ORIGINAL ARTICLE

Hyaluronan impairs vascular function and drug delivery in a mouse model of pancreatic cancer

Michael A Jacobetz,1 Derek S Chan,1,2 Albrecht Neesse,1 Tashinga E Bapiro,1,2 Natalie Cook,1,2 Kristopher K Frese,1 Christine Feig,1 Tomoaki Nakagawa,1 Meredith E Caldwell,1 Heather I Zecchini,1 Martijn P Lolkema,1 Ping Jiang,3 Anne Kulti,3 Curtis B Thompson,3 Daniel C Maneval,3 Duncan I Jodrell,1 Gregory I Frost,3 H M Shepard,3 Jeremy N Skepper,4 David A Tuveson1,2

ABSTRACT

Objective Pancreatic ductal adenocarcinoma (PDA) is characterised by stromal desmoplasia and vascular dysfunction, which critically impair drug delivery. This study examines the role of an abundant extracellular matrix component, the megadalton glycosaminoglycan hyaluronan (HA), as a novel therapeutic target in PDA.

Methods Using a genetically engineered mouse model of PDA, the authors enzymatically depleted HA by a clinically formulated PEGylated human recombinant PH20 hyaluronidase (PEGPH20) and examined tumour perfusion, vascular permeability and drug delivery. The preclinical utility of PEGPH20 in combination with gemcitabine was assessed by short-term and survival studies.

Results PEGPH20 rapidly and sustainably depleted HA, inducing the re-expansion of PDA blood vessels and increasing the intratumoral delivery of two chemotherapeutic agents, doxorubicin and gemcitabine. Moreover, PEGPH20 triggered fenestrations and interendothelial junctional gaps in PDA tumour endothelia and promoted a tumour-specific increase in macromolecular permeability. Finally, combination therapy with PEGPH20 and gemcitabine led to inhibition of PDA tumour growth and prolonged survival over gemcitabine monotherapy, suggesting intermediate clinical utility.

Conclusions The authors demonstrate that HA impedes the intratumoral vasculature in PDA and propose that its enzymatic depletion be explored as a means to improve drug delivery and response in patients with pancreatic cancer.

INTRODUCTION

Pancreatic ductal adenocarcinoma (PDA) is a malignancy with a dire prognosis due to aggressive disease on clinical presentation and poor chemotherapeutic response.1 The fluorinated nucleoside analogue gemcitabine (2’,2’-difluorodeoxycytidine, dFdC) remains the antineoplastic agent of choice, offering a survival benefit of little more than 5 weeks,2 while gemcitabine-based combination therapies have shown limited progress in advancing survival.3

Understanding of genetic alterations in PDA has allowed the generation of genetically engineered mouse models (GEMMs), bearing autochthonous tumours that recapitulate the human pathology.4–6 A mechanism for intrinsic gemcitabine resistance has recently been reported in one such GEMM, the

LSL-KrasG12D/+;LSL-Trp53R172H/+;Pdx-1-Cre (KPC) mouse.7 Compared with subcutaneous tumours of syngeneic origin, KPC tumours demonstrated a desmoplastic stroma and lower mean vessel densities, thus limiting the accumulation of the active gemcitabine triphosphate (dFdCTP).7 A similar perfusion deficit has been observed in an
synergism with cytotoxic agents.14

interstitial hypertension and vascular compression. 10

nogenicity.19 PEGPH20, a PEGylated human recombinant PH20

of HA by intratumoral administration of bovine hyaluronidases

resents an approach in maximising the delivery and hence the

contribute towards interstitial matrix components and inadequate lymphatic drainage

independent study in mice and human PDA.89 Stromal deple-

tion by Smoothened inhibition in KPC mice increased perfusion,

reversible impairment in drug delivery.7

mesenchymal transition and chemoresistance.15 Moreover, HA

e implicated in the processes of angiogenesis, epithelial

receptor tyrosine kinase and small GTPase activity and is

HA may signal through

hyaladherins

such as CD44 to regulate

ficial

Visualisation was performed on a Leica SP5 confocal microscope

Hyaluronan (HA) is a non-sulphated glycosaminoglycan present in the extracellular matrix, composed of N-acetylglu-

cosamine/glucuronic acid disaccharide repeats of variable length. HA may signal through ‘hyaladherins’ such as CD44 to regulate

receptor tyrosine kinase and small GTPase activity and is implicated in the processes of angiogenesis, epithelial–mesenchymal transition and chemoresistance.15 Moreover, HA’s anionic repeats also sequester mobile cations and solvating water, resulting in osmotic swelling that provides structural

support in HA-rich normal and malignant tissues.16 Degradation of HA by intratumoral administration of bovine hyaluronidases showed promise in diminishing tumorous IJP and increasing chemotherapeutic index in xenograft models.17 18 but systemic administration was limited by short residence time and immu-

nogenicity.19 PEGPH20, a PEGylated human recombinant PH20

hyaluronidase, surmounts these issues and has demonstrated comparable activity in vivo, inducing rapid perfusion increase in xenograft tumours.20

HA is a known secretory product of several human pancreatic carcinoma cell lines21 and has been shown as an over-represented glycosaminoglycan in human FDA.22 localised to the stroma and peritumoral connective tissue.23 However, in contrast to other epithelial cancers, the pathological significance of its rheological and signalling properties has not been fully investigated in this malignancy.24 In this study, we sought to investigate the aeti-

ology of vascular compression in the KPC GEMM and identified HA as a critical modi
er of tumorous vascular function. Its enzymatic depletion by PEGPH20 resulted in an improvement in tumour vascular patency, as well as an unexpected selective change in tumour endothelial ultrastructure and macromolecular permeability. Our data predict hyaluronidase synergism with cytotoxic agents and demonstrate a significant survival benefit with combination therapy, providing HA as a novel stromal therapeutic target to consider for patients with pancreatic cancer.

Materials and methods

Mice

Experiments were carried out within the Cancer Research UK Cambridge Research Institute’s Biological Resources Unit, under the terms of the Home Office Project Licenses PPL50/2072 and 80/2559 and subject to Cancer Research UK ethical review. The generation of tumour-bearing KPC (LSL-KrasG12D/+;LSL-


doxorubicin delivery assay, a minimum of

Pdx-1-Cre) mice has previously been described.5 Where appropriate, PC (LSL-Tp53R172H/+;Pdx-1-Cre) littermates, which did not develop any pancreatic lesions within the experimental time frame, served as healthy controls. KPC mice were

enrolled onto studies once tumour volume reached 270±100 mm3, as assessed by three-dimensional ultrasonography.7

Vascular function studies

At least four mice were evaluated for each experimental arm. One hour after the final dose of PEGPH20, mice received an intrave-
nous infusion of fluorophore-labelled lectin only (vascular patency assay) or of fluorophore-labelled lectin and dextran (permeability assay). Thirty minutes later, mice were terminally perfused with 50 ml of 4% paraformaldehyde/phosphate buffered saline (pH 7.4). Perfused tissues were harvested, fixed for 16–24 h in paraformaldehyde and transferred to 70% ethanol before paraffin embedding. Sections were deparaffinised, rehydrated and, for vascular patency assays, immunostained for MECA-32 (see Immunostaining and HA histochemistry section). All sections were counterstained with 4’,6-diamidino-2-phenylindole (DAPI). Visualisation was performed on a Leica S5S confocal microscope (Leica Microsystems, Wetzlar, Germany) using standardised settings, and background signal intensities were established against unlabelled terminally perfused samples. Mean vessel densities were quantified as the average number of CD31+ vessels in a minimum of 10 non-adjacent 40× fields.

Pharmacodelivery studies

For the doxorubicin delivery assay, a minimum of five mice from each arm were included for analysis. Mice received an intrave-
nous infusion of doxorubicin 1 h after the final dose of PEGPH20. Mice were then terminally perfused with paraformaldehyde, and tissues processed as above. Sections were deparaffinised, rehydrated and counterstained with DAPI. Doxorubicin fluorescence was quantified with the CompuCyte iCyts Research Imaging Cytometer and iNovator software (CompuCyte Westwood, MA, USA), as previously described.7

Table 1 Human TMA

<table>
<thead>
<tr>
<th>Tissue origin</th>
<th>% Cases with +HA staining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Tumour (N=117, 56%)</td>
</tr>
<tr>
<td></td>
<td>Normal (N=13, 23%)</td>
</tr>
<tr>
<td>Prostate</td>
<td>Tumour (N=110, 46%)</td>
</tr>
<tr>
<td></td>
<td>Normal (N=17, 5.8%)</td>
</tr>
<tr>
<td>Bladder</td>
<td>Tumour (TCC) (N=106, 43%)</td>
</tr>
<tr>
<td></td>
<td>Normal (N=8, 0%)</td>
</tr>
<tr>
<td>Stomach</td>
<td>Tumour (adenocarcinoma) (N=95, 42%)</td>
</tr>
<tr>
<td></td>
<td>Normal (N=14, 0%)</td>
</tr>
<tr>
<td>Pleura</td>
<td>Tumour (mesothelioma) (N=52, 37%)</td>
</tr>
<tr>
<td></td>
<td>Normal (N=15, 0%)</td>
</tr>
<tr>
<td>Lung</td>
<td>NSCLC (N=169, 29%)</td>
</tr>
<tr>
<td></td>
<td>SCCL (N=21, 10%)</td>
</tr>
<tr>
<td></td>
<td>Normal (N=21, 0%)</td>
</tr>
<tr>
<td>Ovary</td>
<td>Tumour (N=185, 12%)</td>
</tr>
<tr>
<td></td>
<td>Normal (N=31, 0%)</td>
</tr>
<tr>
<td>Colon</td>
<td>Tumour (N=136, 28%)</td>
</tr>
<tr>
<td></td>
<td>Normal (N=25, 8%)</td>
</tr>
<tr>
<td>Bone marrow</td>
<td>Multiple myeloma (N=27, 3.7%)</td>
</tr>
<tr>
<td></td>
<td>Normal (N=35, 0%)</td>
</tr>
<tr>
<td>Pancreas</td>
<td>Ductal adenocarcinoma (N=99, 90%)</td>
</tr>
<tr>
<td></td>
<td>Acinar cell carcinoma (N=2, 0%)</td>
</tr>
<tr>
<td></td>
<td>Mucinous adenocarcinoma (N=5, 100%)</td>
</tr>
<tr>
<td></td>
<td>Papillary adenocarcinoma (N=4, 25%)</td>
</tr>
<tr>
<td></td>
<td>Squamous cell carcinoma (N=2, 100%)</td>
</tr>
<tr>
<td></td>
<td>Normal (N=25, 4%)</td>
</tr>
</tbody>
</table>

HA staining is most common in pancreatic ductal adenocarcinoma in comparison to other major human tumours.

HA, hyaluronan. TMA, tissue microarray. TCC, transitional cell carcinoma. NSCLC, non-small cell lung carcinoma. SCCL, small cell lung carcinoma.
For the gemcitabine delivery assay, a minimum of five mice from each arm were included for analysis. Mice received intravenous gemcitabine 8 h after a single dose of PEGPH20 or vehicle. Plasma was obtained by cardiac puncture under terminal isoflurane anaesthesia, 2 h after gemcitabine administration, and tissues were harvested shortly thereafter. All samples were frozen in liquid nitrogen and processed as described for liquid chromatography-tandem mass spectrometry analysis of fluorinated metabolites.

Survival study
KPC mice bearing tumours of 270±100 mm³ were assigned to one of four arms—vehicle, intraperitoneal gemcitabine, PEGPH20 or PEGPH20/intraperitoneal gemcitabine in combination (dosed 30 min apart)—and treatments were administered accordingly. Once enrolled onto a survival study, mice were monitored by three-dimensional ultrasonography every 3 days to allow calculation of tumour volumes. Endpoint criteria were defined as 20% body weight loss in addition to general morbidity, lethargy, lack of social interaction or development of ascites.

Immunostaining and HA histochemistry
Samples at study end point were fixed in 4% paraformaldehyde or in 10% neutral buffered formalin for 16–24 h and transferred to 70% ethanol before paraffin embedding. Three-micrometre sections were generated, and one section from each sample was stained with H&E for analysis of morphological integrity. Where appropriate, stained sections were scanned at 20× magnification using Aperio ScanScope CS instrument and were analysed in Spectrum (Aperio Vista, CA, USA).

For immunostaining with most antibodies, sections were deparaffinised, rehydrated and antigen retrieval performed with citric acid (pH 6.0) in an 850 W microwave. For CD31 immunostaining, antigen retrieval was performed with proteinase K at 37°C. Non-specific protein binding was blocked with 10% goat serum (Sigma St Louis, MA, USA) for immunohistochemistry and 10% donkey serum (Sigma) for immunofluorescence. Sections were incubated with primary antibodies for 1 h at room temperature or overnight at 4°C. The primary antibodies used were against PV-1 (MECA-32, 1:50; Santa Cruz Biotechnology, Santa Cruz, CA, USA) and CD31 (MEC 13.3, 1:50; BD Biosciences, Franklin Lakes, NJ, USA). For immunohistochemistry, remaining steps were carried out using appropriate Vectastain Elite ABC kits (Vector Laboratories, Burlingame, CA, USA) and DAB Peroxidase Substrate (Vector Laboratories), with haematoxylin counterstaining. For immunofluorescence, sections were incubated with appropriate AlexaFluor-conjugated secondary antibodies for 1 h at room temperature and counterstained with DAPI.

For HA histochemistry, biotinylated HA binding protein (bHABP, Calbiochem catalogue number 385911; Merck KGaA, Darmstadt, Germany) was used. Sections were deparaffinised, rehydrated and blocked with 3% bovine serum albumin (BSA)
prior to incubation with bHABP (1:200 in 1% BSA) overnight at 4°C. Remaining steps were carried out using Vectastain Elite ABC kit Standard (Vector Laboratories) and DAB Peroxidase Substrate (Vector Laboratories), with haematoxylin counterstaining.

**HA tissue microarray**

Tissue microarrays were purchased from US Biomax Inc Rockville, MD, USA and stained with bHABP as described above. The slides were scanned at 20× magnification using Aperio ScanScope CS instrument and analysed in Spectrum automated slide analysis software (Aperio) using the positive pixel count algorithm. A ratio of strong positive stain area to the sum of total stained area was calculated and scored as 3+, 2+, 1+, 0 or 0 when the ratio was more than 25%, 10%-25%, less than 10% or 0, respectively. See Supplemental Methods for further information.

**Statistical analysis**

GraphPad Prism 5 was used for all statistical analyses. The log-rank test was performed on the Kaplan–Meier survival curves, and the Mann–Whitney U test was performed for all other analyses.

**RESULTS**

**HA accumulates in PDA and may be rapidly and sustainably degraded by PEGPH20**

Using a modified histochemical method with bHABP and computer-assisted analysis, we examined the HA content in 204 normal and 1130 malignant human tissue samples. While a minority of normal epithelia demonstrated 1+ staining, HA was more frequently and abundantly detected in epithelial malignancies (table 1). Human PDA had the highest incidence of detectable HA content, and the majority of PDA samples was scored 2+ (figure 1A and data not shown). Notably, HA staining was predominantly associated with the desmoplastic stroma rather than with tumour cells. These histopathological observations were recapitulated in the tumours of KPC mice, where 2+ HA staining was observed in the stroma of most ductal tumours (figure 1B). This confirmed the suitability of the
Figure 3 Depletion of hyaluronan increases macromolecular permeability and induces ultrastructural changes in tumour endothelia. (A) Representative fluorescent images of KPC tumour from vehicle-treated (top panel) and PEGPH20-treated (bottom panel) mice (n=4 mice for each cohort). Mice terminally treated with either low (40 kDa) or high (2 MDa) molecular weight dextrans with biotinylated lectin demonstrate a considerable increase in stromal and vessel permeability at the tumour core in PEGPH20-treated tumours. Arrows denote functional vessels in the field. Scale bar = 500 µm. (B) Scanning electron microscopy images of pancreatic blood vessels in PC (LSL-Trp53R172H/+;Pdx-1-Cre) (upper two panels) and KPC (LSL-KrasG12D/+;LSL-Trp53R172H/+;Pdx-1-Cre) (lower two panels) mice following treatment with either vehicle or PEGPH20 (n=4 mice for each cohort) reveal endothelial fenestrations (white arrowheads) only in PEGPH20-treated KPC mice. (C) Quantification of density of fenestrae in intratumoral KPC blood vessels (n=3 mice for each cohort, four random vessels per mouse) revealed a significant increase following treatment with PEGPH20 (***p<0.0001). (D) Representative transmission electron micrographs from vehicle-treated (left panels) and PEGPH20-treated (right panels) tumours (n=4 mice for each cohort). Vehicle-treated tumours demonstrate juxtaposed endothelial cell membranes (red arrowheads), while prominent interendothelial gaps are present following treatment with PEGPH20 (designated by white diamonds, endothelial cell membranes denoted by blue arrowheads).
GEMM in determining HA’s role in PDA structure and vascular function.

To determine whether HA could be depleted from primary pancreatic tumours, PEGPH20 was intravenously administered to KPC mice and tumours collected over a 3-day time course. A single dose of PEGPH20 at 4.5 mg/kg depleted intratumoral HA in a heterogeneous pattern within hours of administration, with little detectable HA remaining up to 72 h later (figure 1B).

Depletion of HA improves vascular patency and increases chemotherapeutic delivery

Consistent with previous reports,7 8 less than one-third of the untreated KPC tumour vasculature is patent as delineated by *Lycopersicon esculentum* lectin perfusion (figure 2A). To evaluate vascular patency following complete depletion of HA, KPC mice were treated for 3 days with PEGPH20 prior to lectin perfusion and were killed. The hyaluronidase regimen resulted in an increased patency of the tumour vasculature (70% vs 30%, p=0.0286, figure 2A). Moreover, the majority of intratumoral vessels were noted to be prominently open, and, when measured, the mean vessel luminal area was found to be significantly increased (p=0.0085, figure 2B). Since treatment with PEGPH20 did not affect mean vessel density (figure S1), we reasoned that any increased perfusion could be attributed to decompression of existing intratumoral vessels.

We asked if vascular re-expansion might translate to an improvement in drug delivery. Exploiting the autofluorescence of anthracyclines, a significant increase in tumorous doxorubicin uptake was detected following pretreatment with the hyaluronidase (p=0.026, figure 2C). Similarly, mice receiving gemcitabine after a single dose of PEGPH20 demonstrated
significantly increased intratumoral dFdCTP concentrations when compared with vehicle-pretreated counterparts ($p=0.0053$, figure 2D). Of note, PEGPH20 did not alter the plasma pharmacokinetic properties of gemcitabine in control mice (figure S2).

**Depletion of HA increases macromolecular permeability and induces ultrastructural changes in tumour endothelia**

To further characterise the KPC vasculature following HA depletion, fluorophore-conjugated high-molecular-weight dextran (40 kDa and 2 MDa) were infused 30 min prior to tissue collection. Dextran extravasation was minimal in untreated tumour tissue but increased dramatically following PEGPH20 treatment (figure 3A). Notably, macromolecular penetration was not improved in any healthy tissues tested (figure S3), even among those of high HA content such as cardiac muscle, suggestive of selective permeabilisation of the tumour vasculature.

The rapid and extensive intratumoral accumulation of 2 MDa dextran after PEGPH20 administration was unexpected, given
its large Stoke’s radius. This prompted an examination of the
tumour endothelial ultrastructure for vascular integrity and
markers of induced hyperpermeability, which include fenestrae
and intercellular gaps.\textsuperscript{27–29} Notably, scanning electron micros-
copy revealed few fenestrations in the untreated tumour,
comparable to endothelia in the healthy pancreata of control
mice (figure 3B). Moreover, treatment-naive vasculature showed
intact interendothelial junctions by transmission electron micros-
copy (figure 3D). By contrast, PEGPH20 induced a significant
increase in fenestrae (p<0.0001, figure 3B,C) and more prominent
interendothelial gaps (figure 3D), a hyperpermeability-associated
phenotype reminiscent of VEGF-activated vasculature.\textsuperscript{27–29}

Combination therapy with PEGPH20 and gemcitabine inhibits
tumour growth and significantly extends survival

Given the improvement in pharmacodelivery, we evaluated
whether PEGPH20 provided any therapeutic benefit to KPC
mice either alone or in combination with gemcitabine. While
gemcitabine monotherapy decreased tumour growth only
modestly, the combination of PEGPH20 and gemcitabine
significantly inhibited growth over 5 days of treatment
(p<0.001, figure 4A). During the same period, PEGPH20
monotherapy had no effect on tumour growth (figure 4A).
Growth inhibition was accompanied by a decrease in intra-
tumoral proliferation as assessed by phospho-histone H3
staining (p=0.043, figure 4B).

To determine whether these findings impacted upon the
lethality of PDA, KPC mice were subsequently treated for an
extended period with each agent as monotherapy, with a vehicle
or with the gemcitabine/PEGPH20 combination. Similar to the
5-day analysis, treatment with PEGPH20 or gemcitabine alone
had insignificant effects on the survival of KPC mice in
comparison to vehicle-treated mice (figure 4C). However,
extended treatment with the gemcitabine/PEGPH20 combina-
tion significantly improved median survival over gemcitabine
monotherapy (28.5 vs 15 days, p=0.043, figure 4C). Most mice
in the gemcitabine/PEGPH20 combination cohort, experienced
stable tumour growth (figure S4) and hyaluronidase activity
persisted up to study end point (figure S5).

DISCUSSION

We recently proposed that microenvironmental impairment in
drug delivery may contribute towards the intrinsic chemo-
resistance of pancreatic cancer and used the Smoothed
inhibitor IPI-926 to augment the response to gemcitabine in
KPC mice.\textsuperscript{7} However, since hedgehog signalling is implicated in
the survival and propagation of stem-like cancer cells and
cancer-associated fibroblasts,\textsuperscript{30–32} an additional antitumour
effect by IPI-926 could not be excluded. The current study with
PEGPH20 supports the hypothesis that improvement of phar-
cmacodelivery through depletion of select stromal components
may be sufficient for the therapeutic response previously
reported.\textsuperscript{7}

The scarcity of endothelial fenestrations and open inter-
endothelial junctions in treatment-naive KPC tumours stands in
contrast to observations in xenografts, allografts and some
spontaneous tumour models. A defective endothelial monolayer,
characterised by abundant diaphragmed fenestrae and intercel-
lular openings, is associated with VEGF-induced hyper-
permeability\textsuperscript{28,29} and underlies the vascular leakiness seen in
these models.\textsuperscript{29,33} Since these ultrastructural changes may
permit access to therapeutic agents,\textsuperscript{29} their absence may
contribute towards delivery inefficiency in the KPC tumour and
explain the differential chemotherapeutic sensitivities between
spontaneous tumours and other models.\textsuperscript{7} Moreover, the obser-
vation points to relative inactivity of VEGF in the tumour and is
suggestive of signalling antagonism from the abundant angio-
static factors in KPC stroma.\textsuperscript{34} Such an antiangiogenic milieu is
generated by complex tumour–fibroblast interactions in PDA\textsuperscript{35}
and is frequently absent or lost in the pathogenesis of other
tumour models.\textsuperscript{36} Furthermore, the persistence of negative
regulators of angiogenesis would explain the hypovascular
phenotype and the failure of anti-VEGF agents in human PDA
and its GEMMs.\textsuperscript{8,37–39}

The unanticipated induction of fenestrare and impairment of
junctional integrity following PEGPH20 may reflect the role of
HA signalling in maintaining the PDA intratumoral vascular
endothelium in a quiescent state. HA has been shown to impart
increased barrier integrity and resistance to lipopolysaccharide-
induced hyperpermeability through CD44-dependent reorgan-
isation of the endothelial actin cytoskeleton.\textsuperscript{40} Consistent with
this finding, disruption of the HA–CD44 interaction in vivo by
systemic administration of an anti-CD44 monoclonal results in
a rapid permeability increase.\textsuperscript{41} The generation of low-molecu-
lar-weight HA fragments (including oligosaccharides) in large
quantities from intratumoral HA could antagonise existing
HA–CD44 interactions\textsuperscript{42} and may explain for the tumour
specificity of PEGPH20-induced hyperpermeability.

The ultrastructural changes and the vascular re-expansion
from IFP reduction have a multiplicative effect on intratu-
moral diffusion and convection by increasing both compo-
nents of the permeability-surface area product.\textsuperscript{43} Furthermore,
IFP reduction results in a favourable hydrostatic pressure
gradient for convective solute delivery. The specificity of this
effect to the tumour suggests utility as an adjunct to agents of
larger hydrodynamic size, such as polymeric drugs, mono-
clonal antibodies and albumin conjugates. Nonetheless, as
prior work in xenografts suggested monotherapy activity of
PEGPH20,\textsuperscript{40} we cannot exclude the possibility that HA
deposition also sensitises neoplastic cells to gemcitabine
toxicity by removing various survival cues. Finally, the
synergism of PEGPH20 and gemcitabine demonstrated in this
study is of immediate clinical significance and provides
support for investigational trials with this therapeutic
combination (NCT01453153).

Acknowledgements

We thank the members of the Tuveson’s laboratory for
assistance and advice, and the animal care staff, histology and microscopy cores at
Cambridge Research Institute, specifically F Connor, P Mackin, L Young,
L Shelbourne, S Kupczak, M Cronshaw, Y Cheng, M Pryor, E Pryor, B Wilson,
L McDuffus, J Atkinson, J Miller, W Howat and S Reichelt. We also thank E
Miksiewska for assisting with SEM.

Contributors

MAJ, DSC, AN, NC, CF, TN, MPL and KKF performed in vivo
experiments. MAJ, DSC, AN, NC, CF, TN, MPL and KKF performed microsop-
eye experiments. MAJ, DSC, AN, BE, NC, KKF, DCM, CBT and DJF performed
pharmacology studies. MAJ, DSC, AN, HIMS, GIF and DT designed the study and
cowrote the manuscript, and all authors commented on it.

Funding

This research was supported by the University of Cambridge and Cancer
Research UK, the Li Ka Shing Foundation and Hutchison Whampoa Limited, the
National Institute for Health Research Cambridge Biomedical Research Centre and the
European Commission Seventh Framework Programme (FP7 Health 2010 2.4.1-B
contract number 258974); AN was supported by the Mildred Scheel Postdoctoral
Fellowship by the Deutsche Krebshilfe. NC was supported by a Cancer Research UK
Clinician Fellowship. CF was supported by the EMBO long-term fellowship and by
a Marie Curie Intra European Fellowship within the Seventh European Community
Framework Programme. MPL has received a Dutch Cancer Foundation Fellowship
grant (UU2008-4380) to support this work. DT and DJF are group leaders in the Cancer
Research UK Cambridge Research Institute.

Competing interests

DCM, CBT, PJ, AK, HIMS and GIF are employees of Halozyme.

Provenance and peer review

Not commissioned; internally peer reviewed.
Open access This is an open access article distributed under the terms of the Creative Commons Attribution Non-commercial, Non-Derivatives License, which permits use, distribution, and reproduction as is in any medium, provided the original work is properly cited, the work is not altered, the use is non-commercial and is otherwise in compliance with the license. See: http://creativecommons.org/licenses/by-nc-nd/3.0/ and http://creativecommons.org/licenses/by-nc-nd/3.0/legalcode.

REFERENCES
Supplemental Figures

Figure S1 Mean vessel densities of tumours at study endpoint. There is no significance difference in mean vessel densities between tumours in any of the cohorts. The vehicle and gemcitabine treated cohorts are presented together (V/G), as are the PEGPH20 and gemcitabine/PEGPH20 treated cohorts (P/P+G).

Figure S2 Plasma gemcitabine pharmacokinetics from control mice treated with either vehicle (black) or PEGPH20 (green) 1 hour prior to gemcitabine. There is no significance difference in plasma dFdC or dFdU either thirty or sixty minutes after dosing with gemcitabine.

Figure S3 Immunofluorescence micrographs from vehicle or PEGPH20 treated genetic control (PC) mice that were injected with biotinylated lectin (green) and two different molecular weight dextrans (magenta = 40kDa, yellow = 2MDa, n=4 mice per cohort). Normal tissues were not different in interstitial dextran distribution between treatment groups. (Scale bar = 100mm).

Figure S4 Tumour growth curves based on volume for each KPC mouse on each arm of the survival trial. Some mice progressed and were removed from study prior to obtaining an accurate volumetric measurement (e.g. MH812). From the top, vehicle, gemcitabine, PEGPH20, and gemcitabine/PEGPH20 treated cohorts. Y axis = Percent Tumour Volume (0-600%), X axis = Time (-20- to +40 days).

Figure S5 Absence of HA expression at endpoint in PEGPH20 and gemcitabine/PEGPH20 treated cohorts. HA is detectable in vehicle and gemcitabine treated cohorts (top panel, left three images). (Scale bars 4X = 250 μm, 40X = 100 μm). Quantification indicates an enrichment of low-HA expressing tumours in the PEGPH20 and gemcitabine/PEGPH20 treated cohorts at endpoint.
**Supplemental Methods**

**Agent Formulation and Dosing**

PEGPH20 (3.5mg/mL solution, Halozyme) was administered intravenously, one dose of 4.5mg/kg for the gemcitabine delivery assay, two doses of 4.5mg/kg 72 hours apart for the vascular function and doxorubicin delivery assays, and two doses of 5mg/kg per week on days 1 and 4 for the survival study.

Lyophilised streptavidin – AlexaFluor633 (Cat.no. S21375, Invitrogen) and lyophilised biotinylated *Lycopersicon esculentum* lectin (Cat.no. B1175, Vector Labs) were reconstituted with sterile 0.85% saline and mixed to give a working labelling agent (7), administered by slow intravenous injection at 20mg/kg lectin. FITC-conjugated dextran of molecular weight 40kDa and TRITC-conjugated dextran of 2MDa (Cat.no. D1845 and D7139, Invitrogen) were reconstituted with sterile 0.85% saline to 10 mg/ml and a single dose was administered by slow intravenous injection at 40mg/kg.

Doxorubicin hydrochloride powder (Cat.no. D1515, Sigma) was reconstituted with sterile 0.85% saline to 4mg/mL and a single dose was administered by slow intravenous injection at 20mg/kg.

Gemcitabine hydrochloride powder (~48% dFdC, Eli Lilly) was reconstituted with sterile 0.85% saline to 5mg dFdC/mL and administered intraperitoneally, one dose of 100mg dFdC/kg for the aflibercept pharmacodelivery study, and two doses of 100mg dFdC/kg per week on days 1 and 4 for survival studies. For the VEGF\textsuperscript{164} and PEGPH20 pharmacodelivery studies, gemcitabine hydrochloride was reconstituted to 40mg dFdC/mL and a single dose was administered intravenously at 100mg dFdC/kg.
**Electron Microscopy**

Mice were terminally perfused one hour after the final dose of PEGPH20. Terminal perfusion consisted of 0.9% saline containing heparin (1U/ml) followed by 150mL of 3% glutaraldehyde and 1% formaldehyde in 0.1 M HEPES buffer. The tumours were excised and fixed by immersion in the 3% glutaraldehyde/1% formaldehyde solution for a further 24 hours. The tumours were cut into slices and processed for either scanning electron microscopy (SEM) or transmission electron microscopy (TEM).

Tissue used for SEM was dehydrated in 100% ethanol and frozen in liquid nitrogen, followed by fracturing with razor blades cooled in liquid nitrogen. The fractured tissue fragments were rehydrated in deionized water and incubated with 1% osmium ferricyanide at 4°C for 18 hours. The tissue was then treated with 2% uranyl acetate in 0.05M maleate buffer at pH 5.5 for 18 hours at 4°C, before being dehydrated in an ascending series of ethanol solutions. Coverslips were placed in a Polaron critical point dryer (Quorum/Emitech) and glued to SEM stubs with colloidal silver. The stubs were coated with 10nm of gold in a Quorum/Emitech K575X sputter coater and viewed in an FEI-Philips XL30 FEGSEM at 5kv. At least seven tumour core vessels were imaged per mouse, and at least four mice were evaluated for each experiment. Images were recorded at 20,000X magnification and a quadratic lattice was overlain on each image. Point counting was used to determine the percentage of endothelial surface occupied by fenestrae.

Slices used for TEM were dehydrated in 100% ethanol, rinsed twice in acetonitrile, and embedded in Quetol epoxy resin. They were sectioned at 50-70nm using a Leica Ultracut UCT, mounted on 300 mesh grids, stained with uranyl acetate and lead citrate and viewed in a FEI Tecnai G2, TEM operated at 120kv. Images were captured with an AMT XR80B digital camera running Deben software.
HA Tissue Microarray

A blinded pathologist confirmed tissue quality and tissue cores in the arrays with less than 10% of tumour cells or more than 50% of necrotic tissue were excluded for the evaluation. PC3 xenograft tumour tissues served as positive control tissue to determine intensity threshold for positive pixel quantity. HA staining specificity was confirmed by digesting a subset of sections with recombinant human hyaluronidase PH20 (1000 U/mL in PIPES buffer) before addition of bHABP.
Supplemental Figure 1

Mean Vessel Density

Vessels per 40x field

V/G  n=8
P/P+G  n=12
Supplemental Figure 5

HABP Intensity

- **PEGPH20 + Gemcitabine**
  - 46% 0+
  - 53% 1+
  - N=13

- **PEGPH20**
  - 61% 0+
  - 30% 1+
  - 7% 2+
  - N=13

- **Gemcitabine**
  - 46% 0+
  - 38% 1+
  - 15% 2+
  - N=13

- **Untreated**
  - 10% 0+
  - 80% 1+
  - 10% 2+
  - N=10