The concept of metronomic chemotherapy (Browder et al., 2000; Klement et al., 2000; Pasquier et al., 2010; Bocci and Francia, 2014) is now undergoing phase III clinical trial evaluation. In contrast to conventional chemotherapy, which is often administered at maximum tolerated doses (MTDs) separated by long break periods generally ranging from 2 to 3 wk to allow recovery from the toxic side effects, metronomic chemotherapy usually involves the close regular (even daily) administration of chemotherapy drugs administered at lower, less toxic doses per treatment. However, the cumulative dose over time may in fact be similar to the conventional MTD chemotherapy (Kerbel and Grothey, 2015) and is designed with the intention of being less toxic, but also to induce other biological mechanisms that can inhibit tumor growth and metastasis (Pasquier et al., 2010; Bocci and Francia, 2014). These additional mechanisms essentially convert a cytotoxic chemotherapy to the equivalent of a biological cytostatic therapeutic; the major ones implicated thus far mainly involve inhibition of angiogenesis (Browder et al., 2000; Klement et al., 2000), stimulation of the immune system (Ghirighelli et al., 2007; Shaked et al., 2016), and also, to some extent, direct tumor cell killing (Folkins et al., 2009), as summarized in our first figure. There have been a few preliminary studies showing that metronomic chemotherapy may actually target the putative tumor-initiating cell (TIC) subpopulation (Folkins et al., 2009; Vives et al., 2013) in contrast to MTD chemotherapy, which is known to spare and even increase this subpopulation.

The era of metronomic chemotherapy began in 2000 (Browder et al., 2000) and has progressed somewhat slowly, at least from a clinical development perspective, since then. Thus far, the most notable successes, or potential promise, would appear to be its use as a long-term maintenance therapy after patients have been treated upfront with conventional MTD chemotherapy, either with or without a biological agent such as an antiangiogenic drug. Metronomic chemotherapy has also been evaluated in phase III clinical trials in the adjuvant setting of early-stage as well as late-stage disease in breast cancer (Munzone and Colleoni, 2015; Colleoni et al., 2016) and in late-stage metastatic colorectal cancer (Kerbel and Grothey, 2015; Simkens et al., 2015).

In this issue, Chan et al. undertook several parallel approaches to implicate carcinoma-associated fibroblasts (CAFs), NF-κB/STAT1 activation, carcinoma cell CXCR2 signaling, and impact on TICs in the therapy outcomes mediated by either conventional MTD or metronomic chemotherapy (see diagram in our second figure). First, they studied the interaction of human primary CAFs with human tumor cells under 3D cell co-culture conditions (Chan et al., 2016). The CAFs were treated with various concentrations of three well known chemotherapy drugs (doxorubicin, paclitaxel, and the active metabolite of cyclophosphamide), all of which are used to treat breast cancer patients. When exposed to MTD-like concentrations, CAFs significantly enhanced...
Differential effect of MTD versus low-dose metronomic (LDM) chemotherapy on CAF activation. In desmoplastic tumors, CAFs are especially abundant. Conventional MTD chemotherapy regimens can activate CAFs through increased activity of NF-κB and STAT1 transcription factors, which in turn causes the expression and release of ELR+ motif chemokines. These chemokines can bind to the chemokine receptor, CXCR2, expressed by tumor cells, causing a phenotypic conversion to TICs and increasing their relative numbers, thus paradoxically promoting malignant tumor progression. In contrast, by using an LDM chemotherapy regimen, CAFs are not activated or exhibit limited activation. Hence, a therapy-induced increase in TICs is not observed, while tumor growth is inhibited.

or even nullify the overall antitumor efficacy of MTD chemotherapy (summarized in Shaked [2016]).

In contrast to the aforementioned undesirable effects of MTD chemotherapy on CAFs and the impact they can have on the TIC subpopulation and tumor growth, administering the same drugs in lower concentrations in vitro or lower doses in vivo—but at cumulatively similar doses in vivo to the MTD schedule—prevented these MTD effects. This could explain why, counterintuitively, lower doses of chemotherapy, at least if administered in a long-term metronomic-like regimen, may cause antitumor effects that are similar or even superior compared with conventional MTD chemotherapy (Browder et al., 2000; Munoz et al., 2006). The effects reported by Chan et al. (2016) on carcinoma stromal fibroblast may provide metronomic chemotherapy regimens with a particular advantage when treating desmoplastic tumors that have a high CAF content, such as certain types of breast cancer or pancreatic cancer.

These findings are important in part because they impact so many critical areas of tumor biology and therapy. Moreover, they serve to link different cellular elements of the tumor microenvironment and add to the multi-modality mechanisms ascribed to metronomic chemotherapy (Pasquier et al., 2010). What remains less clear is how the results can be translated to the clinic and improve the prospects of metronomic chemotherapy, at least for desmoplastic types of cancer. Can the MTD chemotherapy activation effects on stromal cells be reversed by follow-up metronomic chemotherapy, e.g., using maintenance chemotherapy? The problem remains how to select an optimal “low” metronomic dose as well as treatment schedule for metronomic chemotherapy and the lack of any predictive biomarker to select patients likely to benefit from receiving metronomic chemotherapy. Despite these remaining questions, the results of Chan et al. (2016) provide an additional rationale for the clinical development and assessment of metronomic chemotherapy treatments, particularly as possible maintenance therapies for desmoplastic cancers.

REFERENCES


