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Therapeutic Antibody Targeting of CD47Eliminates
Human Acute Lymphoblastic Leukemia

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Abstract

Acute lymphoblastic leukemia (ALL) is the most common pediatric malignancy and constitutes 15% of adult leukemias. Although overall prognosis for pediatric ALL is favorable, high-risk pediatric patients and most adult patients have significantly worse outcomes. Multiagent chemotherapy is standard of care for both pediatric and adult ALL, but is associated with systemic toxicity and long-term side effects and is relatively ineffective against certain ALL subtypes. Recent efforts have focused on the development of targeted therapies for ALL including monoclonal antibodies. Here, we report the identification of CD47, a protein that inhibits phagocytosis, as an antibody target in standard and high-risk ALL. CD47 was found to be more highly expressed on a subset of human ALL patient samples compared with normal cell counterparts and to be an independent predictor of survival and disease refractoriness in several ALL patient cohorts. In addition, a blocking monoclonal antibody against CD47 enabled phagocytosis of ALL cells by macrophages in vitro and inhibited tumor engraftment in vivo. Significantly, anti-CD47 antibody eliminated ALL in the peripheral blood, bone marrow, spleen, and liver of mice engrafted with primary human ALL. These data provide preclinical support for the development of an anti-CD47 antibody therapy for treatment of human ALL. Cancer Res; 71(4); 1374-84. ©2010 AACR.

Introduction

Acute lymphoblastic leukemia (ALL), a clonal malignancy of lymphocyte precursors, is the most common malignancy in children, comprising nearly one third of all pediatric cancers and 15% of all de novo leukemias. More than 80% of children diagnosed with ALL can achieve cure with multiagent treatment regimens (1). In contrast, the prognosis for adults is significantly worse, with a 5-year event-free survival (EFS) around 40% (1). Within both pediatric and adult ALL, subsets of patients have significantly worse outcomes with stratification into high-risk categories based upon several criteria including age, initial white blood cell count, presence of extramedullary disease at diagnosis, minimal residual disease, cytogenetic and karyotype analysis, and others (2, 3). In terms of cytogenetic risk, the presence of BCR-ABL (Ph+) or mixed lineage leukemia (MLL) rearrangements are associated with an unfavorable prognosis, whereas the TEL-AML1 rearrangement or trisomy of chromosomes 4, 10, or 17 are more favorable (3). In pediatric cases, high-risk patients have relatively poor prognoses with an estimated 4-year EFS of 46% compared with 91% for standard risk patients (3).

Although multiagent chemotherapy is mainstay treatment, monoclonal antibodies have emerged as an attractive therapeutic modality due to the ability to selectively target leukemia cells, thereby minimizing systemic toxicity. Indeed, several monoclonal antibodies are currently in clinical trials for the treatment of ALL (reviewed in ref. 4).

In our previous investigation, we identified CD47 as a therapeutic antibody target in acute myeloid leukemia (AML; ref. 5) and hypothesized that a monoclonal antibody against CD47 could be similarly effective in ALL. As one of several functions, CD47 serves as an inhibitor of phagocytosis against CD47 could be similarly effective in ALL. Because of its ligand, signal regulatory protein α (SIRPα), on phagocytes (6–10). Whereas this function is partly attributed to self-recognition in normal physiologic conditions, many cancers appear to upregulate CD47 as a mechanism of immune evasion (5, 11–13). We have recently demonstrated that this mechanism could be therapeutically targeted in human cancers by a monoclonal blocking anti-CD47 antibody that could eliminate human AML, non-Hodgkin’s lymphoma (NHL), and bladder cancer (5, 12, 13). In the current study, we investigated whether a blocking monoclonal antibody against CD47 could eliminate primary human ALL in vitro and in vivo, to determine the preclinical feasibility of an anti-CD47 antibody therapy in standard and high-risk ALL.
Materials and Methods

Human samples and cell lines

Human normal bone marrow (NBM) cells were purchased from AllCells Inc. Human ALL samples were obtained from patients at the Stanford University Medical Center, with informed consent, according to an IRB (institutional review board)-approved protocol (Stanford IRB 11177). The human T-ALL cell line, CCRF-CEM, was obtained from the American Type Culture Collection (ATCC) on May 2010 from stock frozen in 2007, characterized by morphology and growth curve analysis by ATCC.

Flow cytometry analysis

The following antibodies were used for the analysis of ALL and NBM cells: CD3 APC-Cy7 and CD19 APC (BD Biosciences). CD47 expression was performed with an antihuman CD47 FITC (fluorescein isothiocyanate) antibody (clone B6H12.2, BD Biosciences). For human engraftment analysis in mice, antibodies were used as described previously (5).

ALL microarray gene expression data and statistical analysis

We used previously described methods for statistical analyses of CD47 gene expression data and its relationship to clinical variables (5). A detailed description is presented in the Supplementary Methods.

Therapeutic antibodies

Antihuman CD47 antibodies, anti-SIRPα antibody, IgG control, and anti-CD45 antibodies were used as previously described (5). The anti-CD47 antibody clone BRIC126 was obtained from AbD Serotec.

Generation of mouse and human macrophages

Isolation of mouse and human macrophages were performed as previously described (5).

In vitro phagocytosis assays

Phagocytosis assays were performed as described (5). Briefly, bulk ALL cells were CFSE (carboxyfluorescein succinimidyl ester) labeled and incubated with either mouse or human macrophages in the presence of 10^6:5:1 (2 × 10^5:5 × 10^5).

Ex vivo antibody coating of ALL cells

Human ALL cells were incubated with 30 μg/mL of IgG1 isotype control, anti-CD45, or anti-CD47 antibody for 30 minutes at 4°C. Cells were washed and then 1 × 10^8 to 4 × 10^8 cells were transplanted into sublethally irradiated NOD.Cg-PrkdcscidIl2rgtm1Wjl/SzJ (NSG) adults or pups and analyzed for ALL engraftment in the peripheral blood (PB) and BM 6 to 10 weeks later. Antibody coating of ALL cells was confirmed by flow cytometry with a secondary antibody prior to transplantation into mice. Sublethal irradiation was given at 230 rads and 100 rads for NSG adults and pups, respectively.

In vivo treatment of human ALL-engrafted mice

A total of 1 × 10^6 to 4 × 10^6 bulk human ALL cells were transplanted intravenously into a sublethally irradiated adult NSG mice or into the facial vein of 2- to 4-day-old sublethally irradiated NSG pups. Six weeks later, PB and BM ALL engraftment (B-ALL: hCD45^-CD19^+; T-ALL: hCD45^-CD3^+) was assessed by tail bleed and aspiration of the femur, respectively. Engrafted mice were treated for 14 days with daily 100 μg intraperitoneal injections of either IgG control or anti-CD47 antibody (clone B6H12.2). On day 15, mice were sacrificed and analyzed for ALL engraftment in the PB, BM, spleen, and liver. For treatment of CCRF-CEM-engrafted mice, daily 200 μg injections of either IgG or anti-CD47 antibody was administered for 12 days unless otherwise indicated.

Bone marrow tissue section preparation and staining

Mouse tibias from antibody-treated NSG mice were harvested and preserved in formalin. Hematoxylin and eosin (H&E) staining and immunohistochemistry of human CD45^- cells were performed by Comparative Biosciences Inc.

Generation of a luciferase-positive CCRF-CEM cell line and in vivo imaging

CCRF-CEM cells were transduced with lentivirus encoding the dual reporter gene L2G (Luc-2A-eGFP) as previously described (13). Adult NSG mice were transplanted intravenously into the tail vein with 2 × 10^6 luciferase-labeled CCRF-CEM cells. Posttransplant day 5, mice were treated with daily injections of IgG or anti-CD47 antibody for the indicated times. Bioluminescent imaging was performed as previously described (13).

Secondary transplants of AML-engrafted mice

Human ALL-engrafted mice were treated with daily 200 μg intraperitoneal injections of anti-CD47 antibody or IgG control for 14 days. A total of 2 × 10^6 bulk BM cells from anti-CD47 antibody or IgG-treated mice posttreatment were transplanted into sublethally irradiated NSG adults. AML engraftment of secondary transplants was assessed 6 weeks later by analysis of human CD45^- chimerism in the BM by flow cytometry.

Results

CD47 expression is increased on a subset of human ALL cells compared with normal bone marrow

We first investigated CD47 cell surface expression on primary human ALL and normal BM cells by flow cytometry. We surveyed 17 diverse patients with ALL that included both precursor B- and T-lineage subtypes (Fig. 1A, Supplementary Table S1). Compared with normal mononuclear BM cells, CD47 was more highly expressed on human ALL samples, approximately 2-fold when considering all samples, with similar expression between B and T subtypes (Fig. 1A and B). However, assessing CD47 mRNA expression in a previously described large cohort of ALL patients (14), we found that T-ALL patients expressed significantly higher levels compared with B-ALL patients (Fig. 1B).
CD47 expression is an independent prognostic predictor in mixed and high-risk ALL

Because CD47 expression was increased on ALL samples, with observed heterogeneity in CD47 expression across ALL subtypes, we investigated whether the level of CD47 expression correlated with clinical prognosis. First, CD47 expression was investigated as a prognostic predictor in pediatric ALL patients with mixed risk and treatment utilization gene expression data from a previously described patient cohort (15). This diverse risk cohort included patients with BCR-ABL rearrangements, MLL rearrangements, hyperdiploidy, hypodiploidy, as well as both B- and T-ALL subtypes. Three hundred sixty patients were stratified into high and low CD47-expressing groups based on an optimal cutoff point (see the Materials and Methods section) and clinical outcomes were determined. Among the subset of this cohort with available outcome data (n = 205; ref. 16), patients expressing higher levels of CD47 had worse outcomes, whether CD47 expression was tested as a continuous variable (P = 0.03; HR = 1.78 per 2-fold change in CD47 expression; 95% CI = 1.05–3.03), or as a dichotomous variable relative to an internally validated optimal threshold [uncorrected P = 0.0005, corrected P = 0.01 (ref. 17); HR = 3.05; 95% CI = 1.49-6.26; Fig. 2A and Supplementary Table S2A].

We next investigated the prognostic power of CD47 expression in high-risk ALL patients, specifically in a cohort of 207 patients, uniformly treated, with high risk defined by age older than 10 years, presenting WBC count greater than 50,000/μL, and central nervous system (CNS) or testicular involvement (18). Higher CD47 expression correlated with a worse overall survival when considered as either a continuous variable (P = 0.0009, HR = 3.59 per 2-fold change in CD47 expression; 95% CI = 1.70–7.61) or a dichotomous variable relative to an internally validated optimal threshold (uncorrected P = 0.001, corrected P = 0.01; HR = 2.80; 95% CI = 1.21–6.50; Fig. 2B and Supplementary Table S2B). In multivariate analysis, CD47 expression remained a significant prognostic factor when age at diagnosis, gender, WBC count, CNS involvement, and minimal residual disease were considered as covariates (Supplementary Table S3).

Finally, we utilized a third independent gene expression data set to investigate whether CD47 expression could predict refractoriness to primary treatment (14). Indeed, CD47 expression was higher in uniformly treated patients failing to achieve a complete remission (CR) compared with those that did (Fig. 2C). Taken together, these observations among distinct and diverse cohorts establish that higher expression of CD47 is an independent predictor of adverse outcomes in pediatric patients with standard- and high-risk ALL, including induction failure, refractory disease, and death.

Blocking monoclonal antibodies against CD47 enable phagocytosis of ALL cells

Next, we investigated whether ALL cells could be eliminated by macrophage phagocytosis enabled through blockade of the CD47–SIRPα interaction. We incubated human

Figure 1. CD47 expression is increased on a subset of human ALL cells compared with normal BM. A, relative CD47 protein expression was determined on normal human BM cells and human ALL cells (Supplementary Table S1) by flow cytometry. CD47 expression was increased on bulk ALL cells compared with normal BM cells (P = 0.006). Within all samples, normalized mean expression (and range) was determined as follows: NBM 575.3 (486.6–680.9), bulk ALL 1,020.2 (501.3–1,794.5), B-ALL 980.5 (501.3–1,628.4), and T-ALL 1,034.9 (626.2–1,794.5). Differences between mean expression of NBM and T-ALL (P = 0.03), NBM and B-ALL (P = 0.006) were statistically significant. B, relative CD47 mRNA expression was determined in a large cohort of ALL patients (n = 254) from ref. 14 and subdivided into B or T-ALL subtypes. Using 3 different probe sets, CD47 expression was higher in T-ALL patients compared with B-ALL patients (P < 0.0001 for all 3 probe sets).
macrophages with fluorescently labeled ALL cells in the presence of an IgG1 isotype control, anti-CD45 isotype-matched, or blocking anti-CD47 antibody and measured phagocytosis by fluorescence microscopy (Fig. 3A). Two different blocking anti-CD47 antibodies (B6H12.2 and BRIC126) enabled phagocytosis of ALL cells compared with IgG1 isotype and anti-CD45 antibody controls as measured by phagocytic index (Fig. 3B). Notably, anti-CD47 antibodies enabled phagocytosis of all ALL subtypes profiled, including those with high-risk cytogenetic abnormalities (Ph\(^+\) ALL and MLL\(^+\) ALL). Because several studies report that CD47–SIRP\(\alpha\) signaling may be species specific (19, 20), the ability of anti-CD47 antibody–coated human cells to be phagocytosed by mouse macrophages was determined before proceeding with in vivo antibody treatment experiments in mouse xenotransplants. Similarly, 2 blocking anti-CD47 antibodies (B6H12.2 and BRIC126) enabled increased phagocytosis of ALL cells by mouse macrophage effectors compared with IgG1 isotype and anti-CD45 antibody controls (Fig. 3C). In contrast, no phagocytosis was observed with a nonblocking anti-CD47 antibody (2D3). Finally, blockade of SIRP\(\alpha\) with an antimouse SIRP\(\alpha\) antibody also resulted in increased phagocytosis, thus supporting the proposed mechanism of increased phagocytosis resulting from disruption of the CD47–SIRP\(\alpha\) interaction (Fig. 3C).

**Ex vivo coating of ALL cells with an anti-CD47 antibody inhibits leukemic engraftment**

The ability of a blocking anti-CD47 antibody to eliminate ALL in vivo was investigated by 2 independent methods. First, the anti-CD47 antibody was assessed for inhibition of both B- and T-ALL engraftment using an antibody precoating assay. ALL cells were coated ex vivo with IgG1 isotype control, anti-CD45, or anti-CD47 antibody (B6H12.2), transplanted into sublethally irradiated immunodeficient NOD/SCID/IL2R\(\gamma\) null (NSG) mice, and measured for ALL engraftment in the PB and BM 6 weeks later. Prior to transplantation, coating of ALL cells with antibody was verified by flow cytometry (Fig. 4A). Anti-CD47 antibody significantly inhibited leukemic engraftment of both B- and T-ALL cells in the PB (Fig. 4B) and BM (Fig. 4C) compared with IgG1 isotype or anti-CD45 antibody controls. Interestingly, precoating of T-ALL cells (but not B-ALL cells)

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**Figure 2.** CD47 expression is an independent prognostic predictor in mixed and high-risk ALL. A, pediatric ALL patients (n = 360) with mixed risk and treatment (15) were stratified into CD47 high- and low-expressing groups based on an optimal cutoff point. Disease-free survival (DFS) was determined by Kaplan–Meier analysis (see Supplementary Table S2A). B, pediatric ALL patients (n = 207) with high-risk (defined by age > 10 years, presenting WBC count > 50,000/\(\mu\)L, hypodiploidy, and BCR-ABL–positive disease) and uniform treatment (18) were stratified into CD47 high- and low-expressing groups using a similar approach as in A (see Supplementary Table S2B). C, CD47 expression was analyzed on ALL patients from a third cohort (14), stratified into groups either achieving a CR or no CR.
with anti-CD45 antibody reduced tumor engraftment. Anti-CD45–mediated inhibition of T-ALL engraftment was unlikely due to antibody opsonization, given that B-ALL cells coated with anti-CD45 antibody engrafted similarly to uncoated cells incubated with IgG1 isotype control antibody. Rather the effect observed in T-ALL may be due to the modulation of CD45-dependent functions important to engraftment for T-ALL but not B-ALL. Regardless, precoating with the anti-CD47 antibody nearly completely eliminated ALL engraftment in vivo.

**Anti-CD47 antibody eliminates ALL engraftment in the peripheral blood and bone marrow**

In the second method of investigating anti-CD47 antibody efficacy in vivo, mice were first engrafted with ALL cells and then treated with antibody. B- or T-ALL cells were transplanted into NSG mice with leukemia disease analyzed in the PB or BM 6 weeks later. Mice with significant levels of ALL engraftment (>10% leukemia in the PB and/or BM; range = 10%–98%; data not shown) were then selected for in vivo antibody therapy (Fig. 5A). ALL-engrafted mice were treated with daily intraperitoneal injections of 100 μg IgG control or anti-CD47 antibody (B6H12.2) for 14 days as determined by our prior in vivo studies in AML and NHL (5, 13). Compared with IgG, anti-CD47 antibody therapy reduced the level of circulating leukemia, and in many cases eliminated B- or T-ALL from the blood (Fig. 5A and B) or BM (Fig. 5C). BM histology of antibody-treated mice revealed infiltration of monomorphic leukemic blasts in control IgG-treated mice (Fig. 5D). ALL-engrafted mice treated with anti-CD47 antibody exhibited normal mouse hematopoietic cells with cleared hypocellular areas in the BM (Fig. 5D). Immunohistochemistry of mouse marrows confirmed near complete invasion of human CD45-positive leukemic blasts in IgG-treated marrow compared with few human CD45-positive leukemia cells detected in anti-CD47 antibody–treated marrow (Fig. 5D). In some cases, anti-CD47 antibody therapy had a minimal effect on reducing leukemia in the BM (Fig. 5C, solid blue diamond symbols). We attribute this relative lack of efficacy to the extremely high levels of

Figure 3. Blocking monoclonal anti-CD47 antibodies enable phagocytosis of ALL cells by human and mouse macrophages in vitro. A, primary human ALL cells were fluorescently labeled and incubated with human macrophages in the presence of the indicated antibodies for 2 hours and then examined by fluorescence microscopy (Leica) with Image-Pro Plus software. Representative photomicrographs are shown with ALL cells (green) and arrows indicating macrophages containing phagocytosed ALL cells. B, the phagocytic index (number of target cells ingested per 100 macrophages) was determined for the indicated antibodies. The anti-CD47 antibodies B6H12.2 and BRIC126 enabled significant levels of phagocytosis compared with IgG1 isotype or anti-CD45 antibody controls (P < 0.0001). C, the in vitro phagocytosis assay was conducted using mouse macrophages as effector cells. Compared with IgG1 isotype and anti-CD45 antibody controls, the blocking anti-CD47 antibodies B6H12.2 and BRIC126 (P < 0.0001) and antimouse SIRPα antibody (P = 0.002) enabled phagocytosis of ALL cells. In contrast, the nonblocking anti-CD47 antibody 2D3 did not enable phagocytosis compared with IgG1 isotype (P = 0.17). Each data point represents an ALL patient sample as labeled in Figure 1C. Statistical comparisons were conducted with a 2-sided Student’s t test.
leukemic engraftment in the BM of these mice, where it is likely that an insufficient number of host macrophages were present to mediate phagocytic elimination of leukemic cells. Indeed, a positive correlation was observed between the percentage of human ALL cells remaining after anti-CD47 antibody treatment and the level of pretreatment leukemic burden in the BM (Fig. 5E).

Anti-CD47 antibody eliminates ALL engraftment in the spleen and liver
Hepatomegaly and splenomegaly can cause clinical complications and are a common finding in ALL, being observed in up to 69% of patients at diagnosis (21, 22). Accordingly, we investigated the ability of anti-CD47 antibody to eliminate ALL engrafted in the spleen and liver. We identified 3 B-ALL patient samples (ALL8, ALL21, and ALL22) that gave rise to disease in the spleen and/or liver, with associated splenomegaly, when transplanted into NSG mice. Control IgG–treated, B-ALL–engrafted mice exhibited significant splenomegaly compared with IgG1 isotype control (P = 0.67, considering both B and T-ALL samples). Each symbol represents a different primary ALL sample, with each point representing a different mouse. P values were calculated using the Fisher’s exact test.

Anti-CD47 antibody treatment induces remissions in ALL-engrafted mice
We next investigated whether tumor elimination by anti-CD47 antibody was maintained long-term using 3 independent methods. First, B-ALL–engrafted mice with equivalent levels of leukemia were treated with antibody therapy for 2 weeks with BM analyzed for leukemic disease immediately posttreatment. Consistent with prior experiments, anti-CD47 antibody eliminated leukemic disease compared with IgG controls (Fig. 7A). Treatment was then stopped and BM was analyzed 4 weeks later to assess disease levels. Although control IgG–treated mice exhibited expansion of leukemic disease, anti-CD47 antibody–treated mice had no evidence of disease or relapse (Fig. 7A). In the second method, secondary transplants were performed by transplanting BM from previously treated mice to determine whether anti-CD47 antibody treatment could eliminate ALL tumorigenic potential. Secondary mice transplanted with control IgG–treated BM cells exhibited robust ALL engraftment in the BM whereas mice transplanted with cells from anti-CD47 antibody–treated mice had no evidence of disease or relapse (Fig. 7A). In the third method, secondary transplants were performed by transplanting BM from previously treated mice to determine whether anti-CD47 antibody treatment could eliminate ALL tumorigenic potential. Secondary mice transplanted with control IgG–treated BM cells exhibited robust ALL engraftment in the BM whereas mice transplanted with cells from anti-CD47 antibody–treated mice had no evidence of disease or relapse (Fig. 7A). Third, to investigate the long-term efficacy of anti-CD47 antibody in T-ALL, the human T-ALL cell line, CCRF-CEM, was engineered to express luciferase and transplanted into NSG mice for antibody treatment. Mice were serially monitored for luciferase-positive leukemia by bioluminescent imaging and survival during and after antibody
therapy (Fig. 7C). Anti-CD47 antibody treatment markedly reduced leukemic disease compared with control IgG treatment (Fig. 7C and D). After treatment was stopped, leukemic disease disseminated in control IgG–treated mice leading to death by 25 days posttransplant. In contrast, more than 60% of anti-CD47 antibody–treated mice exhibited long-term survival (Fig. 7E) with no evidence of relapse in surviving mice (Fig. 7D). These experiments demonstrate that anti-CD47 antibody treatment is able to induce long-term clearance of ALL in vivo.

Discussion

We report here that CD47 is expressed at high levels on a large subset of human ALL subtypes is an independent prognostic predictor in ALL for survival and disease refractoriness in both mixed and high-risk ALL patients and is a monoclonal antibody target for elimination of ALL blasts through macrophage-mediated phagocytosis. Together, these data suggest that ALL pathogenesis relies on mechanisms to evade innate immune recognition and that modulation of the innate immune recognition of leukemia cells may be a viable treatment modality.

CD47 is broadly expressed on hematopoietic cells and other normal tissues (23), which could potentially lead to toxic effects with an anti-CD47 antibody therapy. Despite this expression, we have previously demonstrated that administration of anti-CD47 antibody to normal cells including human CD34⁺ BM precursors and PB cells in vitro does not lead to phagocytic engulfment (5, 13). Also, administration of a blocking anti-mouse CD47 antibody to wild-type mice causes minimal toxicity, principally an isolated neutropenia (5). This lack of
Toxicity is likely not entirely due to CD47 expression level, as anti-CD47 antibody equally coated both normal and leukemia cells at the therapeutic dose administered. Alternatively, the phagocytosis stimulated by anti-CD47 antibody may be due to an imbalance of pro- and antiphagocytic signals on leukemic blasts with expression of an as yet uncharacterized positive stimulus for phagocytosis present on leukemia cells but not normal cells. Such candidate stimuli include phosphatidylserine (24), annexin-1 (25), and calreticulin (26) which are targets under active investigation.

Within the last several years, several cell surface proteins have been identified as therapeutic targets with monoclonal antibodies proceeding into early and late phase clinical trials. Most therapeutic antibodies in clinical development have been focused on B-ALL. One candidate is CD20, based on its expression in approximately 40% to 50% of B-ALL cases (reviewed in ref. 27). Rituximab, an anti-CD20 antibody, initially approved for treatment of B-cell lymphoma, has demonstrated a significant survival advantage when added to standard chemotherapy in some ALL clinical trials, particularly against the Burkitt's subtype (28, 29). Although effective in adult CD20⁺ B-ALL, there is a paucity of clinical data on the efficacy of rituximab in pediatric ALL. In contrast to CD20, CD22 is expressed in a larger percentage of B-ALL cases, being present on greater than 90% of B-ALL. Epratuzumab, a humanized monoclonal anti-CD22 antibody, is currently being investigated with early clinical studies in relapsed ALL showing limited effect as a single agent (30). However, anti-CD22 antibody–immunotoxin conjugates are being explored in phase I trials (31, 32), as CD22 is reported to be rapidly internalized upon antibody binding (33). In addition, antibodies and immunotoxins to other antigens including CD19 are currently being explored (ref. 34; and reviewed in ref. 35).

Perhaps the best success of targeted therapy has been observed in Ph⁺ B-ALL. Because its demonstration of efficacy in chronic myeloid leukemia, imatinib, an ABL tyrosine kinase inhibitor, has been utilized in Ph⁺ B-ALL with some success. As a single agent, imatinib can produce response rates of 20% to 30%; however, these response durations are short (36). The combination of imatinib with chemotherapy has been more promising, with 3-year overall survival rates of 55% in patients treated with imatinib + hyperCVAD compared with 15% for patients receiving hyperCVAD alone (37).

In contrast to B-ALL, there are few antibody therapies being investigated for treatment of T-ALL. The most prominent antibody for T-ALL, alemtuzumab, is targeted at CD52, which is expressed on greater than 95% of normal lymphocytes and at higher levels on T compared with B lymphoblasts (38). However, early phase clinical trials do not report a significant benefit as a single agent or in combination with chemotherapy for the treatment of relapsed T-ALL (39).

In contrast to the targeted therapies developed for B-ALL and T-ALL, our data provide a strong preclinical rationale that an anti-CD47 antibody can be effective in eliminating both B- and T-ALL as well as high-risk ALL.

Disclosure of Potential Conflicts of Interest

M.P. Chao, R. Majeti, and I.L. Weissman filed U.S. Patent Application Serial No. 12/321,215 entitled “Methods For Manipulating Phagocytosis Mediated by CD47.” Patent has been filed with Stanford University and not as a commercial entity. I.L. Weissman is co-founder of Stem Cells Inc. and Cellerant Inc. The other authors declared no potential conflicts of interest.
Figure 7. Anti-CD47 antibody treatment induces remissions in ALL-engrafted mice. A, leukemic BM chimerism is shown for mice engrafted with ALL8 either 1 day or 30 days after completion of antibody therapy. Day 1 posttreatment, leukemic disease was eliminated in anti-CD47 antibody–treated mice compared with IgG controls (P < 0.001). Thirty days posttreatment, anti-CD47 antibody–treated mice showed no evidence of relapse (P = 0.68), whereas leukemic burden increased in IgG controls (P < 0.001) in comparison with day 1 posttreatment. Each symbol represents the same mouse 1 day and 30 days posttreatment. B, leukemic engraftment is shown from secondary mouse recipients transplanted with equal numbers of BM cells from mice treated with either IgG or anti-CD47 antibody. BM cells from IgG controls engrafted robustly in secondary recipients, whereas cells from anti-CD47 antibody–treated mice did not engraft (P < 0.0001, Fisher's exact test). Each data point represents a different mouse transplanted with the indicated ALL sample. C, luciferase-expressing CCRF-CEM cells were transplanted into NSG mice and analyzed for engraftment by bioluminescent imaging on day 5 posttransplant (pretreatment) and end of treatment (day 12) with representative mice shown. D, luciferase signal was quantified across all mice (n = 5 per treatment) demonstrating reduction in luciferase-positive leukemia with anti-CD47 antibody treatment compared with IgG control (P < 0.001, 2 way ANOVA), *, three mice died in the IgG cohort on treatment day 12, with subsequent luciferase measurements obtained in the remaining mice. E, Kaplan–Meier analysis was performed with identical treatment conditions as in D (Mantel–Cox test was used to calculate HR and 95% CI). Mice sacrificed due to significant disease-related morbidities were included as disease-related deaths. N = 10 in each treatment group. Arrows represent start and stop of antibody treatment.
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