

Distinct GD3 expression in breast cancer subpopulations after novel thieno[2,3-b]pyridine derivative treatment

Lange, Matthias

Master's thesis / Diplomski rad

2021

Degree Grantor / Ustanova koja je dodijelila akademski / stručni stupanj: **University of Split, School of Medicine / Sveučilište u Splitu, Medicinski fakultet**

Permanent link / Trajna poveznica: <https://um.nsk.hr/um:nbn:hr:171:067672>

Rights / Prava: [In copyright](#)/[Zaštićeno autorskim pravom.](#)

Download date / Datum preuzimanja: **2025-01-02**



Repository / Repozitorij:

[MEFST Repository](#)



**UNIVERSITY OF SPLIT
SCHOOL OF MEDICINE**

MATTHIAS JONATHAN LANGE

**DISTINCT GD3 EXPRESSION IN BREAST CANCER
SUBPOPULATIONS AFTER NOVEL THIENO[2,3-B]PYRIDINE
DERIVATIVE TREATMENT**

DIPLOMA THESIS

Academic year:

2020/ 2021

Mentor:

Assoc. Prof. Vedrana Čikeš Čulić, PhD

Split, July 2021

TABLE OF CONTENTS

ACKNOWLEDGMENT

LIST OF ABBREVIATIONS

1. INTRODUCTION.....	1
1.1 Cancer.....	2
1.2 Triple-negative breast cancer.....	2
1.2.1 Definition.....	2
1.2.2 Epidemiology.....	2
1.2.3 Pathology.....	6
1.2.4 Therapeutic Options.....	7
1.3 Gangliosides.....	9
1.3.1 Definition.....	9
1.3.2 Function.....	9
1.3.3 Biosynthesis.....	10
1.3.4 Ganglioside GD3.....	11
2. OBJECTIVES AND HYPOTHESES.....	12
2.1 Objectives.....	13
2.2 Hypotheses.....	13
3. MATERIALS AND METHODS.....	14
3.1 Chemistry and cell line.....	15
3.2 Flow cytometric analysis.....	16
3.3 Geometric Mean Fluorescence Intensity (GMI).....	17
3.4 Statistical analysis.....	17
4. RESULTS.....	18
4.1 GD3 expression in CD 44+/CD24- CSC.....	19
4.2 GD3 expression in CD 44- epithelial cells.....	20
4.3 GD3 expression in CD 44+/CD24+ hybrid cells.....	22
5. DISCUSSION.....	25
6. CONCLUSIONS.....	28
7. REFERENCES.....	30
8. SUMMARY.....	37
9. CROATIAN SUMMARY.....	39
10. CURRICULUM VITAE.....	41

ACKNOWLEDGMENT

First and foremost, I want to express my most sincere gratitude to my mentor, Assoc. Prof. Vedrana Čikeš Čulić, PhD for finding space for a 6th student to mentor during this year, for good times in the laboratory, and for being a great support throughout the writing process of this thesis.

Secondly, I want to thank my father for encouraging me to start studying medicine in Split and guiding me through difficult times.

LIST OF ABBREVIATIONS

- AKT: protein kinase B
- AKT1: AKT Serine/Threonine Kinase 1
- AR: androgen receptor
- ATCC: American Type Culture Collection
- BCSC: breast cancer stem cell
- BL1: basal-like 1
- BL2: basal-like 2
- BRCA: breast cancer gene
- CSC: cancer stem cell
- CDH1: cadherin 1
- CK5: cytokeratin 5
- DCIS: ductal carcinoma in situ
- DMEM: Dulbecco's modified Eagle medium
- DNA: deoxyribonucleic acid
- EGFR: epidermal growth factor receptor
- ER: estrogen receptor
- FITC: fluorescein isothiocyanate
- GD: disialogangliosides
- GM: monosialoganglioside
- GMI: geometric mean fluorescence intensity
- GQ: tetrasialoganglioside
- GT: trisialoganglioside
- HER2: human epidermal growth factor receptor 2
- IM: immunomodulatory
- KMT2C: Lysine N-methyltransferase 2C
- LAR: luminal androgen receptor
- M: mesenchymal
- MSL: mesenchymal stem-like
- MUC16: mucin 16
- NCDB: National Cancer Data Base
- NF1: neurofibromin 1
- mTOR: mammalian target of rapamycin
- PARP: poly (ADP-ribose) polymerase

- pCR: pathological complete response
- PBS: phosphate-buffer saline
- PE: phycoerythrin
- PI3/K: phosphoinositide 3-kinase
- PIK3CA: phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha
- PKC: protein kinase C
- PR: progesterone receptor
- SD: standard deviation
- TP53: tumor protein 53
- TNBC: triple-negative breast cancer
- VEGF: vascular endothelial growth factor

1. INTRODUCTION

1.1 Cancer

As the second leading cause of death in the United States in 2020 cancer is considered to be a major health problem (1). Cancer is a group of diseases that share features regarding growth dysregulation (2). Due to Darwinian selection, cells with a growth or survival advantage are able to outcompete other cells. These advantages help a single cell to serve as a progeny during the tumor initiation phase. Hence, all cancers are considered to be clonal. Even after the phase of initiation, Darwinian selection continues. This phase is known as progression, during which daughter cells develop more advantageous characteristics for their own survival and spread (3). The hallmarks of cancer are general features shared by different types of cancer. They include sustaining proliferative signaling, evading growth suppressors, resisting cell death, enabling replicative immortality, inducing angiogenesis, and activating invasion and metastasis. Fundamental for these hallmarks are genome instability and inflammation (4). The usual cause of cancer related death is due to metastatic spread, accounting for approximately 90% of cancer deaths (5). For metastatic spread to occur, the cancer cell has to detach from the primary tumor and invade a distant organ (6).

1.2 Triple Negative Breast Cancer (TNBC)

1.2.1 Definition

Breast cancer is defined as triple-negative when it is lacking the expression of estrogen receptor (ER), progesterone receptor (PR), and human epidermal growth factor receptor 2 (HER2) (7). It is important to mention that TNBC and basal-like breast cancer cannot be used as synonyms. This is due to the fact, that up to 20% of basal-like breast cancers express ER or overexpress HER2 and therefore do not match the criteria to be determined as triple-negative (8).

1.2.2 Epidemiology

In 2020 breast cancer was the most common cancer to affect women. In fact, the incidence of breast cancer, which is rare in men, was so high that it turned out to be the most common new cancer even when looking at both sexes together (9). As shown in Figure 1A, 11.7% of all newly diagnosed cancers in both sexes in 2020 were breast cancer, with breast cancer making up 6.9% of all cancer related deaths. The impact of breast cancer gets even

further stressed when looking at its incidence and mortality specifically in females. As can be seen in Figure 1B, 24.5% of all new cancers in women in 2020 were breast cancers, which means that the incidence of breast cancer was approximately 2.25 million. Not only is breast cancer the most frequent one in women, it is also the cancer type responsible for most cancer related deaths. Out of 4.4 million cancer deaths, 15.5% were caused by breast cancer (Figure 1B).

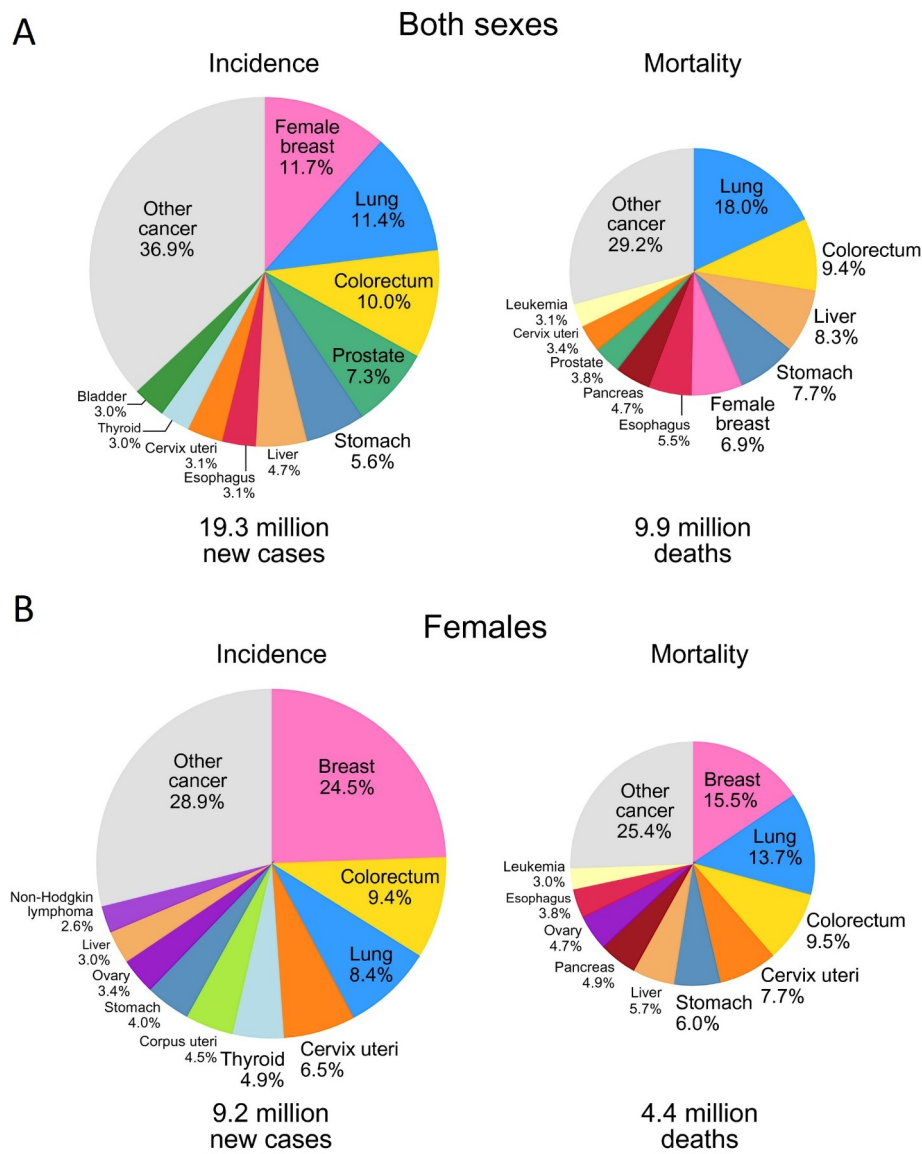


Figure 1 Pie chart showing the incidence and mortality of different cancer types for (A) Both sexes and (B) females. The category “other” encompasses nonmelanoma skin cancers with the exception of basal cell carcinoma for incidence.

Source: GLOBOCAN 2020 (9).

When looking at the incidence and mortality with an age-standardized rate per 100,000 significant differences across different areas of the world can be noticed. The highest incidence worldwide occurs in Belgium (9). This finding goes along with the overall high incidence in Western Europe of 90.7 per 100,000. Also, the other regions of Europe excluding Eastern Europe show a high incidence with 86.4 per 100,000 in Northern Europe and 79.6 per 100,000 in Southern Europe, respectively. Eastern Europe has an incidence of 57.1 per 100,000 which is significantly less than other parts of Europe, yet higher than all African and Asian areas, as well as South America and Central America. The incidences of Australia/ New Zealand with 95.5 per 100,000 and Northern America with 89.4 per 100,000 are also very high (Figure 2). The highest mortality worldwide was found in Barbados (9).

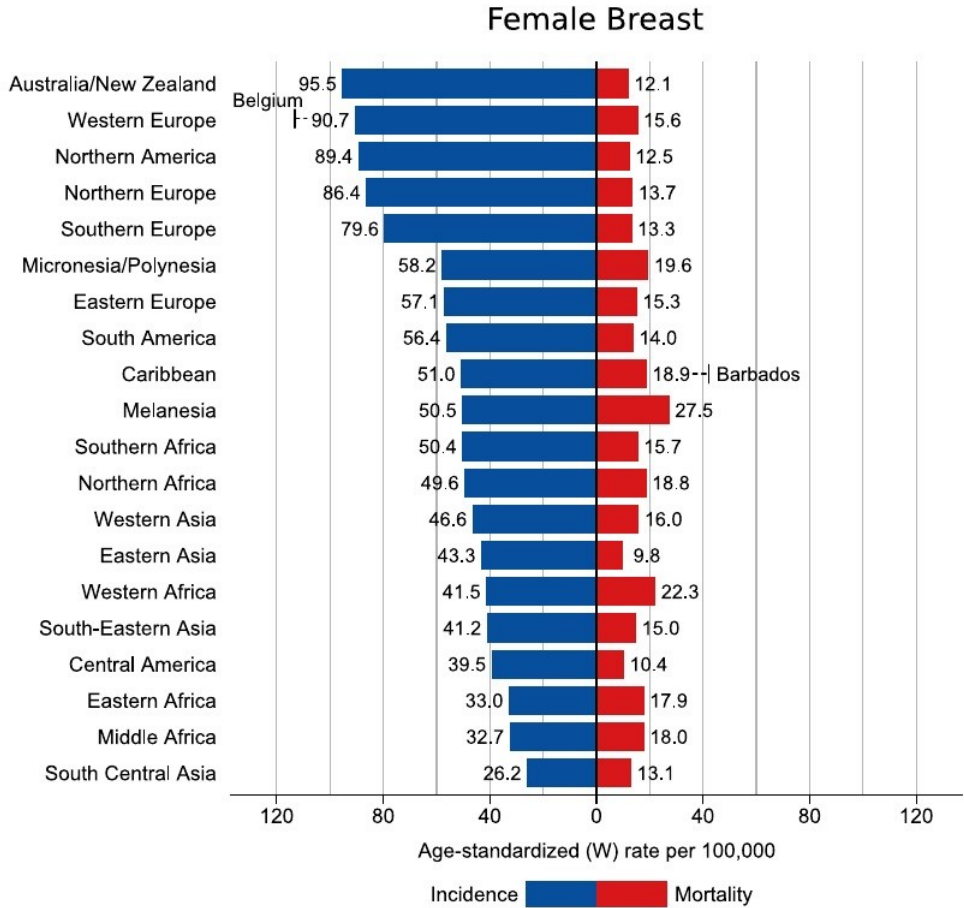


Figure 2. Bar chart showing incidence and mortality of breast cancer in women in different areas of the world. The countries with the highest incidence and mortality are added to the bar chart in respect to their area.

Source: GLOBOCAN2020 (9).

When looking at all invasive breast cancer cases diagnosed between 2010 and 2011 from the National Cancer Data Base (NCDB), it can be observed that the incidence of TNBC is significantly higher in women. Out of 295,801 cases in women 38,628 were triple-negative which is equal to approximately 13%. In comparison, only 185 out of 3,136 (6%) cases in men were triple-negative (10). Ethnicity seems to be an important factor when comparing the individual risk for TNBC. The lowest risk was observed in the Non-Hispanic white and Non-Hispanic Asian population with 11.4% and 11.2% of all breast cancer cases being TNBC. In contrary to this, the percentage of TNBC cases in Non-Hispanic black people was more than twice as much with 23.7% (Table 1). As shown in Table 1, there is an increased risk for TNBC in younger patients in comparison to older patients. In the group of patients younger than 30 years of age 23.3% of breast cancers were triple negative. In different to this, only 10% of breast cancers were triple-negative in the age group above 70. Additionally, there is a gradual decline in TNBC risk with an increase of age.

Table 1. Incidence of triple-negative tumors by sex, race/ethnicity, age, and geographic region. SOURCE: Pasilova et al (10).

	Total cancer number	Nontriple-negative number (%)			Triple-negative number (%)
		HR+ Her2–	HR+ Her2+	HR– Her2+	
Sex					
Female	295,801	214,052 (72.4%)	29,794 (10.1%)	13,327 (4.5%)	38,628 (13.1%)
Male	3,136	2587 (82.5%)	315 (10.0%)	49 (1.6%)	185 (5.9%)
Race/ethnicity					
Non-Hispanic white	235,082	175,760 (74.8%)	22,870 (9.7%)	9669 (4.1%).1%)	26,783 (11.4%)
Non-Hispanic black	33,970	20,255 (59.6%)	3744 (11.0%)	1904 (5.6%)	8,067 (23.7%)
Non-Hisp Asian/P.I.	9,294	6519 (70.1%)	1091 (11.7%)	639 (6.9%)	1,045 (11.2%)
Hispanic	15,536	10,476 (67.4%)	1847 (11.9%)	907 (5.8%)	2,306 (14.8%)
Other/unknown	5,055	3629 (71.8%)	557 (11.0%)	257 (5.1%)	612 (12.1%)
Age					
≤30	2,059	1014 (49.2%)	411 (20.0%)	155 (7.5%)	479 (23.3%)
31–40	15,094	8439 (55.9%)	2494 (16.5%)	978 (6.5%)	3,183 (21.1%)
41–50	51,793	34,894 (67.4%)	6422 (12.4%)	2627 (5.1%)	7,850 (15.2%)
51–60	72,543	49,920 (68.8%)	8051 (11.1%)	4149 (5.7%)	10,423 (14.4%)
61–70	77,870	59,173 (76.0%)	6724 (8.6%)	3061 (3.9%)	8,912 (11.4%)
>70	79,578	63,199 (79.4%)	6007 (7.5%)	2406 (3.0%)	7,966 (10%)
Geographic region					
East South Central	17,319	11,844 (68.4%)	1850 (10.7%)	888 (5.1%)	2,737 (15.8%)
West South Central	23,951	16,634 (69.5%)	2693 (11.2%)	1150 (4.8%)	3,474 (14.5%)
South Atlantic	65,180	46,520 (71.4%)	6502 (10.0%)	3035 (4.7%)	9,123 (14.0%)
East North Central	52,707	38,085 (72.3%)	5162 (9.8%)	2301 (4.4%)	7,159 (13.6%)
Middle Atlantic	46,259	33,908 (73.3%)	4699 (10.2%)	1982 (4.3%)	5,670 (12.3%)
West North Central	21,923	16,223 (74.0%)	2121 (9.7%)	949 (4.3%)	2,630 (12.0%)
Mountain	14,382	10,682 (74.3%)	1377 (9.6%)	619 (4.3%)	1,704 (11.8%)
Pacific	38,647	28,794 (74.5%)	3842 (9.9%)	1699 (4.4%)	4,312 (11.2%)
New England	18,569	13,949 (75.1%)	1863 (10.0%)	753 (4.1%)	2,004 (10.8%)

1.2.3 Pathology

The term triple-negative breast cancer might be misleading as it implies that it is a type of cancer with clearly defined histopathological features. However, it has been shown that there is a variety among TNBCs regarding those features. In a sample of 97 patients with TNBC, 92 of those cancers showed histopathological features of invasive ductal carcinoma. Additionally, cancers with features of apocrine, medullary, spindle cell, or small cell carcinoma were also observed (11). Common morphological features of ductal invasive carcinoma are lymphoid aggregation, high mitotic indices, central necrosis, nuclear pleomorphism, and expression of epidermal growth factor receptor (EGFR) and cytokeratin (CK5) (12).

Based on histological features, TNBCs can be divided into the common subtype, which is the invasive ductal carcinoma, as well as the special subtypes. The special subtypes encompass 47 different subtypes and include metaplastic carcinoma matrix producing type, squamous type, mixed type, and spindle cell type, as well as invasive lobular, adenoid cystic, glycogen-rich clear, and mucinous carcinoma (13). Characteristic pictures of the subtypes can be seen in Figure 3.

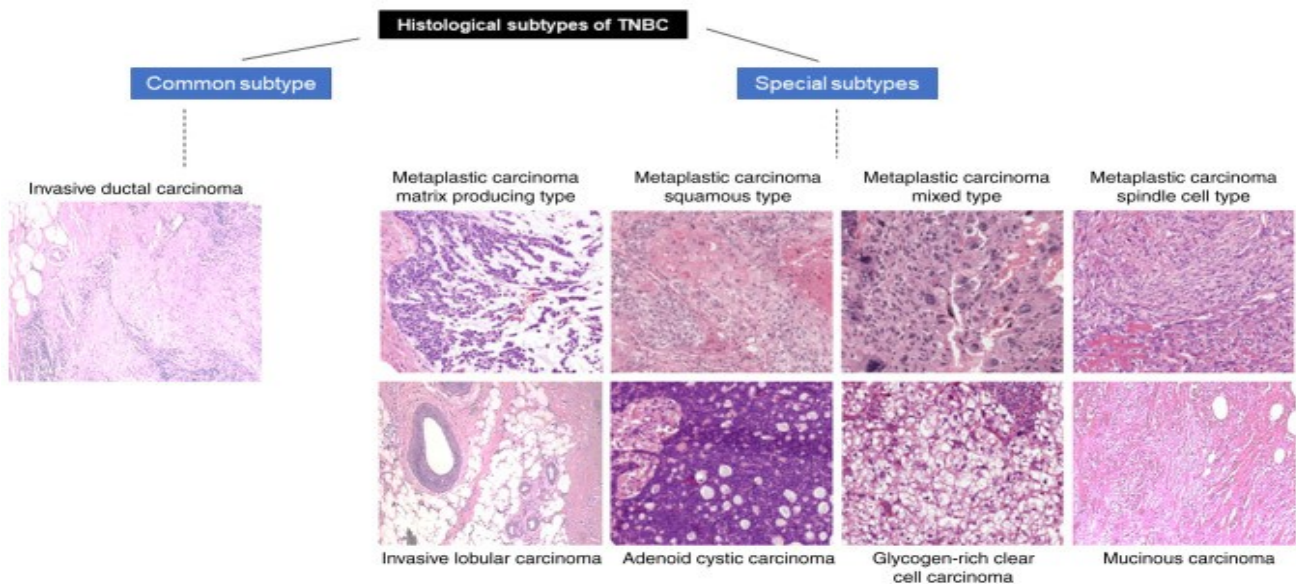


Figure 3. Histological subtypes of TNBC are shown with their characteristic appearance under the microscope.

SOURCE: Manjunath et al (13).

TNBC can also be classified and divided into molecular subtypes based on gene expression. Six different subtypes were identified this way: basal-like 1 (BL1), basal-like 2 (BL2), immunomodulatory (IM), mesenchymal (M), mesenchymal stem-like (MSL), and luminal androgen receptor (LAR) (14). Those subtypes have a heterogeneous mutational profile. Overall, the LAR subtype has the highest mutational burden, whereas the MSL subtype shows a lower mutational burden. The most common mutated gene in exonic regions in all subtypes is the tumor protein 53 (TP53) followed by the mucin 16 (MUC16) and the phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) gene. The most characteristic mutational profile can be seen in the LAR subtype which exhibits mutations in the PIK3CA, Lysine N-methyltransferase 2C (KMT2C), cadherin 1 (CDH1), neurofibromin 1 (NF1) and AKT Serine/Threonine Kinase 1 (AKT1) gene (15).

In the TNBC cell lines BT-549 and Hs 578T different subpopulations according to their expression of the cell surface markers CD44 and CD24 can be found. Those subpopulations are breast cancer stem cell (BCSC) mesenchymal-like cells (CD44⁺/CD24⁻), epithelial cells (CD44⁻/CD24⁺), hybrid cells showing both mesenchymal and epithelial characteristics (CD44⁺/CD24⁺) and CD44⁻/CD24⁻ cells (16). When comparing different histological breast cancer subtypes and their expression of CD44 and CD24, significant differences can be observed. Pure ductal carcinoma in situ (DCIS) has the highest percent of CD44⁺/CD24⁻, followed by CD44⁺/CD24⁺. The highest percent of CD44⁻/CD24⁺ can be seen in DCIS with microinvasion. Invasive ductal carcinoma (IDC) is characterized by a high percent of CD44⁻/CD24⁻ (17). It has been shown that lack of expression of CD44 and CD24 in luminal breast cancer is associated with metastatic properties (18). Furthermore, cells with expression of mixed epithelial and mesenchymal gene expression are highly aggressive. Plasticity and self-renewal are associated with the CD24⁺/CD44⁻ (epithelial) and the CD24⁻/CD44⁺ (mesenchymal) phenotypes respectively (19).

1.2.4 Therapeutic Options

Treatment modalities for TNBC range from surgery, radiation therapy, and chemotherapy, to molecular-directed targeted therapy. Surgical options include mastectomy and breast-conserving surgery (BCS) with subsequent radiation therapy. BCS is the treatment of choice for low grade tumors, whereas mastectomy is used for more advanced cancers as well as tumors with positive margins after previous BCS (20). The local recurrence rate of

TNBC is reduced by postoperative radiotherapy. It has been shown that patients with TNBC without lymph node metastases who underwent BCS with subsequent radiotherapy had a similar outcome to those who underwent mastectomy. Additionally, postoperative radiotherapy improves the outcome and leads to a lower local recurrence rate in patients T1/T2 TNBC with 4 or more positive axillary lymph nodes (21). Despite TNBC being chemotherapy sensitive in early stages, no optimal therapeutic has been established so far. The pathological complete response (pCR) in patients treated solely with anthracyclines ranges from 14 to 47%. The pCR rate of platinum monotherapy ranges from 23 to 90% has been shown to be even higher in patients with breast cancer gene (BRCA) mutations. However, carboplatin has a significant toxicity. The monoclonal antibody pembrolizumab, which acts as an inhibitor of programmed cell death 1 (PD1), improves the pCR when combined with anthracycline and taxane chemotherapy (22). For metastatic disease, a taxane or anthracycline combination can be used as a drug regimen (23).

Another approach is the molecular-directed targeted therapy. Different molecular pathways that play a role in the pathogenesis of TNBC have been explored including vascular endothelial growth factor (VEGF), poly (ADP-ribose) polymerase (PARP), epidermal growth factor receptor (EGFR), mammalian target of rapamycin (mTOR), androgen receptor (AR), as well as anti-PD-1 agents (20).

VEGF is an important mediator of angiogenesis and contributes to growth of cancers, making it a logical therapy target (24). Bevacizumab is a VEGF-A-targeting monoclonal antibody and the first approved angiogenesis inhibitor (25). In a non-randomized phase II study bevacizumab in combination with either docetaxel or paclitaxel, as a first-line treatment for HER2-negative metastatic breast cancer, has led to a progression-free survival of 11.3 months and an overall survival of 35.1 months (26). In a randomized phase III trial, bevacizumab plus chemotherapy has been compared with chemotherapy alone in patients with HER2-negative locally recurrent or metastatic breast cancer after treatment with bevacizumab plus chemotherapy. Progression-free survival was 6.3 months for patients who received bevacizumab and 4.2 months in patients who received chemotherapy alone (27).

PARP-1 and PARP-2 play an important role in the repair of single-strand deoxyribonucleic acid (DNA) breaks (28). Veliparib acts as a PARP inhibitor (29). Adding veliparib to a combination of carboplatin and paclitaxel has been proven to improve progression-free survival in BRCA-mutated advanced breast cancer (30).

Expression of EGFR predominates in TNBC making it a potential target for therapeutic approaches (31). The chimeric mouse-human IgG1 antibody cetuximab targets EGFR signaling and has been used in different cancers (32). Unfortunately, cetuximab did not show promising results in randomized controlled trials which might be due to its partial agonistic action on EGFR (33, 34).

TNBC frequently shows alterations in the phosphoinositide 3-kinase (PI3K)/ protein kinase B (AKT)/ mTOR pathway, leading to the exploration of potential therapeutic drugs which act on this pathway (35). Everolimus is a derivative of rapamycin that acts on mTOR and has been shown to reduce growth of breast cancer cells *in vitro* (36, 37). However, addition of everolimus to a combination of paclitaxel and cisplatin in stage II/III TNBC leads to an increase in adverse reactions without improving pCR (38).

AR expression is a characteristic feature of the LAR subtype, making it a possible target for anti-AR drugs (39). The AR inhibitor enzalutamide, which has been shown to be effective in the treatment of prostate cancer, can inhibit 5-alpha-dihydrotestosterone (DHT)-mediated proliferation of breast cancer lines *in vitro* (40, 41). In a phase II clinical study, enzalutamide has been proven to not cause severe side effects in the treatment of AR expressing TNBC (42).

1.3 Gangliosides

1.3.1 Definition

Gangliosides are defined as sialic acid-containing glycosphingolipids and were discovered by Ernst Klenk who isolated them postmortem from brain tissue of patients with amaurotic idiocy (43). The number of sialic acid residues determines the nomenclature of gangliosides and differentiates between monosialogangliosides (GM), disialogangliosides (GD), trisialogangliosides (GT) and tetrasialoganglioside (GQ), according to Svennerholm (44, 45).

1.3.2 Function

Gangliosides are present in all tissues and fluids but can be mostly found in the nervous system (46). The significance of gangliosides has been demonstrated in knock-out mice which were lacking the genes encoding for GM2 and GM3 resulting in a fatal

neurodegenerative outcome (47). Furthermore, loss of the gene encoding for GM3 resulted in hearing loss in knock-out mice due to degeneration of the organ of Corti (48).

It appears that the gangliosides GT1b, GD3, and GM3 inhibit the activity of protein kinase C (PKC) in cow mammary glands and thereby interfere with PKC mediated signal transduction (49). PKC plays an important role in cell growth, survival, migration, as well as adhesion (50).

1.3.3 Biosynthesis

The synthesis of ceramide in the endoplasmic reticulum marks the beginning of the synthesis of gangliosides (51, 52). In the next step UDP-glucose ceramide glycosyltransferase transfers a glucose residue onto ceramide generating glucosylceramide. Following this, glucosylceramide gets converted into lactosylceramide which is the precursor of GM3 (53, 54). After the generation of GM3 ganglioside synthesis occurs via two different pathways named “a” and “b” pathway (Figure 4).

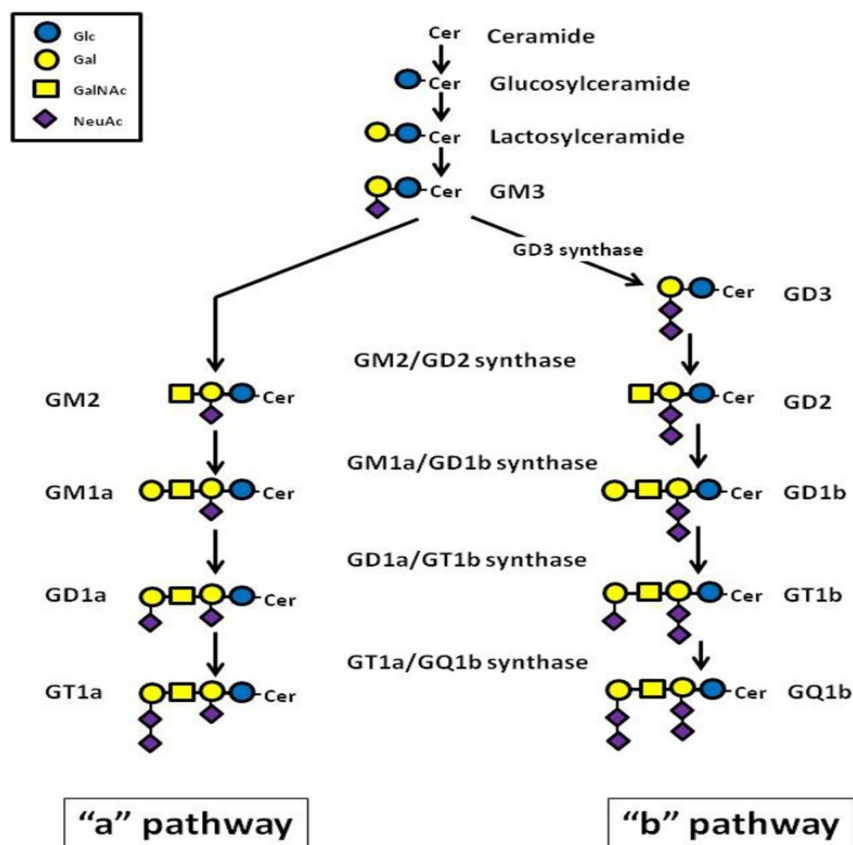


Figure 4. Schematic illustration of ganglioside biosynthesis and the “a” and “b” pathway
 SOURCE: Berois et al (54).

1.3.4 Ganglioside GD3

GD3 is a very important ganglioside in embryonic or undifferentiated cells (55). Studies in knockout mice showed that GD3 appears to be significant for the self-renewal of neural stem cells in the mouse brain (56). Furthermore, alterations of GD3 expression have been demonstrated in Creutzfeldt-Jakob disease suggesting a role in the pathogenesis of this disease (57).

In glioblastoma cell cultures it has been demonstrated that acetylated GD3 aids in tumor survival (58). In addition to this, GD3 can regulate cell proliferation and differentiation via VEGF stimulation (44).

It has been demonstrated, that GD3 levels are 1.7 times increased in breast cancer tissue (59). The importance of GD3 in this type of cancer is further emphasized by the ability of GD3 to activate EGFR signaling in breast cancer cell lines (60).

2. OBJECTIVES AND HYPOTHESES

2.1 Objectives

The aim of this study was to determine the effect of the newly synthesized thieno[2,3-*b*]pyridine anticancer compound (compound 1) on breast cancer stem cells, by focusing on its impact on GD3 expression in the human cell line MDA-MB-231 and its CD44⁺/CD24⁺, as well as CD44⁺/CD24⁻ subpopulations.

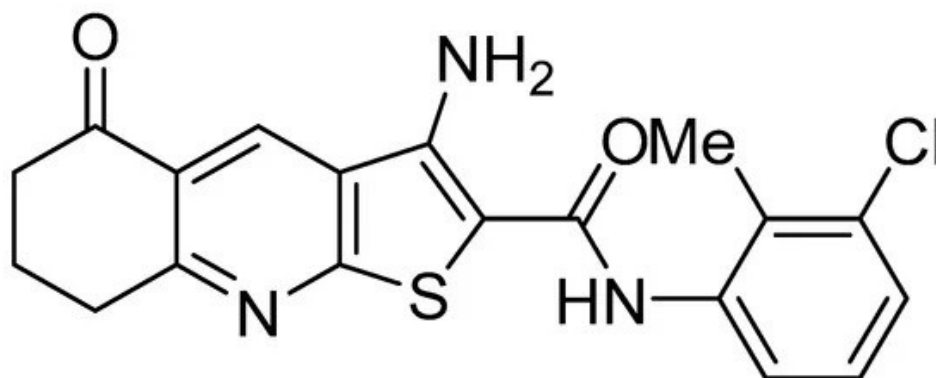
2.2 Hypotheses

1. Treatment with compound 1 leads to a reduction of the GD3 expression in CD44⁺/CD24⁻ CSCs
2. Treatment with compound 1 leads to a reduction of the GD3 expression in CD44⁻ epithelial cells
3. Treatment with compound 1 leads to a reduction of the GD3 expression in CD44⁺/CD24⁺ hybrid cells

3. MATERIALS AND METHODS

3.1 Chemistry and cell line

Compound 1 was prepared in a 3-step fashion from 1,3-cyclohexanedione as reported in Marijan et al (61). The chemical structure of 3-Amino-N-(3-chloro-2-methylphenyl)-5-oxo-5,6,7,8-tetrahydrothieno[2,3- b]quinoline-2-carboxamide (compound 1) can be seen in Figure 5. Cells were obtained from the American Type Culture Collection (ATCC, LGC Standards). Cell line MDA-MB-231 was grown in a humidified incubator at 37 °C and 5% CO₂ in Dulbecco's modified Eagle medium (DMEM, Sigma-Aldrich, Steinheim, Germany) containing 10% fetal bovine serum (EuroClone, Milan, Italy) and 1% antibiotics (EuroClone) (61). Characteristic features of the cell line MDA-MB-231 are shown in Table 2 (62).



Compound 1

Figure 5. Structure of the anticancer thieno[2,3-*b*]pyridine derivative
SOURCE: Marijan et al (61)

Table 2. Characteristics of MDA-MB-231 cell lineSOURCE: <https://www.lgcstandards-atcc.org> (62)

Characteristics	
Organism	Homo sapiens
Cell Type	epithelial cell
Tissue	Breast; Mammary gland
Age	51 years
Gender	Female
Morphology	Epithelial
Growth properties	Adherent
Disease	Adenocarcinoma
Product format	Frozen
Storage conditions	Vapor phase of liquid nitrogen
Intended use	Laboratory research only
Biosafety level	1
Growth conditions	37°C, 100% air
Reagents for cryopreservation	Complete growth medium supplemented with 5% (v/v) DMSO (ATCC 4-X)
Receptor Expression	Epidermal growth factor (EGF), expressed; transforming growth factor alpha (TGF alpha), expressed

3.2 Flow cytometric analysis

An identical number of cells were plated onto six-well plates and treated with 2 M compound 1 for 48 h, as well as the untreated controls, trypsinized and washed with a phosphate-buffered saline (PBS). After an incubation time of 20 minutes with PBS-diluted primary antibodies against GD3 (mouse IgG3) (produced by laboratory of Dr. J. Muthing)(63) at room temperature, cells were incubated with diluted anti-CD44-fluorescein isothiocyanate (FITC) (1:13; BD Biosciences), anti-CD24-phycoerythrin (PE), and secondary antibody to anti-GD3s conjugated with eFluor 660 fluorochrome (1:10; eBioscience) for 20 min in a lightproof area. Following this, cells were resuspended in PBS, and then analyzed via flow

cytometry. The acquisition of data of triple-stained samples was done by a BD Accuri C6 cytometer (BD Biosciences) and analyzed with the FlowLogic Software.

3.3 Geometric Mean Fluorescence Intensity (GMI)

The geometric mean fluorescence intensity (GMI) of GD3s (GD3s expression/ cell), was determined with FlowLogic from a number of cells and the log of fluorescence in a FL4 flow cytometer channel. A standard optical filter of 675/25 nm has been used. The emission wavelength of immunofluorescence of eFluor 660 fluorochrome that is conjugated to a secondary anti-GD3 antibody is 660 nm.

GMI is calculated through the multiplication of cell numbers with the matching fluorescence and adding all results. The following total sum is divided with the total cell number, yielding the GMI (61).

3.4 Statistical analysis

The statistical analysis was done with the student t-test using statistical software Graph-Pad Prism 7.0 (San Diego, Ca, USA) and the significance was set at $P < 0.05$.

4. RESULTS

4.1 GD3 expression in CD44⁺/CD24⁻ CSC

The treatment with compound 1 resulted in an increased percentage of GD3⁺ cells in CD44⁺/CD24⁻ CSCs. The percentage of GD3⁺ cells was 8.9 in the untreated control and 32.5 after treatment ($P < 0.01$) (Figure 6).

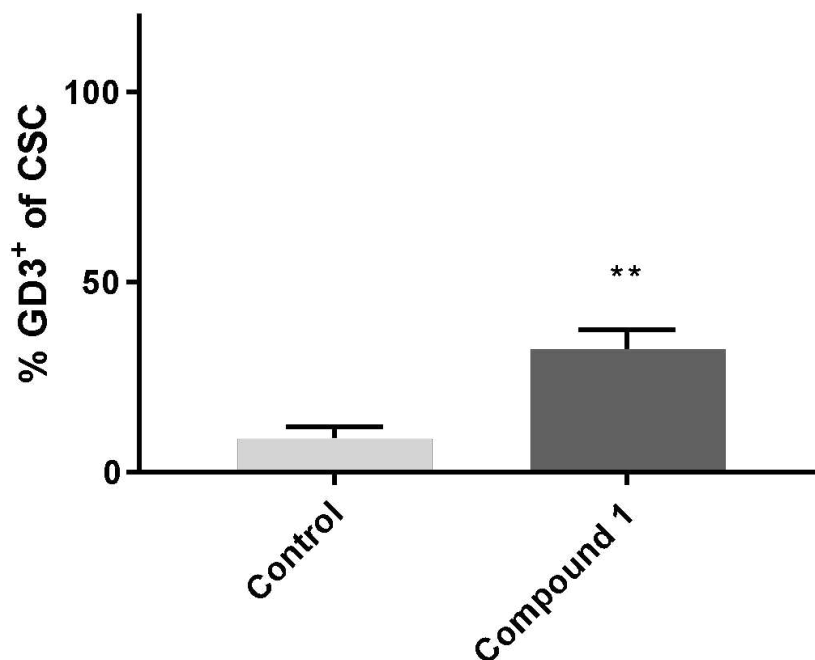


Figure 6. Percentage of GD3⁺ CSCs after compound 1 treatment.

Notes: Percentage of GD3⁺ of CSCs after treatment with compound 1 for 48 h in MDA-MB-231. Data represent are expressed as a mean from experiment performed in triplicate — SD. Columns, mean of cells; bars, SD; ** $P < 0.01$

Abbreviations: CSCs cancer stem cells, SD standard deviation.

Geometric mean fluorescence intensity (GMI) of GD3 (GD3 expression/cell) in CSCs after treatment with compound 1 was 8,673.75 and therefore decreased in comparison to untreated cells with a GMI of 10,682.85 (Figure 7).

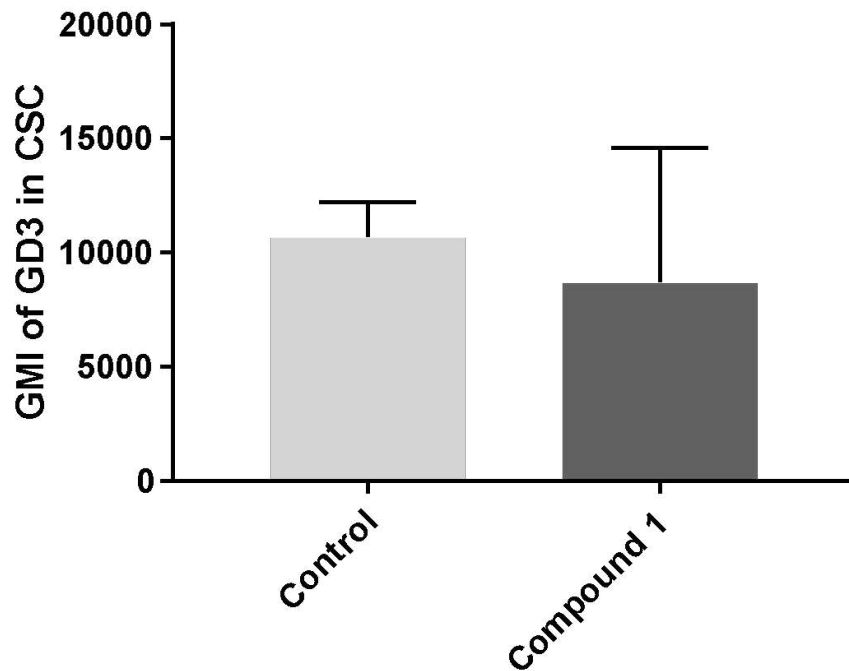


Figure 7. GMI of GD3 in CSCs after compound 1 treatment.

Notes: Expression of GD3 in CSCs after treatment with compound 1 for 48 h in MDA-MB-231. Data represent are expressed as a mean from experiment performed in triplicate — SD. Columns, mean of cells; bars, SD

Abbreviations: CSCs cancer stem cells, SD standard deviation

4.2 GD3 expression in CD44⁺ epithelial cells

The treatment with compound 1 resulted in an increased percentage of GD3⁺ cells in CD44⁺ epithelial cells. The percentage of GD3⁺ cells was 22.2 in the untreated control and 40.6 after treatment ($P < 0.05$) (Figure 8).

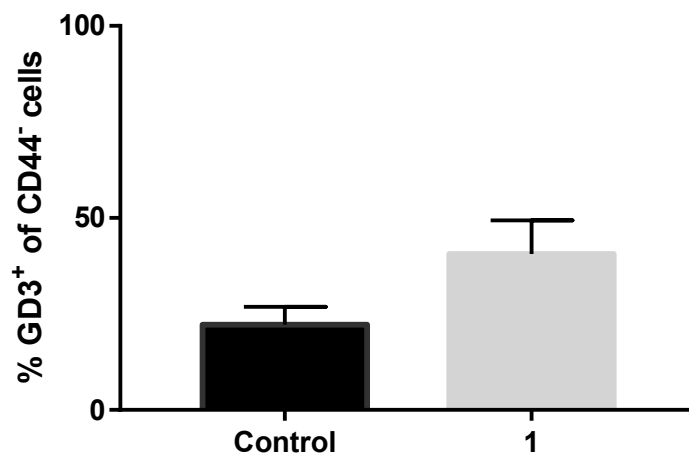


Figure 8. CD44⁻ cells after compound 1 treatment.

Notes: Percentage of GD3⁺ of CD44⁻ epithelial cells after treatment with compound 1 for 48 h in MDA-MB-231. Data represent are expressed as a mean from experiment performed in triplicate — SD. Columns, mean of cells; bars, SD;

Abbreviations: SD standard deviation.

Geometric mean fluorescence intensity (GMI) of GD3 (GD3 expression/cell) in CD44⁻ epithelial cells after treatment with compound 1 was 11,986 and therefore decreased in comparison to untreated cells with a GMI of 5,390 ($P < 0.01$) (Figure 9).

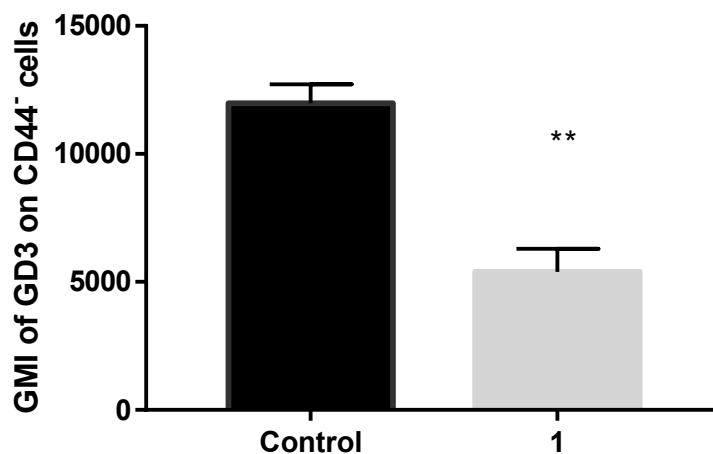


Figure 9. GMI of GD3 in CD44⁻ epithelial cells after compound 1 treatment.

Notes: Expression of GD3 in CD44⁻ epithelial cells after treatment with compound 1 for 48 h in MDA-MB-231. Data represent are expressed as a mean from experiment performed in triplicate — SD. Columns, mean of cells; bars, SD. ****** $P < 0.01$

Abbreviations: SD standard deviation

4.3 GD3 expression in CD44⁺/CD24⁺ hybrid cells

The treatment with compound 1 resulted in an increased percentage of GD3⁺ cells in CD 44⁺/CD24⁺ hybrid cells. The percentage of GD3⁺ cells was 76.3 in the untreated control and 82.9 after treatment ($P > 0.5$) (Figure 10).

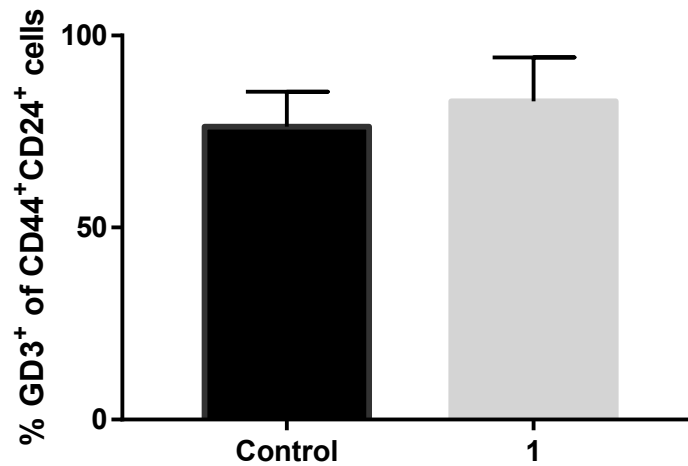


Figure 10. CD44⁺/CD24⁺ cells after compound 1 treatment.

Notes: Percentage of GD3⁺ of CD44⁺/CD24⁺ hybrid cells after treatment with compound 1 for 48 h in MDA-MB-231. Data represent are expressed as a mean from experiment performed in triplicate — SD. Columns, mean of cells; bars, SD;

Abbreviations: SD standard deviation.

Geometric mean fluorescence intensity (GMI) of GD3 (GD3 expression/cell) in CD44⁺/CD24⁺ hybrid cells after treatment with compound 1 was 43,559 and therefore increased in comparison to untreated cells with a GMI of 42,049 ($P > 0.05$).

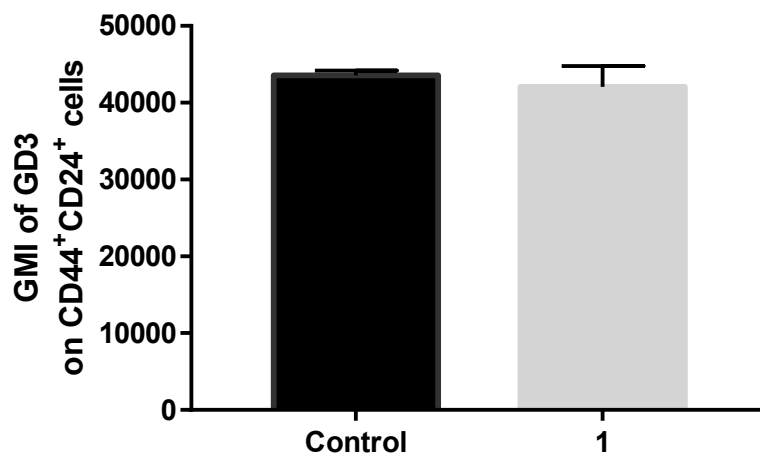


Figure 11. GMI of GD3 in CD44⁺/ CD24⁺ hybrid cells after compound 1 treatment.

Notes: Expression of GD3 in CD44⁺/CD24⁺ hybrid cells after treatment with compound 1 for 48 h in MDA-MB-231. Data represent are expressed as a mean from experiment performed in triplicate — SD. Columns, mean of cells; bars, SD.

Abbreviations: SD standard deviation

5. DISCUSSION

When taking into consideration that up to this day an optimal treatment for TNBC has not been established, exploring new therapeutic options is a logical consequence (22). It has been demonstrated that 3-amino-N-(3-chloro-2-methylphenyl)-5-oxo-5,6,7,8-tetrahydrothieno[2,3-*b*]quinoline-2-carboxamide (compound 1) is not only able to reduce CSCs in the MDA-MB-231 cell line, but also has an impact on morphology and cell migration (61). Its dose- and time-dependent cytotoxicity has been proven in previous studies (64). Therefore, in order to unravel the different effects that compound 1 has on the MDA-MB-231 cell line, we wanted to determine its effect on GD3 expression in different breast cancer subpopulations.

We observed that treatment with compound 1 resulted in an increased percentage of GD3 in CSCs (Figure 6). Interestingly, the GMI of GD3 was decreased in the cells, that were treated with compound in comparison to the untreated control group (Figure 7). A similar observation was made in CD44⁻ epithelial cells, which showed a reduction of GMI of GD3 upon treatment with compound 1 (Figure 8, Figure 9). This shows, that reduction of GD3 expression has occurred in cells which were treated with compound 1. As mentioned before, GD3 expression is advantageous for cancer cells. It plays a role in different signaling pathways including those which involve VEGF, as well as EGFR (44, 60). Furthermore, GD3 has been linked to aid in tumor survival (58). We can conclude that treatment with compound 1 has an impact on GD3 linked signaling pathways, as well as survivability in CSCs and CD44⁻ epithelial cells via the reduction of GD3 expression in these subpopulations.

In different to other subpopulations, hybrid cells (CD44⁺/CD24⁺) did not show a significant reduction in GMI of GD3 (Figure 11). However, it has been shown previously that compound 1 is able to reduce the expression of CD15s in the CD44⁺/CD24⁺ subpopulation (61). It appears that the effect of compound 1 in this subpopulation is more significant in CD15s expression than in GD3 expression.

It has to be mentioned that limiting factors for this study have to be taken into consideration. As an *in vitro* study, no conclusions regarding the safety of the drug in patients can be drawn. However, the experiments were performed in triplicates, eliminating further major limitations of this study. Therefore, one could conduct a new study and explore GD3 expression after treatment with compound 1 in other breast cancer cell lines and compare those results with this study.

Overall, this study shows that GD3 expression in breast cancer subpopulations after novel thieno[2,3-*b*]pyridine derivative treatment, varies upon different subpopulations. A reduction of GD3 expression has been confirmed in CSCs, as well as CD44⁺ epithelial cells. In order to determine a therapeutic dose tolerable for patients, as well as the effect of compound 1 on an organism, further *in vivo* studies have to be conducted.

6. CONCLUSIONS

- Treatment with compound 1 leads to a reduction of the expression of GD3 in CD44⁺/CD24⁻ CSCs
- Treatment with compound 1 leads to reduction of the expression of GD3 in CD44⁻ epithelial cells
- Treatment with compound 1 does not have a significant impact on GD3 expression in CD44⁺/CD24⁺ hybrid cells
- When taking into consideration the role of GD3 in survivability of cancer cells and the impact of compound 1 on its expression in different breast cancer subpopulations, further studies to explore its utility *in vivo* should be conducted.

7. REFERENCES

1. Ahmad FB, Anderson RN. The Leading Causes of Death in the US for 2020. *JAMA*. 2021;325(18):1829-30.
2. Pardee AB. Growth dysregulation in cancer cells. *Adv Cancer Res*. 1994;65:213-28.
3. Kumar, Vinay, et al. *Robbins Basic Pathology*. 10th ed., Elsevier - Health Sciences Division, 2017.
4. Hanahan D, Weinberg RA. Hallmarks of cancer: the next generation. *Cell*. 2011;144(5):646-74.
5. Chaffer CL, Weinberg RA. A perspective on cancer cell metastasis. *Science*. 2011;331(6024):1559-64.
6. Seyfried TN, Huysentruyt LC. On the origin of cancer metastasis. *Crit Rev Oncog*. 2013;18(1-2):43-73.
7. Irvin WJ Jr, Carey LA. What is triple-negative breast cancer?. *Eur J Cancer*. 2008;44(18):2799-805.
8. Lachapelle J, Foulkes WD. Triple-negative and basal-like breast cancer: implications for oncologists. *Curr Oncol*. 2011;18(4):161-4.
9. Sung H, Ferlay J, Siegel RL, Laversanne M, Soerjomataram I, Jemal A, Bray F. Global cancer statistics 2020: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA Cancer J Clin*. 2021; 71: 209- 49.
10. Plasilova ML, Hayse B, Killelea BK, Horowitz NR, Chagpar AB, Lannin DR. Features of triple-negative breast cancer: Analysis of 38,813 cases from the national cancer database. *Medicine (Baltimore)*. 2016;95(35):e4614.
11. Ishikawa Y, Horiguchi J, Toya H, et al. Triple-negative breast cancer: histological subtypes and immunohistochemical and clinicopathological features. *Cancer Sci*. 2011;102(3):656-62.
12. Badve S, Dabbs DJ, Schnitt SJ, et al. Basal-like and triple-negative breast cancers: a critical review with an emphasis on the implications for pathologists and oncologists. *Mod Pathol*. 2011;24(2):157-67
13. Manjunath M, Choudhary B. Triple-negative breast cancer: A run-through of features, classification and current therapies. *Oncol Lett*. 2021;22(1):512.
14. Lehmann BD, Bauer JA, Chen X, et al. Identification of human triple-negative breast cancer subtypes and preclinical models for selection of targeted therapies. *J Clin Invest*. 2011;121(7):2750-67.

15. Bareche Y, Venet D, Ignatiadis M, et al. Unravelling triple-negative breast cancer molecular heterogeneity using an integrative multiomic analysis. *Ann Oncol.* 2018;29(4):895-902.
16. Moreira MP, Brayner FA, Alves LC, Cassali GD, Silva LM. Phenotypic, structural, and ultrastructural analysis of triple-negative breast cancer cell lines and breast cancer stem cell subpopulation. *Eur Biophys J.* 2019;48(7):673-84.
17. Park SY, Lee HE, Li H, Shipitsin M, Gelman R, Polyak K. Heterogeneity for stem cell-related markers according to tumor subtype and histologic stage in breast cancer. *Clin Cancer Res.* 2010;16(3):876-87.
18. Vikram R, Chou WC, Hung SC, Shen CY. Tumorigenic and Metastatic Role of CD44-/low/CD24-/low Cells in Luminal Breast Cancer. *Cancers (Basel).* 2020;12(5):1239.
19. Grosse-Wilde A, Fouquier d'Hérouël A, McIntosh E, et al. Stemness of the hybrid Epithelial/Mesenchymal State in Breast Cancer and Its Association with Poor Survival. *PLoS One.* 2015;10(5):e0126522.
20. Kumar P, Aggarwal R. An overview of triple-negative breast cancer. *Arch Gynecol Obstet.* 2016;293(2):247-69.
21. He MY, Rancoule C, Rehailia-Blanchard A, et al. Radiotherapy in triple-negative breast cancer: Current situation and upcoming strategies. *Crit Rev Oncol Hematol.* 2018;131:96-101.
22. Bergin ART, Loi S. Triple-negative breast cancer: recent treatment advances. *F1000Res.* 2019;8:F1000 Faculty Rev-1342. doi: 10.12688/f1000research.
23. Cardoso F, Senkus E, Costa A, et al. 4th ESO-ESMO International Consensus Guidelines for Advanced Breast Cancer (ABC 4)†. *Ann Oncol.* 2018;29(8):1634-57.
24. Carmeliet P. VEGF as a key mediator of angiogenesis in cancer. *Oncology.* 2005;69 Suppl 3:4-10.
25. Garcia J, Hurwitz HI, Sandler AB, et al. Bevacizumab (Avastin®) in cancer treatment: A review of 15 years of clinical experience and future outlook. *Cancer Treat Rev.* 2020;86:102017.
26. Tiainen L, Tanner M, Lahdenperä O, et al. Bevacizumab Combined with Docetaxel or Paclitaxel as First-line Treatment of HER2-negative Metastatic Breast Cancer. *Anticancer Res.* 2016;36(12):6431-8.

27. von Minckwitz G, Puglisi F, Cortes J, et al. Bevacizumab plus chemotherapy versus chemotherapy alone as second-line treatment for patients with HER2-negative locally recurrent or metastatic breast cancer after first-line treatment with bevacizumab plus chemotherapy (TANIA): an open-label, randomised phase 3 trial. *Lancet Oncol.* 2014;15(11):1269-78.
28. Hoeijmakers JH. Genome maintenance mechanisms for preventing cancer. *Nature.* 2001;411(6835):366-74.
29. Ghisoni E, Giannone G, Tuninetti V, et al. Veliparib: a new therapeutic option in ovarian cancer?. *Future Oncol.* 2019;15(17):1975-87.
30. Diéras V, Han HS, Kaufman B, et al. Veliparib with carboplatin and paclitaxel in BRCA-mutated advanced breast cancer (BROCADE3): a randomised, double-blind, placebo-controlled, phase 3 trial. *Lancet Oncol.* 2020;21(10):1269-82.
31. Changavi AA, Shashikala A, Ramji AS. Epidermal Growth Factor Receptor Expression in Triple Negative and Nontriple Negative Breast Carcinomas. *J Lab Physicians.* 2015;7(2):79-83.
32. Gurdal H, Tuglu MM, Bostanabad SY, Dalkiliç B. Partial agonistic effect of cetuximab on epidermal growth factor receptor and Src kinase activation in triple-negative breast cancer cell lines. *Int J Oncol.* 2019;54(4):1345-56.
32. Chong CR, Jänne PA. The quest to overcome resistance to EGFR-targeted therapies in cancer. *Nat Med.* 2013;19(11):1389-400.
33. Carey LA, Rugo HS, Marcom PK, et al. TBCRC 001: randomized phase II study of cetuximab in combination with carboplatin in stage IV triple-negative breast cancer. *J Clin Oncol.* 2012;30(21):2615-23.
34. Gurdal H, Tuglu MM, Bostanabad SY, Dalkiliç B. Partial agonistic effect of cetuximab on epidermal growth factor receptor and Src kinase activation in triple-negative breast cancer cell lines. *Int J Oncol.* 2019;54(4):1345-56.
35. Costa RLB, Han HS, Gradishar WJ. Targeting the PI3K/AKT/mTOR pathway in triple-negative breast cancer: a review. *Breast Cancer Res Treat.* 2018;169(3):397-406.
36. Guarini A, Minoia C, Giannoccaro M, et al. mTOR as a target of everolimus in refractory/relapsed Hodgkin lymphoma. *Curr Med Chem.* 2012;19(7):945-54.

37. Du L, Li X, Zhen L, et al. Everolimus inhibits breast cancer cell growth through PI3K/AKT/mTOR signaling pathway. *Mol Med Rep.* 2018;17(5):7163-9.
38. Jovanović B, Mayer IA, Mayer EL, et al. A Randomized Phase II Neoadjuvant Study of Cisplatin, Paclitaxel With or Without Everolimus in Patients with Stage II/III Triple-Negative Breast Cancer (TNBC): Responses and Long-term Outcome Correlated with Increased Frequency of DNA Damage Response Gene Mutations, TNBC Subtype, AR Status, and Ki67. *Clin Cancer Res.* 2017;23(15):4035-45.
39. Gerratana L, Basile D, Buono G, et al. Androgen receptor in triple negative breast cancer: A potential target for the targetless subtype. *Cancer Treat Rev.* 2018;68:102-10.
40. Merseburger AS, Haas GP, von Klot CA. An update on enzalutamide in the treatment of prostate cancer. *Ther Adv Urol.* 2015;7(1):9-21.
41. Cochrane DR, Bernales S, Jacobsen BM, et al. Role of the androgen receptor in breast cancer and preclinical analysis of enzalutamide. *Breast Cancer Res.* 2014;16(1):R7.
42. Traina TA, Miller K, Yardley DA, et al. Enzalutamide for the Treatment of Androgen Receptor-Expressing Triple-Negative Breast Cancer. *J Clin Oncol.* 2018;36(9):884-90.
43. Sandhoff R, Sandhoff K. Emerging concepts of ganglioside metabolism. *FEBS Lett.* 2018;592(23):3835-64.
44. Liu J, Zheng X, Pang X, et al. Ganglioside GD3 synthase (GD3S), a novel cancer drug target. *Acta Pharm Sin B.* 2018;8(5):713-20.
45. Svennerholm L. Chromatographic Separation of Human Brain Gangliosides. *J Neurochem.* 1963;10:613-23.
46. Yu RK, Nakatani Y, Yanagisawa M. The role of glycosphingolipid metabolism in the developing brain. *J Lipid Res.* 2009;50 Suppl(Suppl):S440-5.
47. Yamashita T, Wu YP, Sandhoff R, et al. Interruption of ganglioside synthesis produces central nervous system degeneration and altered axon-glial interactions. *Proc Natl Acad Sci U S A.* 2005;102(8):2725-30.
48. Yoshikawa M, Go S, Takasaki K, et al. Mice lacking ganglioside GM3 synthase exhibit complete hearing loss due to selective degeneration of the organ of Corti. *Proc Natl Acad Sci U S A.* 2009;106(23):9483-8.

49. Katoh N, Kira T, Yuasa A. Protein kinase C substrates and ganglioside inhibitors in bovine mammary nuclei. *J Dairy Sci.* 1993;76(11):3400-9.
50. Singh RK, Kumar S, Tomar MS, et al. Classical Protein Kinase C: a novel kinase target in breast cancer. *Clin Transl Oncol.* 2019;21(3):259-67.
51. Stiban J, Caputo L, Colombini M. Ceramide synthesis in the endoplasmic reticulum can permeabilize mitochondria to proapoptotic proteins. *J Lipid Res.* 2008;49(3):625-34.
52. Breiden B, Sandhoff K. Ganglioside Metabolism and Its Inherited Diseases. *Methods Mol Biol.* 2018;1804:97-141.
53. Julien S, Bobowski M, Steenackers A, Le Bourhis X, Delannoy P. How Do Gangliosides Regulate RTKs Signaling?. *Cells.* 2013;2(4):751-67.
54. Berois N, Osinaga E. Glycobiology of neuroblastoma: impact on tumor behavior, prognosis, and therapeutic strategies. *Front Oncol.* 2014;4:114.
55. Dyatlovitskaya EV, Bergelson LD. Glycosphingolipids and antitumor immunity. *Biochim Biophys Acta.* 1987;907(2):125-43.
56. Wang J, Cheng A, Wakade C, Yu RK. Ganglioside GD3 is required for neurogenesis and long-term maintenance of neural stem cells in the postnatal mouse brain. *J Neurosci.* 2014;34(41):13790-800.
57. Ohtani Y, Tamai Y, Ohnuki Y, Miura S. Ganglioside alterations in the central and peripheral nervous systems of patients with Creutzfeldt-Jakob disease. *Neurodegeneration.* 1996;5(4):331-8.
58. Birks SM, Danquah JO, King L, Vlasak R, Gorecki DC, Pilkington GJ. Targeting the GD3 acetylation pathway selectively induces apoptosis in glioblastoma. *Neuro Oncol.* 2011;13(9):950-60.
59. Marquina G, Waki H, Fernandez LE, et al. Gangliosides expressed in human breast cancer. *Cancer Res.* 1996;56(22):5165-71.
60. Liang YJ, Wang CY, Wang IA, et al. Interaction of glycosphingolipids GD3 and GD2 with growth factor receptors maintains breast cancer stem cell phenotype. *Oncotarget.* 2017;8(29):47454-73.
61. Marijan S, Mastelić A, Markotić A, et al. Thieno[2,3-b]Pyridine Derivative Targets Epithelial, Mesenchymal and Hybrid CD15s+ Breast Cancer Cells. *Medicines (Basel).* 2021;8(7):32.

62. Lgcstandards-atcc.org [Internet]. MDA-MB-231 (ATCC HTB-26).; [cited 2021 July 5]. Available from: <https://www.lgcstandards-atcc.org/products/all/HTB-26.aspx/>
63. Meisen I, Peter-Katalinić J, Müthing J. Direct analysis of silica gel extracts from immunostained glycosphingolipids by nanoelectrospray ionization quadrupole time-of-flight mass spectrometry. *Anal Chem.* 2004;76(8):2248-55.
64. Mastelić A, Čikeš Čulić V, Režić Mužinić N, et al. Glycophenotype of breast and prostate cancer stem cells treated with thieno[2,3-b]pyridine anticancer compound. *Drug Des Devel Ther.* 2017;11:759-69.

8. SUMMARY

Objectives: The goal of this study was to determine GD3 expression after treatment with the novel thieno[2,3-*b*]pyridine derivative, by focusing on CD44⁺/CD24⁻ CSCs, CD44⁻ epithelial cells, as well as CD44⁺/CD24⁺ hybrid cells.

Methods: The MDA-MB-231 cell line was treated with 3-amino-N-(3-chloro-2-methylphenyl)-5-oxo-5,6,7,8-tetrahydrothieno[2,3-*b*]quinoline-2-carboxamide (compound 1). Cells were plated onto six-well plates and treated with 2 M compound 1 for 48 h. Following this, cells were stained with anti-GD3, anti-CD44 and anti-CD24 antibodies, and then analyzed via flow cytometry. The acquisition of data of triple-stained samples was done by a BD Accuri C6 cytometer (BD Biosciences) and analyzed with the FlowLogic Software.

Results: Treatment of MDA-MB-231 cells with compound 1 has led to a reduction of the expression of GD3 in CD44⁺/CD24⁻ CSCs, as well as CD44⁻ epithelial cells. GD3 expression in CD44⁺/CD24⁺ hybrid cells was not significantly reduced.

Conclusion: Due to its ability to reduce GD3 expression in different breast cancer subpopulations, compound 1 has a potential to be used in the treatment of triple-negative breast cancer.

9. CROATIAN SUMMARY

Ciljevi: Cilj ove studije bio je utvrditi ekspresiju GD3 nakon tretmana novim derivatom tieno [2,3-b] piridina, posebice na CD44⁺/CD24⁻ matičnim stanicama raka (CSC), CD44⁻ epitelnim stanicama, kao i CD44⁺/CD24⁺ hibridnim stanicama.

Metode: Stanična linija MDA-MB-231 tretirana je s 3-amino-N-(3-kloro-2-metilfenil)-5-okso-5,6,7,8-tetrahidrotienom[2,3-b]kinolin-2-karboksamid (spoj 1). Stanice su nasađene na ploče sa šest jažica i tretirane s 2 M spojem 1 tijekom 48 sati. Nakon toga, stanice su obojane s protu-GD3, protu-CD44 i protu-CD24 protutijelima, a zatim analizirane protočnom citometrijom. Prikupljanje podataka trostruko obojenih stanica rađeno je citometrom BD Accuri C6 (BD Biosciences) i analizirano softverom FlowLogic.

Rezultati: Tretman MDA-MB-231 stanica spojem 1 doveo je do smanjenja ekspresije GD3 na CD44⁺/CD24⁻ CSC, kao i CD44⁻ epitelnim stanicama. Ekspresija GD3 na hibridnim stanicama CD44⁺/CD24⁺ nije bila značajno smanjena.

Zaključak: Zbog svoje sposobnosti smanjenja ekspresije GD3 u različitim subpopulacijama raka dojke, spoj 1 ima potencijal za upotrebu u liječenju trostruko-negativnog raka dojke.

10. CURRICULUM VITAE

Personal information

Name and surname: Matthias Jonathan Lange
Date of birth: 28th of January 1992 in Lindlar (Germany)
Citizenship: German
Address: Brückenstr. 33, 42799 Leichlingen (Germany)
Languages: German (native), English (fluent), Croatian (basic)
E-mail: matthias.j.lange@gmail.com

Education

2015-2021 University of Split School of Medicine, Croatia (medicine)
2012-2014 University of Cologne, Germany (medicine)
2011-2012 Saarland University, Germany (medicine)
2002-2011 Marienschule Opladen, Germany (highschool)