HER2 amplification and PIK3CA mutation were validated as biomarkers for sensitivity to the single-agent phosphoinositide 3-kinase (PI3K) inhibitor, GDC-0941, in breast cancer models. A novel expression profile was developed to identify other breast cancers sensitive to PI3K inhibitors. These expression studies highlighted feedback networks connecting TORC1, PI3K, and mitogen-activated protein kinase (MAPK) pathways, and underscored the potential for combination therapies. Clin Cancer Res; 16(14): 3523–5. ©2010 AACR.

In this issue of Clinical Cancer Research, O'Brien et al. (1) and colleagues, use IC50 values as the primary mode to define sensitivity. This measure provides a quick and robust readout that facilitates comparisons across a large panel of cancer models. Although such assays identify the cell lines whose growth is impacted by the drug, it remains less clear if such data will faithfully predict which cancers will respond to PI3K inhibitors (or other targeted therapies) in a clinical setting. For example, these data may identify cancer cell lines that grow more slowly in response to drug. However, in the clinic, this finding may still amount to disease progression, not tumor shrinkage. Of note, recent studies correlate significant responsiveness to PI3K inhibitors in vivo with the induction of cell death (7, 8). Thus, future efforts to discover clinically useful biomarkers may benefit from implementation of more stringent laboratory criteria for "sensitivity." Thus, O'Brien and colleagues subsequently analyze a subset of cell lines identified as sensitive, by determining the effects of PI3K inhibition on cell cycle arrest, expression of key regulators of the G1 to S transition, induction of apoptosis, and tumor shrinkage in vivo. Of note, despite similar in vitro IC50 values among the PIK3CA-mutant and HER2-amplified cell lines, they did not all show similar in vivo sensitivity. For example, one of the "sensitive" models showed substantial tumor growth in vivo. Indeed, it would be interesting to learn if this cancer cell line had failed to undergo apoptosis in response to PI3K inhibition. Thus, even among sensitive genotypes, we may need additional understanding and biomarkers to identify those cancers that will undergo tumor shrinkage in response to single-agent PI3K inhibitors in the clinic (Fig. 1).

In these breast cancer models, O'Brien and colleagues highlight a feedback system in which PI3K inhibition...
leaves to upregulation of ERBB3 and IRS proteins. This system may stimulate increased flux through downstream pathways, which may reinforce PI3K activation and also signal independently of PI3K. Similar feedback responses have also been described in which MAP/ERK kinase (MEK) or TORC1 inhibition increases PI3K/AKT activation (8–10). Further, Pandolfi and colleagues have described a PI3K-dependent feedback loop in which TORC1 inhibition leads to activation of MAPK signaling (11). These feedbacks will likely contribute to the limited success of single-PI3K pathway inhibitors. Indeed, several laboratories, including ours, have previously shown that combining PI3K and MEK inhibitors may effectively promote cell death and tumor regression in KRAS- and epidermal growth factor receptor (EGFR)-addicted cancers (8, 10, 12, 13).

Fig. 1. A diagram depicting breast cancers classified according to their indicated genetic abnormalities. In each genetic type, the indicated subset will show sensitivity to single-agent PI3K inhibitors using in vitro IC50 assays. An even more refined subset will respond to single-agent PI3K inhibitors with actual tumor shrinkage in vivo and regressions in the clinic. Please note that, for simplicity, the figure does not depict cancers that simultaneously harbor multiple genetic abnormalities. “B” indicates basal subtype and “L” indicates luminal subtype.

The authors note that all of the PTEN null lines identified in their panel as resistant have a basal-like phenotype and, therefore, are likely to exhibit an activated RAS-like transcriptional program that would shift dependence from PI3K to MEK/ERK signaling (9). Indeed, it has been shown that RAS mutations predict for resistance to single-agent PI3K inhibitors (3, 12, 13). Cell lines with KRAS mutations or significant activation of MEK/ERK signaling via another oncogenic driver may be more likely to be insensitive to single-agent PI3K inhibitors regardless of HER2 amplification, PTEN deletion, or PIK3CA mutational status. This finding further highlights the potential of combination therapies and the need for additional biomarkers that predict responsiveness to combined PI3K and MEK inhibition.

The report by O’Brien and colleagues identifies other potential biomarkers, in addition to HER2 amplification and PIK3CA mutation, that correlate with sensitivity in vitro. It will be interesting to determine if PI3K inhibitors induce substantial apoptosis in vitro and tumor regressions in vivo in these cancer models (without HER2 amplification or PIK3CA mutation). Of course, it will be crucial to assess biomarkers identified in laboratory studies in clinical samples from patients who respond to PI3K inhibitors. Neo-adjuvant trials in breast cancer patients can be leveraged to address these translational goals, because they correlate clinical efficacy and pathologic signs of response (e.g., changes in Ki67 levels and induction of caspase cleavage) with the presence of potential biomarkers.
Biomarkers derived from laboratory models and clinical specimens should further define cancers most likely to respond to PI3K inhibitors. Indeed, the use of additional stringent parameters to define "sensitivity" in laboratory models may yield more accurate predictions in the clinic. Additionally, it will be useful to consider biomarkers in addition to HER2 amplification and PIK3CA mutations, and to remain cognizant of feedback compensations, as we continue to further define those patients who will benefit most from single-agent PI3K pathway inhibitors, and those who will require different therapeutics approaches.

Disclosure of Potential Conflicts of Interest
J. Engelman, research grant, Novartis; consultant, Novartis, Sanofi-Aventis. A. Turke disclosed no potential conflicts of interest.

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References
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