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## Prostate stem cell antigen (PSCA) expression in human prostate cancer tissues and its potential role in prostate carcinogenesis and progression of prostate cancer

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### Abstract

**Background:** Prostate stem cell antigen (PSCA) is a recently defined homologue of the Thy-1/Ly-6 family of glycosylphosphatidylinositol (GPI)-anchored cell surface antigens. The purpose of the present study was to examine the expression status of PSCA protein and mRNA in clinical specimens of human prostate cancer (Pca) and to validate it as a potential molecular target for diagnosis and treatment of Pca.

**Materials and Methods:** Immunohistochemical (IHC) and *in situ* hybridization (ISH) analyses of PSCA expression were simultaneously performed on paraffin-embedded sections from 20 benign prostatic hyperplasia (BPH), 20 prostatic intraepithelial neoplasm (PIN) and 48 prostate cancer (Pca) tissues, including 9 androgen-independent prostate cancers. The level of PSCA expression was semiquantitatively scored by assessing both the percentage and intensity of PSCA-positive staining cells in the specimens. Then compared PSCA expression between BPH, PIN and Pca tissues and analysed the correlations of PSCA expression level with pathological grade, clinical stage and progression to androgen-independence in Pca.

**Results:** In BPH and low grade PIN, PSCA protein and mRNA staining were weak or negative and less intense and uniform than that seen in HGPIN and Pca. There were moderate to strong PSCA protein and mRNA expression in 8 of 11 (72.7%) HGPIN and in 40 of 48 (83.4%) Pca specimens examined by IHC and ISH analyses, with statistical significance compared with BPH (20%) and low grade PIN (22.2%) samples ( $p < 0.05$ , respectively). The expression level of PSCA increased with high Gleason grade, advanced stage and progression to androgen-independence ( $p < 0.05$ , respectively). In addition, IHC and ISH staining showed a high degree of correlation between PSCA protein and mRNA overexpression.

**Conclusions:** Our data demonstrate that PSCA as a new cell surface marker is overexpressed by a majority of human Pca. PSCA expression correlates positively with adverse tumor characteristics, such as increasing pathological grade (poor cell differentiation), worsening clinical stage and androgen-independence, and speculatively with prostate carcinogenesis. PSCA protein overexpression results from upregulated transcription of PSCA mRNA. PSCA may have prognostic utility and may be a promising molecular target for diagnosis and treatment of Pca.

## Introduction

Prostate cancer (Pca) is the second leading cause of cancer-related death in American men and is becoming a common cancer increasing in China. Despite recently great progress in the diagnosis and management of localized disease, there continues to be a need for new diagnostic markers that can accurately discriminate between indolent and aggressive variants of Pca. There also continues to be a need for the identification and characterization of potential new therapeutic targets on Pca cells. Current diagnostic and therapeutic modalities for recurrent and metastatic Pca have been limited by a lack of specific target antigens of Pca.

Although a number of prostate-specific genes have been identified (i.e. prostate specific antigen, prostatic acid phosphatase, glandular kallikrein 2), the majority of these are secreted proteins not ideally suited for many immunological strategies. So, the identification of new cell surface antigens is critical to the development of new diagnostic and therapeutic approaches to the management of Pca.

Reiter RE et al [1] reported the identification of prostate stem cell antigen (PSCA), a cell surface antigen that is predominantly prostate specific. The PSCA gene encodes a 123 amino acid glycoprotein, with 30% homology to stem cell antigen 2 (Sca 2). Like Sca-2, PSCA also belongs to a member of the Thy-1/Ly-6 family and is anchored by a glycosylphosphatidylinositol (GPI) linkage. mRNA *in situ* hybridization (ISH) localized PSCA expression in normal prostate to the basal cell epithelium, the putative stem cell compartment of prostatic epithelium, suggesting that PSCA may be a marker of prostate stem/progenitor cells.

In order to examine the status of PSCA protein and mRNA expression in human Pca and validate it as a potential diagnostic and therapeutic target for Pca, we used immunohistochemistry (IHC) and *in situ* hybridization (ISH) simultaneously, and conducted PSCA protein and mRNA expression analyses in paraffin-embedded tissue specimens of benign prostatic hyperplasia (BPH, n = 20), prostate intraepithelial neoplasm (PIN, n = 20) and prostate cancer (Pca, n = 48). Furthermore, we evaluated the possible correlation of PSCA expression level with Pca tumorigenesis, grade, stage and progression to androgen-independence.

## Materials and methods

### Tissue samples

All of the clinical tissue specimens studied herein were obtained from 80 patients of 57–84 years old by prostatectomy, transurethral resection of prostate (TURP) or biopsies. The patients were classified as 20 cases of BPH, 20 cases of PIN, 40 cases of primary Pca, including 9 patients

with recurrent Pca and a history of androgen ablation therapy (orchiectomy and/or hormonal therapy), who were referred to as androgen-independent prostate cancers. Eight specimens were harvested from these androgen-independent Pca patients prior to androgen ablation treatment. Each tissue sample was cut into two parts, one was fixed in 10% formalin for IHC and the other treated with 4% paraformaldehyde/0.1 M PBS PH 7.4 in 0.1% DEPC for 1 h for ISH analysis, and then embedded in paraffin. All paraffin blocks examined were then cut into 5  $\mu$ m sections and mounted on the glass slides specific for IHC and ISH respectively in the usual fashion. H&E-stained section of each Pca was evaluated and assigned a Gleason score by the experienced urological pathologist at our institution based on the criteria of Gleason score [2]. The Gleason sums are summarized in Table 1. Clinical staging was performed according to Jewett-whitmore-prout staging system, as shown in Table 2. In the category of PIN, we graded the specimens into two groups, i.e. low grade PIN (grade I – II) and high grade PIN (HG PIN, grade III) on the basis of literatures [3,4].

### Immunohistochemical (IHC) analysis

Briefly, tissue sections were deparaffinized, dehydrated, and subjected to microwaving in 10 mmol/L citrate buffer, PH 6.0 (Boshide, Wuhan, China) in a 900 W oven for 5 min to induce epitope retrieval. Slides were allowed to cool at room temperature for 30 min. A primary mouse antibody specific to human PSCA (Boshide, Wuhan, China) with a 1:100 dilution was applied to incubate with the slides at room temperature for 2 h. Labeling was detected by sequentially adding biotinylated secondary antibodies and streptavidin-peroxidase, and localized using 3,3'-diaminobenzidine reaction. Sections were then counterstained with hematoxylin. Substitution of the primary antibody with phosphate-buffered-saline (PBS) served as a negative-staining control.

### mRNA in situ hybridization (ISH)

Five- $\mu$ m-thick tissue sections were deparaffinized and dehydrated, then digested in pepsin solution (4 mg/ml in 3% citric acid) for 20 min at 37.5°C, and further processed for ISH. Digoxigenin-labeled sense and antisense human PSCA RNA probes (obtained from Boshide, Wuhan, China) were hybridized to the sections at 48°C overnight. The posthybridization wash with a high stringency was performed sequentially at 37°C in 2  $\times$  standard saline citrate (SSC) for 10 min, in 0.5  $\times$  SSC for 15 min and in 0.2  $\times$  SSC for 30 min. The slides were then incubated to biotinylated mouse anti-digoxigenin antibody at 37.5°C for 1 h followed by washing in 1  $\times$  PBS for 20 min at room temperature, and then to streptavidin-peroxidase at 37.5°C for 20 min followed by washing in 1  $\times$  PBS for 15 min at room temperature. Subsequently, the slides were developed with diaminobenzidine and then coun-

**Table 1: Correlation of PSCA expression with Gleason score**

Gleason score	Intensity × frequency	
	0–6 (%)	9 (%)
2–4	5 (83)	1 (17)
5–7	19 (79)	5 (21)
8–10	5 (28)	13 (72)

**Table 2: Correlation of PSCA expression with clinical stage**

Tumor stage	Intensity × frequency	
	0–6 (%)	9 (%)
≤B	27 (67.5)	13 (32.5)
≥C	2 (25)	6 (75)

terstained with hematoxylin to localize the hybridization signals. Sections hybridized with the sense control probes routinely did not show any specific hybridization signal above background. All slides were hybridized with PBS to substitute for the probes as a negative control.

#### Scoring methods

To determine the correlation between the results of PSCA immunostaining and mRNA *in situ* hybridization, the same scoring manners are taken in the present study for PSCA protein staining by IHC and PSCA mRNA staining by ISH. Each slide was read and scored by two independently experienced urological pathologists using Olympus BX-41 light microscopes. The evaluation was done in a blinded fashion. For each section, five areas of similar grade were analyzed semiquantitatively for the fraction of cells staining. Fifty percent of specimens were randomly chosen and rescored to determine the degree of interobserver and intraobserver concordance. There was greater than 95% intra- and interobserver agreement.

The intensity of PSCA expression evaluated microscopically was graded on a scale of 0 to 3+ with 3 being the highest expression observed (0, no staining; 1+, mildly intense; 2+, moderately intense; 3+, severely intense). The staining density was quantified as the percentage of cells staining positive for PSCA with the primary antibody or hybridization probe, as follows: 0 = no staining; 1 = positive staining in <25% of the sample; 2 = positive staining in 25%–50% of the sample; 3 = positive staining in >50%

of the sample. Intensity score (0 to 3+) was multiplied by the density score (0–3) to give an overall score of 0–9 [1,5]. In this way, we were able to differentiate specimens that may have had focal areas of increased staining from those that had diffuse areas of increased staining [6]. The overall score for each specimen was then categorically assigned to one of the following groups: 0 score, negative expression; 1–2 scores, weak expression; 3–6 scores, moderate expression; 9 score, strong expression.

#### Statistical analysis

Intensity and density of PSCA protein and mRNA expression in BPH, PIN and Pca tissues were compared using the Chi-square and Student's *t*-test. Univariate associations between PSCA expression and Gleason score, clinical stage and progression to androgen-independence were calculated using Fisher's Exact Test. For all analyses,  $p < 0.05$  was considered statistically significant.

#### Results

##### PSCA expression in BPH

In general, PSCA protein and mRNA were expressed weakly in individual samples of BPH. Some areas of prostate expressed weak levels (composite score 1–2), whereas other areas were completely negative (composite score 0). Four cases (20%) of BPH had moderate expression of PSCA protein and mRNA (composite score 4–6) by IHC and ISH. In 2/20 (10%) BPH specimens, PSCA mRNA expression was moderate (composite score 3–6), but PSCA protein expression was weak (composite score

2) in one and negative (composite score 0) in the other. PSCA expression was localized to the basal and secretory epithelial cells, and prostatic stroma was almost negative staining for PSCA protein and mRNA in all cases examined.

#### **PSCA expression in PIN**

In this study, we detected weak or negative expression of PSCA protein and mRNA ( $\leq 2$  scores) in 7 of 9 (77.8%) low grade PIN and in 2 of 11 (18.2%) HGPIN, and moderate expression (3–6 scores) in the rest 2 low grade PIN and 5 of 11 (45.5%) HGPIN. One HGPIN with moderate PSCA mRNA expression (6 score) was found weak staining for PSCA protein (2 score) by IHC. Strong PSCA protein and mRNA expression (9 score) were detected in the remaining 3 of 11 (27.3%) HGPIN. There was a statistically significant difference of PSCA protein and mRNA expression levels observed between HGPIN and BPH ( $p < 0.05$ ), but no statistical difference reached between low grade PIN and BPH ( $p > 0.05$ ).

#### **PSCA expression in Pca**

In order to determine if PSCA protein and mRNA can be detected in prostate cancers and if PSCA expression levels are increased in malignant compared with benign glands, Forty-eight paraffin-embedded Pca specimens were analysed by IHC and ISH. It was shown that 19 of 48 (39.6%) Pca samples stained very strongly for PSCA protein and mRNA with a score of 9 and another 21 (43.8%) specimens displayed moderate staining with scores of 4–6 (Figure 1). In addition, 4 specimens with moderate to strong PSCA mRNA expression (scores of 4–9) had weak protein staining (a score of 2) by IHC analyses. Overall, Pca expressed a significantly higher level of PSCA protein and mRNA than any other specimen category in this study ( $p < 0.05$ , compared with BPH and PIN respectively). The result demonstrates that PSCA protein and mRNA are overexpressed by a majority of human Pca.

#### **Correlation of PSCA expression with Gleason score in Pca**

Using the semi-quantitative scoring method as described in Materials and Methods, we compared the expression level of PSCA protein and mRNA with Gleason grade of Pca, as shown in Table 1. Prostate adenocarcinomas were graded by Gleason score as 2–4 scores = well-differentiation, 5–7 scores = moderate-differentiation and 8–10 scores = poor-differentiation [7]. Seventy-two percent of Gleason scores 8–10 prostate cancers had very strong staining of PSCA compared to 21% with Gleason scores 5–7 and 17% with 2–4 respectively, demonstrating that poorly differentiated Pca had significantly stronger expression of PSCA protein and mRNA than moderately and well differentiated tumors ( $p < 0.05$ ). As depicted in Figure 1, IHC and ISH analyses showed that PSCA protein and mRNA expression in several cases of poorly differen-

tiated Pca were particularly prominent, with more intense and uniform staining. The results indicate that PSCA expression increases significantly with higher tumor grade in human Pca.

#### **Correlation of PSCA expression with clinical stage in Pca**

With regards to PSCA expression in every stage of Pca, we showed the results in Table 2. Seventy-five percent of locally advanced and node positive cancers (i.e. C-D stages) expressed statistically high levels of PSCA versus 32.5% that were organ confined (i.e. A-B stages) ( $p < 0.05$ ). The data demonstrate that PSCA expression increases significantly with advanced tumor stage in human Pca.

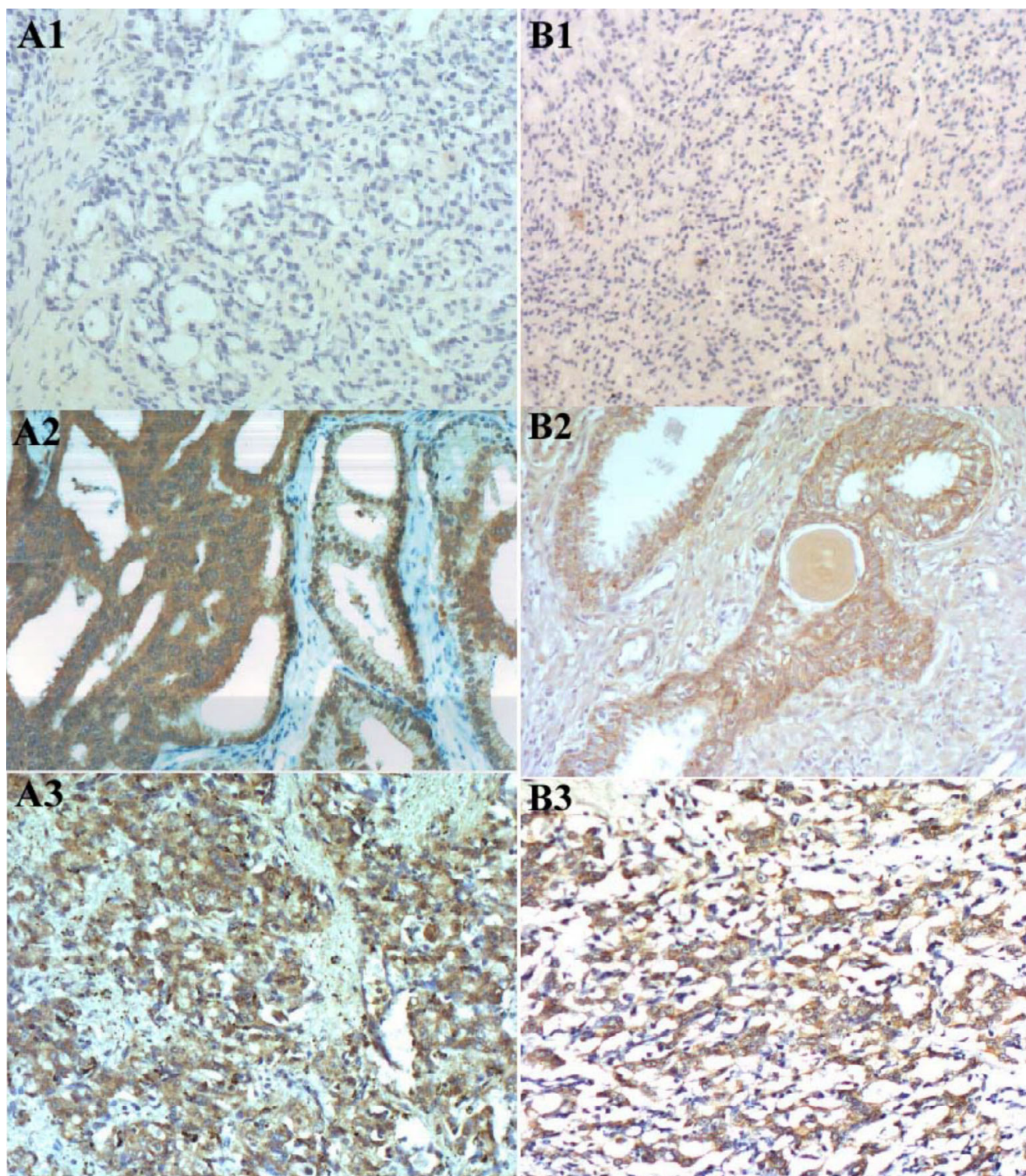
#### **Correlation of PSCA expression with androgen-independent progression of Pca**

All 9 specimens of androgen-independent prostate cancers stained positive for PSCA protein and mRNA. Eight specimens were obtained from patients managed prior to androgen ablation therapy. Seven of eight (87.5%) of these androgen-independent prostate cancers were in the strongest staining category (score = 9), compared with three out of eight (37.5%) of patients with androgen-dependent cancers ( $p < 0.05$ ). The results demonstrate that PSCA expression increases significantly with progression to androgen-independence of human Pca.

It is evident from the results above that within a majority of human prostate cancers the level of PSCA protein and mRNA expression correlates significantly with increasing grade, worsening stage and progression to androgen-independence.

#### **Correlation of PSCA immunostaining and mRNA in situ hybridization**

In all 88 specimens surveyed herein, we compared the results of PSCA IHC staining with mRNA ISH analysis. Positive staining areas and its intensity and density scores evaluated by IHC were identical to those seen by ISH in 79 of 88 (89.8%) specimens (18/20 BPH, 19/20 PIN and 42/48 Pca respectively). Importantly, 27/27 samples with PSCA mRNA composite scores of 0–2, 32/36 samples with scores of 3–6 and 22/24 samples with a score of 9 also had PSCA protein expression scores of 0–2, 3–6 and 9 respectively. However, in 5 samples with PSCA mRNA overall scores of 3–6 and in 2 with scores of 9 there were less or negative PSCA protein expression (i.e. scores of 0–4), suggesting that this may reflect posttranscriptional modification of PSCA or that the epitopes recognized by PSCA mAb may be obscured in some cancers. The data demonstrate that the results of PSCA immunostaining were consistent with those of mRNA ISH analysis, showing a high degree of correlation between PSCA protein and mRNA expression.



### Figure 1

Representatives of PSCA IHC and ISH staining in Pca (A. IHC staining, B. ISH staining,  $\times 200$  magnification). A<sub>1</sub>, B<sub>1</sub>: negative control of IHC and ISH. PBS replacing the primary antibody (A<sub>1</sub>) and hybridization with a sense PSCA probe (B<sub>1</sub>) showed no background staining. A<sub>2</sub>, B<sub>2</sub>: a moderately differentiated Pca (Gleason score = 3+3 = 6) with moderate staining (composite score = 6) in all malignant cells; A<sub>2</sub>: IHC shows not only cell surface but also apparent cytoplasmic staining of PSCA protein. A<sub>3</sub>, B<sub>3</sub>: a poorly differentiated Pca (Gleason score = 4+4 = 8) with very strong staining (composite score = 9) in all malignant cells.

## Discussion

PSCA is homologous to a group of cell surface proteins that mark the earliest phase of hematopoietic development. PSCA mRNA expression is prostate-specific in normal male tissues and is highly up-regulated in both androgen-dependent and-independent Pca xenografts (LAPC-4 tumors). We hypothesize that PSCA may play a role in Pca tumorigenesis and progression, and may serve as a target for Pca diagnosis and treatment. In this study, IHC and ISH showed that in general there were weak or absent PSCA protein and mRNA expression in BPH and low grade PIN tissues. However, PSCA protein and mRNA are widely expressed in HGPIN, the putative precursor of invasive Pca, suggesting that up-regulation of PSCA is an early event in prostate carcinogenesis. Recently, Reiter RE et al [1], using ISH analysis, reported that 97 of 118 (82%) HGPIN specimens stained strongly positive for PSCA mRNA. A very similar finding was seen on mouse PSCA (mPSCA) expression in mouse HGPIN tissues by Tran C. P et al [8]. These data suggest that PSCA may be a new marker associated with transformation of prostate cells and tumorigenesis.

We observed that PSCA protein and mRNA are highly expressed in a large percentage of human prostate cancers, including advanced, poorly differentiated, androgen-independent and metastatic cases. Fluorescence-activated cell sorting and confocal/ immunofluorescent studies demonstrated cell surface expression of PSCA protein in Pca cells [9]. Our IHC expression analysis of PSCA shows not only cell surface but also apparent cytoplasmic staining of PSCA protein in Pca specimens (Figure 1). One possible explanation for this is that anti-PSCA antibody can recognize PSCA peptide precursors that reside in the cytoplasm. Also, it is possible that the positive staining that appears in the cytoplasm is actually from the overlying cell membrane [5]. These data seem to indicate that PSCA is a novel cell surface marker for human Pca.

Our results show that elevated level of PSCA expression correlates with high grade (i.e. poor differentiation), increased tumor stage and progression to androgen-independence of Pca. These findings support the original IHC analyses by Gu Z et al [9], who reported that PSCA protein expressed in 94% of primary Pca and the intensity of PSCA protein expression increased with tumor grade, stage and progression to androgen-independence. Our results also collaborate the recent work of Han KR et al [10], in which the significant association between high PSCA expression and adverse prognostic features such as high Gleason score, seminal vesicle invasion and capsular involvement in Pca was found. It is suggested that PSCA overexpression may be an adverse predictor for recurrence, clinical progression or survival of Pca. Hara H et al [11] used RT-PCR detection of PSA, PSMA and PSCA in 1

ml of peripheral blood to evaluate Pca patients with poor prognosis. The results showed that among 58 Pca patients, each PCR indicated the prognostic value in the hierarchy of PSCA>PSA>PSMA RT-PCR, and extraprostatic cases with positive PSCA PCR indicated lower disease-progression-free survival than those with negative PSCA PCR, demonstrating that PSCA can be used as a prognostic factor. Dubey P et al [12] reported that elevated numbers of PSCA + cells correlate positively with the onset and development of prostate carcinoma over a long time span in the prostates of the TRAMP and PTEN +/- models compared with its normal prostates. Taken together with our present findings, in which PSCA is overexpressed from HGPIN to almost frank carcinoma, it is reasonable and possible to use increased PSCA expression level or increased numbers of PSCA-positive cells in the prostate samples as a prognostic marker to predict the potential onset of this cancer. These data raise the possibility that PSCA may have diagnostic utility or clinical prognostic value in human Pca.

The cause of PSCA overexpression in Pca is not known. One possible mechanism is that it may result from PSCA gene amplification. In humans, PSCA is located on chromosome 8q24.2 [1], which is often amplified in metastatic and recurrent Pca and considered to indicate a poor prognosis [13-15]. Interestingly, PSCA is in close proximity to the c-myc oncogene, which is amplified in >20% of recurrent and metastatic prostate cancers [16,17]. Reiter RE et al [18] reported that PSCA and MYC gene copy numbers were co-amplified in 25% of tumors (five out of twenty), demonstrating that PSCA overexpression is associated with PSCA and MYC coamplification in Pca. Gu Z et al [9] recently reported that in 102 specimens available to compare the results of PSCA immunostaining with their previous mRNA ISH analysis, 92 (90.2%) had identically positive areas of PSCA protein and mRNA expression. Taken together with our findings, in which we detected moderate to strong expression of PSCA protein and mRNA in 34 of 40 (85%) Pca specimens examined simultaneously by IHC and ISH analyses, it is demonstrated that PSCA protein and mRNA overexpressed in human Pca, and that the increased protein level of PSCA was resulted from the upregulated transcription of its mRNA.

At present, the regulation mechanisms of human PSCA expression and its biological function are yet to be elucidated. PSCA expression may be regulated by multiple factors [18]. Watabe T et al [19] reported that transcriptional control is a major component regulating PSCA expression levels. In addition, induction of PSCA expression may be regulated or mediated through cell-cell contact and protein kinase C (PKC) [20]. Homologues of PSCA have diverse activities, and have themselves been involved in

carcinogenesis. Signalling through SCA-2 has been demonstrated to prevent apoptosis in immature thymocytes [21]. Thy-1 is involved in T cell activation and transduces signals through src-like tyrosine kinases [22]. Ly-6 genes have been implicated both in tumorigenesis and in cell-cell adhesion [23-25]. Cell-cell or cell-matrix interaction is critical for local tumor growth and spread to distal sites. From its restricted expression in basal cells of normal prostate and its homology to SCA-2, PSCA may play a role in stem/progenitor cell function, such as self-renewal (i.e. anti-apoptosis) and/or proliferation [1]. Taken together with the results in the present study, we speculate that PSCA may play a role in tumorigenesis and clinical progression of Pca through affecting cell transformation and proliferation. From our results, it is also suggested that PSCA as a new cell surface antigen may have a number of potential uses in the diagnosis, therapy and clinical prognosis of human Pca. PSCA overexpression in prostate biopsies could be used to identify patients at high risk to develop recurrent or metastatic disease, and to discriminate cancers from normal glands in prostatectomy samples. Similarly, the detection of PSCA-overexpressing cells in bone marrow or peripheral blood may identify and predict metastatic progression better than current assays, which identify only PSA-positive or PSMA-positive prostate cells.

In summary, we have shown in this study that PSCA protein and mRNA are maintained in expression from HGPIN through all stages of Pca in a majority of cases, which may be associated with prostate carcinogenesis and correlate positively with high tumor grade (poor cell differentiation), advanced stage and androgen-independent progression. PSCA protein overexpression is due to the upregulation of its mRNA transcription. The results suggest that PSCA may be a promising molecular marker for the clinical prognosis of human Pca and a valuable target for diagnosis and therapy of this tumor.

### Competing interests

None declared.

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