Pharmacological and Clinical Importance of Integrin Antagonists in Treatment of Cancer

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Rec date: Dec 05, 2014; Acc date: Jan 28, 2015; Pub date: Feb 03, 2015

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Abstract

Integrins are heterodimeric molecules that are composed of 18 α-subunits and 8 β-subunits. They exist in 24 distinctive shapes based on combination of these sub-units and are mainly responsible for the adhesion of extracellular matrix (ECM) and immunoglobulin family molecules. Integrins mediate adhesion of epithelial cells to the basement membrane and also help in the migration, proliferation and survival of tumor cells. Studies also reveal that certain integrins act as markers for tumor cells and they also assist in both tumor progression and apoptosis. Studies reveal that unligated integrins in association with caspase 8 result in inhibition of ECM adhesion might result and integrin mediated death (IMD) on the other hand integrins in association with oncogenes or receptor tyrosine kinases can result in enhanced tumorigenesis. Among several types of integrins, α5β3 and α6β1 have gained importance in antiangiogenesis studies.

Hence the role of antiangiogenesis antagonists has come into light. These include a variety of monoclonal antibodies and peptides. Each one of them has their own mechanism of action and antiangiogenesis activity. Current review aims at studying the phase 1 and 2 trails of these antagonists for anti-angiogenic function.

Keywords: Integrins; Integrin mediated death; Extra cellular matrix; Anti-angiogenesis

Introduction

Integrins

Integrins are a heterodimeric cell surface receptors that assist in the adhesion of extracellular matrix (ECM) and immunoglobulin family molecules. They play a vital role in the cell motility and invasion as they can directly adhere to the various components of the ECM. Integrins also control the ECM remodeling and proliferation processes [1]. Integrins are a family of heterodimeric molecules that are composed of 18 α-subunits and 8 β-subunits. They exist in 24 distinctive structures by the combination of these subunits, each one with multiple activation sites and distinctive expression and glycosylation activity based on their composition. The extent to which a cell can adhere or migrate on different matrices can be determined by the composition of the integrin it possesses. The presence of RGD (Arg-Gly-Asp) sequence in the respective ligands can be identified by the presence of the αv and α5β3 integrins. Furthermore the presence of various adhesive sequences in the ECM proteins such as EILDV (Glu-Ile-Leu-Asp-Val) and REDV (Arg-Glu-Asp-Val) can be identified by the presence of the α4β1 integrin. On ligating to the ECM, integrins cluster and recruit various signaling and adaptor proteins. They play a vital role in the cell motility and invasion. Under normal conditions integrins assist in regulating the integrity of the various organs and tissues of the body. The previous studies reveal that αvβ3 integrin, could assist in tumor progression by activating the oncogene-induced transformation. The solid tumors formed from epithelial cells are found to be with higher level of αvβ1, α5β1, α3β1, α6β1 and α5β1 integrins and retained with different expression levels during tumor cell survival, proliferation, progression and migration. The higher expression levels of integrins α5β3, α5β1 and α6β4 in some tumors acts as the marker proteins, while they are under expressed in normal epithelial cells [6]. Integrins in association with oncogenes or receptor tyrosine kinases can result in enhanced tumorigenesis. Integrin αvβ3 along with ERBB2 in breast cancer and α1 activated KRAS-G12D- induce tumors in the lung [3,4,8,9]. Beyond this, integrins assist in recruiting integrins to the membrane microdomains. The extent of cell adhesion and migration on ECM is controlled by the recruitment specific integrins and other Focal adhesion proteins, which in turn become potential candidates for cancer therapy [3-6].

Cell survival is maintained by various integrin mediated mechanisms involving increase in expression of BCL-2, activation of PI3K-AKT, p53, vascular endothelial growth factor 2 (VEGFR2) pathways and by preventing the intrinsic and extrinsic apoptosis pathways [7]. Unligated integrins together with caspase 8 can induce integrin –mediated death (IMD), which is different from anoikis.

Current review aims at studying the phase 1 and 2 trails of these antagonists for anti-angiogenic function.
to the advantages and disadvantages of various integrins, the therapeutic effects of integrin antagonists still remained unexplored as it is believed that inhibition of ECM adhesion might result in IMD. In the current review, we have selected the important of two αvβ3 and αβ5 integrins to enumerate the importance in the generation of antagonists in the treatment of cancer.

**Integrin αvβ3:** The αvβ3 integrins are a part of a family of αv integrins, a group of five members: α5β1, α6β4, αβ8 and αβ5 whose prime function is regulation of cell adhesion to ECM, proliferation and migration. It adheres to the extracellular matrix protein with the help of RGD sequence [6,10,11]. These are the prime type of integrins that are present in the endothelial cells and helps in angiogenesis via the basic fibroblast growth factor (bFGF) and tumor necrosis factor-α and also contribute to the malignant spread of various tumor cells such as breast carcinoma, prostate carcinoma and melanoma [12-14]. Up regulation of αvβ3 integrin is observed profoundly upon neo-vascular formation to vascularize the most of the human cancer cells during angiogenesis and invasion [6,15,16]. Hence the inhibition αvβ3 integrin by cyclic RHD peptides, peptidomimetics and monoclonal antibodies induce endothelial cell apoptosis there by resulting in angiogenesis inhibition and are considered as potential targets to attain antiangiogenic properties.

**Integrin αβ5:** αβ5 integrin interacts with fibronectin (ECM glycoprotein) at the RGD sequence and plays a crucial role in neovascularization by generating survival signals for active endothelial cells and mediates angiogenesis by regulating endothelial cell growth, proliferation and migration in cancerous cells by suppressing the protein kinase A (PKA) [3,4,17]. Stimulation of angiogenesis growth factors such as bFGF, TNFα and IL8 result in the upregulation of integrin αβ5 and its expression is controlled by the home box family transcription factor 3 (Hox 3) [18-21]. The inhibition αβ5 integrin via certain antagonists such as antibodies or small molecules results in the inhibition of endothelial cell survival and proliferation both in vivo and in vitro to block angiogenesis and there by resulting in apoptosis.

**Integrin antagonists in tumor and angiogenesis inhibition**

Integrin antagonists in clinical development include both antibodies and small molecules (Table 1) These antagonists include: (a) chimeric or humanized antibody inhibitors. (b) peptide inhibitors of individual integrins as well as peptides that inhibit integrins, and (c) non-peptide, organic inhibitors. In the current review, an attempt is made to target αv and α5 integrin with different integrin-targeted agents, which are in clinical development and clinical trials in cancer therapy.

<table>
<thead>
<tr>
<th>Integrin</th>
<th>Antagonists</th>
<th>Function</th>
<th>Disadvantage/ Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>αvβ3</td>
<td>Monoclonal ab Vitaxin (LM 609 mAb)</td>
<td>Inhibits cell adhesion, blocks Vitronectin receptors &amp; Bax apoptotic pathway, upregulates matrix degradation inhibitors</td>
<td>Short half life and inefficient interaction</td>
</tr>
<tr>
<td></td>
<td>First generation of MEDI – 523 &amp; Second generation of MEDI-522</td>
<td>Inhibits MAPK pathway, inhibits MMP- activation, lowers TGF-β1 accumulation</td>
<td>No clinical significance due to less affinity and stability</td>
</tr>
<tr>
<td></td>
<td>Intetumumab (CNTO 95)</td>
<td>Inhibits the contact between ECM and tumor cells, inhibits angiogenesis</td>
<td>Safe for long term administration</td>
</tr>
<tr>
<td></td>
<td>EMD 525797 (DI17E6) mAb Non-peptide inhibitors MK0429</td>
<td>Inhibits the ligand binding to αv heterodimers</td>
<td>Efficacy, dose dependent tolerability and under phase II trails</td>
</tr>
<tr>
<td></td>
<td>PSU1404</td>
<td>Inhibits osteoclast formation in bone metastasis</td>
<td>Oral compound is not developed even though safe and tolerable</td>
</tr>
<tr>
<td></td>
<td>IH1062</td>
<td>Inhibits osteoclast bone resorption and inhibits ovarian and breast cancer</td>
<td>Preclinical study is limited</td>
</tr>
<tr>
<td></td>
<td>S 137 and S247 17E6</td>
<td>Inhibit the cell growth and enhance apoptosis by inhibiting the interaction with ligand Inhibits vitronectin binding,</td>
<td>Provides promising results in tumor metastasis</td>
</tr>
<tr>
<td></td>
<td>GIPG0187, RGD antagonists</td>
<td>Decreases BCI-2/Bax ratio and survivin protein</td>
<td>Reduces the development of liver metastasis</td>
</tr>
<tr>
<td></td>
<td>DiaBa-01, novel monomeric P-II SVMP-derived RGD disintegrin ATN-161</td>
<td>Promotes endocytosis of αvβ3 integrin, Anti tumor, anti adhesive and anti metastatic activities</td>
<td>Under clinical trial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decreases Aldehyde dehydrogenase and increases zE-cadherin/vimentin ratio</td>
<td>Under Phase I trials in cancer therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inhibits angiogenesis</td>
<td>Novel in anti-metastatic therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Impairs TGF-β signalling</td>
<td>Under Phase II trials</td>
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<tr>
<td></td>
<td></td>
<td>Inhibits VEGF expression and angiogenesis</td>
<td></td>
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</tbody>
</table>

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**Table 1:** Integrin Antagonists and their Function.
### Table 1: Monoclonal antibodies and other non peptide mediated antagonists of αvβ3 and αvβ1 integrins and the details are given in the text.

<table>
<thead>
<tr>
<th>Integrin</th>
<th>Understanding</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>αvβ1</td>
<td>Volociximab</td>
<td>Inhibits the function of αvβ1 integrin. Induces apoptosis in cancer cells. Inhibits angiogenesis significantly.</td>
</tr>
<tr>
<td>GIPG0187, non peptide RGD antagonists</td>
<td>Decreases Aldehyde dehydrogenase and increases E-cadherin/vimentin ratio. Inhibits angiogenesis. Impairs TGF-β signalling.</td>
<td></td>
</tr>
<tr>
<td>Resveratol, natural polyphenolic antioxidant</td>
<td>Down regulates αvβ1 integrins. Induces apoptosis.</td>
<td></td>
</tr>
</tbody>
</table>

**Vitaxin:** Vitaxin is a function blocking humanized monoclonal antibody that specifically interacts with the integrin αvβ3 [22]. The humanized version is derived from the LM 609 antibody [11,23]. The LM 609 antibody is the most specific anti-integrin αvβ3 mAb which blocks the interaction of αvβ3 complex with its matrix ligands and inhibits the cell adhesion [14]. The LM 609 mAb blocks the VN receptor in the presence of growth factor stimulation and results in activation of p33. It also leads to increase the BAX apoptosis pathway by enhancing the p21waf-1/CID-2 levels. This molecular mechanism triggers the apoptosis of endothelial cells and regression of angiogenic blood vessels. It also blocks the induction of TGF-β1 and stimulate SMC migration by inducing the expression of various ECM proteins and at the same time up regulate the expression of matrix degradation inhibitors and tissue inhibitors of MMPs [24,25]. Despite of numerous clinical studies the therapeutic approach of LM 609 is limited in humans due to its short serum life and inefficient interactions with human immune effector cells [14].

To overcome these issues LM 609 is humanized to interact specifically with integrin αvβ5 and Vitaxin is the first generation (MEDI-523) of humanized version that is developed. The humanized version comprise the human IgG1, kappa and grafted murine CDRs specifically with integrin αvβ5 and Vitaxin is the first generation humanized version that is developed. The humanized version comprise the human IgG1, kappa and grafted murine CDRs towards non linearity. Even though this study did not determine the optimum dose it suggested that vitaxin could administered safely without any toxicity over prolonged periods and evidenced that humanized vitaxin does not appear to be immunogenic [22]. The optimum dose of the vitaxin was characterized in a pilot trial conducted in patients with metastatic cancer. This clinical trial suggested that the doses level of vitaxin equivalent to or in excess 50 mg can be administered and to maintain circulating levels with good plasma recovery a dose of 200 mg is recommended. Because the half-life plasma recovery for 10 mg dose level was very low, for 50 mg it was 76% and for 200 mg it was 95%. The treatment was well tolerated with no significant hypophosphatemia. Only three patients with metastatic renal cell cancer experienced prolonged stable disease on treatment suggesting that MEDI-522 could be further investigated as an anti-integrin αvβ3 monoclonal antibody MEDI-522 (Abegirin).

The second generation MEDI-522 derived from MEDI-523 have greater affinity and stability towards integrin αvβ3. It also retained the tumor targeting and antibody retention properties from predecessor mAb [23,27]. The preclinical in vitro and in vivo inhibitory studies suggested that the continuous serum concentration at a minimum of 10 μg/mL to 30 μg/mL is sufficient for MEDI-522 activity. The safety and tolerability of MEDI-522 was evaluated in Phase-I, open label, dose escalation trail. The patients with solid tumors were treated with MEDI-522 with dose levels ranging from 2 to10 mg/kg. No significant toxicity and maximum tolerated dose was identified but few adverse events noted were low-grade constitutional symptoms, gastrointestinal symptoms, infusion reactions and asymptomatic hypophosphatemia. Only three patients with metastatic renal cell cancer experienced prolonged stable disease on treatment suggesting that MEDI-522 could be further investigated as an anti-integrin αvβ3 [13].

The clinical studies that used immunotherapy with radionuclides showed efficacy of the MEDI-522 and the level of radiotherapy and...
molecular inhibition was also established. In the in vitro and in vivo micro PET studies, MEDI-522 (AbegrinTM) was conjugated with DOTA and labelled with $^{64}$Cu. The $^{64}$Cu-DOTA-Abegrin TM conjugate exhibited high integrin $\alpha_\beta_5$ specificity with shorter half-life in mouse than in humans [28]. In the tumor imaging studies by using $^{111}$In-DOTA-Abegrin TM conjugate the uptake of the conjugate is high in integrin $\alpha_\beta_5$ positive tumors when compared to the $\alpha_\beta_5$ negative tumors and there by exhibiting the high binding affinity to human integrin $\alpha_\beta_5$ [29]. The efficacy and maximum tolerated dose of Abegrin was evaluated in a murine xenograft glioblastoma model in which DOTA-Abegrin was conjugated with $^{90}$Y. Animals treated with 300 $\mu$Ci had higher mortality rate and reduction in all hematologic counts. The distribution of the antibody was found high in liver and spleen and serum 1/2 of $^{90}$Y-DOTA-Abegrin was found to be 12-24 hours. The maximum dose tolerated was 200 $\mu$Ci with maximum antitumor efficacy and no toxicity was observed with good hepatic clearance [30]. The success of radio labelled imaging in vitro and in vivo studies of Abegrin using radionuclides provides the success in to clinic to evaluate the tumor targeting efficacy, dose optimization, dose interval and pharmacokinetics of MEDI-522.

The Phase-I study of the MEDI-522 evaluated the safety, immunogenicity and pharmacokinetics in sixteen patients with solid tumors in dose escalating manner (1, 2, 4 and 6 mg/kg). The treatment was well tolerated at doses up to 6 mg/kg and no evidence of immunogenicity was observed. The only biological effects observed were leucopenia, anaemia, hypocalcemia, hypokalemia, hyponatremia and hypophosphatemia. The pharmacokinetic analysis observed a nonlinear increase in half-life [31]. The antitumor efficacy and safety data of MEDI-522 were assessed in randomized, open-label, two arm Phase-II study. The stage-IV melanoma patients were randomized to receive MEDI-522 and MEDI-522 + dacarbazine. The therapy with MEDI-522 + dacarbazine did not appear to be more effective in metastatic melanoma and the most adverse events observed were gastrointestinal, metabolic and infusion related [32]. These studies specified the binding efficacy of the MEDI-522 for human integrin $\alpha_\beta_5$. Phase I/II clinical studies and will enter Phase III for further evaluation.

**Volociximab:** Volociximab, clinically represents as a first function blocking, high affinity human/mouse chimeric IgG4 monoclonal antibody that specifically interacts with integrin $\alpha_\beta_5$ [33]. The constant region of volociximab comprises human IgG4 heavy and kappa light chain combined with murine antibody variable regions, including the integrin $\alpha_\beta_5$ directed complementarity determining regions [34,35].

In vitro models of angiogenesis, a preclinical evaluation study of volociximab suggest that volociximab is potent inhibitor of angiogenesis. It inhibits the $\alpha_\beta_5$ integrin function by inducing apoptosis in proliferating endothelial cells but not resting cells. The in vitro studies conducted in cynomolgus model of revascularization also suggest that volociximab inhibit integrin $\alpha_\beta_5$ function with a greater inhibitory potential. These data demonstrated that volociximab has therapeutic potential in diseases such as cancer and age-related macular degeneration [36]. The antitumor activity assessment of volociximab in syngeneic rabbit VX2 carcinoma model reported that systemic administration of volociximab whether prophylactically or after the tumor establishment as a potent anti-cancer agent. These studies supported the use of volociximab as potent inhibitor in malignant disease because when maintained relatively high levels of antibody for at least two weeks in the model there was significant decrease in tumor volume growing subcutaneously or intramuscularly [37].

The safety profile, feasibility, anticancer activity, pharmacokinetic and pharmacodynamic behavior of volociximab were evaluated in the phase I study based on the supporting rationale provided by the preclinical studies. In this multicentre, open label, dose-escalation study of 21 patients with tumors, showed unresponsive to standard therapies were administered with volociximab. Over 60 min at dose levels ranging from 0.5 to 15 mg/kg with a total of 223 infusions. But, observed no DLT and neither required dose reductions. The common adverse events observed in high dose groups were fatigue and myalgias, however, there was neither hematologic toxicity nor infectious complications. But few non-hematologic adverse events which included gastrointestinal symptoms, headache, edema, hypertension and low grade constitutional symptoms were observed. The binding and saturation of integrin $\alpha_\beta_5$ sites by volociximab was determined as a dose-dependent because estimates of volociximab declined with increasing doses which was achieved at the highest dose of 15 mg/kg. These findings suggested that volociximab can be safely administered to target multistep angiogenesis process in a feasible and safe approach [38].

The non-randomized Phase II disease specific clinical trials for volociximab were carried in patients with malignant melanoma, pancreatic, renal cell carcinoma, ovarian and non-small cell lung cancers. These clinical trials established the safety and efficacy of volociximab as single-agent or in combination [39]. All these preliminary data demonstrate the efficacy of volociximab but randomized trials and future studies are required to validate the efficacy.

**Intetumumab:** Intetumumab (CNTO 95) is a fully human IgG1 mAb which do not cross react with mouse integrins but have limited cross reactivity with rat integrins [40]. It is generated by immunizing mice transgenic for part of the human immunoglobulin receptors. It recognizes multiple $\alpha v$ integrins with broad specificity with a dissociation constant of Kd 1-24 nmol [41]. Studies conducted showed that CNTO 95 bound to purified human $\alpha_\beta_5$ and $\beta_5$ integrins with high specificity and as a promising agent to inhibit integrin mediated tumor growth and angiogenesis [42]. It inhibits angiogenesis in tumors by ligating with the integrin receptors on the tumor cells and thereby blocking or reducing the signalling between the tumor cells and ECM [43]. The in vitro preclinical studies in nude mice and nude rats demonstrated that CNTO 95 has potent anti-tumor and anti-angiogenic properties where intetumumab dose dependently inhibited the adhesion of HUVECs and human melanoma cells to all $\alpha_\beta_5$ and $\alpha_\beta_5$ ligands, indicating the function blockade of $\alpha_\beta_5$ and $\alpha_\beta_5$ integrins. The in vitro sprouting and inhibitory studies demonstrated CNTO 95 as an inhibitor of angiogenesis because the proliferation of bFGF simulated endothelial cells was inhibited by intetumumab in dose dependent manner compared to unstimulated cells [40]. Another preclinical study in cynomolgusmacaque evaluated the safety of CNTO 95. The results postulated that terminal elimination half-life was increased with dose and reduced clearance of mAb at 10 mg/kg and 50 mg/kg doses. The serum concentration time profile exhibited a short, rapid distribution phase. The in vitro and in vivo immunolocalization studies showed that CNTO 95 bound strongly to human and mouse tissues. This preclinical data suggested that intetumumab is safe for long term administration [44].

The supportive data in preclinical evaluations of intetumumab exhibited the anti tumor and anti angiogenic inhibitory effects of the
antibody. In the Phase I study of CNTO 95 the biological activities like cell motility, cell signalling, tumor growth, tumor metastasis and angiogenesis were determined by using breast carcinoma cells. In four human breast cancer cells (MCF-7, MDA-MB-231, MDA-MB-468, and MX-1) with estrogen positive and negative receptor showed the reduction in cell viability by CNTO 95 in a dose dependent manner. It also specifically inhibits the integrin αv-vitronectin receptor suggesting potential effects of the mAb on cell motility and adhesion. It inhibits this interaction by promoting tyrosine dephosphorylation of FAK and paxillin. The MDA-MB-231 cells in SCID mice treated with CNTO 95 resulted in significant inhibition of metastasis by providing additional anti-cancer benefit [41]. An open label, single centre, first-in-human, multiple administration, dose escalating (0.1, 0.3, 1.0, 3.0, 10.0 mg/kg) study in 24 patients evaluated the safety and pharmacokinetics of CNTO 95. Over all the therapy was well tolerated with only observation of dose related increase adverse events. The low doses (≤3.0 mg/kg) cleared more rapidly from serum where as higher dose (10 mg/kg) cleared more slowly indicating saturation of tissue binding at 10.0 mg/kg. This pharmacokinetics studies indicate the increase of drug exposure in greater than proportional manner over the range evaluated. When pre-treated and post-treated tumor cells with CNTO 95 were observed, the levels of Bcl-2, a proto-oncogene which inhibits apoptosis was distinctly present in pre-treated tumor cells. The immune-histochemical analysis indicate that CNTO 95 was able to penetrate in to the tumor and bind to the target integrin αvβ5 [45]. But this study did not provide any information regarding the maximum tolerated dose (MTD) in pharmacodynamics studies. Another multicentre, open-label Phase-I study conducted with higher dose (20 mg/kg) of CNTO 95 than previous Phase-I (10 mg/kg) in 19 patients observed no dose limiting toxicity, no complete or partial responses and adverse effects like head ache, vomiting, nausea, fatigue were similar to that of previous study. Four patients experienced disease progression, changes in mental status and two metastatic melanoma patients had a stable disease response. The pharmacodynamics assessments suggested down regulation of integrin. AUC and Cmax increased proportionally every 3 weeks and terminal t½ was slightly longer for the 20 mg/kg dose than that of 10 mg/kg dose. These safety evaluation studies suggested the CNTO 95 maximum tolerated dose MTD of 10 mg/kg dose levels for future studies [42]. The safety and efficacy of intetumumab as a single agent or in combination with other agents by using radiation therapy was established. The pharmacokinetics results in a multicentre, randomized, Phase-II in stage-IV melanoma patients in combination with dacarbazine were non-linear with greater than dose- proportional at 10 mg/kg serum concentrations. The therapy with intetumumab and dacarbazine was well tolerated with association of very low grade adverse effects in patients receiving intetumumab and patients treated with dacarbazine experienced hematologic toxicity [46]. The in vitro inhibitory studies in colon cancer cells (HCT 116 which express αvβ3 and RKO cells which express αvβ1αvβ1αvβ3) conferred that combination regimen of CNTO 95 and dacarbazine was greater than drug alone. This dual inhibition reduced paxillin activation and inhibit cell migration in HCT 116 cells but not in RKO cells in low concentrations [47].

The intetumumab and radiation combination therapy in human tumor xenografts and rats established, intetumumab as a potent and effective agent for cancer therapy along with radiation. The human xenograft model in nude rats established with human head, neck and non-small cell lung cancer cell lines established the effectiveness of intetumumab in combination with radiation therapy. A limited antitumor activity was observed with a significant reduction of VEGFR and integrin αv expression along with the density reduction of micro vessels [48]. It also inhibited spontaneous lung metastasis of A 549 tumors. When radiation therapy is combined with intetumumab the perfusion rate and blood volume in tumours were enhanced significantly which were totally different as a single agents of treatment [49]. These results encouraged the potent efficacy of intetumumab along with fractionated radiation therapy and were consistent with the Phase-I.

Studies from uterine serous papillary carcinoma (USPC), colorectal adenocarcinoma, breast cancer demonstrated the anti-metastatic and prognostic effect of intetumumab. The cell adhesion of uterine serous papillary carcinoma (USPC) cell lines that express αv integrins to ECM proteins were significantly inhibited at low doses of intetumumab. The in vitro and in vivo studies employing 8.0 µm pore poly carbonate membrane demonstrated the ability of intetumumab to inhibit the migration of uterine serous papillary carcinoma cells [43]. In a hematogenous metastasis study the rats treated with intetumumab did not develop any brain lesions compared to contrast result of control rats. Intetumumab significantly improved the survival and incidence of multiple brain metastases in MRI was also reduced. It also reduced the human 231 BR-HER2 cells adhesion to the cultured plates with 97-100% viability [50]. These results emphasized the prophylactic effect and the anti-metastatic effect of intetumumab in nude rats. A recent study in non-small cell lung cancer (NSCLC) assessed the potential growth inhibition mechanism by using intetumumab. In the cells deleted with SMARCA 4 gene, ZEB 1 gene expression was up regulated whereas E-cadherin expression was down regulated. These results to gain the information regarding the inhibition mechanism and suggest ZEB 1 acquires SMARC 4 independent mechanism to repress E-cadherin expression. The results also showed strong enrichment in several chromosomal locations in which the down regulated genes were highly enriched on chromosome 19p while the up regulated genes were enriched on chromosome 4q in resistant cells [51]. This information is necessary to support further clinical evaluation of intetumumab to evaluate the antitumor and antiangiogenic effects.

EMD 525797 (DI1756): EMD 525797 (DI1756) is a novel de-immunized monoclonal immunoglobulin G2 antibody that is developed specifically to direct against the human αv integrins. It prevent the cell adhesion and motility of the tumor cells by binding to the human αv integrins and inhibits the ligand binding to all αv heterodimers thereby antagonizing their interactions. The Phase-I studies evaluated the safety, efficacy, tolerability, anti-tumor activity and pharmacokinetics of the DI1756. In a multicentre, open-label, dose escalating (250 mg, 500 mg, 1000 mg, 1500 mg) study enrolled with 26 patients of metastatic CRPC showed a dose-dependent and non-linearity pharmacokinetics profile of EMD 525797. The terminal elimination half-life of low dose (250 mg) observed approximately four fold divergence when compared to high dose level (1500 mg). No DLTs and dose dependent relationship in TEAEs were observed. But there was significant decrease in primary tumor only in one patient and over all the treatment with EMD 525797 was well tolerated and it appeared to be safe in metastatic CRPC patients [52]. In another Phase-I, first-in-human study with 54 subjects studied observed the EMD 525797 elimination from serum with t½ of 13 fold difference to 1500 mg dose group. The results demonstrated that the pharmacokinetics of EMD 525797 was dose-dependent with dose proportion increase of Cmax values and treatment was well tolerated with ascending doses of EMD 525797 (35 mg to 1500 mg) [53].
patients was ongoing with 750 mg and 1500 mg of EMD 525797 [52]. Over all these results suggest EMD 525797 as a potent single agent inhibitor but further evaluation of predictive markers and controlled randomized trials are necessary to evaluate the efficacy of the EMD 52579.

**GIPG0187**: GIPG0187 is a non-peptide RGD antagonist for all six integrin receptors. It displays a unique anti-integrin, anti-tumor, anti angiogenic, anti-osteoporotic and anti-resorptive profile [54]. In human prostate cancer PC-3M-Pro4/luc+ cells treated with GIPG0187, reduced tumor growth and bone metastases were observed. It diminished the aldehyde dehydrogenase and increased the E-Cadherin/vimentin ratio in the in vivo study performed in the prostate cancer cells. In the in vitro study it significantly prevented the ORX-induced bone loss and reduced the number of osteoclasts. These in vitro and in vivo results suggest it as a potent inhibitor of angiogenesis [15]. The exposure of the GIPG0187 to GL-261 and SMA-560 mouse glioma cells resulted in reduced viability and cell death at very low concentrations (1 nM). Also the impaired TGF-β signalling was observed when pSmad2 levels were reduced in GL-261 and SMA-560 mouse glioma cells cultured on the collagen-I coated cell plates [55]. This agent progressed to clinical trials in advanced cancers with the supportive results from Phase-I and further evaluation is much more important for cancer therapy.

**MK0429**: MK0429 is a small, active, potent, non-peptide αvβ3 integrin inhibitor [23,56]. It functions to have potent inhibition activity for osteoclast formation and osteoclastic bone resorption. In multicentre, randomized Phase-I double-blind trial enrolled with 21 HRPC and bone metastatic patients, rapid absorption of mk-0429 at lower dose was evident. The treatment was well tolerated with no DLTs and adverse effects and assumed to be safe [57]. Even though the positive results for safety and tolerability were observed for this orally bioavailable compound it is not being developed.

**PSK1404**: PSK1404 is a non-peptide antagonist for αvβ3 integrin [58]. It inhibits osteoclast bone resorption and exhibits antitumor activity in ovarian and breast cancer cells. In in vitro and in vivo studies it significantly blocked the tumor cell invasion and inhibited bone marrow colonization in αvβ3 integrin expressing cancer cells. It also exhibits multiple inhibitory effects on endothelial cells, cancer cells and osteoclasts [16]. But very limited pre-clinical study is done further evaluation of PSK 1404 is very vital to understand the αvβ3 integrin inhibitory mechanism in bone metastases therapy.

**JIH1062**: JIH1062 (3,5-dichlorophenylbiguanide) is an effective αvβ3 integrin inhibitor derived form 3, 4-dichlorophenylbiguanide. It specifically inhibits the binding of αvβ3 integrin to its vitronectin (ligand to αvβ3 integrin) and leads to cellular apoptosis. In M21 (human melanoma cell line) it induced anoikis, lead to decrease of Bcl-2/Bax ratio and survivin proteins, dephosphorylate Tyr925 in the carboxyl region of FAK. It also inhibited the pulmonary metastases in established melanoma pulmonary metastasis mouse model in dose dependent manner [59]. These in vitro and in vivo results established for JIH1062 in human melanoma cells is promising development to treat and prevent tumor metastasis.

**DisBa-01**: DisBa-01 is a novel monomeric P-II SVMP-derived RGD disintegrin. It is derived from venom gland RNAs of Bothropsalternatus by recombinant DNA techniques. It interacts in a stable and specific manner with purified αvβ3 integrin, induced by bFGF in endothelial cells [60]. DisBa-01 inhibits angiogenesis in a dose dependent manner and by reducing the expression of VEGF and its receptors significantly. In HMEC cells at 10 nM and 100 nM concentrations of DisBa-01 showed the down regulated VEGFR1 and VEGFR2. In fibroblasts it contributed to reduce migration ability by inhibiting the MMP-2 activity. It also impaired the proliferation by αvβ3 and inhibits the adhesion of B16F10 and HMEC-1 to vitronectin. These in vitro reports demonstrate the anti-adhesive properties of DisBa-01. The ex vivo and in vivo studies demonstrate the anti-metastatic and protective effect of disintegrin [61]. All these results describe the essentiality to understand the molecular mechanism underlying that target integrin-mediated processes using novel anti-metastatic therapies.

**S137 and S247**: These are non-peptidic and β-amino acid compounds. The potency of the S137 is slightly lower than S247. Both these compounds inhibit the cell growth, motility, adhesion and enhance the apoptosis of tumor cells in dose dependent manner. In vitro results suggest that they actively inhibit ligand binding to αv integrin and induce apoptosis in HUVCC cells [62,63]. The continuous regime of S247 in an animal model significantly reduced the development of liver metastases with better survival.

**17E6**: 17E6 is a function blocking, non-RGD, allostERIC inhibitor which contacts exclusively the propeller domain of αv integrin. 17E6 antibody behaves as an extracellular ligand and promotes the endocytosis of αvβ3 integrin by preferring integrin dependent-receptor mediated pathway. It alters the distribution of αv integrins on the cell surface and induces the relocalization of focal adhesion proteins [64]. It possesses anti-tumor, anti-adhesive, anti-metastasis activities and interacts specifically against the human and primate αvβ3 αvβ1 and αvβ5 integrins [65,66]. 17E6 significantly inhibited the adhesion of vitronectin and fibrinogen, ligands of αv integrins to cutaneous melanoma DX3 line [67]. A strong morphological change was induced in adhered M21 melanoma cells and blockade of tumor growth was observed in nude mice suggesting the anti-tumor activity of the compound [68]. In signalling cascade events 17E6 plays a vital role by promoting FAK phosphorylation, partially interrupting apoptotic signalling pathway that is activated by β-amyloid, activating FAK/paxillin/p130 CAS signalling pathway, inhibiting the tumor suppressor p53 protein expression, activating cell survival via PI3K/Akt signaling [69]. In the performed in vivo study significantly hindered the tumor growth in the positive αvβ3 xenografts that express the melanoma cells [70]. Study performed using infected macrophages reported a reduced HIV-1 Bal proviral DNA and also inhibited the HIV infection at an early stage of the viral cycle suggesting the interference of 17E6 for HIV replication in macrophages [71]. Currently this monoclonal antibody was in clinical trials for treating cancer.

**ATN-161**: ATN-161 is a five amino acid acetylated, amidated PHSCN peptide derived from the synergy region of human fibrinectin PHSRN sequence [72]. The Arginine amino acid in the original sequence is replaced with cysteine residue. ATN-161 induces neovascularization in matrigel plug assays performed in nude mice and observed a dose dependent regulation of αvβ3 integrin in human microvascular endothelial cells [73]. These down regulation of αvβ3 integrin resulted in apoptosis through the suppression of the Akt activity [74]. PHSCN peptide sequence reduced the tumor growth in rats to much more extent than rats treated with HSPNC which was inactive (because tumor growth in rats treated with HSPNC increased rapidly in both treated and untreated) suggesting the anti-tumorigenic activity of the peptide [75]. In the murine colon cancer model it
decreases the formation of liver metastases with enhanced survival, proposing the anti-metastatic activity [18]. It is also the first PHSRN synergy potent inhibitor sequence with anti-tumorigenic and anti-metastatic to be evaluated in clinical trials where it prevented progression of metastatic disease and recurrence for prolonged periods [76]. In preclinical and Phase-I trials using Lewis lung carcinoma and HT 29 colon carcinoma model a U-shaped dose response was observed for ATN-161 peptide with rapid clearance from serum [77]. The therapy with ATN-161 administration in combination with tetrathiomolybdate and also with 5-fluorouracil also suggested the ATN-161 as more anti-tumorigenic agent [18,78]. Few other analogues of ATN-161 like ATN-453, PHSCN-polysilane dendrimer (Ac-PHSCNGGK-MAP), PhSCN (where Histidine and Cysteine were replaced with D-isomers), PHSC(S-OAc)N, PHSC(S-Me)N, PHSC(S-acm)N reported to be more potent in metastatic human prostate cancer cells [20]. The Phase-II clinical trials of this agent are proceeding to be extremely challenging because no maximum tolerated dose was achieved in former trials.

**Resveratrol**: Resveratrol (3, 4’, 5-trihydroxy-trans-stilbene) is natural polyphenolic antioxidant found in plants and fruits (mostly grapes) in Cis and trans stereoisomer forms, the trans isomer being significantly more potent than Cis isofomer. It regulates the expression of various genes encoding to integrins that are involved in cellular process like apoptosis, metastasis, adhesion and angiogenesis [79,80]. The *in vitro* and *in vivo* studies showed the inhibitory ability of the Resveratrol in chick embryo and murine melanoma B16 by inhibiting the adhesion by down regulation of cellular α<sub>5</sub>β<sub>1</sub> integrins [81]. A recent study reported that in the treatment with Res inhibited the adhesion of ovarian cancer cell to HPMCs, dose dependently [82]. The receptor sites on α<sub>5</sub>β<sub>1</sub> integrin for Res induces apoptosis that is p53-dependent via ERK 1/2, mediated pSer15 and also requires pool of inducible cycloxygenase-2 [83]. However more clinical studies regarding the mechanism of action and how resveratrol induces apoptosis are yet to be examined.

**Conclusion**

In recent years, great progress has been made towards integrin antagonists that target cancer. Their effectiveness in blocking tumour progression has been demonstrated in preclinical as well as clinical studies. At present there are multiple ongoing clinical trials on integrin antagonists agents and few other novel compounds like JSM6427 [84], β-lactam derivatives [6] and a Tenascin (TN)-C derived TNNIA2 peptide [85] showed promising biological activity to target integrins but in deep investigations are necessary for these compounds in the malignancies that express high levels of integrins.

**Acknowledgement**

The authors acknowledges to Acharya Nagarjuna University, Guntur, Andhra Pradesh and Indian Institute of Technology Hyderabad, Telangana for the continuous support and encouragement.

**References**


