Fibroblast Growth Factor Receptors Are Components of Autocrine Signaling Networks in Head and Neck Squamous Cell Carcinoma Cells

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Abstract

Purpose: We previously reported that a fibroblast growth factor (FGF) receptor (FGFR) signaling pathway drives growth of lung cancer cell lines of squamous and large cell histologies. Herein, we explored FGFR dependency in cell lines derived from the tobacco-related malignancy, head and neck squamous cell carcinoma (HNSCC).

Experimental Design: FGF and FGFR mRNA and protein expression was assessed in nine HNSCC cell lines. Dependence on secreted FGF2 for cell growth was tested with FP-1039, an FGFR1-Fc fusion protein. FGFR and epidermal growth factor receptor (EGFR) dependence was defined by sensitivity to multiple inhibitors selective for FGFRs or EGFR.

Results: FGF2 was expressed in eight of the nine HNSCC cell lines examined. Also, FGFR2 and FGFR3 were frequently expressed, whereas only two lines expressed FGFR1. FP-1039 inhibited growth of HNSCC cell lines expressing FGF2, identifying FGF2 as an autocrine growth factor. FGFR inhibitors selectively reduced in vitro growth and extracellular signal-regulated kinase signaling in three HNSCC cell lines, whereas three distinct lines exhibited responsiveness to both EGFR and FGFR inhibitors. Combinations of these drugs yielded additive growth inhibition. Finally, three cell lines were highly sensitive to EGFR tyrosine kinase inhibitors (TKI) with no contribution from FGFR pathways.

Conclusions: FGFR signaling was dominant or codominant with EGFR in six HNSCC lines, whereas three lines exhibited little or no role for FGFRs and were highly EGFR dependent. Thus, the HNSCC cell lines can be divided into subsets defined by sensitivity to EGFR and FGFR-specific TKIs. FGFR inhibitors may represent novel therapeutics to deploy alone or in combination with EGFR inhibitors in HNSCC.

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Introduction

Head and neck squamous cell carcinoma (HNSCC) is the sixth most frequent cancer worldwide with a cancer-associated 5-year survival rate less than 50% (reviewed in refs. 1–4). Risk factors include tobacco use, alcohol consumption, human papilloma virus exposure, and genetic disorders such as Fanconi Anemia. Mutations in well-defined oncogene drivers such as KRAS and epidermal growth factor receptor (EGFR) are generally rare in HNSCC (2) relative to other solid tumors such as non-small cell lung cancer (NSCLC). Yet, frequent overexpression of EGFR and EGFR ligands is seen in HNSCC tumors, with EGFR overexpression identified in up to 90% of tumors (3, 5). On the basis of this rationale, EGFR-specific tyrosine kinase inhibitors (TKI) and blocking antibodies such as cetuximab have been tested in HNSCC patients. Cetuximab yielded modest increases in patient survival when used in combination with standard chemo- and radiotherapies and has been an approved treatment for HNSCC since 2006 (reviewed in refs. 2, 6).

The increased understanding of tumor heterogeneity dictated by different driver oncogenes dominant in distinct subsets of tumors has led to the concept of personalized therapy in NSCLC, breast cancer, and colorectal cancer (7–9). By contrast, personalized treatment approaches for HNSCC lag behind, due in part to limited information on the dominant oncogenes in this cancer. In this regard, the modest impact of EGFR inhibitors observed in HNSCC may, in fact, reflect an averaged response whereby a subset
FGFR Signaling in HNSCC

Translational Relevance

Frequent overexpression of epidermal growth factor receptor (EGFR) is observed in head and neck squamous cell carcinomas (HNSCC). Yet, EGFR inhibitors have failed to exert a major impact on HNSCC patient survival. In this article, we provide evidence that fibroblast growth factor (FGF) 2 and FGF receptors (FGFR) comprise an important growth factor pathway that functions alone, or in combination with EGFR, in distinct subsets of HNSCC cell lines. Deployment of FGFR-specific tyrosine kinase inhibitors as single agents or in combination with EGFR inhibitors may be effective therapeutic strategies in HNSCC.

of highly EGFR-dependent tumors exist within a larger set of EGFR-independent tumors. As a precedent, the initial clinical evaluation of EGFR-specific TKIs in lung cancer patients noted a rather small benefit in survival relative to the larger responses when treatment was restricted to patients with lung tumors bearing mutated EGFR (8, 10). Attempts to correlate clinical response to EGFR targeting with cetuximab in HNSCC with EGFR protein expression (2) or EGFR copy number (11) have proven negative. Thus, it will be necessary to stratify HNSCC into therapy-responsive subsets by a means other than the simple EGFR expression or mutation.

We hypothesize that the insensitivity of the majority of HNSCC to EGFR inhibitors is mediated by dominant activity of alternative receptor tyrosine kinase (RTK) systems in distinct subsets of tumors. Among RTKs with reported activity in HNSCC, the literature highlights MET (12), insulin-like growth factor 1R (IGF-1R; 13), and cooperative roles between platelet-derived growth factor receptor (PDGFR) and vascular endothelial growth factor receptor (VEGFR) (14). Although no functionality has been explored, coexpression of fibroblast growth factors (FGF) and FGFRs may define a distinct subset of HNSCC tumors to be targeted with emerging FGFR-specific TKIs (22).

Materials and Methods

Cell culture

The authenticity of the HNSCC cell lines used in this study was validated by fingerprint analysis by the University of Colorado Cancer Center DNA Sequencing and Analysis Core. All cell lines were routinely cultured in Dulbecco’s modified Eagle’s medium (UMSCC8, UMSCC19, UMSCC25, HN4, HN31, CCL30, and Detroit562) or RPMI-1640 (Ca9-22, 584-A2) growth medium (Invitrogen) supplemented with 10% fetal bovine serum (FBS) with 1% penicillin–streptomycin (Sigma-Aldrich) at 37°C in a humidified 5% CO2 incubator. To reduce mitogenic effects of serum, cells were cultured in serum-free media and treated with 10 nmol/L hydrocortisone, 5 µg/mL insulin, 10 µg/mL transferrin, 10 nmol/L estradiol, 30 nmol/L Na3SeO3, and 1% bovine serum albumin (BSA) where indicated. Primary human oral keratinocytes (HOKs; ScienCell), the immortalized human keratinocyte cell line, HaCaT
Quantitative real-time PCR

Total RNA was purified from cells by using RNeasy mini kits (Qiagen) and aliquots (5 μg) were reverse transcribed in a 20-μL volume by using random hexamers and Moloney murine leukemia virus reverse transcriptase. Aliquots (5 μL) of the reverse transcription reactions were submitted to PCR reactions with SYBR green Jumpstart Taq ReadyMix (Sigma–Aldrich) by using an I Cycler (BioRad). Primers used for FGF2, FGFR1, and FGFR2 quantitative PCR (QPCR) assays are previously described (18), and QPCR analysis of FGFR3 mRNA was carried out with forward primer 5′-CCATCG GCA TTG ACA AGG AC-3′ and reverse primer 5′-GCA TCT TTC TTG ACA TTC AC-3′. Expression of the different mRNAs in samples was normalized to glyceraldehydes-3-phosphate dehydrogenase (GAPDH) mRNA levels measured by quantitative real-time PCR (QRT-PCR) in replicate samples. Data are presented as “relative expression.”

Growth assays

To measure the effect of inhibitors on single cell colony formation in a clonogenic assay, HNSCC cells were seeded in 6-well plates at 100 to 200 cells/well in full growth media. Twenty-four hours later, cells were treated with RO4383596 (provided by Hoffman-La Roche), AZ12908010 (provided by AstraZeneca), AG1478 (Calbiochem), Gefitinib (provided by AstraZeneca), or FP-1039 (http://www.cancer.gov/drugdictionary/?CdrID=599037; provided by FivePrime Therapeutics) and cultured for 9 additional days. Wells were rinsed with phosphate-buffered saline and stained and fixed with 0.5% (wt/vol) crystal violet in 6.0% (vol/vol) gluteraldehyde solution (Fisher Scientific). Following destaining with distilled water, the plates were photographed and total colony area (Fisher Scientific) was normalized to total cellular protein, and the data are presented as pg FGF2/mg cell protein.

Immunoblot analyses

For analysis of phospho-extracellular signal-regulated kinase (ERK) levels in HNSCC cells, 1.5 × 10⁵ cells were plated in wells of 6-well plates. The next day, cells were placed in HITES media for 2 hours to minimize signaling from serum factors and subsequently treated with concentrations of AG1478 (0–0.3 μmol/L) or RO4383596 (0–1 μmol/L) for 2 hours. Cells were rinsed, lysed in 250-μL MKLB, and centrifuged (5 minutes at 13,000 rpm). Supernatants (100 μL) were mixed with 25-μL SDS sample buffer and proteins resolved by SDS-PAGE. Following electrophoretic transfer to nitrocellulose filters and blocking in 3% BSA (Cohn Fraction V, ICN Biomedicals, Inc., Aurora, OH) in Tris-buffered saline with 0.1% Tween 20 (TTBS), the filters were incubated for 16 hours at 4°C with rabbit polyclonal anti-phospho-ERK (Cell Signaling Technology, Inc.). The filters were washed with 4 changes of TTBS, then incubated with alkaline phosphatase-coupled goat anti-rabbit antibodies (Santa Cruz Biotechnology) for 1 hour and re-probed for total ERK1 and ERK2 using a mixture of rabbit polyclonal anti-ERK1 (sc-93) and ERK2 (sc-154; Santa Cruz Biotechnology, Inc.).

For immunoblot analysis of FGFR1, FGFR2, FGFR3, EGFR, and the NaK-ATPase α-subunit, MKLB extracts from HNSCC cells were submitted to SDS-PAGE by using 7.5% acrylamide separating gels. Nitrocellulose filters were blocked in 3% nonfat dehydrated milk in TTBS for 1 hour at room temperature and incubated with antibodies to FGFR1 (sc-57132), FGFR2 (sc-122), FGFR3 (sc-13121), or NaK-ATPase α-subunit (sc-21712) from Santa Cruz Biotechnology Inc. EGFR was detected with a rabbit polyclonal antibody (Cell Signaling Technology, Inc., catalogue no. 2232). Filters were then incubated with alkaline phosphatase-coupled secondary antibodies for 1 hour and developed with Lumi-Phos reagent (Thermo Fisher Scientific).

Results

HNSCC cell lines coexpress FGF2 and FGFR1-3

We previously showed that a subset of NSCLC cell lines, especially of squamous and large cell histologies, coexpress FGFs and FGFRs and induce autocrine signaling contributing to transformed growth (18). To explore if FGFs and FGFR signaling may play a similar role in HNSCC, previously published Affymetrix microarray data (35) from HNSCC cell lines were queried for expression of FGF and FGFR genes (Supplementary Table S1). Of the 22 FGF...
expression. FGFR1 expression was highly expressed in a single HNSCC cell line (584-A2), but expression of FGFR2 and FGFR3 was predicted in the majority of the cell lines. FGFR4 expression was not expressed as assessed by the Affymetrix data (Supplementary Table S1) and was not studied further. Thus, expression array data suggest that components of an FGF2–FGFR signaling pathway are generally detected in HNSCC cell lines.

A panel of 9 HNSCC cell lines was analyzed for FGF2 and FGFR function. The clinical characteristics of the tumors from which the cell lines were derived are summarized in Supplementary Table S2. Among these, HN4, UMSCC8, and HN31 have previously been defined as sensitive to the EGFR-specific TKI, gefitinib, whereas 584-A2 was resistant (35). With the exception of 584-A2 and CCL30, all of the HNSCC cell lines express EGFR protein (see, Fig. 2A). QRT-PCR analysis of FGF2 mRNA (Fig. 1A) and ELISA analysis of cellular FGF2 protein (Fig. 1B) revealed significant expression in 6 of the 9 HNSCC cell lines (584-A2, HN31, HN4, Detroit562, CCL30, and UMSCC8). FGF2 expression was reproducibly detected, albeit at a lower level, in Ca9-22 and UMSCC19, whereas UMSCC25 was negative for FGF2. Consistent with the microarray data (Supplementary Table S1), FGF7 and FGF9 mRNAs were uniformly low or undetectable in HNSCC cell lines as measured by QRT-PCR (data not shown). Measurement of FGFR expression status in the 9 HNSCC cell lines revealed high levels of FGFR1 mRNA (Fig. 1C) and protein (Fig. 2A) in 584-A2 with HN31 and CCL30 expressing lower, but detectable levels. By contrast, 6 of the HNSCC cell lines (UMSCC8, UMSCC25, Detroit562, Ca9-22, HN4, and HN31) expressed detectable FGFR2 mRNA and protein (Figs. 1C and 2A) and 4 of the lines (UMSCC8, UMSCC25, CCL30, and Ca9-22) expressed FGFR3 mRNA and/or protein. Thus, the data in Figures 1 and 2 provide evidence for general expression of FGF2, FGFR2, and FGFR3 and restricted expression of FGFR1 in a panel of 9 HNSCC cell lines.

FGF2 mRNA levels in primary HOK and immortalized human keratinocytes (HaCaT) were markedly lower than expression levels in the HNSCC cell lines and HGF-1 (Fig. 3A). Likewise, the level of FGFR1 protein expression in HOK and HaCaT cells was undetectable compared with the level measured in 584-A2 cells and the gingival fibroblasts (Fig. 3B). By contrast, the relatively high levels of FGFR2 and FGFR3 in UMSCC8 cells (relative to the other 8 HNSCC cell lines) were similar to expression observed in HaCaT and HOK cells (Fig. 3B). A simple interpretation of the findings is that FGF2 and FGFR1 levels are increased in HNSCC cell lines, but FGFR2 and FGFR3 are retained at levels similar to nontransformed oral epithelia modeled by HaCaT and HOK cells.

FGF2 functions as an autocrine growth factor in HNSCC cell lines

To test the role of FGF2 as an autocrine growth factor in HNSCC cell lines, FP-1039, a soluble Fc fusion protein encoding the extracellular ligand-binding domain of FGFR1c (see Materials and Methods), was used as a ligand
trap to sequester FGF2 released into the medium by HNSCC cells. UMSCC19 cells produce little FGF2 (see Fig. 1) and cell growth is not inhibited by FP-1039 (Fig. 3). By contrast, FP-1039 elicited dose-dependent inhibition of anchorage-independent growth of 584-A2, CCL30, and Detroit562 cells that express abundant FGF2. These findings indicate that FGF2 functions as an autocrine growth factor in distinct HNSCC cell lines.

Differential sensitivity of HNSCC cell lines to EGFR and FGFR TKI treatment

As a distinct means to test if the FGF2 and FGFRs constitute a signal pathway contributing to HNSCC growth and transformation, cells were treated with increasing concentrations of the FGFR inhibitor, RO4383596 (18, 36), or an EGFR-specific inhibitor, AG1478, and submitted to immunoblot analyses for basal ERK phosphorylation as a measure of proximal RTK signaling. As shown in Figure 4, CCL30 and 584-A2 responded to RO4383596 with a complete, dose-dependent inhibition of basal ERK phosphorylation, whereas Detroit562 cells exhibited partial reduction of phospho-ERK levels. Moreover, AG1478 was without effect on phospho-ERK levels in these cells. By contrast, UMSCC19, HN4, and HN31 exhibited potent inhibition of ERK signaling in response to AG1478, whereas RO4383596 was without effect. Finally, UMSCC8, Ca9-22, and UMSCC25 cells exhibited partial reduction of phospho-ERK levels in response to both RO4383596 and AG1478. Moreover, a chemically-distinct FGFR-specific TKI, AZ12908010 (19) reduced phospho-ERK levels similarly to RO4383596 (Supplementary Fig. S1), supporting the interpretation that FGFRs are driving signaling of the ERK pathway in these cell lines. On the basis of this
signaling endpoint, some cell lines (584-A2, CCL30, and Detroit 562) exhibit dependence solely on FGFR signaling, whereas others are completely dependent on EGFR signaling (UMSCC19, HN4, and HN31). Finally, Ca9-22, UMSCC25, and UMSCC8 responded to both TKIs with inhibition of basal ERK phosphorylation.

To determine if TKI-induced inhibition of ERK signaling correlated with effects on HNSCC cell growth, the effect of AG1478 or RO4383596 was tested on anchorage-independent or clonogenic growth. As predicted from the findings in Figure 4, growth of CCL30, Detroit562, and 584-A2 was inhibited by RO4383596, but not AG1478 (Fig. 5A and B). By contrast, growth of cell lines exhibiting dominant EGFR signaling (UMSCC19, HN4, and HN31) was reduced by AG1478, but not RO4383596 (Fig. 5C and D). Finally, UMSCC8, UMSCC25, and Ca9-22 cells exhibit growth inhibition in response to either TKI (Fig. 5E and F), indicating that both EGFR and FGFR contribute to growth and transformation in these cell lines.

The growth inhibitory response of UMSCC8, UMSCC25, and Ca9-22 to RO4383596 and AG1478 suggests that both EGFR and FGFRs are active in these cell lines. Therefore, additive inhibition of growth would be predicted in response to treatment with combinations of TKIs targeting EGFR and FGFRs. UMSCC8, UMSCC25, and Ca9-22 cells were treated with single concentrations of AG1478 (100 nmol/L) or RO4383596 (300 nmol/L) or combinations of both drugs and clonogenic growth was measured. Growth of UMSCC25 cells was inhibited by approximately 50%
with AG1478 or RO4383596 and a further inhibition was observed in response to combined treatment with these TKIs (Fig. 6A). Growth of UMSCC8 and Ca9-22 cells was significantly reduced by AG1478 alone, but not by RO4383596 alone. However, treatment with combined AG1478 and RO4383596 induced significantly greater growth inhibition than AG1478 alone (Fig. 6A). Nearly identical results were obtained when the 3 HNSCC cell lines were treated with chemically-distinct EGFR and FGFR-specific TKIs, gefitinib and AZ12908010 (19), respectively (Fig. 6B). Moreover, the EGFR-specific TKIs can be replaced with cetuximab, an anti-EGFR antibody inhibitor with similar results (Fig. 6C). These results indicate that a subset of HNSCC lines exist in which both FGFR and EGFR pathways are simultaneously engaged to drive maximal growth. These results are consistent with the functioning of coactivation networks whereby multiple distinct RTKs simultaneously engage in oncogenic signaling rather than single dominant receptors (37).

Discussion

Our study provides evidence for functioning of an FGF2–FGFR autocrine pathway, either alone or in combination with EGFR, to drive HNSCC growth and transformation. Although there is little prior published evidence for activity of FGPs and FGFRs in growth of HNSCC, previous reports support our observation of coexpression of FGFR2 and distinct FGFRs. For example, analysis of tissue samples reflecting the progression of HNSCC from normal oral mucosa to carcinomas showed increased FGF2, FGFR2, and FGFR3 expression compared with normal surrounding mucosa (38). Also, FGF2 was detected in conditioned medium from HNSCC cell lines (39) and in urine and serum obtained from head and neck cancer patients (40). Thus, similar to our study showing autocrine growth activity of FGFR signaling pathways in NSCLC of squamous and large cell histologies (18), the present study highlights the FGFR pathway as a novel target for therapeutic intervention in HNSCC. These findings also support and extend our previously published results showing sensitivity of a subset of HNSCC cell lines to the EGFR-specific TKI, gefitinib (35) and indicate HNSCC cell lines can be more precisely classified into subsets that are dependent on (i) EGFR signaling, (ii) FGFR signaling, or (iii) both EGFR and FGFRs.

An important question is how the FGFR autocrine pathway may become engaged or activated during progression of HNSCC. In this regard, cancer research presently focuses on increased activity of specific RTKs through somatic mutations to induce gain-of-function phenotypes or through marked overexpression of specific RTKs, often through gene amplification. In this regard, fluorescence in situ hybridization (FISH) analysis of primary oral squamous cell carcinomas revealed amplification of the FGFR1 gene in approximately 17% of oral squamous cell tumors and FGFR1 protein overexpression in approximately 12% (41). Of note, a recent report has shown that FGFR1 is amplified in approximately 20% of NSCLC of the squamous histology but is rare in lung adenocarcinomas (34). Our own inspection of Affymetrix 6.0 SNP array findings deposited in the COSMIC database (http://www.sanger.ac.uk/genetics/CGP/CellLines/) suggests that 2 of the 22 HNSCC cell lines analyzed (HN; sample ID 907059) and (SCC25; sample ID 910701) may have increased copy...
number at the chromosome 8p12 locus containing the \textit{fgfr1} gene. Although these 2 particular cell lines were not tested in our study, we did analyze 584-A2 cells that express abundant FGFR1 mRNA and protein (Fig. 2). Analysis of \textit{fgfr1} gene copy number by FISH in 584-A2 cells revealed no evidence for amplification (data not shown). Regarding a role for somatic gain-of-function mutations in specific FGFRs, a published report revealed frequent (62%) mutation of FGFR3 (G697C) in primary HNSCC derived from Japanese patients (42). However, an independent screening of a French head and neck cancer patient population revealed no evidence for this FGFR3 mutation (43). Also, the COSMIC database reveals no identified FGFR3 mutations in any of the 22 HNSCC cell lines that were sequenced. Thus, it is possible that FGFR3 mutations may be highly restricted to HNSCC derived from specific ethnic populations. Increased frequency of EGFR mutations in patients of Asian ethnicity provides precedent for this possibility (44).

As an alternative mechanism for the observed FGF2 and FGFR2/FGFR3 coexpression in HNSCC cell lines, we propose that FGFR2 and FGFR3 are expressed in normal epithelial cell precursors exemplified by HOK and HaCaT cells (see, Fig. 2) and simply retained and co-opted for a role in transformed growth of HNSCC cells. In support, FGFR2 has been established as a key RTK mediating proliferation and maintenance of normal oral keratinocytes (45–47). The simple retention of FGFR2 and FGFR3 expression as normal mucosa advances to squamous cell carcinoma may be sufficient to contribute to progression of this disease. In this manner, FGFR signaling pathway may contribute to HNSCC transformation through the establishment of an autocrine loop without frequent amplification or mutation of any of the key FGFR components. By

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**Figure 6.** Inhibition of HNSCC growth by combinations of FGFR- and EGFR-specific inhibitors. A, the indicated HNSCC cell lines shown to be responsive to both EGFR- and FGFR-specific TKIs (Fig. 5E and F) were submitted to a clonogenic growth assay in the absence (DMSO, control) or presence of the FGFR TKI, RO4385396 (300 nmol/L), the EGFR-specific TKI, AG1478 (100 nmol/L), or both drugs (AG + RO) at the same concentrations. Clonogenic growth assays were carried out with (B) EGFR-specific TKI, gefitinib (100 nmol/L), and/or the FGFR-specific TKI, AZ12908010 (300 nmol/L) or (C) cetuximab (1 μg/mL) in the presence or absence of AZ12908010 (300 nmol/L). After 2 weeks, colonies were stained and quantified as described in the Materials and Methods. The data are the means and SEM; *, \( P < 0.05 \) by unpaired Student’s \( t \)-test relative to EGFR inhibitor treatment alone.
contrast, a general induction of FGF2 expression may occur in the transition from early lesions to carcinomas. In support, FGF2 expression is low in HOK and HaCaT cells relative to HNSCC cell lines and gingival fibroblasts (Fig. 2). Interestingly, inspection of 2 GEO Dataset expression arrays of HNSCC tumor and normal mucosa samples (Supplementary Fig. S2) reveals no significant differences in FGF2, FGF2R, and FGF3 mRNA expression in HNSCC tumors compared with normal tissues. In fact, FGF3 mRNA levels are somewhat lower in tumors relative to normal tissues. The contributions of FGF2 and FGFR mRNA from non-epithelial stromal cell types present in both the normal and tumor specimens likely accounts for the discrepancy between the findings in Figure 2 and Supplementary Figure S2.

Despite overexpression in approximately 90% of HNSCC tumors, EGFR inhibitors have not exerted a major therapeutic impact (reviewed in refs. 1–4). In fact, our previous study (35) and present experiments (see, Fig. 5) indicate that only a subset of HNSCC cell lines exhibit a significant growth inhibitory response to EGFR-specific TKIs as single agents. Currently, the only EGFR-targeted therapy approved for treatment of locally advanced HNSCC tumors is cetuximab, which has shown modest benefit in patients when used in conjunction with chemotherapy or radiotherapy (2, 6). Clearly, expression of EGFR protein is not an accurate indicator of EGFR dominance in primary HNSCC tumors or in HNSCC cell lines (see, Fig. 2A, Supplementary Table S2; refs. 2, 11). Importantly, the efficacy of EGFR-specific TKIs for treatment of lung cancer was largely underestimated in early trials that failed to appreciate that benefit was largely restricted to those lung adenocarcinomas bearing mutations in EGFR (8). Thus, the relatively weak clinical efficacy of EGFR inhibitors in HNSCC is predicted from the absence of somatic mutations in EGFR (48) and the failure to selectively target a subset of HNSCC tumors in which EGFR is dominant.

Mutations in defined oncogene drivers are rare in HNSCC relative to NSCLC where subsets of lung cancers bearing mutations in KRAS, PIK3CA, EGFR, ERBB2, ALK, and BRAF have emerged (48, 49). Because targeted therapy strategies depend on matching inhibitors with tumors bearing their mutated oncogene targets, the deployment of targeted therapies in HNSCC is problematic. Importantly, this issue is not limited to HNSCC as at least 50% of NSCLC tumors cannot be presently assigned a defined oncogenic driver mutation (49). Yet, we propose that RTKs may still serve as useful targets for therapeutics in HNSCC. Besides EGFR and FGFRs in HNSCC growth, published studies indicate roles for IGF-1R, Met, PDGFR, and VEGFR (12–14). In fact, our study and others (48), provide support for the concept of RTK coactivation networks (37) as the more accurate representation of oncogenic growth factor inputs in HNSCC. Our present study shows potent growth inhibition by an FGFR TKI in a subset of HNSCC cell lines, whereas EGFR-specific TKIs exert strong growth inhibition in a distinct subset of cell lines. Finally, a third subset of HNSCC cell lines exhibited additive growth inhibition upon treatment with combined EGFR and FGFR-specific TKIs (Fig. 6). Additional RTKs including IGF-1R and Met are also likely to be actively engaged in growth signaling in this panel of 9 HNSCC cell lines. Therefore, identifying the minimal set of RTKs that provide dominant or codominant growth inputs in HNSCC as well as discovering biomarkers that define specific RTK networks represent important goals for future investigations. If successful, combinations of TKIs that block the operative RTK coactivation network within a given HNSCC tumor, despite lack of somatic mutations, may prove to be an effective therapeutic strategy for HNSCC.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

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