Serum Glutamate Levels Correlate with Gleason Score and Glutamate Blockade Decreases Proliferation, Migration, and Invasion and Induces Apoptosis in Prostate Cancer Cells

Shahriar Koochekpour1,2, Sunipa Majumdar1, Gissou Azabdaftari3, Kristopher Attwood2,4, Ray Scioneaux1, Dhatchayini Subramani1, Charles Manhardt1, Giovanni D. Lorusso5, Stacey S. Willard1, Hillary Thompson6, Mojgan Shourideh1, Katayoon Rezaei8, Oliver Sartor7, James L. Mohler2,10,11, and Robert L. Vessella9

Abstract

Purpose: During glutaminolysis, glutamine is catabolized to glutamate and incorporated into citric acid cycle and lipogenesis. Serum glutamate levels were measured in patients with primary prostate cancer or metastatic castrate-resistant prostate cancer (mCRPCa) to establish clinical relevance. The effect of glutamate deprivation or blockade by metabotropic glutamate receptor 1 (GRM1) antagonists was investigated on prostate cancer cells’ growth, migration, and invasion to establish biologic relevance.

Experimental Design: Serum glutamate levels were measured in normal men (n = 60) and patients with primary prostate cancer (n = 197) or mCRPCa (n = 109). GRM1 expression in prostatic tissues was examined using immunohistochemistry (IHC). Cell growth, migration, and invasion were determined using cell cytotoxicity and modified Boyden chamber assays, respectively. Apoptosis was detected using immunoblotting against cleaved caspases, PARP, and γ-H2AX.

Results: Univariate and multivariate analyses showed significantly higher serum glutamate levels in Gleason score ≥ 8 than in the Gleason score ≤ 7 and in African Americans than in the Caucasian Americans. African Americans with mCRPCa had significantly higher serum glutamate levels than those with primary prostate cancer or benign prostate. However, in Caucasian Americans, serum glutamate levels were similar in normal research subjects and patients with mCRPCa. IHC showed weak or no expression of GRM1 in luminal acinar epithelial cells of normal or hyperplastic glands but high expression in primary or metastatic prostate cancer tissues. Glutamate deprivation or blockade decreased prostate cancer cells’ proliferation, migration, and invasion and led to apoptotic cell death.

Conclusions: Glutamate expression is mechanistically associated with and may provide a biomarker of prostate cancer aggressiveness. Clin Cancer Res; 18(21): 1–14. ©2012 AACR.

Introduction

Prostate cancer is estimated to account for 29% of all new cancers and is the second leading cause of cancer-related death in men in the United States in 2012 (1). Age, African-American race, and family history are unequivocal risk factors for prostate cancer (2). Focusing on early detection of prostate cancer has the capacity to decrease prostate cancer mortality. Serum prostate-specific antigen (PSA) is used for prostate cancer early detection, but its use is controversial because of its sensitivity and specificity is limited and it does not provide reliable prognostic information. These limitations have led investigators to consider new approaches, using systems biology, to identify biomarkers of prostate cancer aggressiveness. This goal could be reached by defining important interacting cellular networks and/or metabolic pathways that reflect tissue- and disease-specific phenotypes.

Metabolomics has emerged recently as a promising method for prostate cancer detection (3), one that may complement, or even replace current PSA testing. Metabolomics profiling of prostate cancer offers the potential for early detection and discrimination of clinically aggressive tumors from indolent and nonaggressive diseases. Metabolic changes are affected by genetic and epigenetic changes and...
Translational Relevance

Aerobic glycolysis is a hallmark of proliferating normal and malignant cells. During glutaminolysis, glutamine is catabolized to glutamate and incorporated into the citric acid cycle and lipogenesis. Glutamate plays a substantial and overlapping role between metabolic and oncogenic signaling pathways. In this study, we found that serum glutamate levels were increased in patients with primary prostate cancer and directly correlated with Gleason score and prostate cancer aggressiveness. Compared with Caucasian Americans, serum glutamate levels were higher in African Americans with metastatic castrate-resistant prostate cancer (mCPRCa) than those with primary tumors. Immunohistochemical staining showed weak or no expression of metabotropic glutamate receptor 1 (GRM1) in normal prostate cells but overexpression in primary and metastatic prostate cancer. Glutamate deprivation or blockade with GRM1 antagonists reduced prostate cancer cells’ growth, migration, and invasion and proved apoptogenic. Glutamate may provide a metabolic biomarker of prostate cancer aggressiveness, and glutamate metabolism or signaling may provide a target for therapeutic intervention.

Glutamate is a nonessential amino acid and an excitatory neurotransmitter that is involved in neuroembryonic growth and development by regulating proliferation, survival, migration, and invasion of neuronal progenitors and immature neurons (5). A prominent consequence of signaling in rapidly proliferating cancer cells is increased nutrient uptake. Glucose and glutamine are the 2 most abundant nutrients in mammals. During glycolysis and glutaminolysis, glucose is converted to lactate and glutamine to glutamate, respectively (6). In addition to being a precursor of other amino acids and nucleotides, glutamate metabolism is closely linked to ureagenesis, glutathione synthesis, tricarboxylic acid cycle (TCA), amino acid transferase, γ-amino butyric acid signaling, lipogenesis, and ATP production (6). More than 80 years ago, Otto Warburg showed aerobic glycolysis in tumor cells by their high rate of wasteful glucose consumption, increased lactate production, and bioenergetics demand despite accessibility to oxygen (7). This shift from mitochondrial ATP production was later proved to be a hallmark of aggressive tumors and rapidly proliferating nontransformed cells, such as lymphocytes, thymocytes, and erythrocytes (8). In the PC-3 prostate cancer cell line, c-Amy oncogenic transcription increases mitochondrial glutaminase expression that leads to enhanced glutaminolytic activity, catabolic conversion of glutamine to glutamate, and glutamine addiction (9). Taylor and colleagues showed elevated levels of glutamate in 12 prostate cancer compared with 16 BPH tissues and increased levels of additional metabolites in the urea cycle using high throughput quantitative humoral response profiling (10). Glutamate levels were higher in the majority of patients with prostate cancer than in BPH tissues in a follow-up study by the same group (11).

Glutamate in secreted form is a phylogenetically conserved cell signaling molecule in addition to its intracellular activities in bioenergetics, biosynthetic pathways, maintaining amino acids and nucleotide pool, and metabolism (12). The glutamatergic system comprises the glutamate, glutamate receptors (Glur), and glutamate transporters. The GlurS are divided into 2 different categories, the ionotropic glutamate receptors (iGlur) and the metabotropic glutamate receptors (mGluR; ref. 13). The iGluRs are gated ion channels with excitatory action (13). The mGluRs promote cellular signaling pathways via 7 transmembrane domain G-protein–coupled receptors (GPCR) and are subdivided into 3 groups and 8 subtypes: group I (mGluR1 and mGluR5), II (mGluR2 and mGluR3), and III (mGluR4, mGluR6, mGluR7, and mGluR8) based on their pharmacology, sequence homology, response to agonists, and downstream signaling. mGluRs are expressed in a variety of nonneuronal cell types, such as hepatocytes, melanocytes, keratinocytes, myocardial cells, pancreatic cells, and embryonic stem cells (14, 15). Recently, several studies have indicated the involvement of mGluRs in tumorigenesis. mGluRs are highly overexpressed in the nervous system, so initial discoveries of mGluRs in human tumors were reported in neuro-glial–derived tumors, such as gliomas, neuroblastoma, and medulloblastoma (14, 15). Glioma cells secreting high amounts of glutamate have higher growth rates than their isogenic parental cells (16). Glutamate antagonists decreased proliferation of a variety of cancer cells, which include colon adenocarcinoma, melanoma, lung carcinoma, thyroid carcinoma, breast carcinoma, astrocytoma, neuroblastoma, and rhabdomyosarcoma (17). The first proof for the involvement of mGluRs in nonneuronal tumorigenesis was obtained by Chen and colleagues (18, 19). A transgenic mouse line overexpressing mGluR1 (also known as GRM1) in melanocytes was predisposed to spontaneous melanoma development with 100% penetrance, short latency, and high metastatic potential (18, 19). In prostate cancer, mGluR1–5 mRNA expression was reported in PC-3 and LNCaP cells and mGluR6 and 8 were expressed only in LNCaP cells. Dihydrotestosterone (DHT) induced mGluR7 expression and inhibited mGluR8 expression in LNCaP cells (20). The clinical significance or biologic relevance of glutamate in prostate cancer has not been investigated.

In this study, we examined the association between serum glutamate levels and prostate cancer aggressiveness to establish clinical relevance. To determine the biologic relevance, the effect of glutamate deprivation or blockade was
investigated on prostate cancer cells' growth, migration, and invasion.

Materials and Methods

Patients and samples
Primary prostate cancer cases investigated in this study refer to newly diagnosed, untreated, and clinically localized prostate cancer. Normal research subjects in this study are defined as men with no evidence of prostate cancer. Serum samples used to evaluate glutamate levels in normal individuals and men with primary tumor or metastatic castrate-resistant prostate cancer (mCRPCa), were obtained from the biospecimen core facilities at the Louisiana Cancer Research Consortium (LCRC) affiliated to Tulane Medical School and School of Medicine, Louisiana State University Health Sciences Center (LSUHSC, New Orleans, LA) and the tumor bank at the University of Washington Medical Center (UWMC, Washington) after informed consent and without any personal identifiers. Briefly, peripheral blood samples were collected by phlebotomy from consenting normal adult males or patients with primary or mCRPCa in the Urology Oncology clinics at the UWMC and LCRC-affiliated hospitals. All of the controls came from patients who presented at the University of Washington's annual free PSA screening week. All patients were more than 40 years of age, and all stated that they did not have a history of prostate cancer. PSA values were below 4.0 ng/mL. Blood samples from UWMC were processed by centrifugation, and serum samples were stored in aliquots at −80°C within ≤4 hours of draw. Overall, all normal serum samples, 39% of primary prostate cancer, and 69% of mCRPCa samples were obtained from the UWMC. The remainder of serum samples was processed similarly and obtained from the biospecimen core facilities at LCRC. Serum samples were stored until used in the research study; no freeze–thaw cycles were incurred. We did not acquire fasting or postmeal status on any of the research subjects. Prostate cancer aggressiveness was defined using Gleason score, clinical stage, and PSA at diagnosis as: (i) high aggressive (Gleason sum ≥ 8, or PSA > 20 ng/mL, or Gleason sum = 7, and stage cT3–cT4); (ii) low aggressive (Gleason sum < 7, stage cT1–cT2, and PSA <10 ng/mL); or (3) intermediate aggressive (all other cases; ref. 21). The prostate cancer tissue specimens used for immunohistochemistry (IHC) were obtained from Accu-max Array (Accurate Chemical & Scientific Corp.).

Ethical considerations
Ethical approval was obtained from the Institutional Review Boards at University of Washington Medical Center (Seattle, Washington), Tulane Cancer Center, Tulane University School of Medicine (New Orleans, LA), LSUHSC, School of Medicine (New Orleans, LA), and Roswell Park Cancer Institute (Buffalo, NY).

Determination of serum glutamate and creatinine levels
Serum glutamate levels were measured using BioVision’s glutamate assay kit (#K625-100) and the manufacturer's instructions. After plotting the independent glutamate and creatinine standard curves, glutamate and creatinine concentrations of the serum samples were calculated using the formula $C = S_a/S_v\ nmol/\mu L$ or mmol/L, in which $S_a$ is the sample amount of unknown (in nmol) from standard curve and $S_v$ is the sample volume (μL) added to each well. The minimum detectable amounts for serum glutamate or creatinine were 2 nmol/μL. The standard curve reproducibility was shown in 5 independent assays. The intra-assay variance was evaluated in 10 replicates for 3 serum samples of known concentrations on 1 plate. The inter assay precision was tested in 3 independent assays for 3 control samples in triplicates. Stability of serum glutamate was determined by incubating aliquots of serum samples of known glutamate concentrations at −20°C or −70°C for 3, 6, 12, 18, 24, and 36 months.

Immunohistochemical analysis
The ABC detection system (Vector Laboratories Inc.) was used for immunostaining as described previously (22). Affinity purified, polyclonal rabbit anti-human GRM1 antibody (at 1:250, Sigma)- was used as the primary antibody. The incubation time for primary antibody was overnight at 4°C. The slides were counterstained with hematoxylin and mounted for examination. The negative control slides were treated in an identical manner except that the primary antibodies were omitted. Descriptive examinations of cell type–specific anti-GRM1 immunoreactivity in various tissue constituents, normal, hyperplastic, and neoplastic glands in the sections were completed by the study pathologists.

Cell Culture, reagents, and Western blot analysis
Androgen-independent (PC-3, DU145, MDA-PCA2b, VCaP, and 22Rv1) and androgen-sensitive (LNCaP) prostate cancer cell lines were purchased from American Type Culture Collection and maintained in their individually specified medium (23). E006AA cell line was maintained in Dulbecco’s modified Eagle’s medium (DMEM) supplemented with 10% FBS (23). Noncompetitive GRM1 antagonists (riluzole and BAY36-7620) were purchased from Tocris (24). Customized glutamine- and glutamate-free RPMI-1640 or DMEM, dialyzed FBS, and GlutaMAX-I (a dipeptide, L-alanine-L-glutamine) were purchased from LifeTechnologies. GlutaMAX was used as a substitute for glutamine in cell growth, which cannot be degraded or converted into glutamate. Cells were cultured in complete media up to 75% confluency, washed with cold PBS, and whole-cell lysates were extracted as described previously (23). GRM1 was detected using a rabbit polyclonal antibody against human GRM1 (Cat # 19955-1-AP at 1:1,000; Proteintech
Prostate cancer cells’ growth was examined in the presence of GRM1 antagonists,riluzole, and BAY36-7620. Riluzole functions in part by blocking GRM1 signaling and preventing intracellular glutamate release. BAY 36-7620 is a specific noncompetitive antagonist of GRM1 that binds the transmembrane domain of the receptor and stabilizes its inactive transformation (24). Cells were seeded at 500 (PC-3, DU145, and LNCaP) per 200 μL/well and in 24 replicates in 96-well plates in complete medium. After 3 days, culture medium was refreshed and supplemented with DMSO, riluzole, or BAY36-7620 at 0, 1, 10, 25, or 50 μmol/L. Culture plates were incubated at 37°C for 2, 4, or 6 days and the media were refreshed every 48 hours. Cell proliferation was measured using The CellTiter 96 AQueous One Solution Cell Proliferation Assay (Promega).

Prostate cancer cell growth under glutamine- and glutamate-free condition was examined in an independent set of 96-well plates and at cell densities described earlier. Cells were incubated in customized glutamine- and glutamate-free culture media supplemented with 10% diazyed FBS and 2 mmol/L GlutaMAX for 3, 5, or 7 days, and the media were refreshed every 48 hours. After the indicated incubation times, cell proliferation was measured as described earlier and compared with their parallel isogenic cell lines.

Cell migration and invasion assays

Cell migration and invasion assays were conducted using 8-μm transwell filters (Costar) with the modifications described previously (25). For the invasion assay, the upper compartment was coated with 50 μg Matrigel (BD Biosciences) to form a matrix barrier. A suspension of cells (5 × 10^4 for PC-3 or 2 × 10^4 for DU145) in basal medium containing 0.1% bovine serum albumin (BSA) was added to the upper compartment. The lower compartment was filled with 400 μL basal medium containing 10% FBS as chemoattractant. Riluzole or BAY36-7620 was included at equimolar concentrations (0–50 μmol/L) to upper and lower compartments. After 48 hours for PC-3 or 24 hours for DU145, the nonmigratory cells on the upper surface were removed using a cotton swab, and the cells on the lower surface were fixed and stained with Diff-Quick solution (Dade Behring). Migrated or invaded cells in transwell filters were counted from 10 randomly selected fields in at least 4 independent wells. The experiment was repeated 3 times independently.

Statistical design and data analysis

All analyses were conducted using SAS 9.3 (SAS Institute) with a nominal significance level of 0.05. The serum samples were stratified by clinical status of the research subjects (normal, primary prostate cancer, or mCRPCa) with patient demographics (e.g., age, race, etc.) reported as mean and SD for continuous variables, and as frequencies and relative frequencies for categorical variable (Supplementary Tables S1 and S2). Patients with primary prostate cancer were divided into 3 subgroups of aggressiveness (low aggressiveness, intermediate aggressiveness, and high aggressiveness) using clinical criteria as described in “Materials and Methods.” The demographic variables were compared between normal research subjects and men with primary prostate cancer or mCRPCa using one-way ANOVA and an extension of Fisher exact test for continuous and categorical variables, respectively. Age, PSA, and Gleason scores were categorized as: 40–49, 50–59, 60–69, 70–79; ≤4, 4.1–10, ≥10.1; and ≤6, 7, ≥8, respectively.

Serum glutamate levels were compared for variables of interest and among the research subjects using one-way ANOVA, with Tukey-adjusted post hoc pairwise comparisons. All serum samples measurements were log-transformed before statistical analysis. Simple linear regression models were used to assess the association between research subject’s serum glutamate and clinical status (normal, primary prostate cancer with low-, intermediate-, or high-aggressiveness, and mCRPCa) while adjusting for demographic covariates. Tukey-adjusted pairwise comparisons were made between clinical status of research subjects and their demographic strata when appropriate. The covariate-adjusted models considered a single demographic covariate (with and without interactions) as well as multiple demographic covariates, as this information is not applicable or available for normal research subjects and patients with mCRPCa. Only research subjects with primary prostate cancer were considered when Gleason score and stage were included as covariates. All model assumptions were verified graphically using quantile–quantile (QQ) and residual plots.

Results

Serum glutamate levels in normal and prostate cancer research subjects

The research subjects’ race, Gleason scores, PSA values, age, and clinical aggressiveness were described in Supplementary Table S1. Serum creatinine values were within the...
expected range and did not differ significantly among research subject subgroups. Serum PSA levels were found to be significantly \((P < 0.001)\) different among normal individuals \((0.556 \pm 0.03)\), patients with primary prostate cancer \((10.38 \pm 2.19)\)), and patients with mCRPCa \((323.74 \pm 51.43)\). The average age was found to be significantly higher \((P < 0.001)\) in research subjects with mCRPCa \((70.2 \pm 1.0)\) than in those with primary prostate cancer \((62.0 \pm 0.6)\) or normal research subjects \((61.4 \pm 1.2)\). Serum glutamate levels were not significantly different among different age groups of normal research subjects (Supplementary Table S2, \(P = 0.1735)\).

The entire study cohort was analyzed regardless of age and race. When the normal research subjects \((n = 60)\) were used for comparison, serum glutamate levels significantly increased in men with primary prostate cancer \((n = 197; P = 0.003)\) but returned to normal levels in men with mCRPCa \((n = 109; P = 0.002)\) (Fig. 1A, left). When the patients with primary prostate cancer were divided into low, intermediate, and high aggressiveness, glutamate levels were significantly different as: (i) between normal research subjects and intermediate \((P < 0.001)\) or high aggressiveness \((P < 0.001)\); (ii) between low aggressiveness group and intermediate \((P < 0.002)\) or high aggressiveness \((P < 0.001)\) groups; (iii) between intermediate aggressiveness group and mCRPCa \((P < 0.001)\), and (iv) between high aggressiveness and mCRPCa \((P < 0.001)\) (Fig. 1A, middle). Pairwise comparisons indicated a significant association between glutamate levels and Gleason score \((P < 0.001)\). Glutamate levels differed significantly between Gleason \(\leq 6\) \((n = 81)\) and Gleason \(7\) \((n = 72; P < 0.001)\) or Gleason \(\geq 8\) \((n = 30; P < 0.001)\). Glutamate levels were higher in Gleason \(> 8\) than the Gleason 7 groups, but the difference did not reach statistical significance \((P < 0.006; P = 0.96, P = 0.002)\). Univariate analyses, after adjusting for PSA or stage, revealed no significant association between serum glutamate levels and any of the 3 aggressiveness categories in the pool of research subjects with primary prostate cancer (Table 1).

The association between prostate cancer aggressiveness and serum glutamate were explored among primary prostate cancer research subjects while adjusting for potential confounders. Age, PSA, and stage did not seem to be confounders in the single and 2 covariate (confounder) models; they were nonsignificant and did not change the direction or significance of the relationship between serum glutamate levels and prostate cancer aggressiveness. However, the inclusion of Gleason score seemed to overpower the relationship between serum glutamate levels and prostate cancer aggressiveness. The Gleason score seemed to drive the difference between serum levels within the primary prostate cancer research subjects (Tables 1 and 2).

**Serum glutamate levels in Caucasian Americans versus African Americans**

The adjusted analysis involving race indicated that patient clinical status (primary or mCRPCa; \(P < 0.001)\), race \((P = 0.029)\), and interaction \((P = 0.029)\) effects were significant (Table 1). The pairwise comparisons of race within each clinical subgroup of research subjects indicated that a significant difference exists in patients with mCRPCa \((P = 0.037)\). Supplementary Fig. S1 shows that this difference is the result of the significant interaction term, where serum glutamate decreases for Caucasians from the high aggressiveness to mCRPCa but increase for African Americans.

Among Caucasian Americans, pairwise comparisons indicated that significant differences in serum glutamate existed between research subjects with primary prostate cancer and mCRPCa \((P < 0.030; Fig. 1B, left)\), between normal research subjects and those with prostate cancer of high aggressiveness \((P < 0.004)\), between low and high aggressiveness subgroups \((P = 0.001)\), and between mCRPCa and high aggressiveness subgroups \((P < 0.001)\) (Fig. 1B, middle). Among Caucasian American research subjects with primary prostate cancer, a significant difference was found between research subjects with Gleason score \(\leq 6\) and Gleason score 7 \((P < 0.002)\) and between Gleason score \(\leq 6\) and Gleason score \(\geq 8\) \((P < 0.001; Fig. 1B, right)\).

Among African Americans, pairwise comparisons indicated that serum glutamate levels differed between normal research subjects and primary prostate cancer \((P < 0.026)\) and mCRPCa \((P < 0.016; Fig. 1C, left)\). A significant difference in serum glutamate was found in African Americans between the normal research subjects and intermediate aggressiveness subgroup \((P < 0.014)\) and between normal and both high aggressiveness subgroup \((P < 0.027)\) and patients with mCRPCa \((P < 0.038; Fig. 1C, middle)\). Among African-American research subjects with primary prostate cancer, significant differences in serum glutamate levels were found between research subjects with Gleason score \(\leq 6\) or Gleason score \(\geq 8\) \((P < 0.02; Fig. 1C, right)\). The serum glutamate levels differed significantly between the races only in the research subjects with mCRPCa \((P = 0.037; Supplementary Fig. S1)\).

**Immunohistochemical staining of metabotropic glutamate receptor 1 in benign and malignant prostate tissues**

Specificity of anti-GRM1 immunoreactivity was shown by deleting the primary antibody or replacing it with a non-immune serum (data not shown). Basal cells exhibited nuclear staining, whereas no staining was found in luminal acinar epithelial cells of BPH or normal prostate \((n = 10)\) (Fig. 2A). Endothelial cells, infiltrating macrophages, and stromal cells exhibited intense nuclear staining (Fig. 2A, mesenchymal cells). Intense cytoplasmic and nuclear staining was observed in proliferating epithelial cells of glands with basal cell hyperplasia (Supplementary Fig. S2). Moderate to intense cytoplasmic staining was noted in high-grade prostate intraepithelial neoplasia (HGPIN; Fig. 2A). To further determine the GRM1 expression during prostate cancer progression and metastasis, we carried out additional immunohistochemical staining in primary \((n = 15)\) and metastatic prostate cancer tissues \((n = 6)\). Moderate to intense cytoplasmic staining with perinuclear enhancement was noted in prostate cancer with Gleason scores 6 and 7.
Figure 1. Box and whiskers plot of serum glutamate levels in normal individuals and patients with primary or metastatic castrate-resistant prostate cancer (PCa) of Caucasian- or African-American origin. Serum glutamate levels were measured as described in "Materials and Methods." The study cohorts were analyzed according to their clinical status as normal research subjects, primary PCa, or metastatic castrate-resistant PCa (left). All patients with primary PCa were divided according to their aggressiveness score based on Gleason and PSA (middle) or according to Gleason score (right). A, the entire study cohorts. B, the entire study cohorts of Caucasian Americans. C, the entire study cohorts of African Americans. Actual P values are indicated on individual graphs. The distribution of log-transformed serum measurements was compared among groups using one-way ANOVA with Tukey pairwise comparisons. The box frame defines the 25 to 75 percentiles, the ends of error-bar, such as whiskers, depict the minimum and maximum values, and the line within the box marks the median value.
prostate cancer cells invading into extraprostatic adipose tissue of Gleason score 8 (4 + 4), 9, and 10 (Fig. 2A) tumors. Prostate cancer cells invading into extraprostatic adipose tissue exhibited intense cytoplasmic staining (Fig 2A). Intense nuclear staining was observed at tumor–inflammatory interfaces in inflammatory cells, endothelial cells, and isolated macrophages (Fig 2A). Intense cytoplasmic staining was found in multilayer prostate cancer cells infiltrating around nerves (Fig. 2A). Intense cytoplasmic staining with perinuclear enhancement was detected in prostate cancer cells metastatic to bone and the abdominal wall (Fig. 2A and Supplementary Fig. S3). GRM1 staining seemed to be distributed in both nuclear and cytoplasmic compartments. The nuclear staining of GRM1 was heterogeneous.

### Table 1. Single covariate adjusted analysis of serum glutamate levels in normal individuals, patients with primary or metastatic castrate-resistant prostate cancer

<table>
<thead>
<tr>
<th>Variable</th>
<th>Normal Glu (µmol/L ± SE)</th>
<th>Primary prostate cancer (Aggressiveness subgroup) Glu (µmol/L ± SE)</th>
<th>MCRPCa Glu (µmol/L ± SE)</th>
<th>P value&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 60)</td>
<td>Low (n = 80)</td>
<td>Intermediate (n = 68)</td>
<td>High (n = 49)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(n = 80)</th>
<th>(n = 13)</th>
<th>(n = 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(n = 55)</td>
<td>(n = 18)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(n = 30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gla&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PSA&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stage&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Race&lt;sup&gt;f&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PSA: 0.252</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stage: 0.179</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Int: 0.178</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Int: 0.591</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: Glu, glutamate; Int, interaction term; Med, medium; N/A, not available or not applicable.

<sup>a</sup>In each scenario a linear regression model was used to evaluate the association between patient clinical status and log-transformed serum glutamate while adjusting for different patient characteristics and their interaction. All model assumptions were checked graphically using quartile–quartile and residual-plots. Data are presented as mean ± SE.

<sup>b</sup>Only patients with primary prostate cancer were included in the analysis. PSA data was not available for all research subjects in the mCRPCa subgroup.

<sup>c</sup>Interaction term not considered given the frequency of sparse cell counts.

<sup>d</sup>Cannot compute the SE based on a single observation. PSA value for this research subject was 28.0 ng/mL.

<sup>e</sup>The variable of interest was not applicable or analyzed for the specified research subjects.

<sup>f</sup>No research subject was identified in the low-aggressiveness subgroup for the variable of interest.

<sup>g</sup>Comparison made among aggressiveness subgroups of patients with primary prostate cancer.

<sup>h</sup>Clincial status refers to comparison made among all normal research subjects, aggressiveness subgroups of patients with primary prostate cancer, and patients with mCRPCa.
Table 2. Multiple covariate adjusted analysis of serum glutamate levels in patients with primary and metastatic castrate-resistant prostate cancer

<table>
<thead>
<tr>
<th>Adjusted variable of interest</th>
<th>Primary prostate cancer (Aggressiveness Subtype) Glu (µmol/L ± SE)</th>
<th>MCRPCa Glu (µmol/L ± SE)</th>
<th>P values(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Intermediate</td>
<td>High</td>
</tr>
<tr>
<td>Race Race of primary prostate cancer</td>
<td>48.2 ± 2.4</td>
<td>47.9 ± 1.8</td>
<td>N/A</td>
</tr>
<tr>
<td>Whites ≤6</td>
<td>71.5 ± N/A(^b)</td>
<td>63.4 ± 3.7</td>
<td>56.2 ± 5.2</td>
</tr>
<tr>
<td>Whites =7</td>
<td>N/A</td>
<td>N/A</td>
<td>79.1 ± 9.1</td>
</tr>
<tr>
<td>Blacks &lt;4.0</td>
<td>54.4 ± 2.5</td>
<td>63.3 ± 7.2</td>
<td>86.0 ± N/A(^b)</td>
</tr>
<tr>
<td>Blacks 4.1–10</td>
<td>N/A</td>
<td>66.8 ± 3.7</td>
<td>55.7 ± 7.4</td>
</tr>
<tr>
<td>PSA (ng/mL) Race of metastatic prostate cancer</td>
<td>47.9 ± 2.4</td>
<td>60.6 ± 4.3</td>
<td>86.9 ± 12.8</td>
</tr>
<tr>
<td>Whites ≤4.0</td>
<td>55.4 ± 4.4</td>
<td>76.7 ± 12.5</td>
<td>82.8 ± 43.8</td>
</tr>
<tr>
<td>Blacks 4.1–10</td>
<td>54.4 ± 3.2</td>
<td>64.2 ± 4.6</td>
<td>58.5 ± 7.8</td>
</tr>
<tr>
<td>Age (y) Race of clinical status</td>
<td>58.3 ± 5.6</td>
<td>59.9 ± 0.8</td>
<td>N/A</td>
</tr>
<tr>
<td>40–49 ≤6</td>
<td>71.9 ± 15.4</td>
<td>48.1 ± 0.1</td>
<td>N/A</td>
</tr>
<tr>
<td>50–59 ≥7</td>
<td>N/A</td>
<td>N/A</td>
<td>59.3 ± N/A(^b)</td>
</tr>
<tr>
<td>60–69 ≤6</td>
<td>51.0 ± 3.0</td>
<td>46.7 ± 7.5</td>
<td>86.0 ± N/A(^b)</td>
</tr>
<tr>
<td>70+ ≥7</td>
<td>N/A</td>
<td>N/A</td>
<td>79.5 ± 10.5</td>
</tr>
<tr>
<td>PSA (ng/mL) Race of Gleason score</td>
<td>50.9 ± 2.8</td>
<td>49.9 ± 1.0</td>
<td>N/A</td>
</tr>
<tr>
<td>≤4.0 ≤6</td>
<td>N/A</td>
<td>N/A</td>
<td>52.6 ± 4.1</td>
</tr>
<tr>
<td>4.1–10 ≥7</td>
<td>71.5 ± N/A(^b)</td>
<td>61.1 ± 6.6</td>
<td>43.0 ± 1.9</td>
</tr>
<tr>
<td>Abbreviations: Glu, glutamate; Int, interaction term; Med, medium; N/A, not available or not applicable.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(^a)In each scenario a linear regression model was used to evaluate the association between aggressiveness subgroups of research subjects with primary prostate cancer or clinical status of the research subject and log serum glutamate while adjusting for different combinations of patient characteristics. All model assumptions were checked graphically using quartile–quartile and residual-plots.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(^b)Cannot compute the SE based on a single observation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(^c)Clinical status refers to comparison made among all normal research subjects, aggressiveness subgroups of patients with primary prostate cancer, and patients with mCRPCa.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(^d)Comparison made among aggressiveness subgroups of patients with primary prostate cancer.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GRM1 expression in prostate cancer cell lines**

An affinity purified anti-GRM1 antibody detected a strong band at approximately 85 kDa (Fig. 2B) and 3 other weakly expressing bands at approximately 40, 60, and 170 kDa, which were close to the predicted bands based on GRM1 molecular weight described by the manufacturer.
Parallel immunoblotting with anti-GRM1 antibody preabsorbed by its immunogenic peptide confirmed specificity (Fig. 2B).

GRM1 expression in androgen-sensitive LNCaP cells was less than androgen-independent PC-3, DU145 and androgen-independent, and bone metastatic prostate cancer cell lines (i.e., MDA-PCa 2b and VCaP). GRM1 expression in the E006AA cell line obtained from an organ-confined Gleason 6 score prostate cancer from an African American was less than bone-metastatic MDA-PCa2b cells (Fig. 2B). GRM1 expression in 22Rv1 cells was higher than LNCaP cells.

Figure 2. Expression pattern of metabotropic GRM1 in normal and malignant prostate cancer tissues and cells. A, representative IHC results; magnification, ×200. Benign prostate hyperplasia showing nuclear staining in basal cells and absence of staining in normal luminal acinar cells. Intense nuclear and cytoplasmic staining is noted in vascular endothelial cells (v), tissue-infiltrating macrophages (mp), and stromal cells (s). Intense cytoplasmic and nuclear staining is seen in an area of basal cell hyperplasia. Moderate to intense cytoplasmic staining is noted in a representative image of HGPIN, with relatively absence of staining in most nuclei. Moderate to intense cytoplasmic staining with perinuclear enhancement is noted in Gleason 6 (3−3) and Gleason 7 (3−4) tumor. Intense cytoplasmic staining with perinuclear enhancement was observed in malignant luminal acinar cells with Gleason 8 (4−3), Gleason 9 (5−4), and a Gleason 10 tumor. Moderate cytoplasmic staining in a Gleason 3 + 4 tumor with intense nuclear staining was observed in inflammatory (inf) and endothelial cells, and isolated macrophage. Intense cytoplasmic staining was observed in tumor cells invading into extraprostatic adipose (F) and muscle (M) tissues. Perineural invasion was noted by intense cytoplasmic staining of multilayer tumor cells circling around nerve cells (n). Neural structures are negative for staining and the background stroma shows moderate focal nuclear staining. Intense cytoplasmic staining with perinuclear enhancement is noted in scattered bone-metastatic prostate cancer cells. Bone tissue appears as fragmented pieces. Intense cytoplasmic staining was observed in malignant prostate cells metastasized into abdominal wall. B, GRM1 protein expression in prostate cancer cell lines. Western blot analysis was conducted on whole-cell lysates by SDS-PAGE in the presence of reducing agent (top). The anti-GRM1 specificity was examined by probing a duplicate membrane with primary antibody preincubated with 5 μg/mL blocking peptide for 2 hours (middle). Glyceraldehyde-3 phosphate dehydrogenase (GAPDH) detection was used for loading control. LNCaP = androgen-sensitive PCa cell line; PC-3, DU145, MDA-PCa2b, VCaP, and 22Rv1 androgen-independent PCa cell lines; E006AA = primary African American PCa cell line.
Prostate cancer cells growth in glutamate-free culture condition

Proliferation of PC-3, DU145, and LNCaP cells was decreased by 42%, 63%, and 68%, respectively, when cultured for 3, 5, or 7 days in customized glutamine- and glutamate-free culture media supplemented with 10% dialyzed FBS and 2 mmol/L GlutaMAX (Fig. 3A).

Inhibition of prostate cancer cell proliferation by GRM1 antagonists

To evaluate the potential of intracellular glutamate levels on prostate cancer cell growth, we used riluzole that functions in part as the glutamate release inhibitor (14, 15). Inhibition of glutamate release in a cell type-, dose-, and time-dependent manner decreased prostate cancer cell growth (Fig. 3B). LNCaP cells were the most sensitive among the prostate cancer cell lines investigated. LNCaP cells' growth was reduced by 54% (day 2) and by 85% (day 6) compared with their control cell type at the same incubation period (Fig. 3B, right). Among all prostate cancer cells, DU145 cells were least sensitive to riluzole (Fig. 3B, middle). Proliferation of DU145 cells was decreased by 14% (day 2) and by 18% (day 6). However, PC-3 growth was decreased by 10% (day 2) and by 40% on day 6 (Fig. 3B, left).

Figure 3. Inhibition of prostate cancer cell growth by glutamate deprivation or GRM1-antagonist. A, effect of glutamate deprivation on prostate cancer (PCa) cells proliferation. Cells were seeded at 500 (PC-3, DU145, and LNCaP) per 200 μL/well in 24 replicates in 96-well plates in their complete medium. After 3 days, cells were incubated in their maintenance medium or customized glutamine- and glutamate-free culture media supplemented with 10% dialyzed FBS and 2 mmol/L GlutaMAX for 3, 5, or 7 days. The media were refreshed every 48 hours. Cell proliferation was measured by adding 20 μL MTS solution per well for 1 hour and measuring the absorbance at 490/630 nm. Bars, mean ± SEM, *P < 0.001, Student t tests were used to compare cell growth between glutamate-free and complete medium at each day. One-way ANOVA test with Bonferroni corrections was used to compare values among different days for each cell line. B, effect of GRM1-antagonist on PCa cells growth. Cells were seeded as described earlier and were incubated in their complete medium in the presence or absence of riluzole at 10, 25, or 50 μmol/L for 2, 4, or 6 days with media refreshment every 48 hours, followed by cell proliferation assay as described earlier. Data represented the average of 3 independent experiments ± SEM. Statistical significance (P < 0.0001) between the control and treatment groups was evaluated by one-way ANOVA test with Bonferroni adjustment. C, induction of apoptosis by riluzole. Cells were cultured in their complete medium in the presence or absence of riluzole as described earlier. Whole-cell lysate were extracted and immunoblotting was conducted on 30 μg protein using antibodies against cleaved caspases-9, -7, and -3, PARP, and phosphoserine-139 H2AX. Anti-GAPDH antibody was used for control loading. Experiment was repeated twice independently.
To show GRM1 responsiveness as a functional glutamate receptor, independent studies were conducted using BAY36-7620 as a noncompetitive GRM1 antagonist at different concentrations and for a period of 2 to 6 days. As in the riluzole study, cells were maintained in their complete medium containing nondialyzed FBS and l-glutamine (2 mmol/L). BAY36-7620 showed similar growth inhibitory effect on the 3 prostate cancer cell lines and LNCaP cells were found to be the most sensitive cell line (Supplementary Fig. S4).

**Glutamate blockade induces apoptotic cell death**

The expression of cleaved (active) forms of the initiator caspase-9 and its active downstream effectors (caspases-7 and -3) were determined in the cells grown in the presence of riluzole for 4 or 6 days. The expression of cleaved caspase-9, -7, and -3 increased in a cell type–specific and dose-dependent manner in all cells investigated (Fig. 3C). In general, riluzole induced a cell type–specific increase in the expression level of initiator and effector caspases.

The intensity of cleaved PARP expression increased in a dose-dependent manner in all prostate cancer cell lines. H2AX, a member of H2A histone family is phosphorylated on serine residue 139 (known as γ-H2AX) after the activation of the caspase cascade and as a result of apoptotic DNA fragmentation (26). Cell lysates showed a dose-dependent increase in phospho-H2AXSer139 levels in LNCaP cells (Fig. 3C). An increase in γ-H2AX levels was also detected at 50 µmol/L riluzole in PC-3 and DU1145 cells. Accumulation of intracellular glutamate levels secondary to riluzole treatment seemed to be apoptogenic.

**Glutamate blockade decreases prostate cancer cells migration and invasion**

Addition of riluzole or BAY36-7620 to both upper and lower compartments of transwell filters decreased cell motility and invasion in a dose-dependent manner in PC-3 and DU1145 cells (Fig. 4A and B). Riluzole reduced migration of PC-3 cells by 53% and DU1145 cells by 76% and invasion of PC-3 by 65% and DU1145 by 82% (Fig. 4A and B). BAY36-7620 decreased migration of PC-3 cells by 67%, DU1145 cells by 88% and invasion of PC-3 by 83% and DU1145 by 96% (Fig. 4A). Similar data was obtained using a wound assay (Supplementary Fig. S5A–S5C).

**Discussion**

Serum glutamate levels positively correlated with Gleason score and prostate cancer aggressiveness. Immunohistochemical staining showed weak or no expression of GRM1 in luminal acinar cells of normal or benign glands but high expression levels in primary and metastatic prostate cancer tissues. Glutamate deprivation or blockade with GRM1 antagonists decreased prostate cancer cells growth, migration, and invasion and led to apoptotic cell death.

Glycolysis and glutaminolysis are major contributing metabolic pathways of tumorigenesis. Glutamine is the most abundant serum amino acid and a necessary metabolic precursor for other amino acids and nucleotides. Glutamine deprivation decreased cell proliferation, DNA synthesis, and protein synthesis rates in a cell type–dependent manner in hepato cellular carcinoma and several breast and colon adenocarcinoma cells (27). Similarly, the importance of glutamate signaling in cancer has been revealed by antiproliferative activity of glutamate antagonists in different types of human tumor cells, such as melanoma, colon adenocarcinoma, breast carcinoma, astrocytoma, and lung carcinoma (17).

Humoral response profiling of serum samples by Taylor and colleagues revealed elevated levels of nitrogen metabolism during prostate cancer progression (10). Concomitant validation of increased levels of the constituents of nitrogen metabolism pathway was determined further by using high-throughput quantitative profiling of relative levels of metabolites in BPH (n = 16) and organ-confined prostate cancer (n = 12) tissues. This study revealed significantly increased levels of glutamate in the prostate cancer tissues (P = 0.0003) compared with BPH. Further examination of metabolomic changes during prostate cancer progression by the same group verified elevated levels of glutamate in a majority of prostate cancer tissues as compared with benign glands (11).
The excess amount of glutamate in prostate cancer tissues and patients’ serum may be explained by: (i) increased rate of glutaminolysis or glutamine addiction in proliferating prostate cancer cells and (ii) carboxypeptidase function of prostate-specific membrane antigen (PSMA) overexpressed by prostate cancer cells. While “glutamine addiction” serves as a nonspecific metabolic hallmark of malignant and proliferating cells, it is likely that the known enzymatic activity of PSMA may have a key contributing role in glutamate production by prostate cancer cells. PSMA is a type II transmembrane glutamate carboxypeptidase, and glutamate is the major constant product of its enzymatic activity in prostate cancer cells (28, 29). PSMA is overexpressed in prostate cancer and high PSMA expression is associated with advanced tumor stage, poor prognosis, and high risk of biochemical recurrence (28, 30). PSMA-generated glutamate signaling may serve as a nonandrogenic regulator of prostate cancer growth (31). Therefore, PSMA may have critical functions in metabolomics profiling during prostate carcinogenesis and progression.

Analysis of the glutamate receptor, GRM1, in prostate cancer cell lines showed a cell type–dependent expression. GRM1 expression was higher in metastatic or androgen-independent prostate cancer cell lines (e.g., DU145, MDACa2b, VCaP, and 22Rv1) than in the primary (i.e., E006AA) or androgen-sensitive LNCaP cell lines. GRM1 overexpression might be an adaptive change hypersensitizing prostate cancer cells to extracellularly available glutamate or could confer oncogenic activity due to its postreceptor signaling activation. Averaging expression of GRM1 was found sufficient for oncogenic transformation of melanocytes in transgenic mice (18, 19). Overexpression of several members of mGluRs has been reported in other cancers (32–34). Activation of mGluR-triggered signaling pathways may occur in response to free circulating glutamate, glutamate released by tumor cells (autocrine loop), or stromal cells in the tumor microenvironment (paracrine loop). The data presented here also support an intracrine regulatory role for glutamate in prostate cancer cell growth, migration, and invasion.

Intense nuclear staining was detected in basal cells of normal glands and in endothelial cells, infiltrating macrophages, and stromal cells at the tumor–inflammatory interface or tumor microenvironment. Moderate to intense cytoplasmic staining was detected in HGPIN, which is considered to be a precursor lesion to prostate cancer. While “glutamine addiction” serves as a nonspecific metabolic hallmark of malignant and proliferating cells, it is likely that the known enzymatic activity of PSMA may have a key contributing role in glutamate production by prostate cancer cells. PSMA is a type II transmembrane glutamate carboxypeptidase, and glutamate is the major constant product of its enzymatic activity in prostate cancer cells (28, 29). PSMA is overexpressed in prostate cancer and high PSMA expression is associated with advanced tumor stage, poor prognosis, and high risk of biochemical recurrence (28, 30). PSMA-generated glutamate signaling may serve as a nonandrogenic regulator of prostate cancer growth (31). Therefore, PSMA may have critical functions in metabolomics profiling during prostate carcinogenesis and progression.

Prostate cancer cell proliferation was significantly reduced in a time-dependent manner in glutamate-depleted medium or in the presence of GRM1 antagonists (Fig. 3A and B and Supplementary Fig. S4). These data indicated that...
Trock BJ. Application of metabolomics to prostate cancer. Urol Oncol
Costello LC, Franklin RB. Concepts of citrate production and secretion
Komuro H, Rakic P. Modulation of neuronal migration by NMDA

www.aacrjournals.org Clin Cancer Res; 18(21) November 1, 2012
Platz EA, Rimm EB, Willett WC, Kantoff PW, Giovannucci E. Racial
Siegel R, Naishadham D, Jemal A. Cancer statistics, 2012. CA Cancer

multiple signaling pathways may play a major role in metabolic byproduct, or metabolic regulator of interactive apoptotic signaling pathway leading to prostate cancer cell-“glutamate toxicity” and activation of various interactive
However, more than this necessary amount may lead to a certain amount of glutamate is essential for prostate cancer cells growth that may signify “glutamine addiction.” A cell type-specific response to glutamate blockade suggests differential expression levels for GRM1 in different prostate cancer cells or their dependence on glutamate signaling. Excess intracellular glutamate and/or inhibition of GRM1 signaling by riluzole treatment may have deleterious effects on prostate cancer cells growth, migration, and invasion, which cannot be salvaged by an intact extracellularly activated GRM1 signaling. In addition, accessibility to a certain amount of glutamate is essential for prostate cancer cells growth that may signify “glutamine addiction.” However, more than this necessary amount may lead to “glutamate toxicity” and activation of various interactive apoptotic signaling pathway leading to prostate cancer cell-killling. Intracellular glutamate as a metabolic intermediate, metabolic byproduct, or metabolic regulator of interactive multiple signaling pathways may play a major role in malignancy. Glutamate via a combination of intracrine, autocrine, and paracrine pathways may contribute to prostate cancer growth and aggressiveness. Our data suggest that glutamate together with other predictive or prognostic factors may be a useful metabolic marker for early detection and clinical discrimination of aggressive tumors from non-aggressive tumors. Glutamate-initiated signaling pathways may provide novel therapeutic opportunities for prostate cancer. Additional work is needed to ascertain the clinical and therapeutic implications of glutamate dependence in prostate cancer.

Disclosure of Potential Conflict of Interest
The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health or National Cancer Institute. No potential conflicts of interest were disclosed.

Authors’ Contributions
Conception and design: S. Koochekpour, J.L. Mohler
Development of methodology: S. Koochekpour, H. Thompson
Acquisition of data (provided animals, acquired and managed patients, provided facilities, etc.): S. Koochekpour, S. Majumdar, G. Azabdaftari, R. Scioneaux, D. Subramani, K. Rezaei, O. Sartor, R.L. Vessella
Analysis and interpretation of data (e.g., statistical analysis, biostatistics, computational analysis): S. Koochekpour, G. Azabdaftari, K. Attwood, O. Sartor, J.L. Mohler
Writing, review, and/or revision of the manuscript: S. Koochekpour, G. Azabdaftari, O. Sartor, J.L. Mohler, R.L. Vessella
Administrative, technical, or material support (i.e., reporting or organizing data, constructing databases): S. Koochekpour, S. Majumdar, G. Azabdaftari, R. Scioneaux, D. Subramani, C. Manhardt, S.S. Willard, M. Shouirideh, K. Rezaei
Study supervision: S. Koochekpour
Preliminary evaluation of histology slides: G.D. Lorusso

Acknowledgments
The authors thank the patients and their families and physicians for contributing to the studies conducted in the authors’ laboratory. The authors also thank Ms. Rebecca Trautman for editorial assistance.

Grant Support
This work was supported by R01AD005824 (to S. Koochekpour) and by Roswell Park Cancer Institute and National Cancer Institute (NCI) grant #P30 CA016056. Additional support was provided by P01 CA85859 and the Northwest Prostate Cancer SPORE (to R.L. Vessella) and P01 CA77739 (to J.L. Mohler). The costs of publication of this article were defrayed in part by the payment of page charges. This article must therefore be hereby marked advertisement in accordance with 18 U.S.C. Section 1734 solely to indicate this fact.

Received April 28, 2012; revised July 26, 2012; accepted August 24, 2012; published OnlineFirst October 16, 2012.

References
Serum Glutamate Levels Correlate with Gleason Score and Glutamate Blockade Decreases Proliferation, Migration, and Invasion and Induces Apoptosis in Prostate Cancer Cells

Shahriar Koochekpour, Sunipa Majumdar, Gissou Azabdaftari, et al.

Clin Cancer Res Published OnlineFirst October 16, 2012.

Updated version Access the most recent version of this article at: doi:10.1158/1078-0432.CCR-12-1308

Supplementary Material Access the most recent supplemental material at: http://clincancerres.aacrjournals.org/content/suppl/2012/10/18/1078-0432.CCR-12-1308.DC1

E-mail alerts Sign up to receive free email-alerts related to this article or journal.

Reprints and Subscriptions To order reprints of this article or to subscribe to the journal, contact the AACR Publications Department at pubs@aacr.org.

Permissions To request permission to re-use all or part of this article, contact the AACR Publications Department at permissions@aacr.org.