Effects of Vandetanib on Lung Adenocarcinoma Cells Harboring Epidermal Growth Factor Receptor T790M Mutation In vivo

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Abstract

Vandetanib is a novel multitarget tyrosine kinase inhibitor (TKI) that inhibits vascular endothelial growth factor receptor-2 (VEGFR-2), with additional inhibition of epidermal growth factor receptor (EGFR) and rearranged during transfection receptor signaling, which has shown promising results in clinical trials for advanced non–small cell lung cancer. However, the mechanisms of acquired resistance to vandetanib remain unclear. Therefore, we established in vitro vandetanib-resistant PC-9/VanR cells from PC-9, a vandetanib-sensitive lung adenocarcinoma cell line, by chronic exposure to this agent. PC-9/VanR cells were 50-fold more resistant to vandetanib than PC-9 cells in vitro. Compared with PC-9 cells, PC-9/VanR cells showed emergence of an EGFR T790M mutation, moderately elevated MET amplification, and similar VEGFR-2 inhibition by vandetanib. Note that the phospho-MET inhibition in PC-9/VanR was suppressed following EGFR inhibition by an irreversible EGFR-TKI, indicating that MET signaling in PC-9/VanR was dependent on EGFR signaling and that MET amplification was not the primary mechanism of resistance to vandetanib. In contrast to the in vitro experiment, vandetanib effectively inhibited the growth of PC-9/VanR tumors in an in vivo xenograft model through the antiangiogenesis effects of VEGFR-2 inhibition. In conclusion, the multitarget TKI vandetanib induced or selected for the EGFR T790M mutation as observed previously with highly selective EGFR-TKIs. However, vandetanib retained significant efficacy in vivo against xenografts harboring the T790M mutation, providing a strong scientific rationale for investigating vandetanib in clinical settings where acquired resistance through emergence of EGFR T790M mutations limits the effectiveness of highly selective EGFR-TKIs. [Cancer Res 2009;69(12):5091–8]

Introduction

Dramatic clinical responses to the selective epidermal growth factor receptor (EGFR)-tyrosine kinase inhibitors (TKI) gefitinib and erlotinib have been observed in patients with advanced non–small cell lung cancer (NSCLC), especially in those with tumors harboring activating EGFR mutations (1–3). However, selective EGFR-TKIs have shown only limited survival benefits in NSCLC in some clinical trials (4, 5) and the majority of NSCLCs initially sensitive to gefitinib or erlotinib become resistant to these agents within 1 year of therapy (6). In patients with NSCLC who acquire resistance to gefitinib or erlotinib, ∼50% have tumors with a secondary T790M mutation in exon 20 of EGFR (7–10) and ∼20% have tumors with amplification of MET gene (11–13).

Recently, multitarget treatment strategies have been developed for various solid cancers, and a variety of multitarget TKIs [e.g., lapatinib (14), sunitinib (15), and sorafenib (16)] have been introduced for clinical use. In particular, vascular endothelial growth factor receptor (VEGFR) and EGFR seem to be key molecular targets in the treatment of NSCLC (5, 17). VEGFR-2 signaling promotes angiogenesis of the tumor microenvironment and is indirectly related to tumor growth. Bevacizumab, an anti-VEGF monoclonal antibody, has received Food and Drug Administration approval for treatment of nonsquamous NSCLC as well as for colorectal cancer and breast cancer (17, 18). A combination of bevacizumab with erlotinib seemed to have clinical benefit in the treatment of nonsquamous NSCLC (19). Vandetanib (ZACTIMA) is an orally available multitarget TKI inhibiting VEGF-2, with additional inhibition of EGFR and rearranged during transfection (RET) receptor signaling (20–22). Vandetanib has shown promising results in phase II clinical trials in patients with pretreated NSCLC (23–25). Currently, phase III trials of vandetanib versus erlotinib (ZEST) and vandetanib in combination with docetaxel versus docetaxel alone (ZODIAC) are under way in patients with advanced NSCLC who have received prior therapy. However, it remains unknown whether prolonged treatment with multitarget TKIs, such as vandetanib, results in the emergence of the T790M EGFR mutation or MET gene amplification as reported previously for acquired resistance to the highly selective EGFR-TKIs gefitinib and erlotinib (7–13).

In this study, we established an in vitro vandetanib-resistant cell line from vandetanib-sensitive cells by chronic exposure to vandetanib to elucidate the mechanism of acquired resistance to this agent. We also examined the sensitivity of the resistant cells to vandetanib in an in vivo xenograft model.

Materials and Methods

Establishment of a vandetanib-resistant cell line. PC-9 cells were cultured at 37°C with 5% CO2 in RPMI 1640 supplemented with 10% heat-inactivated fetal bovine serum. To establish a vandetanib-resistant subline, the cells were treated with gradually increasing concentrations of vandetanib, starting at 0.01 μmol/L (lower than the IC50 of PC-9 cells). After 3 mo, the cells grew rapidly in the presence of 4 μmol/L vandetanib, and then we performed a single-cell cloning by soft agar and established the vandetanib-resistant cell line (PC-9/VanR).

3-(4,5-Dimethylthiazol-2-yl)-2,5-diphenyltetrazolium bromide assay. Growth inhibition was determined using a modified 3-(4,5-dimethylthiazol-2-yl)-2,5-diphenyltetrazolium bromide (MTT) assay using Cell Counting Kit-8 (Dojindo; ref. 26). Briefly, the cells were placed on published online first June 2, 2009; DOI: 10.1158/0008-5472.CAN-08-4204

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96-well plates at a density of 2,000 per well and continuously exposed to each drug for 72 h. Each assay was performed in triplicate or quadruplicate.

Reagents and antibodies. Vandetanib and gefitinib were kindly provided by AstraZeneca. CL387,785 and SU11274 were purchased from Calbiochem. Bevacizumab was purchased from Chugai Pharmaceutical Co. Rabbit antiserum against EGFR, phospho-specific EGFR (pY1068), phospho-specific HER2 (pY1248), phospho-specific HER3 (pY1289), mitogen-activated protein kinase (MAPK), phospho-MAPK (pMAPK; pT202/pY204), Akt, phospho-specific Akt (ser473), phospho-MET (pMET; pY1234/1235), insulin-like growth factor-1 receptor (IGF-IR), phospho-IGF-IR (pIGF-IR; pY1131), phosphatase and tensin homologue deleted on chromosome 10 (PTEN), and β-actin were purchased from Cell Signaling Technology. Polyclonal antibodies against HER2 and anti-HER3 monoclonal antibodies were purchased from Upstate Biotechnology. Phospho-specific VEGFR-2 (PTEN), and collateral sensitivity to irreversible EGFR-TKI, CL387,785 were purchased from Calbiochem. Bevacizumab was purchased from Chugai Pharmaceutical Co. Vandetanib and gefitinib were kindly provided by AstraZeneca. ZACTIMA is a trademark of the AstraZeneca group of companies.

Immunoblotting analysis. Cells were lysed in radioimmunoprecipitation assay buffer [1% Triton X-100, 0.1% SDS, 50 mmol/L Tris-HCl (pH 7.4), 150 mmol/L NaCl, 1 mmol/L EDTA, 1 mmol/L EGTA, 10 mmol/L 1,2-glycerolphosphate, 10 mmol/L NaF, 1 mmol/L sodium orthovanadate containing protease inhibitor tablets (Roche Applied Sciences GmbH)]. Proteins were separated by electrophoresis on polyacrylamide gels, transferred onto nitrocellulose membranes, and probed with specific antibodies followed by detection with enhanced chemiluminescence plus (GE Healthcare Biosciences).

Sequencing of the EGFR gene. For the EGFR sequence, DNA was extracted from each cell line using a QIAamp DNA Mini kit (Qiagen) and the exons encoding the intracellular domain (exons 18-22) were amplified by PCR. Primer sequences and amplification conditions have been described previously (3). PCR products were processed with a BigDye terminator sequencing kit (Applied Biosystems) and analyzed in both sense and antisense directions for the presence of mutations on an ABI 3100 sequencer (Japanese Applied Biosystems).

cDNA synthesis from mRNA. mRNA samples were prepared for reverse transcription-PCR using an RNeasy Mini kit (Qiagen) according to the manufacturer’s protocol. The cDNA was synthesized using SuperScript II Reverse Transcriptase (Invitrogen).

Quantitative PCR. Quantitative PCR was performed on a GeneAmp 5700 (Japan Applied Biosystems). The copy number ratio of MET to glyceraldehyde-3-phosphate dehydrogenase (GAPDH), a housekeeping gene, was calculated using a genomic DNA sample. The sequences of the Taqman probe and primers for MET and GAPDH were as follows: human MET, 5′-FAM-TGACCTGCGAATGAGAGGTCCTG-TAMRA-3′ (Taqman probe), 5′-CAATTTCTGAGGAGGAAACCT-3′ (forward primer), and 5′-GTCTTCA- CAT-ACTGAAACATGGA-3′ (reverse primer); human GAPDH, 5′-FAM- CAGGAAGAAATGGAG-3′ (Taqman probe), 5′-GTGTTGACAAATTCTTAT- CAC-3′ (forward primer), and 5′-GATGTTGAGGAGATGAGGAAAG-3′ (reverse primer). The ratio of mRNA level of hepatocyte growth factor (HGF) to that of GAPDH was calculated using cDNA sample:genomic DNA sample. The sequences of the Taqman probe, 5′- FAM-GCGAGAGGTGGTGGACCAAACTCCTGCCAGCGAGTTGACTCCAT-3′ (Taqman probe), 5′-GGATCCCTTCTCTTCTTCATCC-3′ (forward primer), and 5′-CACTTTTCTGTTCTCTCC-3′ (reverse primer) were designed as follows: human MET, 5′-GCTACGCTGC-3′ (forward primer), and 5′-GGTGACCAAACTCCTGCCAGCGAGTTGACTCCAT-3′ (reverse primer).

Xenograft model. Female athymic mice at 7 wk of age were purchased from Japan Charles River Co. All mice were provided with sterilized food and water and housed in a barrier facility under a 12-h light/dark cycle. Cells (2 × 106) were injected s.c. into the backs of the mice. At 1 wk after injection, the mice were randomly assigned to one of three or five groups (five to six mice per group) that received either vehicle, 25 mg/kg/d vandetanib, 25 mg/kg/d gefitinib, 5 mg/kg bevacizumab, or 25 mg/kg gefitinib plus 5 mg/kg bevacizumab. Vehicle, vandetanib, and gefitinib were administered once a day, five times a week by gavage. Bevacizumab (5 mg/kg) was administered twice a week i.p. Tumor volume (width2 × length/2) was determined periodically. After the completion of the treatment, two mice per group were sacrificed and the tumor specimens were obtained for analysis. All experiments involving animals were performed under the auspices of the Institutional Animal Care and Research Advisory Committee at the Department of Animal Resources, Okayama University Advanced Science Research.

Immunofluorescence staining. Frozen tissues were used for immunofluorescence analyses to assess microvessel density in xenograft tissues. The samples were cut into 8-μm-thick sections and mounted on MAS-coated glass slides. After fixation with 4% paraformaldehyde, they were washed with PBS, incubated with 10% bovine serum albumin in PBS for 15 min, and then incubated with a 1:100 dilution of rabbit phycoerythrin-conjugated anti-CD31 polyclonal antibody (BD Biosciences) overnight at 4°C in the dark. Nuclei were counterstained with 4′,6-diamidino-2-phenylindole (DAPI; Roche Applied Sciences GmbH) for 2 h in the dark. These slides were examined under a fluorescence microscope (LSM510, Carl Zeiss, Inc.).

Results

Vandetanib-resistant PC-9/VanR cell line established by continuous exposure to vandetanib in vitro. We established a stable vandetanib-resistant PC-9/VanR cell line from vandetanib-sensitive cells by continuous exposure to increasing concentrations of this agent. The human NSCLC cell line PC-9 was chosen as the parent cell line because it is highly sensitive to vandetanib (27). PC-9 was derived from an untreated Japanese patient with pulmonary adenocarcinoma carrying an in-frame deletion in EGFR exon 19 (delE746-A750; ref. 28). On microscopic observation, PC-9/VanR cells showed the same morphology as PC-9 cells (Fig. 1A, a and b). PC-9/VanR cells proliferated more rapidly than PC-9 cells with doubling times of 20.5 and 27.1 hours, respectively (Fig. 1B). The parent PC-9 cells were very sensitive to vandetanib and could not proliferate in the presence of 1 μmol/L of this agent, whereas PC-9/VanR cells continued to grow under this condition (Fig. 1A, c and d). The IC50 ± SD values of vandetanib in PC-9 and PC-9/VanR cells determined by MTT assay were 0.091 ± 0.027 and 4.6 ± 0.28 μmol/L, respectively (Fig. 1C; Table 1). PC-9/VanR cells were 50-fold more resistant to vandetanib than the parental PC-9 cells. The resistance was stable for at least 2 years without exposure to vandetanib. PC-9/VanR cells showed cross-resistance to the selective reversible EGFR-TKI, gefitinib (IC50 ± SD: 8.2 ± 2.0 μmol/L; Table 1), and collateral sensitivity to irreversible EGFR-TKI, CL387,785 (IC50 ± SD: 0.72 ± 0.51 μmol/L; Table 1).

Phosphorylation levels of EGFR and its downstream signal in PC-9/VanR cells were not suppressed by vandetanib treatment. Immunoblotting assay revealed that phospho-EGFR (pEGFR), phospho-HER2, and phospho-HER3 levels in PC-9/VanR cells were slightly higher than those in the parental PC-9 cells (Fig. 2A). RET receptor was not detected by immunoblotting in PC-9 or PC-9/VanR cells (data not shown); RET is mainly expressed in thyroid cancer (29).

The effects of vandetanib on pEGFR, phospho-Akt (pAkt), and pMAPK were also examined by immunoblotting (Fig. 2B). Vandetanib markedly suppressed pEGFR, pAkt, and pMAPK in PC-9 cells but not in the vandetanib-resistant PC-9/VanR cells.

EGFR T790M mutation and moderately increased MET amplification were detected in PC-9/VanR cells. The secondary T790M mutation is the major cause of acquired resistance to gefitinib and erlotinib in vivo and in vitro (7–10). To examine the genetic alterations, including the T790M mutation, we conducted direct sequencing assays of EGFR at exons 18 to 22, which revealed the T790M mutation at exon 20 as a minor peak in PC-9/VanR cells.
of these mutations was detected in the PC-9 and PC-9/VanR cells. No other genetic differences in EGFR DNA sequences between PC-9 and PC-9/VanR cells were detected (32). Next, we used a more sensitive assay for the EGFR T790M mutation: the peptide nucleic acid-locked nucleic acid PCR clamp-based detection test, which can detect 0.1% to 1% of mutated phenotype among normal ones (Mitsubishi Chemical Medience Corp.; refs. 33, 34). Using this method, we detected a T790M mutation in PC-9/VanR cells, but not in PC-9 cells, confirming the results of direct sequencing.

The second major cause of the acquired resistance of NSCLC to EGFR-TKIs in vitro and in vivo involves amplification and overexpression of MET (11–13). We examined differences in MET amplification between PC-9 and PC-9/VanR cells using a quantitative PCR method. MET amplification was moderately but significantly higher in PC-9/VanR cells (Fig. 3B). MET phosphorylation and expression levels were also moderately higher in PC-9/VanR cells based on an immunoblotting analysis (Fig. 3C). Quantitative PCR of the cDNA revealed elevated mRNA levels of HGF, a ligand of MET, in PC-9/VanR cells (Fig. 3D).

**MET** amplification, IGF-IR activation, or other causes were not responsible for the vantetanib resistance in PC-9/VanR cells. To examine whether EGFR T790M mutation or MET amplification primarily conferred resistance to vantetanib, we performed a MTT assay to compare the sensitivity of PC-9 and PC-9/VanR cells with the irreversible EGFR-TKI, CL387,785, which may preferentially inhibit signaling from T790M EGFR (35) and the MET inhibitor SU11274. Similar to PC-9 cells, PC-9/VanR cells were resistant to SU11274 and sensitive to CL387,785 (Fig. 4A; Table 1). These observations suggested that both cell lines remained dependent on EGFR signaling, with growth of neither cell line depending strongly on MET signaling. In addition, the level of pMET in PC-9/VanR cells decreased after treatment with CL387,785 (Fig. 4B), indicating that MET signaling of PC-9/VanR cells was to some extent dependent on EGFR signaling.

Next, we examined total IGF-IR and pIGF-IR in both cell lines by immunoblotting (Fig. 3C), as IGF-IR activation has also been reported to be another cause of acquired resistance to EGFR-TKI (36). The expression levels of IGF-IR were similar and pIGF-IR was undetectable in both cell lines. Similarly, PTEN expression was also unaltered (Fig. 3C), although PTEN inactivation has been reported to cause EGFR-TKI resistance (37–39). VEGFR-2 expression was evident in both PC-9 and PC-9/VanR cells, and we thus also compared the suppression of VEGFR-2 by vantetanib in PC-9 and PC-9/VanR cells (Fig. 4C).

**Table 1.** IC_{50} values of each TKI in PC-9 and PC-9/VanR cells determined by MTT assay

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<th>IC_{50} (μmol/L)</th>
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<tr>
<td>Vandetanib</td>
<td>PC-9 0.091 ± 0.027*</td>
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<tr>
<td></td>
<td>Gefitinib 0.059 ± 0.045*</td>
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<tr>
<td></td>
<td>CL387,785 1.6 ± 0.79*</td>
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<tr>
<td>RR</td>
<td>50 138 0.45</td>
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Abbreviation: RR, relative resistance.

*P < 0.05 (t test).
(pVEGFR-2) was inhibited to a similar extent in PC-9 and PC-9/VanR cells.

Taken together, these observations indicated that the T790M secondary mutation was the major mechanism of in vitro resistance to vandetanib in PC-9/VanR cells.

Effects of vandetanib on T790M harboring tumor in a xenograft model. We examined xenograft tumors to determine the degree of vandetanib resistance caused by the T790M mutation in vivo. In the vehicle-treated animals, PC-9 and PC-9/VanR xenograft tumors grew at almost the same rate (Fig. 5A, left, top and bottom). As anticipated, both vandetanib and gefitinib strongly inhibited the growth of PC-9 xenografts, producing marked tumor regression (Fig. 5A, left, top). In contrast to the in vitro experiment, vandetanib effectively inhibited the growth of PC-9/VanR tumors in the xenograft model, albeit to a lesser extent than in the PC-9 tumor xenografts, producing sustained inhibition of tumor growth rather than tumor regression (Fig. 5A, left, bottom). In contrast, gefitinib only modestly inhibited the growth of PC-9/VanR tumors. To know whether the superiority of vandetanib over gefitinib is confirmed in other cancer cells harboring T790M mutation,
two xenografts were examined using two lung adenocarcinoma cell lines, RPC-9 (exon 19 in-frame deletion/exon 20 T790M) and H1975 (exon 21 L858R/exon 20 T790M), both of which were highly resistant to gefitinib but were more sensitive to vandetanib than gefitinib in vitro (7, 9). The IC\textsubscript{50} ± SD values of gefitinib and vandetanib in the H1975 cells were 14.3 ± 0.7 and 6.9 ± 0.3 μmol/L, respectively. The RPC-9 and H1975 cells are more sensitive to vandetanib than gefitinib in vitro. Vandetanib inhibited the growth of RPC-9 xenografts to a significantly greater extent than gefitinib (P < 0.05), resulting in tumor regression (Fig. 5A, right, top). In the H1975 xenografts, vandetanib inhibited tumor growth to a greater extent than gefitinib (P < 0.05) but was unable to inhibit the growth of H1975 tumors completely (Fig. 5A, right, bottom).

We next examined the cause of the different inhibitory effects of vandetanib and gefitinib on PC-9/VanR xenografts via direct sequencing assay, an immunoblotting analysis, and immunofluorescence staining of PC-9/VanR tumor specimens obtained after completion of 4 weeks of treatment. T790M mutation was preserved in xenografts of every group (data not shown). As anticipated, vandetanib suppressed pVEGFR-2, whereas gefitinib did not (Fig. 5B, top). In addition, vandetanib treatment reduced pEGFR levels more effectively than gefitinib (P < 0.05) but was unable to inhibit the growth of H1975 tumors completely (Fig. 5B, right, bottom).

We next examined the cause of the different inhibitory effects of vandetanib and gefitinib on PC-9/VanR xenografts via direct sequencing assay, an immunoblotting analysis, and immunofluorescence staining of PC-9/VanR tumor specimens obtained after completion of 4 weeks of treatment. T790M mutation was preserved in xenografts of every group (data not shown). As anticipated, vandetanib suppressed pVEGFR-2, whereas gefitinib did not (Fig. 5B, top). In addition, vandetanib treatment reduced pEGFR levels more effectively than gefitinib (P < 0.05) but was unable to inhibit the growth of H1975 tumors completely (Fig. 5B, right, bottom).

To exclude the possibility that the difference of drug distribution between vandetanib and gefitinib to xenografts caused the different tumor inhibition, we assessed pEGFR levels in xenograft tumors 2 hours after administering a single dose of vehicle, vandetanib (25 mg/kg), or gefitinib (25 mg/kg). Vandetanib and gefitinib incompletely inhibited pEGFR to a similar extent and did not alter the total amount of EGFR (Fig. 5B, bottom). From this result, it was estimated that vandetanib and gefitinib achieved similar distribution to PC-9/VanR xenografts.

Because vandetanib can inhibit VEGF signaling, we next stained by immunofluorescence with anti-CD31 antibody detecting microvessels to evaluate the state of angiogenesis in PC-9/VanR tumors. Compared with vehicle- or gefitinib-treated tumors, vandetanib-treated tumors showed markedly fewer CD31-positive cells (Fig. 5C). To confirm whether the superiority of vandetanib over gefitinib in the xenograft models was due to the antiangiogenic effects of vandetanibmediated by inhibition of VEGF signaling, PC-9/VanR xenografts were treated with bevacizumab (a VEGF inhibitor) alone or gefitinib in combination with bevacizumab (Fig. 5D). Bevacizumab alone inhibited tumor growth and combined gefitinib with bevacizumab inhibited tumor growth more efficiently than gefitinib alone.

**Discussion**

This is the first report of a secondary EGFR T790M mutation detected during treatment with a reversible multitarget TKI in vitro. Note that xenograft tumors bearing the T790M mutation remained sensitive to vandetanib, but not gefitinib, although these cell lines were resistant to both agents in vitro.

The T790M mutation at EGFR exon 20 (7–9) and MET gene amplification (11–13) were reported to be major causes of resistance to the selective EGFR-TKIs gefitinib and erlotinib. IGF-IR activation...
(36), PTEN loss (37–39), and D761Y and L747S mutations at EGFR exon 20 (30, 31) have also been reported as other causes of resistance. PC-9/VanR cells acquired the secondary T790M mutation and moderately elevated MET amplification. Although it is possible that both mechanisms could be the causes of vandetanib resistance in PC-9/VanR cells in vitro, the collateral sensitivity to an irreversible EGFR-TKI, CL387,785 (Table 1), like other gefitinib-resistant cell lines bearing the T790M mutations (8, 9), and resistance to the MET inhibitor, SU11274, indicated ongoing oncogene addiction to EGFR signaling in PC-9/VanR cells. The microvessel density in PC-9/VanR xenografts was evaluated by immunofluorescence staining. Frozen samples were taken from xenograft tumors treated with vehicle, vandetanib, or gefitinib after 4 wk of treatment. Vessel endothelial cells and nuclei of tumor cells were stained with anti-CD31 antibody and DAPI, respectively. The mechanism associated with emergence of the T790M mutation during treatment with gefitinib or erlotinib is not fully understood. Vandetanib shares some common structural features with gefitinib or erlotinib (42–44), and these may contribute to the emergence of the T790M mutation during prolonged exposure to vandetanib.
We next examined whether vandetanib still had some advantages over selective EGFR-TKIs even in the presence of an EGFR T790M mutation due to its ability to inhibit other RTKs, including VEGFR-2. First, we compared the sensitivity to vandetanib with that to gefitinib in PC-9/VanR cells in vitro. The IC50 value of vandetanib in PC-9/VanR cells was lower than that of gefitinib, although in the parental PC-9 cells, the IC50 value of vandetanib was higher than that of gefitinib (Table 1). A similar tendency was also observed in RPC-9 cells (exon 19 in-frame deletion/exon 20 T790M), a subline that we had previously established from PC-9 cells by continuous exposure to gefitinib (Table 1). A similar tendency was also observed in RPC-9 cells (exon 19 in-frame deletion/exon 20 T790M), a subline that we had previously established from PC-9 cells by continuous exposure to gefitinib (Table 1). A similar tendency was also observed in RPC-9 cells (exon 19 in-frame deletion/exon 20 T790M), a subline that we had previously established from PC-9 cells by continuous exposure to gefitinib (Table 1).

In vivo, gefitinib treatment in PC-9/VanR xenografts more potently than gefitinib.

With regard to how best to overcome the T790M resistance mutation, irreversible EGFR-TKIs such as HKI-272 and EKB-569 are attracting attention because of their promising effectiveness in the clinical setting. In the phase I trial of H272 and EKB-569, dose-limiting toxicity occurred with these drugs at plasma concentrations of 0.04 to 0.2 μmol/L (48, 49), whereas the in vitro studies were performed using concentrations of >1 μmol/L (41, 47). In the clinical setting, irreversible EGFR-TKIs may reach the maximum tolerated dose (MTD) before exerting the antitumor effect, possibly due to their strong inhibition of EGFR. In contrast to these irreversible EGFR-TKIs, the plasma concentration of vandetanib at MTD was reported to be >2 μmol/L (50), although this is still below the IC50 value of vandetanib in PC-9/VanR cells. In the case of vandetanib, it may be possible that VEGFR-2 inhibition together with the ability to achieve higher plasma drug concentrations would overcome the T790M mutation in a clinical setting.

In conclusion, prolonged exposure of PC-9 cells to the multitarget TKI vandetanib selected for or induced the EGFR T790M mutation, as reported for other highly selective EGFR-TKIs, gefitinib and erlotinib, and produced a cell line (PC-9/VanR) that was resistant to the antitumor effects of vandetanib in vitro. However, in vivo, vandetanib remained effective against PC-9/VanR tumor xenografts. This in vivo efficacy also extended T790M-harbouring RPC-9 and H1975 tumor cell xenografts. These data suggest that vandetanib may produce more durable effects than highly selective EGFR-TKIs in a clinical setting and further investigation of vandetanib in patients harboring T790M mutations is warranted.

Disclosure of Potential Conflicts of Interest

K. Kiura: Honoraria from speakers bureau, AstraZeneca. The other authors disclosed no potential conflicts of interest.

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