



Human breast cancer cells educate macrophages toward the M2 activation status

Sofia Sousa, Régis Brion, Minnamaija Lintunen, Pauliina Kronqvist, Jouko Sandholm, Jukka Mönkkönen, Pirkko-Liisa Kellokumpu-Lehtinen, Susanna Lauttia, Olli Tynnenen, Heikki Joensuu, et al.

► To cite this version:

Sofia Sousa, Régis Brion, Minnamaija Lintunen, Pauliina Kronqvist, Jouko Sandholm, et al.. Human breast cancer cells educate macrophages toward the M2 activation status. *Breast Cancer Research*, 2015, 17, pp.101. 10.1186/s13058-015-0621-0 . inserm-01793465

HAL Id: inserm-01793465

<https://inserm.hal.science/inserm-01793465>

Submitted on 16 May 2018

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.


L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

RESEARCH ARTICLE

Open Access



Human breast cancer cells educate macrophages toward the M2 activation status

Sofia Sousa^{1*} , Régis Brion^{2,3,4}, Minnamaija Lintunen⁵, Pauliina Kronqvist⁵, Jouko Sandholm⁶, Jukka Mönkkönen¹, Pirkko-Liisa Kellokumpu-Lehtinen⁷, Susanna Lauttia⁸, Olli Tynnenen⁹, Heikki Joensuu^{8,10}, Dominique Heymann^{2,3,4} and Jorma A. Määttä^{1,5}

Abstract

Introduction: The immune system plays a major role in cancer progression. In solid tumors, 5–40 % of the tumor mass consists of tumor-associated macrophages (TAMs) and there is usually a correlation between the number of TAMs and poor prognosis, depending on the tumor type. TAMs usually resemble M2 macrophages. Unlike M1-macrophages which have pro-inflammatory and anti-cancer functions, M2-macrophages are immunosuppressive, contribute to the matrix-remodeling, and hence favor tumor growth. The role of TAMs is not fully understood in breast cancer progression.

Methods: Macrophage infiltration (CD68) and activation status (HLA-DR11q, CD163) were evaluated in a large cohort of human primary breast tumors (562 tissue microarray samples), by immunohistochemistry and scored by automated image analysis algorithms. Survival between groups was compared using the Kaplan-Meier life-table method and a Cox multivariate proportional hazards model. Macrophage education by breast cancer cells was assessed by *ex vivo* differentiation of peripheral blood mononuclear cells (PBMCs) in the presence or absence of breast cancer cell conditioned media (MDA-MB231, MCF-7 or T47D cell lines) and M1 or M2 inducing cytokines (respectively IFN- γ , IL-4 and IL-10). Obtained macrophages were analyzed by flow cytometry (CD14, CD16, CD64, CD86, CD200R and CD163), ELISA (IL-6, IL-8, IL-10, monocyte colony stimulating factor M-CSF) and zymography (matrix metalloproteinase 9, MMP-9).

Results: Clinically, we found that high numbers of CD163⁺ M2-macrophages were strongly associated with fast proliferation, poor differentiation, estrogen receptor negativity and histological ductal type ($p < 0.001$) in the studied cohort of human primary breast tumors. We demonstrated *ex vivo* that breast cancer cell-secreted factors modulate macrophage differentiation toward the M2 phenotype. Furthermore, the more aggressive mesenchymal-like cell line MDA-MB231, which secretes high levels of M-CSF, skews macrophages toward the more immunosuppressive M2c subtype.

Conclusions: This study demonstrates that human breast cancer cells influence macrophage differentiation and that TAM differentiation status correlates with recurrence free survival, thus further emphasizing that TAMs can similarly affect therapy efficacy and patient outcome.

Introduction

Metastasis is often explained with the ‘seed and soil’ theory. Conceptually, it implies that the cancer cell (seed) undergoes epithelial to mesenchymal transition (EMT), invades vessels, becomes a circulating tumor cell (CTC), migrates, extravasates, undergoes mesenchymal to

epithelial transition, and eventually colonizes distant sites as a disseminating tumor cell (DTC). ‘Soil’ relates to tumor microenvironment elements which contribute to these processes, making the distant sites permissive to colonization by CTCs or DTCs [1].

The immune system is a major player in the cancer cell/tumor microenvironment crosstalk. In solid tumors, 5–40 % of the tumor mass consists of tumor-associated macrophages (TAMs). Approximately 80 % of the publications in this field report an association between TAMs

* Correspondence: sofia.sousa@uef.fi

¹School of Pharmacy, Faculty of Health Sciences, University of Eastern Finland, Yliopistoranta 1C, P.O. Box 1627, FI-70211 Kuopio, Finland
Full list of author information is available at the end of the article

and poor prognosis [2, 3]. In humans macrophage polarization is a continuum that spans two extremes from the classically activated M1 macrophages to the alternatively activated M2 macrophages. M1 macrophages derive from interferon γ (IFN- γ) or lipopolysaccharide (LPS) stimuli and secrete inflammatory cytokines (e.g., IL-6, IL-12, reactive oxygen species (ROS), reactive nitrogen species (RN) and TNF- α). The validated surface-markers of human M1 macrophages include high levels of CD14 and CD16, CD64, CD86 and HLA-DR α [4, 5]. M2 macrophages, can be further divided into M2a, M2b and M2c macrophages. M2a macrophages arise from IL-4 or IL-13 stimuli and release matrix-remodeling cytokines. Elevated expression of CD200R and CD86 is a validated phenotypic marker of M2a macrophages [4, 5]. M2b macrophages result from the recognition of immune complexes in combination with IL-1 β or LPS stimuli and like M2a macrophages, they are involved in wound healing. The immunosuppressive M2c-macrophages are the outcome of IL-10, TGF- β (transforming growth factor β), glucocorticoids or immune complex rich environments. M2c macrophages generate further IL-10 and matrix-remodeling factors such as matrix metalloproteinases (MMPs) [4, 5]. Elevated CD163 expression is a validated marker of M2c polarization [5].

TAMs, a macrophage population recruited and educated by tumor cells, which are therefore exposed to IL-10, TGF- β , M-CSF (monocyte colony stimulating factor) [6] and other immunosuppressive stimuli [7], are more closely related to the M2 type [8]. In the tumor micro-environment, TAMs will preferentially perform trophic and immunosuppressive rather than immune effector tasks [3, 9, 10]. Hence, TAMs promote epithelial outgrowth and invasion, which are common features of development and cancer [3, 9]. Wickoff et al. have shown that mammary tumors exhibit a paracrine loop between TAMs and cancer cells. TAMs express monocyte colony stimulating factor receptor (M-CSFR, also known as CSF-1R or cFMS), which binds monocyte colony stimulating factor (M-CSF, also known as CSF-1) secreted by cancer cells. Conversely, TAMs secrete epidermal growth factor (EGF) and activate the EGF receptor (EGFR) on the cancer cells. This allows co-migration of the two cell types, thus, enhancing motility and subsequent invasion of healthy surrounding tissue and intravasation [11, 12]. Also, breast cancer cell leucocyte receptor, vascular cell adhesion molecule 1 (VCAM1) binding to TAM α 4-integrin explains the increased survival of VCAM1 $^{+}$ tumor cells in leucocyte-rich environments [13].

Like their phenotype and interactions with tumor cells, the location of TAMs in relation to hypoxic areas is a key parameter controlling tumor growth. In addition to the perivascular TAMs, which take part in cancer cell invasion [11, 12], TAMs are also recruited into hypoxic

areas [14]. Within these avascular areas TAMs alter their gene expression profile, favoring a pro-tumor M2 phenotype [15]. This may explain why in the early stages [16] of cancers of the lung [17], colon [18] and stomach [19], the macrophages in the normoxic milieu display an M1 phenotype and are associated with good prognosis.

Immunohistopathological breast carcinoma studies with restricted numbers of samples ($n = 53$ and 120 , respectively) reveal a gradual increase in the amount of infiltrating macrophages (CD68 $^{+}$) from normal breast tissue to benign proliferative breast disease, ductal carcinoma in situ (DCIS) and infiltrating ductal carcinoma [20, 21]. Two larger studies ($n = 1,322$ and 168 , respectively) confirmed that CD68 $^{+}$ macrophages were associated with higher tumor grade, estrogen receptor (ER) and progesterone receptor (PR) negativity, human epithelial growth factor receptor 2 (HER-2) positivity and a basal phenotype, but led to the conclusion that CD68 expression was not an independent prognostic factor [22, 23]. Another breast cancer cohort study ($n = 144$), looking at total macrophage number (CD68 $^{+}$) and M2 macrophages (CD163 $^{+}$) found that CD163 was also associated with other prognostic markers [24]. It showed that CD68 $^{+}$ cells in the tumor stroma but not in the tumor nest were an independent prognostic factor for decreased cancer-specific survival, accounting for the localization of TAMs in the tumors more than their mere presence. Triple-negative/basal-like breast tumor stroma had more CD163 $^{+}$ and CD68 $^{+}$ cells and a higher proportion of CD163 relative to CD68 when compared to the stroma of luminal A tumors. This indicates a predominance of mature M2 macrophages and possibly immature myeloid-derived cells (MDCs, also CD163 $^{+}$) in triple-negative disease [24].

Several clinical studies have found an association between macrophage infiltration and angiogenesis in breast cancer [22, 25–28]. However, in relation to prognosis it is unanimous that larger studies of macrophage subpopulations are needed. This study intends to fill that gap. Focusing on the expression of M1 and M2 markers in samples from a large cohort of patients with breast cancer ($n = 562$), we looked for possible associations with tumor progression. Additionally, by studying the ex vivo differentiation of human macrophages in the presence of breast cancer conditioned media (CM), we aimed to find possible mechanisms of TAM education. To achieve these aims, we revisited tissue microarrays from a large cohort [29] of early human breast tumors of different subtypes, grades and aggressiveness and used different breast cancer cell lines.

Methods

Human samples

TMA samples ($n = 562$ out of 1,199 patients from the FinXX study, NCT00114816 [29]) were studied

retrospectively. Clinicopathological characteristics of the sub-cohort are described in Table 1. Formalin-fixed, paraffin-embedded tumor samples were used for TMA. Blocks were made using a 1.0-mm tissue cylinder through a histologically representative area of each donor tumor block. From each donor block, 2–4 cores were cut and 15 TMA blocks were prepared, each containing

61–84 tumor samples plus 2–3 liver samples as positive controls.

Immunohistochemical analysis

Sections (4- μ m) of the TMA blocks were stained using standard immunohistochemical techniques for the expression of CD68 (anti-SA2 antibody clone 3C6, Abcam,

Table 1 Patient demographics and relevant clinical characteristics

Factor	Entire series n = 562	CD68 ^a		<i>p</i> ^b	CD163 ^a		<i>p</i> ^b	HLA-Dra ^a		<i>p</i> ^b
		≤369 n = 277	>369 n = 274		≤167.5 n = 270	>167.5 n = 267		≤107 n = 280	>107 n = 275	
Age, years										
≤50	213	95	113		105	98		112	100	
>50	349	182	161	0.093	165	169	0.602	168	175	0.378
Tumor size median										
≤22 mm	283	144	132		137	129		140	138	
>22 mm	278	132	142	0.348	132	138	0.545	139	137	1.000
N.A.	1									
Nodal status										
pN0	65	27	37		28	33		37	28	
pN+	497	250	237	0.169	242	234	0.468	243	247	0.267
Histological type										
Ductal	399	181	211		171	213		204	192	
Lobular	110	66	43		69	33		47	60	
Other	53	30	20	0.010	30	21	<0.001	29	23	0.274
Histological grade										
Grade 1	46	33	13		26	16		20	25	
Grade 2	264	138	119		153	97		127	132	
Grade 3	250	106	140	0.001	91	152	<0.001	131	118	0.518
N.A.	2									
ER status										
Positive	405	215	181		214	171		191	207	
Negative	157	62	93	0.003	56	96	<0.001	89	68	0.065
HER-2 status										
Positive	170	85	83		72	93		93	77	
Negative	392	192	191	0.920	198	174	0.040	187	198	0.183
Biological group										
ER+, HER-2–	314	165	142		173	123		139	168	
ER+, HER2+	91	50	39		41	48		52	39	
ER–, HER2+	79	35	44		31	45		41	38	
ER–, HER2–	78	27	49	0.015	25	51	<0.001	48	30	0.032
Ki67										
≤20 %	271	149	116		158	96		124	140	
>20 %	242	104	134	0.005	92	144	<0.001	126	116	0.252
N.A.	49									

Results are presented as number of patients. ^aThe cutoff values used correspond to the median values of number of positive cells in the entire series. ^bChi-square test. ER estrogen receptor, HER-2 human epidermal growth factor receptor 2, N.A. not available

Cambridge, UK), CD163 (clone 10D6, Novocastra, Newcastle, UK) and HLA-DR α (Dako, Glostrup, Denmark) [30, 31] (detailed information provided in Additional file 1). All the stained TMA slides were scanned using an Olympus virtual microscope equipped with Dotslide using the 10 \times objective (Olympus BX51, Olympus, Munich, Germany), and AxioCam camera (Zeiss, Jena, Germany). Positively stained cells were counted using Fiji equipment version 1.48s (Wayne Rasband, NIH). After color deconvolution for hematoxylin and 3,3'-Diaminobenzidine (DAB), the threshold was set for macrophage visualization. The size limit for particle analysis was carefully chosen to include only macrophages. Damaged samples were excluded from the analysis. The data were analyzed in a double-blinded fashion. The investigators were blinded to the identity and clinical pathological characteristics of each sample while analyzing/scoring the macrophage content and differentiation status. The final numbers of positive cells per marker, per sample were passed on to hypothesis-naïve investigators who performed the statistical analysis of the cohort.

Cell culture

Human breast cancer cell lines MCF-7, MDA-MB231 and T47D, obtained from American Type Culture Collection (ATCC), were grown in Roswell Park Memorial Institute (RPMI)-1640 medium (Sigma-Aldrich, St Louis, MO, USA) supplemented with 10 % fetal bovine serum (FBS) (Gibco, Grand Island, NY, USA) and 100 IU/ml penicillin and streptomycin (Gibco, Bleiswijk, Netherlands) at 37 °C in a 5 % CO₂ atmosphere. After reaching confluence, cell culture medium was changed to medium containing only 1 % FBS and kept in culture for 72 h. At the end of the culture period, the CM were collected from at least three independent cell line batches from each cell type. The CM were centrifuged for 5 minutes at 2,800 g, aliquoted and frozen at -20 °C. CM were used as 50 % supplement of the macrophage differentiation culture medium together with 10 % FBS. The cell lines were recently authenticated by STR (Short tandem repeat) profiling by a certified cell line authentication service (DDC Medical, Fisher Scientific, London, UK). Mycoplasma detection was performed on a routine basis by 4',6-Diamidino-2-phenylindole (DAPI) staining of cultured cells.

Peripheral blood mononuclear cell (PBMC) isolation

PBMCs from five different donors were isolated by centrifugation over Ficoll gradient (Sigma-Aldrich, St Louis, MO, USA). CD14⁺ cells were magnetically labeled with α -CD14 microbeads and positively selected by MACS technology (Miltenyi Biotec, Cologne, Germany).

Macrophage differentiation

To obtain M1, M2a and M2c macrophages, CD14⁺ monocytes were cultured in MEM (Lonza, Basel, Switzerland)

supplemented with 10 % FBS (Gibco, Grand Island, NY, USA) (control, CTR), with IFN- γ (50 ng/ml; M1), or IL-4 (50 ng/ml; M2a), or IL-10 (50 ng/ml; M2c) for 5 days with replacement of half of the culture media at day 3 [32]. To assess the effect of breast cancer cell-line-secreted factors, the same differentiation protocol was carried out in the presence or absence of 50 % CM from MDA-MB231, MCF-7 or T47D cells. For activation status experiments (ELISA), cells were treated with LPS (10 ng/ml, Sigma-Aldrich, St Louis, MO, USA) for one additional day. Unless otherwise stated, all the used cytokines were from R&D Systems (Minneapolis, MN, USA). Supernatants were collected, centrifuged for 5 minutes at 2,800 g, aliquoted and stored at -20 °C until further analysis. Cells were harvested with Accutase (Invitrogen, Paisley, UK), debris were removed by centrifugation (5 minutes at 400 g), and cells were used for flow cytometry analysis. Supernatants were used for ELISA and zymography.

Flow cytometry

Ex vivo polarized macrophages were analyzed by validated flow cytometry methods [5], with the BD LSR II flow cytometer (BD Biosciences, Erembodegem-Dorp, Belgium). In brief, cells were washed with PBS 0.1 % BSA (Sigma-Aldrich, St Louis, MO, USA) and before staining, Fc receptors were blocked with FcR blocking reagent (BD Biosciences, Erembodegem-Dorp, Belgium): 0.2×10^6 cells were incubated with adequate antibody mixes and washed prior to analysis. Surface-marker expression was analyzed with flow cytometry using the following fluorochrome-labeled monoclonal antibodies: CD14-APC-Cy7 (clone 61D3; eBioscience, Paris, France), CD16-PE-Cy7 (clone DJ130c; AbD Serotec, Kidlington, UK), CD64-AF488 (clone 10.1; BioLegend, San Diego, CA, USA), CD200R-PE (clone OX108; AbD Serotec, Kidlington, UK), CD163-AF647 (clone GHI/61; BD Pharmingen, Erembodegem-Dorp, Belgium), and CD86-AF488 (clone IT2.2, BD Pharmingen, Erembodegem-Dorp, Belgium). Equivalent amounts of isotype-matched control antibodies and unstained cells were included in all experiments as negative and autofluorescence controls. Data were analyzed with BD FACSDiva software, after gating on the myeloid population in the FSC/SSC plot. Values were expressed as the percent ratio of the median fluorescence intensity (MedFI) of the marker of interest over the MedFI of the unstained cells.

ELISA

LPS-activated macrophage culture supernatants were used in ELISA for quantification of h-IL-10, h-IL-8, and h-IL-6 according to the manufacturer's instructions (R&D systems). h-M-CSF was quantified in breast cancer cell line CM (Duo set, R&D systems, Minneapolis, MN, USA).

Zymography

The potential proteolytic activity of MMPs in the supernatants of the obtained macrophages was determined by zymography as previously described [33]. The stained polyacrylamide-gelatin gels were observed with the Image Quant RT ECL imager. Densitometry of the bands corresponding to pro-MMP-9 activity (92 kDa) was performed using Fiji equipment version 1.48s (Wayne Rasband, NIH). Presented values are the optical densities of pro-MMP-9-digested bands normalized to the total protein content of the corresponding total cell lysate compared with the density of the equivalent background area.

Statistics

TMA results were analyzed with SAS version 8.2 for Windows (SAS Institute, Cary, NC, USA) using the median values of the numbers of positive cells in the entire series as the cutoff value. Frequency tables were analyzed using the chi-square (χ^2) test. Survival between groups was compared using the Kaplan-Meier life-table method and a Cox multivariate proportional hazards model. The log-rank test was used to confirm the robustness of the analysis. The subgroup analyses were performed including the macrophage markers, the subgroup variable, and their interaction in the Cox model. The Mann-Whitney or Kruskal-Wallis tests were applied when suitable. All *P* values are two-sided and are not adjusted for multiple testing. Experimental data were expressed as median \pm SD, unless otherwise indicated. The Kruskal-Wallis test followed by Dunn's post hoc test was employed to calculate statistically significant differences between the CTR and the various conditions, using GraphPad Prism software.

Study approval

Permission to use the tissues from the FinXX study for research purposes was provided by the Finnish Ministry of Social Affairs and Health. The ethics committee at the Helsinki University Central Hospital (Helsinki, Finland) approved the FinXX study and the current study (permission HUS 35/13/03/02/2015). Ethical approval for the use of peripheral blood from healthy donors was obtained from the Nantes University Hospital Ethics Committee. Samples were obtained from the Établissement Français du Sang with informed consent (agreement reference NTS 2000–24, Avenant n°10).

Online supplemental material

A supplemental table (Additional file 1) and supplemental figures (Additional files 2, 3, 4, 5 and 6) are available online.

Results

Clinical significance of TAM numbers and differentiation status in breast cancer patients

To explore the clinical relevance of TAM differentiation in breast cancer patients, we evaluated total TAM number

(CD68), M1 TAM (HLA-DR α) and M2 TAM (CD163) in a large human breast cancer TMA cohort. There was heterogeneity among the patients in the expression levels of the different macrophage markers (Fig. 1). M2 macrophage number, identified as the number of CD163⁺ cells, was strongly associated with fast proliferation (Ki67 positivity >20 %), poor differentiation (grade 3), ER negativity and histological ductal type (Table 2). None of the individual markers (CD68, HLA-DR α or CD163) was on its own strongly correlated with prognosis, recurrence-free survival (RFS) or overall survival (Additional file 2). In the multivariate Cox model for RFS, markers such as Ki67 positivity >20 %, node positivity and primary tumor size >22 mm were strongly significant predictive factors (*p* <0.001 for tumor size and <0.01 for the other factors). In the same model CD163 was a significant factor (*p* = 0.011) together with other model covariates, such as ER negativity (Table 3).

Human breast cancer cells condition ex vivo differentiation and activation of human macrophages

As a proof of concept, we showed that the isolated CD14⁺ cells could be differentiated to M1 (high CD64, high IL-6 secretion), M2a (high CD200R and CD86, low IL-6 and high IL-8 secretion) and M2c macrophages (high CD163, low IL-6 and high IL-10 secretion), respectively, using IFN- γ , IL-4 and IL-10, thus, demonstrating their proven [34] ex vivo plasticity (Figs. 2, 3 and 4 and Additional file 3). Considering M1 differentiation in the presence of IFN- γ , none of the CM affected the expression levels of M1 surface-markers (Additional file 4) nor the secretion profile (data not shown).

CD14⁺ cells differentiated in the presence of MDA-MB231 CM alone yielded an M2 macrophage population (Fig. 2a-e). This result was most obvious in terms of CD86, CD200R and CD163 expression levels (Fig. 2c-e). The differentiation only in the presence of other CM retained the control phenotype features (Fig. 2a-e and Additional file 3).

Macrophages differentiated in the presence of MDA-MB231 CM produced higher amounts of IL-6, IL-8, IL-10 (Fig. 3a-c) and MMP-9 (Fig. 3j-k) than the CTR or other CM. That scenario remained true when the cells were concomitantly treated with IL-4 (Fig. 3d-f) or IL-10 (Fig. 3g-i), except for IL-6 secretion in the latter treatment (Fig. 3g).

MDA-MB231 cells secrete large amounts of M-CSF, skewing macrophages to an M2c-like phenotype

The strong effects of the MDA-MB231 cells led us to inspect all the CM for dissimilarly secreted macrophage-differentiating factors. We saw no differences in terms of IL-10, transforming growth factor (TGF)- β or IL-4 (data not shown), but only MDA-MB231 cells secreted high amounts of M-CSF (Fig. 2f).

CD14⁺ cells differentiated in the presence of IL-10 and MDA-MB231 or T47D CM (Fig. 2g-i and Additional

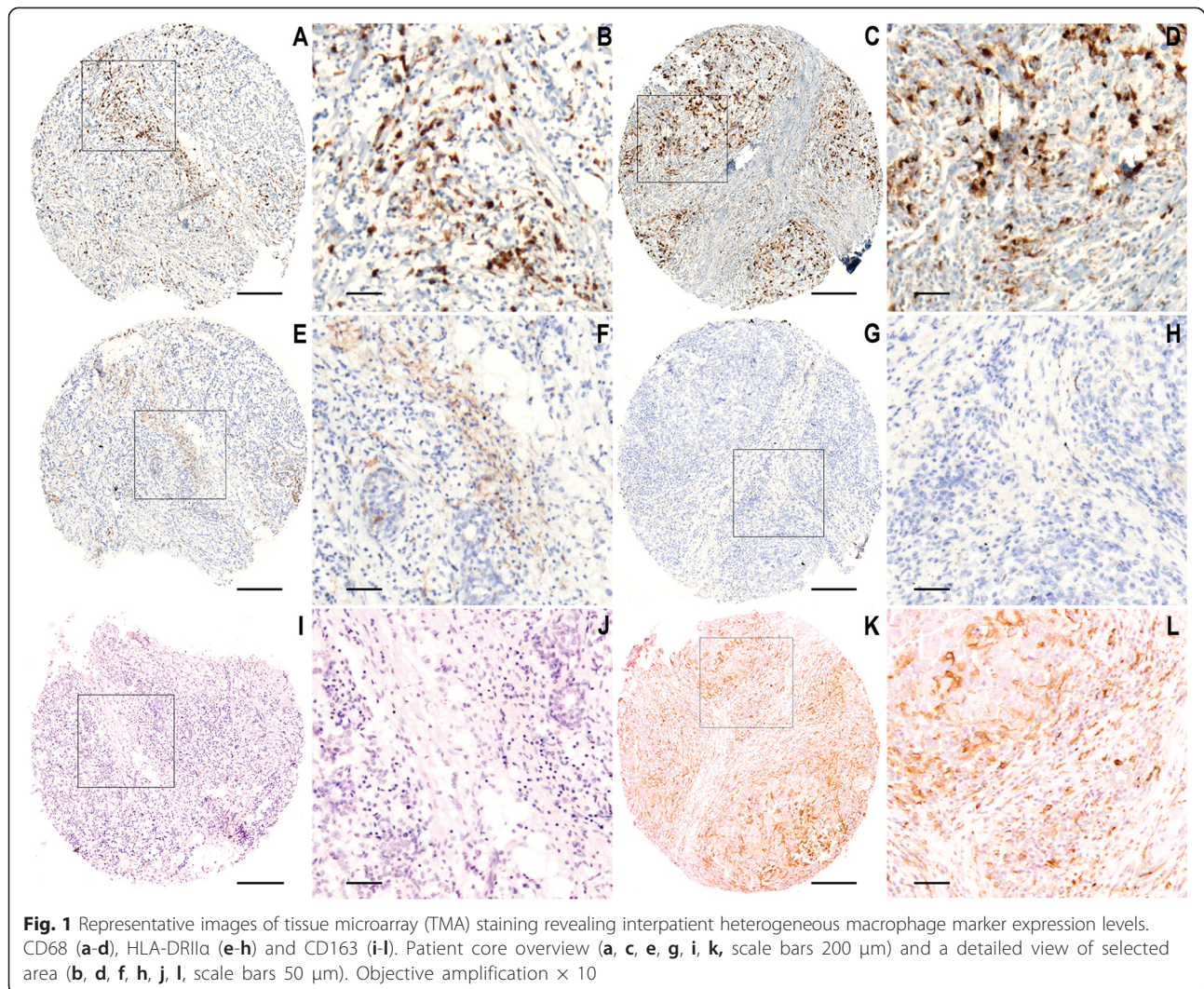


Fig. 1 Representative images of tissue microarray (TMA) staining revealing interpatient heterogeneous macrophage marker expression levels. CD68 (a-d), HLA-DR11a (e-h) and CD163 (i-l). Patient core overview (a, c, e, g, i, k, scale bars 200 μ m) and a detailed view of selected area (b, d, f, h, j, l, scale bars 50 μ m). Objective amplification $\times 10$

file 5) showed a decrease in CD14 expression levels when compared to cells differentiated only with IL-10 (CTR, Fig. 2g). MDA-MB231 CM significantly increased CD163 expression levels (Fig. 2i). The macrophages treated with IL-10 and MDA-MB231 CM secreted more IL-8, IL-10 and MMP-9 than the CTR IL-10-treated macrophages (Fig. 3g-k).

Human breast cancer cells affect M2a macrophage differentiation, rendering macrophages to a mixed M2a/M2c phenotype

When exposed to IL-4, two major macrophage subpopulations arose in all the conditions: CD14^{lo}/CD16^{lo} and CD14^{hi}/CD16^{hi} (Fig. 4). In the presence of breast cancer cell line CM, the relative percentage of each of these subpopulations changed. Instead of a predominance of the CD14^{lo}/CD16^{lo} population (CTR, Fig. 4a), there was a statistically significant inversion toward a predominance of the CD14^{hi}/CD16^{hi} population (Fig. 4a), especially in

the presence of MDA-MB231 ($p < 0.0005$) or T47D CM ($p < 0.05$). MCF-7 CM showed the same trend reaching equilibrium between the two subpopulations not significantly statistically different from the subpopulation distribution in the CTR (IL-4 alone). The detailed analysis of the surface-markers from those subpopulations indicated that MDA-MB231 and T47D CM increase CD14 (Fig. 4b) and decrease CD86 overall expression (Fig. 4j). MDA-MB231 CM increases CD16 (Fig. 4d), CD163 (Fig. 4f) and CD200R expression (Fig. 4h). These fluctuations are mostly due to the CD14^{hi}/CD16^{hi} population (Fig. 4c, e, g, i, k) and the results were statistically significant for the global expression (Fig. 4b, d, f, h, j; $p < 0.05$). Although not statistically significant, MCF-7 CM induced the same trend as T47D CM (Fig. 4a-k).

Only MDA-MB231 CM affected cytokine and MMP-9 secretion, reflecting the exceptionality of this cell line (Fig. 3d-f, j, k). MDA-MB231 CM in the IL-4 condition increased IL-10 secretion (Fig. 3f), and increased IL-6,

Table 2 CD68⁺ and CD163⁺ cell number median values and relevant clinical characteristics

Factor	N = 551	CD68 ⁺ median (range)		<i>P</i> ^a	N = 537	CD163 ⁺ median (range)		<i>P</i> ^a
Histological type								
Ductal	392	418	(0–3634)	<0.001	384	208	(2–1772)	<0.001
Lobular	109	249	(1–3113)		102	106	(3–802)	
Other	50	265	(0–1397)		51	127	(4–1359)	
Histological grade								
Grade 1	46	240	(18–3113)	<0.001	42	125	(5–524)	<0.001
Grade 2	257	337	(0–3634)		250	115	(2–1229)	
Grade 3	246	436	(0–2595)		243	265	(3–1772)	
N.A.	2				2			
ER status								
Positive	396	340	(0–3634)	0.006	385	131	(2–1772)	<0.001
Negative	155	435	(0–2595)		152	268	(6–1743)	
HER-2 status								
Positive	168	363	(9–2673)	0.900	165	221	(2–1772)	0.002
Negative	383	369	(0–3634)		372	148	(3–1359)	
Biological group								
ER+, HER-2–	307	334	(0–3634)	0.023	296	124	(3–1359)	<0.001
ER+, HER-2+	89	343	(12–2673)		89	200	(2–1772)	
ER–, HER-2+	79	424	(9–1306.5)		76	227	(7–1743)	
ER–, HER-2–	76	484	(0–2595)		76	289	(6–1111)	
Ki67								
≤20 %	265	318	(0–3634)	0.002	254	115	(2–1772)	<0.001
>20 %	238	431	(0–2794)		236	263	(3–1743)	
N.A.	48				47			

^aMann-Whitney or Kruskal-Wallis test. ER estrogen receptor, HER-2 human epidermal growth factor receptor 2, N.A. not available

IL-8 (Fig. 3d, e) and MMP-9 secretion (Fig. 3j, k). If compared to MDA-MB231 CM alone, IL-4 combined with MDA-MB231 CM decreased the secretion of IL-6, IL-8 and MMP-9 and increased IL-10 secretion (Fig. 3a-c and Fig. 3j, k). Overall, MDA-MB231 CM in the presence of IL-4 produced a macrophage subpopulation with an intermediate/mixed M2a/M2c phenotype (Additional

file 6), with an abundant production of the immunosuppressive M2c-inducing cytokine IL-10. These macrophages retain matrix-remodeling properties by secreting MMP-9. The possibility that the MCF-7 or T47D CM-induced CD14^{hi}/CD16^{hi} macrophage subpopulations also secrete different levels of cytokines should not be discarded. Those more subtle differences may be masked by the higher titers

Table 3 Independent prognostic factors in Cox multivariate model for recurrence-free survival in years

Variables	Regression coefficient	Standard error	Regression coefficient/ standard error	χ^2	P	Exp (Coef)	95 % CI	
							Lower	Upper
ER ⁺	−0.612	0.252	−2.430	5.903	0.0151	0.542	0.331	0.888
HER-2 ⁺	0.050	0.239	0.211	0.045	0.8326	1.052	0.659	1.679
Ki67 >20%	−0.711	0.269	−2.642	6.981	0.0082	0.491	0.290	0.832
Node positivity	−1.096	0.394	−2.780	7.730	0.0054	0.334	0.154	0.724
Size >22 mm	−0.865	0.237	−3.657	13.372	0.0003	0.421	0.265	0.669
Histological grade 3	−0.071	0.268	−0.266	0.071	0.7899	0.931	0.550	1.575
CD163 >167.5	0.580	0.229	2.531	6.408	0.0114	1.786	1.140	2.798

ER estrogen receptor, HER-2 human epidermal growth factor receptor 2, Coef regression coefficient, χ^2 chi-squared, Exp(Coef) hazard ratio

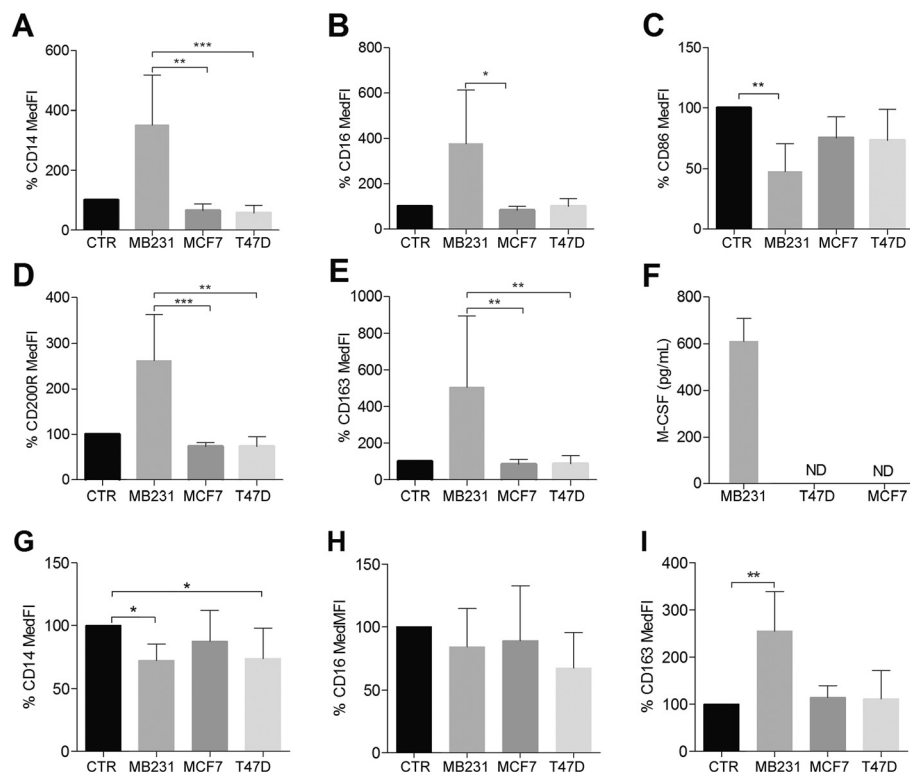


Fig. 2 Flow cytometry analysis of CD14⁺ cells differentiated for 5 days with or without 50 % conditioned media (CM). **a-e** Percentual variation of median fluorescence intensity (MedFI) of CD14, CD16, CD86, CD200R and CD163 compared to control (CTR), n = 5. **f** Monocyte colony stimulating factor (M-CSF) protein levels in breast cancer cell line CM (n = 3). **g-i** Flow cytometry analysis of CD14⁺ cells differentiated in the presence of IL-10 for 5 days with or without 50 % breast cancer cell line CM. Percent variation of MedFI of CD14, CD16 and CD163 compared to CTR (IL-10 alone). Error bars represent + SD, n = 5 *p < 0.05, **p < 0.005 (Kruskal-Wallis analysis followed by Dunn's post hoc test). MB231, MDA-MB231 CM

produced by the MDA-MB231-CM-induced CD14^{hi}/CD16^{hi} subpopulations.

Discussion

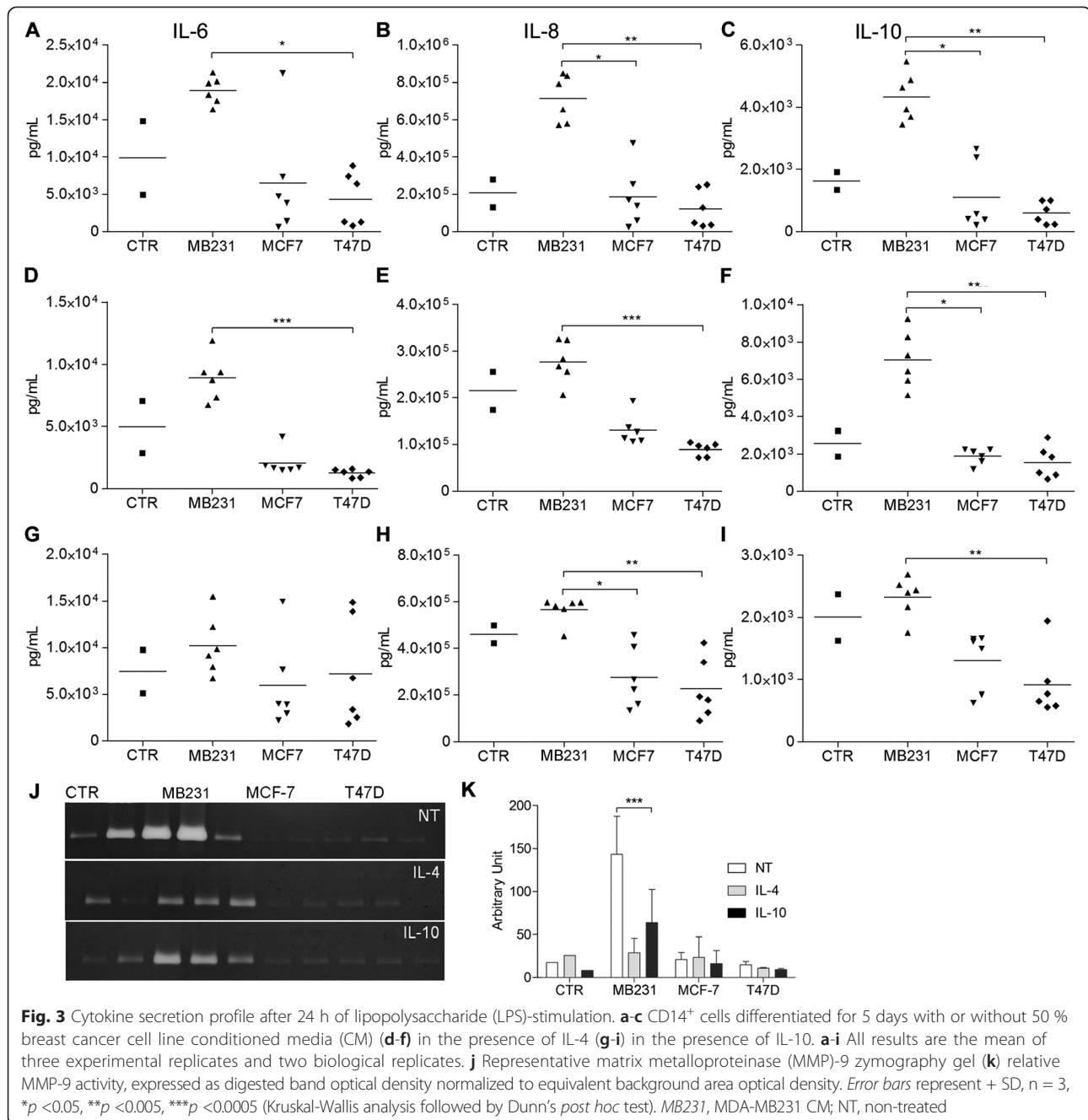
Clinical significance of TAM numbers and differentiation status in breast cancer patients

In this study CD163⁺ cells in primary breast tumor tissue were brought up as a negative prognosis factor for RFS. However, we could not precisely determine which would be the additional interacting factors involved in this effect. It is clear that CD163 correlates with known factors to be associated with a bad prognosis, such as ER negativity, poor differentiation (grade 3) and ductal type (Tables 1 and 2). Previous studies have shown that higher tumor grade [22] and higher Ki67 index are associated with increased CD68⁺ macrophage infiltration in breast tumors [23, 35]. It was suggested that highly proliferative high-grade tumors elicit an active immune response that further supports angiogenesis and tumor growth. Further, these high-grade tumors may secrete higher levels of macrophage-recruiting/modulating cytokines such as M-CSF (ex vivo results, Fig. 2f), IL-10 and/or TGF- β [6], which is in agreement with the high

number of CD163⁺ M2-macrophages. A study exploring stromal gene signatures in DCIS and invasive breast cancer found that higher grade ER-negative and PR-negative tumors are associated with macrophage responses [36]. Macrophage infiltration was present early in the tumor progression at the DCIS stage, and the majority of cases remained positive in matched invasive breast cancer cases, accounting for early macrophage recruitment in breast cancer progression [36]. Although widely accepted as a specific monocyte/macrophage marker, CD163 can also be expressed by immature MDCs, which include myeloid-derived suppressor cells (MDSCs), known to favor tumor progression [24]. Therefore, we cannot exclude the possibility that a percentage of the CD163⁺ cells detected may in fact be MDSCs, which could account for the poor prognostic role of CD163.

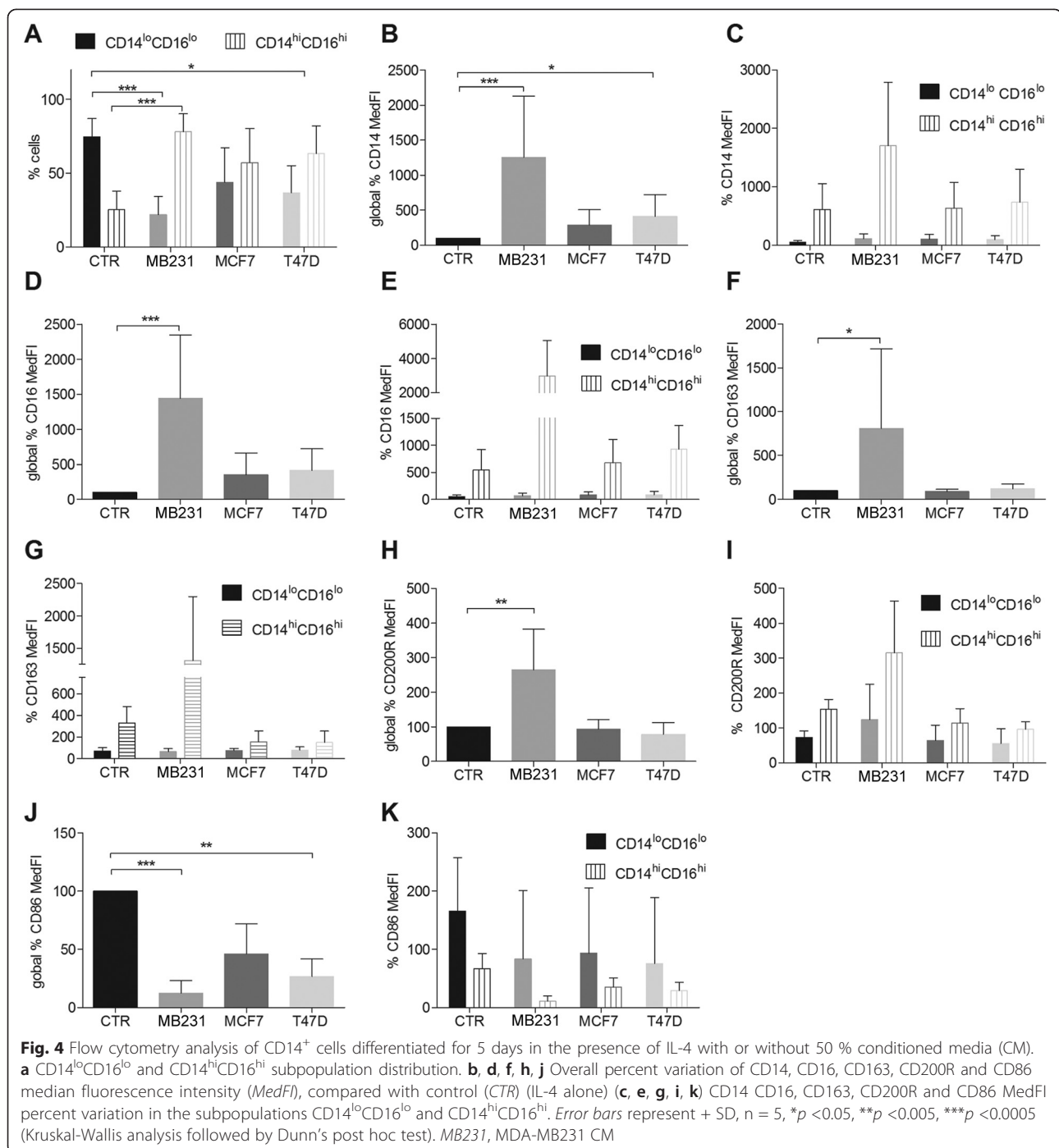
Differential ex vivo conditioning of human macrophage differentiation and activation by different breast cancer cell types

Levano et al. [7] explored the cytokine receptor profile of different breast cancer cell types and found that basal-like cells (e.g., MDA-MB231) express



preferentially granulocyte monocyte colony stimulating factor (GM-CSF), hepatocyte growth factor receptor (HGFR, also known as c-MET), CD44, epithelial growth factor receptor (EGFR), transforming growth factor receptor 2 (TGFR2) and oncostatin M receptor (OSMR). Luminal-type breast cancer cells (e.g., MCF-7 and T47D) express RET (a proto-oncogene which encodes for a receptor tyrosine kinase for members of the glial cell line-derived neurotrophic factor) [7] and leukemia inhibitory factor (LIF) [37]. This suggests that TAMs have a different influence depending on the tumor subtype, as breast

cancer cells will have different receptors for TAM-derived factors [7]. Further, mesenchymal or epithelial-like breast cancer cells respond to or influence TAMs differently. It has been shown that mesenchymal-like breast cancer cells secrete GM-CSF to activate macrophages to a CCL18-expressing TAM-like phenotype and, reciprocally, these TAM-like macrophages sustain the EMT of cancer cells [38]. These findings are not totally unexpected when considering the role of macrophages in mammary gland development during embryogenesis, puberty, pregnancy and lactation. Macrophages in the



mammary gland were proven essential in supporting and activating mammary stem cells necessary for normal morphogenesis [39], branching [9] and in the postpartum-related influx of M2 macrophages [10]. All these developmental processes occur via mechanisms similar to molecular cancer mechanisms, such as vascular endothelial growth factor A (VEGF-A)-stimulated angiogenesis. Additionally, TAMs secrete EGF, TNF- α , VEGF and basic fibroblast growth factor (bFGF) and have

reduced antigen presenting ability. Also the release of IL-10 by both tumor cells and TAMs immunosuppresses cytotoxic T-lymphocytes (CTLs) [9].

A study of murine and human macrophage polarization profiles showed that M-CSF-differentiated human macrophages are pro-M2, meaning that LPS or IFN- γ stimulation can still induce an M1 response. However, if stimulated with IL-4 or IL-10 they become more M2 type than the basal macrophages [40]. M-CSF induces CD163

expression in macrophages which, when LPS-stimulated, secrete higher levels of IL-12p40, TNF- α and IL-6 [34]. Our MDA-MB231 cells produce copious amounts of M-CSF (Fig. 2f), in levels similar to clinical samples and MDA-MB231 cells, as reported previously [6]. Similarly, the monocyte shift toward M2/CD163⁺ TAMs by increased levels of M-CSF has been seen in other tumor types such as glioma [41], clear cell renal carcinoma [42], ovarian carcinoma [43] and a mouse model of osteosarcoma [44]. In those tumor types, the elevated M-CSF and CD163 expression correlates with higher tumor grade [41, 42].

CD163 is a monocyte/macrophage-restricted scavenger receptor. It clears hemoglobin/haptoglobin complexes, hence protecting tissues from hemoglobin-induced oxidative damage [45]. It was recently shown that breast cancer CD163⁺ TAMs correlate with Wnt5a expression, the latter factor being responsible for macrophage reprogramming to an anti-inflammatory M2 status. The same group has reported that Wnt5a acts as a feedback antagonist of toll-like receptor (TLR) signaling, inducing IL-10 secretion [26]. Our results fit this mechanism well, as MDA-MB231 CM induced CD163 expression, a feature of M2c TAMs. This could indicate a parallel increase in Wnt5a that inhibits TLR response and increases IL-10 secretion upon LPS stimulation (Fig. 3c, f, i).

As previously discussed, the M2c-boosted differentiation by MDA-MB231-secreted products may have consequences in terms of microenvironment-aided tumor progression via immunosuppressive, matrix remodeling and scavenging TAM functions. These effects may impair an effective immune tumor rejection as our in vitro findings with murine macrophages and breast cancer cell line CM indicate [46].

The overall decrease of CD86 expression in M2a macrophages by breast cancer CM may contribute to immunosuppressive, tumor-promoting behavior. CD86, also known as B7-2, is a type I transmembrane protein of the immunoglobulin superfamily. It is a co-stimulatory molecule expressed by antigen-presenting cells such as dendritic cells and macrophages. Its binding to CD28 on naïve T-cells is essential for Th2 differentiation, cytokine secretion and induction of effector function [47].

In our system, M2a macrophages differentiated in the presence of IL-4 and MDA-MB231 CM had the potential for increased CD200R signaling which in vivo would indicate an immunosuppressive tumor-promoting environment. CD200R is a myeloid receptor expressed on macrophages, granulocytes, dendritic cells and NK (natural killer) cells [48]. CD200R signaling is known to increase the immune activation threshold, being physiologically relevant in restraining inflammation [48]. CD200 ligand interaction with its receptor CD200R on macrophages decreases TNF- α and IFN- γ secretion [49]. CD200 is expressed by cancer cells and other cell types

like mesenchymal stem cells, thymocytes, activated T cells, B cells and dendritic cells. Studies in different tumor types, including breast cancer, showed that CD200-CD200R interaction delivers an immunosuppressive signal. This signal directly decreases inflammatory cytokine secretion by macrophages, and indirectly increases regulatory T cells (Treg) and decreases effector T-cell numbers, thereby promoting tumor progression by immune evasion [50].

Limitations of the study

In the TMA analysis the median of positive cells for each marker in all samples was used as a cutoff value and analysis of normal breast tissue - probably carrying resting macrophages as a healthy baseline control - could not be included. However, our study brought up differences in TAM activation status between patients relevant to the disease outcome. Larger studies are thus justified to ascertain the exact role of M2 macrophages in disease progression.

In the ex vivo macrophage differentiation studies, the extrapolation of the MDA-MB231 CM effects on macrophage differentiation to the clinical situation of triple-negative breast cancer patients should be made with care. MDA-MB231 is an aggressive model cell line, relevant in the field as it is the parental cell line for several metastatic sub-clones widely used in experiments in vivo [51–53]. The MDA-MB231 cell line belongs to the mesenchymal-like subtype, while cancer cells from triple-negative breast tumors, which can be of seven different subtypes, have phenotypic diversity from epithelial to mesenchymal characters [54]. However, we think our study remains relevant as it shows that breast cancer cells, regardless of their hormone receptor status and epithelial/mesenchymal nature, secrete factors that educate macrophages toward M2 differentiation. The most aggressive one, MDA-MB231, did it most effectively. Further studies are needed to unveil the factors responsible for the effects seen. M-CSF appears to be a key factor in M2 TAM differentiation, as shown by others [6, 55], but as breast cancer cell lines (MCF-7 and T47D) that do not produce M-CSF also affected the M2 phenotype, inducing M2a differentiation, we think there are other relevant M2 skewing factors, which our work cannot address. The discovery of such factors is of utmost relevance, and calls for further studies.

Conclusions

This study combines several lines of evidence for the importance of TAM polarization status in breast cancer progression. For the first time, it is clear that CD163⁺ TAMs associate with other known prognostic factors like fast proliferation, poor differentiation and ER-negativity. CD163⁺ TAMs may be associated with a decrease in RFS according

to the multivariate Cox model. The presented *ex vivo* results are to our knowledge the first demonstrating the modulation of macrophage differentiation solely by breast cancer cell-secreted factors, providing evidence for the mechanisms of breast cancer macrophage education behind clinical findings. Particularly, the mesenchymal-type cell line MDA-MB231 polarizes macrophages toward a mixed M2a/M2c status. It is therefore rational to venture that the screening of TAM activation in breast cancer patients could be useful in predicting patients with a high metastatic risk. The knowledge of TAM activation status may allow the therapeutic targeting of TAMs, once TAMs targeting/modulating agents pass clinical trials and become widely available. These include bisphosphonates [56]; M-CSF and M-CSFR inhibitors and targeting antibodies [57], NCT01316822, NCT01444404; anti-macrophage migration inhibitory factor, NCT01765790 and L-MTP-PE, NCT00631631. There is a scarcity of therapeutic options for patients with triple-negative metastatic breast cancer, and growing resistance to the available options biased by a continuous focus on cancer cell targets, which are by nature genetically unstable and prone to mutations. Approaches such as ours fuel a necessary paradigm change, contributing to the notion that the immunological tumor microenvironment should be taken into account in the development of new multi-target cancer therapies.

Additional files

Additional file 1: Immunohistochemical analysis conditions. (PDF 273 kb)

Additional file 2: Tissue microarray (TMA) analysis of recurrence-free survival and overall survival curves related to the macrophage markers A CD68 B CD163 and C HLA-DR1α. (PDF 22622 kb)

Additional file 3: Flow cytometry analysis of CD14⁺ cells differentiated for 5 days with or without 50 % conditioned media (CM), IFN-γ, IL-4 and IL-10 A mean fluorescence intensity (MFI) of CD14 B CD16 C CD64 D CD163 E CD86 and F CD200R, normalized to MFI of unstained cells; n = 3, ***p < 0.0005. (PDF 1833 kb)

Additional file 4: Flow cytometry analysis of CD14⁺ cells differentiated for 5 days in the presence of IFN-γ with or without 50 % conditioned media (CM) A mean fluorescence intensity (MFI) of CD14 B CD16 and C CD64 normalized to MFI of unstained cells; n = 3. (PDF 2112 kb)

Additional file 5: Representative flow cytometry dot plot of IL-10 macrophages A human macrophages in the presence of IL-10 with or without breast cancer cell line conditioned media (CM), detected with antibodies against CD14, CD16 and CD163 B mean fluorescence intensity (MFI) of the analyzed surface-markers. (PDF 18647 kb)

Additional file 6: Representative flow cytometry dot plot of IL-4 macrophages A human macrophages in the presence of IL-4 with or without breast cancer cell line conditioned media (CM), detected with antibodies against CD14, CD16, CD163, CD200R and CD86 B mean fluorescence intensity (MFI) of the analyzed surface-markers. (PDF 2715 kb)

Abbreviations

ATCC: American Type Culture Collection; bFGF: basic fibroblast growth factor; BSA: bovine serum albumin; CM: conditioned media; CTC: circulating tumor

cell; CTLs: cytotoxic T-lymphocytes; CTR: control; DAB: 3,3'-Diaminobenzidine; DCIS: ductal carcinoma *in situ*; DTC: disseminating tumor cell; EGF: epidermal growth factor; EGFR: epidermal growth factor receptor; ELISA: enzyme-linked immunosorbent assay; EMT: epithelial to mesenchymal transition; ER: estrogen receptor; FBS: fetal bovine serum; GM-CSF: granulocyte monocyte colony stimulating factor; HER-2: human epidermal growth factor receptor 2; HGFR: hepatocyte growth factor receptor; IFN-γ: interferon γ; kDa: kiloDaltons; LIF: leukemia inhibitory factor; LPS: lipopolysaccharide; M-CSF: monocyte colony stimulating factor; M-CSFR: monocyte colony stimulating factor receptor; MDCs: myeloid-derived cells; MDSCs: myeloid-derived suppressor cells; MedFl: median fluorescence intensity; MMP-9: matrix metalloproteinase 9; MMPs: matrix metalloproteinases; NK: natural killer; OSMR: oncostatin M receptor; PBMCs: peripheral blood mononuclear cells; PBS: phosphate-buffered saline; PR: progesterone receptor; RET: proto-oncogene, which encodes for a receptor tyrosine kinase for members of the glial cell line-derived neurotrophic factor; RFS: recurrence-free survival; RNS: reactive nitrogen species; ROS: reactive oxygen species; TAMs: tumor-associated macrophages; TGFβ2: transforming growth factor receptor 2; TGF-β: transforming growth factor β; TLR: toll-like receptor; TMA: tissue microarray; TNF-α: tumor necrosis factor α; Treg: regulatory T-cells; VCAM1: vascular cell adhesion molecule 1; VEGF-A: vascular endothelial growth factor A.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

SS conceived and designed the study, developed the methodology, acquired, analyzed and interpreted the data and wrote and revised the manuscript. RB acquired the flow cytometry data. ML, PK and JS provided technical support in the TMA analysis. SL and OT participated in the TMA study and performed its statistical analysis. HJ participated in the TMA study, acquiring, analyzing, and interpreting the data. DH participated in the study conception and design particularly in supervising the *ex vivo* macrophage differentiation studies. JuM supervised and coordinated the study. JM conceived, designed, supervised and participated in the manuscript writing and revision. All authors read, revised critically for important intellectual content and approved the final manuscript.

Acknowledgements

The current research was funded by the Seventh Framework Programme [FP7/2007-2013] under grant agreement no.264817 – BONE-NET and by the Academy of Finland, decision numbers 132389 and 250917.

Author details

¹School of Pharmacy, Faculty of Health Sciences, University of Eastern Finland, Yliopistonranta 1C, P.O. Box 1627, FI-70211 Kuopio, Finland. ²INSERM, UMR957, Equipe LIGUE 2012, Nantes F-44035, France. ³Université de Nantes, Nantes atlantique universités, Laboratoire de Physiopathologie de la Résorption Osseuse et Thérapie des Tumeurs Osseuses Primitives, Nantes F-44035, France. ⁴CHU de Nantes, Nantes F-44035, France. ⁵Institute of Biomedicine, Department of Cell Biology and Anatomy, University of Turku, Turku, Finland. ⁶Cell Imaging Core, Turku Centre for Biotechnology, University of Turku, and Åbo Akademi University, Turku, Finland. ⁷Medical School, University of Tampere and Department of Oncology Tampere University Hospital, Tampere, Finland. ⁸Laboratory of Molecular Oncology, Biomedicum Helsinki, University of Helsinki, Helsinki, Finland. ⁹Department of Pathology, Haartman Institute, University of Helsinki and HUSLAB, Helsinki, Finland. ¹⁰Comprehensive Cancer Center, Helsinki University Hospital, and Department of Oncology, University of Helsinki, Helsinki, Finland.

Received: 24 April 2015 Accepted: 21 July 2015

Published online: 05 August 2015

References

- Chambers AF, Groom AC, MacDonald IC. Dissemination and growth of cancer cells in metastatic sites. *Nat Rev Cancer*. 2002;2:563–72.
- Bingle L, Brown NJ, Lewis CE. The role of tumour-associated macrophages in tumour progression: implications for new anticancer therapies. *J Pathol*. 2002;196:254–65.
- Pollard JW. Macrophages define the invasive microenvironment in breast cancer. *J Leukocyte Biol*. 2008;84:623–30.

4. Mosser DM, Edwards JP. Exploring the full spectrum of macrophage activation. *Nat Rev Immunol*. 2008;8:958–69.
5. Ambarus CA, Krausz S, van Eijk M, Hamann J, Radstake TR, Reedquist KA, et al. Systematic validation of specific phenotypic markers for in vitro polarized human macrophages. *J Immunol Methods*. 2012;375:196–206.
6. Grugan KD, McCabe FL, Kinder M, Greenplate AR, Harman BC, Ekert JE, et al. Tumor-associated macrophages promote invasion while retaining Fc-dependent anti-tumor function. *J Immunol*. 2012;189:5457–66.
7. Levano KS, Jung EH, Kenny PA. Breast cancer subtypes express distinct receptor repertoires for tumor-associated macrophage derived cytokines. *Biochem Biophys Res Commun*. 2011;411:107–10.
8. Mantovani A, Sozzani S, Locati M, Allavena P, Sica A. Macrophage polarization: Tumor-associated macrophages as a paradigm for polarized M2 mononuclear phagocytes. *Trends Immunol*. 2002;23:549–55.
9. Gyorki D, Asselin-Labat M, van Rooijen N, Lindeman G, Visvader J. Resident macrophages influence stem cell activity in the mammary gland. *Breast Cancer Res*. 2009;11:R62.
10. O'Brien J, Martinson H, Durand-Rougely C, Schedin P. Macrophages are crucial for epithelial cell death and adipocyte repopulation during mammary gland involution. *Development*. 2012;139:269–75.
11. Qian B, Li J, Zhang H, Kitamura T, Zhang J, Campion LR, et al. CCL2 recruits inflammatory monocytes to facilitate breast-tumour metastasis. *Nature*. 2011;475:222–5.
12. Wyckoff J, Wang W, Lin EY, Wang Y, Pixley F, Stanley ER, et al. A paracrine loop between tumor cells and macrophages is required for tumor cell migration in mammary tumors. *Cancer Res*. 2004;64:7022–9.
13. Chen Q, Zhang XH, Massagué J. Macrophage binding to receptor VCAM-1 transmits survival signals in breast cancer cells that invade the lungs. *Cancer Cell*. 2011;20:538–49.
14. Casazza A, Laoui D, Wenes M, Rizzolio S, Bassani N, Mambretti M, et al. Impeding macrophage entry into hypoxic tumor areas by Sema3A/Nrp1 signaling blockade inhibits angiogenesis and restores antitumor immunity. *Cancer Cell*. 2013;24:695–709.
15. Movahedi K, Laoui D, Gysmans C, Baeten M, Stangé G, Van Bossche JD, et al. Different tumor microenvironments contain functionally distinct subsets of macrophages derived from Ly6C(high) monocytes. *Cancer Res*. 2010;70:5728–39.
16. Biswas SK, Sica A, Lewis CE. Plasticity of macrophage function during tumor progression: Regulation by distinct molecular mechanisms. *J Immunol*. 2008;180:2011–7.
17. Ohri CM, Shikotra A, Green RH, Waller DA, Bradding P. Macrophages within NSCLC tumour islets are predominantly of a cytotoxic M1 phenotype associated with extended survival. *Eur Respir J*. 2009;33:118–26.
18. Forsell J, Öberg Å, Henriksson ML, Stenling R, Jung A, Palmqvist R. High macrophage infiltration along the tumor front correlates with improved survival in colon cancer. *Clin Cancer Res*. 2007;13:1472–9.
19. Ohno S, Inagawa H, Dhar DK, Fujii T, Ueda S, Tachibana M, et al. The degree of macrophage infiltration into the cancer cell nest is a significant predictor of survival in gastric cancer patients. *Anticancer Res*. 2003;23:5015–22.
20. Hussein MR, Hassan HI. Analysis of the mononuclear inflammatory cell infiltrate in the normal breast, benign proliferative breast disease, in situ and infiltrating ductal breast carcinomas: preliminary observations. *J Clin Pathol*. 2006;59:972–7.
21. Volodko N, Reiner A, Rudas M, Jakesz R. Tumour-associated macrophages in breast cancer and their prognostic correlations. *Breast*. 1998;7:99–105.
22. Mahmoud SMA, Lee AHS, Paish EC, Macmillan RD, Ellis IO, Green AR. Tumour-infiltrating macrophages and clinical outcome in breast cancer. *J Clin Pathol*. 2012;65:159–63.
23. Al Murri AM, Hilmy M, Bell J, Wilson C, McNicol AM, Lannigan A, et al. The relationship between the systemic inflammatory response, tumour proliferative activity, T-lymphocytic and macrophage infiltration, microvessel density and survival in patients with primary operable breast cancer. *Br J Cancer*. 2008;99:1013–9.
24. Medrek C, Ponten F, Jirstrom K, Leandersson K. The presence of tumor associated macrophages in tumor stroma as a prognostic marker for breast cancer patients. *BMC Cancer*. 2012;12:306–2407–12–306.
25. Leek RD, Lewis CE, Whitehouse R, Greenall M, Clarke J, Harris AL. Association of macrophage infiltration with angiogenesis and prognosis in invasive breast carcinoma. *Cancer Res*. 1996;56:4625–9.
26. Bergenfelz C, Medrek C, Ekström E, Jirstrom K, Janols H, Wullt M, et al. Wnt5a induces a tolerogenic phenotype of macrophages in sepsis and breast cancer patients. *J Immunol*. 2012;188:5448–58.
27. Król M, Mucha J, Majchrzak K, Homa A, Bulkowska M, Majewska A, et al. Macrophages mediate a switch between canonical and non-canonical wnt pathways in canine mammary tumors. *PLoS ONE*. 2014;9:e83995.
28. Ojalvo LS, Whittaker CA, Condeelis JS, Pollard JW. Gene expression analysis of macrophages that facilitate tumor invasion supports a role for Wnt-signaling in mediating their activity in primary mammary tumors. *J Immunol*. 2010;184:702–12.
29. Joensuu H, Kellokumpu-Lehtinen P, Huovinen R, Jukkola-Vuorinen A, Tanner M, Asola R, et al. Adjuvant capecitabine in combination with docetaxel and cyclophosphamide plus epirubicin for breast cancer: an open-label, randomised controlled trial. *Lancet Oncol*. 2009;10:1145–51.
30. Buddingh EP, Kuijper ML, Duim RAJ, Bürger H, Agelopoulos K, Myklebost O, et al. Tumor-infiltrating macrophages are associated with metastasis suppression in high-grade osteosarcoma: A rationale for treatment with macrophage activating agents. *Clin Cancer Res*. 2011;17:2110–9.
31. Ambarus CA, Santegoets KC, van Bon L, Wenink MH, Tak PP, Radstake TR, et al. Soluble immune complexes shift the TLR-induced cytokine production of distinct polarized human macrophage subsets towards IL-10. *PLoS One*. 2012;7:e35994.
32. Guihard P, Danger Y, Brounais B, David E, Brion R, Delecros J, et al. Induction of osteogenesis in mesenchymal stem cells by activated monocytes/macrophages depends on oncostatin M signaling. *Stem Cells*. 2012;30:762–72.
33. Damiens C, Fortun Y, Charrier C, Heymann D, Padrines M. Modulation by soluble factors of gelatinase activities released by osteoblastic cells. *Cytokine*. 2000;12:1727–31.
34. Vogel DYS, Glim JE, Stavenuiter AWD, Breur M, Heijnen P, Amor S, et al. Human macrophage polarization in vitro: Maturation and activation methods compared. *Immunobiology*. 2014;219:695–703.
35. Lin EY, Pollard JW. Tumor-associated macrophages press the angiogenic switch in breast cancer. *Cancer Res*. 2007;67:5064–6.
36. Sharma M, Beck AH, Webster JA, Espinosa I, Montgomery K, Varma S, et al. Analysis of stromal signatures in the tumor microenvironment of ductal carcinoma in situ. *Breast Cancer Res Treat*. 2010;123:397–404.
37. Estrov Z, Samal B, Lapushin R, Kellokumpu-Lehtinen P, Sahin AA, Kurzrock R, et al. Leukemia inhibitory factor binds to human breast cancer cells and stimulates their proliferation. *J Interferon Cytokine Res*. 1995;15:905–13.
38. Su S, Liu Q, Chen J, Chen J, He C, et al. A Positive feedback loop between mesenchymal-like cancer cells and macrophages is essential to breast cancer metastasis. *Cancer Cell*. 2014;25:605–20.
39. Kellokumpu-Lehtinen P, Johansson RM, Pelliniemi LJ. Ultrastructure of human fetal mammary gland. *Anat Rec*. 1987;218:66–72.
40. Jaguin M, Houlbert N, Fardel O, Lecureur V. Polarization profiles of human M-CSF-generated macrophages and comparison of M1-markers in classically activated macrophages from GM-CSF and M-CSF origin. *Cell Immunol*. 2013;281:51–61.
41. Komohara Y, Ohnishi K, Kuratsu J, Takeya M. Possible involvement of the M2 anti-inflammatory macrophage phenotype in growth of human gliomas. *J Pathol*. 2008;216:15–24.
42. Komohara Y, Hasita H, Ohnishi K, Fujiwara Y, Suzu S, Eto M, et al. Macrophage infiltration and its prognostic relevance in clear cell renal cell carcinoma. *Cancer Sci*. 2011;102:1424–31.
43. Duluc D, Delneste Y, Tan F, Moles MP, Grimaud L, Lenoir J, et al. Tumor-associated leukemia inhibitory factor and IL-6 skew monocyte differentiation into tumor-associated macrophage-like cells. *Blood*. 2007;110:4319–30.
44. Ségalliny AI, Mohamadi A, Dizier B, Lokajczyk A, Brion R, Lanel R, et al. Interleukin-34 promotes tumor progression and metastatic process in osteosarcoma through induction of angiogenesis and macrophage recruitment. *Int J of Cancer*. 2015;137:73–85.
45. Schae CA, Vellelian F, Imhof A, Schoedon G, Schae DJ. CD163-expressing monocytes constitute an endotoxin-sensitive Hb clearance compartment within the vascular system. *J Leukoc Biol*. 2007;82:106–10.
46. Sousa S, Auriola S, Monkkonen J, Maatta J. Liposome encapsulated zoledronate favours M1-like behaviour in murine macrophages cultured with soluble factors from breast cancer cells. *BMC Cancer*. 2015;15:4.

47. Santin AD, Hermonat PL, Ravaggi A, Chiriva-Internati M, Cannon MJ, Hiserodt JC, et al. Expression of surface antigens during the differentiation of human dendritic cells vs macrophages from blood monocytes in vitro. *Immunobiology*. 1999;200:187–204.
48. Rygiel TP, Meyaard L. CD200R signaling in tumor tolerance and inflammation: A tricky balance. *Curr Opin Immunol*. 2012;24:233–8.
49. Pietilä M, Lehtonen S, Tuovinen E, Lähteenmäki K, Laitinen S, Leskelä HV, et al. CD200 positive human mesenchymal stem cells suppress TNF- α secretion from CD200 receptor positive macrophage-like cells. *PLoS ONE*. 2012;7:e31671.
50. Gorczynski RM, Chen Z, Khatri I, Podnos A, Yu K. Cure of metastatic growth of EMT6 tumor cells in mice following manipulation of CD200:CD200R signaling. *Breast Cancer Res Treat*. 2013;142:271–82.
51. Peyruchaud O, Winding B, Pécheur I, Serre C, Delmas P, Clézardin P. Early detection of bone metastases in a murine model using fluorescent human breast cancer cells: application to the Use of the bisphosphonate zoledronic acid in the treatment of osteolytic lesions. *J Bone Miner Res*. 2001;16:2027–34.
52. Kang Y, Siegel PM, Shu W, Drobnjak M, Kakonen SM, Cordon-Cardo C, et al. A multigenic program mediating breast cancer metastasis to bone. *Cancer Cell*. 2003;3:537–49.
53. Minn AJ, Gupta GP, Siegel PM, Bos PD, Shu W, Giri DD, et al. Genes that mediate breast cancer metastasis to lung. *Nature*. 2005;436:518–24.
54. Lehmann BD, Bauer JA, Chen X, Sanders ME, Chakravarthy AB, Shyr Y. Identification of human triple-negative breast cancer subtypes and preclinical models for selection of targeted therapies. *J Clin Invest*. 2011;121:2750–60.
55. Solinas G, Schiarea S, Liguori M, Fabbri M, Pesce S, Zammataro L, et al. Tumor-conditioned macrophages secrete migration-stimulating factor: A new marker for M2-polarization, influencing tumor cell motility. *J Immunol*. 2010;185:642–52.
56. Gnant M, Clézardin P. Direct and indirect anticancer activity of bisphosphonates: A brief review of published literature. *Cancer Treat Rev*. 2012;38:407–15.
57. Ségalin A, Tellez-Gabriel M, Heymann M, Heymann D. Receptor tyrosine kinases: Characterisation, mechanism of action and therapeutic interests for bone cancers. *J Bone Oncol*. 2015;4:1–12.

Submit your next manuscript to BioMed Central and take full advantage of:

- Convenient online submission
- Thorough peer review
- No space constraints or color figure charges
- Immediate publication on acceptance
- Inclusion in PubMed, CAS, Scopus and Google Scholar
- Research which is freely available for redistribution

Submit your manuscript at
www.biomedcentral.com/submit

