Radiosensitization of Primary Human Glioblastoma Stem-like Cells with Low-Dose AKT Inhibition

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Abstract

Glioblastoma (GBM) is the most frequent and lethal brain cancer. The lack of early detection methods, the presence of rapidly growing tumor cells, and the high levels of recurrence due to chemo- and radioresistance make this cancer an extremely difficult disease to treat. Emerging studies have focused on inhibiting AKT activation; here, we demonstrate that in primary GBM tumor samples, full-dose inhibition of AKT activity leads to differential responses among samples in the context of cell death and self-renewal, reinforcing the notion that GBM is a heterogeneous disease. In contrast, low-dose AKT inhibition when combined with fractionation of radiation doses leads to a significant apoptosis-mediated cell death of primary patient-derived GBM cells. Therefore, low-dose–targeted therapies might be better for radiosensitization of primary GBM cells and further allow for reducing the clinical toxicities often associated with targeting the AKT/PI3K/mTOR pathway. This work emphasizes the discrepancies between cell lines and primary tumors in drug testing, and indicates that there are salient differences between patients, highlighting the need for personalized medicine in treating high-grade glioma. Mol Cancer Ther; 14(5): 1171–80. ©2015 AACR.

Introduction

Glioblastoma (GBM) is the most frequent and lethal brain cancer. About 22,000 Americans are diagnosed with GBM annually (1). Lack of early-detection methods and rapid growth kinetics, with most patients dying within 2 years, make this cancer especially deadly (2). Currently, the standard of care is safe maximal surgical resection followed by radiotherapy and concurrent and postconcurrent chemotherapy with the oral alkylating agent, temozolomide. However, recurrence is virtually universal and represents a serious impediment to patient survival. Even with the postoperative combination regimen, median survival is generally only extended by a few months. In the past 25 years, this cancer has seen only modest improvements in patient survival.

Although the concept of cancer stem–like cells (CSC) exists in leukemias, the evidence for the same phenomenon in solid tumors and especially in GBM has only been recently solidified with a lineage tracing study (3). CSCs recapitulate the properties of normal component lineages and are characterized by three defining hallmarks: self-renewal, ability to differentiate into multiple lineages, and maintenance of multipotency. GBM contains cellular niches with phenotypic properties supporting self-renewal and multiple factors within the GBM tumor, but several studies suggested that subpopulations of cancer cells in GBM (i.e., brain cancer stem–like cells or BCSCs) are highly resistant to radiotherapy and chemotherapies (2, 10).

Because GBMs are generally poorly differentiated and contain morphologically distinct cells, it appears to fit with the model of BCSCs (3, 11, 12). Furthermore, a classification scheme established by The Cancer Genome Atlas (TCGA) demonstrated that GBMs can be transcriptionally clustered into one of 4 subtypes: proneural, neural, classical, and mesenchymal subtypes. Therefore suggesting that malignant lineages can potentially be derived from both phenotypically diverse tumor-initiating cells (13), including adult neural stem cells (NSC; ref. 14), progenitor cells (15), or even dedifferentiated neurons (16), and distinct signaling axes with core defects primarily in tyrosine kinase receptor, apoptotic, and cell cycle regulatory pathways (17). Most recently, single-cell RNA sequencing of a number of GBM tumors demonstrated the presence of multiple subtypes of single tumor cells within each tumor suggesting that although population studies detect dominant transcriptional programs in GBM, diverse intratumor subtype heterogeneity may be a key biologic feature of GBM (18).
The study of BCSCs is of high clinical importance due to their roles in radio- and chemoresistance. It was suggested that the subfraction of CD133+ putative BCSCs survives radiation treatment better than their CD133− counterpart mostly due to enhanced DNA repair capabilities (7). The ability of CSCs to self-protect from radiation-induced cell death has been further attributed to upregulation of genes that scavenge free radicals and reduce the levels of oxidative stress–induced damage, a common consequence of radiation (19, 20). As radiotherapy remains the primary postoperative therapy for GBM patients, it is important that we focus on potentially resistant BCSCs to reduce posttherapy recurrence, despite BCSCs being phenotypically and molecularly a moving target.

The AKT serine/threonine kinase family, consisting of AKT-1, AKT-2, and AKT-3, is an integral part of the PI3K growth and apoptosis pathway. Aberrant AKT activation and signaling are common in GBM (21) and were linked to GBM progression as demonstrated by conversion of grade III anaplastic astrocytoma to grade IV GBM in an in vitro model (22). Similarly, hyperactivation of AKT signaling was associated with worse progression-free and overall survival in GBM patients (23, 24). It is therefore critical to evaluate AKT inhibitors in the context of BCSCs in GBM. Indeed, several reports have demonstrated that inhibition of AKT is an effective radiosensitizing mechanism (25, 26) that also reduces the CSC population in the nonheterogeneous GBM cell lines by increasing their rates of apoptosis and reducing sphere formation (27, 28).

In the present study, we examined the effects of a pharmacologic AKT inhibitor in combination with radiation on primary GBM samples grown under serum-free conditions that promote BCSC sphere phenotype (4, 9, 18), or expanded in primary human tumor samples were obtained

Materials and Methods

Culture of human GBM cells

Deidentified primary human tumor samples were obtained from GBM patients undergoing craniotomy resection at Robert Wood Johnson University Hospital under an Institutional Review Board–approved protocol. Cells were obtained through mechanical dissociation of the tumor tissue using a blade and plated in DMEM/F12 medium in the presence of B-27 supplement, 20 ng/mL of both human recombinant EGF and human recombinant FGF. The following day, the culture was collected, incubated at 37°C for 1 hour later at 3 Gy in a Gamma-cell 40 Exactor (MDS Nordion), or received the combination of AKT-i and radiation. Treatment was repeated for 5 consecutive days; fresh drug was added to new medium each day.

Clonogenic survival assay

Cells were seeded at various dilutions into 10 cm² tissue culture dishes and allowed to attach overnight. AKT-i (1 μmol/L) was added 1 hour before irradiation (IR) at various doses. Colonies were allowed to grow for 14 days before staining with Methylene Blue and were then counted. Colonies were defined as clusters of greater than 50 cells. Survival fraction is defined as the total number of clones in irradiated cells divided by the total number of clones in identical, nonirradiated cells and reported in log scale.

Soft agar colony formation assays

Cells at a density of 1.5 × 10⁴ growing as a monolayer were seeded in a 0.35% soft agar layer plated on top of a 0.75% hard agar base. The following day, cells were subjected to the 5-day treatment scheme, after which, cells were washed and fresh, plain media were added every other day for 10 days before the cells were imaged.

Immunofluorescence

Chamber slides were coated with poly-ornithine for 1 hour at 37°C and subsequently coated with laminin for 1 hour at 37°C. Cells growing in neurospheres media were plated and allowed to attach overnight before starting a 5-day treatment scheme. At the specified time point, immunofluorescence staining was performed; briefly, cells were fixed in Formaldehyde—Fresh (Fischer Scientific), washed, and permeabilized in a Triton-X-100 PBS solution followed by an hour blocking period in a PBS solution containing 4% BSA and 1% PBS. Primary antibodies were incubated overnight at 4°C in blocking solution followed by incubation with secondary antibodies for 1 hour at room temperature. Slides were mounted with hard set mounting media with DAPI.
(Vector Shield) before imaging with a fluorescent microscope (Zeiss AxioObserver).

Secondary neurosphere formation assay

Cells from primary tumors maintained as neurospheres were grown in 6-well plates and treated for 5 days. After 48 hours, spheres were dissected into a single-cell suspension using Accutase (Gibco) and a syringe needle. Cells were seeded at a clonogenic density (ref. 30; 20 cells per well) into a 96-well plate, and number of secondary spheres formed per well was counted after 14 days.

Western blot

Cells or primary tumor tissues were suspended in cell lyses buffer (Cell Signaling) supplemented with protease inhibitor cocktail (Sigma) followed by a brief sonication. Western blotting was performed according to the manufacturer's protocol (NuPAGE system; Invitrogen) using 25 μg of protein on 4% to 12% Bis-Tris gradient gels. Primary antibodies were incubated overnight at 4°C. Membranes were incubated with secondary antibody for 1 hour at room temperature, and all washes were performed in the SNAP i.d. system. Protein signals were detected using Pierce chemiluminescence method. Antibodies and dilutions used for Western blotting are provided in Supplementary Table S1.

Statistical analysis

All statistical analyses were performed using GraphPad Prism 6 (GraphPad Software Inc.; www.graphpad.com). Data are presented as mean ± SD. Statistical significance was determined by the Student t test or ANOVA (one-way or two-way) with the Bonferroni post-hoc test, unless otherwise indicated. A P value of <0.05 is considered statistically significant and represented by a single asterisk.

Results

Fresh primary samples were received from patients undergoing surgical resection of WHO grade IV gliomas (GBM) at Robert Wood Johnson University Hospital. Cells were maintained under serum-free conditions that promote BCSC sphere phenotype (4, 9, 18), or in adherent monolayers in differentiation conditions (refs. 30; Fig. 1A). Primary cells maintained in adherent monolayers in the presence of serum were positive for glial fibrillary acidic protein (GFAP), the proliferation marker Ki67, the presence of the staining of NESTIN, p-BMI-1, and p-AKT by immunohistochemistry (IHC; Fig. 1D). The number of positive cells as well as the intensity of the staining of NESTIN, p-BMI-1, and p-AKT was scored (Table 1 and Fig. 1E). From IHC analysis, 10 of 12 GBM tumors collected expressed p-AKT with varying degrees of intensity (amount of protein present). BMI-1 expression was associated with GBM stem-like cell self-renewal (34, 35), radiation resistance (36), and apoptotic resistance (37), and elevated BMI-1 expression has previously been shown to correlate with higher grade GBM and worse prognosis (38). Constitutively active and phosphorylated AKT in GBM cells (21). Therefore, inhibition of AKT-i would be essential to eradicate GBM cells. To develop a combination therapy strategy taking advantage of the findings that AKT may be playing a role in cyto-protection and DNA damage repair (41), thus conferring a survival advantage, we utilized a clinically relevant strategy (Fig. 2A) by treating either established GBM cell lines or patient-derived primary GBM cells with 3 Gy of radiation at 1 hour after AKT-i treatment when lower levels of p-AKT would render cells more vulnerable to DNA damage and double-strand breaks.

Secondary neurosphere formation assay

To assess the effects of the AKT inhibitor on patient-derived primary GBM cells, we performed MTT assays to measure cell survival. The IC50 after 24-hour of treatment with the AKT inhibitor was 5 μmol/L, and a time course analysis with protein lysates revealed that p-AKT was most inhibited 1 hour after treatment (data not shown). The current standard of care for newly diagnosed GBM is surgical resection followed by radiotherapy plus Temozolomide (40); however, resistance to therapy and recurrence is virtually universal. Given the high interpatient, inter treatments would be essential to eradicate GBM cells. To develop a combination therapy strategy taking advantage of the findings that AKT may be playing a role in cyto-protection and DNA damage repair (41), thus conferring a survival advantage, we utilized a clinically relevant strategy (Fig. 2A) by treating either established GBM cell lines or patient-derived primary GBM cells with 3 Gy of radiation at 1 hour after AKT-i treatment when lower levels of p-AKT would render cells more vulnerable to DNA damage and double-strand breaks. Cell survival was measured by MTT assays at 24 hours after radiation treatment. Interestingly, with a single dose, the combination treatment was not more effective than treating the cells with AKT-i alone (Fig. 2B), but resulted in greater number of apoptotic cells (Fig. 2C), suggesting that AKT-i might render the radiosensitive GBM cells more apoptotic. Furthermore, to assess the effects of AKT-i on the ability of cells from GBM cell lines in the presence of radiation, a clonogenic survival assay was performed with and without the inhibitor in combination with increasing single fractions of radiation (Fig. 2D). In this clonogenic survival assay, long-term survival of cells from GBM cell lines was significantly impaired in the combination treatment when compared with radiation alone (Supplementary Table S2), but treatment effects were not different between U373 and U87 cells (P = 0.17). To examine the effects of this therapeutic strategy in primary GBM cells, primary tumor cells were subjected to the same treatment parameters as cell lines and evaluated for cell survival (Fig. 2E). In contrast with the effects of AKT-i on the homogeneous cells from GBM cell lines, overall analyses for difference in treatment effects among primary GBM
cells were highly significant ($P = 0.0008$; Supplementary Tables S3 and S4). Although radiation alone failed, the combination of the AKT-i and radiation significantly enhanced killing of primary patient–derived cells from GBM tumors 23950, 26370, 26646, and 26776 (Fig. 2E). Furthermore, clonogenic survival assays of cells from two of these tumors that formed colonies were then used to perform clonogenic assay. Notably, sensitivity to radiation when the AKT-i was used was seen in long-term survival assays only when the AKT-i was combined with higher radiation doses at 6 Gy, and significantly enhanced killing of primary patient–derived cells from GBM tumor 26646. In contrast, the combination of AKT-i and lower radiation doses (e.g., 2 Gy) was significantly radioprotective of primary patient–derived cells from GBM tumors 23950 and 26646 (Fig. 2F and G). Moreover, the combination of AKT-i and radiation significantly reduced the number of neurospheres derived from primary patient–derived GBM cells, an effect that might be attributed to IR, when compared with untreated or AKT-i treatment only (Fig. 2H). These findings reveal inherited radiosensitivity features in GBM cells that may explain treatment failures among primary GBM cells, but not

Figure 1.
Characterization of primary GBM samples. A, model for examining treatment responses among patient-derived GBM cells cultured either in neurosphere or monolayer conditions and treated with AKT-i and/or IR. TRT, treatment. B, GFAP expression (green) in cells cultured from primary tumors (marker of GBM) grown in serum and differentiated; cells were counterstained with DAPI. C, protein lysates derived from primary GBM were probed for phosphorylated AKT and total AKT by Western blotting. D, tumors were fixed, sectioned, and stained for NESTIN, phospho-BMI-1 (p-BMI-1), and phospho-AKT (p-AKT). Images were quantified for amount of positive staining, as well as for intensity of staining. Representative positive and negative cases are shown. E, for quantitative analyses of IHC, H score is calculated as (% at 0) + (% at 1+) + (% at 2+) + (% at 3+) × 3 = range 0–300 based on analyses of at least 10 fields per slide averaged by two qualified examiners.
when treatment effects among established cell lines are considered, highlighting the biologic differences between cell lines and primary GBM tumors that underscore the need for better in vitro drug discovery models.

Because most GBM patients receive a regimen involving multiple doses of chemotherapy and radiotherapy fractionation, we attempted to simulate the clinical settings by modulating the doses and frequency of AKT-i use. Given the shallow dose–response curves of drugs targeting the AKT/PI3K/mTOR pathway that have recently been revealed (42), and that single-cell analyses correlated these responses with significant and heritable cell-to-cell variability (42) and subtype heterogeneity (18), we revisited a clinically feasible regimen where cells derived from primary GBM cultures were treated with a minimal 1 μmol/L of AKT-i followed by 3 Gy IR 1 hour later, every day for 5 days (Fig. 3A). At 48 hours after this 5-day treatment regimen, relative cell survival was determined using an MTT assay (Fig. 3B). In cells derived from established cell lines and primary patient GBM samples, treatment with this low-dose AKT-i by itself did not cause appreciable amounts of cell death compared with the untreated control (Fig. 3B). In the cells treated with 3 Gy IR only for all 5 days, most cells derived from primary patient GBM samples, but not those from established cell lines, showed a moderate amount of cell death (Fig. 3B). However, the combination IR and AKT-i resulted in a more significant decrease in cellular viability compared with the untreated control (Fig. 3B). In the cells treated with 3 Gy IR only for all 5 days, most of cells derived from primary patient GBM samples, but not those from established cell lines, showed a moderate amount of cell death. In contrast, combination treatment was effective in reducing the number of cells capable of initiating colonies from soft agar (P < 0.0001; Fig. 3E), at levels more significant than the colony size reduction achieved with IR only (Supplementary Table S6). These data suggest that a repeated low-dose AKT-i may be more effective in inducing death of cancer cells when combined with IR, but importantly this regimen might reduce the toxicity often associated with chemotherapy and targeting the AKT/PI3K/mTOR pathway. In addition, it appears that the combination therapy is effective in reducing the number of cells capable of initiating colonies in soft agar tumorigenicity assay, whereas IR by itself is effective in decreasing the bulk (size) of colonies formed by GBM cells.

Because AKT is involved in the maintenance of a dedifferentiated "stem-like" state (44), cells derived from primary patient GBM samples were plated onto chamber slides and subjected to the 5-day treatment regimen. At 48 hours after the last "dose," cells were fixed, stained, and analyzed for NESTIN and p-AKT expressions (Fig. 4A–C). IR alone did not affect the levels of NESTIN. In contrast, combination treatment was effective in reducing the levels of NESTIN in all three primary patient GBM samples examined when compared with untreated cells (P < 0.041; Supplementary Table S7). Moreover, combination treatment was significantly more effective than AKT-i alone for GBM tumor 26370 (Fig. 4C). These treatment effects were associated with apoptotic changes, an effect that might be attributed to IR, as demonstrated by increased cleaved PARP and cleaved caspase-3 in lysates from treated cells (Fig. 4D). To assess the stem cell–like potential of treated versus untreated cells, we utilized the secondary repopulation assay as a functional assay rather than selecting for phenotypic BCSC surface markers that are dependent on their niche and culture conditions. Tumor cells were again treated for 5 days and were then replated in fresh media at clonogenic

### Table 1. Primary GBM patient characteristics

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<th>Patient code</th>
<th>Age</th>
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<th>GFAP +/ve</th>
<th>KI67%</th>
<th>IDH1 +/ve</th>
<th>EGFR amp.</th>
<th>PTEN loss</th>
<th>p-AKT score</th>
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**NOTE:** Patient ID codes are indicated in the left column. Analyses for IDH1-positive GBM cells, EGFR amplification (amp.), and PTEN loss were performed based on routine clinical diagnostic tests on samples from GBM biopsies including FISH analyses when possible based on the amount of tissues available. The expressions of BMI-1, NESTIN, and p-AKT were evaluated by IHC analyses.

**Abbreviation:** ND, not done.
Discussion

Our study highlights some of the myriad biologic differences between cell lines and primary tumor specimens as well as the genetic differences between tumors from different patients. A study utilizing data from TCGA categorized GBM tumors into four main subtypes based on molecular profiling (13); however, other studies asserted that there could be distinct variability within a single tumor and even the presence of multiple subtypes of single GBM tumor cells (18, 45, 46). Intratumor heterogeneity may arise from the divergent phenotypic and genetic profiles of BCSCs (3, 11, 47, 48); furthermore, multiple stem cell clones can maintain distinct populations within the same tumor (intratumor heterogeneity; ref. 49) that interact with each other, providing support and complex signaling (46). These nuances make an already challenging cancer to manage even more of a complex signaling maze to target. Therefore, the predicted heterogeneity of chemoresistance requires better in vitro models before investing in more time- and resource-consuming drug screening assays and mouse models, but it is further clear that the distinctions between

concentration of 20 cells per well in 96-well plates (Fig. 4E). Interestingly, cells which had initially only been treated with IR or combination therapy lost their ability to form secondary spheres (Fig. 4E). These studies reveal that combining AKT inhibition with IR effectively decreases the stemness of BCSCs as suggested by reducing NESTIN expression and secondary neurosphere formation. Collectively, our data suggest that lower doses of certain targeted therapies such as AKT-i might be better for radiosensitization of primary GBM cells and afford the opportunity to reduce the toxicities often associated with chemotherapy and targeting the AKT/PI3K/mTOR pathway.
established cell lines and cells isolated from primary tumor samples can be profound (50). Molecular and/or pharmacologic studies done in cell lines could potentially lead to increased failures in the clinic and time lost in finding effective therapeutic strategies. Here, we were able to establish several primary tumors as cells in culture and were able to characterize them for key traits of GBM; they all expressed GFAP, a classic marker of GBM, albeit at different levels. Cells derived from primary GBM tumors predominantly expressed high levels of NESTIN (10/12), reiterating the highly undifferentiated nature of grade IV glioma and corroborating other reports of increased NESTIN expression in higher tumor grades (39, 51). The same was true for the expression of BMI-1, a critical BCSC self-renewal regulator; all of our samples highly expressed BMI-1 (12/12), corroborating data correlating increasing BMI-1 levels with higher tumor grades (37). We also found that levels of phosphorylated/active AKT vary between GBM tumors. Differing expressions of p-AKT have been reported, with 50% of tumors expressed this activated form (52). Yet another group reported dissimilar levels within a single tumor (21). Fifty percent of our samples displayed at least some p-AKT (6/12), validating that p-AKT is indeed an important target in GBM. AKT is associated with oncogenic activities in many cancer types including GBM (27, 53–56). It has been a therapeutic target with attempts to utilize AKT inhibitors in clinical trials (57). Yet another reason to block AKT in GBM is related to its role in DNA damage repair (41, 58), making it a rational target for combination with radiotherapy.

Noting that radiation is the main treatment modality for GBM, we investigated the effects of combining a pan inhibitor of AKT with radiotherapy. Similar to other reports (25–28), we were able to show that GBM cell lines, U373 and U87, were sensitive to a single treatment of 5 μmol/L of a commercially available AKT
inhibitor. Moreover, they were not affected by a single fraction of 3 Gy of radiation or radiosensitized with the AKT inhibitor. However, in long-term clonogenic survival assays, there was a modest but significant decrease in survival in cells treated with the combination. When examining the more clinically relevant primary GBM samples, only 1 of 4 of GBM tumors had 50% cell death with the same concentration of 5 μmol/L of the inhibitor, but all had modest decrease in survival when treated with the combination compared with the untreated. Interestingly, long-term clonogenic survival showed no difference between 2 different tumors treated with the inhibitor and radiation compared with just increasing fractions of radiation, and there was no difference in secondary neurosphere formation in any of tumors when AKT was inhibited. In fact, two of the tumor cells had, on average, double the number of spheres. Radiation treatment was more effective in reducing the self-renewal potential compared with the untreated control. This hints that the levels of activated AKT might be higher in tumors than in cell lines and also that there are probably more complex signaling pathways and feedback loops in GBM tumors than cell lines. These data are in contrast with some of the work demonstrating the utility of inhibiting AKT in combination with radiation (25, 41, 59). However, all of these studies have used monolayer culture–maintained cell lines that are not as accurate of a representation of patient tumors. Another caveat that might explain the difference is the fact that established cell lines are grown in media with serum, whereas our GBM tumor cells were grown in serum-free media. It is plausible that cells growing in serum, which are necessarily more differentiated, are susceptible to ionizing radiation that targets rapidly diving cells. Indeed, a key study supports these findings by demonstrating dynamic parameters related to AKT inhibitor response and variability between individual cells (42).

Figure 4. Expression markers and neurosphere responses of minimal-dose AKT-i in primary GBM cells. A, representative images of cells plated on chamber slides were treated every day for 5 days with AKT-i and radiation; 48 hours later, cells were fixed and stained for NESTIN, p-AKT, and DAPI for nuclear staining. B, quantitation of p-AKT expression per 100 cells per treatment from experiments that were repeated thrice. C, quantitation of NESTIN expression per 100 cells per treatment from experiments that were repeated thrice. D, protein lysates derived from untreated and treated primary GBM cells were probed for p-AKT, total AKT, cleaved PARP, and cleaved caspase 3 against GAPDH as a control by Western blotting. E, self-renewal of GBMs as represented by number of secondary neurosphere formation from cells treated for 5 days. *; P < 0.05.
concentration, we found a radiosensitization effect in all 4
tumors, and decreases in both number and size of colonies
with combination treatment. It was interesting to us that while
the levels of p-AKT were indeed diminished in those treated
every day for 5 days with the inhibitor as expected, total AKT
decreased as well. Speculatively, it is possible that inhibiting
activated AKT feeds back as a negative regulator of the total
levels of protein as well, either directly or through interacting
proteins such as BMI-1.

We have chosen to investigate two “stemness” parameters,
NESTIN expression and secondary neurosphere formation,
rather than using any specific cell surface marker for BCSCs.
In 3 of the 4 tumors tested, the AKT inhibitor significantly
decreased the number of cells expressing NESTIN; however,
a synergistic effect with radiation was only present in one tumor,
26370. To assess the effects of this treatment on BCSCs, we
employed 2 different measures of “stemness” that are not
specific to any single marker; however, although both 23950
and 26370 had a significant decrease in NESTIN expression,
there was no effect on their ability to form secondary neuro-
spheres. Although aggregates were removed and cells were
replated for growth as secondary spheres at a clonal density,
other factors such as the ability to detect quiescent stem cells
might limit the interpretation of this assay (61). In addition,
there is a possibility that culture conditions might modulate the
proportion of stem-like cells and may not be an accurate
reflection of BCSCs in vivo (61). These data are leading us to
believe that a more stringent and consistent functional param-
eters of stem-cell properties need to be developed.

For better management of GBM, it is critical to examine
additional combination therapeutic strategies based on differ-
cences in survival pathways. Given that GBM is a heterogeneous
disease (13), it is plausible to classify GBM tumors into sub-
types based on their corresponding in vitro chemos- and radio-
sensitivity profiles to develop tailored mono-therapy and com-
bination targeted therapy using precision cancer medicine
approaches (49). The establishment of multiple primary GBM
patient-derived cells here brings us closer toward achieving the

References
cells derived from glioblastomas cultured in bFGF and EGF more closely
mirror the phenotype and genotype of primary tumors than do serum-
cultured cell lines. Cancer Cell 2006;9:391–403.
13. Verhaak RG, Hoadley KA, Purdom E, Wang V, Qi Y, Wilkerson MD, et al. Integrated genomic analysis identifies clinically relevant subtypes of gli-
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1180  Mol Cancer Ther; 14(5) May 2015  Molecular Cancer Therapeutics


Molecular Cancer Therapeutics

Radiosensitization of Primary Human Glioblastoma Stem-like Cells with Low-Dose AKT Inhibition

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