Activation of EGFR bypass signaling by TGFα overexpression induces acquired resistance to alectinib in ALK-translocated lung cancer cells

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Running title

TGFα-EGFR signaling in acquired resistance to alectinib

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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 to 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 which acquired resistance to alectinib by the activation of EGFR bypass signaling.
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 \textit{EGFR}, \textit{KRAS}, and the \textit{EML4-ALK} fusion oncogene in non-small cell lung cancer (NSCLC) (2-6). The \textit{EML4-ALK} gene rearrangement was first identified in 2007 in 6.7% of NSCLCs (6). In addition to \textit{EML4}, several other \textit{ALK} fusion partners, such as \textit{KIF5B}, \textit{TFG}, and \textit{KLC1} 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 phosphatidylinositol 3-kinase/protein kinase B (PI3K/AKT) and the extracellular signal-regulated kinase (ERK)/mitogen-activated protein kinase (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 \textit{EML4-ALK} gene rearrangement. Crizotinib, a first generation ALK tyrosine kinase inhibitor (ALK-TKI) that targets ALK, MET, and ROS1 (11-14), showed great efficacy in \textit{EML4-ALK} NSCLC (15); the response rate of patients was 57%.

However, almost all NSCLCs that harbored the \textit{EML4-ALK} gene rearrangement
acquired resistance to crizotinib within 1–2 years, similar to NSCLCs that harbor \textit{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 classified into two types, one alteration of the \textit{EGFR} gene itself, the \textit{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 \textit{ALK} gene itself (such as L1196M, F1174L, C1156Y, G1202R, S1206Y, and G1269A), gene amplification, or activation of a bypass signaling pathway, such as via KIT or EGFR (21-25). The \textit{EML4-ALK} L1196M and \textit{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 tyrosine kinase inhibitors (TKIs) (21, 26). In order 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 \textit{EML4-ALK} rearrangement.
Alectinib also has activity against the product of the *EML4-ALK* L1196M gatekeeper-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, V1180L 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 TGFα-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, USA). No authentication was done by the authors. Cells were cultured in RPMI-1640 growth medium, supplemented with 10% fetal bovine serum 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 (Woburn, MA, USA). Cetuximab was purchased from Keio University Hospital (Tokyo, Japan). Total ALK antibody (#3791S), phospho-ALK (Y1282/1283) antibody (#9687S), total EGFR antibody (#2232), total AKT antibody (#9272), phospho-AKT (S473; D9E) antibody (#4060), total p44/42 MAPK antibody (#9102S), and phospho-p44/42 MAPK (T202/204) antibody (#9101S) were purchased from Cell Signaling Technology (Beverly, MA, USA). Phospho-EGFR (Y1068) antibody (44788G) was purchased from Invitrogen/Life Technologies (Carlsbad, CA, USA). Actin antibody was purchased from Sigma-Aldrich (St. Louis,
MO, USA).

**Cell proliferation assay**

The MTS cell proliferation assay was performed as previously described (34). Briefly, $3 \times 10^3$ 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 0.1–1 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 sodium dodecyl sulfate-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), then exposed to X-ray film.

**Phospho-receptor tyrosine kinase (phosho-RTK) array**

The human phospho-RTK array kit was purchased from R&D Systems (Minneapolis, MN, USA) and screened according to the manufacturer’s protocol, with 150 μg of protein being used for each experiment. Signal intensity was calculated using the LumiVision 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, Franklin Lakes, NJ, USA).
Quantitative RT-PCR (qRT-PCR)

Total RNA was isolated from cells using an RNeasy Mini Kit (Qiagen, Limburg, Netherlands). 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 was performed using the fluorescent SYBR Green dye methodology and an ABI Prism 7000 Sequence Detection System (Life Technologies). Human glyceraldehyde 3-phosphate dehydrogenase (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 EGFR (#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 siLentFect™ transfection reagent (Bio-Rad, Hercules, CA, USA) was used according to the manufacturer’s protocol. We confirmed knockdown of
EGF, TGFα, and EGFR by qRT-PCR.

Fluorescent in situ hybridization (FISH)

FISH analysis of the EML4-ALK gene rearrangement was performed by SRL (Japan).

Mouse xenograft model

All animal experiments were approved by the Laboratory Animal Center, Keio University School of Medicine. Female BALB/c-\textit{nu} mice were purchased from Charles River (Japan). Mice were anesthetized with ketamine. H3122-AR cells were suspended in Matrigel (Corning, NY, USA) and injected subcutaneously. Tumor volume was monitored using a caliper. Once average tumor volume reached 200 mm$^3$, 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 (Cell Signaling Technology). Western blotting was performed as mentioned above.
**Statistical analysis**

Statistical analysis was performed using the GraphPad Prism software, version 4.0 (GraphPad Software, La Jolla, CA, USA). Student’s $t$ test was used for comparisons. All $p$ values were two sided; values of $p < 0.05$ were regarded as statistically significant.
Results

Establishment of alectinib-resistant H3122 (H3122-AR) cells

H3122 cells, which harbor the EML4-ALK gene rearrangement, were cultured with alectinib in order 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 IC_{50} values for alectinib were 38.2 nmol/L for alectinib-naive 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 two weeks. We found that resistance was retained after removing alectinib (Supplementary Fig. S1). In order 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 in order 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 to 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). In order 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, in order 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 to H3122 cells, and the phosphorylation level of ALK in H3122-AR cells was reduced compared to H3122 cells (Fig. 2A, 2B). Furthermore, we found a slight increase in the phosphorylation of human epidermal growth factor receptor 2. In order 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 to 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**

In order 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 afatinib, a second-generation EGFR-TKI (36), alone or afatinib and alectinib in combination for H3122-AR cells. Afatinib as a single agent could not inhibit the proliferation of H3122-AR cells (Supplementary Fig. S2A). Next, we used the MTS assay in order 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 if 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.

In order 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 to 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.

In order to investigate whether alectinib/afatinib combination treatment effectively induced apoptosis in H3122-AR cells, the proportion of apoptotic cells, annexin V-positive cells, in H3122-AR cultures following treatment with alectinib, afatinib, or alectinib/afatinib in combination was evaluated by flow cytometry. Compared to 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 h 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 h of treatment. As expected, the inhibition of downstream pathway was more efficient in combination treatment compared to alectinib or afatinib alone at 24 h (Supplementary Fig. S4). These data indicate that the combination treatment induce more sustained inhibition of downstream pathways compared to 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 TGFα 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). In order to clarify the mechanism of EGFR pathway activation in H3122-AR cells, we performed DNA sequencing of a cDNA representing the tyrosine kinase domain of EGFR; however, no mutations were detected. In order to evaluate the possibility of ligand-induced activation of EGFR, we examined the expression level of EGFR ligands. Until now, seven EGFR ligands, namely EGF, amphiregulin, heparin-binding EGF-like growth factor (HB-EGF), epiregulin, TGFα, epigen, and betacellulin have been reported (39). We found that the expression of EGF and TGFα, but not the other five ligands, were significantly increased in H3122-AR cells compared to H3122 parental cells (Fig. 4A). To clarify the time course of EGF and TGFα 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 μM of alectinib (Supplementary Fig. S5). To determine
whether the inhibition of EGFR ligand binding restores the sensitivity to alectinib in H3122-AR cells, we performed MTS assay with cetuximab, an EGFR antibody which block ligands binding. We found cetuximab restored the sensitivity to alectinib in H3122-AR cells (Supplementary Fig. S2C), indicating the possibility that EGFR ligands contribute to the acquired resistance to alectinib in H3122-AR cells.

In order to evaluate whether the increased expression of EGF or TGFα had a functional role in H3122-AR cells, we performed EGF or TGFα gene-specific knockdown by siRNA. The knockdown of EGF or TGFα gene expression was confirmed by qRT-PCR. We found that the phosphorylation level of EGFR was decreased in TGFα knockdown, but not EGF knockdown (Fig. 4B). To examine if EGF or TGFα knockdown restore the sensitivity to alectinib, we performed MTS assay. We found that TGFα gene knockdown, but not EGF, partially restored the sensitivity of H3122-AR cells to alectinib (Fig. 4C). These data indicate increased expression of TGFα contributes to the acquired resistance to alectinib in H3122-AR cells. To determine whether the combined knockdown of EGF and TGFα can further restore the sensitivity of H3122-AR cells to alectinib, we performed MTS assay. Interestingly, the combined knockdown of EGF and TGFα further restored the sensitivity of H3122-AR cells to alectinib 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 promoted 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 *TGFα* in almost all clones established. We performed MTS assay with *EGF* and/or *TGFα* knockdown for representative clones (Supplementary Fig. S6). We found that *TGFα* gene knockdown partially restored the sensitivity to alectinib in all clones examined. Interestingly, in one clone, H3122-AR3, the combined knockdown of *EGF* and *TGFα* further restored the sensitivity of H3122-AR cells to alectinib compared with either knockdown alone. These data indicate the possibility that TGFα 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 TGFα-EGFR pathway.
Alectinib/afatinib combination treatment is effective against H3122-AR cells in vivo

In order 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 pathological evaluation of tumors revealed the histological phenotype of poorly differentiated adenocarcinoma (Fig. 5B).

We found that, after approximately 20 days, alectinib/afatinib combination treatment effectively and significantly inhibited tumor progression, compared to vehicle, alectinib or afatinib alone (Fig. 5C). In addition, to see if 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). In order to target these driver tyrosine kinases, many small-molecule tyrosine kinase inhibitors 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 alternative bypass-pathway activation. In the case 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-naive Japanese patients with NSCLC in a phase 1/2 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 to 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 TGFα induces resistance to alectinib. Recently, it was reported that exogenous ligands stimulation, including HGF, EGF and TGFα, induce resistance to alectinib in several ALK-translocated lung cancer cells (46). In this study, we found endogenous overexpression of TGFα 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 h of treatment (Supplementary Fig. S4). The activation of downstream signals were 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 present 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.
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Figure legends

Figure 1.

Establishment of alectinib-resistant H3122 cells. A, The results of MTS cell proliferation assays are shown, following treatment of cells with the indicated alectinib concentrations for 72 hours. Error bars indicate standard deviation. B, Results of two-color fluorescent in situ hybridization analysis of H3122 and H3122-AR cells are shown. Arrowheads indicate isolated or split red signals. C, Western blotting analysis of H3122 and H3122-AR cells, for phosphorylated (p-) and total (t-) ALK, AKT, and ERK1/2, is shown. Actin was used as a loading control. D, Flow cytometric data are shown for H3122 and H3122-AR cells treated with dimethyl sulfoxide (DMSO) vehicle or alectinib for 72 hours. The numbers (%) indicate the proportion of annexin V-FITC- and/or propidium iodide-stained cells.

Figure 2.

Increased phosphorylation of EGFR in H3122-AR cells. A, Results of human phospho-RTK array experiments in H3122 and H3122-AR cells. The spots for ALK,
EGFR, and HER2 are indicated with arrows. The spots are shown in duplicate. B, The average proportional intensity of the spots for ALK, EGFR, and HER2 are shown. C, Western blotting analysis of H3122 and H3122-AR cells showing increased phosphorylation of EGFR (p-EGFR) in H3122-AR cells. Total EGFR (t-EGFR) is also shown. Actin was used as a loading control.

Figure 3.

The contribution of EGFR pathway activation to acquired resistance to alectinib in H3122-AR cells. A, Results of the MTS cell proliferation assay are shown. H3122-AR cells were treated with the indicated alectinib and afatinib concentrations. Error bars indicate standard deviation. B, Results of the MTS cell proliferation assay for H3122-AR cells treated with the indicated alectinib concentrations are shown, following transfection with control siRNA or EGFR-targeted siRNAs (#1, #2). Error bars indicate standard deviation. C, Western blotting analysis of H3122 and H3122-AR cells is shown. The cells were treated with or without alectinib (1 µM) and afatinib (1 µM) for 2 hours. The phosphorylated (p-) and total (t-) forms of the indicated proteins were examined. Actin was used as a loading control. D, The proportion of annexin V-positive
cells examined by flow cytometry is shown. H3122-AR cells were treated with or
without alectinib and afatinib for 72 hours. The cells were stained with annexin V-FITC
and propidium iodide. Error bars indicate standard deviation.

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 indicate standard deviation. 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 indicate standard deviation. D,
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 alone, TGFα-targeted alone, or in combination. Error bars indicate
standard deviation.
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.
Fig. 1

A

![Graph showing relative cell viability (%)](image)

**Alectinib (μmol/L)**

- **H3122**
- **H3122-AR**

* P < 0.05

B

![Images showing cell viability analysis](image)

C

<table>
<thead>
<tr>
<th>Cell</th>
<th>H3122</th>
<th>H3122-AR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alectinib (μmol/L)</td>
<td>0</td>
<td>0.1</td>
</tr>
<tr>
<td>p-ALK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>t-ALK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-AKT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>t-AKT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-ERK1/2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>t-ERK1/2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>actin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D

![Images showing annexin V-FITC analysis](image)

H3122

- DMSO
- Alectinib

H3122-AR

- DMSO
- Alectinib

*Note: Images depict cell viability and apoptosis analysis using annexin V-FITC and propidium iodide staining.*
Fig. 2

A

H3122

ALK

H3122-AR

EGFR

HER2

ALK

B

% of control

ALK  EGFR  HER2

H3122

H3122-AR

C

Cell    H3122    H3122-AR

          Alectinib (μmol/L)

          0  0.1  1

p-EGFR

0  0.1  1

t-EGFR

actin

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Fig. 3

A

Relative cell viability (%)

Alectinib (µmol/L)

* P<0.05

B

Relative cell viability (%)

Alectinib (µmol/L)

* P<0.05

C

H3122

H3122-AR

Alectinib

+ + + +

Afatinib

− − + +

p-EGFR

t-EGFR

p-ALK

t-ALK

p-AKT

t-AKT

p-ERK1/2

t-ERK1/2

actin

D

Proportion of annexin V-positive cells (%)

DMSO

Alectinib

Afatinib

Alectinib + Afatinib

* P<0.05
Molecular Cancer Therapeutics

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, et al.

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