Cytochrome P450 3A5 is highly expressed in normal prostate cells but absent in prostate cancer

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Abstract

Testosterone is essential for the growth and function of the luminal prostate cells, but it is also critical for the development of prostate cancer, which in the majority of the cases derives from luminal cells. Cytochrome P450 3A (CYP3A) enzymes hydroxylate testosterone and dehydroepiandrosterone to less active metabolites, which might be the basis for the association between CYP3A polymorphisms and prostate cancer. However, it is unknown whether the CYP3A enzymes are expressed at relevant levels in the prostate and which polymorphisms could affect this tissue-specific CYP3A activity. Thus, we measured CYP3A4, CYP3A5, CYP3A7, and CYP3A43 mRNA in 14 benign prostatic hyperplasias and ten matched non-tumoral/tumoral prostate samples. We found that CYP3A5 mRNA in non-tumoral prostate tissue was 10% of the average amount of liver samples, whereas the expression of the other CYP3A genes was much lower. Similarly to liver, CYP3A*3 polymorphism decreased CYP3A5 mRNA content 13-fold. CYP3A5 protein was detected in non-tumoral prostate microsomes by western blot, and immunohistochemistry (IHC) localized CYP3A5 exclusively in the basolateral prostate cells. In contrast to the normal tissue, IHC and RT-PCR showed that tumoral tissue lacked CYP3A5 expression. In conclusion, prostate basolateral cells express high levels of CYP3A5 which dramatically decrease in tumoral tissue. This finding supports an endogenous function of CYP3A5 related to the metabolism of intra-prostatic androgens and cell growth, and that polymorphisms affecting CYP3A5 activity may result in altered prostate cancer risk and aggressiveness.

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Introduction

Prostate cancer is the second leading cause of cancer death in men, and both genetic and environmental factors have been shown to be important for the development of this disease (Novelli et al. 2004). More than 95% of the prostate tumors derive from luminal cells, which grow in an androgen-dependent manner through androgen receptor activation. There are three distinct glandular regions in the human prostate gland: peripheral, central, and transitional zone comprising: 70, 30, and 5% of the normal glandular prostate mass respectively (Villers et al. 1991). The peripheral zone is the site of origin of most carcinomas and it is the most susceptible region to inflammation, the central zone is resistant to both carcinoma and inflammation, while the transitional zone is the site of origin of benign nodular hyperplasia and rarely carcinomas (McNeal 1969, 1978, McNeal et al. 1988a,b).

Testosterone is essential for prostate cancer development (Feldman & Feldman 2001) and genetic changes affecting the expression/activity of the enzymes metabolizing androgens can influence prostate cancer progression (Makridakis et al. 1997, 1999, Park et al. 2006). For this reason, several studies have focused on cytochromes P450 3A (CYP3As) polymorphisms, the rationale being that, in addition to the prominent role of...
CYP3A enzymes in the metabolism of over 50% of all clinical drugs (Li et al. 1995, Thummel & Wilkinson 1998, Rodriguez-Antona & Ingelman-Sundberg 2006). CYP3A enzymes also metabolize testosterone and dehydroepiandrosterone (DHEA) to hydroxy-metabolites active and easier to eliminate (Ohmori et al. 1998, Kamdem et al. 2004, Miller et al. 2004). Thus, an alteration in the CYP3A prostate activity could change the local testosterone levels and alter the tissue-specific androgen effects, prostate growth, and cancer development.

The CYP3A subfamily comprises four members: CYP3A4, CYP3A5, CYP3A7, and CYP3A43, which have similar substrate specificities but different expression patterns. CYP3A4 is the predominant form in liver and small intestine (Lin et al. 2002). CYP3A5 is also present in liver and gastrointestinal tract but at lower levels and in a bimodal manner due to CYP3A5*3, CYP3A5*6, and CYP3A5*7 defective alleles, the last two present only in Africans (Hustert et al. 2001, Kuehl et al. 2001, Lin et al. 2002, Lee et al. 2003). CYP3A7 is primarily expressed in fetal stages, but CYP3A7*1C allele triggers its expression in adult stages (Kuehl et al. 2001, Burk et al. 2002, Sim et al. 2005). CYP3A43 mRNA has been detected mainly in the prostate, testis, and liver, but at relatively low levels (Domanski et al. 2001, Westlind et al. 2001). With respect to the CYP3A prostate expression, Murray et al. (1995b) found no CYP3A protein in normal prostate tissue, but they detected expression in 61% of tumor samples. In contrast, Moilanen et al. (2007), focusing specifically on CYP3A5, detected CYP3A5 protein in normal and tumoral prostate tissue, but the defective CYP3A5*3 allele seemed to have no effect on protein expression. On the other hand, Di Paolo et al. (2005) found higher amounts of CYP3A4 than CYP3A5 protein in normal tissue and Zhang et al. (2006) found both CYP3A4 and CYP3A5 proteins in most tumoral tissues analyzed. With respect to the mRNA content, CYP3A4, CYP3A5, CYP3A7, and CYP3A43 mRNAs have been detected in normal and tumoral prostate tissue in different works using different techniques (Finnstrom et al. 2001, Stamey et al. 2001, Westlind et al. 2001, Koch et al. 2002). Despite the unclear expression profile and role of the CYP3A enzymes in prostate, several studies have shown an association between different CYP3A single nucleotide polymorphisms (SNPs), mainly CYP3A4*1B, and prostate cancer risk and/or aggressiveness, suggesting that CYP3A enzymes may play an important role in prostate cell growth (Rebeck et al. 1998, Paris et al. 1999, Plummer et al. 2003, Loukola et al. 2004, Bangsi et al. 2006). However, the high degree of ethnic-specific linkage disequilibrium among all CYP3A4, CYP3A5, and CYP3A7 SNPs prevents the identification of the relevant enzyme that could be involved in intraprostatic androgen metabolism and cancer development (Thompson et al. 2004, 2006).

Thus, this study was aimed at identifying the CYP3A enzyme(s) expressed at relevant levels in normal and tumoral prostate tissue and the mechanisms affecting its expression. For that purpose we used quantitative RT-PCR, western blot, and IHC analysis in a panel of normal and matched tumoral prostate samples.

Materials and methods

Human samples

The study included 14 benign prostatic hyperplasia (BPH) tissues and ten matched non-tumoral/tumoral prostate tissues, both fresh and paraffin embedded. Specimens were obtained from the Tumor Bank of the Department of Pathology, Universitary Hospital Virgen de las Nieves, Granada. Twenty-five additional tumoral prostate paraffin sections were obtained from the Department of Pathology from the Hospital of Leon. The specimens were selected from radical prostatectomy by an expert pathologist. Hematoxylin-and eosin-stained sections were examined by a pathologist to determine the percentage of cancer cells in the tumor samples. The Gleason score and T stage of the frozen samples are shown in Table 1. The paraffin samples from the Hospital of Leon had Gleason scores between six and nine and the T stage was T2 or T3 in all cases. In addition, seven liver samples were used for RT-PCR mRNA quantification.

DNA isolation and genotyping

DNA was isolated from the frozen tissue samples using Qiagen DNeasy tissue kit (Qiagen, Valencia, CA, USA) according to manufacturer’s protocol. CYP3A5*3 polymorphism (rs776746, 6986A>G, the reference sequence corresponds to accession number NG_000004.2) was analyzed by PCR using specific primers (Supplementary Table 1, which can be viewed online at http://erc.endocrinology-journals.org/supplemental/) and direct sequencing (sequencer 3730, Applied Biosystems, Foster City, CA, USA). The PCR was initiated by an initial step for 2 min at 94 °C, followed by 36 cycles of 30 s at 94 °C, 30 s at 58 °C, and 45 s at 72 °C, and completed with 7 min at 72 °C.

RNA isolation and real-time quantitative RT-PCR

RNA was isolated from the frozen tissue using TRI reagent (Molecular Research Center Inc., Cincinnati,
One microgram of the total RNA was reverse transcribed using Superscript II Reverse Transcriptase (Invitrogen) and an oligo dT14 primer following manufacturer’s instructions. All the normal tissue samples as well as all carcinomas were from the peripheral zone, while the benign hyperplasia samples were from the transitional zone.

The amounts of CYP3A4, CYP3A5, CYP3A7, and CYP3A43 mRNAs were quantified by real-time PCR with the Sequence Detection System 7900HT (Applied Biosystems), using specific primers and probes (Supplementary Table 2, which can be viewed online at http://erc.endocrinology-journals.org/supplemental/) at a final concentration of 0.9 and 0.2 μM respectively, and the Universal Master Mix (PE Applied Biosystems). The amplification conditions consisted of an initial step at 95 °C for 10 min, followed by 50 cycles of 15 s at 95 °C and 1 min at 60 °C. Standard curves were generated with serial 1/10 dilutions of a pool of seven liver cDNAs. For CYP3A5 mRNA quantification, a pool of two CYP3A5*1/*3 liver cDNAs were used for the standard curve construction and a pool of four CYP3A5*3/*3 liver cDNAs were included for quantification. Normalization was carried out with the internal standard β-glucuronidase (GUS). Negative controls were present in all series of PCR and all assays were carried out in triplicates.

**Subcellular fractionation of human prostate tissues**

Five BPH samples were used to obtain microsomal fractions (samples 112, 113, 114, 118, and 124). The tissues were homogenized with a glass homogenizer in four volumes of ice-cold 50 mM Tris–HCl, pH 7.4 containing 0.25 M sucrose and protease inhibitors. The resulting homogenate was centrifuged at 10 000 g for 20 min at 4 °C, followed by centrifugation at 100 000 g for 1 h at 4 °C. The pellet was washed and resuspended in 0.1 M PBS, pH 7.4 containing 10% glycerol and protease inhibitors (Roche). Protein content was measured by Bio-Rad protein assay (Bio-Rad laboratories). In all cases we obtained sufficient amount of microsomal fraction to perform immunoblot analyses (in average 1.6 mg microsomal protein/g of starting material).

**Immunoblot analysis**

Prostate microsomal proteins were separated by 9% SDS-PAGE using the Mini-PROTEAN III electrophoresis cell (Bio-Rad) and transferred to

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**Table 1 Characteristics of the human prostate samples**

<table>
<thead>
<tr>
<th>Prostate sample</th>
<th>Age (years)</th>
<th>Tissue</th>
<th>Gleason score</th>
<th>T stage&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Relapse&lt;sup&gt;b&lt;/sup&gt;</th>
<th>CYP3A5 genotype</th>
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<td>112</td>
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<td>BPH</td>
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<td>–</td>
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<tr>
<td>113</td>
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<td>–</td>
<td>–</td>
<td>*3/*3</td>
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<tr>
<td>114</td>
<td>70</td>
<td>BPH</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>*1/*3</td>
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<tr>
<td>116</td>
<td>64</td>
<td>BPH</td>
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<td>–</td>
<td>–</td>
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<tr>
<td>118</td>
<td>76</td>
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<td>–</td>
<td>–</td>
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<td>–</td>
<td>–</td>
<td>*1/*3</td>
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<tr>
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<td>–</td>
<td>–</td>
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<td>–</td>
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<tr>
<td>125</td>
<td>70</td>
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<td>–</td>
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<tr>
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<td>–</td>
<td>–</td>
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<tr>
<td>002</td>
<td>61</td>
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<td>3 + 3</td>
<td>T2C</td>
<td>N (22)</td>
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<tr>
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<td>69</td>
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<td>3 + 3</td>
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<td>Y (19)</td>
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<td>3 + 4</td>
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<td>Y (18)</td>
<td>*3/*3</td>
</tr>
<tr>
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<td>3 + 3</td>
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<td>N (29)</td>
<td>*3/*3</td>
</tr>
<tr>
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<td>3 + 4</td>
<td>T3A</td>
<td>Y (16)</td>
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<tr>
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<td>3 + 3</td>
<td>T2B</td>
<td>N (25)</td>
<td>*3/*3</td>
</tr>
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<td>3 + 2</td>
<td>T2B</td>
<td>N (14)</td>
<td>*1/*3</td>
</tr>
<tr>
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<td>61</td>
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<td>3 + 4</td>
<td>T3A</td>
<td>N (23)</td>
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<td>3 + 3</td>
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<td>N (14)</td>
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<tr>
<td>169</td>
<td>51</td>
<td>T + NT&lt;sup&gt;c&lt;/sup&gt;</td>
<td>3 + 3</td>
<td>T2B</td>
<td>N (14)</td>
<td>*3/*3</td>
</tr>
</tbody>
</table>

<sup>a</sup>Tumor clinical classification corresponds to the 6th edition of the AJCC/UICC TNM classification of malignant tumors.

<sup>b</sup>After surgery, PSA levels below 0.1 mg/ml indicate no relapse (N) and PSA levels above 0.1 mg/ml indicate relapse (Y).

<sup>c</sup>The months of follow-up or time to relapse respectively are shown in brackets.

<sup>d</sup>T stands for tumoral and NT stands for non-tumoral tissue in the matched samples.
polyvinylidene fluoride membranes (Immobilon-P Membrane, Millipore, Billerica, MA, USA). Equal loading of proteins was verified by Ponceau S staining. The membranes were blocked and then incubated with an antihuman CYP3A5 antibody (ab22692, Abcam, Cambridge, UK) following manufacturer’s instructions. This is a commercial polyclonal antibody raised against a synthetic hexapeptide including the C-terminal of CYP3A5 and reacting exclusively with CYP3A5, effective both for western blot and immunohistochemistry (IHC). After washing, the membranes were incubated with a goat anti-rabbit (DAKO, Copenhagen, Denmark) secondary antibody, and the corresponding horseradish peroxide signal was visualized using SuperSignal Femto substrate (Pierce, Rockford, IL, USA) and BiomaxLight membranes (Kodak). The CYP3A5 content was determined from standard curves derived from human CYP3A5+P450 reductase Supersomes (BD Biosciences, San Jose, CA, USA). The detection limit under these conditions was of 0.025 pmol CYP3A5/mg microsomal protein.

**Immunohistochemistry (IHC)**

Formalin-fixed, paraffin-embedded tissue sections were immunohistochemically stained using a polyclonal anti-CYP3A5 antibody (1:20000, ab22692, Abcam). Immunohistochemical staining was performed by the DAKO Envision system (DAKO) with a heat induced, antigen retrieval step. Sections from the paraffin-embedded tissue were immersed in boiling 10 mM sodium citrate at pH 6.5 for 2 min in a pressure cooker and finally proteinase K was added for 10 min at room temperature. For the frozen tissues 5 μm sections were cut with a cryostat, dehydrated in 70% ethanol over night, fixed in acetone for 10 min, and stained with the same antibody and dilution used for the paraffin-embedded tissue, without antigen retrieval. Kidney samples were used to optimize the signal detection and the specificity of the signal was assured by following the same immunohistochemical staining procedure but without adding CYP3A5 antibody (Fig. 3E). The results were analyzed by two experienced pathologist (E H and A C) and cytokeratin 34βE12 was used as a marker for prostate basolateral cells.

**Results**

**CYP3A5 is expressed at high levels in normal prostate tissue and its expression is influenced by CYP3A5*3 polymorphism**

We used quantitative RT-PCR to measure the CYP3As mRNA content in 24 non-tumoral prostate tissues and compared it with the expression of a pool of livers, which is the tissue with the highest CYP3A content. There were no significant differences in the CYP3As expression between the 14 BPH (from the transitional zone) and the ten non-tumoral (from the peripheral zone) prostate samples, suggesting that the CYP3A expression is not dependent on the prostate zone. Thus, the 24 tissues were analyzed together. We found that CYP3A5 mRNA content in prostate was the highest (10% hepatic levels), while CYP3A4, CYP3A7, and CYP3A43 mRNA content was much lower (0.0004, 0.05, and 0.15% of the liver respectively), and that more than seven PCR amplification cycles separated CYP3A5 content from the other CYP3A isoform (Fig. 1). The prostate CYP3A5 content represented from 7.9 to 69% of the hepatic levels, depending on the liver used for comparison. For CYP3A4 and CYP3A7 the maximum values were below 1%, while for CYP3A43, due to a very low CYP3A43 content in one of the livers up to 5.4% could be observed. Nevertheless the main CYP3A enzyme in prostate was CYP3A5.

CYP3A5 showed a 16-fold inter-sample variability in the 24 prostate cases studied. In the liver, CYP3A5 expression is influenced to a large extent by CYP3A5*3 polymorphism which, with a 90% frequency in Caucasians, creates a cryptic consensus splice site in intron 3. CYP3A5*3 results mainly in splice variant
mRNAs that contain a premature termination codon (amino acid 102) and only a small amount of correctly spliced CYP3A5 mRNA and protein is produced. Thus, to determine the influence of CYP3A5*3 in prostate, we performed CYP3A5 RT-PCR analysis using liver samples with different CYP3A5 genotypes and quantified both the correctly spliced and the total (correctly spliced plus alternatively spliced) CYP3A5 mRNAs. Similar to liver, CYP3A5*3/*3 prostate samples had lower CYP3A5 mRNA content than those CYP3A5*1/*3 (3.3- and 13-fold lower total and correctly spliced CYP3A5 mRNA in prostate compared with 2.8- and 10-fold difference in the liver samples respectively; Fig. 2A). The CYP3A5 total mRNA content of the prostate samples was 25% of the average amount in liver samples with the same CYP3A5 genotype (Fig. 2A upper panel), while for correctly spliced mRNA it was 15% (Fig. 2A lower panel).

To further characterize the expression of CYP3A5 in prostate, we performed a western blot analysis using a CYP3A5-specific antibody. As shown in Fig. 2B, CYP3A5 protein was detected in only some BPH microsomal fractions. Although there was not a strong correlation between CYP3A5 mRNA and protein content, the strongest signals corresponded to CYP3A5*1/*3 samples. The amount of CYP3A5 protein in sample 124 (with the highest expression) was of 0.15 pmol CYP3A5 per mg of total microsomal protein, which is much lower than CYP3A5 hepatic levels. However, this data should be referred to the prostate cells expressing CYP3A5, thus, it is important to determine CYP3A5 localization.

**CYP3A5 is expressed exclusively in the basolateral cells of the prostate**

IHC was used to determine the localization of CYP3A5 in the prostate tissue. Both in frozen and paraffined tissues, CYP3A5 staining was exclusively localized in the basolateral cells in the 24 non-tumoral samples.
analyzed, specifically in the cytoplasmatic region, as expected for a microsomal protein (Fig. 3A and B). In contrast, stromal and luminal cells did not express CYP3A5. The prostate basolateral cell marker cytokeratin 34βE12 was used to confirm CYP3A5 basal localization (Fig. 3F). The effect of CYP3A5*3 was not evident with the standard IHC conditions. However, when using lower amounts of the antibody, a difference in the intensity of the CYP3A5 signal could be appreciated between CYP3A5*1/*3 and CYP3A5*3/*3 samples (Supplementary Fig. 1, which can be viewed online at http://erc.endocrinology-journals.org/supplemental/). This data implies that since CYP3A5 protein and mRNA quantifications were performed using extracts from total prostate tissue (including stromal, luminal, and basolateral cells), but only the basolateral cells contribute to CYP3A5 expression, the actual CYP3A5 levels of the basolateral cells must be higher than the calculated 15–25% of hepatic mRNA levels and 0.15 pmol/mg microsomal protein.

Tumoral prostate tissue lacks CYP3A5 expression

When we investigated the expression of CYP3A5 in the ten matched non-tumoral samples by IHC, we found that in all of them there was a complete lack of CYP3A5 protein in the tumoral areas of the tissue and that only the surrounding areas containing non-tumoral normal glands showed CYP3A5 staining (Fig. 3C and D). The lack of CYP3A5 expression in the tumor is consistent with its basolateral localization, since prostate tumors lack basal cells. To confirm this, we analyzed the expression of the basolateral marker 34βE12 and found it absent, similarly to CYP3A5, in the prostate cancer regions (data not shown). The lack of CYP3A5 expression in the tumoral areas was confirmed in 25 additional prostate cancer samples (data not shown).

Analysis of the ten matched non-tumoral/tumoral samples by RT-PCR confirmed the IHC results, and we found that CYP3A5 mRNA was significantly lower in the tumoral tissue (in average 61- and 19-fold difference for total and correctly spliced CYP3A5 mRNA respectively; Supplementary Table 2). The detection of some CYP3A5 mRNA by RT-PCR in the tumoral samples can be easily explained by the contribution of contaminating non-tumoral tissue (see Fig. 3C and D). Therefore, the CYP3A5 RT-PCR and the IHC data are in full agreement.

Discussion

Contradictory and incomplete results have been reported with respect to the expression of the CYP3A enzymes in prostate tissue (Murray et al. 1995a, Finnstrom et al. 2001, Stamey et al. 2001, Koch et al. 2002, Di Paolo et al. 2005, Zhang et al. 2006, Moilanen et al. 2007). In this work, we clearly show that of the four human CYP3A enzymes only CYP3A5 had a relevant expression in prostate, with mRNA contents similar to liver (Fig. 1). Specifically, when comparing the CYP3A5 mRNA content of liver samples with prostate samples with the same CYP3A5 genotype, the prostate samples showed about 20% of the hepatic levels (Fig. 2A). Among the prostate samples included in this study, there was a large CYP3A5 mRNA variation, mainly caused by CYP3A5*3 polymorphism, which introduces an alternative splicing site that in the liver decreases the amount of full-coding transcript and

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**Figure 3** CYP3A5 protein detection by immunohistochemistry in prostate non-tumoral and tumoral tissue. Immunohistochemical staining of CYP3A5 was performed in paraffin sections as described in Materials and methods section. In the non-tumoral tissue (A and B) CYP3A5 was localized in the prostate glands, specifically in the basolateral cells of CYP3A5*1/*3 (143N, A) and CYP3A5*3/*3 (169N, B) samples. Immunohistochemical staining of CYP3A5 in paraffin sections of tumoral prostate samples (C and D) showed that CYP3A5 was absent in the tumoral areas (T) and CYP3A5 signal was localized only in the surrounding normal tissue (N). The tumor samples analyzed were: 143T (C), 169T (D). (E) shows the same immunohistochemical staining procedure in 143N but without CYP3A5 antibody and (F) corresponds to an IHC staining using the basolateral marker cytokeratin 34βE12. Original magnification ×20, except for A with ×10 and for B with ×40.
ultimately causes low CYP3A5 protein expression (Kuehl et al. 2001). In this work, CYP3A5*1/*3 prostate samples had 13-fold higher amounts of correctly spliced mRNA than CYP3A5*3/*3 samples and, although the number of samples analyzed was small and the correlation with mRNA levels was not strong, the highest CYP3A5 protein content also corresponded to CYP3A5*1/*3 prostate samples (Fig. 2B). Recently, Moilanen et al. (2007) detected CYP3A5 protein in the prostate, but surprisingly CYP3A5*3/*3 samples showed similar or even higher CYP3A5 protein content than CYP3A5*1/*3 samples, and by IHC they found CYP3A5 protein both in luminal and basolateral cells and both in non-tumoral and tumoral prostate tissues. In contrast, in this work we found that CYP3A5 was exclusively expressed in the basolateral cells of the non-tumoral tissue (Fig. 3A and B), while absent in the tumor (Fig. 3C and D). This data were fully supported by the quantitative RT-PCR analysis in the matched non-tumoral/tumoral samples (Supplementary Table 2). The differences between this and other studies are probably caused by the use of antibodies with low specificity (e.g., CYP3A5 IHC signal by Moilanen et al. was also localized in the nuclei) which is not in agreement with the microsomal localization of CYP3A5 (compare with Fig. 3A) and in the case of mRNA by the use, in some studies, of non-quantitative PCR methods.

Because CYP3A5 protein is exclusively localized in the basolateral cells, and these represent 2% of the total prostate cells (Liu et al. 1997) about 7.5 pmol CYP3A5/mg microsomal basolateral protein can be estimated, which is similar to the 37 pmol found in CYP3A5*1/*3 livers (Liu et al. 1997, Westlind-Johnsson et al. 2003). Similarly, if we take into account that only the basolateral cells contribute to CYP3A5 expression, the CYP3A5 mRNA levels in the prostate basal cells would be ten times higher than that in the liver cells. The difference between the prostatic and hepatic CYP3A5 mRNA and protein contents could indicate a tissue-specific CYP3A5 posttranscriptional regulation. In any case, the high CYP3A5 prostatic expression suggests that CYP3A5 may play a relevant function in the prostate and, since the prostate is not a tissue relevant for drug metabolism, this function must be related to the metabolism of prostatic endogenous CYP3A5 substrates, such as androgens (Ohmori et al. 1998, Miller et al. 2004). In other tissues CYP3A5 has also been shown to play an important endogenous function, and CYP3A5*3 has been shown to influence the systolic blood and pulse pressure, presumably by altering CYP3A5-mediated glucocorticoid metabolism (Kreutz et al. 2005). Thus, by oxidation of testosterone and DHEA in the basolateral prostate cells, CYP3A5 could control their entrance into the luminal cells which grow in a hormone-dependent manner (Masai et al. 1990). In fact, androgens up-regulate CYP3A5 expression in human prostate, suggesting an autoregulatory loop to control testosterone exposure (Moilanen et al. 2007). Consequently, polymorphism affecting CYP3A5 activity could alter the oxidation of androgens in the basolateral cells and ultimately luminal prostate cell growth function and prostate cancer development (Parnes et al. 2005, Zhenhua et al. 2005).

In line with this idea, several publications have associated CYP3A SNPs with prostate cancer risk and aggressiveness (Rebeck 1998, Paris et al. 1999, Plummer et al. 2003, Loukola et al. 2004, Zhenhua et al. 2005, Bangsi et al. 2006). However, most studies have focused on CYP3A4*1B, which does not result in major changes in CYP3A4 expression (Rodriguez-Antona et al. 2005) and is not expressed in the prostate (Fig. 1). The CYP3A locus shows a high degree of linkage disequilibrium (Kuehl et al. 2001, Lee et al. 2003), and ~80% of Caucasians carrying CYP3A4*1B are simultaneously CYP3A5*1 (Wojnowski et al. 2002). In Asians, in which CYP3A4*1B is absent and, thus, is not a confounding factor, CYP3A5*1/*1 men had a 0.23-fold lower risk of developing a low-grade prostate cancer and a 0.31-fold lower risk of developing localized prostate cancer than CYP3A5*3/*3 men (Zhenhua et al. 2005). In Africans, in addition to CYP3A5*3, there are two other common functional CYP3A5 polymorphisms which have not been taken into account in any of the association studies carried out so far: CYP3A5*6, which creates an alternative splicing site similarly to CYP3A5*3, and CYP3A5*7 which has a single nucleotide insertion causing a frameshift and early stop codon (with 13 and 10% frequency respectively; Hustert et al. 2001, Kuehl et al. 2001, Lee et al. 2003). Therefore, the association studies in Africans can only be complete when all three CYP3A5 defective alleles are considered together and compared with the wild-type CYP3A5*1 allele. Undoubtedly, further studies are needed to confirm the association of CYP3A5 functional SNPs with prostate cancer.

In conclusion, we have shown that only CYP3A5 out of the four CYP3A genes is expressed at high levels in the non-tumoral prostate tissue, specifically in the basolateral cells and that this expression does not occur in the tumors. This data reveal an important endogenous role of CYP3A5 in the prostate and association studies between prostate cancer and CYP3A polymorphisms indicate that this function must be related to the metabolism of intra-prostatic androgens and regulation of luminal cell growth. Furthermore, this data suggest that future prostate cancer association...
studies on CYP3A genes should focus on CYP3A5 functional polymorphisms such as CYP3A5*3, *6, and *7 which could be directly associated with prostate cancer risk and aggressiveness.

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