Preliminary Correlations of Clinical Outcome with *in Vitro* Chemosensitivity of Second Passage Human Breast Cancer Cells

Helene S. Smith, Wainer Zoli, Annalisa Volpi, Alan Hiller, Marc Lippman, Sandra Swain, Brian Mayall, Charles Dollbaum, Adeline J. Hackett, and Dino Amadori

Geraldine Brush Cancer Research Institute, Pacific Presbyterian Medical Center, San Francisco, California 94115 [H. S. S., A. H.]; Morgani-Pierantoni Hospital, Forli, Italy [W. Z., A. V., D. A.]; Vincent T. Lombardi Cancer Research Center, Georgetown University Medical Center, Washington, DC 20007 [M. L., S. S.]; Department of Laboratory Medicine, University of California, San Francisco, San Francisco, California 94143 [B. M.]; and Peruta Cancer Research Institute, Oakland, California 94609 [C. D., A. J. H.]

**ABSTRACT**

These studies describe the clinical correlations of 63 *in vitro* chemosensitivity assays on breast cancer cells after short-term monolayer culture. Forty-five of the assays were single agent correlations. Based on cut-off values determined empirically, the test accurately predicted resistance for 36 of 41 patients (88%) who did not respond to the drug. It also predicted sensitivity with a high degree of accuracy: 21 of 22 patients (95%) who responded to the drug tested had a sensitive assay. In five cases, two biopsies were evaluated from the same patient. Whenever assays were performed before and after treatment with a given drug, tumor cells from the second biopsy were more resistant in *vitro* if the patient failed on therapy. If the patient did not fail, but stopped therapy for other reasons, or if there was no intervening therapy with the tested drug, the second biopsies remained similar in drug sensitivity. These results suggest that *in vitro* chemosensitivity assays which accurately predict both sensitivity and resistance can be obtained with breast cancer cells after short-term culture and that further prospective trials are warranted.

**INTRODUCTION**

A number of different *in vitro* chemosensitivity assays have been described which have proven to be highly reliable in predicting response of a patient's tumor to chemotherapy (for reviews see Refs. 1–3). All of these assays have in common that tumor cells taken directly from the patient are treated with drugs and then cultured. Unfortunately, the small size of many breast cancer biopsies makes these assays unsuitable for 70 to 80% of breast specimens (2). This problem is likely to become even more acute because (a) breast cancer biopsies will be smaller as early diagnostic modalities are more frequently used; and (b) new laboratory tests for predicting prognosis will require additional specimen material.

One solution to the problem of small breast cancer size is to amplify the available tumor cells by *in vitro* culture prior to testing for drug sensitivity. This report presents preliminary studies evaluating one such system. To obtain sufficient proliferation at first passage in culture, a medium developed specifically for human mammary epithelium (4) was utilized. In this medium, the proliferating cultures are easily trypsinized to single cells which clone with high efficiency when plated on irradiated fibroblasts (5). Analysis of *X*-ray survival curves excluded the possibility that clumps, rather than single cells, were being plated (6). Furthermore, the number of colonies scored was directly proportional to the number of cells plated (5). With this culture system, the vast majority (>70% of primary breast cancers and hypodermal metastases grow well and clone with high efficiency). In contrast, effusion metastases grow rather slowly in primary culture and usually do not clone (7). Other types of cancers, such as colon or non-small cell lung cancers grow poorly and do not clone.

The cells growing in this assay have been extensively characterized. All of the cultures were uniformly positive for keratins (8) and other epithelial markers (5), proving that epithelial, rather than stromal cells, were being cultured. Other criteria consistently distinguished cultures derived from malignant and nonmalignant tissues, including amion invasiveness (9), multinucleation in response to cytochalasin (10), and presence of a tumor-associated glycoprotein (8). Most recently, the assay was used to show that tumor-derived cultures were sensitive to tumor necrosis factor while nonmalignant mammary epithelium-derived cultures were not (11).

The fact that the cells cultured from tumors differ from those of nonmalignant specimens by so many criteria suggests that at least some bona fide tumor cells are in fact being cultured. However, it is likely that only some, less aggressive, tumor-derived subpopulations are selectively grown in the system. Although cells from hypodermal metastases were more abnormal than those from primary breast cancers, cells from both types of lesions showed only minimal karyotypic changes after culture rather than the gross aneuploidies usually associated with carcinomas. In contrast, effusion metastases, a more aggressive manifestation of the disease which usually grew poorly, were uniformly aneuploid (9, 12, 13).

We have undertaken studies to test the hypothesis that accurate predictive chemosensitivity assays could be obtained with this assay even though (a) the cell cycle kinetics differ from the *in vivo* state since all of the cells are cycling after culture; and (b) there is less heterogeneity since only selected subpopulations grow in this culture system. In a previous study (14), response to doxorubicin in this system was examined. A broad range of sensitivities in specimens from previously untreated patients was shown, indicating inherent differences in drug sensitivity even in proliferating cell cultures. That these differences might be clinically meaningful was suggested by the fact that specimens from donors who had failed doxorubicin-containing chemotherapy regimens had dose-response curves that clustered at the more resistant end of the spectrum.

In this report, we present our continuing studies to evaluate the clinical relevance of the assay by extending our observations to other drugs besides doxorubicin and to prospective predictions of sensitivity. We show that the assay predicts both sensitivity and resistance with a high degree of accuracy.

**MATERIALS AND METHODS**

Specimen Material. Specimens were obtained from discarded surgical material or from patients who had excisional biopsies of skin metastases for the purpose of *in vitro* culture after obtaining appropriate informed consent.
IN VITRO CHEMOSENSITIVITY OF HUMAN BREAST CANCER CELLS

Within 24–48 h of plating, tumor cells migrated from the clumps and began to proliferate extensively. By 6–8 days after plating, the combined effect of cell migration and extensive proliferation was a wide area of epithelial cells with extensive mitotic activity surrounding each clump. Very brief treatment with trypsin at this stage resulted in dissociation of contaminating fibroblasts (which also grew poorly in vitro). The next morning, tumor cells harvested from primary cultures was divided by the mean number of colonies per 100 cells which had migrated from the central clump. This process was termed “partial trypsinization.” The dish was then refed and the dish was washed once with basal salts. Each dish was then refed, and hyaluronidase to digest stroma and basement membranes. The digestion was terminated when observation of a sample showed small clumps and single cells. The clumps were either separated from the dissociated stromal cells by filtration with polyester screen filters or plated directly into T-25 flasks (Corning Glass Works, Corning, NY) in an enriched medium (MM) and which consisted of the following: 30% Dulbecco’s modified Eagle medium, 30% Ham’s F-12 medium, 15% conditioned medium from human fetal intestine epithelial cells, 74 ml; 15% conditioned medium from human bladder epithelial cell line, 767B1; 9.5% conditioned medium from human myoepithelial cell line 578 Bst; 0.5% fetal calf serum; 10 μg insulin/ml (Sigma Chemical Co., St. Louis, MO); 5 mg/ml epidermal growth factor (Collaborative Research, Waltham, MA); 10 mM triiodothyronine (Sigma), 0.1 μg hydrocortisone/ml (Sigma), 10 mM estradiol (Sigma), and 1 mg cholecalciferol/ml (Sigma). The cells lines used for producing conditioned media can be obtained from the American Type Culture Collection (Rockville, MD). Alternately, endothelial cells from human umbilical vein (15) or bovine aorta can replace the cell lines as a source of conditioned media.

RESULTS

Three anthracycline derivatives were evaluated: doxorubicin, 4’-epidoxorubicin, and idarubicinol (the active metabolite of 4-demethoxydaunorubicin). Dose-response curves representing sensitive and resistant assays for each analogue are presented in Fig. 1. All of the anthracycline data accumulated for specimens from patients with no prior therapy are illustrated in Fig. 2.

To obtain clinical correlations, specimens were divided into two categories, those clinically sensitive and those clinically resistant to chemotherapy. Patients were considered clinically resistant with either “progressive” or “stable” disease, and
sensitive with either "partial" or "complete" remissions. Samples from clinical sensitive patients were obtained by biopsy immediately prior to a chemotherapy regimen where sensitivity is defined as a partial or complete response to that therapy. For \textit{in vitro} predictions of sensitivity, only single agent therapies were included in the study since one cannot ascertain which drug or drugs in a combination regimen are responsible for a patient's response to multiagent combinations. Samples from clinically resistant patients were obtained in 2 ways: (a) those biopsied immediately prior to treatment with chemotherapy when the patient subsequently showed either stable or progressive disease on therapy (prospective correlation); or (b) those biopsied at the time of therapeutic failure following treatment (retrospective correlation). We evaluated specimens from clinically resistant patients treated with either single or multidrug regimens since patients failing a given combination regimen would be resistant to all drugs in that regimen.

For the anthracycline derivatives, Fig. 3 compares LD$_{90}$ values for samples from previously untreated patients with LD$_{90}$ values for specimens from patients for whom clinical correlations are available. In Fig. 3, the \textit{closed symbols} indicated primary breast cancers while the \textit{open symbols} represent metastases. One metastatic specimen was to lung (indicated in Fig. 3 by **); all others were hypodermal lesions. As defined in Fig. 3 legend, the different symbols indicate whether the correlations were prospective or retrospective and whether the patients were treated with single or multidrug regimens.

For each of the analogues, there was a broad range of LD$_{90}$ values for specimens from patients with no prior therapy. Most of these were primary breast cancers; however, samples of hypodermal metastases from patients with no prior therapy, although fewer in number, showed the same broad range of LD$_{90}$ values. Those samples classified as clinically resistant \textit{in vivo} tended to cluster with LD$_{90}$ values at the resistant end of the spectrum when tested \textit{in vitro}. In contrast, tumors from patients who responded with either complete or partial responses clustered with more sensitive LD$_{90}$ values.

The accumulated correlations for Vinca alkaloids are illustrated in Fig. 4. Preliminary studies in culture indicated that all specimens gave similar LD$_{90}$ values when assayed with vincristine or vinblastine (data not shown). All of the \textit{in vitro} assays were done with one compound, vinblastine. Most of the patients were also treated with vinblastine; however, two received vincristine not vinblastine. Both of these patients were nonresponders; assays of their tumor yielded LD$_{90}$ values of 0.043 \textmu g/ml and $>0.075$ \textmu g/ml. Similar to the anthracyclines, there was a broad range of LD$_{90}$ values for both primary breast cancers and hypodermal metastases from previously untreated patients. All of the cases where patients responded to therapy with \textit{Vinca} alkaloids clustered at the sensitive end of the LD$_{90}$ value spectrum. Most of the specimens from nonresponders had LD$_{90}$ values more resistant than those of the responders. In three cases, the cells were sensitive to vinblastine, but the patients did not show either an objective partial or complete remission. These three cases are considered negative correlations for the assay. Two of these patients progressed on therapy with vinblastine; however, the third had stable disease for 5 months. When this third patient relapsed, a second biopsy was evaluated and found to have a much higher LD$_{90}$ value ($>0.075$ \textmu g/ml) than the first sample (0.013 \textmu g/ml).

Although \textit{cis}-platinum is not usually used to treat breast cancers, response to this drug was also evaluated (Fig. 5). Again, there was the characteristic range of sensitivities among specimens from previously untreated donors. One patient whose tumor showed a marked sensitivity to \textit{cis}-platinum was treated
with this drug and showed a partial response which lasted for 2 months, at which time therapy was changed to carboplatin, a platinum analogue, for 3 cycles with no change for 4 months. This was done because of neurotoxicity from cis-platinum. The biopsy of a second patient who progressed on therapy with cis-platinum analogue, for 3 cycles with no change for 4 months. This was done because of neurotoxicity from cis-platinum. The biopsy with this drug and showed a partial response which lasted for 2 months, at which time therapy was changed to carboplatin, a platinum analogue, for 3 cycles with no change for 4 months. This was done because of neurotoxicity from cis-platinum. The biopsy of a second patient who progressed on therapy with cis-platinum analogue, for 3 cycles with no change for 4 months. This was done because of neurotoxicity from cis-platinum. The biopsy of a second patient who progressed on therapy with cis-platinum analogue, for 3 cycles with no change for 4 months. This was done because of neurotoxicity from cis-platinum.

Fig. 5. Response to cis-platinum of cultured human breast cancer. All of the symbols present in this figure are explained in legend to Fig. 3.

Table 1 Sensitivity assays: two biopsies from the same individual

<table>
<thead>
<tr>
<th>No. of cases</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second biopsy more resistant than first</td>
<td>Taken after treatment failure</td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Second biopsy similar to first</td>
<td>Therapy stopped for cardiac toxicity</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No intervening therapy with tested drug</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

with this drug and showed a partial response which lasted for 2 months, at which time therapy was changed to carboplatin, a platinum analogue, for 3 cycles with no change for 4 months. This was done because of neurotoxicity from cis-platinum. The biopsy of a second patient who progressed on therapy with cis-platinum and VP16 was considerably more resistant to cis-platinum in vitro.

Further evidence supporting the clinical relevance of the assay is summarized in Table 1 which describes cases where two biopsies were evaluated from the same patient. In all 7 cases examined, the results support the conclusion that the in vitro assay accurately reflects the in vivo response. Whenever assays were performed before and after treatment with a given drug, the LD_{90} values always increased if the patient failed on the therapy. If the patient did not fail, but stopped therapy for other reasons, or if there was no intervening therapy with the given drug, the LD_{90} values remained similar.

In Figs. 3 to 5, a threshold is drawn to separate LD_{90} values that correspond to in vitro sensitivity and resistance. These ranges were picked empirically in order to distinguish optimally between clinical responders and nonresponders. As additional data accumulate, it will be possible to define these values more precisely. Using these values, Table 2 summarizes the data.

Among 41 patients who did not respond to therapy, 36 had assays in the resistant range. In contrast, among 22 patients who responded with at least a partial remission, only 1 patient had a resistant in vitro assay. These differences were highly significant (P < 0.01) by the x^2 test. Included in Table 2 are the results for anthracyclines and vinblastine analyzed separately. In each case, x^2 analysis indicated significance. However, the fact that patients who were resistant to multidrug regimens were compared to patients sensitive to single agents might bias the results by artificially increasing the differences between sensitive and resistant. Therefore, Table 2 also summarizes the data comparing only cases treated with the single agent tested in vivo. Although the number of cases is smaller, the conclusions remain the same.

DISCUSSION

These studies describe in vitro chemosensitivity assays on breast cancer cells after short-term culture. Using empirically defined values, the test accurately predicted resistance for 36 of 41 patients whose tumors did not respond in vivo. The test also predicted sensitivity with a high degree of accuracy: 21 of 22 patients, 95% of whom responded to the drug treated, had a sensitive assay. These results suggest that in vitro chemosensitivity assays which accurately predict both sensitivity and resistance can be obtained with breast cancer cells after short-term culture even though (a) the cell cycle kinetics differ from the in vivo state, since all of the cells are cycling after culture; and (b) there is less heterogeneity because only selected subpopulations grow in this culture system.

The negative correlations may be the result of an inherent limitation of in vitro drug sensitivity assays, since there may be pharmacological reasons for a patient's drug response that cannot be measured in vivo. For example, sufficient drug concentrations may not reach the tumor cells in vivo because the tumor has a poor blood supply or the patient may metabolize and excrete the drug at a rapid rate. If the tumor cells themselves are very resistant, even good drug delivery will not help; therefore, in vitro assays may be best for predicting resistance. Predicting sensitivity may be more difficult because such pharmacological issues may prevent response to the drug in some patients with very sensitive tumor cells.

Other studies have defined these cut-off values as the drug levels achievable in vivo (16) rather than empirically defining the cut-off values for sensitivity and resistance. The latter approach does not consider the fact that effective drug concentrations may vary, depending on factors such as drug bound to culture fluid proteins or plastic substrates, or to drug uptake being different in cultured cells compared to cells in vivo. Therefore, we have relied upon the fact that whatever the effects of culture may be, they will be constant; hence, the relative LD_{90} values, regardless of the absolute values, will reflect the in vivo situation.

The simplest way to obtain clinical correlations is to treat patients with the single agent assayed in vitro. However, very few breast cancer patients are treated with single agents. Therefore, patients treated with multidrug regimens were included in clinical correlations, but only if they did not respond or if they responded but subsequently failed prior to biopsy. Unlike other studies (17), patients who responded to combination regimens
were not included. Our rationale is that patients would fail a multidrug regimen only if their tumors were resistant to every drug in the combination. Hence, a resistant assay in vitro would be a positive correlation while a sensitive assay would be a negative correlation. If a patient responded to combination chemotherapy, a resistant assay in vitro for one of the drugs could not be scored as a negative correlation because the patient might be responding to other drugs in the combination. Therefore, considering a sensitive in vitro assay for one of the drugs as a positive correlation overestimates the accuracy of the assay. Furthermore, there is no proof that the patient actually responded to the drug tested.

For all drugs tested, there was a broad range of sensitivities among specimens from previously untreated patients, suggesting that some cancers are inherently resistant to a given drug. Included among these specimens were both primary breast cancers and hypodermal metastases. Since skin metastases showed the same range of sensitivity as primary breast cancers, it may be possible to use data obtained with primary breast cancers to indicate sensitivity of subsequent lesions if there is no intervening therapy with the same drug. Further studies with primary lesions and metastases from the same patient are needed to test this hypothesis.

One advantage of the assay for use in adjuvant trials is that the success rate for culturing primary breast cancers is greater than 70% (5). A similar high success rate has been found for hypodermal metastases. In contrast, although the enriched medium grows effusions and some lymph node metastases in primary culture, we have found that these cultures tend to grow more slowly than the primary tumors and usually do not clone at second passage (7). Hence, further work to improve the culture system is needed if these advanced tumors also are to be utilized for predictive assays. It is noteworthy that the agar clonogenic assay is most successful with effusion metastases and least effective for primary breast cancers and hypodermal metastases (18). Hence, the two assays may complement each other.

The fact that the assay predicts both sensitivity and resistance for breast cancers is an important first step in using the assay clinically. The correlations in the study were found in patients with metastatic breast cancer and the responses seen were all partial responses. Further studies will be required to determine whether utilization of this assay can modify morbidity and survival of patients with metastatic breast cancer and whether the cost versus benefit ratio is sufficiently high to warrant routine clinical application.

Even if it proves useful to predict which drugs will be most effective against metastatic breast cancer, the ability of results from in vitro assays to change the natural history of advanced breast cancer, using currently available drugs, will be limited. Adjuvant therapy has, however, altered the natural history of breast cancer. Unfortunately, only about 20% of the women treated with adjuvant therapy show a prolongation of overall survival (19). It is highly likely that many of those women who recur after adjuvant therapy do so because of the inherent resistance of their tumors to the drugs used. Thus, a long-range goal of these studies is to develop an in vitro assay which can be used to select the optimal drug regimen when other prognostic tests indicate that adjuvant therapy is warranted. The success of the assay in predicting sensitivity suggests that an appropriate study question to consider would be to use this assay to choose between the standard of care alternatives for adjuvant therapy (i.e., anthracycline versus nonanthracycline-based regimens).

ACKNOWLEDGMENTS

We thank Dr. S. Ganzina (Farmitalia, Milan, Italy) for the experimental drug.

REFERENCES


Preliminary Correlations of Clinical Outcome with in Vitro Chemosensitivity of Second Passage Human Breast Cancer Cells

Helene S. Smith, Wainer Zoli, Annalisa Volpi, et al.


Updated version  Access the most recent version of this article at:
http://cancerres.aacrjournals.org/content/50/10/2943

E-mail alerts  Sign up to receive free email-alerts related to this article or journal.

Reprints and Subscriptions  To order reprints of this article or to subscribe to the journal, contact the AACR Publications Department at pubs@aacr.org.

Permissions  To request permission to re-use all or part of this article, contact the AACR Publications Department at permissions@aacr.org.