Platinum Resistance: The Role of DNA Repair Pathways

Lainie P. Martin, Thomas C. Hamilton, and Russell J. Schilder

Abstract

Although platinum chemotherapeutic agents such as carboplatin, cisplatin, and oxaliplatin are used to treat a broad range of malignant diseases, their efficacy in most cancers is limited by the development of resistance. There are multiple factors that contribute to platinum resistance but alterations of DNA repair processes have been known for some time to be important in mediating resistance. Recently acquired knowledge has provided insight into the molecular mechanisms of DNA repair pathways and their effect on response to chemotherapy. This review will discuss the most important DNA repair pathways known to be involved in the platinum response, i.e., nucleotide excision repair (NER) and mismatch repair (MMR), and will briefly touch on the role of BRCA in DNA repair. The therapeutic implications of alterations in DNA repair which affect response to platinum in the treatment of patients with malignant disease, such as excision repair cross-complementation group 1 (ERCC1) deficiency and mismatch repair deficiency, will be reviewed.

Platinum chemotherapeutic agents have a broad range of activity in malignant disease and are used to treat many types of cancer. They are particularly active against germ cell tumors and epithelial ovarian cancer and play a primary role in the treatment of small cell and non-small cell lung cancer, cervical cancer, head and neck cancer, colorectal cancer, and bladder cancer (1). Unfortunately, resistance has limited the efficacy of these agents in most diseases. Resistance to platinum-based chemotherapy can be intrinsic or acquired and may be mediated by factors outside or within the cancer cell or at its cell membrane. Resistance to platinum chemotherapy is multifactorial (2–6). There are five recognized DNA repair pathways that protect cellular DNA from injury: nucleotide excision repair, mismatch repair (MMR), double-strand break repair, base excision repair, and direct repair. This review will focus on the first two mechanisms, which seem to play a key role in mediating platinum resistance in cancer treatment. They may also be important in assessing patient prognosis in the clinical setting (3, 7).

Cisplatin was the first platinum compound approved for the treatment of cancer, although its initial use was limited by gastrointestinal and renal toxicities. Subsequent efforts to develop an analogue with less toxicity resulted in carboplatin (1). Cisplatin and carboplatin work by binding to DNA and forming DNA adducts leading to intrastrand or interstrand cross-links which disrupt the structure of the DNA molecule, leading to steric changes in the helix (8). Alteration in the structure of the DNA molecule leads to cellular DNA damage recognition and repair which can result in the continued viability of the cell resulting in platinum resistance. It appears that tumor cells can have intrinsic differences in DNA repair mechanisms when compared with their normal counterparts, although alterations may also be acquired.

The role that DNA repair pathways play in mediating platinum resistance has been studied for many years, first in the preclinical, and more recently, in the clinical setting, and this knowledge has recently been used prospectively in the clinical arena (9).

Molecular Mechanisms of DNA Repair

**Nucleotide excision repair.** Pathway nucleotide excision repair seems to be a key pathway involved in mediating resistance or sensitivity to platinum chemotherapeutic agents (8). Nucleotide excision repair is a highly conserved DNA repair pathway that repairs DNA lesions which alter the helical structure of the DNA molecule and interfere with DNA replication and transcription. Important steps in this pathway include the recognition of DNA damage and demarcation of the specific area affected, followed by the formation of a complex to unwind the damaged portion and excise it. Finally, the excised area is resynthesized and ligated to maintain the structure of the DNA molecule. The excision repair cross-complementation group 1 (ERCC1) protein plays a key role in nucleotide excision repair. ERCC1 dimerizes with xeroderma pigmentosum complementation group F, and this complex is required for the excision of the damaged DNA (Fig. 1).

One of the most impressive and important successes of cisplatin-based therapy is in its role in treating metastatic testicular cancer which has resulted in >90% of patients achieving cure (10). Studies of testicular carcinoma cell lines were notable for exquisite cisplatin sensitivity in comparison with cell lines derived from other cancers (11). Further in vitro study showed a deficiency in nucleotide excision repair in these cell lines, and in particular, reduced levels of ERCC1 and xeroderma pigmentosum complementation group F DNA repair proteins (11, 12). This finding has also been shown in multiple studies with human ovarian cancer cell lines,
including cell lines with intrinsic cisplatin resistance which showed increased sensitivity to cisplatin after antisense RNA inhibition of ERCC1 (13). In addition, cell lines that developed resistance in vitro after exposure to cisplatin chemotherapy were found to have increased expression of ERCC1 (14).

**The Mismatch Repair pathway.** MMR is a highly conserved, strand-specific repair pathway which follows a stepwise process, initiated with the recognition of DNA damage (15, 16). MMR proteins, called Mut proteins, recognize mismatched or unmatched DNA base pairs or insertion-deletion loops and initiate the assembly of as yet unknown proteins which excise the affected area after which it is resynthesized by DNA polymerase (Fig. 2). When MMR is deficient, unrepaired areas of DNA accumulate, resulting in microsatellite instability (17). The accumulation occurs when unrepaired base pair mismatches are replicated during DNA synthesis, and due to slippage of the synthetic complex at these areas, repeats are formed. Defects in MMR may be inherited, as in the case of hereditary nonpolyposis colorectal carcinoma (18), or may occur through epigenetic silencing of an essential MMR gene (17, 19, 20). Epigenetic silencing of MMR seems to occur most often through Mut L homologue 1 (hMLH1) promoter hypermethylation, as has been shown in ovarian, endometrial, gastric, and colorectal carcinoma, among others (17, 21, 22).

A functional MMR system is required for the detection of damaged DNA created by cisplatin and carboplatin (23, 24). Platinum complexes interfere with normal MMR activity and prevent a repair from being completed. Inability to complete the repair of the DNA damage leads to apoptosis. When MMR is deficient, cells can continue to proliferate in spite of DNA damage caused by platinating agents, and are thus resistant. The *MLH1* and *MSH2* (Mut S homologue 2) genes seem to be particularly important in the normal function of the MMR system.

It is notable that MMR deficiency seems to confer resistance to cisplatin and carboplatin, and not to oxaliplatin (25), a newer platinum analogue. MMR proteins do not recognize the adducts formed by oxaliplatin, and the repair pathway is not triggered. Therefore, there is no failure of repair resulting in subsequent apoptosis. Oxaliplatin has activity in cells that are resistant to cisplatin and carboplatin (26).

**Recent Advances and Translational Implications**

Evaluation of ERCC1 mRNA levels in tumor samples taken from patients in small retrospective clinical trials of ovarian (27, 28), colorectal (7, 29), and non–small cell lung cancer (30) had shown an inverse correlation with either response to platinum therapy or survival.

More recently, tumor samples from a subgroup of 761 patients with metastatic lung cancer who participated in the International Adjuvant Lung Cancer trial were retrospectively evaluated by immunohistochemical analysis of ERCC1 (31). This study showed a statistically significant survival benefit in patients with low levels of ERCC1 who had received platinum-based chemotherapy, compared to patients with low levels of ERCC1 who did not receive chemotherapy and patients with high levels of ERCC1 who received cisplatin chemotherapy.

The results of the first prospective randomized trial using ERCC1 mRNA levels to assign chemotherapy in patients with non–small cell lung cancer were published recently (9). In this trial, 444 patients with stage IIIB (with malignant effusion) or
stage IV non–small cell lung cancer were enrolled from August 2001 to October 2005 and randomized to a control arm in which they received standard cisplatin/docetaxel chemotherapy versus a genotypic arm in which patients with high levels of ERCC1 received a non–platinum-containing regimen of gemcitabine/docetaxel and patients with low ERCC1 expression received cisplatin/docetaxel. Patients in the experimental (genotypically assigned) arm had a statistically significant improvement in response rate compared with the patients of the control arm, although the progression-free survival and overall survival rates were not significantly different. Of note, 18% of patients in the experimental arm were withdrawn due to the lack of sufficient tumor specimens for analysis.

Additionally, the patients in the control arm did not have specimen analysis for ERCC1 levels, as was done in the International Adjuvant Lung Cancer-Bio study (9).

Data from in vitro systems have shown that suppression of ERCC1 expression enhances or restores platinum sensitivity. This finding has significant therapeutic implications, as the addition of agents targeting ERCC1 may enhance platinum activity and/or reverse resistance, although this has yet to be tested in patients. Of interest, clear cell ovarian cancer has been found to have higher levels of ERCC1 (32). In the treatment of ovarian carcinoma, it is known that patients with clear cell histology tend to have platinum-resistant disease and have a poorer prognosis compared with their counterparts with other histology.

Fig. 2. A, MMR occurs when the Mut protein recognizes a mismatch or insertion/deletion loop. B, the Mut protein orders the assembly of a protein complex which localizes to the affected area on the DNA molecule and excises it. C, DNA polymerase then resynthesizes the missing portion of DNA. D, accumulation of insertion deletion loops on a strand of DNA in the setting of MMR deficiency.
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and after treatment (35). More recently, it has been shown that
cisplatin in paired tumor samples taken from patients before
and with five to six cycles of cisplatin-based chemotherapy, 15
specimens showed microsatellite stability before undergoing
treatment (34). All of these converted to microsatellite
instability in the posttreatment samples, and 11 of the 15
showed down-regulation of hMLH1 expression. Independently,
Fink and co-investigators showed increased MMR deficiency
and down-regulation of hMLH1 expression after treatment with
cisplatin in paired tumor samples taken from patients before
and after treatment (35). More recently, it has been shown that
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Cameron and colleagues have shown success in the reversal
of acquired MMR deficiency through demethylation of the CpG
island of the MLIH1 promoter region using 5-azacytidine (37).
Additionally, it has been shown that a combination of p53
inactivation and MMR deficiency results in cisplatin resistance
(38, 39). Lin and Howell evaluated human colon carcinoma
cells exposed to sequential cycles of cisplatin and found that
treatment with cisplatin led to the selection of resistant lines
and that, although the loss of either p53 or MMR function
resulted in platinum resistance, resistance occurred more rapidly
in cells in which both p53 and MMR were defective.
A small retrospective analysis reviewed the outcome of 83
patients with advanced non–small cell lung cancer treated with
gemcitabine and oxaliplatin versus gemcitabine and cisplatin
(40). A statistically significant difference in the response rate
was seen in patients with hMSH2 deficiency (38% gemcitabine/
oxaliplatin versus 0% gemcitabine/cisplatin), suggesting that
oxaliplatin is active in cells with MMR deficiency.
Gifford and associates evaluated 138 blood samples taken
from patients with ovarian or primary peritoneal carcinoma
who participated in SCOTROC1 (41). This trial included
patients with stage IC to IV disease; patients were randomized
to receive carboplatin with either paclitaxel or docetaxel,
and blood samples were collected before chemotherapy and
at the time of disease relapse. Plasma DNA was analyzed for the
methylation of hMLH1. Twenty-five percent of samples taken at
relapse were positive for methylation of hMLH1 that was not
positive at diagnosis. Additionally, this methylation correlated
with poor overall survival independent of the disease-free interval.
Knowledge of the differential effects of oxaliplatin and
cisplatin/carboplatin in the treatment of cancers with high
incidence of MMR deficiency may indicate that studies should be
done in other disease sites in a fashion similar to those done in
patients with lung cancer based on ERCC1 expression.
However, before such trials can be done, a reproducible
method for evaluating MMR deficiency must be developed
which is efficient enough to be used in real time for patients
awaiting treatment for their cancer. Challenges remain, as not
all of the steps in the pathway and the molecules involved in
MMR are completely elucidated.
On a final note, the evolving story of the role of the tumor
suppressor genes, BRCA-1 and BRCA-2, in DNA repair suggests
that they have roles in mediating the response to chemother-
apic treatment in some cancers (42). Their importance in
homologous recombination during the repair of double-
stranded breaks has been purported as a possible explanation
of the increase in cancer risk in carriers of germ line mutations
of BRCA-1 or BRCA-2 (43). More recently, it has been shown
that BRCA-1 plays an integral role in BSC (BRCA1-associated
surveillance complex), a group of proteins which includes multiple DNA repair proteins, including those
involved in MMR (44). The BRCA pathway can also be
interrupted in sporadic cancers (45). In vitro, it has been shown
that inhibition of the Fanconi anemia/BRCA pathway can
enhance sensitivity to cisplatin in cancer cell lines and that
repair of defects in this pathway can induce cisplatin resistance
(46). One strategy that has been pursued is to inhibit the base
excision repair pathway by targeting the enzyme poly-ADP
ribose polymerase (PARP) in BRCA-1 and BRCA-2 mutant
cells. This was done with RNA interference as well as through
treatment of BRCA-1 or BRCA-2–deficient cells with small
molecule inhibitors of PARP-1 and PARP-2 (47, 48). In both
cases, PARP inhibition resulted in enhanced cell death in
BRCA-deficient cells. PARP inhibitors are currently being
evaluated for safety and efficacy in early phase trials in
combination with various chemotherapeutic agents.
As the capacity to evaluate tumors at the molecular level
expands, such tools are likely to predict response to treatment,
and ultimately lead to more individualized, targeted, and more
effective therapies.

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