

# ER- $\alpha$ 36, a novel isoform of ER- $\alpha$ 66, is commonly over-expressed in apocrine and adenoid cystic carcinomas of the breast

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## ABSTRACT

**Background** ER- $\alpha$ 36 is a novel 36 kDa isoform of the full-length oestrogen receptor alpha (ER- $\alpha$ 66). ER- $\alpha$ 36 primarily localises to the cytoplasm and the plasma membrane, and responds to membrane-initiated oestrogen and antioestrogen signalling pathways.

**Aim** To examine the expression of ER- $\alpha$ 36 in apocrine and adenoid cystic carcinoma of the breast, both of which are consistently ER- $\alpha$ 66 negative and currently lack effective targeted therapeutic options.

**Methods** 19 pure apocrine carcinomas (17 invasive and two in-situ carcinomas) and 11 adenoid cystic carcinomas of the breast were evaluated for ER- $\alpha$ 36 expression, along with expressions of ER- $\alpha$ 66, progesterone receptor (PR) and androgen receptor (AR) using immunohistochemical methods.

**Results** All pure apocrine carcinomas showed a characteristic steroid receptor expression profile (ER- $\alpha$ 66 and PR negative, AR strongly positive). ER- $\alpha$ 36 expression was detected in 18/19 pure apocrine carcinomas (94.7%, 95% CI 75.1 to 98.7) in predominantly membranous and cytoplasmic distribution. When positive, pure apocrine carcinomas uniformly (100% of cells) expressed ER- $\alpha$ 36. All adenoid cystic carcinomas were uniformly negative for all three classic steroid receptors, but ER- $\alpha$ 36 was detected in 8/11 cases (72.7%, 95% CI 42.8 to 90) with the similar sub-cellular pattern of expression as in the pure apocrine carcinomas. When positive, adenoid cystic carcinomas expressed ER- $\alpha$ 36 in the majority of cells (average 76%).

**Conclusion** ER- $\alpha$ 36, a novel isoform of ER- $\alpha$ 66, is frequently over-expressed in apocrine and adenoid cystic carcinomas of the breast. These results indicate a potential for a novel targeted treatment in these cancers.

## INTRODUCTION

Oestrogen receptor alpha (ER- $\alpha$ ) expression in breast cancer is the most important predictor of antioestrogen therapy.<sup>1</sup> Approximately 75% of all breast carcinomas are ER- $\alpha$  positive, which is a good predictor of the treatment response.<sup>2–4</sup> Current immunohistochemical methods use antibodies against the full-length receptor protein (ER- $\alpha$ 66, see figure 1), but there are at least three different isoforms of ER- $\alpha$ 66 described in humans. Two isoforms have been detected in breast cancers.<sup>5,6</sup> These are ER- $\alpha$ 46 and the novel isoform, ER- $\alpha$ 36 which we recently identified and cloned.<sup>7,8</sup> They are generated through multiple promoter usage or

alternative splicing.<sup>5</sup> Although most steroid hormone receptors primarily localise in the nuclei, additional oestrogen receptors have been reported to exist in the cytoplasm and on the plasma membrane.<sup>3</sup>

The novel 36 kDa isoform ER- $\alpha$ 36 lacks the transcriptional activation domains found in ER- $\alpha$ 66. The DNA-binding domain, dimerisation, partial ligand-binding domains as well as three myristoylation sites near the N-terminus are retained in ER- $\alpha$ 36.<sup>7,8</sup> While ER- $\alpha$ 66 is predominantly detected in the cell nucleus, ER- $\alpha$ 36 mainly localises to the cytoplasm and on the plasma membrane.<sup>7,8</sup> ER- $\alpha$ 36 has been shown to transduce the membrane-initiated steroid signalling (MISS) cascade, and function as a dominant-negative effector of oestrogen-dependent and independent transactivation mediated by ER- $\alpha$ 66.<sup>7</sup> We have recently demonstrated the expression of ER- $\alpha$ 36 in both ER- $\alpha$ 66 positive (MCF-7) and negative breast cancer cell lines (MDA-MB-231), as well as in a proportion of invasive breast carcinomas of no special type.<sup>8,9</sup>

In this study, we focused on adenoid cystic carcinoma (ACC) and pure apocrine carcinomas (PAC), two special types of breast carcinomas that are characteristically negative for ER- $\alpha$ 66,<sup>10–12</sup> and showed that the majority of them express ER- $\alpha$ 36 protein.

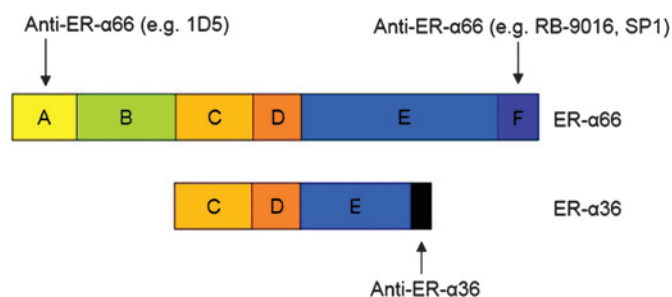
## MATERIALS AND METHODS

### Breast tissue samples

Formalin-fixed, paraffin-embedded tissues (11 adenoid cystic carcinomas and 19 apocrine carcinomas) were selected from the files of the Departments of Pathology at Creighton University Medical Center (Omaha, Nebraska, USA), the Institute of Oncology Ljubljana (Slovenia), Thomas Jefferson University Hospital (Philadelphia, Pennsylvania, USA) and Kansas University Medical Center (Kansas City, Kansas, USA), after the approval of the Institutional Review Board of Creighton University School of Medicine. None of the 30 patients included in this study had received neoadjuvant therapy.

### Immunohistochemistry

Immunohistochemical assays for ER- $\alpha$ 66 (clone 6F11, Ventana Medical Systems, Tucson, Arizona, USA), progesterone receptor (PR; clone 16, Ventana Medical Systems), androgen receptor (AR; clone AR441, DakoCytomation, Carpinteria, California, USA), epidermal growth factor receptor (EGFR;



**Figure 1** Domain structures of oestrogen receptor (ER)- $\alpha$ 66 and ER- $\alpha$ 36. Arrows indicate the specific antibodies and their corresponding epitopes.

(DAKO EGFR PharmDX diagnostic kit; DakoCytomation) and Her-2/neu (Clone CB11, Ventana Medical Systems) expression were previously performed as a part of clinical evaluation. The expression of ER- $\alpha$ 66, PR and AR (the percentage of cells with the nuclear staining), and EGFR and Her-2/neu (the extent and the intensity of the membranous staining) were measured on an automated cellular imaging system (ACIS, ChromaVision Medical Systems, San Juan Capistrano, California, USA). The results of ER- $\alpha$ 66, PR, AR, EGFR and Her-2/neu expression for both cohorts have recently been reported.<sup>11 12</sup>

Antibody used for the detection of ER- $\alpha$ 36 was custom-made by Alpha Diagnostic International (San Antonio, Texas, USA); it was raised against the 20 unique amino acids at the C-terminal of ER- $\alpha$ 36.<sup>8 9</sup> Immunohistochemical staining with this ER- $\alpha$ 36 specific antibody was performed using the rabbit ImmunoCruz Staining System (Santa Cruz, sc-2051, California, USA) according to the manufacturer's instructions. Briefly, slides with 5  $\mu$ m thick formalin-fixed paraffin-embedded tissue sections were deparaffinised and hydrated in sequential treatment of xylene, ethanol and water. Citrate buffer (0.01 M citric acid, pH 8.0) was used to retrieve epitopes in a pressure cooker. Endogenous peroxidase activity was quenched with 3% H<sub>2</sub>O<sub>2</sub> before anti-ER- $\alpha$ 36 (at 1:100 dilution) antibody was applied. Biotinylated secondary antibody and streptavidin-horseradish peroxidase were added subsequently, and 3,3'-diaminobenzidine tetrahydrochloride was used as substrate for chromogenic visualisation before counterstaining with haematoxylin. The extent and cellular distribution of staining was evaluated by two investigators on a double-headed microscope. The subcellular localisation and percentage of positive cells was recorded.

For ER- $\alpha$ 36 expression, only the membranous/cytoplasmic pattern of staining was considered specific.<sup>8 9</sup> Weak (1+) intensity was defined as faint and incomplete membrane positivity. Moderate (2+) intensity and strong (3+) staining were both varying degrees of circumferential staining of membranes and the cytoplasm. The tumour was considered positive if a proportion of stained cells exceeded 1% at any intensity.<sup>9</sup>

### Statistical analysis

To access the differences between proportions, two-sided Fisher's exact tests were used;  $\alpha$  was set at a level of 0.05. The kappa statistic was applied to determine the consistency among the tests and 95% CIs are given around the estimates. Statistical analyses were carried out using SPSS V.17.0.

## RESULTS

### Patient characteristics

The mean age was 62 years (range 53–71 years) for patients diagnosed with ACC and 74 years for PAC (range 63–90 years).

### Special breast cancer subtype characterisation

All PACs (including two in-situ carcinomas) were characteristically ER- $\alpha$ 66 negative, PR negative and AR positive.<sup>11</sup> Her-2/neu over-expression (3+) was observed in 10/19 cases (52.6%, 95% CI 31.53 to 72.80); EGFR expression was observed in 17/19 (89.5%, 95% CI 68.30 to 96.79). Of the two apocrine carcinomas in-situ, one over-expressed Her-2/neu (score 3+) and the other was positive for EGFR (score 3+).

All ACC samples exhibited a characteristic triple-negative breast cancer profile (ER- $\alpha$ 66 negative, PR negative, Her-2/neu negative). EGFR was detected in 7/11 (63.6%, 95% CI 34.89 to 84.83) ACCs, as reported recently.<sup>12</sup>

Table 1 summarises the immunohistochemical characteristics of these two cancer types.

### ER- $\alpha$ 36 protein expression in PAC and ACC

ER- $\alpha$ 36 protein was detected in 18/19 PACs (94.7%, 95% CI 75.13 to 98.77) and in 8/11 cases of ACC (72.7%, 95% CI 42.81 to 90.08). Moderate to strong membranous and cytoplasmic expression (figure 2C,D) was seen in both cancer types. The average percentage of ER- $\alpha$ 36 positive cells was 100% for PAC and 76.2% for ACC. Nuclear staining was absent in all but one case of PAC, which exhibited both nuclear and cytoplasmic/membrane distribution of the ER- $\alpha$ 36.

We also analysed our cases for the co-expression of ER- $\alpha$ 36 with EGFR and Her-2/neu proteins because of reported interactions between membrane steroid receptors and growth factors with tyrosine kinase activity.<sup>13</sup> Co-expression of ER- $\alpha$ 36 and EGFR was observed in 16 cases of PAC and 7 cases of ACC. Although co-expression of ER- $\alpha$ 36 and EGFR in both types of breast carcinomas was statistically significant ( $p=0.018$ ), the measure of agreement was only marginally convincing ( $\kappa=0.52$ , 95% CI 0.12 to 0.93) (table 2). Co-expression of ER- $\alpha$ 36 and Her-2/neu however was not found to have a significant relationship ( $p=1.00$ ).

Adjacent normal breast tissue (ductal epithelium) was negative or showed reduced expression of ER- $\alpha$ 36 in comparison to expression in the malignant epithelium.

## DISCUSSION

ER- $\alpha$ 66 expression is routinely evaluated by immunohistochemistry in all breast cancers since it has been shown to play a pivotal role<sup>2–4</sup> in patient treatment and outcome. Approximately 75% of all breast carcinomas are regarded as ER- $\alpha$ 66 positive, and are thus amenable to targeted therapy with antioestrogens.<sup>2–4</sup>

The ER- $\alpha$  gene (*ESR1*) is composed of six functional domains encoded by eight exons that commonly produce a 66.2 kDa protein (ER- $\alpha$ 66).<sup>5</sup> Numerous ER- $\alpha$  mRNA transcript isoforms of

**Table 1** Immunohistochemical characteristics of 30 breast samples

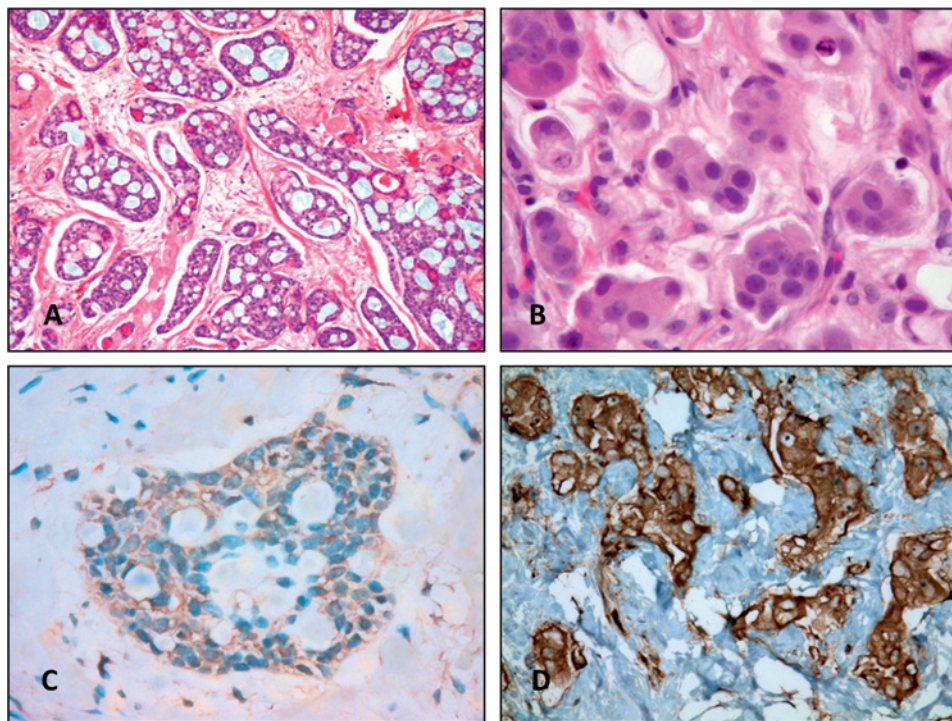
Tumour type	ER- $\alpha$ 66 [95% CI]	PR [95% CI]	Her-2/neu* [95% CI]	EGFR† [95% CI]	ER- $\alpha$ 36 [95% CI]
PAC	0/19 (0%) [0.13 to 16.84]	0/19 (0%) [0.13 to 16.84]	10/19 (52.6%) [31.53 to 72.80]	17/19 (89.5%) [68.30 to 96.79]	18/19 (94.7%) [75.13 to 98.77]
ACC	0/11 (0%) [0.21 to 26.46]	0/11 (0%) [0.21 to 26.46]	0/11 (0%) [0.21 to 26.46]	7/11 (63.6%) [34.89 to 84.83]	8/11 (72.7%) [42.81 to 90.08]

\*Her-2/neu protein positivity defined as 3+ score by immunohistochemistry.

†EGFR protein positivity defined as a membranous staining if a proportion of stained cells exceeded 1% at any intensity.

ER, oestrogen receptor; PR, progesterone receptor; EGFR, epidermal growth factor receptor; PAC, pure apocrine carcinoma; ACC, adenoid cystic carcinoma.

**Figure 2** Representative H&E slides of: (A) a case of adenoid cystic carcinoma of the breast; (B) a pure apocrine carcinoma of the breast; (C) immunohistochemical staining of the tissue samples for ER- $\alpha$ 36, demonstrating strong membrane and cytoplasmic staining in an adenoid cystic carcinoma; (D) a pure apocrine carcinoma of the breast.



the gene have been described,<sup>6</sup> and are generated through alternative splicing or promoter usage.<sup>5</sup> Several isoforms of the ER- $\alpha$  protein have been isolated in humans, including ER- $\alpha$ 36, recently identified and cloned by our group.<sup>7–9</sup> This novel ER- $\alpha$  isoform is a product of a transcript initiated from a previously unidentified promoter in the first intron of the *ER- $\alpha$ 66* gene and is identical to the ER- $\alpha$ 66 encoded by exons 2–6 of the *ER- $\alpha$ 66* gene, resulting in a smaller, 36 kDa protein (ER- $\alpha$ 36).<sup>7, 8</sup> In the experimental cell models of breast cancer, it served as a membrane-based oestrogen receptor mediating MISS and as a dominant-negative modulator of ER- $\alpha$ 66 mediated transcription activity.<sup>7</sup> We have previously reported that ER- $\alpha$ 36 is frequently detected in invasive breast carcinomas of no special type,<sup>9</sup> and that it may also play a role in prognosis.<sup>14</sup>

Our current study showed that ER- $\alpha$ 36 was also frequently expressed in pure apocrine carcinoma and adenoid cystic carcinomas, which are characteristically negative for the full length ER- $\alpha$ 66.<sup>10–12</sup>

ER- $\alpha$ 36 was over-expressed in the neoplastic cells in comparison to adjacent normal ductal epithelia, emphasising its role in tumour progression. It was almost exclusively expressed on the plasma membrane and in the cytoplasm; nuclear staining was observed in only one case of PAC. These results are in accordance with our recently published experimental and clinical investigations in the breast cancer cell lines and human breast cancers, where ER- $\alpha$ 36 expression was localised primarily to the plasma membrane (50%) and the cytoplasm (40%), with little or no nuclear staining (up to 10%).<sup>7–9</sup> Subcellular localisation of ER- $\alpha$ 36 is in sharp contrast to the nuclear localisation of the full-length ER- $\alpha$ 66. Nuclear expression of ER- $\alpha$ 66 is considered a diagnostic hallmark for 'ER-positive' tumours, although functionally active extranuclear pools of ER- $\alpha$ 66 exist.<sup>4, 15</sup> Cytoplasmic ER- $\alpha$ 66 expression can be observed in breast cancer cells after long-term treatment with tamoxifen, coinciding with resistance to the drug.<sup>16</sup> Shi *et al* indicated the importance of ER- $\alpha$ 36 in development of endocrine resistance in a subgroup of invasive breast carcinomas that exhibit co-expression of ER- $\alpha$ 66 and ER- $\alpha$ 36.<sup>14</sup>

Identification of the ER- $\alpha$ 36 isoform in PAC explains reported discrepancies between mRNA detection and negative ER protein expression. Bratthauer *et al* reported that ER mRNA was detectable in all cases of apocrine carcinomas despite a complete absence of ER protein using the commercially available immunohistochemical assay against ER- $\alpha$ 66.<sup>17</sup> The authors used RT-PCR amplification of ER mRNA using primers that covered the first and second exon of the *ER- $\alpha$ 66* messenger RNA, and concluded that the immunohistochemical absence of ER was not a consequence of an abnormal transcript but did not elaborate. We hypothesise that detectable mRNA in apocrine carcinomas might well be one of the alternatively spliced isoforms of ER- $\alpha$  including currently studied ER- $\alpha$ 36. ER- $\alpha$ 36 protein could not have been detected due to the lack of antibody specificity; the ER- $\alpha$ 66 antibody used in their study (clone CC4-5, Novocastra Laboratories) recognises the N-terminal of the ER- $\alpha$ 66 which is not shared between the full-length and ER- $\alpha$ 36 isoform (see figure 1).<sup>18</sup> Other commonly used commercial antibodies (eg, 1D5, SP1, RB-9016) recognise the epitopes located on either the N- or C-terminal of the ER- $\alpha$  gene which are not represented in either ER- $\alpha$ 36 or ER- $\alpha$ 46 isoforms.<sup>5</sup>

Functional importance of ER- $\alpha$ 36 is reportedly related to the non-genomic (non-classic) ER activities, among which activation of the mitogen-activated protein kinase (MAPK/ERK) signalling pathway plays a major role.<sup>8</sup> The MAPK/ERK signalling pathway is activated in response to both oestrogens

**Table 2** Relationship between oestrogen receptor (ER)- $\alpha$ 36 and epidermal growth factor receptor (EGFR) expression

Variable		EGFR		Total
		Negative	Positive	
ER- $\alpha$ 36	Negative	3	1	4
	Positive	3	23	26
Total		6	24	30

$p=0.018$ ,  $\kappa=0.52$  (95% CI 0.12 to 0.93).

## Take-home messages

- ▶ Adenoid cystic carcinoma and pure apocrine carcinoma are two rare, special types of breast cancer characteristically negative for oestrogen receptor- $\alpha$ 66 (ER- $\alpha$ 66).
- ▶ The novel 36 kDa isoform of ER- $\alpha$ 66 (ER- $\alpha$ 36) lacks the transcriptional activation domains of ER- $\alpha$ 66 and predominantly localises to the cytoplasm and on the cell membrane. It mediates non-classic (non-genomic) oestrogen signalling.
- ▶ ER- $\alpha$ 36 is commonly over-expressed in adenoid cystic carcinoma and pure apocrine carcinoma of the breast, which may indicate a potential for novel treatment strategies in these cancers.

(eg, 17 $\beta$ -oestradiol) and antioestrogens (eg, tamoxifen) which might be of particular importance for ER- $\alpha$ 66 negative breast carcinomas since this subgroup might still respond to anti-oestrogen based therapy.<sup>8</sup> Previous experiments demonstrated that the antioestrogens induce a stronger and a more prolonged activation of the MAPK/ERK signalling pathway than the oestrogens.<sup>8</sup>

Our study also revealed a significant relationship between ER- $\alpha$ 36 and EGFR expression, indicating a close interaction of the two membrane-initiated signalling.<sup>13,19</sup> Although Her-2/neu can also be actively involved in membrane-initiated steroid signalling, we could not identify a significant correlation between ER- $\alpha$ 36 and Her-2/neu in our study.

In summary, membranous ER- $\alpha$ 36 is over-expressed in breast tumours showing a complete absence of the full-length ER- $\alpha$ 66 protein, indicating a potential for targeting the non-genomic growth signalling.

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**Competing interests** None declared.

**Ethics approval** This study was conducted with the approval of the Institutional Review Board of Creighton University School of Medicine.

**Provenance and peer review** Not commissioned; externally peer reviewed.

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