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Protein kinase C and cancer: what we know and what we do not

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Abstract

Since their discovery in the late 1970's, protein kinase C (PKC) isozymes represent one of the most extensively studied signaling kinases. PKCs signal through multiple pathways and control the expression of genes relevant for cell cycle progression, tumorigenesis and metastatic dissemination. Despite the vast amount of information concerning the mechanisms that control PKC activation and function in cellular models, the relevance of individual PKC isozymes in the progression of human cancer is still a matter of controversy. Although the expression of PKC isozymes is altered in multiple cancer types, the causal relationship between such changes and the initiation and progression of the disease remains poorly defined. Animal models developed in the last years helped to better understand the involvement of individual PKCs in various cancer types and in the context of specific oncogenic alterations. Unraveling the enormous complexity in the mechanisms by which PKC isozymes impact on tumorigenesis and metastasis is key for reassessing their potential as pharmacological targets for cancer treatment.

Keywords

Protein kinase C (PKC); mitogenesis; apoptosis; survival; tumorigenesis; metastasis; animal models

Introduction

Protein kinase C (PKC), a prototypical class of serine/threonine kinases, exemplifies specific signaling molecules that link multiple cellular processes to cancer. Originally identified as a cellular receptor for the phorbol ester tumor promoters more than 30 years ago [1–2], PKC became the subject of intense studies by academic laboratories and pharmaceutical companies (>50,000 citations in PubMed, which is even more than other ABC kinases such as PKA or PKB/Akt). Extensive work established these kinases as pleiotropic regulators of cell function, including proliferation, differentiation, survival and motility [3]. To date, it is

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clear that PKCs are associated with a number of diseases, including cancer, cardiovascular dysfunctions and metabolic disorders. The complexity in PKC signaling arises from the fact that PKC is a multifamily of structurally related kinases with diverse biological functions. Indeed, mammalian PKCs encompass 10 members that represent the products of 9 different genes located in different chromosomes. PKC isozymes have been classified into three groups: “conventional” or “classical” PKCs (cPKCs) that are composed of PKC α , two splice variants of PKC β (PKC β I and PKC β II) and PKC γ ; “novel” PKCs (nPKCs), a group that includes PKC δ , PKC ϵ , PKC η , and PKC θ ; and “atypical” PKCs (aPKCs) ζ and ι (λ). cPKCs and nPKCs are activated by diacylglycerol (DAG), a lipid second messenger transiently generated upon stimulation of membrane receptors such as tyrosine-kinase and G-protein-coupled receptors. DAG mimics the action of phorbol esters, as they bind to the C1 domains in the regulatory region. Only the cPKCs are calcium-sensitive, as they have a calcium-binding C2 domain (the C2 domain in nPKCs is calcium-insensitive). aPKCs display unique regulatory properties: they are unable to bind DAG or calcium and rather depend on protein-protein interactions and phosphorylation for their activation [3] (Fig. 1).

In the last years we have witnessed major advances in our understanding of the roles of PKCs in tumor development and progression, including in late stages of the disease and metastasis. This review summarizes the knowledge on PKC isozymes in cancer progression and highlights the most recent advances in the field, particularly using genetically modified mouse models in the context of specific oncogenic alterations.

PKC isozyme expression in cancer: chance or causality?

Expression levels of PKC isozymes change in neoplastic diseases. The overall picture is however confusing, partly due to potential issues of antibody specificity in immunohistochemical studies and lack of appropriate validation controls in many reports. The standing question is whether those changes in expression have any causal relationship with disease progression. An additional complication is that, in an era when microarray mRNA databases are routinely used, there are significant discrepancies between the available information on PKC expression at the mRNA and protein levels. This can be epitomized for PKC ϵ , an isozyme that is markedly up-regulated in most epithelial cancers at the protein level [4–7], but shows only marginal or no changes in mRNA databases (Fig. 2). Whereas high expression of PKC ϵ in tumors may involve changes at a transcriptional level, expression underestimation by databases may relate to post-translational events that ultimately modify protein stability. Modeling expression patterns from mRNA expression databases, which in most cases have not been generated from microdissected tissues, can distort the actual profile of PKC protein expression in tumors and ultimately mislead our efforts to correlate those changes with clinicopathological outcomes.

Another important issue that received little attention is the activation status of PKC isozymes in cancer. There is little experimental evidence supporting either hyperactivation or hypoactivation of PKCs in human tumors. Unlike other important kinases implicated in cancer progression, such as Erk, JNK, or Akt, phosphorylation of PKCs does not necessarily correlate with activation status. One impediment to address this important matter is the lack of reliable readouts associated with the activated status of individual PKCs, in particular

PKC isozyme-specific substrates that could be detected in human tumors. Genetically encoded reporters for PKC isozymes reliably detect enzyme activation and substrate phosphorylation in cellular models in culture [8–12]; however, we still lack tools to detect activated PKCs or their specific substrates in tumors by immunohistochemistry. The association of PKCs to membranes is a requisite for the activation of DAG/phorbol ester-regulated PKCs [3]. Whereas some exceptions have been reported, such as the activation by proteolytic cleavage [13], cPKCs and nPKCs translocate to the plasma membrane in response to stimuli such as growth factor receptor activation. Although less understood at a mechanistic level, cPKCs and nPKCs can also redistribute to a number of intracellular compartments, including the translocation to mitochondria, Golgi, endoplasmic reticulum and nuclear membrane. Constitutive association of PKCs to internal membranes has also been reported [14–17]. At present, we do not understand well the significance of such compartmentalization and whether PKCs are fully activated in discrete intracellular locations due to differential membrane compositions, DAG availability, and/or the presence of isozyme-specific protein partners that cooperate for the transition to an activated status. All these factors conspire against a full appreciation on how PKC activation contributes to disease progression.

PKC α : tumor promoter or tumor suppressor?

PKC α has been long recognized as a regulator of multiple aspects of tumor growth, including proliferation, survival, differentiation and motility. As several studies linked PKC α to enhanced proliferation and anti-apoptotic signals [18–22], there has been significant interest in this kinase as a potential target for cancer therapy. However, PKC α had limited success as a drug target for cancer. Indeed, due to its very complex and highly tissue-specific functions, PKC α acts as a tumor promoter or a tumor suppressor depending on the context. To add another level of complexity, PKC α is up-regulated in some cancers (such as bladder, endometrial, and breast cancer) and down-regulated in others (such as colorectal tumors and malignant renal cell carcinomas [23–24]). There is little information on substrates specifically phosphorylated by PKC α or genetic programs controlled by PKC α , thus rendering our comprehension of the molecular basis of this functional diversity incomplete.

Early studies in glioma cellular models established that PKC α is up-regulated relative to astrocytes. Antisense oligonucleotides against PKC α inhibit the proliferation of glioma cells [25]. Consistent with these results, overexpression of PKC α in U87 glioblastoma cells enhances proliferation. Although overexpression of PKC α did not protect U87 cells from apoptosis by etoposide, other studies documented that PKC α renders enhanced resistance to apoptosis in response to radiation and chemotherapy [18, 26–27]. In U1242 glioblastoma cells, PKC α regulates the activation of NF- κ B, which results in a pro-survival phenotype [28]. Aprinocarsen (Ly900003, ISIS 3521), an antisense oligonucleotide directed against the 3'-untranslated region of PKC α , arrests A172 glioma cells and induces p53. Aprinocarsen also impairs tumor growth in xenograft models. In combination with other chemotherapeutic agents, aprinocarsen was shown to have additive or super-additive antitumor effects [29–31]. Despite encouraging responses in early clinical trials, this anti-PKC α agent failed to make it into phase III clinical trials either alone or in combination with other agents [29].

Another PKC α inhibitor, the staurosporine analogue UCN-01 [32] proved to be a potent anti-tumor agent in preclinical models, but its effect cannot be explained simply by PKC α inhibition [33]. It is also intriguing that PKC α RNAi depletion but not PKC α inhibition impairs the growth of glioma cell lines, suggesting that the effect is independent of the catalytic phosphotransferase activity of the enzyme [34].

Another interesting link between PKC α and cancer progression has been established in breast. Ways et al. showed that ectopic overexpression PKC α in MCF-7 breast cancer cells (which express low levels of PKC α) enhances proliferative rate, confers anchorage-independent growth and tumorigenic potential in nude mice, and drastically alters cell shape by inducing loss of an epithelioid morphology. PKC α overexpressing MCF-7 cells have reduced estrogen receptor (ER) levels, suggesting that PKC α contributes to the switch from ER-positive to ER-negative status [35]. Likewise, Tonetti *et al.* found that stable overexpression of PKC α in T47-D breast cancer cells is accompanied by down-regulation of ER function [36] and confers hormone-independent tumor growth that cannot be inhibited by tamoxifen [37]. A recent study suggests that this effect may be mediated by Notch-4 [38]. Elevated PKC α expression was suggested to be a predictor of tamoxifen treatment failure, which fits with the observation that patient tumor samples with elevated PKC α levels are generally negative for estrogen receptor (ER) expression, and these patients respond less to endocrine therapy [39–40]. A recent study by Larsson and coworkers demonstrated that PKC α levels correlates with estrogen receptor (ER) and progesterone receptor negativity, proliferative activity, and tumor grade [41]. Thus, altogether it seems that PKC α is a biomarker for poor prognosis and endocrine therapy resistance in breast cancer. PKC α is also an effector of ErbB2 in breast cancer cells, and ErbB2 siRNA depletion decreases PKC α protein levels. Moreover, ErbB2 overexpression correlates with membrane-associated staining of PKC α in human breast cancer specimens, suggesting that ErbB2 drives the constitutive activation of PKC α [42]. Gö6976, a pharmacological inhibitor of cPKCs [43], abrogates ErbB2-mediated up-regulation of urokinase-type plasminogen activator (uPA) and cell invasion [44]. Whereas PKC α expression is higher in triple-negative breast cancers than to other subtypes [45], we still need to underscore meaningful associations of this PKC with genetic alterations specific for each breast cancer subtype.

In a very recent study by the Weinberg laboratory, PKC α was found to be enriched in epithelial-to-mesenchymal (EMT)-induced mammary cells [46]. Interestingly, inhibitors targeting PKC α preferentially kill mesenchymal cells relative to epithelial cell lines, and likewise, depletion of PKC α using shRNA results in a substantial loss of mesenchymal cells. A PKC α signaling network is activated preferentially in cancer stem cells by PDGF and involves the transcription factor FRA1. The activation of the PDGFR-PKC α -FRA1 pathway in breast cancer stem cells makes them particularly susceptible to pharmacological inhibition of PKC α . Whereas the relevance of this pathway has to be established in other cancer types, this study certainly shed light into the potential therapeutic value of targeting PKC α in epithelial cancers.

Despite the reported pro-tumorigenic effects of PKC α , it has been also described as a growth inhibitory kinase in several cell types. For example, activation of PKC α in non-small cell lung cancer (NSCLC) cells leads to p21^{Cip1} up-regulation, inhibition of cell growth and

senescence [47]. Not surprisingly, aprinocarsen showed no significant benefit for NSCLC patients, either alone or in combination with other chemotherapeutic agents [29].

Years ago, Black and coworkers reported that PKC α activation triggers a program of cell cycle exit-specific events in intestinal crypts through the repression of cyclin D1 translation [48–49]. This effect implicates the activation of the translational repressor 4E-BP1 through a phosphatase 2A-dependent mechanism and in a PI3K/Akt-independent manner [50]. PKC α also inhibits the Wnt/ β -catenin pathway in colon cancer cells and represses the expression of β -catenin target genes such as c-Myc [51], a mechanism that may involve receptor-related orphan receptor alpha ROR α [52]. Interestingly, a small molecule screening identified a compound (CGK062) that promotes PKC α -mediated phosphorylation of β -catenin, leading to its proteasomal degradation. This compound has anti-tumor effects in nude mice [53]. The expression of PKC α in proliferating intestinal epithelial cells is repressed both *in vitro* and *in vivo* by the SOX9 transcription factor [54]. All neoplasm arising in APC $^{-/+}$ mice, which develop multiple intestinal neoplasia, express low levels of PKC α . Remarkably, loss of PKC α directly correlates with aggressiveness of intestinal tumors. Furthermore, tumor formation and aggressiveness are enhanced in double transgenic APC $^{Min/+}$; PKC α $^{-/-}$ mice (Fig. 3A). Interestingly, spontaneous intestinal tumors develop in PKC α $^{-/-}$ mice [55–56]. PKC α also suppresses skin tumor formation induced by DMBA. However, PKC α deficiency does not alter the size or malignancy of skin tumors [57].

PKC α activation by phorbol esters contributes to cell death in androgen-dependent prostate cancer cells. Activation of PKC α in LNCaP cells leads to a rapid and reversible dephosphorylation of Akt possibly via activation of a PP2A phosphatase [58]. Stable DAG analogues with preferred selectivity for PKC α also induce apoptosis in LNCaP cells [59]. A kinase-dead PKC α mutant blocks the apoptotic response elicited by a combination of PMA treatment and radiation, and a constitutively active PKC α mutant sensitizes cells to radiation treatment. While radiation alone reduces initial LNCaP tumor growth and serum PSA levels in mice, combinatorial treatment with PMA or a specific PKC α DAG activator eliminates tumor growth and drastically reduces PSA levels [60].

A very interesting recent study by the group of Alan Fields reported that PKC α plays a key role in K-Ras-mediated lung tumorigenesis [61]. There is an evident loss of expression of PKC α in primary human NSCLC tumors. Remarkably, PKC α knockout mice display enhanced K-Ras lung tumorigenesis (Fig. 3B) and bypass oncogene-induced senescence. The tumor promoting effect caused by loss of PKC α may involve the expansion of bronchoalveolar stem cells (BASCs). Mechanistic analysis determined that loss of PKC α reduces the activation of p38 MAPK in BASCs from K-Ras tumors and augments TGF β 1 mRNA levels. Moreover, a TGF β receptor inhibitor reversed the effect of PKC α loss in K-Ras/PKC α -depleted tumors. This study reported the inhibitors of DNA binding (Id) Id1-3 as potential downstream targets of PKC α -dependent tumor suppressor activity, as also observed in other intestinal cells and fibroblasts [62–63]. Therefore, PKC α suppresses tumor initiation and progression in the K-Ras lung cancer mouse model through a p38 MAPK/TGF β signaling axis.

PKC α has been implicated in invasion and metastasis, mostly as a positive regulator [64–69]. In breast cancer cells, ErbB2-dependent activation of PKC α promotes cell invasion [42]. PKC α overexpressing MCF-7 breast cancer cells display enhanced motility, which was attributed to decreased expression of E-cadherin and β -catenin, and high expression of MMP-2/MMP-9 [70–71]. A specific PKC α peptide inhibitor significantly reduced metastasis of mouse mammary cancer cells to the lungs. Analysis of highly metastatic (4T1) and non-metastatic (JC) mouse mammary cells indicates that the basal activation of PKC α is higher in the former. Treatment with this PKC α antagonistic peptide did not affect tumor growth but blocked metastasis of 4T1 cells to the lungs. PKC α inhibition blocks metastasis by inhibiting the activation of MMPs in combination with decreased NF- κ B activity and CXCL12 receptor levels [72].

PKC β isozymes: spliced variants with distinct involvement in cancer

PKC β I and PKC β II, spliced variants encoded by the *PRKCB* gene have differential tissue expression and a distinct involvement in cancer. PKC β isoforms have been implicated in the progression of many cancer types, including lymphoma, glioblastoma, breast, prostate, and colorectal cancers [73–77]. It is not fully understood why PKC β isoforms have in some cases different functions. This may relate to unique lipid- and protein-interactions via their different C-terminal domains that confer distinctive localization properties [78–80]. However, many studies using pharmacological agents do not distinguish between PKC β subtypes.

Early studies reported elevated PKC β II levels both during the initial stages of tumorigenesis and in colonic carcinomas relative to normal colonic tissue [81–83]. Spindler *et al.* reported that 18% of primary adenocarcinomas exhibit very high levels of PKC β II, which correlates with poor survival rates [84]. PKC β II has been implicated in colon cancer cell proliferation *in vitro* [85–86]. Murray *et al.* generated a transgenic mouse model overexpressing PKC β II in the intestinal epithelium. In addition to epithelial hyperproliferation, these mice display increased susceptibility to carcinogen-induced preneoplastic lesions in the colon [87]. The phenotype has been linked to repression of TGF β signaling and elevated COX-2 expression [73]. In the proximal colon, activated K-Ras induces the expression of PKC β II, activation of the Mek/Erk signaling axis, and increased epithelial cell proliferation [88]. In a cellular model of intestinal cells, stable overexpression of PKC β II confers an invasive phenotype mediated by a Ras/Mek/PKC α /Rac1-dependent pathway [89]. The role of PKC β I in the colon is less clear. Overexpression of PKC β I suppresses the growth of HT29 and SW480 colon cancer cell xenograft [90]. However, other report shows that expression of PKC β I confers resistance to apoptosis by TNF α and paclitaxel [91].

PKC β I expression positively correlates with high Gleason scores in prostate carcinomas, and inhibition of this kinase blocks androgen receptor-induced tumor cell proliferation *in vitro* and xenograft growth *in vivo*. Notably, PKC β I phosphorylates histone H3 and inhibits androgen-dependent transcription [92]. A study using a specific PKC β II peptide inhibitor showed that this isoform is involved in prostate cancer cell proliferation. PKC β II also plays an important role in endothelial cell proliferation, and inhibition of PKC β II reduces angiogenesis. These effects were linked to dysregulation of cytokinesis and microtubule

organization [74]. Enzastaurin, an inhibitor with some degree of specificity towards PKC β , displays antiproliferative effects in PC3 cells [93].

Overexpression of either PKC β I or PKC β II in MCF-7 breast cancer cells promotes cell growth and enhances cyclin D1 levels, whereas dominant-negative PKC β mutants inhibit growth [94]. On the other hand, another report showed that PKC β I overexpression induces a less aggressive biological behavior in MCF-7 cells characterized by reduced tumor formation [95]. In a murine mammary model, PKC β I inhibits tumorigenesis despite having a positive effect on growth in culture. Moreover, tumor cells that overexpress PKC β I have attenuated metastatic capacity to the lungs [96]. Enzastaurin has significant effects on the growth of breast cancer cells *in vitro* and *in vivo* [97–98]. High levels of PKC β II have been reported in several breast cancer cell lines and patient samples. The levels of cytoplasmic PKC β II expression positively correlate with ErbB2/Her2 levels, while nuclear PKC β II positively correlates with ER levels [99].

PKC β II is expressed in human NSCLC specimens with significant variability, both in tumor cells and the stroma [100]. Enzastaurin in combination with the antifolate pemetrexed causes G2/M checkpoint abrogation and apoptosis in lung cancer cells [101]. In cell culture, enzastaurin is a potent inhibitor of VEGF-stimulated proliferation of endothelial cells, and *in vivo* this inhibitor causes a significant reduction in intratumoral vessels that parallels a delay in lung cancer tumor growth [100]. Enzastaurin also enhances the anti-angiogenic effects of radiation in NSCLC models [102]. The PKC β inhibitor, Enzastaurin, regulates proliferation of glioblastoma cells by supporting the activity of GSK3, S6 kinase and Akt [103]. The effect of the PKC β inhibitor was also shown in U87MG human glioblastoma cells inoculated into nude mice. Enzastaurin proved to be efficient as an anti-angiogenic compound in models of glioblastoma [77], however clinical trials in patients with recurrent high-grade glioma show limited success when this inhibitor was used as a monotherapy [104].

Patients with diffuse large B-cell lymphoma that express PKC β have reduced overall survival compared to those that are negative for this kinase [105–106]. Enzastaurin displays pro-apoptotic properties in T-cell and B-cell lymphoma cell lines [107–108]. There is significant interest in using this PKC β inhibitor for the treatment of various types of lymphomas, both as a single agent and in combination therapies [109–110]. Taking advantage of a PKC β knockout mouse model, it has been recently demonstrated that stromal PKC β II is indispensable for the survival of chronic lymphocytic leukemia (CLL) B cells. The fact that stromal PKC β II is up-regulated in biopsies from patients with CLL, and that CLL cells induce the expression of stromal PKC β [111], highlights the need to better understand how this PKC contributes to cancer development in the context of the different tumor microenvironments.

PKC δ : complex roles in apoptosis, tumor growth and metastasis

PKC δ has been widely characterized as a pro-apoptotic and anti-proliferative kinase. In addition, PKC δ has been broadly implicated as a death mediator of chemotherapeutic agents and radiotherapy [112–115]. PKC δ is involved both in DNA damage and receptor-mediated

cell death [3, 115–116]. Initial work from the Reyland lab showed that PKC δ is cleaved by caspase-3 and mobilizes from the cytoplasm to the nucleus after treatment with genotoxic agents [13]. Other studies showed that PKC δ -mediated apoptosis involves the allosteric activation of the enzyme rather than proteolytic cleavage. For example, in androgen-dependent prostate cancer cells, PKC δ activation triggers an apoptotic response without the generation of a constitutively active catalytic fragment [117]. This effect involves the activation of the p38 MAPK cascade [118] and is mediated by a RhoA/ROCK/p21^{Cip1}-dependent pathway [119]. PKC δ -mediated apoptosis in androgen-dependent prostate cancer cells occurs through the autocrine secretion of TNF α and TRAIL, which induce caspase-8 cleavage through the JNK and p38 MAPK cascades [120–122]. The discrepancies in the mechanisms of PKC δ activation among the various studies may be explained by cell type differences and nature of the stimulus.

An inhibitory role for PKC δ in proliferation has been reported in a number of cellular models. The initial observations by Mischak *et al.* that ectopic overexpression of PKC δ confers growth inhibitory properties to NIH 3T3 cells [123], were later recapitulated in many other cell lines. Depending on the cell type, activation of PKC δ can induce cell cycle arrest either in G1 or G2 [49, 124]. Our laboratory showed that treatment of lung cancer cells with phorbol esters induces cell cycle arrest in G1 through the induction of p21^{Cip1} and Rb dephosphorylation [125]. However, it has been also noted that ectopic expression of PKC δ stimulates quiescent cells to initiate G1 phase cell cycle progression. Notably, PKC δ overexpressing cells arrest in S phase rather than completing the cell cycle [126].

It is important to mention that studies ascribed pro-survival properties to PKC δ in a number of tumor models, including breast, lung, pancreatic, and liver cancer [116]. Moreover, ectopic expression of PKC δ in mammary cells confers anchorage-independent growth properties and enhances the resistance to apoptotic stimuli [127]. The scenario that PKC δ could be a tumor promoting kinase rather than a tumor suppressor began to shape new paradigms in PKC isozyme function, and clearly points to an exquisite cell type selectivity.

Data from patients cannot point to a clear link between PKC δ expression levels and clinical outcome. Loss of PKC δ expression has been reported in a few cancer types [128–130], but this down-regulation could not be unambiguously linked to tumorigenesis. PKC δ is up-regulated in some cancer types [131–132]. PKC δ is barely detected in normal prostate epithelial cells, however high PKC δ expression could be observed in prostate pre-neoplastic lesions and carcinomas [133–134]. In breast cancer specimens, PKC δ mRNA levels are significantly higher in ER-positive tumors and a positive correlation between high PKC δ mRNA levels and reduced overall survival has been reported [135]. Interestingly, the expression of PKC θ , an isozyme related to PKC δ , is dysregulated in some cancers [132, 136–138].

Emerging studies using genetically engineered mice began to shed light into the involvement of PKC δ in tumorigenesis. PKC δ skin transgenic mice are resistant to tumor promotion by DMBA/PMA [139]. Studies using PKC δ knockout mice revealed contrasting effects particularly in the context of specific genetic alterations. Reyland and coworkers investigated the involvement of PKC δ in K-Ras-dependent tumorigenesis and found that the

incidence of urethane-induced lung tumors (which display activating mutations in K-Ras) is reduced in a PKC δ -null background. Moreover, PKC δ RNAi depletion inhibits anchorage-independent growth, invasion, migration, and tumorigenesis in K-Ras-dependent NSCLC cells [140]. The Reyland lab also described a positive role for PKC δ in mammary tumorigenesis in the context of ErbB2 overexpression. A meta-analysis of ErbB2-positive breast cancers shows increased PKC δ expression and a negative correlation between PKC δ expression and prognosis. Most remarkably, there is a significant delay in tumor onset in MMTV-ErbB2(Neu) in a PKC δ -null background [141]. A tumorigenic role for PKC δ has been also reported in a model of pancreatic cancer. Indeed, overexpression of PKC δ (as observed in human ductal carcinomas) leads to increased anchorage-independent growth and tumorigenesis *in vivo* [142]. Also, in a PC-3 xenograft model, PKC δ activation promotes tumor growth and increases angiogenesis through a mechanism that involves ROS, NADPH, and HIF-1 α [143].

PKC δ generally has a positive role in migration and invasiveness [144–147]. In prostate cancer cellular models PKC δ has been implicated in invasiveness and the control of collagen secretion induced by overexpression of the oncoprotein PCPH [134]. Breast cancer models provided controversial evidence for the involvement of PKC δ in invasion. Whereas a study showed that PKC δ overexpression in highly motile BT-549 breast cancer cells reduces migration and PKC δ down-regulation enhances motility and MMP-9 secretion in MCF-7 cells [148], other study reported that enhanced migration induced by forced EGFR overexpression in MCF-7 cells requires PKC δ [149]. PKC δ was found to inhibit the production of proteolytic enzymes in murine mammary cells, possibly limiting metastatic dissemination [127]. Down-regulation of PKC δ suppresses lung colonization in the murine mammary breast cancer model MTLn3 without affecting the growth of primary tumor [150]. Studies performed in BL6 murine melanoma cells showed that PKC δ overexpression increases their metastatic capacity *in vivo*, possibly due to an increase in the plasma levels of TGF β 1 [151–152]. A similar pro-metastatic effect of PKC δ has been shown in the human pancreatic cell line PANC1 [142].

The multiplicity of effects regulated by PKC δ and the complexity of the effects in cell cycle regulation, cell motility, tumorigenicity and metastasis, both in positive and negative manners (Fig. 4), would argue that this kinase is not a likely candidate for the therapy of cancer.

PKC ϵ : an oncogenic and metastatic kinase

PKC ϵ has been originally described as an oncogenic kinase [123, 153–154], and is known to signal via the Ras-Raf-1 signaling pathway [155–158] as well as other pathways. PKC ϵ -transformed fibroblasts secrete increased amounts of TGF- β and possibly other mitogens, an indication that growth autocrine loops may account for its oncogenic activity [159–160]. PKC ϵ is overexpressed in a large number of cancers. For example, PKC ϵ is overexpressed in ~75% of primary tumors from invasive ductal breast cancer patients [7]. Increased PKC ϵ staining correlates with high histologic grade, positive ErbB2/Her2 status, and negative estrogen and progesterone receptor status [7]. Overexpression of PKC ϵ has been reported in the majority (>90%) of primary NSCLC cancers relative to normal lung epithelium [5].

PKC ϵ levels are elevated in prostate cancer relative to benign prostatic epithelia [161], and a correlation with aggressiveness of human prostate cancer has been found [4]. PKC η , an isoform related to PKC ϵ , has also been shown to be up-regulated in some cancers [162–163] but down-regulated in others [164].

Not surprisingly, studies from several laboratories highlight a role for PKC ϵ in cell cycle control, specifically in G1 to S progression [165–167]. In addition, PKC ϵ promotes survival in many cell types [6, 168–170]. The survival activity of PKC ϵ involves the modulation of caspases and Bcl-2 family members [168, 171–173]. Forced expression of PKC ϵ in LNCaP prostate cancer cells confers resistance to PMA-induced apoptosis by preventing Bax oligomerization; moreover, it leads to accelerated proliferation of LNCaP cells due to constitutive activation of the Erk cascade [169]. Our laboratory recently demonstrated that PKC ϵ modulates Bad phosphorylation at Ser112 to protect LNCaP prostate cancer cells against apoptosis induced by PMA or TNF α [172]. PKC ϵ protects glioma and lung cancer cells from TRAIL-induced apoptosis [170, 174–175]. Subsequent studies by Basu and coworkers revealed that PKC ϵ inhibits cell death in breast cancer cells, partly by preventing activation and translocation of Bax to the mitochondria [176]. PKC ϵ inhibition/depletion impairs proliferation and anchorage-independent growth of human NSCLC cells [5, 177]. Many pro-apoptotic genes up-regulated upon PKC ϵ RNAi depletion in lung cancer cells are also down-regulated in human lung adenocarcinomas [177]. RWPE-1 cells, a model of normal immortalized prostate epithelial cells, express very low levels of PKC ϵ as compared to different human prostate cancer lines, and ectopic expression of PKC ϵ in RWPE-1 cells confers growth advantage and leads to Erk and Akt activation [6]. Recently, our laboratory identified a key role for PKC ϵ as a mediator of NF- κ B signaling in prostate cancer [178]. PKC ϵ inhibition/depletion impairs constitutive and TNF α -dependent activation of NF- κ B as well as the induction of NF- κ B responsive genes pertaining to cell survival, proliferation, metastasis and invasion, such as COX-2, MMP-9, VEGF, and IL-6 [178].

Overexpression of PKC ϵ in androgen-dependent LNCaP cells initiates tumor growth *in vivo* both in intact and castrated athymic nude mice [179], thereby indicating that PKC ϵ has the potential to advance the progression of prostate cancer and initiate recurrent tumor growth in the absence of androgens. In concordance, another study found that PKC ϵ overexpression in breast cancer cells causes tumor growth in BALB/c mice with significant increase in the incidence and number of spontaneous experimental lung metastases [96]. In line with these results, depletion of PKC ϵ from lung cancer cells using shRNA markedly inhibited xenograft growth in nude mice. Furthermore, the PKC ϵ peptide translocation inhibitor ϵ V1-2 blocks NSCLC tumor growth in nude mice. Moreover, both shRNA depletion and pharmacological inhibition of PKC ϵ causes a strong induction of cell death in xenograft tumors [177].

Unfortunately, there has been little work intending to recapitulate PKC ϵ overexpression as observed in human cancer. Our laboratory developed prostate-specific transgenic mice that overexpress PKC ϵ in the normal prostate *in vivo* under the control of the androgen-responsive probasin (PB) promoter, which leads to the formation of preneoplastic lesions (Fig. 5). Conversely, similar mouse models for other PKCs (PB-PKC α and PB-PKC δ mice) do not display any noticeable phenotypic changes in the prostate. Furthermore, elevated

phospho-Akt as well as hyperactivation of Akt effectors S6 and mTOR could be detected in hyperplasia and PIN lesions from PB-PKC ϵ transgenic mice. Besides, PKC ϵ overexpression confers resistance to apoptosis induced by androgen ablation, highlighting a pro-survival role of PKC ϵ in the mouse prostate [6]. Hyperactivation of NF- κ B and Stat-3 were evident in the PIN lesions of PB-PKC ϵ transgenic mice relative to the normal areas or regions with mild hyperplasia [6, 178].

Prostates of TRAMP mice (a model that spontaneously develops progressive invasive prostate cancer) have very high PKC ϵ protein levels compared to prostates of control mice [4]. A recent study demonstrated that genetic ablation of PKC ϵ in TRAMP mice inhibits prostate cancer development and metastasis [180]. Deletion of PKC ϵ in TRAMP mice decreases the phosphorylation/activation of Stat3 as well as its nuclear translocation and DNA-binding activity. It has been proposed that loss of PKC ϵ in TRAMP transgenic mice reduces the expression of proliferation, survival and metastasis markers, including COX-2, Bcl-xL, cyclin D1 and VEGF, as well as it decreases serum IL-6 levels.

A growing body of evidence indicates that PKC ϵ is implicated in tumor cell invasion and metastasis. Enhanced PKC ϵ levels are associated with invasion and/or metastasis of human breast, glioma and renal cell carcinoma [7, 166, 181]. PKC ϵ contains an actin-binding motif that positions this kinase within a cytoskeletal matrix where many PKC substrates are localized [182–185]. Deletion of this motif abrogates invasion and metastatic spread of tumors driven by PKC ϵ overexpression [186]. In human glioma cells, the PKC-interacting protein RACK1 appears to link activated PKC ϵ to the integrin β chain at focal adhesions, and PKC ϵ mediates the adhesion and motility of cells via Erk phosphorylation [187]. PKC ϵ also promotes the assembly of matrix adhesions containing actin filaments and β 1-integrins, and integrin signaling links PKC ϵ to the Akt survival pathway in recurrent prostate cancer cells [188]. In models of breast and head and neck cancer, PKC ϵ regulates motility and invasion, at least in part due to the activation of small Rho GTPases, specifically RhoA and/or RhoC [7, 189]. Very recent work from our laboratory showed that targeted disruption of PKC ϵ in lung cancer cells reduces motility through Rac1 inactivation. Several extracellular matrix proteases are down-regulated in PKC ϵ -depleted lung cancer cells [190]. Consistent with a role for PKC ϵ in metastatic dissemination, PKC ϵ -depleted NSCLC cells fail to colonize lungs after tail vein injection in mice [190]. Likewise, a study from the Urtreger's laboratory showed that inoculation of PKC ϵ overexpressing breast cancer cells in mice enhances the incidence and number of spontaneous and experimental lung metastases [96].

Verma and coworkers generated skin transgenic mice expressing PKC ϵ under the control of the human K14 promoter, which exhibit phenotypic abnormalities including inflammation, hyperkeratosis, hyperplasia, cellular hypertrophy and ulceration. Highly malignant and metastatic squamous cell carcinomas develop in the skin of PKC ϵ transgenic mice [191–192]. Additionally, PKC ϵ overexpression has been shown to sensitize the mouse skin to UVR-induced carcinogenesis [193]. A subsequent study demonstrated that skin transgenic PKC ϵ mice develop a myeloproliferative-like disease [194].

Altogether, these observations establish that PKC ϵ overexpression is linked to an aggressive phenotype and suggest that targeting PKC ϵ could be an effective anticancer strategy. Whereas the development of PKC ϵ inhibitors targeting the ATP-binding site may be challenging due to the high homology of this site among PKCs, agents directed against domains implicated in translocation may be valuable. In that regard, the PKC ϵ translocation inhibitor ϵ V1-2 has anti-tumorigenic activity in NSCLC cells [177], and a bifunctional peptide in which ϵ V1-2 has been linked to the 12-mer cancer homing peptide HN1 impairs the growth of head and neck squamous cell carcinoma cells in xenografts [195]. Lastly, Ras-driven and EMT-dependent phenotypes in breast cancer cells could be reversed by PF-526355, an ATP mimetic inhibitor with selectivity for PKC ϵ and PKC θ . This inhibitor impairs the growth of MDA-MB-231 breast cancer xenografts in mice, thus representing a promising agent for cancer therapy [196].

Atypical PKCs ζ and ι : opposite roles in cancer

aPKC isozymes, which comprise PKC ζ and PKC ι (PKC λ), are structurally and functionally distinct from other PKCs in that they have a single DAG/phorbol ester unresponsive C1 domain and lack a C2 domain [197–198]. Regardless of controversies in the literature largely due to the use of non-specific approaches such as inhibitory peptides and dominant-negative mutants, many studies point to a tumor suppressor function of PKC ζ , whereas PKC ι essentially fulfills the criteria of an oncogenic kinase (Fig. 6).

Both up- and down-regulation of PKC ζ has been shown in human cancer. PKC ζ up-regulation has been reported in prostate cancer, bladder cancer, and lymphomas [199–204], whereas down-regulated expression of PKC ζ has been shown in glioblastoma, lung cancer, kidney, renal clear cell carcinoma, melanoma, and pancreatic cancer [205–214]. A pro-apoptotic function for PKC ζ has been described in several cancer models. For example, PKC ζ inhibits growth and promotes differentiation and apoptosis in colon cancer cells. The inhibitory effect of PKC ζ on the transformed phenotype of these cells suggests that down-regulation of PKC ζ may contribute to colon tumorigenesis [215]. PKC ζ also exhibits a pro-apoptotic function in ovarian cancer [216]. In murine TRAMP prostate cancer cells, expression of a constitutively activated PKC ζ mutant enhances proliferation, whereas PKC ζ inhibition leads to Akt activation and enhanced cell survival [217]. There are several reports, however, highlighting a pro-survival role for PKC ζ [218–222].

PKC ζ -deficient mice display increased Ras-induced lung carcinogenesis, arguing for a role for this aPKC as a tumor suppressor *in vivo*. It has been postulated that the tumor suppressor activity of PKC ζ occurs through its ability to down-regulate Ras-induced IL-6 production. The enhanced secretion of IL-6 in PKC ζ -deficient Ras-transformed cells is essential for growth under conditions of limited nutrients and mitogens [211]. Genetic inactivation of PKC ζ in mice in a Pten-deficient background leads to invasive prostate carcinoma. A significant correlation between PKC ζ and Pten levels exists in human prostate tumors, and PKC ζ is significantly reduced in metastatic *vs.* primary tumors with low Pten. Analysis of gene signatures in PKC ζ -deficient cells revealed a link with c-Myc. Indeed, c-Myc is a contributor to the more aggressive phenotype associated with PKC ζ loss [223]. Loss of PKC ζ also allows glucose-addicted human cancer cells to reprogram their metabolism in

response to glucose deprivation by augmenting the utilization of glutamine through the serine biosynthetic pathway [224].

Accumulating evidence established that PKC ζ is an oncogenic kinase and that it contributes to the transformed phenotype. Overexpression of PKC ζ is observed in many human cancers, including colon, lung, pancreas, breast, prostate and ovarian cancer. The PKC ζ gene (*PRKCI*) is amplified in some human cancers [225–227], although PKC ζ overexpression is not always associated with gene amplification [228–230]. This has been well summarized in a review by Murray *et al* [231].

PKC ζ expression is elevated in NSCLC tumors and cell lines, and is required for the transformed phenotype of NSCLC cells harboring oncogenic K-Ras mutation [232–235]. NSCLC cell lines without Ras mutation also depend on PKC ζ for their malignant phenotype if they harbor *PRKCI* gene amplification [235]. PKC ζ mediates its effects through a Rac1-Pak-Mek-Erk dependent mechanism [89]. By means of a proteomics approach, Justilien *et al* [236] identified the Rho-GEF Ect2 as a component of the PKC ζ -Par6 complex that is required for transformed growth. The Ect2 gene co-amplifies with *PRKCI* suggesting a coordinated mechanism for tumorigenesis. Disruption of the PKC ζ -Par6 interaction, as caused with the anti-rheumatic agent aurothiomalate (ATM), potently inhibits growth of PKC ζ -overexpressing cell lines. ATM inhibits K-Ras-mediated expansion of bronchoalveolar stem cells and lung tumor growth *in vivo* [233, 237]. On the other hand, aPKCs appear to be dispensable for mammalian hematopoietic stem cell function [238]. PKC ζ has been also implicated in colon and pancreatic cancer using cell lines and animal models [229–230]. PKC ζ is required for hedgehog signaling in basal cell carcinomas. Indeed, PKC ζ functions downstream of smoothened (SMO) to phosphorylate and activate the GLI1 transcription factor. Moreover, PKC ζ is up-regulated in tumors resistant to SMO inhibitors, and targeting PKC ζ suppresses the growth of resistant basal carcinoma cell lines [239]. Other interesting signaling connections have been established for PKC ζ , including mutually antagonistic regulation with RhoB in glioblastoma cell invasion [240], links with the NF- κ B pathway [241–242], as well as association with cell cycle proteins cyclin E in ovarian cancer [226] and S-phase kinase-associated protein 2 (SKP2) in esophageal cancer [243].

Final remarks

Tangible progress has been made in the last 30 years in understanding the regulation and cellular functions of PKC isozymes in cancer. The picture that emerged, however, is less than clear. What we have learned over the last years is that the biology of PKC isozymes is exceptionally complex, and that many studies in cell lines do not necessarily apply to *in vivo* models. For the next wave of studies on PKC function, the generation of animal models recapitulating the scenarios observed in different cancer types should be a priority. However, it is still not known whether the activation status of different members of the PKC family is altered in cancer and whether activated PKCs functionally interact with oncogenes and tumor suppressors genes driving the tumorigenic and metastatic phenotype.

One would expect that PKC is a promising target for cancer therapy, but only for specific PKC isozymes that display oncogenic activity, such as PKC ϵ and PKC ζ . The portfolio of available PKC inhibitors remains narrow, and unfortunately the majority of compounds lack specificity among members of the PKC family or even with other kinases unrelated to PKC. Hence, there is a great need to design selective small molecule inhibitors for PKC isozymes that have sufficient potency to impair PKC function *in vivo*. There may be concrete opportunities to rationally design inhibitors against the ATP-binding site, but this is still challenging due to the high homology among PKCs in that region. Some examples of small molecules capable of disrupting protein-protein interactions for PKC isozymes provided proof-of-principle for alternative approaches in the design of PKC modulators [177, 237, 244]. C1 domain ligands, such as the bryostatins [245–246], did not show major beneficial effects in patients despite their anti-tumor effects in mice [244]. One may envision that PKC isozyme specific inhibitors may possibly work in combined therapies with chemotherapeutic agents for discrete cancer types. Translating PKC modulators into a clinical setting remains a formidable challenge that we face for the next years.

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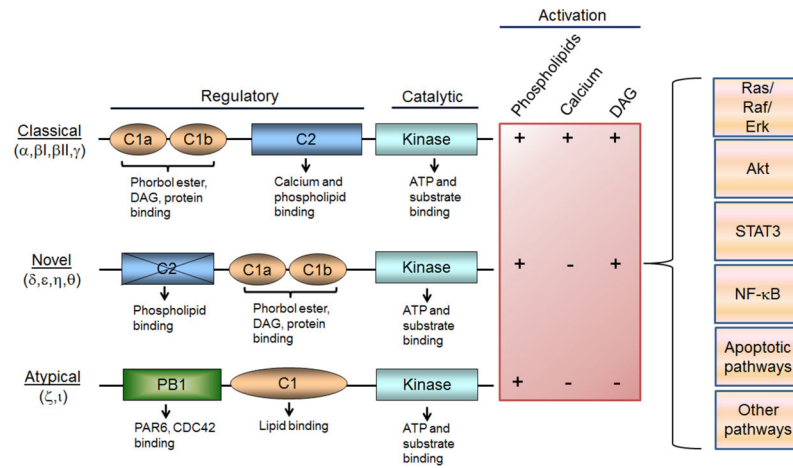


Figure 1. Structure of PKC isozymes. PKCs are multidomain proteins that are regulated by lipids and protein-protein interactions. Diacylglycerol (DAG) generated upon activation of receptors causes the activation of cPKCs and nPKCs, and its actions are mimicked by phorbol esters. aPKCs do not respond to DAG or phorbol esters. PKCs activate a number of signal transduction pathways that regulate tumorigenesis and metastasis.

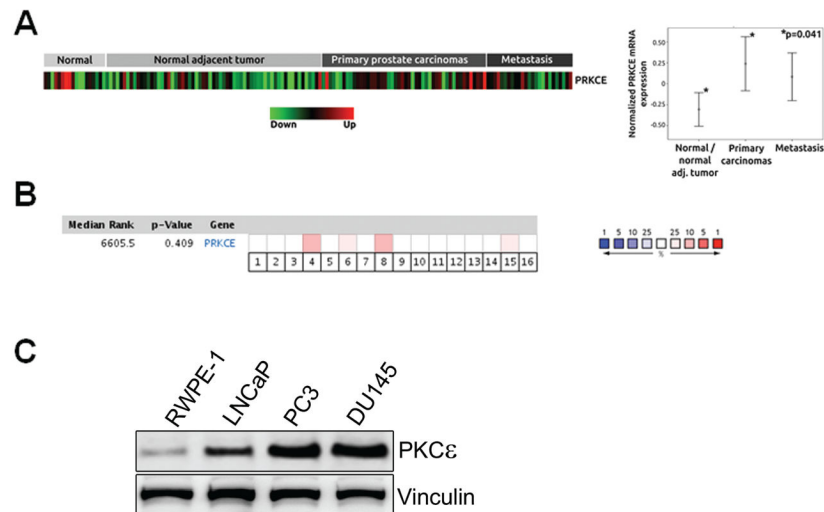


Figure 2.

Expression of PKCε in prostate cancer. (a) *In silico* PKCε mRNA expression profiling in 81 normal/normal adjacent prostate tumors, 48 primary prostate carcinomas and 25 prostate cancer metastasis obtained from a publicly available dataset (GSE6919). *PRKCE*, PKCε gene. (b) Meta-analysis of *PRKCE* mRNA expression across 16 prostate microarray studies from the Oncomine database. This meta-analysis shows non-statistically significant differences in *PRKCE* mRNA expression (combined p-value=0.41) between normal and prostate cancer groups. Red intensity is a representative of the statistical significance in mean difference between normal and prostate cancer for each study. (c) Expression of PKCε in “normal” immortalized prostate epithelial RWPE-1 cells vs. prostate cancer cells. This figure was originally published by Garg R, Blando J, Perez CJ, Wang H, Benavides FJ, and Kazanietz MG. in *J Biol Chem.* 2012 287:37570–37582, © The American Society for Biochemistry and Molecular Biology.

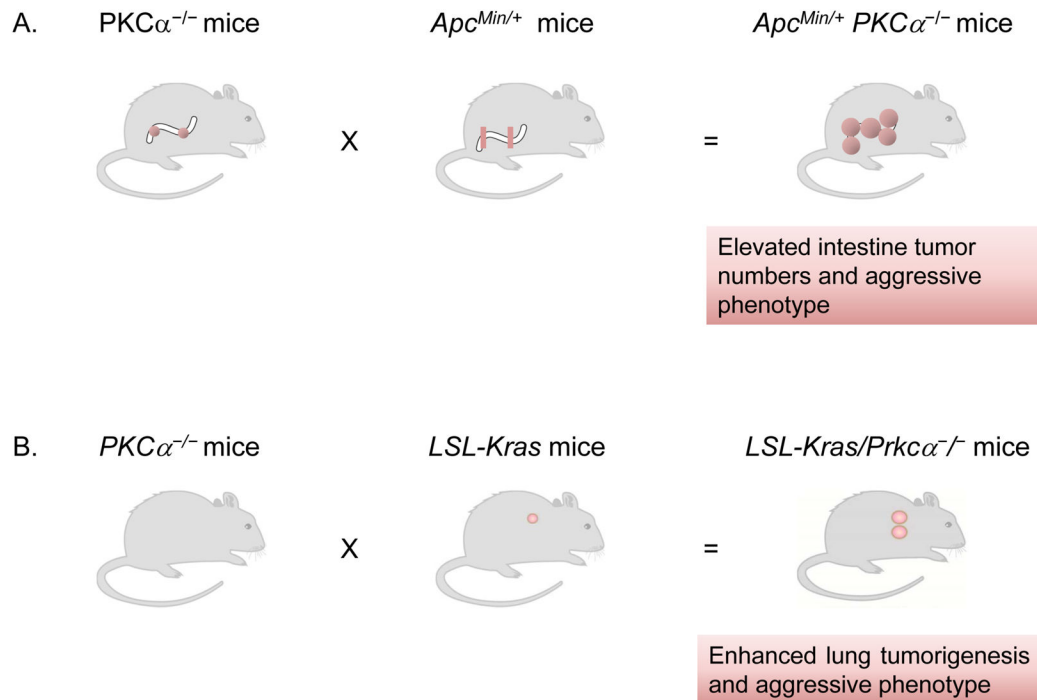


Figure 3.

Loss of $PKC\alpha$ gene enhances tumor progression. (a) Deletion of the $PKC\alpha$ gene enhances the formation of tumors in $APC^{Min/+}$ mice, and those tumors show a more aggressive phenotype. (b) Deletion of $PKC\alpha$ in K-Ras mutant mice resulted in progression of benign tumors to adenocarcinoma. Tumors exhibit high frequency and grade, and are bigger in size.

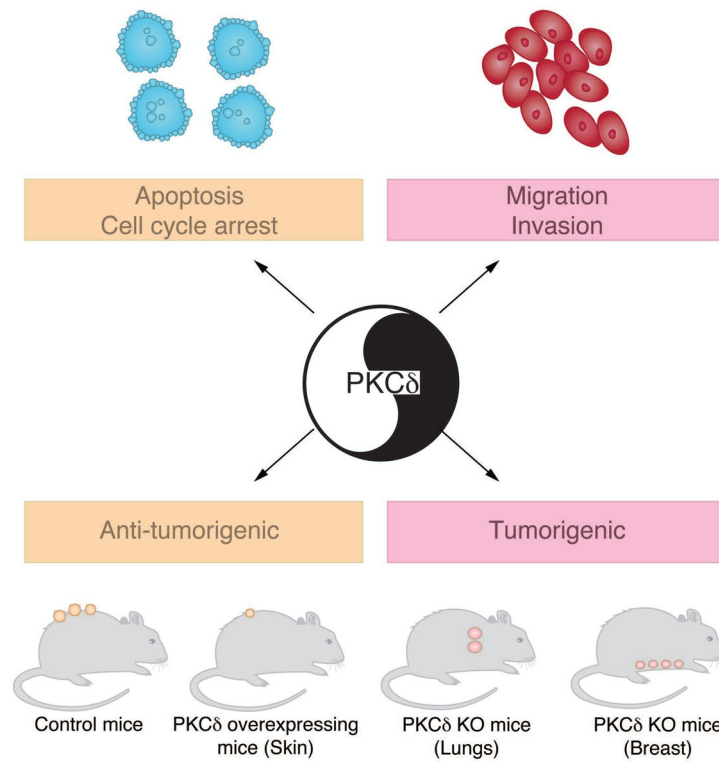


Figure 4. Multiple biological functions regulated by PKC δ . Studies in cellular models established important roles for PKC δ in apoptosis and as a negative regulator of cell cycle progression. PKC δ has been also implicated in cancer cell motility and invasiveness. Studies using animal models showed that PKC δ can either act as a tumor suppressor or contribute to tumorigenesis depending on the context.

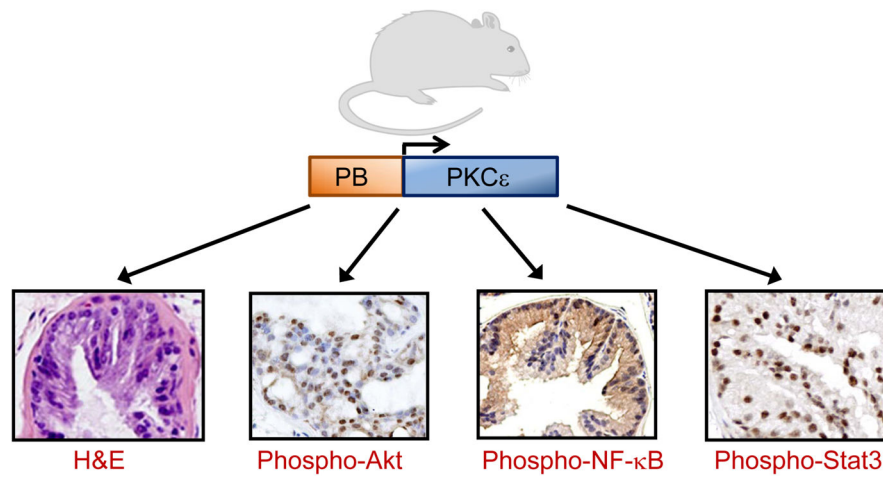


Figure 5. Phenotype of prostate-specific PKC ϵ transgenic mice. Prostate-specific overexpression of PKC ϵ in mice under the control of the probasin (PB) promoter leads to a preneoplastic phenotype. Representative photomicrographs for H&E, phospho-Akt, phospho-NF- κ B and phospho-Stat3 staining in ventral prostates from 12-month old male PB-PKC ϵ mice are shown.

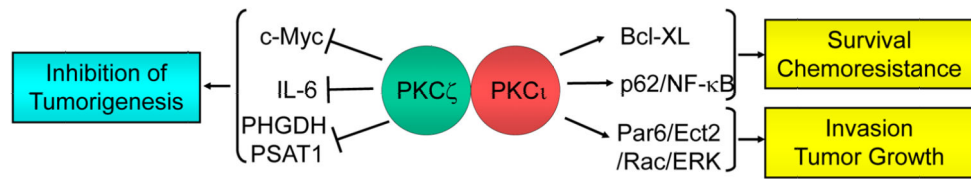


Figure 6. Roles of atypical PKCs in cancer. Most evidence points to PKC ζ as a tumor suppressor protein and PKC ι as an oncogenic kinase.