and 4.1 ± 2.3 × 10^6 on days 1, 3, 5, and 7, respectively (Fig. 1*f*). ACT induced massive recruitment of $CD11b^+Gr1^+$ cells in the tumor with similar kinetics to the CTLs.

Increased infiltrating myeloid cells after ACT is characterized as $Gr1^{int}Ly6C^+$ monocytic MDSC

Tumor-infiltrating cells were harvested from ACT and untreated mice on day 3 after CTL transfer; $CD11b^+Gr1^+$ cells were gated and further analyzed by anti-Ly6C mAb. They were divided into three populations, $Gr1^{high}Ly6C^+$, $Gr1^{int}Ly6C^+$ and $Gr1^{low}Ly6C^-$ cells (Fig. 2*a*). As shown in Figure 2*a*, the $Gr1^{int}Ly6C^+$ cell population was increased from 37.8 ± 5.8% in untreated mice to 79.4 ± 0.6% in ACT mice. The absolute number of $Gr1^{int}Ly6C^+$ cells in ACT mice was 9.2-fold that of control mice (1.2 ± 0.3 × 10^7 *vs.* 1.3 ± 0.3 × 10^6) (Fig. 2*b*). In contrast, the percentage of $Gr1^{high}Ly6C^+$ in ACT mice was decreased to 2.0 ± 0.8% compared with 17.4 ± 10.4% in controls (Fig. 2*a*), although their absolute number was not different (Fig. 2*b*). Because it is known that the Gr1 mAb binds to both Ly6G and Ly6C molecules, we further defined these cells by anti-Ly6G and Ly6C mAbs separately. We found that Ly6G was expressed by $CD11b^+Gr1^{high}Ly6C^+$ cells, but not $CD11b^+$ $Gr1^{int}Ly6C^+$ cells. IL4Rα and F4/80 were expressed by both $Gr1^{int}Ly6C^+$ and $Gr1^{low}Ly6C^-$ populations (Fig. 2*c*). These data show that $CD11b^+Gr1^{high}Ly6G^+Ly6C^+$ granulocytic MDSC, $CD11b^+Gr1^{int}Ly6G^-Ly6C^+$ monocytic MDSC and $CD11b^+Gr1^{low}Ly6G^-Ly6C^-F4/80^{++}$ macrophage were present in the B16 tumors. The cells preferentially accumulating in the tumor following ACT were therefore monocytic MDSC. Accordingly, $CD11b^+Gr1^{high}$ and $CD11b^+Gr1^{int}$cells were sorted from day 3 infiltrating cells from ACT mice and their morphology examined by light microscopy (Fig. 2*d*). Multilobed or polymorph nuclei were observed in $CD11b^+Gr1^{high}$ cells and eccentrically-placed kidney bean-shaped nuclei in $CD11b^+Gr1^{int}$ cells. Consistent with these single cell analysis, infiltration of adoptively-transferred CTLs and recruitment of monocytic MDSCs were observed in the tumor after ACT by immunohistochemistry (Supporting Information Fig. S3). While only a few $CD90.1^+$ CTLs (blue) were detected in the tumor on day1, diffuse infiltration of CTLs were observed in the tumor on day 3 to 7. Infiltration of CTLs were accompanied by 3-5 times more in number of the recruitment of $Ly6C^+$ monocytic MDSCs (green). The distribution of $CD90.1^+$ CTLs, $Ly6C^+$ monocytic MDSCs, and $F4/80^+$ macrophages were compared between the center and the peripery of the tumor on day 3 (Supporting Information Fig.S4). CTLs and macropahges distributed throughout the tumor tissue in a disseminated manner as scattered solitary cells. Aggregates and condensations of monocytic MDSC co-localized with CTLs. These results suggested that tumor infiltrating CTLs recruited monocytic MDSC.

Adoptively-transferred CTLs activate monocytic MDSC

It has been reported that granulocytic MDSC use ROS to mediate suppression,[18] whereas monocytic MDSC use upregulation of NO and arginase.[19] To determine whether cells accumulating in the tumors of ACT mice have such suppressive functions, we assessed the expression of these suppressive molecules by cells isolated from the tumor 3 days after CTL transfer (Fig. 3*a*). First, CD45 expression was used to separate leukocytes from tumor cells. Next, granulocytic MDSC and monocytic MDSC were isolated according to their Gr1 and Ly6C expression as defined in Figure 2*a*. Quantitative RT-PCR was performed with mRNA extracted from tumor cells and leukocytes isolated from ACT and untreated mice. mRNAs for iNOS, arginase I, MMP9, TGFβ, and VEGF were detected in leukocytes from both untreated and ACT mice. Although MMP9, TGFβ, and VEGF were decreased in the ACT mice, iNOS was markedly upregulated in the $Gr1^{int}Ly6C^+$ monocytic MDSCs from these animals. Furthermore, cells were isolated and stained with the mAbs and with CM-H_2DCFDA, an indicator for the production of ROS. As shown in Figure 3*b*, monocytic MDSC from both ACT and control mice produced ROS, but the fluorescence intensity of the former was enhanced relative to the latter (p = 0.04). These results indicate that monocytic MDSC expressed immunosuppressive molecules and that CTL treatment was accompanied by an upregulation of these immunosuppressive molecules in MDSC.

Monocytic MDSC suppress CTL proliferation

The capacity of MDSC to suppress antigen-specific T-cell proliferation was investigated, with the results shown in Figure 4. MDSCs were harvested from B16 tumor 3 days after CTL transfer and positively selected by anti-CD11b magnetic beads. Their purity was 91.6% (data not shown). To prepare responder cells, gp100-specific T cells were isolated from pmel-1 TCR transgenic mice (designated pmel-1 cells) and labeled with CFSE. MDSCs were pulsed with 1 μg/ml hgp100 peptide and co-cultured with CFSE-labeled pmel-1 cells for 3 days. Pmel-1 spleen cells did not proliferate without peptide (Fig. 4, upper left). In the presence of peptide and without MDSCs, 93.0 ± 0.9% of pmel-1 cells experienced cell division within 3 days. When MDSCs were added to the cultures, proliferation was inhibited in a dose-dependent manner. When MDSCs were incubated with pmel-1 cells at a ratio of 0.3:1, 1:1 or 3:1, 22.9 ± 3.8%, 8.2 ± 0.4%, 4.1 ± 0.3% of pmel-1 cells divided, respectively. These results indicate that MDSCs in the tumors of ACT mice inhibited the proliferation of the infused antigen-specific CTLs.

To identify the factors responsible for the immunosuppressive activity of these MDSC, blockade of pmel-1 cell proliferation was tested in the presence of L-NMMA (iNOS inhibitor), *N*-acetyl-L-cysteine (ROS inhibitor) or Nor-NOHA (arginase I inhibitor). By themselves, these reagents had no effect on pmel-1 proliferation at the concentrations used (Fig. 4, upper two lanes). However, in the presence of L-NMMA, inhibition of pmel-1 proliferation by MDSC was completely abrogated. Even when three times more MDSCs were added to the culture, 89.9 ± 1.3% of pmel-1 cells still proliferated.

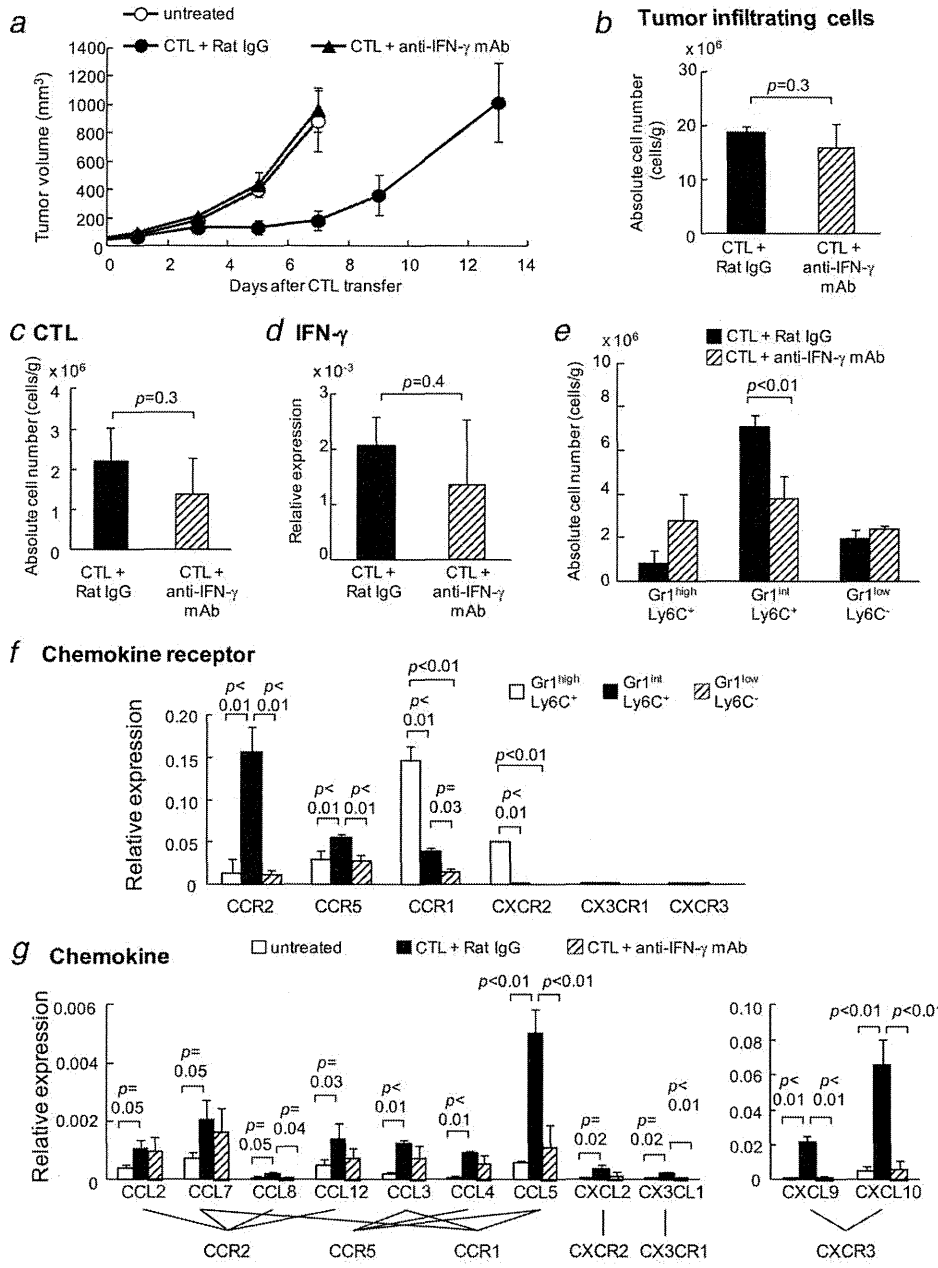

Figure 5. The anti-tumor activity of CTLs and the accumulation of monocytic MDSCs is mediated by IFN-γ. B16 melanoma cells (1×10^6) were implanted subcutaneously in 6-week-old C57BL/6 mice (six or seven mice per group). Tumor growth was measured in mice bearing 9-d B16 tumors that received 1×10^7 CTLs activated *in vitro*. ACT mice were divided into two groups; one received anti-IFN-γ mAb and the other received control Rat IgG_1. (*a*) Tumor volume was compared between untreated and ACT mice w/o anti-IFN-γ mAb treatment. Tumor-infiltrating cells were harvested 3 days after ACT. The number of tumor-infiltrating cells (*b*) and CTLs (*c*) and intratumoral expression of IFN-γ mRNA (*d*) were compared between IFN-γ-treated or control IgG-treated mice after ACT. (*e*) The number of $Gr1^{high}Ly6C^+$ granulocytic MDSC, $Gr1^{int}Ly6C^+$ monocytic MDSC and $Gr1^{low}Ly6C^-$ cells were also compared. ■ CTL + Rat IgG-treated mice, ▨ CTL + anti-IFN-γ mAb-treated mice. (*f*) $Gr1^{high}Ly6C^+$ granulocytic MDSC, $Gr1^{int}Ly6C^+$ monocytic MDSC and $Gr1^{low}Ly6C^-$ cells were sorted from ACT mice without anti-IFN-γ mAb 3 days after CTL transfer and RNA was isolated. The messages for chemokine receptors, CCR2, CCR5, CCR1, CXCR2, CX3CR1 and CXCR3, were compared in these cell populations (□ $Gr1^{high}Ly6C^+$, ■ $Gr1^{int}Ly6C^+$, ▨ $Gr1^{low}Ly6C^-$ cells) by quantitative RT-PCR. (*g*) Tumors were harvested on day 3 after CTL transfer and total RNA was isolated. The mRNA expression of chemokines, CCL2, CCL7, CCL8, CCL12, CCL3, CCL4, CCL5, CXCL2, CX3CL1, CXCL9 and CXCL10, were compared with these animals (□ untreated, ■ CTL + Rat IgG-treated mice, ▨ CTL + anti-IFN-γ mAb-treated mice) by qRT-PCR. All experiments shown were performed independently at least three times with similar results.

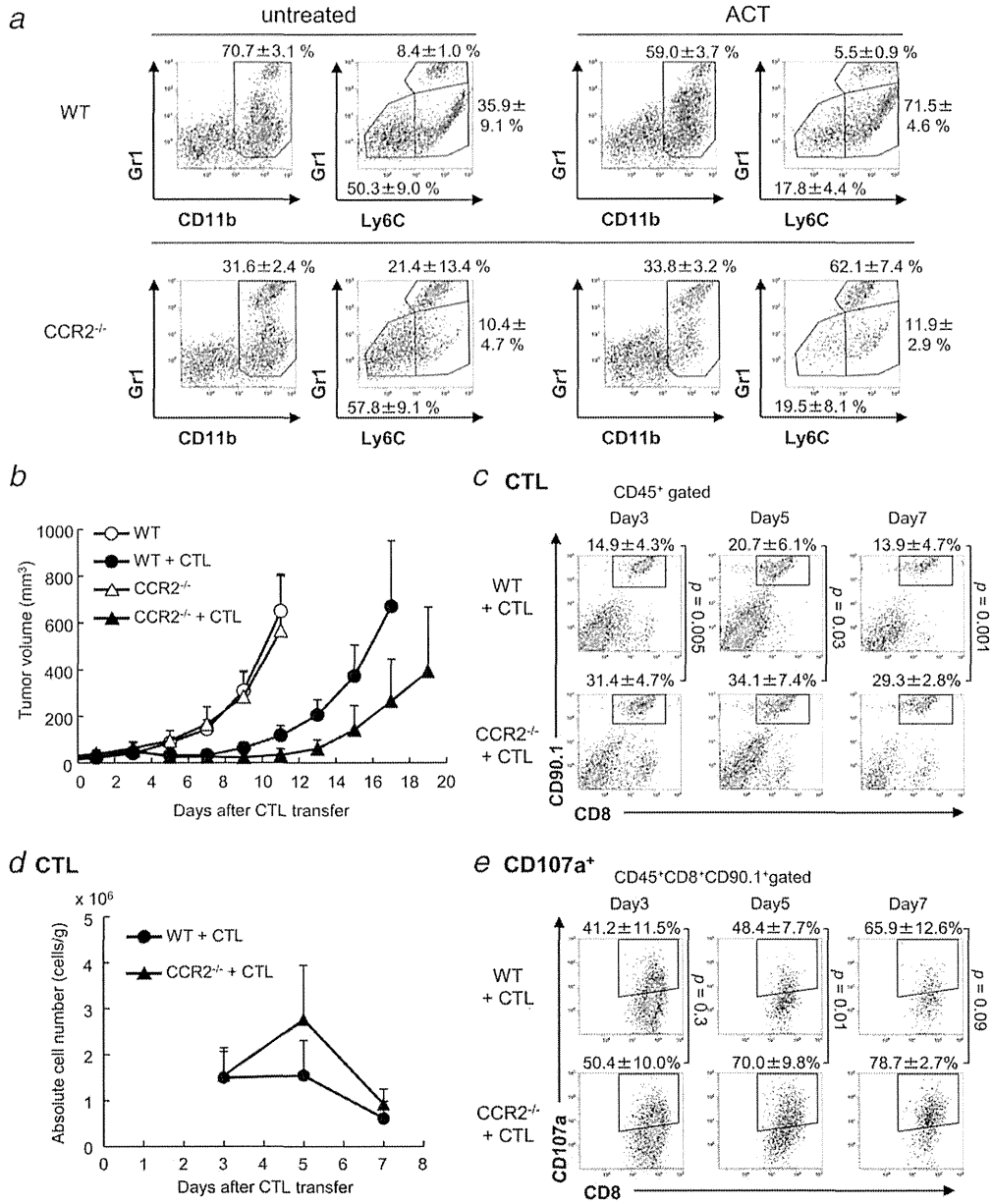

Figure 6. CTL-induced anti-tumor activity and MDSC accumulation in CCR2$^{-/-}$ mice. B16 melanoma cells (1×10^6) were implanted subcutaneously in 6-week-old C57BL/6 mice (WT) or CCR2$^{-/-}$ mice. On day 9, tumor-bearing mice ($n = 4$) received 1×10^7 CTLs. A, Tumor-infiltrating cells were harvested 3 days after CTL transfer and MDSCs were compared with WT and CCR2$^{-/-}$ mice. (*b*) Tumor growth was measured in mice (five to seven mice per group) bearing 9-d B16 tumors w/o 1×10^7 CTL transfer. Suppression of tumor growth by CTLs is augmented in CCR2$^{-/-}$ mice. (*c*) Tumor-infiltrating cells were harvested on day 3, 5, and 7. Cells were gated on CD45$^+$; the infiltration of CTLs into the tumor was compared between WT and CCR2$^{-/-}$ mice. (*d*) The absolute number of CTLs on days 3, 5 and 7 after ACT in WT and CCR2$^{-/-}$ mice. (*e*) Tumor-infiltrating cells were harvested at the indicated time points and stimulated with 1 μg/ml mgp100 peptide. Cells were gated on CD45$^+$CD8$^+$CD90.1$^+$; Externalization of CD107a on CD8$^+$CD90.1$^+$ CTLs was evaluated. Numbers on the images show the percentage of gated cells (mean ± SD). All experiments shown were performed independently at least three times with similar results.

Suppression of pmel-1 proliferation was also diminished by *N*-acetyl-L-cysteine; it was restored to 39.2 ± 2.1% from 4.1 ± 0.3% at an MDSC:CTL ratio of 3:1. Finally, although Nor-NOHA did not restore pmel-1 proliferation at the MDSC:CTL ratio of 3:1, it was slightly increased from 22.9 ± 3.8% to 55.4 ± 5.2% at a ratio of 0.3:1. These results indicate that NO, ROS and Arginase I are all involved in the immunosuppressive activity of MDSCs after ACT.

Both tumor growth suppression and stimulation of monocytic MDSCs by adoptively transferred CTLs is mediated by IFN-γ

To determine the factors responsible for the activation of MDSCs, anti-IFN-γ neutralizing mAb was administered intraperitoneally to ACT mice. On the day of, and 2 days after, CTL transfer, mice received either 500 μg anti-IFN-γ mAb or rat IgG_1 isotype control. Treatment with anti-IFN-γ mAb was found to completely abrogate the anti-tumor activity of transferred CTLs (Fig. 5*a*). Thus, even though mice received CTLs, tumors in anti-IFN-γ mAb-treated mice grew progressively with the same kinetics as in untreated mice. Tumor-infiltrating cells were harvested 3 days after ACT in animals treated or not treated with anti-IFN-γ mAb. The absolute number of tumor infiltrating cells was comparable between these two groups (Fig. 5*b*). The degree of CTL infiltration into the tumor, as well as the level of intra-tumoral IFN-γ expression was the same in anti-IFN-γ mAb-treated and isotype control-treated mice, although slightly but non-significantly reduced in the former (Figs. 5*c* and 5*d*). Nonetheless, the anti-tumor activity of the CTLs was completely abrogated in the anti-IFN-γ mAb-treated mice. The percentage and number of $Gr1^{int}Ly6C^+$ monocytic MDSC in the tumor were both decreased by neutralization of IFN-γ although the overall number of tumor infiltrating cells remained the same (Figs. 5*b* and 5*e*). These results indicate that both tumor growth suppression and expansion of monocytic MDSC in the tumor depend on the IFN-γ produced by the tumor-specific CTLs.

The anti-tumor activity of the CTLs is augmented in the absence of monocytic MDSC

To determine the factors responsible for the recruitment of MDSCs into the tumor, mRNA expression of chemokine receptors was compared on $Gr1^{high}Ly6C^+$, $Gr1^{int}Ly6C^+$ and $Gr1^{low}Ly6C^-$ cells after ACT (Fig. 5*f*). While $Gr1^{high}Ly6C^+$ granulocytic MDSCs express CCR1, $Gr1^{int}Ly6C^+$ monocytic MDSCs expressed CCR2. Consistently, CCR2 ligands, CCL2, CCL7 and CCL12 were expressed in the tumor and up-regulated by ACT (Fig. 5*g*). The up-regulation of CCL7 and CCL12 expression was diminished by anti-IFN-γ treatment. These results suggested that CCR2 axis was involved in the recruitment of monocytic MDSCs into the tumor by ACT.

Therefore, we compared the anti-tumor activity of adoptively-transferred CTLs in $CCR2^{-/-}$ mice. B16 tumor cells were subcutaneously inoculated into C57BL/6 wild-type and $CCR2^{-/-}$ mice. Consistent with our previous report,[20] we found that the $CD11b^+Gr1^{int}Ly6C^+$ monocytic MDSCs decreased in tumor-infiltrating cells from $CCR2^{-/-}$ mice. However, $CD11b^+Gr1^{high}Ly6C^+$ granulocytic MDSC were increased from 8.4 ± 1.0% to 21.4 ± 13.4% (Fig. 6*a*). CTLs were then adoptively transferred and tumor-infiltrating cells harvested on day 3. CTLs in the tumor in wild-type mice were accompanied by the accumulation of $CD11b^+Gr1^+$ cells, especially $Ly6C^+$ monocytic MDSC. In contrast, $CD11b^+Gr1^{int}Ly6C^+$ monocytic MDSC were not present in CTL-treated $CCR2^{-/-}$ mice, which instead accumulated granulocytic MDSC. While 71.5 ± 4.6% of infiltrating cells were monocytic MDSC in wild-type mice, this was only 11.9 ± 2.9% in $CCR2^{-/-}$ mice, which had 62.1 ± 7.4% of granulocytic MDSC (Fig. 6*a*).

As shown in Figure 6*b*, tumors grew progressively not only in wild-type mice, but in $CCR2^{-/-}$ mice as well. As expected, tumor growth was suppressed in mice receiving CTLs by adoptive transfer, and more effectively in the absence of CCR2. These results indicate that the anti-tumor activity of transferred CTLs was augmented in the absence of monocytic MDSC accumulation. To investigate the underlying mechanisms for this, tumor-infiltrating cells were harvested and infiltration of CTLs compared at the indicated time points. The percentages of CTLs in infiltrating cells from wild-type mice at days 3, 5 and 7 were 14.9 ± 4.3%, 20.7 ± 6.1% and 13.9 ± 4.7%, respectively (Fig. 6*c*). In CTL-treated $CCR2^{-/-}$ mice, the infiltration of CTLs into the tumor was increased at days 3, 5 and 7 to 31.4 ± 4.7%, 34.1 ± 7.4% and 29.3 ± 2.8%, respectively. The absolute number of CTLs in the tumor was 3.0 ± 1.4 × 10^6 in $CCR2^{-/-}$ mice compared with 1.7 ± 0.8 × 10^6 in wild-type mice on day 5 after CTL transfer (Fig. 6*d*). More $CD107a^+$ CTLs were present in the tumor of $CCR2^{-/-}$ mice receiving CTLs (Fig. 6*e*). These results indicated that more CTLs infiltrated into the tumor and exerted better effector function in the absence of monocytic MDSC recruitment.

Discussion

Established tumors comprise multiple cellular constituents.[21] Complex interactions between the different cell types in the tumor contribute to the immunosuppressive microenvironment. Here, we examine the effect of ACT on this complex regulatory network in the tumor. Adoptively-transferred CTLs that infiltrated into the tumor and exerted anti-tumor activity were associated with a massive recruitment of other leukocytes (Supporting Information Fig. S1), the majority of which was a $CD11b^+Gr1^{int}Ly6G^-Ly6C^+$ monocytic MDSC population (Figs. 1, 2 and Supporting Information Fig. S3). This resulted in increased immunosuppressive activity in the tumor microenvironment and suppressed the CTLs, forming a negative feedback loop.

MDSCs were originally identified in tumor-bearing mice as $CD11b^+Gr1^+$ cells; they are a heterogeneous cellular population containing macrophages, granulocytes, immature DCs and immature myeloid cells.[22,23] They suppress T-cell responses *in vitro* through direct cell-cell contact or by producing arginase I and iNOS.[24] Antigen-specific CD8 T cell tolerance can be induced by nitration of the TCR-CD8 complex mediated by ROS and peroxynitrite produced by MDSCs.[18] They are divided into two populations: monocytic MDSC and granulocytic MDSC[25] which use different effector molecules and signals to suppress antigen-specific T cell responses. In monocytic MDSCs, IFN-γ signaling through STAT1 results in the production of NO.[26] In contrast, granulocytic MDSCs use ROS for their suppressive function.[18] Consistently, in our study, stronger ROS fluorescence intensity was seen in granulocytic MDSCs than monocytic MDSCs (Fig. 3*b*). In ACT, the recruitment of monocytic MDSCs into the tumor

as a result of CTL tumor infiltration outnumbered granulocytic MDSCs (Fig. 2). Therefore, the immunosuppressive activity of CTL-induced monocytic MDSC accumulation was mediated mainly by iNOS, partly by ROS or arginase I (Fig. 4). Both the absolute number of monocytic MDSCs (Fig. 2*b*) and the per cell expression of iNOS mRNA (Fig. 3*a*) were markedly increased in the tumor by ACT, treatment-induced immunosuppressive microenvironment in the tumor turned tougher than that of steady state condition.

We have reported that the robust induction of IFN-γ mRNA and IFN-γ-producing CTLs can be detected in tumors after ACT.[12] Because IFN-γ is a key effector molecule for CTL anti-tumor activity,[27] we investigated its contribution in our B16-pmel-1 CTL model. CTL-inhibited tumor growth was completely prevented by anti-IFN-γ mAb treatment (Fig. 5). This treatment also prevented the accumulation of monocytic MDSC in the tumor in CTL-treated mice. These results suggested that both suppression of tumor growth and the accumulation of monocytic MDSC at the tumor site were functionally dependent on IFN-γ. This is consistent with the report by Gallina *et al.* that MDSC activity was enhanced by IFN-γ released from activated T cells.[28] Monocytes conditioned by tumors express IL-4Rα and secrete IL-13. These two cytokines amplify the expression of iNOS and arginase, which mediate immunosuppression. Consistently, our study demonstrated that IFN-γ produced by adoptively-transferred antigen-specific CTLs augmented immunosuppressive activities of MDSCs in the quantitative as well as the qualitative sense (Figs. 1–3).

To separate anti-tumor activity of ACT from the pro-tumor immunosuppressive activity of MDSC, we studied events downstream of IFN-γ production, notably which chemokine system was involved in this process. It has been reported that the CCL2/CCR2 pathway mediates recruitment of MDSCs into cancers.[29,30] We had previously reported that the CCL2/CCR2 pathway mediates recruitment of myeloid suppressor cells to cancers by controlling both the mobilization of monocytes from the bone marrow to the blood and their migration to the tumor.[20] Although CX3CR1 and CCR5 are also known to be involved in the regulation of monocyte migration,[31,32] tumor-infiltrating macrophages were not reduced in CX3CR1$^{-/-}$ mice and no significant difference was observed in the efficiency of infiltration into tumors by adoptively transferred CCR5$^{+/-}$ and CCR5$^{-/-}$ bone marrow monocytes.[20] In the present study, we demonstrated that monocytic MDSCs recruited into the tumor after ACT strongly express CCR2 (Fig. 5*f*) and CCR2 ligands were induced in the tumor by ACT (Fig. 5*g*). We also demonstrated that ACT induced more profound anti-tumor effects in B16 tumor-bearing CCR2$^{-/-}$ mice in the absence of monocytic MDSC expansion than in wild-type mice (Fig. 6). These results were consistent with previous report of Lesokhin *et al.* that CCR2^{+} monocytic MDSCs accumulated in the GM-CSF secreting tumor and regulated the efficacy of CD8^{+} T cell therapy.[33] Fridlender *et al.* also reported that CCL2 blockade augments cancer immunotherapy.[34] Consistent with our results, anti-CCL2/CCL12 mAb treatment generated more intratumoral CD8^{+} T cells; however, no changes were observed in CD11b^{+}Ly6G^{+} granulocytic MDSCs or in the CD11b^{+}Ly6C^{+} monocytic MDSCs in their model. It remains to be determined whether and which factors might affect recruitment of MDSC subpopulations after ACT, but clearly CCL2, 7 and 12/CCR2 plays an important role in the accumulation of monocytic MDSC at the tumor site associated with ACT.

Despite the presence of granulocytic MDSC in the tumor after ACT possibly compensating for the reduction of monocytic MDSC in CCR2$^{-/-}$ mice, the anti-tumor activity of the infused CTL was not hampered and tumor growth remained profoundly suppressed. This supports the notion that monocytic MDSC, not granulocytic MDSC, were responsible for the ACT-associated immunosuppression. In line with our results, it has been reported that depletion of immune cells in mice before ACT improved the anti-tumor activity of the treatment.[35,36] Nonmyeloablative lymphodepleting preconditioning by systemic chemotherapy also markedly improved the efficacy of adoptive transfer of tumor infiltrating lymphocytes in melanoma patients.[37,38] The ACT-induced recruitment of MDSCs is presumably prevented under these conditions, because myelopoiesis *per se* was inhibited by preconditioning chemotherapy before ACT.

Recently, Landsberg *et al.* reported that melanoma cells acquired ACT resistance through a mechanism involving IFN-γ-dependent PD-L1 upregulation and TNF-α-dependent reversible loss of melanocytic antigens.[39] These two functionally related CTL-induced adaptive mechanisms together contributed to tumor resistance to ACT. Here, we demonstrated that IFN-γ-dependent secondary accumulation of monocytic MDSCs at the tumor site was also involved in this inhibitory process and further amplified the immunosuppressive network.

In conclusion, dual effects of CTL therapy, suppression of tumor growth and but also stimulation of monocytic MDSCs in the tumor, were both mediated by the IFN-γ produced by the infused tumor-specific CTLs. Considering that ACT triggered counter-regulatory immunosuppressive mechanism *via* recruitment of MDSCs, strategies for regulating this step are desired for optimizing ACT.

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Granulocyte macrophage colony-stimulating factor as a predictor of the response of metastatic renal cell carcinoma to tyrosine kinase inhibitor therapy

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Abstract. This prospective study was conducted to identify predictive markers for the response of metastatic renal cell carcinoma (RCC) to tyrosine kinase inhibitors (TKIs). Patients with histologically proven RCC with at least one measurable metastatic lesion were enrolled in this study. Blood samples were collected prior to treatment and the plasma levels of 27 cytokines were measured. Tumor response was assessed 8-12 weeks after the initiation of TKI treatment. A total of 13 patients (11 men and 2 women) with a median age of 63 years received sunitinib (8 cases), sorafenib (1 case), or axitinib (4 cases). Partial response (PR) was achieved in 5 patients (38%), stable disease (SD) in 4 (30%) and progressive disease (PD) was noted in 4 (30%). The plasma granulocyte macrophage colony-stimulating factor (GM-CSF) level in PR cases was significantly higher compared to that in SD or PD cases (P=0.012). Therefore, GM-CSF may be a predictive biomarker of the response of RCC to TKI treatment, suggesting that TKIs may exert clinical effects not only through suppression of the vascular endothelial growth factor, but also through immune system modulation.

Introduction

Renal cell carcinoma (RCC) is one of the major causes of cancer-related mortality. There were an estimated ~64,700 new cases of RCC and 13,570 deaths in 2012 in the United States (1). Over the last few years, a number of tyrosine kinase inhibitors (TKIs) have been proven to be effective and are currently widely used for the treatment of metastatic RCC. However, the effect of these TKIs appears to be rather limited, with only 31% of naive cases exhibiting an objective response [complete response (CR) or partial response (PR)] to sunitinib treatment in the first-line setting (2) and only 10% of cases with previous cytokine therapy exhibiting a PR to treatment with sorafenib (3). However, thus far, only a limited number of factors that predict the response of RCC to TKIs have been reported. A significant decrease in serum vascular endothelial growth factor (VEGF) receptor-2 levels and/or an increase in serum VEGF levels were observed in patients exhibiting an objective tumor response (4,5). Hypothyroidism and hypertension associated with TKI treatment were also reported to be correlated with a favorable response (6,7).

Although previous studies suggested that TKIs may affect the immune system (8,9), only a limited number of studies have investigated immunological biomarkers for therapeutic prediction. Adotevi *et al* (10) reported that a decrease in regulatory T cells was correlated with a favorable overall survival in cases with metastatic RCC who received sunitinib-based antiangiogenic therapy. Thus, we conducted a prospective study to invesigate predictive immunological biomarkers.

Patients and methods

Patients. Patients with histologically proven RCC with at least one measurable metastatic lesion, who were diagnosed between March, 2012 and June, 2013, were enrolled in this study. Sunitinib, sorafenib or axitinib were administered orally as previously described (2,3,11). Tumor response was assessed 8-12 weeks after the initiation of TKI treatment according to the response evaluation criteria in solid tumors and was classified as CR, PR, stable disease (SD) or progressive disease (PD) (12).

We collected blood samples from the 13 patients prior to treatment. The plasma was deep frozen at -80˚C and stored before measuring the immune function.

Cytokines. A total of 27 cytokines including interleukin (IL)-1β, IL-1ra, IL-2, IL-4, IL-5, IL-6, IL-7, IL-8, IL-9,

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Key words: metastatic, renal cell carcinoma, tyrosine kinase inhibitors, granulocyte macrophage colony-stimulating factor

Table I. Correlation between the clinical effect of tyrosine kinase inhibitors (TKIs) and clinicopathological characteristics among patients with metastatic renal cancer.

Clinical characteristics	Total (n=13)	Clinical effect[a] PR (n=5)	SD (n=4)	PD (n=4)	P-value
Gender					
Male	11	4	4	3	0.603
Female	2	1	0	1	
Age (years)					
≥65	7	2	2	3	0.593
<65	6	3	2	1	
Performance status					
0	8	3	2	3	0.780
1	5	2	2	1	
Laterality					
Right	8	2	3	3	0.479
Left	5	3	1	1	
Nephrectomy					
Radical	11	4	4	3	0.603
Partial	2	1	0	1	
Histology					
Clear cell RCC	11	5	2	4	0.085
Papillary RCC	2	0	2	0	
Nuclear grade					
G1/G2	12	4	4	4	0.449
G3	1	1	0	0	
Stage					
pT1	6	3	1	2	0.593
pT2/pT3/pT4	7	2	3	2	
Lymphovascular invasion					
0	2	1	1	0	0.603
1	11	4	3	4	
Lung metastasis					
No	3	1	2	0	0.267
Yes	10	4	2	4	
Bone metastasis					
No	8	2	4	2	0.180
Yes	5	3	0	2	
TKIs					
Sunitinib	8	4	3	1	0.219
Others	5	1	1	3	
Dose intensity (%)					
100	7	2	2	3	0.593
<100	6	3	2	1	
Previous treatment					
No	2	1	1	0	0.603
Yes	11	4	3	4	
Previous TKI treatment					
No	8	4	3	1	0.219
Yes	5	1	1	3	
Previous cytokine treatment					
No	5	3	1	1	0.479
Yes	8	2	3	3	

Table I. Continued.

Clinical characteristics	Total (n=13)	Clinical effect[a] PR (n=5)	SD (n=4)	PD (n=4)	P-value
Previous mTOR inhibitor treatment					
No	10	4	3	3	0.980
Yes	3	1	1	1	

[a]Best response during the 3-month treatment. The P-values were calculated using the Kruskal-Wallis test. PR, partial response; SD, stable disease; PD, progressive disease; RCC, renal cell carcinoma; mTOR, mammalian target of rapamycin.

IL-10, IL-12, IL-13, IL-15, IL-17, eotaxin, basic fibroblast growth factor, granulocyte colony-stimulating factor, granulocyte macrophage colony-stimulating factor (GM-CSF), interferon-γ (IFN-γ), IFN-γ-induced protein 10, monocyte chemoattractant protein-1, macrophage inflammatory protein (MIP)-1α, platelet-derived growth factor (PDGF)-BB, MIP-1β, regulated on activation, normal T-cell expressed and secreted, tumor necrosis factor-α and VEGF were measured twice by BioPlex Pro Human Cytokine 27 Plex assay (M50-0KCAF0Y; Bio-Rad, Hercules, CA, USA). The assay was performed according to the manufacturer's instructions. Briefly, plasma was centrifuged at 15,000 x g for 10 min at 4°C. The samples were then incubated with microbeads labeled with specific antibodies to one of the aforementioned cytokines for 60 min. Following a washing step, the beads were incubated with the detection antibody cocktail, with each antibody specific to a single cytokine, for 30 min. After another washing step, the beads were incubated with streptavidin-phycoerythrin for 10 min, washed again and the concentration of each cytokine was determined using the array reader. The samples were tested in duplicate on a 96-well plate alongside the standard curve used to generate the results. Unknown concentrations were calculated from a standard curve generated from Bio-Rad supplied standards.

Statistical analysis. The correlation between clinical and cytokine data was analyzed by analysis of variance (ANOVA) and Tukey-Kramer's test using JMP software, version 10.0.0 (SAS, Institute, Cary, NC, USA).

This study was approved by the Institutional Ethics Committee of the Faculty of Medicine and Graduate School of Medicine of the University of Tokyo (no. H22-23-400).

Results

Patient characteristics. A total of 13 patients (8 treated with sunitinib, 1 with sorafenib and 4 with axitinib), including 11 men and 2 women, with a median age of 63 years (range, 50-77 years), were recruited in this study (Table I). The performance status was 0 in 8 and 1 in 5 cases. Eight tumors were located in the right and 5 in the left kidney. Radical nephrectomy was performed in 11 and partial nephrectomy in 2 patients. Histologically, the tumors were diagnosed as 11 clear cell RCCs and 2 papillary RCCs. All the patients had developed metastasis, with the most common metastatic site being the lung (10 cases), followed by bone (5 cases).

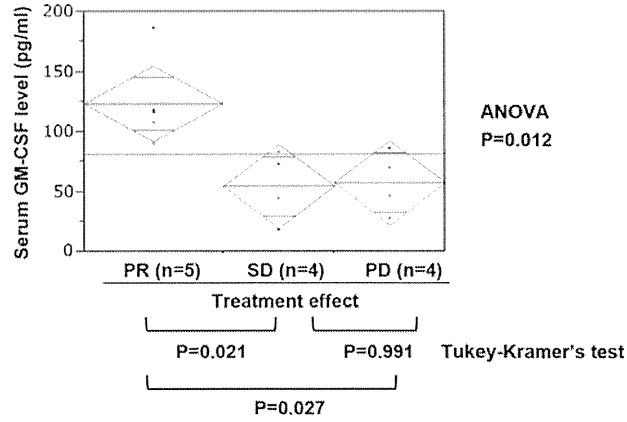

Figure 1. Comparison of serum granulocyte macrophage colony-stimulating factor (GM-CSF) levels among patients who achieved partial response (PR), stable disease (SD) or exhibited progressive disease (PD) after treatment with tyrosine kinase inhibitors. ANOVA, analysis of variance.

Treatment. Two cases received TKI treatment as first-line therapy. Previous systemic treatment included TKIs in 5, mammalian target of rapamycin (mTOR) inhibitors in 3 and cytokines in 8 patients. PR was achieved in 5 cases (38%), SD in 4 (30%) and PD developed in 4 cases (30%). The dose was reduced in 6 patients (46%) due to adverse events.

GM-CSF plasma levels by treatment response. No clinical parameters exhibited a significant correlation with treatment effect (Table I). Among the 27 investigated cytokines, the plasma GM-CSF level in PR cases was significantly higher compared to that in cases with SD or PD (Fig. 1, ANOVA, P=0.012; Tukey-Kramer's test: PR vs. SD, P=0.021; PR vs. PD, P=0.027; and SD vs. PD, P=0.991). The IL-6 level was higher in PD cases, but the difference was not statistically significant (Table II, P=0.141).

Discussion

We demonstrated that plasma GM-CSF may be a predictive marker of the response to TKI treatment. Thus far, only a few studies demonstrated the clinical utility of GM-CSF. The

Table II. Correlation between the clinical effect of tyrosine kinase inhibitors and cytokine levels in patients with metastatic renal cancer.

	Clinical effect			
Cytokines	PR	SD	PD	P-value
GM-CSF	123±36	54±29	57±25	0.012
IL-1β	3.8±4.6	1.9±1.2	1.6±0.2	0.494
IL-1ra	103±98	57±43	60±22	0.536
IL-2	5.2±2	4.8±3.1	5±3	0.971
IL-4	5.6±2.3	4.8±1.8	5.1±2.2	0.864
IL-5	1.1±1.4	0.7±0.8	0.6±0.8	0.791
IL-6	6±2.3	5±2.6	12±8.9	0.141
IL-7	5.3±1.9	4.8±4.9	3.1±2.2	0.605
IL-8	25±13	29±33	19±12	0.779
IL-9	44±12	26±8.8	29±15	0.125
IL-10	4.2±2.9	3.4±1.1	6.4±5.7	0.525
IL-12	19±17	17±15	32±37	0.658
IL-13	5.2±3.9	5.1±3.1	5.1±2.4	0.990
IL-15	5±1.6	3.6±2.3	4.2±0.6	0.479
IL-17	56±15	41±16	59±41	0.613
Eotaxin	183±152	128±126	112±61	0.667
FGF-basic	51±14	42±12	55±22	0.554
G-CSF	66±19	52±18	59±13	0.527
IFN-γ	610±893	207±94	178±21	0.462
IP-10	2,381±1,857	1,386±749	1,906±1,432	0.616
MCP-1	82±68	41±16	47±22	0.388
MIP-1α	2.9±1.1	7.7±12	2.9±1.7	0.561
PDGF-BB	309±306	862±146	213±128	0.508
MIP-1β	178±43	174±141	128±79	0.703
RANTES	3,364±138	2,630±763	2,679±771	0.523
TNF-α	88±92	62±47	43±6.9	0.580
VEGF	108±62	122±79	165±143	0.683

The results are expressed as mean ± standard deviation (pg/ml) and the P-values were calculated using analysis of variance. PR, partial response; SD, stable disease; PD, progressive disease; GM-CSF, granulocyte macrophage colony-stimulating factor; IL, interleukin; FGF, fibroblast growth factor; G-CSF, granulocyte colony-stimulating factor; IFN-γ, interferon-γ; IP-10, IFN-γ-induced protein 10; MCP-1, monocyte chemoattractant protein-1; MIP, macrophage inflammatory protein; RANTES, regulated on activation, normal T-cell expressed and secreted; PDGF, platelet-derived growth factor; TNF-α, tumor necrosis factor-α; VEGF, vascular endothelial growth factor.

plasma GM-CSF level was found to be higher in cervical cancer patients compared to healthy controls (13), while in another study GM-CSF was undetectable in non-cancer patients (14).

GM-CSF promotes the differentiation and expansion of myeloid-derived suppressor cells (MDSCs) (15,16). Antigen-specific $CD8^+$ T-cell tolerance, induced by MDSCs, is known to be one of the main mechanisms of tumor escape (17). Knockdown of GM-CSF in tumor cells may reverse the cytotoxicity to CD8 T lymphocytes: Dolcetti *et al* (15) found that lack of GM-CSF release from 4T1 mammary carcinoma cells reduced the accumulation of $Gr\text{-}1^{int/low}$ MDSC subsets and successfully inhibited tumor-induced tolerance in mice. Similarly, Serafini *et al* (16) demonstrated that inhibition of MDSC function abrogates the proliferation of regulatory T cells and tumor-induced tolerance in antigen-specific T cells, using the A20 B-cell lymphoma model *in vitro* and *in vivo*. However, TKIs may reduce the number of MDSCs in the tumor and normalize T-lymphocyte function: Xin *et al* (18) demonstrated that sunitinib directly induced RCC tumor cell apoptosis through Stat3 inhibition, which was accompanied by a reduction in MDSCs and tumor-infiltrating regulatory T cells.

These reports suggest that high levels of plasma GM-CSF may promote the function of MDSCs and escape of tumor cells from the host immune system. In patients with high GM-CSF levels, TKIs may decrease the function of MDSCs that is upregulated by GM-CSF and reverse the cytotoxicity of regulatory T lymphocytes directly or indirectly, which may lower tumor-induced tolerance and result in favorable treatment effects.

In our study, VEGF was not found to be significantly associated with treatment effect, contrary to previous reports (4,5). GM-CSF was reported to induce VEGF release from the epithelium, resulting in the promotion of carcinogenesis: Wang *et al* (19) demonstrated that, in a colitis-associated cancer model, blocking GM-CSF activity *in vivo* significantly decreased epithelial release of VEGF and abrogated cancer formation. In the plasma, GM-CSF, which is upstream of VEGF, may be a more sensitive biomarker for metastatic RCC treatment compared to VEGF.

As regards other biomarkers, Tran *et al* (20) screened pretreatment cytokines and angiogenic factors in patients with metastatic RCC who received pazopanib treatment and found that high IL-6 was predictive for unfavorable progression-free survival. In our study, IL-6 was also higher in PD cases, but the difference was not statistically significant.

This study had certain limitations. First, this was a single-institution study; and second, our sample size was limited.

In conclusion, high pre-treatment plasma levels of GM-CSF, which is an inducer of immune tolerance, were significantly associated with a favorable response of metastatic RCC to TKI treatment. The result suggests the potential of GM-CSF as a predictive biomarker of the response to TKI treatment. However, further investigation is required to determine the effects of TKIs on abrogating cancer immune tolerance.

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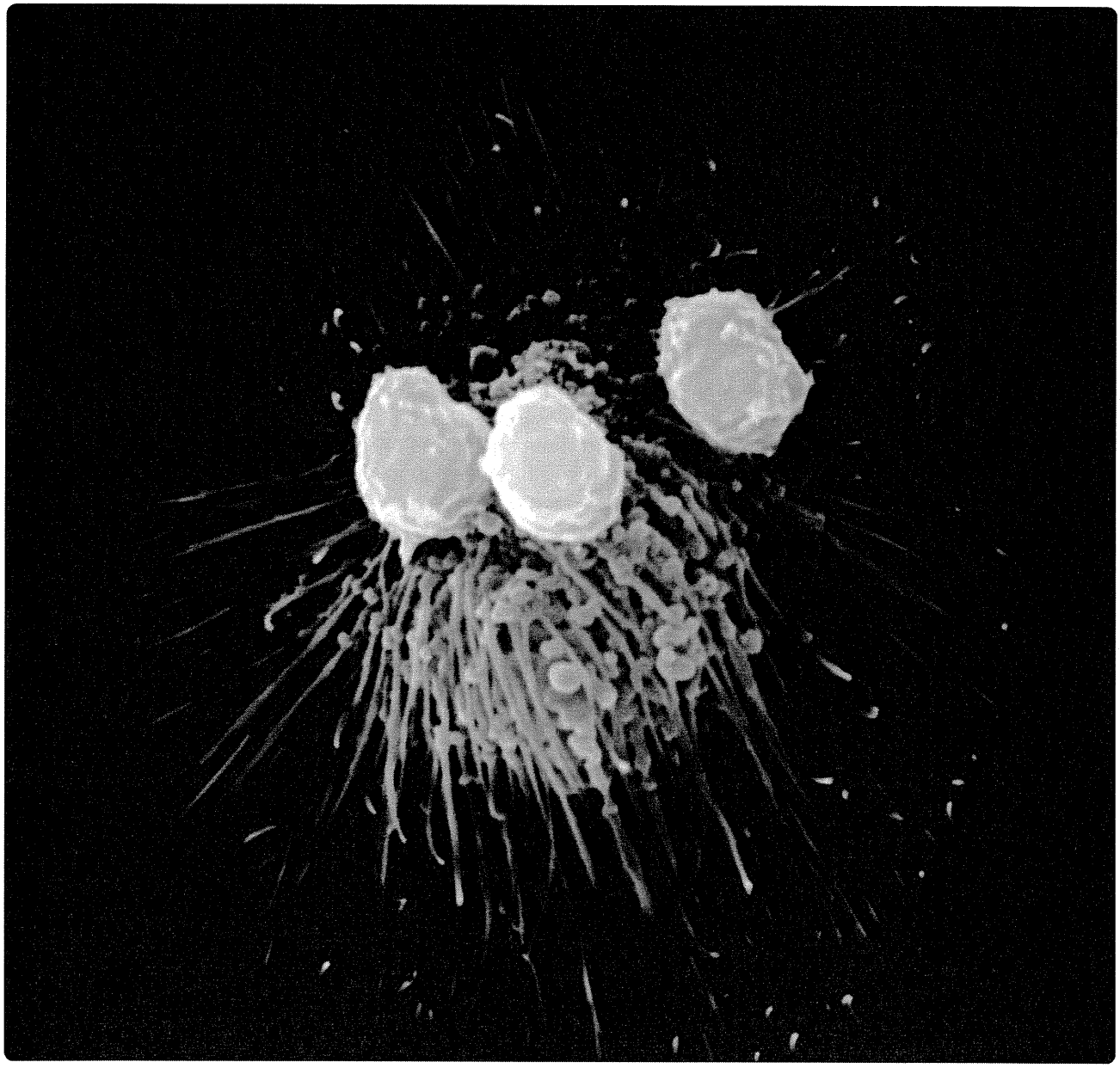

A pilot study of autologous tumor lysate-loaded dendritic cell vaccination combined with sunitinib for metastatic renal cell carcinoma

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RESEARCH ARTICLE Open Access

A pilot study of autologous tumor lysate-loaded dendritic cell vaccination combined with sunitinib for metastatic renal cell carcinoma

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Abstract

Background: Sunitinib, a tyrosine kinase inhibitor currently in use for the treatment of metastatic renal cell carcinoma (mRCC), has been reported to modulate immunosuppressive cells such as myeloid-derived suppressor cells (MDSCs) and regulatory T cells (Tregs) in addition to exerting anti-angiogenic effects. We conducted a clinical trial of dendritic cell (DC)-based immunotherapy together with sunitinib in mRCC patients in an effort to enhance immunotherapeutic efficacy by inhibiting immunosuppressive cells.

Methods: Patients aged ≥20 years with advanced or recurrent mRCC who underwent nephrectomy were eligible for this study. Autologous tumor samples were obtained by surgery under aseptic conditions and used for preparing autologous tumor lysate. About 4 weeks after surgery, leukapheresis was performed to isolate peripheral blood mononuclear cells (PBMCs). DCs were generated from adherent PBMCs in the presence of recombinant human granulocyte macrophage colony-stimulating factor (GM-CSF) (500 IU/ml) and recombinant human IL-4 (500 IU/ml). Autologous tumor lysate was loaded into mature DC by electroporation. Eight patients were enrolled in the study and received sunitinib at a dose of 50 mg p.o. daily for 28 days followed by 14 days of rest. Tumor lysate-loaded DCs were administered subcutaneously every two weeks, with concomitant sunitinib.

Results: No severe adverse events related to vaccination were observed. Sunitinib decreased the frequencies of MDSCs in peripheral blood of 5 patients and of Tregs in 3. Tumor lysate-reactive CD4 or CD8 T cell responses were observed in 5 patients, 4 of whom showed decreased frequencies of Tregs and/or MDSCs. The remaining 3 patients who failed to develop tumor-reactive T cell responses had high levels of IL-8 in their sera and did not show consistent reductions in MDSCs and Tregs.

Conclusions: DC-based immunotherapy combined with sunitinib is safe and feasible for patients with mRCC.

Trial registration: UMIN000002136

Keywords: RCC, Sunitinib, Dendritic cell, Lysate

Background

Renal cell carcinoma (RCC) accounts for 2–3% of all adult cancers. Approximately 20–30% of patients present with metastatic disease. Although surgery is the primary curative therapy for localized RCC, the prognosis for patients with advanced metastatic disease is poor, with a 5-year survival rate of <10% [1,2]. Since the first receptor tyrosine kinase inhibitor (TKI) sorafenib was approved for the treatment of cytokine-refractory metastatic RCC (mRCC), many agents have become available for the treatment of this disease. However, many tumors acquire resistance to these agents by mutating the target genes or activating other pathways that bypass the site of inhibition. This occurs rapidly, often within several months [3]. Therefore, development of other modalities such as immunotherapy is still needed for the treatment of mRCC.

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RCC appears to be one of the most immune-sensitive cancers. This has encouraged the use of immunomodulating treatments such as cytokine-based therapy using IL-2 and/or interferon-α (IFN-α) [4,5]. Nonetheless, nephrectomy is still recommended for patients with mRCC [6], because cytoreductive therapy was shown to provide overall survival benefit in patients treated with IFN-α [7]. Although it is still controversial whether cytoreductive therapy also contributes to the efficacy of TKIs [8], nephrectomy reduces the tumor burden, alleviates symptoms and allows more information on histology to be acquired. In addition, we can utilize the resected tumor as a source of autologous materials, such as tumor lysates, for the production of autologous tumor vaccines. It has been reported that adjuvant treatment with autologous tumor lysate vaccine resulted in a significantly improved overall survival in pT3 stage RCC patients [9]. Antigen-specific vaccination with dendritic cells (DCs) has also been conducted, but with only limited success so far [10-15], possibly due to functionally-defective T cell responses in the tumor microenvironment.

It is well accepted that the tumor microenvironment imposes different degrees of immunosuppression allowing the tumor to evade immune responses [16]. These include the delivery of negative costimulatory signals to T cells (via PD-L1, B7-H4) and production of immunosuppressive factors (eg. IL-10, TGF-β, IDO and others). Recently, promising immunotherapeutic strategies have emerged from our understanding of immunoinhibitory pathways termed "immune checkpoints", which are crucial for maintaining self-tolerance and modulating the duration and magnitude of physiological immune responses. Tumors utilize such immune checkpoints as a resistance mechanism to escape anti-tumor immune responses [17]. Hence, immune checkpoint blockade is a promising approach to activating antitumor immunity. The antibodies that block CTLA-4- and PD-1-dependent interactions have been successfully applied for the treatment of mRCC [18-21].

In addition, different regulatory cell populations, such as MDSCs or Tregs, are involved in this process. The accumulation of MDSCs as well as the suppression of T-cell function in mRCC patients has been reported [22,23]. TKIs such as sunitinib and sorafenib were approved some time ago and are now the mainstay for the treatment of mRCC [24-26]. In addition to its anti-angiogenic effects, sunitinib has been demonstrated to modulate immunosuppressive MDSCs in human [27] and mouse [28]. It has also been reported that sunitinib reverses type-1 immune suppression and decreases Tregs in renal cell carcinoma patients [29]. Furthermore, sunitinib, unlike sorafenib, does not inhibit specific T cell responses [30]. Therefore, sunitinib appears to be a promising molecular target drug for combination therapy together with cancer vaccines for mRCC.

Here, we report the results of a clinical trial in which we evaluated the safety and feasibility of DC-based vaccination combined with sunitinib for mRCC patients and tested whether sunitinib enhances immune responses by reducing immunosuppressive cells.

Results

Patients

Eight patients (5 men and 3 women) with a median age of 68 yr (range, 55–75) were enrolled in this study (Table 1). Two patients were categorized into the MSKCC poor risk group and the other six as having an intermediate risk. One patient (#1808) had unclassified RCC, while the other seven had clear cell RCC. Two patients, #1802 and #1803, received sunitinib or IFN-α and radiation for bone metastasis, respectively, before surgery.

DC Vaccine combined with sunitinib

DCs were successfully generated from all 8 patients (Table 2). Final concentrations of tumor lysate per 10^7 DCs ranged from 0.44 to 1.33 mg (mean value, 0.90 mg). Flow cytometric analysis of the harvested tumor lysate-loaded DCs revealed a phenotype characteristic of mature DCs with high expression of CD40, CD80, CD83, CD86, HLA-ABC, HLA-DR, and CCR7 (Figure 1 and Table 3). While there were some differences in the fluorescent intensities of these molecules among patients' DCs (Additional file 1), the phenotype of these DCs were quite comparable. None of the DC preparations was microbially contaminated. Each patient was given 1×10^7 DCs at each time point, with the exception of one patient (#1823) who received 0.5×10^7 DCs (Table 2). Patients received 6 vaccinations and sunitinib at a dose of 50 mg p.o. daily for 28 days followed by 14 days of rest, according to the schedule (Additional file 2). Vaccination was well-tolerated and no severe vaccination-related toxicity or autoimmune manifestations were observed in any patient.

Frequencies of MDSCs and Tregs in peripheral blood

MDSCs in peripheral blood were evaluated by two criteria (percent of $CD14^-CD15^+$ or $CD33^+HLA\text{-}DR^-$ cells within the $Dye780^-CD45^+$ population) (Additional file 3). In individual patients, decreased percentages of MDSCs were observed in 5 of the 8 patients (#1802, #1803, #1806, #1814, and #1823) by both criteria (Figure 2A and Table 4) compared to pretreatment baseline. No marked changes were observed in patients #1808, #1812 and #1817. Sunitinib significantly reduced the average percentage of $CD14^-CD15^+$ MDSCs in 8 patients from 0.62 ± 1.20% (mean ± SD) at the baseline to 0.083 ± 0.17% at the 6th DC injection ($p = 0.0039$, Wilcoxon signed-rank test); the average percentage of $CD33^+HLA\text{-}DR^-$ MDSCs in 8 patients did not change (2.57 ± 2.86% at the baseline and 3.17 ± 6.73%

Table 1 Patients' characteristics

Patient ID	Age/Sex	Stage	Meta site	MSKCC	Histology	Grade	Prior treatment
1802	72/F	pT3aN2M1	Lung, LN	Poor	Clear cell	2 > 3	Sunitinib
1803	72/M	pT3bN0M1	Liver, lung, bone	Poor	Clear cell	3 > 2	IFN-α, radiation
1806	72/F	pT4N1M1	Lung, LN	Intermediate	Clear cell	3	no
1808	75/M	pT3aN2M1	Lung, LN, bone	Intermediate	Unclassified	3	no
1812	61/M	pT1bN1M1	LN	Intermediate	Clear cell	2 > 1> > 3	no
1814	55/M	pT3aN0M1	Lung	Intermediate	Clear cell	2	no
1817	64/F	pT3bN1M1	Lung, LN, bone	Intermediate	Clear cell	3 > 2	no
1823	57/M	pT1N0M1	Lung, pleura	Intermediate	Clear cell	2 > 3	no

MSKCC, Memorial Sloan Kettering Cancer Center risk criteria; LN, lymph node.

after sunitinib treatment) ($p = 0.23$, Wilcoxon signed-rank test). For Tregs, the percentages of $CD25^+Foxp3^+$ cells within the $Dye450^-CD3^+CD4^+$ population (Additional file 3) were found to be decreased relative to the baseline in patients #1802, #1803 and #1814, but not in patients #1806, #1808, #1812, #1817 and #1823 (Figure 2B). However, there was no statistical difference ($p = 0.273$, Wilcoxon signed-rank test).

DTH reactions and tumor-reactive T cell responses

DTH testing was performed in all 8 patients to detect tumor lysate-reactive responses. Three patients (#1802, #1814 and #1823) had positive DTH reactions (Table 4). Tumor lysate-reactive $CD4^+$ and $CD8^+$ T cell responses in all patients were further investigated in vitro using the IFN-γ secretion assay at different time points after vaccination. Data from an individual patient #1802 are shown in Additional file 3. Before vaccination, the percentage of $CD8^+$ IFN-γ^+ T cells after simulation with EP-DCs or unloaded DCs was essentially identical (1.6%-vs-1.4%, respectively). However, after vaccination, a higher percentage of $CD8^+$ IFN-γ^+ T cells was observed on stimulation with EP-DCs (2.9%) than with unloaded DCs (1.5%). Similarly, a higher percentage of $CD4^+$ IFN-γ^+ T cells was observed on stimulation with EP-DCs (4.5%) than with unloaded DCs (3.0%). These T cell responses fluctuated during the course of treatment and no statistically significant difference in the increase of IFN-γ^+ T cells after vaccination was detected. Figure 2C shows the percentage of tumor lysate-reactive IFN-γ^+ cells (both $CD4^+$ as well as $CD8^+$ T cells) for all 8 patients. When the percentages at any point after vaccination are elevated 3-fold higher than those at the baseline (mean value of the percentages at days 0 and 14), the tumor-reactive T cell responses are considered to be positive. By this criteria, the induction of tumor lysate-reactive $CD4^+$ T cell responses were detected in patients #1802, #1803, #1814 and #1823; patients #1802, #1812, #1814 and #1823 had tumor-reactive $CD8^+$ T cell responses (Table 4). The T cell responses were detected even at the time of registration in Patients #1808 and 1812.

Concentration of IL-8 in the sera

To search for biomarkers predicting responsiveness to combination therapy with sunitinib and DC-based immunotherapy, we analyzed concentrations of IFN-γ, IL-1β, IL-2, IL-4, IL-5, IL-6, IL-8, IL-10, IL-12 p70, TNF-α, and TNF-β in sera from the 8 patients before and during treatment. With the exception of IL-8, which was present at different levels in all patients, serum cytokines were barely detectable. Patients #1806, #1808, #1817 and #1823 had greatly elevated levels of >60 pg/ml IL-8 during treatment (Figure 2D and Table 4), whereas patients #1802, #1803, #1812, and #1814 had basal levels <60 pg/ml.

Table 2 Quality and quantity of tumor lysate-loaded DCs

Patient ID	Tumor lysate used for EP (mg)	DCs used for EP (x10^7)	Tumor lysate (mg)/ 10^7 DCs	Number of DCs injected	Viability (%)
1802	15	29.5	0.51	1x10^7	82.9
1803	15	18.3	0.82	1x10^7	82.1
1806	20	17.1	1.17	1x10^7	92.8
1808	7	16.0	0.44	1x10^7	83.6
1812	20	20.1	1.00	1x10^7	89.0
1814	20	21.5	0.93	1x10^7	91.7
1817	20	20.0	1.00	1x10^7	87.5
1823	20	15.0	1.33	0.5 x10^7	92.4

EP, electroporation.

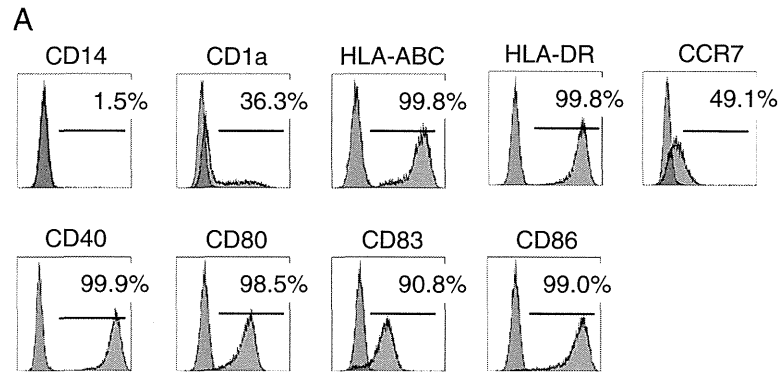

Figure 1 Surface phenotype of DCs; specific mAb staining (red) and isotype control mAb staining (blue).

Clinical responses

The follow-up period ranged from 100 to 1140 days (Table 4). Except for one patient who died of a brain hemorrhage due to hypertension, patients remained alive during the trial with a median overall survival (OS) of 346 days and median progression-free survival (PFS) of 164 days. One patient achieved a complete response (CR), another patient had a partial response (PR), 3 had stable disease (SD) and 2 had progressive disease (PD) according to the RECIST criteria (Table 4). Patient #1814 who achieved the CR was one of three patients who had developed DTH, as well as $CD4^+$ and $CD8^+$ T cell responses. In this patient, the percentages of both MDSCs and Tregs decreased during treatment. In the CT scan, the size of the mass in the left lung decreased from 17.9 mm to 8.2 mm in diameter after 6 immunizations and had disappeared after 10 (Additional file 4). The other patient who had a DTH reaction, #1802, also had $CD4^+$ and $CD8^+$ T cell responses, as well as decreased MDSCs and Tregs, and low IL-8. She manifested SD in spite of multiple tumor metastases in the lung (Additional file 4). Her quality of life was markedly improved by a reduction of the pleural effusion (Additional file 4). As shown in Additional file 4, the tumor volume was decreased and pleural effusion was reduced in patient #1823, who develop also positive DTH, $CD4^+$ and $CD8^+$ T cell responses (Table 4). Patient #1812 was defined as PD when target lesion, supraclavicular lymph node metastasis, was enlarged by 30.3% in size. Therefore, he received surgery to resect the metastatic lymph node and no recurrence was observed with no further treatment.

Safety

The most common adverse events were hand-foot syndrome, stomatitis, peripheral edema and other skin disorders (Table 5). Sunitinib-related severe adverse events were hypertension and hematological and laboratory abnormalities. They were managed with interruption of sunitinib and were reversible in most cases, except for a fatal hypertensive intracranial hemorrhage in patient #1806 who had no brain metastasis. No severe adverse events related to DC therapy were observed.

Discussion

Here we report a clinical trial of DC-based immunotherapy combined with sunitinib in mRCC patients. We evaluated the safety and feasibility of this approach. In the course of treatment, one patient developed cerebral hemorrhage due to hypertension. However, no severe vaccination-related toxicity or autoimmunity was observed in any of the 8

Table 3 The surface phenotype of DCs

Patient ID	% Expression								
	CD14	CD1a	HLA-ABC	HLA-DR	CCR7	CD40	CD80	CD83	CD86
1802	7.8	51.6	98.7	99.7	10.6	99.9	96.4	60.1	96.3
1803	1.4	79.6	99.2	99.9	38.7	99.4	99.1	94.1	99.5
1806	1.5	36.3	99.8	99.8	49.1	99.9	98.5	90.8	99
1808	5.2	53.3	98.8	99.5	43.1	99.4	96.7	75.6	98.7
1812	0.6	83	99.9	99.7	10.3	99.8	99.2	87.4	97.9
1814	0.6	66.5	99.4	99.4	58.3	99.6	98.7	91.5	99.2
1817	1.4	34.7	99.7	98.3	50.3	99.8	96.7	61.8	98
1823	0.8	50.4	99.7	99.6	30.5	99.7	99.3	95.4	99.3

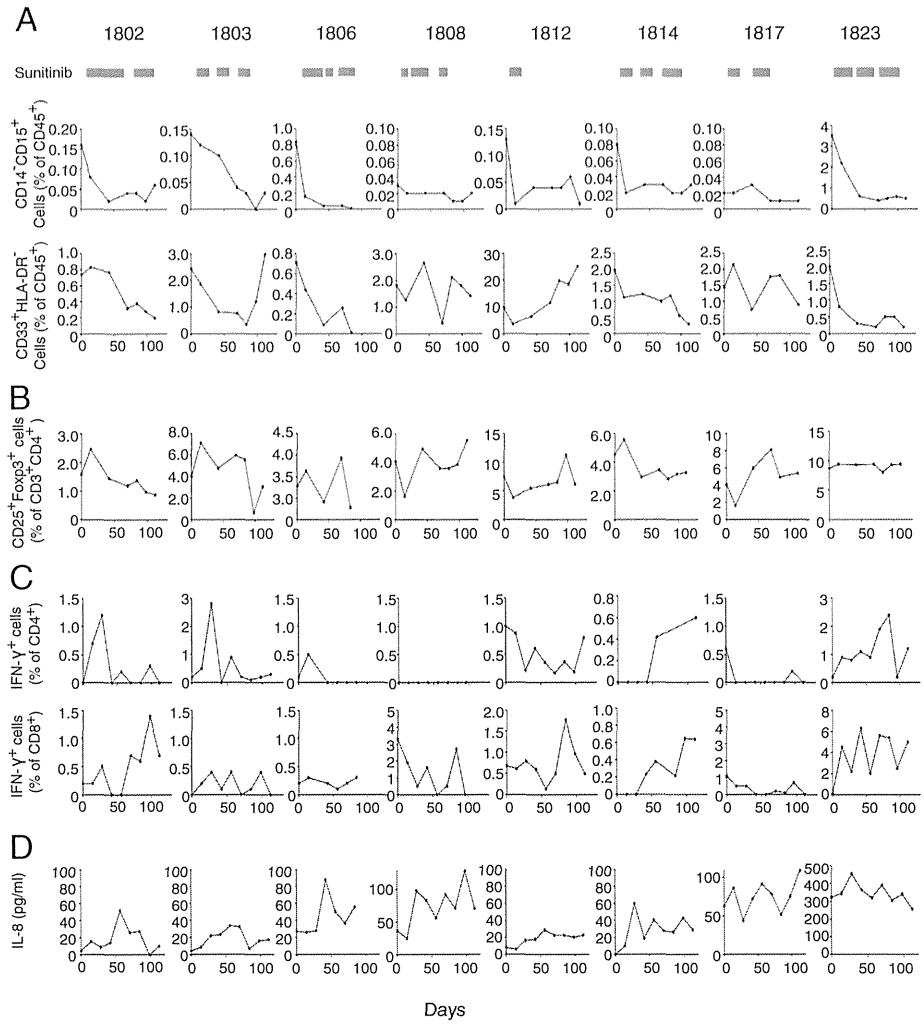

Figure 2 Immunomonitoring. A. Percentages of MDSCs by two criteria. **B**. Percentages of Tregs. **C**. Changes of tumor-reactive IFN-γ$^+$ cells (% of CD4$^+$ or CD8$^+$ T cells). Assay was performed as described in Methods section. **D**. The concentration of IL-8 in sera measured by a cytofluorometry-based ELISA system at different time points during treatment of the 8 patients.

patients treated. Sunitinib decreased the frequencies of peripheral blood MDSCs and/or Tregs. Vaccination with tumor lysate-loaded DCs induced tumor-reactive CD4$^+$ and/or CD8$^+$ T cell responses. The treatment showed some clinical benefits in patients possibly linked to successful control of immunosuppressive cells and induction of T cell responses. This was particularly notable in patient #1814 where lung metastases disappeared. However, there is a possibility that these clinical responses are solely due to sunitinib rather than vaccine-induced immune response, since the DC was given concurrently with sunitinib which is an active drug for the treatment of RCC.

Consistent with previous reports [27,29], we observed reduced percentages of MDSCs during sunitinib treatment, but only in 5 of 8 patients (Figure 2A and Table 4). Of these 5, 4 developed increased tumor-reactive T cell responses. However, the very low number of patients included in this study and the fluctuations in magnitude of T cell responses during the course of treatment make it difficult to conclude the relationship between MDSC and T cell responses. Regarding mechanisms underlying the modulation of MDSCs by sunitinib, it has been shown that this agent inhibits STAT3 signaling. This induces apoptosis in murine MDSCs, where STAT3 is a critical factor responsible for their expansion [31,32]. On the other hand, GM-CSF accumulating in the tumor expands MDSCs to promote sunitinib-resistance due to preferential STAT5 activation, which cannot be suppressed by sunitinib [33]. Thus, to understand the different sensitivity of MDSCs to sunitinib in different mRCC patients, the STAT3 or STAT5 activation status in the MDSCs and expression of cytokines such as GM-CSF in the tumor would need to be investigated.

A decreased percentage of Tregs after sunitinib treatment was also observed, although only in 3 of the 8

Table 4 Immune responses and clinical outcomes in 8 patients

ID	No. DC injection	DTH	CD4 T cell response	CD8 T cell response	MDSCs*	Tregs*	IL-8†	Change in Target Lesions (%)	Clinical Response‡	PFS§(d)	OS§(d)	Prognosis
1802	6	+	+	+	decreased	decreased	low	−25.4	SD	173	339	Dead
1803	6	-	+	-	decreased	decreased	low	0	SD	200	353	Dead
1806	6	-	-	-	decreased	no change	high	−18.4	N.A.¶	100	100	Dead
1808	6	-	-	-	no change	increased	high	−5.4	SD	155	193	Dead
1812	6	-	-	+	no change	no change	low	30.3	PD#	101	1140‖	Alive
1814	12	+	+	+	decreased	decreased	low	−100	CR	347	1127‖	Alive
1817	6	-	-	-	no change	increased	high	−27.8	PD**	88	206	Dead
1823	12	+	+	+	decreased	no change	high	−35.3	PR	342‖	342‖	Alive

PFS, progression free survival; OS, overall survival; CR, complete response; PR, partial response; SD, stable disease; PD, progressive disease.
*Compared to the baseline.
†High or low is defined as more or less than 60 pg/ml in sera.
‡4wks after last injection.
§From the registration (days).
¶Withdrawn from the study by sudden hypertensive cerebral hemorrhage.
‖A censored case due to the termination of the study.
#After surgical removal of target lesion (LN metastasis), no recurrence was observed.
**Though target lesion became smaller, accumulation of pleural effusion was increased.

patients (Figure 2B and Table 4). The mechanism underlying regulation of Tregs by sunitinib remains unclear. It has been proposed that the reduction of Tregs by sunitinib may be an indirect effect of the downregulation of MDSCs and/or increases in IFN-γ production [27]. In our case, reduced frequencies of Tregs were observed in 3 of the 5 patients who did show reduced MDSCs. No reduction of Tregs was seen in a further 3 of 3 patients in whom there was no reduction of MDSCs. Nevertheless, the number of patients was too small to lead to any conclusion.

To identify biomarkers for predicting outcome of combination sunitinib and DC-based immunotherapy, we tested a wide range of cytokines (IFN-γ, IL-1β, IL-2, IL-4, IL-5, IL-6, IL-8, IL-10, IL-12 p70, TNF-α, and TNF-β) in sera from patients before and during treatment. We found IL-8 in all patients, with 4 having highly elevated levels (>60 pg/ml) during treatment. IL-8 is a member of the CXC family of chemokines and is a potent proangiogenic factor [34]. Renal cell carcinoma has been shown to produce IL-8, and IL-8 expression is known to cause mRCC resistance to sunitinib [35,36]. IL-8 angiogenic signaling is thought to functionally compensate for the inhibition of VEGF/VEGFR-mediated angiogenesis. Further, the secretion of IL-8 from cancer cells may have a variety of effects on the tumor microenvironment, because the IL-8 receptors CXCR1 and CXCR2 are expressed on cancer cells, endothelial cells, neutrophils and tumor-associated macrophages. It has been shown that production of IL-8 by tumors induces Treg migration into tumors [36]. IL-8 produced by tumor cells may also recruit MDSCs into tumor sites. Therefore, high IL-8 expression may contribute to shaping the immunosuppressive environment in the tumor and inhibiting tumor-reactive T cell responses. In this study, no reduction of IL-8 was achieved by sunitinib (Figure 2D). Therefore, targeting IL-8 signaling may be required for improving this cancer vaccine.

Cancer immunotherapy based on the regulation of immunosuppressive cells, soluble factors, and signaling pathways are now considered essential element of the treatment of cancer [37]. Similar effects are also achieved by molecular targeted therapy, which primarily aims to inhibit molecular pathways that are crucial for tumor cell growth and survival. Importantly, such small molecule inhibitors may also modulate the immune system, which raises the possibility that targeted therapy might be effectively combined with immunotherapy to improve clinical outcomes [38]. This may indeed be the case in our small pilot study. A reduction of immunosuppressive cells by sunitinib likely contributed to stimulating anti-tumor immune responses induced by tumor lysate-loaded DC vaccines.

Initially 15 patients were planned to be included in this study; we terminate the study with 8 patients reproted here, because other TKIs, pazopanib and axitinib, and mTOR inhibitors, temsirolimus and everolimus, are now available for the RCC treatment in addition to sunitinib and sorafenib. A new pilot study is currently underway to determine the better combination of these molecular target drugs with DC-based immunotherapy. Though our

Table 5 Adverse Events and Laboratory abnormalities

	Grade					
Adverse Events, Regardless of Causality	All	1	2	3	4	5
General disorders						
Fatigue	2		2			
Pyrexia	2	1	1			
Insomnia	1		1			
Gastrointestinal disorders						
Dyspepsia	2		2			
Dysgeusia	2	1	1			
Diarrhea	2	2				
Nausea	1	1				
Esophagitis	1	1				
Respiratory, thoracic and mediastinal disorders						
Cough	1		1			
Musculoskeletal and connective tissue disorders						
Back pain	3	1	2			
Metabolism and nutrition disorders						
Hypothyroidism	4		4			
Skin and subcutaneous tissue disorders						
Hand-foot syndrome	8	2	6			
Stomatitis	4	2	2			
Peripheral Edema	4	3	1			
Anal diseases	3		3			
Skin ulceration	1		1			
Pruritus	1		1			
Trichophytosis	1		1			
Rash	1	1				
Vascular disorders						
Hypertension	3		1	1		1*
Hematological and other laboratory abnormalities						
Anemia	3		1	2		
Leukopenia	3			3		
Neutropenia	3			3		
Lymphocytopenia	3			3		
Thrombocytopenia	3			3		
Increased creatinine	2			2		

*Intracranial hemorrhage.

study has some limitations in that this is a single institution study and sample size was only 8 patients, our results support the notion that immunotargeted therapy represents an appropriate future direction for developing successful treatment of mRCC.

Conclusions

This pilot study of DC-based therapy together with sunitinib for mRCC patients has documented the safety and feasibility of this approach. The reduction of both MDSCs and Tregs was achieved by sunitinib in patients whose serum IL-8 levels were not excessive. Autologous tumor lysate-loaded DCs in combination with sunitinib induced both $CD4^+$ and $CD8^+$ T cell responses in mRCC patients.

Methods

Patient selection

A pilot study of DC-based immunotherapy combined with sunitinib in mRCC patients was conducted. The primary endpoints were the safety and feasibility of this approach; the secondary endpoints were to obtain immunological proof of concept and preliminary data for anti-tumor effect, overall survival (OS) and progression-free survival (PFS). Patients aged ≥20 years with advanced or recurrent mRCC who underwent nephrectomy were eligible for this clinical study of DC therapy combined with sunitinib. To be included, patients had to have an Eastern Cooperative Oncology Group performance status (PS) of 0, 1 or 2, normal kidney, liver, and bone marrow function, and at least 1 measurable cancer lesion assessed by computed tomography. Patients positive for anti-adult T-cell leukemia-associated antigen or anti-human immunodeficiency virus antibody, other primary cancers, uncontrolled infection, active enterocolitis, severe heart disease, severe drug allergy, cryoglobulinemia, or autoimmune disease, were excluded from the study. Those receiving systemic steroid therapy, who were pregnant or lactating, or who had brain metastasis and hypertension were also excluded. The research protocol was approved by the Ethical Committee of our institution and was registered at the University Hospital Medical Information Network Clinical Trials Registry (UMIN-CTR) (Unique trial number: UMIN000002136) on July 2, 2009. Written informed consent was obtained from each patient before they entered the study. The study was performed in accordance with the Declaration of Helsinki.

Generation of DCs

About 4 weeks after surgery, patients underwent leukapheresis to isolate peripheral blood mononuclear cells (PBMCs) using a Fresenius AS.TEC204 with the C4Y white blood cell set. Approximately 5 $\times 10^9$ PBMCs from each patient were allowed to adhere to tissue culture flasks in AIM-V medium (Invitrogen, Carlsbad, CA) at 37°C. After one hour, nonadherent cells were removed by washing with warm medium. To generate immature DCs, adherent PBMCs were cultured in AIM-V for 5 days in the presence of recombinant human granulocyte macrophage colony-stimulating factor (GM-CSF) (500 IU/ml; Berlex Laboratories, Montville, NJ) and recombinant human IL-4 (500 IU/ml; CellGenix Technologie Transfer GmbH, Freiburg, Germany). Immature DCs were then matured by adding GM-CSF (250 IU/ml), recombinant human IL-4 (250 IU/ml), tumor necrosis factor (TNF-α)

(0.01 μg/ml; CellGenix Technologie Transfer GmbH), prostaglandin E2 (PGE2) (1 μg/ml; Sigma, St. Louis, MO) and zoledronate (5 μM; Novartis, Basel, Switzerland) for a further 2 days [39].

Preparation of tumor lysates and electroloading of dendritic cells

Autologous tumor samples were obtained by surgery under aseptic conditions. Tumor tissues were minced with a scalpel in phosphate-buffered saline (PBS). The samples were then lysed by six freezing and thawing cycles, sonicated and centrifuged to produce tumor lysate. Finally the supernatant was filtered using 0.22-μm pore-size filters. The quantitation of total protein was performed using BCA Protein Assay Kit (Pierece Biotechnology, Rockford. IL, USA) according to the manufacturer's instruction. Colorimetric changes were detected by VersaMax microplate reader (Molecular Device Japan, Tokyo, JAPAN) at the wavelength of 562 nm with Softmax Pro software (Molecular Device Japan). Autologous tumor lysate was loaded into mature DCs using a MaxCyte GT electroporation-based system (MaxCyte Inc, Gaithersburg, MD) according to the manufacturer's instructions [40]. Tumor lysate-electroporated DCs, designated EP-DCs, were cryopreserved with 1 ml of autologous serum containing 10% DMSO and stored in liquid N_2 until use.

Immunization schedule

After leukapheresis, patients received sunitinib at a dose of 50 mg p.o. daily for 28 days followed by 14 days of rest. Two weeks after leukapheresis, patients received $1x10^7$ EP-DCs subcutaneously in the deltoid region; DC injection was repeated biweekly six times in total, extended to 12 for one long-surviving patient. For immunomonitoring, peripheral blood was drawn before DC therapy, at each treatment time point and 4 weeks after the last treatment. PBMCs were isolated by density gradient centrifugation using Lymphoprep (Axis-Shield, Oslo, Norway) and stored in liquid N_2 until use. Adverse events were graded according to National Cancer Institute-Common Terminology Criteria for Adverse Events version 4.0. Clinical responses were assessed by computed tomography and classified as complete response (CR), partial response (PR), stable disease (SD), or progressive disease (PD) according to the Response Evaluation Criteria in Solid Tumors (RECIST) criteria, version 1.1 [41].

IFN-γ secretion assay

PBMCs (1×10^6) from each time point and EP-DCs (1×10^5) were thawed and resuspended in AIM-V medium supplemented with 10% heat-inactivated pooled human serum (complete medium), and co-cultured in a 24-well plate at 37°C in a 5% CO_2 atmosphere for 2 days. Recombinant human IL-2 (Chiron, Emeryville, CA) was then added every 2–3 days to a final concentration of 50 IU/ml for another 12 days. The cultured PBMCs were harvested and used as responder cells, as described below. The IFN-γ secretion assay was carried out according to the manufacturer's protocol (Miltenyi Biotec, Bergisch Gladbach, Germany) [42]. Briefly, 1×10^6 responder cells were stimulated with 1×10^5 EP-DCs or mature DCs without electroporation (unloaded DCs) in complete medium for 4 hr at 37°C in a 5% CO_2 atmosphere. The cells were then washed and suspended in 100 μl of cold PBS, and treated with a mouse anti-IFN-γ antibody (IFN-γ catch reagent) (2 μl) for 5 min on ice. The cells were then diluted in complete medium (1 ml) and placed on a slowly rotating device (Miltenyi Biotec) to allow IFN-γ secretion at 37°C in a 5% CO_2 atmosphere. After incubation for 45 min, the cells were washed with cold PBS and treated with Fixable viability dye eFluor 450 (eBioscience, San Diego, CA), PE-labeled anti-IFN-γ (detection reagent), Alexa Fluor 647-labeled anti-human CD3 (Biolegend, San Diego, CA), PC5-labeled anti-human CD8 (Beckman Coulter, Fullerton, CA), and PECy7-labeled anti-human CD4 (Biolegend) mAbs. After incubation for 10 min at 4°C, the cells were washed and analyzed on a Gallios Flow Cytometer (Beckman Coulter).

Tregs and MDSCs

Analysis of Treg percentages in patient PBMC was carried out on thawed samples. Cells were stained in fluorescence-activated cell sorting (FACS) buffer (1× PBS with 2% heat-inactivated fetal bovine serum and 0.02% sodium azide). Nonspecific antibody binding was blocked by pretreatment with Clear Back (Human Fc receptor blocking reagent, MBL, Nagoya, Japan). Cells were stained with Dye450, Alexa Fluor 647-labeled anti-CD3, Alexa Fluor 488-labeled Foxp3, PE-Cy5-labeled CD4, and PE-labeled CD25 Abs according to the instructions for use of the Human Treg Flow Kit (Biolegend). MDSCs were also analyzed by FACS on thawed patient PBMC stained with Dye780, ECD-labeled CD14 (Beckman Coulter), FITC-labeled CD15 (Biolegend), PE-Cy5-labeled CD33 (Biolegend), and PE-labeled HLA-DR (BD Biosciences) Abs for 30 min at 4°C. Cells were washed in buffer and then fixed in 1% paraformaldehyde and analyzed by flow cytometry.

Delayed-type hypersensitivity (DTH)

EP-DCs or unloaded DCs were injected intradermally into different forearms. DTH reactions were evaluated 24 and 48 hours after the 6^{th} injection of DCs and considered to be positive when a skin reaction (>10 mm diameter of erythema) was triggered by EP-DCs but not unloaded DCs.