3-16-2004

**Method of identifying and treating invasive carcinomas (DIV.B)**

Xinqing Chai  
*University of Central Florida*

Julie Chao  
*MUSC Foundation for Research Development*

Lee Chao  
*MUSC Foundation for Research Development*

Limei Chen  
*University of Central Florida*

Find similar works at: [https://stars.library.ucf.edu/patents](https://stars.library.ucf.edu/patents)

University of Central Florida Libraries [http://library.ucf.edu](http://library.ucf.edu)

This Patent is brought to you for free and open access by the Technology Transfer at STARS. It has been accepted for inclusion in UCF Patents by an authorized administrator of STARS. For more information, please contact STARS@ucf.edu.

**Recommended Citation**

Chai, Xinqing; Chao, Julie; Chao, Lee; and Chen, Limei, "Method of identifying and treating invasive carcinomas (DIV.B)" (2004). *UCF Patents*. 356.  
[https://stars.library.ucf.edu/patents/356](https://stars.library.ucf.edu/patents/356)
(54) METHOD OF IDENTIFYING AND TREATING INVASIVE CARCINOMAS

(75) Inventors: Karl X. Chai, Winter Springs, FL (US); Li-Mei Chen, Winter Springs, FL (US); Lee Chao, Mr. Pleasant, SC (US); Julie Chao, Mr. Pleasant, SC (US)

(73) Assignee: University of Central Florida, Orlando, FL (US)

(21) Appl. No.: 10/836,750

(22) Filed: Feb. 18, 2003

(51) Int. Cl. .......................... C12Q 1/68; GOlN 33/48; C07H 21/02

(52) U.S. Cl. .......................... 435/6; 536/23.1; 536/23.2; 536/23.5; 436/64

(58) Field of Search ............................... 429/9.1, 184-1, 429/185.1, 277.1, 94.1, 94.45; 435/6, 325; 436/64; 514/1; 530/350; 536/23.1, 23.2, 23.5

(66) Related U.S. Application Data

(62) Division of application No. 09/755,811, filed on Jan. 5, 2001, now Pat. No. 6,569,684.

(60) Provisional application No. 60/174,801, filed on Jan. 6, 2000.

(60) Primary Examiner—James Housel
Assistant Examiner—Zachariah Lucas

(74) Attorney, Agent, or Firm—Brian S. Steinberger; Law Offices of Brian S. Steinberger, P.A.; Frances L. Olinsted

(57) ABSTRACT

Prostasin protein has been found to be a useful marker for determination of the invasiveness of and as a means to treat human carcinomas. Using RT-PCR and western blot analyses, prostasin protein and mRNA expression were found in normal human prostate epithelial cells and the human prostate cancer cell line LNCaP but not in the highly invasive human prostate cancer cell lines DU-145 and PC-3. Immunohistochemistry studies of human prostate cancer specimens revealed a down-regulation of prostasin in high-grade tumors. Using RT-PCR and western blot analyses, prostasin protein and mRNA expression were found in a non-invasive human breast cancer cell line, MCF-7, while invasive human breast cancer cell lines MDA-MB-231 and MDA-MB-435s were found not to express either the prostasin protein or the mRNA. A non-invasive human breast cancer cell line, MDA-MB-453, was shown to express prostasin mRNA but not prostasin protein. Transfection of DU-145 and PC-3 cells with a full-length human prostasin cDNA restored prostasin expression and reduced the in vitro invasiveness by 68% and 42%, respectively. Transfection of MDA-MB-231 and MDA-MB-435s cells with a full-length human prostasin cDNA restored prostasin expression and reduced the in vitro invasiveness by 50% for either cell line.

6 Claims, 7 Drawing Sheets
OTHER PUBLICATIONS


* cited by examiner
FIG. 1

Human Prostate Gland 20

Normal or Non-Invasive Cancer

YES! 22     NO! 24 or Reduced 26

Prostasin Serine Protease 14

Normal

NO? 12     YES? 16

Human Blood 10

FIG. 2

Human Mammary Gland 200

Non-Invasive Cancer

YES! 220     NO! 240 or Reduced 260

Prostasin Serine Protease 14

Normal

NO? 120     YES? 160

Cancer

Human Blood 100
FIG. 5

Prostasin 40 kDa
Prostasin
β-Actin 556 bp
FIG. 7

Vector Prostasin  Vector Prostasin

DU-145  PC-3

40 kDa

Relative Invasiveness (percentage)

Vector  Prostasin  Vector  Prostasin

p<0.01  p<0.001

FIG. 8

Vector Prostasin  Vector Prostasin

40 kDa

Relative Invasiveness (percentage)

MDA-MB-231  MDA-MB-435s

p<0.01
METHOD OF IDENTIFYING AND TREATING INVASIVE CARCINOMAS

This invention relates to prostates and its use in the diagnosis and treatment of prostate and breast cancers, and is a divisional application to U.S. application Ser. No. 09/755,811 filed on Jan. 5, 2001, now U.S. Pat. No. 6,569,684, which claims the priority to U.S. Provisional Application Ser. No. 60/174,801 filed Jan. 6, 2000 and was supported in part by Department of Defense Prostate Cancer Research Grant DAMD17-98-1-8590, and in part by grants to principal investigator K. X. CHAI from the Florida Hospital Gala Endowed Program for Oncologic Research.

BACKGROUND AND PRIOR ART

For men in the U.S., prostate cancer is the most commonly diagnosed cancer, and the second leading cause of cancer-related death (Greenlee R T, Murray T, Bolden S, Wingo P A. Cancer statistics, 1999. Ca: a Cancer Journal for Clinicians 2000;50:7–33). Prostate cancers originate as localized lesions; some of these localized lesions will progress to become invasive, migratory and metastatic. Our current understanding of the mechanisms of the prostate cancer invasion process, however, is poor. Our ability to predict the acquisition of invasive potentials by a prostate cancer is limited.

The mechanisms leading to the development of a prostate cancer are complex. Currently, it is believed to be the result of multiple transformation steps from normal prostate glandular cells (Carter H B, Piantadosi S, Isaacs J T. Clinical evidence for and implications of the multistep development of prostate cancer. Journal of Urology, 143(4):742–6, 1990). The initial steps result in what are described as prostatic interepithelial neoplastic (PIN) lesions (Isaacs J T, Molecular markers for prostate cancer metastasis. Developing diagnostic methods for predicting the aggressiveness of prostate cancer. [Review] [92 refs] American Journal of Pathology, 150(5):1511–21, 1997). These PIN lesions may then typically have three different fates based on an assessment of their impact to the patient. The PIN lesions can remain as such, not producing histologically detectable prostate cancer, or further transform into histologically detectable prostate cancer. Most of the histologically detectable prostate cancers will be asymptomatic in the patient and remain non-manifest clinically as many are discovered post-mortem (Carter H Colley D, Prostate Cancer: the magnitude of the problem in the United States. In A Multidisciplinary Analysis of Controversies in the Management of Prostate Cancer. (Eds. Colley D, Resnick M, Door R, et al), pp 1–9, Plenum Press a 1988; Carter H B Piantadosi S, Isaacs J T. Clinical evidence for implications of the multistep development of prostate cancer, Journal of Urology, 143(4):742–6, 1990; Scardino P T, Weaver R, Hudson M A. Early detection of prostate cancer. [Review] [102 refs] Human Pathology, 23(3):211–22, 1999). Prostate cancers are diagnosed clinically by an estimate of size and location using the TNM staging system (Denis L J, Staging and prognosis of prostate cancer. European Urology, 24 Suppl 2:13–8, 1993), and by pathological staging based on an examination of the histology of the removed prostate via either biopsy or prostatectomy using a system by D. F. Gleason, (Gleason D F, Classification of prostatic carcinomas. Cancer Chemotherapy Reports-Part 1, 50(3):125–8, 1966). About 50% of prostate cancer cases receiving treatment are diagnosed clinically as advanced, or, non-organ-confined (Scardino P T, Weaver R, Hudson M A. Early detection of prostate cancer.

[Review] [102 refs] Human Pathology, 23(3):211–22, 1992), for which no effective treatment exists (Yagoda A, Petrylak D. Cytotoxic chemotherapy for advanced hormone-resistant prostate cancer, [Review] [63 refs] Cancer. 71(3 Suppl): 1098–109, 1993 and Petrylak, 1993). Of the remaining 50% cases, ¼ (~50,000) are diagnosed as organ-confined but micrometastasis may be present. The final group of patients (~100,000) have truly organ-confined prostate cancer and can be cured by radical prostatectomy (Sgrignoli A R Walsh P C, Steinberg G D, Steiner M S, Epstein J I. Prognostic factors in men with stage D 1 prostate cancer: identification of patients less likely to have prolonged survival after radical prostatectomy [see comments]. Journal of Urology, 152(4):1077–81, 1994; Zincke H, Oesterling J E, Blute N L, Bergstralh E J, Myers R P, Barrett D M, long term (15 years) results after radical prostatectomy for clinically localized (stage T2c or lower) prostate cancer [see comments]. Journal of Urology, 152(5 Pt 2): 1850–7, 1994) or left untreated (watchful waiting) without the risk of life-threatening or life-altering. For the patients with non-organ-confined prostate cancers (discovered via either biopsy or surgery), undergoing systemic treatment early is essential to the management of their cancer (Yagoda A, Petrylak D. Cytotoxic chemotherapy for advanced hormone-resistant prostate cancer [Review] [63 refs] Cancer, 71(3 Suppl): 1098–109, 1993). Consequently, it will be ideal, both medically and economically, if one could precisely predict upon early pathological examination of the tumor, which group of patients will have truly organ-confined disease versus which group will have invasive prostate cancer.

Clinical staging of prostate cancer generally depends on the results of three tests that are performed in the following order: a PSA (prostate-specific antigen) blood test as a screening method; DRE (digital rectal examination) for an initial indication of palpable disease; and, a biopsy to obtain samples for histological examination. Prostate cancers, removed either via biopsy or surgery, are graded histologically by the system of Gleason. (Gleason D F, Classification of prostatic carcinomas. Cancer Chemotherapy Reports—Part 1, 50(3):125–8, 1966), which is an evaluation of how aggressive and how poorly-differentiated the prostate cancers are. The aggressiveness of prostate tumors: of low Gleason scores (<5) is limited; of high Gleason scores (8–10) are highly aggressive; but, for the intermediate Gleason-score (5–7) prostate cancers (76% of prostate tumors), the accuracy of predicting their aggressiveness is poor (Gleason D F, Mellinger G T. Prediction of prognosis for prostatic adenocarcinoma by combined histological grading and clinical staging, Journal of Urology, 111(1): 58–64, 1974). Thus, the ability to accurately determine the aggressiveness of these intermediate Gleason-score prostate tumors has remained as a practical challenge to, and a primary goal for, prostate cancer research (Isaacs J T, Molecular markers for prostate cancer metastasis. Developing diagnostic methods for predicting the aggressiveness of prostate cancer. [Review] [92 refs] American Journal of Pathology, 150(5):1511–21, 1997). Especially with regard to the number of patients (150,000) facing a decision of whether to undergo systemic treatment, the most urgent demand in prostate cancer care is the development of methods to enhance our ability to accurately predict the aggressiveness of the tumors with Gleason scores of 5–7.

It is now commonly believed that cancers occur via multiple transformation steps by accumulating mutations in three classes of genes: proto-oncogenes (Park M, Oncogenes. In The Genetic Basis of Human Cancer (Eds. Vogel...

The historical prostate cancers for which the prediction of clinical aggressiveness is difficult (those with the intermediate Gleason scores 5–7) probably have not gone through the necessary “multi-step” transformation to acquire the potentials to behave aggressively (as would the high-grade cancers). This notion was supported by studies comparing the course of prostate cancer development among men in Japan and in the U.S., and Japanese men who migrated to the U.S. (Carter H B, Plantadosi S, Isaacs J T. Clinical evidence for and implications of the multistep development of prostate cancer. Journal of Urology, 1990; Haenszel W, Kurihara M, Studies of Japanese Migrants, I. Mortality form cancer and other diseases among Japanese in the United States. Journal of the National Cancer Institute, 40(1):43–68, 1968: Akazaki K, Stemmerman G N. Comparative study of latent behavior of prostate cancer markers. Examples of these genes that can$

Breast cancer is the most diagnosed cancer in women and the second leading cancer related cause of death in women (Greenlee R T, Murray T, Bolden S, Wingo P A, Cancer statistics, 1999, Ca: a Cancer Journal for Clinicians 2000;50:7–33). Breast ductal carcinoma in situ (hereinafter indicated as DCIS) incidence has increased dramatically since 1983 as a result of implementing screening programs (Ernst V L, Barclay J. Increases in ductal carcinoma in situ (DCIS) of the breast in relation to mammography: a dilemma. [Review] [34 refs] Journal of the National Cancer Institute. Monographs, (22):151–6, 1997). DCIS is described as a malignant growth of epithelial cells within the ducts and lobules of the breast, and is believed to be the precursor of all invasive breast carcinoma. DCIS itself is non-life-threatening; however, current treatment options for DCIS include mastectomy, lumpectomy, radiotherapy or tamoxifen (Ernst V L, Barclay J. Increases in ductal carcinoma in situ (DCIS) of the breast in relation to mammography: a dilemma. [Review] [34 refs] Journal of the National Cancer Institute. Monographs, (22):151–6, 1997). Hwang E S, Esserman L J. Management of ductal carcinoma in situ, [Review] [91 refs] Surgical Clinics of North America. 79(5):1007–30, viii, 1999). These treatment options for DCIS are at best controversial due primarily to a lack of precision in diagnosis and prognosis of whether the detected DCIS will progress to invasive breast cancer and whether recurrence is likely after treatment, usually with a high percentage being invasive breast cancer (Zaugg K, Bodis S. Is there a role for molecular prognostic factors in the clinical management of ductal carcinoma in situ (DCIS) of the breast? [Review] [49 refs] Radiotherapy & Oncology, 55(2):95–9, 2000). At present, histological grading (nuclear grading and whether comedo-type necrosis is present) and the size of the DCIS are used to provide assessments of risk of DCIS progression to invasive breast cancer (Zaugg K, Bodis S. Is there a role for molecular prognostic factors in the clinical management of ductal carcinoma in situ (DCIS) of the breast? [Review] [49 refs] Radiotherapy & Oncology, 55(2):95–9, 2000). Shokker B S, Sloane P J, DCIS grading schemes and clinical implications. [Review] [40 refs] Histopathology, 35(5):393–400, 19; van de Vijver M J. Ductal carcinoma in situ of the breast: histological classification and genetic alterations. [Review] [69 refs] Recent Results in Cancer Research, 152:123–34, 1998). These parameters are far from being adequate for making the most accurate choice of treatment, resulting in a choice either overly excessive or conservative, in either case, the patient will suffer unnecessarily. Molecular markers can help improve our ability to better diagnose DCIS and stratify treatment options, especially the molecular markers that, themselves, play a role in the progression of DCIS to invasive breast cancer (Zaugg K, Bodis S. Is there a role for molecular prognostic factors in the clinical management of ductal carcinoma in situ (DCIS) of the breast?. [Review] [49 refs] Radiotherapy & Oncology, 55(2):95–9, 2000; Silverstein M J, Masetti R. Hypothesis and practice; are there several types of treatment for ductal carcinoma in situ of the breast? [Review] [53 refs] Recent Results in Cancer Research, 152:105–22, 1998). The tumorigenesis process is a multi-step transformation in which molecular events escalate to the final stage of invasive phenotype (Silverstein M J, Masetti R. Hypothesis and practice; are there several types of treatment for ductal carcinoma in situ of the breast? [Review] [53 refs] Recent Results in Cancer Research, 152:105–22, 1998). The conventional paradigm of protease involvement in the development and progression of cancer has been the assignment of a usually negative role to the
SUMMARY OF THE INVENTION

The first objective of the present invention is to reduce deficiencies in the prior art with specific regard to differential diagnosis of invasive prostate and breast cancers and to treatment of invasive and metastatic prostate and breast cancers.

The second objective of the present invention is to provide a new marker for prostate and breast cancer.

The third objective of the invention is to provide as a drug to patients with carcinoma of the prostate via delivery of a functional prostasin gene.

The fourth objective of the invention is to provide as a drug to patients with carcinoma of the prostate via delivery of a functional prostasin cDNA.

The fifth objective of the invention is to provide as a drug to patients with carcinoma of the breast via delivery of a functional prostasin gene.

The sixth objective of the invention is to provide as a drug to patients with carcinoma of the breast via delivery of a functional prostasin cDNA.

This invention identifies prostasin serine protease as a potential marker, and as a tumor invasion suppressor for prostate and breast cancers and thus provides methods (a), (b), and (c) of determining invasiveness levels of human carcinomas:

(a) using prostasin protein levels, comprising the steps of: sampling a human carcinoma tissue; determining prostasin protein levels in the human carcinoma tissue; preferably applying an immunological reagent-antibody to said tissue wherein the reagent-antibody becomes bound to prostasin protein in said tissue; and determining invasiveness of the human carcinoma tissue based on the prostasin protein levels; or

(b) using prostasin mRNA levels, comprising the steps of: sampling a human carcinoma tissue; determining prostasin mRNA levels in the human carcinoma tissue preferably by applying prostasin-specific anti-sense RNA probes in an in situ hybridization to determine the prostasin mRNA levels in the separated human carcinoma sample tissue; to make possible and determining invasiveness of the human carcinoma tissue based on the prostasin mRNA levels; or

(c) using prostasin gene promoter DA methylation levels, comprising the steps of: sampling a human carcinoma tissue; determining prostasin gene promoter DNA methylation levels in the human carcinoma tissue preferably by applying prostasin-promoter-specific oligonucleotide primers in a PCR to determine the prostasin gene promoter DNA methylation levels in the sampled human carcinoma tissue and determining invasiveness of the human carcinoma tissue based on the prostasin gene promoter DNA methylation levels, as well as a method of treating invasive human carcinomas comprising the steps of: incorporating human prostasin nucleic acid into a selected gene delivery vector nucleic acid to form a recombinant nucleic acid; preferably wherein the nucleic acid includes a gene or cDNA delivering the recombinant nucleic acid into a human carcinoma; and reducing invasiveness of the human carcinoma.

Further objects and advantages of this invention still be apparent from the following detailed description of a presently preferred embodiment, which is illustrated schematically in the accompanying drawings.
Using RT-PCR and western blot analyses, prostasin protein and mRNA expression were found in a non-invasive human breast cancer cell line, MCF-7, while invasive human breast cancer cell lines MDA-MB-231 and MDA-MB-435s were also discovered not to express either the prostasin protein or the mRNA. A non-invasive human breast cancer cell line, MDA-MB-453, was shown to express prostasin mRNA but not prostasin protein. Examination of the prostasin gene promoter in the human prostate and breast cancer cell lines by Southern blot analysis revealed heterogeneous methylation of the promoter in DU-145, PC-3 and MDA-MB-453 cells, and homogeneous methylation of the promoter in MDA-MB-231 and MDA-MB-435s cells. The prostasin gene promoter in normal human prostate epithelial cells, the LNCaP and the prostasin gene promoter in the human prostate and breast cancer cell lines by Southern blot analysis revealed heterogeneous methylation of the promoter in DU-145, PC-3 and MDA-MB-453 cells, and homogeneous methylation of the promoter in MDA-MB-231 and MDA-MB-435s cells. The prostasin gene promoter in normal human prostate epithelial cells, the LNCaP and the prostasin gene promoter in the human prostate and breast cancer cell lines by Southern blot analysis revealed heterogeneous methylation of the promoter in DU-145, PC-3 and MDA-MB-453 cells, and homogeneous methylation of the promoter in MDA-MB-231 and MDA-MB-435s cells. The prostasin gene promoter in normal human prostate epithelial cells, the LNCaP and the prostasin gene promoter in the human prostate and breast cancer cell lines by Southern blot analysis revealed heterogeneous methylation of the promoter in DU-145, PC-3 and MDA-MB-453 cells, and homogeneous methylation of the promoter in MDA-MB-231 and MDA-MB-435s cells. The prostasin gene promoter in normal human prostate epithelial cells, the LNCaP and the prostasin gene promoter in the human prostate and breast cancer cell lines by Southern blot analysis revealed heterogeneous methylation of the promoter in DU-145, PC-3 and MDA-MB-453 cells, and homogeneous methylation of the promoter in MDA-MB-231 and MDA-MB-435s cells. The prostasin gene promoter in normal human prostate epithelial cells, the LNCaP and the prostasin gene promoter in the human prostate and breast cancer cell lines by Southern blot analysis revealed heterogeneous methylation of the promoter in DU-145, PC-3 and MDA-MB-453 cells, and homogeneous methylation of the promoter in MDA-MB-231 and MDA-MB-435s cells.

Expression of prostasin protein is reduced in high-grade human prostate tumor. Prostatectomy specimens from 39 patients (128 sections) were subjected to immunohistochemistry using a prostasin-specific antibody. Overall, in normal, non-tumor or benign prostate epithelia, 89.0% of the examined areas demonstrated positive staining for prostasin protein and 11.0% were considered negative (based on the scoring system used for HercepTest™, DAKO Corporation, Carpinteria, Calif.). In all tumor specimens that were examined, prostasin was detected in 93.3% of the low Gleason grade areas (2 grade 2), 44.4% of Gleason grade 3 areas, 21.1% of Gleason grade 4 areas, and not in Gleason grade 5 areas (data summarized in Table 1). The mean prostasin immunostaining score was found significantly decreased in high-grade prostate tumors as compared to non-tumor areas (ANOVA, p<0.0001).

Representative staining images of non-tumor (benign) areas and prostate tumor areas are shown in FIGS. 4a–4l, which provides immunohistochemical detection of prostasin protein in tissues. Paraffin-embedded human prostate sections were stained for prostasin protein expression evaluation using a specific antibody as described (Yu J X, Chao L, Chao J. Prostasin is a novel human serine proteinase from seminal fluid. Purification, tissue distribution, and localization in prostate gland. Journal of Biological Chemistry, 269(29):18843–8, 1994). Prostasin positive staining (brown color) was detected in the cytoplasm and apical membrane in non-tumor or benign epithelial cells. The prostasin protein was detected in the cytoplasm and on the plasma membrane (apical) of benign epithelial cells lining the secretory lumen as well as in the secretion inside the lumen (FIGS. 4A and 4B, score 3, or ++), confirming the results of (Yu J X, Chao L, Chao J. Prostasin is a novel human serine proteinase from seminal fluid. Purification, tissue distribution, and localization in prostate gland. Journal of Biological Chemistry, 269(29):18843–8, 1994). When a pre-immune rabbit serum was used in place of the prostasin antiserum, no staining was observed in either the non-tumor epithelia (FIGS. 4C and 4D) or tumor epithelia (FIG. 4E). Tumor epithelia displayed various degree: of prostasin immunostaining as shown in FIGS. 4F–4L. In Gleason grade 1–2 tumors, moderate prostasin staining is seen in the cytoplasm and on the plasma membrane of some epithelial cells, as well as in the secretion in the lumen (FIGS. 4G and 4H, score 2, or ++). In Gleason grade 3 tumors, a lesser number of epithelial cells displayed the moderate level prostasin staining (FIGS. 4I and 4J). In Gleason grade 4 tumors, most epithelial cells did not show any prostasin staining, while some prostasin staining can be seen in rare, sporadic tumor cells (FIGS. 4K and 4L, as indicated by the arrow, score 0). Genetically, prostate tumors are heterogeneous and multi-focal in nature, in that one patient’s gross-
Basis of Human Cancer
were digested with the following restriction enzyme com­
At the mRNA level, human prostasin mRNA (via a 232-bp
western blot analysis (upper panel), prostasin (as a
promoter probe (bases 703-1469 of the prostasin gene
location-95 (relative to the transcription initiation site) of the
prostasin promoter, is methylated (hypermethylated) in these
dNA samples. Signal intensity variation may be attributed to aneuploidy.
An examination of the prostasin gene promoter region for
dNA methylation differences among human prostate and
breast cancer cell lines has been made. (see FIG. 6). We
found that cells that express prostasin, normal prostate
epithelial, LNCaP, and MCF7, are unmethylated in the
prostasin promoter while MDA-MB-453 showed heterogeneous
prostasin promoter methylation. For cells that do not
express prostasin, DU-145 and PC-3 showed heterogeneous
prostasin promoter methylation while MDA-MB-231 and
MDA-MB-435 showed homogeneous hypermethylation in the
promoter region of the prostasin gene.
Two human prostate cancer cell lines that do not express
prostasin, the highly invasive DU-145 and PC-3, show
heterogeneous methylation in the promoter region of the
prostasin gene. The result suggests that at least one of the
two (or more) chromosome 16's of these cell lines is
methylated at the prostasin gene locus. The prostasin gene
on the unmethylated chromosome may contain mutations
that silenced the expression. An alternative explanation for the
heterogeneous methylation pattern is that the methyla­
tion occurs in clonal cell populations, however, the lack of
detectable prostasin mRNA in our RT-PCR-Southern blot
analysis in the DU-145 and PC-3 cells argues against this
possibility.
The significance of the finding on prostasin gene promoter
hypermethylation in prostate or breast cancer is that the
measurement of prostasin down-regulation as a cancer
marker may be achieved by using a binary assay (yes-or-no),
instead of a gradually decreasing quantity in the immuno­
histochemistry assay (which is quite arbitrary).
Re-expression of human prostasin protein in invasive
human prostate and breast cancer cells reduces invasiveness
in vitro. At this point, reference should be made to FIG. 7
which shows the prostasin protein expression and in vitro
invasive properties of the DU-145 and the PC-3 transfec­
tsants. DU-145 or PC-3 cells transfected with either a vector
dNA (labeled as “vector”) or a prostasin cDNA construct
(labeled as “prostasin”) were analyzed by a western blot
analysis using a prostasin-specific antibody (upper panel) or
subjected to an in vitro Matrigel chemoinvasion assay
(lower panel) as described in (Liu D F, Rabbani S A.
Induction of urinary plasmiinogen activator by retinoic acid
results in increased invasiveness of human prostate cancer
human prostasin protein (a 40-kDa band) was detected in the
prostasin cDNA-transfected DU-145 or PC-3 cells, but not
in the vector-transfected cells. In the Matrigel chemoinvas­
ion assay, the vector-transfected cells are expressed as being
100% invasive (solid bar), the open bar represents the
relative invasiveness of the human prostasin cDNA-
transfected cells. The data were analyzed by a Student t-test
using the StatView software (Abacus Concepts, Inc.,
Berkeley, Calif.).
It can be seen that Polyclonal DU-145 and PC-3 cells
transfected with the human prostasin cDNA (designated
DU-145/Pro, and PC-3/Pro, respectively) were confirmed to express the human prostasin protein, as shown in the western blot analysis of the cell lysate (FIG. 7, upper panel). The vector-transfected cells, designated DU-145/Vector or PC-3/Vector, respectively, were used as negative control in the western blot. A further examination of the DU-145/Pro and the PC-3/Pro cells by immunocytochemistry confirmed that 100% of the cells expressed the prostasin protein (data not shown). In in vitro Matrigel chemoinvasion assays (FIG. 7, lower panel), the invasiveness of DU-145/Pro cells was determined to be at 32% of that of DU-145. Vector cells (or, the reduction of invasiveness was at 68%). The invasiveness of PC-3/Pro cells was determined to be at 58% of that of PC-3/Vector cells (or, the reduction of invasiveness was at 42%). We performed in vitro cell proliferation assays on DU-145/Pro vs. DU-145/Vector cells, and on PC-3/Pro vs. PC-3/Vector cells, but did not observe any difference between the growth rates of the prostasin cDNA-transfected or the vector-transfected cells over an 8-day period (data not shown).

Forced re-expression of human prostasin in two invasive human breast cancer cell lines reduced invasiveness. A full-length human prostasin cDNA under the control of an RSV promoter was transfected into the invasive breast cancer MDA-MB-231 and MDA-MB-435 cells. Reference should be made to FIG. 8 which shows prostasin protein expression and in vitro invasive properties of the MDA-MB-231 and MDA-MB-435s transfecants. MDA-MB-231 and MDA-MB-435s cells transfected with either a vector DNA (labeled as “vector”) or a prostasin cDNA construct (labeled as “prostasin”) were analyzed by a western blot analysis using a prostasin-specific antibody (upper panel) or subjected to an in vitro Matrigel chemoinvasion assay (lower panel) as referenced in (Liu D F, Rabbani S A. Induction of urinary plasminogen activator by retinoic acid and its expression to reduced invasiveness. The evidence qualifies prostasin as an invasion suppressor, which thus is a marker for diagnosis of invasiveness of prostate and breast cancers, or as a therapeutic agent to treat invasive prostate and breast cancers.

Pathological grading by the Gleason system is performed after either surgery or biopsy, both highly invasive procedures, while blood tests such as that for the PSA prostate cancer marker can offer the hope of accurate diagnosis and prognosis without the harm of an invasive procedure. In practice, however, single markers suffer from an intrinsic limitation that the “positive” identifications are not always confirmed for the “diagnosed” disease. Biopsy is still required for a true positive identification of prostate cancer even in the case of the application of the PSA prostate cancer marker (Catalona W J, Partin A W, Slaug K M, Brailer M K, Flanigan R C, Patel A, Richie J P, deKernion J B, Walsh P C, Scardino P T, Lange P H, Subong E N, Parson R E, Gasior G H, Loveland K G, Southwick P C. Use of the percentage of free prostate-specific antigen to enhance differentiation of prostate cancer from benign prostatic disease: a prospective multicenter clinical trial [see comments]. JAMA, 279(19):1542–7, 1998). As stated above, it has been demonstrated in principle that many markers used in a multivariate approach may provide a highly accurate diagnosis (Greene G I, Kitada Y, Pettaway CA, von Eschenbach A C, Bucana C D, Fidler I J. Correlation of metastasis-related gene expression with metastatic potential in human prostate carcinoma cells implanted in nude mice using an in situ messenger RNA hybridization technique. American Journal of Pathology 150(5): 1571–82, 1997). From the standpoint of prostate cancer genetics, the multivariate approach is well supported by our current understanding. A serum protease structurally and genetically related to the PSA, the hK2 (human glandular kallikrein 2) has shown some promise of joining the list of markers applicable for prostate cancer diagnosis (Saedi M S, Hill T M, Kuus-Reichel K, Kumar A, Payne J, Mikolajczyk S D, Wolffer R L, Rittenhouse H G. The precursor form of the human kallikrein 2, a kallikrein homologous to prostate-specific antigen, is present in human sera and is increased in prostate cancer and benign prostatic hyperplasia. Clinical Chemistry, 44(10):2115–9, 1998). Structurally and in prostate gland biology, prostasin shares many common characteristics with both PSA and hK2, as being a secreted serine protease made in large abundance in prostate epithelial cells (Yu J X, Chao L, Chao J. Prostasin is a novel human serine protease from seminal fluid. Purification, tissue distribution, and localization in prostate gland. Journal of Biological Chemistry, 269(29):18843–8, 1994; Yu J X, Chao L, Chao J. Molecular cloning, tissue-specific expression, and cellular localization of human prostasin mRNA. Journal of Biological Chemistry, 270(22):13483–9, 1995). While high-grade prostate cancer cells produce less PSA protein than normal prostate cells or low-grade prostate cancer cells (Hakalahlil I, Viliko P, Henttu P, Antio-Harmainen H, Soini Y, Viliko R. Evaluation of PAP and PSA gene expression in prostate hyperplasia and prostate carcinoma using northern-blot analyses, in situ hybridization and immunohistochemical stainings with monoclonal and biopspecific antibodies. International Journal of Cancer, 55(4):590–7, 1; Sakai H, Yogi Y, Minami Y, Yushita Y, Kanetake H, Saito Y. Prostate specific antigen and prostatic acid phosphatase immunoreactivity as prognostic indices in prostate cancer patients. Critical Reviews in Clinical Laboratory Sciences, 35(4): 275–368, 1998). By comparison, we also believe prostasin is in the forefront of prostate cancer pathogenesis. As a result, a blood test for the circulating prostasin to indicate the presence and/or the stage of prostate cancer would be highly useful. (as illustrated in FIG. 1). In principal, the feasibility of a blood test based on prostasin detection to indicate...
cancer has been demonstrated by Berteau et al. (1999). These authors (Berteau P, Laribi Eschwege P, Lebars I, Dumas F, Benoit G, Lorée S. Prostasin mRNA to detect prostate cells in blood of cancer patients. Clinical and Chemical Laboratory Medicine 37 (SS): S119, 1999), demonstrated a highly promising potential of using prostasin as a marker to detect circulating prostate epithelial cells, a sign of prostate tissue damage caused by invasive prostate cancer leading to the dissemination of prostate epithelial cells into the circulation. It is expected that a blood test for circulating prostasin to indicate the presence and/or the stage of breast cancer would be highly useful. (as illustrated in FIG. 2).

In summary of the invention, it has been taught herein that: protein prostasin as well as its MRA levels and its gene promoter DNA methylation levels can be used to determine the invasiveness level of human carcinomas; and, provide a method of treating invasive human carcinomas by delivery thereto of a recombinant nucleic acid formed by a human prostasin nucleic acid incorporated into a selected gene delivery vector. Those teachings are repeated for emphasis and the invasiveness level of human carcinomas; and, provide a method of treating invasive human carcinomas by delivery thereto of a recombinant nucleic acid formed by a human prostasin nucleic acid incorporated into a selected gene delivery vector. Those teachings are repeated for emphasis.

1. Immunohistochemistry studies of human prostate cancer specimens revealed a down-regulation of prostasin in high-grade tumors.

2. Using RT-PCR and western blot analyses, prostasin protein and mRNA expression were found in a non-invasive human breast cancer cell line MCF-7, while invasive human breast cancer cell lines, MDA-MB-231 and MDA-MB-435S were found not to express either the prostasin protein or the mRNA. A non-invasive human breast cancer cell line, MDA-MB-453, was shown to express prostasin mRNA but not prostasin protein; and,

3. Examination of the prostasin gene promoter in the human prostate and breast cancer cell lines by Southern blot analysis revealed heterogeneous methylation of the promoter in DU-145, PC-3 and MDA-MB-453 cells, and homogeneous methylation of the promoter in MDA-MB-231 and MDA-MB-435S cells. The prostasin gene promoter in normal human prostate epithelial cells, the LNCaP and the MCF-7 cells was shown to be unmethylated. Transfection of DU-145 and PC-3 cells with a full-length human prostasin cDNA restored prostasin expression and reduced the in vitro invasiveness by 68% and 42%, respectively. Transfection of MDA-MB-231 and MDA-MB-435S cells with a full-length human prostasin cDNA restored prostasin expression and reduced the in vitro invasiveness by 50% for either cell line.

The preferred methods of separating sampled human carcinoma tissue from neighboring normal tissues is by laser capture micro-dissection.

While the invention has been described, disclosed, illustrated and shown in various terms of certain embodiments or modifications which it has presumed in practice, the invention is not intended to be, nor should it be deemed to, limited thereby and such other modifications or embodiments as may be suggested by the teachings herein are particularly reserved especially as they fall within the breadth and scope of the claims here appended.

We claim:

1. A method of determining human prostate carcinomas non-invasiveness using prostasin mRNA levels, comprising the steps of:
   - sampling a human prostate carcinoma tissue;
   - determining prostasin mRNA levels in the human carcinoma tissue;
   - determining the human prostate carcinoma tissue is not invasive based on the prostasin mRNA levels.

2. The method of determining human prostate carcinomas non-invasiveness as in claim 1, wherein the step of determining prostasin mRNA levels includes the step of:
   - applying prostasin-specific oligonucleotide primers in an RT-PCR to determine the prostasin mRNA levels in the sampled human prostate carcinoma tissue.

3. The method of determining human prostate carcinomas non-invasiveness as in claim 1, wherein the step of determining prostasin mRNA levels includes:
   - applying prostasin-specific anti-sense RNA probes in an in situ hybridization to determine the prostasin mRNA levels in the sampled human carcinoma tissue.

4. A method of determining human breast carcinomas non-invasiveness using prostasin mRNA levels, comprising the steps of:
   - sampling a human breast carcinoma tissue;
   - determining prostasin mRNA levels in the human breast carcinoma tissue; and
   - determining the human breast carcinoma tissue is not invasive based on the prostasin mRNA levels.

5. The method of determining human breast carcinomas non-invasiveness as in claim 4, wherein the step of determining prostasin mRNA levels includes the step of:
   - applying prostasin-specific oligonucleotide primers in an RT-PCR to determine the prostasin mRNA levels in the sampled human breast carcinoma tissue.

6. The method of determining human breast carcinomas non-invasiveness as in claim 4, wherein the step of determining prostasin mRNA levels includes the step of:
   - applying prostasin-specific anti-sense RNA probes in an in situ hybridization to determine the prostasin mRNA levels in the sampled human carcinoma tissue.