Mutational Profile of Advanced Primary and Metastatic Radioactive Iodine-Refractory Thyroid Cancers Reveals Distinct Pathogenetic Roles for BRAF, PIK3CA, and AKT1

Julio C. Ricarte-Filho, Mabel Ryder, Dhananjay A. Chitale, Michael Rivera, Adriana Heguy, Marc Ladanyi, Manickam Janakiraman, David Solit, Jeffrey A. Knauf, R. Michael Tuttle, Ronald A. Ghossein, and James A. Fagin

Human Oncology and Pathogenesis Program and Departments of Medicine and Pathology, Memorial Sloan-Kettering Cancer Center, New York, New York

Abstract

Patients with poorly differentiated thyroid cancers (PDTC), anaplastic thyroid cancers (ATC), and radioactive iodine-refractory (RAIR) differentiated thyroid cancers have a high mortality, particularly if positive on [18F]fluorodeoxyglucose (FDG)-positron emission tomography (PET). To obtain comprehensive genetic information on advanced thyroid cancers, we designed an assay panel for mass spectrometry genotyping encompassing the most significant oncogenes in this disease: 111 mutations in RET, BRAF, NRAS, HRAS, KRAS, PIK3CA, AKT1, and other related genes were surveyed in 31 cell lines, 52 primary tumors (34 PDTC and 18 ATC), and 55 RAIR, FDG-PET-positive recurrences and metastases (nodal and distant). Among patients with multiple metastases, 9 of 10 showed between-sample concordance for BRAF or RAS mutations. By contrast, 5 of 6 patients were discordant for BRAF for A logen mutations. AKT1 mutations in one specimen may not reflect the status at other sites because these mutations arise during progression, an important consideration for therapies directed at phosphoinositide 3-kinase effectors. [Cancer Res 2009;69(11):4885–93]

Introduction

Despite the favorable prognosis of well-differentiated thyroid cancer (WDTC), ~5% of them progress to radioactive iodine-refractory (RAIR). [18F]fluorodeoxyglucose (FDG)-positron emission tomography (PET)-positive disease, which commonly leads to death within 5 years. The histology of RAIR, FDG-PET–positive thyroid carcinomas at metastatic and primary sites has been characterized: 50% are poorly differentiated thyroid cancers (PDTC), 23% well-differentiated papillary thyroid cancers (WD-PTC), and 26% tall cell variant PTC (TCV-PTC; ref. 1). Anaplastic carcinomas are invariably RAIR and have a median survival of 0.5 years. Conventional treatment is of marginal benefit for advanced thyroid cancers, emphasizing the importance of developing novel effective therapies.

Progress in our understanding of the genetic alterations underlying the development of thyroid cancer has opened the way for patient-specific therapy by targeting the mutated genes that are causally implicated in this disease. In PTC, nonoverlapping mutations of RET, NTRK, RAS, and BRAF, genes encoding effectors that activate mitogen-activated protein kinase (MAPK), are found in ~70% of cases (2–4). RAS mutations are also found in 50% of follicular thyroid cancers (FTC), which together with PAX8/PPARγ rearrangements are seen in 85% of these tumors (5). PDTC and anaplastic thyroid cancers (ATC) can arise from preexisting WDTC, particularly from PTC. Accordingly, mutations of genes considered to be early events in development of WDTC are also found in PDTC and ATC. Indeed, RET rearrangements and mutations of RAS and BRAF are found in PDTC (13%, 46–55%, and 12–17%, respectively), whereas the latter two have been detected in ATC (6–52% and 25–29%; refs. 6–9). Alterations of effectors of the phosphoinositide 3-kinase (PI3K) signaling pathway, PIK3CA and PTEN, have also been found in thyroid cancer. In contrast to oncogenes encoding MAPK effectors, these genetic alterations are commonly associated with the later stages of thyroid malignant progression, being more frequent in ATC (16% and 14%, respectively) than WD-PTC (2% and 2%, respectively) or FTC (8% and 7%, respectively; ref. 10).

Recently, a transforming mutation (E17K) in the pleckstrin homology domain of the AKT1 gene has been detected in breast, colon, ovarian, and lung cancers (11–13). Alterations of PIK3CA, PTEN, and AKT1 are mutually exclusive in breast cancer (11, 12). To our knowledge, there are no studies examining the prevalence of PIK3CA and AKT1 mutations in PDTC. A single study investigating for AKT1 mutations in FTC and ATC yielded negative findings (14). Compounds that target oncoproteins in the MAPK and PI3K pathways are currently in preclinical and clinical development. It is likely that mapping of genetic alterations in cancer specimens will help determine how patients should be treated. This is particularly important in RAIR cancers, and even more so in those that are also FDG-PET positive, as these are in greatest need of new effective therapies. We designed a thyroid cancer-dedicated platform for matrix-assisted laser desorption/ionization time-of-flight mass spectrometry genotyping (Sequenom) of a comprehensive set of

Note: Supplementary data for this article are available at Cancer Research Online (http://cancerres.aacrjournals.org/).

Requests for reprints: James A. Fagin, Department of Medicine and Human Oncology and Pathogenesis Program, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10065. Phone: 646-888-2136; Fax: 646-422-0075; E-mail: faginj@mskcc.org or Ronald A. Ghossein, Department of Pathology, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10065. E-mail: ghosseiri@mskcc.org.
oncogenic mutations. This method for high-throughput genotyping is very sensitive for detection of sequence alterations (15, 16). This may be important for detection of mutations in advanced thyroid cancers, which commonly have intermingled stromal tissue, including massive infiltration of tumor-associated macrophages (17). Here, we focused on genotyping “druggable” oncogenes encoding signaling effectors in MAPK and PI3K pathways in advanced thyroid cancers.

Materials and Methods

Histopathologic Analysis

Tumors were classified according to WHO 2004 criteria with the exception of TCV-PTC and PDTC. PDTC were defined by proliferative grading features: ≥5 mitoses/10 high-power fields and/or tumor necrosis regardless of architectural pattern (18). This definition differs from the most recent Turin proposal that requires the presence of a solid/trabecular/insular growth pattern in addition to proliferative grading (19). Tumors were classified as TC if they contained ≥50% tall cells. The predominant type of tumor cells present in the PDTC was classified as papillary-like, follicular-like, tall cell, or oncocytic.

Thyroid Cancer Tissues and Cell Lines Studied

We analyzed 52 primary tumors (34 PDTC and 18 ATC) and 55 recurrent and nodal and/or distant metastatic samples from 42 patients with RAIR,FDG-PET-positive thyroid carcinomas diagnosed between 1983 and 2007 at Memorial Sloan-Kettering Cancer Center. We previously characterized the histopathology of 70 patients with recurrent/metastatic RAIR, FDG-PET-positive thyroid carcinomas (1). A patient was deemed RAIR if they had an elevated serum thyroglobulin with structural disease in the setting of a negative radiodiode diagnostic whole-body scan. A patient was entered in the study if (a) he/she had nonradioactive iodine-avid recurrent/metastatic thyroid carcinoma and (b) specimen corresponded to a lesion identified as PET-avid within 2 years of tissue harvesting. Paraffin tissue was available from 42 of 70 patients, which are the focus of the current study. We analyzed 55 samples, including 19 distant metastases at the following sites: bone (5), lung (5), mediastinal lymph node (3), brain (2), skin (2), chest wall (1), and pelvic soft tissue (1); 22 neck lymph node metastases; and 14 recurrences: neck soft-tissue (11) and trachea/esosophagus (3). The study was approved by the Memorial Sloan-Kettering Cancer Center Institutional Review Board. We also used a panel of 31 thyroid cancer cell lines, which were genetically fingerprinted by either single nucleotide polymorphism-comparative genomic hybridization or polymorphic short tandem repeat and verified to be unique (20). All cell lines were grown according to the recommendations of the suppliers and maintained at 5% CO₂ at 37°C.

Nucleic Acid Extraction

When necessary, samples were macrodissected to have at least 50% of tumor cells. Genomic DNA was extracted from formalin-fixed, paraffin-embedded (FFPE) tissues using the PUREGene Genomic DNA purification kit (Genta). DNA from cell lines was extracted using Qiagen DNeasy Blood & Tissue Kit (Qiagen) and RNA was isolated using PrepEase RNA Spin Kit (USB). DNA and RNA from frozen tissues were isolated by AllPrep DNA/Tissue Kit (Qiagen) and RNA was isolated using PrepEase RNA Spin Kit(Gentra). DNA from cell lines was extracted using Qiagen DNeasy Blood embedded (FFPE) tissues using the PUREGene Genomic DNA purification kit (Genta). DNA from cell lines was extracted using Qiagen DNeasy Blood & Tissue Kit (Qiagen) and RNA was isolated using PrepEase RNA Spin Kit (USB). DNA and RNA from frozen tissues were isolated by AllPrep DNA/Tissue Kit (Qiagen) and RNA was isolated using PrepEase RNA Spin Kit(Gentra). DNA from cell lines was extracted using Qiagen DNeasy Blood embedded (FFPE) tissues using the PUREGene Genomic DNA purification kit (Genta). DNA from cell lines was extracted using Qiagen DNeasy Blood & Tissue Kit (Qiagen) and RNA was isolated using PrepEase RNA Spin Kit (USB). DNA and RNA from frozen tissues were isolated by AllPrep DNA/Tissue Kit (Qiagen) and RNA was isolated using PrepEase RNA Spin Kit(Gentra). All cell lines were grown according to the recommendations of the suppliers and maintained at 5% CO₂ at 37°C.

Polymerase (Invitrogen) and analyzed by 2% agarose gel electrophoresis. DNA samples were amplified by PCR using High-Fidelity Taq DNA Polymerase (Invitrogen) and specific primers bracketing the mutation to be analyzed. The purified PCR products were ligated into the pJet1.2/blunt cloning vector using CloneJET PCR Cloning Kit (Fermentas) and the ligation products used to transform DH5α competent bacterial cells (Invitrogen). Positive colonies were screened by colony PCR using High-Fidelity Taq DNA Polymerase (Invitrogen) and analyzed by 2% agarose gel electrophoresis. PCR products of the expected size were sequenced using pJet1.2 sequencing primers.

Screening for RET/PTC and PAX8/PPARγ Rearrangements

We used tumor cDNA as template for quantitative PCR to analyze for unbalanced expression of exons 10 to 11 relative to 12 to 13 of RET, which

---

4 http://www.sanger.ac.uk/genetics/CGP/cosmic/


---

Cancer Res 2009; 69: (11). June 1, 2009 4886 www.aacrjournals.org

Downloaded from cancerres.aacrjournals.org on April 20, 2017. © 2009 American Association for Cancer Research.
flank the rearrangement site in the intron 11. Samples with 12 to 13 > 10 to 11 expression were screened for specific RET recombination events using primers bracketing the respective fusion points of RET/PTC1, RET/PTC2, and RET/PTC3 (22). Positive controls were cDNAs from TPC1 cells (that express RET/PTC1), PClL3 cells expressing RET/PTC2, and a PTC sample expressing RET/PTC3. We screened for the PAX8/PPARγ fusion by RT-PCR using primers for all possible transcripts of PAX8/PPARγ (23). cDNA from FTC samples harboring the rearrangement were used as positive controls. GAPDH was used as internal control. PCR products were resolved by 2% agarose gel electrophoresis and selected cases were sequenced. RET rearrangements were analyzed for all cell lines and in tumors that were wild-type for BRAF or RAS. PAX8/PPARγ was analyzed in all cell lines and primary tumors and in metastatic lesions that were wild-type for BRAF and RAS.

Statistical Methods

Statistical analyses were done using SPSS 14.0 for Windows. Noncontinuous variables were analyzed using Fischer's exact two-sided test and continuous variables were analyzed using unpaired two-sided t tests. Survival analyses were done using Kaplan-Meier log-rank tests. Significance was defined as P < 0.05.

Results

Overall detection of thyroid cancer genetic alterations in cell lines and human tissues. We used mass spectrometry to screen for 111 known mutations in 16 cancer genes. In addition, RET/PTC and PAX8/PPARγ fusion oncogenes were evaluated by quantitative PCR using cDNA as template. We analyzed 31 human thyroid cancer cell lines, 52 primary thyroid cancers (34 PDTC and 18 ATC), and 55 recurrent/metastatic samples from 42 patients with RAIR, FDG-PET-positive thyroid carcinomas. Altogether, we found 122 genetic alterations: these corresponded to 22 of 31 (71%) RET, HRAS, KRAS, NRAS, BRAF, PIK3CA, AKT1, and MET. Many of the mutations found by mass spectrometry (all 9 PIK3CA, 9 AKT1, and a fraction of the RAS- and BRAF-positive tumors and cell lines) were also analyzed by Sanger sequencing to validate the assays. Sequencing and mass spectrometry were 100% concordant for BRAF and RAS mutations. PIK3CA and AKT1 mutations were missed by Sanger sequencing in 11% and 60% of the samples, respectively, indicating that matrix-assisted laser desorption/ionization time-of-flight genotyping was more sensitive in finding mutations. We subcloned PCR products from AKT1 and PIK3CA-mutated samples missed by the Sanger approach and sequenced ~20 to 30 clones of each and found that this technique detected as few as 8% (2 of 24 clones) of mutated cells in a specimen (Fig. 1).

Many of the alterations found in the cell lines have been previously reported and were useful as positive controls for optimization of our genotyping platform (Supplementary Table S2). Cell line oncogene mutations not previously reported included BRAF_T1799A in T235, T238, and KTC2; NRAS_A182G in Hth7 and TT2609-C02; HRAS_C181A in Hth-112; MET_C3029T in ML1; and PIK3CA_G162A in T238. Twenty-one of 31 (68%) thyroid cell lines have a genetic alteration in the MAPK pathway, with BRAF_T1799A being the most common (11 of 31, 35%). None of the MAPK alterations overlapped in the cell lines. We also found 3 PIK3CA mutations in cell lines, which overlapped with BRAF mutation in all cases. A MET_C3029T mutation was found in the ML1 FTC cell line and in one case of ATC. The functional consequence of this alteration in the juxtamembrane domain of MET is controversial, because it has been reported as a somatic mutation conferring tumorigenic advantage (24) and as a germ-line polymorphism (25). Two mesothelioma cell lines harboring this mutation were more sensitive to the MET inhibitor SU11274 than wild-type cells (26). By contrast, we found that growth of ML1 cells was refractory to growth inhibition by SU11274 (IC50 > 10 μmol/L; data not shown).

We also screened for an activating mutation in exon 2 of MEKI (G171T), recently reported in 1% of lung cancers and shown to confer sensitivity to MEK inhibitors. None of the cell lines, primary or metastatic tumors, had this mutation (27). We also screened 13 thyroid cancer cell lines and 36 primary or metastatic PDTC for mutations at 11 additional sites in exons 11 and 15 of BRAF as well as 26 KIT alterations previously found in other cancers. No mutations were found, suggesting that these particular alterations are absent or uncommon in thyroid cancer.

Genotype of primary PDTC and ATC. The genetic alterations found in primary PDTC and ATC are shown in Fig. 2 and Supplementary Table S3. Eight of 18 ATC were derived from PTC (4 TCV and 4 WD), whereas 10 were of unknown origin. PDTC derivation was as follows: 23 of 34 PTC (2 TCV and 21 WD), 7 of 34 FTC, 3 of 34 Hurthle cell carcinomas (HCC), and 1 mixed HCC/PTC (Supplementary Table S3). MAPK changes were present in 25 of 34 (74%) PDTC and 12 of 18 (67%) ATC. We found H/K/N-RAS mutations to be much more prevalent (44%) in PDTC than BRAF mutations (12%; P = 0.002). Moreover, patients with RAS-positive PDTC had a median survival of 6.6 years compared with 3.3 years for BRAF (P = 0.08). Accordingly, BRAF-mutated PDTC were associated with extrathyroidal extension (P = 0.04), whereas RAS mutations were robustly associated with absence of extrathyroidal extension (P = 0.002), consistent with an opposing role of these oncogenes on key prognostic variables in PDTC. Although ATC patients have a rapidly fatal outcome irrespective of tumor genotype, BRAF mutations were more common in this aggressive histotype (44%) than in PDTC (12%; P = 0.02). Six of 34 (17%) PDTC had unbalanced expression of RET exons 10 to 11 versus 12 to 13. One of these cases had a RET/PTC3 rearrangement, whereas the others probably carry RET rearrangements other than RET/PTC1, RET/PTC2, or RET/PTC3 (Supplementary Fig. S1). RET-positive tumors were not associated with differences in survival compared with other groups, although they were associated with extrathyroidal extension (P = 0.01). Five cases of RET/PTC-positive PDTC were derived from PTC and one from a HCC. None of the ATC had RET rearrangements and none of the PDTC or ATC had PAX8/PPARγ fusion oncogenes.

Histology and genotype of recurrent and metastatic RAIR thyroid cancers. There were 55 recurrent/metastatic samples from 42 patients with RAIR disease (Table 1). Their histology was as follows: 32 of 55 (58%) PDTC, 12 of 55 (22%) TCV-PTC, 7 of 55 (13%) WD-PTC, 3 of 55 (5%) HCC, and 1 of 55 (2%) ATC. Overall, 33 of 42 (79%) patients and 44 of 55 (80%) samples had at least one mutation. BRAF mutations were the most frequent, being found alone or associated with another mutation in 62% of the samples, followed by AKTI (16%), RAS (13%), PIK3CA (5%), and RET/PTC (4%). The mutation frequency in recurrent/metastatic samples according to histologic subtype is shown in Table 1 and Supplementary Table S4. BRAF mutations were the most common...
genetic alteration in PDTC (15 of 32, 47%) and PTC (18 of 19, 95%), the latter including both WD-PTC and TCV-PTC. No differences in genotype were found when comparing recurrences or nodal metastases against distant metastases.

Histology and genotype of FDG-PET–positive recurrent/metastatic lesions. Table 2 shows the histotype and mutational analysis of the 35 recurrent/metastatic RAIR tumors that were also FDG-PET positive. BRAF was the most frequently mutated gene, being present in 19 of 35 (54%) samples followed by RAS (11%). BRAF mutations were detected in all 9 (100%) FDG-PET–positive recurrent/metastatic PTC samples and 9 of 23 (39%) FDG-PET–positive PDTC specimens. All 13 (100%) recurrent/metastatic FDG-PET–positive carcinomas containing significant amount of tall cells (TCV-PTC and some PDTC) harbored BRAF mutations, whereas only 6 of 22 (27%) FDG-PET–positive lesions without tall cell features displayed BRAF mutations ($P = 0.00002$).

There was a reciprocal relationship in BRAF and RAS mutation frequency between primary PDTC and FDG-PET–positive PDTC. In primary PDTC, RAS > BRAF (44% versus 12%; $P = 0.002$), whereas BRAF > RAS in FDG-PET–positive PDTC (39% versus 13%; $P = 0.04$; Fig. 2). One RET/PTC2 and one RET/PTC3 were found among the PET-positive PDTC. These were the only RET alterations found in all 55 RAIR recurrent/metastatic samples.

Histopathologic and molecular correlations in patients with multiple tumor specimens. Twelve patients had multiple specimens genotyped (Table 3). For mutations of genes encoding MAPK effectors, 9 of 10 (90%) patients had concordant genotype between the different samples. One patient had the same RAS mutation in two metastatic sites. BRAF mutations were present in 9 patients. In 8 of these (89%), the BRAF mutations were present in all tumor sites tested (Fig. 3). Four of the 12 patients with multiple samples also had specimens of the primary tumor. All
four had a \textit{BRAF} mutation in primary tumors and at all metastatic sites. As opposed to the concordance of MAPK genetic alterations between samples of individual patients, mutations of genes encoding PI3K pathway effectors (\textit{PIK3CA} and \textit{AKT1}) were discordant in 5 of 6 patients.

\textbf{\textit{PIK3CA} and \textit{AKT1} oncogenes in advanced thyroid cancer.} Altogether, 9 of 55 (16\%) recurrent/metastatic samples from 42 patients with RAIR, FDG-PET–positive thyroid carcinomas had an \textit{AKT1} G49A mutation (Supplementary Table S4). None of the primary PDTC or ATC or the cell lines harbored this mutation. We found \textit{AKT1} mutations in 6 of 32 (19\%) PDTC, 1 of 3 (33\%) HCC, and 2 of 12 (17\%) TCV-PTC. All but 2 (7 of 9) had a concomitant \textit{BRAF} mutation. This is the first report of \textit{AKT1} mutations in thyroid cancer, and we therefore expanded the analysis to other possible mutation sites and additional samples. The entire exon 1 of \textit{AKT1} was sequenced in all cancer cell lines, PDTC and ATC, as well as 13 follicular adenomas, 12 PTC, and 3 FTC. No further mutations were found. We found 9 samples with \textit{PIK3CA} alterations: 3 thyroid cancer cell lines, 2 primary PDTC, 1 primary ATC, and 3 recurrent/metastatic lesions from patients with RAIR disease: 1 ATC, 1 PDTC, and 1 WD-PTC. \textit{PIK3CA} mutations were found concomitantly with \textit{BRAF} mutations in 8 of 9 cases. Altogether, 15 of 18 (83\%) cases with mutations in \textit{PIK3CA} or \textit{AKT1} also had a \textit{BRAF} mutation. We also designed Sequenom assays for other putative oncogenes in the PI3K pathway discovered as part of the systematic resequencing of other cancer genomes: RHEB-E139K, RPS6KA3-I416V, RPS6KB1-G289E, PIK3R5-R28C, PRKCZ-S514F, IKBKB-A360S, IKBKB-Q611, FRAP1-P2476L, and FRAP1-S2215Y (28, 29). No samples had mutations at any of these sites.

\textbf{Discussion}

The feasibility of using high-throughput matrix-assisted laser desorption/ionization time-of-flight mass spectrometry to genotype patient tumor samples was recently shown in a large survey of multiple tumor types (15). There are few genotyping studies of advanced thyroid cancer, and particularly no comprehensive survey of mutations in primary and metastatic cancers that are RAIR and/or FDG-PET positive, yet these are the tumors most likely to require treatment with kinase inhibitors. These advanced cancers often have features that alter the sensitivity of mutation detection, such as ploidy changes or infiltration with stromal or immune cells (17). We found that sequence alterations present in only 8\% of cells were

\begin{table}[h]
\begin{tabular}{|c|c|c|c|c|c|c|c|c|c|c|}
\hline
\textbf{Histotype} & \textbf{n} & \textbf{BRAF} & \textbf{BRAF-\textit{AKT1}} & \textbf{BRAF-\textit{PIK3CA}} & \textbf{BRAF-\textit{NRAS}} & \textbf{BRAF total} & \textbf{NRAS} & \textbf{HRAS} & \textbf{RET/PTC} & \textbf{AKT1} & \textbf{Unknown} \\
\hline
WD-PTC & 7 (13) & 4 (57) & — & 1 (14) & 1 (14) & 6 (85) & 1 (14) & — & — & — & — \\
TCV-PTC & 12 (22) & 10 (83) & 2 (17) & — & — & 12 (100) & — & — & — & — & — \\
PDTC & 32 (58) & 9 (28) & 5 (16) & 1 (3) & — & 15 (47) & 3 (9) & 2 (6) & 2 (6) & 1 (3) & 9 (28) \\
ATC & 1 (2) & — & — & 1 (100) & — & 1 (100) & — & — & — & — & — \\
All types & 55 (100) & 23 (42) & 7 (13) & 3 (5) & 1 (2) & 34 (62) & 4 (7) & 2 (4) & 2 (4) & 2 (4) & 11 (20) \\
\hline
\end{tabular}
\caption{Histotype and genotype of 55 samples from 42 patients with RAIR recurrent/metastatic thyroid carcinomas}
\end{table}
detectable by mass spectrometry but missed by Sanger sequencing. Whereas BRAF/RAS mutations were generally detected by both methods, PIK3CA/AKT1 mutations were often missed by Sanger sequencing possibly because the latter occurs later in tumor progression, when the cancer cells are heavily intermingled with stromal cells. Alternatively, the PIK3CA or AKT1 mutations may be subclonal. This approach allowed us to screen for a large number of genetic alterations simultaneously with enhanced sensitivity, yielding a more comprehensive view of the oncogenic abnormalities in advanced forms of the disease.

The histologic definition of PDTC is controversial, and the few genetic studies of this disease have shown conflicting information. Our analysis shows that PDTC with BRAF or RAS mutations have distinct biological and clinical behavior. BRAF mutations predict for poor outcome in WD-PTC (30), and we now show that this also applies to PDTC. A previous analysis of RAS in PDTC showed an association of this oncogene with poor prognosis and aggressive behavior (31). Although this article did not genotype cancers for BRAF, this is inconsistent with our observation. This study found a high prevalence of KRAS mutations in PDTC, whereas we found mostly mutations in NRAS. We are confident about the mutation calls, because we had three assays interrogating NRAS_Q61R, and most KRAS assays for mutations in codons 12 and 13 were validated in colorectal tumors with positive controls for these alterations. The differential outcomes of patients harboring cancers with BRAF and NRAS mutations have been also seen in melanomas (32). Although RAS mutations in PDTC indicate a better prognosis, these patients still have a median survival of 6.6 years (1). Currently, there are no effective therapies for tumors harboring

### Table 2. Histotype and genotype of 35 RAIR, FDG-PET–positive recurrent/metastatic cases

<table>
<thead>
<tr>
<th>Histotype</th>
<th>n (%)</th>
<th>BRAF (%)</th>
<th>BRAF-AKT1 (%)</th>
<th>BRAF-PKI3CA (%)</th>
<th>BRAF-NRAS (%)</th>
<th>BRF total (%)</th>
<th>NRAS (%)</th>
<th>HRAS (%)</th>
<th>RET/PTC (%)</th>
<th>AKT1 (%)</th>
<th>Unknown (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WD-PTC</td>
<td>4 (11)</td>
<td>3 (75)</td>
<td>—</td>
<td>—</td>
<td>1 (25)</td>
<td>4 (100)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>TCV-PTC</td>
<td>5 (14)</td>
<td>5 (100)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>5 (100)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>HCC</td>
<td>2 (6)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>PDTC</td>
<td>23 (66)</td>
<td>6 (26)</td>
<td>3 (13)</td>
<td>—</td>
<td>9 (39)</td>
<td>2 (9)</td>
<td>1 (4)</td>
<td>2 (9)</td>
<td>1 (4)</td>
<td>8 (35)</td>
<td>—</td>
</tr>
<tr>
<td>ATC</td>
<td>1 (3)</td>
<td>—</td>
<td>—</td>
<td>1 (100)</td>
<td>1 (100)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>All types</td>
<td>35 (100)</td>
<td>14 (40)</td>
<td>3 (8)</td>
<td>1 (3)</td>
<td>19 (54)</td>
<td>2 (6)</td>
<td>1 (3)</td>
<td>2 (6)</td>
<td>2 (6)</td>
<td>9 (26)</td>
<td>—</td>
</tr>
</tbody>
</table>

**Table 3. Histotype and genotype of 12 patients with multiple tumor specimens**

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Age, sex</th>
<th>Primary</th>
<th>Rec/met #1</th>
<th>Rec/met #2</th>
<th>Rec/met #3</th>
<th>BRAF/RAS</th>
<th>PIK3CA/AKT1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>65, F</td>
<td>PDTC</td>
<td>PDTC BRAF1799T&gt;A</td>
<td>PDTC BRAF1799T&gt;A</td>
<td>NA</td>
<td>Concordant</td>
<td>NA</td>
</tr>
<tr>
<td>2</td>
<td>78, F</td>
<td>PDTC</td>
<td>PDTC BRAF1799T&gt;A</td>
<td>PDTC BRAF1799T&gt;A</td>
<td>NA</td>
<td>Concordant</td>
<td>NA</td>
</tr>
<tr>
<td>3</td>
<td>49, M</td>
<td>TCV-PTC</td>
<td>TCV-PTC BRAF1799T&gt;A</td>
<td>TCV-PTC BRAF1799T&gt;A</td>
<td>NA</td>
<td>Concordant</td>
<td>NA</td>
</tr>
<tr>
<td>4</td>
<td>85, F</td>
<td>TCV-PTC</td>
<td>TCV-PTC BRAF1799T&gt;A</td>
<td>TCV-PTC BRAF1799T&gt;A</td>
<td>NA</td>
<td>Concordant</td>
<td>NA</td>
</tr>
<tr>
<td>5</td>
<td>61, M</td>
<td>HCC</td>
<td>HCC AKT149G&gt;A</td>
<td>HCC no mutations</td>
<td>NA</td>
<td>NA</td>
<td>Discordant</td>
</tr>
<tr>
<td>6</td>
<td>81, F</td>
<td>NA</td>
<td>PDTC BRAF1799T&gt;A</td>
<td>PDTC BRAF1799T&gt;A</td>
<td>NA</td>
<td>NA</td>
<td>Discordant</td>
</tr>
<tr>
<td>7</td>
<td>67, F</td>
<td>NA</td>
<td>PDTC NRAS182A&gt;G</td>
<td>PDTC NRAS182A&gt;G</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>8</td>
<td>65, F</td>
<td>NA</td>
<td>PDTC no mutations</td>
<td>PDTC no mutations</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>9</td>
<td>58, M</td>
<td>PDTC</td>
<td>PDTC BRAF1799T&gt;A</td>
<td>TCV-PTC BRAF1799T&gt;A</td>
<td>NA</td>
<td>Concordant</td>
<td>Discordant</td>
</tr>
<tr>
<td>10</td>
<td>49, F</td>
<td>NA</td>
<td>TCV-PTC BRAF1799T&gt;A</td>
<td>TCV-PTC BRAF1799T&gt;A</td>
<td>NA</td>
<td>NA</td>
<td>Discordant</td>
</tr>
<tr>
<td>11</td>
<td>25, M</td>
<td>NA</td>
<td>WD PTC BRAF1799T&gt;A</td>
<td>AKT149G&gt;A</td>
<td>NA</td>
<td>NA</td>
<td>Discordant</td>
</tr>
<tr>
<td>12</td>
<td>25, F</td>
<td>NA</td>
<td>PDTC HRAS37G&gt;T</td>
<td>PDTC RET/PTC2</td>
<td>PDTC BRAF1799T&gt;A</td>
<td>Discordant</td>
<td>Discordant</td>
</tr>
</tbody>
</table>

**Abbreviation:** NA, not applicable.
BRAF mutations were present in 62% of RAIR recurrent/metastatic thyroid carcinomas and in 54% of these tumors that were also FDG-PET positive. The difference in BRAF positivity between RAIR tumors and thyroid carcinomas in general is even more marked when comparing these two groups by histotype. Indeed, 100% of FDG-PET–positive RAIR PTC were BRAF positive compared with 45% of PTC in general. This is consistent with a high prevalence of BRAF in thyroid cells in vitro (37). Moreover, human thyroid cancers with BRAF mutations show greater reduction of NIS mRNA compared with tumors with other mutations or with no identifiable genetic changes (38). This report is the first to show an inordinately high prevalence of BRAF mutations in tumors with functional evidence of loss of radioactive iodine avidity. In PDTC, RAIR, FDG-PET–positive tumors harbor BRAF mutations in 39% of the samples, whereas BRAF is significantly less frequent (12%) in primary PDTC, which more commonly presented with RAS mutations (44%). The high frequency of BRAF mutation in RAIR, FDG-PET–positive tumors makes BRAF an attractive target for therapy to induce cell death and/or to restore radioactive iodine uptake. The putative success of such therapeutic strategies requires that all metastatic or recurrent tumors in the same patient harbor the same genetic defect. BRAF mutation is an early event in thyroid cancer pathogenesis (reviewed in ref. 39) and likely to be required for the viability of all subclones of the primary tumor. However, genetic heterogeneity between different primary tumors in multifocal FTC has been reported (40, 41) as well as between primary tumors and regional lymph node metastases (42). By contrast, we found that 8 of 9 patients with BRAF–positive cancers had the same BRAF mutation in all tumor sites tested. Primary tumors of 4 of 9 of these patients were available, and in all of them, the BRAF mutation found in the primary tumor was also present in all metastases. This supports the evidence that BRAF is an early event in thyroid carcinogenesis and increases the likelihood that these tumors may be addicted to the oncoprotein.

Most cancers with RET/PTC rearrangements are WD-PTC, which are usually not associated with aggressive behavior. Accordingly, we found only two recurrent/metastatic RAIR tumors harboring RET/PTC oncogenes. Although rare, this information could be of clinical value as treatment selection becomes more individualized, particularly because multikinase inhibitors with potent activity on RET kinase are entering the clinic (43).

By contrast to BRAF, for which primary and metastatic lesions were highly concordant, mutations in PIK3CA or AKT1 were frequently discordant between metastatic samples of the same individuals, consistent with a late acquisition of these oncogenes during tumor progression. Mutations of AKT1 and PIK3CA were mutually exclusive. This is the first report of AKT1 mutations in this disease. The AKT1_T1799A mutation was first detected in breast, colon, ovarian, and lung cancers. It constitutively activates AKT signaling and induces leukemia in mice (15). AKT1 activation is associated with tumor invasion in papillary and follicular subtypes of thyroid cancer (44, 45). Moreover, PI3K/AKT activation has been proposed to play an important role in the development of FTC metastasis in TRp53/53 mice, which have homozygous inactivating mutations of the thyroid hormone receptor β (44).

PIK3CA/AKT1 mutations almost invariably coexisted with BRAF mutations in our study, pointing to possible cooperativity of coactivation of MAPK and PI3K in disease progression. The
PIK3CA alterations found are within the known hotspots, which have been shown to induce AKT phosphorylation and possess strong oncogenic potential (46). We did not find concomitant alterations in RAS and PIK3CA. This association has been reported in a subset of anaplastic cancers (9) but, based on the current analysis, is likely to be comparatively infrequent.

Thus, the genotype of primary thyroid cancers for BRAF is likely to give an accurate account of the status of this oncogene in metastatic or recurrent lesions. BRAF mutations are concordant between primary and metastatic specimens, yet this is not the case for PIK3CA or AKT1, which has implications for our understanding of the sequence of events in thyroid cancer pathogenesis and on how we may apply this information for patient management.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

Acknowledgments

Received 2/24/09; revised 4/1/09; accepted 4/6/09.

Grant support: NIH grant CA50706, Margot Rosenberg Pultzier Foundation, and a Byrne award from Memorial Sloan-Kettering Cancer Center (J.A. Fagin); and CAPES research grant BEX-0644/07-2 (J.C. Ricarte-Filho). The Memorial Sloan-Kettering Cancer Center Sequenom facility is supported by the Arbinder Fund.

The costs of publication of this article were defrayed in part by the payment of page charges. This article must therefore be hereby marked advertisement in accordance with 18 U.S.C. Section 1734 solely to indicate this fact.

References


Mutational Profile of Advanced Primary and Metastatic Radioactive Iodine-Refractory Thyroid Cancers Reveals Distinct Pathogenetic Roles for BRAF, PIK3CA, and AKT1

Julio C. Ricarte-Filho, Mabel Ryder, Dhananjay A. Chitale, et al.


Updated version  Access the most recent version of this article at: http://cancerres.aacrjournals.org/content/69/11/4885

Supplementary Material Access the most recent supplemental material at: http://cancerres.aacrjournals.org/content/suppl/2009/06/03/69.11.4885.DC1

Cited articles This article cites 46 articles, 14 of which you can access for free at: http://cancerres.aacrjournals.org/content/69/11/4885.full.html#ref-list-1

Citing articles This article has been cited by 37 HighWire-hosted articles. Access the articles at: /content/69/11/4885.full.html#related-urls

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.