration (T_{max}), elimination half-life ($t_{1/2}$), and the AUC from zero to infinity (AUC_{inf}) for all Pt species. Clearance (Cl) and volume of distribution (V_z) were calculated for total plasma Pt.

RESULTS

Patient characteristics

The first patient was dosed on 15 May 2006 and the last study exit visit occurred on 6 February 2008. In total, 17 patients were enrolled and each received at least one dose of NC-6004, representing the intention-to-treat population. Demographic characteristics of patients are summarised in Table 2. All recruited patients were Caucasian, with a median height of 170.0 cm and a median weight of 73.0 kg. Cancer history of patients is summarised in Table 3. The range of tumour types was large, with no specific tumour type represented more across the different groups. Tumour stage was similar between the dosing cohorts.

Dosing and toxicity

The process for dose escalation is shown in Table 3. In total, 41 doses were administered to 17 patients. The maximum number of treatments was four cycles in three patients, and the mean number of administrations per patient was 2.4 cycles. Dose escalation started at 10 mg m^{-2} and was increased up to 40 mg m^{-2} following the accelerated titration method. Owing to grade 2 renal toxicity in cycle 1 of a patient at 40 mg m^{-2}, reported as a serious adverse event (SAE), the study entered stage 2 with a dose escalation up to 120 mg m^{-2} according to modified Fibonacci method.

Infusion-related adverse events are summarised in Table 4. NC-6004 injection was well tolerated in terms of haematological toxicities. Thus, one episode of grade 3 thrombocytopenia at 10 mg m^{-2} and grade 1 thrombocytopenia at 90 mg m^{-2} only were observed (not DLTs). For non-haematological toxicity, the most frequent related adverse events were fatigue (52.9%), anorexia and nausea (47.1%), vomiting (41.2%), and hypersensitivity reaction and renal impairment (35.3%). Significant cisplatin-related ototoxicity and neurotoxicity were not observed at any dose level.

Table 2 Patient characteristics

	NC-6004 dose level (in mg m^{-2})						
	10	20	40	60	90	120	Total
n	1	1	3	3	6	3	17
Age (years)							
Range	55	63	45–65	45–56	48–80	40–71	40–80
Sex							
Male	1	0	2	2	4	1	10
Female	0	1	1	1	2	2	7
ECOG PS[a]							
0	1	0	2	1	4	2	10
1	0	0	1	0	1	1	3
2	0	1	0	1	1	0	3
Previous treatment							
Chemotherapy	1	1	3	3	5	2	15
Surgery	0	0	3	3	3	3	12
Radiotherapy	0	1	1	2	0	3	7
Other therapies for cancer (targeted therapy, immunotherapy, or epigenetic therapy)	0	0	0	2	1	2	5

Abbreviation: ECOG PS = Eastern Cooperative Oncology Group performance status. [a]For one patient at 60 mg m^{-2}, ECOG PS was not assessed at screening, but was assessed at day 1 before infusion.

One out of six patients at 90 mg m^{-2} experienced grade 3 fatigue in cycle 1 (DLT). One out of three patients at 60 mg m^{-2} had grade 3 vomiting in cycle 1, and one patient in each 60, 90, and 120 mg m^{-2} developed grade 3 hypersensitivity reaction (not DLTs). The clinical signs and symptoms of hypersensitivity reactions to NC-6004 were urticarial rash, dizziness, sweating, cough, dyspnoea, hypotension, tingling, swelling of tongue, lip, and pharynx, tightness in chest, and burning sensation, some of which are typical reactions for Pt, and they always developed after a minimum of two cycles of NC-6004. Other infusion-related toxicities were grade 2 or lower. Despite the implementation of post hydration (from 40 mg m^{-2} onwards) and hypersensitivity prophylaxis (from 90 mg m^{-2} onwards), grade 2 renal toxicity accompanied by a reduction in dose and/or delay in dose for 1 week was still observed at 90 and 120 mg m^{-2}, and grade 2 and 3 hypersensitivity reactions (SAEs) also developed at 120 mg m^{-2}. Following these events, it was considered that adding further patients or increasing the dose level would not be reasonable, and the study was discontinued at dosage level of 120 mg m^{-2}. As the effect on renal function at 90 mg m^{-2} dosage was less marked than that observed at 120 mg m^{-2}, the 120 mg m^{-2} dosage was considered to be the MTD, and the RD of NC-6004 as monotherapy for further studies was therefore estimated to be 90 mg m^{-2}, although renal toxicity and hypersensitivity reactions were not defined as potential DLT per protocol.

Therapeutic response

Best overall response calculated by RECIST is shown in Table 3. No patient was assessed as complete response or partial response. Seven patients (41.2%) were evaluated as having had a stable disease (SD) for longer than 4 weeks at the time of the study completion, even though six of these had advanced Stage IV solid tumours. It should be noted that only two out of eight patients (25%) at the dose levels from 10 to 60 mg m^{-2} had a best response of SD, however the SD ratios at 90 and 120 mg m^{-2} were 50 and 67% respectively, suggesting that the efficacy of NC-6004 is more pronounced at higher dose levels. Overall, 14 patients (82.4%) died or experienced tumour progression, and median progression-free survival time was 49 days.

Table 3 Process for dose escalation

Dose ($mg\,m^{-2}$)	Patient no.	Primary tumour (stage)	Cycles received	No. of DLT	Events	Best overall response
Stage 1						
10	101	Lung (IV)	3	0	Hypersensitivity reaction at cycle 3 (previous cisplatin therapy)	SD
20	102	Lung (IV)	2	0		PD
40	103	Colon (IV)	1	0	Grade 2 reduced renal function at cycle 1 (SAE). Cohort was expanded with two more patients.	PD
	204	Hepatic cell (IV)	4	0		SD
	105	Colon (IV)	2	0	Grade 1 reduced renal function at cycle 1. Hydration was implemented for the rest of study.	PD
Stage 2						
60	106	Mesothelioma (IIIA)	2	0	Hypersensitivity reaction at cycle 2 (previous carboplatin therapy).	PD
	207	Colon (IV)	2	0	Hypersensitivity reaction at cycle 2 (previous oxaliplatin therapy).	PD
	108	Oesophagus (IV)	2	0		NE
90	209	Pancreas (IIA)	4	0	Hypersensitivity reaction at cycle 4 (Pt-naïve). Prophylactic treatment was implemented for the rest of study.	SD
	110	Oesophagus (IV)	2	0	Grade 2 reduced renal function at cycle 1.	PD
	112	GIST (IV)	2	0	Grade 2 reduced renal function at cycle 1. Cohort was expanded with three more patients.	PD
	113	Lung (IV)	2	0		SD
	114	Pancreas (IV)	2	1	Grade 3 fatigue at cycle 1 (DLT).	SD
	215	Colon (IV)	2	0		PD
120	216	Melanoma (IV)	2	0	Grade 2 reduced renal function at cycle 1.	PD
	117	Melanoma (IV)	4	0	Grade 2 reduced renal function at cycle 1. Hypersensitivity reaction at cycle 4 (SAE) (Pt-naïve).	SD
	218	Renal cell (IV)	3	0	Hypersensitivity reaction at cycle 3 (SAE) (Pt-naïve).	SD

Abbreviations: DLT = dose-limiting toxicity; GIST = gastrointestinal stromal tumour; PD = progressive disease; Pt = platinum; NE = not estimated; SAE = serious adverse event; SD = stable disease.

Table 4 Summary of all related adverse events

	NC-6004 dose level (in $mg\,m^{-2}$)						
	10	20	40	60	90	120	Total
n	1	1	3	3	6	3	17
Haematological toxicity							
Blood and lymphatic system disorders							
Thrombocytopenia	1	0	0	0	1	0	2
Non-haematological toxicity							
Gastrointestinal disorder							
Constipation	0	0	0	0	0	1	1
Dry mouth	0	0	0	1	0	0	1
Nausea	0	1	1	1	4	1	8
Paraesthesia oral	0	0	0	0	0	1	1
Tongue ulceration	0	0	0	0	1	0	1
Vomiting	0	0	1	1	4	1	7
General disorder and administration site conditions							
Fatigue	1	1	0	1	4	2	9
Infusion site reaction	0	1	0	0	0	0	1
Malaise	0	0	0	0	0	1	1
Immune system disorders							
Hypersensitivity	1	0	0	2	1	2	6
Metabolism and nutrition disorders							
Anorexia	0	0	2	1	4	1	8
Decreased appetite	0	0	0	1	0	0	1
Dehydration	0	0	0	0	1	0	1
Hypomagnesemia	0	0	0	0	1	0	1
Nervous system disorder							
Dizziness	0	0	0	0	0	1	1
Neuropathy peripheral	1	0	0	1	0	0	2
Peripheral sensory neuropathy	0	0	0	0	1	0	1
Renal and urinary disorder							
Renal impairment	0	0	2	0	2	2	6
Skin and subcutaneous tissue disorder							
Alopecia	0	0	0	0	0	1	1
Rash	0	0	0	0	0	1	1

Table 5 Pharmacokinetic parameters per cohort for total, micellar, and ultrafiltrable Pt of NC-6004 (mean ± s.d.)

Analyte	Dose ($mg\,m^{-2}$)	T_{max} (h)	C_{max} ($\mu g\,ml^{-1}$)	$t_{1/2}$ (h)	AUC_{inf} ($h\,\mu g\,ml^{-1}$)	V_z (l)	Cl ($ml\,h^{-1}$)
Total Pt	10	4.0	5.70	24	234	3.0	85
	20	5.4	12.20	20	492	2.0	68
	40	2.0 ± 0.1	25.9 ± 2.4	62 ± 18	1135 ± 78	5.5 ± 2.0	62 ± 11
	60	2.7 ± 1.2	29.9 ± 13.8	93 ± 41	1354 ± 638	6.7 ± 0.5	107 ± 69
	90	5.2 ± 2.2	60.8 ± 12.5	129 ± 40	2836 ± 554	11.8 ± 6.9	61 ± 20
	120	4.4 ± 2.5	85.4 ± 10.8	158 ± 48	4377 ± 563	10.9 ± 3.8	48 ± 9
Micellar Pt	10	—[a]	—[a]	—[a]	—[a]		
	20	6.4	8.90	16	237		
	40	2.0 ± 0.1	13.9 ± 10.4	67 ± 56	509 ± 204		
	60	5.0 ± 1.7	14.4 ± 7.3	18 ± 7	385 ± 153		
	90	4.8 ± 2.4	42.4 ± 20.3	39 ± 27	1579 ± 939		
	120	3.1 ± 1.5	84.6 ± 8.1	87 ± 37	3857 ± 1171		
UF Pt	10	48.7	0.009	114	1.7		
	20	23.5	0.022	71	2.5		
	40	24.0 ± 0.1	0.045 ± 0.014	141 ± 126	4.7 ± 2.1		
	60	26.5 ± 20.9	0.096 ± 0.022	114 ± 47	13.2 ± 5.8		
	90[b]	20.5 ± 7.6	0.205 ± 0.114	123 ± 44	22.6 ± 10.0		
	120[c]	26.4	0.131	115	22.9		

Abbreviations: AUC_{inf} = area under concentration–time curve from zero to infinity; Cmax = maximum concentration; Cl = clearance; Pt = platinum; QC = quality control; T_{max} = time to maximum concentration; UF Pt = ultrafilterable platinum; Vz = volume of distribution. [a]Data not valid – QCs out with acceptance limit. [b]1 data was not valid – QCs out with acceptance limit. [c]2 data were not valid – QCs out with acceptance limit.

Pharmacokinetics

Pharmacokinetic parameters for Pt measured per cohort in the three different matrices are shown in Table 5. A typical plasma concentration–time profile is also shown in Figure 3.

Pharmacokinetics of total plasma Pt was characterised by longer $t_{1/2}$, and higher C_{max} and AUC_{inf} with smaller V_z and Cl compared with those of cisplatin, indicating that the blood circulation of cisplatin was prolonged by the incorporation into the micelles. Thus, the C_{max} and AUC_{inf} of NC-6004 at 120 $mg\,m^{-2}$ were approximately 11-fold higher than those of cisplatin at an equivalent dose (Kitajima *et al*, 1987). The $t_{1/2}$ of NC-6004 at 120 $mg\,m^{-2}$ was longer than that of cisplatin at an equivalent dose, 14.6 min for the initial phase and 73.8 h for the terminal phase (Kitajima *et al*, 1987). The V_z and Cl of NC-6004 were smaller than those of cisplatin, 521 and 350 $ml\,h^{-1}$, respectively (Calvert *et al*, 1993). The AUC_{inf} and C_{max} of NC-6004 increased in a dose-dependent manner, and there was no apparent change in Cl with increasing dose.

For the gel-filterable Pt (intact micellar formulation), the T_{max} was similar to that of total plasma Pt, the $t_{1/2}$ generally mirrored that of total plasma Pt, and the C_{max} and AUC_{inf} values were approximately 88% of those of total plasma Pt.

For the ultrafilterable Pt (active species including cisplatin), the C_{max} at 120 $mg\,m^{-2}$ was 34-fold lower than that of non-protein-bound cisplatin after the administration of an equivalent dose of cisplatin (Kitajima *et al*, 1987), which might be responsible for the lower incidence of toxicity compared with that associated with cisplatin therapy. Conversely, $t_{1/2}$ and AUC_{inf} at 120 $mg\,m^{-2}$ of NC-6004 were 230-fold and 8.5-fold larger, respectively, than those of non-protein-bound cisplatin after the administration of an equivalent dose of cisplatin (Kitajima *et al*, 1987). The persistence of active Pt species might indicate an improved efficacy of NC-6004. Furthermore, T_{max} (24 h or greater) was delayed compared with that of total plasma Pt or gel-filterable Pt, suggesting that NC-6004 provides a delayed and sustained release of potentially active Pt species after the administration period.

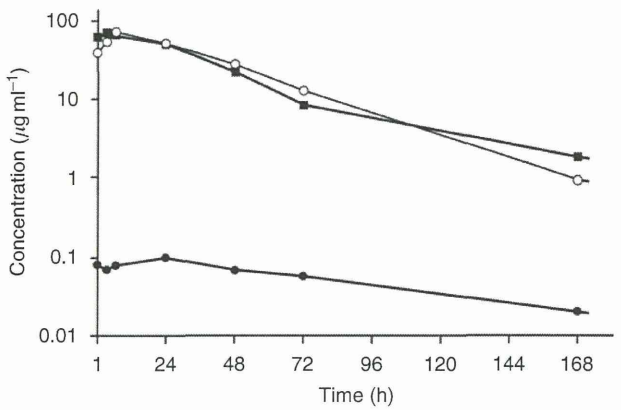

Figure 3 Plasma Pt concentration–time curve from a patient treated at 90 $mg\,m^{-2}$ of NC-6004. ■, total Pt, ○, gel-filterable Pt, ●, ultrafilterable Pt.

DISCUSSION

NC-6004 was well tolerated with minimal nephrotoxicity and no significant myelosuppression, ototoxicity, emesis, or neurotoxicity, but a higher rate of hypersensitivity reactions than predicted. No DLT per protocol was seen at doses up to 90 $mg\,m^{-2}$ where 1 DLT (grade 3 fatigue) was experienced by one out of six patients, and no further DLT per protocol was seen at 120 $mg\,m^{-2}$ when the study was discontinued. In general, the toxicities of NC-6004 were less severe and less frequent compared with cisplatin, particularly nausea/vomiting, anorexia, alopecia, and haematological toxicity.

In this study, dose delays/reductions were mainly due to effects on renal function. Despite the introduction of 1 to 1.5 l of fluid over 2 h, following NC-6004 administration, rising creatinine and/or reduction in estimated creatinine Cl or ^{51}Cr-EDTA Cl affected two out of six patients at 90 $mg\,m^{-2}$ and two out of three patients at 120 $mg\,m^{-2}$, although the creatinine level returned to baseline in 2 weeks. Cisplatin therapy requires a total 8 h hydration, comprising 1–2 l over 4 h of hydration, both before and after the administration of cisplatin, to prevent nephrotoxicity. Another potential advantage of NC-6004 over cisplatin is, therefore, the reduced need for hydration, and that renal impairment was kept to minimum by modest hydration. Whether hydration is absolutely necessary for NC-6004 therapy to reduce the incidence of renal impairment remains to be assessed in a future trial.

Dose interruptions due to toxicity in this study were all related to hypersensitivity reactions, which occurred unpredictably at four

out of six dose levels (10, 60, 90, and 120 mg m^{-2}) in six patients. The first three patients had previous Pt therapy and the last three patients were Pt-naïve, thus, the occurrence of hypersensitivity reaction depends on neither dose level nor the previous Pt exposure. The use of a prophylactic regimen of dexamethasone, ranitidine, and chlorphenamine, previously described, was not sufficient to prevent hypersensitivity reactions in two patients at 120 mg m^{-2}, therefore a more stringent prophylactic regimen (Kwon *et al*, 2002) might be necessary. As most of the patients recruited in this Phase I study progressed by the end of cycle 2, and hypersensitivity reactions developed after a minimum of two cycles of NC-6004, despite the pre-medication, it was considered that this phase I study was not the appropriate setting to assess alternative pre-medication strategies. Therefore, the study was discontinued, so that this problem could be assessed in a future trial. In preclinical studies, the antigenicity of NC-6004 was examined compared with cisplatin, polymer vehicle, polymer-bound cisplatin (not in a micelle form), and cisplatin–plasma protein complex. The results indicated that cisplatin and polymer vehicle are not antigenic, and the highest extent of antigenicity observed was in cisplatin–plasma protein complex, followed by NC-6004 and then polymer-bound cisplatin (not in a micelle form). This suggests that the hypersensitivity reaction to NC-6004 may have been due to plasma protein-bound cisplatin, which is formed by rapid binding of plasma protein to released cisplatin, which then circulates in the blood for a prolonged period. However, the mechanism has not yet been fully clarified.

Taking account of the incidence of hypersensitivity reaction and renal impairment, 120 mg m^{-2} was considered to be close to the MTD, such that 90 mg m^{-2} was most likely the RD for monotherapy for future studies, although the definition per protocol of the MTD was not actually reached.

In spite of the patients generally being heavily pretreated, some evidence of disease stabilisation was seen, and seven patients demonstrated SD after 6 weeks of treatment. Efficacy will be further assessed in a future trial.

The pharmacokinetic analysis indicated the prolonged circulation of NC-6004 in the blood, and delayed and sustained release of potentially active Pt species after the administration of NC-6004. More importantly, the observed lower C_{max} for ultrafilterable Pt compared with that of non-protein-bound cisplatin, after the cisplatin injection, might result in the reduction of cisplatin-related toxicity. Furthermore, the higher AUC_{inf} and $t_{1/2}$ for ultrafilterable Pt compared with that of non-protein-bound cisplatin after the cisplatin injection might enhance the efficacy of NC-6004. However, an increase in the AUC of plasma protein-bound cisplatin because of rapid binding of plasma protein to released cisplatin might result in a higher risk of hypersensitivity reaction.

In conclusion, this Phase I study has confirmed that NC-6004 exhibits pharmacokinetic characteristics completely different from those of cisplatin, resulting in the reduction of cisplatin-related toxicity and the improvement of patient's quality of life so that the patients can take therapy without hospitalisation for hydration and treatment of cisplatin-related toxicities. The data obtained from this study are believed to open new avenues for the use of this micellar formulation in the clinic. The assessment of the most appropriate prophylactic regimen for hypersensitivity reactions, whether hydration is necessary and of efficacy are now underway in ongoing NC-6004 studies.

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New concept of cytotoxic immunoconjugate therapy targeting cancer-induced fibrin clots

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Fibrin clots in non-malignant conditions form only at the onset or during the active stage of disease and disappear within a few weeks as a result of plasmin digestion or replacement with collagen. In contrast, fibrin clot formation and subsequent replacement with collagen in cancer persist for as long as the cancer cells survive in the body. We developed an anti-fibrin chimeric antibody that reacts with fibrin only, and not fibrinogen (the precursor of fibrin), and then attached an anticancer agent (ACA) to the antibody. Thus, the immunoconjugate did not create an immune complex in the blood stream and was selectively accumulated to fibrin clots in the tumor stroma to create a scaffold, from which effective sustained release of the ACA occurred. In a mouse model, the ACA diffused throughout the tumor tissue to damage both tumor cells and vessels, resulting in potent antitumor activity in stroma-rich spontaneous tumors. This new cancer stroma-targeting therapy may result in an increased duration of drug exposure and be a highly effective new therapy, particularly for refractory, stroma-rich cancers. (*Cancer Sci* 2011; 102: 1396–1402)

Low molecular weight (LMW) anticancer agents (ACA), including molecular targeting agents, are very efficient cytocidal agents in the closed space of a monolayer culture dish. The antitumor effects of these agents are determined using subcutaneous tumor xenografts, the pathophysiological features of which are far removed from those of general human cancers. Although there have been numerous reports of genetic and phenotype changes in tumors, there are no pivotal changes in tumor cells that distinguish them from normal dividing cells.[1–6] Unlike the situation in culture, following the administration of LMW ACA to patients, these agents are cleared quickly from tumors in the body. In addition, the ACA are distributed throughout the body, resulting in serious side effects.[7] To overcome off-target effects caused by LMW ACA, immunoconjugate therapy was developed in which an ACA or toxin is conjugated to a cancer cell-specific mAb, which is too large to pass through a normal vessel wall but can extravasate from leaky tumor vessels and accumulate selectively in tumor tissue.[8–12] The kinetics of drug distribution within tumors are considered to be a function of interstitial conductivity, which is determined by the quantity and density of the extracellular matrix (e.g. proteoglycan, fibronectin) and fibrosis (e.g. fibrin, collagen fibers) in the stroma.[13–16] Most human solid tumors have abundant stroma that hinders the distribution of high molecular weight (HMW) agents, including ACA-conjugated antibodies. Consequently, the tissue becomes a barrier preventing the immunoconjugates from attacking cancer cells.[14–16] This led us to design a novel alternative antitumor strategy that turned this apparent handicap into an asset.

In the 19th century, French surgeon Armand Trousseau described, for the first time, thrombophlebitis in patients with stomach cancer.[17] Today, a large body of clinical evidence supports the conclusion that abnormal coagulation followed by fibrin formation occurs in a variety of cancers.[18,19] Different types of tumor cells express the tissue factor that is known to be a cell surface membrane protein and a trigger of the extrinsic coagulation pathway.[18,20] Above all, any malignant tumor erodes adjacent normal or tumor vessels, resulting in microscopic hemorrhages within or adjacent to cancer tissues; fibrin clots should form immediately *in situ* to stop the bleeding. Although fibrin clot formation also occurs in non-malignant disorders, such as cardiac or brain infarction, injuries, and active rheumatoid arthritis, these fibrin clots form only at the onset or during the active stage of the disease. Moreover, these fibrin clots disappear within a few weeks as a result of plasmin digestion or replacement with collagen fibers. In tumor tissues, the fibrin clots are replaced by collagenous stroma in a process similar to that in normal wound healing and other non-malignant diseases.[13] However, unlike non-malignant conditions, fibrin clot formation in cancer tissues lasts for as long as the cancer cells survive in the body. Therefore, unlike growth factors and tyrosine kinases, fibrin clots are pathophysiologically specific for tumors. In that context, we developed an mAb against fibrin to target the tumor stroma. In addition, we exploited the newly developed specialized immunoconjugate linker to conjugate the anti-fibrin mAb with an ACA.

Materials and Methods

Antibodies. A hybridoma producing anti-fibrinogen (mouse IgG clone K88-3) or anti-fibrin antibody (mouse IgM clone 102-10) was established using myeloma cells (P3U1) and lymph node cells from the mouse with immunizing human fibrinogen (Sigma, St. Louis, MO, USA) or fibrin, with the latter converted from fibrinogen by thrombin (Sigma) cleavage. Heavy chain variable and kappa light chain variable cDNAs were cloned into the vector for human IgG1 expression. The vectors were transfected into Chinese hamster ovary (CHO) cells (Riken Bioresource Center, Tsukuba, Japan) and a stable clone (humanized IgG, clone 102-10) was isolated.

Camptothecin-11 (CPT-11; irinotecan) and SN-38 were purchased from Tokyo Chemical Industry (Tokyo, Japan) and Yakult (Tokyo, Japan), respectively.

***In vivo* imaging and immunohistochemistry.** Antibodies were conjugated with Alexa-647 (Invitrogen, Carlsbad, CA, USA) according to the manufacturer's instructions. *In vivo* fluorescence imaging was performed using a confocal fluorescence microscope (A1R; Nikon, Tokyo, Japan) or a small animal imaging system (OV110; Olympus, Tokyo, Japan). For immunohistochemistry, anti-fibrin IgM was incubated with Alexa 488-labeled anti-mouse IgG (Invitrogen) as a secondary antibody. The unbound antibodies were blocked with mouse serum (Dako, Glostrup, Denmark). First, samples were incubated for 30 minutes at room temperature in the dark with the

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immunocomplex (anti-fibrin IgM and Alexa 488 secondary Ab), anti-cytokeratin (Abcam, Cambridge, UK), or anti-CD31 (Becton Dickinson, Franklin Lakes, NJ, USA). Then, samples were incubated for 60 minutes at room temperature in the dark with Alexa 488-, 555- or 647-labeled anti-rabbit IgG (Invitrogen) or phycoerythrin (PE)-labeled anti-rat IgG (Jackson ImmunoResearch, West Grove, PA, USA). Fluorescence images were obtained using a digital high-definition microscopic system (BZ-9000; Keyence, Osaka, Japan).

Synthesis of the SN-38 derivative linker. A detailed description of the synthesis of the linker is provided online as supplementary material for this paper (Data S1). Briefly, PEG was purchased from Quanta BioDesign (Powell, OH, USA) and Merck (Whitehouse Station, NJ, USA). Reagents and solvents were purchased from Sigma and Kanto (Tokyo, Japan). The final structure was composed of one maleimide for the attachment of mAb, one PEG_{12} spacer and three PEG_{27} ester bonds for attachment of three SN-38 molecules. The structure and purity of the chemically synthesized materials were determined by 400-MHz ^{1}H-NMR and ^{13}C-NMR (NMR ECX-400 or NMR AL; JEOL Ltd., Tokyo, Japan) and mass spectrometry (MS AXIMA; Shimadzu, Kyoto, Japan). The derivatives were resolved in DMSO (Sigma).

Immunoconjugate. The interchain disulfides of the Abs were first reduced with 10 mM DTT (Sigma). The number of free thiols was quantified using 5,5′-dithiobis 2-nitrobenzoic acid (DTNB; Wako Pure Chemical Industries, Osaka, Japan). Reduced Abs were purified by gel filtration (Amicon Ultra Centrifugal Filter Devices; Millipore, Billerica, MA, USA) and reacted with linker SN-38 derivative in PBS containing 5 mM EDTA (pH 6) at room temperature for 1 h, then at 4°C overnight. The SN-38-conjugated Abs were purified by gel filtration (Millipore). The concentration of Ab–prodrug conjugates was determined using the Bradford method (Bio-Rad Protein Assay, 500-0006JA; Bio-Rad, Hercules, CA, USA). The number of residual thiols was quantified with DTNB. The ratio of each drug (SN-38)/Ab was determined by comparison of the number of free and residual thiols.

High-performance liquid chromatography. The kinetics of release of SN-38 from the immunoconjugate was investigated *in vitro* at 37°C in 5% glucose (pH 4.6), PBS (pH 7.4), or mouse serum. Whole tumor tissues were mixed with 0.1 M glycine–HCl buffer (pH 3.0)/methanol (5 w/w%) and then homogenized. Samples (100 μL) were then mixed with 20 μL of 1 mM phosphoric acid/methanol (1:1), 40 μL ultrapure water, and 60 μL camptothecin solution (Sigma) as an internal standard. Reaction solutions and plasma were mixed with 0.1 M HCl at 50% (w/w). The samples (50 μL) were then mixed with 20 μL of 1 mM phosphoric acid in methanol (1:1) and 100 μL camptothecin as an internal standard. Samples were vortexed for 10 s and filtered through an Ultrafree-MC (Millipore). To detect immunoconjugated SN-38, samples (20 μL plasma, 100 μL tumor) were diluted with 20 μL methanol (50% w/w) and 20 μL NaOH (0.7 M). After incubation for 15 minutes at room temperature, 20 μL HCl (0.7 M) and 60 μL internal standard solution were added to the samples, and the hydrolysate was then filtered. Reverse-phase HPLC was performed at 35°C on a Mightysil RP-18 GP column (150 × 4.6 mm; Kanto). Samples were injected into an Alliance Waters 2795 HPLC system (Waters, Milford, MA, USA) equipped with a Waters 2475 multi λ fluorescence detector at excitation and emission wavelengths of 365 and 540 nm, respectively, for SN-38 or 365 and 430 nm, respectively, for CPT-11.

Animal model and antitumor effects. Chemical skin carcinogenesis was induced in female FVB/N mice (CLEA, Tokyo, Japan) as described previously.[21,22] Briefly, a single application of 7,12-dimethylbenz[α]anthracene (DMBA; 250 μg/mL in acetone; Sigma) was applied to the shaved dorsal skin of mice. After 1 week, phorbol 12-myristate 13-acetate (PMA); 25 μg/mL in acetone; Sigma) was applied weekly (for a total of 32 times). Carcinoma was determined on the basis of the clinical appearance of characteristic features, according to the previous report.[22] Histological analysis was performed to confirm the diagnosis of carcinoma based on clinical appearance (Fig. 1A). Tumor volume was calculated as (length × width^2)/2. When the mean size of tumors that grew continuously over a period of 3 weeks reached approximately 70 mm^3, the tumors were randomly divided into three groups comprising five tumors in each group such that there was no significant difference in tumor size among them. Immunoconjugates were administered on Days 0, 7, 14, and 21 by tail vein injection. An injection dose of antibody–SN-38 prodrug equal to an SN-38 dose of 13.3 mg/kg was determined by calculations based on the drug (SN-38)/antibody ratio for each drug. Statistical analyses of both antitumor effects and changes in body weight were performed using ANOVA.

All animal procedures were performed in compliance with the *Guidelines for the Care and Use of Experimental Animals* established by the Committee for Animal Experimentation of the National Cancer Center. These guidelines meet the ethical standards required by law and also comply with the guidelines for the use of experimental animals in Japan (http://www.scj.go.jp/ja/info/kohyo/pdf/kohyo-20-k16-2.pdf).

***In vivo* fiber confocal fluorescence microscopy.** For visualization of tumor vessels, 400 μg FITC–dextran (250 kDa; Sigma) was injected into tumor-bearing mice before and 5 days after treatment with the immunoconjugate using the imaging system Cellvizio (Mauna Kea Technologies, Paris, France).[23] Mean vessel diameter, total vessel length, and total area were estimated at six different sites within the tumor before and after treatment using ImageCell software (Mauna Kea Technologies). The length of functional capillary density (FCD) was calculated as (total vessel length/total area). Statistical analyses were performed using Student's *t*-test.

Results

Preparation of anti-fibrin chimeric IgG for stroma targeting. We developed an mAb against fibrin, which is abundant in the stroma of human solid tumors. After extensive screening using two ELISA sets, one for human fibrinogen (the precursor of fibrin that is present physiologically) and the other for human fibrin (which is formed only in some abnormal conditions), we successfully developed an mAb that reacted with human fibrin only and not with human fibrinogen. However, because the mAb obtained was IgM, it was converted into the human IgG format for clinical application using an antibody engineering technique. Another advantage of the mAb was that the mAb cross-reacted with mouse fibrin and not with mouse fibrinogen (Fig. 1B). Chemically induced mouse cutaneous cancer was selected as an appropriate experimental model in which to evaluate the therapeutic effects of our immunoconjugate chemotherapy because this spontaneous carcinogenetic model has marked fibrin deposition and abundant interstitial tissue, as in human cancer (Fig. 1A) and unlike human tumor xenografts, which have fewer fibrin clots and less interstitial tissue.[24,25] In addition, the spontaneous tumors exhibit very slow growth, which is similar to the condition in general human cancer but not in the xenografts.

Using real-time *in vivo* confocal microscope imaging, the anti-fibrin chimeric IgG (AFCA) was found to be distributed in the extravascular component 1 h after injection, whereas the leakage of anti-fibrin IgM from the vessels was so restricted that obvious extravascular distribution was not observed over the same period (Fig. 1C). Using systemic *in vivo* imaging, anti-fibrin IgM, anti-fibrin IgG, and anti-fibrinogen IgG were delivered and retained in the tumor until Day 3, utilizing leaky tumor

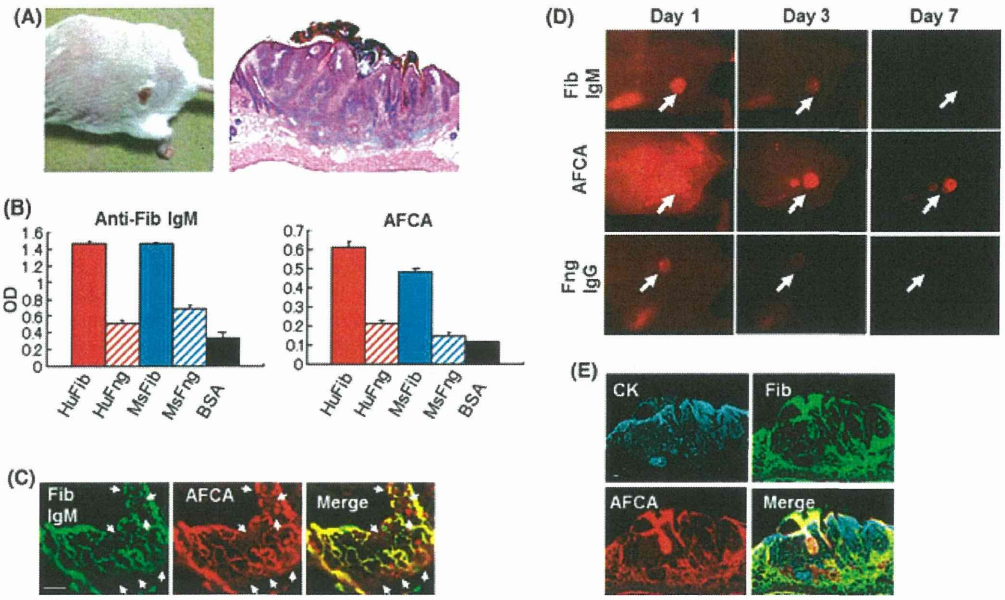

Fig. 1. Preparation and characterization of the anti-fibrin antibody. (A) Chemical skin carcinogenesis. A mouse bearing a tumor (left) and hematoxylin-eosin staining (right) of the tumor. (B) Both anti-fibrin (Fib) IgM and its chimeric IgG (AFCA) were shown to recognize human (Hu) and mouse (Ms) fibrin, but not their fibrinogen (Fng), by ELISA. OD, optimal density. (C) *In vivo* confocal microscope imaging showing leakage of Alexa 488-labeled anti-fibrin IgM (left; green) and Alexa 647-labeled AFCA (middle; red) from tumor vessels 1 h after injection. Arrows indicate the area into which the AFCA has leaked (right; red in Merge). Scale bar, 100 μm. (D) *In vivo* systemic imaging analysis of Alexa 647-labeled anti-fibrin IgM (upper), AFCA (middle), or anti-fibrinogen mAb (lower) on Days 1, 3, and 7 after injection. Arrows indicate each tumor position. (E) Intratumoral distribution of injected fluorescent AFCA (lower left; red) was examined 24 h after injection. Immunohistochemistry with anti-cytokeratin (upper left; light-blue) or anti-fibrin (upper right; green). Yellow indicates the overlap of injected anti-fibrin IgG and deposited fibrin (lower right). Scale bar, 100 μm.

vessels.[10,11] The accumulation of anti-fibrin IgM and anti-fibrinogen IgG was weak and they were eliminated by Day 7; however, on Day 7, AFCA was still highly retained within the tumor (Fig. 1D). Therefore, we used AFCA as a vehicle for drug delivery, providing high accumulation and long-term retention in the tumor. Investigating the intratumoral distribution of AFCA, we found that it was observed mainly in fibrin-positive stroma and was rarely seen in cytokeratin-positive tumor cell areas (Fig. 1E). Thus, we succeeded in developing an anti-fibrin IgG for targeting the tumor stroma.

Drug design, anti-tumor activity, and pharmacokinetic study of the anti-fibrin immunoconjugate. Another special feature of our design is the conjugation of highly cytotoxic SN-38 with each mAb, using a specially produced linker composed mainly of PEG, which provided both increased payload capacity and efficient, sustained drug release within the tumor. The branched composition had one maleimide for the attachment of the mAb, one PEG_{12} spacer, and three PEG_{27} ester bonds for the attachment of three SN-38 molecules (Fig. 2A). There were approximately eight thiol residues able to react with the maleimide in the reduced mAb. The calculated drug (SN-38)/mAb ratio of the immunoconjugate was approximately 24. Previous studies have reported drug/mAb ratios in the range 3–8.[26–28] Therefore, the ratio of 24 obtained in the present study is so far the highest, which means that the drug can be carried with the minimum amount of antibody, resulting in a reduction of both undesirable drug effects in the body and production costs.

The conjugated SN-38 had no cytotoxic effect, which means that the cytotoxic immunoconjugate itself is a prodrug. Consequently, we succeeded in producing a cytotoxic immunoconjugate, namely AFCA-branched-PEG-$(SN\text{-}38)_3$, hereafter abbreviated to AFCA-B-P-$(SN\text{-}38)_3$ (Fig. 2A). The immunoconjugate, via the ester bond, was stable in 5% glucose (pH 4.6) because the phenyl ester bond is stable under acidic conditions and labile under mild alkaline conditions.[29] Under physiological conditions (PBS pH 7.4 and serum) such as in the extracellular environment, the immunoconjugate, via the ester bond, can release SN-38 enzyme independently, gradually, and effectively (Fig. 2B). This bond has already been introduced into clinical use, such as in NK012.[30] The antitumor activity of AFCA-B-P-$(SN\text{-}38)_3$ was evaluated *in vivo* and, following its administration four times weekly at an equivalent SN-38 dose of 13.3 mg/kg per day, showed significant antitumor activity compared with findings in mice treated with either saline or CPT-11 (40 mg/kg per day at the maximum tolerated dose [MTD], equivalent to a dose of 23.2 mg/kg per day SN-38). Although tumors continued to increase in mice treated with CPT-11, the growth of tumors in mice treated with AFCA-B-P-$(SN\text{-}38)_3$ was significantly suppressed for more than 1 month (Fig. 2C). Thus, AFCA-B-P-$(SN\text{-}38)_3$ exerted strong antitumor activity compared with CPT-11 (Fig. 2C). Although treatment-related body weight loss was observed in mice treated with each of the drugs, there was no significant difference in body weight loss between the control group and the CPT-11- and AFCA-B-P-$(SN\text{-}38)_3$-treated groups (Fig. 2D). Blood tests revealed no significant bone marrow toxicity or liver and kidney dysfunction in any of the treatment groups (data not shown).

Release of SN-38 from the anti-fibrin immunoconjugate induces damage to both tumor cells and tumor vessels. After injection of AFCA-B-P-$(SN\text{-}38)_3$, the concentration of total SN-38 (antibody-bound and unbound forms) and free SN-38 (unbound form) in plasma declined gradually within a week, whereas CPT-11 exhibited rapid clearance (Fig. 3A). We then examined the intratumoral distribution of SN-38 released from the immunoconjugate using HPLC. Significantly high concentrations of total and free SN-38 were detected in tumor tissues treated with the immunoconjugate for 168 hours compared with CPT-11 (Fig. 3B). The second significant observation following

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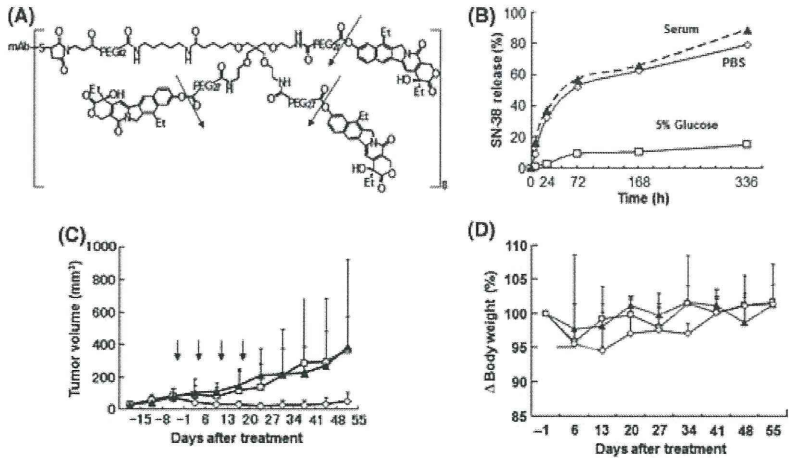

Fig. 2. Drug design, anti-tumor effect and pharmacokinetics of the anti-fibrin immunoconjugate. (A) Drug design of the immunoconjugate: mAb–PEG–three-branched PEG–$(SN\text{-}38)_3$ linked via an ester bond. One antibody bears 24 molecules of SN-38. The arrows indicate the cleavage sites to release free active SN-38. (B) Release of SN-38 from immunoconjugates over time in mouse serum, PBS (pH 7.4), or 5% glucose at 37°C. Data show single values determined at each time point. (C) Antitumor activity was examined *in vivo*. Immunoconjugates (◇), camptothecin-11 (CPT-11; □), or saline (▲), were administered to mice bearing chemical-induced cutaneous tumors via intravenous injection on Days 0, 7, 14, and 21. Arrows indicate the day of administration and the curves illustrate the effect of treatment on tumor size. Data are the mean ± SD ($n = 5$ in each group). $P = 0.0005$ for CPT-11 compared with immunoconjugate; $P < 0.0001$ for saline compared with immunoconjugate. (D) Changes in the relative body weight of mice injected with Immunoconjugates (◇), CPT-11 (□), or saline (▲) on Days 0, 7, 14, and 21. Data are the mean ± SD. There were no significant differences between the three groups ($P = 0.09$ for CPT-11 versus immunoconjugate; $P = 0.0866$ for saline versus immunoconjugate).

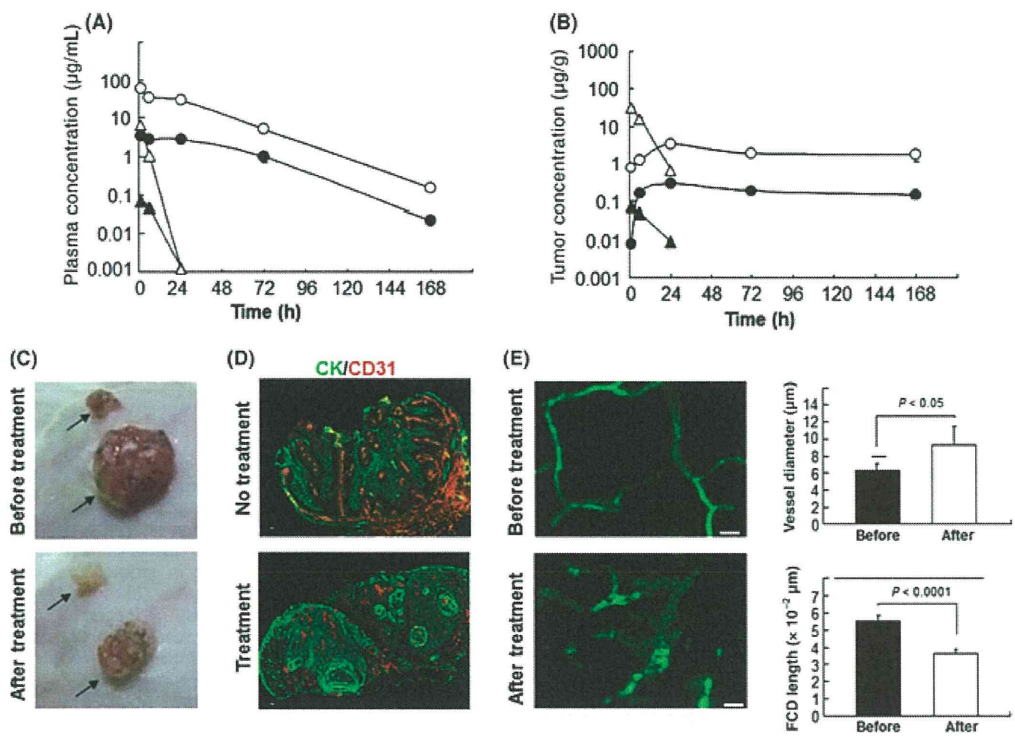

Fig. 3. Drug distribution and antivascular activity of the immunoconjugate. (A,B) Plasma (A) and tumor (B) concentrations of total SN-38 (bound and unbound form; ○), camptothecin-11 (CPT-11; △), and free SN-38 (unbound form) released from the immunoconjugate (●) or converted from CPT-11 (▲) were determined by HPLC 1, 6, 24, 72, and 168 h after injection. (C) The color of the tumor changed from reddish to white 5 days after injection of the immunoconjugate, but not CPT-11. The arrows indicate the position of each tumor. (D) Tumor vessels after injection of the immunoconjugate (Treatment) were examined using CD31 (red) and cytokeratin (CK; green). Untreated mice (No treatment) were used as a control. Scale bar, 100 μm. (E) The left-hand figures show the change of tumor vessels visualized with FITC-dextran before and after the injection of the immunoconjugate, visualized using FITC–dextran by *in vivo* fiber confocal fluorescence microscopy. Quantified vessel diameter and functional capillary density (FCD) length are shown on the right. Scale bars, 20 μm.