Foxp3⁺ T Cells Inhibit Antitumor Immune Memory Modulated by mTOR Inhibition

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Abstract

Inhibition of mTOR signaling enhances antitumor memory lymphocytes. However, pharmacologic mTOR inhibition also enhances regulatory T-cell (Treg) activity. To counter this effect, Treg control was added to mTOR inhibition in preclinical models. Tregs were controlled with CD4-depleting antibodies because CD4 depletion has high translational potential and already has a well-established safety profile in patients. The antitumor activity of the combination therapy was CD8 dependent and controlled growth of syngeneic tumors even when an adoptive immunotherapy was not used. Lymphocytes resulting from the combination therapy could be transferred into naive mice to inhibit aggressive growth of lung metastases. The combination therapy enhanced CD8 memory formation as determined by memory markers and functional studies of immune recall. Removal of Foxp3-expressing T lymphocytes was the mechanism underlying immunologic memory formation following CD4 depletion. This was confirmed using transgenic DEREG (depletion of regulatory T cells) mice to specifically remove Foxp3⁺ T cells. It was further confirmed with reciprocal studies where stimulation of immunologic memory because of CD4 depletion was completely neutralized by adoptively transferring tumor-specific Foxp3⁺ T cells. Also contributing to tumor control, Tregs that eventually recovered following CD4 depletion were less immunosuppressive. These results provide a rationale for further study of mTOR inhibition and CD4 depletion in patients. Cancer Res; 74(8); 2217–28. ©2014 AACR.

Introduction

The immune system can provide protection against cancers. Effective immune stimulation produces long-lasting memory lymphocytes, capable of rapidly responding to repeat antigen challenge. The mTOR pathway is an important checkpoint that governs the formation of CD8 memory cells (1–3). In mouse models, decreased mTOR signaling promotes formation of CD8 memory cells that provide protection against bacteria (4), virus (1) or cancer (2, 3). This is surprising because rapamycin, which is the prototypic mTOR inhibitor, is considered an immunosuppressant and is widely used to prevent rejection of solid organ transplants. In murine models of renal cell carcinoma (RCC) and melanoma, pharmacologic mTOR inhibition had both immune stimulating and immune suppressing effects (2). However, the net effect resulted in decreased tumor growth. Therefore, mTOR inhibitors, which are already approved by the U.S. Food and Drug Administration (FDA) for clinical use, are a promising adjunct for use with cancer vaccines.

Strategies to limit immune suppression by mTOR inhibitors may make this class of drugs even more useful with cancer vaccines. Pharmacologic mTOR inhibition suppresses the immune system at least in part by enhancing CD4 regulatory T-cell (Treg) activity (2, 5). Therefore, we explored a combination therapy targeting the mTOR pathway and Tregs. The most reliable Treg marker is forkhead box transcription factor (FoxP3), which is specific for Tregs and is required for its function (6). Unfortunately, there is no clinical strategy for targeting FoxP3-expressing cells in patients. Therefore, an alternative strategy is to target CD25, which is expressed by the majority of Tregs. However, this strategy has limitations because some Tregs are CD25 negative. Furthermore, activated CD8 lymphocytes express CD25 and can be depleted by CD25-targeting strategies. In murine models, depleting CD25-expressing cells with αCD25 antibodies was effective in preventing tumor growth, but was not effective in treating established tumors (7–9) and has been shown to restrict adoptive immunotherapy (10, 11). Another strategy uses an engineered protein that combines interleukin-2 (IL-2) and diphtheria toxin (denileukin difitox, trade name Ontax) to target CD25-expressing cells. The approach has been tested in patients with RCC or melanoma (12, 13), however clinical effectiveness was limited, possibly because of depletion of CD8 effector cells.

Using preclinical models, we explored a combination of pharmacologic mTOR inhibition and Treg depletion using...
αCD4 antibody. This is an attractive approach because CD4-depleting antibodies have been studied in patients with peripheral T-cell lymphoma (14, 15), Crohn disease (16), and multiple sclerosis (17, 18), and have a well-established safety profile. However, CD4 depletion removes CD4 effector cells, which are required for initiation of an immune response. Therefore, CD4 depletion was timed to occur after immune priming has taken place. In murine models for RCC and melanoma, mTOR inhibition and CD4 depletion produced a robust cellular immune response that was transferable and effective in controlling subcutaneous tumors as well as lung metastases. The combination treatment produced highly effective memory lymphocytes with robust recall responses. The stimulation of immunological memory because of CD4 depletion was attributed to Treg depletion based on experiments using transgenic models to specifically deplete Tregs ("Treg knock-out") or replace tumor-specific Tregs ("Treg knock-in") following CD4 depletion. Another mechanism contributing to the antitumor response was that Tregs that returned after CD4 depletion were less immunosuppressive than Tregs from mice without CD4 manipulation.

Materials and Methods

**Mice and tumor cells**

Female C57BL/6, Balb/c mice and Pmel-1 mice, 6- to 8-week old, were purchased from Jackson Laboratory and housed under pathogen-free conditions. FoxP3-GFP mice were a generous gift from Dr. V. Kuchroo (Harvard University, Boston, MA). DEREG (depletion of regulatory T cells; Tg[Foxp3-DTR/EGFP]/2325spar) transgenic mice was generated and described by T. Sparwasser (19). All experiments involving animals were in compliance with federal and state standards, which include the federal Animal Welfare Act and the NIH guide for the care and use of laboratory animals.

Human gp100-transduced B 16 cells (B16-gp100) were kindly provided by Dr. A. Rahmlwivich from University of Wisconsin-Madison. RENCA, a murine RCC line, was a gift from Dr. A. Bellegroon (University of California, Los Angeles, CA). All cells were periodically authenticated by morphologic and histologic inspection, and animal grafting for assessing their ability to grow and metastasize. Cells were annually tested for mycoplasma using Myco Alert Kit (Lonza). The cells were maintained in Dulbecco’s modified Eagle medium or RPMI 1640 medium supplemented with 10% heat-inactivated FBS (Life Technologies), 2 mmol/L of L-glutamine, 100 units/mL of penicillin, and 100 μg/mL of streptomycin.

Mouse tumors were generated by subcutaneously injecting 2 × 10⁶ cells into the flank. Tumor diameter was measured with calipers twice a week and tumor volume was calculated (shortest diameter² × longest diameter/2). In the lung metastasis model, tumor cells were injected intravenously through the tail vein. Lung metastases were counted using a dissection microscope.

**Antibodies and reagents**

The following monoclonal antibodies (mAb), with or without a fluorescent conjugate, were obtained from Biolegend: anti-CD4 (GK 1.5 and RM4-5), anti-CD8 (53-6.7), anti-CD16/CD32 (9.3), anti-CD90.1 (OX-7), anti-CD11c (N418), anti-Bcl2 (BCL/10C4), anti-T-bet (4B10), anti-CD62L (MEL-14), anti-CD279 (PD-L29F.1A12), anti-FoxP3 (FJK-16s), anti-IFN-γ (XMG1.2), anti-IL-2 (JE56.H4), anti-IL-4 (11B11), IL-17A (eBio1787). CellTrace 5-(and 6-)carboxyfluorescein diacetate succinimidyl ester (CFSE) Cell Proliferation Kit was purchased from Invitrogen. CD4 (GK1.5) and CD8 (2.43) antibodies for T cells depletion were purchased from BioXcell. Temsirolimus was purchased from LC Laboratory.

**T-cell enrichment and Treg sorting**

Mouse spleen and lymph nodes were collected and processed into single-cell suspensions. CD8 and CD4 T cells were negatively enriched using mouse CD8 or CD4 recovery columns (Cedarlane Labs). Purity of CD8 and CD4 cells after negative selection was greater than 85%. FoxP3-GFP cells or antibody stained CD4+CD25+ cells were sorted by MoFlo Cell Sorter.

**Preparation of dendritic cells and T-cell stimulation**

Dendritic cell (DC) preparation has been described (2). To prepare DC vaccine for treatment of mice, DCs were pulsed with tumor cell lysate and activated with 10 μg/mL CpG. DCs were subcutaneously injected into mouse. For in vitro activation of Pmel-1 cells, DC was pulsed with 10 ng/mL mouse gp100 peptide (amino acids 25–33, which is presented by H2-Db class I molecules; Alpha Diagnostic International) and activated with 10 μg/mL CpG for 2 hours. DC was washed with PBS, and cocultured with CFSE-labeled Pmel-1 cells. Pmel-1 cells proliferation was analyzed by FACscan.

**Adaptive transfer, CD4 cells depletion, and mTOR inhibition**

Pmel-1 lymphocytes were isolated from lymph nodes and spleen of naïve Pmel-1 mice. CD8 lymphocytes were enriched by negative selection using Cederlane purification column. At least 85% of the resulting cells were CD8+. A total of 5 × 10⁶ cells were transferred into B57BL/6 mice. The day after adaptive transfer, mice received tumor lysate–pulsed DC vaccine. To deplete CD4 cells, αCD4 was administered approximately 7 and 9 days later; mice were injected intraperitoneally with 250 μg of CD4 mAb (clone GK1.5). To deplete CD8 cells, mice received 250 μg of CD8 mAb (clone 2.43). To deplete FoxP3 cells in DEREG mice, 5 μg DT was injected. Flow cytometry was used to confirm depletion of target cells. For mTor inhibitor treatment, 15 μg temsirolimus was injected intraperitoneally each day for 2 weeks. Flow cytometry was used to analyze memory cells and Treg cells.

**Cytotoxic T lymphocyte assay**

The in vivo cytotoxic T lymphocyte (CTL) assay has been described (2). For the in vitro CTL, fresh splenocytes were cultured in the presence of IL-2 (40 IU/mL; eBioscience), tumor lysate, and H-2K–restricted CA9 peptide (20) for 20 days. Live cells were isolated with the Lympholyte Media (Cedarlane Labs) and used as effector cells. To prepare target cells, RENCA cells were treated with IFN-γ (20 ng/mL; eBioscience) for 24 hours and labeled with CFSE (0.5 μmol/L). Effector and target cells were co-cultured at a ratio of 50:1 at 37°C for 12 hours. Cells were stained with 7-AAD and PE labeled annexin V (eBioscience) on
Temsirolimus slightly decreased the percent of CD8 cells that suppressing effects when administered with the DC vaccine. Temsirolimus had both immune stimulating and immune mice after they were treated with DC vaccine and temsirolimus. MHC class I molecules. Lymphocytes were harvested from B6 expression in Pmel-1 lymphocytes and increase in Tregs. These early marker for memory cell formation (3, 21). Potentially lymphocytes had increased expression of Eomes, which is an tumor itself increased Tregs (Supplementary Fig. S1). There- despite an increase in Tregs. Furthermore, the presence of CD4 depletion enhanced the antitumor effect of mTor inhibition. Temsirolimus can directly inhibit the growth of some tumors (2); therefore, a tumor prevention study was performed to assess the immune effects of temsirolimus. By administering DC vaccine and temsirolimus 13 days before tumor challenge, there is no possibility for a direct antitumor effect, and any decrease in tumor growth can be attributed to immune stimulation. Administering DC vaccine alone decreased growth of B16 tumor cells in mice, however, most mice eventually died because of tumor growth. In contrast, the combination of DC vaccine and temsirolimus resulted in 100% survival and completely prevented the growth of B16 tumor cells.

To assess the immune effect of temsirolimus on specific CD8 lymphocytes, Thy.1 Lpmel-1 lymphocytes were adoptively transferred into Thy.1.B6 mice (Fig. 1B and C). Lpmel-1 transgenic mice carry a rearranged T-cell receptor that recognizes a gp100 epitope (amino acids 25–33) presented by H2-Db MHC class I molecules. Lymphocytes were harvested from B6 mice after they were treated with DC vaccine and temsirolimus. Temsirolimus had both immune stimulating and immune suppressing effects when administered with the DC vaccine. Temsirolimus slightly decreased the percent of CD8 cells that were Lpmel-1 lymphocytes (P-value = 0.08), however, Lpmel-1 lymphocytes had increased expression of Eomes, which is an early marker for memory cell formation (3, 21). Potentially immune suppressive effects included a decrease in Tbet expression in Lpmel-1 lymphocytes and increase in Tregs. These observations were largely mirrored by in vitro mixed lymphocyte culture studies (Fig. 1D and E). In the in vitro studies, temsirolimus significantly decreased the proliferation of Lpmel-1 lymphocytes induced by the DC vaccine.

CD4 depletion enhanced the antitumor effect of mTor inhibition

Temsirolimus produced a net antitumor immune response despite an increase in Tregs. Furthermore, the presence of tumor itself increased Tregs (Supplementary Fig. S1). There-
tumors were treated with temsirolimus alone for 10 days and then challenged with a second RENCA tumor (Fig. 3A). Mice injected with \( \alpha \)CD8 antibody (\( \alpha \)CD8) to deplete CD8 effectors cells had increased growth of the second RENCA tumor, indicating that even temsirolimus alone works at least in part by stimulating an immune response. The combination of temsirolimus and \( \alpha \)CD4 completely prevented the growth of second RENCA tumors; however, \( \alpha \)CD8 removed the antitumor effect on the second tumors, indicating the importance of cellular immunity to tumor control (Fig. 3B).

To further establish the role of the immune system and test our proposed treatment in a more aggressive tumor model, we assessed whether antitumor immunity can be transferred to prevent growth of metastatic lung deposits. The combination of \( \alpha \)CD4 and temsirolimus was used to treat established, subcutaneous RENCA tumors (Fig. 3C). Lymphocytes from these mice were adoptively transferred to naive mice, which were challenged intravenously with RENCA cells. The combination treatment significantly decreased the establishment and growth of lung deposits (Fig. 3C) as quantified by comparing lung weights (Fig. 3D) and counting lung deposits (Fig. 3E). Specific IFN-\( \gamma \) expression in CD8 lymphocytes was increased in the combination therapy group (Fig. 3F). Therefore, memory cells were successfully transferred into naive mice, where they helped control tumor growth.
Combination of CD4 depletion and temsirolimus treatment enhanced function of CD8 memory cells

An important mechanism through which temsirolimus inhibits tumor growth is to enhance the quality of specific CD8 memory (1, 2). Therefore, we characterized the quality of CD8 memory cells with the goal of assessing whether CD4 further enhances the specific CD8 memory formed in the presence of mTOR inhibition. We used a model where DC vaccines stimulated an immune response rather than the tumor itself because the duration of experiments with tumor-bearing mice is limited by rapid tumor growth in the control groups. By using a DC vaccine, long-term memory can be assessed, including recall responses. Thy1.1 Pmel-1 lymphocytes were adoptively transferred into B6 mice, which were then challenged with B16-DC vaccine and treated with αCD4 and temsirolimus (Fig. 4A).

To assess memory cells, splenocytes were harvested before (Fig. 4B) or after (Fig. 4C) rechallenging mice with DC vaccine on day 46. Immediately because rechallenge, there was no significant difference in percent of Pmel-1 lymphocytes in the experimental groups (Fig. 4A). However, the CD8 lymphocytes from mice treated with both αCD4 and temsirolimus had significantly higher expression of memory markers Eomes and BCL2. The CD8 lymphocytes from this group

Figure 2. CD4 depletion enhanced the antitumor effect of mTor inhibition. A, RENCA-CA9 tumor cells were implanted into Balb/c mice (n = 5 per group) on day 0. CD4 lymphocytes were depleted with αCD4 antibody on days 6 and 10. Mice were treated with daily temsirolimus on days 14 to 34. Tumor growth was monitored. Results are representative of triplicate experiments. B, in the same experiment, lymphocytes were harvested on day 45, restimulated with CA9 peptide, and stained for CD8 and IFN-γ. Results are representative of duplicate experiments. C, for the in vitro CTL assay, splenocytes were harvested on day 45 and cultured with IL-2, RENCA lysate, and CA9 peptide. Target cells were prepared by labeling RENCA cells with CFSE. Effector and target cells were cocultured at a ratio of 50:1 and analyzed by FACS for the percent of CFSE− cells that were 7-AAD positive and Annexin V negative. D, following CD4 depletion, spleen, lymph node, and blood were collected on days 0, 1, and 10. Lymphocytes were stained for CD4, CD8, and FoxP3 and analyzed by flow cytometry. E–F, the percentages of CD4 cells in the spleen, lymph node, and blood on days 0, 1, and 10 following CD4 depletion are reported. E, following CD4 depletion, percentages of splenocytes that were CD4 or CD8 positive are reported, and percent of CD4 cells that were FoxP3 positive is reported. F, in the same experiment, the absolute numbers of splenocytes positive for CD4, CD8, and CD4/FoxP3 are reported. Histograms, mean ± SEM.

*, P < 0.05; **, P < 0.01; ***, P < 0.005.
had significantly higher expression of CD62L, which is a marker for highly effective central memory cells. Consistent with high-quality memory cells, following rechallenge with DC vaccine, the Pmel-1 cells in the combination treatment group had the greatest expansion and CD8 cells had the highest Tbet and IL-2 expression (Fig. 4C). Interestingly, even after rechallenge, the expanded CD8 cells from the combination treatment group had the highest expression of Eomes.

Others have reported that Tregs are necessary, during immune priming, for CD8 memory formation (23, 24). Therefore, in our treatment models, Tregs were depleted at least 6 days after primary immune stimulation. However, we verified the importance of having CD4 cells during immune priming. When CD4 depletion was performed before immune priming, CD8 memory formation was poor, as indicated by a weak tumor-specific CD8 expansion after stimulation of memory cells and low Eomes expression (Supplementary Fig. S4).

Depleting or replacing Foxp3 Treg cells alter CTL function in vivo

Our original hypothesis was that depletion of Tregs normally induced by temsirolimus will enhance antitumor immunity. We selected CD4 depletion as a strategy for depleting Tregs because CD4 depletion is feasible in patients. However, we wanted to test whether the effect of CD4 depletion can be directly attributed to Tregs depletion. Therefore, we used DEREG transgenic mice, which carry a DTR-eGFP transgene under the control of Foxp3 promoter, allowing specific depletion of Tregs by administering diphtheria toxin (19). In an experiment analogous to one shown in Fig. 2, diphtheria toxin was administered on days 6 and 10, in place of aCD4 (Fig. 5A).
The immune system was stimulated with DC vaccine and specific immune memory was assessed on day 35 by in vivo CTL and IFN-γ staining. Diphtheria toxin administration removed nearly all CD4⁺FoxP3⁺ lymphocytes (Fig. 5B). Specific killing and IFN-γ staining significantly increased in mice treated with diphtheria toxin and temsirolimus when compared with control groups (Fig. 5C and D). Therefore, removing Tregs had a similar immune effect to CD4 depletion.

To fully establish Treg depletion as the underlying mechanism for immune stimulation following CD4 depletion, Tregs were replaced after CD4 depletion (Fig. 6A). Mice treated with αCD4 and temsirolimus developed the best-specific immune memory as assessed by in vivo CTL (Fig. 6B). However, when Tregs from mice treated with diphtheria toxin vaccine were adoptively transferred, specific killing and CD8 lymphocyte IFN-γ response decreased to that of control mice that only received the DC vaccine (Fig. 6B and C). These experiments confirm that with αCD4 it is the Treg depletion that enhances specific immune memory formation.

**Following CD4 depletion, Treg population that eventually recovers is less immunosuppressive**

Following treatment with DC vaccine, αCD4, and temsirolimus, the Treg population eventually recovers (Fig. 7A). Between experimental groups, the differences in absolute number of Tregs in the spleen were not statistically significant. However, the treatments may have had a long-term effect on Treg function. Therefore, we assessed the immunosuppressive function of the recovered Tregs. CD4 lymphocytes were sorted based on CD25 status (Fig. 7B). The vast majority of the CD4⁺CD25⁺ cells were FoxP3 positive and we considered Tregs, and the vast majority of CD4⁺CD25⁻ cells were FoxP3 negative and were considered CD4 effector cells. In functional studies, control CD4⁺CD25⁺ cells suppressed the proliferation of CD8 lymphocytes. However, CD4⁺CD25⁻ that recovered after CD4 depletion were less immunosuppressive, possibly because they were less likely to be tumor-specific Tregs (Fig. 7D). Interestingly, following CD4 depletion, the recovered CD4 effector cells were also less effective as indicated by lower IFN-γ and IL-4 production (Fig. 7C). It is possible that both CD4 effector cells and Tregs were less likely to be tumor specific.

**Discussion**

Immunotherapeutic approaches have proven effective for the treatment of solid tumors. The FDA-approved sipuleucel-T, which became the first commercially available cancer vaccine for the treatment of a solid tumor (25). Ipilimumab, a monoclonal antibody targeting CTLA4, was more recently approved.
for the treatment of melanoma (26). Immune checkpoint inhibitors that target CTLA4 and PD-1 are being actively investigated in a large number of clinical trials for various malignancies. There have always been hints that immune-based therapies can even be curative in subsets of patients with metastatic disease (27), but recent advances in immunotherapy reaffirm that durable complete responses are possible (28). Therefore, immunotherapy is one of the most promising approaches to cancer therapy.

A hallmark of durable immune responses is the generation of immune memory. The mTOR pathway has emerged as a critical determinant of immune memory (1–3). We confirmed prior observations that pharmacologic mTOR inhibition with temsirolimus can enhance the efficacy of adoptive immunotherapy (Fig. 1). Temsirolimus enhanced the expression of CD8 lymphocyte markers associated with memory formation, both in vivo and in vitro. However, it also increased the proportion of T cells expressing FoxP3. This was an expected finding because the canonical mTOR inhibitor, rapamycin, is routinely used in the clinic as an immune suppressant, and its primarily mode of action is believed to be through enhanced Treg activity (29, 30).

We reasoned that a combination therapy that includes a strategy to control Tregs would further enhance antitumor immunity. We elected to use a depleting αCD4 antibody because of its potential for clinical translation. The combination of αCD4 and temsirolimus was highly effective in controlling established RENCA tumors even when a cancer-specific vaccine was not used (Fig. 2). Temsirolimus is known to directly inhibit the growth of RENCA cells (2); therefore, we assessed the immune contribution to the antitumor effect. By depleting CD8 cells, antitumor activity was shown to be dependent on CD8 cells (Fig. 3). Further confirmation of immune stimulation was provided by transferring CD8 lymphocytes from treated mice to naïve mice. In a very aggressive tumor model, the transferred lymphocytes were effective in controlling growth of metastatic deposits.

Temsirolimus enhanced CD8 memory formation. Therefore, we assessed memory formation with the combination of temsirolimus and αCD4 (Fig. 4). The combination therapy produced CD8 lymphocytes with the strongest memory phenotype, capable of rapidly expanding in response to a repeat antigen challenge. Although Tregs have been described as a barrier to formation of antitumor memory (31), other recent studies indicate that Tregs are required during immune priming to generate high-avidity primary responders and functional CD8 memory (23, 24). In our model, Tregs were present during immune priming because CD4 depletion was initiated at least 6 days after immune stimulation.

CD4 depletion was also timed to allow CD4 effector cells to help prime CD8 cells and contribute to memory lymphocyte formation (Figs. 2–4). During immune priming, CD4 activity is dominated by helper function. Although it has been reported that CD4 cells are not required for priming, they are required for effective CD8 memory formation (32–34). CD8 memory cells formed in the absence of CD4 cells had an exhausted phenotype and increased PD-1 expression (32, 34). In our study,
the CD8 memory cells formed in the absence of CD4 were less capable of responding to a second challenge and had lower Eomes expression (Supplementary Fig. S4). Following immune priming, CD4 activity is dominated by regulatory function. Therefore, we and others have shown that CD4 depletion at this point leads to enhanced formation of both central and effector CD8 memory (35) and enhanced tumor control (35, 36).

Prior studies have assumed that the effects of CD4 depletion were because of Treg depletion. In this study, we use 2 separate experiments to empirically identify Treg depletion as the underlying mechanism: we selectively depleted FoxP3 expressing cells (“knock-down”) or replaced FoxP3 expressing cells following CD4 depletion (“knock-in”; Figs. 5 and 6). These experiments clearly identify Treg depletion as the mechanism accounting for enhanced immunity following CD4 depletion. Interestingly, intratumor Treg depletion has been identified as the primary mode of action for ipilimumab (37), which has been proven effective in a phase III trial of melanoma (38). Therefore, an intriguing possibility is that CD4 depletion may produce a similar immune effect in patients as ipilimumab.

Our study provides a preclinical rationale for CD4 depletion in patients. Multiple clinical trials have already documented the safety of CD4 depletion in humans (14, 15, 17, 39–44). Near complete CD4 depletion was achieved in several trials of chimeric αCD4 antibodies for refractory cutaneous T-cell lymphoma, and no serious infections or other dose-related toxicities were noted (14, 15, 44). A CD4-depleting chimeric monoclonal antibody was evaluated in 2 separate randomized, double-blind, placebo-controlled studies for rheumatoid arthritis (16, 17).

Figure 6. Adoptive transfer of FoxP3+ Tregs reduced CTL function in vivo in mice treated with the combination of CD4 depletion and temsirolimus. A, experimental scheme: B6 received tumor lysate–pulsed DC vaccine, and were treated intraperitoneally with αCD4 antibody on days 6 and 10, and daily temsirolimus on days 14 to 24 (n = 6 per group). Tregs, sorted from lymphocytes from GFP-FoxP3 mice that received tumor lysate–pulsed DC vaccine (pooled from 3 mice), were adoptively transferred on day 20 and in vivo CTL assay was performed on day 35. B, the in vivo CTL results were analyzed by flow cytometry using splenocytes harvested 14 hours following injection of target cells (n = 3–6 per group). Results are representative of duplicate experiments. C, on day 45, mice were restimulated with DC vaccine and splenocytes were stained for CD8 and IFN-γ expression. Histogram, mean ± SEM. *P < 0.05; **P < 0.01; ***P < 0.005.
arthritis (41, 43). Although CD4 depletion did not have a therapeutic effect for rheumatoid arthritis, there were no significant adverse event, and no patient suffered from opportunistic infections. Even long-term CD4 depletion seems to be safe because some patients in one of the trials were treated with CD4 for more than 9 months (43). After completing CD4-depleting treatment, patients have been followed for safety: 24 patients were followed for 30 months and no opportunistic infections or other significant adverse effects were seen (40). In addition, strong support for the safety of CD4 depletion comes from a clinical trial where CD4 depletion was added to a standard immunosuppressive regimen in heart transplant patients. These are patients where standard therapy already puts them at high risk for opportunistic infections. Patients in the CD4 depletion group actually had fewer episodes of infection than patients receiving standard immunosuppression (39).

Several studies have tried to explain why CD4 depletion had no therapeutic effect for autoimmune disorders. In multiple clinical trials, αCD4 preferentially depleted naive CD4 cells and tended to preserve memory CD4 cells (17, 45, 46). One study estimated that unprimed CD4 cells were 3 times more sensitive...
to depletion than primed CD4 cells (45). This feature is desirable for cancer immunotherapy. In addition, CD4 depletion decreased the number of IL-4-producing Th2 cells whereas the number of IFN-γ-producing Th1 cells remained stable, thus significantly increasing the Th1/Th2 ratio. In our animal model, we also noted that the percent of IL-2-producing Th1 cells increased following CD4 depletion because of larger drops in number of Th2 and Th17 cells (Supplementary Fig. S3). Therefore, the persistence of Th1 memory cells, along with CD8 memory cells, may explain the lack of benefit when treating chronic autoimmune disease. However, previously primed memory cells are beneficial for cancer immunotherapy where Th1 and CD8 memory cells contribute to antitumor immunity.

Another important observation in preclinical tumor models is that even partial CD4 depletion may be effective for enhancing the efficacy of cancer vaccines (47). Following CD4 depletion, CD4 counts and Tregs recover. However, the Tregs that recover were less immunosuppressive (Fig. 7). Antigen-specific Tregs have been reported to suppress antitumor immunity (48) and it is possible that the recovered Tregs may be less likely to be tumor specific.

The possibility of combining a CD4 antibody with mTOR inhibitors, which are already commercially available to treat cancers, is attractive. The tumor itself may provide sufficient antigen stimulation and additional adoptive immunotherapy may not be needed. The combination therapy seems to enhance immune memory and remove Tregs. A clear understanding of the mechanism-of-action of the proposed therapy helps bolster the rationale for further clinical investigation.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

Authors' Contributions

Conception and design: Y. Wang, R. Figlin, H.L. Kim
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Acquisition of data (provided animals, acquired and managed patients, provided facilities, etc.): Y. Wang, T. Sparwasser, R. Figlin
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