Increased Ectonucleotidase Expression and Activity in Regulatory T Cells of Patients with Head and Neck Cancer

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Abstract  **Purpose:** Regulatory T cell (Treg) frequency and activity are increased in cancer patients and play a major role in tumor escape. Although disease progression is favored by the presence of Treg, mechanisms used by Treg to suppress antitumor immunity are unknown. The ectonucleotidases CD39 and CD73 are expressed in Treg and convert ATP into immunosuppressive adenosine. In this study, the involvement of the adenosinergic pathway in Treg-mediated suppression in head and neck squamous cell carcinoma (HNSCC) patients was evaluated.

**Experimental Design:** HNSCC patients with an active disease (n = 19) and patients with no evident disease after therapy (n = 14) were studied. Ectonucleotidase expression on CD4+ T cells and CD4+CD25high Treg was evaluated by flow cytometry and compared with normal controls. Ectonucleotidase activity was also compared within these three groups. The data were analyzed for associations of ectonucleotidase expression/function with disease stage.

**Results:** The percentages and expression levels of CD39 and CD73 in CD4+ T cells and Treg were greater in HNSCC than in normal controls and highest in patients with no evident disease. Patients' Treg hydrolyzed ATP at higher rates and produced higher levels of adenosine than normal controls' Treg. The increased frequency and enzymatic activity of CD4+CD39+ cells corresponded to increased adenosine-mediated suppression of effector T cells, which was partly inhibited by ARL67156, an ectonucleotidase inhibitor, and by ZM241385, a selective A2a/A2b receptor antagonist.

**Conclusions:** CD39+ Treg frequency and adenosine-mediated suppression are significantly increased in HNSCC patients. The adenosinergic pathway is involved in Treg-mediated immunosuppression in cancer and its attenuation could be a promising immunotherapeutic strategy for patients with HNSCC. (Clin Cancer Res 2009;15(20):6348–57)

Head and neck squamous cell carcinoma (HNSCC), arising from the mucosal epithelium, is the fifth most common type of cancer worldwide and the sixth most common cause of cancer-related mortality (1, 2). Although advances in surgical methods, chemotherapy, and radiation have improved patients' treatment and quality of life, the overall outcome and survival rate among patients with this disease have not notably improved (3). Therefore, novel therapeutic strategies are necessary for the treatment of HNSCC. Recent studies have focused on the dynamic interplay and coevolution of antitumor immune responses and tumor progression in HNSCC (4, 5). These studies have shown that T lymphocytes play a major albeit contradictory role in local tumor expansion, metastasis, and neoangiogenesis. In most human cancers, regulatory T cells (Treg), a small subset of CD4+ T cells, are significantly increased in the peripheral blood as well as in the tumor microenvironment (6–8). Treg are phenotypically defined as CD4+CD25high FOXP3+ and modulate immune responses by suppressing functions of other T cells. To date, at least two types of Treg are known to exist in man: (a) naturally occurring Treg, which develop in the thymus and are responsible for maintaining peripheral tolerance using cell contact–dependent or cell contact–independent suppression (9, 10), and (b) inducible Treg (Tr1), which arise in the periphery on antigen exposure and...
Ectonucleotidase Expression in Treg of HNSCC Patients

Elevations in adenosine levels are responsible for suppressor functions of single-cell–sorted CD4^+CD39^+ Treg in patients with an active disease as well as those with no evident disease after successful therapy. Further, HNSCC patients with a late-stage disease have a significantly higher frequency and activity levels of adenosine-generating CD4^+CD39^+ Treg than those with an early-stage disease.

Materials and Methods

HNSCC patients and healthy volunteers. Peripheral venous blood samples were obtained from 33 HNSCC patients and 15 age-matched normal controls. All patients were seen in the Outpatient Clinic of the Department of Otolaryngology at the University of Pittsburgh Medical Center between November 2007 and July 2008. All subjects signed an informed consent approved by the Institutional Review Board of the University of Pittsburgh. The normal controls cohort included 4 females and 11 males with a mean age of 57 ± 12 years (range, 45-67 years). The patient cohort included 8 females and 25 males with a mean age of 62 ± 12 years (range, 41-77 years). The clinicopathologic data for the patient group are listed in Table 1. At the time of blood draws, 19 patients had an active disease, including 18 newly diagnosed cases and 1 patient with a recurrent disease. The other 14 patients had no evidence of disease following oncologic therapies. In all of the patients, a surgical removal of the primary tumor was done and 7 patients additionally received an adjuvant radiochemotherapy. When applied, radiochemotherapy was finished from 3 weeks to 12 months before the time of blood draws for immunologic studies.

Collection of peripheral blood mononuclear cells. Blood samples (20-30 mL) were drawn into heparinized tubes and centrifuged on Ficoll-Hypaque gradients (GE Healthcare Bioscience). Peripheral blood mononuclear cells (PBMC) were recovered, washed in AIM-V medium (Invitrogen), counted in a trypan blue dye, and immediately used for experiments.

Separation of Treg. CD4^+CD25^+ T cells, which served as responder cells, were freshly isolated by negative selection from PBMC (normal controls and HNSCC) using the Regulatory T cell Separation Kit and AutoMACS (Miltenyi Biotech). CD4^+CD39^+ and CD4^+CD25^{high} Treg cells were single-cell–sorted from PBMC following staining for lymphocytes with the relevant markers.

Antibodies. The following anti-human monoclonal antibodies (mAb) were used for flow cytometry: anti-CD3-ECD, anti-CD4-ECD, anti-CD4-PC5, anti-CD25-PC5, anti-FOX3-FTITC (clone PCH101), anti-CD39-FTITC, anti-CD39-PE, anti-CD73-PE, unconjugated anti-CD73, and anti-CTLA4-PE. Antibodies and their respective isotypes, which served as negative controls for surface as well as intracellular staining, were purchased from Beckman Coulter, except for anti-FOX3 (clone PCH101), anti-CD39-FTITC, and anti-CD39-PE, which were purchased from eBioscience. Also, anti-CD73-PE was purchased from BD Pharmingen. The anti-CTLA4-PE antibody was purchased from R&D Systems, and the unconjugated anti-CD73 antibody was purchased from Santa Cruz Biotechnology. The FITC-conjugated AffiniPure goat anti-mouse secondary antibody was purchased from Jackson ImmunoResearch. Before use, all antibodies were titrated using activated as well as nonactivated PBMC to determine the optimal staining dilution for each.

Surface and intracellular staining. Freshly isolated cells were stained for flow cytometry as described previously (1). Briefly, cells were incubated with the antibodies for surface markers for 30 min at 4°C in the dark and then fixed with 2% (w/v) paraformaldehyde in PBS for 15 min. Afterwards, the cells were permeabilized with 0.1% (w/v) saponin in PBS for 30 min and stained with antibodies specific for intracellular markers for 30 min at 4°C in the dark. Cells were washed twice with 0.1% saponin in PBS, resuspended in a flow solution, and immediately analyzed by flow cytometry. Appropriate isotype controls were included for each sample.
Flow cytometry. Flow cytometry was done using a EPICS XL-MCL flow cytometer equipped with Expo32 software (Beckman Coulter). The acquisition and analysis gates were restricted to the lymphocyte gate based on characteristic properties of the cells in the forward scatter and side scatter. Forward scatter and side scatter were set in a linear gate based on characteristic properties of the cells in the forward scatter channel. Forward scatter and side scatter were set in a linear gate based on characteristic properties of the cells in the forward scatter channel. Analytes in triplicate wells. The percentage of ATP hydrolysis was determined by using the following formula: \[ \frac{1 - (CPM \text{ ATP}_{\text{sample}})}{CPM \text{ ATP}_{\text{alone}} + CPM \text{ ATP for cells}_{\text{alone}}} \times 100. \]

### Table 1. Clinicopathologic characteristics of enrolled HNSCC patients

<table>
<thead>
<tr>
<th>Age (y), range</th>
<th>Sex</th>
<th>Tumor site</th>
<th>Tumor differentiation</th>
<th>Tumor stage</th>
<th>Nodal status</th>
<th>Status at blood draw</th>
<th>Disease stage (active disease)</th>
</tr>
</thead>
<tbody>
<tr>
<td>41-77</td>
<td>Male</td>
<td>Nasopharynx</td>
<td>G1</td>
<td>T1</td>
<td>N0</td>
<td>Active disease</td>
<td>Early stage</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Oral cavity</td>
<td>G2</td>
<td>T2</td>
<td>N1</td>
<td>Recurrent disease</td>
<td>Advanced stage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Larynx</td>
<td>G3</td>
<td>T3</td>
<td>N2</td>
<td>No evident disease</td>
<td>Therapy before blood draw</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not determined</td>
<td>Gx</td>
<td>T4</td>
<td>N3</td>
<td>Surgery alone</td>
<td>(no evident disease)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tx</td>
<td>Nx</td>
<td>Surgery + radiochemotherapy</td>
<td></td>
</tr>
</tbody>
</table>

#### Mass spectrometric analysis of adenosine production.

CD4+CD25+ or CD4+CD25high T cells (25,000 per well) from normal controls as well as HNSCC patients were incubated with 10 μmol/L exogenous ATP in wells of 96-well flat-bottomed plates. To selected wells, ARL67156 or α,β-methylene ADP, an ecto-5'-NT/CD73 inhibitor (100 μmol/L; Sigma-Aldrich), was added. Cell supernatants were collected after various incubation time points. Samples were centrifuged and boiled for 2 min and stored on dry ice until analysis. Adenosine was measured on a Thermofinnigan LCQ Duo mass spectrometer equipped with electrospray ionization. The samples were separated using a C18 column (Eclipse XDB-C18, 4.6 × 150 mm, 5 μm). A mobile phase consisted of 0.1% formic acid and water and methanol solution. The flow rate of a mobile phase was 0.6 mL/min. The analytes were monitored with single-ion monitoring in the positive-ion mode; for adenosine, the mass-to-charge ratio was 268; for 10-13C-adenosine (internal standard), the mass-to-charge ratio was 278. The internal standard (10-13C-adenosine) in supernatants is 10 pg/μL. The average concentration of adenosine was determined in duplicate wells.

#### Suppression assays.

Single-cell–sorted CD4+CD39+ cells were tested for suppression of proliferation activity in cocultures with autologous CD4+CD25+ responder cells as described previously (21). CFSE-labeled autologous CD4+CD25+ cells (10^5 per well) were incubated in wells of flat-bottomed 96-well plates at the suppressor/responder cell ratios of 1:1, 1:2, 1:5, and 1:10. Using the same assay format, either ARL67165 (250 μmol/L) or MRS191 (0.5 μmol/L, both from Sigma-Aldrich); ZM241385 (0.3 μmol/L), MRS1706 (0.5 μmol/L), or DPCPX (0.5 μmol/L; all from Tocris Bioscience); or neutralizing anti-TGF-β1 mAb and/or anti-IL-10 mAb (1 μg/mL; both from R&D Systems) or appropriate isotype controls were added to selected wells 30 min before adding the suppressor cells. To induce proliferation, responder cells were stimulated with plate-bound OKT-3 (2 μg/mL) and soluble anti-CD28 mAb (2 μg/mL; Miltenyi) in the presence of 150 IU/mL IL-2 for 5 days. All CFSE data were analyzed using the ModFit software provided by Verity Software House as described previously (21).

#### Immunofluorescence.

HNSCC tissue samples were embedded in OCT, and 5 mm frozen sections were cut in a cryostat, fixed for 10 min in cold acetone/ethanol (1:1), and dried at room temperature. The following anti-human antibodies were used for staining: anti-CD4-FITC, CD25-PE (BD Pharmingen), anti-CD39, and anti-CD73 (Santa Cruz Biotechnology). As secondary antibody, Cy5-labeled donkey anti-rabbit (Jackson ImmunoResearch) was used. To eliminate nonspecific binding of secondary antibodies, tissue sections were incubated with 10% donkey serum for 1 h and then washed extensively in PBS. Sections were incubated with the primary antibodies for 1 h at room temperature in a moist chamber. Non-specific binding of secondary antibodies under the same conditions. Primary antibodies were omitted in all negative controls. Sections were mounted in a mounting medium with 4',6-diamidino-2-phenylindole (Vector Laboratories) to trace cell nuclei. Slides were evaluated in the Olympus Provis (Olympus) fluorescence microscope under ×400 magnification. For digital image analysis, the software Adobe Photoshop 6.0 version was used.

#### Statistical analysis.

All data are mean ± SD of at least three experiments and medians. Data were analyzed using the Kruskal-Wallis test or Wilcoxon Mann-Whitney test for comparisons across outcome groups (normal controls versus patients with an active disease versus patients with no evident disease). Data are presented in box plots showing the mean, median, and interquartile range. Changes in adenosine production and ATP hydrolysis were analyzed with the Student’s t test. Analyses were done using SAS version 9.1 or Stat Xact 8 and a significance level of 0.05 was assumed.

### Results

Expression of CD39 on CD4+ T cells and Treg in the peripheral blood of HNSCC and normal controls. PBMC were obtained from normal controls and HNSCC patients who either had...
an active disease or had no evident disease. The frequency of CD4+CD39+ T cells was initially examined by flow cytometry in the total CD3+CD4+ cell population in PBMC. Patients with an active disease had significantly higher frequency of CD4+CD39+ T cells than normal controls [12 ± 4% (median, 11.35) versus 6 ± 4% (median, 5.5); P < 0.01; Fig. 1A and B]. Also, the level of expression, the mean fluorescence intensity (MFI), of CD39 on CD4+ cells was increased in patients with an active disease versus normal controls [20 ± 4% (median, 20.0) versus 14 ± 4% (median, 14.3); P < 0.001; Fig. 1C]. CD4+ T cells of patients with no evident disease also expressed higher levels of CD39 [MFI = 24 ± 4 (median, 23.8) versus 20 ± 4 (median, 20.0); P < 0.001; Fig. 1C] and these patients also had the highest frequency of CD4+CD39+ cells [15 ± 8% (median, 14.0) versus 12 ± 4% (median, 11.35); P < 0.01; Fig. 1A and B].

Because CD25high and FOXP3 have been generally used as markers for human Treg, we have examined whether CD4+CD25high cells, of which 83 ± 10% were also FOXP3+, as reported previously by us (ref. 8; range, 67-95%; n = 15), expressed CD39. Gating on CD4+CD25high cells (MFI > 120; ref. 8), we observed higher expression levels and frequencies of CD39 compared with CD4+CD25− cells in all three cohorts (data not shown). Further, the frequency and MFI of CD4+CD25high CD39+ were significantly higher in the peripheral blood of HNSCC than in normal controls, with the highest percentage and levels of CD39 expression observed in the peripheral blood of patients with no evident disease (Fig. 1D and E). Gating on CD4+CD39+ cells, we observed that up to 80% of these cells were FOXP3+ and mostly CTLA-4+ in all three cohorts (data not shown).

Expression of CD73 in CD3+CD4+ T cells and Treg in the peripheral blood of HNSCC and normal controls. The final step in adenosine production is catalyzed by CD73, a 5′-ectonucleotidase. Because adenosine is the metabolite responsible for immunosuppression of effector T cells, it was important to determine expression and activity of CD73 in CD4+ T cells and Treg. Similar to our previously reported data, intracellular staining for CD73 revealed that 75 ± 6% of CD4+CD25high are CD73+ compared with 15 ± 4% of non-Treg.7 In CD3+CD4+ T cells, the level of CD73 expression was increased in patients with an active disease compared with normal controls (data not shown). In Treg, the frequency as well as MFI of CD73 were increased in the peripheral blood of patients with HNSCC compared with normal controls, although the difference was not statistically significant (data not shown). Most of the CD4+CD73+ cells coexpressed FOXP3+ and CTLA4+ in all three cohorts (data not shown).

Correlation of CD39 expression with disease progression and radiochemotherapy. To determine whether any relationship could be established between percentages of CD39+ cells present in the peripheral circulation and disease progression, we divided HNSCC patients with an active disease into those with an early-stage disease without lymph node metastasis and those with an advanced-stage disease and involved lymph nodes (Table 1). The frequency of CD4+CD39+ T cells was significantly increased ($P < 0.01$) in patients with the late-stage disease compared with those with the early-stage disease [8 ± 5% (median, 8.15) versus 11 ± 4% (median, 90.5); Fig. 2A]. A significant increase in the level of CD39 expression (MFI) was also observed in the late-stage disease group ($P < 0.01$; data not shown). The percentage of CD39+ Treg within the CD4+CD25high subset was as well significantly higher in patients with the late-stage disease [82 ± 11% (median, 80.7) versus 89 ± 6% (median, 90.5); $P < 0.03$; Fig. 2B].

Among patients with no evident disease, a significant increase in the percentage of CD39+ Treg was observed in patients who were treated with surgery in combination with radiochemotherapy compared with patients treated with surgery alone [83 ± 6% (median, 77.0) versus 92 ± 4% (median, 91.5); $P < 0.01$; Fig. 2C]. Overall, these phenotypic data suggest that significant changes in the frequency of CD4+CD39+ and CD4+CD25highCD39+ cells occur with disease progression and that therapy has an effect on the frequency of CD4+CD39+ T cells in the peripheral circulation.

**In situ analysis of CD39+ and CD73+ Treg in head and neck tumor tissues.** Next, the presence and distribution of CD4+CD39+ and CD73+ Treg in HNSCC biopsy tissue was evaluated using multicolor immunofluorescence and confocal microscopy (Fig. 3A-D). Tumor tissue sections were stained with labeled mAb. As shown in Fig. 3C, CD4+CD25+CD39+ cells (violet) infiltrate the tumor tissue. In fact, most of the CD4+CD25+ cells (yellow) in the tumor express CD39 and are localized in the proximity of CD4+CD25+ cells (green; see inset), suggesting that these cell subsets interact in situ. However, Treg are not the only cells in the tumor that express CD39. Endothelial cells have been reported to also express CD39 and show increased activity in the tumor microenvironment facilitating neoangiogenesis (22). As shown in Fig. 3D, most of the CD73+ cells are colocalized to CD4+CD25+ cells (violet). These cells seem to be arranged in clusters, which are localized close to effector T cells. Also, the tumor cells seem to express CD73. These findings support the conclusion that CD39+ Treg as well as CD73+ Treg accumulate in HNSCC tissues and are in direct contact with effector T cells.

**Hydrolysis of exogenous ATP by Treg in HNSCC versus normal controls.** Although the frequency and expression levels for the ectonucleotidases CD39 and CD73 on Treg were higher in HNSCC patients than normal controls, it was important to determine whether their enzymatic activities were also increased in parallel. Single-cell–sorted CD4+CD25high cells were, therefore, obtained from the peripheral blood of subjects in all three cohorts and incubated with 10 μmol/L exogenous ATP for 60 min. Compared with normal controls, Treg of patients with an active disease or no evident disease hydrolyzed significantly more ATP ($P < 0.05$; Fig. 4A). On the prior addition of ARL67156, a selective inhibitor of ecto-ATPases, the ability of Treg cells to hydrolyze ATP was significantly decreased in all three groups ($P < 0.001$; Fig. 4A). Subdivision of the patients with an active disease into early and advanced stages revealed an increase in Treg-mediated hydrolysis of ATP in cells obtained from patients with an advanced-stage disease (data not shown).

**Adenosine production by Treg in HNSCC versus normal control cells.** To further analyze the activity of the ectonucleotidases.
CD39 and CD73 in Treg, we compared the ability of CD4+CD25high Treg and autologous CD4+CD25- cells obtained from patients with an active disease to produce adenosine following the addition of 10 μmol/L exogenous ATP. Adenosine levels were measured in the cell supernatants collected at various time points after ATP addition. CD4+CD25high cells produced more adenosine than CD4+CD25- cells (Supplementary Table S1; \( P \leq 0.001 \)). Compared with Treg of normal controls, those isolated from patients with an active disease produced almost six times more adenosine after 60 min (Table 2). Also, when no exogenous ATP was added to the cultures, the amount of adenosine after 60 min measured in the supernatant of Treg from patients with an active disease was significantly increased compared with that measured with Treg of normal controls (Table 2; \( P \leq 0.001 \)). On coincubation of CD4+CD25high cells with ARL67156, adenosine production was almost completely blocked (Table 2; \( P < 0.001 \)). Also, we observed a complete inhibition of adenosine production by CD4+CD25high cells when α,β-methylene ADP was added to selected wells (Table 2; \( P \leq 0.001 \)).

Suppressor function of circulating CD4+CD39+ in HNSCC versus normal controls. To analyze suppressor activity of CD4+CD39+ cells, single-cell–sorted CD4+CD39+ cells suppressor cells from freshly isolated PBMC were coincubated with autologous CD4+CD25+ responder cells at different suppressor/responder cell ratios. After a 5-day culture, the mean suppressor activity of CD4+CD39+ cells at the 1:1 suppressor/responder cell ratio was 38 ± 3% in normal controls, whereas an increase up to 82 ± 3% in patients with an active disease and up to 93 ± 5% in patients with no evident disease were observed (Fig. 4B). The suppression of proliferation linearly decreased on further dilution of suppressor cells (Fig. 4B). Because Treg from HNSCC patients are increased in ectonucleotidase expression and activity, the generation of high levels of adenosine most likely contributes to the suppressive function of these cells.

Effects of ectonucleotidase inhibitors on suppression mediated by CD4+CD39+ cells. To further test the hypothesis that adenosine generated by Treg due to ectonucleotidase activity is responsible...
for immunosuppression of responder cell proliferation, additional coculture experiments were done. Specifically, the addition of ARL67156, a structural analogue of ATP and an ectonucleotidase inhibitor, to cocultures of CD4+CD39+ cells serving as suppressor cells with autologous responder cells resulted in a significant decrease of the suppression compared with cultures without the inhibitor in patients with an active disease (82 ± 9% versus 22 ± 1%; P < 0.001; Fig. 4C) and patients with no evident disease (93 ± 5% versus 23 ± 4%; P < 0.001; Fig. 4D).

Effects of adenosine receptor antagonists on suppression mediated by CD4+CD39+ cells. Because the immunosuppressive effects of adenosine are known to be mediated via the A2AR, which is expressed on effector T cells (23), we expected to see a decrease of suppression in responder cell proliferation, when this receptor was blocked on effector T cells. Therefore, we added ZM241385, a selective A2a and A2b receptor antagonist, to the above described responder/suppressor cell cocultures. As expected, the addition of ZM241385 significantly blocked the suppression mediated by CD4+CD39+ cells at the 1:1 suppressor/responder cell ratio in patients with an active disease (20 ± 4% versus 82 ± 9%; P < 0.001) and patients with no evident disease (25 ± 3% versus 92 ± 4%; P < 0.001; as shown in Fig. 4C and D). An almost complete block of CD4+CD39+ Treg-mediated immune suppression was observed after adding ZM241385 and neutralizing anti-TGF-β1 and anti-IL-10 mAbs to the cocultures (9 ± 2% versus 83 ± 3%; P < 0.001; Fig. 4E).

Addition of other adenosine receptor antagonists such as DPCPX (a selective A1 receptor antagonist), MRS1191 (a selective A3 receptor antagonist), or MRS1706 (a selective A2b receptor antagonist) did not show any effect on CD39+ T cell–mediated suppression on responder cell proliferation. In aggregate, the data suggest that suppression of effector T-cell proliferation by...
has been reported that appreciable amounts of adenosine are present in the interstitial fluid/tumor microenvironment of solid tumors at concentrations sufficient to inhibit cell-mediated immune responses to tumor cells (47). Interestingly, both tumor cells and Treg appear to employ the adenosinergic pathway for downregulating immune responses. The expression of CD39 and CD73 is upregulated on Treg present in the peripheral blood and tumor tissues of patients with HNSCC, which is in concert with an increased activity of these enzymes in Treg. Furthermore, CD4+CD39+ Treg accumulate in the tumor microenvironment, which is characterized by elevated levels of ATP due to the rapid proliferation and death of tumor cells. In this microenvironment, CD4+CD39+CD73+ Treg are able to generate high levels of immunosuppressive adenosine. Also, extracellular adenosine enhances the generation of Treg as shown by us8 and others (48). Adenosine mediates immunosuppression by binding to A2aR expressed on the surface of effector T cells (19, 20). A2aR-deficient mice show enhanced antitumor immune responses mediated by T cells and a significant reduction in tumor growth compared with wild-type animals (23). In our study, blocking of these receptors on the surface of effector T cells decreased suppressor functions of Treg, confirming that the suppressive effects of Treg are mediated via A2aR signaling and subsequently by an increase in the level of intracellular cyclic AMP. However, it remains unclear whether A2aR-mediated immune suppression has clinical significance or is implicated in cancer pathogenesis.

Experiments in murine models and our data strongly suggest that cancer progression of human cancer involves the up-regulation of the Treg-associated adenosinergic pathway. This study shows for the first time a significant correlation between CD39 expression on Treg and the disease stage in HNSCC. Increased CD39 expression (percent positive cells and MFI) in T cells of patients with cancer is likely related to accumulation of Treg in the tumor and peripheral circulation as reported previously by us and others (6–8). This Treg accumulation might be related to inflammatory infiltrates and proinflammatory cytokines present in the tumor microenvironment, including that of HNSCC (49). The characteristics of the tumor microenvironment, specifically cyclooxygenase-2 and prostaglandin E2 expression, contribute to up-regulation of CD39 in Treg as indicated by our preliminary results. Although observed in a relatively small patient cohort, a differential ectonucleotidase expression on Treg of HNSCC patients with various disease stages may prove to be a significant biomarker of disease prognosis in the future. A significantly increased ectonucleotidase expression and activity was observed in Treg of HNSCC patients who received adjuvant radiochemotherapy compared with those treated with surgery alone, confirming previously published data by us in a cohort of HNSCC patients with no evident disease treated with radiochemotherapy (8). Both radiation and chemotherapy lead to chronic tissue inflammation and oxidative stress. Infiltration of Treg and their accumulation in inflamed/damaged tissues likely represent a normal physiologic response. Therefore, it is not surprising that radiochemotherapy can induce accumulations of CD39+ Treg and enhance/maintain their enzymatic functions. During inflammation, ATP released from necrotic tumor cells as well as

### Table 2. Adenosine production by Treg obtained from the peripheral blood of normal donors and HNSCC patients

<table>
<thead>
<tr>
<th></th>
<th>Normal controls</th>
<th>Active disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>No inhibitor</td>
<td>131 ± 40</td>
<td>754 ± 147</td>
</tr>
<tr>
<td>+ ARL67156</td>
<td>35 ± 12</td>
<td>102 ± 21</td>
</tr>
<tr>
<td>+ α,β-Methylene ADP</td>
<td>10 ± 6</td>
<td>16 ± 8</td>
</tr>
</tbody>
</table>

NOTE: Cells were incubated with exogenous ATP (10 μmol/L) and supernatants were collected after 60 min. Adenosine concentrations were measured using mass spectrometry. ARL67156, an ectonucleotidase inhibitor (250 μmol/L/mL), or α,β-methylene ADP, a CD73 inhibitor (100 μmol/L/mL), was added to selected wells. Data represent three individual experiments.

CD39+ Treg is in part mediated by the engagement of the A2aR on these effector cells and on the ability of Treg to produce immunosuppressive cytokines TGF-β1 and IL-10.

### Discussion

In patients with cancer, Treg frequencies appear to correlate with the disease status and survival and seem to influence tumor progression (5, 6, 8, 24). Mechanisms known to be involved in enhanced Treg-mediated suppression seen in cancer patients include the involvement of immunosuppressive cytokines IL-10 and TGF-β, the production and secretion of perforin and granzyme B, and the expression of Fas/FasL on Treg (8, 25). Another potential mechanism of suppression involves ectonucleotidase-mediated production of adenosine, which has long been known as one of the most suppressive factors for immune cells (16–20, 26, 27). Although overexpression of ectonucleotidases in naturally occurring Treg has been recently described in normal controls and patients with multiple sclerosis (15), ours is the first study describing the involvement of ectonucleotidases in Treg-mediated suppression in cancer patients.

Several recent studies have emphasized the importance of the adenosinergic pathway in the process of tumor escape (19, 20). CD4+CD39+CD73+ Treg are able to generate high levels of immunosuppressive cytokines IL-10 and TGF-β. In murine models and our data strongly suggest that cancer progression of human cancer involves the up-regulation of the Treg-associated adenosinergic pathway. This study shows for the first time a significant correlation between CD39 expression on Treg and the disease stage in HNSCC. Increased CD39 expression (percent positive cells and MFI) in T cells of patients with cancer is likely related to accumulation of Treg in the tumor and peripheral circulation as reported previously by us and others (6–8). This Treg accumulation might be related to inflammatory infiltrates and proinflammatory cytokines present in the tumor microenvironment, including that of HNSCC (49). The characteristics of the tumor microenvironment, specifically cyclooxygenase-2 and prostaglandin E2 expression, contribute to up-regulation of CD39 in Treg as indicated by our preliminary results. Although observed in a relatively small patient cohort, a differential ectonucleotidase expression on Treg of HNSCC patients with various disease stages may prove to be a significant biomarker of disease prognosis in the future.

A significantly increased ectonucleotidase expression and activity was observed in Treg of HNSCC patients who received adjuvant radiochemotherapy compared with those treated with surgery alone, confirming previously published data by us in a cohort of HNSCC patients with no evident disease treated with radiochemotherapy (8). Both radiation and chemotherapy lead to chronic tissue inflammation and oxidative stress. Infiltration of Treg and their accumulation in inflamed/damaged tissues likely represent a normal physiologic response. Therefore, it is not surprising that radiochemotherapy can induce accumulations of CD39+ Treg and enhance/maintain their enzymatic functions. During inflammation, ATP released from necrotic tumor cells as well as

8 Unpublished data.
9 M. Mandaparthi, unpublished data.
various inflammatory cell types, including mast cells, lymphocytes, and macrophages, is rapidly degraded to adenosine. Increased CD39 expression on inflammatory cells in chronic inflammation and neoplastic formations has been reported previously (50) and might be a compensatory response to inflammation, pro-inflammatory states, or radiochemotherapy of Treg in cancer patients. Future studies are needed to determine whether CD39 and CD73 expression is regulated by the tissue microenvironment (e.g., hypoxia) and whether it synergizes with cyclic AMP–induced signaling.

In summary, this study evaluates for the first time the involvement of adenosine in Treg-mediated immunosuppression in patients with HNSCC, which can be blocked by using A2aR antagonists and CD39 inhibitors. This knowledge could be important for the development of novel strategies aimed at enhancing the effectiveness of immune-based therapies for solid tumors. Potentially, application of A2aR antagonists in immune-competent cells and preventing CD39 activity on Treg and tumor cells, thus decreasing adenosine levels, might prove to be effective in enhancing antitumor immune responses.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

References


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