Measurement of 1,25-Dihydroxyvitamin D₃ Receptors in Breast Cancer and Their Relationship to Biochemical and Clinical Indices

Hedley C. Freake, Gamini Abeyasekera, Junji Iwasaki, Claudio Marcocci, Iain MacIntyre, Richard A. McClelland, Robert A. Skilton, Douglas F. Easton, and R. Charles Coombes

Department of Chemical Pathology, Royal Postgraduate Medical School, Ducane Road, London W12 OHS [H. C. F., G. A., J. I., C. M., I. M.]; Ludwig Institute for Cancer Research [R. A. M., R. A. S., R. C. J] and Institute of Cancer Research [D. F. E.], Royal Marsden Hospital, Sutton, Surrey SM2 5PX, United Kingdom

ABSTRACT

Both normal and malignant breast tissue contain the specific receptor for 1,25-dihydroxyvitamin D₃ (1,25-(OH)₂D₃). A recent study has shown its presence in 80% of surgically removed breast tumors, although only at low levels. We have measured the 1,25-(OH)₂D₃ receptor in breast tumors from 68 patients and have found it at similar frequency (75%) but at much higher concentrations (range, <1 to 30 fmol/mg protein). This receptor has the same characteristics as that measured in classic 1,25-(OH)₂D₃ target tissues and was distinguished by sucrose gradient centrifugation from plasma contaminants. Complete case histories and follow-up were available on 56 of these patients, and 1,25-(OH)₂D₃ receptor status (<8 or >8 fmol/mg protein) was not related to the level of estrogen receptors, menopausal status, T-stage or histology of tumors, or presence of ⁹⁹mTc phosphate hot spots on bone scans. The lack of relationship between the level of 1,25-(OH)₂D₃ receptors and other prognostic indicators suggests its potential as a new independent variable for assessing breast cancer patients. However, at this stage, 1,25-(OH)₂D₃ receptor status did not result in any significant difference in probability of survival or metastasis-free survival. Assessment of the importance of this variable for treatment or outcome must await an increased number of patients and a longer time since surgery.

INTRODUCTION

Breast cancer is characterized by its high incidence, poor prognosis and, in at least 80% of advanced cases, secondary bone involvement (14, 16). The measurement of steroid receptors has become a routine part of the management of the disease, and the presence of estrogen receptors has been correlated with favorable response to endocrine therapy and improved survival prospects (18, 20, 30).

Specific binding of 1,25-(OH)₂D₃⁴ was first demonstrated in breast using a continuous human breast cancer cell line (MCF7) (7). It has since been found in other human breast cell lines (9) and recently, at an incidence of 80% in a series of surgically removed breast tumors (8).

The 1,25-(OH)₂D₃ receptor is also found in lactating (but not virgin) breast tissue (16) where, as in its classic target tissues of intestine, bone and kidney (25), it appears to mediate the transport of calcium (13). The effects of 1,25-(OH)₂D₃ on neoplastic breast tissue in vivo are unknown, although in vitro we have found that physiological doses of 1,25-(OH)₂D₃ stimulate the growth of a human breast cancer cell line (T47D) (10), whereas high concentrations of the hormone inhibit cell division (5, 11).

The previous study on the frequency of the 1,25-(OH)₂D₃ receptor in human breast cancer detected the receptor in 80% of the tumors examined but found no relationships between its presence and any of the other parameters examined, including other steroid hormone receptors (8). However, the 1,25-(OH)₂D₃ receptor was detected only at extremely low levels (mean concentration, 1.9 ± 0.4 (S.D.) fmol/mg protein) using a single saturating dose assay. We have improved the techniques for cytosol preparation, measured the 1,25-(OH)₂D₃ receptor by saturation analysis, and have found much higher concentrations. We have therefore reexamined the relationship between the level of the receptor and other biochemical and clinical indices.

MATERIALS AND METHODS

[³H]-1,25-(OH)₂D₃ (specific activity, 148 to 163 Ci/mmol), [³H]-25-OH-D₃ (specific activity, 110 Ci/mmol), and [2,4,6,7-³H]estradiol (specific activity, 85 to 110 Ci/mmol) were purchased from Amersham International, Buckinghamshire, England. Nonradioactive 25-OH-D₃ and 1,25-(OH)₂-D₃ were the gift of Dr. R. S. B. Ehsanullah, Roche Products, Welwyn Garden City, Hertfordshire, England. All reagents were of analytical grade and were the gift of Dr. R. S. B. Ehsanullah, Roche Products, Welwyn Garden City, Hertfordshire, England. All reagents were of analytical grade and were obtained through commercial suppliers.

Patients. Tumors were obtained from 68 patients with primary breast cancer. Estrogen receptor analysis was carried out on most of these samples, and full history, staging, histology, and follow-up were available in 56 patients.

Patients presenting with primary breast cancer were staged using a standard set of investigations (3) including a Tc phosphate bone scan and treated by mastectomy or local excision and radiotherapy. They were followed up at 3-month intervals until metastatic disease was present.

Tumors. Breast tumors were snap frozen in liquid nitrogen upon removal, and stored in liquid nitrogen for up to 1 year before assay. The only requirements for inclusion in the study were that samples should have histological confirmation of the presence of breast carcinoma tissue and be at least 1 g in weight. This enabled receptor measurements for both 1,25-(OH)₂D₃ and estrogen to be made.

1,25-(OH)₂D₃ Receptor Assay. Samples were chopped with a blade over ice while still frozen and freeze-crushed after cooling in liquid nitrogen using a Braun Mikrodismembrator (F. T. Scientific Instruments, Tewkesbury, Gloucestershire, England). The resultant powder was weighed and taken up in 3 ml ice-cold Tris buffer [10 mM Tris-HCl, pH 7.4 at 4 °C, 0.3 mM KCl, 1 mM ethylenebis(oxyethylenetri)tetraacetic acid, 1.5 mM dithiothreitol, 10 mM sodium molybdate, and Trasylol (200 KIU/ml)]. Cytosols were prepared by centrifugation at 88,000 χ g for 1 hr at 4 °C in the T70 rotor of a Beckman L8-70 ultracentrifuge. Protein was estimated by the method of Lowry (21).
1,25-(OH)2D3 receptor concentration was determined by saturation analysis as described previously (22). Briefly, 200-μl aliquots of cytosol were incubated for 2 hr at 25° in duplicate with increasing amounts of [3H]-1,25-(OH)2D3 (final concentration, 50 to 750 pm) in the presence or absence of 100-fold excess of nonradioactive hormone. No significant degradation of receptor occurred at this temperature. A similar excess of 25-OHD3 was used in parallel incubations to ensure specificity of displacement for 1,25-(OH)2D3. Free hormone was pelleted with dextran-coated charcoal, and bound radioactivity was determined by liquid scintillation counting. Eel liver, a 1,25-(OH)2D3-receptor-positive tissue (22), was included in each assay as a high pool.

Discontinuous 5 to 20% sucrose gradients (w/v, in the same Tris buffer) were prepared, allowed to equilibrate at room temperature, and cooled on ice before use. Tumor cytosols were labeled with [3H]-1,25-(OH)2D3 or [3H]-25-OHD3 with or without 100-fold excess nonradioactive competitors and applied to the gradients as described previously (22). They were centrifuged at 288,000 x g for 14 hr at 4° in the SW55 T1 rotor of a Beckman L8-70 ultracentrifuge.

1,25-(OH)2D3 Receptor Assay. 75% of the 68 tumor cytosols assayed contained greater than 1 fmol/mg protein of the 1,25-(OH)2D3 binding protein, as determined by Scatchard analysis of saturation plots (Table 1). The equilibrium dissociation constant for this binding protein was 1.72 ± 1.53 x 10-10 M. Eel liver was included in each assay as a high pool, and analysis of values obtained for 1,25-(OH)2D3 receptor concentrations in these cytosols showed an interassay coefficient of variation of 25% (flc).

In no case was 25-OHD3 in 100-fold excess able to compete with [3H]-1,25-(OH)2D3 for binding in these cytosols. Sucre gradient analysis of [3H]-1,25-(OH)2D3 and [3H]-25-OHD3 binding in human breast cancer cytosols. Cytosols were incubated with (A) [3H]-1,25-(OH)2D3, or (B) [3H]-25-OHD3 alone (•, A), or with 100-fold excess nonradioactive 1,25-(OH)2D3 (O) or 25-OHD3 (△). Unbound steroid was precipitated with charcoal, and the labeled cytosols were applied to 5 to 20% sucrose gradients and spun at 288,000 x g for 14 hr at 4°. The gradients were divided into 150-μl fractions from the bottom and counted by liquid scintillation. T, top; B, bottom fraction. Sedimentation markers, run in parallel gradients, were [125I]ovalbumin (5.75S) and [14C]bovine serum albumin (4.4S).

RESULTS

1,25-(OH)2D3 Receptor Assay. 75% of the 68 tumor cytosols assayed contained greater than 1 fmol/mg protein of the 1,25-(OH)2D3 binding protein, as determined by Scatchard analysis of saturation plots (Table 1). The equilibrium dissociation constant for this binding protein was 1.72 ± 1.53 x 10-10 M. Eel liver was included in each assay as a high pool, and analysis of values obtained for 1,25-(OH)2D3 receptor concentrations in these cytosols showed an interassay coefficient of variation of 25% (flc = 37.0 ± 9.2 fmol/mg protein; n = 13).

In no case was 25-OHD3 in 100-fold excess able to compete with [3H]-1,25-(OH)2D3 for binding in these cytosols. Sucrose gradient analysis of [3H]-1,25-(OH)2D3-labeled cytosols showed that binding was to a single 3.7S peak, which could be abolished by coincubation with 100-fold excess 1,25-(OH)2D3 but not 25-OHD3 (Chart 1). When cytosols were similarly incubated with [3H]-25-OHD3, a large peak of radioactivity was found in the 6S region (Chart 1). This peak was slightly reduced by coincubation with excess 25-OHD3, but 1,25-(OH)2D3 produced no ablative effect.

Relationship to Estrogen Receptor Content. 63% of the tumors examined were classified as estrogen receptor positive (RC > 10 fmol/mg protein). No correlation was observed between the levels of the 1,25-(OH)2D3 and estrogen receptors in these tumors (Chart 2). Similarly, no relationship was observed between either receptor in the 20 tumors which were homogenized prior to division for assay. Consequently, these have been included in the larger group.

Relationship to Other Indices. Complete histories and follow-up were available in 56 of the original 68 cases, and so possible relationships between 1,25-(OH)2D3 receptor status and other factors were investigated using this number of patients. The 56 cases were divided into 1,25-(OH)2D3 receptor-positive and -negative groups at a cutoff point of 8 fmol/mg protein, chosen on grounds of assay precision. This division gave roughly equal numbers in each group. No relationships were found between 1,25-(OH)2D3 receptor status and menopausal status, tumor histology (infiltrating ductal or other), T-stage of tumor, number of positive nodes, or presence of hot spots on bone scans (Table 2). Similar results were obtained if higher or lower cutoff values of receptor concentration were used (data not shown).
1,25-(OH)2D3 Receptors and Breast Cancer

Chart 2. Relationship between receptor levels for estrogen and 1,25-(OH)2D3 in human breast cancer cytosols. Cytosolic concentrations of the receptors were determined as described in "Materials and Methods" and then transformed logarithmically. ER, estrogen receptor concentration; DR, 1,25-(OH)2D3 receptor concentration, both in fmol/mg protein. There is no significant correlation between the levels of the 2 receptors, r = 0.16.

Table 2
Relationship of 1,25-(OH)2D3 receptor status to other parameters

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Prognosis. We have examined the relapse rate of patients since the biopsy of the primary tumor. Over a 2-year period, 17 patients have relapsed, 11 of whom had 1,25-(OH)2D3 receptor <8 fmol/mg protein, and 6 had a content of >8 fmol/mg protein. Four patients have relapsed with skeletal metastases so far, 2 in each group. Only 8 patients have died, 6 of whom had 1,25-(OH)2D3 >8 fmol/mg protein. The logrank test showed no significant difference in overall survival (p = 0.21) between the 1,25-(OH)2D3 receptor-positive and -negative groups.

The survival curves are shown in Chart 3. In addition, no significant difference in survival or metastasis-free survival was seen by taking levels of 1,25-(OH)2D3 receptor higher or lower than 8 fmol/mg protein as the cutoff point between positive and negative groups (data not shown).

DISCUSSION
Our results confirm that the 1,25-(OH)2D3 receptor is present in human breast tumors and at concentrations higher than was thought previously. Use of Scatchard analysis has shown that this binding protein has an equilibrium dissociation constant very similar to those measured in numerous human and other tissues (1, 6, 10, 22, 25).

The binding protein is selective for 1,25-(OH)2D3 and appears as a single 3.7S peak upon sucrose gradient centrifugation. This eliminates the possibility that the binding seen was due to the DBP, which forms a 6S complex with intracellular actin upon tissue homogenization (29). Incubation of cytosols with [3H]-25-OHD3 showed that the 6S protein was present and in relatively high amounts in comparison with the 1,25-(OH)2D3 receptor but that under the conditions used the dihydroxylated metabolite was not bound to it. It is known that human DBP has a lower affinity for 1,25-(OH)2D3 than it does for 25-OH-D3 (17), and it appears that the tracer amounts of [3H]-1,25-(OH)2D3 used in these studies were not bound by the plasma vitamin D-binding protein-actin complex. This is not the case in rodents, where the 6S protein can mask low concentrations of cytosolic receptor (1). Thus, 1,25-(OH)2D3 receptor measurements can be performed in human normal and neoplastic tissue cytosols, without interference from plasma contamination.

The higher levels of receptor as measured here in comparison to the study of Eiseman et al. (8) are probably attributable to improved recovery due to revised methods of cytosol preparation. Freeze-crushing can produce complete cellular disruption without any elevation of temperature. Other techniques may result in underestimation of the amount of 1,25-(OH)2D3 receptor.
present due to incomplete homogenization of the tough tissue together with inactivation of the labile receptor by local heating. Like other steroid hormone receptors, the unoccupied 1,25-(OH)_{2}D_{3} receptor is unstable, and it seems inevitable that the levels finally measured in a cytosol preparation reflect both the intrinsic receptor content of the tissue and the degree of degradation that occurs during homogenization and assay. However, given the heterogeneity of tumor samples, the levels of receptor measured here are appropriate, relative to those seen both in other 1,25-(OH)_{2}D_{3} target tissues (1, 22, 25) and in breast cancer cell lines (7, 9, 11). Standardization of measurement techniques could speed the assessment of the importance of this parameter.

Estrogen receptors are routinely measured in surgically removed breast tumors. Patients with receptor-positive tumors will probably respond to endocrine therapy (23, 24) and will also survive longer (20, 30) than will those with estrogen-receptor-negative lesions. In common with Eisman et al. (8), we found no correlation between the levels of available receptors for estrogen and 1,25-(OH)_{2}D_{3}. In addition, we have shown that this lack of correlation cannot be ascribed to heterogeneity of individual tumors. There are other important characteristics of patients with primary breast cancer such as menopausal status, isotopic bone scan results, and tumors-nodes-metastasis staging and histological type of the tumor itself.

These parameters were all monitored on 56 patients in this study, and no relationship between them and 1,25-(OH)_{2}D_{3} receptor status was found. Thus, although the number of patients is as yet relatively small, it appears that 1,25-(OH)_{2}D_{3} receptor status represents a new and independent characteristic of breast tumors.

We have attempted to assess the importance of this characteristic by examining the probabilities of survival and metastasis-free survival in patients with 1,25-(OH)_{2}D_{3} receptor-positive and -negative tumors. No difference in either parameter was seen, but given the relatively short time since primary surgery and the number of these patients this is inconclusive. Large differences in survival or metastasis-free survival would not be inconsistent with this data. Therefore, it is too early to say whether the presence of 1,25-(OH)_{2}D_{3} receptors in their tumors influences survival or metastasis-free survival in breast cancer patients.

The pattern of development of metastases is a nonrandom event and may depend on properties of the original tumor cells which enable them to grow in selected tissue environments (27). Breast tumors metastasize with high frequency to bone, and it has been suggested that tumor invasion of bone involves both activation of osteoclasts and direct resorption by tumor cells (15). Certainly, breast cancer cell lines are capable of resorbing devitalized bone in vitro (4). In addition, such cell lines have been shown to be 1,25-(OH)_{2}D_{3} receptor positive (9).

It is possible that the peculiar ability of these cells to grow in bone may be related to their possession of this receptor. It is not known whether the transformed cells also possess other parts of the poorly understood calcium-transporting mechanism that exists in classic vitamin D target tissue such as intestine, bone, kidney (25), and probably breast (13). Interestingly, the VX2 carcinoma, a rabbit tumor which invades bone and is frequently used as a model for bone metastases (15) also possesses the 1,25-(OH)_{2}D_{3} receptor protein (12).

We have shown that near-physiological concentrations of 1,25-(OH)_{2}D_{3} stimulate the growth of a human breast cancer cell line (T47D) in culture (10). Higher doses of hormone inhibit growth (11), and similar inhibition has been reported by Eisman et al. (5). Although in vivo effects remain unknown, it may be that the levels of 1,25-(OH)_{2}D_{3} receptor present may enable us to gain some insight into new approaches for therapy of human breast tumors.

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