Anastrozole and celecoxib for endometriosis treatment, good to keep them apart?

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Abstract

Endometriosis is a benign gynecological disease. Cyclooxygenase-2 (COX-2) and aromatase proteins have been shown to be overexpressed in eutopic endometrium from women suffering from this disease compared to disease-free women. Furthermore, inhibition of these molecules individually was demonstrated to have antiproliferative and proapoptotic effects both in vitro and in vivo in several models. In this study, the effect of combining celecoxib, a selective COX-2 inhibitor, and anastrozole, an aromatase inhibitor, on the implantation and growth of endometriotic like lesions in a murine model of endometriosis was evaluated. Endometriosis was surgically induced in female BALB/c mice. After 28 days of treatment with celecoxib, anastrozole, or their combination, animals were killed and lesions were counted, measured, excised, and fixed. Immunohistochemistry for proliferating cell nuclear antigen and CD34 was performed for assessment of cell proliferation and vascularization. TUNEL technique was performed for apoptosis evaluation. Celecoxib was the only treatment to significantly reduce the number of lesions established per mouse, their size and vascularized area. In addition, cell proliferation was significantly diminished and apoptosis was significantly enhanced by both individual treatments. When the therapies were combined, they reversed their effects. These results confirm that celecoxib and anastrozole separately decrease endometriotic growth, but when combined they might have antagonizing effects.


Introduction

Endometriosis is a benign disease that is characterized by the presence of endometrial tissue outside the uterine cavity where it proliferates and forms new blood vessels essential for its further development (Lousse et al. 2012). As an estrogen-dependent disease, treatments available up to date aim mainly at reducing estrogen levels (Ozkan et al. 2008). As endometriosis affects women in reproductive age and given that current available treatments mostly impede ovulation (Rocha et al. 2012), it is the goal of recent research to find alternatives to the existing treatments reducing the side effects of those now accessible.

We and others have studied the involvement of cyclooxygenase-2 (COX-2) in this pathology (Matsuzaki et al. 2004, Banu et al. 2008, Olivares et al. 2008, 2011), which has been described to be overexpressed not only in eutopic and ectopic endometrium from endometriosis patients (Ota et al. 2001, Fagotti et al. 2004) but also in a wide variety of cancers (Mendes et al. 2009, Ghosh et al. 2010, Wang et al. 2010). Selective COX-2 inhibitors are a special class of nonsteroidal anti-inflammatory drugs that were developed to treat pain and inflammation without inhibiting COX-1, thus sparing the gastrointestinal system (Wadman 2007). The COXs are the enzymes responsible for the synthesis of pain mediators including prostaglandins (PGs). Particularly, high concentration of PGE$_2$ has been found in the peritoneal fluid of patients with endometriosis, primarily provided by activated macrophages and the endometriotic lesions (Wu et al. 2010). Our group has demonstrated that selective inhibition of COX-2 activity with celecoxib reduces the proliferation rate of endometrial epithelial cells as well as it augments their apoptosis levels both in vitro and in vivo (Olivares et al. 2008, 2011). Similar results were obtained by other investigators demonstrating that the inhibition of COX-2 activity has antiproliferative, proapoptotic, and anti-angiogenic effects in several in vivo and in vitro cancer models (Gupta et al. 2004, Basu et al. 2005, Dandekar et al. 2005, Barnes et al. 2007) and in other models of endometriosis (Dogan et al. 2004, Laschke et al. 2007, Machado et al. 2010). Moreover, a COX-2 inhibitor has been used in a pilot study evaluating pain response in endometriosis patients with good results (Cobellis et al. 2004).

Similarly, aromatase has also been found to be overexpressed in endometriosis with higher protein and mRNA levels in eutopic endometrium from patients compared with control women as well as in ectopic endometrium (Bulun et al. 1997, 2002, Kyama et al. 2008). In this sense, two aromatase inhibitors, letrozole
and anastrozole, have also been tested in vitro and in vivo in our laboratory and demonstrated to have antiproliferative and proapoptotic effects (Meresman et al. 2005, Bilotas et al. 2010).

COX-2 is overexpressed in some malignancies including carcinoma of the breast. COX2 mRNA and protein levels have been found to correlate with aromatase levels within human breast cancer tissue. The current understanding of the role of COX-2 in breast cancer suggests that COX-2 inhibitors may have a role in chemoprevention, which is based in part on the generic issues of anti-angiogenesis and proapoptotic processes and in part on a tissue-specific inhibition of estrogen synthesis (Davies et al. 2002). It has been reported that celecoxib induces a marked inhibition of aromatase protein expression, assessed by western blot, in human breast cancer cell lines (Bocca et al. 2011). In addition, treatment with COX2 siRNAs resulted in suppression of the aromatase gene CYP19A1 (CYP19) in breast cancer cells (Brueggemeier et al. 2007). In another experimental model, Sirianni et al. (2009) reported that inhibition of COX-2 downregulates aromatase activity and decreases proliferation of Leydig tumor cells. In addition, previous studies had shown that aromatase and COX-2 simultaneous inhibition might have additive or even synergic effects (Bundred & Barnes 2005, Ebert et al. 2005, Chow et al. 2008, Dirix et al. 2008, Falandry et al. 2009).

Furthermore, a feed forward loop has been described between aromatase and PGE2 in endometriosis. Aromatase synthesizes estrogens, which in turn stimulate the production of PGE2 via COX-2, and PGE2 stimulates aromatase activity (Bulun et al. 2002). This describes a perfect circle in this system in which high expression of aromatase will produce high concentrations of estrogens, which will stimulate COX-2 activity producing high concentrations of PGE2, stimulating again aromatase.

Considering all these data and in sight of the feed forward loop established between these molecules in endometriosis, we decided to investigate the effect of combining a COX-2 inhibitor with an aromatase inhibitor, celecoxib and anastrozole respectively, in a murine model of endometriosis.

For this purpose, we treated mice with induced endometriotic like lesions with anastrozole, celecoxib, or both drugs combined, during a 4-week period and studied their effects on the development of the disease and cell proliferation, apoptosis, and vascularization within the lesions.

Results

Celecoxib inhibits the establishment and growth of endometriotic like lesions

After 4 weeks of treatment with anastrozole, celecoxib, or their combination, animals were killed and the abdominal cavity was explored to localize and measure the lesions developed. Figure 1 shows the results obtained for the number of lesions established, according to the treatment the animals received, as well as the volume of those developed.

When mice received celecoxib as the only treatment, not only the lesions established diminished compared to the control group (\(P < 0.05\); Fig. 1A) but also the size of those established and developed was significantly smaller (\(P < 0.01\) vs control; Fig. 1B). However, when animals received either anastrozole alone or combined with celecoxib, the number of lesions established as well as their size did not differ from those of the control group.

Figure 1 Celecoxib reduces the number and size of established lesions. Mice underwent surgery for endometriosis induction. After 28 days of treatment with vehicle, celecoxib, anastrozole, or both drugs simultaneously, mice were killed and the number of lesions established was counted and measured. (A) Celecoxib significantly reduced the number of lesions established per mouse. Scatter plot for lesion establishment; median, minimum, and maximum are shown. Control, 2 (1–3); celecoxib, 0 (0–2); anastrozole, 2 (0–3); Anas + Cele, 2 (0–2). (B) Celecoxib had a significant effect reducing endometriotic like lesion size. Scatter plot for the development of lesions in each group; median, minimum, and maximum are shown. Control, 7.238 (2.832–32.28); celecoxib, 0 (0–8.588); anastrozole, 4.177 (0–25.21); Anas + Cele, 7.574 (0–16.49). n = 9 (control), 10 (celecoxib), 8 (anastrozole), and 7 (Anas + Cele). *\(P < 0.05\) vs control group; **\(P < 0.01\) vs control group.
The COX-2 and aromatase inhibitors affect endometriotic like lesion development

Developed endometriotic like lesions were excised and fixed for cell proliferation, apoptosis, and vascularization evaluation. Cell proliferation in the epithelial fraction of the lesions was significantly diminished compared with the control group when animals were treated with celecoxib or anastrozole separately (P<0.05 for both groups vs control); when the treatments were combined, cell proliferation within the lesions as assessed by proliferating cell nuclear antigen (PCNA) immunohistochemistry was similar to the control group (P>0.05). The results are shown in Fig. 2A.

Accordingly, the number of apoptotic epithelial cells was quantified by the TUNEL technique and the results showed that the combination of the compounds had no effect on cell death whereas the administration of either of them alone significantly enhanced TUNEL-positive cells (P<0.05 for anastrozole or celecoxib vs control; P>0.05 for anastrozole + celecoxib vs control). Results are shown in Fig. 2B.

When vascular density was assessed within the endometriotic like lesions by immunohistochemistry of CD34, only the treatment of celecoxib administered on its own showed an inhibitory effect (P<0.05 vs control). The aromatase inhibitor alone or in combination with the COX-2 inhibitor had no effect on vascular density compared to the control group (P>0.05; Fig. 3).

COX-2 immunostaining would be enhanced by celecoxib and inhibited by anastrozole

COX-2 protein expression was evaluated in a semi-quantitative fashion on developed endometriotic like lesions after treatment with celecoxib, anastrozole, or their combination. When animals received celecoxib alone, COX-2 immunoreactivity was apparently stimulated while anastrozole seemed to inhibit it, in both cases, compared to the control group. When the compounds were administered in combination, the immunostaining of COX-2 was comparable to that in the lesions from control mice. However, there was no statistical significance in the changes observed. In all cases, and as reported earlier (Hayes & Rock 2002), immunoreactivity of COX-2 was evident both in the epithelial and stromal fraction but higher in the epithelial one. Results are shown in Fig. 4.

Discussion

Endometriosis affects a large number of women all over the world, and great efforts are being taken by researchers to give better and longer lasting answers to patients. Treatment for endometriosis is usually performed with surgery and/or medications. Up-to-date treatment options are poor and do not really cure this disease; they aim mainly at reducing pain and endometriotic growth. Nevertheless, the high recurrence rate of this
illness is one of the most challenging problems we face nowadays. In this sense, investigations are focusing on finding new and more effective alternatives for patients.

In this study, and taking into account previous results obtained in our laboratory (Bilotas et al. 2010, Olivares et al. 2011) and earlier promising results obtained in cancer (Chow et al. 2008, Falandry et al. 2009), we decided to combine two inhibitors: COX-2 and aromatase. Already some years ago, Ebert et al. (2005) reviewed the importance of aiming at these molecules given the abnormalities present within the eutopic and ectopic endometrium of endometriosis patients and acknowledging the positive feedback loop present between these molecules (Bulun et al. 2002).

Indeed, few studies had been conducted in breast cancer patients combining exemestane, an aromatase inhibitor, with celecoxib with somewhat inconclusive results. While some authors suggested that the addition of celecoxib to exemestane treatment might have promising benefits (Chow et al. 2008, Falandry et al. 2009), others did not find a beneficial effect from this combination (Dirix et al. 2008).

Our first results showed that celecoxib was the only treatment capable of reducing not only the size of established lesions but also the number of lesions. We had already seen this strong inhibitory effect of celecoxib in a previous work; at that time, we had combined the treatment of celecoxib with a PPARγ agonist, rosiglitazone, obtaining no additional benefit with this combination (Olivares et al. 2011). In this study, the treatment with the aromatase inhibitor and the combination of both inhibitors did not reduce the number of lesions established nor their size compared to the control animals.

**Figure 3** Effect of celecoxib on endometriotic-like lesion vascular density. Mice underwent surgery for endometriosis induction. After 28 days of treatment with vehicle, celecoxib, anastrozole, or both drugs simultaneously, mice were killed and implants were removed and fixed. Vascular density within the implants was evaluated performing immunohistochemistry of CD34. Left panel: after treatment with celecoxib, vascular density was diminished compared with control mice. Results are expressed as mean±S.E.M. *P<0.05 vs control group. n=5 for all groups. Right panel: representative micrographs of CD34 staining. (i) Control group, (ii) celecoxib group, (iii) anastrozole group, (iv) celecoxib+anastrozole group. Inset: negative control, an immunoglobulin of the same immunoglobulin class and concentration as the primary antibody was used. Magnification, 400×.

**Figure 4** Effect of celecoxib and anastrozole on COX-2 immunoreactivity. Mice underwent surgery for endometriosis induction. After 28 days of treatment with vehicle, celecoxib, anastrozole, or both drugs simultaneously, mice were killed and implants were removed and fixed. COX-2 expression was evaluated performing immunohistochemistry. Left panel: semiquantification of the immunostaining of COX-2 in the developed lesions. When treated with celecoxib, COX-2 immunostaining showed a tendency to be enhanced; with anastrozole, reduced; and when combined, it seemed unaltered; in all cases compared with control mice. Results are expressed as mean±S.E.M. P>0.05 vs control group. n=5 for all groups. Right panel: representative micrographs of COX-2 staining. (i) Control group, (ii) celecoxib group, (iii) anastrozole group, (iv) celecoxib+anastrozole group. Inset: negative control, an immunoglobulin of the same immunoglobulin class and concentration as the primary antibody was used. Magnification, 400×.
Even though aromatase and COX-2 inhibition had been postulated to have additive or even synergic effects in breast cancer (Goss & Strasser-Weippl 2004, Chow et al. 2008), some authors have not found a clear beneficial effect from this combination (Dirix et al. 2008, Falandry et al. 2009). The results we are presenting are more in agreement with the latter.

We then investigated the rate of cell proliferation and apoptosis in the lesions developed in all groups. We observed that cell proliferation in the epithelial fraction of the lesions was significantly diminished and apoptotic levels were significantly augmented, when animals were treated with celecoxib or anastrozole separately compared with the control group. It is important to note that even though the rate of cell proliferation was seen significantly reduced in both of these groups, the incidence of this decrease was only evidenced macroscopically, in the celecoxib-treated animals at the doses and period tested. It was also observed that the administration of anastrozole and celecoxib together reversed the effects of either of them alone. Based on these data, we could speculate that these two compounds, against all odds, were having an antagonistic effect, but further studies are needed to test this hypothesis.

On the other hand, we only obtained a significant reduction in vascularization with the treatment with celecoxib alone. In accordance with our results, treatment with another selective COX-2 inhibitor had been reported to reduce microvessel density in a SCID mouse model of endometriosis (Ozawa et al. 2006). Furthermore, another study in a xenograft model of breast cancer showed that the use of letrozole, another aromatase inhibitor, did not reduce the number of CD31-stained vessels, another well-established vascularization marker (Banerjee et al. 2010).

In contrast, Hull et al. found that nimesulide does not reduce lesion size nor blood vessel development in an estrogen-supplemented nude mouse model of endometriosis. The authors suggest that the effect of COX-2 inhibition may be obscured by iatrogenically administered estrogen (Hull et al. 2005). Nevertheless, other authors have demonstrated COX-2 inhibitors to be effective in ovariectomized endometriosis mouse models (Efstathiou et al. 2005, Ozawa et al. 2006).

In this work, we have also examined COX-2 immunoreactivity in the developed endometriotic lesions. Although we did not obtain a statistical significant difference in the changes of COX-2 immunostaining, we observed a tendency to be enhanced when the mice received celecoxib while the aromatase inhibitor reduced it, both compared with the control group. These results are in agreement with the reports that have established the existence of a negative feedback loop between the product from the activity of COX-2 and its protein levels. When the activity of the enzyme is inhibited, this loop disappears and its protein levels augment (Basu et al. 2005, Ohneseit et al. 2007). On the other hand, it is known that the product from aromatase activity stimulates mRNA and protein levels, as well as the activity, of COX-2 (Bulun et al. 2002). With the support from previous reports, the observed reduction in COX-2 immunostaining after anastrozole treatment is consistent with the interaction between these two enzymes and their products. Furthermore, even though it has been reported that the inhibition of COX-2 activity also inhibits the protein expression of aromatase in breast cancer cell lines in vitro (Bocca et al. 2011), when exemestane was combined with celecoxib, the protein levels of aromatase were seen unaltered in breast cancer patients (Lustberg et al. 2011).

There are no studies published in the field of endometriosis where the combination of anastrozole with celecoxib, or any other aromatase or COX-2 inhibitors, has been tested. In breast cancer research, the combination of celecoxib has been evaluated with exemestane. Exemestane and anastrozole, both well-known and thoroughly studied third-generation aromatase inhibitors, do have distinct ways of action. Anastrozole, as well as letrozole, is a reversible nonsteroidal inhibitor, whereas exemestane is an irreversible steroidal inhibitor (Geisler 2011). Maybe it is on this difference where it resides the contrasting results we have obtained.

Furthermore, we have performed this study using the mentioned mouse model of endometriosis and it has to be considered the possibility that women’s endometrium might not have the same response to the treatment with these compounds. The tissue implanted in the mouse peritoneum in this particular model consists of not only endometrial cells but it also contains myometrial tissue; this is not the case in the endometriotic lesions developed in women. Moreover, women’s endometriotic lesions are exposed to the natural hormonal fluctuations due to the menstrual cycle rather than the much shorter and more rapidly changing estrous cycle of the mouse, which may further affect the tissue developing in the peritoneal cavity. Further studies should be held in humans as to being able to state the certainty of the results presented here. This is an approach and a modelization of a very complicated human disease and the results should be interpreted in this sense. Nevertheless, this is a well-established and accepted model of endometriosis, which has been thoroughly used not only in our laboratory (Bilotas et al. 2010, Olivares et al. 2011, Ricci et al. 2011) but by other investigators too (Fang et al. 2002, Becker et al. 2006, Grummer 2006, Pelch et al. 2010).

To the best of our knowledge, this is the first study to investigate the combination of these two compounds in endometriosis research. More studies should be addressed to study the pharmacology of these compounds as to evaluate whether they might be having antagonizing effects. In the light of the results presented,
it may be a possibility. Our previous and present works have undoubtedly demonstrated the efficacy of celecoxib and anastrozole as monotherapies, and although their combination should benefit the patient theoretically, we cannot state it so far.

Materials and Methods

Animals

In this study, 40 2-month-old female BALB/c mice were used. All procedures were performed according to NIH Guidelines for the Care and Use of Laboratory Animals and approved by the Ethics and Research Committee from the Instituto de Biología y Medicina Experimental (Buenos Aires, Argentina). A total of six animals died or were killed 2 to 3 days after surgery because they did not fully recover from the procedure.

Surgical induction of endometriosis and treatment

Endometriosis-like lesions were induced through transplantation of one of the uterine horns to the bowel mesentery as described previously (Bilotas et al. 2010, Olivares et al. 2011, Ricci et al. 2011). Briefly, animals were deeply anesthetized with an i.p. injection of ketamine (100 mg/kg; Holliday Scott, Buenos Aires, Argentina) and xylazine (10 mg/kg; Richmond, Buenos Aires, Argentina). Mice underwent laparotomy by midventral incision to expose the uterus and intestine. The right uterine horn was removed, opened longitudinally, and cut into square pieces measuring ~4 mm². Three equal pieces of tissue were then sutured onto serosal layer with a single 6-0 nylon suture (Supralon, Ethicon, NJ, USA) with endometrial tissue facing the serosa. The abdomen was then closed with a 5-0 nylon suture.

Animals were assigned into four different treatment groups: control, 150 µl vehicle; celecoxib, 1500 ppm celecoxib (Pfizer) in chow (+150 µl vehicle); anastrozole (0.5 mg/kg s.c. injection, anastrozole was reconstituted in physiological solution) (AstraZeneca, London, UK), and celecoxib + anastrozole, received the treatments combined. All treatments were administered daily, started in postoperative day 1 and continued during 28 days. The amount of celecoxib consumed by each animal was estimated weighing the chow 1 day and the next, this difference was divided by the number of animals per cage; the chow was replaced and weighed every day. Each animal consumed 4.65 ± 0.17 mg celecoxib per day. No evidence of toxicity was noted at the doses administered based on body weight, food consumption, grooming behavior, or activity levels compared with controls.

Endometriotic like lesions evaluation

After 4 weeks of treatment, animals were killed by cervical dislocation. The abdomen was opened by ventral midline incision. Implantation sites were localized by the presence of a lesion or by suture alone. Lesions were counted and measured for volume determination using the formula: 

$$V = \frac{4}{3}\pi r^2 R$$

(where \(r\) and \(R\) are the radiuses, \(r < R\); Brodie et al. 2003). Then lesions were excised, fixed, and paraffin embedded. Specimens were cut into 5 µm serial sections. Four to five non-contiguous sections from each specimen were stained with hematoxylin–eosin and examined microscopically for the presence of histological hallmarks (glands and stroma) of endometriosis.

Immunohistochemistry for PCNA, CD34, and COX-2

Serial sections of endometriotic lesions were subjected to standard immunohistochemistry. Tissue sections were incubated overnight with the primary antibody (rabbit anti-mouse PCNA polyclonal, 1:300, FL-261, Santa Cruz Biotechnology; rat anti-mouse CD34 monoclonal, 1:50, ab8158 Abcam, Cambridge, MA, USA; or rabbit anti-COX-2 polyclonal, 1:200, sc-1747, Santa Cruz Biotechnology) at 4°C. After that, sections were treated for 60 min with the corresponding secondary biotinylated antibody (goat anti-rabbit IgG, 1:200, B7389; or goat anti-rat IgG 1:500, B7139; both from Sigma–Aldrich) followed by incubation with streptavidin–peroxidase (LSAB+ System, Dako, Carpinteria, CA, USA). Binding was visualized incubating sections with DAB and lightly counterstaining with haematoxylin, before permanent mounting.

The number of cells expressing immunoreactivity for PCNA was established using a standard light microscope. A total of 300 epithelial cells were counted and the percentage of PCNA-positive cells was calculated. Any nuclear staining was regarded as positive.

For determining the percentage of vascularized area, lesions were analyzed with ImageJ 1.33u Software (NIH, Bethesda, MD, USA). The area positive for CD34 was visualized and marked or delimited by the usage of this software. For each animal evaluated, ten fields were micrographed; for each micrograph, all positive area/s were delimited, added, and then divided by the total area of the micrograph, obtaining a percentage of vascularized area per micrograph. This process was done for every set of ten micrographs per animal. Then the media for the ten micrographs was calculated, obtaining the media percentage of vascularized area per animal and the media per treatment was calculated (Olivares et al. 2011, Ricci et al. 2011).

A semi-quantitative analysis of cells expressing COX-2 immunoreactivity was done using a standard light microscope. Briefly, slides were evaluated blinded to treatment by two independent observers. Ten fields were evaluated, and overall staining was recorded (0, absence of staining; 1, mild staining; 2, moderate staining; and 3, marked).

TUNEL assay

For apoptosis quantification, sections were processed for in situ immunohistochemical localization of nuclei exhibiting DNA fragmentation using the apoptosis detection kit Apoptag Plus (Chemicon International, Temecula, CA, USA). Sections were treated according to the manufacturer’s instructions as described previously (Meresman et al. 2000). The number of cells positive for TUNEL stain was established using a standard light microscope at 400× magnification. A total of 300 epithelial cells were counted and the percentage of TUNEL-positive cells was calculated.
Statistical analysis

Statistical analyses were performed using GraphPad Instat V4.0 Software (for Windows, GraphPad Software, San Diego, CA, USA). Statistical comparisons between groups were performed using nonparametric Kruskal–Wallis test with Dunn’s multiple comparison post test. Results were expressed as median (minimum–maximum) or as mean ± S.E.M. In all cases, statistical significance was considered when P < 0.05.

Declaration of interest

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

Funding

This study was supported by ANPCYT (Préstamo BID PICT 01632), CONICET (PIP 1223), and Fundación Roemmers, Buenos Aires, Argentina.

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Received 1 October 2012
First decision 29 October 2012
Accepted 12 November 2012