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Award Number: W81XWH-05-1-0390

TITLE: Chemoprevention of Breast Cancer by Mimicking the Protective Effect of Early First Birth

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REPORT DATE: June 2011

TYPE OF REPORT: Final

PREPARED FOR: U.S. Army Medical Research and Materiel Command
Fort Detrick, Maryland 21702-5012

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REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

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1. REPORT DATE (DD-MM-YYYY) 01-06-2011		2. REPORT TYPE Final		3. DATES COVERED (From - To) 2 MAY 2005 - 2 MAY 2011	
4. TITLE AND SUBTITLE Chemoprevention of Breast Cancer by Mimicking the Protective Effect of Early First Birth				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER W81XWH-05-1-0390	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S) Malcolm Pike E-Mail: mcpike@usc.edu				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) University of Southern California Los Angeles, CA 90069				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES) U.S. Army Medical Research and Materiel Command Fort Detrick, Maryland 21702-5012				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION / AVAILABILITY STATEMENT Approved for Public Release; Distribution Unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT We have shown in the rat that pregnancy, and also estradiol, estradiol plus progesterone, and beta-HCG are protective against mammary cancer; associated RNA expression changes have been identified. No definitive evidence was obtained of parity or hormonal prevention of mammary cancer in mice. Breast gene expression in parous and nulliparous women showed marked between-women differences but failed to distinguish parous from nulliparous women. ER and PR expression, and cell proliferation in the breast epithelium has been studied by immunohistochemistry in four protocols relating to chemoprevention: (1) parous and nulliparous women; (2) women in the first trimester of pregnancy; (3) women briefly exposed to high estrogen levels; and (4) women using oral contraceptives with markedly different progestin doses. Further studies are ongoing. Pregnancy reduced PRA expression and lower PRA distinguished parous from nulliparous women, but PRA was not affected by brief high level estrogen exposure. Reduced progestin failed to reduce breast proliferation. Stromal DNA methylation characterization of the parous and nulliparous samples has begun. Pregnancy reduces mammographic density and breast cancer risk. How these are related has been studied in a large autopsy series; results suggest that part of the protection may be the result of a reduction in breast epithelium; further studies of these samples are ongoing.					
15. SUBJECT TERMS Breast cancer, chemoprevention					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			19b. TELEPHONE NUMBER (include area code)
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Table of Contents

	<u>Page</u>
Introduction.....	4
Body.....	4
Key Research Accomplishments.....	27
Reportable Outcomes.....	29
Conclusion.....	30
References.....	31
Appendices.....	32

INTRODUCTION: This Innovator Award is designed to provide insight into the ways in which a chemoprevention regimen can mimic the protective effect of a full-term pregnancy (a birth) against breast cancer. In addition, we are aiming to understand the mechanisms underlying the risk associated with increased mammographic density, the strongest known risk factor for breast cancer after the highly penetrant genetic risk factors of BRCA1 and BRCA2 mutations. Mammographic densities are permanently reduced by births; and this relationship is being explored to determine if this is an important part of the mechanism by which births provide protection against breast cancer. This work is being conducted both in humans and rodents.

BODY: The Innovator Award consists of four projects (Projects 1 and 2 have been carried out through a subcontract to our colleague Dr. Lewis Chodosh at the University of Pennsylvania, and Projects 3 and 4 are being completed by the team at USC).

Projects 1 and 2

Task 1: Months 1-12: Treat rats with different hormonal chemoprevention regimens, harvest mammary tissue, and isolate RNA.

As described in the Year 3 Progress Report, this task was completed on schedule.

Task 2: Months 6-24: Analyze morphological changes and determine global gene expression profiles for rat mammary gland samples from rats treated with different hormonal chemoprevention regimens.

As described in the Year 4 Progress Report, this task was completed on schedule.

Task 3: Months 6-36: Identify genes that are expressed in a parity-specific manner in the rat.

As described in the Year 3 Progress Report, this task was completed on schedule and the results published (Blakely et al., 2006).

Task 4: Months 6-36: Identify genes whose expression in rats correlates with protection against breast cancer.

As described in the Year 3 Progress Report, this task was completed on schedule.

Task 5: Months 1-48: Isolate RNA from human mammary gland samples and control epithelial and stromal samples.

As described in the Year 4 Progress Report, this task was completed on schedule.

Task 6: Months 3-52: Determine global gene expression profiles for human mammary gland samples using oligonucleotide microarrays.

As described in the Year 4 Progress Report, this task was completed ahead of schedule.

Task 7: Months 12-60: Identify genes whose expression in the mammary gland in women reflects aspects of reproductive history that impact on breast cancer susceptibility.

This task has been completed on schedule.

Preliminary results have suggested that identifying genes whose expression correlates with reproductive history may be confounded by significant variations in epithelial content among breast samples. Below we discuss these results and our attempts to overcome this technical difficulty.

As a preliminary approach toward completing this task, we explored the use of principal component analysis (PCA) to provide an overview of the variables accounting for global difference in gene expression between these samples. PCA uses the most variant genes in a dataset (~6700 for this dataset), and projects samples within a virtual three-dimensional space based on gene expression. The first two components typically reflect the most robust differences in gene expression among samples. Breast samples for nulliparous (green) and parous (pink) microarrays did not appear to be distinguishable on the basis of the first two components by PCA (Fig. 1). This finding suggests that reproductive history does not explain the most dominant inter-patient differences in gene expression. By comparison, in analogous studies using rodent samples, parity-induced gene expression changes typically predominate the first two components in a PCA, thereby rendering nulliparous and parous samples into unique gene expression space.

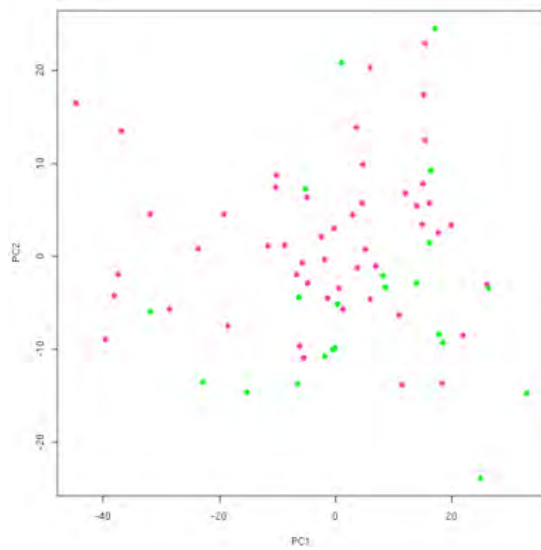


Figure 1: Principal Component Analysis based on the expression of ~6700 variant probe sets demonstrates that nulliparous (green) and parous (pink) samples do not separate by the first 2 components, suggesting that reproductive history is not the largest discriminator for this data set.

In light of this finding, we sought to identify the genes that contribute to the first and second components of the PCA. Genes characteristic of epithelial cells or epithelial content were found to constitute the predominant number of genes identified. Based on this information, we then coded samples from high (red) to low (blue) according to epithelial gene expression using PCA analysis. This analysis confirmed that the pattern observed for our data set can be explained by the relative epithelial content in the original frozen samples (Fig. 2).

The above variability in gene expression patterns based upon epithelial content confounded our ability to address gene expression changes based on reproductive history. To circumvent these issues, we proposed using a mathematical approach termed “expression deconvolution.” Past experience dictates that the interpretation of gene expression data derived from complex organs composed of multiple cell types (like the breast) is complicated by the fact that observed changes in gene expression may be due either to cell-intrinsic changes in gene expression or to changes in the relative abundance of different cell types. Consequently, *bona fide* changes in intrinsic gene regulation can either be mimicked or masked by changes in the relative proportion of different cellular compartments. Therefore, we sought to generate reference expression data from purified populations of constituent cell types within the mammary gland, and to then use this information to computationally adjust for differences in cellular compartments within samples.

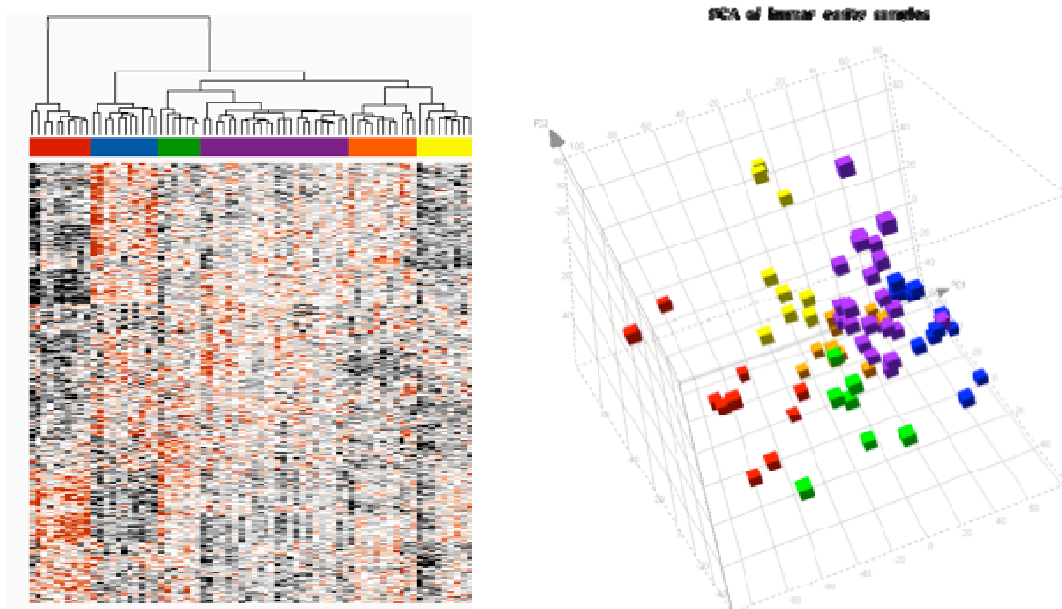


Figure 2. Hierarchical clustering of gene expression data derived from the 72 normal human breast tissue samples demonstrates that epithelial content of the individual samples drives expression to a greater extent than does reproductive history (left). Principal component analysis of individual samples color-coded for high expression of epithelial genes (red) to low expression (blue).

To accomplish this goal, we generated mRNA from purified epithelial, adipose, and fibrous tissue derived from reduction mammoplasties to serve as a reference for compartment adjustment, and profiled each compartments from 8 samples on Affymetrix GeneChips. Samples passing QC were subsequently analyzed by PCA using ~5700 genes with high variance across the data set. With the exception of two adipose samples (which likely contained undetectable fibrous contamination), all cellular subtypes were distinguishable by PCA. Moreover, cell types that were maintained in culture (epithelial and fibroblast) appeared to be distinct from the uncultured tissues obtained from gross dissection (Fig. 3).

As an initial attempt at defining genes that could serve as discriminators of

compartment class, we compiled lists of genes that were unique to adipose, cultured epithelial cells and cultured fibroblasts. We next used these lists of genes as reference datasets to enable us to estimate the proportion of each cellular compartment present within a complex mixture of cell types.

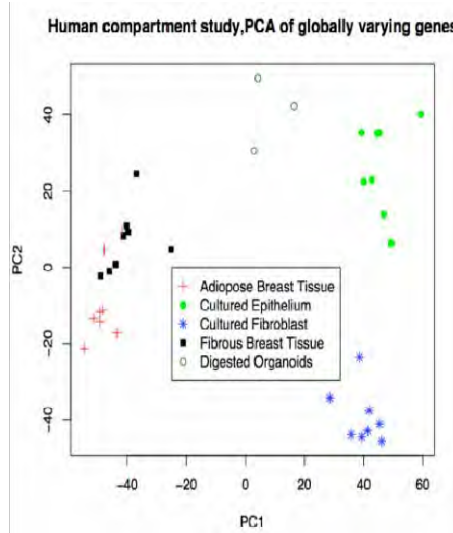


Figure 3. Principal Component Analysis of tissue compartments isolated from human reduction mammoplasties demonstrate almost complete separation by tissue type using ~5700 genes with high variance.

Initially, we speculated that if we identified samples from our data set that possessed similar epithelial content, we would be able to investigate conserved parity-induced gene expression changes. Accordingly, we selected a subset of samples, from both nulliparous and parous cohorts, that exhibited similar epithelial content. Next, we identified candidate genes from our previously derived core rodent gene signature that were either up- or down-regulated as a result of parity (Table 1 and 2, respectively). Consistent with findings in rodents, expression of IGFBP5, a member of the growth hormone Igf1 axis, showed a trend toward up-regulation in parous as compared to nulliparous women (Fig. 4). Similarly, Kruppel-like factor 9 (KLP9) appeared to have a conserved trend toward higher expression in parous samples (Fig. 4).

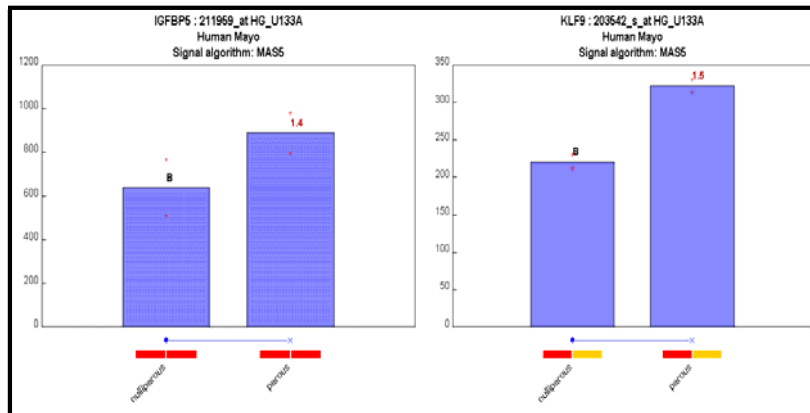


Figure 4: Gene expression analysis of IGFBP5 (left) and KLP9 (right) for a subset of nulliparous and parous samples.

To investigate whether genes identified as being down-regulated according to the core rodent signature were conserved, we looked at the expression of Periostin, a gene involved in cell adhesion in the extracellular matrix, as well as the expression of Lumican, a proteoglycan also integral to the extracellular matrix (Fig. 5). For both markers, the trend toward lower expression in parous samples appeared to be conserved. Consequently, we believe that human samples in which we can control for epithelial content will in fact maintain gene expression changes that define the parous mammary gland.

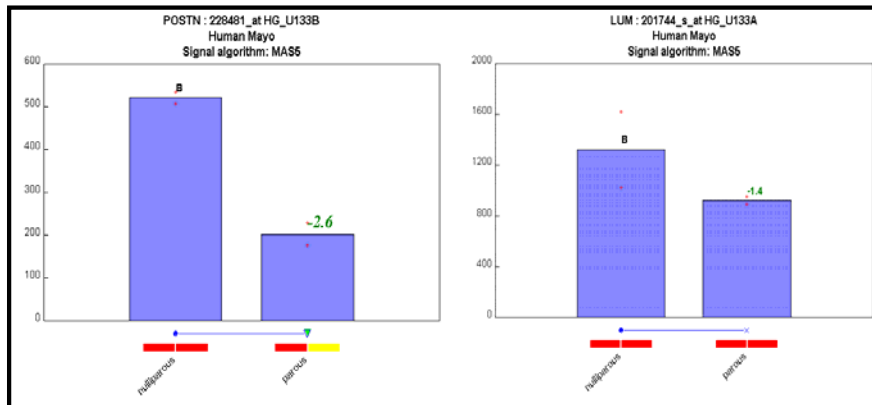


Figure 5: Gene expression analysis of Periostin (left) and Lumican (right) for a subset of nulliparous and parous samples.

Task 8: Months 1-36: Determine the effect of short-term, low-dose estradiol and progesterone treatment on MNU-induced mammary tumor susceptibility.

As described in the Year 3 Progress Report, this task was completed on schedule.

Task 9: Months 12-60: Determine the effect of hormone treatment on MNU-induced mammary epithelial proliferation.

Work on this task was delayed to allow for work on the other tasks.

Task 10: Months 12-60: Determine whether p53 loss abrogates pregnancy-induced protection against carcinogen-induced mammary tumorigenesis.

This task was initiated and completed on schedule. In order to address this aim, we first needed to demonstrate that the hormone-induced protection against mammary tumors that has been observed in rats is also operative in mice. This is because mice, but not rats, offer the opportunity to use genetic knockouts, which would be the preferred approach for addressing the involvement of p53 in pregnancy-induced protection, by demonstrating that p53 mutant mice do not exhibit parity-induced protection against breast cancer.

During the previous study period we performed a number of experiments to

determine whether mice exhibit hormone-induced protection. We tested multiple strains—BALBc/J mice, which have been shown by the Medina lab to be afforded protection by hormone treatment, and FVB mice, which is the strain used in many laboratories for studies of mammary tumorigenesis in genetically engineered mice. We tested BALBc/J mice from a commercial source as well as a BALBc/J substrain obtained directly from the Medina lab. We also tested whether hormone treatment can delay tumorigenesis initiated by the Neu oncogene in MMTV-Neu transgenic mice. As described in last year's report, E+P treatment did not afford protection against mammary tumorigenesis in any of these experiments.

This result was unanticipated, given that the Medina laboratory had previously demonstrated that E+P treatment confers protection against mammary carcinogenesis in BALBc mice. We reasoned that endogenous phytoestrogens present in the mouse diet used in our experiments could have confounded our results by altering the hormonal milieu of experimental mice. To address this issue, in the previous study period we tested whether mice that were maintained on a low phytoestrogen diet exhibited hormone-induced protection. Breeders were fed the low phytoestrogen diet AIN-76 Blue at the time of mating, and female offspring were used for tumorigenesis experiments. Experimental animals were also fed AIN-76 Blue at weaning and throughout the course of experiments. Mice were treated with estrogen plus progesterone (E+P) for 21 days beginning at 7 weeks of age, followed by DMBA administration from 12 to 18 weeks to induce tumorigenesis.

As described in the last report, the results of this experiment revealed that E+P treatment caused a modest delay in mammary tumorigenesis, however this delay was not statistically significant (Fig. 6). In addition, interpretation of these results was hampered by the high mortality induced by DMBA in this experiment.

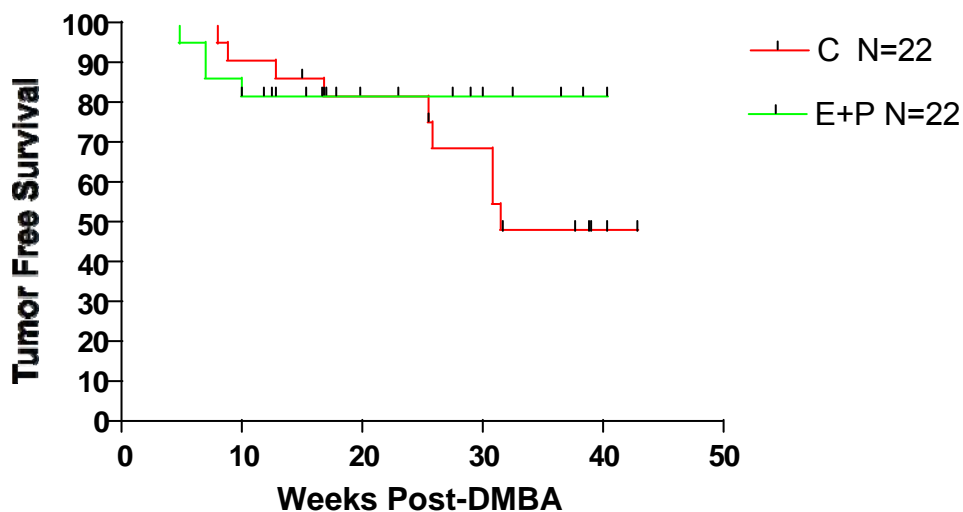


Figure 6. E+P treatment confers a modest delay in DMBA-induced mammary tumorigenesis in BALBc/J mice on a low phytoestrogen diet. $p=0.32$.

In the current study period, we performed experiments to confirm this preliminary result and to attempt to circumvent the high mortality that we observed, since this markedly limited the statistical power of our studies. To accomplish this, we first performed the identical experiment in another strain of mice, FVB. Insofar as this is the strain used by our laboratory for all transgenic models of breast cancer, demonstrating hormone-induced protection in this strain would be an important experimental advance.

FVB mice were fed a low phytoestrogen diet, AIN-76 Blue, at weaning and throughout the course of the experiment. Mice were implanted with pellets containing estrogen and progesterone (200 ug estrogen, 15 mg progesterone) at 7 weeks of age. After 21 days, pellets were removed and glands were allowed to regress for 14 days. Mice were then treated with DMBA weekly for 6 weeks, and monitored for tumor formation. As with BALBc mice, we observed high mortality in FVB mice treated with this experimental regimen. This high rate of mortality again prevented us from determining whether E+P confers protection against DMBA-induced mammary tumors. However, when we compared tumor formation in surviving mice between the two cohorts, we did not observe a statistically significant degree of protection against tumorigenesis by E+P (Figure 7).

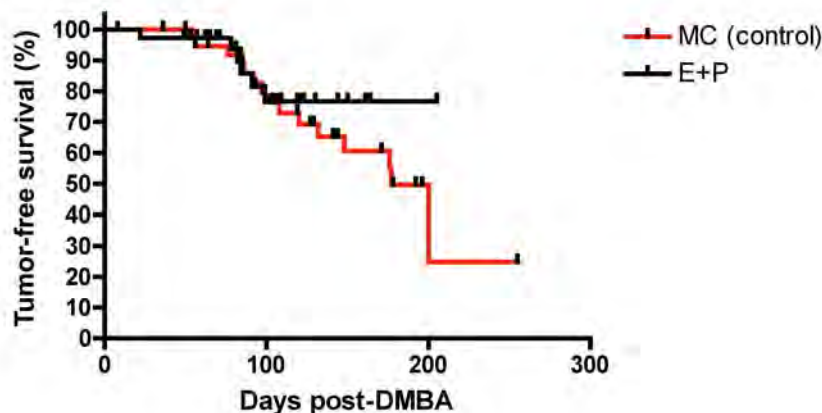


Figure 7. E+P treatment does not delay DMBA-induced mammary tumorigenesis in FVB mice fed a low phytoestrogen diet. $p=0.42$.

As described in the prior study period, in light of the potential protection conferred by E+P treatment when mice are fed a low phytoestrogen diet, we next tested whether E+P could delay tumorigenesis in MMTV-neu mice maintained on this diet. MMTV-neu mice fed AIN-76 Blue were treated with E+P or cellulose control at 7 weeks of age for 21 days, and then monitored for tumor formation. Unlike DMBA-induced tumorigenesis, E+P treatment did not delay tumorigenesis in MMTV-neu mice, even when fed a low phytoestrogen diet (Fig. 8). This suggests that this experimental paradigm may not be suitable for studying parity- or hormone-induced protection in mice.

In summary, our findings obtained during this study period, coupled with those from prior years, indicate that parity-induced protection in mice is not a robust experimental phenomenon. These results were consistently obtained in several strains of mice, in tumors induced by chemical carcinogens and by oncogene expression, and irrespective of the phytoestrogen content of the experimental diet. Given this inability to demonstrate hormone-induced protection in mice, we were not able to address whether the p53 pathway is required for parity-induced protection, since this question can only be addressed directly in genetically engineered animal models deficient for p53, which do not exist in the rat.

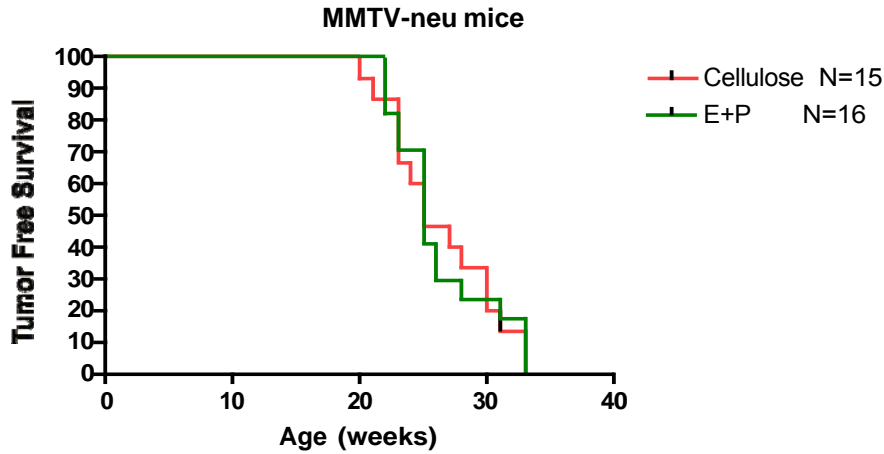


Figure 8. E+P treatment does not delay MMTV-Neu-induced mammary tumorigenesis in mice fed a low phytoestrogen diet. $p=0.91$

Project 3

This project aims to recruit subjects being treated with a variety of hormonal regimens to have pre- and/or post-treatment breast biopsies. The treatment with the hormonal agents may or may not be a study procedure. A number of cellular, hormonal and genetic analyses will be carried out on the biopsy specimens.

Task 1. Months 1-48: Develop appropriate protocols and treatment regimens.

Completed.

Task 2. Months 24-56: Recruit subjects to the treatment protocols.

Task 2a. Recruit 10 women receiving high dose progestin (Megace) for the treatment of endometrial hyperplasia (as standard of care). For this research protocol, the subjects will receive a breast biopsy before Megace treatment, and after three months of Megace treatment.

For various reasons, but mainly because USC gynecologists have put very few women on Megace, we only succeeded in obtaining biopsies on three women on this protocol and have discontinued recruitment. Given that the goal of this protocol was to study the effect of high-dose progestins on the breast, we opened the protocol described in Project 3 Task 2c to study women receiving Depot Medroxy-progesterone Acetate (see below).

Task 2b. Recruit 40 women seeking oral contraceptives to be randomized to a low-dose progestin content oral contraceptive or a standard progestin content oral contraceptive and to have a breast biopsy after three months of oral contraceptive use.

Completed. See below for description of the results.

Task 2c. Recruit 36 women receiving Depot Medroxy-progesterone Acetate (DMPA; Depot Provera®) as part of standard of care. For this research protocol, the subjects will receive a breast biopsy on day 7 ± 1 , day 14 ± 1 or day 21 ± 1 (12 subjects on each of these three days) after their 2nd or subsequent consecutive DMPA injection.

This protocol was planned to augment Task 2a as it measures the effect of high levels of progestins. DMPA is a 3-month injectable contraceptive with progestin levels in the first month after injection equivalent to third trimester pregnancy levels. We have recruited nine women to date. We have recruited through the Love/Avon Army of Women (n=3) as well as through local Planned Parenthood clinics (n=6). Recruitment is ongoing with another e-mail blast to the Love/Avon Army of Women planned in the coming weeks. We also continue to receive referrals from Planned Parenthood.

Task 2d. Recruit 50 volunteer women who are not pregnant and not currently receiving any hormonal agents to undergo a breast biopsy. This protocol will specifically recruit women into the following categories: premenopausal, nulliparous –

under the age of 30 (5 women)/over the age of 30 (5 women); premenopausal, parous – under the age of 30 (10 women)/over the age of 30 (5 women); and postmenopausal – nulliparous (15 women)/parous (10 women).

This protocol was modified to allow us to recruit 100 women (25 additional premenopausal parous and 25 premenopausal nulliparous) to make up for the shortfall in recruitment in Project 4, Task 1. We have thus far recruited 48 women into this protocol. We have found that women are very willing to participate in this protocol and expect to complete recruitment by August 2011.

Task 3. Months 30-58: Assay tissue samples* for cellular, hormonal and gene expression markers to determine pre- and/or post-treatment tissue characteristics.

We have completed assays for Ki67 (MIB1), ER, PRA and PRB, by immunohistochemistry (IHC), in the vast majority of the breast biopsy samples we have collected. IHC assays for the remaining samples are ongoing. We have also completed assays for γ H2AX on a large number of the samples. γ H2AX measures DNA damage and is being assayed in order to study whether such damage varies with pregnancy, parity, oral contraceptive use and other factors of interest. Several manuscripts (attached) have been published/submitted.

Task 4. Months 30-58: Assay blood samples* for hormone levels.

Blood samples taken ‘immediately’ before the prospectively collected breast biopsies have been analyzed for estradiol (E2) and progesterone (P4). See Chung *et al.* (attached). Further assays have been conducted for ethinyl-estradiol (EE2) and norethindrone (NET) as described in Hovanessian-Larsen *et al.* (attached).

Task 5. Months 30-60: Conduct data analysis* to compare pre- and/or post-treatment tissue characteristics, to compare these changes to the differences noted between nulliparous and parous women, and to prepare manuscripts as appropriate.

*The tissue and blood assays as well as the subsequent data analysis include specimens (including breast biopsies) collected on protocols funded *via* other mechanisms that directly relate to this Innovator Award. These include specimens from: (1) 33 women undergoing a termination of pregnancy - breast biopsy obtained immediately after the termination and a subsequent biopsy several months later in a small number of them (a source of non-pregnant tissue). This protocol was aimed at measuring the effects of pregnancy levels of estradiol and progesterone. (2) 10 oocyte donors, *i.e.*, women receiving daily injections of follicle stimulating hormone (FSH) which results in the development of multiple ovarian follicles for oocyte donation to other women. This protocol was aimed at measuring the effects of greatly increased circulating estrogen levels without the other changes that occur in pregnancy. The breast biopsy was obtained on the day of, or the day prior to, oocyte retrieval. (3) 37 post-menopausal women receiving menopausal estrogen therapy that also includes intra-vaginal micronized progesterone (E+P) or placebo (E alone). This protocol was aimed at measuring the

effects of low levels of natural progesterone. Nineteen women on E+P were recruited and eighteen women on E alone.

Studies of nulliparous, parous and 'pregnant' breast

We have published a manuscript (Taylor *et al.*, 2009; attached) which compares cellular markers in the tissue collected as part of Project 4 with 'pregnant' breast tissue. This manuscript reported our studies of nuclear staining for the progesterone and estrogen receptors (PRA, PRB, ER α) and cell proliferation (Ki67, MIB1) in the epithelium of the breast terminal duct lobular unit (TDLU) of 26 naturally cycling premenopausal women and 30 pregnant women (median 8.1 weeks gestation). Results are shown in Figure 3.5.1. PRA expression decreased from a mean of 17.8% of epithelial cells in cycling subjects to 6.2% in pregnant subjects ($P = 0.013$). MIB1 expression increased from 1.7% in cycling subjects to 16.0% in pregnant subjects ($P < 0.001$). PRB and ER α expression were slightly lower in pregnant subjects but the differences were not statistically significant. Sixteen of the non-pregnant subjects were nulliparous and ten were parous. PRA was statistically significantly lower in parous women than in nulliparous women (32.2% in nulliparous women vs 10.2%; $P = 0.014$). PRB (23.5 vs 12.9%), ER α (14.4 vs 8.6%) and MIB1 (2.2 vs 1.2%) were also lower in parous women, but the differences were not statistically significant. PRA expression may be a most useful marker of the reduction in risk with pregnancy and may be of use in evaluating the effect of any chemoprevention regimen aimed at achieving a similar reduction in risk. Short-term changes in PRA expression while the chemoprevention is being administered may also be an important marker (see results of the preliminary analysis of the results of Task 2b below). A most important aspect of these findings was that the marked decreases in PRA in pregnancy and in parous women have also been found in the rat. This lends much credence to the rat model for studying the protective effect of pregnancy, and suggests that the gene changes found in the rat (Projects 1 and 2 above) may be directly applicable to the human situation.

Studies of E2 and P4 effects on the 'pregnant' breast

We have a manuscript in review (Chung *et al.*, attached) which reports our studies of nuclear staining for the progesterone receptors (PRA, PRB) and estrogen receptor (ER α) and cell proliferation (Ki67, MIB1) in the epithelium of the breast terminal duct lobular unit (TDLU) 30 pregnant women (median 8.1 weeks gestation) as they relate to the levels of serum estradiol (E2) and progesterone (P4). This manuscript also compares these results to what occurs in 26 naturally cycling women and to results obtained from studying the changes in the breast in oocyte donors.

Figure 3.5.2 shows the relationships of serum E2 and P4 to gestational age in the 'pregnant' women. E2 increased steadily with gestational age, from ~2,000 pmol/l at 5 weeks gestation to ~27,000 pmol/l at 18 weeks gestation. P4 did not change from the mid-luteal peak of ~40 nmol/l until around week 11 of gestation, after which it increased to ~80 nmol/l. Figure 3.5.3 shows the E2 and P4 values of the individual oocyte donors in the seven days before oocyte retrieval. E2 increased steadily in each subject until the day before oocyte retrieval – on the day of retrieval, E2 had fallen from a median of ~15,300 to ~6,000 pmol/l. P4 also increased steadily in each subject; the median value increased from 1.1 nmol/l at seven days before oocyte retrieval to 4.1 nmol/l at two days before retrieval, and then, after hCG treatment, to 18.0 nmol/l on the day before oocyte retrieval and to 36.3 nmol/l on the day of retrieval. For comparison, in naturally cycling

women the follicular phase maximum E2 is ~1,100 pmol/l, the luteal phase maximum E2 is ~510 pmol/l, and the luteal phase maximum P4 is ~40 nmol/l.

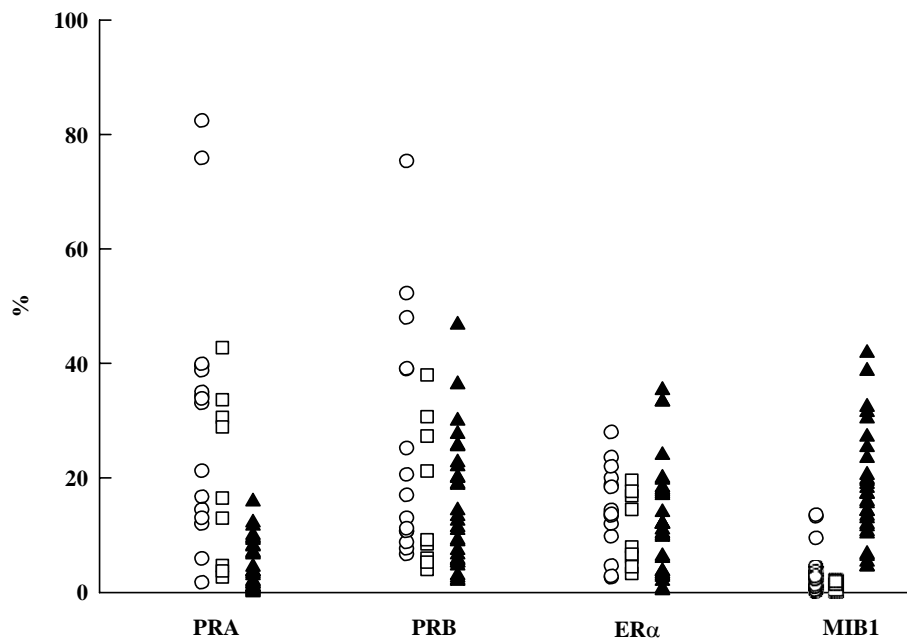


Fig. 1 % of cells expressing nuclear PRA, PRB, ER α and MIB1 in premenopausal nulliparous (○), premenopausal parous (□) and pregnant (▲) women.

Figure 3.5.1. Figure 1 from Taylor *et al.* (2009).

Figure 3.5.4 shows the relation between MIB1 for the pregnant women plotted against their E2 on the day of biopsy and for the oocyte donors plotted against their E2 on the day before biopsy, while Figure 3.5.5 shows the relation between MIB1 for the 10 oocyte donors and the 30 pregnant women plotted against their P4 on the day of biopsy. For the pregnant women, there was no relationship between MIB1 and E2 or P4. For the oocyte donors, there was a strong positive relationship between MIB1 and E2 on the day before biopsy – correlation, $r = 0.76$ ($P = 0.010$); while the correlation between MIB1 and E2 on the day of biopsy was much weaker – $r = 0.17$ ($P = 0.65$). For the oocyte donors, there was no relationship between MIB1 and P4 on the day of biopsy or P4 on the day before biopsy; however, two of the four oocyte donors with low MIB1 values had the lowest P4 values.

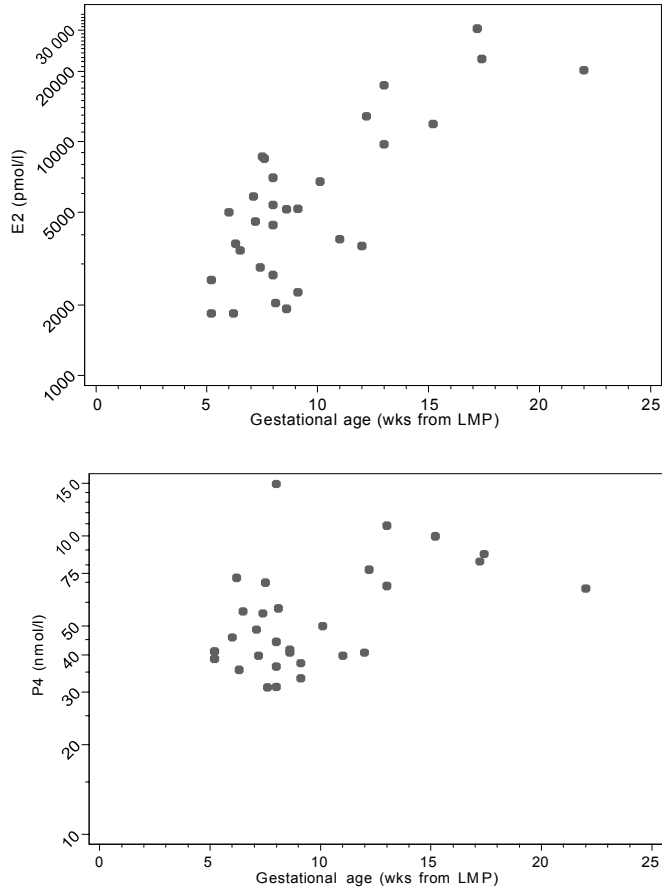


Figure 2. Individual pregnant women estradiol (E2) and progesterone (P4) values vs gestational age.

Figure 3.5.2. Figure 2 from Chung *et al.* (in review).

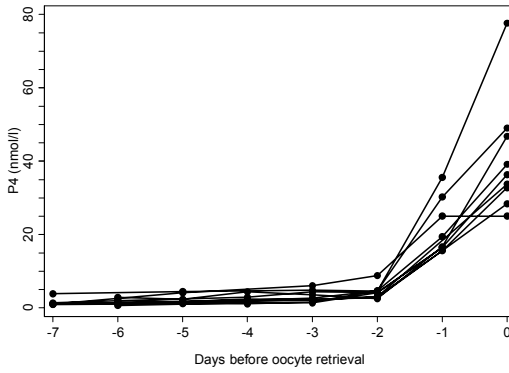
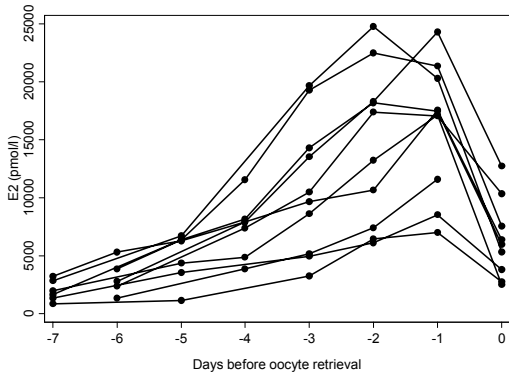


Figure 1. Individual oocyte donor estradiol (E2) and progesterone (P4) values in the week before oocyte retrieval.

Figure 3.5.3. Figure 1 from Chung *et al.* (in review).

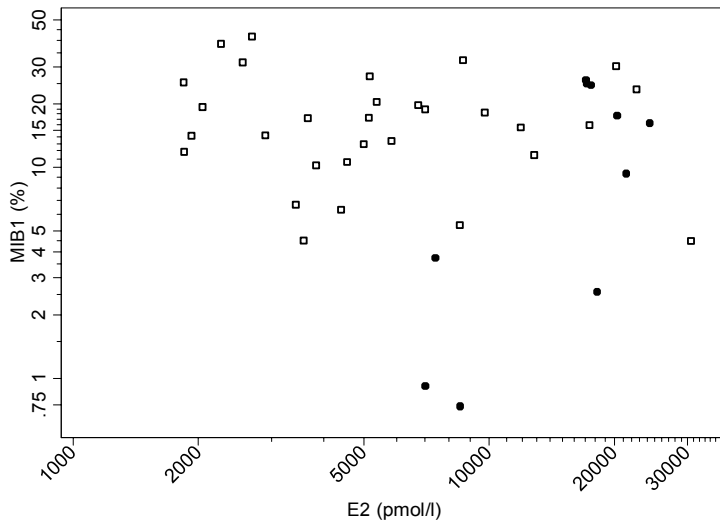


Figure 3. Individual woman TDLU epithelial cell MIB1 values vs estradiol (E2) values - E2 values for oocyte donors on the day before biopsy (•); E2 values for ‘pregnant’ women on the day of biopsy (◻).

Figure 3.5.4. Figure 3 from Chung *et al.* (in review).

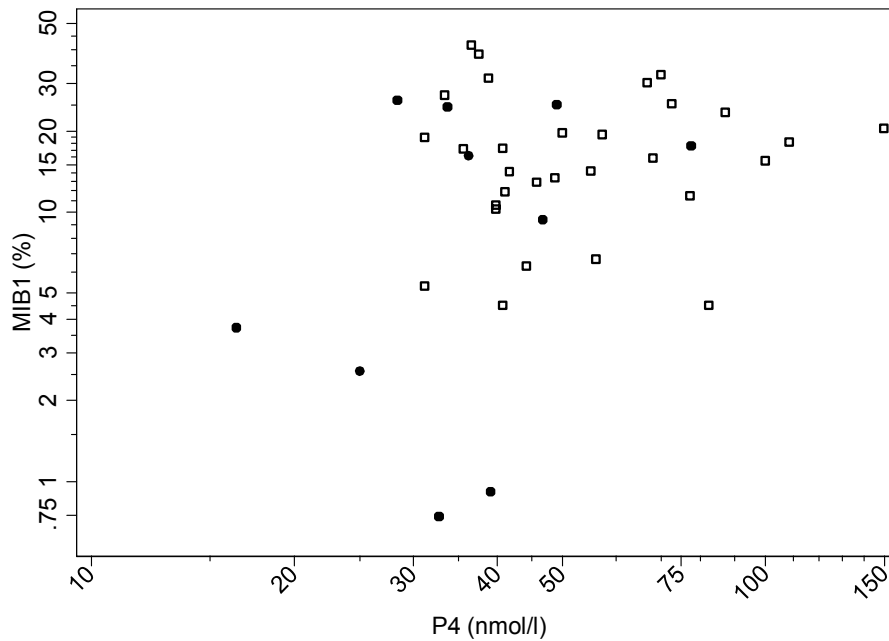


Figure 4. Individual woman TDLU epithelial cell MIB1 values vs progesterone (P4) values on day of biopsy - oocyte donors (•); ‘pregnant’ women (◻).

Figure 3.5.5. Figure 2 from Chung *et al.* (in review).

The means (and 95% confidence intervals) of the proportion of epithelial cells with positive nuclear staining for MIB1, PRA, PRB and ER α are given in Table 3.5.1. The MIB1 mean value was increased from 1.8% in the cycling women to 7.0% in the oocyte donors ($P = 0.003$) and to 14.1% in the seven oocyte donors whose serum E2 values on the day before biopsy exceeded 10,000 pmol/l ($P < 0.001$). This latter mean value of 14.1% is very close to the mean value of 15.4% seen in the pregnant women.

The PRA mean value was slightly lower in the oocyte donors (17.8%) than in the cycling women (23.5%), but was not as low as in the pregnant women (3.9%). The difference between the oocyte donors and the cycling women was not statistically significant. The PRB mean values were similar in all three groups of women. The ER α mean value was lower in oocyte donors (6.8%) than in cycling women (12.0%).

We previously reported that parous naturally cycling women had significantly lower PRA values than nulliparous naturally cycling women, and lower values of MIB1, PRB, and ER α , but the differences for these factors were not statistically significant. Parity had no effect on MIB1, PRA and ER α in pregnant women, but the PRB mean was marginally statistically significantly greater in the parous group ($P = 0.049$). Eight of the 10 oocyte donors were nulliparous, so that we had no power to investigate the effects of parity in the oocyte donors.

Table 1 Mean (with 95% confidence limits) percentages of MIB1, PRA, PRB, and ER α in oocyte donors, pregnant women, and naturally cycling women

Group		Mean ^a	lcl ^a	ucl ^a	P value: All ^b	P value: E2>10,000 pmol/l ^b
MIB1	Oocyte Donor: All (N = 10)	7.0	3.0	16.5		
	Oocyte Donor: E2>10,000 pmol/l (N = 7)	14.1	7.6	26.1		
	Pregnant (N = 30)	15.4	12.4	19.1	0.016	0.76
	Cycling (N = 26)	1.8	1.2	2.7	0.003	<0.001
PRA	Oocyte Donor: All	17.8	13.4	22.9		
	Oocyte Donor: E2>10,000 pmol/l	19.0	13.8	25.0		
	Pregnant	3.9	2.5	5.5	<0.001	<0.001
	Cycling	23.5	16.2	32.2	0.37	0.55
PRB	Oocyte Donor: All	16.9	11.3	23.6		
	Oocyte Donor: E2>10,000 pmol/l	20.0	12.6	29.0		
	Pregnant	12.8	9.4	16.8	0.31	0.14
	Cycling	19.2	13.3	26.0	0.67	0.90
ER α	Oocyte Donor: All	6.8	4.3	9.9		
	Oocyte Donor: E2>10,000 pmol/l	5.5	3.4	8.1		
	Pregnant	11.0	7.9	14.6	0.15	0.089
	Cycling	12.0	9.2	15.2	0.034	0.014

^a Calculations were made with transformed values – logarithmic for MIB1, and square root for PRA, PRB, and ER α . Values are adjusted for ethnicity, parity and age. lcl and ucl are lower and upper 95% confidence interval values, respectively.

^b P values are for comparisons with oocyte donors.

Table 3.5.1. Table 1 from Chung *et al.* (in review).

This is the first study to evaluate the immediate effects of short-term exposure to high levels of endogenous estrogen on breast tissue. A large increase in breast-cell proliferation occurred in most of the oocyte donors, similar to the increase seen in pregnant women. In the oocyte donors the increase in MIB1 expression was only definitely seen when their E2 exceeded 10,000 pmol/l and their P4 exceeded 28 nmol/l. In contrast, the pregnant women demonstrated the same level of breast-cell proliferation over the whole range of observed serum E2 values from ~1,800 pmol/l to ~30,000 pmol/l with no evidence of a dose-response. When we re-plotted Figure 3 using non-SHBG-bound E2 rather than E2, a very similar picture was seen. Higher levels of proliferation in pregnant women may be due to their longer exposure to high levels of E2 and to longer exposure to luteal (or higher) levels of P4, it may also be due to their higher ER α expression (see below).

We previously reported that PRA decreased steadily with gestational age in pregnant women (Taylor *et al.*, 2009) and although there was already some decrease early on in pregnancy, PRA only reached very low levels (~1%) after week 12 of gestation. There was a non-statistically significant 24% reduction of PRA in oocyte donors compared to naturally cycling women, but this was small relative to the reduction seen in pregnant women. We also previously reported that “overall there was little difference in ER α expression between non-pregnant and pregnant subjects”, but the data strongly suggested that “ER α expression is increased early on in pregnancy (<8 weeks gestation) and then declines to lower levels than are seen in non-pregnant subjects”. In contrast, ER α expression in oocyte donors was low.

Based on a strictly limited amount of epidemiological data but considerable data from rodent experiments, it is possible that a short-term pregnancy and short-term relatively high levels of estrogen may provide some long-term protection against breast

cancer. However, the fetoplacental unit in pregnant women is responsible for major endocrinologic changes which are not present in women undergoing ovarian stimulation. Thus, a number of factors in a pregnant woman may contribute to long-term protection against breast cancer. The effects of the high levels of endogenous E2 and P4 achieved during human full-term pregnancy are two-fold: a transient increase in breast cancer risk followed by a significant long-term permanent decrease in risk if the pregnancy occurs prior to around age 32, with the protective effect being greater the earlier the age at which the pregnancy occurs. The mechanism for the protective effect remains unclear, but has been attributed in part to hormonal changes, in particular a reduction in prolactin levels, and may possibly be due to hormone-induced changes in breast function leading to lower breast-cell proliferation and possibly other effects. Breast-tissue mRNA expression differences between parous and nulliparous rodents have been observed, but whether such changes occur in humans has not been established. There is some evidence that terminated pregnancies may also provide a lesser degree of protection against breast cancer. There are no data available on the effects of a terminated pregnancy on long-term prolactin levels, breast cell proliferation or any other possibly relevant factors.

The same phenomenon of full-term pregnancy-induced protection against mammary carcinogenesis is observed in rats. The protective effect in the rat can also be achieved by administration of exogenous E2 and P4: the serum level of E2 appears to have to be no greater than twice the maximum seen during the estrus cycle and the serum level of P4 appears to have to be no greater than the maximum seen during the estrus cycle. With E2+P4 administration substantial protection could be achieved with as little as 7 days of administration.

There are large differences in the effects of pregnancy in women and in the rat: the ovary is the sole source of serum estrogen and the major source of serum progesterone in pregnancy in the rat, while in women the main source of estrogen and progesterone moves from the ovary to the placenta during the latter part of the first trimester.

The serum E2 levels in cycling rats vary from 50 to 250 pmol/l; the maximum value of 250 pmol/l is only exceeded during the third week of pregnancy, when it rises to ~500 pmol/l. Due to the absence of circulating sex-hormone binding globulin (SHBG) in the rat, virtually all of the circulating E2 is free and thus, biologically active. The levels of serum E2 in cycling women are two to three times the levels in the cycling rat, and, contrary to what occurs in the rat, these are greatly increased in pregnancy – they are increased some 5-fold in the first trimester, some 20-fold in the second trimester and some 40-fold in the third trimester compared to the maximum of around 1,100 pmol/l at the pre-ovulatory E2 peak. However, most of the E2 in human pregnancy circulates bound to SHBG. Whether the results in the rat of short-term E2 exposure at only twice the maximum estrus serum E2 level are of relevance to the human situation is, thus, not at all clear.

The serum P4 levels in cycling rats vary from 45 to 160 nmol/l; the levels steadily increase during pregnancy and reach a maximum of 320 nmol/l in the second week, approximately double the maximum seen in the estrus cycle, and then decline in the third week. The levels of serum P4 in cycling women are lower, at 1.5 – 40 nmol/l, than the levels in the cycling rat. Serum P4 levels in women increase steadily during pregnancy – they are increased some 2-fold in the first trimester, some 4-fold in the second trimester and some 10-fold in the third trimester compared to the maximum of around 40 nmol/l at the luteal-phase serum P4 peak. The maximum seen during pregnancy in women is thus not greatly increased over the maximum level seen in the rat estrus cycle, and the results in the rat of short-term P4 exposure at the maximum estrus cycle serum P4 level could

possibly be of more relevance to the human situation.

If short-term high levels of serum E2 do provide long-term protection against breast cancer, we might expect that the breast would change in oocyte donors in a way similar to that seen in pregnant women. The short-term high levels of endogenous E2 did cause a dramatic increase in breast-cell proliferation similar to that associated with pregnancy, but the reduction in PRA was much less than that seen in pregnant women. Studies comparing nulliparous oocyte donors at some time after donation to parous women are needed.

Study of effects of oral contraceptive progestin dose on the breast

We have a manuscript in review (Hovanessian-Larsen *et al.*, attached) describing the completely unexpected and most important results obtained from the samples obtained from the completion of Task 2b. Task 2b was a randomized trial comparing the effects on breast tissue of two FDA approved and commonly prescribed oral contraceptives (OCs) – OrthoNovum 1/35[®] and Ovcon 35[®]. These two OCs both contain 35 µg of the estrogen, ethinyl-estradiol (EE2), but different doses of the progestin, norethindrone (NET) – OrthoNovum 1/35 contains 1 mg of NET while Ovcon 35 contains 0.4 mg NET. The hypothesis being tested was that Ovcon 35 would be associated with a much lower level of proliferation of TDLU breast epithelial cells than OrthoNovum 1/35 based on the much lower (60% lower) level of progestin in Ovcon 35. We had previously shown based on the results of studies of the increased breast cancer risk from use of menopausal estrogen/progestin therapy (MEPT) that such a difference in dose level (based on the progestin medroxyprogesterone acetate, MPA, used in MEPT in the US) should lead to a close to proportional drop in breast cell proliferation. The 1 mg dose of NET has been equated to an MPA dose of 10 mg (the usual dose of MPA in sequential MEPT) so that this expectation was based on roughly equivalent changes in dose with MEPT (10 mg versus 2.5 mg MPA).

Thirty-three women were randomly assigned 1:1 to the two OCs. All completed the study including contributing a breast-biopsy specimen. Five of the breast-biopsy specimens contained insufficient TDLU epithelial tissue for analysis and one of the remaining women was diagnosed with a follicular cyst. The means (and 95% confidence intervals) of the proportion of epithelial cells with positive nuclear staining for Ki67, PRA, PRB and ERα for the remaining 27 women are given in Table 3.5.2.

Table 1. Mean values (95% confidence intervals) of Ki67 (MIB1), PRA, PRB and ERα associated with two OCs with different progestin (NET) doses

Measure	NET Dose		P ^a
	1 mg	0.4 mg	
Ki67	7.8 (4.4 – 13.9)	12.5 (7.0 – 22.3)	0.27
PRA	7.6 (5.3 – 10.4)	16.7 (8.6 – 27.3)	0.041
PRB	12.0 (8.8 – 15.8)	23.7 (14.1 – 35.7)	0.030
ERα	9.0 (5.5 – 13.3)	18.2 (10.0 – 28.8)	0.056

^aTwo-sided significance level for difference between NET doses.

Table 3.5.2. Table 1 from Hovanessian-Larsen *et al.* (in review).

Completely contrary to expectation, the Ki67 mean value *increased* 60% from 7.8% to 12.5% with the *decrease* in NET dose from 1.0 mg to 0.4 mg. The increases in estrogen and progesterone receptors with this decrease in NET dose were quite striking: the PRA mean value increased 120% from 7.6% to 16.7%, the PRB mean value increased 98% from 12.0% to 23.7%, and the ER α mean value increased 102% from 9.0% to 18.2%.

This approximate doubling of the levels of each of PRA, PRB, and ER α is the first report of an effect of NET dose on PRA, PRB, and ER α expression levels in the breast. These increases in receptor levels is quite sufficient to explain the observed failure to see a decrease in Ki67 with the lower dose of NET, and is likely to be a key part of the explanation why epidemiological studies in general have failed to identify differences in risk of breast cancer by dose of progestin in the OC. Whether this effect of NET dose on receptor levels holds true for other progestins is not known. Increasing progesterone levels after ovulation in the normal menstrual cycle are associated with markedly lower ER expression in almost all studies, but the studies of changes in PR expression over the menstrual cycle are inconsistent.

Studies of ER expression in the breast during an OC cycle have found lower levels in the three weeks on active estrogen-progestin than in the week on placebo, and the levels during OC use are lower than the levels seen during the menstrual cycle. However, studies of PR expression have found higher levels in the three weeks on active estrogen- progestin than in the week on placebo, and the results from the three studies that have investigated how the PR expression levels during OC use compare to the levels seen during the menstrual cycle have produced inconclusive results. There have been no reports on the effects of dose of EE2 or on the effects of the dose and type of progestin in the OC on these findings.

Early studies reported found little difference between OC users and normally cycling women in TDLU breast cell proliferation as measured by thymidine labeling index (TLI). The mean TLIs reported by the two main studies were 0.95% vs 0.84% and 2.9% and 2.9% for OC and natural cycles respectively. More recent studies using Ki67 as the marker of cell proliferation have found some evidence that average proliferation on OCs is greater than over the menstrual cycle – 10.6% vs 9.0%, and 4.8% vs 2.2% respectively. The Ki67 figure of 7.8% we observed with the much more commonly used 1 mg NET OC of 7.8% should not be taken as an average figure for the OC cycle since there is clear evidence that proliferation is lower in the placebo week and there is some evidence that proliferation may be at its maximum towards the end of the active pill phase when we took our breast biopsy samples.

The results presented here provide clear evidence that decreasing the dose of the progestin NET in an OC from 1 mg to 0.4 mg increases ER α , PRA and PRB in the breast epithelium. There is indirect evidence strongly suggesting that decreasing the dose of EE2 in an OC will decrease PR, but it may increase ER. An OC with the same NET dose but lower EE2 dose may therefore be associated with a decreased proliferation of breast epithelium. We are currently investigating this possibility in a non-DoD-funded randomized trial similar to the one reported here. Whether it is possible to adjust the doses to achieve an average proliferation rate which is less than that occurring in a normal menstrual cycle is unknown.

Project 4

This project calls for the recruitment of 150 elective reduction mammoplasty, mastopexy or breast augmentation patients. The aim is to collect breast tissue from these women and conduct the same types of cellular, hormonal and genetic analyses as is being done in Project 3. In addition, cellular analyses on 100 tissue slides from previous reduction mammoplasties, and 100 autopsy breast tissue samples will be conducted.

Task 1. Months 1-48: Recruit 150 women undergoing elective reduction mammoplasty, mastopexy or breast augmentation to the protocol.

We have recruited 34 women undergoing an elective reduction mammoplasty. We have not been able to recruit any patients to the elective reduction mammoplasty, mastopex or breast augmentation protocols in the past 36 months. This is because the number of patients being seen by our plastic surgeons for this procedure has decreased drastically with the decline in the economy and other factors. As we became aware of this we wrote an additional protocol designed to obtain normal breast tissue from volunteers willing to undergo a breast biopsy (Project 3, Task 2d). We have been very successful at recruiting for this volunteer protocol and have thus far recruited 48 women (see above). We increased the number of women to be recruited to this protocol from 50 to 100 in order to achieve a sufficient number of specimens.

Task 1a. Months 1-36: Identify and conduct cellular assays on 100 tissue samples from previous reduction mammoplasties.

We have consented and obtained detailed questionnaire data on 99 women who had had a previous reduction mammoplasty. We are currently carrying out microdissection of the stroma for these specimens and will use these samples in the validation of the DNA methylation signatures we identify in Project 4, Task 4 (see below).

Task 1b. Months 23-54: Identify and conduct cellular assays on 100 autopsy breast tissue samples.

We have, in fact, obtained 230 such tissue samples. These samples were collected by Dr. Sue Bartow while working at the Office of the New Mexico Medical Investigator between December 1978 and December 1983; she collected randomly selected breast tissue from autopsied women (Bartow *et al.*, 1997). Dr Bartow kindly made these tissues available to us. Initially we found that IHC on these samples was not satisfactory. With further work on antigen retrieval, we have succeeded in obtaining satisfactory IHC results. A subset of these samples are now being assayed for Ki67, PRA, PRB and ER α in order initially to clarify the issues concerning variation between the follicular and luteal phase of the menstrual cycle raised in the discussion of our manuscript of the effects of progestin dose in oral contraceptives (Hovanessian-Larsen *et al.*, attached). Analysis of microdissected stroma from these samples will be conducted as described in Task 1a above.

A secondary aim of this award is to better understand mammographic density as it is the strongest breast cancer risk factor after the major genetic factors of BRCA1/2. These

Bartow samples are a very valuable resource in this regard. Samples of this tissue from women without breast cancer were used by Dr. Norman Boyd and colleagues to measure constituents of the tissue (Li *et al.*, 2005). Specifically from tissue slices which had been X-rayed (Faxitron) by Dr. Bartow and the Faxitron density measured (Faxitron percent density; Faxitron %), Dr. Boyd and colleagues obtained slides and measured the areas of the slide occupied by tissue (total area, TA), by collagen (collagen area, CA) and by epithelial nuclear material (epithelial nuclear area, ENA). From these measurements they calculated collagen percent ($CP = 100 \times CA/TA$; Collagen %) and epithelial nuclear area percent ($ENP = 100 \times ENA/TA$; Epithelial Nuclear Area %) and showed that Collagen % was highly correlated with Faxitron %. Dr. Boyd and colleagues kindly provided this data to us to allow us to investigate more fully the relationship between Collagen % and Epithelial Nuclear Area % and how they relate to other personal data that Dr. Bartow had collected on the women in the study. We initially submitted a manuscript of our reanalysis of the Boyd data but withdrew it when we realized that further pathological analysis might be able to significantly add to the conclusions that could be drawn from these samples regarding the reasons why mammographic density was such a strong risk factor for breast cancer. We have now conducted further analyses on these samples and a manuscript describing our results is being prepared for submission.

Task 2. Months 5-48: Assay tissue samples for hormonal and cellular markers to determine dense and non-dense tissue characteristics, and their association with glandular tissue proliferation.

We have assayed the tissue for a series of hormonal and cellular markers. To date, we have characterized ER expression, PR-A expression, PR-B expression, as well as quantified cell proliferation in the samples collected as part of Tasks 1 and 1a (Taylor *et al.*, 2009).

Task 3. Months 5-48: Assay blood samples for hormone levels.

Blood samples from pregnant women, oocyte donors and premenopausal women in different phases of the menstrual cycle and parity state have been assayed for E2 and P4. The first analysis of these data is included in Chung *et al.* (attached).

Task 4. Months 37-48: Conduct gene expression arrays on the dense and non-dense tissue samples to determine if the expression profiles differ.

We previously showed (Hawes *et al.*, 2006) as part of this grant that almost all breast epithelial tissue is contained within dense collagen areas. It is clear therefore that non-dense tissue samples consist mainly of fat. The amount of breast epithelial tissue in a breast is highly correlated with the amount of mammographic density (collagen), but less than directly proportional to the amount of density. Work done under Task 1b above has shown that the concentration of epithelium within the dense area is greater in the breasts with lower mammographic density. The question posed here in Task 4 is thus better expressed as what are the differences in dense tissue epithelium from women with less vs more density. To do this we need to know the mammographic density in the woman providing the breast tissue sample. We only have this information on the Bartow

samples. Analyses of Ki67, PRA, PRB and ER α in these samples are currently being carried out. DNA methylation analysis is planned as soon as we have a methylation method working satisfactorily. We have decided to look at DNA methylation markers first because DNA is more stable than RNA used for gene expression studies. We carried out laser capture microdissection (LCM) on fresh frozen and more recently collected fixed normal tissue samples in an attempt to obtain separate epithelial and stromal cell populations but found that the process of LCM affected the quality of the material to such an extent that even for DNA methylation studies tissue that has been subjected to LCM does not produce high quality data. (We must emphasize that normal breast epithelial tissue is a small proportion of the dense tissue and requires much more laborious and difficult collection than is the case with tumor tissue.) As a result, we have instead been performing microdissection of the stromal tissue (ensuring that we do not include vascular structures). These samples are in the queue to run on the Illumina 450K methylation DNA panel. Using these data we will identify profiles of DNA methylation markers for nulliparous and parous women and then validate these markers using additional samples collected in Project4, Task 1a. Once this is satisfactorily accomplished we will run samples collected from low and high mammographically dense tissue using the Bartow samples using the Illumina 450K methylation DNA panel

Task 5. Months 13-60: Conduct data analysis to compare dense and non-dense tissue characteristics and prepare manuscripts as appropriate.

As we stated above under Task 1b: ‘We initially submitted a manuscript of our reanalysis of the Boyd data but withdrew it when we realized that further pathological analysis might be able to significantly add to the conclusions that could be drawn from these samples regarding the reasons why mammographic density was such a strong risk factor for breast cancer. We have now conducted further analyses on these samples and a manuscript describing our results is being prepared for submission.’

KEY RESEARCH ACCOMPLISHMENTS:

- Evaluation of tissue samples from reduction mammoplasties resulting in a seminal publication on the relation of mammographic densities to epithelium (Hawes *et al.*, *Breast Cancer Research*, 8:R24-29, 2006).
- Discovery of a sustaining decrease in PRA after pregnancy as a potential marker of the protective effect of pregnancy on breast cancer risk (*Breast Cancer Res Treat*, 118:161-168, 2009).
- Submission of a key manuscript describing the completely unexpected lack of decrease, and possible increase, in breast cell proliferation when the dose of the progestin, norethindrone, in oral contraceptives is reduced by 60% and the apparent reason for this being the concomitant increase in estrogen and progesterone receptors (Hovanessian-Larsen *et al.*, in review).
- Submission of a key manuscript describing the effect of short-term high-dose estrogen exposure on breast cell proliferation, and ER α , PRA and PRB expression compared to naturally cycling women and pregnant women (Chung *et al.*, in review).
- Identification of genes expressed in a parity-specific manner in multiple rat strains resulting in a key publication (Blakely *et al.*, *Cancer Res*, 66:6421-6431, 2006; 67:844-846, 2007).
- Treatment of rats with hormonal chemoprevention regimens and determination of effective regimens.
- Evaluation of rat mammary gland morphology.
- Identification of genes whose expression correlates with parity in human samples that are matched for epithelial-cell content.
- Demonstration that low-dose and short-term hormone treatment of rats reduces mammary tumor susceptibility.
- Failure to recapitulate hormone and parity-induced protection against mammary tumorigenesis in mice following extensive attempts in multiple strains of mice, including experiments in which the mice were fed a low phytoestrogen diet.
- Development and initiation of a protocol to allow us to evaluate the appropriateness of a progestin-based breast cancer chemopreventive approach.
- Development and initiation of a protocol to collect interview data and tissue specimens on women having elective reduction mammoplasties.
- Development of a protocol to allow us to evaluate breast cell proliferation in women receiving different progestin-dose oral contraceptives.
- Development of a protocol to allow us to evaluate breast cell proliferation in women receiving micronized progesterone versus placebo to determine the effect of exogenous progesterone on proliferation.
- Development of a protocol to allow us to evaluate the effects of high dose estrogen on breast tissue.
- Development of a protocol to allow us to collect breast tissue from healthy volunteers.
- Contact and interview 99 additional previous reduction mammoplasty subjects to obtain demographic, reproductive, and hormone use data.
- Staining and evaluation of breast epithelial-cell proliferation (Ki67), ER α , PRA, and PRB expression in previously obtained reduction mammoplasty samples and prospectively collected reduction mammoplasty samples.

- DNA extraction and successful DNA methylation quality control results from microdissected stromal tissue.
- Development of a network of collaborators at USC and across the United States to further the work being funded by this grant.
 - At USC we continue to have regular monthly meetings of our working group of investigators with expertise in endocrinology, gynecology, breast cancer pathology, oncology, radiology, epidemiology and molecular biology to review progress of the various projects and specific related tasks and to discuss any data generated from the studies and any new questions that may arise from our studies or published literature.
 - We continue to have fruitful collaborations with Dr. Sue Bartow for studies on breast specimens from autopsies performed in New Mexico. These are the same specimens utilized by Dr. Norman Boyd's group (Li *et al.*, *Cancer Epidemiol Biomarkers Prev* 14:343-349, 2005) and we have collaborated and are continuing to collaborate with Dr. Boyd in analyzing these data further.
- Demonstration that low-dose and short-term hormone treatment of rats reduces mammary tumor susceptibility.
- Extensive attempts to recapitulate hormone and parity-induced protection against mammary tumorigenesis in mice.
- Receipt of grant funding to study the effect of reducing the estrogen dose in an oral contraceptive, while keeping the progestin dose constant, on breast cell proliferation, and ER α , PRA and PRB expression.
- Receipt of grant funding to study the effect of hCG, a known chemopreventive agent against mammary cancer in rodents, on breast tissue in women.

REPORTABLE OUTCOMES:

1. Blakely CM, Stoddard AJ, Belka GK, Dugan KD, Notarfrancesco KL, Moody SE, D'Cruz CM, and Chodosh LA. Hormone-induced protection against mammary tumorigenesis is conserved in multiple rat strains and identifies a core gene expression signature induced by pregnancy. *Cancer Research*, 66:6421-6431, 2006; erratum in 67:844-846, 2007.
2. Hawes D, Downey S, Pearce CL, Bartow S, Wan P, Pike MC, Wu AH. Dense breast stromal tissue shows greatly increased concentration of breast epithelium but no increase in its proliferative activity. *Breast Cancer Res*, 8:R24-29, 2006.
3. Taylor D, Pearce CL, Hovanessian-Larsen L, Downey S, Spicer DV, Bartow S, Ling C, Pike MC, Wu AH, Hawes D. Progesterone and estrogen receptors in pregnant and premenopausal non-pregnant normal human breast. *Breast Cancer Res Treat* 118:161-168, 2009.

CONCLUSION:

Our finding that PRA expression is altered during and following pregnancy, precisely as is seen in the rat model of mammary carcinogenesis, provides a potentially important insight into a marker for mimicking the protective effect of a pregnancy on breast cancer risk.

Our finding that breast epithelial tissue in women is overwhelmingly concentrated in mammographically dense areas of the breast (areas of high collagen concentration not seen in rodent breast) provides a deep insight into the reason for increased mammographic density being so closely associated with increased risk of breast cancer – women with increased mammographic density have more breast epithelium. Breast densities are reduced in parous compared to nulliparous women, so that this ties in closely with our work on changes in the breast after pregnancy.

We have demonstrated that oocyte donors undergoing controlled ovarian hyperstimulation have greatly increased levels of estrogen and of breast cell proliferation, both comparable in the majority of donors to the levels seen in the first trimester of pregnancy. This increased cell proliferation is of short duration. Whether their greatly increased estrogen levels are associated with any long-term beneficial effects on the breast, as occurs in rodent models, is not known, but is being investigated by the recruitment of nulliparous women for study who have previously been oocyte donors.

Our finding that a lower progestin dose in oral contraceptives does not lead to lower breast-cell proliferation compared to women on a higher progestin dose pill suggests that estrogen dose may be the relevant component in oral contraceptives in terms of affecting breast epithelial-cell proliferation. We have obtained funding to test this hypothesis and are in discussion with animal and in vitro experimentalists to find a way to distinguish between the different progestins in terms of their effect of the breast.

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3. Hawes D, Downey S, Pearce CL, Bartow S, Wan P, Pike MC, Wu AH. Dense breast stromal tissue shows greatly increased concentration of breast epithelium but no increase in its proliferative activity. *Breast Cancer Res* 8:R24-29, 2006.
4. Lee SA, Ross RK, Pike MC. An overview of menopausal oestrogen-progestin hormone therapy and breast cancer risk. *Brit J Cancer* 92:2049-2058, 2005.
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APPENDICES:

1. List of personnel
2. Blakely CM, Stoddard AJ, Belka GK, Dugan KD, Notarfrancesco KL, Moody SE, D'Cruz CM, and Chodosh LA. Hormone-induced protection against mammary tumorigenesis is conserved in multiple rat strains and identifies a core gene expression signature induced by pregnancy. *Cancer Research*, 66:6421-6431, 2006; erratum in 67:844-846, 2007.
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Hormone-Induced Protection against Mammary Tumorigenesis Is Conserved in Multiple Rat Strains and Identifies a Core Gene Expression Signature Induced by Pregnancy

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Abstract

Women who have their first child early in life have a substantially lower lifetime risk of breast cancer. The mechanism for this is unknown. Similar to humans, rats exhibit parity-induced protection against mammary tumorigenesis. To explore the basis for this phenomenon, we identified persistent pregnancy-induced changes in mammary gene expression that are tightly associated with protection against tumorigenesis in multiple inbred rat strains. Four inbred rat strains that exhibit marked differences in their intrinsic susceptibilities to carcinogen-induced mammary tumorigenesis were each shown to display significant protection against methylnitrosourea-induced mammary tumorigenesis following treatment with pregnancy levels of estradiol and progesterone. Microarray expression profiling of parous and nulliparous mammary tissue from these four strains yielded a common 70-gene signature. Examination of the genes constituting this signature implicated alterations in transforming growth factor- β signaling, the extracellular matrix, amphiregulin expression, and the growth hormone/insulin-like growth factor I axis in pregnancy-induced alterations in breast cancer risk. Notably, related molecular changes have been associated with decreased mammographic density, which itself is strongly associated with decreased breast cancer risk. Our findings show that hormone-induced protection against mammary tumorigenesis is widely conserved among divergent rat strains and define a gene expression signature that is tightly correlated with reduced mammary tumor susceptibility as a consequence of a normal developmental event. Given the conservation of this signature, these pathways may contribute to pregnancy-induced protection against breast cancer. (Cancer Res 2006; 66(12): 6421-31)

Introduction

Epidemiologic studies clearly show that a woman's risk of developing breast cancer is influenced by reproductive endocrine events (1). For example, early age at first full-term pregnancy, as well as increasing parity and duration of lactation, have each been shown to reduce breast cancer risk (2, 3). In particular, women who have their first child before the age of 20 have up to a

50% reduction in lifetime breast cancer risk compared with their nulliparous counterparts (2). Notably, the protective effects of an early full-term pregnancy have been observed in multiple ethnic groups and geographic locations, suggesting that parity-induced protection results from intrinsic biological changes in the breast rather than specific socioeconomic or environmental factors. At present, however, the biological mechanisms underlying this phenomenon are unknown.

Several models to explain the protective effects of parity have been proposed. For instance, parity has been hypothesized to induce the terminal differentiation of a subpopulation of mammary epithelial cells, thereby decreasing their susceptibility to oncogenesis (4). Related to this, parity has been suggested to induce changes in cell fate within the mammary gland, resulting in a population of mammary epithelial cells that are more resistant to oncogenic stimuli by virtue of decreased local growth factor expression and/or increased transforming growth factor (Tgf)- β 3 and p53 activity (5, 6). Others have suggested that the process of involution that follows pregnancy and lactation acts to eliminate premalignant cells or cells that are particularly susceptible to oncogenic transformation (5). Conversely, parity-induced decreases in breast cancer susceptibility could also be due to persistent changes in circulating hormones or growth factors rather than local effects on the mammary gland (7). At present, however, only limited cellular or molecular evidence exists to support any of these models.

Similar to humans, both rats and mice exhibit parity-induced protection against mammary tumorigenesis. Administration of the chemical carcinogens, 7,12-dimethylbenzanthracene or methylnitrosourea, to nulliparous rats results in the development of hormone-dependent mammary adenocarcinomas that are histologically similar to human breast cancers (8). In outbred Sprague-Dawley, and inbred Lewis and Wistar-Furth rats, a full-term pregnancy either shortly before or after carcinogen exposure results in a high degree of protection against mammary carcinogenesis (7, 9, 10). Similarly, treatment of rats with pregnancy-related hormones, such as 17- β -estradiol (E) and progesterone (P), can mimic the protective effects of pregnancy in rat mammary carcinogenesis models (11, 12). This suggests that the mechanisms of parity-induced protection and estradiol and progesterone-induced protection may be similar. Using analogous approaches, Medina and colleagues have shown parity-induced as well as hormone-induced protection against 7,12-dimethylbenzanthracene-initiated carcinogenesis in mice (13, 14). As such, rodent models recapitulate the ability of reproductive endocrine events to modulate breast cancer risk as observed in humans. This, in turn, permits the mechanisms of parity-induced protection to be studied within defined genetic and reproductive contexts.

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doi:10.1158/0008-5472.CAN-05-4235

Previously, analyses of gene expression changes that occur in rodent models in response to parity, or hormonal treatments that mimic parity, have been used to suggest potential cellular and molecular mechanisms for pregnancy-induced protection against breast cancer (6, 15). Rosen and colleagues used subtractive hybridization analysis to identify genes in the mammary glands of Wistar-Furth rats that were persistently up-regulated 4 weeks posttreatment with estradiol and progesterone (15). Estradiol and progesterone treatment was found to increase the mRNA expression of a wide range of genes, including those involved in differentiation, cell growth, and chromatin remodeling. Similarly, we used microarray expression profiling to assess global gene expression changes induced by parity in the mammary glands of FVB mice (6). This analysis revealed parity-induced increases in epithelial differentiation markers, *Tgfb3* and its downstream targets, and cellular markers reflecting the influx of macrophages and lymphocytes into the parous gland. We also found that parity resulted in persistent decreases in the expression of a number of growth factor-encoding genes, including amphiregulin (*Areg*) and insulin-like growth factor (*Igf-I*). Together, these studies provided initial insights into cellular and molecular mechanisms that could contribute to parity-induced protection.

Notably, early first full-term pregnancy in humans primarily decreases the incidence of estrogen receptor (ER)-positive breast cancers (16). Because rats are more similar to humans than are mice with respect to the incidence of ER-positive mammary tumors (17), in the present study we used microarray expression profiling to identify persistent gene expression changes in the mammary glands of this rodent species to explore potential mechanisms of parity-induced protection. To date, a comprehensive analysis of parity-induced up-regulated and down-regulated gene expression changes in the rat has not been performed.

A major challenge posed by global gene expression surveys is the large number of differentially expressed genes that are typically identified, only a few of which may contribute causally to the phenomenon under study. Consequently, we considered approaches to identifying parity-induced changes in the rat mammary gland that would permit the resulting list of expressed genes to be narrowed to those most robustly associated with parity-induced protection against mammary tumorigenesis. Given the marked genetic and biological heterogeneity between different inbred rat strains, we reasoned that identifying expression changes that are conserved across multiple strains exhibiting hormone-induced protection against mammary tumorigenesis would facilitate the identification of a core set of genes associated with parity-induced protection against breast cancer.

To achieve this goal, we focused on gene expression changes that are conserved among different strains of rats that exhibit hormone-induced protection against mammary tumorigenesis. We first identified four genetically distinct inbred rat strains that exhibit hormone-induced protection against methylnitrosourea-induced mammary tumorigenesis independent of their inherent susceptibility to this carcinogen. We then used oligonucleotide microarrays to identify a core 70-gene expression signature that closely reflects parity-induced changes in the mammary gland that were conserved among each of these strains. The results of this analysis extend prior observations with respect to parity-induced changes in the growth hormone/*Igf-I* axis, identify novel parity-induced changes associated with the extracellular matrix (ECM), and implicate a core set of pathways in pregnancy-induced protection against breast cancer.

Materials and Methods

Animals and tissues. Lewis, Wistar-Furth, Fischer 344, and Copenhagen rats (Harlan, Indianapolis, IN) were housed under 12-hour light/12-hour dark cycles with access to food and water ad libitum. Animal care was performed according to institutional guidelines. To generate parous (G1P1) rats, 9-week-old females were mated and allowed to lactate for 21 days after parturition. After 28 days of postlactational involution, rats were sacrificed by carbon dioxide asphyxiation and the abdominal mammary glands were harvested and snap-frozen following lymph node removal, or whole-mounted and fixed in 4% paraformaldehyde. Whole-mounted glands were stained with carmine alum as previously described (6). For histologic analysis of whole mammary glands and tumors, paraffin-embedded tissues were sectioned and stained with H&E or Mason's trichrome as previously described (6). Tissues were harvested from age-matched nulliparous (G0P0) animals in an identical manner.

Carcinogen and hormone treatments. Twenty-five to 30 nulliparous female Lewis, Fischer 344, Wistar-Furth, and Copenhagen rats were weighed and treated at 7 weeks of age with methylnitrosourea (Sigma-Aldrich, St. Louis, MO) at a dose of 50 mg/kg by a single i.p. injection. At 9 weeks of age, animals from each strain were assigned to one of two groups and treated with hormone pellets (Innovative Research, Sarasota, FL) by s.c. implantation. Group 1 received pellets containing 35 mg of 17- β -estradiol + 35 mg of progesterone, whereas group 2 received pellets containing placebo. Pellets were removed after 21 days of treatment. No signs of toxicity were observed. The development of mammary tumors was assessed by weekly palpation. Animals were sacrificed at a predetermined tumor burden, or at 60 weeks postmethylnitrosourea. At sacrifice, all mammary glands were assessed for tumors, which were fixed in 4% paraformaldehyde and embedded in paraffin. Tumor samples from each strain were confirmed as carcinomas by histologic evaluation. Statistical differences in tumor-free survival between experimental groups were determined by log rank tests and by the generation of hazard ratios (HR) based on the slope of the survival curves using GraphPad Prism 4.0 software.

Microarray analysis. RNA was isolated from snap-frozen abdominal mammary glands by the guanidine thiocyanate/cesium chloride method as previously described (6). Ten micrograms of total RNA from individual Wistar-Furth (six G0P0 and five G1P1), Fischer 344 (eight G0P0 and six G1P1), and Copenhagen (six G0P0 and five G1P1) rats was used to generate cDNA and biotinylated cRNA as previously described (6). For Lewis rats, three G0P0 and three G1P1 samples were analyzed, each of which was comprised of 10 μ g of pooled RNA from three animals. To permit the identification of epithelial as well as stromal gene expression changes, intact mammary glands (with lymph nodes removed) were used. Samples were hybridized to high-density oligonucleotide microarrays (RGU34A) containing ~8,800 probe sets representing ~4,700 genes and expressed sequence tags. Affymetrix comparative algorithms (MAS 5.0) and Chipstat were used to identify genes that were differentially expressed between nulliparous and parous samples (18). Robust Multichip Average signal values were generated using Bioconductor (19).

Genes were selected for further analysis whose expression changed significantly by the above analysis in three out of four strains. Significance was assessed by randomly generating eight lists equal in size to the up-regulated and down-regulated lists for each strain from the population of nonredundant genes called present on the chip in at least one sample (2,428 genes). One million random draw trials were performed to calculate a nominal *P* value for combined list length and to estimate the false discovery rate (FDR) using the median list size occurring by chance.

Hierarchical clustering was done using R statistical software¹ and as described (20). Mouse genes were identified using the Homologene database (National Center for Biotechnology Information).

Quantitative real-time PCR. Five micrograms of DNase-treated RNA were used to generate cDNA by standard methods. *Csn2*, *Mmp12*, *Tgfb3*,

¹ <http://www.R-project.org>.

Igfbp5, *Areg*, *Igf-I*, *Ghr*, *Serpinh1*, and *Sparc* were selected for confirmation by quantitative real-time PCR (QRT-PCR) using TaqMan assays (Applied Biosystems, Foster City, CA). *B2m* was used as a control (21, 22). Reactions were performed in duplicate in 384-well microtiter plates in an ABI Prism Sequence Detection System according to standard methods (Applied Biosystems). One-tailed *t* tests were performed to determine statistical significance using Prism 4.0 software.

Results

Hormone-induced protection in inbred rat strains. To determine whether hormone-induced protection against mammary tumorigenesis is a feature unique to carcinogen-sensitive strains, we compared the extent of protection induced by hormones in four different rat strains: Lewis, Wistar-Furth, Fischer 344, and Copenhagen. Two of these strains (Lewis and Wistar-Furth) have been reported to exhibit hormone-induced protection (9, 12). However, it has not been determined whether carcinogen-resistant strains of rats, such as Copenhagen (23), also exhibit protection. Female rats from each strain were treated with a single dose of methylnitrosourea at 7 weeks of age, followed by s.c. implantation of either placebo or hormone pellets (35 mg of estradiol + 35 mg of progesterone) at 9 weeks of age. Among the placebo-treated groups, Lewis rats exhibited the highest susceptibility to methylnitrosourea-induced mammary tumorigenesis with 100% penetrance and a median tumor latency of 13 weeks (Fig. 1A). Fischer 344 and Wistar-Furth rats displayed intermediate carcinogen sensitivity with latencies of 24 and 36 weeks, respectively. In contrast, Copenhagen rats exhibited a high degree of resistance to methylnitrosourea-induced mammary tumorigenesis with only 5 of 12 animals developing mammary tumors, with an average latency of 51 weeks.

Surprisingly, despite the wide variance in carcinogen sensitivity of nulliparous rats from these four strains, estradiol and progesterone treatment induced a significant ($P < 0.05$) degree of protection against mammary tumorigenesis in each strain (Fig. 1B). For example, whereas Lewis and Copenhagen strains differed markedly in their sensitivity to methylnitrosourea, they exhibited strikingly similar degrees of hormone-induced protection with HRs of 0.19 [95% confidence interval (CI), 0.05-0.40] and 0.16 (95% CI, 0.02-0.63), respectively. The Wistar-Furth (HR, 0.31; 95% CI, 0.09-0.90) and Fischer 344 (HR, 0.38; 95% CI, 0.10-0.71) strains exhibited lesser, but significant degrees of protection. These experiments show that hormone treatments that mimic pregnancy confer protection against mammary tumorigenesis in each strain irrespective of the intrinsic carcinogen susceptibility of nulliparous animals from that strain.

Morphologic changes induced by parity in the rat mammary gland. Parity-induced changes in breast cancer susceptibility have been reported to be accompanied by persistent changes in the structure of the mammary gland in humans, as well as in rats and mice (4, 6). Consistent with this, carmine-stained whole-mount analysis of nulliparous and parous mammary glands from each of the four rat strains revealed that the architecture of the parous mammary epithelial tree was more complex than that of age-matched nulliparous animals, with a higher degree of ductal side-branching (Fig. 1C). These effects were observed in each of the four strains analyzed, suggesting that changes in the structural and cellular composition of the mammary gland may occur as a consequence of parity.

Microarray analysis of parity-induced changes in the rat mammary gland. The similar morphologic changes induced by parity suggested that the hormone-induced protection against

mammary tumorigenesis that we observed in different rat strains might be accompanied by common molecular alterations. To identify these changes, we first performed oligonucleotide microarray expression profiling on pooled samples from nulliparous and parous Lewis rats. Genes whose expression changes were considered to be statistically significant using established algorithms, and whose expression changed by at least 1.2-fold as a result of parity, were selected for further analysis (18). This combined analytic approach has previously been shown to be capable of identifying differentially expressed genes with high sensitivity and specificity (18). Gene expression analysis performed in this manner identified 75 up-regulated and 148 down-regulated genes in parous compared with nulliparous mammary glands. Examination of this list of differentially expressed genes confirmed our previous findings in mice that parity results in the persistent up-regulation of *Tgfb3*, as well as differentiation and immune markers, as well as the persistent down-regulation of growth factor encoding genes, such as *Areg* and *Igf-I* (ref. 6; data not shown).

To narrow the list of candidate genes whose regulation might contribute to the protected state associated with parity, we attempted to identify parity-induced gene expression changes that were conserved across multiple rat strains. To this end, total RNA was isolated from the mammary glands of nulliparous and parous Wistar-Furth, Fischer 344, and Copenhagen rats, and analyzed on RGU34A arrays in a manner analogous to that employed for Lewis rats. This led to the identification of 68, 64, and 92 parity up-regulated genes and 132, 209, and 149 parity down-regulated genes in Wistar-Furth, Fischer 344, and Copenhagen rats, respectively.

Unsupervised hierarchical clustering performed using the expression profiles of 1,954 globally varying genes across the nulliparous and parous data sets representing the four rat strains revealed that samples clustered primarily based on strain without regard to parity status (Fig. 2A). This suggested that the principal source of global variation in gene expression across these data sets was due to genetic differences between strains rather than reproductive history. This observation suggested that determining which parity-induced gene expression changes were conserved among these highly divergent rat strains could represent a powerful approach to defining a parity-related gene expression signature correlated with hormone-induced protection against mammary tumorigenesis.

To identify parity-induced gene expression changes that were conserved across strains, we selected genes that exhibited ≥ 1.2 -fold change in at least three of the four strains analyzed. This led to the identification of 24 up-regulated (Table 1) and 46 down-regulated genes (Table 2). Based on the number of parity-induced gene expression changes observed for each strain, an overlap of this size is highly unlikely by chance (up-regulated: $P < 1 \times 10^{-6}$, FDR < 1%; down-regulated: $P < 1 \times 10^{-6}$, FDR = 4%). As such, this approach led to the identification of 70 genes whose expression is persistently altered by parity across multiple strains of rats that exhibit hormone-induced protection against mammary tumorigenesis.

A gene expression signature distinguishes parous and nulliparous rats and mice. To confirm the validity of the 70-gene parity-related expression signature derived from the above studies, we performed oligonucleotide microarray analysis on samples from nulliparous and parous Lewis rats that were generated independently from those used to derive this signature. Hierarchical clustering analysis of these independent samples using the 70-gene signature revealed that the expression profiles of these genes were sufficient to accurately distinguish parous from nulliparous Lewis rat samples in a blinded manner (Fig. 2B).

To determine whether this parity-related signature could distinguish between nulliparous and parous mammary glands from multiple strains of rats, Lewis, Wistar-Furth, Fischer 344, and Copenhagen microarray data sets were clustered in an unsupervised manner based solely on the expression of the 70 genes comprising the parity signature (Fig. 2C). In each of the four rat strains examined, the 70-gene signature was sufficient

to distinguish parous from nulliparous rats (Fig. 2C). Thus, this signature reflects parity-induced gene expression changes that are highly conserved among four genetically divergent rat strains.

Early full-term pregnancy has been reported to result in protection against mammary tumorigenesis in mice, as it does in humans and rats (13). Accordingly, we mapped the 70 genes

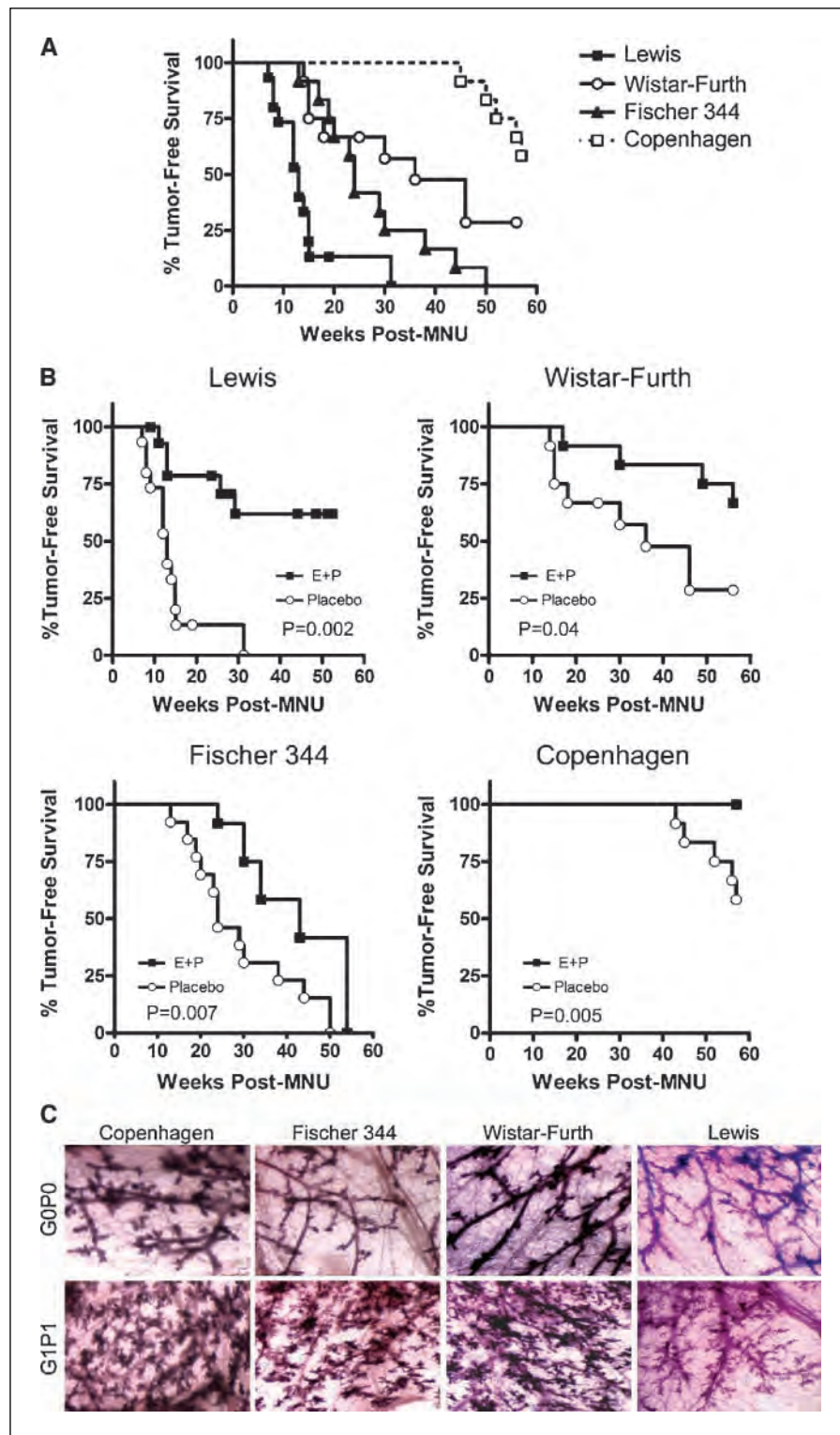
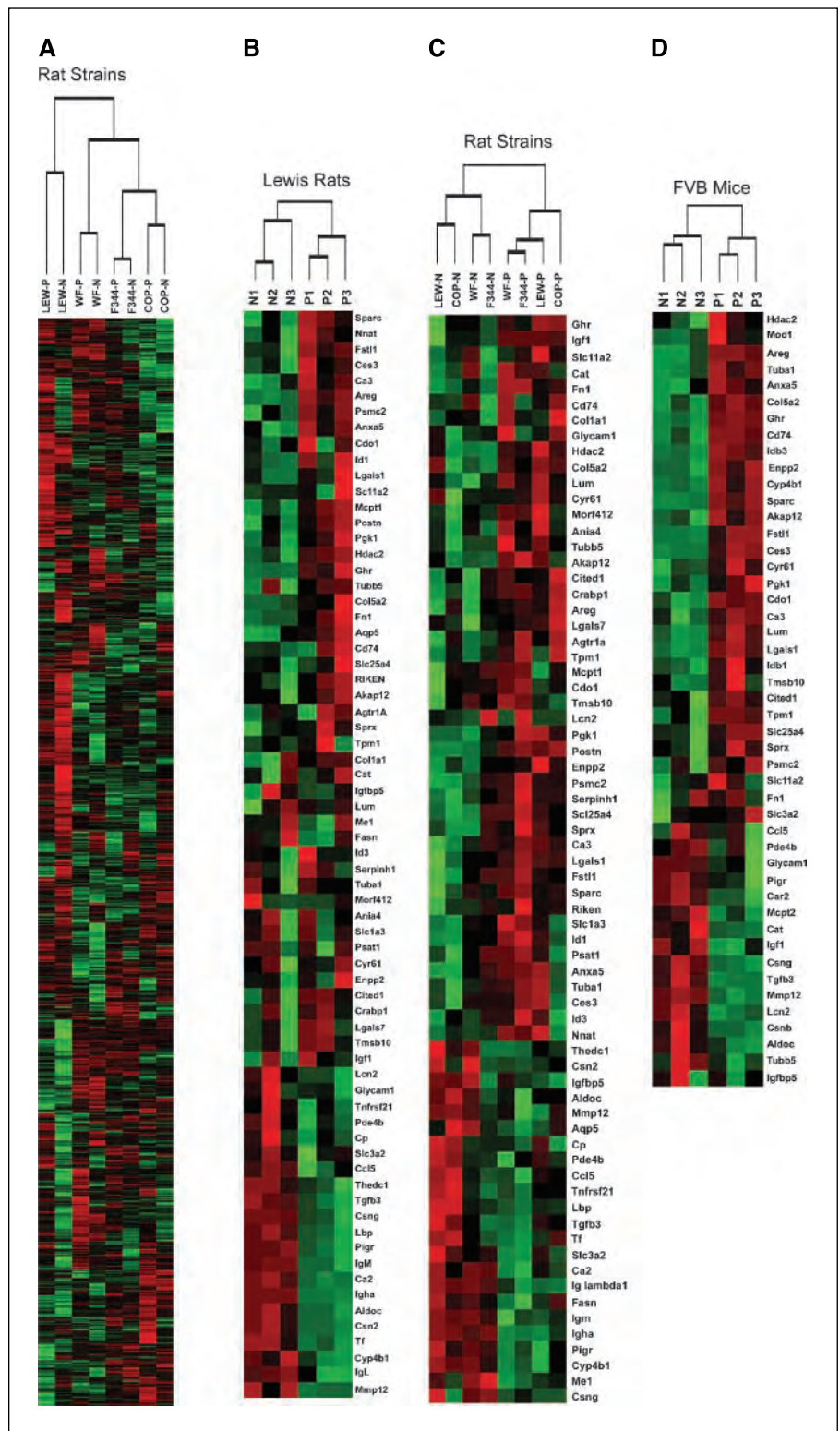


Figure 1. Hormone-induced protection against mammary tumorigenesis is conserved among multiple rat strains. **A**, Kaplan-Meier curves plotting the time to the formation of a first mammary tumor in placebo-treated groups for Lewis ($n = 15$), Wistar-Furth ($n = 12$), Fischer 344 ($n = 13$), and Copenhagen ($n = 12$) rats treated with methylnitrosourea (MNU) at 7 weeks of age. Significant differences in tumor incidence were identified between Lewis and Wistar-Furth ($P = 0.0003$), Lewis and Fischer 344 ($P = 0.0005$), Lewis and Copenhagen ($P = 0.0001$), Wistar-Furth and Copenhagen ($P = 0.024$), and Fischer 344 and Copenhagen ($P = 0.0001$) as determined by a log rank test. Wistar-Furth and Fischer 344 were not significantly different ($P = 0.14$). **B**, mammary tumor incidence for placebo and estradiol and progesterone-treated rats is plotted for each strain. Cohort sizes for estradiol and progesterone-treated animals were: Lewis ($n = 16$), Wistar-Furth ($n = 12$), Fischer 344 ($n = 12$), and Copenhagen ($n = 12$). Each strain exhibited significantly decreased tumor incidence in estradiol and progesterone-treated compared with placebo-treated cohorts. **C**, carmine-stained whole mounts of abdominal mammary glands from nulliparous (G0P0) and parous (G1P1) rats from each strain (original magnification, $\times 50$). Samples are representative of three animals per group.

Figure 2. A parity-related gene expression signature distinguishes between nulliparous and parous rats and mice. Unsupervised hierarchical clustering analysis. Nulliparous (*N*), parous (*P*), Lewis (*LEW*), Fischer 344 (*F344*), Wistar-Furth (*WF*), and Copenhagen (*COP*). **A**, nulliparous and parous samples from each strain were clustered based on the median expression values of ~1,900 genes exhibiting global variation in gene expression across the data sets. **B**, six independent Lewis samples [three nulliparous (N1-N3) and three parous (P1-P3)] were clustered based solely on the expression of genes in the 70-gene parity signature. **C**, clustering analysis based solely on the expression of the 70-gene parity signature was performed on nulliparous and parous samples from Lewis, Wistar-Furth, Fischer, and Copenhagen rats. **D**, the 70-gene rat parity signature was mapped to the mouse genome using Homologene, yielding 47 mouse genes. Six FVB mouse samples [three nulliparous (N1-N3) and three parous (P1-P3)] were clustered based on the expression profiles of these 47 genes.



constituting the rat parity signature to the mouse genome, and assessed their expression profiles in nulliparous and parous FVB mouse mammary samples. Of the 70 genes that were mapped, 47 were represented on Affymetrix MGU74Av2 microarrays. These 47 genes were sufficient to distinguish nulliparous from parous samples in a blinded manner (Fig. 2D). Thus, a parity-related gene

expression signature generated in the rat is able to predict reproductive history in the mouse, suggesting that the persistent molecular alterations that occur in response to parity are conserved across rodent species.

Among the 70 genes that we identified as being consistently regulated by parity, at least five categories were evident.

Table 1. Genes up-regulated in parous rats

Gene name	Symbol	Gene ID	Function	Category	Fold-change G1P1 versus G0P0				
					Lewis	WF	F344	Cop	Median
Immunoglobulin heavy chain	<i>Igha</i>	314487	Immunoglobulin	Immune	39.4	25.4	4.5	6.9	25.4
Casein β	<i>Csn2</i>	29173	Milk protein	Differentiation	8.0	5.2	1.9	1.5	5.2
IgM light chain		287965	Immunoglobulin	Immune	2.5	3.8	1.8	1.6	2.5
Matrix metalloproteinase 12	<i>Mmp12</i>	117033	Proteolysis	ECM/Immune	2.6	1.4	2.0	1.3	2.0
Casein γ	<i>Csng</i>	114595	Milk protein	Differentiation	3.1	1.9	1.2	0.9	1.9
Fatty acid synthase	<i>Fasn</i>	50671	Fatty acid biosynthesis	Metabolism/ differentiation	2.0	1.6	1.7	0.9	1.7
Cytochrome P450, family 4, subfamily b,1	<i>Cyp4b1</i>	24307	Monooxygenase activity	Metabolism	1.6	1.5	1.2	1.2	1.5
Carbonic anhydrase 2	<i>Ca2</i>	54231	Carbon dioxide hydration	Metabolism	1.5	1.5	1.4	1.1	1.5
Ig lambda-1 chain C region		363828	Immunoglobulin	Immune	1.5	1.4	1.4	1.3	1.4
Malic enzyme 1	<i>Me1</i>	24552	Pyruvate synthesis	Metabolism	1.3	1.4	1.4	1.1	1.4
Insulin-like growth factor binding protein 5	<i>Igfbp5</i>	25285	Igf-I-binding	Growth factor/ ECM	2.4	1.4	0.9	2.7	1.4
Lipopolysaccharide binding protein	<i>Lbp</i>	29469	Antibacterial	Immune	2.1	1.3	1.4	2.0	1.4
Polymeric immunoglobulin receptor	<i>Pigr</i>	25046	Transcytosis	Immune	1.7	1.4	1.2	1.1	1.4
Transforming growth factor, β 3	<i>Tgfb3</i>	25717	Cell growth/ proliferation	Tgf- β	1.5	1.3	1.2	1.4	1.3
Aquaporin 5	<i>Aqp5</i>	25241	Water transport	Transporter	1.3	1.7	1.2	1.5	1.3
Phosphodiesterase 4B	<i>Pde4b</i>	24626	Cyclic AMP phosphodiesterase	Signal transduction	1.3	1.4	1.0	1.4	1.3
Thioesterase domain containing 1	<i>Thecd1</i>	64669	Fatty acid biosynthesis	Metabolism/ differentiation	1.9	1.2	1.3	1.5	1.3
Transferrin	<i>Tf</i>	24825	Iron transport	Transport/ differentiation	1.4	1.2	1.3	1.5	1.3
Ceruloplasmin	<i>Cp</i>	24268	Copper transport	Transport/ differentiation	1.3	1.0	1.2	2.2	1.2
Similar to death receptor 6	<i>Tnfrsf21</i>	316256	Apoptosis	Signal transduction	1.3	1.0	1.2	1.3	1.2
Aldolase C, fructose-biphosphate	<i>Aldoc</i>	24191	Fructose metabolism	Metabolism	1.2	1.2	1.1	1.3	1.2
Lipocalin 2	<i>Lcn2</i>	170496	Iron binding/antibacterial	Immune	1.3	1.1	1.2	1.4	1.2
Solute carrier family 3, member 2	<i>Slc3a2</i>	50567	Amino acid transporter	Transporter	1.2	1.1	1.2	1.3	1.2

NOTE: Genes identified as up-regulated by at least 1.2-fold in three out of four rat strains as a result of parity are reported from the highest to lowest median fold change. Gene names and symbols are reported based on the Rat Genome Database, and Gene ID according to Entrez Gene. Gene functions and categories are based on Gene Ontology.

Abbreviations: WF, Wistar-Furth; F344, Fischer 344; Cop, Copenhagen.

These included the previously identified differentiation, immune, Tgf- β , and growth factor categories (6), as well as an additional category of genes that are involved in ECM structure and function (Tables 1 and 2). We previously showed that clustering based on genes in each of the first four categories was sufficient to distinguish between nulliparous and parous rats (6). In an analogous manner, we tested whether unsupervised clustering based solely on ECM-related genes would be sufficient to differentiate between nulliparous and parous rat or mouse samples. In each case, ECM-related gene expression patterns alone were sufficient to distinguish between nulliparous and parous mammary samples from the four different rat strains (Fig. 3A), from independent mammary samples derived

from nulliparous and parous Lewis rats (Fig. 3B), and from mammary samples derived from FVB mice (Fig. 3C). This indicates that differential expression of a subset of genes involved in ECM structure and function represents a conserved feature of parity-induced changes in the rodent mammary gland.

Parity up-regulates *Tgfb3* and expression of differentiation and immune markers. Our previous analysis of parity-induced gene expression changes in FVB mice was consistent with the parity-induced up-regulation of Tgf- β 3 activity. Similarly, in the current study, we found that *Tgfb3* expression was up-regulated by parity in each of the four rat strains examined (Table 1). This finding was confirmed by QRT-PCR

Table 2. Genes down-regulated in parous rats

Gene name	Symbol	Gene ID	Function	Category	Fold-change G1P1 versus G0P0				
					Lewis	WF	F344	Cop	Median
Periostin	<i>Postn</i>	361945	Transcription factor	Differentiation	1.9	2.1	1.8	2.2	2.0
Amphiregulin	<i>Areg</i>	29183	Epidermal growth factor receptor ligand	Growth factor	3.5	2.1	1.7	1.9	2.0
Cellular retinoic acid binding protein I	<i>Crabp1</i>	25061	Retinoic acid receptor signaling	Signal transduction	1.8	2.1	1.3	1.5	1.7
Insulin-like growth factor 1	<i>Igf-1</i>	24482	Cell proliferation/survival	Growth factor	1.7	1.2	1.5	1.5	1.5
Fibronectin 1	<i fn1<="" i=""></i>	25661	Integrin signaling	ECM	1.4	1.3	1.5	1.6	1.5
A kinase (PRKA) anchor protein (gravin) 12	<i>Akap12</i>	83425	Scaffolding protein	Signal transduction	1.2	1.6	1.6	1.3	1.4
Neuronatin	<i>Nnat</i>	94270	Protein transport		2.0	1.4	1.5	0.9	1.4
Glycosylation dependent cell adhesion molecule 1	<i>Glycam1</i>	25258	Selectin ligand	Differentiation	0.5	2.2	1.2	1.7	1.4
Secreted acidic cysteine rich glycoprotein	<i>Sparc</i>	24791	ECM Formation	ECM	1.6	1.1	1.4	1.4	1.4
Ectonucleotide pyrophosphatase/phosphodiesterase 2	<i>Enpp2</i>	84050	Lysophospholipase	Cell motility	2.1	1.4	1.4	1.0	1.4
Lectin, galactose binding, soluble 1	<i>Lgals1</i>	56646	Integrin signaling	ECM	1.5	1.2	1.4	1.4	1.4
Inhibitor of DNA binding 1, helix-loop-helix protein	<i>Id1</i>	25261	Transcriptional repression	Tgf- β	1.4	1.4	1.4	1.1	1.4
Follistatin-like 1	<i>Fstl1</i>	79210			1.5	1.7	1.2	1.2	1.4
Phosphoserine aminotransferase 1	<i>Psat1</i>	293820	Serine biosynthesis	Metabolism	1.4	1.2	1.5	1.3	1.4
Lumican	<i>Lum</i>	81682	Proteoglycan	ECM	1.3	1.5	1.1	1.4	1.3
Melanocyte-specific gene 1 protein	<i>Cited1</i>	64466	Transcription factor	Signal transduction	1.4	1.9	1.2	1.3	1.3
Serine proteinase inhibitor, clade H, member 1	<i>Serpinh1</i>	29345	Procollagen binding	ECM	1.4	1.3	1.3	1.4	1.3
Sushi-repeat-containing protein	<i>Sprx</i>	64316			1.3	1.3	1.3	1.5	1.3
Carboxylesterase 3	<i>Ces3</i>	113902	Fatty acid metabolism	Metabolism	1.8	1.1	1.3	1.4	1.3
Cysteine rich protein 61	<i>Cyr61</i>	83476	Integrin signaling	ECM	1.1	1.3	1.3	1.6	1.3
Solute carrier family 1, member 3	<i>Slc1a3</i>	29483	Amino acid transporter	Transporter	1.4	1.3	1.3	1.1	1.3
Similar to RIKEN cDNA 6330406I15	<i>RDG1307396</i>	360757			1.6	1.2	1.3	1.3	1.3
Catalase	<i>Cat</i>	24248	Hydrogen peroxide reductase	ROS	1.7	1.0	1.4	1.2	1.3
Tropomyosin 1, α	<i>Tpm1</i>	24851	Actin binding		1.1	1.3	1.3	1.3	1.3
Activity and neurotransmitter-induced early gene protein 4	<i>Ania4</i>	360341	CAM kinase	Kinase	1.5	1.2	1.2	1.3	1.3
Solute carrier family 11, member 2	<i>Slc11a2</i>	25715	Divalent metal ion transporter	Transporter	1.4	1.0	1.3	1.2	1.3
Inhibitor of DNA binding 3, helix-loop-helix protein	<i>Id3</i>	25585	Transcriptional repression	Tgf- β	1.5	1.2	1.3	0.9	1.3
Solute carrier family 25 member 4	<i>Slc25a4</i>	85333	Nucleotide translocator	Transporter	1.3	1.3	1.2	1.3	1.3
Growth hormone receptor	<i>Ghr</i>	25235	Growth hormone signaling	Growth factor	2.1	1.1	1.2	1.3	1.3
Phosphoglycerate kinase 1	<i>Pgk1</i>	24644	Phosphoprotein glycolysis	Metabolism	1.6	1.2	1.3	1.2	1.3

(Continued on the following page)

Table 2. Genes down-regulated in parous rats (Cont'd)

Gene name	Symbol	Gene ID	Function	Category	Fold-change G1P1 versus G0P0				
					Lewis	WF	F344	Cop	Median
Cytosolic cysteine dioxygenase 1	<i>Cdo1</i>	81718	Cysteine metabolism	Metabolism	1.5	1.2	1.2	1.3	1.3
Mast cell protease 1	<i>Mcpt1</i>	29265	Proteolysis	ECM	1.6	1.3	1.2	1.2	1.2
Collagen, type V, $\alpha 2$	<i>Col5a2</i>	85250	ECM structural protein	ECM	1.0	1.2	1.3	1.5	1.2
Carbonic anhydrase 3	<i>Ca3</i>	54232	Carbon metabolism	Metabolism	1.8	1.2	1.1	1.3	1.2
Tubulin, $\alpha 1$	<i>Tuba1</i>	64158	Microtubule component	Cell structure	1.5	1.2	1.2	1.2	1.2
Angiotensin II receptor, type 1	<i>Agtr1A</i>	24180	Angiotensin receptor	Signal transduction	1.3	1.2	1.2	1.3	1.2
Collagen, type I, $\alpha 1$	<i>Col1a1</i>	29393	ECM structural protein	ECM	1.1	1.2	1.2	1.8	1.2
Annexin A5	<i>Anxa5</i>	25673	Calcium ion binding		1.6	1.2	1.2	1.2	1.2
Thymosin, $\beta 10$	<i>Tmsb10</i>	50665	Actin binding		1.3	1.2	1.2	1.0	1.2
Tubulin, $\beta 5$	<i>Tubb5</i>	29214	Microtubule component	Cell structure	1.1	1.3	1.2	1.2	1.2
Histone deacetylase 2	<i>Hdac2</i>	84577	Chromatin rearrangement		1.2	1.2	1.3	1.1	1.2
Lectin, galactose binding, soluble 7	<i>Lgals7</i>	29518	Galactose binding		1.1	1.8	1.2	1.2	1.2
CD74 antigen	<i>Cd74</i>	25599		Immune	1.2	1.2	1.0	1.3	1.2
Proteasome 26S subunit, ATPase 2	<i>Psmc2</i>	25581	Protein degradation		1.3	1.1	1.2	1.1	1.2
MORF-related gene X	<i>Morf412</i>	317413			1.4	1.2	1.1	1.2	1.2

NOTE: Genes identified as down-regulated by at least 1.2-fold in three out of four rat strains as a result of parity are reported from the highest to lowest median fold change. Gene names and symbols are reported based on the Rat Genome Database, and Gene ID according to Entrez Gene. Gene functions and categories are based on Gene Ontology.

Abbreviations: WF, Wistar-Furth; F344, Fischer 344; Cop, Copenhagen.

analysis of independent parous and nulliparous Lewis rat samples (Fig. 4A).

Also consistent with our prior observations, parity resulted in a persistent increase in the expression of genes involved in mammary differentiation, including the milk proteins β -casein and γ -casein, and the metal ion transporters ceruloplasmin and transferrin (ref. 6; Table 1; Fig. 4A).

As we have previously shown in the mouse, the 70-gene rat parity-related gene expression signature reflected the increased presence of immune cells in the parous mammary gland. In particular, increased expression of multiple immunoglobulin heavy and light chain genes in the parous gland suggested an increase in the population of plasma cells, whereas up-regulation of *Mmp12* and *Tnfrsf21* was consistent with increased numbers of macrophages and T cells (Table 1; Fig. 4A). Similarly, increased antibacterial and antiviral activity was suggested by the up-regulation of *Lbp*, *Lcn2*, and *Ccl5* (refs. 24–26; Table 1).

Parity results in down-regulation of amphiregulin and the growth hormone/Igf-I axis. Previous gene expression profiling of mouse mammary development revealed that parity results in a persistent decrease in the expression of several growth factor-encoding genes, including *Areg* and *Igf-I* (6). The present study confirmed that decreased expression of *Areg* and *Igf-I* are consistent features of the parous state in rats (Table 2; Fig. 4B). Additional evidence supporting parity-induced down-regulation of the growth hormone/Igf-I axis in the mammary glands of multiple rat strains was suggested by a decrease in growth hormone receptor (*Ghr*) expression (Table 2; Fig. 4B) as well as an increase in

Igfbp5 expression (Table 1; Fig. 4A), which functions to sequester local Igf-I in the ECM (27).

Parity regulates ECM gene expression. Mammary epithelial-ECM interactions play an important role in both normal mammary gland development and tumorigenesis (28). Moreover, persistent changes in the structure and function of the ECM have been shown in the mammary glands of parous rats (29). In the present study, microarray expression profiling suggested that a principal effect of parity in the rodent mammary gland is alteration of ECM gene expression. Thirteen of the 70 genes constituting the parity signature encode ECM structural components or proteins that regulate ECM formation or signaling (Tables 1 and 2). Notably, the majority of ECM-related gene expression changes induced by parity represented decreases in expression, including the ECM structural components, fibronectin 1, lumican, and collagen type I and collagen type V (Table 2). Parity-induced decreases in the expression of genes that regulate ECM formation or cellular interactions were also observed, including, *Sparc*, *Lgals1*, *Lgals7*, *Serpinh1*, *Cyr61*, and *Mcpt1* (Table 2; Fig. 4B).

To determine whether these parity-induced ECM-related gene expression changes were accompanied by differences in ECM structure, we stained histologic sections with Mason's trichrome to evaluate total collagen content. Although proximal epithelial structures seemed similar with respect to periductal trichrome staining (data not shown), a significant decrease in the extent of trichrome staining surrounding distal ducts was observed in the parous gland (Fig. 4C). These results provide further evidence that parity results in structural changes in the ECM.

Discussion

Women who have their first child early in life have a substantially reduced lifetime risk of breast cancer, an effect that is largely restricted to ER-positive tumors. Similar to humans, rats frequently develop ER-positive breast cancers and exhibit parity-induced protection against mammary tumorigenesis. In the current study, we set out to identify persistent parity-induced changes in gene expression that are conserved among multiple rat strains that exhibit hormone-induced protection against mammary tumorigenesis. We found that four genetically diverse inbred rat strains exhibit hormone-induced protection against mammary tumorigenesis and share a 70-gene pregnancy-induced expression signature. Our findings constitute the first global survey of parity-induced changes in gene expression in the rat—which represents the principal model for studying this phenomenon—as well as the first study to show conservation of parity-induced gene expression changes in multiple inbred rat strains that exhibit hormone-induced protection. Beyond suggesting that parity-induced protection is as robust and widely conserved a phenomenon in rats as it is in humans, our findings provide new insights into potential mechanisms by which early first-full term pregnancy decreases breast cancer risk.

These current studies extend our previous observations that parity results in persistently increased mammary expression of *Tgfb3* to include multiple additional strains of rats. Notably, loss of Tgf- β signaling in stromal fibroblasts promotes the growth and invasion of mammary carcinomas (30). Tgf- β may also have direct effects on mammary epithelial cells, resulting in the inhibition of mammary tumorigenesis (31). The sum of these effects is predicted to decrease the susceptibility of the parous gland to oncogenic transformation.

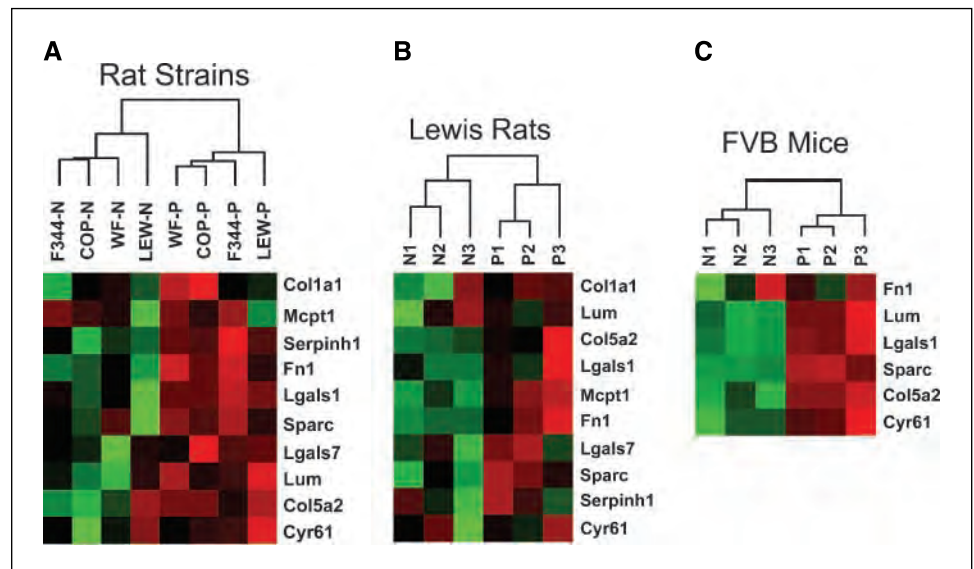
One of the most consistent and robust parity-induced changes in gene expression that we have observed in the rodent mammary gland is down-regulation of the epidermal growth factor receptor ligand, *Areg*. AREG is overexpressed in a high proportion of human breast cancers and correlates with large tumor size and nodal involvement (32). Studies in genetically engineered mice and mammary epithelial cell lines suggest an important role

for AREG in driving mammary epithelial proliferation, whereas recent evidence indicates that this growth factor may alter the ECM by the regulation of protease expression and secretion, including matrix metalloproteinase-2, matrix metalloproteinase-9, urokinase-type plasminogen activator, and plasminogen activator inhibitor-1 (33). Thus, parity-mediated down-regulation of *Areg* may not only inhibit epithelial proliferation, but may also hinder the invasive abilities of transformed cells in the mammary gland.

In addition to the down-regulation of *Areg*, we have confirmed that parity also results in the persistent down-regulation of *Igf-I*. Notably, a strong positive correlation exists between serum IGF-I levels and breast cancer risk in premenopausal women (34). Local and serum levels of IGF-I are regulated by growth hormone through its interaction with growth hormone receptor (35). Additional findings indicate that parity results in a persistent decrease in circulating growth hormone levels in rats (7); moreover, treatment of parous rats with Igf-I results in an increase in carcinogen-induced mammary tumorigenesis to levels similar to those observed in nulliparous controls (36). Consistent with this, spontaneous dwarf rats, which lack functional growth hormone, are highly resistant to carcinogen-induced mammary tumorigenesis (37).

Additional evidence for down-regulation of the growth hormone/Igf-I axis within the parous mammary gland was suggested in the present study by increases in *Igfbp5* expression and decreases in *Ghr* expression. As such, our findings suggest that—in addition to reducing circulating levels of growth hormone—parity may modulate local expression and activity of Igf-I within the mammary gland. Whereas Igf-I acts directly on mammary epithelial cells to promote proliferation and inhibit apoptosis (38), Igf-I in the mammary gland is likely produced in the stromal compartment in response to *Ghr* signaling (39). Local regulation of Igf-I activity also occurs through interactions with Igf-I binding proteins, such as *Igfbp5*, which binds and sequesters Igf-I in the ECM (40). As such, parity-induced down-regulation of *Ghr* and Igf-I expression in the mammary gland, coupled with up-regulation of *Igfbp5* expression, would be predicted to result in decreased Igf-I activity. This represents a

Figure 3. ECM gene expression distinguishes between nulliparous and parous rats and mice. Unsupervised hierarchical clustering analysis. A, a subset of parity-regulated genes involved in ECM structure and regulation was used to cluster nulliparous and parous mammary samples from Lewis (*LEW*), Wistar-Furth (*WF*), Fischer (*F344*), and Copenhagen (*COP*) rats. B, six independent Lewis samples [three nulliparous (N1-N3) and three parous (P1-P3) samples] were clustered based on the expression of ECM-related genes. C, six FVB mouse samples [three nulliparous (N1-N3) and three parous (P1-P3)] were clustered based on the expression of ECM-related genes identified in the rat parity signature that were mapped to the mouse genome.



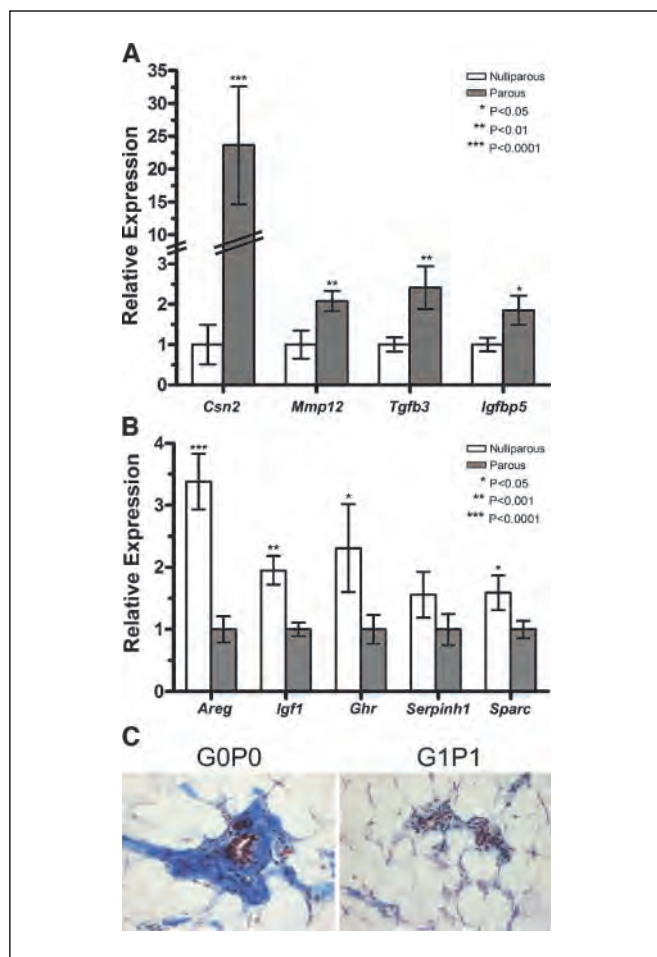


Figure 4. Confirmation of gene expression changes. *A* and *B*, TaqMan QRT-PCR was performed on cDNAs generated from 21 nulliparous and 21 parous Lewis rat mammary samples. Each reaction was performed in duplicate. Expression values for each gene were normalized to *B2m*. *A*, relative expression of parity up-regulated genes. *White columns*, mean expression in nulliparous samples normalized to 1.0 for each gene; *gray columns*, mean expression of each gene in parous relative to nulliparous samples; *bars*, \pm SE. *B*, relative expression of parity down-regulated genes. *White columns*, mean expression of each gene in nulliparous relative to parous samples; *gray columns*, mean expression in parous samples normalized to 1.0 for each gene; *bars*, \pm SE. *P* values were generated using a one-tailed, unpaired Student's *t* test. *C*, Mason's trichrome staining. Abdominal mammary glands from nulliparous and parous Lewis rats were stained with Mason's trichrome to assess total collagen present in the ECM surrounding epithelial structures. Images are representative of distal structures in the mammary glands of three nulliparous and three parous Lewis rats (original magnification, \times 200).

plausible mechanism by which parity may confer protection against breast cancer.

The functional unit of the mammary gland consists of a complex stroma that surrounds the epithelial compartment. Stromal-epithelial interactions play a prominent role, not only in mammary development, but also in tumorigenesis (28). Fibroblasts represent the most prominent cell type of the periductal stroma and, in addition to secreting growth factors that activate epithelial receptors, they are the primary synthesizers of ECM constituents such as fibronectin, collagen, and proteoglycans. Accumulating evidence indicates that stromal constituents, including fibroblasts and ECM structural components, could have differential effects on epithelial cells depending on the

source of the tissue from which they are isolated (41). Consistent with this, Schedin et al. have shown that the ability of mammary epithelial cells to form ductal structures in culture is markedly influenced by the developmental context of the ECM in which they are cultured (29). Further support for the role of ECM regulation in parity-induced protection against breast cancer comes from our observation that parous mammary glands exhibit decreased trichrome staining as well as persistent down-regulation of ECM structural and regulatory genes. Because cross-talk between epithelial and stroma cells occurs through local growth factors and their receptors (42), it is possible that parity-induced down-regulation of *Areg* and *Igf-I* in combination with up-regulation of *Tgfb3* may alter stromal-epithelial interactions in such a way as to decrease susceptibility to mammary carcinogenesis.

Finally, it is interesting to speculate that parity-induced changes in the ECM may be related to measures of breast cancer risk associated with mammographic breast density. Increased mammographic density has been consistently shown to correlate with high breast cancer risk (43). Mammographic density has also been reported to be negatively correlated with parity (44). Although breast density was initially believed to reflect the epithelial content of the breast, current evidence suggests that ECM composition—in particular collagen and proteoglycans such as lumican—may be the primary determinant of mammographic density (44, 45). Intriguingly, recent studies have implicated the ratio of serum IGF-I to IGFBP3 as a major determinant of mammographic density (46). Consistent with this, Guo et al. found increased IGF-I tissue staining in samples from women with increased breast density (45). Our findings support the hypothesis that parity decreases Igf-I expression and activity and diminishes the expression of selected ECM structural components. Together, these changes may lead to decreases in both mammographic breast density and breast cancer risk. Validation of this hypothesis will require confirmation that parity alters local IGF-I levels and mammographic breast density in women, and that modulation of Igf-I in rodent models will alter breast density as well as pregnancy-induced protection against breast cancer.

In summary, the results presented in this study extend previous observations that parity results in local changes in growth factor gene expression in the mammary gland. We hypothesize that the evolutionarily conserved parity-induced alterations in gene expression identified in this study result in the modification of the extracellular environment and changes in stromal-epithelial interactions. We hypothesize that the ultimate effect of these changes is to create a tumor suppressive state, thereby providing a potential mechanism to explain parity-induced protection against mammary tumorigenesis. Whether analogous parity-induced changes occur in the human breast remains an important yet unresolved question.

Acknowledgments

Received 11/29/2005; revised 3/28/2006; accepted 4/24/2006.

Grant support: CA92910 from the National Cancer Institute, grants W81XWH-05-1-0405, W81XWH-05-1-0390, DAMD17-03-1-0345 (C.M. Blakely), and DAMD17-00-1-0401 (S.E. Moody) from the U.S. Army Breast Cancer Research Program, and grants from the Breast Cancer Research Foundation and the Emerald Foundation.

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The authors thank the members of the Chodosh Laboratory for helpful discussions and critical reading of the manuscript.

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Research article

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Dense breast stromal tissue shows greatly increased concentration of breast epithelium but no increase in its proliferative activity

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Received: 2 Feb 2006 Revisions requested: 21 Feb 2006 Revisions received: 8 Mar 2006 Accepted: 30 Mar 2006 Published: 28 Apr 2006

Breast Cancer Research 2006, **8**:R24 (doi:10.1186/bcr1408)

This article is online at: <http://breast-cancer-research.com/content/8/2/R24>

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Abstract

Introduction Increased mammographic density is a strong risk factor for breast cancer. The reasons for this are not clear; two obvious possibilities are increased epithelial cell proliferation in mammographically dense areas and increased breast epithelium in women with mammographically dense breasts. We addressed this question by studying the number of epithelial cells in terminal duct lobular units (TDLUs) and in ducts, and their proliferation rates, as they related to local breast densities defined histologically within individual women.

Method We studied deep breast tissue away from subcutaneous fat obtained from 12 healthy women undergoing reduction mammoplasty. A slide from each specimen was stained with the cell-proliferation marker MIB1. Each slide was divided into (sets of) areas of low, medium and high density of connective tissue (CT; highly correlated with mammographic densities). Within each of the areas, the numbers of epithelial cells in TDLUs and ducts, and the numbers MIB1 positive, were counted.

Results The relative concentration (RC) of epithelial cells in high compared with low CT density areas was 12.3 (95% confidence interval (CI) 10.9 to 13.8) in TDLUs and 34.1 (95% CI 26.9 to 43.2) in ducts. There was a much smaller difference between medium and low CT density areas: RC = 1.4 (95% CI 1.2 to 1.6) in TDLUs and 1.9 (95% CI 1.5 to 2.3) in ducts. The relative mitotic rate (RMR; MIB1 positive) of epithelial cells in high compared with low CT density areas was 0.59 (95% CI 0.53 to 0.66) in TDLUs and 0.65 (95% CI 0.53 to 0.79) in ducts; the figures for the comparison of medium with low CT density areas were 0.58 (95% CI 0.48 to 0.70) in TDLUs and 0.66 (95% CI 0.44 to 0.97) in ducts.

Conclusion Breast epithelial cells are overwhelmingly concentrated in high CT density areas. Their proliferation rate in areas of high and medium CT density is lower than that in low CT density areas. The increased breast cancer risk associated with increased mammographic densities may simply be a reflection of increased epithelial cell numbers. Why epithelium is concentrated in high CT density areas remains to be explained.

Introduction

On a mammogram, fat appears radiolucent or dark, whereas stromal and epithelial tissue appears radio-dense or white. The amount of mammographic density is a strong independent predictor of breast cancer risk [1,2]. The biological basis for this increased risk is poorly understood. A critical question is

whether densities are directly related to risk or are simply a marker of risk. We addressed this question recently by studying the location of small ductal carcinoma *in situ* (DCIS) lesions as revealed by microcalcifications, and showed that such DCIS occurs overwhelmingly in the mammographically dense areas of the breast [3]. Most DCIS lesions in our study

a_H , a_L , a_M = the areas of the slide classified as being of high, low and medium CT density (in μm^2); CI = confidence interval; CT = connective tissue; DAB = 3,3'-diaminobenzidine tetrahydrochloride; DCIS = ductal carcinoma *in situ*; n_H , n_L , n_M = the numbers of epithelial cells staining positive for MIB1 within high, low and medium CT density areas; RC = relative concentration; RMR = relative mitotic rate; TDLU = terminal duct lobular unit; t_H , t_L , t_M = the numbers of epithelial cells within high, low and medium CT density areas;

Table 1**Relation between relative concentration of epithelial cells and connective tissue density**

CT density	RC	95% CI	<i>p</i>
TDLUs			
Low	1.0		
Medium	1.4	1.2–1.6	<0.001
High	12.3	10.9–13.8	<0.001
Ducts			
Low	1.0		
Medium	1.9	1.5–2.3	<0.001
High	34.1	26.9–43.2	<0.001

CI, confidence interval; CT, connective tissue; RC, relative concentration (per unit area); TDLUs, terminal duct lobular units.

occurred in the lateral-superior quadrant, as has been found in previous studies [4], and 'correlated strongly with the average percentage density in the different mammographic quadrants' [3]. Pre-DCIS mammograms that were taken on average about two years previously showed that the areas subsequently exhibiting DCIS were clearly dense at the time of the earlier mammogram, and this suggests that this relationship was not brought about by the presence of the DCIS. The reasons for these findings are not clear; two obvious possibilities are increased epithelial cell proliferation in mammographically dense areas of the breast and increased breast epithelium in women with mammographically dense breasts. Two groups have investigated the relationship between the amount of mammographic density of a woman and the amount of her breast epithelial tissue [5,6]. Alowami and colleagues [5] used tissue obtained from biopsies investigating breast lesions that were subsequently diagnosed as benign or pre-invasive breast disease; they studied tissue 'distant from the diagnostic lesion' without reference to its location as regards mammographic density (that is, 'random' tissue). They found that the median density of duct lobular units was 28% higher in breasts whose overall mammographic density was 50% or more ($n = 27$) than in breasts whose overall mammographic density was less than 25% ($n = 35$); this result was not statistically significant and the result was described as showing 'no difference in the density of epithelial components' [5]. Li and colleagues [6] also found in their much larger study ($n = 236$) of 'random' breast tissue collected from normal women by Bartow and colleagues [7] in their autopsy study of accidental deaths in New Mexico that women with high mammographic density had greater amounts of epithelial tissue (as measured by area of epithelial nuclear staining) and the result was highly statistically significant. Breast epithelial proliferation rates as they relate to mammographic densities in healthy women have not been well studied [8]. We have addressed these questions by studying the number of epithelial cells in terminal duct lobular units (TDLUs) and in breast ducts, and their respective prolif-

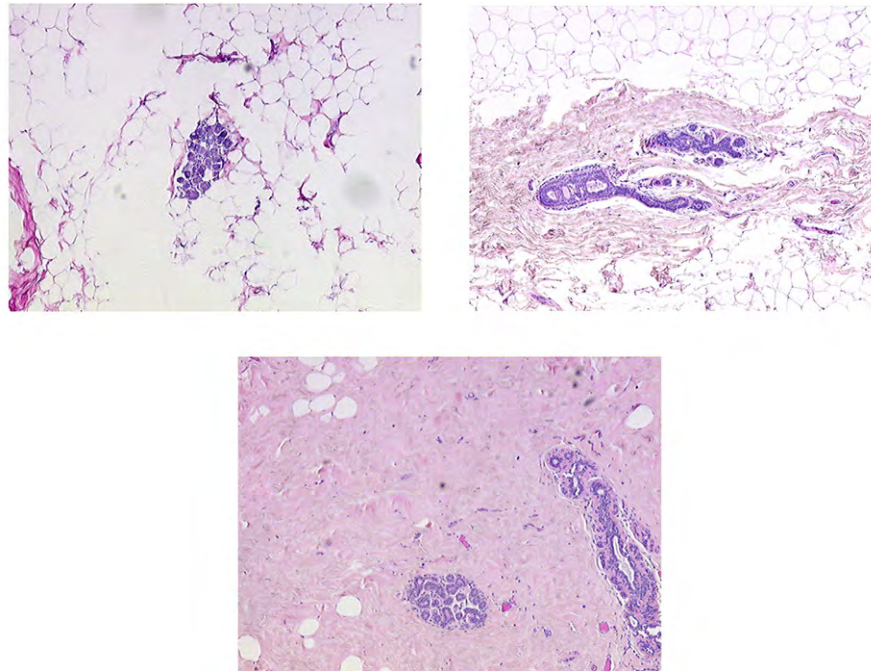
eration rates as they relate to local histological breast densities within individual women.

Materials and methods

We retrospectively identified 15 consecutive healthy women who had undergone a reduction mammoplasty performed by one of us (SD) at the University of Southern California medical facilities. The study protocol was approved by the Institutional Review Board of the University of Southern California School of Medicine.

For each participant we obtained the formalin-fixed paraffin-embedded block of tissue that had been routinely processed and saved from her surgery. A single slide was cut from each block and stained with the proliferation marker MIB1 (BioGenex Laboratories, San Ramon, CA, USA). The slides were prepared in accordance with our previously published protocol [9]; the chromogen used was 3,3'-diaminobenzidine tetrahydrochloride (DAB). On microscopic examination one of the slides contained skin and two other slides showed areas of disintegration; all three were deemed unsuitable for study.

Each of the remaining 12 slides was divided into (sets of) areas of low, medium and high density of connective tissue (CT) (highly correlated with densities as defined by mammographic criteria [10]); see Figure 1. The total size of each of the three areas (in μm^2), and within each of the three areas the numbers of epithelial cells in TDLUs and ducts and the numbers that were MIB1 positive, were counted with the help of an automated microscope system that digitized the images and permitted the outlining of relevant areas on a high-resolution computer screen (ACIS II; Clariant, Inc., San Juan Capistrano, CA, USA). The total numbers of epithelial cells in different outlined areas within the CT density-defined areas was then automatically counted by the ACIS II nuclear counting software program, which is based on color identification. Hematoxylin was used to counterstain the MIB1-negative nuclei blue, and the DAB chromogen marked the MIB1-positive nuclei brown.

Figure 1

Example of areas of low, medium (upper right) and high (lower center) CT density.

The software calculated the numbers of MIB1-negative and MIB1-positive cells on the basis of these color differences.

Statistical analysis

For each slide, and separately for TDLU and ductal cells, three sets of values were obtained: first, the areas of the slide classified as being of low, medium or high CT density (a_L , a_M and a_H in μm^2); second, the numbers of epithelial cells within these areas (t_L , t_M and t_H); and third, the numbers of these epithelial cells staining positive for MIB1 (n_L , n_M and n_H). On the null hypothesis of no association between the t 's and the a 's – that is, no association between the numbers of epithelial cells and the CT density of the local tissue – the expected value of the t 's is simply proportional to the related a 's, so that, for example, the expected value of t_H is $(t_L + t_M + t_H) \times a_H / (a_L + a_M + a_H)$. Similarly, on the null hypothesis of no association between MIB1 positivity as a proportion of epithelial cells and the CT density of the local tissue, the expected value of the n 's is simply proportional to the related t 's, so that, for example, the expected value of n_H is $(n_L + n_M + n_H) \times t_H / (t_L + t_M + t_H)$. We analyzed these data with standard statistical software as implemented in the STATA statistical software package (procedure cs; Stata Corporation, Austin, TX, USA); the ratios of epithelial concentration (cells per unit area) and the ratios of proportions of epithelial cells staining positive for MIB1 are the measures of effect. All statistical significance levels (p values) quoted are two-sided.

Results

The 12 subjects included in the analysis were aged 18 to 60 years with a median age of 33 years; only one subject was aged 50 years or older.

Areas of the slides of low CT density comprised on average 44% of the total of areas of low plus medium plus high CT density ($a_L / (a_L + a_M + a_H)$), whereas areas of high CT density comprised on average 35% of the total area ($a_H / (a_L + a_M + a_H)$).

Table 1 shows the summary relative concentrations (RCs; ratios of cells per unit area) of epithelial cells in the three areas defined by CT density separately for TDLU cells and for ductal cells. The concentration of TDLU epithelial cells is slightly greater in the areas of medium CT density than in the areas of low CT density (RC = 1.4, 95% confidence interval (CI) 1.2 to 1.6; $p < 0.001$) but is much greater in the areas of high CT density (RC = 12.3, 95% CI 10.8 to 13.8; $p < 0.001$). The TDLU results for the individual slides (women) comparing areas of high CT density with areas of low CT density are shown in Figure 2. Although the results from individual subjects do differ somewhat, the RCs were not correlated with age (the only variable available on these women) and the summary RC seems to be a fair representation of the overall results. The results for ducts were similar.

Table 2 shows the summary relative mitotic rates (RMRs) of epithelial cells staining MIB1 positive in the three areas defined by CT density separately for TDLU cells and for ductal

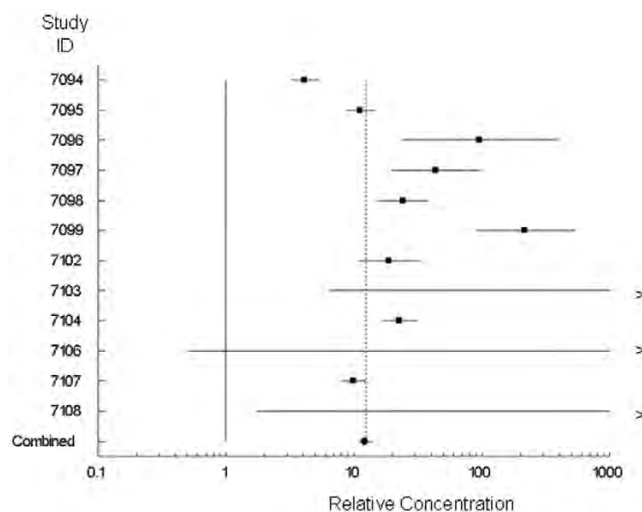
Table 2

Relation between relative mitotic rate (MIB1 positive) of epithelial cells and connective tissue density

CT density	RMR	95% CI	<i>p</i>
TDLUs			
Low	1.00		
Medium	0.58	0.48–0.70	<0.001
High	0.59	0.53–0.66	<0.001
Ducts			
Low	1.00		
Medium	0.66	0.44–0.97	0.035
High	0.65	0.53–0.79	<0.001

CI, confidence interval; CT, connective tissue; RMR, relative mitotic rate; TDLUs, terminal duct lobular units.

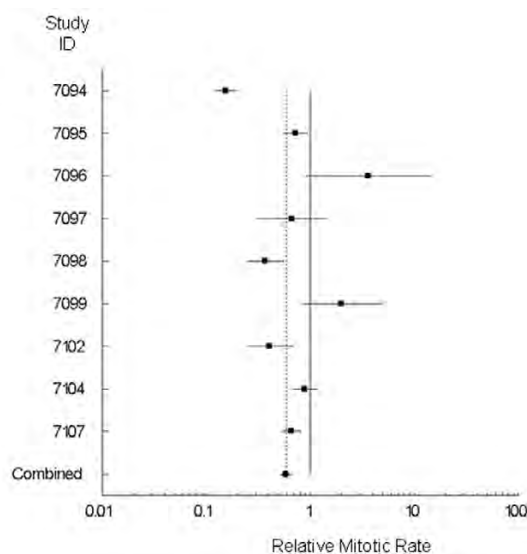
Figure 2



RCs (with 95% CIs) of TDLU epithelial cells in high and low CT areas.

cells. The proportion of TDLU epithelial cells staining MIB1 positive is statistically significantly less (RMR ≈ 0.6) both in the areas of medium CT density (*p* < 0.001) and in the areas of high CT density (*p* < 0.001) than in the areas of low CT density. The median MIB1-positive proportion was about 4%. Almost all the women in this study were premenopausal on the basis of their age; this figure is close to the Ki67 figure of 4.5% given for healthy premenopausal women in the study of Hargreaves and colleagues [11]. The TDLU results for the individual slides (women) comparing areas of high CT density with areas of low CT density are shown in Figure 3. Again, although the results from individual subjects do differ somewhat, the RMRs were not correlated with age (the only variable available on these women) and the summary RMR seems to be a fair representation of the overall results. The results for ducts were again similar. There was no difference in the proliferation rates of epithelial cells in TDLUs and ducts within the same CT den-

Figure 3



RMRs (with 95% CIs) of TDLU epithelial cells in high and low CT areas.

density area of individual women (RMR = 1.01, 95% CI 0.98 to 1.04; *p* = 0.42).

More details of the results are provided in the Additional file.

Discussion

Mammographic density is a very strong risk factor for breast cancer. The two groups of investigators [5,6] that studied random biopsies (single slides) from women with different mammographic densities found that the extent of mammographic densities was most strongly correlated with the amount of collagen on the slide. A weaker correlation was found with the amount of epithelial tissue. The findings reported here suggest that the relation between the extent of mammographic density and the amount of epithelial tissue is directly related to the increased concentration of collagen (the main component of

'connective tissue' as shown by collagen staining; see Figure 1) in women with high mammographic densities, because breast epithelium is overwhelmingly confined to areas of high CT density. In the earlier studies of random biopsies [5,6] the weaker relationship between mammographic density and epithelium concentration than between mammographic density and collagen concentration could be simply due to the much greater statistical variability of epithelial tissue in a random slide than one would see for collagen, which occupies a much greater extent of the slide. These results suggest that the increasing breast cancer risk associated with increasing mammographic density might be simply a reflection of more breast epithelial tissue.

We found that the proliferation rate of epithelial cells in areas of high CT density was much lower than in areas of low CT density, arguing against the possibility that dense stroma has a growth factor role in the increased breast cancer risk of women with mammographically dense breasts. In the study of Stomper and colleagues [8], comparison was made between single biopsies of either fat or dense areas in different women; they found no difference in the proliferation rates in the dense and fat areas. Further work is warranted but there is clearly no evidence that areas of high CT density are associated with increased proliferation.

Our results were obtained by conducting a comprehensive count of all the cells in each slide per subject (instead of counting a selected region) and allowed the comparison of proliferation rates in areas of differing CT density within an individual. This permitted us to control completely automatically for factors such as age, menopausal status, or time in the menstrual cycle in the analysis. This gave us great statistical power so that highly statistically significant results could be obtained even with small numbers of subjects.

This study used tissue obtained at reduction mammoplasty performed on women with large breasts. We do not believe that this affects the validity of our findings because the tissue samples were taken deep in the breast away from the subcutaneous fat, but this requires confirmation in future studies. Further studies are also needed relating the CT densities to such risk factors as parity and to understand the biology of the relationship between CT densities and breast epithelium.

Conclusion

The basis of the strong relationship between mammographic density and breast cancer risk may be simply that mammographically dense breasts contain more breast epithelial tissue. Why breast epithelial tissue should be associated with CT densities is not known. Does breast epithelium induce densities? Alternatively, can breast epithelium effectively survive only in areas of densities? Understanding the nature of the interaction between dense CT stroma and epithelial tissue should be a major focus of breast cancer research.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

DH, AHW, CLP and MCP participated in the design of the study. DH supervised the preparation of the slides and analyzed the slides with the ACIS II system. SD performed all the reduction mammoplasties that provided the tissues used in this analysis and consulted on the tissue obtained from reduction mammoplasties. SB consulted on the interpretation of the results and provided insight into the relationship between mammographic densities and tissue characteristics. CLP coordinated the study. MCP supervised the statistical analysis which was carried out by PW. AHW, CLP and MCP conceived of the study. MCP, DH and AHW drafted the manuscript; all authors read and approved the final manuscript.

Additional files

The following Additional files are available online:

Additional File 1

A Word file containing two tables of detailed results from this study.

See <http://www.biomedcentral.com/content/supplementary/bcr1408-S1.doc>

Acknowledgements

This work was supported by a Department of Defense Congressionally Mandated Breast Cancer Program Grant BC 044808, by the USC/Norris Comprehensive Cancer Center Core Grant P30 CA14089, and by generously donated funds from the endowment established by Flora L Thornton for the Chair of Preventive Medicine at the USC/Norris Comprehensive Cancer Center. The funding sources had no role in this report.

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Progesterone and estrogen receptors in pregnant and premenopausal non-pregnant normal human breast

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Received: 28 April 2008 / Accepted: 16 January 2009 / Published online: 10 February 2009
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Abstract We report here our studies of nuclear staining for the progesterone and estrogen receptors (PRA, PRB, ER α) and cell proliferation (MIB1) in the breast terminal duct lobular unit epithelium of 26 naturally cycling premenopausal women and 30 pregnant women (median 8.1 weeks gestation). Square root transformations of the PRA, PRB and ER α values, and a logarithmic transformation of the MIB1 values, were made to achieve more normal distributions of the values. PRA expression decreased from a mean of 17.8% of epithelial cells in cycling subjects to 6.2% in pregnant subjects ($P = 0.013$). MIB1 expression increased from 1.7% in cycling subjects to 16.0% in pregnant subjects ($P < 0.001$). PRB and ER α expression was slightly lower in pregnant subjects but the differences were

not statistically significant. Sixteen of the non-pregnant subjects were nulliparous and ten were parous so that we had limited power to detect changes associated with parity. PRA was statistically significantly lower in parous women than in nulliparous women (32.2% in nulliparous women vs. 10.2%; $P = 0.014$). PRB (23.5 vs. 12.9%), ER α (14.4 vs. 8.6%) and MIB1 (2.2 vs. 1.2%) were also lower in parous women, but the differences were not statistically significant. The marked decreases in PRA in pregnancy and in parous women has also been found in the rat. A reduction in PRA expression may be a useful marker of the reduction in risk with pregnancy and may be of use in evaluating the effect of any chemoprevention regimen aimed at mimicking pregnancy. Short-term changes in PRA expression while the chemoprevention is being administered may be a more useful marker.

DeShawn Taylor, Celeste Leigh Pearce, Linda Hovanessian-Larsen, Susan Downey are to be considered joint first authors of this report based on their pivotal contributions to the studies reported here.

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Keywords Breast · Estrogen receptor · Progesterone receptor · Parity · Pregnancy

Introduction

The progesterone receptor (PR) is expressed in two isoforms, progesterone receptor A (PRA) and progesterone receptor B (PRB) [1]. Kariagina et al. [2] described the varying expression of these two receptors in the breast epithelium of nulliparous and parous rats at differing ages, and noted that the results differed radically from the results seen in mice [3]. Their major findings in rats were: (a) The percentage of lobular cells expressing PRA (PRA + cells) declined steadily from 6 weeks of age (puberty) to 14 weeks of age in nulliparous rats, was much lower during pregnancy (8–10 days of pregnancy) and only partly recovered after involution. (b) The percentage of PRB + lobular cells was relatively constant from 3 to 14 weeks of age in nulliparous rats, and was not altered during pregnancy or after involution. These authors suggested that, since human and rat mammary glands share many features [4, 5], their finding might be applicable to the human breast. These findings in rats suggested that measuring PRA may be a simple method of distinguishing a parous from a nulliparous breast, which, if substantiated in the human breast, may be most helpful as a relatively easily obtained biomarker of possible success in chemoprevention efforts aimed at achieving the protection associated with an early pregnancy.

There are few data available on PRA and PRB expression in normal human breast tissue. We report here our findings regarding PRA and PRB expression in normal human breast tissue obtained from women undergoing reduction mammoplasties as well as from women immediately after a pregnancy termination (within 10 min of the termination). We also report here our findings for estrogen receptor α (ER α) and cell proliferation in these same breast samples.

Materials and methods

Specimen collection

We retrospectively identified 13 healthy naturally cycling premenopausal women who had undergone a reduction mammoplasty and for whom we could obtain the formalin-fixed paraffin-embedded (FFPE) block of tissue saved from her surgery that had been routinely processed at the University of Southern California Department of Pathology. We also prospectively collected breast tissue (frozen within 30 min of excision) from 8 healthy premenopausal women

who were undergoing reduction mammoplasty and 5 healthy volunteers and processed this tissue in a similar manner. The mammoplasty surgeries were all performed by one of us (SD) either at the University of Southern California medical facilities or at the Pacific SurgiCenter, while the tissue from the volunteers were obtained using ultrasound guided 14-gauge core needle biopsies (LHL). Women who reported current use of hormonal contraception were excluded from the current analyses.

Ultrasound guided 14-gauge core needle breast biopsy tissue was also prospectively collected from 33 women who had undergone a pregnancy termination within the preceding 10 min. Samples of these tissues were processed in a similar manner to that described above, i.e., FFPE in a routine manner at the University of Southern California Department of Pathology. Thirty samples were suitable for analysis.

An in-person interview was conducted with the prospectively recruited mammoplasty subjects, the healthy volunteers and the pregnancy termination subjects, and a telephone interview was conducted with the retrospectively recruited mammoplasty subjects. The interview collected detailed information on reproductive and menstrual factors using a structured questionnaire.

The study protocols were approved by the Institutional Review Board (IRB) of the University of Southern California Keck School of Medicine, and as appropriate, with the IRBs of St. John's Hospital and Health Center (for Pacific SurgiCenter) and of the Department of Defense Congressionally Directed Breast Cancer Research Program. The prospectively collected samples were obtained after the women had signed an informed consent agreeing to participate in this research. The women from whom the retrospectively collected samples were obtained also provided verbal informed consent agreeing to participate in this research.

Immunohistochemistry

Immunohistochemical (IHC) analysis was performed as follows: For all studies, multiple adjacent FFPE sections were cut at 5 μ m, deparaffinized and hydrated. All slides were also subject to antigen retrieval which was performed by heating the slides in 10 mmol/l sodium citrate buffer (pH 6) at 110°C for 30 min in a pressure cooker in a microwave oven [6]. Endogenous peroxidase activity was blocked by incubation in 3% H₂O₂ in phosphate-buffered saline for 10 min, followed by blocking of nonspecific sites with SuperBlock blocking buffer (Pierce, Rockford, IL, USA) for 1 h both at room temperature [7].

For the single marker studies, the sections were incubated for analysis with the following antibodies: PRA, the mouse monoclonal antibody NCL-PGR-312 (Novocastra

Laboratories Ltd, Newcastle upon Tyne, UK) at a concentration of 1:5,000; PRB, the mouse monoclonal antibody NCL-PGR-B (Novocastra Laboratories Ltd, Newcastle upon Tyne, UK) at a concentration of 1:100; ER α , the mouse monoclonal antibody ER Ab-12 (Clone 6F11) (Neomarkers, Kalamazoo, MI, USA) at a concentration of 1:100; and MIB1, a proliferation marker, the mouse monoclonal antihuman Ki67 antibody (Dako Cytomation, Carpinteria, CA, USA) at a concentration of 1:500. After incubation with the primary antibodies, antibody binding was localized with the ABC staining kit from Vector Laboratories (Burlingame, CA, USA) according to the manufacturer's instructions and peroxidase activity was detected using 3,3'-diaminobenzidine substrate solution (DAB; Biocare, Concord, CA, USA). A wash step with phosphate buffer solutions (PBS) for 10 min was carried out between each step of the immunostaining. Slides were counterstained with hematoxylin and mounted in mounting medium for examination.

A selection of the slides were also double-stained to permit luminal-epithelial and myoepithelial tissue to be clearly distinguished and to evaluate the co-expression of different markers. The myoepithelial cells were detected using an antibody for smooth muscle actin (SMA; Dako Cytomation, Carpinteria, CA, USA) at a concentration of 1:4000. SMA is localized in the cytoplasm of the cells and is easily distinguished from nuclear staining; on double-stained slides actin was detected using DAB. Ferengi blue was the second chromogen for both PRA and PRB. In slides that were double-stained for PRA and PRB, PRA was stained with Ferengi Blue (Biocare, Concord, CA, USA) and PRB with DAB. No hematoxylin counterstain was applied to the double-stained slides.

In the single-marker slides, we used the Automated Cellular Imaging System II (ACIS II, Clariant, Aliso Viejo, CA, USA) to assess all terminal duct lobular units (TDLUs) on a single slide or the first 100 target areas containing TDLUs selected systematically from left to right and top to bottom on the slide if there were an excessive number of epithelial cells present. A clear distinction between luminal-epithelial cells and myoepithelial cells in TDLUs is frequently difficult to make on conventionally stained slides. For this reason we counted the total numbers of luminal-epithelial + myoepithelial cells (referred to as epithelial cells) and the percentage of them positive for the relevant marker using the ACIS II which is a cellular imaging system that digitizes the images and permits the user to identify and quantitate relevant areas on a high-resolution computer screen based on color differentiation. The ACIS II software program does not function optimally when both nuclear and cytoplasmic staining is present. Due to some cytoplasmic staining in addition to nuclear positivity found in the ER α slides from the pregnant subjects

we used conventional light microscopy and manual counting methods for assessing the TDLUs in these cases. If scant epithelial tissue was present all epithelial cells were counted, in most cases we randomly identified 300 epithelial cells, in cases with a large amount of epithelium present we counted 500 epithelial cells to avoid sampling bias. The percentage of cells positive was determined by identifying the number of cells with nuclear positivity for the selected marker versus those negative or positive.

In the double-marker slides we used the Nuance FLEXTM spectral imaging system (Cambridge Research & Instrumentation, Inc., Woburn, MA, USA) to assess the co-expression of markers on a single slide.

Statistical analysis

We analyzed these data using standard statistical software (Stata, Stata Corporation, Austin, TX, USA). Differences in expression and tests for trend in expression were tested for significance by standard *t*-tests and regression tests after adjustment for age and ethnicity (African American, Hispanic Whites, non-Hispanic Whites) and after transformation of the variables to achieve more normal distributions of values (square root transformations of PRA, PRB and ER α , and logarithmic transformation of MIB1). The comparison of non-pregnant to pregnant results was also adjusted for prior parity (nulliparous/parous). All statistical significance levels (*P* values) quoted are two sided.

Results

Non-pregnant subjects

The means (and 95% confidence intervals) of the proportion of epithelial cells with positive nuclear staining for PRA, PRB, ER α and MIB1 in non-pregnant subjects subclassified by parity (nulliparous vs. parous) are given in Table 1. The individual values are shown in Fig. 1.

Table 1 Mean (\pm 95% CI) percentages of PRA, PRB, ER α and MIB1 nuclear staining in premenopausal non-pregnant nulliparous and parous subjects

	Nulliparous (<i>N</i> = 16)	Parous (<i>N</i> = 10)	<i>P</i> value
PRA	32.2 (22.6–43.4)	10.2 (3.3–20.9)	0.014
PRB	23.5 (14.6–34.5)	12.9 (4.9–24.7)	0.20
ER α	14.4 (10.4–19.0)	8.6 (4.7–13.6)	0.11
MIB1	2.2 (1.3–3.7)	1.2 (0.6–2.6)	0.26

Comparison of parous and nulliparous subjects with square root transformation of PRA, PRB and ER α values, and logarithmic transformation of MIB1 values, and adjusted for ethnicity and age

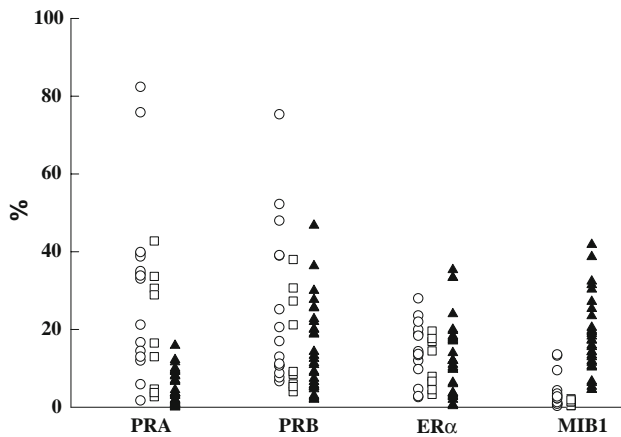


Fig. 1 Percentage of cells expressing nuclear PRA, PRB, ER α and MIB1 in premenopausal nulliparous (○), premenopausal parous (□) and pregnant (▲) women

PRA and PRB

A higher proportion of cells were positive for PRA in nulliparous compared to parous women (mean values: 32.2 vs. 10.2%; $P = 0.014$). There was also a higher proportion of cells positive for PRB in nulliparous compared to parous women (23.5 vs. 12.9%), but this difference was not statistically significant ($P = 0.20$).

PRA was expressed in the luminal epithelium but almost never expressed in the myoepithelium (Fig. 2A). PRB was expressed in both luminal epithelium and myoepithelium (Fig. 2B). The proportion of cells expressing PRB in the luminal epithelium was greater than the proportion expressing PRB in the myoepithelium, although this was difficult to assess completely satisfactorily due to the morphology of the myoepithelial cells which does not permit clear nuclear visualization in many cases.

ER α

A higher proportion of cells were positive for ER α in nulliparous compared to parous women (mean values: 14.4 vs. 8.6%), but this was also not statistically significant ($P = 0.11$). ER α was not expressed in the myoepithelium.

MIB1

A higher proportion of cells were positive for MIB1 in nulliparous women compared to parous women (mean values: 2.2 vs. 1.2%), but this was again not statistically significant ($P = 0.26$).

MIB1 expression was much lower in the myoepithelium than in the luminal epithelium.

We found no evidence that weight affected these results.

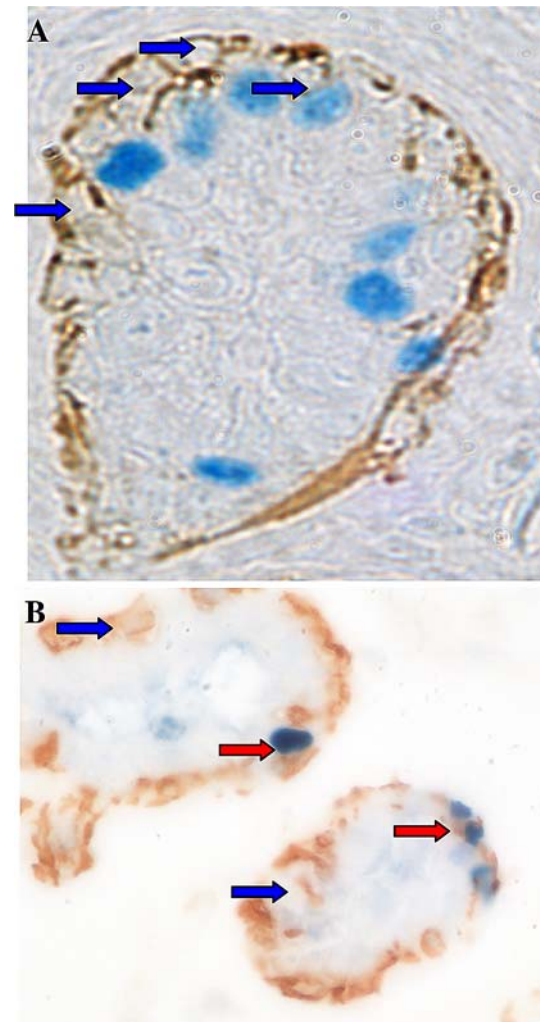


Fig. 2 **A** Double staining for PRA (blue) and SMA (brown) showing myoepithelial cells are negative for PRA (blue arrows). **B** Double staining for PRB (blue) and SMA (brown) showing myoepithelial cells positive (red arrows) and negative (blue arrows) for PRB

Pregnant subjects

The gestational age of the pregnant subjects varied from 5 to 23 weeks (median 8.1 weeks, interquartile range 7.2–12.0 weeks). Results are presented in Table 2.

PRA and PRB

A mean of 6.2% of epithelial cells expressed nuclear PRA. A mean of 14.2% of epithelial cells expressed nuclear PRB. As in the non-pregnant subjects, PRA was almost never expressed in the myoepithelium while PRB was expressed in both luminal epithelium and myoepithelium. In the luminal epithelium almost all cells expressing PRA expressed PRB, but many luminal epithelial cells expressed PRB without expressing PRA (Fig. 3).

Table 2 Mean ($\pm 95\%$ CI) percentages of PRA, PRB, ER α and MIB1 nuclear staining in naturally cycling premenopausal and pregnant subjects

	Non-pregnant ($N = 26$)	Pregnant ($N = 30$)	P value
PRA	17.8 (11.5–25.6)	6.2 (3.1–10.3)	0.013
PRB	17.3 (10.9–25.2)	14.2 (9.1–20.5)	0.57
ER α	12.3 (8.1–17.5)	10.6 (7.1–14.8)	0.63
MIB1	1.7 (1.1–2.6)	16.0 (11.0–23.3)	<0.001

Comparison of pregnant and non-pregnant subjects with square root transformation of PRA, PRB, and ER α values, and logarithmic transformation of MIB1 values; and adjusted for ethnicity, age and prior parity (parous/nulliparous)

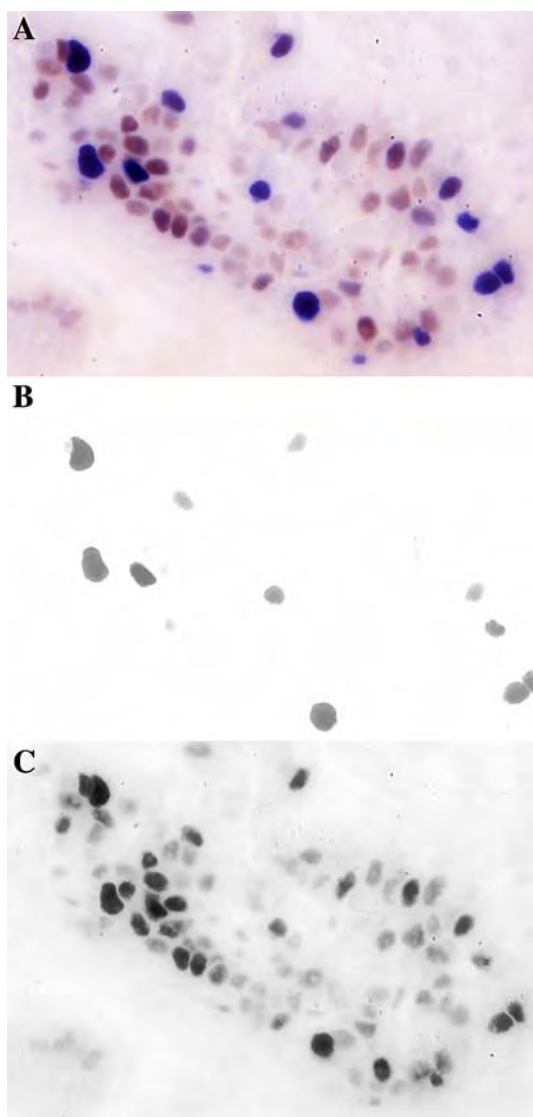


Fig. 3 **A** Composite spectral image showing PRA (blue) and PRB (brown) positive cells in a pregnant subject. **B** PRA positive cells only. **C** PRB positive cells only. There are many PRB positive cells that do not co-express PRA

ER α

A mean of 10.6% of epithelial cells expressed nuclear ER α . As in non-pregnant subjects, ER α was not expressed in the myoepithelium.

MIB1

A mean of 16.0% of epithelial cells expressed nuclear MIB1. As in non-pregnant subjects, MIB1 expression was much lower in the myoepithelium than in the luminal epithelium.

There was statistically significant evidence ($P_{\text{trend}} = 0.043$) of a decline in PRA expression with gestational age; a mean of 8.4% of cells were PRA + at a gestational age of <12 weeks vs. 1.8% at a gestational age of ≥ 12 weeks (Fig. 4). There was also a statistically significant ($P_{\text{trend}} = 0.004$) decline in ER α expression with gestational age; a mean of 13.4% at a gestational age of <12 weeks vs. 4.6% at a gestational age of ≥ 12 weeks (Fig. 4). PRB expression also declined with gestational age, but the effect was smaller and not statistically significant ($P = 0.65$). There was no effect of gestational age on MIB1 expression.

The results for PRA and MIB1 in pregnant women were markedly different from the results in non-pregnant women. PRA expression was much decreased in pregnant women [mean values: 17.8% in non-pregnant subjects vs. 6.2% in pregnant subjects ($P = 0.013$)], and MIB1 was much increased [1.7 vs. 16.0% ($P < 0.001$)].

As can be seen in Fig. 1, the results for PRA, PRB, ER α and MIB1 varied widely between different subjects. The results frequently also varied widely within a single slide; this was due in part to the positive cells tending to cluster within single TDLUs as is illustrated in Fig. 5 for ER α

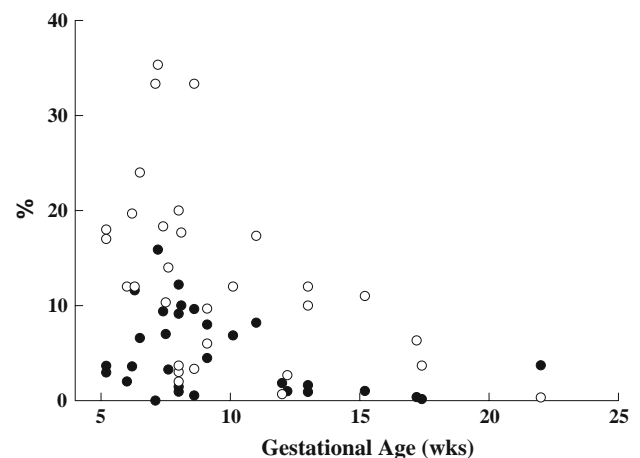


Fig. 4 Nuclear PRA (●) and ER α (○) expression in pregnant women by gestational age

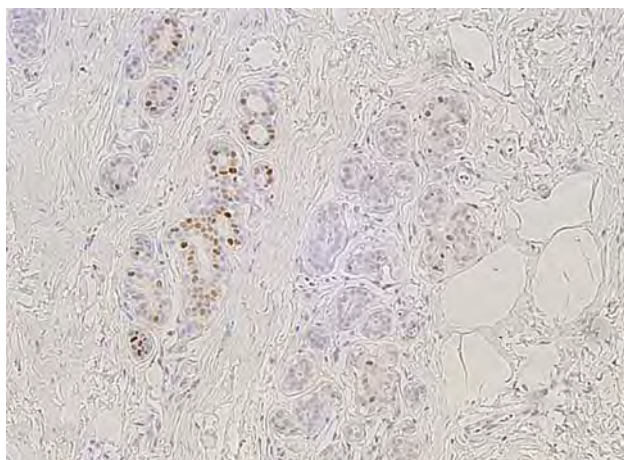


Fig. 5 Number of ER positive cells (*brown nuclei*) can vary significantly between TDLUs as seen in this photomicrograph

in a non-pregnant subject and as has previously been reported [8].

PRA, PRB, ER α and MIB1 were not expressed in the non-pregnant or pregnant breast stromal fibroblasts.

Discussion

In women, a full-term birth at a young age is associated with a long-term significantly reduced risk of breast cancer and induced abortions also provide protection although to a lesser extent [9]. A clear goal for breast cancer chemoprevention efforts is to mimic the protective effect of such early pregnancies. In order to evaluate the effectiveness of any such chemoprevention effort, a biomarker indicative of achieving the desired effect must be identified.

Data from studies in rats show that expression of PRA is substantially decreased during and following pregnancy, suggesting that PRA levels may be such a marker. We have clearly shown a similar reduction in PRA expression in the human breast. PRA expression was decreased from a mean of 32.2% in nulliparous non-pregnant subjects to 6.2% in pregnant subjects, and only rose to 10.2% in parous non-pregnant subjects. PRA expression was decreased early on in pregnancy (<8 weeks gestation, see Fig. 4) and decreased further with increasing gestational age.

There was little or no change in PRB expression in pregnant subjects; this is precisely as seen in the rat [2]. PRB expression was lower in parous subjects but the difference was not statistically significant, and there was no difference in PRB expression between nulliparous and parous rats [2].

PRB was frequently expressed in myoepithelial cells as well as in luminal epithelial cells, whereas PRA expression was almost exclusively confined to luminal epithelial cells.

This effective restriction of PRA to luminal cells, while PRB was expressed in both types of epithelium, was also found in the rat [2]. In the rat, Kariagina et al. [2] found that PRB was more frequently expressed in myoepithelial cells than in luminal cells (~95 vs. ~60% for all epithelial cells). We did not see this. The proportion of cells expressing PRB in the luminal epithelium appeared to be greater than the proportion expressing it in the myoepithelium.

These results differ from the results reported by Mote et al. [10] who found that PRA and PRB were co-expressed at similar levels. Their study was performed on FFPE breast tissue samples from autopsies of premenopausal women obtained some 20 years previously by one of us [11]. We were unsuccessful at staining these autopsy specimens for PRA or PRB.

Overall there was little difference in ER α expression between non-pregnant and pregnant subjects, but the results shown in Fig. 4 strongly suggest that ER α expression is increased early on in pregnancy (<8 weeks gestation) and then declines to lower levels than are seen in non-pregnant subjects. ER α expression was also lower in parous subjects but the difference was again not statistically significant. Although estrogen receptor β , ER β , is present in a high proportion of luminal and myoepithelial cells in the normal human breast, knock-out studies have shown that ER α is the key ER in the breast [12, 13]. ER α is found in the luminal epithelium but not in any other cell type in the breast [14, 15]. Although it has been stated that all cells expressing PR also express ER α [13], this was not seen in the non-pregnant human breast in a number of studies [16–20] that found that PR was expressed more frequently than ER, although the reverse has also been reported [21, 22]. We also found that PRA was much more frequently expressed than ER α . We found some evidence of a decrease in ER α expression in parous women, but this difference was not statistically significant, and was not seen in the study of Battersby et al. [19].

MIB1 expression increased from 1.7% in non-pregnant women to 16.0% in pregnant women. The increase in breast cell proliferation in early pregnancy is, of course, well known [16, 23, 24]. MIB1 expression was also lower in parous subjects but the difference was again not statistically significant. Olsson et al. [25] also found a decrease in MIB1 expression in parous women in a small study, but this was not found in the studies reported by Longacre and Bartow [26], Anderson et al. [27] or Williams et al. [28]. Freudenhake et al. [29] reported lower MIB1 expression in parous women but their results were completely confounded with an age effect. Our finding of lower MIB1 expression in myoepithelium than in luminal epithelium confirms the results reported by Joshi et al. [30].

Epithelial staining for PRA, PRB, ER α and MIB1 were all nuclear in the non-pregnant subjects as has been

previously reported [14, 16, 23, 24]. The same held for PRA, PRB and MIB1 in pregnant subjects, but ER α showed a diffuse cytoplasmic blush in a large proportion of the pregnant subjects along with the nuclear positivity staining. Our finding of no staining of fibroblasts for PR or ER α confirms results from earlier studies [21, 31].

Experiments in mice and observations from human breast tumor studies both suggest that PRA has a deleterious effect on breast tissue [32]. In the mouse, breast development is normal in the absence of PRA, but overexpression of PRA results in a hyperplastic state [33]. Also, in PR-positive breast cancer tissue, the PRA to PRB ratio is increased with two-thirds of the tumors studied showing more PRA and a quarter showing a fourfold increase of PRA [34]. This suggests that an overabundance of PRA is a harmful characteristic and this is in line with parity being associated with a decreased risk of breast cancer and our observation of pregnancy appearing to induce long-term reductions in the expression of PRA.

A reduction in PRA expression may be a useful marker of the reduction in risk with pregnancy. However, the extent of the overlap (Fig. 1) between the results from nulliparous and parous women mean that large numbers of subjects will likely be required if it is to be used to establish such an effect with any chemoprevention regimen aimed at mimicking pregnancy. If before and after treatment samples can be obtained a change may be easier to detect. Short-term changes in PRA expression while the chemoprevention is being administered may be a more useful marker.

Acknowledgments We wish to express our sincerest gratitude to the women who agreed to be part of these studies. We also wish to express our thanks to Ms. Peggy Wan and Ms. A. Rebecca Anderson for extensive help with the management of the study and the statistical analysis. Drs. Christine Clarke and Patricia Mote provided very valuable advice on certain aspects of immunohistochemistry and pointed us to the best antibody for detection of PRB; we are most grateful for this help. This work was supported by a Department of Defense Congressionally Directed Breast Cancer Research Program Grant BC 044808, by the USC/Norris Comprehensive Cancer Center Core Grant P30 CA14089, funds from the endowment established by Flora L. Thornton for the Chair of Preventive Medicine at the Keck School of Medicine of USC and an anonymous donor grant to DT. The funding sources had no role in this report. Disclosure statement: The authors declare that they have nothing to disclose.

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1 **Breast Epithelial Cell Proliferation is Markedly Increased with Short-term High Levels of**
2 **Endogenous Estrogen Secondary to Controlled Ovarian Hyperstimulation**

3

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15 based on their pivotal contributions to the study reported here.

16

17 Abbreviated Title: Breast Cell Changes in Oocyte Donors

18 Key Terms: Oocyte donors; Breast epithelium; Estradiol

19 Precis: Oocyte donors have greatly increased levels of serum estradiol and breast cell proliferation
20 comparable to the levels seen in the first trimester of pregnancy.

21

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25

26 This work was supported by the Department of Defense Congressionally Directed Breast Cancer

27 Research Program Grant BC 044808 to MCP, by the USC/Norris Comprehensive Cancer Center Core
28 Grant P30 CA14089, funds from the endowment established by Flora L. Thornton for the Chair of
29 Preventive Medicine at the Keck School of Medicine of USC and funds from an anonymous donor grant
30 to DT. The funding sources had no role in this report.

31

32 Disclosure Summary: All authors declare that there is no conflict of interest in this study.

33

34 Word count: 3426

35 **Abstract**

36

37 **Context:** Oocyte donors have high serum estradiol (E2) levels similar to first trimester pregnancy levels.

38 **Objective:** To compare breast epithelial cell proliferation and receptor levels in oocyte donors, in early
39 pregnancy and in cycling women.

40 **Design:** Breast and blood samples were obtained from 10 donors. We studied the terminal duct lobular
41 units for Ki67, PRA, PRB and ER α and compared these to serum E2 and progesterone (P4). We made
42 similar observations on 30 pregnant women at 5 to 18 weeks gestation and on 26 cycling women.

43 **Results:** *Oocyte Donors:* Peak E2 (mean ~15,300 pmol/l) was reached on the day before donation. Peak
44 P4 (mean 36.3 nmol/l) was reached on the day of donation. Mean Ki67 was 7.0%, significantly greater
45 than the 1.8% of cycling women. Mean Ki67 was 14.1% in the seven donors with E2>10,000 pmol/l.

46 *Pregnant Women:* Mean E2 rose from ~2,000 pmol/l at 5 weeks to ~27,000 pmol/l at 18 weeks gestation.
47 P4 did not change from ~40 nmol/l until around gestational week 11 when it increased to ~80 nmol/l.
48 Mean Ki67 was 15.4% and did not vary with E2.

49 **Conclusion:** Oocyte donors have greatly increased levels of E2 and of breast cell proliferation, both
50 comparable in the majority of donors to the levels seen in the first trimester of pregnancy. This increased
51 cell proliferation is of short duration. Whether their greatly increased E2 levels are associated with any
52 long-term beneficial effects on the breast, as occurs in rodent models, is not known.

53 Estradiol (E2) and progesterone (P4) are critically important in the pathogenesis of breast cancer
54 (1-2). Infertility treatments involving controlled ovarian hyperstimulation are known to cause a transient
55 large increase in serum E2 to the levels seen in first trimester pregnancy, while P4 levels are no greater
56 than are seen in the luteal phase of the menstrual cycle (3-4). The effects of this short-term high
57 endogenous E2 exposure on normal breast tissue are unknown.

58 As part of studies of the changes in human breast associated with pregnancy, we have studied
59 breast tissue from naturally cycling nulliparous and parous women and from women immediately after a
60 pregnancy termination (5). We report here our studies of the epithelium of the breast terminal duct
61 lobular unit (TDLU) at the end of the ovarian stimulation phase in 10 oocyte donors (women having
62 ovarian hyperstimulation to donate oocytes for use by other women). We report on proliferation (Ki67),
63 progesterone receptors A and B (PRA, PRB), and estrogen receptor α (ER α), as compared to the results
64 obtained from 30 women sampled between 5 and 22 weeks of gestation (weeks since last menstrual
65 period, LMP) (5) and to the results obtained from 26 naturally cycling women.

66

67 **Patients and Methods**

68 *Recruitment of Oocyte Donors*

69 Women attending the *In vitro* Fertilization Clinic at the University of Southern California (USC) to
70 donate oocytes for the use of other women were invited to volunteer for this study. Women who
71 expressed a desire to participate and provided written informed consent underwent a routine clinical
72 breast examination; no abnormalities were found. The research-related procedures included a menstrual
73 and reproductive history questionnaire, a blood sample on the day of oocyte retrieval and a breast biopsy
74 immediately after the oocyte retrieval or on the day before if necessary.

75 Subjects underwent standard clinical protocols for ovarian stimulation. Daily subcutaneous
76 injections of follicle stimulating hormone for approximately 10-14 days with regular monitoring of serum
77 E2 and ultrasound measurement of ovarian follicles. When the follicles were determined to be mature,
78 human chorionic gonadotropin (10,000 IU) was administered by subcutaneous injection and oocytes were

79 retrieved under intravenous sedation by trans-vaginal ultrasound guided needle aspiration approximately
80 36 hours later.

81 *Recruitment of Pregnant Women and Naturally Cycling Women*

82 The recruitment of pregnant women and cycling women has been described previously (5). Briefly,
83 the pregnant samples were collected from women who had undergone a pregnancy termination within the
84 preceding 10 minutes. The samples from cycling women were obtained from women undergoing a
85 reduction mammoplasty; some of these samples were collected prospectively and others from formalin-
86 fixed paraffin-embedded (FFPE) tissue blocks, that had been routinely processed at the USC Department
87 of Pathology.

88 All study protocols described here were approved by the Institutional Review Board (IRB) of the
89 USC Keck School of Medicine and where appropriate the IRB of the Department of Defense
90 Congressionally Directed Breast Cancer Research Program. The prospectively collected samples were
91 obtained after the women had signed an informed consent. The samples obtained retrospectively from the
92 cycling women were used after the women had been contacted and given consent for their samples to be
93 used.

94 *Tissue Procurement*

95 For the biopsy tissue samples an ultrasound guided 14-gauge core needle breast biopsy was
96 performed in a region of ultrasonographically normal dense breast tissue in the upper outer quadrant of
97 the breast. After anesthetizing the breast with 1% lidocaine, a small incision was made to facilitate entry
98 of the biopsy needle. Multiple core biopsy samples were obtained through the same single incision. The
99 majority of the biopsy specimens were frozen within 30 min of excision and a number were FFPE treated
100 in a routine manner at the USC Department of Pathology.

101 *Immunohistochemistry*

102 Immunohistochemical (IHC) analysis of the FFPE samples was performed as follows: Multiple
103 adjacent FFPE sections were cut at 5 μm , deparaffinized and hydrated. All slides were subject to antigen
104 retrieval which was performed by heating the slides in 10 mmol/l sodium citrate buffer (pH 6) at 110°C

105 for 30 min in a pressure cooker in a microwave oven. Endogenous peroxidase activity was blocked by
106 incubation in 3% H₂O₂ for 20 min, followed by blocking of nonspecific sites with SuperBlock blocking
107 buffer (Pierce, Rockford, IL, USA) for 1 h both at room temperature [see (5)].

108 The sections were incubated with the following antibodies: MIB1, a proliferation marker, the mouse
109 monoclonal antihuman Ki67 antibody (Dako Cytomation, Carpinteria, CA, USA) at a concentration of
110 1:500; PRA, the mouse monoclonal antibody NCL-PGR-312 (Novocastra Laboratories Ltd, Newcastle
111 upon Tyne, UK) at a concentration of 1:5,000; PRB, the mouse monoclonal antibody NCL-PGR-B
112 (Novocastra Laboratories Ltd., Newcastle upon Tyne, UK) at a concentration of 1:100; and ER α , the
113 mouse monoclonal antibody ER Ab-12 (Clone 6F11) (Neomarkers, Kalamazoo, MI, USA) at a
114 concentration of 1:100. After incubation with the primary antibodies, antibody binding was localized
115 with the secondary antibody for 45 minutes and then with the ABC staining kit from Vector Laboratories
116 (Burlingame, CA, USA) according to the manufacturer's instructions, and peroxidase activity was
117 detected using 3,3'-diaminobenzidine substrate solution (DAB; Biocare, Concord, CA, USA). A wash
118 step with phosphate buffer solutions (PBS) for 10 min was carried out between each step of the
119 immunostaining. Slides were counterstained with hematoxylin and mounted in mounting medium for
120 examination.

121 We generally assessed all TDLUs on a single slide. A clear distinction between luminal-epithelial
122 cells and myoepithelial cells in TDLUs is frequently difficult to make on conventionally stained slides.
123 For this reason we counted the total numbers of luminal-epithelial + myoepithelial cells (epithelial cells)
124 and the percentage of them positive for the relevant marker using the Automated Cellular Imaging System
125 II (ACIS II, Clariant, Aliso Viejo, CA, USA), which digitizes the images and permits the user to identify
126 and quantitate relevant areas on a high-resolution computer screen based on color differentiation. The
127 ACIS II software program does not function optimally when both nuclear and cytoplasmic staining is
128 present. Due to some background cytoplasmic staining in addition to nuclear positivity found in the ER α
129 slides from the pregnant subjects, we used conventional light microscopy and manual counting for

130 assessing the TDLUs in these cases; we counted 500 epithelial cells except in a few cases with scant
131 epithelial tissue. Only nuclear staining was regarded as positive staining.

132 *Blood Specimens*

133 The blood specimens obtained during oocyte stimulation and at breast biopsy were processed in a
134 standard manner and the serum frozen at -20C. E2 and P4 were quantified by specific radioimmunoassay
135 as described previously (6, 7). SHBG was measured by a chemiluminescent immunoassay on the
136 Immulite Analyzer (Siemens Medical Solutions diagnostics, Malvern, PA, USA). The coefficients of
137 variation for E2, P4 and SHBG were 14.7%, 7.8% and 3.7%, respectively. No serum results were given
138 in our previous publication on pregnant and naturally cycling women (5). Non-SHBG-bound E2 was
139 calculated by the method of Södergård *et al.* (8) using the parameters given by Dunn *et al.* (9)

140 *Statistical analysis*

141 We analyzed these data using Stata (Stata Corporation, Austin, TX, USA). Differences in expression
142 and tests for trend in expression were tested for significance by standard t-tests and regression tests after
143 transformation of the variables to achieve more normal distributions of values (square root
144 transformations of PRA, PRB and ER α , and logarithmic transformation of MIB1) (5). E2, P4 and SHBG
145 values were logarithmically transformed. Testing for the effects of prior births, age and ethnicity on the
146 results were carried out by inclusion of terms for these in regression analyses. All statistical significance
147 levels (P values) quoted are two sided.

148

149 **Results**

150 We recruited 13 oocyte donors who provided informed consent. One decided to withdraw from the
151 study prior to undergoing the breast biopsy. The remaining 12 completed the study protocol. The
152 biopsies from two of the women had no epithelium in the specimen – these women were excluded from
153 further study. Of the remaining 10, eight had their biopsy on the day of oocyte donation and two on the
154 day before due to their unavailability on the donation day.

155 Figure 1 shows the E2 and P4 values of the individual subjects in the seven days before oocyte
156 retrieval. E2 increased steadily in each subject until the day before oocyte retrieval – on the day of
157 retrieval, E2 had fallen from a median of ~15,300 to ~6,000 pmol/l. P4 also increased steadily in each
158 subject; the median value increased from 1.1 nmol/l at seven days before oocyte retrieval to 4.1 nmol/l at
159 two days before retrieval, and then, after hCG treatment, to 18.0 nmol/l on the day before oocyte retrieval
160 and to 36.3 nmol/l on the day of retrieval.

161 For comparison, in naturally cycling women the follicular phase maximum E2 is ~1,100 pmol/l, the
162 luteal phase maximum E2 is ~510 pmol/l (8), and the luteal phase maximum P4 is ~40 nmol/l (10).

163 Figure 2 shows the relationships of serum E2 and P4 to gestational age in the pregnant women (5).
164 E2 increased steadily with gestational age, from ~2,000 pmol/l at 5 weeks gestation to ~27,000 pmol/l at
165 18 weeks gestation. P4 did not change from the mid-luteal peak of ~40 nmol/l until around week 11 of
166 gestation, after which it increased to ~80 nmol/l.

167 Figure 3 shows the relation between MIB1 for the oocyte donors plotted against their E2 on the day
168 before biopsy, and for the 30 pregnant women plotted against their E2 on the day of biopsy, while Figure
169 4 shows the relation between MIB1 for the 10 oocyte donors and the 30 pregnant women plotted against
170 their P4 on the day of biopsy.

171 For the oocyte donors, there was a strong positive relationship between MIB1 and E2 on the day
172 before biopsy (see figure) – correlation, $r = 0.76$ ($P = 0.010$); while the correlation between MIB1 and E2
173 on the day of biopsy was much weaker – $r = 0.17$ ($P = 0.65$) (data not shown). For the oocyte donors,
174 there was no relationship between MIB1 and P4 on the day of biopsy or P4 on the day before biopsy;
175 however, two of the four oocyte donors with low MIB1 values had the lowest P4 values. For the pregnant
176 women, there was no relationship between MIB1 and E2 or P4.

177 The means (and 95% confidence intervals) of the proportion of epithelial cells with positive nuclear
178 staining for MIB1, PRA, PRB and ER α are given in Table 1.

179 The MIB1 mean value was increased from 1.8% in the cycling women to 7.0% in the oocyte donors
180 ($P = 0.003$) and to 14.1% in the seven oocyte donors whose serum E2 values on the day before biopsy

181 exceeded 10,000 pmol/l ($P < 0.001$). This latter mean value of 14.1% is very close to the mean value of
182 15.4% seen in the pregnant women.

183 The PRA mean value was slightly lower in the oocyte donors (17.8%) than in the cycling women
184 (23.5%), but was not as low as in the pregnant women (3.9%). The difference between the oocyte donors
185 and the cycling women was not statistically significant. The PRB mean values were similar in all three
186 groups of women. The $ER\alpha$ mean value was lower in oocyte donors (6.8%) than in cycling women
187 (12.0%).

188 The results shown in Table 1 are the values as measured without adjustment for the potential
189 confounders of parity, age or ethnicity. Adjustment for ethnicity and age had little effect on any of the
190 values shown. We previously reported that parous naturally cycling women had significantly lower PRA
191 values than nulliparous naturally cycling women (5), and lower values of MIB1, PRB, and $ER\alpha$, but the
192 differences for these factors were not statistically significant. Parity had no effect on MIB1, PRA and
193 $ER\alpha$ in pregnant women, but the PRB mean was marginally statistically significantly greater in the parous
194 group ($P = 0.049$). Eight of the 10 oocyte donors were nulliparous, so that we had no power to investigate
195 the effects of parity in the oocyte donors. Adjustment for parity made little difference to the comparisons
196 shown in Table 1 and no differences to the statistical significance of the comparisons.

197

198 **Discussion**

199 This is the first study, to our knowledge, to evaluate the immediate effects of short-term exposure to
200 high levels of endogenous estrogen on breast tissue. A large increase in breast-cell proliferation occurred
201 in most of the oocyte donors, similar to the increase seen in pregnant women. In the oocyte donors the
202 increase in MIB1 expression was only definitely seen when their E2 exceeded 10,000 pmol/l and their P4
203 exceeded 28 nmol/l. In contrast, the pregnant women demonstrated the same level of breast-cell
204 proliferation over the whole range of observed serum E2 values from ~1,800 pmol/l to ~30,000 pmol/l
205 with no evidence of a dose-response.

206 When we re-plotted Figure 3 using non-SHBG-bound E2 rather than E2, a very similar picture was
207 seen: in oocyte donors the non-SHBG-bound E2 needed to exceed 2,200 pmol/l to have a high MIB1
208 value, while for the pregnant women no relation was seen between MIB1 and non-SHBG-bound E2.
209 Likewise, it is unlikely that the contribution of estriol (E3) and estetrol (E4) to the overall estrogenic
210 milieu in pregnant women explains their higher proliferation because these two hormones are at very low
211 levels through gestational week 8 where most of our subjects with E2 concentrations below 10,000 pmol/l
212 lie (Figure 3; 11-13). Higher levels of proliferation in pregnant women may be due to their longer
213 exposure to high levels of E2 and to longer exposure to luteal (or higher) levels of P4, it may also be due
214 to their higher ER α expression (see below).

215 Prolactin is a breast cell mitogen and prolactin levels increase starting around week 5 of gestation
216 (14). The proliferation effect of E2 may be enhanced as prolactin has been reported to induce estrogen
217 receptor expression in the breast (15). Prolactin levels vary greatly during the day with a maximum
218 during sleep and a rapid fall-off on waking. Time of blood draw was not recorded for our study subjects
219 and therefore do not provide useful information on the comparison of prolactin levels in oocyte donors
220 and pregnant women.

221 We previously reported that PRA decreased steadily with gestational age in pregnant women (5) and
222 although there was already some decrease early on in pregnancy, PRA only reached very low levels
223 (~1%) after week 12 of gestation. There was a non-statistically significant 24% reduction of PRA in
224 oocyte donors compared to naturally cycling women, but this was small relative to the reduction seen in
225 pregnant women. We also previously reported that “overall there was little difference in ER α expression
226 between non-pregnant and pregnant subjects”, but the data strongly suggested that “ER α expression is
227 increased early on in pregnancy (<8 weeks gestation) and then declines to lower levels than are seen in
228 non-pregnant subjects”. In contrast, ER α expression in oocyte donors was low.

229 Based on a strictly limited amount of epidemiological data but considerable data from rodent
230 experiments (see below), it is possible that a short-term pregnancy and short-term relatively high levels of
231 estrogen may provide some long-term protection against breast cancer. However, the fetoplacental unit in

232 pregnant women is responsible for major endocrinologic changes which are not present in women
233 undergoing ovarian stimulation. Thus, a number of factors in a pregnant woman may contribute to long-
234 term protection against breast cancer. The effects of the high levels of endogenous E2 and P4 achieved
235 during human full-term pregnancy are two-fold: a transient increase in breast cancer risk followed by a
236 significant long-term permanent decrease in risk if the pregnancy occurs prior to around age 32, with the
237 protective effect being greater the earlier the age at which the pregnancy occurs (16-20). The mechanism
238 for the protective effect remains unclear, but has been attributed in part to hormonal changes, in particular
239 a reduction in prolactin levels (21), and may possibly be due to hormone-induced changes in breast
240 function leading to lower breast-cell proliferation and possibly other effects. Breast-tissue mRNA
241 expression differences between parous and nulliparous rodents have been observed (22, 23), but whether
242 such changes occur in humans has not been satisfactorily established. There is some evidence that
243 terminated pregnancies may also provide a lesser degree of protection against breast cancer (24). There
244 are no data available on the effects of a terminated pregnancy on long-term prolactin levels, breast cell
245 proliferation or any other possibly relevant factors.

246 The same phenomenon of full-term pregnancy-induced protection against mammary carcinogenesis
247 is observed in rats. When exposed to a carcinogen delivered after the pregnancy the incidence of
248 mammary cancer is reduced by as much as 80% or more (25). There is again some evidence that
249 terminated pregnancies may also provide protection: Sinha *et al.* (26) found a 45% reduction in mammary
250 cancer incidence when the pregnancy was terminated after as short a time period as 5 days, but the only
251 other study that has investigated this found no protective effect of early termination (27). The protective
252 effect in the rat can also be achieved by administration of exogenous E2 and P4 (25, 28, 29). In the
253 experiments of Grubbs *et al.* (28), administration of E2 achieved a 21% reduction in mammary cancer
254 incidence, of P4 a 31% reduction, and of E2+P4 a 79% reduction: the serum level of E2 appears to have
255 been no greater than twice the maximum seen during the estrus cycle and the serum level of P4 appears to
256 have been no greater than the maximum seen during the estrus cycle. Guzman *et al.* (29) and Medina *et*

257 *al.* (30) found that with E2+P4 substantial protection could be achieved with as little as 7-10 days of
258 administration.

259 There are large differences in the effects of pregnancy in women and in the rat: the ovary is the sole
260 source of serum estrogen and the major source of serum progesterone in pregnancy in the rat, while in
261 women the main source of estrogen and progesterone moves from the ovary to the placenta during the
262 latter part of the first trimester (40). Table 2 shows the serum E2 levels in cycling and pregnant women
263 and in the cycling and pregnant rat. (Note: the values in Table 2 were abstracted from different reports
264 and should only be taken as approximate.)

265 The serum E2 levels in cycling rats vary from 50 to 250 pmol/l; the maximum value of 250 pmol/l is
266 only exceeded during the third week of pregnancy, when it approximately doubles to a maximum of
267 around 500 pmol/l. Due to the absence of circulating sex-hormone binding globulin (SHBG) in the rat,
268 virtually all of the circulating E2 is free and thus, biologically active. The levels of serum E2 in cycling
269 women are two to three times the levels in the cycling rat, and, contrary to what occurs in the rat, these
270 are greatly increased in pregnancy – they are increased some 5-fold in the first trimester, some 20-fold in
271 the second trimester and some 40-fold in the third trimester compared to the maximum of around 1,100
272 pmol/l at the pre-ovulatory E2 peak. However, most of the E2 in human pregnancy circulates bound to
273 SHBG. Whether the results in the rat of short-term E2 exposure at only twice the maximum estrus serum
274 E2 level are of relevance to the human situation is, thus, not at all clear.

275 The serum P4 levels in cycling rats vary from 45 to 160 nmol/l; the levels steadily increase during
276 pregnancy and reach a maximum of 320 nmol/l in the second week, approximately double the maximum
277 seen in the estrus cycle, and then decline in the third week. The levels of serum P4 in cycling women are
278 lower, at 1.5 – 40 nmol/l, than the levels in the cycling rat. Serum P4 levels in women increase steadily
279 during pregnancy – they are increased some 2-fold in the first trimester, some 4-fold in the second
280 trimester and some 10-fold in the third trimester compared to the maximum of around 40 nmol/l at the
281 luteal-phase serum P4 peak. The maximum seen during pregnancy in women is thus not greatly increased

282 over the maximum level seen in the rat estrus cycle, and the results in the rat of short-term P4 exposure at
283 the maximum estrus cycle serum P4 level could possibly be of more relevance to the human situation.

284 If short-term high levels of serum E2 do provide long-term protection against breast cancer, we
285 might expect that the breast would change in oocyte donors in a way similar to that seen in pregnant
286 women. The short-term high levels of endogenous E2 did cause a dramatic increase in breast-cell
287 proliferation similar to that associated with pregnancy, but the reduction in PRA was much less than that
288 seen in pregnant women. Studies comparing nulliparous oocyte donors at some time after donation to
289 parous women are needed.

290

291 **Acknowledgments**

292 We wish to express our sincerest gratitude to the women who agreed to be part of the studies
293 discussed here. We also wish to express our thanks to Ms. Peggy Wan for extensive help with the
294 statistical analysis.

295

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Table 1 Mean (with 95% confidence limits) percentages of MIB1, PRA, PRB, and ER α in oocyte donors, pregnant women, and naturally cycling women

Group		Mean ^a	lcl ^a	ucl ^a	P value: All ^b	P value: E2>10,000 pmol/l ^b
MIB1	Oocyte Donor: All (N = 10)	7.0	3.0	16.5		
	Oocyte Donor: E2>10,000 pmol/l (N = 7)	14.1	7.6	26.1		
	Pregnant (N = 30)	15.4	12.4	19.1	0.016	0.76
	Cycling (N = 26)	1.8	1.2	2.7	0.003	<0.001
PRA	Oocyte Donor: All	17.8	13.4	22.9		
	Oocyte Donor: E2>10,000 pmol/l	19.0	13.8	25.0		
	Pregnant	3.9	2.5	5.5	<0.001	<0.001
	Cycling	23.5	16.2	32.2	0.37	0.55
PRB	Oocyte Donor: All	16.9	11.3	23.6		
	Oocyte Donor: E2>10,000 pmol/l	20.0	12.6	29.0		
	Pregnant	12.8	9.4	16.8	0.31	0.14
	Cycling	19.2	13.3	26.0	0.67	0.90
ER α	Oocyte Donor: All	6.8	4.3	9.9		
	Oocyte Donor: E2>10,000 pmol/l	5.5	3.4	8.1		
	Pregnant	11.0	7.9	14.6	0.15	0.089
	Cycling	12.0	9.2	15.2	0.034	0.014

400 ^aCalculations were made with transformed values – logarithmic for MIB1, and square root for PRA, PRB,
401 and ER α . Values are adjusted for ethnicity, parity and age. lcl and ucl are lower and upper 95%
402 confidence interval values, respectively.

403 ^bP values are for comparisons with oocyte donors.

404

405
 406 **Table 2** Estradiol (E2) and progesterone (P4) concentrations during cycling and pregnancy in humans
 407 and rats
 408

			E2 (pmol/l)	P4 (nmol/l)
Human				
	Cycling		150 – 650 ^a	1.5 – 40 ^a
	Pregnant	1 st trimester	1,000 – 8,000 ^b	45 – 90 ^b
		2 nd trimester	8,000 – 32,000	90 - 230
		3 rd trimester	32,000 – 56,000	230 – 580
Rat				
	Cycling		50 – 250 ^c	45 – 160 ^d
	Pregnant	1 st week	50 ^e	240 ^f
		2 nd week	150	320
		3 rd week	500	240

409 ^aGoebelsmann and Mishell (10).

410 ^bO’Leary *et al.* (32).

411 ^cKalra and Kalra (33), Nequin *et al.* (34), Haim (35), Strange *et al.* (36).

412 ^dNequin *et al.* (34), Haim (35), Strange *et al.* (36).

413 ^eGuzman *et al.* (37).

414 ^fSanyal (38), Macdonald and Matt (39).

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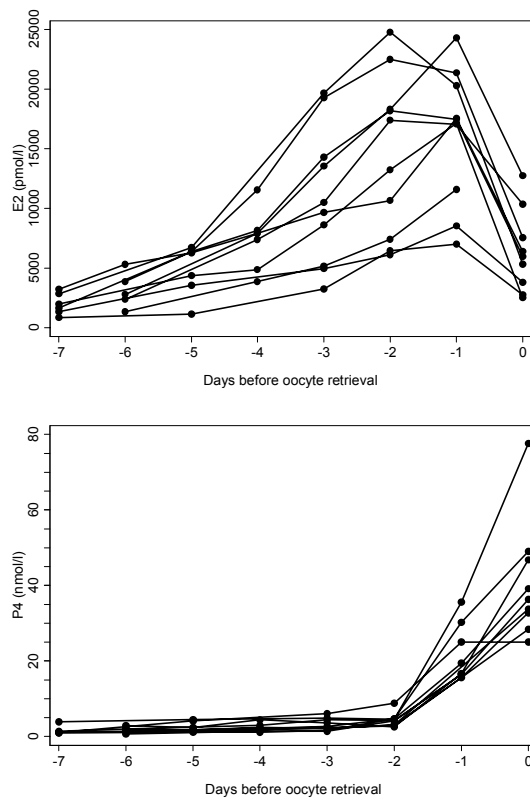


Figure 1. Individual oocyte donor estradiol (E2) and progesterone (P4) values in the week before oocyte retrieval.

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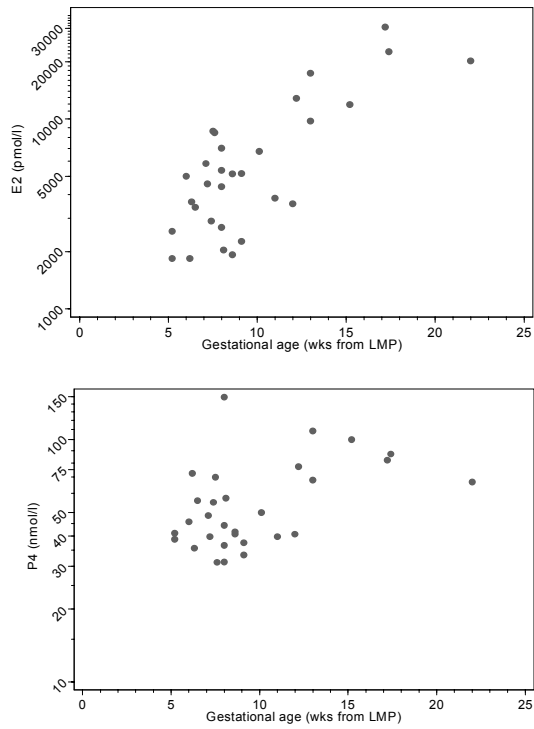


Figure 2. Individual pregnant women estradiol (E2) and progesterone (P4) values vs gestational age.

417

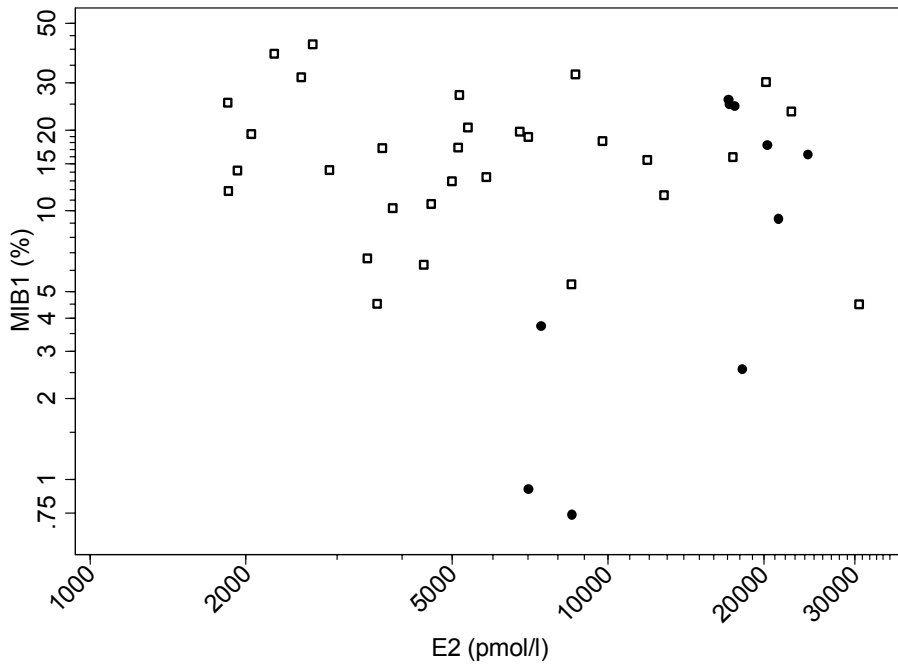


Figure 3. Individual woman TDLU epithelial cell MIB1 values vs estradiol (E2) values - E2 values for oocyte donors on the day before biopsy (•); E2 values for ‘pregnant’ women on the day of biopsy (◻).

418

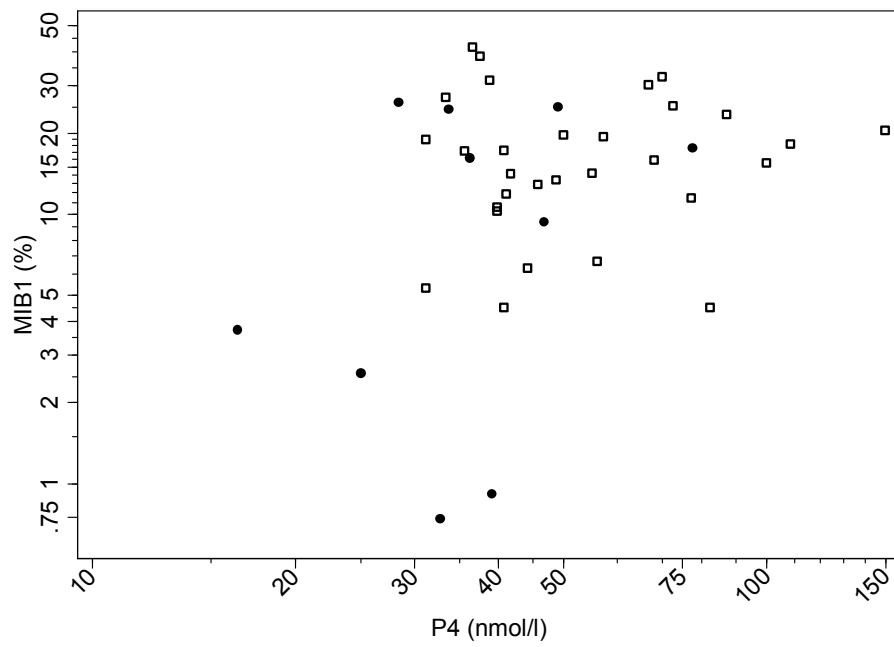


Figure 4. Individual woman TDLU epithelial cell MIB1 values vs progesterone (P4) values on day of biopsy - oocyte donors (•); ‘pregnant’ women (◻).

Oral contraceptive progestin dose: lowering norethindrone dose does not lead to lower breast epithelial-cell proliferation

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Disclosure statement: The authors declare that they have nothing to disclose.

Funding support: This work was supported by a Department of Defense Congressionally Directed Breast Cancer Research Program Grant BC 044808, by the USC/Norris Comprehensive Cancer Center Core Grant P30 CA14089, funds from the endowment established by Flora L. Thornton for the Chair of

Preventive Medicine at the Keck School of Medicine of USC and funds from an anonymous donor grant to DT. The funding sources had no role in this report.

Running title: OC progestin dose and breast proliferation

Capsule: A 60% lower dose of norethindrone (1 mg to 0.6 mg) in an oral contraceptive did not decrease breast epithelial-cell proliferation, possibly due to marked increases in PR and ER.

Abstract

Objective: To assess the effect on breast-cell proliferation of lowering the progestin dose in an oral contraceptive (OC).

Design: Randomized trial.

Setting: Academic department of obstetrics and gynecology.

Patients: Premenopausal volunteers.

Intervention(s): 33 women were randomly assigned to two OCs with 35 µg ethinylestradiol but different doses of norethindrone (NET) – Ortho Novum 1/35[®] (1 mg NET) or Ovcon 35[®] (0.4 mg NET).

Main Outcome Measure(s): At the end of the active pill phase of the third OC cycle, a breast biopsy was performed and the epithelial cells of the terminal duct lobular units were analyzed for Ki67 (MIB1), PRA, PRB, and ER α .

Results: The biopsies from 27 women had sufficient epithelium for analysis. The average MIB1 percentage was higher with the lower progestin dose (12.5% vs 7.8%, P = 0.27). PRA, PRB and ER α were also higher with the lower dose (PRA: 16.7% vs 7.6%, P = 0.041; 23.7% vs 12.0%, P = 0.030; ER α : 18.2% vs 9.0%, P = 0.056).

Conclusions: Lowering the NET dose did not decrease breast-cell proliferation. The reason may be that PRA, PRB and ER α were twice as high with the lower dose. Reducing EE2 while keeping NET constant may accomplish a reduction in proliferation.

Keywords: Breast-Cell Proliferation; Estrogen Receptor; Oral Contraceptives; Progesterone Receptor; Progestin; Norethisterone.

Ovarian hormones play a crucial role at all stages of the development of breast cancer. Two observations hold the key to our understanding of the relationship of ovarian hormones to breast cancer risk: earlier menopause, whether natural or through bilateral oophorectomy, significantly reduces breast cancer risk [1,2]; and the rate of breast epithelial-cell proliferation in the luteal phase of the menstrual cycle is about double the rate in the follicular phase, and the rate in the follicular phase is considerably higher than in the postmenopausal period [3,4].

These observations indicate that the hormonal pattern of premenopausal women – cyclic production of relatively large amounts of estradiol (E2) and progesterone (P4) – causes a greater rate of increase in risk of breast cancer than the hormonal pattern of postmenopausal women – constant low E2 and very low P4. Factors other than E2 and P4 may be involved, but E2 and P4 are critical factors that provide an explanation of much of what is known about the epidemiology of breast cancer. These conclusions extend more generally to estrogens and progestins as classes of hormones although their precise effects are more complicated since synthetic progestins, in particular, often have androgenic and other effects. Breast epithelial-cell proliferation is higher in women on menopausal estrogen-progestin therapy (MEPT) than in women on menopausal estrogen therapy (MET) [5], and epidemiological studies have shown that MEPT significantly increases a postmenopausal woman's risk of breast cancer and that the effect is greater than with MET [6,7].

Our analysis of the studies of the effects of MEPT on breast cancer risk showed that a lowering of the dose of the progestin, medroxyprogesterone acetate (MPA), from 10 mg to 2.5 mg significantly reduced the increased breast cancer risk from the MEPT despite extending the number of days the MPA was given from ~10 per 28 day cycle to every day [6]. It appeared reasonable to hypothesize that this lowering of effect was due to a reduction in breast epithelial-cell proliferation and specifically in epithelial cells in terminal duct lobular units (TDLUs). A 10 mg dose of MPA is generally considered as

approximately equivalent to a 1 mg dose of the progestin, norethindrone (NET) [8], a common dose of NET in a number of oral contraceptives (OCs). It was thus also reasonable to hypothesize that reducing the dose of NET in an OC would lead to a reduction in breast epithelial-cell proliferation. This hypothesis regarding breast-epithelial-cell proliferation as it relates to progestin dose in the OC can be directly addressed through comparing the Ortho Novum 1/35[®] OC to the Ovcon 35[®] OC. Ortho Novum 1/35[®] contains 35 µg of ethinyl estradiol (EE2) and 1 mg of NET; Ovcon 35[®] contains the same dose of EE2 (35 µg), but only 0.4 mg of NET. The aim of this study was to investigate whether the predicted effect on the proliferation rate of breast epithelial cells in TDLUs does in fact occur.

MATERIALS AND METHODS

The study protocol was approved by the Institutional Review Board (IRB) of the University of Southern California Keck School of Medicine, and by the IRB of the Department of Defense Congressionally Directed Breast Cancer Research Program.

Recruitment of Subjects

Women attending clinics at Los Angeles County/University of Southern California Women's and Children's Hospital who were being prescribed an OC solely for contraception were invited to volunteer for this study.

To be eligible for the study subjects had to be: premenopausal aged 18-34; currently taking or wishing to start taking an OC for contraception; a non-smoker; and willing to refrain from consumption of grapefruit or grapefruit juice during the study (grapefruit interferes with metabolism of exogenously administered OCs). Subjects with any of the following were ineligible: abnormal breast examination; history or current therapeutic or prophylactic use of anticoagulants; known bleeding disorder or history of unexplained bleeding or bruising; history of breast cancer or previous diagnostic breast biopsy;

known allergy to local anesthetic; currently pregnant or pregnant within the previous 6 months; or having any standard contraindication to being prescribed an OC.

Women who expressed a desire to participate and provided written informed consent underwent a routine clinical breast examination. If there was an abnormal finding on the breast examination, the subject was to be excluded from the study; no such abnormalities were found. Eligible subjects were administered a menstrual and reproductive history questionnaire, and height and weight were measured. Subjects were provided with three 28-day cycle packs of Ortho Novum 1/35[®] or Ovcon 35[®] with instructions to take the pills each evening. The particular OC was chosen at random with the brand name provided to the attending physician in a sealed envelope only to be opened after the subject had been enrolled and had completed the above procedures.

The prospectively collected samples were obtained after the women had signed an informed consent agreeing to participate in this research.

Tissue Procurement

An ultrasound guided 14-gauge core needle breast biopsy was performed in a region of ultrasonographically normal dense breast tissue in the upper outer quadrant of the breast. After anesthetizing the breast with 1% lidocaine, a small incision was made to facilitate entry of the biopsy needle. Multiple core biopsy samples were obtained through the same single incision. The majority of the biopsy specimens were frozen within 30 min of excision and a number were formalin-fixed and paraffin-embedded (FFPE) in a routine manner at the University of Southern California Department of Pathology.

The biopsy was performed, after two run-in OC cycles, during the third consecutive OC cycle at the end of the third week of active OC pill use.

Immunohistochemistry

Immunohistochemical (IHC) analysis of the FFPE samples was performed for Ki67 (MIB1), a proliferation marker, progesterone receptors A and B (PRA, PRB), and estrogen receptor α (ER α). Multiple adjacent FFPE sections were cut at 5 μ m, deparaffinized and hydrated. All slides were subject to antigen retrieval which was performed by heating the slides in 10 mmol/l sodium citrate buffer (pH 6) at 110°C for 30 min in a pressure cooker in a microwave oven [9]. Endogenous peroxidase activity was blocked by incubation in 3% H₂O₂ in phosphate-buffered saline for 10 min, followed by blocking of nonspecific sites with SuperBlock blocking buffer (Pierce, Rockford, IL, USA) for 1 h both at room temperature [10].

The sections were incubated for analysis with the following antibodies: MIB1, the mouse monoclonal antihuman Ki67 antibody (Dako Cytomation, Carpinteria, CA, USA) at a concentration of 1:500; PRA, the mouse monoclonal antibody NCL-PGR-312 (Novocastra Laboratories Ltd, Newcastle upon Tyne, UK) at a concentration of 1:5,000; PRB, the mouse monoclonal antibody NCL-PGR-B (Novocastra Laboratories Ltd., Newcastle upon Tyne, UK) at a concentration of 1:100; ER α , the mouse monoclonal antibody ER Ab-12 (Clone 6FH) (Neomarkers, Kalamazoo, MI, USA) at a concentration of 1:100. After incubation with the primary antibodies, antibody binding was localized with the ABC staining kit from Vector Laboratories (Burlingame, CA, USA) according to the manufacturer's instructions and peroxidase activity was detected using 3,3'-diaminobenzidine substrate solution (DAB; Biocare, Concord, CA, USA). A wash step with phosphate buffer solutions (PBS) for 10 min was carried out between each step of the immunostaining. Slides were counterstained with hematoxylin and mounted in mounting medium for examination. A clear distinction between luminal-epithelial cells and myoepithelial cells in TDLUs is frequently difficult to make on conventionally stained slides. In these IHC studies we counted the total numbers of luminal-epithelial + myoepithelial cells (together referred to as epithelial cells) and the percentage of them positive for the relevant marker.

The markers MIB1, PRA, PRB, and ER α are all nuclear. For each marker, we used the Automated Cellular Imaging System II (ACIS II; Clariant, Aliso Viejo, CA, USA) to assess all TDLUs on a single slide or the first 100 target areas containing TDLUs selected systematically from left to right and top to bottom on the slide if there was a large number of epithelial cells present. The ACIS II is a cellular imaging system that digitizes the images and permits the user to identify and quantitate relevant areas on a high-resolution computer screen based on color differentiation.

Statistical analysis

We analyzed these data using the statistical package program Stata 11 (Stata Corporation, College Station, TX, USA). Differences in expression and tests for trend in expression were tested for significance by standard t-tests and regression tests after adjustment for age and ethnicity (African American, Hispanic Whites, non-Hispanic Whites) and after transformation of the variables to achieve more normal distributions of values (logarithmic transformation of MIB1, and square root transformations of PRA, PRB, and ER α). All statistical significance levels (P values) quoted are two sided. The study planned on obtaining tissue samples from 30 women, 15 on each of the two OCs.

RESULTS

Thirty-three women were randomly assigned 1:1 to the two OCs: Ortho Novum 1/35[®] and Ovcon 35[®]. All completed the study including contributing a breast-biopsy specimen. Five of the breast-biopsy specimens contained insufficient TDLU epithelial tissue for analysis and one of the remaining women was diagnosed with a follicular cyst following the finding that her serum E2 was ~7,900 pmol/l on the day of biopsy. The means (and 95% confidence intervals) of the proportion of epithelial cells with positive nuclear staining for Ki67, PRA, PRB and ER α for the remaining 27 women are given in Table 1.

Completely contrary to expectation, the Ki67 mean value increased 60% from 7.8% to 12.5%

with the reduction in NET dose from 1.0 mg to 0.4 mg, although this increase in Ki67 was not statistically significant ($P=0.27$). Concomitantly with this increase, the PRA mean value increased 120% from 7.6% to 16.7% ($P = 0.041$), the PRB mean value increased 98% from 12.0% to 23.7% ($P = 0.030$), and the ER α mean value increased 102% from 9.0% to 18.2%, although this latter difference was not quite conventionally statistically significant ($P = 0.056$).

DISCUSSION

The predicted reduction in TDLU breast epithelial-cell proliferation with the 60% reduction in NET dose was not observed. The observed mean value of Ki67 in fact increased, although this increase was not statistically significant. Concomitantly with this failure to observe a decrease in Ki67 with the reduction in NET dose, the levels of each of PRA, PRB, and ER α approximately doubled. This is the first report of an effect of NET dose on PRA, PRB, and ER α expression levels in the breast. Whether this increase in steroid receptor levels with decreasing progestin dose explains the failure to see a decrease in Ki67 is unclear. We did not measure the pharmacokinetics of EE2 and NET in these women and were thus not able to see whether these values together with the receptor levels were associated with the Ki67 values. The receptor levels themselves (within an OC type) were not associated with the Ki67 values.

This failure to observe a simple dose effect of this progestin on breast epithelial-cell proliferation is likely to be at least part of the explanation why epidemiological studies have in general failed to identify differences in risk of breast cancer by dose of progestin in the OC. Whether this effect of NET dose on receptor levels holds true for other progestins is not known. Increasing progesterone levels after ovulation in the normal menstrual cycle are associated with markedly lower ER expression in almost all studies (Table 2), but the studies of changes in PR expression over the menstrual cycle are inconsistent (Table 3).

Studies of ER expression in the breast during an OC cycle have found lower levels in the three weeks on active estrogen-progestin than in the week on placebo (Table 2), and the levels during OC use are lower than the levels seen during the menstrual cycle (Table 2). However, studies of PR expression have found higher levels in the three weeks on active estrogen-progestin than in the week on placebo (Table 3), and the results from the three studies that have investigated how the PR expression levels during OC use compare to the levels seen during the menstrual cycle have produced inconclusive results (Table 3). There have been no reports on the effects of dose of EE2 or on the effects of the dose and type of progestin in the OC on these findings.

Early studies reported by Anderson *et al.* [18] and Williams *et al.* [14] found little difference between OC users and normally cycling women in TDLU breast cell proliferation as measured by thymidine labeling index (TLI). The mean TLIs reported by Anderson *et al.* [22] were 0.95% and 0.84% for OC and natural cycles respectively. The equivalent figures reported by Williams *et al.* [14] were 2.9% and 2.9%. The more recent studies of Olsson *et al.* [24] and Isaksson *et al.* [26] using Ki67 as the marker of cell proliferation have each found some evidence that average proliferation on OCs is greater than over the menstrual cycle – 10.6% vs 9.0%, and 4.8% vs 2.2% respectively. (The figures obtained by Narvaiza *et al.* [29] may be distorted – see footnote to Table 4.) The Ki67 figure of 7.8% we observed with the much more commonly used 1 mg NET OC of 7.8% should not be taken as an average figure for the OC cycle since there is clear evidence that proliferation is lower in the placebo week and there is some evidence that proliferation may be at its maximum towards the end of the active pill phase when we took our breast biopsy samples.

The results presented here provide clear evidence that decreasing the dose of the progestin NET in an OC from 1 mg to 0.4 mg increases ER α , PRA and PRB in the breast epithelium. There is indirect evidence strongly suggesting that decreasing the dose of EE2 in an OC will decrease PR, but it may increase ER [5]. An OC with the same NET dose but lower EE2 dose may therefore be associated with a

decreased proliferation of breast epithelium. We are currently investigating this possibility in a randomized trial similar to the one reported here. Whether it is possible to adjust the doses to achieve an average proliferation rate which is less than that occurring in a normal menstrual cycle is unknown.

Acknowledgments

We wish to express our sincerest gratitude to the women who agreed to be part of this study. We also wish to express our thanks to Ms. A. Rebecca Anderson and Ms. Peggy Wan for extensive help with the management of the study and the statistical analysis.

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Table 1

Mean values (95% confidence intervals) of MIB1, PRA, PRB and ER α associated with two OCs with different progestin (NET) doses

Measure	NET Dose		p ^a
	1 mg	0.4 mg	
Ki67	7.8 (4.4 – 13.9)	12.5 (7.0 – 22.3)	0.27
PRA	7.6 (5.3 – 10.4)	16.7 (8.6 – 27.3)	0.041
PRB	12.0 (8.8 – 15.8)	23.7 (14.1 – 35.7)	0.030
ER α	9.0 (5.5 – 13.3)	18.2 (10.0 – 28.8)	0.056

^a Two-sided significance level for difference between NET doses.

Table 2

ER expression in the normal menstrual cycle and on OCs

Reference	Measure	Menstrual cycle week ^a			
		1	2	3	4
Markopoulos [11]	+ ve cases	60% (35)		0% (33)	
Jacquemier [12]	+ ve cells	3.9% (7)		9.4% (4)	
Ricketts [13]	+ ve cases	25% (60)		12% (52)	
Williams [14]	+ ve cells	4.3% (17)	4.3% (14)	3.7% (8)	2.2% (6)
Battersby [15]	+ ve cases	58% (14)	64% (27)	30% (20)	35% (24)
Söderqvist [16]	+ve cells	18% (31)		4% (28)	
Isaksson [17]	fmol/mg protein	0.7 (3)		0.7 (9)	
Hallberg [18]	fmol/mg protein	5.6 (12)		3.8 (17)	
Reference	Measure	OC week			
		1 (placebo)	2	3	4
Williams [14]	+ve cells	2.9% (8)	0.1% (5)	0.4% (8)	1.3% (7)
Battersby [15]	+ve cells	40% (13)	34% (19)	20% (16)	16% (20)
Hallberg [18]	fmol/mg protein	2.3 (20)			

^a Values are given with number of subjects in parentheses.

Table 3

PR expression in the normal menstrual cycle and on OCs

Reference	Measure	Menstrual cycle week			
		1	2	3	4
Jacquemier [12]	+ve cells	16% (7)		47% (4)	
Ricketts [13]	+ve cases	24% (46)		32% (41)	
Williams [14]	+ve cells	12% (14)	10%(13)	17% (9)	9% (6)
Battersby [15]	+ve cases	70% (13)	82% (21)	72% (17)	73% (18)
Söderqvist [16]	+ve cells	19% (31)		28% (28)	
Isaksson [17]	fmol/mg protein	2.0 (3)		2.0 (9)	
Hallberg [18]	fmol/mg protein	38 (12)		15 (17)	
Reference	Measure	OC week			
		1 (placebo)	2	3	4
Williams [14]	+ve cells	9% (6)	13% (4)	10% (7)	11% (6)
Battersby [15]	+ve cases	58% (12)	59% (17)	77% (13)	84% (19)
Hallberg [18]	fmol/mg protein				10 (20)

^a Values are given with number of subjects in parentheses.

Table 4

Breast epithelial cell proliferation in the normal menstrual cycle and on OCs

Reference	Measure	Menstrual cycle week ^a			
		1	2	3	4
Masters [19]	TLI	0.5% (14)		0.9% (19)	
Meyer [20]	TLI	0.17% (21)		0.79% (19)	
Anderson [3]	Mitoses	0.10% (24)	0.07% (25)	0.11% (21)	0.40% (29)
Longacre & Bartow [21]	Mitoses	0.25% (19)	0.25% (20)	0.25% (12)	0.60% (24)
Anderson [22]	TLI	0.63% (20)	0.38% (53)	0.81% (53)	1.52% (48)
Williams [14]	TLI	1.8% (33)	1.5% (37)	3.4% (31)	3.6% (26)
Nazario [23]	Mitoses	0.0% (15)		1.2% (15)	
Olsson [24]	Ki67	6.3% (19)		11.6% (21)	
Söderqvist [25]	Ki67	1.7% (34)		2.0% (38)	
Hofseth [5]	Ki67	1.0% (14)		2.6% (14)	
Isaksson [26]	Ki67			2.2% (53)	
Feuerhake [27]	Ki67	0.72% (8)	0.70% (8)	0.82% (8)	1.37% (8)
Navarrete [28]	Ki67	1.3% (21)		3.0% (21)	
Narvaiza [29]	Ki67	1.1% (10)	3.9% (10)	2.7% (10)	5.4% (10)

Reference	Measure	OC week			
		1 (placebo)	2	3	4
Meyer [20]	TLI	0.81% (2)		2.12% (7)	
Anderson [22]	TLI	0.67% (32)	0.63% (38)	0.98% (40)	1.52% (50)
Williams [14]	TLI	1.5% (12)	2.8% (16)	2.9% (11)	3.0% (10)
Olsson [24]	Ki67	7.4% (8)		13.8% (10)	
Isaksson [26]	Ki67			4.8% (53)	
Feuerhake [27]	Ki67			0.88% (10)	
Narvaiza [29] ^b	Ki67	4.4% (10)	7.0% (10)	5.5% (10)	4.8% (10)

^a Values are given with number of subjects in parentheses.

^b These figures were obtained in the first cycle of OC use with the first day of active estrogen-progestin being administered on the first day of menses. The first week of OC use may therefore be distorted by a carry-over effect from the previous natural cycle.