Bortezomib-Induced Unfolded Protein Response Increases Oncolytic HSV-1 Replication Resulting in Synergistic Antitumor Effects

Ji Young Yoo1, Brian S. Hurwitz1,2, Chelsea Bolyard3, Jun-Ge Yu4, Jianying Zhang5, Karuppaijah Selvendiran6, Kellie S. Rath6, Shun He7, Zachary Bailey10, David Eaves10, Timothy P. Cripe8, Deborah S. Parris9, Michael A. Caligiuri7, Jianhua Yu7, Matthew Old4, and Balveen Kaur1

Abstract

**Background:** Bortezomib is an FDA-approved proteasome inhibitor, and oncolytic herpes simplex virus-1 (oHSV) is a promising therapeutic approach for cancer. We tested the impact of combining bortezomib with oHSV for antitumor efficacy.

**Experimental Design:** The synergistic interaction between oHSV and bortezomib was calculated using Chou–Talalay analysis. Viral replication was evaluated using plaque assay and immune fluorescence. Western blot assays were used to evaluate induction of estrogen receptor (ER) stress and unfolded protein response (UPR). Inhibitors targeting Hsp90 were utilized to investigate the mechanism of cell killing. Antitumor efficacy in vivo was evaluated using subcutaneous and intracranial tumor xenografts of glioma and head and neck cancer. Survival was analyzed by Kaplan–Meier curves and two-sided log-rank test.

**Results:** Combination treatment with bortezomib and oHSV (34.5ENVE), displayed strong synergistic interaction in ovarian cancer, head and neck cancer, glioma, and malignant peripheral nerve sheath tumor (MPNST) cells. Bortezomib treatment induced ER stress, evident by strong induction of Grp78, CHOP, PERK, and IRE1α (Western blot analysis) and the UPR (induction of hsp40, 70, and 90). Bortezomib treatment of cells at both sublethal and lethal doses increased viral replication (P < 0.001), but inhibition of Hsp90 ablated this response, reducing viral replication and synergistic cell killing. The combination of bortezomib and 34.5ENVE significantly enhanced antitumor efficacy in multiple different tumor models in vivo.

**Conclusions:** The dramatic synergy of bortezomib and 34.5ENVE is mediated by bortezomib-induced UPR and warrants future clinical testing in patients. Clin Cancer Res; 20(14); 3787–98. ©2014 AACR.

Introduction

Oncolytic herpes simplex virus-1 (oHSV) therapy utilizes viruses that are engineered to infect and replicate in cancer cells with minimal damage to non-neoplastic tissue. This therapy is currently being evaluated for safety and efficacy in multiple phase I, II, and III clinical trials (1). The results from a phase III testing of T-Vec (an oHSV developed by Amgen) have shown promising results in tumor shrinkage. Although the overall survival data have yet to be established, there is a significant need to optimize this promising therapy in vivo. Although second- and third-generation viruses are being created and tested in preclinical studies, drug-virus combinations can be rapidly translated to clinical trials to maximize efficacy and minimize toxicity (2).

The proteasome is a cellular organelle that controls degradation and recycling of a wide variety of proteins that regulate diverse cellular functions, including cell-cycle progression, cell death, gene expression, signal transduction, metabolism, morphogenesis, differentiation, antigen presentation, and neuronal function. Inhibition of the proteasome...
Translational Relevance

This study describes synergy between proteasome inhibition and oncolytic herpes simplex virus-1 (oHSV). Induction of the cellular unfolded protein response (UPR) is usually associated with resistance to proteasome inhibition and other chemotherapies. Here, we found that proteasome inhibition-induced UPR sensitizes cells to oncolysis. Interestingly HSV-1 is known to exploit the proteasome during its replication cycle and proteasome inhibitors have been suggested as antiviral agents. In contrast, this study shows that bortezomib treatment increases viral replication, a finding additionally supported by the clinical observation of increased incidence of latent virus reactivation in patients treated with bortezomib. Because bortezomib is FDA approved, its combination with oHSV can be rapidly translated in patients with multiple solid tumors. This study paves the way for a combination treatment strategy that can utilize suboptimal doses of bortezomib in conjunction with oHSV to maximize efficacy with minimal toxicity.

Cytotoxicity assay

The cytotoxicity of bortezomib and 34.5ENVE in each cell line was determined by a standard MTT assay (Roche) as manufacturer’s instructions. To measure 50% effective dose (ED$_{50}$) of each bortezomib or 34.5ENVE alone, cells were plated onto 96-well plates of approximately 50% confluence on day zero and then treated with bortezomib or PBS for 16 hours before drug washout and infection with 34.5ENVE or Hank’s Balanced Salt Solution (HBSS). Cell viability was measured 72 hours postinfection. To measure synergistic cell killing, cells were treated with bortezomib and 34.5ENVE (as detailed above) at serially diluted concentrations of 0.0625, 0.125, 0.25, 0.5, 1, 2, and 4 times their ED$_{50}$ in a constant ratio. Cell viability was measured 72 hours postinfection. All assays were performed in triplicate. For rescue assay with geldanamycin and 17-AAG, cells were
pretreated with either agent for 1 hour before bortezomib treatment.

**In vitro viral replication assay**

Cells were treated ± bortezomib (at indicated doses) for 16 hours, and following drug washout cells were infected with 34.5ENVE (at indicated doses) for 2 hours. Seventy-two hours postinfection, cells and supernatant were collected, and the number of infectious particles present in the resulting supernatant was determined as previously described (9).

**Western blot analysis and antibodies**

Cell lysates were fractionated by SDS-PAGE and transferred to polyvinylidenedifluoride membranes. In UL30 detection experiments, cell and nuclear fractions were separated by NE-PER Nuclear and Cytoplasmic Extraction Reagents (Thermo Scientific, Cat# 78835). Blocked membranes were then incubated with antibodies against Anti-LC3B, calnexin, PERK, IRE1α, PDI, Bip/GRP78, CHOP, Ero1-Lα, HSP40, HSP70, HSP90, and GAPDH (Abcam; each diluted 1:1,000); horseradish peroxidase (HRP)-conjugated secondary anti-mouse antibody (each diluted 1:1,000; GE Healthcare); HRP-conjugated secondary goat anti-rabbit antibody (each diluted 1:1,000; Dako), and the immunoreactive bands were visualized using an enhanced chemiluminescence (GE Healthcare). UL30 antibody (diluted 1:100) used was purified rabbit IgG raised against recombinant *Escherichia coli*-expressed bacteriophage T7 gene 10 protein fused with the C-terminal portion of the HSV-1 pol gene (11).

**Animal surgery**

All mice experiments were housed and handled in accordance with the Subcommittee on Research Animal Care of the Ohio State University (Columbus, OH) guidelines and adhered to the NIH Guide for the Care and Use of Laboratory Animals. Female athymic nu/nu mice (Charles River Laboratories) were used for all *in vivo* experiments. Nude mice with subcutaneous tumors (100 mm³) were randomized to be treated with either intraperitoneal PBS or bortezomib (0.8 mg/kg) twice a week. For intracranial tumor studies, anesthetized nude mice were implanted with bortezomib (0.8 mg/kg) twice a week. For intracranial tumors (MPNST), and glioma to bortezomib or 34.5ENVE alone *in vitro* was evaluated. Cells were treated with indicated doses of bortezomib and/or oHSV and cell death was measured by a standard MTT assay. Figure 1A shows that combination treatment increased cell killing compared with the predicted additive effects (dotted line), suggesting synergistic cell killing.

To further evaluate synergistic interaction between bortezomib and oHSV, we measured sensitivity of each cell line to bortezomib and oHSV. Briefly, cells were treated with bortezomib at concentrations ranging from 0.1 to 500 nmol/L for 16 hours, followed by drug washout. To test sensitivity to 34.5ENVE, cells were infected with different doses of oHSV ranging from 0.001 to 0.5 multiplicity of infection (MOI) defined as virus pfu/cell. Seventy-two hours following bortezomib washout or 34.5ENVE infection, cell viability was measured by a standard MTT assay. The ED₅₀ of bortezomib and 34.5ENVE was each defined as the dosage yielding 50% cell viability at 72 hours following infection.
Figure 1. Effect of bortezomib and oHSV on cancer cell killing. A, treatment of ovarian cancer, head and neck cancer, and glioma cells with bortezomib and oHSV showed more than additive cell killing. Briefly, the indicated cells were treated with sublethal doses of bortezomib or PBS for 16 hours, followed by washout drug and treatment with sublethal doses of 34.5ENVE or PBS. Seventy-two hours later from 34.5ENVE infection, cell viability was measured via MTT assay. (Continued on the following page.)
treatment as compared with untreated controls. Supplementary Table S1 shows the sensitivity of each cell line to bortezomib and 34.5ENVE. To study the interaction between bortezomib and 34.5ENVE, cells were treated with bortezomib for 16 hours, followed by drug washout and treatment with 34.5ENVE at concentrations of 0.0625, 0.125, 0.25, 0.5, 1, 2, and 4 times of their ED<sub>50</sub> in a constant ratio. Cell viability was measured 72 hours after virus infection. The results were analyzed using the median-effect method of Chou–Talalay (COMPUISYN; ref. 12). Figure 1B shows combination index plots of Chou–Talalay. The plots show synergistic cell killing between bortezomib and 34.5ENVE (combination) in PA1, A2780-CS (cisplatin sensitive), SKOV3, and A2780-CR (cisplatin resistant) ovarian cancer cells CAL27, UMSCC11A, and UMSCC74A, head and neck squamous cell carcinomas and in U251T3, LN229, and U87ΔEGFR glioma cells (Fig. 1B). In a separate experiment, similar synergistic cell killing was observed when clinical grade oHSV1716 was used in combination with bortezomib to treat MPNST cells (Supplementary Fig. S1; CI values less than 1 at all fractions affected). To evaluate the effect of bortezomib on oHSV safety, we compared the cytotoxic ability of oHSV toward NHA, HUVEC, and hepatocyte cells treated with/without ED<sub>50</sub> concentrations of bortezomib (Fig. 1C). In all three normal cells tested, no additive (dotted line) or synergy was observed between bortezomib and 34.5ENVE. These data support the conclusion that the combination of bortezomib and oHSV significantly increased sensitivity to cell death for a wide variety of solid tumor cells but not for normal cells.

**Impact of bortezomib on oHSV replication**

To investigate the impact of bortezomib on 34.5ENVE replication, U251T3 glioma cells were treated with sublethal and ED<sub>50</sub> doses of bortezomib (2 and 12 nmol/L) followed by 34.5ENVE infection (Fig. 2A and B). Fluorescent microscopy was used to image GFP-positive (infected) cells, 48 hours postinfection. Figure 2A shows increased GFP-positive infected cells in both concentrations of bortezomib, indicating that bortezomib treatment increased viral replication in vitro. In addition, quantification of viral titers showed a significant increase in viral titer in the both sublethal and ED<sub>50</sub> doses of bortezomib (Fig. 2B–C). Quantification of viral titers in cells treated with or without bortezomib revealed a significant increase in viral replication in the multiple cell lines treated with sublethal doses of bortezomib in all cells tested: ovarian: SKOV3 cells: 20.3-fold, head and neck cancer cells: CAL27: 1.8-fold, UMSCC74A: 1.8-fold, and glioma: U87ΔEGFR: 8.4-fold (Fig. 2C and supplementary Table S2). Collectively, these data demonstrate that bortezomib increased viral replication.

**Efficacy of combination treatment in patient-derived primary tumor cells ex vivo**

Next, we tested synergistic interaction of bortezomib and 34.5ENVE in ovarian cancer patient ascites derived tumor cells and glioblastoma (GBM) patient-derived primary GBM neurospheres (GBM169) ex vivo (Fig. 2D). Briefly, cells were treated with bortezomib for 16 hours, followed by drug washout and treatment with 34.5ENVE at concentrations of 0.0625, 0.125, 0.25, 0.5, 1, 2, and 4 times of their ED<sub>50</sub> in a constant ratio. Cell viability was measured 72 hours after virus infection. The results were analyzed using the median-effect method of Chou–Talalay (COMPUSYN). Synergistic cell killing was obvious in both patient-derived ascites and primary GBM neurosphere cells (Fig. 2D). Patient-derived primary GBM neurosphere cells (GBM169) pretreated with or without bortezomib were labeled with red cell tracker and treated with 34.5ENVE. Fluorescent microscopy images showed increased GFP-positive infected cells in bortezomib-treated cells (Fig. 2E). Quantification of viral titers in cells treated with or without bortezomib revealed a significant increase in viral replication in both patient ascites and primary GBM neurospheres: Ovarian patient ascites: 4.3-fold and GBM169: 1.9-folds increase over oHSV alone (Fig. 2F).

**ER stress and unfolded protein response in cells treated with bortezomib and oHSV**

Bortezomib is reversible proteasome inhibitor that blocks the chymotrypsin-like activity of the proteasome resulting in the accumulation of unfolded proteins. Accumulation of unfolded proteins induces ER stress leading to caspase-dependent apoptosis (13–15). Treatment of both glioma and head and neck cancer cells with bortezomib showed induction of proteins indicative of ER stress in a dose-dependent manner (Fig. 3A and Supplementary Fig. S2A). In contrast, oHSV is known to disarm ER stress during infection (16). To test the impact of combination treatment of oHSV and bortezomib on ER stress, we measured changes in levels of cellular proteins that are induced during ER stress. Increased expression of PERK, Calnexin, Ire1α, Chop, Ero1-Lα, and GRP78 proteins was observed in oHSV-infected and uninfected glioma and head and neck cancer cells after bortezomib treatment (Fig. 3B and Supplementary Fig. S2B).

Along with ER stress, unfolded proteins also lead to the induction of an UPR, which constitutes increased expression of HSP and cellular chaperone proteins. Both glioma...
Figure 2. Effect of bortezomib treatment on viral replication. U251T3 cells were treated with 2 or 12 nmol/L bortezomib for 16 hours before drug washout and 34.5ENVE infection (MOI = 0.002 with 2 nmol/L bortezomib and 0.01 for 12 nmol/L bortezomib) and evaluated for virus replication. A, bright field (Top) and fluorescence microscopic images (bottom) of GFP-positive infected cells 48 hours postinfection demonstrate increased virus replication following bortezomib treatment at both sublethal (2 nmol/L) and ED50 (12 nmol/L) concentrations relative to no bortezomib-treated cells (magnification, ×100). (Continued on the following page.)
and head and neck cancer cells treated with bortezomib showed a dose-dependent induction of HSP proteins (Fig. 3C and Supplementary Fig. S2C). Consistent with this, we observed induction of HSPs (HSP40, 70, and 90α) in oHSV-infected and uninfected glioma and head and neck cancer cells pretreated with bortezomib (Fig. 3D and Supplementary Fig. S2D). Hsp90α induction was observed at both low and high concentrations of bortezomib treatment of glioma and head and neck cancer cells. HSP90 has been previously shown to be important for localization of HSV polymerase to the nucleus (17), thus we hypothesized that bortezomib-induced HSP90 induction could be critical for the increased viral replication and cell killing following combination treatment. To test this hypothesis, we examined the impact of geldanamycin, an HSP90 inhibitor, on combination treatment-induced tumor cell cytotoxicity. Figure 4A shows combination index plots of Chou–Talalay of glioma cells treated with bortezomib and 34.5ENVE in the presence or absence of geldanamycin. Treatment of glioma cells with geldanamycin reduced synergistic cell killing interactions between 34.5ENVE and bortezomib (Fig. 4A). The synergistic interaction of the combination treatment was also reduced in cells treated with 17-AAG, a less toxic alternative HSP90 inhibitor (Fig. 4B), supporting the significance of HSP90 in oHSV and bortezomib synergistic cell killing. Consistent with the importance of HSP90, both 17-AAG and geldanamycin treatment resulted in a loss of the increased viral replication achieved by bortezomib treatment (Fig. 4C). HSP90 is thought to increase HSV polymerase localization to the nucleus. To directly test whether bortezomib treatment affected nuclear localization of HSV polymerase (UL30), we compared the cytosolic and nuclear fractions (C.F and N.F, respectively) of oHSV-infected cells treated without/with bortezomib at the indicated concentrations (Fig. 4D). Increased nuclear localization of UL30 was observed in bortezomib-treated cells. Collectively, these results demonstrate that the induction of HSP90 by bortezomib is essential for the synergy with 34.5ENVE treatment.

**Combination treatment increased therapeutic efficacy in vivo**

We next examined the therapeutic efficacy of bortezomib in subcutaneous U251T3 glioma model (Fig. 5A). Mice bearing the U251T3 glioma tumor xenograft displayed tumor growth inhibition of 91.7% in response to combinatorial treatment. Moreover, at day 23 after treatment, six out of eight tumors treated with bortezomib plus 34.5ENVE had completely regressed.

Combination treatment also improved survival of mice bearing intracranial GBM169 tumors (Fig. 5B). All mice treated with PBS, bortezomib alone, or 34.5ENVE alone died with a median survival of 31 days (bortezomib alone: HR of survival = 1.18, P = 0.927; 34.5ENVE alone: HR of survival = 0.89, P = 0.797). Whereas, by day 100 following treatment, 70% (median survival > 100 days; HR of survival = 0.11, P < 0.001) of the animals in the bortezomib combined with 34.5ENVE group were still viable (Fig. 5B).

Similar tumor growth suppression was observed in a combination with 34.5ENVE in the CAL27 head and neck xenograft model established in nude mice (Fig. 5C and D). Untreated tumors grew rapidly, leading to a tumor volume of 1,407.36 mm³ by day 33 (95% confidence interval = 1,142.36 to 1,672.36 mm³), whereas mean tumor volumes of bortezomib, 34.5ENVE, and combination treated mice were 920.43 mm³ (difference with PBS = −486.93 mm³, P = 0.004), 217.23 (difference with PBS = −1190.13 mm³, P < 0.001), and 116.46 mm³ (difference with PBS = −1290.90 mm³, P < 0.001), respectively (Fig. 5C). These data correlate to 34.6, 84.6, and 91.7% tumor growth inhibition, respectively, compared with control PBS-treated mice. In addition, combination treatment resulted in increased survival of mice (Fig. 5D). Together these results highlight the translational significance of combining bortezomib treatment with oHSV therapy for both glioma and head and neck cancers.

**Combination treatment increased viral replication and necrotic cell death in vivo**

The apparent enhanced antitumor efficacy and survival benefit resulting from combinatorial treatment was further investigated by immunohistological examination of CAL27 subcutaneous tumor xenografts 3 days after virus treatment. As shown in Fig. 6, there was significantly increased HSV staining in tumors treated with combination treatment as compared with tumors treated with oHSV alone. A large portion of tumor sections derived from tumors treated with...
bortezomib and oHSV were necrotic, as evident with H&E staining (Fig. 6).

Discussion

oHSV therapy has shown promise in preclinical models and several clinical studies testing its efficacy in patients are ongoing and interim analysis of a large-phase three trial for a GMCSF expressing oncolytic HSV has revealed significant improvement in durable response rates (18). Proteasome inhibition has recently emerged as a promising target in cancer therapy, but its efficacy in conjunction with oHSV has not been previously investigated. Here, we report the first study to show that proteasome inhibition with bortezomib can be combined with oHSV to effectively target various solid tumors. Such combinatorial strategies hold great promise as cancer treatments because they can enhance efficacy while minimizing toxicity (19). We utilized Chou–Talalay analysis and found that bortezomib interacted synergistically with oHSV in vitro in killing various solid cancer cells, including ovarian, head and neck, MPNST, and glioma. Importantly, combination treatment resulted in a greater than 2- to 8-fold decrease in the dosage of either bortezomib or oHSV necessary for similar cell killing.

HSV-1 encoded ICP0 is an E3 ubiquitin ligase that utilizes cellular machinery to selectively degrade host proteins that enhance the innate antiviral immune response (20, 21). The proteasome has three distinct proteolytic activities: chymotrypsin-like, trypsin-like, and caspase-like activities. Specifically, the chymotrypsin-like activity of the proteasome has also been shown to be important for virus entry (22). In addition, dysregulation of cellular ubiquitin-proteasome system has been shown to augment antiviral activity against HSV-1 and HSV-2 viruses (23). These results suggest that it may be counterintuitive to utilize bortezomib to increase the efficacy of oHSV. However, although ICP0-mediated modification leads to degradation of cellular antiviral proteins (21), its own proteasomal degradation by SIAH-1, a cellular ubiquitin ligase, has also been shown to inhibit viral infection (24). Clinically, increased incidence of herpes zoster, Varicella zoster virus, and hepatitis B virus reactivation has also been noted in patients treated with bortezomib (25–28). Interestingly an oncolytic adenovirus was shown to synergize with bortezomib by increasing cellular apoptosis in vitro and by its immunomodulatory effects in vivo (29). Bortezomib treatment has also been found to increase apoptosis of EBV-positive transformed B cells suggesting that it may be a novel strategy for the treatment of EBV-related malignancies.

Figure 3. Effect of bortezomib on ER stress and UPR in infected and uninfected cancer cells. A, Dose-dependent induction of ER stress in U251T3 cells. Shown are immunoblot analyses of cell lysates from U251T3 glioma cells treated with bortezomib for 16 hours probed for expression of the indicated proteins. B, ER stress is not increased in cells treated with both bortezomib and oHSV compared with bortezomib only treated cells. Shown are immune blot analyses of the U251T3 cells treated with/without bortezomib (12 nmol/L) for 16 hours before 34.5ENVE infection at an MOI of 0.01 or 1. Cells were harvested 2 and 6 hours postinfection, and cell lysates were probed with antibodies against ER stress-related pathway (calnexin, PERK, IRE1α, Bip/GRP78, CHOP, and Ero1-Lα) GAPDH was used as a loading control. C, dose-dependent induction of HSP40, 70, and 90α in U251T3 cancer cells. Shown are immunoblot analyses of cell lysates from the indicated cells treated with bortezomib for 16 hours probed for expression of the indicated proteins. D, bortezomib pretreatment induced HSPs expression in uninfected and oHSV-infected U251T3 cells. U251T3 cells treated with/without bortezomib were infected with 34.5ENVE (MOI = 1) and cells were harvested 2 and 6 hours postinfection. Cell lysates were probed with antibodies against HSP40, HSP70, and HSP90α. GAPDH was used as a loading control.
associated lymphomas (30). Although our data show no evidence of increased apoptosis, we have not examined the contribution of immunomodulatory effects on virus propagation and antitumor immune responses generation in vivo. Bortezomib-induced activation of UPR has also been shown to induce cellular transcription factors that can activate EBV viral promoters and promote a lytic switch. Direct activation of EBV lytic cycle by bortezomib has also been reported in a variety of tumor cells. This effect is thought to be due to the induction of C/EBPB, a cellular transcription factor that can then initiate the activation of EBV lytic gene expression (31). Although bortezomib has been shown to increase EBV replication, other studies have also found that bortezomib inhibits VSV via activation of NF-kB, resulting in an antiviral state that ultimately inhibits VSV propagation (32). Consistent with these reports, treatment of myeloma cells with bortezomib was found to inhibit VSV replication and show less than additive cell killing in vitro (33). Interestingly, the authors found that despite the antagonistic results in vitro bortezomib and VSV treatment improved antitumor efficacy in vivo. These seemingly contradictory studies make the combination of...
bortezomib and oHSV both promising and intriguing. Here, our results demonstrate increased virus replication and cancer cell killing when cells are pretreated with bortezomib before oHSV infection. In infected macrophages and dendritic cells in vivo, proteasome-mediated degradation of viral capsid proteins has also been shown to release viral genomic DNA into the cytoplasm activating antiviral IFN responses in macrophages post HSV-1 and CMV infections and can aid in viral clearance (7). Immune suppression with bortezomib may account for the increased virus reactivation observed in patients and in vivo tumor-bearing mice in our experiments. In the context of our study, we have not investigated the effect of bortezomib on antiviral and antitumor immune responses that are generated with oHSV treatment. Future studies to investigate this interaction would be of interest.

Resistance to bortezomib remains a clinical challenge and the induction of the UPR has been correlated with the development of resistance to apoptosis initiated by proteasome inhibition (34). The UPR leads to the induction of HSPs: a group of ubiquitously expressed chaperon proteins that ensure correct folding and prevent aggregation of specific target proteins. These chaperone proteins coordinate and rescue ER stress and are thought to contribute toward bortezomib resistance (34). Interestingly, HSP90 is also utilized by HSV-1–encoded DNA polymerase for its proper localization to the nucleus (35, 36). Our results show that the induction of HSP90 as part of the UPR

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<th>Tumor volume (mm³)</th>
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Figure 5. oHSV and bortezomib treatment enhance antitumor efficacy and survival in vivo. A, athymic nude mice were subcutaneously implanted with U251T3 glioma cells. When tumor size reached around 100 mm³, PBS or bortezomib (0.8 mg/kg) were administered via intraperitoneal injection twice a week for the duration of the experiment. Seven days after initiation of drug treatment mice were injected intratumorally with $5 \times 10^7$ pfu of 34.5ENVE or PBS. Data points represent the mean and 95% confidence intervals of the tumor size in each group at the indicated time points ($N = 8/\text{group}$). B, athymic nude mice with intracranial GBM169 cells were treated with/without bortezomib (0.8 mg/kg administered intraperitoneally twice a week for the duration of the experiment) and were treated with intratumoral injection of HBSS or $1 \times 10^5$ pfu of 34.5ENVE on day 14. Data shown are Kaplan–Meier survival curves of animals in each group. ($N = 9/\text{group for mice treated with PBS or bortezomib alone, and } N = 10/\text{group for mice treated with bortezomib and oHSV}$). C, athymic nude mice were subcutaneously implanted with CAL27 head and neck cancer cells. When tumor size reached around 100 mm³, PBS or bortezomib (0.8 mg/kg) were administered via intraperitoneal injection twice a week for the duration of the experiment. Following one week of bortezomib treatment, animals were injected intratumorally with HBSS or $1 \times 10^5$ pfu of oHSV. Tumor volume was measured regularly after treatment. Data points represent the mean of the tumor size and 95% confidence intervals for each group at the indicated time points ($n = 10/\text{group}$). D, Kaplan–Meier survival curves of the data in C. The percentage of surviving mice was determined by monitoring the death of mice over a period of 80 days after treatment.
activated by bortezomib is responsible for increased virus replication, and HSV90 inhibitors ablated the synergistic cell killing and increased viral replication induced by bortezomib. Together these results indicate that the combination of oHSV therapy with bortezomib is an attractive strategy to enhance therapy or deal with the development of resistance to bortezomib treatment. Here, we show that the UPR induced by bortezomib increases viral replication in vitro. It is interesting to speculate whether different proteasome inhibitors with different affinities for distinct proteolytic activities of the proteasome and/or their different half life of each inhibitor may account for the increased oHSV replication observed in bortezomib-treated cells but inhibition with wild-type virus observed with other proteasome inhibitors. In this study, the lack of bortezomib alone to show therapeutic efficacy in mice bearing intracranial glioma is consistent with the lack of response observed in patients with glioma after bortezomib treatment (37). However, the enhanced survival with combination treatment is consistent with our results which show that even sublethal doses of bortezomib can also increase viral replication and improve cell killing in vitro. Although it is interesting to speculate that tumors which can induce UPR in response to bortezomib would be most sensitive to combination of bortezomib and oHSV, future studies will identify biomarkers to predict tumor types that will be most sensitive to this combination treatment.

Recently, bortezomib was found to synergize with oncolytic reovirus therapy in the treatment of multiple myeloma by induction of ER stress and NOXA-dependent cellular apoptosis (15). Although reovirus induces ER stress in infected cells, HSV-1 is known to hijack cellular pathways to override ER stress signaling and maintain ER homeostasis (38). Here, we show that combination of bortezomib and oHSV did not exacerbate ER stress in cells compared with cells treated with only bortezomib. To our knowledge, this is the first report showing synergy between oHSV and bortezomib. This study offers a novel therapeutic treatment strategy for cancer therapy that can be rapidly translated in patients with multiple solid tumors.

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

Disclaimer
Any opinions, findings, and conclusions expressed in this material are those of the authors and do not necessarily reflect those of the Pelotonia Fellowship Program.

Authors’ Contributions
Conception and design: J.Y. Yoo, B.S. Hurwitz, C. Bolyard, T.P. Cripe, D.S. Parris, M. Old, B. Kaur
Acquisition of data (provided animals, acquired and managed patients, provided facilities, etc.): J.Y. Yoo, B.S. Hurwitz, C. Bolyard, J.-G. Yu, K. Selvendiran, K.S. Rath, S. He, Z. Bailey, D. Eaves, T.P. Cripe, M. Old
Analysis and interpretation of data (e.g., statistical analysis, biostatistics, computational analysis): J.Y. Yoo, B.S. Hurwitz, C. Bolyard, J.-G. Yu, J. Zhang, Z. Bailey, D. Eaves, T.P. Cripe, D.S. Parris, M.A. Caligiuri, M. Old, B. Kaur
Writing, review, and/or revision of the manuscript: J.Y. Yoo, B.S. Hurwitz, T.P. Cripe, M.A. Caligiuri, M. Old, B. Kaur
Administrative, technical, or material support (i.e., reporting or organizing data, constructing databases): B.S. Hurwitz, D. Eaves, D.S. Parris
Study supervision: M.A. Caligiuri, M. Old, B. Kaur

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