The renin–angiotensin system in the breast and breast cancer

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Abstract

Much evidence now suggests that angiotensin II has roles in normal functions of the breast that may be altered or attenuated in cancer. Both angiotensin type 1 (AT1) and type 2 (AT2) receptors are present particularly in the secretory epithelium. Additionally, all the elements of a tissue renin–angiotensin system, angiotensinogen, prorenin and angiotensin-converting enzyme (ACE), are also present and distributed in different cell types in a manner suggesting a close relationship with sites of angiotensin II activity. These findings are consistent with the concept that stromal elements and myoepithelium are instrumental in maintaining normal epithelial structure and function. In disease, this system becomes disrupted, particularly in invasive carcinoma. Both AT1 and AT2 receptors are present in tumours and may be up-regulated in some. Experimentally, angiotensin II, acting via the AT1 receptor, increases tumour cell proliferation and angiogenesis, both these are inhibited by blocking its production or function. Epidemiological evidence on the effect of expression levels of ACE or the distribution of ACE or AT1 receptor variants in many types of cancer gives indirect support to these concepts. It is possible that there is a case for the therapeutic use of high doses of ACE inhibitors and AT1 receptor blockers in breast cancer, as there may be for AT2 receptor agonists, though this awaits full investigation. Attention is drawn to the possibility of blocking specific AT1-mediated intracellular signalling pathways, for example by AT1-directed antibodies, which exploit the possibility that the extracellular N-terminus of the AT1 receptor may have previously unsuspected signalling roles.

Introduction

In the treatment of breast cancer, the various ways of removing the effects of oestrogen, first by surgery and then by the use of drugs, such as tamoxifen and the aromatase inhibitors, which block the actions of oestrogens or prevent their formation, have been hugely successful (Barnes et al. 2004, Howell & Dowsett 2004, Jones & Buzdar 2004). Indeed, the critical association between oestrogens, oestrogen receptor (ER) expression and cancer is so entrenched in relation to the breast that the terms ‘receptor-positive’ or ‘receptor-negative’ tumours are a widely accepted shorthand for ER alone (e.g. Yaren et al. (2007)).

This long-established connection between oestrogen and breast tumours preceded the more general realisation that the misdirection of normal growth regulatory processes underlies many cancers. Subversion of growth factor receptor structure and function is a well-understood mechanism of oncogene action (Ross et al. 2004, Bianco et al. 2005, Hynes & Lane 2005, Pal & Pegram 2005, Zhang et al. 2005). In the breast, mechanisms that regulate tissue and tumour growth are multifactorial, and many hormones, growth factors and intracellular signalling pathways are involved (Haagensen 1986, Dickson et al. 1992, Hansen & Bissell 2000, Tucker 2000, Pollard 2001, Goffin et al. 2002, Singer et al. 2003, Lamote et al. 2004, Nicolini et al. 2006, Cheng et al. 2008). Several of these have been targeted for drug development, particularly in tumours that either do not contain ER or are unresponsive to anti-oestrogens.

The systemic renin–angiotensin system (RAS) and the generation of angiotensin II (Fig. 1) has as major roles the regulation of blood pressure, and the adrenal secretion of aldosterone (Mulrow 1999, de Gasparo et al. 2000, Kaschina & Unger 2003). The actions of angiotensin II in the regulation of vasoconstriction have even been used to facilitate better accessibility of...
chemotherapeutic drugs to tumours (Noguchi et al. 1988, Goldberg et al. 1990, Yamaue et al. 1990, Anderson et al. 1991). Angiotensins III and IV and angiotensin 1–7 may also be produced, and may act through the same two receptor types as angiotensin II, i.e. angiotensin type 1 and 2 (AT1 and AT2) receptors though with varying effectiveness (de Gasparo et al. 2000, Le et al. 2002). Angiotensin IV also acts through an insulin-regulated transmembrane enzyme designated as the AT4 receptor (Thomas & Mendelsohn 2003, Chai et al. 2004), and angiotensin 1–7 primarily through MasR, the product of the Mas oncogene (Neo et al. 2010).

Angiotensin receptors AT1 and AT2 are widespread, and they uniformly occur in secretory epithelia. In addition to its functions in the maintenance of blood pressure and hypertension, angiotensin II has also well-studied actions on electrolyte and water transport in the kidney, and elsewhere, including across other epithelial surfaces (Wong et al. 1990, Norris et al. 1991, Lees et al. 1993, Quan & Baum 1996, Wang & Giebisch 1996, Leung et al. 1997, Mahmood et al. 2002) where it also affects ciliary beat frequency (Saridogan et al. 1996a).


Accordingly, it is appropriate to consider angiotensin II among the growth promoting and tissue modelling factors that may be subverted in cancer.

**Angiotensin in cancer**

**Epidemiological evidence**


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**Figure 1** The renin–angiotensin system. In normal tissue, and in cancer, the major active hormone is usually considered to be angiotensin II, though angiotensins III and IV, and angiotensin 1–7 have also been implicated (see text).
Indirect patient evidence supports the role in cancer (Deshayes & Nahmias 2005). Thus, the AT1 receptor has been reported to be up-regulated in various hyperplastic and cancer tissues (De Paepe et al. 2001), though not according to all reports (Dinh et al. 2002). Additionally, polymorphisms in angiotensinogen, AT1 receptors and angiotensin-converting enzyme (ACE) have been associated with breast cancer risk (Koh et al. 2003, 2005, Arima et al. 2006, Gonzalez-Zuloeta Ladd et al. 2007, Yaren et al. 2007, van der Knaap et al. 2008, Mendizabal-Ruiz et al. 2011). Such polymorphisms have recently been extensively reviewed and discussed (Xi et al. 2011). One widely studied polymorphism is a 278 bp Alu insertion/deletion (I/D) polymorphism in intron 16 of the ACE gene that apparently accounts for 50% of the variability in circulating ACE levels (Rigat et al. 1990). Though earlier studies suggested that this had no strong predictive value (Haiman et al. 2003), more recently the DD phenotype has been associated with increased risk and poor prognosis in breast cancer (Gonzalez-Zuloeta Ladd et al. 2005, Yaren et al. 2007, van der Knaap et al. 2008, Rosenthal & Gavras 2009). Interestingly, the same ACE polymorphism may also increase risk in benign prostatic hyperplasia (BHP) and prostate cancer, whereas the A1166C substitution in the AT1 receptor increases BHP risk alone (Sierra Diaz et al. 2009). Conversely, the C allele carriers have reduced breast cancer risk (Mendizabal-Ruiz et al. 2011). Three further AT1 receptor substitutions (A168G, C535T and T825A) have also been associated with reduced breast cancer risk (Koh et al. 2005).

More direct patient evidence has been elusive. The first report of the potential utility of ACE inhibitors in preventing cancer development was that of Lever et al. (1998) who surveyed data from patients receiving these medications for other reasons, but their findings were not confirmed by others (Meier et al. 2000, Li et al. 2003, Gonzalez-Perez et al. 2004, Ronquist et al. 2004, Fryzek et al. 2006, Rosenthal & Gavras 2009), nor, in similar patient studies was the use of angiotensin II antagonists in any way linked with the disease (Fryzek et al. 2006, Teo 2011). One report suggests that candesartan, an AT1 receptor blocker, when used at a dose similar to that used in patients for other reasons, has beneficial effects in prostate cancer, in that circulating prostate-specific antigen is reduced (Uemura et al. 2005a), though this study does not appear to have been repeated. Others have even suggested a modest increase in cancers of all types in patients receiving angiotensin receptor blockers (Sipahi et al. 2010), though this too has been contested (Volpe et al. 2011). The failure to make such associations may depend on variations in gene expression, and patients with low ACE expression phenotype may have poorer breast cancer outcomes than high ACE-expressing subjects (Yaren et al. 2007), though again there appear to be conflicting findings (Yaren et al. 2007, van der Knaap et al. 2008). Nevertheless, RAS inhibiting drugs may benefit high ACE-expressing patients but not others (van der Knaap et al. 2008). It is possible that anti-RAS drugs are more effective in combination. In patients with advanced pancreatic cancer receiving the nucleoside analogue gemcitabine, lower doses of losartan and other RAS inhibitors were effective in improving outcomes (Nakai et al. 2010). One way in which this might occur has been described by Diop-Frimpong et al. (2011). Drawing on previous work (Stylianopoulos et al. 2010) demonstrating the effect of collagen fibre networks, such as those that occur in connective tissue, on the diffusion of drugs, Diop-Frimpong et al. (2011) demonstrated that losartan blocks collagen I production by breast carcinoma-associated fibroblasts, potentially facilitating drug accessibility.

In contrast to the patient data, both ACE inhibitors and AT1 receptor antagonists are effective in vitro: they inhibit growth in many different types of tumour cells, including breast cancer cells (Chen et al. 1991, Reddy et al. 1995, Small et al. 1997, Rivera et al. 2001, Uemura et al. 2008, Inigo et al. 2009, Ino et al. 2011). In experimental animals in vivo, on the other hand, for example in xenografts of SKOV-3 ovarian tumour in mice or of C6 rat glioma cell tumours in rats, much higher doses of candesartan and losartan, respectively, were needed to demonstrate tumour regression than those generally used in patients (Rivera et al. 2001, Suganuma et al. 2005). It is perhaps because high doses are required when these drugs alone are used that the epidemiological studies on patients receiving antihypertensive treatment for cardiovascular disease show no benefit in incidence of cancer.

The discovery of the zinc metalloprotease ACE2 introduced a new aspect of angiotensin signalling (Donoghue et al. 2000). ACE2 prefersentially hydrolyses angiotensin I to angiotensin 1–9, and angiotensin II to angiotensin 1–7 (Fleming et al. 2006; see Fig. 1). Angiotensin 1–7 has properties different from those of angiotensin II and may oppose angiotensin II functions. In particular, it is anti-proliferative and reduces fibrosis in breast tumours, and angiogenesis in lung tumours (Menon et al. 2007, Soto-Pantoja et al. 2009, Cook et al. 2010, Gallagher et al. 2011), and has been used with benefit in phase I patient trials (Petty et al. 2009).
Angiogenesis

Additionally, although both ACE inhibitors and AT1 receptor antagonists may be effective on animal tumours *in vivo*, the results are more ambiguous than *in vitro*, and at least in part could be due to their antiangiogenic actions (Volpert et al. 1996, Fujimoto et al. 2001, Fujita et al. 2002, 2005, Yoshiji et al. 2004, Kosaka et al. 2007, De Paeppe 2009, Miyajima et al. 2009). The important part played by angiogenesis in the development of cancer has frequently been emphasised. There is considerable evidence that cancer growth and spread is angiogenesis dependent, tumour cells themselves can produce angiogenic factors and inhibition of angiogenesis can limit tumour growth (Weidner 2004, Sharma et al. 2005, Clapp et al. 2009), including in the breast (Heffelfinger 2007, Groves et al. 2011). It is difficult to assess the importance of this process in relation to the direct effects of angiotensin II on tumour growth and cell proliferation. Certainly, angiotensin II is involved in angiogenesis. Several *in vitro* studies have shown that vascular endothelial growth factor (VEGF) expression is stimulated by angiotensin II or inhibited by ACE or angiotensin blockers in tumour cells, including squamous cell (Yasumatsu et al. 2004) ovarian (Suganuma et al. 2005), prostate (Kosaka et al. 2007) and rat pituitary tumour cells (Ptasinska-Wnuk et al. 2007). Similar conclusions have been reached from *in vivo* studies. Thus, AT1 receptor expression and angiogenesis were correlated in ovarian tumours and in astrocytomas (Ino et al. 2006, Arrieta et al. 2008). Angiotensin II supported VEGF production and angiogenesis in xenografts of ovarian cancer cells (Suganuma et al. 2005) and AT1 receptor blockade inhibited both of these actions in xenografts of ovarian and gastric tumour cells (Suganuma et al. 2005, Huang et al. 2008). AT1 receptor blockade also inhibited angiogenesis in murine Lewis lung tumours (Imai et al. 2007) and through this means enhanced the effectiveness of radiation treatment in murine melanoma (Ohnuma et al. 2009, Otake et al. 2009) and in murine renal tumours (Miyajima et al. 2009). However, in *in vivo* studies in which S-180 murine sarcoma cell tumours were developed in AT1α receptor null mice, angiogenesis, along with VEGF expression, was both reduced and partially refractory to AT1 receptor blockade when compared with normal tissue. Hence, host angiotensin II activity is instrumental in supporting angiogenesis in host stromal cells in addition to any effect it has on the cancer cells themselves (Fujita et al. 2002, 2005, Imai et al. 2007).

Actions of angiotensin II on breast cancer cells

As in other tissues, angiotensin II acts on the AT1 receptor to promote cell proliferation in breast cancer cells (Muscella et al. 2002). The AT1-mediated signalling involves the protein kinase C (PKC, zeta and iota)/Ca2+/inositol trisphosphate (IP3) pathways, and also extracellular signal-related kinase (ERK) activation (Greco et al. 2002a,b, 2003, Muscella et al. 2003, 2005). Angiotensin II also activates Na+/K+ ATPase (Muscella et al. 2002, 2005).

Angiotensin II has further possible roles involved in cell adhesion and invasion. Specifically, again acting via the AT1 receptor, it inhibits expression of integrin subtypes α3 and β1 and also binding to and invasion through components of the extracellular matrix. In contrast to its actions on proliferation, these effects of angiotensin II may be regarded as potentially beneficial (Puddefoot et al. 2006). Consequently, RAS blockade may not always be entirely an appropriate therapy in cancer, perhaps also explaining its apparent lack of benefit in patients. Conflicting evidence on the efficacy of anti-RAS treatment has also been discussed in the context of cardiovascular disease (Magy et al. 2005).

Angiotensin II, ER and growth factors

Because of the well-known importance of ER and growth factors and their interrelationship in breast cancer, it is relevant to examine their interactions with the RAS. The interrelationship between the RAS and ER is complex. Depending on the tissue, oestrogen has varyingly been reported to down-regulate AT1 receptors, in rat pituitary and hypothalamus (Seltzer et al. 1992, Kisley et al. 1999) and dog kidney, myocardium, liver and adrenal (Owonikoko et al. 2004; see also Fischer et al. 2002), but to up-regulate them at other sites, including rat kidney (Baiardi et al. 2005) and sheep uterine artery endothelium (Sullivan et al. 2005). Consistent with RAS up-regulation by oestrogen, intensity of AT1 receptor staining is most intense in the periovulatory period in human fallopian tube and uterine epithelia (Saridogan et al. 1996a,b) and the AT2 receptor is also high during the proliferative phase in human myometrium (Pucell et al. 1987, Mancina et al. 1996), as it is in the rat ovary (Pucell et al. 1987, Mancina et al. 1996). However, such changes do not necessarily reflect the functions of the RAS as a whole and other RAS components may respond independently, for example renin and ACE activities are reduced in various tissues by oestrogen (Fischer et al. 1996).
et al. 2002), though angiotensinogen is increased (Gordon et al. 1992, Klett et al. 1993, Fischer et al. 2002). Oestrogen stimulates plasma renin activity (PRA) and RAS activity in sheep (Magness et al. 1993), though in women high PRA is associated with the luteal phase (Sealey et al. 1994, Chapman et al. 1997, Chidambaram et al. 2002). In breast duct cancer cells, angiotensin II treatment in vitro reduces ER and increases PR (Small et al. 1997).

The relationship between ER and AT1 is thus incompletely resolved. It may be that angiotensin II signalling is more significant in ER-negative breast tumours (Herr et al. 2008), in which a role has been postulated for AT1 receptors in the non-genomic response to oestrogen (Lim et al. 2006), though there is a subset of ER-positive (and ERBB2-negative) tumours that shows marked overexpression of AT1 receptors (Rhodes et al. 2009). This appears to contrast with vascular smooth muscle cells in which the ER blocker raloxifene (in the presence of oestradiol) inhibited angiotensin II-stimulated proliferation (Wang et al. 2007).

Angiotensin receptor signalling also interacts with growth factors in breast cancer cells. Thus, ERKs are activated by angiotensin II directly via PKC and indirectly via epidermal growth factor receptor (EGFR)-mediated phosphatidylinositol-3 kinase-serine-threonine protein kinases (PI3-kinase/Akt/mTOR/p70S6K1) signalling pathways (Greco et al. 2002b, 2003, Chiu et al. 2005, Han et al. 2007). In more detail, the AT1 receptor, linked to Gq/11, signals both by Ca2+/IP3 and by diacylglycerol-linked events, and also by tyrosine kinase activation, including via EGFR-linked PI3-kinase and Akt signalling, with subsequent activation of ERK1 and ERK2 (Greco et al. 2003, Shah et al. 2004, Han et al. 2007, Kim et al. 2009). Such EGFR activation is at least in part mediated via angiotensin II-stimulated metalloproteinase activity (Liebmann 2011, Smith et al. 2011; see below). There is extensive crosstalk with other receptors, including insulin and growth factor signalling pathways (Shah et al. 2006, Redondo et al. 2007, Escano et al. 2008, Muscogiuri et al. 2008, Olivarres-Reyes et al. 2009, Arellano-Plancarte et al. 2010). Conversely, the AT2 receptor is thought to activate phosphatase activity and block AT1 receptor-mediated intracellular signalling events, including phospholipase activation and the phosphorylation of signalling components. These pathways have been extensively discussed elsewhere (de Gasparo et al. 2000, de Gasparo 2002, Kaschina & Unger 2003, Deshayes & Nahmias 2005, Louis et al. 2010, Zhao et al. 2010).

**The local RAS in the breast**

**Tissue remodelling and matrix metalloproteinases**

In the normal cycle of events in the breast, the ductal system, which begins to develop in puberty, stabilises in the adult but proliferates extensively during pregnancy to enable production of a high level of secretory activity during lactation. After lactation ceases, the ducts undergo apoptotic involuion (Fig. 2; Wiseman & Werb 2002, Boutinaud et al. 2004, Green & Streuli 2004). Because of the relationship between the stage of the cycle and the incidence of metaplastic change, Villadsen (2005) and Russo et al. (2006) postulated that there are at least two types, or a hierarchy, of stem cells. The whole process does not involve the ducts alone, and stromal cells and their products, including growth factors and integrins, are also strongly implicated (Chrenek et al. 2001, Pollard 2001, Wiseman & Werb 2002, Barcellos-Hoff & Medina 2005, Zechmann et al. 2007). Because of its sites of origin, described below, and the location of its receptors, it is appropriate to consider angiotensin II among these factors and that, perhaps acting through both receptor types, it is instrumental in both proliferative and apoptotic phases of the normal cycle.

The breast cycle (Fig. 2) and its sequence of development and resorption reflect, among other things, synthesis and proteolysis of proteins of the extracellular matrix and the basement membrane, such as collagen, in a balanced manner (Morini et al. 2000, Sun et al. 2006). Hydrolysis of extracellular matrix proteins is catalysed at the basement membrane by the zinc-dependent matrix metalloproteinases (MMPs) present in stromal and secretory cells of normal and diseased tissue (Werb et al. 1996, Lebeau et al. 1999, Bodey et al. 2001). Accordingly, these enzymes are also involved in the invasive process (Ambili et al. 1998, Rudolph-Owen & Matrisian 1998)) and high MMP levels are associated with poor outcomes (Duffy et al. 2000). Because epithelial cells depend on the functions of the basement membrane and their constituents, protein breakdown contributes to epithelial dysfunction. In many tissues, angiotensin II plays a key part in such tissue remodelling, and it affects both MMP activity and collagen synthesis (Gack et al. 1994, Ford et al. 1999, Dzau 2001, Galis & Khatri 2002, Shah et al. 2004, Chiu et al. 2005, Yang et al. 2005, Karakiulakis et al. 2007, Kim et al. 2007). As MMPs are located in myoepithelial cells, like prorenin (see below), it is clear that locally produced angiotensin II may have such a role in the breast.
All the functions of angiotensin II described so far acquire an additional perspective in the light of our understanding of the tissue-based RAS. This is because the significant factor in both normal function and in disease may not be the angiotensin II in the blood, but that which is locally produced, within the tissue.


These tissue RASs may be perturbed in cancer. For example, in a mouse model of colorectal cancer metastases, ACE expression was increased (though ACE2 was decreased) in tumour-bearing livers, as well as in the tumours themselves. Tumour volume was reduced by the ACE inhibitor captopril. Liver angiotensinogen was unaffected by the tumours and decreased in captopril treatment, whereas ACE in both liver and tumour tissues was further increased. AT1 receptor expression was elevated by tumour induction and reduced by captopril: MasR, the putative receptor for angiotensin 1–7, was increased by captopril (Neo et al. 2010). The possibility that angiotensin III may have a specific role has also been suggested in studies on rats with N-methyl nitrosourea-induced breast tumours, in which soluble and membrane-bound aspartyl and glutamyl aminopeptidase activities are increased whereas soluble aminopeptidase N and B activities are decreased, both of which potentially increase angiotensin III production, with reduced angiotensins II and IV (del Pilar Carrera et al. 2010).

**Localisation of RAS components**

In studies on the sites of (pro)renin gene transcription, (pro)renin mRNA was found in most of the breast samples examined, invariably in close proximity to the ductal epithelium but not within the epithelium itself. Prorenin mRNA was abundant in the stroma immediately adjacent to the ducts, in myoepithelial cells in

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**Figure 2** The breast cycle: note particularly extensive duct and gland development during pregnancy and lactation, followed by apoptotic involution when lactation ceases (cf. Wiseman & Werb (2002), Boutinaud et al. (2004) and Green & Streuli (2004)). Drawing by Bronwen Vinson. Reproduced from Vinson et al. (2007) with kind permission from Springer Science and Business Media.
normal tissue and in early cancer stages but tended to be lost from both sites in more advanced disease, paralleling the partial loss of AT1 receptors (Tahmasebi et al. 1998; Fig. 3). Confirmation of these findings, and evidence for other RAS components, was obtained using quantitative RT-PCR and the presence of RNA coding for angiotensinogen, prorenin, ACE and both AT1 and AT2 receptors was demonstrated in normal and diseased breast tissues, supporting the hypothesis that a tissue RAS is present in the breast. As in the in situ hybridisation data (Tahmasebi et al. 1998), there was significantly less (pro)renin mRNA in carcinoma than in normal tissue, and indeed, ACE and angiotensinogen mRNAs were also reduced in carcinoma compared with normal tissue (Tahmasebi et al. 2006). This reflects the earlier finding that AT1 receptors are reduced in advanced tumours.

mRNA coding for prorenin was distributed between myoepithelium and, most extensively in fibroblasts and connective tissue close to the ducts. Conversely, prorenin protein itself was mostly present in myoepithelial cells and absent from the connective tissue. Of course, this distribution could represent differences in mRNA translation between the two cell types, but a rather different picture emerges in cancer. Although the distribution of prorenin and its mRNA in ductal and in lobular carcinoma in situ was similar to normal, in more advanced conditions, as the myoepithelium was lost, prorenin protein was only sparsely present in the epithelium, but it was located in fibroblasts. Here, though always present, it appeared to decrease in amount as malignancy advanced (Tahmasebi et al. 1998; Fig. 3). Two possibilities present themselves, one is that the prorenin mRNA that is ever present in breast fibroblasts is translated only in cancer. Alternatively, it is always translated, even in normal tissue, but the prorenin formed is normally transported elsewhere, to the myoepithelium or to the epithelium (though this latter is not frequently observed). Whatever the explanation, it is evident that the functions of the breast RAS may be greatly perturbed in cancer. Similar processes may well occur in other types of cancer, for example in the pancreas (Lau & Leung 2011).

There is a difficulty in testing this concept of an entirely localised RAS in any tissue – what can in situ

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Figure 3 Both angiotensin II receptors and ACE are present in epithelial cells and in cancer cells. Sites of (pro)renin mRNA transcription (dark shading) are shown in (i) normal breast ducts, (ii) intraductal carcinoma in situ and (iii) invasive carcinoma. The myoepithelial source of (pro)renin transcription is lost as cancer develops. As in normal tissue this lies in close proximity to the epithelium, the configuration strongly suggests that angiotensin II can be produced at its epithelial site of action. This tightly linked system is lost in cancer, suggesting that the AT1 and AT2 receptor-containing carcinoma eventually becomes deprived of its source of angiotensin II. Adapted from Tahmasebi et al. (1998, 2006). e, epithelium; m, myoepithelium; f, fibroblast; t, tumour; s, stroma. Drawing by Bronwen Vinson. Reproduced from Vinson et al. (2007) with kind permission from Springer Science and Business Media.
hybridisation or immunocytochemistry reveal about the state of activation of any of the components? Prorenin provides a key example here: the methods used in the papers cited above do not distinguish between the cleaved or activated forms. The primary mechanism for prorenin activation has been considered to be through cleavage by prohormone convertases (Benjannet et al. 1992), which may be highly expressed in cancer, including breast tumours, and this is associated with greater oestrogen dependency (Cheng et al. 1997, 2001). Of course, prohormone convertases may be involved in tumorigenic processes that do not involve either prorenin or angiotensin II (Siegfried et al. 2003, Scamuffa et al. 2008). Alternatively, the discovery of a specific prorenin receptor that binds prorenin and activates intracellular signalling pathways while at the same time activating its enzymic activity in the absence of cleavage opens new possibilities (Nguyen & Contrepas 2008, Nguyen 2011). These and related questions of activation of the breast RAS will need to be addressed in future.

Like the AT1 receptor, ACE is present in the secretory epithelium of the normal breast and also in diseased breast tissue (Tahmasebi et al. 2006), suggesting that angiotensin II may be formed directly in the cells on which it acts. However, in cancer, the overall loss and changes in the distribution of prorenin described above may mean that as the disease progresses, neither substrate for the enzyme nor ligand for the receptor remains available. Malignancy is thus correlated with the deregulation of RAS function.

These findings and this proposed mechanism have considerable resonance with other authors' concepts of the role of the stromal and myoepithelial interaction with the secretory epithelium and with cancer. Kalluri & Weinberg (2009) have proposed that one class of epithelial–mesenchymal transformations (EMTs), which they call type 3 EMT (to distinguish from implantation and wound-healing forms, types 1 and 2), is characteristic of the transformation of polarised and highly differentiated epithelial cells into mesenchymal cells. Such cells secrete extracellular matrix components and are highly mobile and invasive, though there is a reverse transformation (MET) at sites of metastatic colonisation (Kalluri 2009, Kalluri & Weinberg 2009). EMTs, of whatever type, are initiated as the epithelial cells that invade through the basement membrane. A number of factors are thought to be involved, including insulin-like growth factor, transforming growth factor β, platelet-derived growth factor, integrins and the signalling pathways they evoke, with all of which AT1 and AT2 receptors may interact.

So what retains epithelia in their normal functional state? Here, the focus is on myoepithelial cells. These too are now known to be important in cancer progression. First rather overlooked, as they only infrequently produce tumours, they are now thought to be natural tumour suppressors because of their role in maintaining epithelial cell polarity and cell cycle progression and inhibiting cell migration and invasion (Lakhani & O’Hare 2001, Poljak & Hu 2005). This has been postulated to be due to the secretion of proteinase and angiogenic inhibitors (Barsky & Karlin 2005). Additionally, as well as inflammatory cells, fibroblasts have also been thought to be the source of factors affecting tumour development (Tlsty & Coussens 2006). These concepts received direct experimental support when MCF7 breast cancer cells were grown in vitro in an environment of extracellular matrices of type I collagen, or reconstituted basement membrane proteins, together with human fibroblasts. Surviving cells in the presence of collagen organised into clusters, while the further addition of basement membrane proteins induced MCF7 cell polarisation and the formation of lumina, and the presence of fibroblasts induced the formation of elongated structures (Krause et al. 2010). Furthermore, differences in gene expression between core biopsies of breast tumours with varying degrees of stromal content were taken to indicate the influence of the stroma (Cleator et al. 2006). So the stromal and myoepithelial localisation of RAS components strongly suggests that angiotensin II may have an important, possibly crucial role in this context.

**Implications for therapy**

One way in which beneficial advances have been made despite initially discouraging data has been to identify subsets of patients who may benefit where others may not. A key example here is in the identification of a subgroup of breast tumours that overexpress the ERBB2 (HER2) tyrosine kinase receptor and are thus sensitive to the monoclonal antibody trastuzumab (Nahta et al. 2006, Nahta & Esteva 2007). More and more it becomes clear that patient profiling in this way yields benefit, and this may well be true for the RAS in breast. It is known that a significant subset of breast tumours overexpress the AT1 receptor, and although there are various mechanisms for this, one way may be that AT1 receptor expression is directly controlled by ER, leading to a subset of ER-positive, ERBB2-negative tumours that overexpress AT1 receptor (Ateeq et al. 2009, Rhodes et al. 2009).
Because of the possibility of both beneficial and disadvantageous effects of AT1 receptor inhibition, it is worth exploring whether means exist to selectively inhibit individual signalling events. This possibility has been discussed in a recent review, in which the signalling roles of individual domains of the receptor were explored, though the possibility that the extracellular N-terminal domain might be involved was not considered (Aplin et al. 2009). There may, however, be good reasons to consider the N-terminus in this light because there appear to be ligand binding or signalling determinants in this region (Hjorth et al. 1994, Oliveira et al. 2007), and a particular role for Arg23 has been identified (Santos et al. 2004).

In this respect, the activity of monoclonal antibody 6313/G2 directed against a sequence in the N-terminal domain of the AT1 receptor has provided further information, as it appears to enhance some signalling pathways while inhibiting others. Though not affecting angiotensin II binding to the receptor (Barker et al. 1993) the antibody directly stimulates aldosterone secretion via the IP3 pathway in rat glomerulosa cells in vitro, though it also blocks PKC activation, apparently by interrupting receptor internalization (Kapas et al. 1994, Vinson et al. 1994). In other studies on rat vascular smooth muscle cells, basal and angiotensin-stimulated tritiated thymidine incorporation into rat arterial smooth muscle cells was inhibited by 6313/G2, inducing a transient increase in intracellular calcium in cultured rat arterial smooth muscle cells, but reducing PKC and MAPK signal transduction (Xiao et al. 2008). A short-chain fragment variable of this antibody also blocked AT1 receptor-mediated caspase-3/7 inhibition in breast cancer cells and dose dependently gave significant tumour regression in breast xenografts in vivo. These data support the view that differential inhibition of angiotensin II-stimulated signalling pathways may be achieved in this way (Redondo-Muller et al. 2008).

Conclusions

There can now be no doubt that the RAS is involved both in the normal physiology (and perhaps development) of the breast and in the ontogeny of breast carcinoma, and possibly other cancers. There is strong evidence that blocking the pathways of AT1 receptor-mediated angiotensin signalling can have beneficial effects. However, in view of the multiple actions of angiotensin II on breast cancer cells, some of which themselves may be considered to be beneficial, this is not without potential cost. In identifying the AT1 receptor as a new target for breast cancer therapy, development of agents that more precisely discriminate between individual signalling pathways is an important goal. The monoclonal antibody 6313/G2 and its recombinant counterpart demonstrate that this kind of approach may be entirely feasible.

Declaration of interest

Queen Mary, University of London owns IP related to antibodies against the AT1 receptor, currently licensed to Oncobiopharm Ltd.

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