Angiogenesis inhibition in high grade glioma

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Chapter 1.

General introduction
Perspectives on malignant glioma

Tumors in the human brain

In the western population brain tumors occur approximately in 70 per 100.000 persons each year (Oncoline, 2007). Ninety percent of these tumors are metastases of solid tumors elsewhere in the body, e.g. breast or lung (Oncoline, 2007). Beside these metastatic tumors, 10 percent arise from the brain tissue itself, the so-called primary brain tumors. Their incidence is 5-7 per 100.000 persons per year. For the Netherlands in 2006, 1006 new patients with primary brain tumors were registered (IKCnet, 2006).

Eighty percent of the primary brain tumors originate from the glial tissue component, e.g. astrocytes, oligodendrocytes, ependym, and plexus choroidae (Louis et al., 2007). Brain tumors are often initially diagnosed when patients present with neurological symptoms, headache, nausea, vomiting, papilledema, character changes and/or epilepsy, caused by tumor progression leading to increased intracranial pressure, and impression and damage of vital neurological structures (DeAngelis, 2001). However, ongoing improvement of imaging techniques leads to earlier recognition of brain tumors.

Human brain tumors from glial origin

Low grade gliomas, grade I and II, are well differentiated tumors characterized by a low growth rate and a relatively mild clinical behavior, whereas grade III and IV high grade gliomas (HGG) are poorly differentiated, aggressive tumors with a high growth rate and a tendency to invade the normal brain. Grade IV, or Glioblastoma Multiforme (GBM) is discriminated from grade III gliomas by abundant vascular proliferation. Dr. Hans-Joachim Scherer was the first neuropathologist to describe GBM in detail, during the period 1934 - 1941 (Peiffer and Kleihues, 1999). Both grade III and IV gliomas display a high degree of vascular permeability around a necrotizing tumor core displaying fields of pallisading necrosis and have the tendency to furtively invade normal brain tissue, although contrast-enhanced MRI suggests the presence of a discrete border to the lesion. Tumor cells typically extend microscopically several centimeters away from the visible contrast-enhanced area and, in some cases, can extend throughout the entire hemisphere or large portions of the brain— a condition known as gliomatosis cerebri (DeAngelis, 2001).

Grade III tumors, or anaplastic astrocytomas, show little histogenetic differentiation. Patients of less than 50 years of age have an estimated median Overall Survival (OS) of almost 5 years, while this is around 2 years in patients over age 50 (Curran, Jr. et al., 1993; Stupp et al., 2007). Grade IV tumors (malignant glioma, glioblastoma multiforme, GBM, i.e. more than one shape or appearance) are the most devastating malignant disease of the brain (Wen and Kesari, 2008). Since 2005 standard treatment, consisting of surgery, irradiation and chemotherapy, yields an OS of 14.6 months, even in selected patient populations (Stupp et al., 2005).

Grade IV tumors mostly present as de novo malignancies not preceded by an earlier stage of low grade lesions. Therefore these tumors are called primary GBM.
(Ohgaki and Kleihues, 2007). Patients are typically of middle to elder age with a short clinical history and rapid disease progression. The more rare secondary GBMs, roughly 5% of the cases, arise from low grade glial tumors (Ohgaki et al., 2004). These patients tend to be younger at presentation and show a higher overall survival.

A new paradigm for cancer
During the past century, the scientific approach to cancer was based on the paradigm that cancer cells within one tumor differ in morphology, marker expression, proliferation capacity and tumorigenicity based on the existence of genetically distinct clones (Nowell, 1976). Availability of new techniques such as immunofluorescent flow cytometry (FACS) shed new light on an alternative model, favoring a hierarchical organization within the tumor with a stem cell compartment, similar to normal organs (Clarke et al., 2006). While being highly fashionably in the beginning of the 21st century, this so-called Cancer Stem Cell (CSC) theory has already been suggested in 1867 by Julius Friedrich Cohnheim, in his work Über Entzündung und Eiterung (Cohnheim, 1867).

First serious attempts to gain insight into the nature of hierarchical tumor organization were made in the 1970’s (Hamburger and Salmon, 1977). With 21st century techniques available, evidence is compiling that cancer indeed does not consist of a homogenous cell population, but contains several cell compartments, including a small subpopulation of multi-potent CSCs. This relatively small subset of slowly cycling cells undergoes self renewal for an unlimited period of time and gives rise to a larger bulk population of cells that have committed to a particular fate and have finite division capacity (Reya et al., 2001). The gold standard for this so-called ‘stemness’ of CSCs is the ability to generate a phenocopy of the original malignancy in immunocompromised mice, that displays the variety of differentiated cells of the original tumor (Clarke et al., 2006). Furthermore, serial transplantation of this xenotransplanted tumor into new recipient mice confirms self-renewal potential of the CSC population.

Importantly, the CSC paradigm greatly influences the approach for development of new cancer treatments, because it predicts that only eradicating the CSC component will stop tumor growth and let the tumor regress (Figure 1). It also offers a comprehensible explanation why tumors recur under present anti-cancer treatment regiments. The present strategies are directed against the tumor bulk, and not to the CSC fraction that is much more resistant to irradiation and chemotherapy (Dean et al., 2005; Vermeulen et al., 2008). With this in mind it is even very well possible that experimental treatments were rejected in clinical trials because of irresponsible tumor bulk, while drug activity against the small CSC fraction was unnoticed (Huff et al., 2006).

As one of the first solid malignancies following shortly after the discovery of a CD44+/CD24- CSC population in breast cancer, GBM showed to contain a CSC fraction positive for marker CD133 (Singh et al., 2004; Al-Hajj et al., 2003). While non-CSC containing tumor lines do not re-grow tumors even with 100,000 cells injected, transplanting as little as 100 CD133+ cells into immune-deficient mice give rise to tumors that mirrored the original patients’ tumors (Singh et al., 2004). For research purposes, glioma CSCs can be expanded under specialized culture conditions, i.e. serum-free suspension culture with the addition of bFGF and EGF. Compared with classic serum-cultured cell lines, not only the gene expression pattern of serum-free cultures more closely mirrors the primary tumor, but also the xenotransplanted tumors are more similar to the original patient tumors in their in vivo biology (Lee et al., 2006).

Tumor environment
For tumor growth and support cancer cells rely on their environment, additionally this support from the microenvironment significantly influences resistance to treatment (Becher et al., 2008). Moreover, it is suggested that the microenvironment is a key component in the maintenance of CSCs (Gilbertson and Rich, 2007). For GBM it is proposed that endothelial cells shape a perivascular niche for the CSC fraction (Calabrese et al., 2007). Following, obstruction of communication between niche cells and CSCs can be an attractive treatment modality for GBM (Christensen et al., 2008; Hambardzumyan et al., 2008). To investigate this interaction, complex techniques are needed to model the vascular niche for CSCs in vitro and in vivo. First, the regularly cultured human endothelial cells derived from umbilical
veins (HUVECs) differ greatly in gene-expression patterns from the endothelial cells that are derived from human GBM (Charalambous et al., 2005). Second, the intimate relationship with the tumor cells is further expressed by the changes in phenotype of endothelial cells inside a tumor (Charalambous et al., 2006). Therefore, an improved in vitro system is welcome that enables co-culturing of both tumor-derived endothelial cells and CSCs (Chapter 2).

Treatment modalities for GBM

Surgery

In the Netherlands, in 1889 the first brain tumor was removed surgically by J.A. Guldenarm, guided by psychiatrist C. Winkler (Koekkoek and Pieters, 2008). During the first decades almost half of the procedures ended fatal for the patient. From 1910, arise of antisepsis and narcosis, new imaging techniques (e.g. plain X-ray of the skull and cerebral ventriculography) and knowledge about brain functioning and brain structure cleared the way for a more precise surgical treatment of brain tumors. With the introduction of carotid angiography in the 1950’s and Computed Tomography (CT) in 1973 more complex surgery was feasible. These radiologic improvements extended survival of GBM patients in the 1970’s to median 4 - 6 months (Walker et al., 1978; Walker et al., 1980). From then on, further improvement of techniques focused on imaging like MRI-guided neuro-navigation, intra-operative MRI, functional MRI and fluorescence-guided surgery (Stummer et al., 2006; Asthagiri et al., 2007).

Irradiation

Of all GBM treatments available up to today, the biggest survival increasing break-through came from application of ionizing radiation following surgery (Walker et al., 1980). Irradiation of brain tumors started in the 1920’s when 200KeV X-rays enabled treatment of tumors located up to a few cm under the skin. In 1935 first reports on irradiation of brain tumors were published. Since then, irradiation techniques and treatment planning were further optimized, and normal tissues were better spared (Leibel et al., 1975). In the 1980’s surgery followed by 30x 1.8 - 2Gy irradiation increased the median overall survival to 11 months (Walker et al., 1980). This became the standard irradiation schedule for GBM.

Strategies to further increase tumor dose are brachytherapy and stereotactic radiosurgery (Selker et al., 2002; Tsao et al., 2005). Recently, retrospective analysis revealed that when surgical resection is performed and less than 98% of the enhancing tumor is removed, the patient survival is not better than that of irradiation alone (Lacroix et al., 2001). The mean extent of tumor resection in all 416 patients was 89%. In 197 patients a resection of more than 98% of the tumor was achieved as shown by comparing tumor volumes between preoperative and postoperative MR images.

Chemotherapy

The last 4 decades, numerous chemotherapeutical agents have been tested in GBM, e.g. carmustine (BCNU), lomustine (CCNU), irinotecan (CPT-11) and carboplatin; all agents displayed disappointing activity in GBM, except for temozolomide (TMZ) (Nieder et al., 2006a; Wong et al., 1999). After demonstrating anti-cancer activity in relapsed gliomas, temozolomide was tested in the primary treatment of GBM as part of a combination schedule comprising surgery and radiotherapy. Added to irradiation, as radiosensitizer after surgery and as monotherapy during 6 months after chemoradiation, this schedule extended median overall survival in a selected patient population with approximately 3 more months to 14.6 months compared to surgery and radiotherapy alone (Figure 2). This schedule is therefore the current standard adjuvant therapy for primary GBM (Stupp et al., 2005; Stupp et al., 2009).

Failing primary treatment: recurrent GBM

Despite these developments in treatment strategies, GBM almost always recur. Recurrent GBM is genotypically almost identical to its preceding tumor (van Nijterik et al., 2006), although CSCs harvested from the recurred tumor are more aggressive then those cultured from the primary tumor of the same patient (Huang et al., 2008). Re-resection, systemic chemotherapy, and sometimes re-irradiation are used in second line (Nieder et al., 2006a). Despite second line treatment, the progression free survival after 6 months (PFS6) is approximately 20% for recurrent disease (Wong et al., 1999). Therefore no standardized treatment is established due to marginal results of these experimental treatments.

Experimental regimens for (recurrent) GBM

Best OS results for recurrent GBM are reached with TMZ. This treatment was demonstrated to increase survival as second-line therapy in TMZ naive patients when compared to historical controls (Wong et al., 1999). However, because most patients nowadays received TMZ as initial treatment, a rechallenge with TMZ at the same treatment schedule in second line is often not as effective as in naive patients, with a median OS ranging from 25 - 61 weeks in different studies (Wick et al., 2009).
To overcome resistance, alternative TMZ schedules (other than 150-200 mg/m2 on 5 days of each 28-day cycle) are deployed with continuous low dose administration (Chapter 7). Protracted TMZ regimens may deplete O6-methylguanine-methyltransferase (MGMT), a DNA repair protein that is an important factor in TMZ resistance (Tolcher et al., 2003), and offer a higher dose intensity per month of delivery. Several preclinical studies demonstrated that continuous daily administration of cytotoxic drugs at low dose have potential anti-angiogenic activity, even below the maximum tolerated dose (Browder et al., 2000; Bertolini et al., 2003; Kerbel and Kamen, 2004; Tu et al., 2005; Kim et al., 2006; Zhou et al., 2007). Although several responses have been reported in TMZ non-naive patients receiving second line regimens with daily low dose TMZ regimens, the duration is short and a survival advantage has never been demonstrated clearly (Kong et al., 2006; Perry et al., 2008a; Perry et al., 2008b; Jauch et al., 2008; Kesari et al., 2009; Wick et al., 2009). Better understanding of cancer biology due to fundamental research efforts has led to the exploration of target-directed cancer treatments. Last years numerous clinical trials have been performed, targeting specific aberrant functioning molecules in cancer cells and abnormal angiogenesis in the micro-environment (Wen and Kesari, 2008). According to several recently performed clinical studies, angiogenesis inhibition seems also to be an attractive approach in patients with recurrent GBM. The phenotypical features of GBM (high pro-angiogenic activity) cued researchers in the late 1990’s to experiments with anti-angiogenic treatment. This strategy proved to be successful in multiple in vivo model systems (Lund et al., 2000; Kozin et al., 2001; Hess et al., 2001; Winkler et al., 2004; Sarkaria et al., 2002; Tabatabai et al., 2007). These first results strongly stimulated the neuro-oncology community to thoroughly explore vascular endothelial growth factor (VEGF) inhibition in the clinical setting.

Drugs targeting angiogenesis

In angiogenesis, i.e. the formation and re-arrangement of blood vessels, numerous molecules are involved like VEGF, angiopoietin, neuropilins, integrins, PDGF and fibroblast growth factor (Norden et al., 2008). VEGF has been identified as key mediator of angiogenesis and is influencing cancer cell survival, local tumor growth and development of metastasis (Folkman, 1986). VEGF protects against apoptosis-inducing agents, stimulates proliferation and increases angiogenic potential (Gorski et al., 1999; Geng et al., 2001; Harney and Bouchier-Hayes, 2002; Gupta et al., 2002).

The VEGF pathway comprises of a family of ligands VEGF-a to VEGF-d and placental growth factor (PIGF) (Figure 3). VEGF is secreted by all human cells, but in larger amounts by tumor cells, and the signal is read out by VEGF-receptors, from which VEGFR-2 has a pivotal function. This receptor is predominantly present on endothelial cells and on circulating bone marrow-derived endothelial progenitor cells that contribute to newly formed vessels (Cross et al., 2003).

Significantly elevated levels of VEGF are found in the tissue and cyst fluid of GBM and VEGF concentrations clearly correlate with the vascularity of these tumors (Takano et al., 1996). Even in GBM tumor cells infiltrating the surrounding brain tissue, a high expression of VEGF is found (Johansson et al., 2002). VEGF plays an important role in aberrant tumor angiogenesis in GBM, characterized by structurally and functionally abnormal blood vessels leading to edema formation, high intra-tumoral interstitial pressure, tissue hypoxia and further stimulation of angiogenesis. Vasogenic brain edema and high interstitial pressure of the cerebrum contribute to hypoxia-induced tumor progression and resistance to both radiotherapy and chemotherapy (Jain et al., 2007). Anti-VEGF treatment results in a rapid “normalization” of the tumor vasculature by passively pruning the immature and leaky vessels and actively remodeling the remaining vasculature so that it more closely resembles the normal vasculature. A decrease of interstitial pressure in the tumor, and a depletion of tumor vessels have been reported after long-term anti-VEGF treatment (Batchelor et al., 2007).

Another feature of anti-angiogenesis treatment could be the interference with the communication of cancer stem cells (CSCs) and their presumed vascular niche (Calabrese et al., 2007). This feature further increases the

Angiogenesis inhibition and its potential in GBM

The binding of VEGF-A to VEGFR-2 leads to a cascade of different signaling pathways, resulting in the up-regulation of genes involved in mediating the proliferation and migration of endothelial cells and promoting their survival and vascular permeability. For example, it leads to intracellular activation of the MAPK pathway and subsequent initiation of DNA synthesis and cell growth, whereas activation of the PI3K–Akt pathway leads to increased endothelial-cell survival. Activation of src can lead to actin cytoskeleton changes and induction of cell migration. The role of VEGFR-1 in sprouting angiogenesis is much less clear. Binding of VEGF-C to VEGFR-3 mediates lymphangiogenesis. VEGF165 can bind to neuropilin (NRP) receptors, which can act as co-receptors with VEGFR-2 (horizontal arrow) to regulate angiogenesis. Adapted from Kerbel, 2008.
Irradiation is the pivotal treatment for GBM. Since angiogenesis inhibitors are thought to normalize tumor vessels resulting in improved blood flow and oxygenation (Jain, 2005), they might potentiate the cell kill and sensitize the effects of irradiation (Nieder et al., 2006b). In vivo modeling of combined irradiation and angiogenesis inhibition has its limitations. High-dose external beam irradiation of the mouse brain is restricted by acute irradiation toxicity to the esophagus and trachea, therefore single fraction or low-dose short-term irradiation is usually applied (Lund et al., 2000; Kozin et al., 2001; Hess et al., 2001; Winkler et al., 2004; Sarkaria et al., 2006; Tabataei et al., 2007). These pre-clinical GBM models predominantly show an additive effect of combined irradiation and angiogenesis. Rationale behind this effect is that radiation therapy not only inflicts damage to GBM cells, but more important also to the tumor micro-environment, e.g. endothelial cells (Fuchs and Kolesnick, 2005). In response to irradiation, endothelial cells and tumor cells start to produce VEGF which may induce apoptosis resistance in endothelial cells and decreased oxygenation of the tumor by promoting aberrant vessel formation, hyperpermeability, and increased interstitial pressure. This treatment-induced VEGF-production has also been described for temozolomide (Fischer et al., 2007).

Combined modalities, combined side effects?
Several clinical studies in colorectal, and head neck cancer have demonstrated that radiotherapy in combination with bevacizumab is a feasible and safe approach (Willett et al., 2005; Willett et al., 2009; Seiwert et al., 2008; Czito et al., 2007; Crane et al., 2006). Recently, results of combined bevacizumab, radiotherapy and chemotherapy (TMZ) have been presented of patients with GBM (Narayana et al., 2008; Lai et al., 2008). These phase II trials showed that the combined approach (radiotherapy in combination with bevacizumab) is feasible and relatively safe in patients with GBM, although toxicities (e.g. intratumoral hemorrhage, wound dehiscence, and bowel perforation) and patterns of relapse (e.g. satellite formation) need to be monitored closely (Lai et al., 2008; Narayana et al., 2009; Gutin et al., 2009).

Furthermore, the anti-edema effect of angiogenesis inhibition may improve neurological function and allow better clinical tolerance and efficacy of fractionated radiation, since well-known adverse effects of radiation are brain/tumor necrosis and exacerbation of vasogenic edema with increased interstitial pressure (Gonzalez et al., 2007).

Imaging modalities for GBM
MRI is the most important imaging modality for GBM. On T1-weighted sequences the enhancing tumor rim can be distinguished from the surrounding hypo-intense regions with vasogenic edema or microscopic tumor infiltration. Nowadays, new techniques like functional imaging, high-resolution spectroscopic imaging and diffusion techniques may contribute to pre-therapeutic grading and characterization of gliomas (Lemort et al., 2007). Diffusion techniques hold promise in predicting survival in malignant astrocytoma and could help to define areas for biopsy. Perfusion-weighted MRI techniques offer potential markers of tumor angiogenesis and capillary permeability, and correlate well with vascular endothelial growth factor expression in grade II and grade III tumors (Law et al., 2003). Recently, the value of Apparent Diffusion Coefficient (ADC) as predictor for progression free survival of recurrent glioma treated with angiogenesis inhibitors was shown (Pope et al., 2009). Techniques that quantify perfusion and permeability of tumors are regarded to give insight into anti-angiogenic treatment responses. Earlier it was shown that glioma capillary blood volumes assessed by DSC-MRI and vessel permeability assessed by DCE-MRI correlated with tumor grade (Law et al., 2004). Its value for evaluation of treatment responses is examined in chapter 7.
References


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