Research Article

Metformin Prevents the Development of Oral Squamous Cell Carcinomas from Carcinogen-Induced Premalignant Lesions

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Abstract

Head and neck squamous cell carcinoma (HNSCC) is a major public health concern. The recent identification of the mTOR complex 1 (mTORC1) signaling pathway as a highly prevalent molecular signature underlying HNSCC pathogenesis has provided the foundation to search for novel therapeutic approaches to prevent and treat HNSCC. Here, we asked whether metformin, the most widely used medication for the treatment of type II diabetes, which acts in part by stimulating the AMP-activated protein kinase (AMPK) signaling pathway thereby reducing mTORC1 activity, may lower the risk of HNSCC development. Indeed, we show that metformin reduces the growth of HNSCC cells and diminishes their mTORC1 activity by both AMPK-dependent and-independent mechanisms. We also optimized an oral-specific carcinogenesis mouse model that results in the accumulation of multiple oral premalignant lesions at the end of the carcinogen exposure, some of which then spontaneously progress into HNSCC. Using this mouse model, we observed that metformin specifically inhibits mTORC1 in the basal proliferating epithelial layer of oral premalignant lesions. Remarkably, metformin prevented the development of HNSCC by reducing significantly the size and number of carcinogen-induced oral tumoral lesions and by preventing their spontaneous conversion to squamous cell carcinomas. Collectively, our data underscore the potential clinical benefits of using metformin as a targeted chemopreventive agent in the control of HNSCC development and progression.

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Introduction

Head and neck squamous cell carcinoma (HNSCC), most of which arise in the oral cavity, continues to be a major public health concern. In 2011, more than 49,200 new cases of HNSCC will be diagnosed, and 11,400 deaths are predicted to occur from this disease in the United States alone (1). The recent identification of the phosphoinositide 3-kinase (PI3K), Akt, and mTOR complex 1 (mTORC1) signaling pathway as a highly prevalent molecular signature underlying HNSCC pathogenesis (2–8) has provided the foundation to search for novel molecular-targeted strategies to halt the disease process.

In HNSCC, the activation of mTORC1 may result from the overactivity of EGF receptor (EGFR), which is often aberrantly overexpressed in HNSCC thereby causing the phosphorylation and activation of the lipid kinase PI3K, or by the downregulation of the expression of the tumor suppressor protein PTEN, which acts as a lipid phosphatase inhibiting the accumulation of the PI3K enzymatic product, phosphatidylinositol (3,4,5)-triphosphate (PIP3; reviewed in ref. 9). Alternatively, PIP3 levels can be raised by the presence of activating mutations in the PI3K and the ras oncogene, and by inactivating mutations in the Pten tumor suppressor gene, all of which have now been established to occur in a nonoverlapping fashion in HNSCC (6, 7). The accumulation of PIP3 stimulates the kinase Akt, which inactivates the tumor suppressor protein complex TSC1/TSC2 (10), leading to the accumulation of active GTP-bound Rheb, which in turn activates mTOR (10) as part of the conserved kinase complex mTORC1 (11). The mTORC1 oncogenic network supports a progressive metabolic reprogramming that favors cancer cell macromolecular biosynthesis, proliferation, survival, and ultimately metastasis (11). Indeed, recent analysis of the HNSCC genomic landscape indicates that the accumulation of mutations in the Akt/mTOR pathway may represent the most prominent oncogenic driver in...
HNSCC (6, 7), thus providing the genetic basis for current efforts aimed at targeting mTOR in this highly prevalent malignancy.

Of interest, this emerging information suggests that the use of mTORC1 inhibitors, such as sirolimus (rapamycin), everolimus (RAD001), or temsirolimus (CCI-779) could be explored for preventing HNSCC progression. However, their potential immunosuppressive activity and other dose-dependent side effects may raise safety concerns about the long-term use of rapamycin and derivatives (rapalogs) as chemopreventive agents in patients diagnosed with premalignant oral lesions, where only 10% to 15% of which are expected to progress to HNSCC overtime. In this regard, recent studies indicate that metformin, the most widely used drug in the United States for the treatment of type II diabetes, may lower the risk of cancer and/or improve cancer prognosis (12–14). Approximately 120 million people use metformin worldwide (15), and compelling evidence shows that metformin treatment can reduce tumor cell growth in part by reducing mTORC1 activity (reviewed in ref. 16).

These inhibitory effects seem to be controlled by the AMP-activated protein kinase (AMPK) signaling pathway, a key sensing mechanism of cellular bioenergetics (17, 18). As a mild inhibitor of mitochondrial complex I, metformin induces AMPK activation following the inhibition of oxidative phosphorylation, which leads to an increase in cellular AMP levels (19) and the consequent activation of AMPK after its phosphorylation by the serine/threonine kinase LKB1 (20). AMPK phosphorylates and activates TSC2, hence antagonizing the small GTPase Rheb and reducing mTORC1 activity (21). Therefore, in malignancies where the mTORC1 pathway is frequently hyperactivated, such as HNSCC, targeting AMPK activation by metformin appears highly desirable.

Here, we show that metformin treatment inhibits mTORC1 activation in representative human-derived HNSCC cell lines and confirmed that metformin triggers AMPK pathway activation and prevents tumor cell proliferation in these HNSCC cells. However, we observed that the inhibitory action of metformin on mTORC1 activity appears to occur via an AMPK-independent mechanism. This was observed in both HNSCC cells after LKB1 knockdown and in HeLa cells where LKB1 is mutated and inactive. Encouraged by these results, we optimized a recently established oral-specific carcinogenesis mouse model aimed at exploiting it to examine the ability to halt the conversion of oral premalignant lesions into HNSCC (22). We show that mTORC1 inhibition by metformin occurs primarily in the basal proliferating layer of oral premalignant lesions, as evidenced by the hypophosphorylation of the ribosomal protein S6, a common mTORC1 downstream surrogate marker. Remarkably, metformin prevented the development of HNSCC by significantly reducing the size and number of carcinogen-induced oral tumoral lesions and by preventing their spontaneous conversion to squamous cell carcinomas (SCC). Collectively, our data underscore the potential clinical use of metformin as a targeted chemo-preventive agent in the control of HNSCC development and progression.

Materials and Methods

Reagents, cell lines, tissue culture, and transfections

4-Nitroquinoline-1-oxide (4NQO; Sigma-Aldrich) was added to the drinking water to a final concentration of 50 µg/mL. Metformin (Spectrum Chemical) was diluted in sterile saline and administered to mice by intraperitoneal (i.p.) injections at a dose of 50 mg/kg/d. HaCat cells (a nontransformed skin keratinocyte cell line), human-derived HNSCC cell lines Cal-27, HN12, HN13, and Hep2 (2), and cervical SCC HeLa cells were grown and maintained as described in Supplementary Materials and underwent DNA authentication (Genetica DNA Laboratories, Inc.) to ensure consistency in cell identity in comparison with their source. DNA interference (RNAi) experiments were carried out in cells transfected with commercially available LKB1 siRNAs (Qiagen), HiPerfect transfection reagent (Qiagen), and serum-free, antibiotic-free Dulbecco’s Modified Eagle’s Medium at a final concentration of 25 nmol/L as previously described (23). Two LKB1 target sequences were used: Hs_STK11_5 and Hs_STK11_7. All Starts siRNA (Qiagen) served as the nontargeted control. Cells were treated with metformin at the indicated dose and time, using rapamycin (LC Laboratories) as a control. See Supplementary Materials for additional details.

Western blotting, cell proliferation and viability assays, and ATP assay

Immunodetection was carried out as previously described (2), using antibodies from Cell Signaling Technology against phospho-4E-Ser240/244, ribosomal protein S6, phospho-acetyl-CoA carboxylase (Ser79), phospho-AMPKα (p-AMPKα; Thr172), phospho-4E-BP, non-Phospho-4E-BP (T46), p70S6K, and LKB1. Mouse monoclonal antitubulin was purchased from Santa Cruz. For proliferation assays, cells were grown in 24-well plates and incubated with 0.5 µCi [3H]-thymidine/mL (Perkin Elmer) for the last 4 hours of treatment, lysed, and radioactivity incorporated into cellular DNA counted in a liquid scintillation counter. For viability assays, the CellTiter 96 AQueous One Solution (MTS) reagent was used following the manufacturer’s protocol (Promega) as previously described (24). Cellular ATP levels were assessed by using an ATP assay kit (Calbiochem) as previously described (25). See Supplementary Materials for additional information.

Experimental animal model and plasma levels of IGF-1 and insulin

All animal studies were carried out according to NIH-approved protocols, in compliance with the Guide for the Care and Use of Laboratory Animals. Female C57Bl/6 mice 4- to 6-week-old were given either water (control) or 4NQO in the drinking water for the indicated time and then
reverted to regular water and monitored until week 22. All animals underwent a biweekly full oral cavity examination under anesthesia and euthanized at the indicated time points for tissue retrieval. Tissues were fixed and processed for paraffin embedding for histopathologic diagnosis and further immunohistochemical studies (22). For the analysis of the effect of metformin on tumor development, mice were exposed to 4NQO for 14 weeks and randomly distributed into treatment and control groups, which received daily i.p. injections with metformin (50 mg/kg/d) or an equal volume of diluent (sterile saline). All animals were euthanized on week 22, and tissue retrieval was carried out as described earlier. Mice were sacrificed 2 hours after the last administration of metformin, and plasma levels of insulin-like growth factor-1 (IGF-1) and insulin were determined by the Abnova Igf1 (Mouse) ELISA Kit and Millipore Mouse Insulin ELISA Kit, respectively, following the manufacturer instructions. See Supplementary Materials for additional information.

Immunohistochemistry and immunofluorescence
Anti phospho-S6 (Ser235/236, #2211S; Cell Signaling Technology), anti-cytokeratin 5 (Thermo Scientific; MS-1896-R7), anti-Ki-67 anti-mouse antibody (DAKO; M7249) were used for immunohistochemical analysis of paraffin sections as described (ref. 22; see Supplementary Materials). Stained slides were scanned with an Aperio CS Scanscope (Aperio) and quantified using the available Aperio algorithms. For immunofluorescence studies, tissue sections were processed as described (22) and mounted with Vectashield (Vector Laboratories). See Supplementary Materials for additional information.

T-cell proliferation assay and flow cytometry
Spleen cells (5 × 10⁴ cells) from 4NQO metformin-treated or 4NQO control mice were cultured in the presence or absence of anti-CD3 antibody (0.5 mg/mL). The cultured cells were pulsed [³H]-thymidine for the final 16 hours, collected, and radioactivity measured as earlier. Flow cytometric analysis was conducted as described before (26). Cells were stained with antibodies to indicated surface markers followed by intracellular cytokine antibodies by the BD Cytofix/Cytoperm Kit (BD Biosciences). Foxp3 staining was carried out according to the manufacturer’s instruction (eBioscience). The following fluorescein-conjugated anti-mouse antibodies were purchased from BD Biosciences: anti–IFN-γ, anti-CD4, anti-CD8, anti-Foxp3, as well as their respective isotype control antibodies. Anti-IL-17 was purchased from BioLegend.

Statistical analysis
ANOVA followed by the Tukey t test were used to analyze the differences between groups after treatments. Data analysis was done with GraphPad Prism version 5.01 for Windows (GraphPad Software); P values of less than 0.05 were considered statistically significant. Two-tailed, unpaired t tests were used to analyze the differences in tumor growth between experimental groups, as well as differences in Ki-67 expression and low- and high-grade dysplasia between treated and control groups.

Results

Metformin treatment inhibits HNSCC cell proliferation
Metformin exerts an antiproliferative effect in cultured tumor cells derived from a variety of human cancers (18, 27, 28). To determine whether metformin impairs HNSCC cell proliferation, increasing doses of the drug were used to treat HN12 cells (Fig. 1A), a representative HNSCC cell line that is sensitive to the antitumoral effect of mTORC1 inhibition (2). A significant reduction in tumor cell proliferation, as determined by [³H] thymidine incorporation, was evident following treatment with the 10 and 20 mmol/L doses. A similar growth inhibitory activity was observed in other HNSCC cell lines (Supplementary Fig. S1A). Noteworthy, while metformin triggered a marginal decrease in cell viability in nontransformed HaCat keratinocytic cells, a similar dose-dependent decline in cell viability was observed in other HNSCC cell lines including HN13 and Hep2 cells (Supplementary Fig. S2). Metformin also induced a significant reduction in HN12 cell viability when assessed daily for 4 days (Fig. 1B).

mTORC1 pathway activity is downregulated by metformin through an AMPK-independent mechanism
Metformin treatment leads to AMPK activation following a cellular bioenergetic crisis that increases the AMP/ATP ratio (29). In this regard, we observed that following treatment of HN12 cells with metformin, the expression levels of p-AMPKα (Thr172) and its downstream target ACC (p-ACC) were upregulated in a dose-dependent manner (Fig. 1C). Not surprisingly, activation of AMPK signaling following metformin also resulted in a dose-dependent, concomitant reduction in mTORC1 activity, as judged by the hypophosphorylated status of ribosomal protein S6 (Fig. 1C) and the mTOR downstream targets p70S6K and 4E-BP (Supplementary Fig. S1). As depicted in Fig. 1D, AMPKα phosphorylation increased within 15 minutes following treatment with metformin, reached its peak at 2 hours, and decreased thereafter, suggesting a direct correlation between p-AMPK levels with the ongoing bioenergetic crisis. Indeed, metformin-treated HN12 cells showed a dramatic drop in cellular ATP levels when compared with untreated cells (Supplementary Fig. S3). These events began relatively early after adding metformin (30 minutes) and lasted for at least 8 hours. A similar response was evident with 2-deoxy-D-glucose (2-DG), a positive control used to mimic energy stress. However, it was noticeable that while no p-AMPK levels were detected at 16 and 24 hours following metformin treatment, the phosphorylated status of ribosomal protein S6, started to decrease at about 8 hours and remained down for at least 24 hours. These unexpected findings suggested either a long-lasting effect of metformin-induced AMPK activation or the potential influence of alternative mechanisms driving mTORC1 inhibition in response to cellular energy stress.
To examine whether AMPK activation plays an indispensable role on mTORC1 pathway inhibition in HNSCC cells treated with metformin, we decided to knockdown LKB1, the main upstream serine/threonine kinase responsible for driving AMPK activation and decreasing gluconeogenesis in the liver in response to metformin (20). Interestingly, we found that in LKB1-depleted HN12 cells, metformin treatments significantly reduced the level of phosphorylated S6 to a similar extent as the control siRNA-transfected cells, suggesting that in HNSCC, metformin-induced mTORC1 inhibition occurs through signaling mechanisms that are independent of the LKB1/AMPK pathway (Fig. 1E). We confirmed these findings in experiments using HeLa cells, which exhibit endogenous impaired LKB1 activity as a result of complete methylation of the LKB1 promoter region (30). In this regard, we found that in the absence of AMPK activation, metformin treatment led to a marked decrease in mTORC1 activity and tumor cell proliferation, respectively (Fig. 1F and Supplementary Fig. S1 and S3). Overall, these data suggest that metformin might trigger a stress response driven by an alternative, AMPK-independent signaling mechanism to cope with the ongoing cellular energetic crisis.
Optimization of the oral chemical carcinogenesis model using 4NQO to study the conversion of oral premalignant lesions into SCCs

We have recently shown that through the use of an oral-specific carcinogenesis model induced by low-dose 4NQO in the drinking water, immunocompetent C57Bl/6 mice inevitably developed oral SCCs (22). 4NQO is a synthetic water-soluble chemical carcinogen that forms DNA adducts, causes adenosine for guanosine substitutions, and induces intracellular oxidative stress resulting in mutations and DNA strand breaks, all similar to the genetic alterations provoked by tobacco carcinogens, and hence 4NQO often serves as a surrogate for tobacco exposure (31). Emerging studies from our and other groups suggest that this animal model may provide a predictable preclinical strategy to mimic human HNSCC carcinogenesis, which can be used to investigate the efficacy of novel therapeutic approaches for HNSCC treatment (31). However, using this experimental approach most mice exhibit 1 to 3 carcinomas together with multiple dysplastic lesions at the end of the carcinogen exposure, thus limiting the ability to examine the benefit of preventive agents unless they also display anticaner properties. In the present study, we first decided to conduct an optimization protocol to study the conversion of potential oral premalignant lesions (i.e., epithelial dysplasias) into SCCs, hence affording the opportunity to explore novel chemopreventive strategies to halt tumor progression.

To this end, C57Bl6 mice were exposed to 4NQO in the drinking water either for 8, 10, 12, 14, or 16 weeks (Fig. 2A). Within each of the groups, half of the mice were euthanized following termination of the 4NQO administering period, whereas the other half of the remaining mice were reverted to regular water and evaluated until week 22. Examples of gross anatomic appearance and histologic features of

<table>
<thead>
<tr>
<th>Lesions (number/mouse)</th>
<th>Dysplasia</th>
<th>Carcinoma</th>
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<tbody>
<tr>
<td><strong>Weeks</strong></td>
<td>low grade</td>
<td>high grade</td>
</tr>
<tr>
<td>0</td>
<td>1.6 ± 0.3</td>
<td>2.6 ± 0.3</td>
</tr>
<tr>
<td>2</td>
<td>0.4 ± 0.2</td>
<td>0.2 ± 0.1</td>
</tr>
<tr>
<td>8</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Figure 2. Optimization scheme of the 4NQO oral-specific chemical carcinogenesis model shows time-dependent malignant progression of oral epithelial dysplastic lesions. A, the indicated groups of mice (n = 20) were randomly divided and administered with 4NQO in the drinking water (50 μg/mL) for the indicated time (8, 10, 12, 14, and 16 weeks). Mice were then sacrificed or switched to regular water and sacrificed at week 22 from the initiation of the 4NQO administration. The tongue of each mouse was processed for detailed histologic examination as described in Materials and Methods. The average of the number of lesions per mouse, classified as low-grade dysplasia, high-grade dysplasia, or carcinoma based on histopathologic examination was recorded at the end of the 4NQO administration as well as on week 22 from the initiation of carcinogen exposure. B, representative photographs of lesions observed in mice at the indicated time since the initiation of carcinogen exposure in mice treated with 4NQO for 14 weeks. No evident gross alteration were observed at week 4; small elevated white lesions and discoloration are seen at week 8; the lesions grow to small berry-like elevations at week 16 and to ill-defined indurated white or congestive areas, often ulcerated, at week 22. Microscopically, the series of photograph depict the sequence of histologic changes on the dorsal tongue from a normal epithelium at week 4, through mild to moderate atypia at week 8, several dysplastic cellular alterations at week 16 (note the increasing thickness of the epithelium), to a fully infiltrating well-differentiated SCC at week 22.
tumoral lesions appearing in the tongue of 4NQO treated mice are shown in Fig. 2B. At each time point, detailed histologic analysis revealed the presence of multiple low-grade epithelial dysplasias in all mice exposed to 4NQO for at least 8 weeks. However, mice began accumulating high-grade dysplasias (2–3 lesions per mouse) only after 12 weeks of oral carcinogen treatment (Fig. 2A). This dependence on carcinogen exposure was clearly reflected in the number of squamous carcinomas after 22 weeks from the initiation of 4NQO administration. None of the animals exposed to 4NQO for 8 weeks developed malignant lesions, whereas very few of the mice treated for 10 weeks developed squamous carcinomas at this time point (week 22). When analyzed after 22 weeks, the average number of malignant lesions was 0.5 in mice treated with 4NQO for 12 weeks, whereas most of the mice had at least one SCC if treated with the chemical carcinogen for 14 weeks and exhibited multiple carcinomas after treating for 16 weeks (Fig. 2A). Thus, while 4NQO exposure for 12 to 16 weeks causes primarily epithelial dysplasias, these lesions continue to progress into SCCs even after switching to regular water not containing 4NQO, underscoring the long-lasting effects of 4NQO on oral epithelial tissues. These findings suggest that 4NQO initially triggers genetic alterations in oral epithelial cells that result in the development of mainly premalignant lesions, which can then spontaneously progress into carcinomas. Indeed, the carcinogen 4NQO may be regarded as a surrogate of tobacco exposure, as judged by the striking gross and histopathologic resemblance of 4NQO-induced oral carcinogenesis to the premalignant and malignant lesions commonly observed in humans (Fig. 2B). For practical purposes, based on this analysis we selected for further studies the inclusion of 4NQO in the drinking water for 14 weeks, as the ratio of the number of squamous carcinomas...
after 22 weeks with respect to the average number of potential premalignant lesions at the end of the carcinogen exposure is approximately 1:7, which is similar to the rate of conversion of human potential premalignancies into carcinomas (32).

**Metformin reduces the size and number of oral tumors induced by 4NQO and halts the progression of potential premalignant lesions**

We next asked whether treating mice with metformin may prevent HNSCC progression, and if so, whether inhibition of the mTORC1 pathway may contribute to the tumor growth inhibitory responses. Following a 14-week exposure to 4NQO in the drinking water, mice were randomly assigned to receive daily administration of metformin (50 mg/kg/d) or an equal volume of sterile saline (control group) for 8 weeks. During this 8-week period, mice were reverted to drinking water only. Whereas the number and size of oral lesions in the control mice increased in a time-dependent manner, a significant reduction in these parameters was initially evident in the metformin group after 4 weeks of treatment (week 18) and remained lower until the conclusion of the experimental period (week 22; Fig. 3A). By week 22, mice exposed to 4NQO predictably developed visible and palpable irregular, whitish, papillary-like oral tumors mainly localized on the tongue. Conversely, the number and sizes of the visible oral lesions were significantly decreased in mice that were treated with metformin (Fig. 3B–D).
Histologic examination of all oral lesions at week 22 of control and metformin-treated mice after exposure to 4NQO for 14 weeks revealed a striking impact of metformin in tumor progression (Fig. 4A–H). In particular, whereas metformin reduced the overall number of benign and malignant tumor lesions to less than half of those observed in the control group (Fig. 4E), it nearly abolished the progression to SCCs, with a single malignant lesion within the group of treated mice, while most control mice exhibited one to 2 cancer lesions (Fig. 4F). We also observed a significant decrease in the number of low- and high-grade dysplasias after metformin treatment (Fig. 4G and H). These results indicate that systemically administered metformin apparently hampered the progressive increase in the number and size of oral lesions, suggesting a potential interference of the neoplastic transformation process induced by 4NQO exposure.

Metformin exerted a very limited impact on serum components and metabolic markers (Table 1) as well as in the plasma levels of insulin and IGF-1 (Supplementary Fig. S4). We also investigated whether metformin treatment affected immune responses in mice. We showed that metformin decreased slightly the frequency of both CD4<sup>+</sup> and CD8<sup>+</sup> T cells in the spleens compared with the control mice (Table 1). However, T-cell proliferation of splenic cells was surprisingly increased in response to T-cell receptor stimulation with CD3-specific antibody (Table 1). This suggests the T-cell proliferative response per se was not reduced, but rather enhanced, considering the decreased frequency of T cells in the spleen. We next compared the T-cell subsets in the mice treated with metformin with those in control mice and showed that metformin significantly enhanced T-helper (T<sub>h</sub>)17 cells without changing T<sub>h</sub>1 and Foxp3<sup>+</sup> regulatory T cells (T<sub>reg</sub>; Table 1). These data together indicate that metformin treatment does not lead to immunosuppression, rather it might enhance the potential of T-cell proliferation and differentiation.

### Table 1. Effect of metformin administration on serum components and immune cell profiles

<table>
<thead>
<tr>
<th>Blood (serum)</th>
<th>Control</th>
<th>Metformin</th>
</tr>
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<tbody>
<tr>
<td>Glucose, mg/dL</td>
<td>103.8 ± 14.3</td>
<td>107.3 ± 10.0</td>
</tr>
<tr>
<td>Cholesterol, mg/dL</td>
<td>99.8 ± 9.4</td>
<td>82.2 ± 9.0</td>
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<tr>
<td>Triglycerides, mg/dL</td>
<td>74.0 ± 9.2</td>
<td>80.3 ± 9.8</td>
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<tr>
<td>Sodium, mmol/L</td>
<td>153.3 ± 1.0</td>
<td>152.5 ± 1.1</td>
</tr>
<tr>
<td>Potassium, mmol/L</td>
<td>6.9 ± 0.2</td>
<td>7.6 ± 0.5</td>
</tr>
<tr>
<td>Chloride, mmol/L</td>
<td>113.0 ± 2.1</td>
<td>115.2 ± 0.6</td>
</tr>
<tr>
<td>Creatinine, mg/dL</td>
<td>0.1 ± 0.0</td>
<td>0.1 ± 0.0</td>
</tr>
<tr>
<td>BUN, mg/dL</td>
<td>24.2 ± 2.5</td>
<td>213.0 ± 9.0</td>
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<tr>
<td>Calcium, mmol/L</td>
<td>2.3 ± 0.0</td>
<td>2.3 ± 0.0</td>
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<tr>
<td>Magnesium, mmol/L</td>
<td>1.3 ± 0.0</td>
<td>1.2 ± 0.0</td>
</tr>
<tr>
<td>Phosphorous, mg/dL</td>
<td>7.9 ± 0.1</td>
<td>8.3 ± 0.3</td>
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<tr>
<td>Alkaline phosphatase, U/L</td>
<td>82.5 ± 6.2</td>
<td>88.2 ± 10.5</td>
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<tr>
<td>ALT, U/L</td>
<td>125.0 ± 29.7</td>
<td>198.8 ± 56.7</td>
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<tr>
<td>AST, U/L</td>
<td>232.0 ± 20.1</td>
<td>248.3 ± 14.3</td>
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<tr>
<td>Amylase, U/L</td>
<td>&gt;650.0 ± 0.0</td>
<td>&gt;650.0 ± 0.0</td>
</tr>
<tr>
<td>CK, total, U/L</td>
<td>&gt;800.0 ± 0.0</td>
<td>&gt;800.0 ± 0.0</td>
</tr>
<tr>
<td>Lactate dehydrogenase, U/L</td>
<td>&gt;600.0 ± 0.0</td>
<td>&gt;600.0 ± 0.0</td>
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<tr>
<td>Protein, total, g/dL</td>
<td>5.3 ± 0.0</td>
<td>5.2 ± 0.2</td>
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<tr>
<td>Uric acid, mg/dL</td>
<td>3.5 ± 0.0</td>
<td>3.0 ± 0.1</td>
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#### Spleen T-cell proliferation

<table>
<thead>
<tr>
<th>Spleen T cells</th>
<th>Control</th>
<th>Metformin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media, 10&lt;sup&gt;-3&lt;/sup&gt; cpm</td>
<td>3.9 ± 0.5</td>
<td>5.5 ± 1.5</td>
</tr>
<tr>
<td>CD3, 10&lt;sup&gt;-3&lt;/sup&gt; cpm</td>
<td>16.5 ± 1.6</td>
<td>27.8 ± 2.9b</td>
</tr>
</tbody>
</table>

#### Spleen T cells

<table>
<thead>
<tr>
<th>% total cells labeled</th>
<th>Control</th>
<th>Metformin</th>
</tr>
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<tbody>
<tr>
<td>CD4&lt;sup&gt;+&lt;/sup&gt;</td>
<td>22.9 ± 1.2</td>
<td>16.8 ± 1.5&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>CD8&lt;sup&gt;+&lt;/sup&gt;</td>
<td>29.8 ± 1.5</td>
<td>10.5 ± 1.9&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>T&lt;sub&gt;h&lt;/sub&gt;1</td>
<td>12.6 ± 1.3</td>
<td>13.4 ± 1.1</td>
</tr>
<tr>
<td>T&lt;sub&gt;h&lt;/sub&gt;17</td>
<td>1.4 ± 0.1</td>
<td>3.4 ± 0.5&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>T&lt;sub&gt;reg&lt;/sub&gt;</td>
<td>26.9 ± 1.1</td>
<td>27.2 ± 1.1</td>
</tr>
</tbody>
</table>

**NOTE:** Mice were administered 4NQO diluted in the drinking water for 14 weeks, divided into 2 groups, and given either daily i.p. injections of metformin at a dose of 50 mg/kg/d or an equal volume of sterile saline for a period of 8 weeks, as described in Fig. 3. Mice were euthanized on week 22 from the initiation of 4NQO exposure, and serum and spleen T cells isolated as described in Materials and Methods. Serum components, spleen T-cell proliferation, and spleen T-cell subtypes were analyzed as described in Materials and Methods. Metformin exerted a very limited impact on serum components and metabolic markers and did not reduce the T-cell proliferative response. Metformin significantly enhanced T<sub>h</sub>17 cells without changing T<sub>h</sub>1 and Foxp3<sup>+</sup> regulatory T cells (T<sub>reg</sub>), an effect that is under current investigation.  
<sup>a</sup>P < 0.05.  
<sup>b</sup>P < 0.01.  
<sup>c</sup>P < 0.001.

Metformin decreases mTORC1 activity in the basal layer of dysplastic squamous lesions

Metformin treatment decreased the basal proliferation of hyperplastic regions in the tongue of 4NQO-treated mice (Fig. 5A). In this regard, emerging studies indicate that metformin may lower the risk of cancer and/or improve cancer prognosis in part by inhibiting the mTORC1 pathway (16). Hyperactivation of the mTORC1 signaling pathway is a frequent event in HNSCC, playing an important role in promoting carcinogenesis, as judged from studies in human HNSCC and in the murine 4NQO carcinogenic model (2, 4, 9, 22). Despite of the persistent activation of the mTORC1 pathway in this cancer type, the effects of metformin on this major oncogenic signaling pathway remains unexplored. By the immunohistochemical analyses against the phosphorylated form of S6, pS6, we confirmed previously reported findings by our group supporting that pS6 immunoreactivity is clearly restricted to the upper nonproliferating parabasal epithelial cell layer, whereas basal and suprabasal cells lack positive staining in normal lingual mucosa derived from normal...
control mice as well as in 4NQO-induced hyperplastic lingual lesions (Fig. 5B; ref. 22). Although a similar pattern of pS6 immunostaining was detected in 4NQO-induced dysplastic lesions, it was noticeable that a considerable number of basal and suprabasal cells were pS6 positive (Fig. 5B). In contrast, pS6 is clearly positive in most cells in oral SCC, as we have observed in a large number of human HNSCC lesions (3), and in the 4NQO-induced oral cancer experimental model (Fig. 5B, right). Thus, it seems reasonable to imply that a progressive dysregulation of the mTORC1 pathway occurs early in the carcinogenic process, with basal proliferating epithelial cells exhibiting mTORC1 activation, a process that then may become an intricate event driving the malignant conversion of premalignant lesions.

In this regard, an interesting finding was the observation that pS6 immunoreactivity in dysplastic lesions derived from 4NQO-exposed mice treated with metformin showed a highly significant reduction in the number of basal and suprabasal cells showing positive pS6 reactivity. Similar observations were noticed when immunofluorescence stainings in normal lingual mucosa and dysplastic lesions were carried out against pS6 and keratin 5 (K5), a ubiquitous keratin commonly localized in the basal and suprabasal layers of the oral epithelium. As
shown in Fig. 5C, metformin treatment was able to significantly reverse the increase in pS6 reactivity observed in the basal cells of dysplastic lesions of control-treated 4NQO mice.

Overall, these results systematically show that metformin deters carcinogen-induced HNSCC development and progression, most likely through the inhibition of mTORC1 activity within a dysplastic epithelial niche occupied by proliferating basal and suprabasal cells. These compelling findings imply that the use of metformin to block the activity of this major oncogenic pathway early in the carcinogenic process may offer a promising chemopreventive strategy to control the development of a cancer type where locoregional invasion, nodal metastasis, and chemoresistance are hallmarks of advanced disease and poor patient survival (33).

Discussion

The identification of the mTORC1 signaling network as frequently hyperactivated early in the carcinogenic process, including preneoplastic lesions, and in fully established HNSCC points to this major oncogenic pathway as a potential target to deter disease progression (2–5). Indeed, we have recently showed that chronic administration of rapamycin prevents the malignant conversion of tumoral lesions and promotes the regression of advanced carcinogen-induced HNSCCs that developed in mice receiving prolonged administration of 4NQO in the drinking water (22). Despite these promising results, it should be taken into consideration that from a chemopreventive perspective, utilization of a drug such as rapamycin, which can exert immunosuppressive and other undesirable systemic side effects (i.e., thrombocytopenia and hyperlipidemia), may not represent the best option to chronically target low-risk patients exhibiting epithelial dysplasia. To this end, it is imperative that chemoprevention protocols must incorporate pharmacologic agents with proven efficacy, which should also include a well-established record of tolerability, safety, and minimal toxicity (34). Here, we show that chronic treatment with metformin, the most widely used oral antidiabetic worldwide, hindered the progression of 4NQO-induced preneoplastic lesions showing low- and high-grade dysplastic lesions, thus supporting the potential use of metformin for HNSCC chemoprevention.

Metformin reduced the mTORC1 activity in the basal layer of oral cancer premalignant lesions, which is likely to harbor the precursors of the HNSCC tumor-initiating cells. However, the precise mechanism by which metformin diminishes mTORC1 activity both in vitro and in vivo is still unclear and likely involves multiple complementary molecular processes. For example, metformin...
can reduce the circulating levels of insulin and IGF-1 (35), which could impact on the growth potential of premalignant oral epithelial cells in vivo. This could also explain the relative high concentrations of metformin required to achieve a biologic response in HNSCC cells in vitro, although this can be also explained by the low levels of transporters involved in metformin incorporation into cells in vitro (35). The decrease in circulating insulin and IGF-1 seems to be particularly relevant for lung cancer models, in which the high sucrose diet used and/or distinct mice strain may sensitise the mice to the IGF-1 and insulin lowering activity of metformin, as recently reported (35). On the other hand, the best-studied direct action of metformin involves the inhibition of mitochondrial complex I and the consequent activation of AMPK upon increased cellular AMP levels (19). Indeed, we observed that HNSCC cells exposed to metformin display reduced levels of ATP, and increased levels of active AMPK and of the phosphorylated form of its direct downstream target, ACC. However, the activation of AMPK requires its phosphorylation by the upstream tumor suppressor serine/threonine kinase LKB1 (20). Knockdown of LKB1 in HNSCC cells and the use of cervical SCCs that do not express LKB1 revealed that this kinase, and hence AMPK activation, may not be strictly required to diminish mTORC1 function in response to metformin. Similar observations were recently reported in prostate cancer cells, in which the authors described a novel mechanism by which metformin blocks mTORC1 by activating the expression of the mTOR inhibitor known as REDD1 (36). However, in this case REDD1 expression involves a p53-dependent pathway, which is triggered by metformin in this tumor type (36). As most HNSCC exhibit p53 mutations or functional inactivation of this tumor suppressor, for example by human papilloma virus (HPV)-encoded E6 proteins in HPV-associated HNSCC and cervical SCC (37), this recently described p53-REDD1 axis blocking mTORC1 may not be functional in HNSCC. Alternatively, metformin may stimulate REDD1 expression by a yet to be identified transcriptional program, or inhibit mTORC1 by additional mechanism such as those recently described impinging on Rag GTPases (38). Certainly, the appreciation of the complexity of the molecular mechanisms perturbed by metformin has increased over the past few years, and we can envision that further work may soon help dissect the precise AMPK-dependent and -independent pathways by which metformin regulate mTORC1 function in HNSCC cells and their preneoplastic precursors and the relative contribution of circulating IGF-1 and insulin in this process.

Similar to the pathogenesis of most solid tumors, SCCs of the head and neck are often associated with a multistage process that requires the progressive acquisition of genetic and epigenetic alterations. In the particular case of HNSCC tumors, which are largely diagnosed in the oral cavity and pharynx, these changes are generally triggered by the chronic exposure to carcinogenic substances associated with chronic tobacco use or betel nut chewing (39, 40). During this multistep carcinogenesis, it is not uncommon that premalignant lesions clinically evident as leukoplasias or erythroplasias reveal dysplastic cellular changes susceptible to malignant transformation (32). Although, it is predicted that the rate of malignant conversion of epithelial dysplasias is relatively low (10%–15%), it would be highly desirable to target these lesions to halt tumor progression and ultimately prevent the increased morbidity associated with HNSCC, which greatly impacts patient overall prognosis and survival. Continuing efforts to elucidate key cellular and molecular abnormalities underlying the pathogenesis of HNSCC are now shedding light into the development of novel molecularly targeted approaches for HNSCC prevention and treatment.

In this regard, the notion of using an U.S. Food and Drug Administration (FDA)-approved drug like metformin as a chemopreventive agent to control oral carcinogenesis is definitely appealing. Although in our studies we used metformin delivered by i.p. injection to ensure a precise dose, similar results were obtained in preliminary studies when metformin was administered through water consumption, as reported in lung cancer animal models (35). Thus, these studies could be considered as a proof-of-principle aimed at using orally available drugs, such as metformin, in at-risk patients. Indeed, because of its well-accepted safety profile and tolerance relative to its long-term use, metformin may become an attractive chemopreventive agent to hamper the progression of premalignant lesions highly dependent on mTORC1 activity. In addition prolonged metformin administration may also decrease the recurrence rate of previously resected tumors, as it may prevent the malignant conversion of subclinical lesions involving epithelial cells harboring genetic alterations caused, for example, by prolonged exposure to tobacco carcinogens in the same field than the primary HNSCC lesion. Overall, while additional future studies may help define how metformin decreases mTORC1 activity in oral epithelial cells, our present results may provide a strong rationale for the early evaluation of metformin and related agents for oral cancer prevention in its at-risk patient population.

Disclosure of Potential Conflicts of Interest
No potential conflicts of interest were disclosed.

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References

1. Siegel R, Ward E, Brawley O, Jemal A. Cancer statistics, 2011: the impact of eliminating socioeconomic and racial disparities on prema-
5. Molinolo AA, Hewitt SM, Amornphimoltham P, Keelawat S, Rang-
daeng S, Meneses Garcia A, et al. Dissecting the Akt/mammalian target of rapamycin signaling network: emerging results from the head
9. Patel V, Marsh CA, Dorsam RT, Mikelis CM, Masedunskas A, Amorn-
18. Sengupta S, Peterson TR, Laplante M, Oh S, Sabatini DM. mTORC1
19. controls fasting-induced ketogenesis and its modulation by ageing.
25. Bowker SL, Majumdar SR, Veugelers P, Johnson JA. Increased cancer-
26. related mortality for patients with type 2 diabetes who use sulfo-
33. Dowling RJ, Zakhikhan M, Fantus IG, Pollak M, Sonenberg N. Metfor-
37. El-Mir MY, Nogueira V, Fontaine E, Averet N, Rigoulet M, Levevre X.
39. Shaw RJ, Lamia KA, Vasquez D, Koo SH, Bardeesy N, Depinho RA, et al. The kinase LKB1 mediates glucose homeostasis in liver and
40. Inoki K, Li Y, Xu T, Guan KL. Rheb GTPase is a direct target of TSC2 GAP activity and regulates mTOR signaling. Genes Dev 2003;17:
41. 1299–34.
42. Czerniński R, Amornphimoltham P, Patel V, Molinolo AA, Gutkind JS. Targeting mammalian target of rapamycin by rapamycin prevents
44. Castilho RM, Sivarize CH, Leelavahanakul K, Zheng Y, Bugge T, Gutkind JS. Ral1 is required for epithelial stem cell function during
47. Schneider A, Yonis RH, Gutkind JS. Hypoxia-induced energy stress inhibits the mTOR pathway by activating an AMPK/REDD1 signaling
52. moral effect in vitro and in vivo through a decrease of cyclin D1 level. Oncogene 2008;27:3576–86.
53. Cantrell LA, Zhou C, Mendivil A, Malloy KM, Gehrig PA, Bae-Jump VL. Metformin is a potent inhibitor of endometrial cancer cell prolifera-
57. Tissen M, Yikolkala A, Makela TP. Growth suppression by Lkb1 is mediated by a G1 cell cycle arrest. Proc Natl Acad Sci U S A 1999;96:
58. 9248–51.
63. Klass CM, Shin DM. Current status and future perspectives of che-
68. Scheffner M, Werness BA, Huibregtse JM, Levine AJ, Howley PM. The E6 oncoprotein encoded by human papillomavirus types 16 and 18
71. Published OnlineFirst March 31, 2012; DOI: 10.1158/1940-6207.CAPR-11-0502
Cancer Prevention Research

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Lynn Vitale-Cross, Alfredo A. Molinolo, Daniel Martin, et al.

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