

Fig. 5 Treatment of NOD/Rag-2/Jak3-deficient mice with bevacizumab (Bv) or tocilizumab (Toc) suppressed the development of PEL in vivo. **a** Photograph of untreated and treated ascites-bearing mice 4 weeks after inoculation with BCBL-1 intraperitoneally. **b** The volume of ascites 4 weeks after inoculation with BCBL-1 cells in mice

is shown as the mean \pm SD of 7 mice. ***P < 0.001 when compared with ascites volume. c Invasion of PEL cells into the organs of BCBL-1-inoculated mice on day 28. Hematoxylin–eosin staining and immunohistochemical staining using anti-LANA (PA1-73 N anti-body) were performed to detect BCBL-1 in the liver and lungs

Discussion

PEL is a highly aggressive lymphoma that is resistant to conventional chemotherapy. Recent studies proposed new

therapeutic strategies for PEL such as inhibition of NF- κ B (Keller et al. 2000), activating TRAIL-mediated apoptosis by IFN- α and azidothymidine (Toomey et al. 2001; Wu et al. 2005), and inducing lytic replication of HHV-8



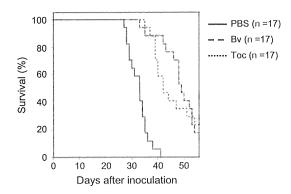


Fig. 6 Overall survival curve. Treatment with bevacizumab (Bv) or tocilizumab (Toc) prolonged survival in vivo

concomitantly with blocking virus production (Klass et al. 2005). These strategies are considered to be effective, but there is no proven standard therapy targeting specific molecules that are related to PEL pathogenesis. PEL has a unique clinical presentation with malignant effusion, causing treatment difficulty; therefore, targeting malignant effusion is a reasonable strategy in the treatment of PEL. We evaluated the efficacy of bevacizumab and tocilizumab in terms of controlling fluid retention. Although a direct antiproliferative effect of bevacizumab or tocilizumab on PEL cells was not observed in vitro (Fig. 2), both mAbs significantly suppressed in vivo ascites formation in a PEL mouse model. Treatment with mouse anti-human VEGF mAb has been reported to inhibit the development of ascites in SCID/beige mice inoculated intraperitoneally with PEL cells (Aoki and Tosato 1999). Our study evaluated the therapeutic effect of a humanized anti-VEGF mAb, bevacizumab, on PEL xenograft NRJ mice by not only the volume of ascites, but also the efficacy for organ invasion and overall survival. Furthermore, we assessed the effect of anti-IL-6 receptor mAb, tocilizumab, on PEL in vitro and in vivo for the first time.

PEL cells produce VEGF and IL-6, and express IL-6R α (Fig. 1); however, the direct anti-proliferative effect of bevacizumab or tocilizumab on PEL cells was not observed in vitro (Fig. 2). These results demonstrated that VEGF and IL-6 are not critical growth factors but other pathogenic factors in PEL cells. In vivo efficacy of bevacizumab and tocilizumab indicates the potential role of VEGF and IL-6 for fluid retention.

IL-6 signaling is characterized by the binding of mammalian forms of IL-6 to membrane-bound IL-6R. The IL-6/IL-6R complex binds and activates gp130, leading to downstream activation of signaling pathways such as the JAK/STAT and MAPK/ERK pathways. Unlike normal cells, constitutively activated Stat3 is detected in a wide variety of human cancer cells, including PEL (Aoki et al. 2003; Al Zaid Siddiquee and Turkson 2008). As depicted in Fig. 3,

tocilizumab decreased VEGF mRNA and IL-6-induced VEGF production. Although Jak2 inhibitor AG490 directly suppressed Stat3 phosphorylation and induced apoptosis in PEL cells (Aoki et al. 2003), tocilizumab inhibited IL-6-mediated Stat3 phosphorylation (Fig. 4a) and Stat3 binding to VEGF promoter (Fig. 4b), inducing no growth inhibition (Fig. 2). We showed that IL-6 increased VEGF via additional Stat3 phosphorylation and Stat3 binding to VEGF promoter in PEL cells. The mechanism of tumor development in AIDS patients is a multistep and multifactorial process. Although the HIV-induced immunocompromised status is obviously involved in the development of PEL, cytokines may also contribute to the pathogenesis. Since the production of IL-6 is induced by HIV (Nakajima et al. 1989; Birx et al. 1990; Scala et al. 1994) and IL-6 increases in the plasma of HIV patients (Breen et al. 1990; Rieckmann et al. 1991), co-infection with HIV is considered to contribute to the pathogenesis of PEL, at least via the production of IL-6.

HHV-8-infected cells secrete not only human IL-6 (hIL-6) but also viral IL-6 (vIL-6). In contrast to hIL-6, vIL-6 does not require hIL-6R for receptor complex formation and signaling initiation (Molden et al. 1997; Osborne et al. 1999; Mullberg et al. 2000). vIL-6 has been also reported to promote VEGF secretion (Aoki et al. 1999); however, vIL-6 is mainly expressed not in latently infected cells but in the lytic lifecycle of HHV-8 infection (Nicholas et al. 1998), and the affinity of vIL-6 to gp130 is one thousand times lower than that of human IL-6 (Aoki et al. 2001). In addition, vIL-6 has been shown to cause the pathogenesis by inducing endogenous IL-6 expression in cell lines from patients with multicentric Castleman's disease (MCD) (Mori et al. 2000) and in transgenic (Tg) mice that constitutively express vIL-6 under control of the MHC class promoter (Suthaus et al. 2012). The production of endogenous IL-6 but not vIL-6 is largely required for the development of the MCD-like phenotype in Tg mice (Suthaus et al. 2012). Taken together, endogenous IL-6 plays an important role in HHV-8-associated diseases and is considered to be a promising therapeutic target, even in the presence of vIL-6.

In conclusion, we have shown the potent efficacy of bevacizumab and tocilizumab against PEL. Although inhibitory effects of tocilizumab on a PEL mouse model other than suppressing VEGF are expected because inhibition of VEGF was not complete in vitro, inhibition of IL-6R could be a promising therapeutic strategy for PEL from its in vivo effectiveness. Our data provide new insights into controlling fluid retention in PEL and the rationale for a clinical study in a single agent or in combination with conventional chemotherapy.

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Conflict of interest The authors have declared that no conflict of interest exists.

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