Intracerebral CpG Immunotherapy with Carbon Nanotubes Abrogates Growth of Subcutaneous Melanomas in Mice

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Abstract

Purpose: Recently, we showed that intratumoral delivery of low-dose, immunostimulatory CpG oligodeoxynucleotides conjugated with carbon nanotubes (CNT-CpG) was more effective than free CpG and not only eradicated intracranial (i.c.) gliomas but also induced antitumor immunity that protected mice from subsequent i.c. or systemic tumor rechallenge. Here, we examined whether the same "intracerebral immunotherapy" strategy could be applied to the treatment of metastatic brain tumors.

Experimental Design: Mice with both i.c. and s.c. melanomas were injected intratumorally with CNT-CpG into either location. Antitumor responses were assessed by flow cytometry, bioluminescent imaging, and animal survival.

Results: When given s.c., CNT-CpG response was mostly local, and it only modestly inhibited the growth of i.c. melanomas. However, i.c. CNT-CpG abrogated the growth of not only brain but also s.c. tumors. Furthermore, compared with s.c. injections, i.c. CNT-CpG elicited a stronger inflammatory response that resulted in more potent antitumor cytotoxicity and improved in vivo trafficking of effector cells into both i.c. and s.c. tumors. To investigate factors that accounted for these observations, CNT-CpG biodistribution and cellular inflammatory responses were examined in both tumor locations. Intracranial melanomas retained the CNT-CpG particles longer and were infiltrated by Toll-like receptor (TLR-9)–positive microglia. In contrast, myeloid-derived suppressive cells were more abundant in s.c. tumors. Although depletion of these cells before s.c. CNT-CpG therapy enhanced its cytotoxic responses, antitumor responses to brain melanomas were unchanged.

Conclusions: These findings suggest that intracerebral CNT-CpG immunotherapy is more effective than systemic therapy in generating antitumor responses that target both brain and systemic melanomas.

Clin Cancer Res; 18(20); 5628–38. ©2012 AACR.

Introduction

The brain is a common location for tumor metastasis; approximately one third of patients with systemic cancer ultimately develop central nervous system (CNS) involvement (1). This is due, in part, to the blood–brain barrier and the brain’s “immune-privileged” status that, respectively, prevent the penetration of chemotherapeutic drugs and inflammatory cells into the CNS (1). Recent work, however, has shown that CNS immunosurveillance does indeed take place under both healthy and inflammatory conditions (2). In experimental gliomas, for example, activated T cells have the ability to find their targets in the brain (3). These observations have prompted the development of vaccine therapies against brain tumors (4). However, despite induction of an effective systemic immunity, the immunosuppressive microenvironment of the tumor itself may attenuate the host antitumor responses.

Local immunosuppressive tumor milieu caused by low levels of MHC class I expression, production of immunosuppressive factors, and scarcity of antigen-presenting cells have all been considered to account for the poor immune responsiveness of brain tumors (5). One strategy to overcome these local barriers is through activation of the innate immune system. Cells that comprise this system, including microglia, macrophages, monocytes, natural killer (NK), and dendritic cells (DC), express pattern recognition receptors which collectively recognize macromolecules that are broadly expressed by micro-organisms. Among these, activation of Toll-like receptors (TLR) has been shown to

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Note: Supplementary data for this article are available at Clinical Cancer Research Online (http://clincancerres.aacrjournals.org/).

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doi: 10.1158/1078-0432.CCR-12-1911
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enhance phagocytosis, promote secretion of T-helper (T\textsubscript{H}1) cytokines, and mediate leukocyte recruitment to infected tissues (6–8). Consequently, agonists such as CpG oligodeoxynucleotides (CpG) that bind TLR9 have been evaluated as cancer vaccine adjuvants and have shown some efficacy in inducing adaptive and antigen-specific, cellular antitumor immune responses in animal models (9). However, early-stage clinical trials in patients with melanoma and gliomas have been less promising (6, 10–11). Furthermore, high doses of CpG may exacerbate brain edema when directly injected into brain tumors. Because TLR9 is located on endosomes, we hypothesized that poor CpG uptake by tumor-associated inflammatory cells may account for the weak clinical responses and therefore evaluated nanoparticles to improve the delivery of CpG into brain tumors.

To enhance CpG activity, functionalized carbon nanotubes (CNT) were conjugated with CpG (CNT-CpG) and tested in glioma-bearing mice (12). The CNTs not only enhanced CpG uptake by tumor-associated leukocytes but also resulted in the eradication of intracranial (i.c.) gliomas, even at low doses (12). Interestingly, surviving animals also exhibited a durable tumor-free remission and were protected from metastatic brain tumors. Here, we have confirmed these findings in a melanoma model by showing that intracranial CNT-CpG therapy not only inhibited the growth of brain tumors but also subcutaneous melanomas. To our knowledge, these results have not been previously reported and they suggest that intracerebral CNT-CpG therapy may have use for the treatment of not only of gliomas but also of metastatic brain tumors.

**Materials and Methods**

**Reagents**

Thiolated CpG (5’-TGACATGAAACGTTGAGATGA-3’) was constructed as described by Rosi and colleagues (13) and labeled with Cy5.5 (Lumiprobe, LLC). All flow monoclonal antibodies [mAb; i.e., CD11b, CD45, CD11c, CD8, NK1.1, Ly-6C (clone RB6-8C5), and Ly-6G (clone HK1.4)] and isotype controls were purchased from BD Biosciences or eBiosciences.

**Cell lines**

B16.F10 melanoma cell line of C57BL/6 origin was purchased from American Type Culture Collection in 2011 and stably transfected with firefly luciferase expression vector. Positive clones (B16.F10-luc) were selected using zeocin (1 mg/mL) and G418 and cultured in Dulbecco’s Modified Eagle’s Media (DMEM) supplemented with 10% FBS, penicillin (100 u/mL), and streptomycin (100 μg/mL) at 37°C in a humidified 5% CO₂ atmosphere. Tumorigenicity of the B16.F10-luc cells was authenticated by histologic characterization of melanomas generated in mice.

**Single-walled CNT construction and functionalization**

Single-walled CNTs measuring 200 to 400 nm in length were generated and characterized by electron microscopy as previously described (12). CNT functionalization was conducted using methods described by Liu and colleagues (14). Briefly, hipco CNTs were sonicated extensively (1 hour) in a solution of 1,2-distearoyl-Sn-glycero-3-phosphocholanoamine-N-[amino PEG 2000] from Avanti Polar Lipids. The supernatant solution of PEG-CNT was collected after centrifugation at 24,000 × g for 6 hours. After removal of excess PEG molecules with an Amicon centrifugal filter unit (100 kDa), functionalized PEG-CNTs were conjugated with Sulfo-LC-SPDP (Thermo Fisher Scientific Inc.) for 1 hour at room temperature. After removal of excess Sulfo-LC-SPDP with an Amicon centrifugal filter unit (100 kDa; Millipore), the CNT conjugates were quantified using a SpectraMax M2 (Sunnyvale) spectrometer with a weight extinction coefficient of 0.0465 L/mg/cm at 808 nm. CNT-bound CpG was quantified by subtracting the unbound CpGs from total CpGs added before the conjugation reaction.

**In vitro NF-κB assay**

RAW MP cells (RAW-Blue) stably transfected with a reporter construct expressing a secreted embryonic alkaline phosphatase gene under the control of a promoter inducible by the transcription factors NF-κB and AP-1 (Invivogen) were used to measure TLR9 activation. Upon TLR stimulation, RAW-Blue cells induce the activation of NF-κB and AP-1 and subsequently the secretion of quantifiable secreted embryonic alkaline phosphatase.

**Tumor implantation, treatment, and imaging**

All animals were housed and handled in accordance with the guidelines of City of Hope Institutional Animal Care and Use Committee (IACUC). Intracranial tumors were constructed as described by Rosi and colleagues (13). All experiments were approved by the IACUC. Intracranial tumor...
implantation was conducted stereotactically at a depth of 3 mm through a burr hole placed 2 mm lateral and 0.5 mm anterior to the bregma as previously described (15). B16. F10-luc cells were harvested by trypsination, counted, and resuspended in PBS. Female C57BL/6 mice (Jackson Laboratory) weighing 15 to 25 g were anesthetized by intraperitoneal administration of ketamine (132 mg/kg) and xylazine (8.8 mg/kg) and immobilized in a stereotactic head frame. Intracranial tumors implantation was conducted by injecting 3 μL of PBS containing 5 × 10^3 tumor cells through a small burr hole. Subcutaneous tumors were generated by injecting 100 μL of PBS containing 10^4 tumor cells. Four days after i.c. and s.c. tumor implantation, mice received intratumoral (i.t.) injections of PBS (control, 10 μL), free CpG (5 μg/10 μL PBS), PL-PEG–functionalized blank CNT (2.5 μg), and CpG conjugated to CNT (CNT-CpG; 2.5 μg CNT/5 μg CpG/10 μL PBS) at the same stereotactic coordinates used for tumor implantation. Depending on the experimental design, 1 to 3 injections were given every 3 to 4 days. Tumor growth was assessed by a Xenogen IVIS In Vivo Imaging System (Xenogen) as previously described (12).

**In vivo uptake and distribution studies**

Mice bearing i.c. tumors were injected i.t. with CNT bound to Cy5.5-labeled CpG (CNT-CpG5.5, 2.5 μg CNT/5 μg CpG/10 μL PBS) or free CpG5.5 (5 μg CpG/10 μL PBS). In vivo Cy5.5 signal was measured with a Xenogen IVIS Imaging System. For direct imaging, tumors were harvested at various time intervals, frozen, embedded in optimum cutting temperature (O.C.T.; Tissue-Tek), and 10-μm sections were cut using a cryostat (Leica Microsystems). Sections were mounted in Vectashield mounting medium containing 4,6-diamidino-2-phenylindole (DAPI; Vector). Images were obtained by Nikon Eclipse 80i microscope (Nikon Japan) and were prepared by Metamorph imaging software.

**Chromium release cytotoxicity assay**

Cytotoxicity against B16.F10 melanoma cells was determined using a standard 51Cr release assay (16). Briefly, effector cells were derived from spleens of B16.F10-bearing C57BL6 mice (n = 4) treated with either i.c. or s.c. CNT-CpG. CNT-CpG injections were given 3 times, 4 days after initial tumor implantation, and every subsequent 3 days. Mice were sacrificed 48 hours after the final treatment and splenocytes (effectors) were harvested and co-incubated with irradiated (30,000 rad) B16.F10 cells for 7 days. Effectors were then co-incubated for 6 hours with 5,000 51Cr-loaded B16.F10 targets in 96-well plates at ratios of 100:1, 20:1, and 4:1 (in triplicate). Radioactivity released into the supernatant was measured using a Cobra Quantum gamma counter (PerkinElmer). Percent specific lysis was calculated as: ([experimental release − spontaneous release]/[maximum release − spontaneous release]) × 100%.

**Flow cytometric analysis**

Tumors were harvested and examined by flow cytometry as previously described (12). Cell suspensions from brain and s.c. tissue were forced through a 40-μm filter. Freshly prepared samples were resuspended in 0.1 mol/L PBS containing 1% FBS and 2 mol/L EDTA and incubated with Cy3/IgG-specific Ab to block nonspecific binding. Samples were then stained with different combinations of mAb or isotype controls for 1 hour at 4°C and analyzed by a CyAn fluorescence cell sorter (BDIS). Inflammatory cells were gated and separated from the remainder of the sorted cells on the basis of forward versus side-scatter analysis and staining characteristics. FlowJo 8.4.7 software (Tree Star, Inc.) was used for data analysis, and the proportion of each cell type was measured as percentage of total inflammatory cells. Tumor macrophages were gated as CD45<sup>high</sup> CD11b<sup>+</sup> and microglia as CD45<sup>low</sup> CD11b<sup>+</sup>, based on a previously described phenotypic characterization (17). In vivo TLR9 staining was carried out by using fixation/permeabilization solution according to the manufacturer’s instructions (BD Pharmingen).

**In vivo leukocyte trafficking**

Mice bearing either i.c. or s.c. tumors (n = 3/group) were given 3 injections of i.t. CNT-CpG 4 days after initial tumor implantation and every subsequent 3 days. Splenocytes were isolated 24 hours later the third injection and incubated with carboxyfluorescein succinimidyl ester (CFSE; 5 mmol/L) for 5 minutes and then washed with 10 mL of medium containing 5% FBS. Labeled cells were re-injected through the tail vein into untreated recipient mice (1 × 10<sup>9</sup> cells per mouse) that had been implanted with i.c. and s.c. melanomas 10 days earlier (n = 5/group). Mice were harvested 24 hours later and tested for presence of CFSE-labeled NK and CD8 cells by flow cytometry.

**NK, CD8, and Gr-1 depletion**

NK and CD8 depletion studies were carried out as described previously (12). In these experiments, mice were injected with anti-CD8, anti-NK1.1, or control IgG (200 μg/mouse, intraperitoneally) mAb 1 day before tumor implantation and each i.t. CNT-CpG injection. Leukocyte depletion was confirmed with fluorescence-activated cell-sorting (FACS) analysis of peripheral blood (12). For Gr-1 depletion studies, the RB6-8C5 hybridoma (originally produced by Robert L. Coffman) was used to generate the Gr-1 mAb (against Ly6C<sup>+</sup>) and was a kind gift from Dr. Hans Schreiber. The hybridoma was maintained in RPMI containing 10% FBS. To assess the role of myeloid-derived suppressive cells (MDSC) on CNT-CpG therapy, mice were treated with anti-Gr-1 mAb or control IgG (30 mg/mouse) 1 day prior and every 3 days after tumor implantation (a total of 5 injections). Animals were then implanted with both i.c. and s.c. tumors and then treated with i.t. PBS or CNT-CpG 4, 7, and 10 days later.

**Statistical analysis**

Statistical comparison in all different experimental conditions was conducted with the Prism software using 2-way ANOVA or the Student t test. Survival was plotted using a
Kaplan–Meir survival curve, and statistical significance was determined by the log-rank (Mantel–Cox) test. A $P$ value of less than 0.05 was considered significant.

Results

**CNT-CpG antitumor response**

To control for variations in CNT-CpG preparations, CNT-CpG-mediated TLR9 activation was examined using an *in vitro* NF-κB assay before *in vivo* testing (Supplementary Fig. S1). Only those CNT-CpG preparations that increased NF-κB activity at least 2-fold over an equivalent dose of free CpG at 24 hours were selected for animal studies. In our experience, CNT-CpG preparations with less activity have not shown significant antitumor response in this model (unpublished data).

To confirm whether i.c. CNT-CpG elicited a systemic antitumor response, mice with both i.c. and s.c. B16.F10-luc melanomas were treated twice i.c. with CNT-CpG or with CNTs that were functionalized only with PL-PEG and do not have any tumoricidal effect (12, 18). When administered i.c., CNT-CpG inhibited the growth of not only i.c. but also s.c. melanomas (Fig. 1). To test whether this
antitumor effect was specific for CNT delivery, a group of mice were treated i.c. with free CpG in a similar experiment (Supplementary Fig. S2). At these low doses (i.e. (5 μg), i.c. CpG had no effect on i.c. tumors, but it did inhibit s.c. tumor growth, although not as much as CNT-CpG (Supplementary Fig. S2A). Furthermore, i.c. CNT-CpG antitumor responses were mediated by both CD8 and NK cells (Supplementary Fig. S2B), similar to our observations in i.c. gliomas (12). These findings suggested that low doses of i.c. CNT-CpG were able to generate not only a local but also a systemic antitumor response. However, unlike glioma models where 60% of tumors were completely eradicated by i.c. CNT-CpG, melanoma-bearing mice were not cured by this treatment (Supplementary Fig. S2B). To further evaluate the impact of tumor microenvironment on CNT-CpG efficacy, a similar experiment was carried out except that animals were treated with either i.c. or s.c. CNT-CpG (Fig. 2). As before, untreated mice died within 2 weeks of tumor implantation from CNS disease (not shown), and i.c. CNT-CpG inhibited the growth of both i.c. and s.c. melanomas (Fig. 2A and B). Of note, development of this systemic immune response required tumor presence in the CNS, as mice that lacked i.c. melanomas did not exhibit antitumor activity against s.c. tumors (Fig. 2B). Unlike i.c. therapy, s.c. CNT-CpG response was mostly local (Fig. 2B) and not as effective in controlling the growth of i.c. melanomas (Fig. 2A and C). These observations suggested that the stronger antitumor efficacy of i.c. CNT-CpG was due to either better CNS trafficking of cytotoxic cells caused by blood–brain barrier disruption or CNS-specific microenvironmental factors that enhanced immune responses to CNT-CpG. To test these possibilities, we next assessed the inflammatory responses to CNT-CpG therapy in both tumor locations.

Role of tumor location in CNT-CpG inflammatory responses

To investigate cellular responses to CNT-CpG therapy, mice bearing 4-day-old i.c. and s.c. B16.F10 melanomas received i.t. PBS or CNT-CpG and tumor inflammatory cells were analyzed by FACS after 24 hours (Fig. 3). Treatment with i.c. CNT-CpG increased the infiltration of MP (CD45hi CD11b+) and NK, CD8, and CD4 cells into brain tumors (Fig. 3A) but had no effect on inflammatory cell infiltration into the untreated s.c. tumors in the same animals (Fig. 3B). After CNT-CpG treatment, microglia (CD45low CD11b+) in i.c. tumors decreased in proportion to other leukocytes as a result of tumor location.
result of influx of other inflammatory cells (Fig. 3A). In contrast to i.c. injections, s.c. CNT-CpG treatment promoted macrophages (CD11b+), and to a lesser extent, NK infiltration; CD8 and CD4 influx were not significantly affected (Fig. 3B). Therefore, i.c. CNT-CpG appeared to induce a stronger local inflammatory reaction in tumors compared with s.c. injections. To test whether the local cellular responses to CNT-CpG correlated with systemic antitumor activity, splenocytes from the treated animals were harvested and tested for tumor cytotoxicity. Interestingly, effector cells from i.c. CNT-CpG–injected mice elicited a stronger ex vivo antitumor response when compared with subcutaneously treated tumors (Fig. 3C). To evaluate leukocyte trafficking, splenocytes from mice bearing either brain or s.c. tumors that were treated with i.t. CNT-CpG were isolated and re-injected into untreated recipient mice with both i.c. and s.c. tumors. Interestingly, when compared with s.c. treatment, NK and CD8 cells that were isolated from intracranially treated mice appeared to have improved trafficking into both i.c. and s.c. tumors that had not been treated with CNT-CpG (Fig. 3D). These observations suggested that CNS microenvironmental factors enhanced both antitumor responses and trafficking of effector cells generated by intracerebral CNT-CpG.

**CNT-CpG distribution**

To study the role of tumor location on CNT-CpG distribution, mice with both i.c. and s.c. melanomas were injected i.t. with free CpG5.5 or CNT-CpG5.5. Tumor growth and Cy5.5 signal were then monitored by Xenogen imaging (Fig. 4A). Although both CpG and CNT-CpG were completely cleared from s.c. tumors (Fig. 4B), some Cy5.5 signal was still detectable in i.c. tumors even after 7 days of injections (Fig. 4C). Also, conjugation of CpG to CNT did not appear to change its clearance from tumors. Because the antitumor activity of free CpG was weaker than CNT-CpG (Supplementary Fig. S2), we next compared the regional distribution of free CpG to CNT-CpG in i.c. melanomas (Fig. 4D). Within a few days, free CpG appeared to diffuse away from the injection site, whereas CNT-CpG particles...
dispersed around the tumor margin. Therefore, even though the overall free CpG5.5 signal intensity was similar to CNT-CpG5.5, its distribution around i.c. tumors was different, possibly due to uptake of CNT-CpG complexes by tumor-associated leukocytes and their migration around tumor periphery (12, 18). To further study the role of tumor microenvironment on CNT-CpG response, we next evaluated the expression of TLR9 (CpG receptor) by tumor-associated inflammatory cells.

**TLR9 expression**

We previously showed that inflammatory cells (notably microglia, macrophages, and NK cells) are the main carriers of CNT-CpG particles in experimental gliomas (12, 18). To further characterize microenvironmental differences that may have accounted for CNT-CpG antitumor responses, we studied the expression of TLR9 in tumor-associated leukocytes in i.c. and s.c. melanomas (Fig. 5). Microglia were the most frequent inflammatory cells in newly implanted untreated i.c. tumors (50%-60%) and accounted for most of the TLR9-positive cells. However, infiltrating NK and CD11c (dendritic) cells (not shown), which accounted for less than 10% of tumor leukocytes, also expressed TLR9. In s.c. melanomas, macrophages, NK, and CD11c cells each accounted for less than 10% of tumor-associated inflammatory cells but equally expressed TLR9. Also, concurrent growth of i.c. and s.c. tumors in the same animal did not significantly influence TLR9 expression in newly implanted tumors.
Because CD11b+ cells markedly increased in i.c. and s.c. tumors after CNT-CpG therapy (Fig. 3A and B) and because these cells are composed of a heterogeneous cell population, we next characterized the impact of tumor microenvironment on CD11b+ phenotypes (Fig. 6). At baseline, the proportion of infiltrating macrophages with MDSC phenotype (Gr-1+) was very low in early-stage i.c. tumors (Fig. 6A). After CNT-CpG injection, however, both Ly6C+ and Ly6G+ cells equally increased in the injected i.c. tumors. In s.c. tumors, however, Gr-1+ cells were more prevalent at baseline and significantly increased after CNT-CpG treatment (Fig. 6B). Interestingly, the proportion of monocytic MDSCs (M-MDSCs; Ly6Chigh) was higher than granulocytic MDSCs (G-MDSCs, Ly6G+Ly6Clow) in the CNT-CpG–treated s.c. tumors. Although both cell types are considered to be MDSCs, M-MDSCs have a higher tumor-suppressive activity in mice (19). To test whether MDSCs in s.c. tumors played a role in weaker antitumor responses, these cells were depleted before CNT-CpG therapy.

**Gr-1 depletion**

To assess the role of MDSCs on CNT-CpG therapy, mice were treated with either anti-Gr-1 mAb or control IgG before tumor implantation and CNT-CpG therapy. Analysis of tumors 2 days after the final CNT-CpG treatment showed a decrease in tumor-infiltrating M-MDSCs (but an increase in G-MDSCs) in s.c. tumors (Supplementary Fig. S3). Interesting, alterations in MDSC profile with anti-Gr-1 mAb enhanced the antitumor cytotoxicity of effector cells isolated from s.c. but not i.c. CNT-CpG–treated animals (Fig. 6C). Despite an increase in ex vivo cytotoxicity, however, in vivo antitumor response against i.c. melanomas remained the same and s.c. CNT-CpG–treated animals had similar survival even after Gr-1 depletion (Fig. 6D). These findings suggest that although infiltration of MDSCs may have partially abrogated the immunostimulatory functions of CNT-CpG, effector cell trafficking into i.c. tumors may have still limited the remote antitumor efficacy of cytotoxic cells that were primed in the s.c. tumors.

**Discussion**

Immunotherapy is an attractive treatment modality for immunogenic tumors such as melanomas. Although various approaches for melanoma immunotherapy have been pursued with mixed results, recent findings from a phase III randomized trial of cytotoxic T-lymphocyte–associated antigen (CTLA)-1 blocking agent have validated the efficacy of this approach (20). One limitation for effective melanoma immunotherapy, however, may be the high frequency of brain metastasis which occurs in 10% to 70% of patients (21, 22). Although activated T cells can penetrate i.c. tumors, clinical studies have shown that less than 50% of CNS metastases respond to systemic adoptive immunotherapy in patients with melanoma (23). Therefore, there is a need for improved immune targeting of metastatic brain tumors. Recently, while examining the role of CpG
immunotherapy with nanoparticles, we observed a systemic antitumor response in experimental gliomas (12). Here, we have confirmed these findings in a melanoma model by showing that i.c. CNT-CpG inhibited the growth of both brain and s.c. melanomas. To our knowledge, these results have not been previously reported and they suggest that intracerebral CNT-CpG therapy may have use for the treatment of not only of gliomas but also of metastatic brain tumors.

Brain has been considered to be an “immune privileged” organ. Tumors that are spontaneously rejected when implanted into the s.c. tissue can propagate in the CNS of immunocompetent hosts (24). Furthermore, systemic implantation of some tumors can generate effective memory T-cell responses that are capable of rejecting tumors in the brain (24). In fact, this phenomenon (which has been partly attributed to local immunosuppressive brain microenvironment) is being exploited to develop vaccines against malignant gliomas. Here, however, we show that when stimulated with CNT-CpG, the “immune privileged” status of the brain can be reversed, resulting in the generation of antitumor immune responses that may even be superior to systemic stimulation. Our findings, while counterintuitive, highlight unique CNS factors that may be important in potentiating immune responses to CNT-CpG therapy.

Besides direct intracerebral injection of pro-inflammatory molecules such as CpG, other approaches have been attempted to enhance local CNS immune responses against i.c. tumors. Brain immune privilege could be overcome through exogenous expression of fms-like tyrosine kinase ligand 3, which resulted in DC recruitment and antigen presentation (25). Others have shown improvement in antitumor responses to CNT-CpG therapy. A and B, quantification of MDSCs. Mice bearing both i.c. and s.c. tumors were injected with i.c. PBS (baseline) or i.c. or s.c. CNT-CpG 4 days after tumor implantation. Proportion of MDSCs was quantified by flow cytometry in both brain (A) and s.c. (B) tumors 24 hours after CNT-CpG injection. M-MDSCs (Ly6G$^{high}$) and G-MDSCs (Ly6G$^{low}$) are shown as red and green events, respectively, in representative dot plots. n = 4 mice/group. C and D, impact of Gr-1 depletion on CNT-CpG antitumor response. Mice were treated with anti-Gr-1 mAb or control IgG 1 day before and every 3 days after tumor implantation. A, mice (n = 4) bearing 4-day-old i.c. and s.c. tumors were treated with intratumoral PBS or CNT-CpG (3 injections as in Fig. 3C), splenocytes were harvested 48 hours later and examined for killing of B16.F10 target cells. D, antitumor response was measured in mice bearing both i.c. and s.c. tumors treated only with s.c. CNT-CpG 4, 7, and 10 days (arrows) after tumor implantation. n = 7 mice/group. Data are representative of 2 separate experiments, bars. *, P < 0.05; **, P < 0.001. ns, not statistically significant.
and colleagues found improved survival of patients with recurrent gliomas when they received i.t. DC vaccines in addition to intradermal administration (27). Although the value of i.c. vaccine approaches to enhance systemic therapies against brain tumors has been suggested in these studies, the use of this approach for immunotherapy of systemic tumors has not yet been reported.

In this study, we noted antitumor immune responses to be stronger when CNT-CpG was injected into i.c. tumors as compared with s.c. tumors. In contrast to s.c. CNT-CpG, which suppressed s.c. tumor growth but only had a modest inhibitory effect on i.c. melanomas, i.c. CNT-CpG abrogated the growth of both i.c. and s.c. tumors. Intracerebral administration of CNT-CpG also induced a stronger local inflammatory response and a more potent antitumor cytotoxicity and improved trafficking of effector cells into tumors. These findings support the presence of unique CNS factors that potentiated CNT-CpG responses. Presence of TLR9-expressing microglial cells, which are unique CNS macrophages capable of phagocytosis and T-cell activation, may have played a role in this process. These cells may have also accounted for delayed clearance of nanoparticles from the brain.

We previously showed functionalize CNTs to be non-toxic and enhanced CpG immune responses in glioma models (12, 18). Although this immune activation may not be unique to the CNT delivery mechanism and may also occur with other nanoparticles that promote CpG uptake into TLR9-containing endosomes, we noted several features that may be unique to the brain. First, distribution of CNT-CpG and CpG appeared to be different in i.c. tumors compared with s.c. melanomas. Although CNT-CpG and CpG completely cleared from s.c. tumors, some were retained in i.c. tumors even after a week of injection. Because of the potential for dissociation of Cy5.5 from CNT-CpG and CpG from CNTs, this experiment may not have exactly measured the biodistribution of CNT complexes. On the basis of previous studies with functionalized CNTs, we predict that the CNT complexes are phagocytosed by tumor-associated microglia in the brain, and their retention and wider distribution around tumors may have accounted for a stronger immune response following intracerebral CNT-CpG injections. In contrast to our glioma model, however, i.c. melanomas were not completely eradicated by i.t. CNT-CpG treatment in these experiments. Therefore, future studies will evaluate this approach in conjunction with other therapies such as CILY-4 and death protein inhibitors that have shown efficacies as immunomodulators.

Disclosure of Potential Conflicts of Interest
No potential conflicts of interest were disclosed.

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Acknowledgments
The authors thank Dr. Harish Manohara (Jet Propulsion Laboratory, Pasadena, CA) for providing the CNTs and Dr. Piotr Swiderski (Department of Molecular Medicine, City of Hope Beckman Research Institute) for generating thiolated CpG constructs.

Grant Support
This work was supported by R21CA131765, R01CA155769, James S. McDonnell Foundation (B. Badie), ThinkCure Foundation (B. Badie and D.J.)
Diamond), and PO1-CA030206 and CA077544 (D.J. Diamond). The City of Hope Flow Cytometry Core was equipped in part through funding provided by ONR N00014-02-1 0958, DOD 1435-04-03GT-73134, and NSF DBI-9707143.

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Received June 12, 2012; revised August 9, 2012; accepted August 13, 2012; published OnlineFirst August 17, 2012.

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doi:10.1158/1078-0432.CCR-12-1911

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