Cyclooxygenase-2: a target for the prevention and treatment of breast cancer

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Abstract

Cyclooxygenase-2 (COX-2), an inducible prostaglandin synthase, is normally expressed in parts of the kidney and brain. Aberrant COX-2 expression was first reported in colorectal carcinomas and adenomas, and has now been detected in various human cancers, including those of the breast. Strikingly, COX-2 overexpression in murine mammary gland is sufficient to cause tumour formation. To date, the role of COX-2 in tumorigenesis has been most intensively studied in the colon. Thus, the relationship between COX-2 and neoplasia can best be illustrated with reference to intestinal tumorigenesis. Here we consider the potential utility of selective COX-2 inhibitors for the prevention and treatment of breast cancer. Data for cancers of the colon and breast are compared where possible. In addition, the mechanisms by which COX-2 is upregulated in cancers and contributes to tumorigenesis are discussed. Importantly, several recent studies of mammary tumorigenesis in animal models have found selective COX-2 inhibitors to be effective in the prevention and treatment of breast cancer. Clinical trials will be needed to determine whether COX-2 inhibition represents a useful approach to preventing or treating human breast cancer.

Introduction

Cyclooxygenase-2 (COX-2) is emerging as an increasingly promising pharmacological target for the prevention and treatment of many human cancers. COX-1 and COX-2 are prostaglandin (PG) synthases which catalyse sequential synthesis of prostaglandin G₂ (PGG₂) and PGH₂ from arachidonic acid by virtue of intrinsic cyclooxygenase and peroxidase activities (Fig. 1). PGH₂ is then converted by specific isomerases to other eicosanoids, including PGs, thromboxane (Tx) and prostacyclin. Cyclooxygenase-derived prostanoids contribute to many normal physiological processes including haemostasis, platelet aggregation, kidney and gastric function, reproduction, pain and fever. Despite the similar enzymatic activities of COX-1 and COX-2, the COX-1 and COX-2 genes have distinct properties, and differing expression patterns (Table 1). While COX-1 is constitutively expressed, COX-2 is upregulated in response to growth factors, tumour promoters and cytokines (reviewed by Herschman 1996). Additionally, COX-2 is responsive to several oncosenes, including v-src, v-Ha-ras, HER-2/neu and Wnt genes (Xie & Herschman 1995, Subbaramaiah et al. 1996, Sheng et al. 1998b, Howe et al. 1999, Vadlamudi et al. 1999, Haertel-Wiesmann et al. 2000). Thus, increased PG synthesis is detected in inflamed and neoplastic tissues. Analysis of COX-2-deficient mice suggests that COX-2 is normally important for post-natal renal development and multiple female reproductive processes including ovulation, fertilisation, implantation and decidualisation (Dinckul et al. 1995, Morham et al. 1995, Lim et al. 1997, 1999a). Aberrant COX-2 expression has been detected in multiple human cancers, as shown in Table 2. Together, a weight of epidemiological, pharmacological, genetic and expression data combine to suggest an important role for COX-2 in tumorigenesis, particularly in colorectal cancer. There is recent evidence that COX-2 may also represent a novel target for the prevention and treatment of breast cancer.

Cyclooxygenase activity is inhibited by nonsteroidal anti-inflammatory drugs (NSAIDs) such as aspirin and sulindac, which are most commonly administered for the relief of pain and inflammation. However, adverse side effects including peptic ulcer disease are associated with the use of such compounds, which are nonselective inhibitors of...
Figure 1 Biosynthesis of prostaglandins. Arachidonic acid, released from membrane phospholipids by phospholipase A2 action (reaction 1), is metabolised by cyclooxygenases to PGH2 in two steps. PGG2 is generated by cyclooxygenase activity (reaction 2), then converted to PGH2 by the peroxidase activity (reaction 3); both enzyme activities are intrinsic to COX-1 and COX-2. PGH2 can be converted to several eicosanoids by specific isomerases. Additionally, MDA (malondialdehyde) can be produced enzymatically or by degradation of PGH2. TxA2, thromboxane A2.

Table 1 Properties of COX-1 and COX-2.

<table>
<thead>
<tr>
<th></th>
<th>COX-1</th>
<th>COX-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expression</td>
<td>Constitutive</td>
<td>Inducible</td>
</tr>
<tr>
<td>Size of gene</td>
<td>22 kb</td>
<td>8.3 kb</td>
</tr>
<tr>
<td>mRNA transcript</td>
<td>2.7 kb</td>
<td>4.5 kb, with multiple Shaw-Kamen sequences</td>
</tr>
<tr>
<td>Size of protein</td>
<td>72 kDa</td>
<td>72/74 kDa doublet</td>
</tr>
<tr>
<td>Localisation</td>
<td>Endoplasmic reticulum, nuclear envelope</td>
<td>Endoplasmic reticulum, nuclear envelope</td>
</tr>
<tr>
<td>Expression pattern</td>
<td>Most tissues, including stomach, kidney, colon and platelets</td>
<td>Regions of brain and kidney, activated macrophages, synoviocytes during inflammation, malignant epithelial cells. Expression stimulated by cytokines, growth factors, oncogenes and tumour promoters</td>
</tr>
</tbody>
</table>

COX-1 and COX-2. In fact, prior to the development of selective COX-2 inhibitors, there were an estimated 100 000 hospitalisations and 16 500 deaths per year in the United States related to NSAID use (Singh 1998). Toxicity associated with the use of nonselective NSAIDs was the major stimulus to develop selective COX-2 inhibitors. Endoscopically controlled studies show that selective COX-2 inhibitors are far less ulcerogenic than classical NSAIDs (Langman et al. 1999, Simon et al. 1999). Since selective COX-2 inhibitors appear sufficiently safe to allow large scale administration on a chronic basis to healthy individuals, they represent potentially useful agents for cancer chemoprevention.

**COX-2 and cancer: epidemiology and expression**

**Colon cancer**

One of the first clues that cyclooxygenase inhibition might be an effective approach to preventing cancer came from...
epithelial component, but could also be detected in carcinomas, COX-2 protein localised predominantly to the COX-2 expression in 9 of 20 adenomas examined. In Kutchera (Eberhart 1996) with the virtually undetectable expression in normal mucosa upregulation was observed in colon carcinomas compared with the virtually undetectable expression in normal mucosa (Eberhart et al. 1994). The basis for the lack of consistency among different studies is unclear. One potential explanation is that some NSAIDs may have restricted bioavailability in breast tissue. Thus, conflicting data obtained in separate studies may reflect the usage of different NSAIDs in the populations examined. Another potential complication is that significant COX-2 overexpression may be limited to a subset of human breast cancers, which could certainly confound epidemiological analyses. Approximately 85% of human colorectal adenocarcinomas overexpress COX-2 (Eberhart et al. 1994, Kargman et al. 1995, Sano et al. 1995, Kutchera et al. 1996).

Together, these epidemiological and expression studies suggested a role for COX-2 in colorectal tumorigenesis. This idea is supported by the results of clinical trials. Treatment with the NSAID sulindac or with celecoxib, a selective COX-2 inhibitor, causes a decrease in the size and number of polyps in familial adenomatous polyposis patients (Giardiello et al. 1993, Steinbach et al. 2000). Thus, overexpression of COX-2 appears to contribute to colorectal cancer and cyclooxygenase inhibitors are likely to be useful chemopreventive agents.

**Breast cancer**

In contrast to colon cancer, the role of COX-2 in breast cancer is less clear. Epidemiological studies conducted to investigate the relationship between NSAID use and breast cancer incidence have reported conflicting findings. Several studies have failed to find a significant relationship between aspirin use and breast cancer risk (Paganini-Hill et al. 1989, Thun et al. 1991, Egan et al. 1996). However, other analyses have revealed an association between NSAID consumption and decreased breast cancer incidence. Friedman & Ury (1980) found significantly reduced breast cancer incidence in 4867 women who used indomethacin, compared with age-matched controls. Harris and colleagues (1996) compared NSAID use in 511 women with newly diagnosed breast cancer with 1534 population control subjects, and found that the relative risk of breast cancer was reduced to 66% in women using NSAIDs at least 3 times per week for at least one year. Two additional studies also found that NSAIDs protected against breast cancer (Schreinemachers & Everson 1994, Sharpe et al. 2000). The basis for the lack of consistency among different studies is unclear. One potential explanation is that some NSAIDs may have restricted bioavailability in breast tissue. Thus, conflicting data obtained in separate studies may reflect the usage of different NSAIDs in the populations examined. Another potential complication is that significant COX-2 overexpression may be limited to a subset of human breast cancers, which could certainly confound epidemiological analyses. Approximately 85% of human colorectal adenocarcinomas overexpress COX-2 (Eberhart et al. 1994, Kargman et al. 1995, Sano et al. 1995, Kutchera et al. 1996). This could account for the strong correlation between regular NSAID use and reduced cancer incidence (Thun et al. 1991, Greenberg et al. 1993, Logan et al. 1993, Suh et al. 1993, Reeves et al. 1996). In contrast, as discussed below, COX-2 is not abundantly overexpressed in the majority of human breast cancers (Hwang et al. 1998, Subbaramaiah et al. 1999b). With this in mind, it is predictable that the results of epidemiological studies would be less clear-cut for breast than colon cancer even if NSAIDs were active against COX-2-positive breast cancers.

Enhanced COX expression in breast cancer was first suggested by reports of elevated PG levels in breast tumours (Tan et al. 1974, Bennett et al. 1977, Rolland et al. 1980). PG production was increased in human breast cancers, particularly in those from patients with metastatic disease (Bennett et al.)

**Table 2 COX-2 overexpression in human tumours.**

<table>
<thead>
<tr>
<th>Organ site</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td>Parrett et al. (1997), Hwang et al. (1998), Masferrer et al. (2000), Subbaramaiah et al. (1999b), Soslow et al. (2000)</td>
</tr>
<tr>
<td>Cervical dysplasia and cancer</td>
<td></td>
</tr>
<tr>
<td>Prostate carcinoma</td>
<td></td>
</tr>
<tr>
<td>Bladder transitional cell carcinoma</td>
<td></td>
</tr>
<tr>
<td>Hepatocellular carcinoma</td>
<td>Mohammed et al. (1999)</td>
</tr>
<tr>
<td>Pancreatic cancer</td>
<td></td>
</tr>
<tr>
<td>Skin cancer</td>
<td></td>
</tr>
<tr>
<td>Lung cancer</td>
<td></td>
</tr>
<tr>
<td>Head and neck cancer</td>
<td></td>
</tr>
<tr>
<td>Colorectal adenomas and carcinomas</td>
<td>Eberhart et al. (1994), Kargman et al. (1995), Sano et al. (1995), Kutchera et al. (1996)</td>
</tr>
<tr>
<td>Gastric cancer</td>
<td></td>
</tr>
<tr>
<td>Barrett's oesophagus and oesophageal cancer</td>
<td>Wilson et al. (1998)</td>
</tr>
</tbody>
</table>
COX-2 expression has been detected in breast cancer-derived cell lines (Schrey & Patel 1995, Liu & Rose 1996, Gilhooly & Rose 1999). Interestingly, there appears to be a correlation between invasiveness/metastatic potential and PG production/COX-2 expression in both cell lines and tumour specimens (Bennett et al. 1977, Rolland et al. 1980, Liu & Rose 1996). However, there are conflicting data regarding the frequency of COX-2 expression in breast cancers. Parrett et al. (1997) detected COX-2 expression in 13/13 human breast tumours by reverse transcriptase-coupled polymerase chain reaction (RT-PCR), compared with no detectable expression in normal human breast tissue, and observed a correlation between COX-2 expression and increasing tumour cell density. Immunohistochemistry revealed COX-2 protein in the epithelial cells of the tumours, with no expression in the stromal compartment. In contrast, Hwang and colleagues (1998) analysed 44 tumour samples by Western blotting but only detected COX-2 protein in 2 of the 44 samples. These apparently discrepant observations can be reconciled by consideration of the following. First, the failure to detect COX-2 by Western blotting or RNase protection (Hwang et al. 1998) may reflect the relative insensitivity of these techniques compared with RT-PCR. The second important caveat is that COX-2 expression may be predominantly associated with certain subsets of human breast cancers (Gilhooly & Rose 1999, Subbaramaiah et al. 1999b). We have examined COX-2 expression in 29 microdissected human breast cancers using a coupled immunoprecipitation/Western blotting assay, which confers increased sensitivity relative to direct Western blotting of lysates. High levels of COX-2 protein were detected in 14 of 15 HER-2/neu-overexpressing breast cancers. In contrast, COX-2 was detected in only 4 of 14 HER-2/neu-negative breast cancers, and was expressed at significantly lower levels than in the HER-2/neu-positive samples (Subbaramaiah et al. 1999b). Immunohistochemistry localised COX-2 protein to epithelial cells and the vasculature. Thus, it seems likely that significant overexpression of COX-2 may be largely confined to those breast cancers in which HER-2/neu is overexpressed, or in which the signalling pathways normally activated by HER-2/neu are activated by an alternative event such as ras mutation (Gilhooly & Rose 1999). Since HER-2/neu overexpression is limited to 20–30% of human breast cancers, conflicting epidemiological data may reflect differing proportions of HER-2/neu-positive cancers in the various studies. Based on these recent findings, it would be of considerable interest to compare the efficacy of NSAIDs in preventing HER-2/neu-positive and -negative breast cancers.

Howe et al.: COX-2 and breast cancer

1977, Rolland et al. 1980). PG production and COX-2 expression have also been detected in breast cancer-derived cell lines (Schrey & Patel 1995, Liu & Rose 1996, Gilhooly & Rose 1999). Interestingly, there appears to be a correlation between invasiveness/metastatic potential and PG production/COX-2 expression in both cell lines and tumour specimens (Bennett et al. 1977, Rolland et al. 1980, Liu & Rose 1996). However, there are conflicting data regarding the frequency of COX-2 expression in breast cancers. Parrett et al. (1997) detected COX-2 expression in 13/13 human breast tumours by reverse transcriptase-coupled polymerase chain reaction (RT-PCR), compared with no detectable expression in normal human breast tissue, and observed a correlation between COX-2 expression and increasing tumour cell density. Immunohistochemistry revealed COX-2 protein in the epithelial cells of the tumours, with no expression in the stromal compartment. In contrast, Hwang and colleagues (1998) analysed 44 tumour samples by Western blotting but only detected COX-2 protein in 2 of the 44 samples. These apparently discrepant observations can be reconciled by consideration of the following. First, the failure to detect COX-2 by Western blotting or RNase protection (Hwang et al. 1998) may reflect the relative insensitivity of these techniques compared with RT-PCR. The second important caveat is that COX-2 expression may be predominantly associated with certain subsets of human breast cancers (Gilhooly & Rose 1999, Subbaramaiah et al. 1999b). We have examined COX-2 expression in 29 microdissected human breast cancers using a coupled immunoprecipitation/Western blotting assay, which confers increased sensitivity relative to direct Western blotting of lysates. High levels of COX-2 protein were detected in 14 of 15 HER-2/neu-overexpressing breast cancers. In contrast, COX-2 was detected in only 4 of 14 HER-2/neu-negative breast cancers, and was expressed at significantly lower levels than in the HER-2/neu-positive samples (Subbaramaiah et al. 1999b). Immunohistochemistry localised COX-2 protein to epithelial cells and the vasculature. Thus, it seems likely that significant overexpression of COX-2 may be largely confined to those breast cancers in which HER-2/neu is overexpressed, or in which the signalling pathways normally activated by HER-2/neu are activated by an alternative event such as ras mutation (Gilhooly & Rose 1999). Since HER-2/neu overexpression is limited to 20–30% of human breast cancers, conflicting epidemiological data may reflect differing proportions of HER-2/neu-positive cancers in the various studies. Based on these recent findings, it would be of considerable interest to compare the efficacy of NSAIDs in preventing HER-2/neu-positive and -negative breast cancers.

COX-2 is expressed in intestinal and mammary tumours in rodents

Rodent models of intestinal tumorigenesis can be divided into carcinogen-induced tumour models, and those in which tumour formation is induced by introduction of germline mutations into tumour suppressor genes such as Apc. In humans, germline mutation of the APC gene is responsible for familial adenomatous polyposis (FAP), in which individuals develop numerous adenomatous colorectal polyps, which predispose to colorectal carcinomas. In addition, APC is mutated in approximately 85% of sporadic colorectal carcinomas. Several mice strains have been developed which harbour mutations in one Apc allele, including the Min mouse (Moser et al. 1990), Apc1716 (Oshima et al. 1995), Apc1638N (Fodde et al. 1994), and Apc474 (Sasai et al. 2000). These mice consistently develop intestinal adenomas, although these are more prevalent in the small intestine than in the colon. Analysis of adenomatous polyps from Min mice revealed increased COX-2 expression relative to normal mucosa (Williams et al. 1996). Elevated expression of COX-2 was also detected in colonic mucosa and tumours from rats treated with azoxymethane (AOM) (DuBois et al. 1996a, Singh et al. 1997). Thus COX-2 is commonly overexpressed in both human colorectal cancers and animal models of colorectal cancer. The cellular localisation of COX-2 in both human and rodent tumours continues to be investigated.

Rodent models have also been used to examine COX-2 expression in mammary tumours. In the rat, COX-1 is ubiquitously expressed in virgin, pregnant, lactating, and post-lactational mammary glands, but COX-2 is only detectable in the mammary glands of lactating animals (Badawi et al. 1999). Treatment of ovariectomised animals with oestradiol and progesterone causes induction of COX-2 and PG synthesis (Badawi & Archer 1998, Badawi et al. 1999), suggesting that COX-2 transcription is susceptible to hormonal regulation. COX-2 protein has been detected in rat mammary tumours induced by various carcinogens, including N-nitrosomethyl urea (NMU), dimethylbenz[a]anthracene (DMBA) and 2-amino-1-methyl-6-phenylimidazo[4,5-b]pyridine (PhIP) (Robertson et al. 1998, Hamid et al. 1999, Nakatsugi et al. 2000). Based on immunohistochemical analyses, COX-2 protein was observed in the epithelial cells within the mammary tumours (Robertson et al. 1998, Nakatsugi et al. 2000). Interestingly, dietary administration of n-6 polyunsaturated fatty acids (PUFAs) in the form of safflower oil stimulated COX-2 expression in rat mammary glands, suggesting a potential mechanism by which n-6-PUFAs may contribute to mammary tumorigenesis (Badawi et al. 1998).

In addition to these rat studies, COX-2 protein levels have also been examined in mammary tissues from transgenic mice strains that develop mammary tumours due to mammary-targeted oncogene expression. Significant amounts of COX-2 protein were detected in mammary tumours from mice overexpressing neu (K Subbaramaiah and A J Dannenberg, unpublished observations), consistent with our findings in HER-2/neu-overexpressing human...
breast cancers (Subbaramaiah et al. 1999b). We have also found increased COX-2 protein in mammary tumours from Wnt-1 transgenic mice, relative to the levels in normal mammary gland (Fig. 2; Howe et al. 2001). Consistent with this, COX-2 is transcriptionally upregulated in mouse mammary epithelial cell lines engineered to express Wnt-1 (Howe et al. 1999), and expression is also increased in response to transformation by other oncogenes (Subbaramaiah et al. 1996).

**Mechanisms of COX-2 upregulation**

There is evidence that COX-2 is upregulated in both neoplastic and stromal cells within tumours. Hence, multiple mechanisms are likely to account for overexpression of COX-2 in these different cell types. It is relevant, therefore, to evaluate the effects of different stimuli in various cell types. COX-2 expression is normally regulated at both transcriptional and post-transcriptional levels, and can also be regulated by the rate of protein synthesis and/or degradation. The human COX-2 promoter contains multiple transcription factor binding sites, including a cAMP response element (CRE), and potential binding sites for Myb, nuclear factor interleukin-6 (NF-IL6), nuclear factor κB (NF-κB), and Ets factors (Genbank Accession Number 505116). Of these, the sites proximal to the transcription start site (Fig. 3) have been shown to be differentially responsive to various stimuli. Induction of COX-2 by v-src, serum, platelet-derived growth factor (PDGF) and ceramide requires activation of both Ras/Raf-1/ERK and Ras/MEKK1/JNK signal transduction pathways and is predominantly mediated via the CRE (Xie & Herschman 1995, 1996, Subbaramaiah et al. 1998a). In contrast, the NF-IL6 and NF-κB sites are required for induction of COX-2 in response to tumour necrosis factor (TNF) in osteoblasts (Yamamoto et al. 1995). The NF-IL6 and CRE sites have been identified as being critical for the induction of COX-2 in response to other stimuli, including lipopolysaccharide (LPS) and immunoglobulin E receptor aggregation (Inoue et al. 1995, Reddy et al. 2000b, Wadleigh et al. 2000). Other studies have implicated the NF-κB site as being important for LPS- and benzo[a]pyrene-mediated induction of COX-2 (Hwang et al. 1997, Yan et al. 2000). The expression of COX-2 can also be increased by stabilisation of the COX-2 transcript (Ristimaki et al. 1994, Sheng et al. 1998b). The 3′ untranslated region of COX-2 mRNA contains a 116 nucleotide AU-rich sequence element (ARE) which can negatively regulate transcript stability and modulate translation (Dixon et al. 2000).

During tumorigenesis, increased expression of COX-2 is likely to be a consequence of multiple effects. For example, transcriptional activation is likely to occur in response to growth factors and oncogenes. Moreover, since wildtype p53 decreases COX-2 transcription, loss-of-function p53 mutations may contribute to COX-2 upregulation (Subbaramaiah et al. 1999a). Dixon et al. (2000) speculated that ARE-binding proteins which normally negatively regulate transcript stability may be defective in tumour cells. This, too, could result in increased levels of COX-2. The relative importance of these different factors is likely to vary in different tissues. In mouse skin carcinogenesis, promoter activation by upstream stimulatory factor (USF) and CCAAT/enhancer binding proteins (C/EBPs) appears to be important (Kim & Fischer 1998). By contrast, bile acids, which have been implicated in the promotion of

In colorectal cancer cells, constitutive COX-2 expression is likely to result from a combination of transcriptional, post-transcriptional and translational effects (Hsi et al. 1999, Shao et al. 2000). Mutation of NF-IL6 and CRE elements has been shown to diminish COX-2 promoter activity in two colorectal cancer cell lines (Shao et al. 2000), implicating these sites in transcriptional upregulation. Interestingly, we have recently detected a requirement for the NF-IL6 site for stimulation of the COX-2 promoter by Ets factors of the PEA3 subfamily (Howe et al. 2001). PEA3 factors stimulate human COX-2 promoter activity up to 20-fold when overexpressed in 293 human embryonic kidney cells. Since PEA3 factors are highly expressed in colorectal cancer cell lines, intestinal tumours, and Wnt-1-expressing mammary cell lines and tumours (Crawford et al. 2001, Howe et al. 2001), we speculate that PEA3 factors may contribute to COX-2 induction during both intestinal and mammary tumorigenesis. Increased expression of c-myb may also contribute, since c-myb is upregulated in colon tumours and breast cancers (Guérin et al. 1990, Ramsay et al. 1992) and c-myb overexpression causes modest induction of COX-2 promoter activity (Ramsay et al. 2000).

COX-2 expression can also be affected by dietary fat. Chemically induced mammary carcinogenesis is promoted by dietary n-6-PUFAs, which enhance tissue levels of arachidonic acid, and inhibited by n-3-PUFAs (reviewed by Rose & Connolly 1999). In experimental models, COX-2 expression in mammary tissue and tumours is decreased in animals fed an n-3-PUFA-rich diet (i.e. menhaden oil) relative to those fed a diet high in n-6-PUFAs (i.e. corn or safflower oil) (Badawi et al. 1998, Hamid et al. 1999). Similarly, dietary fish oil decreased the expression of COX-2 and the incidence of colorectal tumours in AOM-treated rats (Singh et al. 1997). This may help to explain epidemiological observations of decreased breast and colon cancer risk in populations with diets rich in fish oils (Rose & Connolly 1999).

Evidence from rodent models that COX-2 contributes to cancer

Genetic evidence for a role for COX-2 in tumour formation

Definitive evidence linking cyclooxygenases to tumorigenesis was first provided by studies using mice with targeted disruptions of the COX-1 or COX-2 genes. Oshima et al. (1996) pioneered these experiments by generating Apc<sup>min</sup>, COX-2-null mice. Intestinal adenoma incidence was reduced by 86% in COX-2 knockout mice, and by 66% in COX-2 heterozygotes, relative to COX-2 wildtype mice carrying the Apc mutation (Oshima et al. 1996). Tumour size was also significantly reduced in COX-2-deficient mice. COX-2 deficiency also protects against chemically induced papilloma formation in mouse skin (Tiano et al. 1997), and COX-2-null embryonic stem cells have a dramatically reduced ability to form teratomas when injected into syngeneic mice (Zhang et al. 2000a). Interestingly, disruption of either COX-1 or COX-2 caused similar reductions in tumour multiplicity in the Min mouse (Chulada et al. 2000), suggesting that both enzymes can impact on tumorigenesis. The results of similar studies to determine the effects of COX-2 deficiency on the incidence of mammary cancer are eagerly awaited. However, results from the converse experiment designed to address the consequence of COX-2 overexpression in mammary gland have recently been reported (Liu et al. 2001). Liu and colleagues overexpressed human COX-2 from the mouse mammary tumor virus (MMTV) promoter, and demonstrated that COX-2 overexpression was sufficient to cause breast tumour formation in more than 85% of multiparous mice. Virgin females did not develop tumours, but exhibited precocious lobuloalveolar differentiation and enhanced expression of the milk protein β-casein. MMTV-driven COX-2 expression increased during pregnancy, suggesting a basis for the failure of virgin animals to develop tumours. Interestingly, mammary gland involution was delayed in COX-2 transgenic mice, with a decrease in the apoptotic index of mammary epithelial cells, and COX-2-induced tumor tissue expressed...
Pharmaceutical studies in rat breast cancer models

Carcinogen-induced rat mammary tumours have been used as a model system to test various NSAIDs and, more recently, selective COX-2 inhibitors for their chemopreventive potential (Table 4). In general, indomethacin was found to reduce the incidence and multiplicity of DMBA-induced tumours (Carter et al. 1983, 1989, McCormick et al. 1985, Noguchi et al. 1991). Because the incidence of breast cancer may be affected by dietary fat, some of these studies have compared NSAID effects in cohorts of animals fed low-versus high-fat diets. Carter et al. (1983) found that indomethacin reduced tumour incidence in DMBA-treated animals fed 18% corn oil to the level observed in DMBA-treated animals fed 5% corn oil, but did not see an effect on incidence in the low-fat cohort. In contrast, two other studies found that the inhibitory effect of indomethacin was not confined to rats fed high-fat diets (McCormick et al. 1985, Noguchi et al. 1991). Interestingly, McCormick et al. (1985) found that indomethacin treatment from 2 weeks before to 1 week after DMBA administration primarily targeted benign tumours. However, when treatment with indomethacin was initiated 1 week after DMBA and continued until the end of the trial, the multiplicity of malignant tumours was also significantly reduced. Conflicting data were obtained by Abou-el-Ela et al. (1989) who found no inhibition of mammary tumorigenesis by indomethacin. The basis for these discrepant observations is unclear. Two additional NSAIDs, flurbiprofen and aspirin, are also capable of reducing carcinogen-induced mammary tumorigenesis (McCormick & Moon 1983, Suzui et al. 1997, Mori et al. 1999), although piroxicam was not found to be effective in one study (Kitagawa & Noguchi 1994).

Two recent studies evaluated the effects of selective COX-2 inhibitors on mammary tumorigenesis. As shown in Fig. 4A, treatment with celecoxib significantly delayed tumour onset in DMBA-treated rats, and was more effective than ibuprofen (Harris et al. 2000). Dietary administration

Table 3 Chemoprevention of intestinal tumorigenesis in rodents using selective COX-2 inhibitors.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Animal</th>
<th>Model</th>
<th>Tumour type</th>
<th>Drug</th>
<th>Effect on tumour multiplicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oshima et al. (1996)</td>
<td>Mouse</td>
<td>ΔApc</td>
<td>Adenoma</td>
<td>MF tricyclic</td>
<td>62% inhibition</td>
</tr>
<tr>
<td>Nakatsugi et al. (1997)</td>
<td>Mouse</td>
<td>Apc Min</td>
<td>Adenoma</td>
<td>Nimesulide</td>
<td>48% inhibition</td>
</tr>
<tr>
<td>Kawamori et al. (1998)</td>
<td>Rat</td>
<td>AOM</td>
<td>Colon carcinoma</td>
<td>Celecoxib</td>
<td>97% inhibition</td>
</tr>
<tr>
<td>Fukutake et al. (1998)</td>
<td>Mouse</td>
<td>AOM</td>
<td>Colon carcinoma</td>
<td>Nimesulide</td>
<td>81% inhibition</td>
</tr>
<tr>
<td>Reddy et al. (2000a)</td>
<td>Rat</td>
<td>AOM</td>
<td>Colon carcinoma</td>
<td>Celecoxib</td>
<td>84% inhibition</td>
</tr>
<tr>
<td>Sasai et al. (2000)</td>
<td>Mouse</td>
<td>ΔApc</td>
<td>Adenoma</td>
<td>JTE-522</td>
<td>32% inhibition</td>
</tr>
<tr>
<td>Jacoby et al. (2000b)</td>
<td>Mouse</td>
<td>Apc Min</td>
<td>Adenoma</td>
<td>Celecoxib</td>
<td>71% inhibition</td>
</tr>
</tbody>
</table>

Several of these studies tested a range of drug concentrations. The effect on tumour multiplicity (number of tumours per animal) reported in this table was that achieved at the highest drug dose tested. In addition to inhibition of tumour multiplicity, these agents also caused reduced tumour incidence (proportion of animals with tumours). Note that individual studies examined different endpoints -- carcinomas or adenomas.
Table 4: Chemoprevention of mammary tumorigenesis in rats using cyclooxygenase inhibitors

<table>
<thead>
<tr>
<th>Reference</th>
<th>Tumour induction</th>
<th>Drug</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carter et al. (1983)</td>
<td>DMBA/18% corn oil</td>
<td>Indomethacin</td>
<td>54% inhibition of tumour multiplicity; reduction in tumour incidence</td>
</tr>
<tr>
<td>McCormick &amp; Moon (1983)</td>
<td>NMU</td>
<td>Flurbiprofen</td>
<td>Reduction in tumour incidence and multiplicity at low NMU dose</td>
</tr>
<tr>
<td>McCormick et al. (1985)</td>
<td>DMBA</td>
<td>Indomethacin</td>
<td>Reduction in benign or malignant tumours according to period of drug administration</td>
</tr>
<tr>
<td>Abou-el-Ela et al. (1989)</td>
<td>DMBA/20% fat</td>
<td>Indomethacin</td>
<td>Inhibition of tumorigenesis in animals fed 4 or 12% linoleate</td>
</tr>
<tr>
<td>Carter et al. (1989)</td>
<td>DMBA/20% fat</td>
<td>Indomethacin</td>
<td>No inhibition</td>
</tr>
<tr>
<td>Noguchi et al. (1991)</td>
<td>DMBA/20% corn oil</td>
<td>Indomethacin</td>
<td>61% inhibition of tumour multiplicity; reduction in tumour incidence</td>
</tr>
<tr>
<td>Kitagawa &amp; Noguchi (1994)</td>
<td>DMBA/20% soybean oil</td>
<td>Piroxicam</td>
<td>No inhibition</td>
</tr>
<tr>
<td>Suzui et al. (1997)</td>
<td>PhIP/high corn oil</td>
<td>Aspirin</td>
<td>44% inhibition of tumour multiplicity</td>
</tr>
<tr>
<td>Mori et al. (1999)</td>
<td>PhIP/high fat</td>
<td>Aspirin</td>
<td>Inhibited tumour multiplicity</td>
</tr>
<tr>
<td>Harris et al. (2000)</td>
<td>DMBA</td>
<td>Celecoxib</td>
<td>86% inhibition of tumour multiplicity; 68% reduction in tumour incidence</td>
</tr>
<tr>
<td>Nakatsugi et al. (2000)</td>
<td>PhIP/24% corn oil</td>
<td>Nimesulide</td>
<td>54% inhibition of tumour multiplicity; 28% reduction in tumour incidence</td>
</tr>
</tbody>
</table>
Figure 4. Celecoxib is effective for breast cancer prevention and treatment. (A) Rats were assigned to a control diet, or a diet containing 1500 ppm ibuprofen or 1500 ppm celecoxib 7 days prior to a single intragastric dose of DMBA, and tumour incidence was measured for 16 weeks. This figure is reproduced with permission from Harris et al. (2000). (B) Rats were maintained for four months after a single intragastric dose of DMBA to allow palpable tumour development, then assigned to a control diet or a diet containing 1500 ppm celecoxib, and tumour size was monitored for 6 weeks. This figure is reproduced with permission from Alshafie et al. (2000).
This table is reproduced with permission from Nakatsugi et al. (2000).

However, in adipose tissue adjacent to breast tumours, aromatase is normally expressed from promoter I.4, which distinct transcripts are generated. In adipose tissue, oestrogen synthesis, has three promoters, I.4, I.3 and II, from which PGs interact with the production of TNFα by dendritic cells (Stolina et al. 2000). Thus, PG-mediated immune suppression may contribute to tumorigenesis, since this may allow tumours to avoid immune surveillance that might otherwise limit their growth.

In breast tissue, PGs may also stimulate proliferation indirectly by increasing oestrogen biosynthesis (Harris et al. 1996). The aromatase gene CYP19, which is responsible for oestrogen synthesis, has three promoters, I.4, I.3 and II, from which distinct transcripts are generated. In adipose tissue, aromatase is normally expressed from promoter I.4. However, in adipose tissue adjacent to breast tumours, CYP19 tends to be expressed from promoter II. Recently, PGE2 has been demonstrated to increase aromatase activity (Zhao et al. 1996, Purohit et al. 1999) and cause CYP19 promoter switching to promoter II in adipose stromal cells (Zhao et al. 1996). These data suggest that PG overproduction can induce aromatase, leading to increased oestrogen synthesis. Consistent with this, a positive correlation has been observed between CYP19 and COX expression in human breast cancer specimens (Brueggemeier et al. 1999). Thus it is possible that PG-mediated oestrogen overproduction may be an important organ site-specific consequence of COX-2 upregulation in breast cancer.

### Cyclooxygenase-mediated production of mutagens

Thus far, the potential contributions of PG overproduction to tumorigenesis, including increased cellular proliferation and diminished immune surveillance, have been discussed. However, COX-2 overexpression may also have PG-independent consequences. In particular, COX-2 overexpression may result in increased production of mutagens. Malondialdehyde (MDA) can be produced by isomerisation of PGH2, both enzymatically and non-enzymatically (Fig. 1). Therefore, MDA production may be elevated due to increased availability of the precursor molecule PGH2. MDA forms adducts with deoxynucleosides and induces frame-shifts and base-pair substitutions, and thus has potent mutagenic activity (Marnett 1992). Additional carcinogens can be formed by oxidation of aromatic amines, heterocyclic amines, and dihydriodiol derivatives of polycyclic hydrocarbons (Wiese et al. 2001). This oxidation step is catalysed by the peroxidase activity of cyclooxygenase, which requires a reductant to convert PGG2 to PGH2. Thus, COX-2 overexpression may lead to DNA damage, thereby contributing to carcinogenesis. Consistent with this hypothesis, the selective COX-2 inhibitor nimesulide decreases formation of the mutagen 8-oxo-7,8-dihydro-2′-deoxyguanosine in the colonic mucosa (Tardieu et al. 2000).

### Effects on angiogenesis

Recently, it has become apparent that cyclooxygenases are involved in angiogenesis (reviewed by Gately 2000). This is a crucial facet of tumorigenesis since neovascularisation is required for tumours to grow beyond 2–3 mm in size. Experiments in the 1980s showed that xenograft vascularisation was significantly reduced by the NSAIDs indomethacin, diclofenac and aspirin (Peterson 1983). More recently, COX-2 has been specifically implicated. In vitro, selective COX-2 inhibitors decrease endothelial tubule formation (Tsujii et al. 1998, Jones et al. 1999), while, in vivo, selective COX-2 inhibitors reduce angiogenesis in several models (Majima et al. 1997, Daniel et al. 1999, Sawaoka et al. 1999, Yamada et al. 1999, Masferrer et al. 2000). A representative illustration of celecoxib-mediated inhibition of corneal angiogenesis is shown in Fig. 5.

In an interesting corollary, Lewis lung carcinoma xenografts showed marked attenuation of growth when implanted in COX-2-null mice, but grew normally in COX-1-deficient mice (Williams et al. 2000a). The tumours from COX-2 knockout mice exhibited 30% decreased vascular density, implicating host COX-2 in tumour neovascularisation. It seems likely that COX-2 in epithelial cells, endothelial cells and fibroblasts may contribute to the angiogenic process, although there are some

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**Table 5** Effects of nimesulide on the incidence, multiplicity and volume of mammary carcinomas induced by PhIP in Sprague-Dawley rats. Results are means ± S.E.

<table>
<thead>
<tr>
<th></th>
<th>Control diet</th>
<th>400 ppm nimesulide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour incidence (% rats with cancers)</td>
<td>30/42 (71%)</td>
<td>19/37 (51%)</td>
</tr>
<tr>
<td>Multiplicity (no. of cancers/ rat)</td>
<td>2.6 ± 0.5</td>
<td>1.2 ± 0.2*</td>
</tr>
<tr>
<td>Cancer volume/rat (cm³)</td>
<td>4.1 ± 1.3</td>
<td>1.1 ± 0.4*</td>
</tr>
<tr>
<td>Effective no. of rats</td>
<td>42</td>
<td>37</td>
</tr>
</tbody>
</table>

*Significantly different from the control diet group by Welch’s t test (P >0.05). This table is reproduced with permission from Nakatsugi et al. (2000).
discrepancies between observations made in vivo and in vitro (Majima et al. 1997, Tsujii et al. 1998, Daniel et al. 1999, Masferrer et al. 2000, Williams et al. 2000a). COX-2 apparently contributes to the production of pro-angiogenic factors, including vascular endothelial growth factor (VEGF), basic fibroblast growth factor (bFGF), transforming growth factor-1, PDGF, and endothelin-1. NS-398 treatment of a COX-2-overexpressing colorectal cancer cell line diminishes secretion of these factors (Tsujii et al. 1998), and COX-2 (–/–) fibroblasts have a 94% reduction in the ability to produce VEGF relative to wild-type fibroblasts (Williams et al. 2000a). However, the molecular mechanisms underlying COX-2-mediated production of pro-angiogenic factors remain to be defined.

COX-1 can also contribute to angiogenesis. Nonselective NSAIDs decrease the vascularisation of xenografts comprised of cells not expressing COX-2 (Sawaoka et al. 1999). Moreover, NSAIDs inhibit endothelial tubule formation even when cells do not express COX-2 (Tsujii et al. 1998, Jones et al. 1999). Thus both COX-1 and COX-2 are likely to contribute to tumour vascularisation. The possibility that COX-2 inhibitors diminish tumorigenesis.
partly by preventing angiogenesis further enhances their attractiveness as potential anti-cancer agents.

**Effects of COX-2 overexpression on cell invasiveness and apoptosis**

The potential consequences of COX-2 overexpression have been addressed in vitro by generation of cell lines overexpressing COX-2. In particular, rat intestinal epithelial cells stably overexpressing COX-2 show several altered characteristics, including increased adhesion to extracellular matrix, resistance to butyrate-induced apoptosis and a delayed transit through the G1 phase of the cell cycle (Tsuji & DuBois 1995, DuBois et al. 1996b). Additionally, stable COX-2 expression in Caco-2 cells or in the breast cancer cell line Hs578T increases expression or activity of enzymes capable of digesting the basement membrane, presumably contributing to the observed increase in ability to invade through a layer of Matrigel (Tsuji et al. 1997, Takahashi et al. 1999). All of these characteristics may contribute to tumorigenicity, although the molecular mechanism(s) by which COX-2 causes these effects is unknown.

Much interest has centred on the ability of COX-2 to suppress apoptosis. Diminished apoptosis is thought to favour carcinogenesis by permitting survival of cells that have acquired mutations, and thus is viewed as one of the central mechanisms of tumorigenesis. Conversely, many NSAIDs enhance apoptotic cell death, although this is unlikely to be solely due to inhibition of cyclooxygenase activity (see below). Several hypotheses have been advanced to account for suppression of apoptosis in response to COX-2 overexpression. The ability of PGE$_2$ to inhibit apoptosis caused by a selective COX-2 inhibitor, and concomitantly to induce Bcl-2, suggests that PG-mediated upregulation of Bcl-2 may suppress apoptosis (Sheng et al. 1998a). Alternatively, since arachidonic acid stimulates apoptosis, enhanced COX-2 expression could inhibit apoptosis by increasing the conversion of arachidonic acid to PG (Chan et al. 1998, Cao et al. 2000). Kinzler and colleagues propose that arachidonic acid stimulates the conversion of sphingomyelin to ceramide, which then causes apoptosis (Chan et al. 1998). They further suggest that the apoptosis-promoting effect of NSAIDs such as sulindac is due to NSAID-induced accumulation of arachidonic acid. In contrast, although Prescott and co-workers also consider arachidonate to be a key determinant of apoptosis, they do not observe increased levels of ceramide in response to exogenous administration of arachidonic acid (Cao et al. 2000).

Clearly, the suppression of apoptosis associated with COX-2 overexpression could be an important factor in tumorigenesis, although the precise mechanistic basis remains uncertain. Interestingly, an apoptosis-related protein was found in a two-hybrid screen designed to identify proteins that interact with cyclooxygenases (Ballif et al. 1996). Nucleobindin associates with DNA from apoptotic cells, and can itself promote apoptosis. The interaction of COX-1 and COX-2 with nucleobindin may contribute to COX-mediated suppression of apoptosis, potentially via sequestration of nucleobindin, but further studies are required to fully understand the significance of the interaction.

As mentioned above, multiple NSAIDs, including selective COX-2 inhibitors, induce apoptosis in a variety of cells (Lu et al. 1995, Hara et al. 1997, Sheng et al. 1998a, Ding et al. 2000, Hida et al. 2000, Li et al. 2000). The simplest interpretation of this phenomenon is that, since COX-2 overexpression suppresses apoptosis, inhibition of COX-2 activity is sufficient to induce apoptosis. However, NSAID-induced apoptosis has also been demonstrated in cell lines that do not express COX-2, including COX-2-null mouse embryo fibroblasts (Hanif et al. 1996, Elder et al. 1997, Zhang et al. 1999). Additionally, non-cyclooxygenase-inhibiting sulindac metabolites such as sulindac sulphone retain the ability to induce apoptosis (Piazza et al. 1997, Lim et al. 1999b). Thus, NSAIDs most likely stimulate apoptosis via both COX-dependent and -independent mechanisms (Rigas & Shiff 2000), including inhibition of the protein kinase Akt (Hsu et al. 2000) and suppression of NF-kB activation (Kopp & Ghosh 1994, Grilli et al. 1996, Yin et al. 1998, Yamamoto et al. 1999).

**Clinical prospects for COX-2 inhibitors and breast cancer**

The weight of evidence implicating COX-2 in colorectal cancer has stimulated clinical trials to investigate the efficacy of selective COX-2 inhibitors in individuals at risk for colorectal cancer. Treatment with celecoxib has been shown to reduce the size and number of polyps in FAP patients (Steinbach et al. 2000), and is currently being evaluated for efficacy in preventing sporadic colorectal adenomas. Undoubtedly the potential use of selective COX-2 inhibitors for the treatment of colorectal cancer will also be investigated.

Here we have reviewed evidence that aberrant COX-2 expression is also associated with breast cancer, both in rodent models and in the human disease. Selective COX-2 inhibitors have proved effective in preventing experimental breast cancer (Harris et al. 2000, Nakatsuji et al. 2000). Whether COX-2 inhibitors will also be useful for preventing breast cancer in high-risk individuals needs to be investigated. In addition, selective COX-2 inhibitors may have a role in the treatment of breast cancer (Alshafie et al. 2000). Since COX-2 is overexpressed in HER-2/neu-positive breast cancers (Subbaramaiah et al. 1999b), selective COX-2 inhibitors should be evaluated as therapy in this patient population. Because COX-2-derived PGs may enhance aromatase activity, a therapeutic regimen combining a selective COX-2 inhibitor with an aromatase inhibitor should be considered. There is also recent evidence that
microtubule-interfering agents, including taxol, stimulate COX-2 transcription (Subbaramaiah et al. 2000). This could decrease the efficacy of this class of drugs. Thus, coadministration of a selective COX-2 inhibitor with drugs such as taxol might enhance their anti-cancer activity. Finally, a number of natural substances have been identified that inhibit the transcriptional activation of COX-2. Examples include retinoids, triterpenoids, antioxidants and resorcinols (Mestre et al. 1997a,b, Chinery et al. 1998, Subbaramaiah et al. 1998b, Suh et al. 1998, Mutoh et al. 2000). Some of these compounds also inhibit experimental breast cancer. Hence, it is possible that studies of COX-2 will provide insights that will prove useful in developing dietary recommendations to decrease cancer risk.

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