Abstract

Treating bone cancer pain continues to be a clinical challenge and underlying mechanisms of bone cancer pain remain elusive. Here, we report that EphB1 receptor forward signaling in the spinal cord is critical to the development of bone cancer pain and morphine tolerance in treating bone cancer pain. Tibia bone cavity tumor cell implantation (TCI) produces bone cancer–related thermal hyperalgesia, mechanical allodynia, spontaneous and movement-evoked pain behaviors, and bone destruction. Production and persistence of these pain behaviors are well correlated with TCI-induced upregulation of EphB1 receptor and its ligand ephrinB2 in the dorsal horn and primary sensory neurons. Spinal administration of an EphB1 receptor blocking reagent EphB2-Fc prevents and reverses bone cancer pain behaviors and the associated induction of c-Fos and activation of astrocytes and microglial cells, NR1 and NR2B receptors, Src within the N-methyl-D-aspartate receptor complex, and the subsequent Ca\(^{2+}\)-dependent signals. The exogenous ligand ephrinB2-Fc upregulates level of phosphorylation of NR1 and NR2B receptors depending on the activation of EphB1 receptor. Spinal administration of EphB2-Fc and ephrinB2-Fc induces downregulation of EphB1 and ephrinB2, respectively, accompanied with increased activity of matrix metalloproteinase (MMP)-2/9. Blocking MMP-2 or MMP-9 reverses EphB1-Fc treatment–induced downregulation of EphB1 receptor. In addition, spinal blocking or targeted mutation of EphB1 receptor reverses morphine tolerance in treating bone cancer pain in rats and defensive pain in mice. These findings show a critical mechanism underlying the pathogenesis of bone cancer pain and suggest a potential target for treating bone cancer pain and improving analgesic effect of morphine clinically. Cancer Res; 71(13); 4392–402. ©2011 AACR

Introduction

Bone cancer pain is one of the most common symptoms presented by patients with primary bone sarcomas and predominantly occurs as distant metastases of non-bone primary tumors, notably those in breast, prostate, and lung (1, 2). Tumor cells act to cause pain in many ways. Production of prostaglandin and other molecules by tumors, tumor-derived macrophages, and other host cells stimulate osteoclast-mediated bone resorption. Nociceptors in bone are stimulated via activation of transient receptors potential vanilloid type-1, endothelin A, and TrkA receptor. Activation is directed by acid microenvironment, endothelin-1, and nerve growth factor, respectively (2). Mechanisms of bone cancer pain are complex and may involve a combination of inflammatory and neuropathic pain (2, 3) with unique characteristics. For instance, bone cancer pain markedly increases expression of glial fibrillary acidic protein (GFAP; ref. 4), but not substance P and calcitonin gene–regulated peptide (CGRP) in the dorsal horn (DH) of the spinal cord or galanin and neuropeptides Y in dorsal root ganglion (DRG) neurons (2). Despite decades of thorough study, the specific cellular and molecular mechanisms underlying bone cancer pain remain elusive and the clinical approaches for treating bone cancer pain are limited.

Eph receptors, named for its expression in an erythropoietin-producing human hepatocellular carcinoma cell line, consist of the largest family of receptor tyrosine kinases, which play vital roles in transmitting external signals to the interior of many types of cells. EphB receptors and their ligands ephrins are critical cues in regulating cell shape, adhesion/repulsion, migration, and positioning during developmental processes (5–7). Alteration of mechanisms controlling adhesion and...
motility has a central role in promoting tumor invasion and angiogenesis (8-10). Altered expression of ephrins and/or Eph receptors has been implicated in tumor progression in a number of human malignancies (11-13). Recently, we have found that ephrinB–EphB receptor signaling is involved in pain after nerve injury or opiate withdrawal (14-16). We hypothesized that the ephrinB–EphB receptor signaling might play an important yet unknown role in development of bone cancer pain. EphrinB–EphB interaction is well known to lead bidirectional signals, the forward and the reverse signaling (17). There is no clear evidence if either the forward or the reverse signaling or both is necessary for production and/or persistent of any pain status. Here, we show that the forward but not the reverse signaling of EphB1 receptor in the spinal cord is critical to development of bone cancer pain. Spinal inhibition of EphB1 receptor can relieve bone cancer pain and rescue analgesic effect of morphine in treating bone cancer pain.

Materials and Methods

Animals, anesthesia, drugs, and administration

All animals were used in accordance with the regulations of the ethics committee of the International Association for the Study of Pain and all protocols approved by the Institutional Animal Care and Use Committees. Adult, male, and Sprague-Dawley rats; adult, male, and female CD-1 mice (Charles River Laboratories); and the EphB1−/− and EphB1+/+ mice (Henchemeyer Laboratory at the University of Texas Southwestern Medical Center, Dallas, Texas) were used in this study. All surgeries were done under anesthesia with pentobarbital [Sigma, 50 mg/kg, intraperitoneally (i.p.)]. An EphB1 receptor blocking reagent EphB2-Fc and an EphB1 receptor activator ephrinB2-Fc were used to determine the possible roles of EphB1 receptor in tumor cell implantation (TCI)-induced pain-like behaviors and the associated neurochemical alterations. EphB2-Fc can combine with the endogenous ephrinBs, and thus EphB1 is substituted and cleaved. This may result in inhibition of the downstream signals of EphB1. EphrinB2-Fc can combine with EphB1 receptor activate EphB1 receptor and the downstream signals. Inhibitors for MMP-2 (matrix metalloproteinase; MMP2i) and MMP-9 (FN439) were used to inhibit MMP-2/9 in modulation of EphB1. Each of the drugs was used in PBS or dimethyl sulfoxide (DMSO) and then injected intrathecally (i.t., 10 μL) into rats (by means of lumbar puncture at the intervertebral space of L4–5 and L5–6 for multiple injections). These drugs and their final concentrations were: EphB2-Fc (2 or 5 μg), ephrinB2-Fc (2 μg), FN439 (100 μg), MMP2i (10 μg), DMSO (1%; Sigma-Aldrich), and immunoglobulin (Ig) G-Fc (2 or 5 μg, Jackson Laboratories).

Model of bone cancer pain

Tumor cells were extracted from ascitic fluid of rats that received Walker-256 rat mammary gland carcinoma cells. TCI was mimicked by injecting the cells (1 × 10^5 cells/μL, 5 μL) into the intramedullary space of the right tibia to induce bone cancer in rats (18).

Assessment of bone cancer–related pain behaviors

Thermal hyperalgesia was determined by the significant shortened latency of foot withdrawal in response to heat stimulation. Mechanical allodynia was indicated by a significant decrease in the threshold of paw withdrawal to mechanical indentation of the plantar surface of each hindpaw. The protocols were similar to those described previously (19, 20).

Western blotting

Protein precipitation procedures in conjunction with Western blots were employed to identify temporal expression of EphB1, ephrinB2 protein, and their phosphorylation. Protocols were similar to those described previously (14, 21). EphB1 and ephrinB2 were immunoprecipitated from 2 mg total protein/mL tissue lysate by using an anti-EphB1 antibody [2 μg; Santa Cruz Technology (SCT)] complex with proteine G-agarose (Invitrogen) and wheat germ agglutinin linked to agarose (Sigma), respectively. EphrinB2 and its phosphorylation were detected by anti-ephrinB2 (C20, SCT) and antiphosphotyrosine antibody PY99 (SCT), respectively (22). EphB1 and its phosphorylation were detected by anti-EphB1 antibody (Q20, SCT) and phosphotyrosine antibody 4G10 (Upstate Biotechnology), respectively (23). NR2A immunoprecipitation was done by anti-NR2A antibody followed by adsorption to protein G-beads. Whole-cell protein extracts lysates were used to identify temporal expression of the phosphorylated protein levels of NR1(pNR1), NR2B(pNR2B), Src(pSrc), extracellular signal regulated kinase (ERK; pERK), CaMKII(pCaMKII), cAMP responsive element binding protein (CREB; pCREB), glyceraldehyde 3-phosphate dehydrogenase (GAPDH). The primary antibodies were used including pNR1(Ser897), 1:800 (Millipore); pNR2B(Tyr1472), 1:300 (Chemicon); pSrc(Tyr418), 1:800 (Abcam); pERK1/2(Thr202/Tyr204), 1:500; pCaMKII(Thr286), 1:1,000 (Cell Signaling Technology); GAPDH, 1:1,000 (Sigma); and GFAP and pCREB (Ser133/SCT). The filters were then developed by enhanced chemiluminescence reagents (PerkinElmer) with secondary antibodies (Chemicon). Data were analyzed with a Molecular Imager (Gel DocTM XR, 170-8170) and the associated software Quantity One-4.6.5 (Bio-Rad Laboratories).

Immunohistochemistry

Sections of the spinal cord or DRG tissues were incubated with polyclonal rabbit antibodies of anti-EphB1 (1:20) and anti-ephrinB2 (1:20; SCT) and mouse monoclonal antineuronal nuclear protein (NeuN; 1:100; Alexa Fluor-488 conjugated, MAB377X; Chemicon). Rabbit IgG (1:200; Vector Laboratories) was used as an isotype control. Morphologic details were examined with a confocal microscope (Leica TCS SP2, Germany). The protocols were similar to those described previously (14, 21).

Morphine tolerance tests

Each of CD-1, EphB1−/−, or EphB1+/+ mice were placed on a 55°C hot plate apparatus and the latency to lick a paw was measured following s.c. morphine injection. Protocol for testing acute tolerance (Mor100-10): the latency to lick a paw was measured at 0.5, 1, 1.5, and 2 hours following the
second dose (10 mg/kg, i.p.) administrated 24 hours after the 
first dose of morphine (100 mg/kg). Protocol for testing 
chronic tolerance (Mor10): morphine (10 mg/kg) was injected 
daily for 7 days, and the analgesic effect was measured 30 
minutes after each injection. To examine the role of EphB 
receptor in morphine tolerance, EphB2-Fc (2 μg, i.t.), or its Fc 
control was administrated 30 minutes prior to the morphine 
at 100 mg/kg in acute tolerance or each of the morphine 
injection at 10 mg/kg in the chronic tolerance in CD-1 mice. 

Statistical analyses

SPSS Rel 15 was used to conduct all the statistical analyses. 
Alteration of expression of the proteins detected and the 
behavioral responses to thermal and mechanical stimuli over 
time among groups were tested with 1-way and 2-way ANOVA 
with repeated measures followed by Bonferroni post hoc tests, 
respectively. All data are presented as means ± SEM. Statistical 
results are considered significant if \( P < 0.05 \).

Results

Activity and distribution of EphB1 and ephrinB2 in the 
spinal cord following TCI

Level of protein expression and phosphorylation of EphB1 
receptor and its ligand ephrinB2 in the spinal cord was 
increased significantly in a time-dependent manner after 
TCI, whereas they were at low levels in naive rats (Fig. 1A 
and B). Phosphorylation of EphB1 was slightly decreased on 
the postoperative 21 days, but not altered during postopera-
tive 3 to 14 days because ratio of EphB1 and pEphB1 was 
remained the same. The increased EphB1 and ephrinB2 
immunoreactivity was distributed predominately in the super-
ficial DH ipsilateral to TCI (Fig. 1C). EphB1 immunoreactivity 
was colocalized primarily with neurons (NeuN, red) ipsilateral to TCI. Magnification: 100× (C) and 200× (D).
microglia (Supplementary Fig. S1B). In primary afferent terminals within the DH and the nociceptors within the DRG, ephrinB2 immunoreactivity was colocalized with peptidergic CGRP, but not the nonpeptidergic IB4 fibers and cells (Supplementary Fig. S1C and D). These results show that TCI can cause an upregulation of EphB1 and ephrinB2 expression in the neurons and astrocytes within the DH; the ephrinB2 may originate, at least partly, from the peptidergic CGRP-nociceptive neurons.

Blocking EphB1 receptor activation prevents and suppresses behavioral and neurochemical signs of bone cancer pain

Rats that received TCI exhibited thermal hyperalgesia and mechanical allodynia (Fig. 2). They also exhibited spontaneous pain manifested as guarding and movement-evoked pain manifested as guarding, flinching, and reduced limb use (Supplementary Fig. S2). Production and persistence of these pain-related behaviors were greatly delayed and suppressed by an EphB1 receptor inhibitor EphB2-Fc administrated (each 5 μg, i.t.) on the postoperative 3, 4, and 5 days (A) and C) or 7, 8, and 9 days (B) and D (indicated by the arrows). TCI was done on day 0(A). Eight rats were included in each group. *, P < 0.05 and **, P < 0.01 indicate significant differences compared to the group of control (Sham+Fc). ##, P < 0.05 and ###, P < 0.01 indicate significant differences compared to the corresponding TCI group.

Blocking EphB1 receptor activation suppresses TCI-induced increase of level of pNR1, pNR2B, pSrc, pERK, pCaMKII, and pCREB in the spinal cord

N-methyl-D-aspartate receptors (NMDAR) have a well-developed role in neural plasticity and various pain states. Src family kinases can enhance NMDAR function (24–26) and ephrinB2 may activate NR2B receptor via Src during inflammatory hyperalgesia (27). TCI treatment significantly increased levels of pNR1, pNR2B, pSrc (Tyr418; Fig. 3A), pERK, pCaMKII, and pCREB (Fig. 3B). Timing patterns of upregulation of these phosphorylated molecules were well matched with that of bone cancer pain-related behaviors (see Fig. 2). Repetitive treatment with EphB2-Fc (each 5 μg, i.t., once a day on postoperative 7, 8, and 9 days, respectively) inhibited the expression of these molecules (Fig. 3). Expression of pNR2A was neither altered by TCI nor EphB2-Fc treatment (Fig. 3A). These results suggest that TCI-induced activation of NR1 and NR2B receptors, Src, and the subsequent Ca$^{2+}$-dependent signals may be secondary to activation of the ephrinB–EphB receptor signaling.

EphB2-Fc inhibits TCI-induced increase in expression of EphB1 but not ephrinB2

EphrinB–EphB interaction is well known to lead bidirectional signals, the forward and the reverse signaling (17). There is no evidence if either the forward or the reverse signaling or both are necessary for production and maintenance of any pain status. Here, we showed that TCI-induced upregulation...
of expression of EphB1 receptor was cancelled by EphB2-Fc (5 μg, i.t.) in a single dose on the postoperative 7 day (Fig. 4A) or repetitive doses on postoperative 7, 8, and 9 days, respectively (Fig. 4B). Inhibition occurred within 2 hours and persisted for at least a week. EphB2-Fc treatment did not affect TCI-induced increase of expression of ephrinB2 and PY99 (Fig. 4C). These results, together with those shown in Figure 3, indicate that EphB1 downregulation may contribute to inhibition of pNR1, pNR2B, pSrc(Tyr418), pERK1/2, pCaMKII, and pCREB and reduction of bone cancer pain behaviors following EphB2-Fc treatment; whereas continuous activation of ephrinB2 is unable to maintain activation of these signals and the pain status.

EphrinB2-Fc activates NR1 and NR2B and induces thermal hyperalgesia on the condition of EphB1 receptor activation in naive rats

Spinal administration of an exogenous EphB1 receptor activator ephrinB2-Fc (2 μg) increased the level of pEphB1, but not the overall receptor expression of EphB1 (Fig. 5A), and upregulated levels of pNR1 and pNR2B (Fig. 5B). It also decreased ephrinB2 expression, but not its phosphorylation PY99, because the ratio ephrinB2/PY99 was maintained at the same level (Supplementary Fig. S5A) and resulted in thermal hypersensitivity (Supplementary Fig. S5B). Repetitive ephrinB2-Fc (2 μg, i.t., once a day for 3 consecutive days) produced similar effects on phosphorylation or expression of these molecules and thermal hypersensitivity (Supplementary Fig. S6). We further examined whether ephrinB2-Fc–induced activation of NR1 and NR2B and thermal hypersensitivity would be dependent on activation of the EphB1 receptor. TCI-induced upregulation of EphB1 was inhibited by EphB2-Fc treatment (see Fig. 4). In naive rats, EphB2-Fc treatment (5 μg, for 3 consecutive days) greatly inhibited expression of EphB1 and its phosphorylation (Fig. 5C). Under this condition, ephrinB2-Fc (2 μg) failed to activate or rescue EphB1 (Fig. 5C), NR1, and NR2B (Fig. 5D), but continued to downregulate ephrinB2 (Supplementary Fig. S7A). In addition, ephrinB2-Fc treatment caused thermal hypersensitivity in naive rats, but failed to do so when coadministered with EphB2-Fc (Supplementary Fig. S7B). These results indicate that activation of EphB1 receptor is required for ephrinB2-Fc to activate NR1 and NR2B and further induce thermal hypersensitivity, suggesting that EphB1 and NR1/2 activation is necessary for the development of thermal hyperalgesia. Downregulation of ephrinB2 is not sufficient or unnecessary for ephrinB2-Fc–induced thermal hypersensitivity.
Inhibition of MMP-2 or MMP-9 activation prevents EphB2-Fc–induced downregulation of EphB1 in naive and TCI rats

Spinal administration of EphB2-Fc results in downregulation of EphB1 protein, in addition to inhibition of TCI-induced pain-like behaviors and neurochemical alterations. Since EphB–ephrinB interactions can be broken by MMPs, which cleave EphB receptors (28–30), we examined possible roles of spinal MMP-9/2 in EphB2-Fc–induced EphB1 downregulation. With EphB2-Fc administration, levels of EphB1 and pEphB1 were further downregulated from already low levels in naive rats (Fig. 6A) and TCI rats, back to control (Sham) levels from greatly increased levels (Fig. 6B), respectively. The EphB2-Fc–induced downregulation of EphB1 was completely prevented by blocking MMP-2 with MMP2i (10 μg) or MMP-9 with FN439 (100 μg; Fig. 6A and B) and the level of EphB1 was brought back to levels originally seen in (i) naive and (ii) TCI (B), respectively. However, without EphB2-Fc treatment, blocking MMP-2 or MMP-9 inhibited TCI-induced upregulation of EphB1 and brought the upregulated EphB1 back to control (Sham) levels (Fig. 6C, left), while keeping EphB1 at its physiological levels in naive rats (Fig. 6C, right).

Administration of exogenous MMP-2 or MMP-9 caused an increase rather than a decline in the activation (phosphorylation) of EphB1 without altering the expression of EphB1 protein in naive rats (Fig. 6D, left) and did not significantly alter increased levels of EphB1 in TCI rats (Fig. 6D, right). Gelatin zymography showed that activity of both MMP-2 and MMP-2 was greatly increased following EphB2-Fc or ephrinB2-Fc treatment (Supplementary Fig. S8). These results indicate that MMP-2/9 have different roles, with and without EphB2-Fc treatment, in the modulation of EphB1. Without EphB2-Fc treatment, they may upregulate the EphB1 level.

Blocking EphB1 receptor activation rescues analgesic effect of morphine in treating bone cancer pain

Morphine has been used in reducing cancer pain, particularly in advanced and terminal patients, but its tolerance following repeated use has limited its clinical use. Given that EphB1 receptor may be a potential target for treating bone cancer pain, we extended our experiments to examine whether morphine tolerance in treating bone cancer pain would be involved in the activation of ephrinB–EphB signaling. Injection of morphine (10 mg/kg, s.c., twice a day, 12 hours intervals) significantly suppressed thermal hyperalgesia in TCI rats. Such an analgesic effect decreased and then disappeared (tolerance) 6 to 7 days after repeated use of morphine (Fig. 7A). Coadministrations of EphB2-Fc at lower doses (each 2 μg accompanied with morphine), which alone was not enough to reduce the hyperalgesia, successfully rescued the analgesic effect of morphine (prevented morphine tolerance) in treating bone cancer hyperalgesia (Fig. 7A). Meanwhile, increased level of phosphorylation and expression of EphB1 following TCI...
and morphine treatment were inhibited by repetitive EphB2-Fc treatment (Fig. 7B).

We further investigated the role of EphB1 receptor in morphine tolerance by using standard protocols for testing acute and chronic morphine tolerance in naive and EphB1 receptor knock out (Ephb1<sup>−/−</sup>) mice. Both acute (Fig. 7C) and chronic (Fig. 7D) morphine tolerance were reduced by coadministration of EphB2-Fc (each 2 μg, i.t.) with morphine or by targeted mutation of EphB1. Meanwhile, acute (Supplementary Fig. S9A and B) and chronic (Supplementary Fig. S9C) morphine treatment significantly increased the expression of EphB1 and its phosphorylation, and this effect was inhibited by EphB2-Fc (Supplementary Fig. S9B and C). These results indicate that the EphB1 receptor is involved in development of morphine tolerance.

**Discussion**

Our study reveals a critical role for the ephrinB–EphB receptor signaling in bone cancer pain and morphine tolerance in treating bone cancer pain. TCI greatly activates spinal ephrinB2–EphB1 receptor signaling, which then induces activation of NR1 and NR2B receptors and the downstream pathways, resulting in bone cancer pain. EphB1 is required for the production and persistence of bone cancer pain and the functional link among the ephrinB–EphB receptor signaling, NR1 and NR2B receptors, and downstream responses. Cleavage of EphB1 receptor may be mediated by MMP-2 and MMP-9. These findings provide a novel mechanism underlying the pathogenesis of bone cancer pain. EphB1 receptor is also required for the development of morphine tolerance. Thus, EphB1 receptor may be a potential target for treating bone cancer pain and reducing opioid tolerance in treating bone cancer pain clinically.

EphB receptors and their ligands, ephrins, are critical cues in regulating cell shape, adhesion/repulsion, migration, and positioning during developmental processes (5–7, 31). Alteration of mechanisms controlling adhesion and motility has a central role in promoting tumor invasion and angiogenesis (8–10). Here, we show that TCI-induced activation of EphB1 receptor and its ligand ephrinB2 are well correlated with the timing patterns of TCI-induced bone cancer pain behaviors. The increased EphB1 receptor and ephrinB2 are predominantly localized with neurons and some astrocytes in the DH, an essential area for the generation and processing of pain signals. EphrinB2 in the peripheral nociceptors may be transported and redistributed along the CGRP fibers, to the presynaptic membranes of their central terminals, where it triggers a series of postsynaptic effects. EphB receptors regulate synaptic plasticity by interaction with NMDARs (32–34). NMDARs have a well-developed role in neural plasticity and various pain states. Within the NMDAR complex, the nonreceptor tyrosine kinase, Src, provides dynamic gain control of NMDAR function via balancing its activity with striatal enriched tyrosine (24–27, 35). We also show that blocking EphB1 receptor activation largely diminished TCI-induced phosphorylation of NR1 and NR2B receptors, Src(Tyr418), and subsequent activation of various Ca<sup>2+</sup>-dependent signalizing enzymes, CREB, induction of c-Fos, and bone cancer–related pain behaviors. Therefore, we hypothesize that peripheral nerve damage due to cancer cell invasion leads to upregulation of the presynaptic ephrinB2 ligand and postsynaptic EphB1 receptor molecules in primary neurons and the DH. Such an increased expression of ephrinB–EphB
signaling then leads to postsynaptic EphB1 receptor forward signaling clustering and reciprocal phosphorylation on multiple tyrosine residues (32, 36). Thus, downstream signaling proteins containing SH2 domains, including Src family kinases (36, 37), which are physically associated with EphB receptors and NMDARs, and phosphorylate NMDARs on tyrosines (38) may be recruited. This results in the subsequent activation of Ca\(^{2+}\)-dependent signaling pathways and behavioral manifestations.

We noted the fact that ephrinB2-Fc treatment and TCI-induced thermal hyperalgesia may involve EphB1 receptor, probably via 2 different mechanisms. EphrinB2-Fc treatment may induce true EphB1 receptor activation, because it does not affect overall receptor expression, but increases the level of phosphorylation of EphB1. EphrinB2-Fc treatment also downregulates the expression of both ephrinB2 and PY99. On the contrary, TCI induces an upregulation of both EphB1 and pEphB1, and ephrinB2 and PY99.

Ephrin–Eph interaction is well known to lead bidirectional signals which are propagated into the ephrinB-expressing cells (reverse signaling) and the EphB-expressing cells (forward signaling). It is unknown if either of the forward or reverse signaling or both are important in pain processing. Our findings in this bone cancer model may support that...
EphB1 receptor forward signaling is critical to the development and maintenance of pain and activation of NR1 and NR2B receptors and subsequent Ca^{2+}-dependent signals. When EphB1 is inhibited, pain behaviors and NMDARs activation are inhibited even though the ephrinB2 continues to be active. When EphB1 receptor is activated, NMDARs are activated and pain is induced even though ephrinB2 is downregulated. A recent study, by deleting ephrinB2 in Nav1.8+ nociceptive sensory neurons, indicates that presynaptic ephrinB2 expression may play a role in regulating inflammatory pain and some types of neuropathic pain through the regulation of synaptic plasticity in the DH (39).

Another interesting phenomenon is that EphB2-Fc treatment results in downregulation of EphB1 protein accompanied with increased activity of MMP-2 and MMP-9 in the spinal cord. Such EphB1 downregulation can be prevented or rescued by blocking MMP-2 or MMP-9. We hypothesize that during EphB2-Fc treatment, EphB2-Fc combines with endogenous ephrinB2 and thus EphB1 is substituted and cleaved (downregulation) mediated by MMP-2 and/or MMP-9. This results in inhibition of the downstream signals of the EphB1. In contrast, without EphB2-Fc treatment, exogenous ephrinB2-Fc or TCI-induced increased ephrinB2 combines with EphB1 and results in upregulation of EphB1 and activation of the downstream signals. In this process, neither ephrinB2-Fc nor ephrinB2 causes downregulation of EphB1 although it induces activation of MMP-2 and MMP-9; thus, blocking MMP-2 or MMP-9 does not cause downregulation of EphB1.

**Figure 7.** Spinal administration of EphB2-Fc rescues analgesic effect of morphine (Mor) in treating TCI-induced thermal hyperalgesia in rats and defensive pain in mice. A, effects of EphB2-Fc and Mor on thermal hyperalgesia. Mor: 10 mg/kg, s.c., twice a day. EphB2-Fc: 2 μg, i.t., once a day. Eight rats were included in each group. B, effects of EphB2-Fc and Mor on expression of EphB1. Five samples were included in each group. C and D, effects of EphB2-Fc or targeted mutation of EphB1 on acute (Mor100-10) and chronic (Mor10) Mor tolerance. Data were calculated as the percentage of maximal possible effect [MPE (%)]. A total of 10 mice were included in each group. EphB2-Fc or its Fc control (each 2 μg) was administrated 30 minutes before the first dose of Mor in acute tolerance or each of Mor injection in chronic tolerance model. *, P < 0.05 and **, P < 0.01 indicate significant differences compared to the corresponding control group, PBS (A), Naive (B), Mor or EphB1+/+ (C) and (D). #, P < 0.05 and ##, P < 0.01 indicate significant differences compared to the corresponding group of Mor.
EphB1. In summary, MMP-2/9 may mediate EphB1 cleavage during EphB-Fc treatment and thus enhance the inhibitory effect of EphB2-Fc on EphB1 signaling; whereas MMP-2/9 alone may activate rather than cleave EphB1. Interactions between EphB1 and MMPs need to be further examined and they are beyond the scope of this article.

Cancer pain poses a major challenge clinically. Opioid drugs, with or without coanalgesics/adjuvant analgesics, are used to treat moderate to severe pain. However, the effective use of morphine as a treatment on such pain is limited by morphine tolerance and concerns related to addiction and opioid administration—associated severe, sometimes debilitating side effects (40–43). This study shows that pharmacological blockade or genetic deletion of EphB1 receptor can prevent morphine tolerance in treating bone cancer pain and defensive pain, respectively. In addition, we have recently found that inhibition of EphB1 receptor can prevent or largely diminish morphine physical dependence (14). Thus, blocking EphB1 receptor may be a potential pharmaceutical therapy that cannot only relieve bone cancer pain, but also facilitate the clinical utility of opioid drugs in treating bone cancer pain.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

Grant Support

Parker Research Foundation (PCCRF-BSR089405), Natural Science Foundation of China (30628027, 81000475, and 30901401), and National Institute of Health (R0166322).

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.

Received October 22, 2010; revised April 27, 2011; accepted May 4, 2011; published OnlineFirst May 9, 2011.

References


# Blocking EphB1 Receptor Forward Signaling in Spinal Cord Relieves Bone Cancer Pain and Rescues Analgesic Effect of Morphine Treatment in Rodents

Su Liu, Wen-Tao Liu, Yue-Peng Liu, et al.

*Cancer Res* 2011;71:4392-4402. Published OnlineFirst May 9, 2011.

<table>
<thead>
<tr>
<th>Updated version</th>
<th>Access the most recent version of this article at: doi:10.1158/0008-5472.CAN-10-3870</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplementary Material</td>
<td>Access the most recent supplemental material at: <a href="http://cancerres.aacrjournals.org/content/suppl/2011/05/09/0008-5472.CAN-10-3870.DC1">http://cancerres.aacrjournals.org/content/suppl/2011/05/09/0008-5472.CAN-10-3870.DC1</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cited articles</th>
<th>This article cites 43 articles, 9 of which you can access for free at: <a href="http://cancerres.aacrjournals.org/content/71/13/4392.full#ref-list-1">http://cancerres.aacrjournals.org/content/71/13/4392.full#ref-list-1</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Citing articles</td>
<td>This article has been cited by 3 HighWire-hosted articles. Access the articles at: <a href="http://cancerres.aacrjournals.org/content/71/13/4392.full#related-urls">http://cancerres.aacrjournals.org/content/71/13/4392.full#related-urls</a></td>
</tr>
</tbody>
</table>

**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.