

Pilot Study of Rosiglitazone Therapy in Women with Breast Cancer: Effects of Short-term Therapy on Tumor Tissue and Serum Markers

Lisa D. Yee,¹ Nita Williams,² Ping Wen,² Donn C. Young,³ Joanne Lester,¹ Maria V. Johnson,¹ William B. Farrar,¹ Michael J. Walker,¹ Stephen P. Povoski,¹ Saul Suster,² and Charis Eng^{4,5,6,7,8}

Abstract Purpose: Peroxisome proliferator-activated receptor γ (PPAR γ) is a steroid nuclear receptor that is activated by natural compounds such as specific fatty acids and synthetic drugs such as thiazolidinedione antidiabetic agents. Expressed in normal and malignant mammary epithelial cells, activation of PPAR γ is associated with antiproliferative effects on human breast cancer cells in preclinical studies. The purpose of this study was to test the hypothesis that PPAR γ ligand therapy might inhibit tumor growth and progression in human breast cancer.

Experimental Design: We conducted a pilot trial of short-term (2-6 weeks) treatment with the thiazolidinedione rosiglitazone in 38 women with early-stage (T_{is}-T₂, N₀₋₁, M₀) breast cancer, administered between the time of diagnostic biopsy and definitive surgery.

Results: Short-term treatment with rosiglitazone (8 mg/d) did not elicit significant effects on breast tumor cell proliferation using Ki67 expression as a measure of cell proliferation and surrogate marker of tumor growth and progression. In pretreatment tumors notable for nuclear expression of PPAR γ by immunohistochemistry, down-regulation of nuclear PPAR γ expression occurred following rosiglitazone administration ($P = 0.005$). No *PPARG* mutations were identified, and the incidence of P12A and H446H polymorphisms did not differ relative to U.S. controls ($P = 0.5$). Treatment with rosiglitazone resulted in increased serum adiponectin ($P < 0.001$), decreased insulin levels ($P = 0.005$), and increased insulin sensitivity ($P = 0.004$). Rosiglitazone was well tolerated without serious adverse events.

Conclusion: Our data indicate that short-term rosiglitazone therapy in early-stage breast cancer patients leads to local and systemic effects on PPAR γ signaling that may be relevant to breast cancer.

Peroxisome proliferator-activated receptor γ (PPAR γ) is a ligand-activated transcription factor homologous to other members of the steroid receptor superfamily, including the retinoid, vitamin D, thyroid, estrogen, and progesterone receptors. PPAR γ binds to specific DNA sequences, known as peroxisome proliferator response elements, forming a heterodimer with retinoid X receptor to initiate transcription of downstream genes (1-3). Ligands for PPAR γ include specific fatty acids, eicosanoids, and synthetic compound (4-6).

Synthetic ligands for PPAR γ include the thiazolidinediones, a class of oral hypoglycemic drugs that reduce hyperglycemia and hyperinsulinemia in insulin-resistant states. Rosiglitazone (Avandia, Glaxo SmithKline Beecham, Philadelphia, PA) is a thiazolidinedione in clinical use for treatment of type 2 diabetes mellitus. Activation of PPAR γ regulates the expression of insulin-responsive genes involved in the regulation of glucose and fatty acid metabolism. Rosiglitazone reduces blood glucose levels and hyperinsulinemia in rodent models of type 2 diabetes mellitus, which seems to be mediated by the action of insulin in liver, muscle, and fat tissue.

Highly expressed in adipose tissue, PPAR γ is also expressed by benign and malignant breast epithelium (7-9). Thiazolidinedione activators of PPAR γ seem to promote tumor cell differentiation and inhibit tumor cell proliferation (7). *In vivo* studies using xenograft or carcinogen-induced models of mammary tumorigenesis indicate inhibitory effects of PPAR γ ligand treatment (10, 11). Furthermore, PPAR γ haploinsufficiency (PPAR $\gamma^{+/-}$) also confers increased susceptibility to dimethylbenz(a)anthracene-induced mammary carcinogenesis (12). These studies suggest that PPAR γ ligands could serve as negative regulators of breast cancer development and progression.

We conducted a pilot trial of rosiglitazone to test the hypothesis that ligand activation of PPAR γ in human breast cancer leads to the inhibition of tumor growth and progression.

Authors' Affiliations: ¹Division of Surgical Oncology, Department of Surgery and Departments of ²Pathology and ³Biostatistics, The Ohio State University, Columbus, Ohio; ⁴Genomic Medicine Institute, ⁵Lerner Research Institute, and ⁶Taussig Cancer Center, Cleveland Clinic Foundation; and ⁷Department of Genetics and ⁸CASE Comprehensive Cancer Center, Case Western Reserve University School of Medicine, Cleveland, Ohio

Received 8/7/06; revised 10/6/06; accepted 10/16/06.

Grant support: Department of Defense grant DAMD 170110357 (L.D. Yee and C. Eng), the General Clinical Research Center at The Ohio State University, grant M01-RR00034 from the National Center of Research Resources of the NIH, and the Doris Duke Distinguished Clinical Scientist Award (C. Eng).

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.

Requests for reprints: Lisa D. Yee, Department of Surgery, Division of Surgical Oncology, N924 Doan Hall, 410 West 10th Avenue, Columbus, OH 43210. Phone: 614-293-6654; Fax: 614-293-3465; E-mail: lisa.yee@osumc.edu.

© 2007 American Association for Cancer Research.

doi:10.1158/1078-0432.CCR-06-1947

To this end, short-term treatment with rosiglitazone in women with breast cancer during the period between the diagnostic breast biopsy and definitive surgical procedure of lumpectomy or mastectomy was initiated to prospectively evaluate the effect of this PPAR γ ligand in modulating tumor cell proliferation. Differences in Ki67 nuclear staining in tumor specimens from the initial biopsy versus subsequent reexcision served as the primary study end point, using Ki67 expression as a surrogate measure of tumor growth. Secondary objectives included determination of (a) tolerability and toxicity of rosiglitazone during the short-term treatment of women newly diagnosed with breast cancer; (b) differences in tumor cell differentiation in pretreatment and posttreatment tumor samples; (c) the association of *PPARG* gene mutations in breast cancer specimens; and (d) alterations of exploratory serum markers of insulin resistance and rosiglitazone administration.

Patients and Methods

Patients. Women newly diagnosed with breast cancer following core needle or nonexcisional biopsy, to undergo definitive surgery for breast cancer for T_{is}, T₁, T₂ tumors, were eligible to participate. Given the inhibitory effects of PPAR γ ligands on normal and malignant mammary epithelial proliferation *in vitro* and mammary carcinogenesis in animal models, we viewed both *in situ* and invasive breast cancers as potentially responsive to rosiglitazone. Subjects were screened for sufficient tumor tissue in biopsy blocks as well as residual tumor in the breast by clinical examination and/or imaging studies. Ineligibility criteria included abnormal fasting blood glucose or liver function tests and history of diabetes mellitus, heart failure, peripheral edema, and/or liver disease.

For purposes of comparing *PPARG* germ-line variant frequencies in cases (those with breast cancer) and controls, we used genomic DNA extracted from 110 unrelated white (of Northern and Western European origin) populational controls, who were healthy volunteers resident in the central Ohio region.

Trial design. An open-label clinical trial was conducted at The Ohio State University with approval of the Institutional Review Board of The Ohio State University and Human Subjects Review Board of the Department of Defense. After obtaining informed consent, rosiglitazone was administered orally at 4 mg twice a day for 2 to 6 weeks until the morning of lumpectomy or mastectomy. Patients used a daily diary to record all adverse events that occurred during the treatment period. Study personnel also contacted patients at least once during the treatment period to assess compliance and any potential problems. Formalin-fixed, paraffin-embedded tumor samples from the biopsy and lumpectomy or mastectomy procedures were used for the correlative tissue analyses. Serum alanine transaminase levels were checked before study entry, every 2 weeks while on the study medication, and at 4 weeks following the last dose of drug on the day of definitive breast cancer surgery. Additional blood samples were obtained at baseline, day of surgery, and 1 month after surgery from patients participating in serum biomarker analyses.

Statistical considerations

Sample size. Our projected sample size of 34 patients was based on an estimated effect size from published studies of proliferation indices of 0.5 with a two-sided α of 0.05 and a power of 0.8 using a paired *t* test or Wilcoxon matched-pairs signed-ranks test.

For the genetic analyses, we based sample size calculations on tests of the primary hypotheses that polymorphisms in *PPARG* will be associated with disease status (13, 14). Each of the described polymorphisms occurs at a single nucleotide, with only 2 bases observed in the population, such that the sample size of 34 subjects

would be more than sufficient to detect association when a minimum of two (P12A and H446H) and a possible four simultaneous comparisons are done.

Analysis. Analysis of proliferation was done using paired *t* tests and Wilcoxon matched-pairs signed-ranks tests of data from specimens taken at initial biopsy and at surgery following rosiglitazone treatment. Analysis of adiponectin and insulin sensitivity over three time points was done using ANOVA; if the overall *P* value was significant, paired *t* tests were used to compare data at time points. Analysis of categorical data was done using Fisher's exact test. Discordance in change in categories of nuclear and cytoplasmic staining intensity was analyzed using the McNemar test. Two-tailed $P \leq 0.05$ was considered statistically significant. Analyses were done using SPSS 14.0 (SPSS, Inc., Chicago, IL).

For *PPARG* mutation analysis, 110 controls as described above were matched to cases with a control/case ratio of 2.97. The statistical power calculations were done assuming a control/case ratio of 2, to provide conservative power calculations. The data from Zhou et al. (13) were used to estimate the allele frequencies and association effect size. The association test seeks evidence that the polymorphic allele is associated with disease. The resulting contingency tables included both alleles for each individual and implicitly assumed that the two alleles are independent (conditioned on disease status). We used a type I error probability of 0.05, and all proposed statistical comparisons were two sided. Based on standard normal approximations implemented in S-Plus 3.4 (Mathsoft, Inc., Needham, MA) and for the sample size of 34, the power to detect the association at the two sites exceeds 0.75. After a Bonferroni correction for multiple comparisons, the power at the two sites is ~ 0.7 .

Serum analyses

Fasting blood draws were obtained from all subjects at the time of enrollment (time 0), every 2 weeks while on study drug and/or day of surgery (time 1), and ~ 30 days following the last dose on the day of surgery (time 2). These samples were processed by the Ohio State University Clinical Laboratories for alanine transaminase, with glucose and insulin levels obtained at time 0 and time 2. For 17 subjects, additional sera from blood samples collected at the time of enrollment, day of surgery, and 1 month after surgery were stored at -80°C until analysis. Samples were analyzed in duplicate for C-peptide of insulin by RIA (Diagnostic Systems Laboratories, Inc., Webster, TX); insulin by chemiluminescence methods (Diagnostic Products Corporation, Los Angeles, CA); glucose by immobilized enzyme technology using the YSI 2300 Stat Plus Glucose and Lactate Analyzer (YSI International, Yellow Springs, OH); insulin-like growth factor (IGF)-I and IGF binding protein 3 using the Advantage chemiluminescence autoanalyzer (Nichols Diagnostics, San Clemente, CA); leptin and adiponectin by RIA (Linco Research, St. Charles, MO); and interleukin-6 and matrix metalloproteinase-9 (total) by ELISA (R&D Systems, Minneapolis, MN). All assays were done according to the manufacturers' instructions at the General Clinical Research Center of The Ohio State University.

Histologic analysis

Routine staining with H&E was done on all tumor tissue specimens. Immunohistochemistry was done with 4- μm -thick tissue sections using standard techniques. Following deparaffinization and rehydration through xylenes and graded ethanol solutions, slides were quenched for 5 min in a 3% hydrogen peroxide solution to block endogenous peroxidase activity. Antigen retrieval was done by incubating slides in citrate buffer pH 6.1 (DAKO, Carpinteria, CA) in a vegetable steamer. Slides were then placed on a DAKO Autostainer (DAKO) and incubated with either primary antibody to PPAR γ (Santa Cruz Biotechnology, Santa Cruz, CA) at 1:12 dilution for 60 min or Ki67 (DAKO, M7240) at 1:150 dilution for 30 min at room temperature. Following blocking for endogenous biotin with an avidin/biotin blocking system (DAKO), the Labeled Streptavidin-Biotin Complex Plus (DAKO) was used. Slides were then counterstained in Richard Allen hematoxylin, dehydrated

through graded ethanol solutions, and coverslipped. Slides were analyzed blindly, with assessment of Ki67 expression as percent of positive tumor cells and PPAR γ expression as 0 to 3+ staining intensity of tumor cell nucleus and/or cytoplasm.

DNA extraction and PPAR γ analysis

Tissues from 10- μ m-thick sections of paraffin-embedded tumor and case-matched normal breast tissue were scraped from slides or obtained via laser capture microdissection as needed. The samples were deparaffinized, followed by DNA isolation using a modified QIAamp (Qiagen, Valencia CA). As previously described, DNA amplification was done and confirmed in agarose gels, followed by loading samples onto 15% to 65% gradient gels for differential gradient gel electrophoresis (13). Migration patterns were compared with historic sample controls.

Results

Patients and treatment. Between February 2002 and August 2004, 39 patients were enrolled in the trial at the Ohio State University. Thirty-eight patients completed the study. One subject withdrew to undergo surgery at an earlier date; with only 2 days of study medication, she was not eligible for evaluation. Based on self-reports and pill counts, compliance to the treatment was excellent at nearly 100%. All subjects completed the study with a 1 month postoperative visit and blood draw. Four subjects did not have sufficient tumor tissue for the correlative analyses despite pre-enrollment screening efforts to avoid this outcome. Additional blood samples were obtained from 17 subjects for serum biomarker analyses. Patient and tumor characteristics are depicted in Table 1.

Rosiglitazone does not alter cell proliferation. Ki67 is a nuclear protein expressed by proliferating cells, thus indicative of tumor cell proliferation. Analysis of Ki67 immunoreactivity as either the mean percentage of immunostained cell nuclei or as the observed range of heterogeneous staining did not disclose statistically significant differences between Ki67 expression in pretreatment and posttreatment tumor samples (Table 2). Discontinuation of hormone replacement therapy or oral contraceptive use at the time of breast cancer diagnosis did not significantly affect the overall results ($n = 6$), with decreased Ki67 expression levels in three subjects and stable values in the other three patients.

Similarly, comparison of H&E-stained sections from pretreatment and posttreatment tumor specimens failed to identify differences in tubule formation, mitotic activity, and nuclear morphology as measures of tumor cell differentiation (data not shown).

Rosiglitazone effects on PPAR γ expression in breast tumor specimens. PPAR γ immunostaining intensity was scored from 0 (none) to 3+ (highest) in breast cancer tissue specimens pre- and post-rosiglitazone treatment ($n = 34$), with instances of heterogeneous staining indicated as a range of intensity scores. PPAR γ expression did not differ significantly when assessed as increased, decreased, or unchanged from baseline levels, with overlap between the range of pretreatment or posttreatment values designated as unchanged ($P = 0.24$; Table 3). However, using absolute values of mean intensity scores, PPAR γ immunostaining decreased with short-term rosiglitazone therapy ($P < 0.001$). Baseline nuclear and cytoplasmic staining intensities of 1.01 ± 0.88 (SD) and 1.29 ± 0.71 decreased to

0.37 ± 0.57 ($P = 0.004$) and 0.9 ± 0.49 ($P = 0.21$), respectively. When considering only cases with baseline PPAR γ immunostaining levels of 1+ to 2+ ($n = 17$; i.e. those with potential for decreasing or increasing to 0 or 3+, respectively), nuclear PPAR γ expression decreased significantly in 84% (14 of 17) of patients following administration of rosiglitazone ($P = 0.005$; Table 4).

Somatic mutations in PPAR γ . In 37 cases of matched tumor and normal breast tissue specimens, we did not identify any subjects with somatic mutations in PPAR γ . One case did not have sufficient tissue for analysis. There were two patients with the P12A polymorphism, one with the H446H polymorphism, and five with both polymorphisms. No significant differences in the distribution of alleles at each site relative to U.S. controls ($P = 0.5$) were detected.

Rosiglitazone treatment increases adiponectin levels and insulin sensitivity. In 17 patients, fasting serum samples obtained pretreatment and posttreatment (day of surgery and then 1 month after surgery) were analyzed for insulin, glucose, C-peptide, IGF-I, IGF binding protein 3, adiponectin, leptin, interleukin-6, and matrix metalloproteinase-9 levels (Table 5). Glucose levels obtained before initiation of rosiglitazone treatment were significantly lower than both posttherapy time points ($P = 0.019$), but all of the levels were within normal limits, ranging from ~ 55 to 70 mg/dL and ~ 64 to 85 mg/dL, respectively. Insulin levels were lower on the last day of

Table 1. Patient and tumor characteristics

Age range (median), y	27-85 (52)
Race, n (%)	
White	36 (95)
African American	2 (5)
Menopausal status, n (%)	
Pre- or peri-menopausal	16 (42)
Postmenopausal	19 (50)
Unknown	3 (8)
Hormone use, n (%)	
None	22
Past history	8
Current at diagnosis	8
Tumor size, n (%)	
T _{is}	2 (5)
T _{1mic}	2 (5)
T _{1a}	2 (5)
T _{1b}	4 (11)
T _{1c}	16 (42)
T ₂	12 (32)
Axillary nodal status, n (%)	
Negative	29 (76)
Positive	9 (24)
Stage, n (%)	
0	2 (5)
I	20 (53)
IIA	8 (21)
IIB	8 (21)
Estrogen receptor	
Negative	10
Positive	26
Progesterone receptor	
Negative	15
Positive	21
HER-2/neu overexpression	
Negative	28
Positive	8

Table 2. Ki67 expression in biopsy and surgical specimens

Pre-rosiglitazone (mean)	Post-rosiglitazone (mean)	Δ pre-post (Δ mean)*
<5	<5	↔
<5	<5	↔
5	5	↔
70-90 (80)	70-90 (80)	↔ (↔)
5-10 (7.5)	5-10 (7.5)	↔ (↔)
70-80 (75)	70-80 (75)	↔ (↔)
20-40 (30)	20-40 (30)	↔ (↔)
10-30 (20)	10-30 (20)	↔ (↔)
60-90 (75)	60-90 (75)	↔ (↔)
30-50 (40)	30-50 (40)	↔ (↔)
5-10 (7.5)	5-10 (7.5)	↔ (↔)
10	5-10 (7.5)	↔ (↓)
5-10 (7.5)	5	↔ (↓)
20-40 (30)	20-30 (25)	↔ (↓)
40-60 (50)	30-50 (40)	↔ (↓)
10-39 (20)	5-10 (7.5)	↔ (↓)
10-30 (20)	10-20 (15)	↔ (↓)
0-10 (5)	<5	↔ (↓)
10	10-20 (15)	↔ (↑)
5-10 (7.5)	10-20 (15)	↔ (↑)
30-40 (35)	30-50 (40)	↔ (↑)
10-30 (20)	20-30 (25)	↔ (↑)
10-20 (15)	20-40 (30)	↔ (↑)
5-10 (7.5)	10-20 (15)	↔ (↑)
10	10-20 (15)	↔ (↑)
10-20 (15)	5	↓ (↓)
20-30 (25)	5	↓ (↓)
20-40 (30)	5-10 (7.5)	↓ (↓)
10	5	↓
20-30 (25)	<1	↓ (↓)
5-10 (7.5)	<5	↓ (↓)
<1	10	↑

NOTE: Ki67 expression was assessed as percentage of cell nuclei with immunostaining in 32 evaluable cases, with the range of staining indicated for instances of heterogeneity. Change (Δ) between pretreatment and posttreatment values is indicated as increased (↑), decreased (↓), or unchanged (↔). Unchanged values include those with overlap between ranges of pretreatment and posttreatment staining.

**P* nonsignificant at >0.05.

treatment (day of surgery) compared with both the pretreatment and 1 month posttreatment levels ($P = 0.005$). As calculated by the quantitative insulin sensitivity check index [QUICKI = $1 / [\log(I) + \log(G)]$; ref. 15], insulin sensitivity increased with rosiglitazone relative to pretreatment and posttreatment values ($P = 0.004$). Adiponectin levels significantly increased with rosiglitazone administration, as samples obtained on the day of surgery had significantly higher levels than those obtained before therapy or 1 month after discontinuation of the study drug ($P < 0.001$ and $P < 0.001$, respectively). The adiponectin levels at these first and last time points did not differ ($P = 0.99$).

Levels of C-peptide, as a measure of insulin secretion and disposal, did not differ significantly between the pretherapy and day of surgery ($P = 0.90$) and 1 month posttreatment ($P = 0.07$), but the 1 month posttreatment levels were higher than those on the day of surgery ($P = 0.024$) with an overall significant decrease between treated and untreated conditions ($P = 0.014$). IGF-I ($P = 0.91$), IGF binding protein 3 ($P = 0.98$),

leptin ($P = 0.57$), interleukin-6 ($P = 0.86$), and matrix metalloproteinase-9 ($P = 0.61$) did not differ significantly between any of the time points.

Tolerability and toxicity of rosiglitazone. Rosiglitazone was tolerated without any serious or unexpected adverse events. Nineteen of 38 (50%) subjects reported no adverse events, whereas 19 patients experienced single or multiple adverse events. Most of the reported events seemed to be unrelated to the study intervention and were grade 1 or 2 in severity. Table 6 summarizes the rosiglitazone-related adverse events. Transient grade 1 elevations of alanine transaminase were observed in two subjects and probably related to rosiglitazone therapy. One of the subjects had initiated chemotherapy with doxorubicin and cyclophosphamide before the 30-day postoperative visit, and the second instance occurred with the alanine transaminase level obtained the day after surgery rather than before the procedure. Upper respiratory infection symptoms, a known side effect of rosiglitazone, were reported by one subject and also likely related to the study intervention. Five of six reported headaches (four grade 1 and one grade 2) seemed possibly related to rosiglitazone.

Discussion

Despite preclinical evidence of the antiproliferative effects of thiazolidinediones in breast cancer, we did not detect significant differences in Ki67 expression between pretreatment and posttreatment tumor tissues in this prospective study of rosiglitazone therapy in early-stage breast cancer patients. Rosiglitazone at 8 mg yields a maximum serum concentration ($C_{\max} \pm SD$) of 598 ± 117 mg/mL (Avandia package insert) or $1.67 \mu\text{mol/L}$, which is within the 1 to 10 $\mu\text{mol/L}$ range used to induce antiproliferative effects on mammary epithelial cells *in vitro* (9, 16). The lack of effect on Ki67 expression may relate to the short treatment period as well as the use of a dose capable of insulin sensitization, but not tumor suppression, on an acute basis. Indeed, serum indices of increased insulin sensitivity showed systemic effects of the drug in the subset of subjects tested. Possibly, combination therapy with a retinoid X receptor ligand or other agent might have yielded significant short-term effects on tumor cell proliferation, as suggested by preclinical studies (10, 17).

Additionally, heterogeneity of tumor features, such as expression of specific cofactors and/or corepressors, stage of disease, and certain patient characteristics may confound the results (18–20). For example, a recent study suggests that the coactivator amplified-in-breast cancer 3 is needed for the

Table 3. Cross-tabulation of changes in nuclear and cytoplasmic PPAR γ expression relative to baseline

Change in cytoplasmic PPAR γ	Change in nuclear PPAR γ			Total
	Decreased	Increased	Unchanged	
Decreased	13	0	2	15
Increased	0	1	3	4
Unchanged	2	2	11	15
Total	15	3	16	34

Table 4. Cross-tabulation of PPAR γ expression pretreatment and posttreatment

	Staining intensity score	Nuclear PPAR γ post-rosiglitazone							Total
		0.00	0.25	0.50	0.75	1.00	1.50	2.00	
Nuclear PPAR γ pre-treatment	0.00	3	0	1	0	0	0	2	6
	0.25	2	1	0	1	1	0	0	5
	0.50	1	0	1	0	0	0	0	2
	0.75	0	1	0	0	0	0	0	1
	1.00	5	0	1	0	2	0	0	8
	1.25	0	1	1	0	0	0	0	2
	1.50	3	0	0	0	0	1	0	4
	2.00	2	0	1	0	0	0	0	3
Total	3.00	3	0	0	0	0	0	0	3
Total		19	3	5	1	3	1	2	34

	Staining intensity score	Cytoplasmic PPAR γ post-rosiglitazone							Total
		0.00	0.25	0.50	0.75	1.00	1.50	2.00	
Cytoplasmic PPAR γ pre-rosiglitazone	0.00	0	0	0	0	1	0	0	1
	0.50	0	0	1	1	0	0	0	2
	0.75	1	0	1	1	0	0	0	3
	1.00	0	2	3	1	6	4	1	17
	1.50	0	0	0	0	1	1	1	3
	2.00	1	0	2	0	2	0	0	5
	3.00	0	0	0	0	3	0	0	3
Total		2	2	7	3	13	5	2	34

inhibition of cell proliferation by PPAR γ (21). Studies from our own group also indicate that responsiveness to rosiglitazone requires at least one functional *PTEN* allele such that tumors with homozygous *PTEN* deletions or promoter mutations would prove refractory to treatment (22). Furthermore, signaling cross-talk between PPAR γ and estrogen receptor could lead to differential effects of PPAR γ ligand activation in breast cancer (23, 24). These reports raise the possibility that specific molecular profiles of the breast cancer may predict response to rosiglitazone and perhaps other thiazolidenediones. Despite a decrease in Ki67 immunostaining after rosiglitazone administration in seven subjects, our small sample size did not support subset analyses to assess correlation with specific tumor and/or patient characteristics (e.g., estrogen receptor expression, tumor size, and menopausal status).

Intriguingly, rosiglitazone treatment is associated with down-regulation of nuclear PPAR γ expression in breast cancers with a minimum threshold level of PPAR γ expression. Our data indicate that tumors with nuclear PPAR γ immunostaining intensity at 1+ to 2+ are likely to respond to rosiglitazone with decreased nuclear expression, whereas PPAR γ expression does not change significantly if baseline levels are low to negligible. Decreased expression of nuclear PPAR γ raises the possibility of receptor activation and subsequent degradation, as observed *in vitro* (25), and may indicate rosiglitazone-mediated effects on breast cancer cell signaling in specific tumors. Localization of this nuclear receptor to the cytoplasm is of uncertain significance. Although tumor cell proliferation seems to be unaffected by short-term rosiglitazone therapy, further studies are needed to evaluate other end points of PPAR γ signaling that might affect mammary carcinogenesis.

Of interest is the increase in serum adiponectin levels as a result of rosiglitazone administration. Expressed in adipose

tissue and strongly induced during *in vitro* differentiation of preadipocytes, adiponectin is a 30-kDa protein secreted by adipose tissue with insulin-sensitizing and anti-inflammatory effects (26, 27). PPAR γ activation stimulates adiponectin production *in vitro* and *in vivo*, and circulating adiponectin levels seem to be markedly suppressed in insulin-resistant subjects with dominant negative PPAR γ mutations (P467L, V290M; ref. 28). Thus, adiponectin seems to be useful as an early and specific biomarker for PPAR γ activation.

Serum adiponectin levels may also inversely correlate with breast cancer risk based on case-control studies in women newly diagnosed with breast cancer (29). Additionally, adiponectin is a potential endogenous inhibitor of angiogenesis, suppressing endothelial cell proliferation and migration *in vitro* and neovascularization *in vivo* (30). Adiponectin levels also correlate inversely with insulin resistance, a factor associated with increased risk for breast cancer (31). Our data indicate that adiponectin levels in early-stage breast cancer patients can be increased by short-term drug intervention. The potential therapeutic implications of modulating adiponectin levels require further study.

We initially found somatic *PPARG* mutations in exons 3 and 5 with loss of function in 4 of 55 sporadic colon cancers originating mainly from Finland (32), but a subsequent study screening exons 3 and 5 in *PPARG* in nearly 400 clinical samples (including 37 breast cancers) and cell lines suggests that mutations in these specific exons occur rarely in human malignancies (33). Additionally, screening of 170 primary colorectal tumors and 12 liver metastases failed to identify a loss-of-function point mutation in exon 6 (K422Q) detected in colon cancer cell lines (34). With analyses limited to specific *PPARG* exons, however, these latter two reports are somewhat problematic for evaluation of a putative tumor suppressor gene. Nonetheless, our analysis of 37 women with breast cancer for

Table 5. Serum markers of insulin resistance and PPAR γ activation \pm rosiglitazone therapy

	Time	Subjects (n)	Mean (SD)	P
Adiponectin	0	17	16.39 (7.54)	<0.001
	1	17	29.69 (10.12)	
	2	17	16.87 (7.13)	
C-peptide	0	17	1.51 (1.11)	0.014
	1	17	1.28 (0.93)	
	2	17	2.65 (1.96)	
Glucose	0	17	63.09 (17.24)	0.019
	1	16	74.09 (18.28)	
	2	17	77.90 (12.74)	
IGF-I	0	17	161.48 (45.37)	0.905
	1	17	161.28 (49.89)	
	2	17	167.35 (39.42)	
IGFBP3	0	17	2,154.49 (570.04)	0.976
	1	17	2,142.23 (425.14)	
	2	17	2,178.38 (448.94)	
IL-6	0	13	4.66 (5.57)	0.864
	1	14	5.76 (7.74)	
	2	13	4.70 (3.81)	
Insulin	0	16	7.15 (4.61)	0.005
	1	17	4.09 (2.50)	
	2	17	8.83 (4.80)	
Leptin	0	17	14.41 (6.95)	0.569
	1	16	13.06 (5.73)	
	2	16	15.43 (6.08)	
MMP-9	0	17	842.41 (737.41)	0.609
	1	17	652.30 (530.25)	
	2	17	914.09 (1,018.62)	
QUICKI	0	16	3.32 (0.70)	0.004
	1	17	3.93 (0.85)	
	2	17	3.14 (0.43)	

NOTE: Serum samples were obtained at baseline (time 0), last day of drug (time 1), and 30 d after the last dose (time 2).
Abbreviations: IGFBP3, IGF binding protein 3; IL-6, interleukin-6; MMP-9, matrix metalloproteinase 9.

mutation of exons II, 1, 2, 3, 4, 5, and 6 did not detect any known somatic or germ-line *PPARG* mutations. Furthermore, the frequency of PPAR γ gene polymorphisms in these breast cancer patients followed the distribution of the control population. Although the Pro12Ala polymorphism has been associated with body mass index and insulin sensitivity (35, 36), the small number of study subjects with a specific PPAR γ polymorphism precluded correlation with tumor and/or patient characteristics. *PPARG* mutations do not seem to account for tumor response to PPAR γ activation by specific ligands in this subset of breast cancer patients.

Previous clinical trials have evaluated the efficacy of thiazolidinedione therapy in subjects with advanced metastatic cancer, conducted with troglitazone before its withdrawal from clinical use. A pilot study of patients with unresectable advanced liposarcoma indicated potential for differentiating effects with troglitazone (37). Although troglitazone seemed to induce stable or decreased prostate-specific antigen levels in 41 patients with metastatic prostate cancer in a phase II study (38), a randomized placebo-controlled trial of rosiglitazone in men with increasing prostate-specific antigen levels following treatment for prostate cancer showed no effects on disease progression and prostate-specific antigen doubling time (39). Additionally, phase II studies of troglitazone in metastatic colorectal and refractory metastatic breast cancer failed to show beneficial effects on disease progression (40, 41). In the latter trial of 22 stage IV breast cancer patients with an 8-week median treatment duration, troglitazone did not prevent disease progression. Together with our findings that short-term thiazolidinedione exposure does not significantly influence the proliferation of established tumors at a surgically respectable stage, clinical trial results in advanced and early-stage breast cancer do not support a role for such drugs as single-agent therapy at the current dosing regimen. These negative findings lead us to speculate that antiproliferative effects may require longer-term and/or combination therapy with other nuclear receptor agonists; alternatively, another hypothesis to test is whether intervention with PPAR γ ligand therapy at earlier stages of carcinogenesis can prevent progression to preinvasive and invasive disease. Future clinical studies of rosiglitazone could also target a specific molecular subtype of breast cancer to optimize response based on the expression of other nuclear receptors, cofactors, and downstream signaling factors that influence the activity of PPAR γ (20, 21).

Not surprisingly, short-term treatment of nondiabetic breast cancer patients with rosiglitazone is well tolerated. Fifty percent of the subjects did not experience any adverse events, and reported adverse events were mild to moderate in severity and generally unrelated to the study intervention. Although the eligibility criteria led to selection of subjects at low risk for anticipated complications (e.g., absence of history of liver disease, diabetes mellitus, cardiac disease, edema), this study shows that rosiglitazone treatment is a tolerable, feasible intervention in women with breast cancer.

In summary, our study shows that short-term treatment with rosiglitazone does not significantly alter tumor cell proliferation, as assessed by Ki67 immunostaining of pretreatment and posttreatment tumor tissues, although the changes

Table 6. Adverse events caused by rosiglitazone

Adverse event	Grade 1	Grade 2	Relationship to therapy
↑Alanine transaminase	2		2 probably related
Headache	5		4 possibly related, 1 unrelated
		1	1 possibly related
Chest cold/upper respiratory infection		2	1 probably related, 1 unrelated

NOTE: Nineteen of 38 subjects reported adverse events. Unrelated adverse events: fatigue (4), nausea (4), reduced appetite (1), increased appetite (1), dry mouth (2), back pain (1), wound infection (1), dyspepsia (1), vomiting (1), lightheadedness (1), hot flashes (1), sore throat (1), sinus infection (1), migraine headaches (2).

in PPAR γ expression from baseline suggest the potential for receptor-mediated signaling following ligand activation. The specific gene targets for PPAR γ -mediated signaling in this setting require further elucidation and may relate to insulin sensitization and other metabolic effects. Indeed, the increase in serum adiponectin and the increase in insulin sensitivity point to potential risk reduction benefits with longer-term treatment. Such effects may also prove ineffectual in treating established breast cancers on a short-term basis or as single-agent therapy. Potentially specific tumor and/or patient

characteristics may influence responsiveness to rosiglitazone and other PPAR γ ligands and could be addressed in future studies.

Acknowledgments

We thank Susan Moseley for assistance with the serum ELISA and RIA analyses; Susie Jones for conducting the immunohistochemical procedures; Sharon Cheung for patient accrual, data, and protocol management; and our patients for their participation in the study.

References

- Krey G, Keller H, Mahfoudi A, et al. *Xenopus* peroxisome proliferator activated receptors: genomic organization, response element recognition, heterodimer formation with retinoid X receptor and activation by fatty acids. *J Steroid Biochem Mol Biol* 1993;47:65–73.
- Zhu Y, Qi C, Korenberg JR, et al. Structural organization of mouse peroxisome proliferator-activated receptor γ (mPPAR γ) gene: alternative promoter use and different splicing yield two mPPAR γ isoforms. *Proc Natl Acad Sci U S A* 1995;92:7921–5.
- Kliwer SA, Umesonon K, Noonan DJ, Heyman RA, Evans RM. Convergence of 9-*cis* retinoic acid and peroxisome proliferator signalling pathways through heterodimer formation of their receptors. *Nature* 1992;358:771–4.
- Chawla A, Lazar MA. Peroxisome proliferator and retinoid signaling pathways co-regulate preadipocyte phenotype and survival. *Proc Natl Acad Sci U S A* 1994;91:1786–90.
- Tontonoz P, Hu E, Graves RA, Budavari AI, Spiegelman BM. mPPAR γ : tissue-specific regulator of an adipocyte enhancer. *Genes* 1994;8:1224–34.
- Spiegelman BM. PPAR- γ : adipogenic regulator and thiazolidinedione receptor. *Diabetes* 1998;47:507–14.
- Mueller E, Sarraf P, Tontonoz P, et al. Terminal differentiation of human breast cancer through PPAR γ . *Mol Cell* 1998;1:465–70.
- Yee LD, Sabourin CLK, Li L, et al. Peroxisome proliferator-activated receptor γ activation in human breast cancer. *Int J Oncol* 1999;15:967–73.
- Yee LD, Guo Y, Bradbury J, Suster S, Clinton SK, Seewaldt VL. The antiproliferative effects of PPAR γ ligands in normal human mammary epithelial cells. *Breast Cancer Res Treat* 2003;78:179–92.
- Elstner E, Muller C, Koshizuka K, et al. Ligands for peroxisome proliferator-activated receptor γ and retinoic acid receptor inhibit growth and induce apoptosis of human breast cancer cells *in vitro* and in BNX mice. *Proc Natl Acad Sci U S A* 1998;95:8806–11.
- Suh N, Wang Y, Williams CR, et al. A new ligand for the peroxisome proliferator-activated receptor- γ (PPAR- γ), GW7845, inhibits rat mammary carcinogenesis. *Cancer Res* 1999;59:5671–3.
- Nicol CJ, Yoon M, Ward JM, et al. PPAR γ influences susceptibility to DMBA-induced mammary, ovarian and skin carcinogenesis. *Carcinogenesis* 2004;25:1747–55.
- Zhou X-P, Smith WM, Gimm O, et al. Over-representation of PPAR sequence variants in sporadic cases of glioblastoma multiforme: preliminary evidence for common low penetrance modifiers for brain tumour risk in the general population. *J Med Genet* 2000;37:410–4.
- Fleis JL. *Statistical methods for rates and proportions*. New York: Wiley-Liss and Co; 1981.
- Katz A, Nambi SS, Mather K, et al. Quantitative insulin sensitivity check index: a simple, accurate method for assessing insulin sensitivity in humans. *J Clin Endocrinol Metab* 2000;85:2402–10.
- Patel L, Pass I, Coxon P, Downes CP, Smith SA, Macphee CH. Tumor suppressor and anti-inflammatory actions of PPAR(agonists are mediated via up-regulation of PTEN. *Curr Biol* 2001;11:764–8.
- Elstner E, Williamson EA, Zang C, et al. Novel therapeutic approach: ligands for PPAR γ and retinoid receptors induce apoptosis in bcl-2-positive human breast cancer cells. *Breast Cancer Res Treat* 2002;74:155–65.
- Gronemeyer H, Gustafsson J-A, Laudet V. Principles for modulation of the nuclear receptor superfamily. *Nat Rev Drug Discov* 2004;3:950–64.
- Jiang WG, Douglas-Jones A, Mansel RE. Expression of peroxisome-proliferator activated receptor γ (PPAR γ) and the PPAR γ co-activator, PGC-1, in human breast cancer correlates with clinical outcomes. *Int J Cancer* 2003;106:752–7.
- Allred CD, Kilgore MW. Selective activation of PPAR γ in breast, colon, and lung cancer cell lines. *Mol Cell Endocrinol* 2005;235:21–9.
- Zhang H, Kuang S-Q, Liao L, Zhou S, Xu J. Haploid inactivation of the Amplified-in-Breast Cancer 3 coactivator reduces the inhibitory effect of peroxisome proliferator-activated receptor γ and retinoid X receptor on cell proliferation and accelerates polyoma middle-T antigen-induced mammary tumorigenesis in mice. *Cancer Res* 2004;64:7169–77.
- Teresi RE, Shaiu C-W, Chen C-S, Chatterjee VK, Waite KA, Eng C. Increased PTEN expression due to transcriptional activation of PPAR γ by Lovastatin and Rosiglitazone. *Int J Cancer* 2006;118:2390–8.
- Keller H, Givel F, Perroud M, Wahli W. Signaling cross-talk between peroxisome proliferator-activated receptor/retinoid X receptor and estrogen receptor through estrogen response elements. *Mol Endocrinol* 1995;9:794–804.
- Bonfiglioli D, Gabriele S, Aquila S, et al. Estrogen receptor α binds to peroxisome proliferator-activated receptor response element and negatively interferes with peroxisome proliferator-activated receptor γ signaling in breast cancer cells. *Clin Cancer Res* 2005;11:6139–47.
- Hauser S, Adelmant G, Sarraf P, Wright HM, Mueller E, Spiegelman BM. Degradation of the peroxisome proliferator-activated receptor γ is linked to ligand-dependent activation. *J Biol Chem* 2000;275:18527–33.
- Diez JJ, Iglesias P. The role of the novel adipocyte-derived hormone adiponectin in human disease. *Eur J Endocrinol* 2003;148:293–300.
- Scherer PE, Williams S, Fogliano M, Baldini G, Lodish HF. A novel serum protein similar to C1q, produced exclusively in adipocytes. *J Biol Chem* 1995;270:26746–9.
- Combs TP, Wagner JA, Berger J, et al. Induction of adipocyte complement-related protein of 30 kilodaltons by PPAR γ agonists: a potential mechanism of insulin sensitization. *Endocrinology* 2002;143:998–1007.
- Mantzoros C, Petridou E, Dessypris N, et al. Adiponectin and breast cancer risk. *J Clin Endocrinol Metab* 2004;89:1102–7.
- Brakenhielm E, Veitonmaki N, Cao R, et al. Adiponectin-induced antiangiogenesis and antitumor activity involve caspase-mediated endothelial cell apoptosis. *Proc Natl Acad Sci U S A* 2004;101:2476–81.
- Stoll BA. Upper abdominal obesity, insulin resistance and breast cancer risk. *Int J Obes Relat Metab Disord* 2002;26:747–53.
- Sarraf P, Mueller E, Smith WM, et al. Loss-of-function mutations in PPAR γ associated with human colon cancer. *Mol Cell* 1999;3:799–804.
- Ikezo T, Miller CW, Kawano S, et al. Mutational analysis of the peroxisome proliferator-activated receptor gene in human malignancies. *Cancer Res* 2001;61:5307–10.
- Bouanchaud D, Buecher B. The PPAR γ K422Q mutation does not contribute to troglitazone inefficiency in colon cancer treatment. *Cancer Lett* 2005;224:111–6.
- Deeb SS, Fajas L, Nemoto M, et al. A Pro12Ala substitution in PPAR γ 2 associated with decreased receptor activity, lower body mass index and improved insulin sensitivity. *Nat Genet* 1998;20:284–7.
- Memisoglu A, Hu FB, Hankinson SE, et al. Interaction between a peroxisome proliferator-activated receptor γ gene polymorphism and dietary intake in relation to body mass. *Hum Mol Genet* 2003;12:2923–9.
- Demetri GD, Fletcher CDM, Mueller E, et al. Induction of solid tumor differentiation by the peroxisome proliferator-activated receptor- γ ligand troglitazone in patients with liposarcoma. *Proc Natl Acad Sci U S A* 1999;96:3951–6.
- Mueller E, Smith M, Sarraf P, et al. Effects of ligand activation of peroxisome proliferator-activated receptor γ in human prostate cancer. *Proc Natl Acad Sci U S A* 2000;97:10990–5.
- Smith MR, Manola J, Kaufman DS, et al. Rosiglitazone versus placebo for men with prostate carcinoma and a rising serum prostate-specific antigen level after radical prostatectomy and/or radiation therapy. *Cancer* 2004;101:1569–74.
- Kulke MH, Demetri GD, Sharpless NE, et al. A phase II study of troglitazone, an activator of the PPAR γ receptor, in patients with chemotherapy-resistant metastatic colorectal cancer. *Cancer J* 2002;8:395–9.
- Burstein HJ, Demetri GD, Mueller E, Sarraf P, Spiegelman BM, Winer EP. Use of the peroxisome proliferator-activated receptor (PPAR) γ ligand troglitazone as treatment for refractory breast cancer: a phase II study. *Breast Cancer Res Treat* 2003;79:391–7.

Clinical Cancer Research

Pilot Study of Rosiglitazone Therapy in Women with Breast Cancer: Effects of Short-term Therapy on Tumor Tissue and Serum Markers

Lisa D. Yee, Nita Williams, Ping Wen, et al.

Clin Cancer Res 2007;13:246-252.

Updated version Access the most recent version of this article at:
<http://clincancerres.aacrjournals.org/content/13/1/246>

Cited articles This article cites 40 articles, 15 of which you can access for free at:
<http://clincancerres.aacrjournals.org/content/13/1/246.full#ref-list-1>

Citing articles This article has been cited by 9 HighWire-hosted articles. Access the articles at:
<http://clincancerres.aacrjournals.org/content/13/1/246.full#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, use this link
<http://clincancerres.aacrjournals.org/content/13/1/246>.
Click on "Request Permissions" which will take you to the Copyright Clearance Center's (CCC) Rightslink site.