Fibroblast growth factor receptors, developmental corruption and malignant disease

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Fibroblast growth factors (FGF) are a family of ligands that bind to four different types of cell surface receptor entitled, FGFR1, FGFR2, FGFR3 and FGFR4. These receptors differ in their ligand binding affinity and tissue distribution. The prototypical receptor structure is that of an extracellular region comprising three immunoglobulin (Ig)-like domains, a hydrophobic transmembrane segment and a split intracellular tyrosine kinase domain. Alternative gene splicing affecting the extracellular third Ig loop also creates different receptor isoforms entitled FGFRIIIb and FGFRIIIc. Somatic fibroblast growth factor receptor (FGFR) mutations are implicated in different types of cancer and germline FGFR mutations occur in developmental syndromes particularly those in which craniosynostosis is a feature. The mutations found in both conditions are often identical. Many somatic FGFR mutations in cancer are gain-of-function mutations of established preclinical oncogenic potential. Gene amplification can also occur with 19–22% of squamous cell lung cancers for example having amplification of FGFR1. Ontologic comparators can be informative such as aberrant spermatogenesis being implicated in both spermatocytic seminomas and Apert syndrome. The former arises from somatic FGFR3 mutations and Apert syndrome arises from germline FGFR2 mutations. Finally, therapeutics directed at inhibiting the FGF/FGFR interaction are a promising subject for clinical trials.

Introduction

FGF ligands and receptors

Fibroblast growth factors (FGFs) are a family of homologous polypeptide ligands that bind to their cognate fibroblast growth factor receptors (FGFRs). Their effects are exerted in a context-dependent manner with different roles in different tumor types. For example, FGFs have tumor suppressive activity in medulloblastomas and prostate cancer but are tumor drivers in other malignancies. Signaling mediated by FGFs can cause mitogenesis, proliferation, differentiation, cellular migration, angiogenesis and repair of tissue injury.

There are 22 FGF ligand genes in humans comprising six subfamilies based on differing phylogeny and sequence homology. The encoded ligands were previously considered to be paracrine factors; however, the ligands FGF19, FGF21 and FGF23 have more recently been recognized as endocrine factors, which are dependent on the presence of Klotho proteins in the target tissue. These FGF’s participate in the regulation of bile acid, cholesterol, glucose, vitamin D and phosphate homeostasis (1–4). There are also four FGF homologous factors (previously designated FGF11–FGF14) that have high sequence identity with FGF family members. They do not activate FGFRs and therefore are no-longer considered to be FGF family members. Furthermore, FGF15 is the mouse ortholog of human FGF19 thereby giving a total of 18 recognized biologically active FGF ligands (5).

There are four cell surface FGFR isoforms that are differentially activated by FGF ligands in conjunction with the scaffold protein heparan sulfate proteoglycan (6). FGF ligand binding to the FGFR causes receptor dimerization, transphosphorylation and activation of an intracellulrry tyrosine kinase domain that is separated into two contiguous active regions (7,8). Activation also includes FGF substrate 2 (FRS2) that activates the growth factor receptor bound 2 (Grb2) of sevenless 1 complex and thereby the mitogen-activated protein kinase (MAPK) pathway when phosphorylated (Figure 1c) (9–12). There is also a non-tyrosine kinase receptor called FGFRL1 (7). Oncogenic mutations of the FGFRs are detailed in Table I. These can sometimes cause receptor activation by creating a cysteine residue that forms an intermolecular disulfide bond with consequent ligand-independent receptor dimerization, for example, R245C. In another circumstance, a conformational change of the activation loop of the receptors tyrosine kinase domain can arise, for example, K650/652E (6,13,14).

The ligand specificity of FGFR1, FGFR2 and FGFR3 is partially determined by alternative splicing within the C-terminal half of the third immunoglobulin (Ig) loop of the extracellular FGF binding domain. This is illustrated in Figure 1b. This alternative splicing creates a IIIb isoform (in which exon 8 is used) that is preferentially expressed in epithelial cells and a IIIc isoform (in which exon 9 is used) that is preferential expression in mesenchymal cells. The IIIb isoform preferentially binds secreted FGF ligands from adjacent mesenchyme, and the IIIc isoform usually binds ligands secreted from the adjacent epithelium. The configuration of this paracrine arrangement has the benefit of obviating inadvertent autocrine stimulation. This safeguard fails in disorders such as Apert’s syndrome in which there is incorrect FGF ligand binding with inappropriate FGF autocrine activation. Normally, the fibroblast ligands FGFR3, 7, 10 and 22 exclusively bind to the IIIb isoform, FGF1 binds to both the IIIb and IIIc isoforms, whereas the other 13 FGF ligands with established FGF stimulatory effects have preferential binding to the IIIc isoforms (16). Interestingly, murine studies have established an important role for the IIb isoform of FGFR2 in mesenchymal–epithelial signaling during organogenesis (17). Finally, in stem cells, FGF signaling cascades can interact with the Hedgehog, Wnt, Notch and bone morphogenic protein signaling pathways (18,19).

FGFR and developmental biology

(i) Craniosynostosis. Craniosynostosis is the premature closure of sutures, which are the lines where two bones formed by intramembranous ossification meet. The incidence of craniosynostosis is 1 in 2000 live births with 80–90% being isolated and 10–20% occurring as a phenotypic feature of a syndrome. In isolated cases, the sagittal suture is most frequently affected (55%), followed by the coronal (20%), lambdoid (5%) and metopic sutures (5%). The majority of cases of craniosynostosis occurring as part of a recognized syndrome arise from dominant gain-of-function mutations within the FGFR1, FGFR2 or FGFR3 genes, leading to constitutive ligand-independent receptor activation. These include Crouzon, Pfeiffer, Apert, Jackson-Weiss, Beare-Stevenson and Muenke syndromes. In

Abbreviations: FGF, epidermal growth factor receptor; FGF, fibroblast growth factor; FGFR, fibroblast growth factor receptor; FRS2, FGF substrate 2; GRB2, growth factor receptor bound 2; HCC, hepatocellular carcinoma; Ig, immunoglobulin; MAPK, mitogen-activated protein kinase; NSCLC, nonsmall cell lung carcinoma; TACC, transforming acidic coiled-coil; VEGFR, vascular endothelial growth factor receptor.

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addition to mutations in the FGFR genes leading to syndromic cases of craniosynostosis, abnormalities involving the transcription factors MSX2 (Boston-type craniosynostosis), TWIST (Saethre-Chotzen and Baller-Gerold) and the ligand EPHRIN-B1 can also cause craniosynostosis.

Physiologically, FGFs are expressed in the osteoblastic front of the membranous bones and at low levels mediate cellular proliferation through FGFR2. At high levels, they cause osteoblastic differentiation mediated by FGFR1. The concentration of FGF ligand diminishes with increasing distance from the suture. Interestingly, a recent study found evidence that FGFR1 amplification predicts sensitivity to the pan-FGFR kinase inhibitor NVP-BGJ398 in osteosarcoma (2199). The relationship between osteoblast differentiation and FGF–FGFR-mediated signaling in osteosarcoma is a subject for further research.

Crouzon syndrome has an autosomal dominant pattern of inheritance. It is the most common syndrome in which craniosynostosis is a feature with an incidence of 1 in 25 000 children. It is caused by mutations of FGFR2 exon 9(B) or exon 7(U) that affect the Ig-like domain III of the encoded FGFR2. Symptoms and signs of Crouzon syndrome are restricted to the head and neck. Pfeiffer syndrome is usually caused by FGFR2 exon 9(B) mutations that also affect Ig-like domain III of FGFR2, but 5% of cases arise from a FGFR1 exon 5, P252R mutation. Craniofacial abnormalities in Pfeiffer syndrome resemble those of Crouzon syndrome, but in addition, there is broadening of the great toes and thumb with variable cutaneous syndactyly. Coronal craniosynostosis and midface hypoplasia are also characteristic. Experimental introduction of the gain-of-function mutation Fgfr2c<sup>enu24272</sup> to create Fgfr2c Cys342Tyr heterozygous mice demonstrated that the arising mutant phenotype including craniosynostosis is related to FGFR2c regulation of the osteoblast lineage (21). FGFR2 missense gene mutations that cause Crouzon syndrome in humans include the FGFR2, Cys342Tyr amino acid substitution. An effect on the proliferation of chondrocytes but not gene expression suggested that FGFR2c co-operates with FGFR3 to create the cartilaginous model for endochondral ossification.

Apert syndrome usually arises from FGFR2 exon 7(u), Ser252Trp or Pro253Arg mutations of the highly conserved region linking FGFR2 Ig-like domains II and III. The disorder is less common but phenotypically more severe than other syndromes in which craniosynostosis is a feature. Experimentally, it has been found that by a dominant negative effect, soluble FGFR2 inhibits the enhanced osteoblastic differentiation seen in this condition (22). In general, the majority of FGFR mutations are ligand independent; however, some mutations such as Ser252Trp and Pro253Arg in the translated FGFR2 ectodomain cause phenotypic alterations by altered ligand binding affinity. Apert syndrome arises because of enhanced ligand binding affinity and concurrent promotion of inappropriate ligand binding (23, 24). The Ser252Trp substitution allows FGFR2c to bind to and be activated by the mesenchymally expressed ligands, FGF7 or FGF10. Epithelially expressed FGF2b is activated by FGFR2, FGFR6 and FGFR9 ligands, again violating the cardinal governing rules of FGFR2 ligand specificity (25). Another disorder, Muenke syndrome has comparatively mild phenotypic manifestations and accounts for 8% of cases of craniosynostosis. Affected patients may have deafness or brachydactyly. These patients usually have a FGFR3, Pro250Arg mutation that affects the region between Ig-like domains II and III of FGFR3. The described gain-of-function mutations all increase the affinity of FGF ligand binding to their respective FGFRs.

Investigators at Children’s Hospital of Philadelphia noted that there is an identical amino acid substitution in FGFR1, FGFR2 and FGFR3 in different craniosynostosis syndromes. They performed a PCR restriction enzyme assay on 113 patients with differing...
for before the commencement of meiosis (the two cellular divisions that create sperm) (29). This evidence of a selective advantage of pathogenic \( \text{FGFR2} \) mutations in the male germ line was commented on by experts as evidence of a new category of gene mutation. Descriptively, this category consists of ‘hot-spot’ gene mutations clustered at just one or two nucleotide sites leading to developmental disorders, which occur almost exclusively in males and rise markedly with age (30).

It is now established that exemplary examples of this hot-spot class are \( \text{FGFR3} \) and achondroplasia, and \( \text{FGFR2} \) and Apert’s syndrome. \( \text{RET} \) gene mutations that are found in multiple endocrine neoplasia are also included within this descriptive category. Interestingly, \( \text{RET} \) is functionally important in spermagonia and all three genes encode receptor tyrosine kinases.

Importantly, \( \text{FGFR3} \) mutations are also linked with spermatocytic seminomas, which occur more frequently in older men (31). In a screen of 30 spermatocytic seminomas tested for oncogenic mutations in 17 genes, 2 mutations in \( \text{FGFR3} \) (both 1948A\( \rightarrow \)G encoding K650E that incidentally causes thanatophoric dysplasia in the germline) and 5 mutations in \( \text{HRAS} \) were identified (32–34). The investigators inferred that a common ‘selfish’ pathway is activated by paternal age effect mutations that contribute to proliferation within the testis with consequential diverse next generation phenotypes of malignancies, fetal lethality and congenital syndromes (29). This was supported by an immunohistochemical study that found localized cellular aggregates with enhanced \( \text{FGFR3} \) immunohistochemical detection and pAKT as a marker of downstream signal activation. It appears that populations of spermagonia in individual seminiferous tubules are clonally mosaics in older men (35).

As afore-described \( \text{FGFR2} \) mutations in Apert syndrome increase the clonal expansion of male germ cells. Therefore, selective advantages are conferred on spermagonia that possess the \( \text{FGFR3} \) mutations found in spermatocytic seminoma and Apert syndrome. The \( \text{FGFR3} \) gene and cancer

The \( \text{FGFR3} \) gene is located on chromosome 4p16.3. \( \text{FGFR3} \) mutations occur in urothelial bladder tumors. These tumors are classified as either superficial (stage pTa or pT1) or muscle invasive (stage pT2 or greater) and are graded from grade 1 to grade 3 (G1–G3). A prospective Spanish study of \( \text{FGFR3} \) mutation status in 772 superficial urothelial tumors evaluated the prevalence and prognostic significance of \( \text{FGFR3} \) gene mutations. These mutations were more frequent in TaG1 (61%) and TaG2 (58%) tumors compared with TaG3 (34%) or T1G3 (17%) tumors (36). Overall, \( \text{FGFR3} \) gene mutations were associated with lower tumor grade and stage with the prevalence of \( \text{FGFR3} \) mutations decreasing as the depth of invasion and grade increased. The study supported the preceding concept that \( \text{FGFR3} \) mutant tumors are associated with a good prognosis. Ninety-one percent of \( \text{FGFR3} \) sequence changes were accounted for by S249C, Y375C, S248C or G372C. F386L polymorphisms occurred more often in low-grade tumors (odds ratio, 6.97) and the A393E amino acid substitution was significantly more common in tumors of low malignant potential. Multivariate analysis of all the superficial tumors did establish that \( \text{FGFR3} \) mutations are associated with an increased risk of recurrence. Stratified subset analysis, however, found that this was restricted to the TaG1 \( \text{FGFR3} \) mutant cohort (hazard ratio 2.12, 95% confidence interval 1.28–3.53; \( P = 0.004 \)).

In another European study of \( \sim \)4700 cases of urothelial bladder cancer and 45 000 controls, the T allele of rs798766 on chromosome 4p16.3 was linked with urothelial bladder cancer (odds ratio 1.24 (37). The locus of this allele which is within one intron of the transforming acidic coiled-coil (\( \text{TACC3} \)) gene, 70 kb from \( \text{FGFR3} \), was associated with a greater risk of recurrence in low-grade Ta bladder tumors. Furthermore, rs798766 is more common in Ta tumors with \( \text{FGFR3} \) activating gene mutations than wild-type \( \text{FGFR3} \). In a final reflection of practical significance, \( \text{FGFR3} \) mutation status was found to be superior to grade in predicting clinical outcome in a series of 286 well-differentiated urothelial cell carcinomas in which \( \text{FGFR3} \) mutations were detected in 60% of cases (36,38).

Glioblastomas multiforme is the most common malignant brain tumor in adults and fusion genes involving \( \text{FGFR} \) members are present

<table>
<thead>
<tr>
<th>Table 1. Established oncogenic mutations of the ( \text{FGFR} )</th>
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Adapted from Greulich et al. (15) and COSMIC database (Catalogue of Somatic Mutations in Cancer, Sanger, UK). Documents in descending order oncogenic mutations from the extracellular encoding region to the intracellular encoded domain for each individual \( \text{FGFR} \) (15). Described mutations are not solely restricted to the \( \text{Ig} \) or protein kinase domains, but colors green/blue are used to assist.

(\( \text{i} \)) A selfish path. Activating point mutations of \( \text{FGFR3} \) usually causes autosomal dominant skeletal dysplasias with defective growth of long tubular bones. Achondroplasia is the most common cause of dwarfism and nearly always arises from a Gly380Arg transmembrane \( \text{FGFR3} \) mutation. Functionally, this mutation promotes an interaction between transmembrane helices (27). \( \text{FGFR3} \) mutations are usually inherited as spontaneous new mutations through the paternal lineage and the incidence of achondroplasia increases with increasing paternal age. In an apparent epidemiologic–pathogenic discordance in achondroplasia, sperm derived from cohorts of normal men of differing ages only exhibit a slight increase in mutant sperm with increased paternal age (28). A vicarious clarifying insight was provided by investigators from the University of Oxford. In a separate investigation on Apert syndrome, they looked for mutation of cytosine 755 within \( \text{FGFR2} \), which has the highest inferred mutation within this gene, from sperm of men with different ages. Sixty-six percent of cases of Apert syndrome arise from \( \text{FGFR2} \) 755 C-to-G transversions. Paradoxically, though these mutations are detrimental to embryonic development, they are enriched because they lead to a selective advantage to the spermagonia in which they arise. The observed birth prevalence of Apert’s syndrome was 200- to 800-fold greater than that which would be expected from the background 755 C-to-G transversions rate. This disparity was because mutant spermagonia were positively selected

\[ \text{FGFR3} \]
in a small subgroup. These fusion genes were identified by investigators using short-term cultures of stem-like cells derived from nine glioblastomas multiformes. Subsequent massively parallel, paired-end sequencing of expressed transcripts established a FGFR-TACC fusion gene frequency of 3%. The fusion gene is an in-frame fusion of the tyrosine kinase coding domain of FGFR1 or FGFR3 with the TACC encoding regions of the TACC1 or TACC3 genes, respectively (39). Functionally, the FGFR-TACC fusion protein product disrupts the mitotic spindle leading to cellular aneuploidy. Experimentally, viral transfection of Ink4A/Arf−/− astrocytes with either FGFR3-TACC3 or FGFR1-TACC1 followed by subcutaneous injection into immunodeficient mice leads to glial fibrillary acidic-protein positive, gliomas. Cells containing the FGFR-TACC fusion proteins were also stereotactically transduced into normal mice. It was found that the FGFR3-TACC3 fusion possesses constitutive phosphorylation of the tyrosine kinase domain and the adaptor protein FRS2. This was ablated by treatment with PD173074, which specifically inhibits FGFR-associated tyrosine kinase activity. A K508M mutation had a similar effect. When mice with xenografted intracellular FGFR3-TACC3 initiated glioma were treated with PD173074, tumor growth was inhibited. Furthermore, treatment with another FGFR inhibitor, AZD4547 doubled the survival time compared with control. This was inferred to be evidence of the fusion gene’s oncogenic effect and the potential therapeutic efficacy that may arise from targeting this gene fusion.

FGFR3 mutations are also important in the pathogenesis of seborrheic keratosis. Transgenic mice with an activating S249C FGFR3 mutation targeted to the epidermal basal cell layer have ligand-independent activation of Fgfr3. This is the most frequent FGFR3 mutation in carcinomas and the identical mutation also causes thanatophoric dysplasia, the most common lethal skeletal dysplasia (40–42). These transgenic mice develop benign epithelial tumors with phenotypic similarity to seborrheic keratosis and acanthosis nigricans. In one publication, 62 cases of seborrheic keratosis were screened for FGFR3 mutations and 39% were found to have somatic activating FGFR3 mutations. There are three main histologic variants of seborrheic keratosis: hyperkeratosis, acanthotic and seborrheic (43). In a further study evaluating 65 acanthotic seborrheic keratoses, 57% had somatic activating FGFR3 mutations (44). These mutations were present in both flat (initial) and thick keratosis and were associated with increased patient age, localization to the head and neck (P < 0.01) as well as increased expression of bcl-2. FGFR3 mutations have also been found in cervical cancer. Lastly, gain-of-function mutations and overexpression of FGFR3 are the most common mutations seen in multiple myeloma (45). Also of interest to hematologists, FGFR1 translocations have been identified in patients with chromosome 8p11 myeloproliferative syndrome (46).
resistance to endocrine therapy and an unfavorable prognosis. A further 15–30% of breast cancers have amplification of FGFR3, which is correlated with an aggressive clinical phenotype.

Oncogenic activating mutations of the FGFR2 tyrosine kinase domain occur in 12% of cases of endometrial cancer (56). Cell line studies of malignant endometrial cells with activating FGFR2 mutations have shown that inhibition of FGFR2 kinase activity using PD173074 inhibited transformation as well as decreased anchorage-independent cell growth and survival. This infers an oncogenic importance and a potential therapeutic benefit in targeting this mutant receptor. An investigation not restricted to FGFR evaluation was performed in 233 gastric cancers (193 primary tumors and 40 cell lines) and 98 primary non-malignant-matched gastric samples (57). The intent was to determine the most prevalent molecular targets and to find systemic patterns of exclusivity and co-occurrence within the molecular targets identified. Five gastric cancer subgroups were identified, which were defined by signature genomic alterations: FGFR2 (9%), KRAS (9%), epidermal growth factor receptor (EGFR; 8%), ERBB2 (8%) and MET (4%). Evidently, these subgroups are related to receptor tyrosine kinase/RAS signaling and were amplified in a mutually exclusive fashion. Receptor tyrosine kinase/RAS amplification occurred in ~37% of the gastric cancer cases. Of potential therapeutic importance, the FGFR2-amplified tumors were sensitive to the FGFR vascular endothelial growth factor receptor (VEGFR) inhibitor Dovitinib. In diffuse-type gastric cancer, FGFR2 overexpression is correlated with an unfavorable prognosis (58). In these cases, FGFR2 amplification can be identified by FISH (59). A FISH image of an FGFR2-amplified gastric cancer is shown in Figure 2. In this case, many of the cells are triploid/tetraploid/polysonic, but it is a case of true FGFR2 amplification. In another study, direct sequencing of exons IIIa and IIIc on 30 matched primary gastric tumors and normal tissue identified two heterozygous FGFR2 mutations: (i) a missense mutation (Ser267Pro) in exon IIIa and (ii) a splice site mutation (940-2A G) in exon IIIc (49). These mutations are identical to the activating mutations found in Crouzon, Apert and Pfeiffer syndrome (60).

**FGFR and lung cancer**

Frequent and focal FGFR1 amplification occurs in ~9–22% of cases of squamous cell lung cancer (61). In a high-resolution genomic analysis of 232 primary lung cancers, 155 of which were squamous cell lung cancer, this abnormality was not identified in subtypes other than squamous cell carcinoma. Twenty-five significant amplification peaks were identified, which included SOX2 on chromosome 3q26.33, and a peak on chromosome 8p12, which included FGFR1 and FLJ43582. Of the cases with FGFR1 amplification (n = 15), 73% were from smokers with none of the remaining cases arising from patients who had never smoked. In an independent validation series of squamous cell lung cancers (n = 153), a 22% frequency of FGFR1 amplification (four or more copies) was established by FISH. A separate evaluation of a publically available single nucleotide polymorphism array data set of 581 lung cancers found FGFR1 amplification in ~1% of non-squamous cell lung cancers. Cell-based screening using the non-isofrom-specific FGFR inhibitor PD173074 found that it inhibited growth and induces apoptosis in cell lines with the FGFR1 amplification. FGFR1 was validated as the critical target of PD173074-mediated antitumor efficacy in FGFR1-amplified cell lines using knockdown and ectopic expression of the FGFR1-resistant allele FGFR1(MIII). Mice engrafted with FGFR1-amplified cells treated with PD173074 had tumor regression. MAPK signaling is the key pathway engaged by FGFR1 amplification. FGFR1 amplification is not the only important recent molecular discovery in squamous cell lung cancer. In a separate investigation, investigators sequenced the tyrosine kinase in squamous cell lung cancers and cell lines (62). They found gain-of-function mutations in the discoidin domain receptor (DDDR2) tyrosine kinase gene, a putative oncogenic event, in 3.8% of cases. These mutations were associated with sensitivity to Dasatinib preclinically and in a single demonstrative clinical case. An independent series of 524 patients were enrolled in a study searching for driver gene mutations in non-small cell lung carcinoma (NSCLC). A DDR2 mutation frequency of 4.4% was found, with a FGFR2 mutation frequency of 2.2%. The FGFR2 mutations only occurred in cases of squamous cell lung cancer arising in smokers (63).

Finally, ~10% of cases of NSCLC (squamous cell carcinoma, large cell carcinoma and adenocarcinoma) have mutations in exons 18, 19 or 21 of the tyrosine kinase domain of the EGFR. Somatic mutations of the EGFR gene are small mutations, which affect amino acid residues from 747 to 750 or point mutations, most frequently replacement of leucine by arginine at codon 858 (64,65). These alterations confer sensitivity to treatment with the adenosine triphosphate-competitive anilinoquinazoline inhibitors, gefitinib and erlotinib (66). Unfortunately, secondary acquired resistance with progressive disease arises in all treated cases, and molecularly, this acquired resistance can occur in different ways. The first such resistance mechanism described was the gatekeeper EGFR mutation T790M (67). Acquired resistance to gefitinib can also arise from amplification of chromosome region 7q31.1-q33.3, which contains the c-Met gene, as well as by phosphorylation of the insulin-like growth factor type 1 receptor and constitutive activation of phosphatidylinositol 3-kinase (68,69). More recently, it has been discovered that de-repression of FGFR2 and FGFR3 can cause secondary acquired resistance (70). Gene expression analysis of NSCLC cell lines with EGFR signaling that had been treated with gefitinib demonstrate increased expression of FGFR2 and FGFR3 (70). In a luciferase reporter construct, inhibitors of MEK (MAP/ERK kinase) and c-Src stimulated fgfr2-luc activity at similar levels to gefitinib. It was inferred that FGFR2 and FGFR3 signaling is a mechanism of acquired resistance to tyrosine kinase inhibition and combination treatment with both EGFR and FGFR tyrosine kinase inhibitors is a possible therapeutic potential.

**FGFR4 and cancer**

The FGFR4 gene is located at chromosome 3q35–qter. An increased incidence of prostate cancer in Caucasian males is associated with homozygosity of the FGFR4 Arg388 allele, and this mutation is associated with clinically aggressive disease (71). This mutant allele is also significantly associated with advanced tumor stage and reduced overall survival in squamous cell carcinoma of the oral cavity and oropharynx (72).

**Prognostic importance of FGF’s in pancreatic cancer**

Correlation of gene expression with prognosis is of oncologic interest because if a gene’s expression is associated with an adverse prognosis, this may vicariously infer it having a possible driver oncogenic role. FGFs have been found to be of prognostic importance in pancreatic cancer. An immunohistochemical analysis of 78 pancreatic carcinomas...
found a significant proportion of pancreatic cancer cells overexpress acid FGF (60%) and basic FGF (56%) (73). High expression was also found in adjoining atrophic exocrine pancreatic cells. The presence of either type of FGF was significantly correlated with advanced tumor stage. Basic FGF overexpression was also associated with a shorter survival. The mean postoperative survival time was 15.9 ± 1.2 months for cases of pancreatic cancer with absent basic FGF, compared with 9.1 ± 0.8 months for pancreatic cancers that were positive for basic FGF.

**Anti-FGFR drugs**

Targeting the FGF ligand–FGFR interaction is promising for supportive care and the treatment of cancer and has been the subject of other reviews (74–76). In supportive care, Palifermin is an N-truncated form of FGF7 (keratinocyte growth factor). A double-blind trial has been performed on patients receiving treatment for hematologic cancers, of Palifermin compared with placebo. Palifermin was administered for three consecutive days prior to high-dose chemotherapy, as well as 3 days subsequent to hematopoietic stem cell transplantation. The median duration and incidence of grade 4 mucositis were reduced from 9 to 6 days and from 62 to 20%, respectively, in the treatment arm (77).

FGFR-directed therapeutics are subcategorized as either selective FGFR inhibitors or multitargeted tyrosine kinase inhibitors. Selective inhibitors include NVP-BGJ398, AZD4547 and LY287445. Non-selective inhibitors include those that target FGFR and VEGFRs (e.g. LY2874455 or Brivanib), triple angiokinase inhibitor (e.g. BIBF 1120) or inhibitors with a wide target spectrum (e.g. Roferafinib or Pazopanib). Most compounds of therapeutic interest have an IC50 < 200 nmol against one of the FGFR subtypes. The literature is dominated by preclinical and phase I trials. A phase II trial of TKI258 (Dovitinib), a tyrosine kinase inhibitor of FGFR1, FGFR2, FGFR3, VEGFR and PDGFR (platter-derived growth factor receptor), was however conducted in breast cancer. A preceding study of 880 breast tumors detected amplification of FGFR1 in 8.7% of cases. FGFR1 amplification was more common in Her-2 negative disease and was the strongest independent predictor of a poor prognosis (78). The phase II clinical trial was performed on heavily pretreated patients with HER2-negative, visceral metastatic disease (79). Patients were stratified into four groups based on FGFR1 amplification and hormone receptor status. Dovitinib was efficacious in the FGFR1-amplified hormone receptor positive subset (25% had a non-confirmed partial response rate and/or stable disease rate of 24 weeks).

Toxicity data of the consequences of FGFR inhibition are often confounded in studies of non-selective tyrosine kinase inhibitors, but the FGFR specificity of BGJ398, AZD4547 and LY287445 have been suggested as probably more informative (74). Hyperphosphatemia and calcification of tissue arising from blockade of FGFR23 signaling are clinically important unanticipated toxicities. Hyperphosphatemia may be managed with phosphate binders and diuretics.

**Specific therapeutics**

NVP-BGJ398 is a pan-FGFR kinase inhibitor (20). A preclinical study of 500 osteosarcoma cell lines found that amplification of FGFR1 may be a predictive biomarker of sensitivity to treatment with NVP-BGJ398. Furthermore, data derived from the Cancer Cell Line Encyclopedia (a collection of 1000 cell lines derived from multiple differing malignancies) demonstrated that cancer cell lines with FGFI9 copy number gain at the 11q13 amplion are sensitive to NVP-BGJ398. This sensitivity was restricted to a cohort that had concomitant expression of the glycloside 1, β-Klotho in the target tissue. A proportion of hepatocellular carcinomas (HCCs) with this molecular description are sensitive to NVP-BGJ398. In three liver cancer cell lines sensitive to NVP-BGJ398, constitutive FRS2 Tyr phosphorylation was ablated. These cell lines also expressed FGFR4 with short hairpin RNA studies providing evidence that although the majority of chromosome 11q13 amplified tumor types may not respond to FGFI9/FGFR4 inhibition, a subgroup of FGFI9-amplified liver cancers with concomitant β-Klotho may benefit. Additionally, an anti-FGFI9 monoclonal antibody has been found to prevent hepatocellular tumors in transgenic mice (80,81).

AZD4547 inhibits the tyrosine kinases FGFR1, FGFR2 and FGFR3. AZD4547 caused tumor regression in a xenografted mouse model of a human cancer. Antitumor activity was associated pharmacodynamics modulation of phospho-FGFR3. A phase II of AZD4547 versus paclitaxel in advanced gastric carcinoma or gastro-esophageal junction cancers with FGFR2 amplification or polysomy is accruing (clinical trials.gov: NCT01457846).

LY2874455 is a FGFR dominant inhibitor with lower VEGFR2 activity. Antitumor effects have been observed in several cancer cell lines treated with LY2874455, including those derived from gastric cancer, NSCLC, multiple myeloma and bladder cancer. It also had antitumor activity in different tumor xenograft models of these cancer types (82).

**Non-specific therapeutics**

Brivanib is an inhibitor of FGFR tyrosine kinase signaling and a potent inhibitor of VEGFR2 (83). In a mouse model, it was shown to inhibit growth of human HCC (84). A phase II study of Brivanib as first-line treatment involving 55 patients with advanced HCC demonstrated a response rate of 7.3% and a disease control rate of 51%. Median progression-free survival was 2.7 months and overall survival was 10 months (85). Most frequent adverse effects included hypertension, fatigue and diarrhea. A subsequent phase II trial involving Brivanib in the second line was conducted on 46 patients with advanced HCC who had failed prior antiangiogenic therapy (86). The oral antiangiogenic multikinase inhibitor exclusive of FGFR, Sorafenib is already Food and Drug Administration approved for the systemic treatment of advanced HCC based on the results of a phase III trial (87,88). In that trial, the partial response rate was 4.6%, with a disease control rate of 45.7%. Median overall survival was 9.79 months with a median time to disease progression of 2.7 months.

BIBF 1120 is a triple angiokinase inhibitor that targets VEGF, PDGFR and FGFR (R18). A phase I dose-escalation study of BIBF 1120 with pemetrexed was conducted on patients with NSCLC previously treated with one first-line platinum-based chemotherapy regimen (89). The stable disease rate was 50% with a median progression-free survival of 5.4 months. In a comparative study of interest, a phase III trial of pemetrexed versus docetaxel in patients with NSCLC who had previously been treated with chemotherapy demonstrated a mean progression-free survival of 2.9 months in each arm (90).

Finally, therapeutics that target FGF ligand–FGFR-mediated signaling can present a target profile that far exceeds the FGF–FGFR axis alone. This makes it difficult to establish the true benefit accruing from selective FGFR inhibition. An especially permissive example is Regorafenib, which is an oral multikinase inhibitor of angiogenesis (VEGFR1, VEGFR2, VEGFR3 and TIE2), of oncogenic kinases (KIT, RAF and RET) as well as stromal PDGFR-β and FGFR1 (91). Evidently, much of its therapeutic efficacy is probably attributable to its wide spectrum of therapeutic targets in addition to FGFR1. Its efficacy in selected malignancies is established.

**Conclusion**

Therapeutic targeting of the FGF–FGFR interaction offers a new molecular avenue to treat cancer. The treatment possibilities are dominated by malignancies with FGFR abnormalities such as mutations or amplification. This review covers the implications of FGFR abnormalities in both development and cancer. Lacunae of information remain to be filled by further research in this branch of ontology, but the potential of what remains to be found is tremendously exciting.

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