Prostaglandin EP receptors: Targets for treatment and prevention of colorectal cancer?

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Abstract
The importance of the prostaglandin (PG) synthesis pathway, particularly the rate-limiting enzymatic step catalyzed by cyclooxygenase, to colorectal carcinogenesis and development of novel anticolicorectal cancer therapy is well established. The predominant PG species in benign and malignant colorectal tumors is PGE2. PGE2 acts via four EP receptors termed EP1 to EP4. Recently, EP receptors have been identified as potential targets for treatment and/or prevention of colorectal cancer. This review summarizes existing knowledge of the expression and function of the EP receptor subtypes in human and rodent intestine during tumorigenic progression and describes the current literature on targeting EP receptor signaling during intestinal tumorigenesis. [Mol Cancer Ther 2004;3(8):1031–9]

The Prostaglandin Synthesis Pathway during Colorectal Carcinogenesis

The importance of the prostaglandin (PG) synthesis pathway (Fig. 1) as a potential target for treatment and/or prevention of colorectal cancer is well established (1, 2). The rate-limiting step of the PG pathway is catalyzed by the cyclooxygenase (COX) enzyme, whereby arachidonic acid is converted to an unstable PG endoperoxide intermediate PGH2 (Fig. 1). PGH2 is converted to a series of different PGs dependent on the profile of specific PG synthases present in a particular cell or tissue (Fig. 1; ref. 3). PGs have a relatively short half-life and are believed to act over short distances in an autocrine or paracrine manner via specific cell surface and/or nuclear receptors (3). There are five classes of cell surface PG receptors corresponding to the main PG species termed EP, DP, FP, IP, and TP (Fig. 1; ref. 3). In addition, nuclear peroxisome proliferator-activated receptors α and γ are receptors for PGL2 and cyclopentenone PGs such as 15-d-PGJ2 (a breakdown product of PGD2), respectively (4).

Until recently, the inducible isoform of COX, COX-2, was the focus of attention for cancer researchers, as a role for this isoform has been described during the early stages of intestinal tumorigenesis (benign adenoma development) as well as at later stages of colorectal carcinogenesis (invasion and metastasis of cancer cells; refs. 1, 2). However, the emergence of a role for the constitutive isoform of COX, COX-1, during intestinal tumorigenesis (5, 6), the fact that COX-2 expression by human colorectal neoplasms is not invariably (7), and the increased understanding that selective COX-2 inhibitors are not free of unwanted side effects (particularly on renal and cardiovascular systems; ref. 8) have led to a reevaluation of other potential targets in the PG synthesis pathway downstream of COX for treatment and/or prevention of gastrointestinal (GI) carcinogenesis, including PGE synthases (6, 9). Another attractive target for inhibition of the activity of the PG synthesis pathway is inhibition of downstream receptor signaling. Currently, there is little known about the expression and function of DP, FP, IP, and TP receptors in the intestine. Although these PG receptor families are deserving of attention, this particular review is restricted to a summary of current knowledge on the expression and function of EP receptor subtypes, as this class of receptors has been studied most intensely, given that PGE2 is established as the predominant PG present in colorectal tumors.

PGE2 is the Predominant PG during Colorectal Carcinogenesis

Although PGE2 is widely considered to be the most important PG species with regard to colorectal carcinogenesis, there are surprisingly little comparative data on tissue levels of different PGs in human and rodent intestinal tumors. This is perhaps related to the difficulty in measuring true steady-state mucosal PG levels following the tissue disruption necessary for tissue procurement. This is important when considering the relevance of the effects of different concentrations of PGE2 in in vitro experiments. PGE2 has been reported to be the predominant PG product of ex vivo COX biosynthesis in normal human colonic mucosal homogenates (10). Moreover, levels of PGE2 have been noted to be higher than those of other measured PGs such as PGD2 and PGI2 (measured as its breakdown product 6-keto-PGF1α) in human colorectal adenomas and adenocarcinomas (11, 12).
A larger body of evidence exists that PGE2 levels are increased in neoplastic colorectal lesions compared with normal mucosa. Several studies, using different methodologies for measurement of tissue PGE2 content, have shown that PGE2 levels are significantly increased in benign and malignant human and rodent colorectal tumors compared with paired histologically normal colorectal mucosa (11–15). Increased PGE2 levels are apparent in benign adenomas as well as in established adenocarcinomas, although whether there is a quantitative increase in PGE2 content during adenoma-carcinoma progression requires further investigation (13). The PGE2 level increases in a size-dependent manner in colorectal adenomas in familial adenomatous polyposis patients (11). The PGE2 content of venous blood draining from human colorectal cancers also increases as the tumor size increases (16). In both dimethylhydrazine-induced and ApcMin/+ mouse models of intestinal tumorigenesis, PGE2 levels have been noted to be higher in macroscopically normal intestinal mucosa compared with mucosa from untreated or wild-type animals (17, 18). These findings have been mirrored in one human study, in which ex vivo PGE2 synthesis by histologically normal mucosa from patients with a colorectal cancer was significantly higher than that of colorectal mucosa from control patients (13).

**PGE2 Production by Human Colorectal Cancer Cells In vitro**

There is also a paucity of data on relative PG production by cultured malignant colorectal epithelial cells in vitro. In general, PGE2 has been used as a “readout” of COX activity in colorectal epithelial cells without detailed analysis of synthesis of other PGs. The small amount of comparative data that exist is in keeping with the data from tissue analysis of PGE2 levels, in that PGE2 also seems to be a major PG exported from cultured colorectal cancer cells [e.g., HCA-7 and Caco-2 cells (19–21)], although there are cell line–specific differences in the relative production of individual PGs (19, 21). PG production and release from human colorectal epithelial cells cannot be inferred from levels of cellular COX expression (20, 21). For example, HT-29 human colorectal cancer cells constitutively express COX-2 but do not synthesize detectable levels of PGE2 (20). However, transfection of the HT-29 COX-2 gene into HCT116 human colorectal cancer cells promoted PGE2 synthesis, implying that another factor intrinsic to HT-29 cells controls PGE2 synthesis and/or export in this particular cell line (20).

It has also become clear recently that the stromal cell population in tumors is also capable of significant PG synthesis. For example, isolated fibroblasts from hereditary nonpolyposis colorectal cancer tumors produce large quantities of PGI2, which has antiapoptotic activity on cocultured HCA-7 human colorectal cancer cells (22), and ex vivo tumor-associated macrophages from human colorectal cancers produce significant levels of PGE2 (23).

**EP Receptors**

PGE2 is the ligand for four EP receptor subtypes termed EP1 to EP4, which are the products of separate genes (Table 1; ref. 24). In addition, multiple splice variants of EP3 are recognized (3, 24). The known physiologic roles of the EP receptors in the GI tract are summarized in Table 1 (25–30). Understanding of the pharmacology and physiologic roles of each of the EP receptors has been enhanced greatly by derivation of individual EP receptor “knockout” mouse models, data from which have recently been reviewed extensively elsewhere (31, 32). Detailed discussion of the physiology of PGE2 and EP receptor signaling is beyond the scope of this review but has recently been summarized in a series of articles (33–36). In general, knowledge of the roles of each of the EP receptor subtypes has lagged behind understanding of the effects of PGE2 on GI physiology.

EP receptors are all cell surface, seven-transmembrane domain, rhodopsin-type G protein–coupled receptors (3, 24). There is also some evidence that EP receptors (particularly EP1) can localize to the nuclear membrane in cultured endothelial cells (37). EP receptors are highly conserved between mammalian species (24). However, there are significant differences in the structure and pharmacology of the EP receptor subtypes within species (Table 1). EP1 signaling is coupled to phospholipase C/inositol trisphosphate signaling, leading to mobilization of intracellular calcium, whereas EP2 and EP4 receptor signaling generates increased intracellular cyclic AMP (cAMP) levels via coupling to Gs proteins. EP3 has generally been considered to couple to a Gi protein leading to reduction in intracellular cAMP levels. However,
Table 1. EP receptor signaling pathways and cellular localization in the normal large intestine

<table>
<thead>
<tr>
<th>Receptor</th>
<th>Second Messenger Signal</th>
<th>Tissue Localization</th>
<th>Physiologic Role in the GI Tract</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP1*</td>
<td>Phospholipase C/inositol trisphosphate</td>
<td>Epithelium (H), epithelium, glial cells, and longitudinal muscle (R)</td>
<td>GI tract motility (R)</td>
</tr>
<tr>
<td>EP2</td>
<td>Increased cAMP</td>
<td>Epithelium (R)</td>
<td>Chloride secretion (H)</td>
</tr>
<tr>
<td>EP3†</td>
<td>Decreased cAMP</td>
<td>Epithelium (H), epithelium, glial cells, and longitudinal muscle (R)</td>
<td>Duodenal bicarbonate secretion (M) and GI tract motility (R)</td>
</tr>
<tr>
<td>EP4</td>
<td>Increased cAMP</td>
<td>Epithelium and lamina propria cells (H), and epithelium (M and R)</td>
<td>Gastric mucus production (R) and chloride secretion (H)</td>
</tr>
</tbody>
</table>

NOTE: H, human (25–27); M, mouse (28); and R, rat (29, 30).
†There are two human EP1 splice variants.
‡mRNAs for all four EP receptors are strongly expressed by goblet cells in rat colonic epithelium (29).
§There are eight human EP3 splice variants; at least one of which mediates an increase in intracellular cAMP levels via Gs. Activation of at least two EP3 isoforms also leads to increased inositol trisphosphate levels via Gs.

activation of at least one EP3 splice variant leads to increased cAMP levels, suggesting functional coupling to a Gs protein (38). In keeping with data on other G protein–coupled receptors, there may be plasticity of EP receptor signaling such that PGE2 binding and G protein coupling to individual EP receptors may alter depending on the local PGE2 concentration and other cell-specific and tissue-specific factors (39).

Recently, EP2 and EP4 receptor activation has been linked to increased β-catenin/T-cell transcriptional activity in human embryonic kidney cells via phosphorylation and hence inhibition of glycogen synthase kinase-3 (GSK-3; refs. 40, 41). Increased β-catenin/T-cell factor transcription secondary to loss of adenomatous polyposis coli (APC) tumor suppressor gene function is a pivotal event that commonly initiates colorectal carcinogenesis (42). However, the relevance of EP2/EP4 receptor–induced β-catenin up-regulation in colorectal epithelial cells, which already contain only mutant APC, remains to be determined. EP2 inhibits GSK-3 predominantly via a protein kinase A–dependent mechanism, whereas EP4 preferentially uses a phosphatidylinositol 3-kinase–dependent mechanism (40). Increased β-catenin phosphorylation and hence inhibition of glycogen synthase kinase-3, presumably via an increase in β-catenin protein levels, consequent on reduced β-catenin phosphorylation by GSK-3. EP4 receptor signaling also leads to ERK signaling. EP1 receptor signaling can also activate ERK signaling in human colorectal cancer cells. Whether activation of phosphatidylinositol 3-kinase and ERK signaling occurs directly from EP receptors or indirectly through a mechanism that could involve intracellular (C1) or extracellular (C2) EGFR activation is currently unknown. Abbreviations: (-), inhibition; EGFR, early growth response factor.

The Effect of PGE2 on Colorectal Epithelial Cells In vitro

There are rather contradictory reports of the effect of PGE2 and individual EP receptor agonists on intestinal epithelial cell proliferation and apoptosis, which are likely to reflect cell line–specific differences in EP receptor expression and use of different proliferation and apoptosis assays. These studies have generally employed micromolar (VEGF) production by HCT116 human colorectal cancer cells via ERK signaling (47). Current knowledge of the relationship between EP receptor signaling events and other signal transduction pathways is summarized in Fig. 2.

Figure 2. The relationship between EP receptor (EP) activation by PGE2 and other signal transduction pathways. Signaling through EP2 leads to GSK-3 phosphorylation via a protein kinase A–dependent mechanism (A). EP4 receptor activation also leads to GSK-3 phosphorylation, but this occurs via a mechanism involving phosphatidylinositol 3-kinase and AKT (B). GSK-3 inactivation by EP2 and EP4 signaling in human embryonic kidney cells has been shown to lead to increased transcriptional activity of β-catenin, presumably via an increase in β-catenin protein levels, consequent on reduced β-catenin phosphorylation by GSK-3. EP4 receptor signaling also leads to ERK signaling. EP1 receptor signaling can also activate ERK signaling in human colorectal cancer cells. Whether activation of phosphatidylinositol 3-kinase and ERK signaling occurs directly from EP receptors or indirectly through a mechanism that could involve intracellular (C1) or extracellular (C2) EGFR activation is currently unknown. Abbreviations: (-), inhibition; EGFR, early growth response factor.
concentrations of PGE2, Qiao et al. (48) have described dose-dependent and time-dependent proliferative activity of PGE2 and its stable analogue 16,16-dimethyl-PGE2 (dmPGE2) on HT-29 and SW1116 human colorectal cancer cells. Interestingly, there was a "bell-shaped" dose-response relationship for SW1116 cells suggesting differential activation of EP receptors at different PGE2 concentrations (this phenomenon has also been reported following treatment of HT-29 human colorectal cancer cells with PGE1; ref. 49). However, PGE2 had no effect on apoptosis in this study. By contrast, another study failed to show any effect of similar concentrations of PGE2 on proliferation of HT-29 cells and could not detect changes in either intracellular cAMP or calcium concentrations (50). Similar findings were reported by Parker et al. (21) who found that PGE2 did not alter human colorectal cancer cell (including HT-29 as well as SW480, SW488, and Caco-2 cell lines) proliferation until antiproliferative effects became apparent at concentrations above 20 μmol/L. The HT-29 human colorectal cancer cell line consists of a heterogeneous population of colorectal epithelial cells including cells with goblet cell and absorptive cell phenotypes (51). Differences in EP receptor expression between subpopulations of cells in HT-29 cell cultures could explain discrepant data from investigators using different HT-29 cell cultures. For example, dmPGE2 promotes proliferation of a mucus-secreting HT-29 human colorectal goblet cell clone (52). Growth stimulatory activity of PGE2 has also been described in LS174T and HCA-7 human colorectal cancer cells (53, 54), but antiproliferative activity against HCT116 human colorectal cancer cells has been noted in the same study (54). PGE2 also inhibits apoptosis of HCA-7 human colorectal cancer cells, which is associated with increased BCL-2 protein expression (54). The human small intestinal epithelial cell line T84 is also protected by PGE2 from apoptosis induced by staurosporine or anti-FAS antibody (55). However, PGE2 alone has been reported to have no effect on nontransformed rat IEC-6 intestinal epithelial cells (56, 57).

PGE2 has also been shown to have other effects on colorectal epithelial cells, which may be associated with growth modulation. Mucin release is increased by PGE2 administration to LS174T and HT-29-18N2 human colorectal cancer cells (52, 58), and T84 cell barrier function is enhanced by PGE2 (25). Sheng et al. (53) have described an increase in motility and invasive behavior of LS174T human colorectal cancer cells by nanomolar concentrations of PGE2.

Many studies have attempted to investigate the role of endogenously produced PGE2 in colorectal epithelial cells using COX inhibitors [including nonsteroidal anti-inflammatory drugs (NSAIDs)], but analysis of the role of PGE2 in these experiments is difficult because of potential concomitant changes in levels of non-E-type PGs and the existence of possible COX-independent mechanisms of action of NSAIDs (59).

Only a subset of the in vitro studies on colorectal epithelial cells have contained experiments that implicate particular EP receptors in the bioactivity of PGE2. Some studies have implicated EP2 and/or EP4 signaling based on increased cAMP levels (25, 55). Other studies have used EP receptor agonists to implicate EP4 receptor signaling in promotion of a protumorigenic phenotype and mucin release in LS174T human colorectal cancer cells (53, 54). EP1 receptor signaling seems to be necessary for stimulation of VEGF production (and by inference, proangiogenic behavior) by PGE2 in HCT116 human colorectal cancer cells (47).

**The Effect of PGE2 on Colorectal Epithelial Cell Proliferation and Intestinal Tumorigenesis In vivo**

Administration of dmPGE2 to normal BALB/c mice for 15 days has been reported to increase mouse colonocyte proliferation (measured by flow cytometric proliferating cell nuclear antigen expression by isolated colonocytes; ref. 48). However, in other experimental settings, PGE2 analogues seem to be mitotically inactive (60, 61). There have been several studies in which NSAIDs such as indomethacin have been used to infer the activity of endogenous PGE2 on intestinal epithelial turnover in vivo (62). However, it is difficult to draw conclusions regarding the role of PGE2 from these studies for the reasons outlined above.

In keeping with the general theme that the effect of PGE2 on GI epithelial cells is context dependent, data that have emerged from the use of rodent intestinal tumorigenesis

### Table 2. The effect of PGE2 and PGE2 analogues on rodent intestinal tumorigenesis

<table>
<thead>
<tr>
<th>Model</th>
<th>PGE2 Analogue</th>
<th>EP Receptor Activity</th>
<th>Weekly Dose (µg)</th>
<th>Duration (wk)</th>
<th>% Untreated Tumor Number</th>
<th>Change in Tumor Size</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>ApcMin/+</em> mouse (63)</td>
<td>dmPGE2 + 17-phenyltrinor-PGE2</td>
<td>EP2–EP4</td>
<td>180</td>
<td>1</td>
<td>83</td>
<td>↓</td>
</tr>
<tr>
<td><em>ApcMin/+</em> mouse (65)</td>
<td>dmPGE2</td>
<td>EP1, EP3</td>
<td>180</td>
<td>7</td>
<td>50</td>
<td>↓</td>
</tr>
<tr>
<td>Rat azoxymethane-induced colon carcinogenesis (64)</td>
<td>PGE2</td>
<td>EP2–EP4</td>
<td>0.03</td>
<td>25</td>
<td>280</td>
<td>↑</td>
</tr>
</tbody>
</table>

*All dosings were by i.p. injection apart from the study by Hansen-Petrik et al. (63), in which 10 µg of each analogue were given by daily gavage.

6 days.

PGE2 β-cyclodextrin clathrate.
models have not been consistent (Table 2). PGE$_2$ analogues have been shown to reverse abrogation of tumor growth by the NSAID sulindac in the Apc$^{Min/+}$ mouse model of familial adenomatous polyposis (63), and reduction of systemic PGE$_2$ availability using a neutralizing anti-PGE$_2$ antibody decreases tumor multiplicity in this model (63). Others have reported that i.p. administration of PGE$_2$ promotes azoxymethane-induced colonic tumors (Table 2; ref. 64). However, data exist that challenge the idea that PGE$_2$ is the main COX-derived PG species responsible for protumorigenic activity in the Apc$^{Min/+}$ mouse model (Table 2). Two independent groups have reported that i.p. administration of the PGE$_2$ analogue dmPGE$_2$ alone (65) or in combination with 17-phenyl-trinor-PGE$_2$ (63) is associated with a reduction in the number and size of Apc$^{Min/+}$ mouse adenomas (Table 2). Possible explanations for discrepancies in these data include the use of PGE$_2$ analogues with differing EP receptor specificity (Table 2). It should also be noted that the majority of adenomas occur in the small intestine (not the colon) of the Apc$^{Min/+}$ mouse, and possible tissue-specific differences in EP function during intestinal tumorigenesis between the mouse small intestine and colon (see below) should be taken into consideration. The use of the i.p. route of administration of PGE$_2$ means that systemic activity of PGE$_2$, which could affect intestinal tumorigenesis (by alteration of mesenteric blood flow, for example), cannot be ruled out in the above studies.

Expression of Individual EP Receptor Isoforms in Normal Large Intestine and during Intestinal Tumorigenesis

The majority of studies of intestinal EP receptors have investigated expression at the mRNA level [by reverse transcription-PCR (RT-PCR) or in situ hybridization] due to the lack of well-characterized antibodies to EP receptors. Antibody characterization has been hampered by the discovery of different molecular weight forms of EP receptors (e.g., EP4) in different tissues, which may be explained by differential glycosylation (66). Data on localization of EP receptors EP1 to EP4 in rodent and human intestine are summarized in Table 1 (25–30). In summary, each of the EP receptors EP1 to EP4 in rodent and human intestine are consistently been shown to reduce intestinal adenoma or polyp formation (67, 68). In a similar pattern to previous reports (67, 70), treatment with the EP1 antagonist was associated with a prominent reduction in polyp number, whereas a reduction in tumor size was linked to EP4 antagonism (79). This suggests that different EP receptors may have roles at different stages (initiation versus progression) of intestinal tumorigenesis.

The Role of Individual EP Receptor Isoforms during Intestinal Tumorigenesis

Several studies have now been published (70–78), which have explored the role of individual EP receptor subtypes during intestinal tumorigenesis using genetic deletion and pharmacologic manipulation of EP receptors (Table 3). EP1, EP2, and EP4 receptor signaling have all been implicated in intestinal tumorigenesis in different rodent models (Table 3). By contrast, EP3 receptor “knockout” does not seem to impact on intestinal tumorigenesis (Table 3). Genetic deletion or inhibition of a single EP receptor has consistently been shown to reduce intestinal adenoma or aberrant crypt focus (ACF) development by 40% to 60%. This compares with an 80% to 90% reduction in neoplasia in the same models associated with genetic deletion of either COX isoform (particularly COX-2). Therefore, these data suggest that more than one EP receptor subtype is involved in intestinal tumorigenesis in these models and/or that other PGs (acting via alternative PG receptors) may contribute to the promotion of tumorigenesis by COX. A recently published study of the concurrent use of EP1 and EP4 antagonists in the Apc$^{1309}$ mouse model of familial adenomatous polyposis is consistent with this concept, in that the effects of the two inhibitors were additive and produced a polytlop number 44% of untreated control animals (79). In a similar pattern to previous reports (67, 70), treatment with the EP1 antagonist was associated with a prominent reduction in polyp number, whereas a reduction in tumor size was linked to EP4 antagonism (79). This suggests that different EP receptors may have roles at different stages of intestinal tumorigenesis.

It should again be remembered that adenomas in Apc$^{Min/+}$, Apc$^{716}$, and Apc$^{1309}$ mouse models occur predominantly in the small intestine and that the relevance of chemically induced ACFs to sporadic colorectal carcinogenesis remains unclear (80). Therefore, the relevance of
these rodent data to human colorectal cancer development is uncertain. Advances in the field of EP receptor signaling during human colorectal carcinogenesis will only follow careful delineation of EP receptor subtype localization and levels at different stages of cancer development [i.e., adenoma (polyp) versus cancer] in parallel with in vitro studies of EP receptor function in epithelial and stromal cells derived from human colorectal tumors.

Two carefully performed studies have also implicated a role for individual EP receptor subtypes in other solid tumor models in mice (81, 82). EP3 (and to a lesser extent EP2) has been implicated in tumor-associated angiogenesis in sarcoma-180 and sponge implantation models via stromal fibroblast VEGF production (81). This highlights the potential tissue and model specificity of EP receptor PGE2 signaling that is becoming apparent, as EP3 is the one EP receptor subtype that has consistently not been implicated in the studies using intestinal tumorigenesis models (Table 3). By contrast, in polyps of the ApcD716 model, stromal cell PGE2-EP2 receptor signaling has been

Table 3. The number of colonic ACF or intestinal polyps in mouse models of intestinal tumorigenesis following either genetic deletion or pharmacologic inhibition of EP receptor subtypes or COX isoforms

<table>
<thead>
<tr>
<th>Receptor</th>
<th>Azoxymethane-Induced ACF Development*</th>
<th>ApcMinc Mouse Polyposis†</th>
<th>ApcD716 Mouse Polyposis‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP1</td>
<td>65% (GD; ref. 70)</td>
<td>56% (P; ref. 70)</td>
<td>No difference (GD; ref. 68)</td>
</tr>
<tr>
<td></td>
<td>65% (P; refs. 70, 71)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP2</td>
<td>ND</td>
<td>No Δ polypl size</td>
<td>58% (GD; ref. 68)</td>
</tr>
<tr>
<td>EP3</td>
<td>No difference (GD; ref. 67)</td>
<td>ND</td>
<td>No difference (GD; ref. 68)</td>
</tr>
<tr>
<td>EP4</td>
<td>56% (GD; ref. 67)</td>
<td>69% (P; ref. 67)</td>
<td>No difference (EP4−/− only; ref. 68)</td>
</tr>
<tr>
<td></td>
<td>67% (P; ref. 67)</td>
<td>Polyp size decreased</td>
<td></td>
</tr>
<tr>
<td>COX-1</td>
<td>60% (P; ref. 72)</td>
<td>23% (GD; ref. 5)</td>
<td>59%* (P; ref. 72)</td>
</tr>
<tr>
<td>COX-2</td>
<td>63% (P; ref. 73)</td>
<td>16% (GD; ref. 5)</td>
<td>14% (GD; ref. 76)</td>
</tr>
<tr>
<td></td>
<td>3% (P; ref. 74)</td>
<td>29% (P; ref. 75)</td>
<td>45% (P; refs. 77, 78)</td>
</tr>
<tr>
<td>Anti-PGE2 antibody</td>
<td>ND</td>
<td>67% (63)</td>
<td>ND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Δ polypl size</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: ND, not determined.
*Azoxymethane-induced ACF number following either genetic deletion (GD) or pharmacologic inhibition (P) as a percentage of wild-type or control ACF multiplicity.
†Polyp (or adenoma) number following either genetic deletion (GD) or pharmacologic inhibition (P) as a percentage of wild-type or control polyp multiplicity. Δ, change.
‡The ApcD309 mouse model of familial adenomatous polyposis was used in this study.
§Percentage of azoxymethane-induced tumor (not ACF) multiplicity in untreated rats.

Figure 3. PGE2-EP receptor signaling during intestinal tumorigenesis. PGE2 (derived from COX-1-mediated and/or COX-2-mediated PG synthesis pathways) can act in an autocrine and/or paracrine manner in stromal and epithelial cell compartments of tumors. It is unclear what the contribution is of each cellular compartment to PGE2 bioactivity in colorectal neoplasms. Currently, evidence is perhaps strongest for a role for stromal cell (fibroblast and/or macrophage) EP receptor (subtypes 2 and 3) signaling in promotion of angiogenesis (A) and impairment of host immune antitumor surveillance (B). PGE2 also contributes to T-lymphocyte development (87) and a switch from a Th1 to Th2 predominant immune response (88). It is unknown whether endothelial cells express EP receptors and so whether PGE2 has direct activity on the vasculature. At least part of the angiogenic activity of COX-2 is believed to be mediated by increased expression of the proangiogenic factor VEGF. Direct PGE2-EP receptor signaling (subtypes 2 and 4) in epithelial cells is also likely to be important in intestinal neoplasms in vivo (C).
associated with increased microvessel number and VEGF expression (83). The concept of tissue heterogeneity in EP receptor function is further strengthened by data from other solid tumor transplantation models (including the MC26 mouse colorectal cancer cell model), in which EP2 has not been implicated in angiogenesis (82). Instead, this study provided evidence for a role for PGE2-EP receptor signaling in tumor-associated inhibition of dendritic cell differentiation and function, thereby leading to impairment of host immune antitumor surveillance (82).

Therefore, the weight of the current evidence for EP receptor signaling in different tumorigenesis models would suggest a significant role for the stromal cell (rather than tumor cell) component of neoplasms, including proangiogenic behavior of intestinal epithelial cells (56). This evidence along with consistent EP receptor expression from colorectal epithelial cells in vitro suggests that PGE2-EP receptor signaling also contributes directly to epithelial cell behavior, as well as angiogenesis and the immune response, during intestinal tumorigenesis.

**Therapeutic Implications of EP Receptor Signaling for Treatment of GI Cancer**

EP receptors represent ideal targets for pharmacologic agents, and PGE2 analogues and synthetic drugs, which can selectively activate or antagonize signaling from one or more EP receptor subtypes, have now been developed and used experimentally (31). As outlined above, some of these agents have been shown to have antineoplastic activity, with no reported extraintestinal toxicity, in rodents (67, 70, 71, 79). Pertinent to the suitability of these agents for clinical trials in humans is the question of which EP receptors mediate the various physiologic roles of PGE2 such as gastric mucosal protection and renal homeostasis. Although a large literature exists on the pharmacologic properties of PGE2 (in the presence or absence of NSAIDs) on small intestinal permeability and protection as well as on gastric mucosal defense, research into the role of individual EP receptors in these processes is in its infancy (33–36). One relevant study has implicated PGE2-EP3 (but not EP1) receptor signaling in duodenal bicarbonate secretion and maintenance of mucosal integrity in studies of EP receptor “knockout” mice (89). Potential physiologic roles for EP receptors in vivo can also be hypothesized from in vitro data. For example, the EP4 receptor mediates mucus production and protects against apoptosis in colonic and gastric epithelial cells (54, 58, 90). Therefore, antagonism of the EP4 receptor could promote mucosal injury in vivo. The extent of EP receptor redundancy in individual organs will govern whether individual EP receptor agonists and antagonists have toxicity in humans.

**Summary**

A large body of evidence exists that the PG synthesis pathway, via PGE2-EP receptor signaling, plays an important role in colorectal carcinogenesis (Fig. 3). Available data suggest that EP1, EP2, and EP4 receptors all play a role in the early stages of intestinal tumorigenesis (ACF and adenoma development). Other solid tumor models, which perhaps have more relevance to established colorectal cancer, have implicated EP3 and EP2 receptors in the host angiogenic response. In keeping with the idea that there may be redundancy of EP receptor signaling function and that EP receptor function varies at distinct stages (e.g., initiation versus progression) of tumorigenesis, comparison of the effects of single EP receptor and COX isoform gene deletion suggests that antagonism at any one EP receptor will not have the preventative efficacy of inhibition of either or both COX enzymes. More research is now needed to determine the activity and toxicity of single/combination EP receptor antagonists in preclinical models to prompt phase I and II clinical evaluation of these agents. Drugs targeting individual EP receptors may eventually find a role as adjunctive therapy (with, for example, selective COX-2 and/or PGE synthase inhibition) in defined groups of patients with colorectal neoplasia.

**References**


