CD74 expression and its therapeutic potential in thyroid carcinoma

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Abstract

CD74, the invariant chain of major histocompatibility complex class II, is also a receptor for macrophage migration inhibitory factor (MIF). CD74 and MIF have been associated with tumor progression and metastasis in hematologic and solid tumors. In this study, we found that 60 and 65% of papillary thyroid cancers were positive for CD74 and MIF immunohistochemical staining respectively. Anaplastic thyroid cancer was negative for MIF, but mostly positive for CD74 expression. Normal thyroid tissue and follicular adenomas were negative for CD74 expression. CD74 expression in papillary thyroid cancer was associated with larger tumor size ($P<0.043$), extrathyroidal invasion ($P<0.021$), advanced TNM stage ($P=0.006$), and higher MACIS score ($P=0.026$). No clinicopathological parameter was associated with MIF expression. Treatment with anti-CD74 antibody in thyroid cancer cells inhibited cell growth, colony formation, cell migration and invasion, and vascular endothelial growth factor secretion. In contrast, treatment with recombinant MIF induced an increase in cell invasion. Anti-CD74 treatment reduced AKT phosphorylation and stimulated AMPK activation. Our findings suggest that CD74 overexpression in thyroid cancer is associated with advanced tumor stage and may serve as a therapeutic target.

Key Words

- CD74
- macrophage migration inhibitory factor
- thyroid cancer
- antibody

Introduction

The majority of follicular cell-derived thyroid cancers is differentiated carcinomas and can be treated successfully with a combination of surgery and radioactive iodine therapy. For patients with advanced thyroid cancer, whose disease progresses despite standard therapy, treatment options are limited and survival is poor (Haugen & Sherman 2013). Targeted therapies have begun receiving attention in recent years. Currently, the multikinase inhibitor sorafenib is the only targeted agent approved by the US Food and Drug Administration for the treatment of radioactive iodine-refractory differentiated thyroid cancer. Further fundamental research is needed to discover new therapeutic targets with better effectiveness and lower toxicity.

CD74, also known as the invariant chain of major histocompatibility complex (MHC) class II, functions as an MHC-II chaperone and participates in the trafficking of MHC-II molecules in antigen-presenting cells (Borghese & Clanchy 2011). It has been shown that CD74 might be expressed independently of MHC-II, and CD74 can bind...
to non-MHC-II proteins (Ogrinc et al. 1993, Henne et al. 1995). Moreover, CD74 is a cell membrane receptor for macrophage migration inhibitory factor (MIF), a pleiotropic cytokine that has pro-inflammatory and pro-tumorigenic properties (Leng et al. 2003). This ligand–receptor interaction may be an important link between chronic inflammation and carcinogenesis (Bucala & Donnelly 2007). The expression of MIF and/or CD74 has been explored in several forms of cancer (Ren et al. 2005, Xu et al. 2008, Nagata et al. 2009, Cheng et al. 2011a). In addition, MIF has been identified as a hypoxia-induced gene, and its expression serves to activate a proangiogenic transcriptional program (Winner et al. 2007).

In autoimmune thyroid disease, MIF production in response to thyroid antigens, but not to control antigens, has been described (Lamki et al. 1973). Recently, using a nationwide population-based study, we reported an increased risk for the development of thyroid cancer after a diagnosis of thyroiditis (Liu et al. 2014). Considering that MIF upregulation is associated with autoimmune thyroid disease and certain types of cancer, it is therefore interesting to investigate whether a differential expression of MIF and CD74 exists in thyroid cancer. Furthermore, the restricted expression of CD74 among normal tissues and its rapid internalization make CD74 an attractive therapeutic target for cancer therapy (Hansen et al. 1996). Milatuzumab, a humanized MAB that recognizes CD74, is currently under investigation. In a phase 1 trial, mono-therapy with milatuzumab was able to stabilize advanced multiple myeloma (Kaufman et al. 2013). In this study, we evaluated the significance of MIF and CD74 expressions in thyroid cancer and the effects of anti-CD74 antibody on thyroid cancer cells.

Materials and methods

Patients and tissue samples

This study was approved by the Institutional Review Board (IRB) of MacKay Memorial Hospital (10MMHIS077). From January 2001 to November 2007, 334 patients underwent thyroidectomy with therapeutic intent for newly diagnosed differentiated thyroid cancer at our institution. Incidental microcarcinomas were excluded. Eligible patients were de-identified and randomly selected for entry into the study. Each patient had complete clinical and histopathological profile at diagnosis. Nonetheless, follow-up data were not available because of stringent de-identification of patient records. Finally, a total of 108 patients comprised our main study cohort. Lesions consisted of 103 papillary carcinomas and five anaplastic carcinomas. Of the 103 papillary carcinomas, ten showed a follicular structure and were diagnosed as follicular variant of papillary carcinoma. Lymph node metastasis was present in 58 (56%) of 103 patients with papillary thyroid cancer. Among these patients, metastatic lymph nodes from 27 (47%) patients were included for the immunohistochemical study. In addition, sections of five follicular adenomas and five samples from Graves’ disease were submitted to immunohistochemical analysis.

For western blot analysis, total proteins were extracted from eight paired samples of papillary thyroid cancer, four paired samples of follicular adenoma, four samples from Hashimoto’s thyroiditis, and four from Graves’ disease. All were collected during surgery and immediately snap-frozen in liquid nitrogen.

Cell culture and reagents

Human papillary thyroid carcinoma cell lines BCPAP and K1 were purchased from the German Collection of Microorganisms and Cell Cultures (DSMZ, Braunschweig, Germany) and the European Collection of Cell Cultures (ECACC, Salisbury, UK) respectively. Both have been authenticated to be unique thyroid cancer cell lines (Schweppe et al. 2008). The expression of thyroid-specific genes is shown in Supplementary Figure S1, see section on supplementary data given at the end of this article. BCPAP harbored the homozygous mutation of BRAF, whereas K1 had the heterozygous mutation. BCPAP cells were cultured at 37 °C in a humidified atmosphere of 5% CO₂ in RPMI 1640 medium (Gibco; Life Technologies) supplemented with 10% fetal bovine serum (FBS). K1 cells were cultured in DMEM (Gibco) mixed with Ham’s F12 (Sigma) and MCDB 105 (Sigma) medium in 2:1:1 proportions, supplemented with 10% FBS and 2 mM L-glutamine. Recombinant human MIF (#289-MF) was purchased from R&D Systems (Minneapolis, MN, USA). Anti-human CD74 antibody (specific for the extracellular domain of CD74, C-16; #sc-5438) was obtained from Santa Cruz Biotechnology.

Cell viability and colony formation assay

Cell growth was determined using the thiazolyl blue tetrazolium (MTT) bromide colorimetric assay. Briefly, BCPAP and K1 cells (4000 cells/well) were seeded onto 96-well plates and were allowed to grow in complete culture media for 24 h. Thereafter, the media was replaced with culture media containing 1% FBS for a further
24–72 h. The cells were treated with isotype control, recombinant human MIF (200 ng/ml), or anti-CD74 antibody (5 μg/ml). At the indicated time points, 100 μl (5 mg/ml) of MTT reagent (Sigma) was added to the cell culture and cells were incubated at 37 °C for 4 h. Formazan crystals converted from tetrazolium salts by viable cells were solubilized with acidified isopropanol. The absorbance was measured at 570 nm by a Varioskan Flash microplate reader (Thermo Fisher Scientific, Waltham, MA, USA). The absorbance of control cells was defined as 100%.

Colony formation assay was performed as previously described (Cheng et al. 2014). In brief, BCPAP (1000 cells/well) and K1 cells (500 cells/well) were seeded into six-well plates, allowed to adhere for 24 h, and treated with isotype control, recombinant human MIF (200 ng/ml) or anti-CD74 antibody (5 μg/ml) from day 2. After 10–12 days, colonies were stained with 3% crystal violet and examined by microscopy. The colonies containing >50 cells were counted in five nonoverlapping fields.

**Wound healing assay**

Cell migration was determined using the wound healing assay, which was modified from our published method (Cheng et al. 2011b). BCPAP and K1 cells were trypsinized, counted, and seeded into six-well plates in culture media. After 24 h, monolayers of cells were wounded using a sterile 300 μl micropipette tip to scratch on the confluent cells. The culture media were replaced with the medium (1% FBS) containing isotype control, recombinant human MIF (200 ng/ml), or anti-CD74 antibody (5 μg/ml) following scratch. The cells were photographed at 0, 20, 30, 40, and 48 h. Wound closure measurement was performed in four different fields using ImageJ Software (National Institutes of Health, Bethesda, MD, USA).

**Invasion assay**

Cell invasion was assessed using the BioCoat Matrigel invasion chamber with 8 μm pore diameter (#354481; Corning Life Sciences, Tewksbury, MA, USA). A total of 1 x 10^5 cells were seeded onto the inserts in culture media containing 1% FBS with isotype control, recombinant human MIF (200 ng/ml) or anti-CD74 antibody (5 μg/ml). The inserts were placed into a six-well plate with 10% serum-containing culture medium as a chemoattractant. The plates were incubated for 24–48 h at 37 °C. The cells that invaded the Matrigel matrix to the lower surface of the membrane were fixed and stained with Diff-Quik (Sysmex, Kobe, Japan), and counted under a light microscope in five nonoverlapping fields.

**Western blotting analysis**

Tissue or cellular proteins were extracted, quantified, and subjected to gel electrophoresis according to the standard procedures as we described previously (Cheng et al. 2012). A total of 30–50 μg of total protein was separated by electrophoresis on 10–12% SDS polyacrylamide gels. Fractionated proteins were transferred to a nitrocellulose membrane, and transfer was controlled by Ponceau staining. After transfer, the membrane was blocked with 5% skimmed milk or 5% BSA for 30 min at room temperature. The proteins were probed with antibodies against MIF (#ab55445; Abcam, Cambridge, MA, USA), CD74 (#ab64103; Abcam), phospho-AKT (Thr³⁰⁸) (#4056; Cell Signaling, Danvers, MA, USA), phospho-AKT (Ser⁴⁷³) (#9271; Cell Signaling), total AKT (#2920; Cell Signaling), phospho-AMPKα (Thr¹⁷²) (#2531; Cell Signaling), total AMPK (#2532; Cell Signaling), and β-actin (Sigma) at 4 °C overnight. The results were visualized by chemiluminescence with the Amersham ECL Detection System (GE Healthcare, Piscataway, NJ, USA). The blot signals were quantified by densitometry (ImageJ Software) and normalized to β-actin.

**Cytokine detection**

Vascular endothelial growth factor (VEGF) concentrations were determined using an ELISA (#DVE00; R&D Systems) according to the manufacturer’s instructions. The cell culture supernatants were collected after each experiment and centrifuged to remove cells and debris. The optical density (OD) was measured at 450 nm and concentrations extrapolated from a standard curve. The sensitivity of the assays was 9 pg/ml.

**Immunohistochemistry**

The expression of MIF and CD74 in tissue sections was studied by immunohistochemical staining as described previously (Cheng et al. 2013). Briefly, 5 μm sections of paraffin-embedded tissue blocks were deparaffinized in xylene and rehydrated in a graded series of ethanol. For antigen retrieval, the slides were immersed in a Tris–EDTA Buffer (10 mM Tris base, 1 mM EDTA solution, 0.05% Tween 20, and pH 9) and boiled for 20 min in a pressure cooker while maintaining the pressure. Endogenous peroxidase activity was quenched with 3% hydrogen peroxide.
peroxidase in methanol for 10 min. The slides were then incubated with primary antibodies against MIF (#ab55445; Abcam) and CD74 (#ab64103; Abcam) in humid chambers at 4 °C overnight. The slides were washed and further incubated with goat-anti-mouse MACH2 HRP polymer (Biocare Medical, Concord, CA, USA) for 30 min at room temperature. The chromogenic reaction was done with 0.02% 3,3'-diaminobenzidine (Sigma) for 30 min. All slides were counterstained with hematoxylin, dehydrated, cleared, and cover slipped. Negative control slides in the absence of primary or secondary antibody were included for each staining.

**Evaluation of immunostaining**

Cytoplasmic immunoreactivity was evaluated semiquantitatively as previously reported (Cheng et al. 2013). Staining intensity was scored as 0 (no staining), 1 (weak), 2 (moderate), and 3 (strong). Staining proportion was scored as 0 (>1%), 1 (1–25%), 2 (26–50%), and 3 (>50%), according to the percentage of positively stained cells. Multiplied scores of intensity and proportion were used as the final staining score. Positive expression was defined by final staining scores 6 and 9, whereas the remaining cases (final scores 0–4) were classified as negative expression.

**Analysis of publicly available gene expression datasets**

We accessed the National Center for Biotechnology Information Gene Expression Omnibus (http://www.ncbi.nlm.nih.gov/geo/) and identified publicly available thyroid cancer datasets. GSE3678 comprises gene expression data of seven paired samples of papillary thyroid cancer. GSE3467 (He et al. 2005) comprises gene expression data of nine paired samples of papillary thyroid cancer. GSE33630 (Hebrant et al. 2012) comprises gene expression data of 45 normal thyroid and 49 papillary thyroid cancer samples obtained from Ukraine via the Chernobyl Tissue Bank, as well as 11 anaplastic thyroid cancer samples from different hospitals in France and Belgium. Affymetrix Human Genome U133 Plus 2.0 Arrays were used in these datasets.

**Statistical analyses**

Categorical patient characteristics are expressed as proportions, while continuous variables are expressed as medians with 25th and 75th percentiles (defining the interquartile range). χ², Fisher's exact test, or Cochran–Armitage trend test was used to compare categorical variables. Continuous variables were compared using the Mann–Whitney U test or Student’s t-test. The Kendall’s r-b test was used to determine the relationship between expressions of markers. Throughout the analysis, P values <0.05 (two-sided hypotheses) were considered to be statistically significant. Statistical analyses were performed using STATA for Windows, release 11 (Stata Corp., College Station, TX, USA).

**Results**

**Expression analysis using microarray database**

Relative expression of MIF and CD74 was examined in different sets of thyroid carcinoma using microarray database GSE3678, GSE3467, and GSE33630 downloaded from the Gene Expression Omnibus database. There was no significant difference in the expression level of MIF between normal thyroid and papillary carcinoma, whereas CD74 expression was significantly increased in papillary carcinoma compared with normal thyroid (Fig. 1). Anaplastic cancer samples showed significantly lower

![Figure 1](http://erc.endocrinology-journals.org/doi/abs/10.1530/ERC-14-0269)

Gene expression levels of macrophage migration inhibitory factor (MIF) and CD74 in normal thyroid, papillary thyroid cancer (PTC), and anaplastic thyroid cancer (ATC). Three different datasets were examined: (A) GSE3678 dataset, (B) GSE3467 dataset (He et al. 2005), and (C) GSE33630 dataset (Hebrant et al. 2012). P values were determined by the Mann–Whitney U test. *P<0.05, **P<0.01, and ***P<0.001; NS, non-significant.
expression of MIF and higher expression of CD74 as compared with normal thyroid specimens (Fig. 1C).

**Tissue expression in thyroid cancer**

Immunohistochemical staining for MIF and CD74 was performed in 103 papillary cancers, 27 corresponding metastatic lymph nodes, and five anaplastic cancers. Based on our predetermined criteria, 67 (65%) and 62 (60%) papillary cancers were positive for MIF and CD74 staining respectively (Fig. 2A). In all, 44 (43%) exhibited both MIF and CD74 expression. There was no correlation between the expression of MIF and CD74 ($P = 0.124$). Among patients with papillary cancer, lymph nodes positive for metastasis were randomly selected from 27 patients and subjected to immunohistochemical analysis. We observed that MIF immunoreactivity appeared in 25 (93%) of 27 patients, whereas positive CD74 expression was evident in 21 (78%). There was no significant correlation in MIF or CD74 expression between the primary tumor and metastatic lymph nodes ($P = 0.828$ and $P = 0.946$ respectively).

In the five anaplastic cancers, three showed no MIF staining within anaplastic components, and two had faint staining, which was also classified as negative expression. Positive CD74 immunoreactivity was present in 4 (80%) of five cases. Our findings are consistent with those of microarray gene expression data. Additional five follicular adenomas and five samples from Graves’ disease were analyzed. MIF immunoreactivity was positive in four follicular adenomas and three samples from Graves’ disease respectively. No CD74 positive staining was noted in these tissue samples of benign thyroid lesions (Supplementary Figure S2, see section on supplementary data given at the end of this article). Our findings suggest that CD74 overexpression in thyroid cancer is relatively specific to malignant transformation.

Western blotting analysis was used to evaluate the expression of MIF and CD74 in eight paired (normal and tumor) samples of papillary thyroid cancer (Fig. 2B). There was a trend toward increased MIF and CD74 expression in the tumor part. It is noteworthy that CD74 expression was barely detectable in the normal thyroid tissue.

**Figure 2**

Tissue expression of macrophage migration inhibitory factor (MIF) and CD74 in thyroid cancer. (A) Representative microphotographs of immunohistochemical staining in normal thyroid, papillary thyroid cancer (PTC), metastatic lymph node, and anaplastic thyroid cancer (ATC). Original magnification, 100× for normal thyroid, 200× for PTC, 40× for lymph node, and 100× for ATC. (B) Protein expression determined by western blotting analysis in paired PTC samples (T, tumor; N, adjacent normal thyroid tissue). Bands were quantified by densitometry and normalized to the β-actin levels. T/N ratios were plotted on a vertical scatter plot. Horizontal bars indicate the mean for each group. A full colour version of this figure is available at http://dx.doi.org/10.1530/ERC-14-0269.
An inconsistent pattern of MIF expression was observed in samples of follicular adenoma, Hashimoto’s thyroiditis, and Graves’ disease (Supplementary Figure S2). These benign thyroid lesions did not show CD74 expression.

Clinicopathological correlations

To investigate the potential role of MIF and CD74 in thyroid cancer, the 103 samples of papillary cancer were divided into two groups with positive and negative MIF/CD74 expression and compared for a series of clinicopathological parameters. As given in Table 1, we have not observed any parameter that was associated with the MIF expression. However, papillary cancer positive for CD74 expression was associated with larger tumor size, higher rate of extrathyroidal invasion, and more advanced TNM stage (Table 2). MACIS scoring system developed at the Mayo Clinic uses metastasis, age, completeness of resection, local invasion, and tumor size to stratify patients with papillary thyroid carcinoma (Hay et al. 1993). In accordance, CD74-positive thyroid cancer had significantly higher MACIS scores ($P=0.026$). The expression of MIF or CD74 was not associated with follicular variant or the presence of concurrent lymphocytic thyroiditis. Given that CD74 is overexpressed in thyroid cancer and associated with advanced tumor stage, we hypothesize that CD74 might be a potential therapeutic target in thyroid cancer.

Reduced cell growth with anti-CD74 antibody treatment

Two papillary thyroid cancer cell lines, BCPAP and K1, were evaluated for the expression of CD74. Both thyroid cancer cells were positive for CD74 expression (Supplementary Figure S3). Treatment with MIF did not alter the CD74 expression, whereas anti-CD74 neutralizing antibody (which binds the CD74 extracellular domain) remarkably decreased the CD74 expression in both cell lines.

We then tested the effects of MIF and anti-CD74 antibody on cell growth. Both cells were treated with vehicle (PBS) control, isotype control, recombinant human MIF, or anti-CD74 antibody. The results of vehicle control and isotype control were similar, and thus only the results of isotype control were shown. As shown in Fig. 3A, treatment with anti-CD74 antibody significantly suppressed cell growth after 48 h. There was no significant

Table 1 Correlation of macrophage migration inhibitory factor (MIF) expression with clinicopathological parameters in patients with papillary thyroid carcinoma ($n=103$)

<table>
<thead>
<tr>
<th></th>
<th>MIF (+) ($n=67$)</th>
<th>MIF (-) ($n=36$)</th>
<th>$P$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>52 (78%)</td>
<td>29 (81%)</td>
<td>0.728</td>
</tr>
<tr>
<td>Age (years)$^a$</td>
<td>41 (33–49)</td>
<td>40 (30–51)</td>
<td>0.561</td>
</tr>
<tr>
<td>Hashimoto’s thyroiditis</td>
<td>3 (4%)</td>
<td>3 (8%)</td>
<td>0.419</td>
</tr>
<tr>
<td>Tumor size (cm)$^a$</td>
<td>2.5 (2.0–3.2)</td>
<td>2.1 (1.8–2.6)</td>
<td>0.111</td>
</tr>
<tr>
<td>Extrathyroidal invasion$^b$</td>
<td>41 (61%)</td>
<td>27 (75%)</td>
<td>0.100</td>
</tr>
<tr>
<td>No</td>
<td>19 (28%)</td>
<td>9 (25%)</td>
<td></td>
</tr>
<tr>
<td>Microscopic</td>
<td>7 (10%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Macrogenic</td>
<td>22 (33%)</td>
<td>15 (42%)</td>
<td>0.373</td>
</tr>
<tr>
<td>Lymph node metastasis$^b$</td>
<td>29 (43%)</td>
<td>16 (44%)</td>
<td>0.610</td>
</tr>
<tr>
<td>N0</td>
<td>25 (37%)</td>
<td>16 (44%)</td>
<td></td>
</tr>
<tr>
<td>N1a</td>
<td>13 (19%)</td>
<td>4 (11%)</td>
<td></td>
</tr>
<tr>
<td>Distant metastasis</td>
<td>2 (3%)</td>
<td>0 (0%)</td>
<td>0.541</td>
</tr>
<tr>
<td>TNM stage$^b$</td>
<td>46 (69%)</td>
<td>29 (81%)</td>
<td>0.189</td>
</tr>
<tr>
<td>Stage 1</td>
<td>5 (7%)</td>
<td>2 (6%)</td>
<td></td>
</tr>
<tr>
<td>Stage 2</td>
<td>9 (13%)</td>
<td>3 (8%)</td>
<td></td>
</tr>
<tr>
<td>Stage 4</td>
<td>7 (10%)</td>
<td>2 (6%)</td>
<td></td>
</tr>
<tr>
<td>MACIS score$^a$</td>
<td>4.8 (4.0–5.9)</td>
<td>4.5 (3.9–5.5)</td>
<td>0.252</td>
</tr>
<tr>
<td>MACIS $\geq$6</td>
<td>15 (22%)</td>
<td>4 (11%)</td>
<td>0.191</td>
</tr>
</tbody>
</table>

Data are expressed as number (percentage) or median (interquartile range).

MACIS, Mayo Clinic’s metastasis, patient age, completeness of resection, local invasion, and tumor size.

$^a$Mann-Whitney U test.

$^b$Cochran–Armitage test.

Table 2 Correlation of CD74 expression with clinicopathological parameters in patients with papillary thyroid carcinoma ($n=103$)

<table>
<thead>
<tr>
<th></th>
<th>CD74 (+) ($n=62$)</th>
<th>CD74 (-) ($n=41$)</th>
<th>$P$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>50 (81%)</td>
<td>31 (76%)</td>
<td>0.542</td>
</tr>
<tr>
<td>Age (years)$^a$</td>
<td>42 (33–51)</td>
<td>37 (31–47)</td>
<td>0.103</td>
</tr>
<tr>
<td>Hashimoto’s thyroiditis</td>
<td>4 (6%)</td>
<td>2 (5%)</td>
<td>1.000</td>
</tr>
<tr>
<td>Tumor size (cm)$^a$</td>
<td>2.5 (2.0–3.2)</td>
<td>2.1 (1.5–2.5)</td>
<td>0.043</td>
</tr>
<tr>
<td>Extrathyroidal invasion$^b$</td>
<td>36 (58%)</td>
<td>32 (78%)</td>
<td>0.021</td>
</tr>
<tr>
<td>No</td>
<td>19 (31%)</td>
<td>9 (22%)</td>
<td></td>
</tr>
<tr>
<td>Microscopic</td>
<td>7 (11%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Macrogenic</td>
<td>20 (32%)</td>
<td>17 (41%)</td>
<td>0.341</td>
</tr>
<tr>
<td>Lymph node metastasis$^b$</td>
<td>28 (45%)</td>
<td>17 (41%)</td>
<td></td>
</tr>
<tr>
<td>N0</td>
<td>22 (35%)</td>
<td>19 (46%)</td>
<td></td>
</tr>
<tr>
<td>N1a</td>
<td>12 (19%)</td>
<td>5 (12%)</td>
<td></td>
</tr>
<tr>
<td>Distant metastasis</td>
<td>2 (3%)</td>
<td>0 (0%)</td>
<td>0.516</td>
</tr>
<tr>
<td>TNM stage$^b$</td>
<td>39 (63%)</td>
<td>36 (88%)</td>
<td>0.006</td>
</tr>
<tr>
<td>Stage 1</td>
<td>6 (10%)</td>
<td>1 (2%)</td>
<td></td>
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<tr>
<td>Stage 2</td>
<td>9 (15%)</td>
<td>3 (7%)</td>
<td></td>
</tr>
<tr>
<td>Stage 3</td>
<td>8 (13%)</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>MACIS score$^a$</td>
<td>5.1 (4.0–6.0)</td>
<td>4.4 (3.9–5.2)</td>
<td>0.026</td>
</tr>
<tr>
<td>MACIS $\geq$6</td>
<td>16 (26%)</td>
<td>3 (7%)</td>
<td>0.020</td>
</tr>
</tbody>
</table>

Data are expressed as number (percentage) or median (interquartile range).

MACIS, Mayo Clinic’s metastasis, patient age, completeness of resection, local invasion, and tumor size.

$^a$Mann-Whitney test.

$^b$Cochran–Armitage trend test.
Effect on cell growth with MIF treatment. In concordance with the results of MTT assay, treatment with anti-CD74 antibody inhibited anchorage-dependent colony formation by 86% in BCPAP cells and 35% in K1 cells (Fig. 3B). In addition, the size of colonies in anti-CD74 antibody-treated cells was smaller as compared with isotype control-treated cells. Paradoxically, clonogenic assays showed that MIF treatment significantly reduced the colony numbers by 32% in BCPAP cells but not in K1 cells.

Decreased cell migration and invasion with anti-CD74 antibody treatment

In the same experimental conditions using MTT assay, cell migration and invasion were evaluated in thyroid cancer cells. With treatment with anti-CD74 antibody, cell migration was reduced by 34% in BCPAP cells and 29% in K1 cells (Fig. 4A). MIF treatment had no effect on cell migration. Similarly, treatment with anti-CD74 antibody significantly reduced the invasiveness through matrigel (BCPAP, 48% and K1, 35%) compared with controls (Fig. 4B). Interestingly, treatment with recombinant human MIF led to a remarkable increase in invasion in both BCPAP (67% increase) and K1 (69% increase) cells.

Decreased VEGF secretion with anti-CD74 antibody treatment

Previous study showed that MIF induced VEGF secretion in a dose-dependent manner in cervical cancer cells, which could be inhibited by anti-CD74 antibody (Cheng et al. 2011a). To study the effects on VEGF secretion in thyroid cancer, BCPAP and K1 cells were treated with the same experimental protocol previously used. As shown in Fig. 5A, MIF did not stimulate VEGF secretion in thyroid cancer cells. However, treatment with

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Figure 3
Effects of CD74 modulation on cell growth and colony formation in human thyroid cancer cells. (A) BCPAP and K1 cells were treated with isotype control, recombinant human macrophage migration inhibitory factor (MIF, 200 ng/ml), or anti-CD74 antibody (CD74Ab, 5 μg/ml) for 24–72 h. Cell viability, determined with thiazolyl blue tetrazolium (MTT) assay, was calculated by comparing results with control cells (100% viable). (B) Quantification of colonies formed following treatment with isotype control, MIF, or CD74Ab in BCPAP and K1 cells. P values were determined by the Student’s t-test. *P < 0.05, **P < 0.01, and ***P < 0.001. A full colour version of this figure is available at http://dx.doi.org/10.1530/ERC-14-0269.
anti-CD74 antibody modestly decreased VEGF secretion by 29% in BCPAP cells and 12% in K1 cells.

**Survival pathways involved in CD74 modulation**

To investigate the mechanisms involved in CD74 modulation, the expression of the phosphorylation of AKT and AMPK was determined following treatment with anti-CD74 antibody. Stimulation of surface CD74 induces a signaling cascade resulting in AKT activation and cell proliferation (Starlets et al. 2006). Furthermore, impaired AMPK activation was observed in the hearts of CD74-knockout mice during ischemia (Qi et al. 2014). Decreased AKT Thr308 phosphorylation was observed following anti-CD74 antibody treatment, while AKT Ser473 phosphorylation was slightly reduced (Fig. 5B). In addition, AMPK phosphorylation increased upon stimulation with anti-CD74 antibody in both cell lines. There was no change in the expression of total AKT or total AMPK. These results indicate that PI3K/AKT and AMPK pathways may play a
role in the inhibitory effects seen following treatment with anti-CD74 antibody.

**Discussion**

In this study, we for the first time demonstrated that CD74 was overexpressed in tumorous parts of thyroid malignancy and was associated with advanced tumor stage. Our initial hypothesis was that MIF may represent a link between inflammation and thyroid cancer. MIF binds to CD74, and correlations between the expression of CD74 and MIF have been reported (Cheng et al. 2011a, Zheng et al. 2012). However, based on our results, CD74 expression did not correlate with MIF expression in thyroid cancer. Furthermore, anaplastic thyroid cancer showed a decreased MIF expression. CD74 expression is generally observed in tumor with advanced stage and worse survival (Nagata et al. 2009, Zheng et al. 2012). On the other hand, intracellular MIF expression may have different implications from exogenous MIF stimulation. For instance, breast cancer with abundant cytosolic MIF expression was associated with better disease-specific overall and recurrence-free survival (Verjans et al. 2009). Considering that there was no significant difference in clinicopathological parameters between MIF-positive and MIF-negative tumors, MIF probably plays a minor role in thyroid cancer development and progression. CD74 instead might be more appropriate for therapeutic intervention in thyroid cancer.

We observed that treatment with anti-CD74 antibody inhibited cell growth, migration, and invasion in thyroid cancer cells. In DU-145 prostate cancer cells, anti-CD74 treatment reduced cell viability to the extent similar to that observed following knockdown of CD74 by RNA interference (Meyer-Siegler et al. 2006). Furthermore, anti-CD74 treatment successfully suppressed cell invasion in prostate cancer cells expressing cell surface CD74. In MKN-45 gastric cancer cells, lipopolysaccharide-induced cell
proliferation was similarly reduced with either knockdown of CD74 or anti-CD74 treatment (Zheng et al. 2012). Antibody therapeutics in cancer is used to specifically target a molecule with antigenic differences between normal and malignant tissues (Sliwkowski & Mellman 2013). Moreover, CD74 is a suitable carrier for antibody–drug conjugates for its high expression on neoplastic cells and rapid internalization. Various chemotherapeutic or radioactive agents have been used to prepare a conjugate in hematologic and solid tumors (Govindan 2013). It has been shown that downregulation of CD74 or anti-CD74 treatment (Zheng et al. 2012) resulted in AKT activation and cell proliferation (Starlets 2007). Despite our intriguing findings suggesting relatively specific expression of CD74 in malignant thyroid cancer tissues, further in vivo studies are warranted to evaluate the efficacy and safety of targeting CD74 in thyroid cancer.

Cancer-induced immune stimulation and suppression may lead to local and systemic cytokine alterations. Among cytokine alterations associated with malignancy, significantly increased serum MIF concentrations have been reported in several types of cancer (Lippitz 2013). In esophageal and breast cancer, tissue MIF expression correlated with microvessel density (Ren et al. 2005, Xu et al. 2008). In cervical cancer, either MIF or CD74 expression was positively associated with higher microvessel density (Cheng et al. 2011a). MIF has been shown to interact with and stabilize hypoxia-inducible factor 1 alpha, a master regulator of hypoxic/ischemic vascular responses (Winner et al. 2007). In this study, MIF treatment did not induce VEGF secretion in thyroid cancer cells. In contrast, anti-CD74 antibody modestly reduced the secretion of VEGF. Our findings are consistent with those of Kindt et al. (2014) that CD74 knockdown reduced VEGF production from SCCVII cells. A large body of evidence indicates that VEGF plays a critical role in angiogenesis and metastasis (Phay & Ringel 2013). Clinical applications of VEGF in thyroid cancer have included diagnosis, prediction of prognosis, and treatment (Lin & Chao 2005). Collectively, these findings provide further evidence that CD74 may serve as a potential target for the intervention of thyroid cancer.

AKT signaling plays an important role in the progression of thyroid cancer (Shinohara et al. 2007). It was shown that MIF prevents apoptosis and promotes tumor cell survival by directly activating the AKT pathway (Lue et al. 2007). The function of AKT is regulated by phosphorylation on two sites. Maximal AKT activity requires Thr308 phosphorylation mediated by PDK1 and Ser473 phosphorylation by mTOR complex 2 (mTORC2; Manning & Cantley 2007). It has been shown that stimulation of surface CD74 induced a signaling cascade resulting in AKT activation and cell proliferation (Starlets et al. 2006). CD74 (but not MIF) stimulation induced upregulation of monocyte chemoattractant protein 1, which was prevented by an AKT inhibitor (Martin-Ventura et al. 2009). Our data are in concordance with these results and suggested an association between inhibition of PI3K/AKT pathway and suppressive effects following treatment with anti-CD74 antibody.

AMPK is a master energy sensor and functions to monitor and maintain cellular and organismal metabolism. AKT negatively regulates AMPK by decreasing the AMP:ATP ratio (Hahn-Windgassen et al. 2005). In this respect, we found that anti-CD74 treatment inhibited AKT phosphorylation and meanwhile activated the AMPK pathway. MIF stimulation activates the cardioprotective AMPK pathway during ischemia (Miller et al. 2008). Nonetheless, AMPK activation had a greater degree of impairment in CD74−/− than MIF−/− hearts during ischemia (Qi et al. 2014). The sequence or interaction of AKT inhibition and AMPK activation could not be determined in this study. In the opposite direction, AMPK may suppress AKT activity through activation of PTEN or protein phosphatase 2A (Huang et al. 2008, Kim et al. 2009). AMPK agonists are currently under investigation for cancer treatment. Metformin use in diabetic patients with thyroid cancer is associated with higher remission rate (Klubo-Giewezdzinska et al. 2013). The role of AMPK activation in tumor suppressive effects associated with CD74 modulation remains to be clarified.

One limitation of our study is that follow-up data are not available for analysis. Therefore, we could not affirm whether patients with a CD74-positive tumor have a worse overall or disease-specific survival. Furthermore, the number of benign thyroid lesions studied is small. The specificity of CD74 overexpression in malignant thyroid tissue needs to be verified in a larger series of tumors. We observed CD74 overexpression in 60% of the primary papillary cancer and 78% of the corresponding metastatic lymph nodes. There was no association of CD74 expression between the primary tumor and metastatic nodes. It is unclear whether CD74 overexpression develops de novo during metastasis or CD74-positive cells carrying greater migratory/invading capacity are selected in the metastatic process.

In summary, we report the characterization of CD74 expression in thyroid cancer and demonstrate that treatment with anti-CD74 antibody effectively modulates malignant cell phenotype. Although the findings appear to rebut the initial hypothesis that MIF/CD74 mediates the link between inflammation and thyroid cancer, our
results indicate that CD74 may serve as a therapeutic target molecule in advanced thyroid cancer.

Supplementary data
This is linked to the online version of the paper at http://dx.doi.org/10.1530/ERC-14-0269.

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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