The role of oestrogen receptor \( \alpha \) in human thyroid cancer: contributions from coregulatory proteins and the tyrosine kinase receptor HER2

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Abstract

Epidemiological, clinical, and molecular studies suggest a role for oestrogen in thyroid cancer. How oestrogen mediates its effects and the consequence of it on clinical outcome has not been fully elucidated. The participation of coregulatory proteins in modulating oestrogen receptor (ER) function and input of crosstalk with the tyrosine kinase receptor HER2 was investigated. Oestrogen induced cell proliferation in the follicular thyroid cancer (FTC)-133 cells, but not in the anaplastic 8305C cell line. Knockdown of the coactivator steroid receptor coactivator (SRC)-1 inhibited FTC-133 basal, but not oestrogen induced, cell proliferation. Oestrogen also increased protein expression of SRC-1 and the ER target gene cyclin D1 in the FTC-133 cell line. ER\( \alpha \), ER\( \beta \), the coregulatory proteins SRC-1 and nuclear corepressor (NCoR), and the tyrosine kinase receptor HER2 were localised by immunohistochemistry and immnofluorescence in paraffin-embedded tissue from thyroid tumour patients \( (n=111) \). ER\( \alpha \) was colocalised with both SRC-1 and NCoR to the nuclei of the tumour epithelial cells. Expression of ER\( \alpha \) and NCoR was found predominantly in non-anaplastic tumours and was significantly associated with well-differentiated tumours and reduced incidence of disease recurrence. In non-anaplastic tumours, HER2 was significantly associated with SRC-1, and these proteins were associated with poorly differentiated tumours, capsular invasion and disease recurrence. Totally, 87% of anaplastic tumours were positive for SRC-1. Kaplan–Meier estimates of disease-free survival indicated that in thyroid cancer, SRC-1 strongly correlates with reduced disease-free survival \( (P<0.001) \), whereas NCoR predicted increased survival \( (P<0.001) \). These data suggest opposing roles for the coregulators SRC-1 and NCoR in thyroid tumour progression.

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Introduction

Thyroid carcinoma constitutes 1% of all new malignant disease. Of these, 94% are differentiated follicular or papillary carcinomas. A further 5% are medullary carcinomas derived from neuroendocrine cells. The remaining are anaplastic tumours arising from dedifferentiation of the differentiated type (Figge 1999). In view of the low incidence and largely favourable prognosis, therapeutic advances are minimal. Despite multimodal therapy, there has been no improvement in survival rates over the past two decades (Teppo et al. 1998, Sherman 2003).

Malignant disease of the thyroid gland is three times more common in females than in males. Despite this, the prognosis is more favourable in females. Well-differentiated carcinomas have a female preponderance...
and are most frequent in the postpubertal and premenopausal age groups. The use of the oral contraceptive pill is associated with a higher risk of thyroid cancer. An increased incidence is similarly seen in patients treated with oestrogen therapy for gynaecological conditions, but not for postmenopausal patients treated with low-dose oestrogen replacement therapy. Recently, it has been shown that among parous women of reproductive age, a recent pregnancy is associated with approximately a doubling in thyroid cancer risk. Pregnancy is associated with elevated serum thyroid hormone and oestrogen level, further supporting a role for oestrogen in thyroid carcinogenesis (Rossing et al. 2000). This gender difference is observed worldwide and suggests that thyroid tumour development and progression may be influenced by oestrogen as previously demonstrated in breast cancer. Furthermore, Kishino et al. (1997) identified a beneficial role for high-dose tamoxifen in multidrug resistant thyroid cancer.

Oestrogens play a critical role in endocrine tumours, including those of the breast, prostate and thyroid. Oestrogen mediates its genomic actions through binding its nuclear receptor leading to transcription and translation of genes relevant to tumour progression. The oestrogen receptor (ER) is encoded for by two genes, ERα and ERβ. Though both isoforms of the receptor have been identified in human thyroid tumour tissue, it is ERα that has been associated with increased oestrogen-dependent cell proliferation (Zeng et al. 2008). Oestrogen can also mediate its effects independently of its classic nuclear receptor. Studies in the thyroid have shown that oestrogen can utilise the G-coupled protein GPCR30 to drive both gene transcription and cellular growth (Vivacqua et al. 2006).

Central to the functioning of ER are the coregulatory proteins. These are present at rate-limiting amounts in the nucleus, thereby regulating transcription of target genes. Coactivators possess histone acetylation activity, which may directly influence gene expression through local depression of chromatin. These coactivators include the p160 (160 kDa) protein family members steroid receptor coactivator (SRC-1) and amplified in breast cancer (AIB-1). In the absence of ligand, the ER maintains transcriptional silencing through recruitment of the nuclear corepressors (NCoRs) silencing mediator of retinoid and thyroid receptors and NCoR (Chen & Evans 1995, Jenster & Spencer 1997). On binding to its receptor, oestrogen releases the resident corepressor and recruits coactivator in order to initiate successful transcription and translation of the target gene (Smith & O’Malley 2004). In the setting of breast cancer, these molecular switches have been shown to be prognostically significant (Myers et al. 2004, McIlroy et al. 2006). Aberrant expression of p160 proteins has been associated with resistance to endocrine therapies and the development of tumour recurrence (Osborne et al. 2003, Redmond et al. 2009). Furthermore, unlike other oncogenes, recent studies provide evidence of a specific role for SRC-1 in the development of metastasis (Qin et al. 2009, Wang et al. 2009). The presence of the coregulatory proteins in thyroid cancer and their prognostic significance, if any, have not yet been examined.

We hypothesised that ER signalling plays a role in the progression of thyroid cancer. To test this, we examined the proliferative effects of oestrogen in thyroid cancer and the effects of oestrogen on the expression of its target gene, cyclin D1. In addition, we analysed a cohort of thyroid cancer patients to determine the presence and significance of ERα, ERβ and the coregulatory proteins, SRC-1 and NCoR, and the tyrosine kinase receptor HER2 in relation tumour type and disease progression.

Materials and methods

Patient selection

Tumour specimens from consecutive patients with thyroid cancer treated at St Vincent’s University Hospital, Dublin from 1990 to 2001 were selected. Histologically, normal thyroid tissue specimens were obtained from patients who underwent surgery for multinodular goitre. The cancer specimens arose from patients who had not had previous therapy for thyroid cancer and had undergone primary surgical resection. Patients with non-anaplastic tumours <10 mm underwent surgery alone, and those with tumours >10 mm underwent surgery followed by radio-iodine therapy. Patients with anaplastic tumours received radio-therapy.

Clinicopathological parameters

Variables analysed included size, pathological subtype, extremes of age (<10 and >40), gender, degree of differentiation and capsular invasion. Median follow-up was 10.2 years.

Immunohistochemistry

Five micron (5 μm thick) tissue sections were taken from paraffin-embedded thyroid cancer and multinodular goitre. Following antigen retrieval, sections were incubated with primary antibodies as...
follows: rabbit anti-human ERα (1 μg/ml), rabbit anti-human SRC-1 (1 μg/ml), rabbit anti-human NCoR (1 μg/ml; Santa Cruz Biotechnology, Santa Cruz, CA, USA) and mouse anti-human ERβ (5 μg/ml; Serotec, Oxford, UK). The primary antibodies were incubated for 1 h at room temperature. Sections were subsequently incubated with the corresponding biotin-labelled secondary antibody (0.5% in PBS; Vector Laboratories, Burlingame, CA, USA) for 30 min, followed by peroxidase-labelled avidin–biotin complex (Vector Laboratories) for 30 min. Sections were developed in 3,3-diaminobenzidine tetrahydrochloride for 8 min and counterstained with haematoxylin for 3 min, then passed through increasing concentrations of industrial methylated spirits (IMS) (70 and 100%) and then xylene. Immunostained slides were scored using the Allred scoring system (Harvey et al. 1999). A combined score of three or higher was defined as positive staining. Each slide was observed by two independent observers blinded to the clinicopathological factors of interest. The interobserver correlation coefficient was determined. These coefficients ranged from 0.909 to 0.972 indicating a high level of interobserver reliability (Fleiss 1986).

Assessment of HER2 status

HER2 status was evaluated using the Dako (Glostrup, Denmark) HercepTest immunocytochemical assay. Scoring was assessed according to the manufacturer’s instructions (0–3). In tumour samples scoring +2 with the Hercept test, HER2 status was confirmed by fluorescent in situ hybridisation using the PathVysion kit probe to detect amplification of the HER2 gene (spectrum orange labelled HER2 and spectrum green labelled α satellite centromeric region for chromosome 17; Vysis Inc., Downers Grove, IL, USA) according to the manufacturer’s instructions.

Immunofluorescence

Thyroid cancer sections were prepared as above and incubated in goat serum (ERα) for 60 min. Goat anti-rabbit ERα (10 μg/ml in 10% human serum) was placed on each slide for 90 min. The sections were rinsed in PBS and incubated with the corresponding secondary fluorochrome-conjugated antibody (1 in 100; Sigma–Aldrich) for 60 min. The slides were rinsed in PBS and blocked in rabbit serum for 90 min and washed with PBS. Each slide was incubated with either rabbit anti-human SRC-1 or rabbit anti-human NCoR (both 10 μg/ml in 10% human serum) for 90 min, followed by a wash in PBS. The slides were incubated with the corresponding fluorochrome-conjugated antibody (1 in 100) for 60 min. Sections were rinsed in PBS and mounted (Dako). Sections were examined under a fluorescent microscope. Negative controls were performed using matched IgG, and no staining was detected.

Cell culture treatments

The follicular thyroid cancer (FTC)-133 cell line (ECACC, Wiltshire, UK) was grown in DMEM and Ham’s F12 (1:1) supplemented with 10% FCS and 2 mM l-glutamine (Gibco). The 8305C anaplastic thyroid cancer cell line 8305C (ECACC) was grown in EMEM (Sigma) supplemented with 10% FCS, 2 mM l-glutamine and 1% non-essential amino acids. Cells were incubated in a humidified atmosphere of 5% CO2 at 37 °C. Experiments were carried out when cells reached 90% confluence. Cells were maintained in steroid and phenol-free minimum essential medium (Gibco) for 72 h prior to treatment. Cells were then incubated in the presence and absence of 17β-oestradiol (OE2) or Faslodex (ICI 182 780) (10 nM) for 24 h and then harvested.

Western blotting

Proteins (100 μg) were resolved on a polyacrylamide gel (12% for ERα, SRC-1 and cyclin D1, and 6% for NCoR) at 110 V for 120 min and were transferred to a nitrocellulose membrane (250 mA for 60 min for ERα, SRC-1 and cyclin D1, and 90 min for NCoR). Membranes were incubated for 60 min in blocking buffer (5% non-fat dry milk and 0.05% Tween-20 in TBS) at room temperature and subsequently with primary antibody, rabbit anti-human ERα (2 μg/ml), rabbit anti-human ERβ (2 μg/ml), rabbit anti-human SRC-1 (2 μg/ml), rabbit anti-human NCoR (2 μg/ml) or rabbit anti-human cyclin D1 (2 μg/ml) in blocking buffer overnight at 4 °C. The membranes were washed prior to incubation with the corresponding HRP secondary antibody (1 in 2000 for ERα, ERβ, cyclin D1 and SRC-1, and 1 in 3300 for NCoR) in blocking buffer for 60 min at room temperature. The membranes were washed and developed with intensified chemiluminescence (Pierce, Rockford, IL, USA).

Proliferation assays

The FTC-133 and 8305C cells were seeded on a 12-well plate. Cells were treated with either 10 nM 17-OE2 or ICI-182 780 alone or in combination as described above. Methyl thioazole tetrazolium (500 μg/ml) was added to each well, and following a 4-h incubation period, absorbance was read at 570 nm.
siRNA
Pre-designed and validated siRNA directed against SRC-1 (Ambion, Austin, TX, USA, cat no. 115458) were used in the knockdown studies (Redmond et al. 2009).

Flow cytometry
Cells were harvested by centrifugation at 200 g for 4 min and washed in 10 ml ice-cold PBS. Cell pellets were resuspended in 200 µl PBS and fixed in 2 ml ice-cold 70% (v/v) ethanol at 4 °C overnight. Cells were centrifuged at 300 g for 4 min, ethanol was removed and the pellets were resuspended in 400 µl PBS. RNase A (0.5 mg/ml) and propidium iodide (200 µM) were added, and samples were incubated in the dark at 37 °C for 30 min. Cell cycle profiles were analysed on an Accuri C6 flow cytometer using CFlow Software.

Statistical analysis
Univariate analysis was performed using Fisher’s exact test for categorical variables and using Wilcoxon’s test for continuous variables. Two-sided P values of <0.05 were considered to be statistically significant. Kaplan–Meier estimates of disease-specific survival functions were computed, and the Wilcoxon test was used to compare survival curves.

Results
Thyroid cancer cell cycle, proliferation and protein expression
Cell cycle phase of follicular (FTC-133) and anaplastic (8305C) thyroid cancer cell lines was assessed by flow cytometry. Anaplastic thyroid cancer cells had a greater percentage of cells in the G2/M phase in comparison to the follicular cell line (Fig. 1A). There was no discernable difference observed in cell cycle phase in either of the thyroid cancer cells following treatment with β-OE2. However, oestrogen increased overall cellular proliferation of the FTC-133 cell line (Fig. 1B). The ER antagonist ICI 182 780 (Faslodex) inhibited oestrogen-dependent FTC-133 cell proliferation. Oestrogen had no effect on cell proliferation in the 8305C cell line (Fig. 1D).

Localisation of ER and coregulatory proteins in human thyroid cancer tissue
ERα, ERβ, SRC-1 and NCoR were all found to be expressed in a subset of thyroid tumour patients. ERα and the coregulatory proteins were strongly expressed in the nucleus with some cytoplasmic staining also observed (Fig. 2A). Expression of SRC-1 was detected exclusively in the tumour tissue, whereas ERα and NCoR were also present in the surrounding normal and goitre tissue. In patients who were positive for ERα and the coregulatory proteins, ERα was found to colocalise with both SRC-1 and NCoR in the nucleus of the tumour epithelial cells (Fig. 2B).

Expression of ER and coregulatory proteins in thyroid tumour subtypes
Qualitative expression of the receptors ERα and HER2, along with the coregulatory proteins SRC-1 and NCoR, was examined in subtypes of thyroid cancers (Fig. 3A). ERα and NCoR were found to be expressed in both normal thyroid tissue and non-anaplastic tumours, including papillary, follicular and adenoma. ERβ was found to be expressed predominantly in papillary tumours. A low percentage (<10%) of papillary and follicular tumours expressed SRC-1. In contrast, a high percentage of anaplastic tumours (87%) expressed SRC-1, and a low number of these tumours were positive for ERα.

In the patient population, ERα expression was positively associated with NCoR and negatively associated with HER2 and SRC-1 (Table 1). In terms of clinicopathological characteristics, no association was observed between expression of the ERα and the coregulatory proteins in relation to extremes of age (<10 and >40 years), gender or tumour size. ERα and NCoR expression was positively associated with well-differentiated tumours and inversely with disease recurrence. Whereas, both the tyrosine kinase receptor HER2 and coactivator SRC-1 associated with capsular invasion and recurrence (Table 1).

Kaplan–Meier estimates of disease-free survival indicate that patients with anaplastic tumours have significantly reduced survival compared with
Figure 1 (A) Flow cytometry analysis of cell cycle phase in follicular (FTC-133) and anaplastic (8305C) breast cancer cell lines. Percentage of cells in G2/M phase under control conditions and following treatment with 17β-oestradiol and Faslodex (48 h) alone and in combination. Results are expressed as mean ± S.D. of individual experiments (n=3). (B) Cell proliferation was analysed by MTT assay. FTC-133 and 8305C thyroid cancer cells were cultured in the presence of 17β-oestradiol and Faslodex (24 h) alone and in combination. Results are expressed as mean ± S.D. of individual experiments (n=3). (C) Protein expression of ERα, ERβ, SRC-1, NCoR and cyclin D1 in the FTC-133 and 8305C human thyroid cancer cell line was assessed by western blotting post-incubation with β-oestradiol (E) (24 h). Membranes were also probed for β-actin. Optical density readings were calculated relative to β-actin, control values (C) were normalised to one and the treated group was expressed as a ratio. Results are expressed as mean ± S.D. (n=3). (D) Successful knockdown of SRC-1 with siRNA was confirmed by western blot. Knockdown of SRC-1 inhibited basal cell proliferation in the follicular (FTC-133), but not anaplastic (8305C) thyroid cancer cell line. Results are expressed as mean ± S.D. (n=3).
non-anaplastic tumours ($P<0.001$; Fig. 3B). In the whole patient cohort, SRC-1 significantly predicted poor disease-free survival ($P<0.001$), whereas expression of NCoR predicted a good prognosis ($P<0.001$; Fig. 3B).

In order to more clearly define a role for these coregulatory proteins in thyroid cancer subtypes, we analysed expression of SRC-1, NCoR and HER2 expression in anaplastic versus non-anaplastic tumours (Table 2). NCoR was expressed in 55% of non-anaplastic tumours and associated positively with well-differentiated cancers ($P<0.001$). Both SRC-1 and HER2 were expressed in 17% of non-anaplastic tumours, and these proteins were significantly associated with each other ($P<0.001$) and with disease recurrence ($P=0.001$ and $P<0.005$ respectively). Totally, 87% of anaplastic tumours were positive for SRC-1, whereas no expression of either NCoR or HER2 was observed. All patients with anaplastic tumours had a disease recurrence (Table 2).

Discussion

Epidemiological, translational and clinical evidence suggests a role for oestrogens in the development of thyroid cancer (Kishino et al. 1997, Rossing et al. 2000, Lee et al. 2003, Zeng et al. 2008). Recent reports suggest that oestrogen can increase ERα expression in non-anaplastic papillary cancer cells, increase cellular proliferation and inhibit pro-apoptotic protein expression. In thyroid cancer, oestrogen can also activate extranuclear effects of ER, in particular by signalling through the G protein-coupled receptor GPR30 (Vivacqua et al. 2006). No alteration, however,
in cellular proliferation in anaplastic thyroid carcinoma cells has been observed. In this study, we employed cell line models of follicular and anaplastic thyroid cancer. The follicular cancer cells (FTC-133) were originally derived from a lymph node metastasis of a follicular thyroid carcinoma. These cells do, however, retain differentiated thyrocytic function and are responsive to growth factors. The anaplastic cell line, 8305C, was established from an undifferentiated thyroid and is positive for both EGFR and HER2 (Murakawa et al. 2005). From cell cycle analysis, 8305C cells had a greater percentage of cells in the G2/M phase in comparison to the FTC-133 cells. Oestrogen had no effect on cell cycle phase in either cell line. However, in the FTC-133 cells, oestrogen induced cellular proliferation, which was inhibited by the ER antagonist ICI 182 780 (Faslodex) and increased protein expression of its target gene cyclin D1. In our patient cohort, ERα was found to be highly expressed in both normal thyroid tissue and non-anaplastic tumours, including papillary, follicular and adenoma. However, only 10% of anaplastic tumours were positive for ERα. Expression of the steroid receptor was positively associated with well-differentiated tumours and

Figure 3 (A) Expression levels of ERα, ERβ, SRC-1, NCoR and HER2 in thyroid cancer specimens represented as percentages observed in each of the pathological subtypes encountered. (B) Patients with anaplastic disease were found to have a significantly reduced period of disease-free survival (i). Positivity for SRC-1 was shown to result in poor survival (ii), whereas expression of NCoR associates with longer disease remission (iii).
The corepressor significantly associated with non-anaplastic tumours and normal thyroid tissue. In the entire thyroid cancer patient population, there was a reverse relationship with disease recurrence. These data suggest that in thyroid cancer, oestrogen signalling is associated with non-aggressive, well-differentiated tumours, which have a favourable prognosis. Where the proliferation of thyroid cancer cells is promoted by ERα, proliferation is thought to be reduced by enhanced expression of ERβ (Zeng et al. 2008). In this study, ERβ expression was observed in both the follicular and anaplastic cancer cell lines; however, at a tissue level, ERβ was found to be expressed predominantly in papillary thyroid cancer patients, suggesting that a functional role for ERβ may be principally in this cancer subtype.

The magnitude of ER gene regulation is influenced not only by the ligand, but also by the presence of specific co-regulatory proteins, present at rate-limiting levels, which modulate transcription. Studies from our group in breast cancer suggest that while expression of the coactivator protein SRC-1 correlates with reduced time to disease recurrence, the presence of the corepressor NCoR predicts enhanced disease-free survival (Myers et al. 2005, Al-azawi et al. 2008, Redmond et al. 2009). In the thyroid patient population, NCoR was found exclusively in the non-anaplastic tumours and normal thyroid tissue. The corepressor significantly associated with expression of ERα, inversely associated with capsular invasion and positively with well-differentiated tumours. Furthermore, Kaplan–Meier estimates of disease-free survival demonstrated that NCoR significantly predicted enhanced survival in thyroid cancer patients. In contrast, in the FTC-133 follicular cancer cell line, SRC-1 protein expression was elevated in the presence of oestrogen, and knockdown of the coactivator protein inhibited cell proliferation. However, knockdown of SRC-1 had no effect on oestrogen-induced FTC-133 cell growth, suggesting that coactivator functional redundancy similar to that seen in the breast may also be relevant in thyroid cancer (Xu & Li 2003). SRC-1 was expressed in a subset of non-anaplastic patients. Expression of SRC-1 was associated with disease recurrence and inversely associated with well-differentiated tumours. Though only low levels of SRC-1 were detected in the 8305C anaplastic cell line and knockdown of the coactivator had no effect on cell proliferation, SRC-1 was found to be highly expressed in the anaplastic patient population. These observations are in line with recent studies in the breast, which describe a specific role for SRC-1 in the development of tumour metastasis (Qin et al. 2009, Wang et al. 2009). Furthermore, in the entire thyroid cancer patient population, there was a

Table 1: Associations with clinicopathological parameters as determined by Fisher’s exact test. Association of variables oestrogen receptor α (ERα), steroid receptor coactivator-1 (SRC-1), nuclear corepressor (NCoR), HER2 and recurrence were evaluated in conjunction with clinical classifications.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Total n=63</th>
<th>ERα positive (n=25)</th>
<th>SRC-1 positive (n=57)</th>
<th>NCoR positive (n=18)</th>
<th>HER2 positive (n=27)</th>
<th>Recurrence (n=27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capsular invasion</td>
<td>24</td>
<td>9/63 (0.028)*</td>
<td>13/25 (&lt;0.001)</td>
<td>5/57 (0.001)*</td>
<td>17/18 (&lt;0.001)</td>
<td>7/27 (0.593)</td>
</tr>
<tr>
<td>Well differentiated</td>
<td>76</td>
<td>54/63 (&lt;0.001)*</td>
<td>1/25 (&lt;0.001)*</td>
<td>52/57 (&lt;0.001)</td>
<td>0/18 (&lt;0.001)</td>
<td>7/27 (&lt;0.001)*</td>
</tr>
<tr>
<td>ERα positive</td>
<td>63</td>
<td>–</td>
<td>5/25 (&lt;0.001)*</td>
<td>42/57 (&lt;0.001)</td>
<td>5/18 (&lt;0.001)</td>
<td>10/27 (0.025)*</td>
</tr>
<tr>
<td>SRC-1 positive</td>
<td>25</td>
<td>5/63 (&lt;0.001)*</td>
<td>–</td>
<td>1/57 (&lt;0.001)</td>
<td>11/18 (&lt;0.001)</td>
<td>16/27 (&lt;0.001)</td>
</tr>
<tr>
<td>NCoR positive</td>
<td>57</td>
<td>42/63 (&lt;0.001)</td>
<td>1/25 (&lt;0.001)</td>
<td>–</td>
<td>2/18 (&lt;0.001)</td>
<td>8/27 (&lt;0.014)*</td>
</tr>
<tr>
<td>HER2 positive</td>
<td>18</td>
<td>5/63 (0.007)</td>
<td>11/25 (&lt;0.001)</td>
<td>2/57 (&lt;0.001)</td>
<td>–</td>
<td>8/27 (0.039)</td>
</tr>
<tr>
<td>Recurrence</td>
<td>27</td>
<td>4/63 (0.003)</td>
<td>12/25 (&lt;0.001)</td>
<td>2/57 (&lt;0.001)</td>
<td>7/18 (0.007)</td>
<td>–</td>
</tr>
</tbody>
</table>

*Reverse relationship.

Table 2: Association of steroid receptor coactivator-1 (SRC-1), nuclear corepressor (NCoR), HER2, differentiation and recurrence were evaluated by Fisher’s exact test in the anaplastic and non-anaplastic patient populations.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Anaplastic n=8</th>
<th>Non-anaplastic n=103</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRC-1 (n=7)</td>
<td>HER2 (n=0)</td>
<td>NCoR (n=0)</td>
</tr>
<tr>
<td>SRC-1</td>
<td>HER2 (n=18)</td>
<td>NCoR (n=57)</td>
</tr>
<tr>
<td>SRC-1</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>HER2</td>
<td>0/7</td>
<td>–</td>
</tr>
<tr>
<td>NCoR</td>
<td>0/7</td>
<td>–</td>
</tr>
<tr>
<td>Recurrence</td>
<td>7/7</td>
<td>–</td>
</tr>
<tr>
<td>Well differentiated</td>
<td>0/7</td>
<td>–</td>
</tr>
</tbody>
</table>

*Inverse relationship.
strong correlation between SRC-1 expression and reduced disease-free survival.

Abnormalities in growth factor signalling pathways play an intrinsic role in endocrine tumour disease progression. In human breast cancer, the growth factor receptor HER2 is overexpressed in 20–30% of tumours (Berget et al. 1988). Molecular and clinical evidence suggests that crosstalk between steroid receptor and growth factor pathways contributes to endocrine insensitivity, at least in part through phosphorylation and activation of coactivator proteins (Osborne et al. 2005). We have previously described a positive association between expression of the coactivators, SRC-1 and AIB1, and the growth factor receptor, HER2, in a cohort of breast tumour patients (Myers et al. 2005) and shown that the risk ratio of recurrence in HER2-positive patients with elevated SRC-1 is 16.82 (Fleming et al. 2004).

Several groups have reported HER2 expression in thyroid cancer (Ensinger et al. 2003, Mondi et al. 2003, Wiseman et al. 2008), though results from these studies remain inconclusive. Mondi et al. (2003) observed no significant expression of HER2 in benign or malignant thyroid tissue, and Wiseman et al. (2008) found that HER2 was not significantly expressed in anaplastic tumours. However, others have reported that in papillary thyroid carcinoma, expression of HER2 was associated with disease recurrence (Ensinger et al. 2003). In this study, though no detectable levels of HER2 were observed in anaplastic tumours, 17% of non-anaplastic tumours were positive for HER2. Expression of the tyrosine kinase receptor was associated with capsular invasion, inversely with well-differentiated tumours and positively with disease recurrence. Of interest, in the non-anaplastic tumour population, HER2 was positively associated with SRC-1 and inversely associated with NCoR.

This is the first translational study to take a comprehensive look at oestrogen signalling in relation to the contribution of steroid receptor coregulatory proteins and tyrosine kinase receptor status in human thyroid cancer. Data that have emerged from this study establish ER signalling, in conjunction with its corepressor protein NCoR as a mediator of well-differentiated tumours with a favourable prognosis. The coactivator protein SRC-1 is associated with invasion, poor differentiation, tumour recurrence and reduced disease-free survival. In non-anaplastic tumours, SRC-1 strongly associates with HER2, suggesting that crosstalk with the tyrosine kinase receptor may activate SRC-1 in this tumour subtype. In anaplastic thyroid cancer, SRC-1 does not appear to mediate these effects through the steroid receptor ER.

The ability of steroid coactivator proteins to function independently of ER has been previously described by our group and others (Goel & Janknecht 2004, Myers et al. 2005, Al-azawi et al. 2008). Though the signalling mechanism of SRC-1 in cellular dedifferentiation in anaplastic thyroid carcinoma has yet to be resolved, this protein may represent a new therapeutic target for this rare, but rapidly fatal disease.

Declaration of interest

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

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Author contribution statement

D Kavanagh, E Myers, M McIlroy and F Bane performed the experiments; M McIlroy was responsible for statistical analysis and manuscript preparation; T Crotty, pathology expertise; E McDermott and A Hill provided tumour specimens and were instrumental in creating a clinical framework to relate the data back to the patient; Leonie Young designed the experiments and was responsible for the successful execution of the study.

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