Bevacizumab-Induced Alterations in Vascular Permeability and Drug Delivery: A Novel Approach to Augment Regional Chemotherapy for In-Transit Melanoma

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Abstract

**Purpose:** To investigate whether the systemically administered anti-VEGF monoclonal antibody bevacizumab could improve regional chemotherapy treatment of advanced extremity melanoma by enhancing delivery and tumor uptake of regionally infused melphalan (LPAM).

**Experimental Design:** After treatment with systemic bevacizumab or saline, changes in vascular permeability were determined by spectrophotometric analysis of tumors infused with Evan’s blue dye. Changes in vascular structure and tumor hemoglobin-oxygen saturation HbO2 were determined by intravital microscopy and diffuse reflectance spectroscopy, respectively. Rats bearing the low-VEGF secreting DM738 and the high-VEGF secreting DM443 melanoma xenografts underwent isolated limb infusion (ILI) with melphalan (LPAM) or saline via the femoral vessels. The effect of bevacizumab on terminal drug delivery was determined by immunohistochemical analysis of LPAM-DNA adducts in tumor tissues.

**Results:** Single-dose bevacizumab given three days before ILI with LPAM significantly decreased vascular permeability (50.3% in DM443, \( P < 0.01 \) and 35% in DM738, \( P < 0.01 \)) and interstitial fluid pressure (57% in DM443, \( P < 0.01 \) and 50% in DM738, \( P = 0.01 \)). HbO2 decreased from baseline in mice following treatment with bevacizumab. Systemic bevacizumab significantly enhanced tumor response to ILI with LPAM in two melanoma xenografts, DM443 and DM738, increasing quadrupling time 37% and 113%, respectively (\( P = 0.03 \)). Immunohistochemical analyses of tumor specimens showed that pretreatment with systemic bevacizumab markedly increased LPAM-DNA adduct formation.

**Conclusions:** Systemic treatment with bevacizumab before regional chemotherapy increases delivery of LPAM to tumor cells and represents a novel way to augment response to regional therapy for advanced extremity melanoma. *Clin Cancer Res; 18(12); 3328–39. ©2012 AACR.*

Introduction

While the incidence of several other cancers declines, the incidence of melanoma continues to rise and is now the most common fatal malignancy of young adults and the sixth most common cancer among Americans. In 2009, there were an estimated 68,720 people newly diagnosed with invasive melanoma, and more than 8,650 people died of melanoma in the United States (1). Unfortunately, mortality rates for metastatic melanoma have remained high in part because of its high resistance to standard cytotoxic agents (2). A major breakthrough for the treatment of metastatic melanoma has been the recent U.S. Food and Drug Administration (FDA)-approval for the anti-CTLA4 antibody (ipilimumab) and a specific inhibitor targeting the V600E-activating BRAF mutation (vemurafenib) found in approximately 50% of patients with melanoma (3). For patients who recur after treatment with these new therapies, response to other systemic therapy is poor, with standard agents such as dacarbazine, temozolomide, and paclitaxel having complete response rates of <15% (2).

A significant fraction of patients with melanoma will recur with in-transit disease which represents multifocal metastases that have spread through the lymphatic system occurring between the site of the primary lesion and the regional draining lymph node basin (4). This pattern of recurrence is associated with an unfavorable prognosis, having 5-year survival rates ranging from 25% to 30% (5). Historically, standard systemic chemotherapy or immunotherapy has provided little benefit for in-transit disease (6). However, for patients with in-transit disease confined to the extremities, regional chemotherapy delivered by...
isolated limb perfusion (ILP) or isolated limb infusion (ILI) is a viable treatment option.

Briefly, ILP is conducted by surgically exposing the femoral or subclavian vessels and then cannulating them at the root of the limb. Next, an eschar tourniquet is placed proximal to the cannulated vessels and the limb is perfused with a high-flow, melphalan-based perfusate using a membrane oxygenator to maintain physiologic oxygenation and pH (5). ILI is a generally less-invasive surgical technique and is conducted by percutaneous catheterization of the involved limb followed by infusion of melphalan in a low-flow circuit without an oxygenator such that tissue becomes hypoxic and acidic (7).

Using these techniques, complete response rates ranging from 30% to 60% have been reported in larger series (5). Although these initial response rates represent an improvement over systemic therapy, at least 40% of patients with in-transit melanoma will eventually recur after regional chemotherapy (8). Thus, novel strategies are needed to improve durable responses rates of locally advance melanoma to regional therapy.

Strategies to optimize delivery of cytotoxic agents to melanoma during regional chemotherapy may enhance not only the initial response to treatment but also the durability of this response. Melanoma induces angiogenesis that results in tumor vasculature which is anatomically and functionally distinct from that seen in normal tissue (9, 10). The vasculature of solid tumors has been characterized as tortuous, dilated, saccular, and irregular in its pattern of interconnection (11). This erratic tumor vasculature can pose a barrier to optimal drug delivery thus limiting the efficacy of cytotoxic therapy. An important mediator of tumor angiogenesis is VEGF, a cytokine which stimulates angiogenesis and is normally seen during embryonic development as well as in postinjury angiogenesis (12). VEGF is a multifunctional cytokine capable of stimulating endothelial cell proliferation, migration, and survival (13). VEGF is also a potent stimulator of vessel permeability (14). Commonly overexpressed in metastatic melanoma, high serum levels of VEGF have been correlated with adverse prognosis and implicated as an important mediator in creating a dysfunctional vascular network antagonizing optimal drug penetration (15).

Bevacizumab is an FDA-approved monoclonal antibody to VEGF that neutralizes all isoforms of VEGF. It has been used in combination with standard chemotherapies in patients with metastatic colorectal, brain, and lung cancers and is being investigated in combination with other chemotherapy agents for melanoma in multiple clinical trials across the United States (16–18). Bevacizumab also offers a unique tool to temporally restore the balance between angiogenic stimulators and angiogenic inhibitors (11). Emerging evidence shows that vascular targeting agents such as bevacizumab can transiently "normalize" tumor microvasculature toward that seen in normal tissues thereby creating an optimal window for chemotherapy delivery (19). By effectively neutralizing VEGF, bevacizumab is theorized to prune immature and leaky vessels characteristic of solid tumors, leading to functional changes that include increased tumor oxygenation and drug penetration (11). Although beneficial when used in a well circumscribed window, sustained antiangiogenic treatment may lead to severe tumor vessel regression that blocks penetration of therapeutic drugs into the tumor antagonizing, rather than augmenting, cytotoxic therapy. Thus, systemic therapies, which are often administered in multiple doses, may initially benefit from the antiangiogenic therapy but will be hindered at later time points as tumor vessels wither and become inadequate for drug delivery (19).

Because regional chemotherapy is administrated as a single infusion or perfusion of high-dose cytotoxic therapy (5), it is an ideal modality to test whether bevacizumab can enhance drug delivery and subsequently improve tumor response. In this report, we provide preclinical evidence that systemically administered bevacizumab decreases tumor vascular permeability and interstitial fluid pressure (IPF) leading to increased drug delivery and improved efficacy of regionally infused melphalan. Pretreatment with systemic bevacizumab before arterial infusion of melphalan improves drug penetration and tumor responses, supporting bevacizumab as a beneficial adjunct to regional therapy for melanoma.

### Materials and Methods

**Melanoma cell lines and reagents**

Tumor cell lines derived from human melanomas (DM lines) were courtesy of Dr. H. Seigler (Duke University Medical Center, Durham, NC). Cells were cultured in Isco’s Modified Dulbecco’s Medium with 10% FBS, 2 mmol/L glutamine, 1,000 IU/mL penicillin, and 100 mg/ml streptomycin and grown at 37°C and 5% CO₂. Bevacizumab (Avastin by Genentech) was purchased from the Duke University Pharmacy.

**Quantification of melanoma cell VEGF secretion and its modulation with bevacizumab**

Human VEGF Quantikine ELISA Kits (R&D Systems) were used according to the directions of the manufacturer.
Two-hundred microliters of conditioned media were collected from triplicate samples.

VEGF neutralization and its effect on melphalan sensitivity of melanoma cells

Using cell survival as an endpoint, DM443 and DM738 cells were plated at $1 \times 10^3$ per well in a 96-well microtiter plate and after 24 hours, treated with 0 to 2 mg/mL bevacizumab and refed with fresh medium containing 0 to 150 $\mu$mol/L melphalan. Cell survival was measured after 72 hours, using the Cell Titer-Blue assay (Promega), as per the manufacturer’s instructions, with excitation and emission wavelengths of 560 and 590 nm, respectively. Surviving fractions, SF, were computed using the equation: $SF = F_S / F_C$, where $F_S$ and $F_C$ are the fluorescence of treated and untreated cells, respectively, normalized against background fluorescence.

Hyperspectral analysis of tumor vasculature after treatment with bevacizumab

The preparation of the dorsal skin-fold window chamber has been described elsewhere (20). All procedures used in this study were approved by the Duke University Institutional Animal Care and Use Committee. Briefly, a 12-mm diameter flap of skin was dissected away from opposing surfaces of the dorsal skin flap of anesthetized nude mice, leaving a fascial plane with associated vasculature. The hole was held vertically away from the body with a titanium saddle that was sutured to both sides of the flap. A total of 3–4 weeks after inoculation, mice ($n = 8$) were injected with intraperitoneal bevacizumab (5 mg/kg) or equivalent volumes of intraperitoneal normal saline ($n = 9$). All tumors were monitored optically before treatment and then daily for 6 days after treatment. Briefly, animals were anesthetized with inhaled 1.5% isoflurane gas mixed with oxygen. A bifurcated fiber optic probe using separate illumination and collection paths was noninvasively applied in direct contact with DM443 xenografts and secured with a clamp to prevent movement. Diffuse reflectance was the measured in the spectral range of 480 and 650 nm. The acquired diffuse reflectance spectra were calibrated and analyzed using an inverse scalable Monte Carlo model to obtain wavelength-dependent scattering and absorption spectra (22). The concentration of oxygenated hemoglobin (HbO$_2$) and deoxygenated hemoglobin (dHb) was derived using the Beer–Lambert equation. Total hemoglobin (Hb) was calculated by the sum of HbO$_2$ and dHb. Differences in %ΔHb and %ΔHbO$_2$ were compared between treatments with a Mann–Whitney U test using the commercially available software GraphPad Prism.

Rat xenograft studies

Female nude rats (6-week-old; Charles River Laboratories International, Inc.) were injected subcutaneously in the right flank with $5 \times 10^6$ DM443 melanoma cells suspended in 100 $\mu$L of normal growth medium. Three mice did not grow tumors. Once tumor diameters reached 8 to 10 mm (~2–3 weeks after inoculation), mice ($n = 8$) were injected with intraperitoneal bevacizumab (5 mg/kg) or equivalent volumes of intraperitoneal normal saline ($n = 9$). All tumors were monitored optically before treatment and then daily for 6 days after treatment. Briefly, animals were anesthetized with inhaled 1.5% isoflurane gas mixed with oxygen. A bifurcated fiber optic probe using separate illumination and collection paths was noninvasively applied in direct contact with DM443 xenografts and secured with a clamp to prevent movement. Diffuse reflectance was measured in the spectral range of 480 and 650 nm. The acquired diffuse reflectance spectra were calibrated and analyzed using an inverse scalable Monte Carlo model to obtain wavelength-dependent scattering and absorption spectra (22). The concentration of oxygenated hemoglobin (HbO$_2$) and deoxygenated hemoglobin (dHb) was derived using the Beer–Lambert equation. Total hemoglobin (Hb) was calculated by the sum of HbO$_2$ and dHb. Differences in %ΔHb and %ΔHbO$_2$ were compared between treatments with a Mann–Whitney U test using the commercially available software GraphPad Prism.

Diffuse reflectance spectroscopy for quantitative tumor hemoglobin concentration and oxygen saturation

A total of 20 nude mice were inoculated subcutaneously in the right flank with $3 \times 10^6$ DM443 melanoma cells suspended in 100 $\mu$L of normal growth medium. Three mice did not grow tumors. Once tumor diameters reached 8 to 10 mm (~2–3 weeks after inoculation), mice ($n = 8$) were injected with intraperitoneal bevacizumab (5 mg/kg) or equivalent volumes of intraperitoneal normal saline ($n = 9$). All tumors were monitored optically before treatment and then daily for 6 days after treatment. Briefly, animals were anesthetized with inhaled 1.5% isoflurane gas mixed with oxygen. A bifurcated fiber optic probe using separate illumination and collection paths was noninvasively applied in direct contact with DM443 xenografts and secured with a clamp to prevent movement. Diffuse reflectance was measured in the spectral range of 480 and 650 nm. The acquired diffuse reflectance spectra were calibrated and analyzed using an inverse scalable Monte Carlo model to obtain wavelength-dependent scattering and absorption spectra (22). The concentration of oxygenated hemoglobin (HbO$_2$) and deoxygenated hemoglobin (dHb) was derived using the Beer–Lambert equation. Total hemoglobin (Hb) was calculated by the sum of HbO$_2$ and dHb. Differences in %ΔHb and %ΔHbO$_2$ were compared between treatments with a Mann–Whitney U test using the commercially available software GraphPad Prism.
Tumor vascular permeability

ILI was conducted as described earlier. Rats received an injection of bevacizumab 5 mg/kg intraperitoneally (i.p.) or saline 3 days before a 15-minute infusion of Evan’s Blue dye solution (50 mg/kg dissolved in normal saline and infused at 1.5 mL/min) followed by a 2-minute saline washout (3.0 mL/min). Animals were euthanized and tumors were excised followed by incubation in formamide solution for 72 hours at 37°C to extract the Evan’s blue dye. To quantify the Evan’s blue, absorbance of the formamide solution was measured at 595 and 655 nm and normalized to tumor volume.

Interstitial fluid pressure

Tumor IFP measurements were made with a needle probe pressure monitor (Intra-Compartmental Pressure Monitor System, Stryker), fitted with an 18-gauge side-ported needle (Stryker) and connected to a syringe filled with 0.9% saline. Using isoflurane anesthesia, the needle probe was inserted into the center of the tumor on the hind limb of the rat. IFP was recorded in mm Hg when the measurement stabilized.

Immunohistochemistry of tumor vessel density

Ten DM738 (n = 5, saline; n = 5, 5 mg/kg i.p. bevacizumab) and 13 DM443 (n = 6, saline; 7.5 mg/kg bevacizumab) xenografts were flash-frozen using liquid nitrogen. They were then cut into 10 μm cross-sections using a LEICA CM 1850 cryotome (Meyer Instruments Incorporated) and maintained at −24°C to −28°C. Sections were then fixed in acetone for 30 minutes, allowed to dry for 1 hour, and then blocked for 30 minutes at room temperature with 5% donkey serum (Jackson ImmunoResearch) in PBS. Sections were then incubated with primary antibody (1:200 mouse anti-rat CD31, BD bioscience) at room temperature for 1 hour, followed by a 30-minute incubation with a fluorescent-conjugated secondary antibody (1:100; Jackson ImmunoResearch) at room temperature. Samples were rinsed with PBS 3 times for 5 minutes each between every consecutive step.

Immunohistochemical staining for CD31 was assessed with a Zeiss AxioScop II microscope with a scanning stage. Images of whole tumors were recorded at ×5 magnification and subsequently segmented and evaluated in ImageJ. Distinct immunoreactive endothelial cells were counted as individual microvessels, and nonspecific staining of nonepithelial structures was disregarded in microvessel counts. Mean microvessel density for CD31 was calculated over the total area of the tumor.

Immunohistochemistry of DNA-melphalan adduct

Rats were treated with bevacizumab (5 mg/kg i.p.) or saline 3 days before ILI. Rats were then euthanized 24 hours after LPAM- or saline-ILI. Tumors were then fixed with formalin, paraffin-embedded, and stained using immunohistochemistry as previously described (23, 24). Treated and nontreated DM443 cells were used as positive and negative controls for the MP5/73 antibody which was kindly provided by Dr. M.J. Tilby, Northern Institute for Cancer Research, Newcastle University, Newcastle upon Tyne, United Kingdom (25).

Results

Melanoma cell lines secrete VEGF

To evaluate the therapeutic potential of anti-VEGF therapy for the treatment of in-transit melanoma, we measured VEGF secretion across 11 melanoma cell lines capable of forming tumor xenografts in our animal model of extremity melanoma. VEGF secretion was variable across these cell lines, with A2058, DM792, DM751, and DM738, an LPAM-resistant cell line, showing little to no VEGF secretion whereas DM443, a moderately LPAM-sensitive cell line, showing high levels of VEGF secretion (Supplementary Fig. S1A). To confirm bevacizumab can effectively neutralize melanoma VEGF secretion in vitro, we treated DM443 and DM738 cells, grown to 80% confluence, with 0 to 2.0 mg/mL bevacizumab for 24 to 72 hours. Bevacizumab at all concentrations tested effectively prevented detection of VEGF by ELISA (Supplementary Fig. S1B and S1C).

Bevacizumab does not alter in vitro LPAM chemosensitivity

VEGF possesses multiple cytokine functions and can act as a potent mitogen for endothelial cell proliferation. Given the possibility that VEGF might act as an autocrine growth factor for melanoma (27), we tested whether VEGF neutralization in itself could augment chemosensitivity of melanoma cells to melphalan in an endothelial cell-free system using a low-VEGF secreting, melanoma cell line (LPAM-resistant DM738) and a high-VEGF secreting, melanoma cell line (LPAM-sensitive DM443). VEGF neutralization in an endothelial cell-free system had no effect on the LPAM chemosensitivity for either DM443 or DM738 (Supplementary Fig. S2). On the basis of these data and others (19, 28), we focused our studies on evaluating 2 potential mechanisms by which bevacizumab could augment tumor cytotoxicity to regionally delivered chemotherapy through...
2 separate temporal effects: (i) neutralization of VEGF would lead to normalization of tumor microvasculature resulting in a more optimal vascular anatomy for delivering cytotoxic therapy and (ii) impairment of the requisite angiogenesis needed for further tumor growth.

**Bevacizumab decreases vascular permeability and interstitial pressure of melanoma xenografts**

Previous studies have shown bevacizumab to significantly decrease tumor vascular permeability and the peak functional effects of bevacizumab to occur 3 days after treatment (14, 19, 26, 29). On the basis of this evidence, we hypothesized that a single dose of bevacizumab, given 3 days before ILI would decrease vessel permeability. To test this, ILI was conducted on tumor-bearing rats using Evan’s blue dye as the infusate. Absorbance of Evan’s blue dye was measured and used as a surrogate of vascular permeability in the xenograft. As shown in Fig. 1A and B, bevacizumab (5 mg/kg) given 3 days before ILI significantly decreased vascular permeability of Evan’s blue dye by 70% in DM443 xenografts and 30% in DM738 xenografts.

Increased vascular permeability seen in tumor vasculature may lead to increased IFP which can hinder effective drug delivery to tumor cells (30). Thus, we also measured IFP in melanoma xenografts 3 days after treatment with i.p. bevacizumab (5 mg/kg). Mean IFP measurements in bevacizumab-treated animals were 57% (14.9 ± 0.9 vs. 8.3 ± 0.8 mm Hg, \( P < 0.01 \)) and 50% (18.0 ± 2.9 vs. 9.1 ± 1.2 mm Hg, \( P = 0.01 \)) lower than saline-treated controls for both DM443 and DM738 xenografts, respectively (Fig. 1C and D).

**Bevacizumab decreases hemoglobin oxygen saturation in melanoma tumors**

Tumor vascular normalization is hypothesized to induce a transient increase in tumor tissue oxygenation after treatments with antiangiogenic agents (11). To test the effect of bevacizumab on tumor tissue oxygenation, we measured tumor hemoglobin saturation \( HbO_2 \) using diffuse reflectance spectroscopy; a method which has been previously validated as a surrogate for tissue oxygenation (31). Nude mice bearing DM443 melanoma xenografts were treated with 5 mg/kg of i.p. bevacizumab (n = 8) or saline (n = 9). The effects of systemic bevacizumab on tumor total hemoglobin (Hb) and \( HbO_2 \) levels, Hb and \( HbO_2 \) were measured at baseline before treatment and daily for 6 days using diffuse reflectance spectroscopy. Daily \( HbO_2 \) levels were shown to be consistently lower than baseline measurements in the bevacizumab-treated mice than in saline-treated controls \( (P = 0.004) \). Hb levels in both groups decreased as much as 30% from baseline measurements without discernible differences between treatment groups \( (P = 0.38; \text{Fig. 2}) \).
control, no discernible differences were found in vascular tortuosity or VLD after treatment with systemic bevacizumab (Fig. 3B and C).

To confirm the results of the intravitral microscopy experiments, we compared tumor vascular density in bevacizumab- and saline-treated xenografts as determined from immunohistochemical staining for the vascular marker CD31. Representative cross-sections for both xenografts are shown in Fig. 4A and B. Overall, no significant differences in tumor vascular densities were found in either xenograft after treatment with bevacizumab (Fig. 4C and D).

**Systemic bevacizumab increases delivery of regionally administered melphan**

To better understand the effects of systemic bevacizumab on the delivery of regional melphan during ILI, short-term survival surgeries were carried out on nude rats bearing the DM443 and DM738 xenografts. Three days before surgery rats were treated with a single dose of bevacizumab (5 mg/kg). Twenty-four hours after regional infusion tumor tissue was harvested for analysis of LPAM-DNA adduct formation using the specific antibody MP5 as previously described. Animals treated with bevacizumab before infusion of regional melphan had significantly higher levels of LPAM-DNA adducts than animals infused with melphan alone. DM443 and DM738 xenografts showed an approximate 2- and 6-fold increase, respectively, in LPAM-DNA adduct reactivity for animals pretreated with bevacizumab before regional infusion as compared with those treated with systemic saline followed by LPAM infusion (Fig. 5). Tumors from animals receiving saline infusion (either alone or following bevacizumab treatment) showed no staining for LPAM-DNA adducts. Taken together, these results show that systemic bevacizumab induced microvasculature changes as early as 3 days after treatment which led to both a decrease in vascular permeability and an increase in the delivery of LPAM through the ILI circuit.

**Bevacizumab significantly increases response of melanoma xenografts to regional melphan**

Having showed that regionally infused melphan given 3 days after systemic bevacizumab treatment led to improved drug delivery into the tumor, we evaluated tumor growth after systemic bevacizumab using our preclinical animal model of ILI with melphan. Tumor-bearing nude rats were treated with bevacizumab or saline control at day 0 and infused with melphan or saline at day 3 based on preliminary functional data as well as previous reports (19, 26). Growth curves for both DM738 and DM443 xenografts after systemic saline injection and regional saline infusion are depicted by the black line and show baseline in vivo growth characteristics for both melanoma cell lines. DM443 baseline growth kinetics were significantly slower than DM738 (quadrupling time of 34.0 vs. 13.7 days, P < 0.0001 t test), which is consistent with our previous experience using these xenografts (supplementary Table S1; refs. 23, 34). Bevacizumab showed significant tumor growth inhibition 30 days after treatment when used in
combination with regionally delivered melphalan in both the low-VEGF secreting, fast growing DM738 xenograft ($P = 0.0007$, one-way ANOVA) and the high-VEGF secreting, slower growing DM443 xenograft ($P = 0.0335$, one-way ANOVA). Systemically administered bevacizumab alone showed similar efficacy to regional melphalan infusion alone for the low-VEGF secreting DM738 xenograft but not for the high-VEGF secreting DM443 xenograft (Fig. 6A and B). Combination therapy of systemic bevacizumab followed by regional melphalan infusion had the most robust effect on tumor growth inhibition for both xenografts, with a 37% and 113% increase in quadrupling time for DM443 and DM738, respectively, as compared with melphalan infusion alone (Supplementary Table S1).

Discussion

This study shows that systemic bevacizumab given before ILI with melphalan augments response by increasing delivery of melphalan to the tumor cells. This is first study to evaluate the use of bevacizumab as a part of a regional therapy strategy with the specific intent of augmenting the delivery of chemotherapy to a tumor. Our results, in the context of melanoma, clearly support the emerging concept that the efficacy of antiangiogenic therapy in combination with chemotherapy is not simply an additive effect of long-term hypoxia resulting from tumor vasculature destruction and cytotoxicity from the chemotherapy. Rather it is a synergistic effect resulting from modulation of tumor vascular supply leading to improved delivery and penetration of conventional chemotherapeutic agents (11). Rats undergoing limb infusions of high-dose melphalan 3 days after administration of bevacizumab had a robust and significantly greater response than either chemotherapy or bevacizumab alone.

Antiangiogenic therapies such as bevacizumab were developed with the goal of starving tumors of their blood...
supply. Whereas this effect was observed in preclinical models (35), antivascular agents have failed to control tumor growth through vascular effects alone in the clinical setting (36). Although ineffective as a monotherapy, bevacizumab in combination with conventional chemotherapy has improved overall survival in previously untreated patients with colorectal and lung cancer (17, 36). The mechanisms by which antiangiogenic therapies such as bevacizumab augment cytotoxic therapy are controversial. One theory is that bevacizumab in combination with cytotoxic agents acts synergistically by targeting both tumor cells with cytotoxic therapy and vascular stroma with bevacizumab (37). A second theory revolves around the concept of tumor vascular “normalization,” where tumor vessels are transiently remodeled structurally and functionally to resemble normal blood vessels (11). This normalization may synergistically enhance cytotoxic agent efficacy by overcoming physiologic barriers to drug delivery created by aberrant tumor vasculature (11, 19).

The findings presented in this study are in agreement with reports which show that targeting VEGF with compounds such as bevacizumab can manipulate tumor vasculature to augment cytotoxic therapy (19, 26, 38–40). In this study, we build on the current body of literature by reporting that bevacizumab can augment regional chemotherapy delivery by decreasing tumor vascular permeability and IFP.

In general, criteria for tumor vascular normalization would include functional decreases in vessel permeability and IFP, improved tissue oxygenation, and augmented drug delivery to tumor cells in the context of structural changes such as decreased tumor vessel density, tortuosity, and VLD (11, 26). In contrast to previous reports, the results of our studies failed to show a change in tumor microvasculature structure or improvement in tumor oxygenation after treatment with antiangiogenic therapy. In our murine model engrafted with a human melanoma xenograft, bevacizumab did not lessen tumor vessel tortuosity or VLD, and it did not significantly increase tumor hemoglobin saturation. These discrepancies may, in part, be due to limitations of our preclinical model, which used a neutralizing human-VEGF antibody with weak affinity for murine-VEGF. Although these results may have been influenced by a partial VEGF blockade, in which only VEGF produced from the human melanoma xenograft was neutralized,
bevacizumab-induced changes in tumor oxygenation and microvasculature have been previously reported in the syngeneic B16 mouse melanoma models (26). It is also possible that other structural alterations such as increases in interendothelial cell gaps or pericyte coverage could have occurred but not been measured in this report. Finally, the results of our experimental models may have been measured during a more persistent window of functional vascular normalization, which could have occurred after a more transient window of structural normalization had past (41). Taken together, we cannot conclude with certainty that structural vascular normalization did not occur in bevacizumab-treated animals.

Despite a lack of conclusive evidence supporting structural vascular normalization, our results are in support of functional vascular normalization as evidence by enhanced drug delivery in the setting of by decreased tumor vessel permeability and IFP. These results support an important role for IFP in the dynamics of blood supply to the tumor. It has long been recognized that VEGF acts by increasing blood vessel permeability (14, 29). This, in turn, can lead to a loss of normal oncotic and hydrostatic pressure gradients (42) which eventually will cause IFP levels to rise. The decreased permeability seen with antiangiogenic agents such as bevacizumab, therefore, could lead to decreased IFP levels creating a pressure gradient across blood vessel walls and tumor interstitium that is conducive to drug penetration into tumor cells (30). Overcoming this pressure gradient is critically important for delivery of small molecules such as LPAM, for which 60% to 90% of the drug is bound to plasma proteins (43).

Figure 5. Systemic bevacizumab (Bev.) increases delivery of regionally administered melphalan. Immunohistochemistry of tissue slices taken from saline-, melphalan (LPAM)-, bevacizumab-, and melphalan plus bevacizumab-treated samples. LPAM-DNA adduct formation were measured using the antibody M5/73. Representative images are shown from rats used in each treatment arm for both DM443 and DM738 tumors. For both DM443 and DM738 xenografts, LPAM-DNA adduct formation was higher (brown stain) in the bevacizumab plus melphalan–treated samples compared with the melphalan alone–treated samples. As expected, no LPAM–DNA adduct staining was seen in samples that were not exposed to LPAM. Average staining intensity for each treatment group for both xenografts is plotted with error bars representing SEM. *, one-way ANOVA. Abbreviations: intra-arterial.
Bevacizumab Augments Regional Chemotherapy for Melanoma

II trials (44–46). One of the most publicized is the phase II BEAM study funded by Roche, which investigated the efficacy of bevacizumab in combination with carboplatin and paclitaxel versus chemotherapy alone in 214 patients with melanoma. Although initially reported to show meaningful improvement in overall survival in a late breaking abstract at the ECCO-ESMO cancer congress in Berlin, the statistical review of the data failed to show a significant difference (47). Bevacizumab in combination with chemotherapy was well tolerated with overall survival (12.3 vs. 9.2 months in control arm, \(P = 0.19\)) and progression-free survival (median 5.6 vs. 4.2 months in control arm, \(P = 0.14\)) trending toward clinical benefit but not reaching statistical significance. Bevacizumab likely can only augment delivery of cytotoxic therapy when tumors are large enough to have the characteristic leaky, saccular, and aberrant neovasculature characteristic of malignancies. This concept may explain the recent results of the phase III National Surgical Adjuvant Breast and Bowel Project (NSABP) C-08 trial which showed no improvement in disease-free survival (DFS) for stage II and III colon patients given bevacizumab in addition to adjuvant-modified FOLFOX6 (infusional/bolus fluorouracil, leucovorin, and oxaliplatin) therapy (48). It is possible that patients in this study had tumors that were developing resistance to bevacizumab or the small foci of disease present in some of the patients after resection did not have sufficient tumor neovascularization to fully benefit from the addition of bevacizumab to their treatment course.

The results reported in this study lend support to the use of bevacizumab to augment drug delivery in the setting of regional chemotherapy. In many respects, regional chemotherapy is the ideal platform to test the efficacy of vascular targeting agents in augmenting cytotoxic therapy. In accordance to the preclinical data presented here, patients with in-transit melanoma confined to an extremity could receive a single dose of bevacizumab 3 days before the one-time delivery of cytotoxic therapy. In this setting of regional chemotherapy delivery, any later effects of bevacizumab which could hinder cytotoxic agent delivery would be inconsequential.

Our preclinical data suggest that systemically administered bevacizumab synergistically improves response to regionally delivered melphalan by decreasing blood vessel permeability and improving drug delivery to the tumor as evidenced by the increased formation of DNA-LPAM adducts. Given these preclinical results, a phase I clinical study has been proposed and is currently under institutional review. A precursor study, examining the distribution of hypoxic regions within in-transit lesions using the drug EF5 and how hypoxia effects melphalan drug delivery is currently Institutional Review Board approved and accruing patients. ILI has become a popular technique for delivering regional chemotherapy. In many respects, regional chemotherapy is the ideal platform to test the efficacy of vascular targeting agents in augmenting cytotoxic therapy. In accordance to the preclinical data presented here, patients with in-transit melanoma confined to an extremity could receive a single dose of bevacizumab 3 days before the one-time delivery of cytotoxic therapy. In this setting of regional chemotherapy delivery, any later effects of bevacizumab which could hinder cytotoxic agent delivery would be inconsequential.
sorafenib given for 1 week before and after melphalan-based ILI in patients with advanced extremity melanoma (50).

Clinical trials in the setting of in-transit disease of the extremity while providing important tools toward improving regional response rates can, in addition, provide tremendous insight into how to optimally use targeted agents in conjunction with chemotherapeutic agents because of the ease of obtaining sequential tissue biopsies to evaluate the effect of the targeted agent on the tumor concurrently with the ability to obtain drug pharmacokinetic data. Studies like the one proposed in this article using systemic bevacizumab and regional melphalan can have application to other tumor types where regional therapy is widely used such as peritoneal perfusion for abdominal carcinomatosis or liver infusion/perfusion for isolated liver metastasis. Furthermore, they can also provide important insight on how to develop rational strategies of incorporating targeted agents into systemic chemotherapeutic protocols for metastatic melanoma for which few effective treatment options currently exist.

Disclosure of Potential Conflicts of Interest

D.S. Tyler has commercial research grant from Adherex Technologies and Roche/Schering; material transfer agreements with Bayer, Schering, and Genta pharmaceuticals; honoraria from speakers bureau for Novartis; and is the consultant/advisor board member for Genentech. No potential conflicts of interest were disclosed by other authors.

Grant Support

The study was supported by Duke University Melanoma Research Fund and VA Merit Review grant (to D.S. Tyler), NIH grant ST32CA093245 (to R.S. Turley and J.C. Padussis), CA40355 (to M.W. Dewhirst), Department of Defense grant BC081195 (to A.N. Fontanella), NIH Loan Repayment (to R.S. Turley).

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Received November 23, 2011; revised March 22, 2012; accepted April 2, 2012; published OnlineFirst April 10, 2012.

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