Activation of EGFR Bypass Signaling by TGFα Overexpression Induces Acquired Resistance to Alectinib in ALK-Translocated Lung Cancer Cells

Tetsuo Tani, Hiroyuki Yasuda, Junko Hamamoto, Aoi Kuroda, Daisuke Arai, Kota Ishioka, Keiko Ohgino, Masayoshi Miyawaki, Ichiro Kawada, Katsuhiko Naoki, Yuichiro Hayashi, Tomoko Betsuyaku, and Kenzo Soejima

Abstract

Alectinib is a highly selective ALK inhibitor and shows promising efficacy in non–small cell lung cancers (NSCLCs) harboring the EML4-ALK gene rearrangement. The precise mechanism of acquired resistance to alectinib is not well defined. The purpose of this study was to clarify the mechanism of acquired resistance to alectinib in ALK-translocated lung cancer cells. We established alectinib-resistant cells (H3122-AR) from the H3122 NSCLC cell line, harboring the EML4-ALK gene rearrangement, by long-term exposure to alectinib. The mechanism of acquired resistance to alectinib in H3122-AR cells was evaluated by phospho-receptor tyrosine kinase (phospho-RTK) array screening and Western blotting. No mutation of the ALK-TK domain was found. Phospho-RTK array analysis revealed that the phosphorylation level of EGFR was increased in H3122-AR cells compared with H3122. Expression of TGFα, one of the EGFR ligands, was significantly increased and knockdown of TGFα restored the sensitivity to alectinib in H3122-AR cells. We found combination therapy targeting ALK and EGFR with alectinib and afatinib showed efficacy both in vitro and in a mouse xenograft model. We propose a preclinical rationale to use the combination therapy with alectinib and afatinib in NSCLC that acquired resistance to alectinib by the activation of EGFR bypass signaling. Mol Cancer Ther; 15(1); 162–71. ©2015 AACR.

Introduction

Lung cancer is the leading cause of cancer-related mortality worldwide (1). Recent molecular characterization of lung cancer enabled us to identify driver oncogenes, such as EGFR, KRAS, and the EML4-ALK fusion oncogene in non–small cell lung cancer (NSCLC; refs. 2–6). The EML4-ALK gene rearrangement was first identified in 2007 in 6.7% of NSCLCs (6). In addition to EML4, several other ALK fusion partners, such as KIF5B, TFG, and KLCI were identified (7–9). Fusions with the products of these partners induce oligomerization of the ALK, anaplastic lymphoma receptor tyrosine kinase, which leads to its constitutive activation (10). The activation of ALK subsequently induces the activation of downstream pathways, including the PI3K/protein kinase B (PI3K/AKT) and the extracellular signal-regulated kinase (ERK)/MAPK pathways. After the 2007 study, ALK tyrosine kinase was regarded as an effective target in a subgroup of patients with NSCLC that harbor the EML4-ALK gene rearrangement. Crizotinib, the first generation ALK tyrosine kinase inhibitor (ALK-TKI) that targets ALK, MET, and ROS1 (11–14), showed great efficacy in EML4-ALK NSCLC (15); the response rate of patients was 57%. However, almost all NSCLCs that harbored the EML4-ALK gene rearrangement acquired resistance to crizotinib within 1 to 2 years, similar to NSCLCs that harbor EGFR mutations, which acquired resistance to the EGFR-TKIs gefitinib and erlotinib (16, 17). The mechanisms of acquired resistance to EGFR-TKIs have been studied extensively. In general, they can be clearly divided into two types, one alteration of the EGFR gene itself, the EGFR T790M mutation (16, 17), and the other activation of a bypass signaling pathway, such as via MET, AXL, or FGFR1 (18–20). Similar mechanisms of acquired resistance were identified for crizotinib in several studies. These include secondary mutations of the ALK gene itself (such as L1196M, F1174L, C1156Y, G1202R, S1206Y, and G1269A), gene amplification, or activation of a bypass signal pathway, such as via Kit or EGFR (21–25). The EML4-ALK L1196M and EGFR T790M mutations are called “gatekeeper” mutations, because of the key location of the encoded amino acid substitutions at the entrance to a hydrophobic pocket at the back of the ATP binding cleft (26). These gatekeeper mutations induce a conformational change of the ATP binding pocket of ALK or EGFR, which induces steric hindrance of TKIs (refs. 21, 26).

To overcome acquired resistance to crizotinib, several second-generation ALK-TKIs have been developed (27–29). Of these, alectinib is a highly selective ALK inhibitor and has high activity against NSCLC with the EML4-ALK rearrangement. Alectinib also
has activity against the product of the *EML4-ALK* L1196M gate-keeper-mutant gene (30). In a recent report, alectinib showed promising efficacy in crizotinib-untreated and -treated patients with NSCLC (31, 32). The response rate was 94% in crizotinib-naive patients. Strikingly, alectinib was also effective in crizotinib-treated patients, in whom the response rate was 55%.

Until now, the mechanism of acquired resistance to alectinib has not been well defined. In a recent report, two novel *ALK* mutations were identified, Y1180L and I1171T, which conferred alectinib resistance (33). However, other mechanisms of acquired resistance to alectinib have not been clarified. In this study, we found that the activation of a TGFβ–EGFR signaling pathway contributes to acquired resistance to alectinib. We propose the possibility that treatment that concomitantly targets the ALK and EGFR pathways may overcome resistance to alectinib in the subgroup of NSCLCs that harbor *ALK* translocations.

**Materials and Methods**

**Cell line**

The NCI-H3122 cell line, which harbors the *EML4-ALK* E13; A20 fusion, was a gift from S. Kobayashi (Beth Israel Deaconess Medical Center, Boston, MA). No authentication was done by the authors. Cells were cultured in RPMI1640 growth medium, supplemented with 10% FBS at 37°C in a humidified 5% CO₂ incubator.

**Reagents**

Alectinib was a gift from Chugai Pharmaceutical Co. Ltd (Japan). Afatinib and erlotinib were purchased from LC Laboratories. Cetuximab was purchased from Keio University Pharmaceutical Co., Ltd (Japan). Actin antibody was purchased from Sigma-Aldrich. Phospho-EGFR (Y1068) antibody (#9101S) were purchased from Cell Signaling Technology. Phospho-p44/42 MAPK (T202/204) antibody (#9102S) and phospho-p44/42 MAPK (T202/204) antibody (#9101S) were purchased from Cell Signaling Technology. Phospho-EGFR (Y1068) antibody (44788G) was purchased from Invitrogen/Life Technologies. The NCI-H3122 cell line, which harbors the *EML4-ALK* E13; A20 fusion, was a gift from S. Kobayashi (Beth Israel Deaconess Medical Center, Boston, MA). No authentication was done by the authors. Cells were cultured in RPMI1640 growth medium, supplemented with 10% FBS at 37°C in a humidified 5% CO₂ incubator.

**Cell proliferation assay**

The MTS cell proliferation assay was performed as previously described (34). Briefly, 3 × 10⁵ cells/well were seeded in 96-well plates. Twenty-four hours after seeding the cells, various concentrations of alectinib or afatinib were added to each well. Control cells were treated with the same concentration of the vehicle, dimethyl sulfoxide (DMSO). Seventy-two hours after treatment, absorbance was measured. All experiments were carried out at least three times.

**Western blotting analysis**

Cells were treated with alectinib or afatinib at various concentrations. Alectinib was used at concentrations of 0.1 to 1 μmol/L, and afatinib was used at a concentration of 1 μmol/L. Cells were lysed in Cell Lysis Buffer (Cell Signaling Technology). Equal amounts of protein per lane were loaded on SDS-polyacrylamide gels. Separated proteins were transferred to polyvinylidene fluoride membranes. The membranes were incubated overnight with primary antibodies at 4°C and then incubated with secondary antibodies for 1 hour. For the detection of proteins, the membranes were incubated with agitation in LumiGLO reagent and peroxide (Cell Signaling Technology), and then exposed to X-ray film.

**Phospho-receptor tyrosine kinase array**

The human phospho-receptor tyrosine kinase (phospho-RTK) array kit was purchased from R&D Systems and screened according to the manufacturer’s protocol, with 150 μg of protein being used for each experiment. Signal intensity was calculated using the LumisVision Analyzer software (Aisin Seiki, Japan).

**Apoptosis assay**

Cells (30,000/well) were seeded in 6-well plates. The cells were treated with alectinib and afatinib, as single agents or in combination. Cells were treated with alectinib and afatinib at 1 μmol/L for 72 hours. Control cells were treated with the same concentration of the vehicle, DMSO. We analyzed the apoptotic status of cells using the TACS Annexin V-FITC Apoptosis Detection Kit (R&D Systems), according to the manufacturer’s protocol. The proportion of apoptotic cells was evaluated by flow cytometric analysis, using the BD FACSCalibur system (Becton Dickinson).

**Quantitative RT-PCR**

Total RNA was isolated from cells using an RNeasy Mini Kit (Qiagen). The RNA was subjected to reverse transcription using the High-Capacity RNA-to-cDNA Kit (Life Technologies), according to the manufacturer’s protocol. Quantitative RT-PCR (qRT-PCR) was performed using the fluorescent SYBR Green dye methodology and an ABI Prism 7000 Sequence Detection System (Life Technologies). Human GAPDH was used for normalization of input cDNA. The sequences of primers used in this study are summarized in Supplementary Table S1.

**siRNAs targeting *EGF*, TGFα, and EGFR**

Cells were transfected with siRNAs that were specific for *EGF* (#s501229 and #s4519; Life Technologies), TGFα (#s14051 and #s14052; Life Technologies), or EGR (#s563 and #s564; Life Technologies), or with negative control siRNA. The Ambion Silencer Select Negative Control mix (Life Technologies) was used according to the manufacturer’s protocol. The siSilencer transfection reagent (Bio-Rad) was used according to the manufacturer’s protocol. We confirmed knockdown of *EGF*, TGFα, and EGR by qRT-PCR.

**FISH**

FISH analysis of the *EML4-ALK* gene rearrangement was performed by SRL.

**Mouse xenograft model**

All animal experiments were approved by the Laboratory Animal Center, Keio University School of Medicine. Female BALB/c-nu mice were purchased from Charles River. Mice were anesthetized with ketamine. H3122-AR cells were suspended in Matrigel and injected subcutaneously. Tumor volume was monitored using a caliper. Once average tumor volume reached 200 mm³, mice were randomized, and received vehicle, alectinib (6 mg/kg) alone, afatinib (20 mg/kg) alone, or alectinib and afatinib in combination; mice were treated once a day by intragastric administration. Animals were humanely sacrificed and tumor tissues were harvested. For Western blotting, proteins were extracted from representative tumor tissues using Cell Lysis Buffer.
Establishment of alectinib-resistant H3122 cells

H3122 cells, which harbor the EML4-ALK gene rearrangement, were cultured with alectinib to establish alectinib-resistant H3122 (H3122-AR) cells. The initial alectinib concentration was 0.01 μmol/L, and this was incrementally increased to 1 μmol/L. After 6 months of exposure to the drug, the H3122-AR cells were established. Their resistance to alectinib was confirmed by the MTS cell proliferation assay (Fig. 1A). The calculated IC50 values for alectinib-naïve H3122 parental cells and >3 μmol/L for H3122-AR cells. To evaluate the reversibility of the resistance in H3122-AR cells, we removed alectinib for two weeks and performed MTS cell proliferation assay after the 2 weeks. We found that resistance was retained after removing alectinib (Supplementary Fig. S1). To confirm that H3122 cells and H3122-AR cells retained the EML4-ALK gene rearrangement, we performed FISH analysis, because loss of the EML4-ALK gene rearrangement was previously reported in crizotinib-resistant tumors (23). We found that both H3122 and H3122-AR cells retained the EML4-ALK gene rearrangement (Fig. 1B). Next, we performed Western blotting for H3122 and H3122-AR cells to examine the effect of alectinib on downstream pathways, including the PI3K/AKT pathway and the MAPK pathway (Fig. 1C). The phosphorylation of ALK, AKT, and ERK1/2 was efficiently inhibited by alectinib in H3122 cells. The phosphorylation of ALK was also efficiently inhibited by alectinib; however, the phosphorylation of AKT and ERK1/2 was less efficiently inhibited by alectinib in H3122-AR cells compared with H3122 cells. To examine whether H3122-AR cells were resistant to apoptosis induced by alectinib, the level of apoptotic cells in H3122 and H3122-AR cultures following alectinib treatment was evaluated by flow cytometry; the proportion of propidium iodide–positive and annexin V–positive cells was evaluated (Fig. 1D). Alectinib efficiently induced apoptosis in H3122 cells. However, alectinib induced apoptosis less efficiently in H3122-AR cells. These results indicate that H3122-AR cells have acquired resistance to alectinib.

Increased phosphorylation of EGFR in H3122-AR cells

Until now, the mechanisms of acquired resistance to ALK-TKIs (crizotinib or TAE684) were reported to be alteration of the ALK gene itself or activation of bypass signaling (21, 24, 35). To clarify the mechanism of acquired resistance to alectinib in H3122-AR cells, we first performed DNA sequencing of a cDNA representing the ALK tyrosine kinase domain. We did not find any novel mutations affecting the ALK tyrosine kinase domain, spanning exons 21–28. Next, to evaluate the activation of bypass pathways,
we examined the phosphorylation level of other receptor tyrosine kinases, using a human phospho-RTK array kit, in both H3122 and H3122-AR cells. Phospho-RTK array experiments revealed that the phosphorylation level of EGFR in H3122-AR cells was increased compared with H3122 cells, and the phosphorylation level of ALK in H3122-AR cells was reduced compared with H3122 cells (Fig. 2A and B). Furthermore, we found a slight increase in the phosphorylation of HER2. To confirm the increased phosphorylation of EGFR, we performed Western blotting of cells that had been treated with or without alectinib (Fig. 2C). As expected, the phosphorylation level of EGFR (Y1068) was increased in H3122-AR cells compared with H3122 parental cells, even though the expression level of total EGFR was not increased. We found that the phosphorylation level of EGFR in H3122-AR cells was not affected by alectinib treatment. These results indicate that the EGFR pathway is activated in H3122-AR cells.

**EGFR pathway activation contributes to acquired resistance to alectinib in H3122-AR cells**

To investigate whether EGFR pathway activation has a functional role in the acquired resistance to alectinib in H3122-AR cells, we performed the MTS cell proliferation assay with alectinib, a second-generation EGFR-TKI (36), alone or alectinib and afatinib in combination for H3122-AR cells. Alectinib as a single agent could not inhibit the proliferation of H3122-AR cells (Supplementary Fig. S2A). Next, we used the MTS assay to examine whether combined treatment with alectinib and afatinib, could inhibit the proliferation of H3122-AR cells. We found that addition of afatinib partially restored the sensitivity of H3122-AR cells to alectinib (Fig. 3A). In addition, we performed similar MTS assay with alectinib and erlotinib, another EGFR-TKIs. Again, we found that addition of erlotinib partially restored the sensitivity of H3122-AR cells to alectinib, although the effect was less significant when compared with afatinib (Supplementary Fig. S2B). Because afatinib is a panhuman epidermal growth factor receptor family inhibitor and TKIs induce non-specific, off-target effects, especially at high concentrations, we performed EGFR gene-specific knockdown by siRNA in H3122-AR cells (Fig. 3B). The knockdown of **EGFR** gene expression was confirmed by qRT-PCR. We found that **EGFR** gene knockdown restored the sensitivity of H3122-AR cells to alectinib. These data indicate that EGFR contributes to the acquired resistance to alectinib in H3122-AR cells. To examine whether EGFR pathway inhibition induces additional sensitivity to alectinib in H3122 parental cells, we performed MTS cell proliferation assay with afatinib or EGFR siRNA (Supplementary Fig. S3). We found no additional effect of afatinib or EGFR siRNA. These data indicate that EGFR pathway activation contributes to acquired resistance to alectinib in H3122-AR cells but not in H3122 parental cells.

To investigate whether alectinib/afatinib combination treatment effectively inhibited the activation of pathways downstream of ALK and EGFR, including the PI3K/AKT pathway, and MAPK pathway, in H3122-AR cells, we performed Western blotting for both H3122 and H3122-AR cells (Fig. 3C). We found that alectinib efficiently inhibited the phosphorylation of ALK, AKT, and ERK1/2 in H3122 parental cells; in contrast, afatinib did not alter the phosphorylation level of ALK, AKT, or ERK1/2 in these cells. In H3122-AR cells, the phosphorylation level of ALK was
decreased compared with H3122 parental cells. We found that alectinib/afatinib combination treatment efficiently inhibited the phosphorylation of AKT and ERK1/2. Interestingly, the phosphorylation of AKT and ERK1/2 in H3122-AR cells was partially inhibited by afatinib alone. Although there are some discrepancies, between the aforementioned MTS assay data and Western blotting data for the analysis of proteins downstream of ALK and EGFR, the Western blotting data indicate that signals are mainly transduced to downstream signaling proteins through EGFR rather than ALK in H3122-AR cells.

To investigate whether alectinib/afatinib combination treatment effectively induced apoptosis in H3122-AR cells, we performed flow cytometry. Compared with alectinib alone, alectinib/afatinib combination treatment increased the proportion of apoptotic cells from 10.54% to 24.33% (P < 0.05; Fig. 3D). Again, we noticed some discrepancies between the results of the Western blotting (Fig. 3C) and the apoptosis assay (Fig. 3D). None of the signal pathways measured were inhibited more by the combination treatment relative to any single agent after 2 hours of treatment. We expected that the duration of the treatment could partially explain the discrepancy. We performed Western blotting at longer treatment duration, because the data of the MTS assay or the apoptosis assay was obtained after 72 hours of treatment. As expected, the inhibition of downstream pathway was more efficient in combination treatment compared to alectinib or afatinib alone at 24 hours (Supplementary Fig. S4). These data indicate that the combination treatment induce more sustained inhibition of downstream pathways compared with alectinib or afatinib alone.

In summary, these data indicate that activation of the EGFR signaling pathway contributes to an acquired resistance to alectinib in H3122-AR cells, and that treatment with alectinib/afatinib in combination effectively eliminates H3122-AR cells in vitro.

**Contribution of TGFβ to the acquired resistance to alectinib in H3122-AR cells**

Activation of EGFR occurs through ligand stimulation or mutation of EGFR affecting the tyrosine kinase domain (37, 38). To clarify the mechanism of EGFR pathway activation in H3122-AR cells, we performed DNA sequencing of a cDNA representing the EGFR gene in H3122-AR cells, we performed DNA sequencing of a cDNA representing the EGFR gene. Until now, seven EGFR ligands, namely EGF, amphiregulin, heparin-binding EGF-like growth factor (HB-EGF), epiregulin, TGFβ, epigen, and betacellulin have been reported (39). We found that the expression of EGF and TGFβ, but not the other five ligands, were significantly increased in H3122-AR cells compared with H3122 parental cells (Fig. 4A). To clarify the time course of EGF and TGFβ induction following alectinib treatment, we performed
qRT-PCR using H3122 cells which were preserved at multiple alectinib concentrations during the process of alectinib exposure. We found the levels of EGF and TGFα expression started to increase at around 0.1–0.3 µmol/L of alectinib (Supplementary Fig. S5). To determine whether the inhibition of EGFR ligand binding restores the sensitivity to alectinib in H3122-AR cells, we

Figure 4. Contribution of TGFα to the acquired resistance to alectinib in H3122-AR cells. A, expression of the indicated genes is shown for H3122 and H3122-AR cells relative to the expression of GAPDH. Error bars, SD. B, Western blotting analysis is shown for H3122-AR cells transfected with control siRNA, EGF-targeted siRNAs (1, 2), or TGFα-targeted siRNAs (1, 2). Phosphorylated (p-) and total (t-) EGFR are shown. Actin was used as a loading control. C, results of the MTS cell proliferation assay for H3122-AR cells treated with the indicated alectinib concentrations are shown, following transfection with control siRNA, EGF-targeted (1, 2), or TGFα-targeted siRNAs (1, 2). Error bars, SD. D, results of the MTS cell proliferation assay for H3122-AR cells treated with the indicated alectinib concentrations in combination. Error bars, SD.
To evaluate whether the increased expression of EGF or TGFa had a functional role in H3122-AR cells, we performed EGF or TGFa gene-specific knockdown by siRNA. The knockdown of EGF or TGFa gene expression was confirmed by qRT-PCR. We found that the phosphorylation level of EGFR was decreased in TGFa knockdown, but not EGF knockdown (Fig. 4B). To examine whether EGF or TGFa knockdown restore the sensitivity to alectinib, we performed MTS assay. We found that TGFa gene knockdown, but not EGF, partially restored the sensitivity of H3122-AR cells to alectinib (Fig. 4C). These data indicate increased expression of TGFa contributes to the acquired resistance to alectinib in H3122-AR cells. To determine whether the combined knockdown of EGF and TGFa can further restore the sensitivity of H3122-AR cells to alectinib, we performed MTS assay. Interestingly, the combined knockdown of EGF and TGFa further restored the sensitivity of H3122-AR cells compared with either single knockdown (Fig. 4D). These data indicate that increased expression of EGF also contributes to the acquired resistance to alectinib in H3122-AR cells, even though the restoration of sensitivity was limited.

The fact that the combination knockdown restored the sensitivity to alectinib in H3122-AR cells prompted us to examine the heterogeneity of H3122-AR cells. To examine the heterogeneity of H3122-AR cells, we established single cell–derived clones from H3122-AR cells. We confirmed the increased expression of EGF and TGFa in almost all clones established. We performed MTS assay with EGF and/or TGFa knockdown for representative clones (Supplementary Fig. S6). We found that TGFa gene knockdown partially restored the sensitivity to alectinib in all clones examined. Interestingly, in one clone, H3122-AR3, the combined knockdown of EGF and TGFa further restored the sensitivity of H3122-AR cells to alectinib compared with either knockdown alone. These data indicate the possibility that TGFa contributes to the acquired resistance to alectinib in a major population of H3122-AR cells, and that EGF contributes to the acquired resistance to alectinib in a minor population of H3122-AR cells, representing the heterogeneity of H3122-AR cells. All these data indicate the main mechanism of acquired resistance to alectinib in H3122-AR was exerted through the TGFa–EGFR pathway.

Combination treatment is effective against H3122-AR cells in vivo

To examine whether alectinib/afatinib combination treatment was effective against H3122-AR cells in vivo, we employed a mouse xenograft model. Mice with H3122-AR–induced tumors were treated with vehicle, alectinib, afatinib, or alectinib/afatinib in combination. During treatment, the body weight of the mice (Supplementary Fig. S7) and tumor size were monitored. Tumor formation was confirmed by macroscopic analysis (Fig. 5A) and pathologic evaluation of tumors revealed the histologic phenotype of poorly differentiated adenocarcinoma (Fig. SB). We found that, after approximately 20 days, alectinib/afatinib combination treatment effectively and significantly inhibited tumor progression, compared with vehicle, alectinib, or afatinib alone (Fig. SC).

In addition, to see whether alectinib/afatinib combination treatment effectively inhibits the downstream pathways of ALK and EGFR, we performed Western blotting using tumor samples. We found that alectinib/afatinib combination treatment efficiently inhibited the phosphorylation of AKT and ERK1/2. These data indicate that alectinib/afatinib combination treatment is effective against H3122-AR cells in vivo.

Discussion

Recent advancements in the understanding of cancer biology have revealed tyrosine kinases’ oncogenic function, and tyrosine kinase–specific targeted therapies have been developed. In NSCLC, several tyrosine kinases have been identified as oncogenic drivers; these include EGFR, ALK, FGFR1, ROS1, and RET (2, 4, 6, 40–42). To target these driver tyrosine kinases, many small-molecule TKIs have been developed. Of especial note, EGFR-TKIs, such as gefitinib and erlotinib, and ALK-TKIs, such as crizotinib, have made a significant contribution to the improved prognosis of patients with lung cancer (43–45). Although these EGFR-TKIs and ALK-TKIs are powerful treatments for EGFR-mutated or ALK-translocated NSCLCs, cancer cells inevitably acquire resistance to TKIs. To improve further the prognosis of patients with lung cancer, a thorough understanding of the mechanisms of acquired resistance is essential. The mechanisms of acquired resistance to EGFR-TKIs, such as gefitinib and erlotinib, have been well defined; they include gatekeeper mutation, EGFR T790M, of the EGFR gene itself or activating bypass pathway at downstream of EGFR-TKIs, MET, AXL, and FGFR1 signaling pathways contribute to the acquired resistance to EGFR-TKIs. In the case of ALK-TKIs, activation of the EGFR signaling pathway was reported as a mechanism of acquired resistance to crizotinib or TAE684 (24, 35), but not alectinib.

Alectinib is a second-generation and highly selective ALK-TKI. Alectinib showed an objective response rate of 94% in ALK translocation–positive/ALK inhibitor–naïve Japanese patients with NSCLC in a phase I/II clinical study, with an excellent safety profile (31). As a consequence, the Pharmaceutical and Medical Devices Agency approved alectinib for use from July 2014 in Japan. It was reported that alectinib also has activity against NSCLC that harbors the gatekeeper ALK L1196M mutation as well as EML4–ALK translocation (30). Considering its higher efficacy and safety compared with crizotinib, alectinib is expected to take the place of crizotinib as the front-line treatment for most patients with ALK translocation–positive NSCLC in the near future. Therefore, elucidation of the mechanisms of acquired resistance to alectinib is of great importance. Recently, a novel mechanism of acquired resistance to alectinib was reported (33). The authors used an in vitro model of chronic alectinib exposure in H3122 cells and found two novel ALK mutations. However, until now, EGFR pathway activation in acquired resistance to alectinib has not been identified.

In this study, we have identified a novel mechanism of acquired resistance to alectinib; we show that EGFR pathway activation by TGFa induces resistance to alectinib. Recently, it was reported that exogenous ligands stimulation, including HGF, EGF, and TGFa, induce resistance to alectinib in several ALK-translocated lung cancer cells (46). In this study, we found endogenous overexpression of TGFa induces resistance to alectinib. Alectinib/afatinib...
combination treatment was effective against H3122-AR cells both in vitro and in vivo. The phosphorylation of AKT and ERK1/2 was inhibited by treatment with afatinib alone (Fig. 3C). These data indicate the possibility that the signal to the PI3K/AKT and MAPK pathways was mainly transduced through EGFR rather than ALK in H3122-AR cells. We speculate that the function as driver oncogene has shifted from ALK to EGFR. However, there was discrepancy between data from western blotting of downstream proteins, and data from the MTS cell proliferation or apoptosis assays (Fig. 3). Afatinib alone did not inhibit cell proliferation, nor did it induce apoptosis; only alectinib/afatinib combination treatment induced apoptosis in H3122-AR cells. This discrepancy was partially explained by the results of the Western blotting after 24 hours of treatment (Supplementary Fig. S4). The activation of downstream signals was persistently inhibited only in the alectinib/afatinib combination treatment. These data indicate the possibility that EGFR and ALK cooperate to transduce signals to downstream proteins.

Furthermore, there are some limitations to the current study. First, it is unclear whether long-term alectinib treatment itself increased TGFα expression in H3122 cells, or whether alectinib selectively eliminated H3122 cells that expressed low levels of TGFα such that only cells expressing high levels of TGFα survived as H3122-AR cells. Considering tumor heterogeneity and the finding that increased expression of EGF and TGFα was not observed in early alectinib exposure phase (Supplementary Fig. S5), we speculate that the latter case is more likely, although difficult to prove. Second, we could not identify a patient who was treated with alectinib, and experienced relapse after alectinib treatment. It remains elusive whether acquired resistance to alectinib through EGFR activation occur in human ALK-translocated lung cancers. Third, there seems to be a discrepancy between the in vitro MTS assay data and the in vivo efficacy data, with the in vivo data appearing to be more impressive. This suggests that other mechanisms of acquired resistance could be involved. For further characterization of acquired resistance to alectinib, additional in vitro, in vivo, and human studies are necessary.

At present, we do not know what proportion of acquired resistance to alectinib can be explained by EGFR pathway activation; however, we expect that some patients with ALK-translocated lung cancer will benefit from the addition of EGFR-TKIs to their therapeutic regime after disease progression on alectinib.

**Disclosure of Potential Conflicts of Interest**

No potential conflicts of interest were disclosed.

**Figure 5.** Alectinib/afatinib combination treatment is effective against H3122-AR cells in vivo. Tumor-bearing mice were randomized into vehicle, alectinib, afatinib, or alectinib/afatinib treatment groups. A, representative images of tumor-bearing mice. B, representative images of tumor samples stained with hematoxylin-eosin. C, tumor size was measured and tumor volume calculated. The values indicate average tumor volume in each group. *, P < 0.05 for the combination of alectinib/afatinib versus other treatments (vehicle, alectinib alone, and afatinib alone). D, Western blotting analysis of tumor samples is shown. The mice were treated with vehicle, alectinib, afatinib or alectinib/afatinib combination. The phosphorylated (p-) and total (t-) forms of the indicated proteins were examined. Actin was used as a loading control.
Authors' Contributions

Conception and design: T. Tani, H. Yasuda, I. Kawada, K. Naoki, T. Betsuyaku, K. Soejima

Acquisition of data (provided animals, acquired and managed patients, provided facilities, etc.): H. Yasuda, J. Hamamoto, D. Arai, K. Ishioka, M. Miyawaki

Analysis and interpretation of data (e.g., statistical analysis, biostatistics, computational analysis): T. Tani, H. Yasuda, J. Hamamoto, I. Kawada, K. Naoki, Y. Hayashi, T. Betsuyaku

Writing, review, and/or revision of the manuscript: T. Tani, H. Yasuda, K. Naoki, T. Betsuyaku, K. Soejima

Administrative, technical, or material support (i.e., reporting or organizing data, constructing databases): H. Yasuda, J. Hamamoto, A. Kuroda, D. Arai, K. Ishioka, T. Betsuyaku

Study supervision: H. Yasuda, K. Naoki, T. Betsuyaku, K. Soejima

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