**Table 4. Patient outcomes**

| Patient no | Follow-up, d | Outcome | Cause of death |
|---|---|---|---|
| 1 | 144 | Died | VOD and pulmonary hemorrhage |
| 2 | 50 | Died | VOD and MOF |
| 3 | 170 | Died | Pulmonary hypertension |
| 4 | 247 | Died | Fungal septic thrombosis of pulmonary veins and pulmonary artery with pulmonary hemorrhagic necrosis |
| 5 | 414 | Alive and well; limited skin GVHD | |
| 6 | 17 | Died | Pulmonary hemorrhage, VOD |
| 7 | 50 | Died | GVHD, MOF |
| 8 | 22 | Died | ARDS, posttransplantation cytokine storm syndrome |
| 9 | 1765 | Alive and well | |
| 10 | 285 | Died | Drug-resistant *P aeruginosa* sepsis |
| 11 | 13 | Died | Cardiac toxicity, MOF, asystole |
| 12 | 140 | Died | Encephalitis, HLH with CNS involvement |
| 13 | 1057 | Alive and well | |
| 14 | 149 | Alive and well | |
| 15 | 125 | Died | Pneumonitis and respiratory failure |
| 16 | 273 | Alive and well | |
| 17 | 416 | Died | Pneumonia and respiratory failure; chronic extensive GVHD |
| 18 | 867 | Alive and well | |
| 19 | 139 | Alive and well | |

MOF indicates multiorgan failure; and ARDS, acute respiratory distress syndrome.

remission, or active. The patient who received the intermediate-intensity regimen (patient 8) was excluded from the analysis. Although there are a limited number of patients in our series, it is notable that of the surviving patients (n = 7), all were reported to be in remission of HLH at the time of HCT. Of the deceased patients (n = 12), half were reported to be in partial remission or have active disease at the time of HCT. It is also notable that of the 7 surviving patients, all but 1 received grafts from HLA-matched donors, whereas of the 12 deceased patients, only 3 received grafts from HLA-matched donors. Multivariate analysis suggested that MAC regimens and HLH that was not in remission conveyed statistically significant negative influences on survival (Figure 1C and Table 5). Match was significant in univariate analysis (data not shown), but was not significant once controlled for conditioning regimen and HLH remission status. Survival for patients receiving RIC who were reported to be in remission from HLH is 86% ($P = .03$; Figure 1C).

Because XIAP functions as an inhibitor of apoptosis and is widely expressed, we also sought to determine whether residual protein expression may offer some protective benefit for survival after allogeneic HCT. Twelve patients were reported to have had analysis of XIAP protein expression. Of 5 patients with no detectable XIAP, 2 are alive and well (40%). Of 7 patients with detectable decreased or truncated protein expression, 3 are alive and well (43%). We conclude that in this limited cohort, the presence of detectable XIAP does not appear to confer a survival advantage.

## Discussion

Deficiency of XIAP is a newly recognized disorder, and the results of the present study survey reveal that transplantation outcomes overall appear poor compared with the outcomes typically expected of patients with XLP and FHLH. There was a high incidence of conditioning-related toxicity, which may be related to the lack of ubiquitously expressed XIAP and the resultant loss of its antiapoptotic and other functions. In particular, only 1 patient treated with MAC is currently surviving (14%). This is in sharp contrast to the typical survival rates in other forms of HLH, which are generally greater than 50%.[1-7,11-13] There was a preponderance of hepatic VOD and pulmonary hemorrhage in MAC patients. Although VOD has been reported in patients with HLH who undergo MAC regimens, it appears that the 50% incidence of VOD in this series is high compared with previous reports of 20%-30%.[3,4] However, because of the small number of patients included in the present study, it is difficult to conclude definitively that XIAP deficiency predisposes patients to an increased risk of liver and pulmonary toxicity. In addition, a high proportion of MAC patients received grafts from HLA-mismatched donors or had HLH that was not in remission at the time of transplantation, which may have contributed to the poor outcomes. Regardless, based on the poor survival outcomes, MAC protocols should be cautioned against and avoided in patients with XIAP deficiency.

With regard to the RIC cohort, the overall survival of just over half of patients appears to be decreased compared with the relatively high survival rates expected for HLH patients undergoing RIC HCT, which are typically greater than 80%.[10,11] However, the causes of death among the patients with XIAP deficiency were heterogeneous and we found no clear evidence to suggest that the deaths were related to deficiency of XIAP. The survival of RIC patients reported to be in remission from HLH was 86%, and the impact of HLH status was significant. This suggests that RIC transplantation outcomes for patients with XIAP deficiency who are in remission from HLH may be equivalent to that of other forms of XLP and FHLH. Infectious complications were common after HCT in both MAC and RIC patients. These complications do not appear to be increased compared with reports of transplantation outcomes for patients with HLH.[9,11]

Given our findings, the question of whether to pursue allogeneic RIC HCT is somewhat difficult to answer and is further complicated by the limited amount of information regarding outcomes of patients with XIAP deficiency not treated with transplantation. In the largest published series to date (N = 30), approximately 40% of patients with XIAP deficiency died at a mean age of 16 years predominantly because of HLH, colitis, or complications of allogeneic HCT.[30] Overall, the small numbers of patients make it difficult to draw a firm conclusion regarding recommendations for

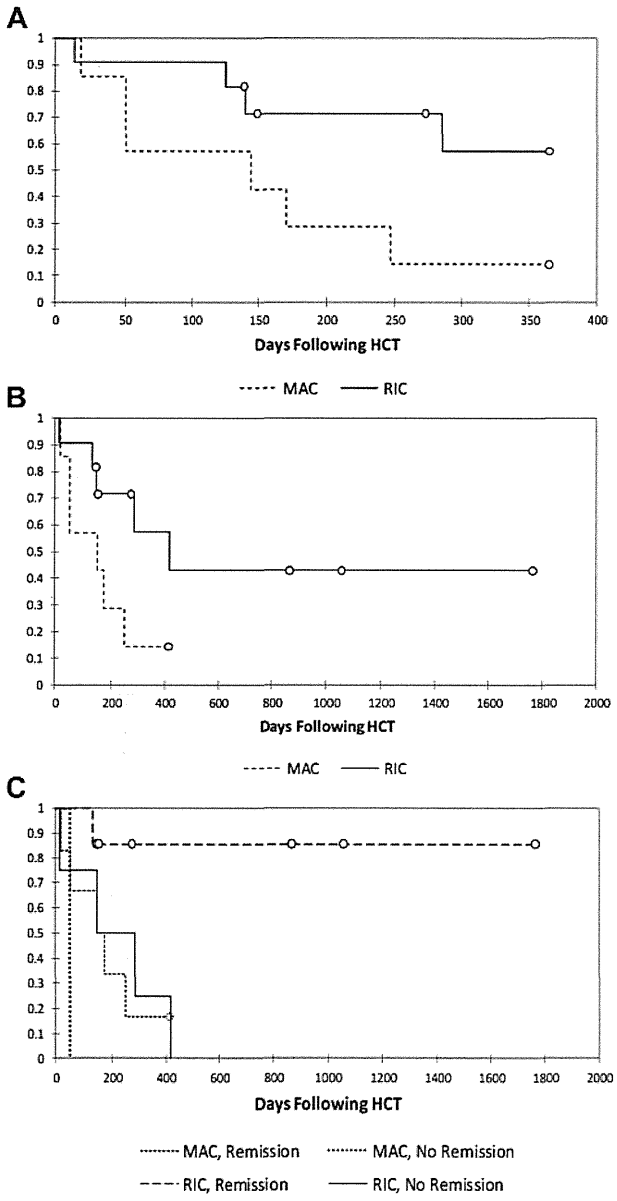


**Figure 1. Kaplan-Meier survival analyses.** Shown are analyses of 1-year survival (A), long-term survival (B), and survival stratified by reported HLH status at the time of transplantation (C; $P = .035$) in patients treated with MAC or RIC regimens.

RIC HCT for patients with XIAP deficiency. At this time, based on the available information, it is the our opinion that RIC protocols should be pursued with caution in young patients with XIAP deficiency who have a compelling clinical history and for whom a good stem cell donor is available. Preferably, patients should have no active lymphoproliferative disease or HLH and aggressive efforts should be made to ensure remission of HLH. The outcomes of all patients with XIAP deficiency should be monitored to further support evidence-based decisions regarding optimal treatment strategies.

**Table 5. Cox proportional hazard regression model analysis**

| Variable | *P* | HR | HR 95% CI | |
|---|---|---|---|---|
| A | | | | |
| Conditioning (MAC vs RIC) | .0251 | 7.524 | 1.287 | 44.000 |
| Match (match vs mismatch) | .2744* | 0.471 | 0.122 | 1.816 |
| HLH activity (not in remission vs remission) | .0806 | 4.322 | 0.837 | 22.330 |
| B | | | | |
| Conditioning (MAC vs RIC) | .0181 | 6.348 | 1.371 | 29.394 |
| HLH activity (not in remission vs remission) | .0218 | 5.301 | 1.275 | 22.046 |

In part A of the table, multivariate analysis included preparative regimen, match, and HLH activity; in part B, the effects of preparative regimen and HLH activity were analyzed with removal of the nonsignificant match effect.

HR indicates hazard ratio; and CI, confidence interval.

*The effect of match was statistically significant in univariate analysis.

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## Authorship

Contribution: R.A.M. and K.R. designed the study, collected and analyzed the patient data, and wrote the manuscript; P.K., K.L., I.M., A.F., S.L., P.S., V.B., K.H., H.K., S.M., D.A.M., D.D., J.C., D.N.D., P.J.A., P.V., A.R.K., M.B.J., and J.J.B. collected the patient data and edited the manuscript; D.L. and M.K. performed the statistical analyses; and A.H.F. designed and oversaw the study and edited the manuscript.

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# Aggressive Transformation of Juvenile Myelomonocytic Leukemia Associated with Duplication of Oncogenic *KRAS* due to Acquired Uniparental Disomy

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A small fraction of cases of juvenile myelomonocytic leukemia (JMML) develop massive disease activation. Through genomic analysis of JMML, which developed in an individual with mosaicism for oncogenic *KRAS* mutation with rapid progression, we identified acquired uniparental disomy at 12p. We demonstrated that duplication of oncogenic *KRAS* is associated with rapid JMML progression. *(J Pediatr 2013;■:■-■).*

Juvenile myelomonocytic leukemia (JMML) is a rare pediatric myeloproliferative disorder, characterized by malignant transformation in the stem cell compartment with clonal proliferation of progeny that variably retain the capacity to differentiate. The clinical course of JMML is heterogeneous. Some patients require prompt allogeneic hematopoietic stem cell transplantation, whereas some demonstrate a milder clinical course, and some of them eventually exhibit spontaneous improvement.[1] Recent investigations into the molecular pathogenesis of JMML revealed that approximately 80% of patients harbored mutually exclusive mutations in genes regulating the Ras-mitogen-activated protein kinase (MAPK) pathway, including *RAS*, *PTPN11*, *NF1*, and *CBL*, leading to aberrant activation of the Ras-MAPK pathway.[1,2] The spectrum of mutations described thus far in JMML provides potential new opportunities for both diagnosis and therapy.

Previous studies reported that a small fraction of patients with JMML develop rapid and massive disease activation after an indolent clinical course. A report showed the incidence of progression to blastic phase to be 13%.[3] The etiology of the aggressive transformation remains unelucidated, however. We present a patient with JMML with a *KRAS* mutation who developed aggressive transformation and died. We performed genomic analysis to investigate the molecular pathology of this rapid and fatal progression.

## Methods

A 1-year-old boy presented with leukocytosis (white blood cell count 46 800/mm$^3$, 20% monocytes, no blast cells) and hepatosplenomegaly. Bone marrow aspiration revealed hypercellular marrow, with 0.5% blast cells. Karyotyping was normal, and reverse-transcription polymerase chain reaction detected no *BCR-ABL* fusion. Fetal hemoglobin concentration was elevated (22%). Spontaneous growth of colony-forming unit granulocyte macrophages and hypersensitivity to granulocyte macrophage colony-stimulating factor were demonstrated, and mutation analysis revealed a heterozygous *KRAS* mutation (G12D: GGT>GAT) in peripheral blood mononuclear cells (PBMCs), all of which were consistent with JMML.[4] By 2 months after diagnosis, leukocytosis and hepatosplenomegaly had progressed. Oral 6-mercaptopurine (6-MP) therapy was started, and the patient remained stable for the next 10 months.

At 1 year after diagnosis, the patient suddenly developed tachypnea, impaired consciousness, and massive hepatosplenomegaly. Laboratory data revealed a white blood cell count of 124 400/mm$^3$ (38% monocytes, 5% blast cells; **Figure 1**, A). The patient's condition deteriorated rapidly, and he died from respiratory dysfunction. Autopsy revealed dysplastic cells infiltrating the bone marrow, lymph nodes, central nervous system, lungs, liver, spleen, pancreas, and kidneys (**Figures 1**, B and 2; **Figure 2** available at www.jpeds.com).

Our genomic analysis was approved by the Ethics Board of the University of Tokyo, and informed consent was obtained from the child's guardian. Direct sequencing of the *KRAS* gene was performed for his normal muscle, heart, and lung (obtained at autopsy) and for PBMCs at diagnosis and at progression. Genome-wide analysis for genetic lesions was performed by single nucleotide polymorphism (SNP) array analysis. DNA

| | |
|---|---|
| 6-MP | 6-mercaptopurine |
| JMML | Juvenile myelomonocytic leukemia |
| MAPK | Mitogen-activated protein kinase |
| PBMC | Peripheral blood mononuclear cell |
| SNP | Single nucleotide polymorphism |
| UPD | Uniparental disomy |

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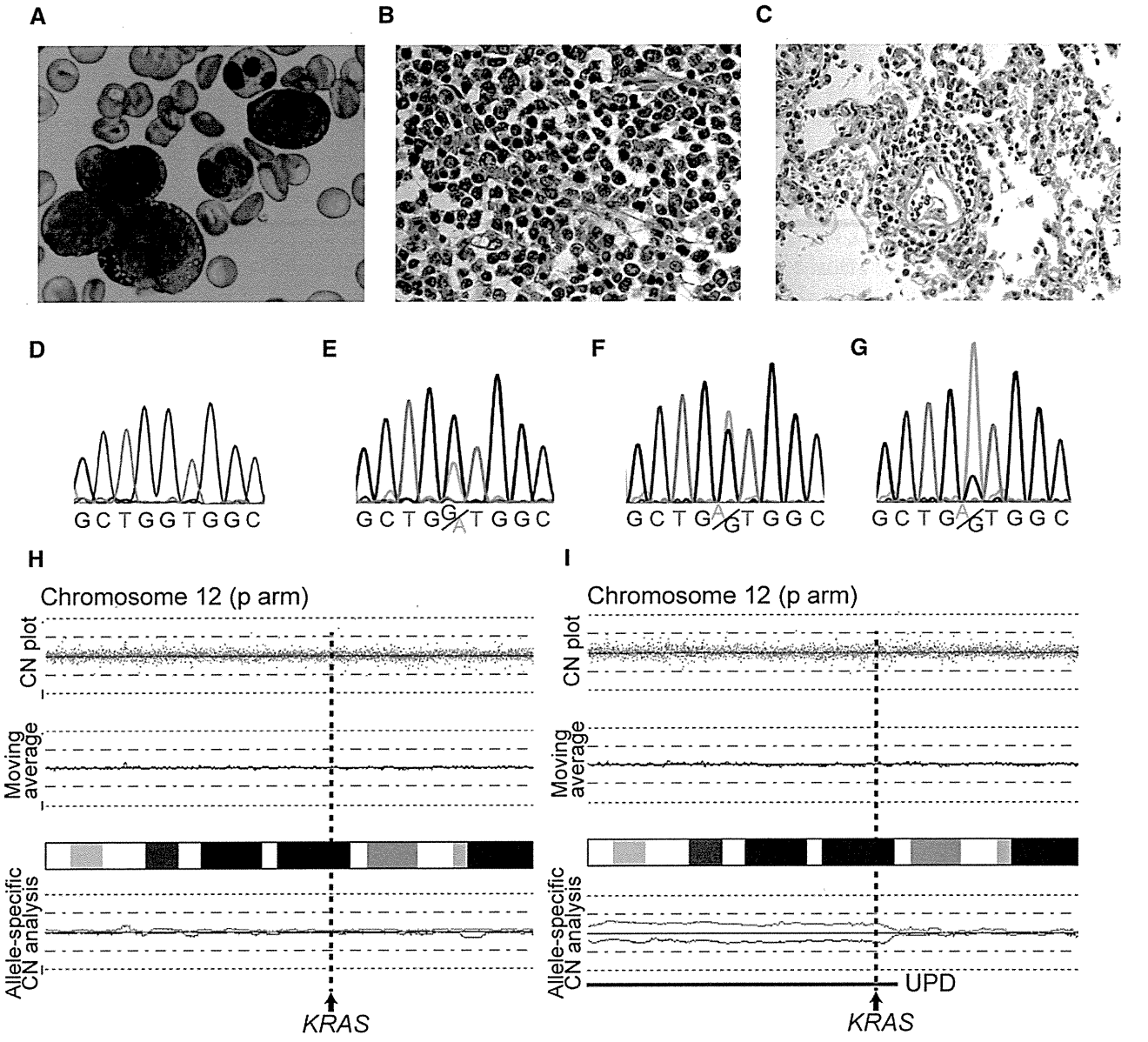


**Figure 1.** Blood smear, autopsy, and genomic analysis results. **A,** May-Giemsa staining of peripheral blood at progression. Hematoxylin & eosin staining of **B,** bone marrow and **C,** lung. Results of direct sequencing for the *KRAS* gene in **D,** heart, **E,** muscle, **F,** peripheral blood at diagnosis, and **G,** peripheral blood at progression. Results of SNP array analysis for PBMCs at **H,** diagnosis and **I,** progression. UPD at the 12p locus was detected at progression (*brown line*), whereas UPD was absent at diagnosis. Total copy number plots from each probe (*red points*) and moving average (n = 20; *blue line*) are shown *above* the cytoband. Results from allele-specific analyses are given *below* the cytoband. The larger allele is presented in *red*; the smaller allele, in *blue*. *CN*, copy number.

extracted from samples was analyzed using the GeneChip Human Mapping 250K *NspI* array (Affymetrix, Santa Clara, California). The data thus obtained were processed using CNAG/AsCNAR software (http://www.genome.umin.jp).[5,6]

## Results and Discussion

This case shows that JMML can progress rapidly during an indolent clinical course, with invasion into multiple organs. The aggressive transformation of JMML is similar to that of blast crisis in chronic myelogenous leukemia but is rare,[2,3] and the definition and molecular biology of the blast crisis–like aggressive transformation of JMML remain unclear.

Direct sequencing of the *KRAS* gene revealed a mutation in normal muscle. The same mutation was found in the lung, but not in the heart. The mutation was also detected in PBMCs at diagnosis, and the mutation became homozygous in PBMCs at progression (**Figure 1**, D-G). SNP array analysis

detected uniparental disomy (UPD) at the 12p locus, which included the *KRAS* gene, in PBMCs at progression (**Figure 1**, I). The UPD was absent in PBMCs at diagnosis (**Figure 1**, H). Our genome-wide analysis for copy number alteration and allelic imbalances using high-density SNP arrays detected no other genetic abnormalities in samples, either at diagnosis or at progression.

Recent research identified germline/somatic mutations in genes regulating the Ras-MAPK pathway as responsible for JMML pathogenesis, but the underlying mechanism of aggressive transformation remains unclear. Reportedly, abrogation of the wild-type *NRAS* allele was evident at progression, similar to our results.[7] Loss of the remaining *KRAS* allele could be associated with JMML progression because the wild-type *KRAS* allele functions as a tumor suppressor.[8] However, we determined that UPD at the 12p locus occurred at progression, leading to both a loss of the remaining allele and an increase in the dosage of the mutant *KRAS* allele. Previous studies have found strong associations between UPD at oncogene loci and the onset of various hematologic neoplasms, such as *NRAS* in chronic myelomonocytic leukemia[9,10] and *CBL* in adult myelodysplastic syndrome.[11] Our analysis suggested that UPD of mutant *KRAS* contributed to aggressive transformation as a second hit in our patient, leading to increased aberrant activation of the Ras-MAPK pathway (**Figure 3**).

Our patient received oral 6-MP for disease stabilization before progression. Of note, 6-MP has a DNA-damaging effect. A previous report suggested a correlation between 6-MP maintenance therapy and secondary malignant neoplasms.[12] Although an association between 6-MP and progression is unelucidated, it is possible that 6-MP might induce the second hit, followed by progression to cell transformation.

We found no genomic lesions other than the *KRAS* mutation in samples obtained at diagnosis, and the first hit for JMML onset remains undetermined. Previous reports have identified other genetic and epigenetic abnormalities were associated with JMML pathogenesis, including mutation of *TP53* and methylation of *BMP4*, *CALCA*, *CDKN2B*, and *RARB*.[13] However, direct sequencing of *TP53* and methylation-specific polymerase chain reaction showed that *BMP4* and *RARB* were not methylated and *CALCA* was methylated both at diagnosis and at progression, and *CDKN2B* was partially methylated only at progression. Further research is needed to elucidate the etiology of JMML.

In our patient, we detected *KRAS* G13D mutation in normal muscle cells in which we pathologically excluded blood infiltration. However, we found no facial gestalt or developmental retardation characteristic of Noonan or cardio-facio-cutaneous syndromes, both of which are caused by germline *KRAS* mutations. We assumed that this is because the patient was mosaic for a *KRAS* mutation, supported by sequencing results using other normal cells (**Figure 1**, D and E). Here we report a patient with JMML and oncogenic *KRAS* mosaicism who developed JMML. In another report of 2 cases of *NRAS* mosaic mutation with JMML, *NRAS* mutations remained heterozygous, and both patients exhibited an indolent clinical course.[14]

It is accepted that most patients with JMML harboring a *KRAS* mutation experience an indolent clinical course, and some achieve spontaneous remission.[1,15] However, as we report here, some patients with JMML with a *KRAS* mutation experience aggressive transformation, which is potentially fatal. We suggest that UPD at the mutated *KRAS* gene causes more potent activation of the Ras-MAPK pathway, facilitating transformation. Consequently, inhibition of this pathway could be a therapeutic target for JMML. ■

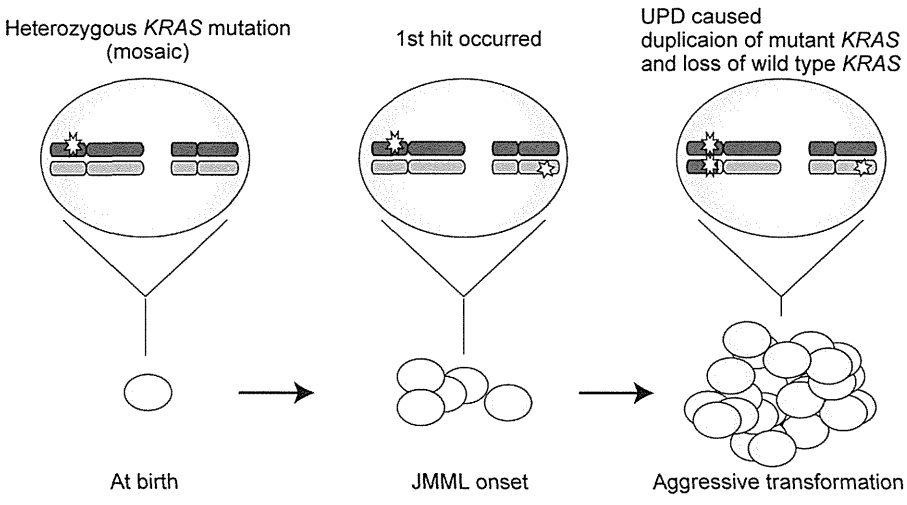


**Figure 3.** Hypothetical model of onset of JMML and its aggressive transformation. Sequential genetic events, starting with the presence of a *KRAS* mutation, are indicated. A first hit contributed to JMML onset, although that first hit remains undetermined. *KRAS*-mutated cells acquired UPD at the 12p locus, leading to both a loss of the wild-type *KRAS* allele and an increase in the dosage of the mutant *KRAS* allele, followed by aggressive transformation.

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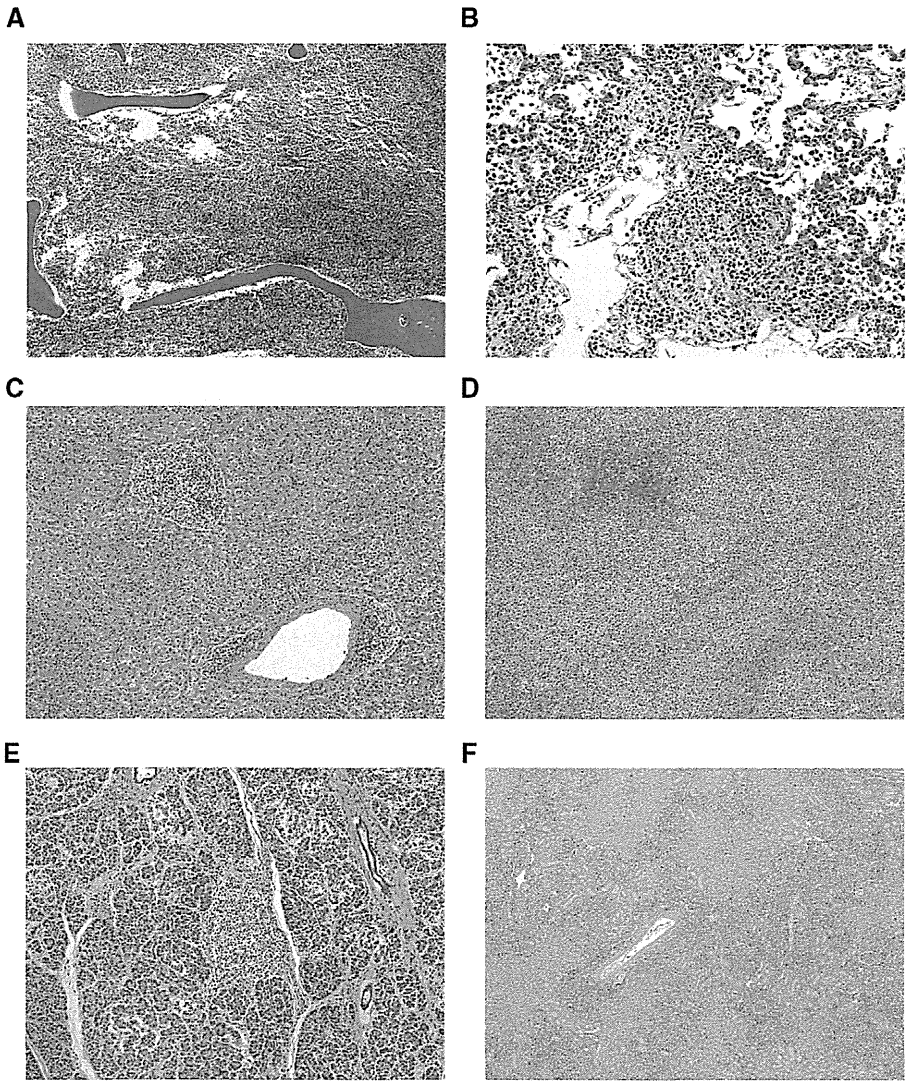


**Figure 2.** Autopsy revealed dysplastic cells infiltrated into mutiple organs. Hematoxylin & eosin staining of **A,** bone marrow; **B,** lung; **C,** liver; **D,** spleen; **E,** pancreas; and **F,** kidney.

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**LETTER TO THE EDITOR**

# Successful syngeneic PBSC transplantation for a patient with refractory Evans syndrome

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Evans syndrome (ES) is a haematological disorder characterised by the simultaneous or sequential development of autoimmune thrombocytopenia (AITP) and autoimmune haemolytic anaemia (AIHA). Haematopoietic SCT (HSCT) is an effective treatment for autoimmune cytopenias such as AITP, AIHA and ES. In patients who are successfully treated, self-reacting lymphocyte clones could be eliminated or inhibited with myeloablative conditioning and/or through the graft versus autoimmunity (GVA) effect, such that a cure or long-term remission is reasonably expected at the cost of the toxicity associated with HSCT.[1]

A 10-year-old boy was diagnosed with AIHA in November 2004. Although he responded to corticosteroid (CS), repeated recurrence was observed when the CS dose was tapered off. Fluctuating thrombocytopenia was identified in September 2006, and thus a diagnosis of ES was made. No underlying disease including autoimmune lymphoproliferative syndrome (ALPS) was identified.[2]

While fluctuating, the number of thrombocytes would sometimes fall to $1 \times 10^9$/L or less. Intracranial haemorrhage, severe epistaxis and buccal bleeding occurred during the clinical course. Although multiple therapeutic options that are reportedly effective for the treatment of ES, including high-dose intravenous immunoglobulin infusion (IVIG), CsA, rituximab, cepharanthine, vincristine, mycophenolate mofetil, 6-mercaptopurine, dapsone, danazol, and high-dose CY together with splenectomy and accessory splenectomy, had been used since the onset of ES, the results were unsatisfactory (Figure 1).

Among the treatments, the patient had been given prednisolone and CsA for 6 and 2 years, respectively, at variable doses. He had a Cushingoid appearance, short stature, acne and verrucae on the skin, a compression fracture of a lumbar vertebra, chronic intermittent headache, stiffness of the muscles, insomnia, lymphocytopenia and osteoporosis, which were thought to be adverse effects due to one of these two agents.

As the patient has an identical twin brother, a syngeneic HSCT was planned because no other treatment modality was considered promising. Withdrawal from CS and CsA, which had been given for an extended period, was also thought to be desirable. The donor-to-be brother was completely healthy with no evidence of ALPS. The suggestion of syngeneic HSCT was made to the patient, the parents and the brother, and written consent from the family was obtained.

The conditioning regimen consisted of CY at a dose of 50 mg/kg/day i.v. infusion from day $-4$ to $-1$ before the transplant. The donor was given G-CSF for mobilisation. A total of $7.7 \times 10^8$/kg of unmanipulated PBMC ($3.8 \times 10^6$/kg of CD34-positive cells) was harvested and infused into the patient in October 2010.

Neutrophil recovery ($0.5 \times 10^9$/L) was identified on day 10. The patient's platelet level reached a normal level on day 180. His platelet count and Hb level at 8 months post transplantation were $17.3 \times 10^9$/L and 14.7 g/dL, respectively. The patient remains in remission without therapy 17 months after the syngeneic PBSCT, the longest remission period ever experienced by this patient (Figure 1). Of note, although the levels of haptoglobin, indirect bilirubin, aspartate transaminase, lactate dehydrogenase and reticulocytes are normal, the direct Coombs test remains positive up to day 582, suggesting that minimal autoantibody is being produced by long-lived plasma cells with limited extravascular haemolysis due to splenectomy and accessory splenectomy. In this case, however, the patient is still deemed to be in CR by the definition of Passweg.[1]

We surveyed the literature and identified 18 reports detailing a total of 23 patients with ES treated with 26 HSCTs. The definitions of CR, relapse (REL) and treatment-related mortality (TRM) used herein are defined using the definitions of Passweg.[1] The median age of the patients who underwent HSCT is 21 years. The median time course from the onset of the disease to HSCT is 5.42 years, and a median of seven treatment modalities were used before HSCT. Of the 26 HSCTs, 15 were autologous and 11 were allogeneic. CD34-positive cell selection was employed in all of the autologous HSCTs except for 2, for which the details were not described. The results were compared between autologous and allogeneic HSCTs (Table 1). More patients who underwent allogeneic HSCT likely achieved CR than patients who underwent autologous HSCT at the cost of therapeutic toxicity: CR was attained in 4 out of 15 autologous transplantations and in 8 out of 11 allogeneic transplantations. REL occurred in 5 out of 15 patients who underwent autologous transplantation. A list of information on patients and HSCTs collected here and organised in a table can be provided upon request.

We reasoned that HSCT is indicated for those cases with ES (i) when continued immunosuppressive intervention reduced the quality of life of the patients and (ii) when the disease activity is not satisfactorily controlled with the conventional therapy described herein or elsewhere.[3] The indications for HSCT in the present case are in line with the current EBMT autoimmune diseases working party guidelines, which describe the indications for HSCT as a treatment for immune cytopenia, paediatric cases and syngeneic transplantation.[4]

Recently, TPO receptor antagonists have become a promising treatment option for chronic AITP. The indications for HSCT for the treatment of ES could therefore be revised if TPO receptor antagonists are demonstrated to be effective for the control of thrombocytopenia in patients with ES. However, future evaluations are required to determine the long-term therapeutic significance of these drugs.

A syngeneic immune system has been reported to cause a graft versus host reaction, possibly due to post-somatic modification.[5] Studies comparing the T-cell repertoire before and after the transplantation could have scientific significance. A prospective study and material banking should provide some information on the possible effects of GVA in syngeneic transplantation.

Zayden *et al.*[6] reported effective syngeneic PBSCT for a case of chronic ITP. They employed reduced myeloablative conditioning with CY and TBI. The patient had been in CR for 12 months after the syngeneic HSCT without any transplantation-related toxicity. Their experience and ours suggests that when available, a syngeneic transplant could be the preferred treatment if the expected outcomes of conventional therapies are sufficiently

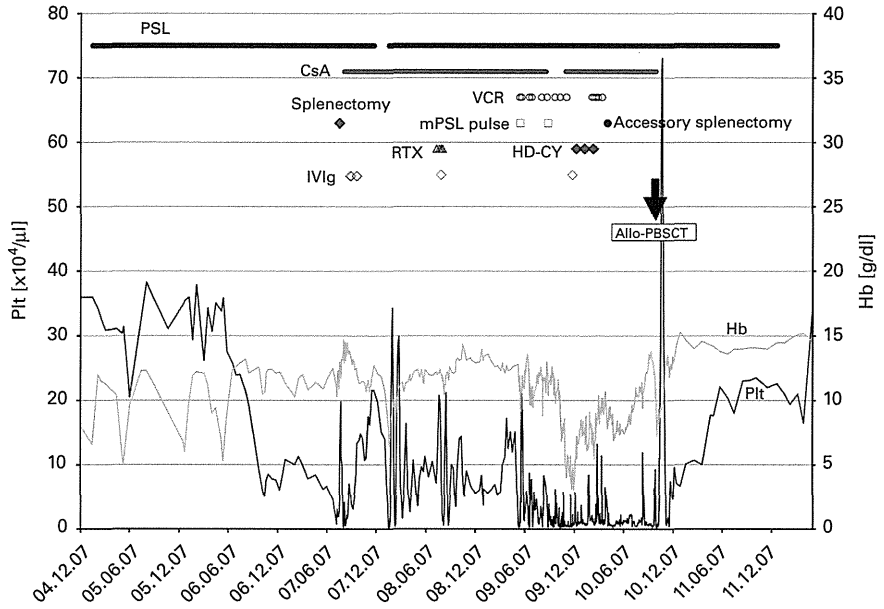


**Figure 1.** The time course of platelet count, the Hb level and the selected treatments that were at least partially or transiently effective. Black line, platelet number ($\times 10^4$/mm$^3$, left axis); grey line, Hb level (g/dL, right axis). PSL = prednisolone; VCR = vincristine; mPSL pulse = methylprednisolone pulse therapy; IVIg = high-dose gammaglobulin; RTX = rituximab; allo-PBSCT = allogeneic PBSCT. Note that PSL had been given for physiological replacement after transplantation due to steroid therapy for an extended period.

**Table 1.** Outcomes of the patients treated with HSCT

| | *Autologous* | *Allogeneic* |
|---|---|---|
| CR/PR | 4 | 7 |
| NR | 4 | 0 |
| REL | 5 | 1 |
| TRM | 1 | 3 |
| IE | 1 | 0 |
| Total | 15 | 11 |

Abbreviations: HSCT = haematopoietic SCT; IE = inevaluable; NR = no response; REL = relapse; TRM = treatment-related mortality.

limited to justify the expected adverse effect of HSCT. Although the clinical course of our patient after the transplant is uneventful thus far, careful observation is definitely necessary because a REL of ES 5 years after allogeneic transplant despite full donor chimerism is reported.[7]

## CONFLICT OF INTEREST

The authors declare no conflict of interest.

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# *CBL* mutations in infant acute lymphoblastic leukaemia

Infant acute lymphoblastic leukaemia (ALL) is relatively rare, occurring in approximately 2·5–5% of cases of childhood ALL (Biondi *et al*, 2000). Infant ALLs are much more likely to present with high leucocyte counts, hepatosplenomegaly and overt central nervous system (CNS) diseases (Taki *et al*, 1996). T cell phenotype is much less common in infants, while myeloid antigen co-expression and the absence of CD10 expression are more frequent in infants than in older children with ALL. When molecular techniques [such as fluorescence *in situ* hybridization (FISH) or Southern blot analysis] are used in addition to karyotype, *MLL* gene rearrangements (*MLL*-R) are found in 70–80% of infant ALL compared with only 2–4% of older children with ALL (Taki *et al*, 1996; Biondi *et al*, 2000). Thus, infant ALL appears to be biologically distinct from the disease in older children (more than 1 year old).

In this regard, recent reports of somatic mutations of the *CBL* proto-oncogene in myeloid neoplasms are intriguing, because these *CBL* mutations were shown to result in aberrant tyrosine kinase signalling, which also leads to activation of RAS signalling pathways. So far, we and others have reported that *CBL* mutations occur in a variety of myeloid neoplasms, including *de novo* acute myeloid leukaemia (AML) (Caligiuri *et al*, 2007), myelodysplastic syndrome (MDS), and myeloproliferative neoplasm, especially in chronic myelomonocytic leukaemia (CMML) (Sanada *et al*, 2009), and juvenile myelomonocytic leukaemia (JMML) (Shiba *et al*, 2010). The importance of *CBL* mutations regarding leukaemogenesis is substantially increased. Recently, we found *CBL* mutation in therapy-related AML with *MLL*-R (Shiba *et al*, 2011). Interestingly, the *MLL-CBL* fusion gene has been reported in a *de novo* AML case (Fu *et al*, 2003), and this prompted us to search for possible *CBL* mutations in infant ALL with *MLL-R*.

Because *CBL* mutations thus far reported were almost all clustered within exons 8–9 that encode Linker/RING finger domains (Caligiuri *et al*, 2007; Sanada *et al*, 2009; Shiba *et al*, 2010), we confined our mutation analysis to these exons, in which polymerase chain reaction-amplified exons 8–9 were subjected to direct sequencing using an ABI PRISM 310 Genetic Analyser (Applied Biosystems, Branchburg, NJ, USA). The study adhered to the principles of the Helsinki Declaration, and was conducted under the regulations enacted by the Ethics Board of Gunma Children's Medical Centre.

*CBL* gene analysis was performed in 41 infant ALL patients in which *MLL*-R was found in 33 patients (80·5%), including 15 patients with t(4;11)(q21;q23), 4 with t(9;11)(p22;q23) and 5 with t(11;19)(q23;p13.3). Median age at diagnosis was 4·7 months (range, 0–12 months). We also performed *CBL* gene mutation analysis in 28 B cell precursor (BCP)-ALL patients (age range, 1–14 years).

Heterozygous mutations of the *CBL* gene were identified in 2 (4·9%) of 41 infant ALL patients, but not in older children with BCP-ALL. These were located in exon 8 (Fig 1). One patient was a 3-month-old female with t(4;11)(q21;q23) and the other patient was a 6-month-old male with t(11;19)(q23;p13.3). They were registered and treated on two Japanese infant leukaemia protocols, MLL96 and MLL98 respectively (Isoyama *et al*, 2002; Kosaka *et al*, 2004). Although strong association between *CBL* mutations and 11q-acquired uniparental disomy (aUPD) has been reported (Sanada *et al*, 2009), we did not perform the single nucleotide polymorphism array analysis due to lack of DNA.

*MLL*-R are more frequent in younger infants; up to 90% of infant ALL less than 6 months old at diagnosis have detectable *MLL*-R compared with 30–50% of infant ALL aged 6–12 months (Taki *et al*, 1996). *MLL*-R ALL has a characteristic gene expression profile that significantly differs from that of non-*MLL*-R BCP-ALL and of AML, confirming that *MLL*-R ALL is a biologically unique leukaemia subtype.

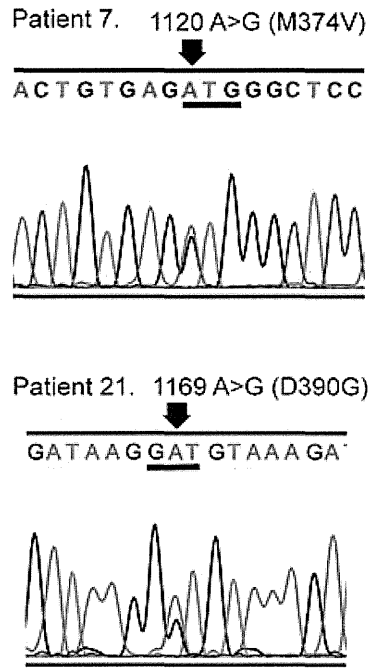


Fig 1. Identification of *CBL* mutations. Heterozygous mutations of the *CBL* gene were identified in Patients 7 and 21.

Thus, the distinctive presenting features and clinical behaviour of infant ALL appear to be primarily due to the high frequency of *MLL*-R in this age group. However, outcome data comparing infant and non-infant patients with *MLL*-R suggest that there may be other factors which impact the prognosis of infant ALL. Both of the patients with *CBL* mutations were diagnosed before 6 months of age. In our previous report, all of three cases with *CBL* mutation developed JMML before 4 months of age (Shiba *et al*, 2010). These data suggested that *CBL* mutation may have a strong association with very early onset disease. *CBL* mutations have been reported as germline mutations in JMML (Niemeyer *et al*, 2010). Unfortunately, we could not investigate whether the mutations in our cases were germline mutations or not, because somatic cells were not available.

*CBL* mutations have been found in approximately 5% of 2000 samples from patients with myeloid neoplasms, including AML transformed from MDS. Gene aberrations in addition to *MLL*-R have rarely been reported in infant ALL. No reports of ALL with *CBL* mutations have so far been reported, suggesting that the pathogenesis of infant ALL is different from paediatric or adult ALL. To our knowledge, this is the first report of infant ALL patients with 11q23 translocation/*MLL*-R and *CBL* mutations. The present study suggests that alterations of *CBL* gene and *MLL*-R may cooperatively play a pathogenic role in the development of infant ALL with *MLL*-R.

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## Author's contributions

TT and YH designed the study. JT, MH, TK, MS and EI provided critical reagents and samples. NS and MP performed the experiments. EI, HA and SO supervised the work. NS and MP analysed the results. NS, TT, and YH wrote the paper and all the authors critically reviewed and revised it.

## Conflict of interest

The authors declare no conflict of interest.

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# Association of an increased frequency of CD14$^+$HLA-DR$^{lo/neg}$ monocytes with decreased time to progression in chronic lymphocytic leukaemia (CLL)

Clinically important immune dysregulation is an early feature of leukaemia/small lymphocytic lymphoma (CLL) that often precedes other clinical manifestations of this disease. Defects in the adaptive immune system in patients with CLL results in quantitative and qualitative abnormalities in antibody production, and profound changes in T and Natural Killer (NK) cell numbers, ratios, and function (Palmer *et al*, 2008; Gonzalez-Rodriguez *et al*, 2010). Monocytes and macrophages, critical for adaptive and innate immune responses, also have an important role in the function of the CLL cell microenvironment, and this relationship continues to be explored (Caligaris-Cappio, 2011). However, little is known about the effects of CLL on monocyte/macrophage physiology and whether alterations in monocytes have any clinical role in CLL. We were especially interested in the possible role of immunosuppressive CD14+ monocytes with reduced HLA-DR expression in CLL as we have observed this phenomena in glioblastoma (Gustafson *et al*, 2010), non-Hodgkin lymphoma (Lin *et al*, 2011) and prostate cancer (Vuk-Pavlovic *et al*, 2010).

To identify potential monocyte alterations by CLL in patients, we performed flow cytometric analysis of peripheral

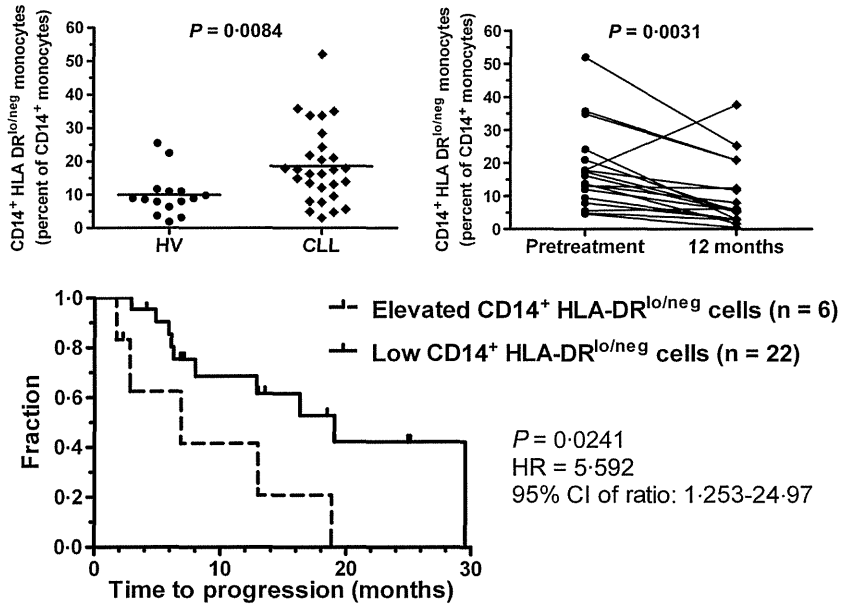


Fig 1. CD14$^+$HLA-DR$^{lo/neg}$ Monocytes in CLL. Blood from 29 CLL patients and 15 healthy volunteers were used for immune phenotyping. There was no age difference (median of 59 vs. 58 years, respectively; $P$ = 0·2896). Patients were eligible for the clinical trial (ClinicalTrials.gov NCT00562328) if diagnosed with previously untreated high-risk CLL using standard criteria and did not meet guidelines for conventional treatment. Blood was collected before initiation of treatment and 6, 9, and 12 months after completion of treatment in patients who had a sustained response. The percentage of CD14+ cells with a loss of HLA-DR staining was determined and compared between CLL patients and healthy volunteers (HV; upper left). CLL patients with a sustained response to treatment had a decrease in the frequency of CD14$^+$HLA-DR$^{lo/neg}$ monocytes 12 months after completion of treatment compared to measurement prior to treatment (upper right). Kaplan–Meyer survival curve comparing CLL patients with elevated ratios (>2·5 standard deviations) of CD14$^+$HLA-DR$^{lo/neg}$ monocytes when compared to healthy volunteers (dashed line) or with ratios similar to those seen in healthy volunteers (solid line; bottom panel). HR, Hazard Ratio; 95% CI, 95% confidence interval.

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# HuR Maintains a Replicative Life Span by Repressing the ARF Tumor Suppressor

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**$p19^{ARF}$ plays an essential role in the senescence of mouse cells, and its expression is lost by methylation or deletion of the *ARF* locus; otherwise, p53 is inactivated to bypass senescence. *ARF* expression is tightly regulated, but little is known about its post-transcriptional regulation. Here, we show that an RNA-binding protein, HuR (human antigen R), represses *ARF* mRNA translation, thereby maintaining the replicative life span of mouse embryonic fibroblasts (MEFs). Loss of HuR results in premature senescence, with concomitant increases in $p19^{ARF}$ but not $p16^{Ink4a}$ levels, and this senescence is not observed in *ARF*-null MEFs that retain an intact *Ink4a* locus. HuR depletion does not alter *ARF* transcription or stability but enhances ribosome association with *ARF* mRNA. Under these conditions, *ARF* mRNA accumulates in nucleoli, where it associates with nucleolin. Furthermore, adipose-specific deletion of the *HuR* gene results in increased $p19^{ARF}$ expression in aged animals, which is accompanied by decreased insulin sensitivity. Together, our findings demonstrate that $p19^{ARF}$ is also regulated at the translational level, and this translational regulation restrains the cellular life span and tissue functions *in vivo*.**

Most mammalian somatic cells have a limited replicative life span when cultured *in vitro* and eventually undergo irreversible growth arrest, called cellular senescence (1). Senescence is caused by excessive extracellular or intracellular stress, and senescent cells are observed in tissues of aged animals and in tissues that experience prolonged inflammation (2, 3). Two major tumor suppressor pathways, the $p19^{ARF}$ ($p14^{ARF}$ in humans)-p53 and $p16^{Ink4a}$-retinoblastoma (Rb) pathways, play critical roles in inducing and maintaining permanent cell cycle arrest during cellular senescence (4, 5), and inactivation of these proteins bypasses cellular senescence, allowing damaged cells to survive and proliferate. Thus, senescence prevents the spread of damaged cells, eliminating potential malignant transformation, and acts as a potent tumor-suppressive mechanism in mammals (6, 7).

Human antigen R (HuR) is a ubiquitously expressed member of the ELAV/Hu protein family and is involved in diverse biological processes (8, 9). Loss of HuR causes midgestational embryonic lethality due to placental defects (10). Animals rescued from this defect can develop to later stages but mostly die by embryonic day 19.5 and exhibit prominent defects in skeletal and splenic development. *HuR* encodes an RNA-binding protein that controls the stability, translation, splicing, and intracellular localization of its target mRNA (11, 12). Canonically, HuR directly binds to AU-rich elements (ARE) in the 3′ untranslated region (3′UTR) of its target mRNA, and the biological consequence of HuR association varies depending on the mRNA to which it binds (13, 14). In most cases, HuR stabilizes the mRNA associated with it; for instance, HuR has been shown to stabilize *VEGF*, β-*actin*, *DNMT3b*, and *TNF*-α mRNA (15–18). The mechanisms by which HuR regulates mRNA stability are not fully understood, but competition with other ARE-binding proteins is likely to be involved (19). Additionally, HuR is involved in microRNA (miRNA) recruitment to target mRNA. In this case, binding of HuR adjacent to the let-7 binding site on c-*Myc* mRNA facilitates the recruitment of let-7-loaded miRNA-induced silencing complexes (RISC) (20). Conversely, HuR has been shown to compete with miR-494 on *Nucleolin* mRNA (21).

It has become evident that HuR controls replicative senescence in human diploid fibroblasts (HDFs) (22). HuR levels decline during senescence in HDFs and are low in aged human tissues, and miR-519 is responsible for the downregulation of HuR in senescent HDFs (23, 24). HuR destabilizes *Ink4a* mRNA, the encoded protein of which, $p16^{Ink4a}$, plays an important role in the cellular senescence of HDFs. HuR recruits RISC to *Ink4a* mRNA, and this process does not require miRNA but is mediated by the direct interaction of RISC with HuR proteins on mRNA (25). Additionally, HuR controls the mRNA metabolism of other senescence-related genes, including *p53*, *p21*, and *cyclin D1*, in response to cellular stress, such as UV (19, 26, 27). Therefore, HuR likely participates in cellular senescence by organizing the expression of multiple genes.

While the involvement of HuR in human cellular senescence has been documented, little is known about the function of HuR in the replicative senescence of mouse cells. Unlike in human cells, where the Ink4a-Rb pathway plays a pivotal role in senescence, in mouse cells, the ARF-p53 pathway is essential and $p16^{Ink4a}$ is dispensable for senescence (28, 29). We show here that HuR maintains a replicative life span by repressing expression of the $p19^{ARF}$ tumor suppressor in mouse embryonic fibroblasts (MEFs). RNA

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interference (RNAi)-mediated HuR silencing in MEFs prematurely induces cellular senescence by activating the ARF-p53 pathway. In *HuR*-depleted cells, $p19^{ARF}$ levels, but not $p16^{Ink4a}$ levels, are increased due to enhanced translation of *ARF* mRNA. HuR associates weakly with the 5′UTR of *ARF* mRNA in living cells. In the absence of HuR, *ARF* mRNA accumulates in the nucleolus, where it associates with nucleolin, and nucleolin is required for $p19^{ARF}$ induction in HuR knockdown cells. Translational regulation is also observed *in vivo*, and adipose-specific *HuR* knockouts revealed progressive insulin resistance, with concomitant increased expression of $p19^{ARF}$. Thus, HuR translationally represses $p19^{ARF}$ expression under normal conditions, thereby inhibiting cellular senescence and maintaining tissue functions *in vivo*.

## MATERIALS AND METHODS

**Cells and culture conditions.** NIH 3T3 and 293T cells were maintained in Dulbecco's modified Eagle's medium (DMEM) supplemented with 10% fetal calf serum (FCS) and 100 U/ml penicillin-streptomycin. MEFs were cultured in medium supplemented with 0.1 mM nonessential amino acids, 55 μM 2-mercaptoethanol, and 10 μg/ml gentamicin instead of penicillin and streptomycin. To analyze mRNA or protein stability, cells were treated with 2 μg/ml of actinomycin D or 100 μg/ml of cycloheximide (CHX), respectively. To induce adipocytic differentiation, cells were kept confluent for 2 days and switched to differentiation medium (DMEM containing 5 μg/ml insulin, 1 μM dexamethasone, and 0.5 mM 3-isobutyl-1-methylxanthine [IBMX; Sigma Chemicals, St. Louis, MO]). For 5-ethynil-2′-deoxyuridine (EdU) staining, cells were pulse-labeled with 10 μM EdU for 45 min. Labeled cells were visualized using the Click-iT EdU Alexa Fluor imaging kit according to the manufacturer's instructions (Life Technologies, Carlsbad, CA).

**Senescence-associated β-galactosidase and Oil Red O staining.** Cells were washed in phosphate-buffered saline (PBS), fixed for 3 to 5 min (room temperature) in 2% formaldehyde-0.2% glutaraldehyde, washed, and incubated at 37°C with β-galactosidase (β-Gal) stain solution containing 1 mg of 5-bromo-4-chloro-3-indolyl-β-D-galactoside, 40 mM citric acid-sodium phosphate (pH 6.0), 5 mM potassium ferrocyanide, 5 mM potassium ferricyanide, 150 mM NaCl, and 2 mM $MgCl_2$. Staining was evident after 12 to 16 h (2). To stain adipocytes, cells were washed twice with PBS and then incubated with 60% filtered Oil Red O solution (3 mg/ml of 2-propanol) for 30 min at 37°C. Cells were washed with 60% 2-propanol briefly and then with water before visualization. Phase-contrast images were taken with a Plan FI 40×/0.60 lens (Olympus, Tokyo, Japan) at ambient temperature using an inverted microscope (model IX71; Olympus) equipped with a DP70 digital camera system (Olympus). Images were acquired using DP Controller software (Olympus).

**Plasmids, transfection, retrovirus production, and infection.** Mouse *ARF* and *Ink4a* cDNAs were obtained by PCR using the following primers: for full-length *ARF*, 5′-AAGGATCCTCTCGAGGTGCCTCAACGCC-3′ (sense) and 5′-AACTCGAGGACATTTTAAAAAGTATC-3′ (antisense); for Δ3′UTR *ARF*, the full-length sense primer and 5′-AAACTCGAGCT ATGCCCGTCGGTCTGGGC-3′ (antisense); for Δ5′UTR *ARF*, 5′-AAG GATCCATGGGTCGCAGGTTCTTGG-3′ (sense) and the full-length antisense primer; for full-length *Ink4a*, 5′-AAGGATCCACTGGTCACACG ACTGGGC-3′ (sense) and 5′-AAGAATTCGACATTTTAAAAAGTAT C-3′ (antisense); and for the *Ink4a* open reading frame (ORF), 5′-AAGG ATCCATGGAGTCCGCTGCAGACAG-3′ (sense) and 5′-AAGAATTCT TAGCTCTGCTCTTGGG-3′ (antisense). PCR products were digested with BamHI and XhoI (*ARF*) or BamHI and EcoRI (*Ink4a*) and cloned into a pcDNA3 vector (Life Technologies). For *ARF*-MS2, *ARF* cDNA (full length or Δ5′UTR) was cloned into the BamHI/XbaI sites of pcDNA3.1 Hygro (Life Technologies). The plasmid was then digested with NotI and XbaI, and annealed oligonucleotides, including a 2×MS2 tag sequence (sense, GGCCGCAAACATGAGGATCACCCATGTCCAT GGTCGACGAGCTCAAACATGAGGATCACCCATGTCT, and antisense, CTAGAGACATGGGTGATCCTCATGTTTGAGCTCGTCGA CCATGGACATGGGTGATCCTCATGTTTGC), were ligated. MS2-enhanced green fluorescent protein (EGFP)-nuclear localization signal (NLS) cDNA (30) and GFP-L10a expression plasmids were provided by Takashi Funatsu (University of Tokyo) and Leo Tsuda (National Center for Geriatrics and Gerontology), respectively. GFP-L10 cDNA was cloned into a murine stem cell virus (MSCV) vector.

For knockdown of nucleolin, 1 million MEFs were plated in a 10-cm-diameter dish and cultured in a medium without antibiotics. Synthetic small interfering RNA (siRNA) (Thermo Fisher Scientific, Lafayette, CO) was transfected using DhamaFect1 (Thermo Fisher Scientific) according to the manufacturer's instructions. Cells were collected at 48 h posttransfection for subsequent analysis.

For retrovirus production, 293T cells were transfected with retroviral expression plasmids together with helper plasmids, as described previously (31). Culture supernatants were harvested 24 to 60 h after transfection, pooled, and stored on ice. Exponentially growing cells in 10-cm-diameter culture dishes were infected with 3 ml of a fresh virus-containing supernatant in complete medium containing 8 μg/ml Polybrene. Infection was confirmed either by GFP expression or by selection for drug resistance.

**RNA analyses.** RNAs were prepared from cells or immune complexes using TriPure isolation reagent (Roche, Indianapolis, IN), reverse transcribed using a PrimeScript reverse transcriptase (RT) reagent kit with the genomic DNA (gDNA) Eraser (TaKaRa, Shiga, Japan), and subjected to PCR using the following primers: for *PAI-1*, 5′-TCAGAGCAACAAGTT CAACTACACTGAG-3′ (sense) and 5′-CCCACTGTCAAGGCTCCATC ACTTGCCCCA-3′ (antisense); for *HuR*, 5′-TTGGGCTACGGTTTT GTGAAC-3′ (sense) and 5′-CCCACTGATGTATAAGTTGGCAT-3′ (antisense); for *ARF*, 5′-GCCGCACCGGAATCCT-3′ (sense) and 5′-TT GAGCAGAAGAGCTGCTACGT-3′ (antisense); for *Ink4a*, 5′-CCCAAC GCCCCGAACT-3′ (sense) and 5′-GCAGAAGAGCTGCTACGTGAA-3′ (antisense); for *c-myc*, 5′-TCTATTTGGGGACAGTGTTC-3′ (sense) and 5′-GGTCATAGTTCCTGTTGGTG-3′ (antisense); for *p53*, 5′-TGGAGA GTATTTCACCCTCAAGA-3′ (sense) and 5′-CTCCTCTGTAGCATGG GCATC-3′ (antisense); for *β-actin*, 5′-CTAAGGCCAACCGTGAAAA G-3′ (sense) and 5′-ACCAGAGGCATACAGGGACA-3′ (antisense); for 18S rRNA 5′-AGTCCCTGCCCTTTGTACACA-3′ (sense) and 5′-GATC CGAGGGCCTCACTAAAC-3′ (antisense); for *AUF-1*, 5′-TTTCTCCAG ACACACCTGAAGA-3′ (sense) and 5′-CTGTTCCTTTGACATGGCTA CTT-3′ (antisense); and for *GFP*, 5′-TCTGCACCACCGGCAAGCTG-3′ (sense) and 5′-TGCGCTCCTGGACGTAGCCT-3′ (antisense). Real-time PCR analysis was carried out on a Chromo4 real-time PCR system (Bio-Rad, Hercules, CA).

**Immunoblotting and preparation of cytoplasmic and nuclear fractions.** Cell lysates were separated by SDS-PAGE and transferred to polyvinylidene difluoride (PVDF) membranes (Millipore, Billerica, MA). Proteins were detected with antibodies to γ-tubulin (GTU-88; Sigma Chemicals, St. Lois, MO), $p19^{ARF}$, $p16^{Ink4a}$, HuR, nucleolin, CDK4, lamin A/C, GFP, α-tubulin, peroxisome proliferator-activated receptor gamma (PPARγ) CCAAT/enhancer binding protein α (C/EBPα), C/EBPβ, C/EBPδ (5-C3-1, M-156, 3A2, MS-3, C-22, H-110, FL, B-7, E-8, 14AA, C-19, and C-22; all from Santa Cruz Biotechnology, Santa Cruz, CA), RPL10 (Atlas Antibodies, Stockholm, Sweden), RPL11 (3A4A7; Life Technologies), and RPS6 (54D2; Cell Signaling Technology, Danvers, MA). The intensities of the bands were determined using NIH's ImageJ. Cytoplasmic and nuclear fractions were generated using a Paris kit (Life Technologies).

**Immunoprecipitation/RT-PCR.** To analyze ribosome-mRNA association, cells were incubated in the presence of 0.1 mM CHX for 5 min and then suspended in ice-cold extraction buffer containing 10 mM HEPES-KOH (pH 7.4), 150 mM KCl, 5 mM $MgCl_2$, 0.5 mM dithiothreitol (DTT), 100 μg/ml CHX, protease inhibitors, and 40 U recombinant RNase inhibitor (Toyobo, Osaka, Japan) with a homogenizer. Homogenates were centrifuged for 10 min at 2,000 × *g* to pellet large cell debris, and Nonidet

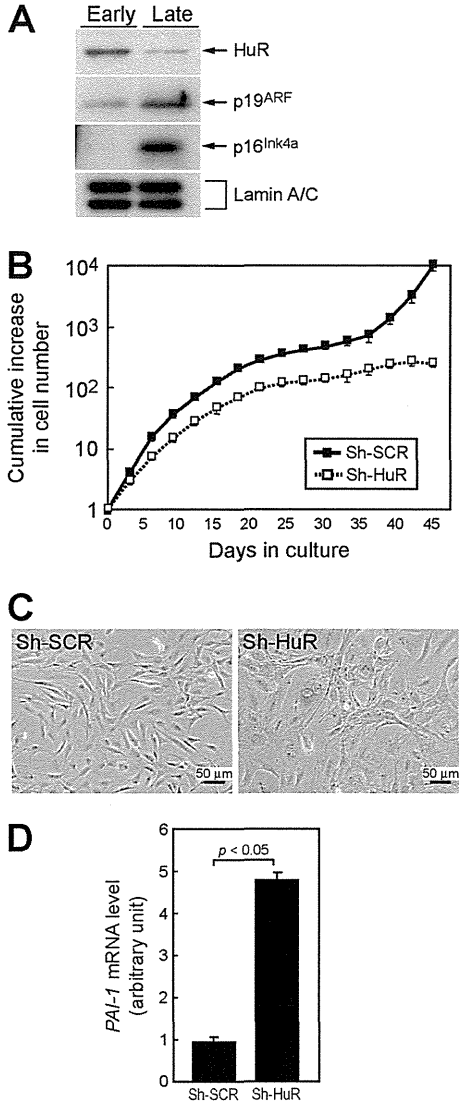


FIG 1 Loss of HuR leads to acute cellular senescence in MEFs. (A) Lysates from early-passage (passage 2 [P2]) and late-passage (P10) MEFs were analyzed for expression of the indicated proteins by immunoblotting. Lamin A/C was used as a loading control. (B) Wild-type MEFs infected with control (sh-SCR) or sh-HuR retroviruses were cultured by the NIH 3T3 protocol. Error bars represent standard errors of the means (SEM) of results from triplicate wells. (C) Cells (10 days postinfection) were stained with SA-β-Gal. (D) Expression of *PAI-1* mRNA was analyzed by real-time PCR. Values were normalized to those for *GAPDH* in each sample. Data are representative of three independent experiments. Error bars represent SEM of results from triplicate samples.

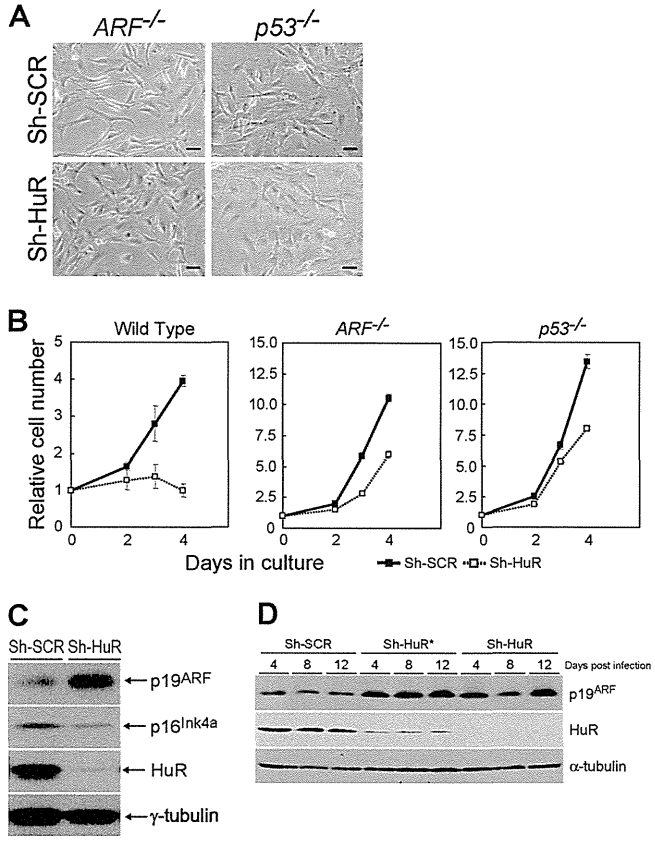


FIG 2 Senescence in HuR-depleted MEFs is dependent on the ARF-p53 pathway. (A) MEFs prepared from *ARF*- or *p53*-null animals were infected with control or sh-HuR retroviruses. Infected cells were stained for SA-β-Gal. Bars, 25 μm. (B) Control or sh-HuR MEFs with the indicated genotypes were analyzed for their growth rates. Error bars represent means ± SE of results from triplicate wells. (C) Cell lysates were prepared from wild-type MEFs infected with control or sh-HuR retroviruses. The expression of the indicated proteins was analyzed by immunoblotting. γ-Tubulin was used as a loading control. (D) Wild-type MEFs were infected with two independent sh-HuR retroviruses that target different regions of *HuR* mRNA. Cell lysates were prepared at 4, 8, and 12 days postinfection and analyzed for the expression of the indicated proteins by immunoblotting.

P-40 (NP-40; Nacalai Tesque, Kyoto, Japan) was added to the supernatant at a final concentration of 1%. After incubation on ice for 5 min, clarified lysates were cleared by centrifugation for 10 min at 13,000 × *g*. Protein A magnetic beads (Millipore) and anti-GFP (mFx73; Wako, Osaka, Japan) were preincubated at room temperature for 30 min and added to the supernatant. The mixture was incubated at 4°C with end-over-end rotation for 3 h. Beads were subsequently collected on a magnetic rack, washed three times with high-salt wash buffer (10 mM HEPES-KOH [pH 7.4], 350 mM KCl, 5 mM $MgCl_2$, 1% NP-40, 0.5 mM DTT, and 100 μg/ml CHX), and immediately placed in TriPure isolation reagent to extract bound RNAs from polysomes (32). RNA was subjected to real-time PCR analysis as described above.

For polysomal fractionation, cells were incubated in the presence of 0.1 mM cycloheximide for 5 min and lysed in a buffer containing 50 mM Tris-Cl (pH 7.5), 0.1 M NaCl, 10 mM $MgCl_2$, 2 mM DTT, 200 U/ml RNase inhibitor (Toyobo, Osaka, Japan), 100 μg/ml cycloheximide, 200 μg/ml Heparan, 0.5% NP-40, and protease inhibitors. One milliliter of lysates cleared by centrifugation was loaded onto 15-to-40% sucrose gradients in a buffer (9 ml) containing 150 mM NaCl, 5 mM $MgCl_2$, and 25 mM Tris-Cl (pH 7.5), centrifuged using an Sw41 rotor (Beckman Coulter, Fullerton, CA) (34,000 rpm, 140 min, 4 °C), and separated into 120 fractions. RNA and protein were recovered from each fraction and analyzed by real-time PCR and immunoblotting, respectively.

To analyze HuR-RNA and nucleolin-RNA complexes, cell lysates prepared using a buffer containing 50 mM HEPES (pH 7.5), 150 mM NaCl, 1 mM EDTA, 2.5 mM EGTA, 1 mM DTT, 0.2% Tween 20, 10% glycerol, and protease inhibitors were incubated at 4°C for 3 h together with protein A magnetic beads preincubated with antihemagglutinin (anti-HA) (3F10; Roche, Indianapolis, IN), anti-HuR (3A2; Santa Cruz Biotechnology), or antinucleolin (MS-3; Santa Cruz Biotechnology). Magnetic beads were washed three times with the buffer and suspended in TriPure isolation reagent to recover RNA associated with HA-tagged or endogenous HuR protein. RNAs were quantified using real-time PCR.

For UV cross-linking and immunoprecipitation, cells in a 10-cm-diameter dish were washed twice with PBS and irradiated with UV (150 mJ/cm$^2$) in the presence of 6 ml PBS. Irradiated cells were harvested and resuspended in a buffer containing 50 mM Tris (pH 7.4), 100 mM NaCl, 1% NP-40, 0.1% SDS, 0.5% sodium deoxycholate, 40 U/ml RNase inhibitor, and protease inhibitors. Lysates were treated with DNase I at 37°C for 3 min, cleared by centrifugation, and incubated with magnetic protein G beads pretreated with anti-HuR for 3 h at 4°C. Beads were washed twice with high-salt buffer (50 mM Tris [pH 7.4], 1 M NaCl, 1 mM EDTA, 1% NP-40, 0.1% SDS, and 0.5% sodium deoxycholate) and then twice with wash buffer (20 mM Tris [pH 7.4], 10 mM $MgCl_2$, and 0.2% Tween 20) and resuspended in PK buffer (100 mM Tris [pH 7.4], 50 mM NaCl, and 10 mM EDTA) containing proteinase K for 20 min at 37°C. An equal amount of PK buffer containing 7 M urea was added, the mixture was incubated for 20 min at 37°C, and supernatants were collected and subjected to phenol-chloroform extraction. RNAs were isolated from the aqueous phase by ethanol precipitation and subjected to real-time PCR analysis as described above.

**Immunohistochemistry.** Immunohistochemistry was performed on frozen sections of adipose tissue from $HuR^{floxed/floxed}$ ($HuR^{fl/fl}$) or $HuR^{fl/fl}$ AP2-Cre mice. Sections were fixed with 4% paraformaldehyde in PBS for 15 min, rinsed, and then placed into a covered Coplin jar containing citrate buffer (1.8 mM citric acid, 8 mM sodium citrate, pH 6.0) that had been preheated to 100°C for 30 min. Sections were rinsed in PBS for 10 min, blocked with 10% FCS in 0.1% Triton X-100–PBS for 1 h, and incubated with 5 μg/ml of anti-$p19^{ARF}$ (5-C3-1) and anti-HuR (H-280; Santa Cruz Biotechnology) in Can Get Signal Solution A (Toyobo) at 4°C overnight. Proteins were visualized with Cy3- or Alexa Fluor 488-labeled secondary antibodies (Jackson ImmunoResearch, West Grove, PA), and slides were mounted using Vectashield and DAPI (4′,6-diamidino-2-phenylindole; Vector Laboratories, Burlingame, CA). Fluorescence images were taken with a Nikon CFI Plan Apo λ 40×/0.95-numerical-aperture lens at ambient temperature using an inverted microscope (Biorevo BZ-9000; Keyence, Osaka, Japan). Images were acquired using BZ-II Viewer software (Keyence).

**Insulin and glucose tolerance tests.** Animals were fasted for 4 h (for the insulin test) or overnight (for the glucose test) and intraperitoneally injected with insulin (0.75 unit/kg of body weight) or glucose (1 g/kg). Following these injections, tail vein blood (approximately 5 μl) was collected, and glucose was measured using a glucose meter (LifeScan, Milpitas, CA).

## RESULTS

**HuR regulates the replicative senescence of murine fibroblasts.** HuR levels decline during senescence in human fibroblasts (22). We checked HuR levels in early- and late-passage mouse embryonic fibroblasts. As in human fibroblasts, HuR was downregulated in senescent MEFs where $p19^{ARF}$ and $p16^{Ink4a}$ levels were increased (Fig. 1A). To test if downregulation of HuR was sufficient to induce replicative senescence, MEFs were infected with retroviruses encoding short hairpin RNA (shRNA) that inhibits short hairpin HuR (sh-HuR) expression or control sh scramble (sh-SCR) (33). Infected cells were selected with puromycin and cultured according to the NIH 3T3 protocol (34). As shown in Fig. 1B, HuR knockdown cells had much shorter replicative life spans than control shRNA-expressing cells, and these cells showed the typical characteristics of cellular senescence, including a flattened shape and increased activity of senescence-associated β-galactosidase (SA-β-Gal) (Fig. 1C). In addition, another senescence marker, *plasminogen activator inhibitor-1* (*PAI-1*), was increased in HuR-depleted cells (Fig. 1D) (35). These data suggest that loss of HuR results in acute cellular senescence in mouse fibroblasts.

The ARF-p53 pathway plays an essential role in mouse cellular senescence. *ARF*- or *p53*-null cells do not undergo cellular senescence upon serial passage or oncogenic activation (36–39). To clarify the roles of the ARF-p53 pathway in the senescence of HuR knockdown MEFs, cells derived from $ARF^{-/-}$ or $p53^{-/-}$ animals were infected with retroviruses encoding sh-SCR or sh-HuR. Unlike in wild-type MEFs, no SA-β-Gal staining was observed in $ARF^{-/-}$ and $p53^{-/-}$ cells (Fig. 2A). HuR depletion consistently caused significant cell growth arrest only in wild-type MEFs, and *ARF*- or *p53*-null cells continued to proliferate irrespective of HuR status (Fig. 2B). However, HuR knockdown had a weak growth-inhibitory effect in these cells, which is consistent with earlier reports showing that HuR targets several growth-related genes (40). These results suggest that cellular senescence induced by HuR depletion is strictly dependent on the ARF-p53 pathway, while other factors may also be involved in cell growth regulation by HuR.

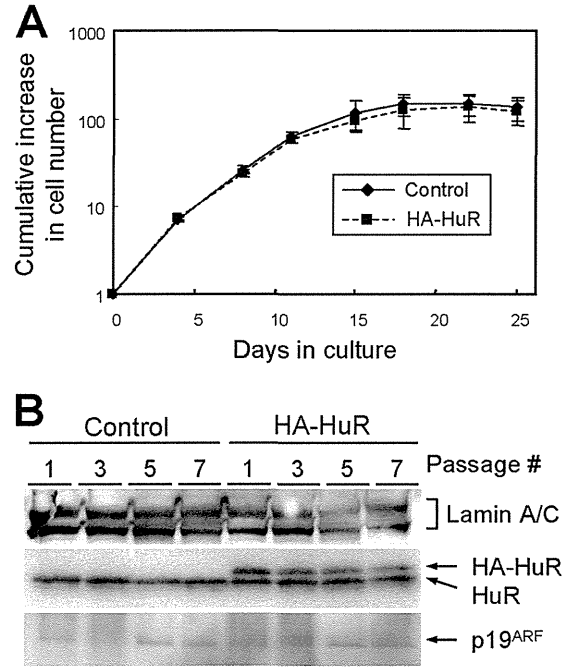


FIG 3 HuR overexpression does not affect $p19^{ARF}$ levels or replicative life spans. (A) Wild-type MEFs were infected with retroviruses encoding GFP (control) or HA-HuR. Infected cells were cultured by the NIH 3T3 protocol. Error bars represent SEM of results from triplicate wells. (B) Cell lysates were prepared at the indicated passage numbers. The expression of the indicated proteins was analyzed by immunoblotting. Lamin A/C was used as a loading control.

**$p19^{ARF}$ is induced in HuR knockdown cells.** During cellular senescence, $p19^{ARF}$ and $p16^{Ink4a}$ levels are increased and lead the activating signals to p53 and pRb, respectively (41). Since senescence induced by HuR depletion requires *ARF* (Fig. 1C and 2A), we checked the levels of these proteins in control and sh-HuR MEFs. Loss of HuR expression led to a significant increase in $p19^{ARF}$ levels (Fig. 2C), while $p16^{Ink4a}$ levels were not increased in these cells. Similar results were obtained using another shRNA, one that targets different regions of the *HuR* gene (33), confirming that increased levels of $p19^{ARF}$ were not due to the off-target effects of sh-HuR (Fig. 2D). On the other hand, overexpression of HuR did not affect either the cells' replicative life span or $p19^{ARF}$ levels (Fig. 3A and B).

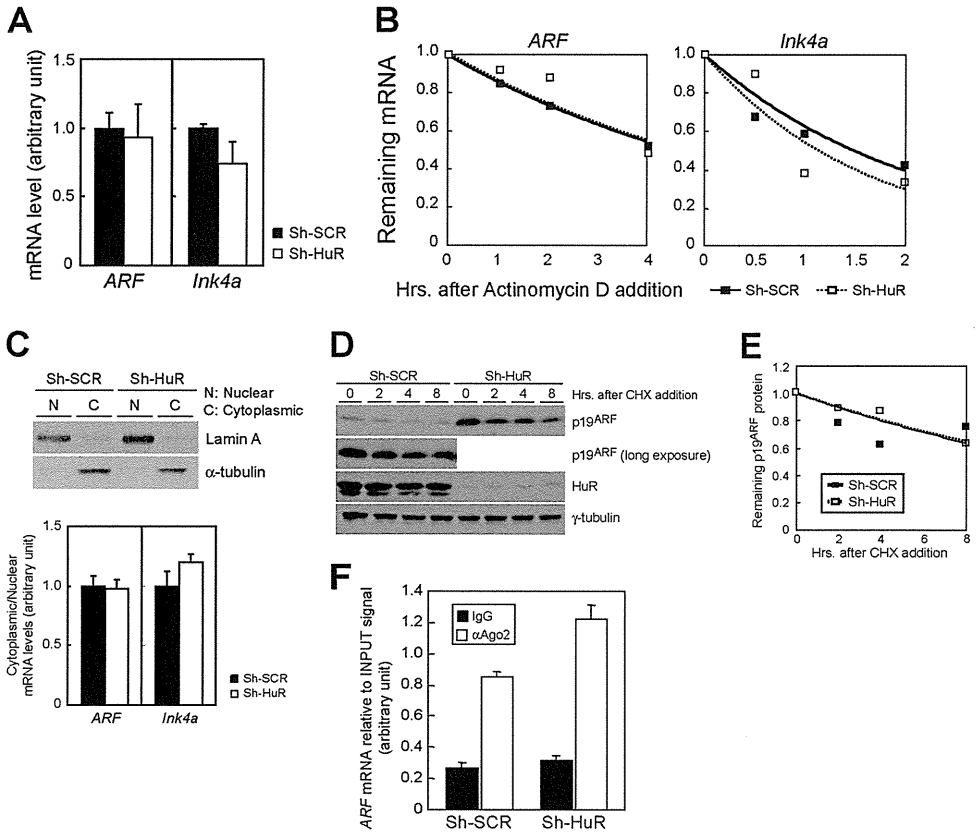


FIG 4 HuR does not affect *ARF* mRNA transcription, stability, nuclear export, or $p19^{ARF}$ turnover. (A) The expression of *ARF* and *Ink4a* mRNA in control and sh-HuR MEFs was analyzed by real-time PCR. mRNA in each sample was normalized to 18S rRNA. (B) Control or sh-HuR retrovirus-infected MEFs were treated with actinomycin D for the indicated periods. Total RNA was extracted at each time point, and *ARF* and *Ink4a* mRNA levels relative to the 18S rRNA level were analyzed by real-time PCR. (C) Nuclear and cytoplasmic fractions were prepared from control and sh-HuR MEFs. (Upper blot) Samples were analyzed by immunoblotting using Lamin (for the nuclear marker) and α-tubulin (for the cytoplasmic marker) antibodies. (Lower blot) RNA was isolated from these fractions. *ARF* and *Ink4a* mRNA levels were quantified by real-time PCR and normalized to the 18S rRNA level in each fraction, and the ratios of cytoplasmic mRNA to nuclear mRNA were determined. (D) Wild-type MEFs infected with control or sh-HuR retroviruses were treated with cycloheximide (CHX) for the indicated periods. Cell lysates were prepared, and $p19^{ARF}$ levels were analyzed by immunoblotting. (E) The intensity of the $p19^{ARF}$ band in each sample was determined using ImageJ and plotted. (F) HuR does not affect Ago2 association with *ARF* mRNA in mouse cells. Lysates of MEFs expressing sh-SCR or sh-HuR were immunoprecipitated using Ago2 or a control antibody. RNA recovered from the immune complex was analyzed using real-time PCR. Error bars represent SEM of results from triplicate samples.

**HuR does not affect ARF mRNA or protein stability.** The above results indicate that, unlike in HDFs, HuR regulates the expression of $p19^{ARF}$ but not of $p16^{Ink4a}$ in MEFs. To gain insights into how HuR regulates $p19^{ARF}$ expression, we first compared *ARF* mRNA levels in control and sh-HuR MEFs. Real-time PCR analysis revealed no increase in *ARF* or *Ink4a* mRNA levels in the presence or absence of HuR (Fig. 4A), implying that HuR was not involved in the transcriptional regulation of these genes. We next checked whether HuR could affect the stability of these mRNAs. Cells were treated with actinomycin D to block *de novo* mRNA synthesis, and the remaining mRNA was chased by real-time PCR. Although HuR has been shown to negatively regulate *Ink4a* mRNA stability in human fibroblasts (25), there was no significant difference in the levels of stability of *ARF* mRNA in MEFs (Fig. 4B). Likewise, we observed no difference in the ratios of cytoplasmic to nuclear *ARF* and *Ink4a* mRNA between these cells; therefore, it is unlikely that HuR regulates the nuclear export of these mRNAs (Fig. 4C). We also compared levels of protein stability in these cells with a cycloheximide chase but did not observe changes in $p19^{ARF}$ stability (Fig. 4D and E).

In human cells, HuR has been shown to destabilize *Ink4a* mRNA by recruiting RISC to it (25). We therefore wished to determine if this was also the case with *ARF* regulation in MEFs. Lysates from sh-SCR and sh-HuR MEFs were immunoprecipitated using Ago2 antibodies, and RNAs recovered from immune complexes were subjected to real-time PCR analysis for *ARF*. *ARF* mRNA was enriched in the Ago2 immune complex from sh-SCR cells, suggesting that RISC is also involved in *ARF* mRNA regulation (Fig. 4F). Nonetheless, we did not observe any decrease in the RISC-*ARF* mRNA interaction in HuR-depleted cells. Thus, unlike in human cells, RISC is not involved in HuR-mediated *ARF* mRNA regulation.

**HuR translationally regulates $p19^{ARF}$ expression.** Next, we checked the possibility that HuR affects the translation of *ARF* mRNA since it has been well established that HuR regulates the translation of its target mRNAs (13, 40). MEFs were infected with GFP or GFP fused to ribosomal protein L10a (GFP-L10a) together with sh-SCR or sh-HuR retroviruses. Cytoplasmic lysates were immunoprecipitated using GFP antibody to purify ribosome-mRNA complexes (32, 42). Immunoblotting confirmed that GFP-

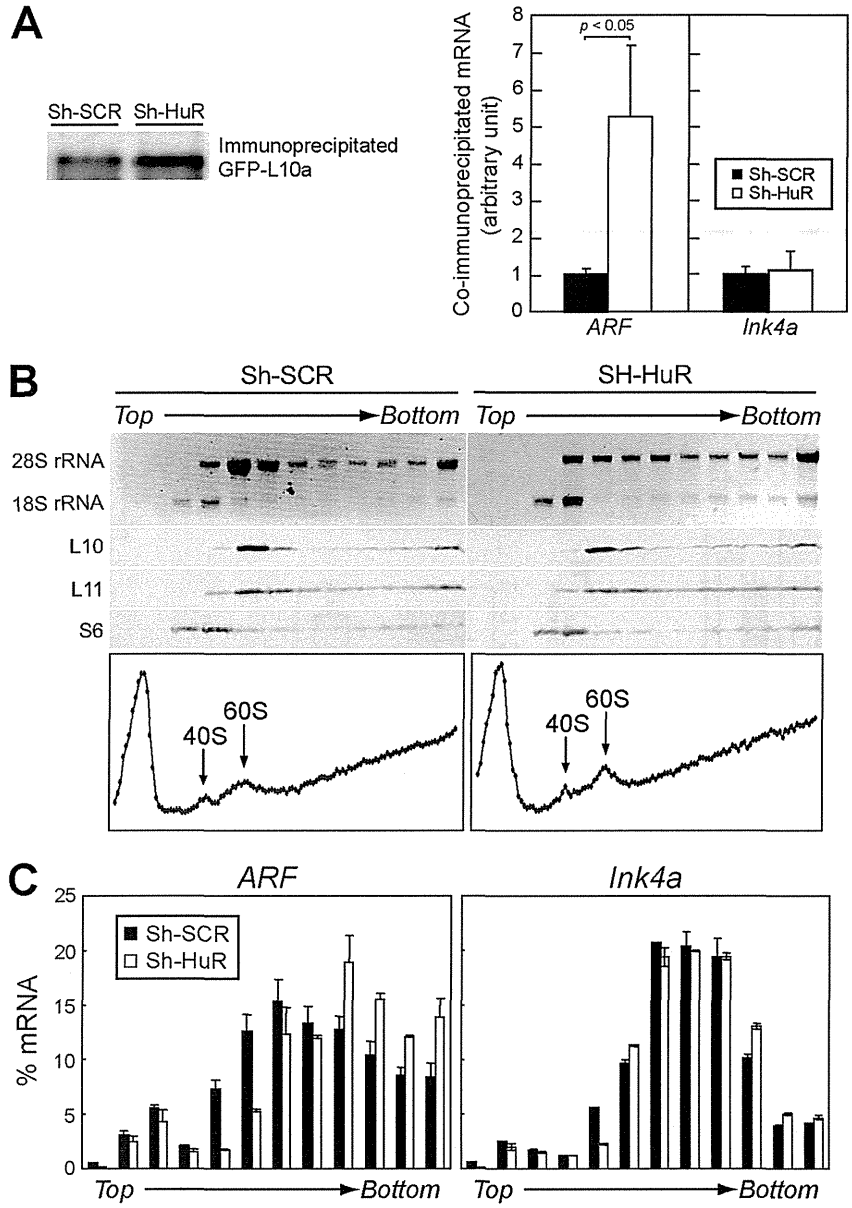


FIG 5 HuR regulates the translation of *ARF* mRNA. (A) Wild-type MEFs were infected with sh-SCR or sh-HuR retroviruses together with GFP or GFP-L10 retroviruses. Cytoplasmic lysates were immunoprecipitated using GFP antibody. Immunoblotting using GFP antibody indicated that equal amounts of GFP-L10 protein were immunoprecipitated. RNAs were extracted from immune complexes and subjected to real-time PCR analysis. Amounts of *ARF* or *Ink4a* mRNA in each sample were normalized to 18S rRNA in the complex. Data are representative of three independent experiments. Error bars represent SEM of results from triplicate samples. (B) Cytoplasmic lysates prepared from MEFs infected with sh-SCR or sh-HuR retroviruses were fractionated by sucrose density gradient centrifugation. Samples were manually separated into 120 fractions, and the relative values of optical densities at 254 nm were plotted (graphs). Ten fractions were pooled, and 28S and 18S rRNAs and ribosomal proteins (L10, L11, and S6) were visualized by ethidium bromide staining and immunoblotting, respectively. (C) The amount of *ARF* or *Ink4a* mRNA in each fraction was analyzed using real-time PCR.

L10a proteins were specifically enriched in immunoprecipitated complexes, and equivalent amounts of GFP-L10a were obtained from control and sh-HuR cells (Fig. 5A). RNAs were then recovered from immune complexes and subjected to real-time PCR analysis. *ARF* mRNA was significantly enriched in the ribosome complex in sh-HuR cells; the amount of ribosome-associated *ARF* mRNA was more than five times higher than that of the control, while no change in ribosome association with *Ink4a* mRNA was observed under these conditions. To further validate the *ARF* mRNA-ribosome association, cytoplasmic lysates were fractionated into polysome/nonpolysome fractions by sucrose gradient sedimentation (Fig. 5B). RNAs were recovered from each fraction, and *ARF* and *Ink4a* mRNAs were analyzed by real-time PCR. As in the GFP-L10a immunoprecipitation experiment (Fig. 5A), we observed more *ARF* mRNA in the polysome fractions of HuR-depleted cells than in the nonpolysome fractions (Fig. 5C). Together, these results indicate that HuR specifically represses p19$^{ARF}$ expression by inhibiting mRNA-ribosome association.

We next sought to investigate if HuR affects *ARF* mRNA localization. To this end, *ARF* mRNA, including both its 5′- and its

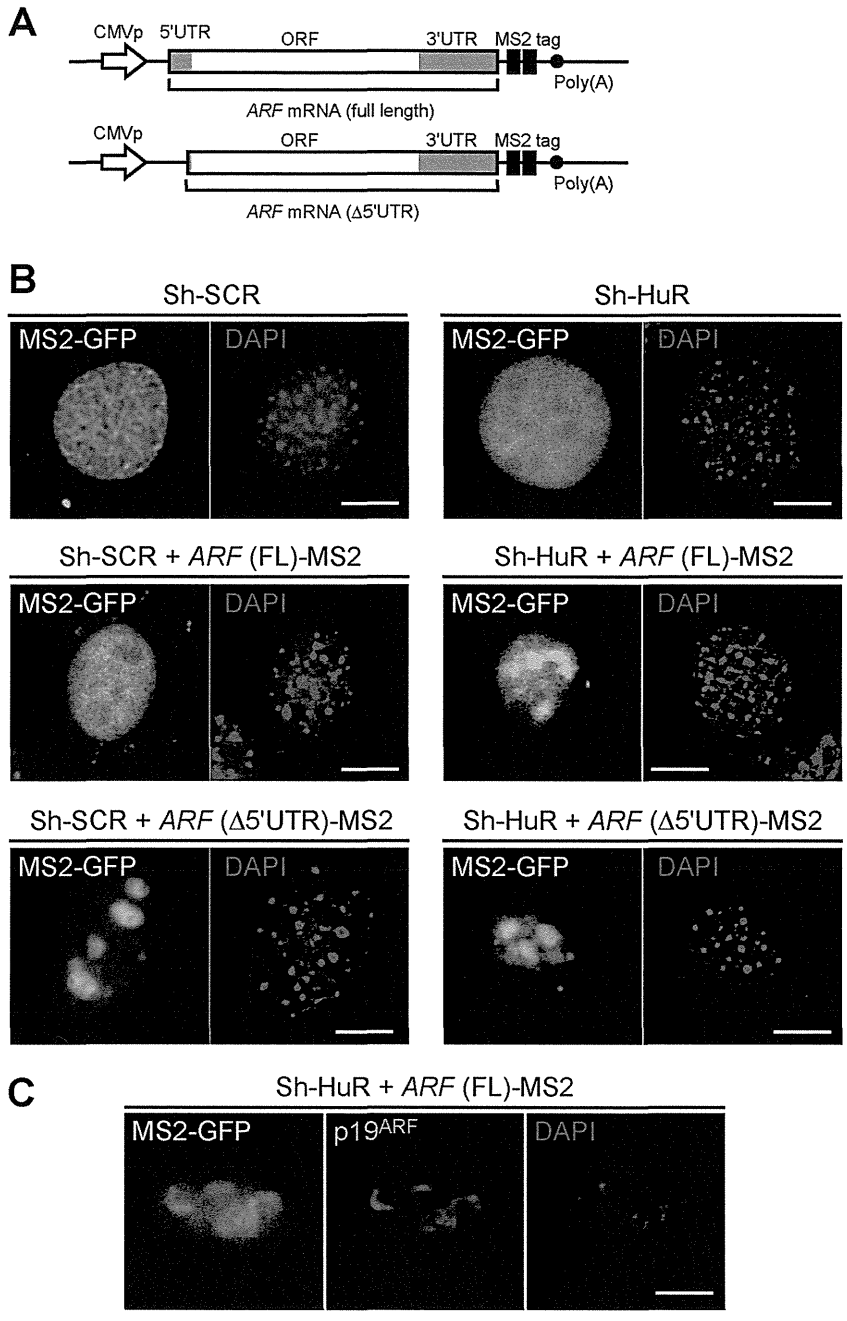


FIG 6 Loss of HuR relocalizes *ARF* mRNA to nucleoli. (A) DNA constructs for the expression of MS2-tagged *ARF* mRNA (full length or Δ5′UTR). CMVp, cytomegalovirus promoter. (B) Sh-SCR- or sh-HuR-expressing *ARF p53* DKO cells were transiently transfected with MS2-GFP-NLS plasmids. Where indicated, cells were cotransfected with MS2-tagged *ARF* (full length or Δ5′UTR)-expressing plasmids. Three days later, cells were fixed in paraformaldehyde and stained with DAPI. Bars, 10 μm (C) Sh-HuR-expressing *ARF p53* DKO cells were transiently transfected with MS2-GFP-NLS together with MS2-tagged *ARF* (full length)-expressing plasmids. Cells were stained using $p19^{ARF}$ antibody and DAPI.

3′UTR, was conjugated to tandem MS2-binding sequences (MS2 tag in Fig. 6A) (43) and coexpressed with MS2-EGFP fusion protein with a nuclear localization signal (MS2-EGFP-NLS) in *ARF* and *p53* double-knockout (DKO) MEFs expressing sh-SCR or sh-HuR (30). In the absence of *ARF* mRNA, the GFP signal was observed only in the nucleus, irrespective of HuR status (Fig. 6B). In cells expressing MS2-tagged *ARF* mRNA, the GFP signal was also observed in the nucleus, indicating that the majority of *ARF* mRNA remains in the nucleus. Interestingly, we observed that *ARF* mRNA (full length) specifically accumulated in a subnuclear compartment when HuR was depleted. This subnuclear compartment represented nucleoli, since the GFP signal colocalized with $p19^{ARF}$ (Fig. 6C). Thus, HuR also regulates the nuclear trafficking of *ARF* mRNA, which may contribute to translational regulation (44).

**HuR associates with ARF mRNA in living cells.** Since our re-