Inhibition of mTOR Radiosensitizes Soft Tissue Sarcoma and Tumor Vasculature

James D. Murphy, Aaron C. Spalding, Yash R. Somnay, Sonja Markwart, Michael E. Ray, and Daniel A. Hamstra

Abstract

Purpose: The PI3K/Akt/mTOR prosurvival pathway is frequently up-regulated in soft tissue sarcoma. Mammalian target of rapamycin (mTOR) inhibitors, such as rapamycin, have recently shown clinical benefit in soft tissue sarcoma, and mTOR inhibition has also been associated with radiosensitization of carcinoma and endothelial cells. This study tested the hypothesis that rapamycin radiosensitizes soft tissue sarcoma and endothelial cells in vitro and in vivo through the inhibition of mTOR.

Experimental Design: Colony formation assays were done to determine the radiosensitizing properties of rapamycin on three human soft tissue sarcoma cell lines (SK-LMS-1, SW-872, and HT-1080) and human dermal microvascular endothelial cells (HDMEC). The functional effects of rapamycin and radiation on the endothelial compartment were evaluated with microvascular sprouting assays. The in vivo radiosensitizing activity of rapamycin was assessed with s.c. SK-LMS-1 nude mice xenografts treated with concurrent daily rapamycin, radiation, or both for three weeks.

Results: In vitro radiosensitization was shown in all three soft tissue sarcoma cell lines with minimally cytotoxic doses of rapamycin. SK-LMS-1 xenografts displayed significant tumour growth delay with rapamycin and radiation compared with either treatment alone. Radiation resulted in transient increased mTOR function, whereas rapamycin abolished this signaling in irradiated and unirradiated samples. In HDMEC, rapamycin and radiation reduced microvessel sprouting, but did not alter colony formation.

Conclusions: Minimally cytotoxic concentrations of rapamycin inhibited the mTOR cascade in culture and in vivo while radiosensitizing soft tissue sarcoma, and produced synergistic effects with radiation on HDMEC microvessel formation. By targeting both tumor and endothelial compartments, rapamycin produced potent radiosensitization of soft tissue sarcoma xenografts. Clinical trials combining rapamycin and radiotherapy in soft tissue sarcoma are warranted.

The mammalian target of rapamycin (mTOR) is a serine-threonine kinase downstream in the phosphatidylinositol 3-kinase (PI3K)/Akt survival pathway. In normal mammalian cells mTOR is responsible for growth and proliferation (1, 2). Dysregulation of mTOR signaling has been implicated in oncogenesis through activation of the PI3K/Akt pathway in several human cancers including sarcoma, breast, ovarian, colon, brain, and lung (3–6). Additionally, in soft tissue sarcoma, there is evidence for decreased expression or mutation in PTEN (phosphate and tensin homolog deleted on chromosome 10), the tumor suppressor of PI3K, which leads to deregulated signaling down this pathway (7–10).

Given its downstream location in the PI3K/Akt pathway, mTOR is an attractive therapeutic target because inhibition of mTOR may avoid potential side effects of inhibiting broader acting upstream kinases (11). Activated mTOR phosphorylates two main targets, p70 s6 kinase (p70s6k) and 4E-BP1 (12–14). Rapamycin, in complex with endogenous FK506 binding protein (FKBP-12), is a potent and specific inhibitor of mTOR kinase activity. Rapamycin and recently developed rapamycin analogues (AP23573, CCI779, and RAD001) have shown antitumor activity in preclinical tumor models (15–21) and clinical studies (22, 23). In addition, a recent phase II study showed a 27% clinical response in advanced soft tissue sarcoma patients treated with the rapamycin analogue AP23573 (24).

In addition to basal activity in oncogenesis, the prosurvival PI3K/Akt/mTOR pathway can also be activated in response to radiotherapy (25, 26), which led to preclinical studies combining mTOR inhibitors with radiotherapy. These studies showed in vitro radiosensitization in prostate and breast cancer cell lines, and in vivo radiosensitization in prostate, breast, and glioblastoma tumor models (21, 25, 27, 28). Additionally,
mediated radiosensitization in preclinical models of soft tissue sarcoma. The purpose of this study was to examine the role for and mechanism of rapamycin—mTOR inhibitors have been shown to inhibit angiogenesis (20, 21, 29) and to sensitize tumor vasculature to ionizing radiation (30). The mechanism of in vivo radiosensitization has not been fully elucidated, but these findings suggest that combining mTOR inhibition with radiation results in radiosensitization of both the primary tumor and the cells within the vascular endothelial compartment.

Materials and Methods

Cell culture and in vitro treatment. SK-LMS-1 leiomyosarcoma, HT-1080 fibrosarcoma, and SW-872 liposarcoma cells were obtained from the American Type Culture Collection. Cells were maintained in MEM (HT-1080) or DMEM (SW-872 and SK-LMS-1) containing 10% fetal bovine serum. Prior to irradiation or treatment with rapamycin, exponentially growing cells were placed in media with decreased serum (1% fetal bovine serum) for 16 h. Rapamycin (LKT Laboratories) was dissolved in 100% ethanol to a concentration of 10 mg/mL and stored at −20°C until treatment, at which time it was further dissolved into a solution containing 5% PEG400 and 5% Tween80. The final concentration of ethanol was 5%. Irradiation was carried out using a Philips 250 kV orthovoltage unit at a dose rate of approximately 2 Gy/min. Dosimetry was carried out using an ionization chamber connected to an electrometer system that is directly traceable to a National Institute of Standards and Technology calibration.

Western blot analysis. At the appropriate time point after treatment, plates of cells were placed on ice, washed twice with ice-cold PBS prior to the addition of lysis buffer (50 mmol/L Tris HCl [pH 8.0], 150 mmol/L NaCl, 1% nonidet P-40, protease inhibitor [Roche], and phosphatase inhibitor [Sigma]). Xenografted tumor samples were snap-frozen in liquid nitrogen immediately following excision, then crushed with a liquid nitrogen–cooled mortar and pestle prior to the addition of lysis buffer. Protein samples were quantified, sonicated, and boiled prior to resolution with 8% to 10% SDS-PAGE gel. Western blots were incubated with anti–phosphorylated (phospho)-p70s6k (Thr 389), total p70s6k, phospho-mTOR, total mTOR, and phospho-Akt antibodies (Cell Signaling) overnight at 4°C with gentle agitation. Blots were then incubated with horseradish peroxidase–conjugated goat antirabbit secondary antibody (1:10,000, Jackson ImmunoResearch Laboratories) for 1 h at room temperature, prior to being developed with Pierce ECL Western Blotting Substrate system. Films were scanned and analysis was done with ImageJ software (NIH). Densitometric values are reported as mean ± SE. Western blots were done two to three times, with representative data shown.

Colony formation assay. Radiosensitization was assessed after a 90-min exposure to rapamycin with radiation delivered 60 min into rapamycin treatment. Controls were treated with the vehicle alone, and all conditions received equal amounts of ethanol, PEG400, and Tween80. Upon completion of treatment, floating cells were collected and added to the trypsinized adherent cells. This combination of cells was then washed with PBS, counted on a Coulter Counter, and replated in media with 10% fetal bovine serum at clonal density. After 5 to 10 d of incubation, colonies were fixed with 7:1 methanol:acetic acid, and stained with 0.5% crystal violet. Only colonies with >50 cells were counted. Each condition per colony forming assay was plated in triplicate. Each complete colony forming assay was repeated at least once, with representative data shown.

Radiosensitization by rapamycin was determined by fitting radiation survival curves to each drug concentration using the linear quadratic equation. The mean inactivation dose (linear area under the cell survival curve; ref. 38) was calculated for each condition, and dose enhancement ratios (DER) were determined by dividing the mean inactivation dose of control cells by the mean inactivation dose of treated cells. DERs >1 indicate radiosensitization.

Endothelial cell culture and sprouting assay. Human dermal microvascular endothelial cells (HDMEC; Cell systems) were used to investigate the effects of rapamycin on endothelial cell growth and function. HDMEC were maintained in EGM-2 media (Lonza) supplemented with 50 ng/mL of rhVEGF 165. Six-well plates were precoated with collagen (Cohesion). HDMECs were added to each well, and allowed to adhere overnight. Cells were treated with 50 ng/mL rhVEGF 165 in fresh media daily. The day after plating, cells were treated with vehicle or rapamycin for 48 h, and received radiation after 24 h into rapamycin treatment. The number of tubular structures were assessed daily with a phase microscope at 200×, counting six random high-powered fields per well, with three wells per condition. The fractional product method was utilized to test for evidence of synergy (40).

Tumor growth experiments. Exponentially growing SK-LMS-1 cells (5 × 104) were suspended in 200 μL PBS and injected s.c. into the
flanks of 6- to 8-week-old athymic male nude mice (Charles River Labs). Treatment commenced once tumors reached an average volume of 150 mm³. Mice were randomized into four treatment groups (control, rapamycin alone, radiation alone, and rapamycin plus radiation) with seven mice per arm. Based on an *a priori* power analyses using a similar dataset (41), it was determined that seven mice would provide adequate power (81%) to detect a 1.5-fold difference in growth delay. Treatment commenced on day 1, and rapamycin was administered via i.p. injection on days 1-5, 8-12, and 15-19, at a dose of 2 mg/kg. Radiation was given daily in 2 Gy fractions, 1 h after rapamycin injection, for a total dose of 30 Gy. Mice were anesthetized with i.p. injections of ketamine (80 mg/kg) and xylazine (4 mg/kg), and were placed prone in custom-made holders. Cerrobend shielding was placed over the entire mouse minus the tumor creating a conformal treatment field. After radiation, the mice were kept warm with heating pads until fully recovered from anesthesia. Animals were handled

Fig. 1. mTOR inhibition sensitizes soft tissue sarcoma to radiation. SK-LMS-1 cells treated with increasing doses of rapamycin for 60 min and prepared for Western blot (A) and densitometric analysis (B). SK-LMS-1 cells treated with rapamycin for 60 min, irradiated, harvested immediately, and prepared for Western blot (C) and densitometric analysis (D). Data points (B and D), mean ± SE. Colony forming assay as described in Materials and Methods for SK-LMS-1 cells (E), HT-1080 cells (F), and SW-872 cells (G). Data points (E, F, and G), average ± SE of triplicate plating from one colony forming assay.
Table 1. Cytotoxicity with rapamycin in soft tissue sarcoma

<table>
<thead>
<tr>
<th>Cell line</th>
<th>Surviving fraction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 nmol/L</td>
</tr>
<tr>
<td>SK-LMS-1</td>
<td>99% ± 4%</td>
</tr>
<tr>
<td>HT-1080</td>
<td>76% ± 6%</td>
</tr>
<tr>
<td>SW-872</td>
<td>66% ± 3%</td>
</tr>
</tbody>
</table>

According to the University of Michigan Laboratory Animals Maintenance Manual.

Tumor volumes (V) were estimated using the volume of an ellipsoid: \( V = \frac{k}{6} \times D_1 \times (D_2)^2 \), where \( D_1 \) and \( D_2 \) are the longer and shorter perpendicular diameters, respectively. Tumor growth was expressed as relative change in volume compared with day 1. Growth delay (GD) of a treatment arm \( (GD_{rap+RT}) \) was defined as the time interval from day 1 through when a tumor reached 5 times its day 1 volume. The growth delay enhancement ratio (GDER) was defined as the following: \( GDER = (GD_{rap+RT} - GD_{rap alone})/GD_{RT alone} \). GDER > 1 implies synergism between rapamycin and radiation. Animals were euthanized when tumor volumes reached 1.5 cm³. Additionally, one animal from each group was sacrificed on day 5 of treatment, 30 min after receiving radiation and the tumor was prepared for immunohistochemistry.

**Immunohistochemistry and tumor vasculature analysis.** The harvested xenograft tumors described above were formalin-fixed, paraffin-embedded, and stained with an anti-CD31 antibody. Microvascular density was quantified by counting the number of blood vessels per 400× field. Six random fields per tumor were selected, and the results indicate the average ± SE of the six counts.

### Results

**mTOR signaling is increased with radiation and inhibited with rapamycin.** In order to assess the response of soft tissue sarcoma cell lines to rapamycin alone, SK-LMS-1 cells were exposed to increasing doses of rapamycin for one hour prior to analysis. Treatment with rapamycin decreased phosphorylation of mTOR in a dose-dependent fashion, and completely abolished phosphorylation of p70s6k, which is directly downstream of mTOR and is a common marker of mTOR function (Fig. 1A and B), whereas levels of total mTOR and total p70s6k remained unchanged.

Irradiation of SK-LMS-1 cells produced a transient increase in the amount of phosphorylated Akt, but the increase in phosphorylated mTOR was less pronounced. Accordingly, we observed a transient increase in phospho-p70s6k, whereas the expression of total p70s6k remained unchanged. This radiation-induced increase in phospho-p70s6k was inhibited by treatment with rapamycin (Fig. 1C and D). Stimulation with fetal bovine serum (10%) was used as a positive control as it is known to increase signaling down the mTOR pathway, and this too was inhibited with rapamycin treatment.

**Rapamycin sensitizes soft tissue sarcoma to radiation in vitro.** Having ascertained that rapamycin treatment could inhibit mTOR signaling in soft tissue sarcoma, we next assessed if this would lead to radiosensitization. We first established the cytotoxicity profile of rapamycin alone prior to examining its potential as a radiosensitizer. After a 90-minute treatment with doses up to 300 nmol/L rapamycin, the surviving fraction of SK-LMS-1 cells was not significantly decreased as assessed by colony formation assay. However, this same dose of rapamycin was moderately toxic to the HT-1080 and SW-872 cell lines (Tables 1). Nocytotoxic to moderately cytotoxic (IC₅₀) doses were chosen to evaluate the radiosensitizing properties of rapamycin. All three soft tissue sarcoma cell lines showed radiosensitization to rapamycin (Fig. 1E, F, and G), with DERs
Rapamycin and radiation cause decreased vascular sprouting. To determine the effects of rapamycin and radiation on vascular endothelial cells, monolayers of HDMEC in culture were treated with rapamycin or radiation. As with soft tissue sarcoma cells, one-hour incubation with rapamycin even at doses as low as 3 nmol/L was sufficient to inhibit phospho-p70s6k without changing the expression of total p70s6k (Fig. 2A and B). Unlike with soft tissue sarcoma cells, however, radiation did not increase the phosphorylation of p70s6k. Furthermore, unlike with soft tissue sarcoma which were radiosensitized with noncytotoxic concentrations of rapamycin that inhibited p70s6k phosphorylation, we were unable to radiosensitize HDMECs with conventional colony formation assay even at doses of drug that abolished p70s6k phosphorylation (Fig. 2C).

With the use of a vascular sprouting assay, HDMECs were treated with rapamycin (3 nmol/L), radiation (2 Gy), or the combination, and microvessel sprout formation was then monitored to assess HDMEC function in addition to cytotoxicity. Qualitatively, the combination of clinically relevant doses of rapamycin and radiation resulted in a dramatic inhibition of microvessel formation that was greater than either treatment alone (Supplemental Fig. S1), despite the fact that this combination did not result in any increase in cytotoxicity to HDMEC. Quantitatively, radiation alone caused a modest decrease in microvessel sprout formation by 21 ± 6%, and 3 nmol/L rapamycin similarly caused a 34 ± 12% inhibition (Fig. 2D). More importantly, the combination of radiation and rapamycin resulted in 73 ± 5% inhibition of sprout formation (P < 0.01 by one-way ANOVA). The observed inhibition of microvessel formation in HDMEC treated with rapamycin and radiation was greater than would be expected by a simple additive effect (P < 0.05, Supplemental Table S1). This suggests synergy between rapamycin and radiation, resulting in greater reduction of endothelial sprouting than with either treatment alone.

Rapamycin is a potent radiosensitizer in vivo. Having ascertained that clinically achievable doses of rapamycin and radiation could potentially sensitize both the tumor and vascular compartments in vitro, we next assessed the combination of rapamycin and radiotherapy in vivo using SK-LMS-1 xenografts (Table 2). A treatment schedule consisting of daily rapamycin and daily fractionated radiation was chosen to mimic a regimen that could be used in a clinical setting. Initial evaluation determined that daily i.p. rapamycin doses of 2 mg/kg produced a slight growth delay in comparison with control tumors (data not shown). Additionally, a single dose of 2 mg/kg rapamycin inhibited mTOR activity as shown by reduction of phospho-p70s6k in both irradiated and unirradiated tumors (Fig. 3A) while not altering total p70s6k expression.

Using this combination regimen, xenografts treated with daily rapamycin and radiation resulted in significant tumor GD when compared with either modality alone (Fig. 3B). The GD for tumors treated with single modality radiation or rapamycin were 5.7 ± 3.7 days and 10.1 ± 1.2 days, respectively, whereas the GD for tumors treated with both modalities was 35.9 ± 2.6 days (P < 0.0001 compared with radiation or rapamycin alone). The GD enhancement ratio for this combined rapamycin and radiation group was 4.6, indicating significant synergism with rapamycin and radiation. Treatment-related toxicity measured as percent body weight loss was minimal, with the greatest weight loss occurring in the rapamycin plus radiation group. Weight loss in this group was <5%, and all animals had returned to their starting weight within 3 days of the end of treatment, suggesting that this treatment regimen was well tolerated.

Table 2. In vitro sarcoma radiosensitization with rapamycin

<table>
<thead>
<tr>
<th>Cell line</th>
<th>Dose enhancement ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 nmol/L</td>
</tr>
<tr>
<td>SK-LMS-1</td>
<td>1.13 ± 0.05</td>
</tr>
<tr>
<td>HT-1080</td>
<td>1.1 ± 0.04</td>
</tr>
<tr>
<td>SW-872</td>
<td>1.04 ± 0.22</td>
</tr>
</tbody>
</table>

mTOR inhibition and radiation reduce microvessel density in vivo. To investigate the in vivo effects of rapamycin on tumor vasculature, we harvested tumors on day 5 of treatment, and quantified microvessel density as based upon staining for CD31, a marker for vascular endothelial cells (Fig. 4). After just 5 days of treatment, tumors treated with radiation (Fig. 4B) or rapamycin (Fig. 4C) showed 38 ± 6% and 38 ± 6% reductions, respectively, in microvessel formation when compared with controls (Fig. 4A; P < 0.005 for each). Confirming the effect...

Fig. 3. In vivo radiosensitization with rapamycin. A, athymic nude mice with SK-LMS-1 xenografted tumors were treated with rapamycin (2 mg/kg), followed 60 min later by radiation (2 Gy), and then harvested for Western blot analysis. B, mice were treated with rapamycin before radiation daily for 3 wk. Data points represent average relative tumor volume of seven mice per group. Error bars, SE.

Downloaded from clincancerres.aacjournals.org on July 14, 2017. © 2009 American Association for Cancer Research.
observed \textit{in vitro}, the combination of rapamycin and radiation (Fig. 4D) resulted in a 75 ± 5% reduction when compared with control-treated tumors ($P < 0.0005$). In addition, the combination treatment was more effective in reducing the number of CD31-positive cells than either radiation or rapamycin treatment alone ($P < 0.0005$).

**Discussion**

The mTOR pathway is frequently up-regulated in a variety of sarcoma histologies. A recent study examining patient tumor samples found that between 78% and 90% of leiomyosarcomas, malignant fibrous histiocytomas, and dedifferentiated liposarcomas have increased phosphorylated Akt (3). This study also found significantly increased levels of phospho-p70s6k and eIF-4BP, particularly in leiomyosarcomas and malignant fibrous histiocytoma histologies. Another report retrospectively examined rhabdomyosarcoma tumor samples and found that increased phospho-Akt, phospho-p70s6k, and phospho-4EBP1 were associated with poor recurrence-free and overall survival (42). A clinical trial with the Akt inhibitor perifosine has shown prolonged responses in the subset of patients with advanced soft tissue sarcoma (43). Another promising large phase II clinical trial with the rapamycin analogue AP23573 showed a 27% clinical benefit response in soft tissue sarcoma patients (24). These clinical and histologic studies provide compelling evidence of sarcoma’s dependence on the mTOR pathway.

The key finding of this present study is that inhibition of mTOR with rapamycin sensitizes both sarcoma cells and tumor vasculature to radiation, and targeting both tumor and endothelial compartments produced potent radiosensitization in soft tissue sarcoma xenografts. This is the first study to show the radiosensitizing effects of mTOR inhibition with both \textit{in vitro} and \textit{in vivo} preclinical models of sarcoma. Prior research suggested that \textit{in vitro} radiosensitization secondary to mTOR inhibition is cell line-specific, and likely dependent upon dysregulation of the PI3K/Akt/mTOR pathway. For example, breast cancer and PTEN-deficient prostate cancer cell lines showed radiosensitization with mTOR inhibition as a monolayer in culture (25, 27). It has also been postulated that this \textit{in vitro} sensitivity to mTOR inhibition may depend upon the feedback loop between Akt and mTOR such that mTOR inhibition would only be expected to result in radiosensitization in the presence of deregulated Akt (44). In contrast, U87 and GL261 glioma cells were not radiosensitized by mTOR inhibition \textit{in vitro}, but both cell lines showed increased sensitivity to radiotherapy with mTOR inhibitors in xenograft models, suggesting that \textit{in vitro} models may not adequately address the unique interaction among radiation, mTOR inhibition, and the tumor microenvironment (28, 30). Finally, the degree of sensitization in xenografts may be schedule-dependent, for in a second study using U87 xenografts this combination was only additive (45). Interestingly, all of these studies utilized hypofractionated radiation schedules with doses of radiation on the order of 4 to 5 Gy delivered over 5 to 7 fractions. It is possible that these studies took advantage of the postulated increased vascular effects of ionizing radiation by using larger than conventional radiation fractions (46).

The supra-additive effects of mTOR inhibition and radiation shown \textit{in vivo} are likely in part secondary to radiosensitization of the vascular compartment. Previously, it was found that rapamycin sensitized human umbilical vein cells to radiation \textit{in vitro}, but this study utilized significantly higher doses of rapamycin (100 nmol/L) than would be clinically achievable in humans (30). Using a clinically relevant dose of rapamycin (3 nmol/L ref. 47), we did not appreciate radiosensitization with HDMECs \textit{via} colony formation assays. However, we found...
that rapamycin and radiation caused markedly decreased vascular sprout formation even in the absence of cytotoxicity likely due to down-regulation of angiogenic cytokines such as vascular endothelial growth factor (21, 39, 48). Although our xenograft experiments utilized doses of rapamycin that are higher than achievable in human serum, Luker et al. (49), using a novel bioluminescent system, found that in vivo inhibition of the interaction between mTOR and FK506 binding protein has a Ki of only 1.5 ± 0.3 nmol/L, which they confirmed in vitro and which would be clinically achievable and would concur with the inhibition of the phosphorylation of p70S6K that we observed in HDMEC with low levels of rapamycin. Taken together, these findings suggest that the antiangiogenic effects of rapamycin and radiotherapy may be effective in treating a variety of malignancies regardless if the tumor cells themselves show significant radiosensitization to rapamycin.

The precise mechanism of cell death induced by the combination of irradiation and mTOR inhibition is unclear, but others have implicated both apoptosis (25) and autophagy (50). Prior studies have also linked irradiation with a transient increase in signaling down the Akt/mTOR survival pathway, paradoxically associating radiotherapy with activating resistance (25–28). Increased Akt signaling has also been associated with pathologic increases in blood vessel formation (29). Thus, rapamycin and rapamycin analogues may inhibit both a radiation-mediated prosurvival signal as well as a proangiogenic signal, which both could underlie the synergistic increase in tumor control observed in vivo. Given the role of the PI3K/Akt/mTOR signaling cascade in both tumor and endothelial cells and the potential for radiosensitization of both of these, we are actively investigating mechanisms of cell death. At present, however, it appears that the greatest benefit from the combination of radiation and rapamycin in vivo may have come from the functional inhibition of angiogenesis because rapamycin was only a modest radiosensitizer of soft tissue sarcoma cells in vitro.

Although inhibition of single proangiogenic pathways are compelling and are being investigated in combination with radiation therapy, the targeting of more than one angiogenic pathway may be important (51) because tumors are postulated to utilize multiple mechanisms to modulate new blood vessel growth, and the inhibition of a single pathway may lead to compensatory up-regulation of parallel pathways (52). Importantly, rapamycin itself may disrupt multiple paracrine networks of angiogenic cytokines found in sarcoma. Inhibition of mTOR has been shown to reduce vascular endothelial growth factor secretion by rhabdomyosarcoma cells, both in vitro and animal models (20) whereas both rapamycin and its analogue everolimus also suppress interleukin-6 secretion in renal transplant patients, thus inhibiting endothelial cell proliferation (53). Furthermore, hypoxia induces both fibroblast growth factor and platelet-derived growth factor through mTOR activation, leading to mitogenesis, increased DNA synthesis, and proliferation of endothelial cells (54). Because rapamycin has been shown to interfere with these cytokines, clinical trials investigating mTOR inhibitors may show cytokine changes as a correlate for tumor blood vessel density, noninvasive measures of tumor blood flow, and clinical outcome.

In conclusion, mTOR inhibition radiosensitized both the tumor and vascular compartments, and produced potent in vivo radiosensitization. In light of the recent encouraging clinical data with mTOR inhibitors as monotherapy, our study provides compelling preclinical evidence for translating this combination into clinical practice in the treatment of soft tissue sarcoma.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

Acknowledgments

We thank Mary Davis and Suresh B. Patil for their technical assistance.

References


53. Lehle K, Birnbaum DE, Preuner JG. Predominant inhibition of interleukin-6 synthesis in patient-specific endothelial cells by mTOR inhibitors below a concentration range where cell proliferation is affected and mitotic arrest takes place. Transplant Proc 2005;37:159–61.

Inhibition of mTOR Radiosensitizes Soft Tissue Sarcoma and Tumor Vasculature

James D. Murphy, Aaron C. Spalding, Yash R. Somnay, et al.


Updated version  Access the most recent version of this article at: http://clincancerres.aacrjournals.org/content/15/2/589

Supplementary Material  Access the most recent supplemental material at: http://clincancerres.aacrjournals.org/content/suppl/2009/01/11/15.2.589.DC1

Cited articles  This article cites 47 articles, 18 of which you can access for free at: http://clincancerres.aacrjournals.org/content/15/2/589.full#ref-list-1

Citing articles  This article has been cited by 4 HighWire-hosted articles. Access the articles at: http://clincancerres.aacrjournals.org/content/15/2/589.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, contact the AACR Publications Department at permissions@aacr.org.