Development of T Cells Redirected to Glypican-3 for the Treatment of Hepatocellular Carcinoma

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Abstract

Purpose: The aim of our study is to elucidate whether T cells expressing GPC3-targeted chimeric antigen receptor (CAR) can efficiently eliminate GPC3-positive HCC cells and their potential in the treatment of HCC.

Experimental Design: T cells expressing a first-generation and third-generation GPC3-targeted CAR were prepared using lentiviral vector transduction. The in vitro and in vivo cytotoxic activities of the genetically engineered CAR T cells were evaluated against various HCC cell lines.

Results: GPC3-targeted CAR T cells could efficiently kill GPC3-positive HCC cells but not GPC3-negative cells in vitro. These cytotoxic activities seemed to be positively correlated with GPC3 expression levels in the target cells. In addition, T cells expressing the third-generation GPC3-targeted CAR could eradicate HCC xenografts with high level of GPC3 expression and efficiently suppress the growth of HCC xenografts with low GPC3 expression level in vivo. The survival of the mice bearing established orthotopic Huh-7 xenografts was significantly prolonged by the treatment with the third-generation GPC3-targeted CAR T cells.

Conclusions: GPC3-targeted CAR T cells could potently eliminate GPC3-positive HCC cells, thereby providing a promising therapeutic intervention for GPC3-positive HCC.

Introduction

Hepatocellular carcinoma (HCC) is the fifth most common cancer and the third most common cause of cancer mortality worldwide (1). Currently, surgery is the most effective treatment for HCC. However, tumor recurrence after a curative liver resection is very high, and the 5-year survival rate remains at only 10% (2). Moreover, because the majority of patients with HCC are diagnosed at a late disease stage, potentially curative therapies, including chemotherapy, chemoembolization, ablation, and proton beam therapy, are frequently ineffective. Sorafenib (Nexavar), the first clinically approved targeted drug therapy for HCC, could only extend the overall survival by 2 to 3 months (3). Thus, it remains an urgent need for effective, life-prolonging strategies in the management of patients with HCC.

Immunotherapy based on T cells modified with a chimeric antigen receptor (CAR) has been demonstrated as a promising strategy for cancer treatment (4). CAR T cells can specifically recognize tumor-associated antigen and eliminate tumor cells in a non–major histocompatibility complex-restricted manner. Several pilot clinical trials using CAR T cells have recently been reported with promising clinical outcomes (5).

GPC3 is a member of the glypican family of heparan sulfate (HS) proteoglycans that are attached to the cell surface by a glycosylphosphatidylinositol (GPI) anchor. GPC3 plays an important role in cellular growth, differentiation, and migration (6). Multiple studies have demonstrated that GPC3 is an attractive liver cancer–specific target because it is highly expressed in HCC but limited expressed in normal tissues (7). Currently, GPC3-targeted immunotherapeutic strategies utilizing antibodies or a peptide vaccine have been explored for HCC treatment (8–12). The clinical data of the monoclonal antibody GC33 indicated that it was well tolerated in advanced HCC, suggesting that GPC3 is a relatively safe target.
Translational Relevance

There are limited strategies for the treatment of hepatocellular carcinomas (HCC). A majority of HCC cells express Glypican-3 (GPC3), which has restricted expression in normal tissues. In this study, we engineered T cells with a first- and a third-generation (composed of costimulatory signaling domains from CD28 and CD137) chimeric antigen receptor (CAR) targeting GPC3. Our study indicates that the third-generation GPC3-targeted CAR T cells can efficiently destroy GPC3-positive human HCC cells in vitro and in vivo. Our preclinical study suggests that adoptive transfer of T cells expressing a CAR-targeting GPC3 presents a promising therapeutic strategy to treat HCC. Future clinical trials on this novel strategy are warranted.

However, according to experimental knockdown results, GPC3 is not a lethal gene to HCC cells (13). Moreover, the naked antibody could not completely eliminate tumors in mouse models, and no partial or complete response was observed in the 15 patients evaluated during the phase I clinical trial of GC33, suggesting that the therapeutic effects of a naked antibody may not be potent enough for curative treatment of HCC (14). In the phase I clinical trial of a GPC3-derived peptide vaccine for patients with HCC, the median overall survival seemed enough for curative treatment of HCC (14). In the phase I clinical trial of GC33, suggesting that the therapeutic effects of a naked antibody may not be potent enough for curative treatment of HCC (14). In the phase I clinical trial of a GPC3-derived peptide vaccine for patients with HCC, the median overall survival seemed enough for curative treatment of HCC (14).

Cell lines

Human HCC cell lines (HepG2, Hep3B, PLC/PRF/5, and SK-HEP-1) and 293T were obtained from the ATCC. Huh-7 cell line was obtained from the RIKEN Cell Bank. These cell lines were tested and authenticated by DNA profiling for polymorphic short tandem repeat markers. For bioluminescence assays, Huh-7 cells with enforced expression of firefly luciferase (Fluc<sup>−/−</sup>) were established. 293T and HCC cells were cultured in DMEM supplemented with 10% FBS. All cells were routinely tested for mycoplasma contamination.

Lentivirus production

Recombinant lentiviral particles were produced by a calcium phosphate transfection system (17). Lentiviral particles were concentrated 30-fold by ultracentrifugation (Beckman Optima XL-100 K, Beckman) for 2 hours at 28,000 rpm.

Isolation, activation, transduction, and expansion of human T cells

Peripheral blood mononuclear cells (PBMC) derived from human donors were provided by the Shanghai Blood Center. Primary human CD4<sup>+</sup> and CD8<sup>+</sup> T cells were isolated from PBMCs by the negative selection using RosetteSep kits (Stem Cells Technology). CD4<sup>+</sup> and CD8<sup>+</sup> T cells mixed at a 1:1 ratio were stimulated for 24 hours with anti-CD3/anti-CD28 antibodies immobilized on osyl-activated paramagnetic beads (Invitrogen) at a cell/bead ratio of 1:1 in accordance with the manufacturer’s instructions. T cells were then transduced with the lentiviral vector at a multiplicity of infection of 8 U/cell. The transduced T cells were cultured at a concentration of 5 × 10<sup>5</sup> cells/ml in the presence of recombinant human IL2 (300 U/ml; Shanghai Huaxin High Biotech) every other day. Genetically modified T cells were used for functional assays when the lymphocyte volume and proliferation showed a decrease.

Western blot analysis

The cell lysate was denatured and electrophoresed by SDS-PAGE. The samples were then transferred to a nitrocellulose membrane (Bio-Rad) and immunoblotted with the targeted antibodies.
Cytotoxicity assays

The specific cytotoxicity of CAR-modified T cells toward various HCC cells at the different effector:target ratios of 3:1, 1:1, and 1:3 was measured after coculturing for 18 hours by lactate dehydrogenase assay using the CytoTox 96 nonradioactive cytotoxicity kit (Promega) according to the manufacturer’s instructions.

Cytokine release assays

The IFNγ and IL2 cytokines secreted by the varying genetically modified T cells were measured using an ELISA kit (MultiSciences Biotechnology).

Xenograft models of human hepatocellular carcinoma

Six- to 8-week-old NOD/SCID mice were housed and treated under specific pathogen-free conditions at the Experimental Animal Center of Shanghai Jiaotong University School of Medicine (Shanghai, China). All animal experiments were carried out according to the protocols approved by the Shanghai Medical Experimental Animal Care Commission. For the established subcutaneous (s.c.) Huh-7 models, mice were inoculated subcutaneously with 2 × 10^6 Huh-7 cells on the right flank on day 0. When the tumor burden was approximately 200 to 300 mm³, mice were randomly allocated into four groups (n = 6) and assigned to receive one of the following injections: (i) genetically modified αGPC3-28BBZ CAR T cells dissolved in sterile saline (αGPC3-28BBZ); (ii) genetically modified 2D3-28BBZ CAR T cells in sterile saline (2D3-28BBZ); (iii) genetically modified mock T cells in sterile saline (Mock); and (iv) saline only without T cells. On day 13, to deplete of host lymphocyte compartments using cyclophosphamide and enhance the tumor treatment efficacy of the administered T cells (18), mice were injected intraperitoneally (i.p.) with 200 mg/
kg of cyclophosphamide. Then, $8 \times 10^6 \alpha$GPC3-28BBZ
CAR T cells were intravenously (i.v.) injected on day 14. In
established subcutaneous PLC/PRF/5 models, mice were
inoculated with $5 \times 10^6$ PLC/PRF/5 cells in the
right flank on day 0. On day 21, when the tumor burden
was about 100 to 150 mm$^3$, the mice received cyclophos-
phamide (200 mg/kg i.p.), two doses of $8 \times 10^6 \alpha$GPC3-
28BBZ CAR T cells were intravenously injected on days 22
and 30. Tumor dimensions were measured with calipers,
and tumor volumes were calculated using the formula $V = \frac{1}{2} (\text{length} \times \text{width}^2)$. Mice were euthanized when the
mean tumor burden in the control mice reached 1,500 to
2,000 mm$^3$. Xenografts were fixed with formalin, embed-
ded in paraffin, and sections were cut and processed for
IHC staining. For the established orthotopic HCC model,
mice were inoculated with $2 \times 10^6$ Huh-7 (Fluc$^+$) cells
in the liver on day 0. On day 13, mice were grouped ($n = 5$)
and received the injection of cyclophosphamide (200 mg/
kg i.p.) followed by the treatments with two doses of
intravenous injections of $5 \times 10^6$ genetically modified T
cells on days 14 and 21. The mice were imaged every week
following T-cell administration to evaluate whether
\(\alpha\)GPC3-28BBZ CAR T cells could suppress tumor growth
or prolong the survival of the mice bearing orthotopic
HCC xenografts. The transduction efficiencies of geneti-
cally modified T cells used in experimental assays were
about 50%.

**Bioluminescence imaging**

Isoflurane-anesthetized animals were imaged using the
IVIS system (IVIS) followed by the intraperitoneal
injection of 150 mg/kg D-luciferin (Promega). The data
were quantified using Living Image software (Caliper Life
Sciences).

**IHC**

The HLiv-HCC150CS-01 tissue microarray (Outdo Bio-
tech) and sections of the normal kidney and gastric glands
were immunostained using an anti-GPC3 antibody (mAb
1G12, BioMosaics Inc). To assess the persistence of the
administered human T cells in xenografts, the sections of
formalin-fixed, paraffin-embedded tumor tissues were
immunostained using an anti-CD3 antibody (Thermo Sci-
technical RM-9107-S0).

**Statistical analysis**

Statistical analysis was performed by two-way repeated
measures ANOVA with Bonferroni post-tests for the
tumor burden (tumor volume, tumor weight, and photon
counts). Differences in the absolute number of various
transferred T cells were evaluated by Student’s t test. The
overall survival statistics were calculated using the log-
rank test (19). GraphPad Prism 5.0 was used for the
statistical calculations. $P < 0.05$ (*), $P < 0.01$ (**), and
$P < 0.001$ (*** ) were considered statistically significant.

Additional information is described in Supplementary
Methods.

**Results**

**Generation of CAR-GPC3 T cells by lentiviral vector transduction**

As shown in Fig. 1A, the lentiviral expression vectors
encoding the GPC3-targeted CARs including \(\alpha\)GPC3-Z,
\(\alpha\)GPC3-28BBZ, or negative control CARs including
\(\alpha\)GPC3-DZ and 2D3-28BBZ efficiently transduced human
T cells to coexpress the CAR protein and eGFP using the
"self-clearing" F2A peptide, respectively. The genetically
modified T cells began to expand after activation. On day
7, the expression of the different CARs in the transduced T
cells was demonstrated through eGFP expression. The trans-
duction efficiencies were about 55% (Fig. 1B). According to
viable cell counting assays (Trypan blue exclusion), the
\(\alpha\)CD3/\(\alpha\)CD28-coated beads could induce 200- to 300-fold
expansions of CAR-modified T cells on day 18. In the presence
of OKT3 (100 ng/ml) and recombinant human IL2 (300 U/ml),
the expansion could be further increased by 10- to 20-fold (Fig. 1C)
after subsequent stimulation for 7 days with cells of \(\gamma\)-irradiated K562-based artificial anti-
gen-presenting cells (referred to as aK562-64/86) which
express the membrane-bound extra-domains of CD64 and
CD86 (Supplementary Fig. S2). To determine the antigen-
specific expansion, the well-known GPC3-positive Huh-7
cells and GPC3-negative SK-HEP-1 cells were used for
specific stimulations on day 18. The results indicated that
T cells expressing \(\alpha\)GPC3-28BBZ were expanded by the stimulation of GPC3-positive Huh-7 cells but not by
GPC3-negative SK-HEP-1 cells. In addition, both GPC3$^+$
and GPC3$^-$ HCC cell lines failed to elicit the expansion of
mock or 2D3-28BBZ transduced T cells (Fig. 1D).

**Cytokines produced by GPC3-targeted CAR T cells**

Surface expression of GPC3 on five HCC cell lines was
determined. The results of FACS and Western blot analysis
(Fig. 2A) confirmed that SK-HEP-1 had no GPC3 expres-
sion, and the other four HCC cell lines had varying levels of
GPC3 expression. In the cytokine production assay, greater
amounts of IL2 (Fig. 2B) and IFN$\gamma$ (Fig. 2C) were produced
by \(\alpha\)GPC3-28BBZ CAR T cells than \(\alpha\)GPC3-Z CAR T cells or the
control T cells including mock, \(\alpha\)GPC3-DZ, or 2D3-
28BBZ transduced T cells, when cocultured with GPC3-
positive cells. However, almost no induction of IL2 or IFN$\gamma$
was observed when any of the engineered T cells were
cocultured with SK-HEP-1 cells (Fig. 2B and C). Intriguing-
ly, there was a positive correlation between IFN$\gamma$ secretion
in GPC3-redirected CAR T cells transfected with either
\(\alpha\)GPC3-28BBZ or \(\alpha\)GPC3-Z and the MFI of GPC3 expres-
sion on the target cells (Fig. 2D).

**In vitro cytotoxicity of T cells redirected to GPC3 on HCC cells**

To determine whether T cells targeting GPC3 could spe-
cifically recognize and kill GPC3-positive HCC cells, cyto-
toxicity assays were performed by incubating the genetically
modified T cells with each of the five HCC cell lines. The
results indicated that both \(\alpha\)GPC3-28BBZ and \(\alpha\)GPC3-Z
CAR T cells could efficiently lyse the four GPC3-positive HCC cell lines, but not the GPC3-negative SK-HEP-1 cell line (Fig. 3A), while the control effector cells (mock, aGPC3-DZ or 2D3-28BBZ) could not initiate specific lysis on those HCC cells.

It was reported that two types of soluble GPC3 (sGPC3) exist in the blood serum of patients with HCC (20, 21). One is the N-terminal region of GPC3 (GPC3N, residues: S25-R358); the other is the full-length GPC3 without GPI (GPC3\textsubscript{D}GPI, residues: Q25-S560). To elucidate whether sGPC3 can prevent the activation and functional activity of the GPC3-targeted CAR T cells, the cytotoxic activities of the aGPC3-28BBZ–modified T cells toward Huh-7 cells in the presence or absence of three types of recombinant sGPC3 were determined. The results indicated that the GC33-binding peptide fusion protein and GPC3\textsubscript{D}GPI, but not GPC3N, could inhibit the cytotoxic activities of the aGPC3-28BBZ–modified T cells toward Huh-7 cells in the presence or absence of three types of recombiant sGPC3 were determined. The results indicated that the GC33-binding peptide fusion protein and GPC3\textsubscript{D}GPI, but not GPC3N, could inhibit the cytotoxic activities of the aGPC3-28BBZ–modified T cells toward Huh-7 cells. However, this suppression was mild, as the highest inhibition ratio was approximately 10% even at a concentration of 1,000 ng/mL GPC3\textsubscript{D}GPI (Fig. 3B).

**CAR T cells redirected to GPC3 suppress the tumorigenesis of subcutaneous Huh-7 xenografts**

NOD/SCID mice were coinjected subcutaneously with the Huh-7 tumor cells and transduced T cells at an E:T ratio of 1:1 on the right flanks, with an additional group receiving the aGPC3-28BBZ T cells at an E:T ratio of 1:2. The results indicated that 2 out of the 6 mice were tumor free in the group that received aGPC3-Z CAR T cells, while all mice were tumor free in the group that received aGPC3-28BBZ CAR T cells, even at an E:T ratio of 1:2 (Supplementary Fig. S3A). In contrast, tumor outgrowth was observed in all mice in the control groups (Supplementary Fig. S3B). The results indicated the aGPC3-28BBZ CAR T cells displayed a significantly stronger lytic activity than the aGPC3-Z CAR T cells did.

**aGPC3-28BBZ CAR T cells suppressed the growth of established subcutaneous GPC3-positive HCC xenografts**

To further explore the antitumor activities of aGPC3-28BBZ CAR T cells, NOD/SCID mice bearing established subcutaneous Huh-7 xenografts were used. The potent antitumor effect was observed in the mice treated with aGPC3-28BBZ CAR T cells, whereas the other genetically modified T cells did not suppress tumor growth (Fig. 4A). At the experimental endpoint (day 28), 3 of the 5 mice treated with the aGPC3-28BBZ CAR T cells were tumor free, whereas all mice in the control groups carried large tumors (Supplementary Fig. S4A). The antitumor effect of the aGPC3-28BBZ CAR T cells was very significant compared with the control groups, respectively ($P < 0.001$; Fig. 4A, Supplementary Fig. S4B). These results suggested that GPC3-targeted CAR T cells could specifically eliminate Huh-7 cells in vivo.

To elucidate whether the in vivo cancer cell eliminating ability of aGPC3-28BBZ CAR T cells is dependent on the
expression level of GPC3, mice bearing PLC/PRF/5 xenografts were also treated with the genetically modified T cells. Compared with the control groups, the αGPC3-28BBZ CAR T cells could significantly suppress the growth of PLC/PRF/5 tumors (Fig. 4B). At the end of the study (day 47), the mice bearing PLC/PRF/5 tumors treated with αGPC3-28BBZ CAR T cells still carried residual tumors (Supplementary Fig. S4C). The tumors treated with αGPC3-28BBZ CAR T cells were significantly smaller in weight than those in the control groups (αGPC3-28BBZ vs. saline, \( P = 0.0332; \) αGPC3-28BBZ vs. mock, \( P = 0.021; \) αGPC3-28BBZ vs. 2D3-28BBZ, \( P = 0.0367; \) Supplementary Fig. S4D). The results of these two models implicated that the cytotoxic activities of GPC3-targeted CAR T cells were dependent on the GPC3 expression level on the target cells.

Previous studies have indicated that the persistence of transferred T cells in vivo is highly correlated with tumor regression (22, 23). Therefore, we also detected the numbers of human T cells in the peripheral blood of mice bearing subcutaneous established Huh-7 or PLC/PRF/5 xenografts 1 week after T-cell infusion. The results indicated that CD4⁺ and CD8⁺ T cell numbers were highest in the group treated with αGPC3-28BBZ CAR T cells in both groups (\( P < 0.01; \) Fig. 4C and D). In addition, the persisting T-cell number of the PLC/PRF/5 group was less than that of the Huh-7 group (CD4⁺ T cells: 123.5 ± 16 vs. 148 ± 20; CD8⁺ T cells: 246.5 ± 26 vs. 374.5 ± 33). The persistence of human T cells was further certified by immunostaining of the sections of Huh-7 tumors treated with αGPC3-28BBZ CAR T cells. The results revealed that human CD3⁺ T cells had accumulated in residual tumors 2 weeks after intravenous T-cell administration (Fig. 5), while fewer T cells could be detected in the sections treated with saline alone.

**Human GPC3-targeted CAR T cells potently suppressed the growth of established orthotopic Huh-7 xenografts**

To better evaluate the antitumor activities of GPC3-targeted CAR T cells, mice orthotopically transplanted with Huh-7 (fluc⁺) cells were used. After one week of treatment, the group with αGPC3-28BBZ CAR T cells had the lowest tumor burden among the T-cell-transferred groups (Fig. 6A). In the third week after the first dose of

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**Figure 3.** *In vitro* cytotoxic activities of GPC3-targeted CAR T cells. A, primary human T cells transduced with the indicated lentiviral vectors were coincubated with the five HCC cell lines at the varying effector:target ratios for 18 hours, respectively. Cell lysis was determined by a standard nonradioactive cytotoxic assay. Each data reflects the mean ± SEM of triplicates. B, cytotoxicity of αGPC3-28BBZ CAR T cells on Huh-7 cells in the presence or absence of mammalian cell-expressed GPC3,GPI and GPC3N, E.coli-expressed GST-fused G33-binding peptide or BSA at the effector:target ratio of 3:1 for 18 hours.
T-cell administration, the mice in the three control groups had swollen abdomens, whereas the mice of the αGPC3-28BBZ CAR T-cell–treated group had the normal abdomen (Supplementary Fig. S5). At the end of this study, 3 out of 5 of the mice in the group receiving the αGPC3-28BBZ CAR T cells were liver tumor free, whereas all mice in the control groups carried large hepatomas (data not shown). One week after the last infusion, the total number of human CD4^+ and CD8^+ T cells and CAR-positive T cells from mice treated with αGPC3-28BBZ CAR T cells was significantly higher than those in the control groups, respectively (**, P < 0.001). The time point of T cells infusion or saline in figure A and B was shown with arrow. C and D, the quantities of circulating human CD4^+ and CD8^+ T cells from mice bearing Huh-7 xenografts or PLC/PRF/5 xenografts treated with the indicated genetically modified T cells. Mean cell concentration (cells/µL) ± SEM for mice in genetically modified T cell treatment group and P values are shown.

Figure 4. In vivo antitumor activities of αGPC3-28BBZ CAR T cells on established subcutaneous HCC tumor xenografts. A, growth curve of Huh-7 xenografts treated with the indicated T cells or saline. At the endpoint, the residual tumors treated with αGPC3-28BBZ CAR T cells was significantly smaller than those in the control groups, respectively (**, P < 0.001). B, growth curve of PLC/PRF/5 xenografts treated with the indicated T cells or saline. On day 47, the tumor in αGPC3-28BBZ group was significantly smaller than that in each control group (**, P < 0.05). The time point of T cells infusion or saline in figure A and B was shown with arrow. C and D, the quantities of circulating human CD4^+ and CD8^+ T cells from mice bearing Huh-7 xenografts or PLC/PRF/5 xenografts treated with the indicated genetically modified T cells. Mean cell concentration (cells/µL) ± SEM for mice in genetically modified T cell treatment group and P values are shown.
Discussion

In this study, we developed GPC3-targeted CAR T cells with or without the costimulatory signaling domains of CD28 and CD137. Both types of GPC3-targeted CAR T cells could specifically destroy the HCC cells in an antigen-dependent manner. Similar to previous reports (25), the αGPC3-28BBZ CAR T cells that had the costimulatory signaling domains displayed a significantly stronger cytotoxic activity against the GPC3⁺ HCC cells than the αGPC3-Z CAR T cells did, suggesting that the intracellular CD28 and CD137 costimulatory domains contributed to the increased cytotoxic activities.

Our data on established Huh-7 subcutaneous and orthotopic xenografts indicated that αGPC3-28BBZ CAR T cells could eradicate liver cancer cells possessing a high level of GPC3 expression. Compared with Huh-7 cells, PLC/PRF/5 cells, which had a significantly lower level of GPC3 expression, displayed less sensitivity to GPC3-targeted CAR T cells both in vitro and in vivo. In addition, there is a positive relationship between IFNγ secretion from GPC3-targeted CAR T cells and the GPC3 expression level in HCC cells. Together, these data suggested that GPC3 expression level on the cell surface of HCC cell lines might be used as an indicator of the antitumor efficacy of GPC3-targeted CAR T cells.

Our previous study revealed that the levels of sGPC3 were 99.94 ± 267.20 ng/mL with a median level of 15.11 ng/mL (26). Our in vitro data in this study indicated that even a high concentration (approximately 1,000 ng/mL) of GPC3AGPI could only mildly inhibit the cytotoxic activity of GPC3-targeted CAR T cells against GPC3-positive HCC cells. We also observed that the GPC3AGPI (1,000 ng/mL) had no significant effect on IFNγ and IL2 secreted by the GPC3-targeted CAR T cells as well as the expansion of GPC3-redirected T cells (data not shown). Therefore, the persistence of sGPC3 in most of the patients with HCC might not significantly inhibit the clinical efficacy of GPC3-targeted CAR T cells. However, the actual effect of the sGPC3 on the antitumor effect of CAR T cells in vivo needs further study.

A major concern about CAR T cells, especially when the costimulatory signaling domain of CD28 or CD137 is included, is the on-target off-tumor effect. Previously, one patient with breast cancer died after the treatment with CAR T cells redirected to Erbb2 due to the expression of this receptor in lung tissues (27). Therefore, the specificity of the cancer-associated antigen targeted by the CAR T cells is vitally important. Although several studies have indicated that GPC3 is absent in normal tissues, a study by Baumhoer and colleagues revealed that although most normal tissues stained negatively for GPC3, gastric glands [3/7 (43%)], kidney tubules [9/17 (53%)], and testicular germ cells [2/16 (13%)] stained positively (7). Therefore, we examined the GPC3 expression in the kidney and gastric glands. Fortunately, our study revealed that there are no obvious GPC3 expression in normal kidney tissues (10/10) and gastric glands (10/10; Supplementary Fig. S7). The contradictory results may be ascribed to the different samples used. Another possibility is the false positivity of immunostaining. Anyway, considering the individual difference, we thought it should be cautious when the GPC3-redirected CAR T cells were applied in clinical trial. Several strategies such as the incorporation of suicide switches (28, 29), a “tumor sensing” approach by combining two types of antigen recognition with balanced signaling (30) or iCARs technology (31) might be used to minimize the potential off-target toxicity of the CAR T cells.

As we know, one of the major challenges for cancer treatment lies in its heterogeneity. Several testis-antigens have been targeted by T-cell–based immunotherapy.
However, most of the testis antigens are heterogeneously expressed in the tumor tissue (32). In the tumor tissue microarray of 75 primary HCC patients, the different levels of GPC3 expression were evaluated by two experienced pathologists using a 4-point scale according to the staining intensity (Supplementary Fig. S8A). Similar to previous reports (7, 33), our data indicated that GPC3 was expressed in 70.7% (53 out of 75) of patients with HCC (Supplementary Fig. S8B). In GPC3-positive patients, 77% (41 out of 53) of patients carried high levels of GPC3 expression (score ≥ 2). Importantly, unlike testis-antigen, in patients carrying a high level of GPC3 expression, GPC3 seemed to be homogenously expressed in HCC tissues with a mean rate of GPC3-positive hepatoma cells equal to 88% (Supplementary Fig. S8C). This will be an important factor in the long-term clinical efficacy of GPC3-directed CAR T cells.

Taken together, the results of this study constitute the first report concerning CAR T cells redirected to GPC3 and the first report about HCC treatment using CAR T cells. With their potent cancer cell-eliminating capacity, GPC3-targeted CAR T cells may be a promising therapeutic option for HCC treatment.

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

Authors' Contributions
Conception and design: H. Wang, Z. Li
Development of methodology: X. Pan, J. Kong, H. Wang
Acquisition of data (provided animals, acquired and managed patients, provided facilities, etc.): H. Gao, K. Li, H. Tu, Z. Li
Analysis and interpretation of data (e.g., statistical analysis, biostatistics, computational analysis): H. Gao, H. Jiang, Z. Li
Writing, review, and/or revision of the manuscript: H. Gao, Z. Li

Figure 6. αGPC3-28BBZ CAR T cells potently suppressed the established orthotopic Huh-7 xenografts in vivo. A, NOD/SCID mice bearing Huh-7 (Fluc) orthotopic tumor were intravenous injected with 5 × 10^6 genetically-modified T cells on day 14 and 21, respectively. Mice were imaged weekly. Tumor growth was assessed by total bioluminescence signals. The growth of tumors treated with αGPC3-28BBZ CAR T cells was potently suppressed when compared with the control groups. B, the quantitative analysis of human CD4^+ and CD8^+ T cells by TruCount tubes. C, GFP-positive peripheral blood cells were also counted. Mean cell concentration (cells/μL) ± SEM for all evaluable mice in each treatment group are shown. D, the overall survival of mice treated with the indicated T cells or saline.
Administrative, technical, or material support (i.e., reporting or organizing data, constructing databases): H. Tu, B. Shi

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References


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