Research Article

eRapa Restores a Normal Life Span in a FAP Mouse Model

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Abstract

Mutation of a single copy of the adenomatous polyposis coli (APC) gene results in familial adenomatous polyposis (FAP), which confers an extremely high risk for colon cancer. ApcMin/+ mice exhibit multiple intestinal neoplasia (MIN) that causes anemia and death from bleeding by 6 months. Mechanistic target of rapamycin complex 1 (mTORC1) inhibitors were shown to improve ApcMin/+ mouse survival when administered by oral gavage or added directly to the chow, but these mice still died from neoplasia well short of a natural life span. The National Institute of Aging Intervention Testing Program showed that enterically targeted rapamycin (eRapa) extended life span for wild-type genetically heterogeneous mice in part by inhibiting age-associated cancer. We hypothesized that eRapa would be effective in preventing neoplasia and extend survival of ApcMin/+ mice. We show that eRapa improved survival of ApcMin/+ mice in a dose-dependent manner. Remarkably, and in contrast to previous reports, most of the ApcMin/+ mice fed 42 parts per million eRapa lived beyond the median life span reported for wild-type syngeneic mice. Furthermore, chronic eRapa did not cause detrimental immune effects in mouse models of cancer, infection, or autoimmunity, thus assuaging concerns that chronic rapamycin treatment suppresses immunity. Our studies suggest that a novel formulation (enteric targeting) of a well-known and widely used drug (rapamycin) can dramatically improve its efficacy in targeted settings. eRapa or other mTORC1 inhibitors could serve as effective cancer preventatives for people with FAP without suppressing the immune system, thus reducing the dependency on surgery as standard therapy. Cancer Prev Res; 7(1); 169–78. ©2013 AACR.

Introduction

Familial adenomatous polyposis (FAP) is an autosomal dominant disease caused by mutation of the adenomatous polyposis coli (APC) gene, located on chromosome 5. APC inhibits the progrowth WNT signaling pathway by regulating β-catenin nuclear localization and its mutation results in the development of numerous adenomatous colorectal polyps at a young age. Polyposis inevitably progresses to colorectal cancer if left untreated. Given the predictable development of colorectal cancer in patients with FAP, the safest preventative strategy is surgical resection of the colon before cancer develops. Genetic screening and endoscopy in concert with prophylactic total colectomy significantly improve the overall survival of patients with FAP. Unfortunately, colonoscopies identify only 56% and 77% of tumors on the right and left side of the colon, respectively (1), and total colectomy is morbid and life altering. Further, the second leading cause of death in FAP is duodenal adenocarcinoma. Ninety percent of patients with FAP develop duodenal polyps, the precursor lesions of duodenal adenocarcinoma. Ninety percent of patients with FAP develop duodenal adenocarcinoma and of these 5% will develop duodenal adenocarcinoma in their lifetime (2). Duodenal surgery is currently indicated for patients with FAP with severe duodenal polyposis or duodenal carcinoma at the expense of significant morbidity. Thus, this patient population has a strong need for nonsurgical treatments to prevent or reduce polyp formation and carcinogenesis in the gastrointestinal track with the possibility of reducing the need for life-altering surgery.

Hence, the goal of our study was to test enterically targeted rapamycin (eRapa) in the ApcMin/+ mouse model and assess whether this intervention delayed or prevented...
hemorrhaging intestinal neoplasia that lead to anemia and mortality. Notably, the etiology for intestinal tumors in Apc\(^{min/+}\) mice is the same as most FAP lesions, so interventions that prevent neoplasia in the Apc\(^{min/+}\) mouse model are also likely to work for FAP.

Rapamycin has been proposed to be a cancer-preventative agent. It allosterically inhibits mechanistic target of rapamycin complex 1 (mTORC1) when bound to FKBP12. mTORC1 promotes cell growth (mass) by coordinating numerous cellular processes, including macromolecule biosynthesis in response to nutrient, energy, and growth factor stimuli (3). Upregulation of mTOR contributes to the development and growth of cancer, including intestinal tumors, making the mTOR pathway an attractive candidate for anticancer therapy (4). Recent evidence suggests that mTORC1 inhibition delays or prevents cancer in human kidney transplant patients treated with rapamycin (5) and mouse cancer models (6, 7). Thus, rapamycin could be an effective anticancer prophylactic agent.

Two previous studies support the use of rapamycin in delaying intestinal neoplasias in Apc\(^{-}\)mutated mouse models. In one study, a rapamycin derivative, RAD001 (everolimus) was administered by oral gavage (3 or 10 mg/kg body weight/day, 5 times a week; ref. 8) and the other rapamycin (sirolimus) was administered by oral gavage (3 or 10 mg/kg body weight/day, 5 times a week; ref. 8). Both studies showed that these agents improved survival in Apc\(^{-}\)mutant mice although they died from intestinal neoplasias before the median life span for wild-type syngenic C57BL/6J mice [median life spans for the median life span for wild-type syngenic C57BL/6J mice, although they died from intestinal neoplasias before the median life span for wild-type syngenic C57BL/6J mice (10, 11)].

We tested if enteric rapamycin delivery could improve efficacy to prevent intestinal polyposis in Apc\(^{min/+}\) mice. eRapa prevented or significantly delayed intestinal neoplasia in Apc\(^{min/+}\) mice and improved survival and other health span indicators without eliciting undesirable side effects like immune suppression. Survival was prolonged beyond that of the median life span for wild-type mice supporting the possibility that enteric targeting of mTORC1 inhibitors could serve as safe and effective preventative to complement cancer surveillance procedures indicated for patients with a high risk for intestinal cancers.

Materials and Methods

**Rapamycin diets**

Preparation of rapamycin diets was described previously (6). The concentration of rapamycin in food was expressed as ng/mg food (parts per million, ppm).

**Mice, eRapa chow, and rapamycin blood levels**

We treated and housed mice according to Institutional Animal Care and Use Committee standards. Cohorts of Apc\(^{min/+}\) mice (Jackson Laboratories; C57BL/6-ApcMin/J) or C57BL/6 wild-type mice were fed microencapsulated rapamycin-containing diets either containing a concentration of 14 mg/kg food (14 ppm), which provided a dose of ~2.24 mg of rapamycin/kg body weight/day (12, 13) or 42 mg/kg food (42 ppm; ref. 14), which provided a dose of ~6.72 mg of rapamycin/kg body weight/day. Control diet was the same but with empty capsules. We housed mice in accordance with the NIH guide for the care and use of lab animals.

In our longevity studies, mice were allowed to live out their life span, i.e., there was no censoring due to morbidity in the groups of mice used to measure life span. Mice were euthanized only if they were either (1) unable to eat or drink, (2) bleeding from a tumor or other condition, or (3) when they were laterally recumbent, i.e., they failed to move when prodded or were unable to right themselves. Rapamycin blood levels were done as previously described (6).

**Measurement of rapamycin in intestine tissue**

Reagents and our high-pressure liquid chromatography/mass spectrometry (LC/MS/MS) system were previously described (6). Rapamycin was quantified in mouse small intestine tissue according to the following protocol. Briefly, 100 mg of calibrator, control, and unknown tissue samples were mixed by sonication (three 5-second bursts) with 10 μL of 0.5 μg/mL ascomycin (ASC0; internal standard) and 300 μL of a solution containing 0.1% formic acid and 10 mmol/L ammonium formate dissolved in 95% HPLC-grade methanol. After sonication, the samples were vortexed vigorously for 2 minutes, and then centrifuged at 15,000× g for 5 minutes at 23 °C (subsequent centrifugations were performed under the same conditions). Supernatants were transferred to 1.5 mL microfilterfuge tubes and spun at 15,000 g for 1 minute and then 40 μL of the final extracts were injected into the liquid chromatography/tandem mass spectrometry (LC/MS-MS). The ratio of the peak area of rapamycin to that of the internal standard ASC0 (response ratio) for each unknown sample was compared against a linear regression of calibrator response ratios at 0, 1.78, 3.13, 6.25, 12.5, 50, and 100 μg/g to quantify rapamycin. The concentration of rapamycin was expressed as μg/g of tissue (ppm).

**Pathology**

The severity of neoplastic lesions was assessed using the grading system previously described (15). Two pathologists separately examined all of the samples without knowledge of the genotype or diet.

**Immunoblots**

Because Western blotting of intestinal tissue is difficult, we optimized a procedure as follows. Mouse small intestine (~15–35 mg) was ground to a powder with a mortar and pestle after cryofracture. Powdered tissue was lysed by homogenization in 5× dry weight radioimmunoprecipitation assay (RIPA; modified) buffer (150 mmol/L sodium chloride, 50 mmol/L Tris-HCl, pH 7.4, 1 mmol/L ethylene-diaminetetraacetic acid, 1 mmol/L phenylmethylsulfonyl fluoride, 1% Triton X-100, 1% sodium deoxycholic acid, 0.1% sodium dodecyl sulfate, and one Pierce protease and phosphatase inhibitor mini tablet/10 mL). Debris was cleared by centrifugation. Bio-Rad Protein Assay was used.
to determine protein concentrations and ~40–50 μg of each sample was mixed with SDS loading dye, boiled, and separated on a gel before transfer to nitrocellulose (35 minutes at 20 V, Bio-Rad Semi Dry transfer) using Towbin buffer containing 0.0375% SDS. Blots were dried, cut into strips, and blocked for 1 hour at room temperature in Odyssey blocking buffer. Individual strips were incubated overnight at 4°C in appropriate primary antibodies and then for 1 hour at room temperature in corresponding IRDye secondary antibodies. Blots were washed 4 times (5 minutes each) in TBS-T after each antibody incubation with a final wash in TBS before scanning and quantification on an Odyssey Imager. We quantified fluorescent signals as integrated intensities (II K counts) using the Odyssey Imaging System, Application version 3.0 software. We integrated intensities (II K counts) using the Odyssey InfraRed Imaging System, Application version 3.0 software. We used a local background subtraction method to subtract independent background values from each box: the median background function with a 3-pixel width border above and below each box was subtracted from individual counts. We calculated ratios for each antibody against the pan-actin loading control using II K counts. The respective antibody to pan-actin ratio was then used to calculate phosphorylated protein to total protein ratio. Prism 5 (GraphPad Software, Inc.) was used to analyze and graph the data. We used an unpaired two-tailed t test or Mann–Whitney test (nonparametric for rpS6) to obtain P values. P values below 0.05 were considered significant. All Odyssey products and IRDye secondary antibodies were obtained from LI-COR Biosciences. All antibodies were diluted into Odyssey Blocking buffer + 0.2% Tween 20, Actin, pan Ab-5 (clone ACTIN05) mouse monoclonal primary antibody was obtained from Thermo Fisher and all other primary antibodies were obtained from Cell Signaling Technologies; phospho rpS6 (Ser240/244) rabbit polyclonal and rpS6 (5G10) mouse monoclonal, phospho AKT (Ser473) rabbit polyclonal, and AKT rabbit polyclonal.

Activity assay
Mice were individually housed in clear, Plexiglas cages (38 × 20 × 11.5 cm) for 36 hours (two light and one dark phase) to assess spontaneous activity as described (16).

Hematocrit
Red blood cells were packed using centrifugation in the presence of anticoagulant and percentage of pellet (% packed cell volume) to supernatant was reported. Blood was either collected at time of sacrifice or from the tail vein.

Cell lines
We obtained authenticated mycoplasma free cell lines from the American Type Culture Collection (ATCC) for use in our studies. We tested cells periodically for mycoplasma according to ATTC recommendations.

B16 tumor model
B16F10 melanoma cells were cultivated and injected subcutaneously (125,000 cells/flank), growth was measured with Vernier calipers and immunity was studied as we previously described (17).

Toxoplasma gondii challenge
Tachyzoites of T. gondii (ME49 strain expressing ovalbumin) were cultivated and used to challenge mice, and immunity was studied all as we described (18–20). Mice were fed eRapa 14 ppm or Eudragit control for 30 days before, and during the infection with 10,000 tachyzoites by intraperitoneal inoculation. Animals were sacrificed 11 days after inoculation for immune studies.

Bm12 autoimmunity model
Autoimmune kidney disease was induced by transfer of bm12 splenocytes into BL6 mice, and kidney disease was monitored by albuminuria as described (21). Mice were fed eRapa 14 ppm or Eudragit control for 30 days before, and during the postsplenocyte transfer monitoring period of 12 weeks. Immune events were analyzed as for tumor and T. gondii–challenged mice.

Regulatory T cell and myeloid-derived suppressor cell suppression assays
These assays were performed as described (17). Briefly, CD4−CD25− naive T cells from naive C57BL/6 mice were incubated with carboxyfluoroscein succinimidyl ester, a fluorescent dye. Anti-CD3/anti-CD28 beads were added to induce T-cell proliferation, and flow cytometry sorted CD4−CD25+ regulatory T cells or CD11b+Gr-1hi myeloid-derived suppressor cells were added at indicated ratios. Suppression was measured by dye dilution in indicator T cells by flow cytometry 4 days later.

Results and Discussion
We tested the ability of eRapa to inhibit mTORC1 signaling in the small intestine in which polyps primarily develop in ApoMin/+ mice. Eudragit S-100, the excipient in our eRapa microencapsulated formulation, dissolves at pH greater than 7 and is designed for colonic drug delivery in humans (22). Eudragit S-100 also provides rapamycin stability in mouse chow and improves rapamycin blood levels (12–14), which is ideal for long-term disease prevention studies. The mTORC1 substrate S6 kinase 1 phosphorylates the small ribosomal subunit protein S6 (rpS6) in response to nutrient and growth factor stimuli (23). Therefore, we measured rpS6 phosphorylation in 607- to 627-day-old female C57BL/6 mice fed eRapa for 42 days using the same doses as the National Institute on Aging (NIA) Intervention Testing Program (14 and 42 ppm; refs. 12–14). Chronic eRapa treatment inhibited rpS6 Ser240/244 phosphorylation in the proximal and distal segments of the small intestine demonstrating mTORC1 inhibition (Fig. 1A). These results were reproduced in the distal intestine from multiple mice (Fig. 1A, right; Fig. 1B). Because rpS6 is encoded by a 5′ TOP-containing mRNA (24) and as mTORC1 regulates translation of 5′ TOP-containing mRNAs (25), we also assayed rpS6 content in lysates. There were no differences in the levels of rpS6 relative to actin,
encoded by a non-5′TOP mRNA (Fig. 1C). We found blood levels from treated mice averaged 37 and 170 ng/mL for the 14 and 42 ppm group, respectively (a 4.6-fold increase in response to 3-fold higher concentration in the food; Fig. 1D). These blood concentrations are higher than the therapeutic range used for organ transplant recipients (26). We also observed a dose response in proximal and distal small intestine tissue levels of rapamycin (Fig. 1E). Note the increase in rapamycin levels in distal intestine compared with proximal, which is consistent with the pH gradient approaching neutrality thereby resulting in an increase drug release by Eudragit. Because phosphorylation of rpS6 by S6 kinase plays a role in ribosome biogenesis (27), eRapa-mediated depression of rpS6 phosphorylation indicates decrease ribosome biogenesis, which would inhibit cell growth needed for polyp formation. Thus, eRapa is an effective and convenient method to deliver rapamycin to both the small intestine and blood indicating eRapa could have both local and systemic effects.

We also examined the status of the other major arm of mTORC1 effectors, the cap-binding translation initiation factor, eIF4E and its binding repressor, 4E-BP1, which are implicated in cancer growth (28). We detected no significant effects on this arm of the pathway, including no alterations in the ratio eIF4E to its repressor 4E-BP1 (data not shown). Thus, the major effect of chronic rapamycin treatment directed to the small intestine seems to be a reduction of S6K1 activity manifested by decreased rpS6 phosphorylation.

Chronic rapamycin improved survival of ApcMin/+ mice (n = 5 females/group) in a dose-dependent manner (Fig. 2A, P < 0.005, log-rank test, and 2B for rapamycin blood
levels). The ApcMin/+ cohort fed control chow lived 164 to 182 days (median 174) versus the 14 ppm eRapa cohort that lived 570 to 685 days (median 668). The 42 ppm eRapa fed ApcMin/+ mice lived 559 to 1,093 days (median 937, approximately a 5.4-fold increase in life span over our control cohort). Our Supplementary video S1 at 902 days of age shows that three surviving mice were active and appeared healthy. Previous studies have shown the median life span for C57BL/6J mice is in the range of 692 to 866 days (e.g., see shaded area in the graph in Fig. 2A; refs. 10, 11). The shaded area of the graph also includes female C57BL/6 survival results reported by Zhang and colleagues (16), and is representative of the colony in Nathan Shock Aging Animal and Longevity Assessment Core in the Barshop Institute.
Center for Longevity and Aging Studies, the facility used for housing our Apc\textsuperscript{Min/+} mice. Thus, the 14 ppm eRapa-fed mice live close to this range, whereas four out of five of the 42 ppm eRapa-fed mice lived within this range and three surpassed it. In addition, the life span of eRapa-fed Apc\textsuperscript{Min/+} mice mimics the longevity of wild-type C57BL/6Nia mice fed a 14 ppm eRapa diet beginning at 19 months of age (16). The blood levels of rapamycin achieved by 14 and 42 ppm diets in the Apc\textsuperscript{Min/+} mice (Fig. 2B) were lower than those observed for wild-type C57BL/6 mice (Fig. 1D). Although the exact reason for this difference is unknown, possibilities include variation in lots of eRapa-containing foods, differential drug absorption in wild-type mice compared with Apc\textsuperscript{Min/+}, and/or slower drug clearance in older mice (607–627 days for wild-type, compared with 217 and 308 days Apc\textsuperscript{Min/+}).

Necropsies were performed on Apc\textsuperscript{Min/+} mice that were sacrificed as they became moribund (unable to move and severely dehydrated) or recently after death. At necropsy, there was a reduction in the number of intestinal neoplasms for the 42 ppm cohort as compared with the control and 14 ppm eRapa dose cohorts (Table 1 and Fig. 2C). The first mouse to die in the 42 ppm eRapa dose cohort (#15, Table 1) was found soon after death with an intact intestine. There were no gross pathologic lesions, including intestinal adenomas. Therefore, this mouse appeared to die from something other than intestinal neoplasms. The second mouse to die in this cohort (#13) was sacrificed when she was no longer able to move. Intestinal cancer likely contributed to her death as she had multiple grade 5 adenocarcinomas (Table 1). During the review and revision of this article, one Apc\textsuperscript{Min/+} mouse was still alive at 1,087 days (October 3, 2013, Supplementary video S2), and she appeared to be a healthy old mouse. This mouse died 6 days later with a diagnosis of one grade 2 adenocarcinoma located in the distal segment of the small intestine and a thrombus located in the atrium of the heart (Table 1). Our results suggest that eRapa improves survival of Apc-mutant mice better than the delivery methods used in previous studies. eRapa’s superior performance was not due to higher rapamycin doses because the 14 ppm dose (2.24 mg/kg/day) was lower than all other reported doses (3 and 10 mg/kg/day by oral gavage, ref 8; 40 mg/kg food pellet, ref. 9), yet exerted a greater improvement in survival. Analyses of eRapa effects on intestines and tumors of Apc\textsuperscript{Min/+} mice were not done in our survival studies because we find necropsy materials unsuitable for immunoassays of mTORC1 status. As mice approach death, they stop eating and drug levels likely drop significantly. Thus, off-tumor target effects of higher doses of rapamycin could also explain the dose responses we observed and require additional investigation.

As observed by Fujishita and colleagues’ study of Apc\textsuperscript{S716+} mice (8), Apc\textsuperscript{Min/+} mice treated with both low- and high-dose eRapa also developed adenocarcinoma in the intestine, albeit in lower number in the high-dose group (Table 1). One possibility for resistance of these tumors to chronic rapamycin is due to resistance of the mTORC1-4E-BP1 axis resulting from prolonged treatment (29–31). In agreement, our cross-sectional analysis of mouse organs shows no significant effects of chronic rapamycin treatment of 4E-BP1 phosphorylation. However, we do see a trend toward an increase in the ratio of elf4E to 4E-BP1 levels (data not shown), which has been reported to cause resistance of cancer cells to active-site mTOR inhibitors (28). Finally, treatments with rapamycin or rapalogs result in the activation of a negative

<table>
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<th>Mouse</th>
<th>Age at death (days)</th>
<th>Diagnosis</th>
<th>Diagnosis grade</th>
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<td>Focal hyperplasia</td>
<td>1</td>
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<td>995</td>
<td>1 adenocarcinoma</td>
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<td>Distal small intestine</td>
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<td>#14</td>
<td>1093</td>
<td>1 adenocarcinoma</td>
<td>2</td>
<td>Proximal small intestine</td>
</tr>
<tr>
<td>#15</td>
<td>559</td>
<td>Not determined</td>
<td>NA</td>
<td>No intestinal polyps</td>
</tr>
</tbody>
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NOTE: grades: 0, normal; 1, minimal; 2, mild; 3, moderate; 4, moderately severe; 5, severe. Abbreviation: NA, not applicable.
feedback loop resulting in activation of mTORC2 that phosphorylates and activates Akt (32, 33), which is a progrowth, prosurvival pathway suggested to cause rapamycin resistance (34). In our analysis of tissues, we observe no significant effects on Akt Ser473 phosphorylation and a small decrease in Akt levels in distal small intestine (Fig. 2D and E). This suggests that rebound activation of this progrowth signaling pathway is less likely to be a factor in resistant tumors.

We measured the activity of ApcMin/+ mice as a surrogate for health. At 164 to 167 days, the eRapa-fed mice (both doses) exhibited a higher level of activity than control-fed mice during both the light (inactive) and dark (active) phases (Fig. 2F, \( P < 0.001 \)). eRapa-fed mice at both doses showed greater activity during the dark phase as compared with the light phase (\( P < 0.001 \)), whereas control-fed mice show no difference between these phases (\( P = 0.415 \)). Thus, ApcMin/+ mice on etapa maintained diurnal rhythm and activity levels similar to wild-type C57BL/6 mice, suggesting better health versus ApcMin/+ mice on control chow.

Hematocrits were measured (Fig. 2G) to determine the severity of intestinal bleeding that causes death. A normal hematocrit for wild-type C57BL/6 mice is 44 ± 0.4 (35). At 164 days, two of the control mice exhibited hematocrits of 17% and 19% consistent with their early demise. The 14 ppm eRapa-fed cohort exhibited an average hematocrit of 45% at 217 days (\( n = 5 \)), 40% at 308 days (\( n = 5 \)), and 24% at 588 days (\( n = 4 \)), consistent with adenomas developing much later as verified by end-of-life necropsy. The 42 ppm eRapa-fed cohort exhibited average hematocrits of 46% at 217 days (\( n = 5 \)), 48% at 308 days (\( n = 5 \)), 44% at 588 days (\( n = 4 \)), 37% at 734 days (\( n = 4 \)), 43% (\( n = 3 \)) at 849 days, and 40% (\( n = 3 \)) at 902 days. For the 734-day time point, one of the 42 ppm eRapa-fed cohort had an abnormally low hematocrit (27%), suggesting she had intestinal adenomas by this time. This mouse died at 750 days with adenocarcinomas (Table 1). The other mice in the 42 ppm eRapa-fed cohort had normal or near normal hematocrits as late as 902 days suggesting a low adenoma burden. Thus, our study supports the possibility that etapa could be administered prophylactically to FAP or similar patients to delay or prevent intestinal neoplasia and surgical intervention.

Rapamycin targeted for release in the upper GI tract might also be an effective preventive for patients who have had colectomies but are at high risk for duodenal polyps and adenocarcinoma.

Rapamycin would need to have few harmful side effects in healthy adults if it is to be used as a prophylactic. One study found rapamycin caused glucose intolerance and insulin insensitivity in C57BL6/J mice (36) but these problems were not found in another study on the HET3 mouse used by the Intervention Testing Program (37) suggesting a difference in strain background (C57BL/6 versus HET3), environment, and/or delivery method (IP injections versus intestinal release by eRapa). Another study on C57BL/6 mice found that eRapa extended the life span of male C57BL/6 mice but also caused nephrotoxicity and testicular degeneration (38). However, nephrotoxicity was not found in other studies on C57BL/6 mice (16) or HET-3 mice (14). Thus, the only common toxicity associated with chronic rapamycin treatment is testicular degeneration (39).

Our observation that chronic eRapa exposure extends life span and ameliorates many age-dependent changes supports the notion that eRapa is safe, because toxic compounds would predictably shorten life span, not extend it. Furthermore, that eRapa-fed ApcMin/+ mice with blood levels of 10 to 28 ng/mL (often exceeding human therapeutic levels; Fig. 2) live longer than the reported life span for syngeneic mice is inconsistent with clinically significant immunosuppression or other toxicities. Yet, a criticism of mouse studies is that mice are housed in a pathogen-free environment that could mask potential problems with long-term rapamycin treatments.

To test for the possibility that eRapa is immunosuppressive in our setting, we evaluated its effects in several additional, relevant models. In a mouse melanoma model, 4-month-old mice were fed 14 ppm eRapa for 3 months and then challenged with B16 tumor cells. Tumor growth was similar between the eRapa and control mice (Fig. 3A) as previously reported (40). Regulatory T cells and myeloid-derived suppressor cells inhibit antitumor immunity generally and specifically in the B16 tumor model (17). However, 14 ppm eRapa did not increase regulatory T-cell or myeloid-derived suppressor cell numbers or suppression.
in the B16 tumor model (Fig. 3B and C). Thus, in this tumor model we found no detrimental immune effects of chronic eRapa and specifically no increase in tumor-mediated immune suppression. In a T. gondii challenge model, in which we and others have shown that survival following infection with this parasite depends on antigen-specific immunity and IFN-γ production (18, 20), eRapa at 14 ppm did not alter the numbers of antigen-specific CD8+ T cells or their IFN-γ production (Fig. 4). In the well-established bm12 transfer model of autoimmunity, eRapa at 14 ppm did not accelerate autoimmune kidney disease, affect Treg numbers or function or alter host T-cell numbers or activation versus Eudragit controls (not shown). Similarly, recent publications specifically examining rapamycin immune effects demonstrate that rapamycin boosts immunity to infection (41), including in a transplant model without worsening GVHD (42), all underscoring the fact that rapamycin at clinically relevant concentrations that prolong life is not apparently immunosuppressive. When the optimal dose for increasing FAP survival is established, additional work will be required to assess specific immune effects at that dose.

Nonsteroidal anti-inflammatory drugs (NSAID) and various dietary supplements have been studied as potential chemoprevention agents. A large aspirin study showed daily consumption for 5 years or longer reduced cancer-related death in humans, including deaths from gastrointestinal cancers (43). Aspirin inhibits mTOR and activates AMP-activated protein kinase (AMPK). However, in contrast to eRapa, aspirin extended median life span only in males (44). Aspirin can also cause significant side effects, including gastrointestinal bleeding. Sulindac can be given to delay the progression of polyposis in the retained rectum among patients after colectomy with ileorectal anastomosis in conjunction with a strict endoscopic surveillance regimen (45), whereas the cyclooxygenase inhibitor celecoxib reduced colorectal adenomas in a 6-month trial in FAP adults (46). Despite apparent effectiveness, neither sulindac nor celecoxib is recommended as a primary prevention agent as reports suggest potential cardiovascular toxicity.
with COX-2 inhibitors in FAP. Furthermore, nonselective (COX-1 and COX-2) NSAIDs, including sulindac and naproxen, were suggested to increase cardiovascular thrombosis events. Thus, these agents are not ideal for cancer prevention.

Chemo prevention should ideally be well-tolerated, non-toxic, effective, and inexpensive, for long-term use. As shown in Fig. 2, enteric targeting of mTORC1 inhibitors demonstrates significant potential in meeting these first criteria and cost will decrease significantly when the rapamycin US patent (#5,100,899) expires in 2013.

We now need to determine the optimal eRapa dose to extend life span without toxic side effects and unravel its mechanism(s) of action. In this regard, it is interesting that mTORC1 mediates caloric restriction and rapamycin effects on intestinal crypt stem cell function and renewal (47), and identified as the cells-of-origin of intestinal cancer in ApcMin/+ mice (48). In sum, this report shows that targeted delivery of rapamycin (which is demonstrated here and elsewhere to be safe and to extend maximum life span in preclinical models) could be an effective prevention strategy for patients with FAP and others predisposed to intestinal cancer. Further work is required to assess potential benefits of chronic eRapa treatment versus possible risks associated with chronic mTOR inhibition, which reports of transplant and cancers patients clearly demonstrate are manageable (49, 50), before moving into cancer prevention clinical trials.

Disclosure of Potential Conflicts of Interest
C.B. Livi, R. Strong, and Z.D. Sharp are consultants and advisory board members for Rapamycin Holdings, Inc. No potential conflicts of interest were disclosed by the other authors.

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