

## Review Article

# Protein Kinase C (PKC) Isozymes and Cancer

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Protein kinase C (PKC) is a family of phospholipid-dependent serine/threonine kinases, which can be further classified into three PKC isozymes subfamilies: conventional or classic, novel or nonclassic, and atypical. PKC isozymes are known to be involved in cell proliferation, survival, invasion, migration, apoptosis, angiogenesis, and drug resistance. Because of their key roles in cell signaling, PKC isozymes also have the potential to be promising therapeutic targets for several diseases, such as cardiovascular diseases, immune and inflammatory diseases, neurological diseases, metabolic disorders, and multiple types of cancer. This review primarily focuses on the activation, mechanism, and function of PKC isozymes during cancer development and progression.

## 1. Introduction

Protein kinase C (PKC) is a family of phospholipid-dependent serine/threonine kinases that function in numerous different cell types. Based on their structural and activation characteristics, this protein family can be further classified into three subfamilies: conventional or classic PKC isozymes ( $\alpha$ ,  $\beta$ I,  $\beta$ II, and  $\gamma$ ), novel or nonclassic PKC isozymes ( $\delta$ ,  $\epsilon$ ,  $\eta$ , and  $\theta$ ), and atypical PKC isozymes ( $\zeta$ ,  $\iota$ , and  $\lambda$ ). The activation of cPKCs requires diacylglycerol (DAG) as the primary activator along with phosphatidylserine (PS) and calcium ( $\text{Ca}^{2+}$ ) as cofactors of activation. The nPKCs are also regulated by DAG and PS but do not require  $\text{Ca}^{2+}$  for activation. In the case of aPKCs, their activity is stimulated only by PS and not by DAG and  $\text{Ca}^{2+}$  [1, 2].

PKC isozymes are involved in multiple signal transduction systems that respond to a variety of external stimulators, including hormones, growth factors, and other membrane receptor ligands. For this reason, PKC isozymes can act as therapeutic targets for several diseases, such as cardiovascular diseases (e.g., atherosclerosis, myocardial fibrosis, cardiac hypertrophy, and hypertension) (for reviews, see [3, 4]), immune and inflammatory diseases (e.g., asthma, arthritis, and hepatitis) [5, 6], neurological diseases (e.g., Alzheimer's disease and bipolar disorder) [7, 8], and metabolic disorders

(e.g., obesity, insulin resistance, hyperglycemia, and hypercholesterolemia) [9–11]. Further, significant work has also explored the activation, mechanism, and function of PKC isozymes in the development and progression of multiple types of cancer, which will be the primary focus of this review.

## 2. PKC Isozymes and Their Target Proteins

There are five consensus phosphorylation site motifs recognized by PKC isozymes, each of which has an essential basic amino acid (arginine (R) and/or lysine (K)) at the  $-2$  and/or  $-3$  amino-terminal position relative to that of the serine (S) or threonine (T) phosphorylation site. The five motifs are as follows: (R/K)X(S/T), (R/K)(R/K)X(S/T), (R/K)XX(S/T), (R/K)X(S/T)XR/K, and (R/K)XX(S/T)XR/K [12]. A list of target protein substrates for PKC isozymes and their phosphorylation sites are presented in Table S1 (see supplementary materials available online at <http://dx.doi.org/10.1155/2014/231418>) which has been modified and upgraded from a previous paper [12].

Through target protein phosphorylation, PKC isozymes can directly or indirectly participate in diverse biological phenomena, such as cell cycle regulation (e.g., MARCKS, p53, and p21 (also known as p21<sup>Cip1</sup> or p21<sup>Waf1/Cip1</sup>)), cell adhesion (e.g., adducins and integrins), DNA synthesis and transcription (e.g., transcription factor C/EBP and glycogen

synthetase kinase  $3\beta$  (GSK3 $\beta$ )), cell motility (e.g., RhoA and integrins), apoptosis (e.g., Bad and Bcl-2), drug resistance (e.g., P-glycoprotein (P-gp; also known as MDRI or ABCB1)), and cell growth and differentiation (e.g., basic fibroblast growth factor (bFGF), epidermal growth factor receptor (EGFR), v-raf-1 murine leukemia viral oncogene homolog 1 (Raf1), and H-Ras) (Table S1).

Further, it is also possible for each PKC isozyme to phosphorylate unique “isozyme-specific” proteins, which can also alter cell function. These types of PKC isozyme-specific substrates or inhibitors may be useful for characterizing intracellular signaling pathways for each PKC isozyme. Although the function of PKC isozyme inhibitors and their clinical applications have been reported by several groups, PKC isozyme-specific inhibitors are very rare, with the majority of the inhibitor studies focusing on the use of bisindolymaleimide (LY333531) and enzastaurin (LY317615) for PKC $\beta$  inhibition and antisense oligonucleotides (aprinocarsen (ISIS3521) and ISIS9606) for PKC $\alpha$  inhibition (e.g., for review, see [7, 13–16]). Furthermore, only two PKC isozyme-specific peptide substrates have been identified, peptide 422–426 (RFAVRDM-RQTVAVGVKAVDKK) of eukaryotic elongation factor-1 $\alpha$  for PKC $\delta$  [17] and Alphatomega peptide (FKKQGSFAKKK) for PKC $\alpha$  [18], both of which have been utilized to characterize PKC isozyme-mediated cellular functions [19–21] and for developing cancer diagnostic [22, 23] or therapeutic tools [24–26].

### 3. PKC Isozymes and Cancer

In cancer cells, PKC isozymes are involved in cell proliferation, survival, invasion, migration, apoptosis, angiogenesis, and anticancer drug resistance through their increased or decreased participation in various cellular signaling pathways. During cancer cell proliferation and survival; for example, PKC isozymes stimulate survival or proliferation-associated signaling pathways, such as Ras/Raf/MEK/ERK or PI3K/Akt (also known as PKB)/mTOR pathways, but suppress the expression of cancer suppressor-associated or apoptotic signals such as caspase cascade or Bax subfamily (Figure 1). However, the activation status of PKC isozymes and the downstream signaling cascades can be affected by different internal and external cellular conditions. This is particularly true during short- or long-term 12-*O*-tetradecanoylphorbol 13-acetate (TPA) treatment, whereby short-term TPA treatment increases PKC activation, but long-term treatment downregulates PKC isozyme function [2, 27].

Furthermore, the expression patterns and functions of PKC isozymes in cancer cells largely depend on the type of cancer being investigated; however, the mechanism is not clear. For example, PKC $\delta$  acts as an antiapoptotic regulator in chronic lymphocytic leukemia (CLL) but as a proapoptotic regulator in acute myeloid leukemia (AML) (see Section 3.10. Myeloid and lymphocytic leukemia). PKC $\alpha$  shows proliferative functions in several types of cancer but has antiproliferative functions in colon cancer cells (see Section 3.3. Colon cancer). Importantly, PKC isozymes that

are specifically overexpressed in certain types of cancer can be used as diagnostic or therapeutic targets. Thus, understanding the role and expression of individual PKC isozymes in each type of cancer may help to elucidate important cues for discovering novel drugs and for developing diagnostic or therapeutic tools. This section further discusses PKC isozymes and their roles in multiple types of cancer cells as summarized in Table 1.

**3.1. Bladder Cancer.** PKC $\alpha$ ,  $\beta$ I,  $\beta$ II,  $\delta$ ,  $\epsilon$ ,  $\eta$ , and  $\zeta$  have all been detected in bladder cancer cells and tissues. PKC $\beta$ I,  $\beta$ II,  $\delta$ , and  $\eta$  are found primarily in low-grade and low-stage cancers and decrease with increasing cancer stage and grade. However, PKC $\alpha$  and  $\zeta$  show the opposite expression pattern, increasing in levels as the cancer progresses [28–30], and are associated with more aggressive bladder cancer. Patients with a higher membrane/cytosol ratio of PKC $\alpha$  show a shorter recurrence-free period than patients with a lower membrane/cytosol ratio after treatment with the anticancer drug adriamycin. Further, transfection of PKC $\alpha$  into bladder cancer cells increases resistance against adriamycin [31]. It has also recently been shown that the phosphoinositide-specific phospholipase C $\epsilon$  (PLC $\epsilon$ ), an effector protein of Ras and Rap [32], induces the proliferation of human bladder cancer cell line BIU-87 through the activation of PKC $\alpha$  [33]. However, the PKC $\alpha$ -mediated proliferation of bladder cancer cells can be repressed. T24 cells treated with the PKC $\alpha$ / $\beta$  inhibitor GO6976, for example, show G<sub>0/1</sub> arrest and reduced proliferation [34]. Moreover, addition of this inhibitor to bladder cancer cells 5637 and T24 results in more efficient inhibition of cell migration and invasion and greater promotion of cell-cell and cell-matrix junctions than those achieved using the PKC $\alpha$  inhibitor Safingol, which has similar but less pronounced effects [35].

Similarly, in T24 cells, the binding of hyaluronic acid (HA) fragments to CD44 can activate the NF- $\kappa$ B pathway through not only PKC $\zeta$ , but also Ras and I $\kappa$ B kinases 1 and 2 [36]. Researchers have speculated that these signaling pathways may be related to cancer cell migration and invasion [37] or survival and antiapoptosis [38].

Activation of PKC $\delta$  and c-Jun N-terminal kinase (JNK) results in the depletion of growth factors, which reduces cell-cell adhesions, promotes reactive oxygen species (ROS) production, and increases T24 cell motility and scattering [39].

**3.2. Breast Cancer.** In breast cancer cells, several PKC isozymes, such as PKC $\alpha$ ,  $\beta$ ,  $\delta$ ,  $\epsilon$ ,  $\zeta$ ,  $\eta$ , and  $\theta$  participate in cell proliferation, differentiation, survival, and apoptosis. Although PKC $\alpha$  is very important for controlling the proliferation of breast cancer cells through the activation of extracellular signal-regulated kinase (ERK) [40] and telomerase [41], many research efforts focus on its function in metastasis and drug resistance. PKC $\alpha$  expression contributes to the metastasis of breast cancer cells through upregulation of activity of matrix metalloproteinases (MMPs) (e.g., MMP-9) [42–44], urokinase-type plasminogen activator (uPA) [44, 45], NF- $\kappa$ B [42], and osteopontin receptor  $\alpha$ v $\beta$ 3 [46], as

TABLE 1: PKC isozymes and their roles in multiple types of cancer cells.

Cancer types	PKC isozymes	Roles of PKC isozymes	References	
Bladder cancer	PKC $\alpha$	Cell proliferation and anticancer drug resistance	[31, 33]	
	PKC $\delta$	Cell motility	[39]	
Breast cancer	PKC $\alpha$	Cell proliferation and metastasis, antiapoptosis, antiestrogen resistance	[40, 42, 43, 45, 50, 53]	
	PKC $\epsilon$	Cell metastasis and antiapoptosis	[63, 65, 67]	
	PKC $\eta$	Cell growth, survival, and antiapoptosis	[68–70, 72]	
	PKC $\zeta$	Cell metastasis	[74]	
Colon cancer	PKC $\delta$	Cell survival, migration, invasion, proliferation, antiestrogen resistance, and proapoptosis	[80, 83, 84, 86, 88, 90, 92, 94, 97]	
	PKC $\alpha$	Antiproliferation and anticancer drug resistance	[110–112, 119, 120]	
	PKC $\beta$ II	Cell proliferation and invasion when cells overexpressing PKC $\beta$ II are used	[123, 124, 130]	
	PKC $\iota$	Carcinogenesis	[134, 135]	
	PKC $\zeta$	Antiproliferation, differentiation, and proapoptosis	[136–138]	
Gastric (stomach) cancer	PKC $\delta$	Cell proliferation and pro- and antiapoptosis	[142, 144, 145, 147, 152, 153]	
	PKC $\alpha$	Cell proliferation and antiapoptosis	[158, 160, 161]	
	PKC $\beta$ I	Antiapoptosis	[164, 165]	
Gastrointestinal stromal tumor (GIST)	PKC $\delta$	Cell invasion and proapoptosis	[170–172]	
	PKC $\theta$	Cell proliferation and antiapoptosis	[175]	
Glioma	PKC $\alpha$	Cell proliferation, survival, invasion, migration, antiapoptosis, and anticancer drug resistance	[189, 190, 192, 196, 197, 204]	
	PKC $\epsilon$	Cell survival, invasion, migration, and antiapoptosis	[206, 207, 209]	
	PKC $\zeta$	Cell proliferation, survival, invasion, and migration	[212–214, 216, 217]	
	PKC $\iota$	Cell proliferation, survival, and invasion	[218, 220, 221, 223]	
	PKC $\eta$	Cell proliferation and antiapoptosis	[224, 225, 227]	
Head and neck cancer	PKC $\delta$	Cell proliferation, invasion, and pro-/antiapoptosis	[228–231, 240–242]	
	PKC $\alpha$	Cell growth and survival	[245–247]	
	PKC $\epsilon$	Cell proliferation and invasion	[248, 249]	
	PKC $\zeta$	Cell proliferation, invasion, and migration	[250, 251, 253]	
Liver cancer (hepatocellular carcinoma)	PKC $\iota$	Cell proliferation and antiapoptosis	[256, 257]	
	PKC $\alpha$	Cell growth, invasion, and migration	[269, 271, 272, 276, 280]	
	PKC $\epsilon$	Cell growth and migration	[276, 285]	
Lung cancer	PKC $\delta$	Cell invasion and migration	[282]	
	PKC $\alpha$	Cell proliferation, metastasis, and antiapoptosis	[288, 291, 293]	
	PKC $\epsilon$	Cell proliferation, metastasis, and antiapoptosis	[299, 301, 303–305]	
	PKC $\iota$	Cell growth, survival, and invasion	[307, 308, 311, 313]	
	PKC $\eta$	Cell metastasis and antiapoptosis	[321, 322]	
Melanoma	PKC $\delta$	Cell survival, invasion, migration, and antiapoptosis	[323–326]	
	PKC $\alpha$	Cell survival, invasion, and migration	[336, 337]	
	PKC $\epsilon$	Antiapoptosis	[342–344]	
Myeloid and lymphocytic leukemia	PKC $\delta$	Cell metastasis	[347, 348]	
	Acute lymphocytic leukemia (ALL)	PKC $\alpha$	Anticancer drug resistance	[367]
	Chronic lymphocytic leukemia (CLL)	PKC $\beta$	Cell survival	[357]
	Acute myeloid leukemia (AML)	PKC $\beta$ II	Cell proliferation, survival, and antiapoptosis	[351, 359, 360, 363]
		PKC $\delta$	Cell survival	[364, 365]
	Chronic myeloid leukemia (CML)	PKC $\alpha$	Antiapoptosis	[370, 376, 379]
		PKC $\delta$	Proapoptosis	[382–386]
PKC $\beta$ II		Cell proliferation and survival	[368]	
	PKC $\delta$	Proapoptosis	[374, 375]	

TABLE 1: Continued.

Cancer types	PKC isozymes	Roles of PKC isozymes	References
Ovarian cancer	PKC $\alpha$	Cell proliferation and invasion	[389, 390]
	PKC $\iota$	Cell proliferation	[392, 393]
	PKC $\zeta$	Proapoptosis	[394]
Pancreatic cancer	PKC $\alpha$	Cell differentiation, migration, and antiapoptosis	[397, 398, 400, 401]
	PKC $\zeta$	Cell survival and metastasis	[405, 407, 408]
	PKC $\iota$	Angiogenesis and cell metastasis	[409, 411]
	PKC $\beta$ I	Cell migration and antiapoptosis	[412]
	PKC $\delta$	Cell growth and anticancer drug resistance	[416, 417]
Prostate cancer	PKC $\alpha$	Cell growth, migration, invasion, angiogenesis, and pro-/antiapoptosis	[425, 428–432, 436]
	PKC $\epsilon$	Cell growth, survival, invasion, antiapoptosis, and anticancer drug resistance	[438–441, 443–445, 447]
	PKC $\zeta$	Cell proliferation	[456]
	PKC $\eta$	Antiapoptosis	[457]
	PKC $\beta$ II	Cell growth and angiogenesis	[458]
Renal cell carcinoma (kidney cancer)	PKC $\alpha$	Cell migration, invasion, angiogenesis, and proapoptosis	[420, 459, 460, 468–470]
	PKC $\alpha$	Cell invasion	[475]
	PKC $\epsilon$	Cell growth, invasion, and migration	[475, 479]
Thyroid cancer	PKC $\delta$	Cell migration and invasion	[482–484]
	PKC $\alpha$	Cell survival	[485, 486]
	PKC $\epsilon$	Cell survival and pro-/antiapoptosis	[492–494]
	PKC $\delta$	Antiproliferation and cell migration	[497–499]

well as through increasing the cell surface levels of C-X-C chemokine receptor type 4 (CXCR4) (also known as CXCL12), which is also associated with lung metastasis of breast cancer cells [42]. During tyrosine kinase receptor ErbB2 (also known as HER2, CD340, or neu)-mediated breast cancer cell invasion, ErbB2 upregulates PKC $\alpha$  through c-Src kinase, leading to upregulation of uPA and uPA receptors that facilitate cell invasion and migration [44, 45].

Anti-estrogen hormonal therapy (e.g., tamoxifen (TAM)) is effective for estrogen receptor  $\alpha$  (ER $\alpha$ ) positive/progesterone receptor positive breast cancers; however, resistance to this treatment is one of major issues to be overcome in breast cancer therapy. Breast cancer anti-estrogen resistance is mainly due to the loss of ER $\alpha$ , but it can still occur when ER $\alpha$  is still present [47–49]. Further, research has indicated that PKC $\alpha$  may be a critical factor in breast cancer anti-estrogen resistance. PKC $\alpha$  and ER $\alpha$  expression are inversely related [47] and PKC $\alpha$  is positively correlated with triple-negative breast cancers, which show no expression of ERs, progesterone receptors, or ErbB2 [50, 51]. Breast cancer cells with overexpression of PKC $\alpha$  also show high resistance for TAM treatment and hormone (e.g., estrogen)-independent growth [52–55], but inhibition of PKC $\alpha$  induces TAM sensitivity [53–55]. The underlying mechanism of breast cancer anti-estrogen resistance also includes ERK2 activation by PKC $\alpha$  [48]. In addition, PKC $\alpha$  expression in breast cancer cells inhibits heregulin-induced apoptosis through the upregulation of

Bcl-2 and downregulation of caspase-7 [56]. PKC $\alpha$  also participates in multidrug resistance (MDR) in breast cancer cells [57, 58]. Overexpression of PKC $\alpha$  in MCF-7 cells alters  $\beta$ 5- and  $\beta$ 3-integrin expression by translational and posttranslational mechanisms, respectively, leading to the increased metastatic capacity of cancer cells [59]. Thus, PKC $\alpha$  expression in breast cancer cells may be closely associated with poor prognosis and survival [49, 60].

In a previous study, activation of PKC $\beta$ I and  $\beta$ II in MCF-7 cells promoted growth and enhanced expression of cyclin D1, which is a regulator of G<sub>1</sub> to S phase transition in mammalian cells [61]. Contrary to this, Grossoni's group has reported that overexpression of PKC $\beta$ I in the breast cancer cell line LM3 actually reduces cell growth and expression of the metastasis-related proteases, uPA, and MMP-2 [62]. Thus, further research is required to decipher the true function of the PKC $\beta$ I and PKC $\beta$ II isozymes in breast cancer.

For PKC $\epsilon$ , downregulation along with the overexpression of microRNA miR-31 appears to reduce oncogenic NF- $\kappa$ B activity and enhance apoptosis and chemo- and radiosensitivity of breast cancer cells. These responses are caused by impaired expression of antiapoptotic Bcl-2 protein [63]. However, when PKC $\epsilon$  activation occurs through HA binding to its receptor CD44, it increases the Nanog-mediated miR-21 production in MCF-7 cells. This process inhibits production of the tumor suppressor protein PDCD4, while enhancing the expression of antiapoptosis genes and anticancer drug resistance in MCF-7 cells [38]. In addition, activation of



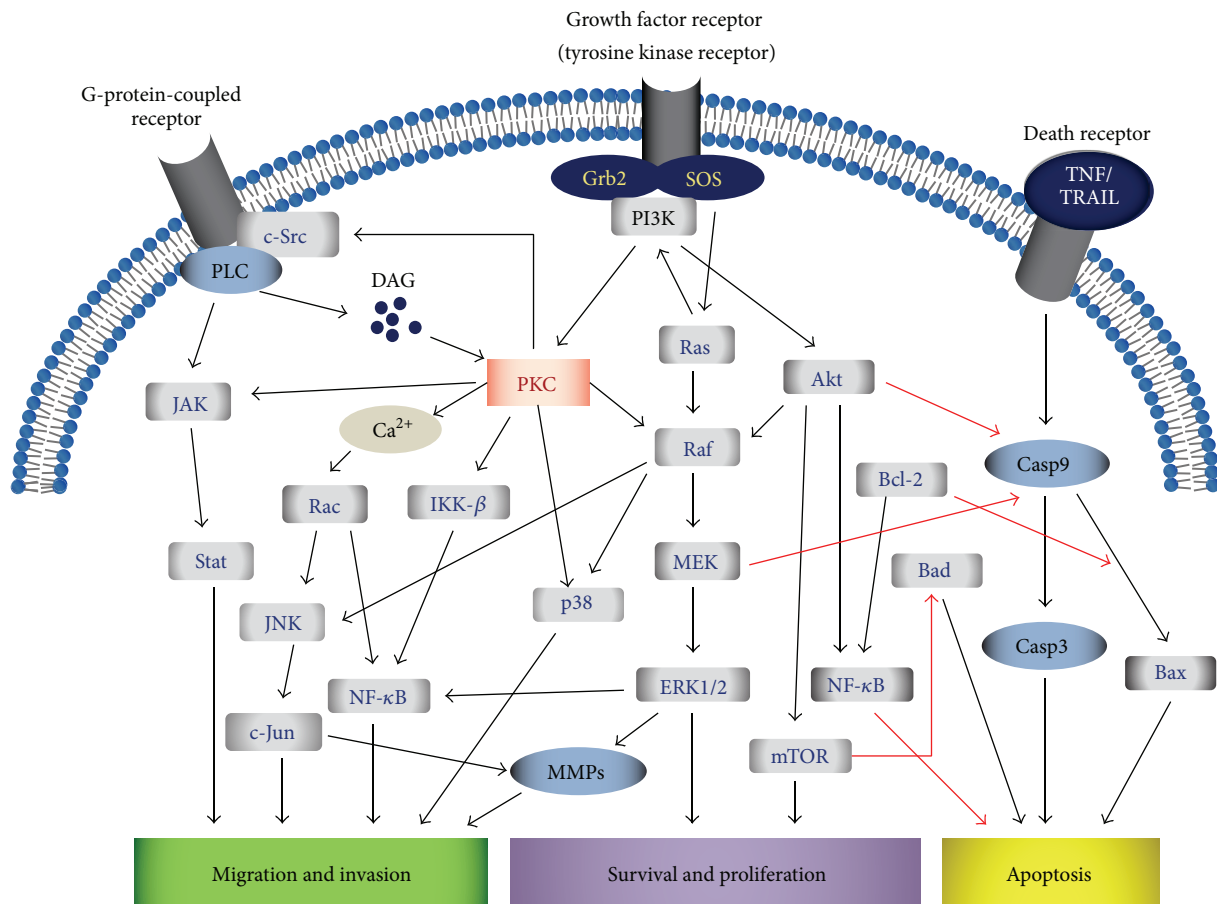


FIGURE 1: Multiple signaling pathways, involving PKC isozyme regulation and signal transduction, are affected during cancer. PKC isozymes directly or indirectly participate in diverse biological phenomena in cancer cells such as cell migration, invasion, survival, proliferation, and apoptosis. Casp, caspase; JAK, Janus kinase; Grb2, growth factor receptor-bound protein 2; SOS, son of sevenless homolog; also see abbreviations in the text. Black arrows indicate activation cascade, while red arrows are used to show the inhibition cascade.

glucocorticoid receptor (GR) by stimulating GR agonists, such as hydrocortisone and dexamethasone, can inhibit p53-dependent apoptosis of breast cancer cells through an increase in the levels of PKC $\epsilon$  messenger RNA (mRNA) and protein [64]. PKC $\epsilon$  can also protect breast cancer cells from major death factor tumor necrosis factor  $\alpha$  (TNF $\alpha$ )-induced cell death through DNA-dependent protein kinase-mediated Akt activation [65], Akt-dependent murine double minute 2 activation, and p53 downregulation [66]. Further, PKC $\epsilon$ -induced polymeric fibronectin assembly is required for the pulmonary metastasis of breast cancer cells [67].

Upregulation of PKC $\eta$  in malignant breast cells is also associated with cancer cell growth and survival [68], likely through hormone-dependent cell growth pathways [69]. PKC $\eta$  expression in the membrane of breast cancer cells after chemotherapy tends to predict a poor patient prognosis [70]. PKC $\eta$ -mediated inhibition of proapoptotic JNK activity protects breast cancer cells from chemotherapy and irradiation therapy [71]. In addition, overexpression of PKC $\eta$  delays TNF-induced cell death in MCF-7 cells by reducing the activation of caspase-8 and caspase-7 [72]. In spite of low

levels of PKC $\eta$  being found in most invasive breast cancer lesions (75%), invasive cancers containing high PKC $\eta$  are associated with positive lymph node status [73].

PKC $\zeta$ -mediated hepatocyte growth factor (HGF) activation increases CXCR4 expression, resulting in breast cancer cell metastasis [74]. PKC $\zeta$  also stimulates estrogen-mediated breast cancer cell growth by stabilizing steroid receptor coactivator-3 (SRC-3; also known as AIB1, ACTR, pCIP, RAC3, or TRAM-1) [75]. On the other hand, overexpression of PKC $\zeta$  can inhibit growth factor-mediated Akt phosphorylation and activation, namely, through feedback inhibition of the phosphatidylinositol 3-kinase (PI3K)/Akt signaling cascade [76].

Accumulation of PKC $\theta$ -activated Fra-1 in invasive, ER-negative breast cancer cells has been associated with increased cell invasion and migration [77]. In addition, PKC $\theta$ -mediated Akt activation inhibits forkhead box class-O 3a (FOXO3a), which is the transcriptional activator of ER $\alpha$  promoter B and its targets, ER $\alpha$  and p27<sup>Kip1</sup>, and also induces c-Rel activation, which has been associated with the early development of breast cancer cells. These signaling

changes by Akt activation result in proliferation, survival, and invasion of breast cancer cells [78].

PKC $\delta$  isozyme shows both prosurvival and proapoptotic functions in breast cancer cells. PKC $\delta$  expression is significantly higher in ER-positive than ER-negative breast cancers and is associated with poor patient survival [79]. PKC $\delta$  promotes survival of breast cancer cells through the inhibition or activation of several signaling pathways, such as inhibition of TNF-related apoptosis-inducing ligand (TRAIL)-induced caspase activation [80, 81], inhibition of Notch1 intracellular domain-dependent transcriptional activity [82], reduction of anticancer drug taxol-induced monocyte chemoattractant protein-1 expression [83], and activation of Akt and NF- $\kappa$ B [84, 85]. PKC $\delta$  also shows increased antiestrogen resistance in estrogen- and TAM-induced MCF-7 cells through the activation of Akt and mitogen-activated protein kinases (MAPKs) [86]. In ER negative MDA-MB-231 breast cancer cells, PKC $\delta$  supports their survival by inhibiting ERK1/2 activation and increasing the levels of ERK1/2 phosphatase MKP3 and its regulator, E3 ubiquitin ligase Nedd4 [87].

On the other hand, proapoptotic effects of PKC $\delta$  in breast cancer cells have also been reported. Exposure of MCF-7 cells to ultraviolet (UV) light increases apoptosis of cells through PKC $\delta$ -dependent phosphorylation of acid sphingomyelinase [88]. Furthermore, sangivamycin, an antiproliferative agent, induces mitochondria-mediated apoptotic cell death of MCF-7/ADR cells by increasing JNK phosphorylation and cleavage of lamin A and poly (ADP-ribose) polymerase. These apoptotic responses have all been identified as being PKC $\delta$ -dependent [89]. Treating MCF-7 cells with inositol hexaphosphate (IP $_6$ ) causes an increase of PKC $\delta$  associated with a decrease of ERK1/2 and Akt activation. This IP $_6$ -mediated PKC $\delta$  activation enhances upregulation of p27<sup>Kip</sup> and hyperphosphorylation of retinoblastoma protein (pRb or Rb), resulting in an increase in apoptosis (G $_1$  arrest) of MCF-7 cells [90]. PKC $\delta$ -dependent inhibition of ERK1/2 and upregulation of JNK also lead to G $_1$  arrest in SKBR3 breast cancer cells after phorbol-myristate-acetate (PMA; note that a common alternative name for PMA is TPA) treatment [91].

In addition, PKC $\delta$  acts as a proliferative signal in breast cancer cells. PKC $\delta$  elevates cell proliferation in ErbB2-positive breast cancer cells via c-Src and ERK activation [92]. The inflammatory mediator bradykinin (BK) is required for the PKC $\delta$ / $\epsilon$ /Akt/ERK1/2 signaling complex utilized to mediate MCF-7 cell proliferation [93]. In estrogen-dependent breast cancer cells, TPA-mediated PKC $\delta$  activation leads to activation and nuclear translocation of ER $\alpha$  and enhanced ER-dependent reporter gene expression thereby suggesting a role of PKC $\delta$  as a proproliferative factor [94]. Cell proliferation requiring estrogen (e.g., 17- $\beta$ -estradiol) also needs ERK1/2 activation through the HRG/HER-2/PKC $\delta$ /Ras pathway [95]. Interestingly, TPA-induced PKC $\delta$  activation in ER negative cells shows a different pattern compared to ER positive breast cancer cells. The increase in PKC $\delta$  expression is significantly higher in ER positive MCF-7 cells than in ER negative MDA-MB-231 cells, leading to higher levels of cyclin dependent kinase (Cdk) inhibitor p21<sup>Waf1/Cip1</sup> in MCF-7 cells [96].

In addition to its proapoptotic, prosurvival, and proliferative functions, PKC $\delta$  also plays a critical role in breast cancer cell migration and invasion. In highly metastatic breast cancer cell lines (e.g., MDA-MB-231 and C3L5), expression of PKC $\delta$  efficiently increases cell migration and invasion by inhibiting the small GTPase Cdc42 [97]. TPA-induced MMP-9 activation and migration of breast cancer cells are also stimulated by the PKC $\delta$ /ERK/c-Jun/activator protein-1 signaling pathway, but quercetin and kalopanaxsaponin can be used to block these signaling pathways [98, 99]. Moreover, platelets can promote invasion of MCF-7 cells through the activation of PKC $\delta$  and upregulation of MMP-9 [100]. In contrast, Jackson's group has demonstrated that PKC $\delta$  suppresses MMP-9 secretion and breast cancer cell survival and migration [101].

**3.3. Colon Cancer.** PKC $\alpha$ ,  $\beta$ ,  $\delta$ ,  $\epsilon$ , and  $\zeta$  are found in both rat and human colonic mucosa, while PKC $\eta$  is detected in human colonic mucosa only [102]. There is no difference in the levels of PKC $\alpha$ ,  $\delta$ , and  $\epsilon$  mRNA between normal mucosa and human colon adenocarcinoma, but the levels PKC $\beta$  and  $\eta$  mRNAs are significantly lower in human colon adenocarcinoma than in normal mucosa. The reduction of PKC $\beta$  and  $\eta$  mRNA occurs early in the multistage process of colon carcinogenesis [103]. Western blotting analysis, on the other hand, has indicated that expression of PKC $\beta$  and  $\epsilon$  protein is significantly decreased in colon cancer tissues, while PKC $\alpha$  and  $\zeta$  show no significant difference in expression between normal mucosa and colon cancer tissues [104].

In a recent study, colon epithelial cells (CECs) showed high levels of PKC $\epsilon$  with no TRAIL expression, but luminal CECs show the opposite result. This support previous results indicating that PKC $\epsilon$  is required for TRAIL-induced differentiation of the colorectal cancer cell line HT29 [105]. Further, activated PKC $\epsilon$  is also necessary for proteinase-activated receptor 1 (PAR1)-mediated HT29 cell migration and matrix adhesion [106].

Although the levels of PKC $\alpha$  are similar between normal and cancerous colon tissue, increasing evidence shows that PKC $\alpha$  does participate in growth arrest [107, 108] and cancer suppression in the intestine epithelium [109–113]. Suppression of cell growth in colon cancer cells by PKC $\alpha$  is thought to occur through the regulation of EGFR signaling [110]; ERK-mediated inhibition of the inhibitor of DNA binding 1, a proproliferative factor [112]; downregulation of  $\beta$ -catenin and its target genes *cyclin D1* and *c-Myc* [111, 113]; and PKC $\alpha$ -mediated phosphorylation of retinoic acid-related orphan nuclear receptor  $\alpha$ , which downregulates the Wnt/ $\beta$ -catenin signaling [114]. In contrast to these results, a recent study has suggested that PKC $\alpha$  activation is involved in the activation of ERK1/2/NF- $\kappa$ B through the tissue factor/VIIa/PAR2 pathway and this signaling pathway leads to enhanced proliferation, migration, and survival for the colon cancer cell line SW620 [115].

Alternately, PKC $\alpha$  can also enhance cell adhesion and anticancer resistance through a different signal pathway than that used during antiproliferation. High migratory activity of colon cancer cells is related to high PKC $\alpha$  and low E-cadherin

expression [116]. PKC $\alpha$  also regulates transforming growth factor (TGF)- $\beta$ -induced expression of the matrix adhesion molecules, fibronectin and laminin, leading to the induction of E-cadherin [117, 118]. In addition, PKC $\alpha$  can induce P-gp-mediated MDR in human colon cancer cells [119–121]; thus, downregulation of PKC $\alpha$  may increase the sensitivity to anticancer agents [122].

The low levels of PKC $\beta$  in colon cancer cells allow transgenic mice and cells stably expressing PKC $\beta$  to be used to investigate the role of PKC $\beta$  in colon cancer cells. In transgenic PKC $\beta$ II animals and PKC $\beta$ II-expressing cell lines, the presence of PKC $\beta$ II results in hyperproliferation of intestinal epithelial cells and enhanced cancer formation after exposure to azoxymethane, a potent carcinogen used to induce colon cancer [123–126]. These responses are achieved through the reduction of TGF- $\beta$  receptor type II expression and associated growth inhibition [124, 127], activation of Wnt/adenomatous polyposis coli/ $\beta$ -catenin proliferative signaling [123], and reduction of cyclooxygenase type 2 (Cox-2) expression [127]. Overexpression of PKC $\beta$ II also induces invasion in intestinal epithelial cells through a Ras/PKC $\iota$ /Rac1/MAPK kinase (MEK)-dependent signaling pathway [128] and represses apoptosis at the luminal surface in transgenic rats [129].

PKC $\beta$ I is activated in the presence of secondary bile acids (e.g., deoxycholic acid, lithocholic acid, and ursodeoxycholic acid) in colon cancer tissues [104]. Furthermore, the human colon adenocarcinoma cell line HT-29 stably expressing PKC $\beta$ I shows high resistance to TNF $\alpha$ - and paclitaxel-induced apoptosis [130]. Overexpression of PKC $\beta$ I and  $\beta$ II in differentiated colon carcinoma HD3 cells blocks their differentiation but increases their proliferation through p57 MAPK activation [131, 132]. These data suggest that PKC $\beta$  inhibitors (e.g., enzastaurin) may be efficient for the prevention of colon cancer because PKC $\beta$ I and II appear to be involved in carcinogen-induced colon cancer initiation and progression [122, 124, 125, 133].

PKC $\iota$  is also required for Ras- and azoxymethane-induced colon carcinogenesis [134, 135], but unlike PKC $\beta$ II, PKC $\iota$  functions mainly in the later stage of azoxymethane-induced colon carcinogenesis and is essential for mutant adenomatous polyposis coli (APC)-mediated carcinogenesis [135].

Like PKC $\alpha$ , PKC $\zeta$  protein expression does not differ between normal and cancerous tissues, but PKC $\zeta$  does appear to be associated with the inhibition of colon cancer cell growth and enhancement of differentiation and apoptosis [136, 137]. In a recent study, the loss of PKC $\zeta$  resulted in an increase in intestinal carcinogenesis, upregulation of two metabolic enzymes, 3-phosphoglycerate dehydrogenase and phosphoserine aminotransferase-1, and inhibition of caspase-3 activation. Thus, colon cancer patients with low levels of PKC $\zeta$  show a significantly poorer prognosis, compared with patients with higher levels [138]. In contrast, PKC $\zeta$  stably depleted SW480 colon cancer cells by decreasing cell proliferation, expression of Wnt target gene *c-Myc*, and tumorigenic activity in grafted mice [139]. Dexniguldipine hydrochloride (B8509-035) also suppresses the growth of HT-29 cells through the inhibition of PKC $\zeta$  expression [140].

Similar to PKC $\beta$ , PKC $\zeta$  could likely be an efficient target for chemoprevention of colon cancer [141]. Thus, further research is needed to understand the true function of PKC $\zeta$  in colon cancer.

In colon cancer cells, PKC $\delta$  can inhibit cell growth and proliferation by mediating changes in several cellular signaling pathways by enhancing phosphorylation of APC [142], p53 expression [143, 144], and p21<sup>Waf1/Cip1</sup> activity [144] and by reducing  $\beta$ -catenin stabilization [140] and cyclins (e.g., D1, D3, and E) [145, 146].

PKC $\delta$  expression may also act as a proapoptotic regulator in colon cancer cells. This regulation is required for G<sub>0</sub>/G<sub>1</sub> arrest [147], inhibition of anchorage-independent growth [147], and enhanced Bax levels [146]. The apoptotic pathway utilized by PKC $\delta$  also appears to be independent of caspase-3 [148]. In contrast, PKC $\delta$  may have antiapoptotic functions as well. For example, apoptosis is prevented by the PKC $\delta$ /NF- $\kappa$ B/cIAP-2 pathway [149] and activation of the FLICE-like inhibitory protein [150].

Furthermore, PKC $\delta$  is involved in colon cancer cell migration and invasion through activation of the metastasis enhancing protein KITENIN [151], KIT-SCF activation, PKC $\delta$ -induced KIT recycling [152], phosphorylation of the mRNA-binding protein HuR at serine 318 [153], and stimulation of Nox1-dependent superoxide production [154].

### 3.4. Gastric (Stomach) Cancer

**3.4.1. General Gastric Carcinoma.** Overexpression of PKC $\alpha$  in human gastric carcinoma is significantly correlated to poor prognosis and clinicopathological parameters, such as histologic type, depth of invasion, pathologic stage, and distant metastasis [155, 156]. In the vincristine-induced MDR human gastric cancer cell line SGC7901/vincristine, higher levels of PKC $\alpha$  are found compared with those detected in untreated (i.e., not MDR) SGC7901 cells [157]. Thus, inhibition of PKC $\alpha$  may enhance antiproliferative and proapoptotic signaling in gastric cancer cells thereby increasing the therapeutic efficacy for gastric cancer [158–161]. In contrast, addition of TPA to gastric cancer cells enhances PKC $\alpha$ -mediated cell apoptosis [162, 163].

After addition of indomethacin, a nonsteroidal anti-inflammatory drug, into gastric cancer cells, PKC $\beta$ I, but not PKC $\beta$ II, acts as a mediator of cancer cell survival, and its overexpression, which is associated with overexpression of p21<sup>Waf1/Cip1</sup> promotes activation of antiapoptotic mechanism [164, 165]. On the other hand, addition of the PKC $\beta$  inhibitor enzastaurin into gastric cancer cells induces apoptosis through the ribosomal S6 kinase and Bad pathways [166].

Gastric adenocarcinoma exhibits loss of PKC $\zeta$  [167], while overexpression of PKC $\lambda$ / $\iota$  can be a prognostic factor for gastric cancer recurrence [168]. However, low PKC $\lambda$ / $\iota$  expression along with high expression of kidney and brain protein (KIBRA; also known as WWC1), which is a scaffold protein containing aPKC-binding domains, has also been shown to have detrimental results, as they are correlated with invasion and poor prognosis in gastric cancer [169].



PKC $\delta$  positively controls cisplatin- and sphingosine-induced cell death in MKN28 cells. The former is correlated with overexpression of p53 and the latter with enhanced SDK and caspase-9 production [170, 171]. In addition, enhanced PKC $\delta$  expression and phosphorylation can increase cell motility and invasion by cooperating with the Smad-dependent TGF- $\beta$ 1 pathway and integrin ( $\alpha$ 2 or  $\alpha$ 3) expression and activation [172].

**3.4.2. Gastrointestinal Stromal Tumor.** Gastrointestinal stromal tumor (GIST) is the most common mesenchymal tumor of the gastrointestinal tract, being primarily found in the stomach and small intestine. The five-year survival rate of patients with KIT-negative GIST is lower than that of patients with KIT-positive GIST (KIT is also known as CD117, proto-oncogene c-kit, tyrosine-protein kinase Kit, or mast/stem cell growth factor receptor) [173]. PKC $\theta$  expression is observed in GISTs but is undetectable in other mesenchymal tumors, including non-GIST soft tissue sarcomas [174]. PKC $\theta$  knockdown in KIT-positive GISTs leads to inhibition of PI3K/Akt signaling, upregulation of the cyclin-dependent kinase inhibitors p21 and p27, and induction of antiproliferative and apoptotic factors [175]. Thus, PKC $\theta$  is recognized as a useful biomarker for the diagnosis of KIT- and/or DOG1-negative GISTs [176–178], while it shows high sensitivity toward KIT-positive GISTs [174, 179, 180]. However, it should be noted that these sensitivity and specificity of PKC $\theta$  toward KIT-negative GISTs were not observed in all studies [173].

**3.5. Glioma.** Among gliomas, astrocytomas are the most common and are classified in four prognostic grades: pilocytic astrocytoma (grade I), low-grade astrocytoma (grade II), anaplastic astrocytoma (grade III), and glioblastoma (grade IV). Grade III and IV are considered to be the most rapidly progressive, invasive malignant gliomas [181]. In the rat malignant glioma cell line C6, one study has reported the detection of PKC $\alpha$ ,  $\delta$ ,  $\epsilon$ , and  $\zeta$  [182], but González's group did not detect PKC $\zeta$  in these cells [183]. Moreover, PKC $\alpha$ ,  $\gamma$ ,  $\delta$  (very low levels),  $\epsilon$ , and  $\zeta$  have been identified in multiple human malignant glioma cell lines (e.g., A172, A2781, U87, U138, U373, and A1235) and tissues [184–186]. For PKC $\beta$ , there are conflicting reports, some which indicate PKC $\beta$  detection [186, 187], while others show no PKC $\beta$  expression [184, 185, 188]. In TPA-treated glioma cells, PKC $\alpha$  is translocated from the cytosolic fraction to the membrane following short-term exposure but is downregulated following long-term exposures [182, 185].

Higher levels of PKC $\alpha$  in malignant gliomas compared to low-grade astrocytomas result in enhanced proliferation and decreased apoptosis for the malignant gliomas [186]. PKC $\alpha$ -mediated ERK1/2 activation is also required for the proliferation and survival of glioma cells [189]. Moreover, PKC $\alpha$  acts as a signaling intermediate between EGFR and mammalian target of rapamycin (mTOR) in glioma cells; the activation of which leads to Akt-independent proliferation of glioma cells [190]. Interestingly, PKC $\alpha$  protein, but not its activity, is essential for glioma cell proliferation and survival. These results mean that the use of adenosine

triphosphate (ATP) competitive inhibitors to treat glioma will be less efficient [191]. In addition, increased expression of glutamate transporters, also known as excitatory amino-acid transporters, leads to prolonged survival and reduced tumor growth in glioma-bearing animals [192]. Further, PKC $\alpha$  is involved in the activation and redistribution of glutamate transporters [183, 193, 194]. However, there is a report that inhibition of PKC $\alpha$  and  $\epsilon$  has no effect on proliferation of glioma cells thereby suggesting no therapeutic benefit of PKC $\alpha$  in regard to proliferation prevention [195].

Cooperation of inhibition of PKC $\alpha$  and suppression of glutathione S-transferase P1, which is associated with anti-cancer drug resistance, can efficiently increase the apoptosis of glioma cells by the anticancer drug cisplatin [196]. Combination of endostatin, an inhibitor of angiogenesis, and PKC $\alpha$  inhibition significantly increases the survival of malignant glioma-bearing animals [197]. Reduction of the antiapoptotic protein Bcl-XL is also involved in glioma cell death through the inhibition of PKC $\alpha$  [198]. However, aprinocarsen, an antisense oligonucleotide against PKC $\alpha$ , shows no clinical benefit in patients with recurrent high-grade astrocytomas [199].

There are many reports proving a close relationship between PKC $\alpha$  expression and high invasion and migration of malignant glioma cells [200–204]. As mentioned above, translocation of PKC $\alpha$  from the cytosolic fraction to the glioma cell membrane after TPA treatment increases ERK/NF- $\kappa$ B-dependent MMP-9 activation and cell migration [200]. PKC $\alpha$ -induced phosphorylation and downregulation of low-density lipoprotein receptor-related protein stimulate the secretion of uPA and the invasion of glioma cells into the surrounding normal brain tissue [201]. Furthermore, invasion and migration of glioma cells involve several signaling pathways such as PKC $\alpha$ -mediated N-cadherin cleavage [202], increased motility by PKC $\alpha$ -mediated NG2 phosphorylation at Thr-2256 [203], and PKC $\alpha$  or  $\epsilon$ /SRF-mediated RTVP-1 expression [204].

PKC $\epsilon$  also appears to be overexpressed in malignant glioma cell lines and tissues (grades III and IV) [184–186, 205]. Its overexpression in glioma cells inhibits proteasome inhibitor- and TRAIL-induced apoptosis and increases cell survival [206, 207]. Signal transducers and activators of transcription 3 (Stat3) activation by PKC $\epsilon$  in glioma cells also stimulate cell invasion. These responses are found in not only glioma, but also several additional types of human cancer cells, including prostate, skin (melanoma), bladder, colon, lung, pancreatic, and breast [208]. Furthermore, galectin-1, a homodimeric adhesion molecule, is linked with the trafficking of  $\beta$ 1-integrin, which is controlled by a PKC $\epsilon$ /vimentin-dependent pathway. These molecular responses are important for glioma cell migration [209]. In PMA-induced adhesion and migration of glioma cells, PKC $\epsilon$  shows different response compared to PKC $\alpha$  in regard to ERK activation. PKC $\epsilon$  induces the activation of ERK at focal adhesions, while PKC $\alpha$  induces the activation of nuclear ERK [210]. Importantly, inhibition of PKC $\epsilon$  has been shown to block the proliferation of glioma cells [211].

PKC $\zeta$  may also be a therapeutic target for treating gliomas because of its involvement in proliferation, invasion,



and migration of glioma cells. Phosphorylated PKC $\theta/\delta/\beta$ -integrin and PKC  $\zeta/\beta$ -integrin complexes are stimulated following radiation exposure, resulting in enhanced radioresistance of glioma cells [212]. Further, downregulation of uPA receptor and cathepsin B using small hairpin RNA efficiently disrupts these complex formations [212]. In addition to  $\beta$ 1-integrin activation [212, 213], PKC $\zeta$  is involved in glioma cell migration and invasion by controlling its interaction with ZIP/p62 [214] and MMP-9 expression [213, 215]. Furthermore, PKC $\zeta$  also plays a key role in the proliferation of glioma cells, which in C6 cells is modulated through P2Y<sub>12</sub> receptor signal transduction by the RhoA-dependent PKC $\zeta$ /Raf1/MEK/ERK pathway [216]. Activation of PKC $\zeta$ /p70S6K pathway by muscarinic acetylcholine receptor also increases carbachol-induced DNA synthesis and proliferation in 1321 N1 astrocytoma cells [217].

Although previous studies have failed to show the existence of PKC $\iota$  in normal glioma cells [184–186], PKC $\iota$  is abundant in all malignant gliomas, especially in highly proliferative glioma cell lines, such as T98G and U-138MG [218]. Proliferation of glioma cells is controlled through the PI3K/PKC $\iota$ /Cdk7/Cdk2-mediated pathway [219, 220]. Inactivation of Bad and disruption of the Bad/Bcl-XL dimer by PKC $\iota$  also enhance glioma cell survival [221]. Furthermore, PKC $\iota$  participates in antiapoptosis of glioma cells through the downregulation of p38 MAPK signaling [222] and glioma cell invasion and motility through the repression of actin stress fiber formation by RhoB [223].

Although PKC $\eta$  shows low detection rates in glioma cell lines [195], its potential as a therapeutic target for glioma has been demonstrated. PKC $\eta$  expression enhances glioma proliferation and cell growth through MEK1/2/ERK1/2/Elk-1 [224] or Akt/mTOR pathways [225]. PKC $\eta$  also plays an important role in rapamycin-insensitive cell proliferation [226]. Moreover, PKC $\eta$  expression increases glioma cell resistance to UV- and  $\gamma$ -irradiation-induced apoptosis through the downregulation of caspase-9 activation [227].

PKC $\delta$  phosphorylation at tyrosine 311 (e.g., by c-Abl tyrosine kinase) and 332 (e.g., by c-Src tyrosine kinase) is an important process during caspase-3-dependent cleavage of PKC $\delta$ , a process that can enhance apoptosis of glioma cells [228, 229]. For example, PKC $\delta$  phosphorylation at tyrosine 332 by c-Src increases the sensitivity of glioma cells to TRAIL and cisplatin [228]. Moreover, different locations of PKC $\delta$  expression in glioma cells can influence its proapoptotic and antiapoptotic effects. Cytosolic PKC $\delta$  increases p38 phosphorylation and decreases Akt phosphorylation and expression of X-linked inhibitor of apoptosis protein (XIAP), while nuclear PKC $\delta$  increases JNK activation, all of which result in enhanced apoptotic effects. However, PKC $\delta$  localized in the endoplasmic reticulum leads to antiapoptosis of glioma cells [230]. Phosphorylation at tyrosine 155 and cleavage of PKC $\delta$  increase its translocation to the endoplasmic reticulum and ability to block TRAIL-induced apoptosis [231]. Phosphorylation of PKC $\delta$  at tyrosine 52, 64, and 155 is associated with the virulent strain of Sindbis virus neurovirulent and can induce glioma cell apoptosis [232]. Phosphorylation of PKC $\delta$  at 64 and 287 is also essential for the apoptotic effect observed after etoposide treatment [233–235]. Furthermore, penta-

acetyl geniposide-induced apoptosis requires the interaction of activated neutral sphingomyelinase and p75, which is mediated by activated PKC $\delta$  [236, 237]. PKC $\delta$ -mediated ROS production has also been indicated to increase paraquat (1,1'-dimethyl-4,4'-bipyridinium)-induced glioma cell death [238]. In a recent study, however, activation of PKC $\delta$  in patient-derived glioma cells increased the fractionated-radiation-induced expansion of glioma-initiating cells and resistance to cancer treatment [239].

EGFR transactivation by enhanced PKC $\delta$ /c-Src signaling pathway stimulates glioma cell proliferation [240]. Activation of PKC $\delta$  also stimulates glioma cell invasion and motility by EGF-induced translocation of sphingosine kinase 1 and upregulation of plasminogen activator inhibitor-1 [241] as well as tenascin-C-induced upregulation of MMP-12 [242].

**3.6. Head and Neck Cancer.** Head and neck cancers occur mainly in the squamous cells of the oropharynx, oral cavity, hypopharynx, and larynx and are often referred to as head and neck squamous cell carcinomas (HNSCCs) [243, 244].

PKC $\alpha$  activation increases DNA synthesis and cell growth by activating ERK and cyclin E synthesis, but miR-105 acts as an inverse regulator for both DNA synthesis and cyclin E protein expression [245]. In chemokine receptor 7-positive HNSCC cells, PKC $\alpha$  is required for activation and nuclear translocation of NF- $\kappa$ B induced by chemokine (C-C motif) ligand 19, resulting in enhanced cell survival [246, 247].

PKC $\epsilon$ , on the other hand, is involved in cell proliferation, DNA replication, and invasion in HNSCC cells [248, 249]. These cellular functions can be blocked by miR-107, which can inhibit PKC $\epsilon$  activation [249]. PKC $\epsilon$ -mediated HNSCC cell invasion and motility can be induced through activation of RhoA and C [248].

PKC $\zeta$  activation by phosphorylation at tyrosine 417 plays an important role in EGF-mediated ERK activation, DNA synthesis, and cell proliferation in HNSCCs [250, 251], while depletion of PLC- $\gamma$ 1 or PI3K enhancer may abolish EGF-mediated SCC cell proliferation [252]. Furthermore, inhibition of PKC $\zeta$  can reduce epithelial-mesenchymal transition (EMT), invasion, and migration of oral SCC mediated by the loss of interferon-induced protein with tetratricopeptide repeats 2 (IFIT2) and E-cadherin. Oral SCC patients with reduced IFIT2 levels show higher rates of metastasis and poorer prognoses compared with oral SCC patients with enhanced IFIT2 levels [253]. In addition, PKC $\alpha$ ,  $\beta$ I,  $\delta$ , and  $\zeta$  are involved in the regulation of telomerase activity by direct or indirect phosphorylation of telomerase proteins, and PKC $\zeta$  is also a key regulator in nasopharyngeal cancer originating in nasopharynx [254].

PKC $\iota$  expression is elevated in HNSCCs [255]. Further, there is a positive relationship between PKC $\iota$  expression and esophageal SCC cell size, lymph node metastasis, and clinical stage [256]. PKC $\iota$  activation is also related to the expression of S-phase kinase-associated protein 2 through the PI3K/Akt pathway, leading to resistance of esophageal SCCs to anoikis [257]. However, downregulation of PKC $\iota$  enhances the sensitivity of esophageal SCC KYSE30 cells to oxidative stress-induced apoptosis [258]. Thus, PKC $\iota$  may

be related to poor SCC prognosis. It also seems that high nuclear PKC $\theta$  and PKC $\beta$ II expression has been correlated to a high recurrence of oral SCCs and poor survival in patients [259, 260].

**3.7. Liver Cancer [Hepatocellular Carcinoma (HCC)].** Five PKC isozymes  $\alpha$ ,  $\beta$ II,  $\delta$ ,  $\epsilon$ , and  $\zeta$  are present in normal rat hepatocytes, the rat HCC cell line FAO, and in the human HCC cell line HepG2 (all but PKC $\delta$ ) [261]. In Hep3B cells, different patterns of PKC isozymes have been reported, such as PKC $\alpha$ ,  $\delta$ ,  $\epsilon$ ,  $\zeta$ , and  $\iota$  [262] and PKC $\alpha$ ,  $\gamma$ ,  $\delta$ ,  $\epsilon$ , and  $\zeta$  [263]. Furthermore, PKC $\beta$ II and  $\theta$  are downregulated in human HCC tissues and are correlated with the grade of HCC and hepatitis B virus infection, respectively [264]. High levels of PKC $\iota$  are detected in HCC tissues compared with that in adjacent normal tissues, and show a positive correlation with cyclin E expression, pathological differentiation, and cell invasion and metastasis [265, 266]. PKC $\eta$  is downregulated in HCC tissues and its downregulation is correlated with poor long-term survival in patients [267].

PKC $\alpha$  expression is higher in poorly differentiated HCC (e.g., SK-Hep-1) than in well-differentiated HCC (e.g., HepG2 and Hep3B) [268]. A remarkable reduction of cell growth, migration, and invasion has also been identified in the poorly differentiated HCC cell type SK-Hep-1 treated with siRNA PKC $\alpha$  or antisense PKC $\alpha$  oligonucleotide. These responses are associated with the downregulation of p38, rather than JNK and ERK signaling, indicating that p38 plays a key role in PKC $\alpha$ -mediated HCC cell invasion [269]. Furthermore, Tsai's group has reported that lower levels of membrane-bound PKC $\alpha$  are detected in surgical specimens of HCC compared to adjacent normal tissue and they hypothesize that a negative correlation exists between PKC $\alpha$  activity and the size of HCC [270]. In HepG2 cells, TPA-induced generation of ROS is PKC $\alpha$ -dependent and leads to sustained activation of PKC $\alpha$  and ERK along with a reduction of E-cadherin. These changes in signaling stimulate HepG2 migration and cell cycle arrest [271–273]. TPA-induced growth arrest in the G<sub>0</sub>/G<sub>1</sub> phase, upregulation of cancer suppressor gene miR-101, and downregulation of enhancer of zeste homolog 2 during embryonic ectoderm development in HepG2 cells are all PKC $\alpha$ -dependent [274]. Downregulation of PKC $\alpha$  by adding TPA into Hep3B cells also decreases the production of erythropoietin [263], which is a glycoprotein hormone that is stimulated under the hypoxic environment [275]. On the other hand, expression of PKC $\alpha$  and  $\delta$  suppresses HGF-induced phosphorylation of ERK and paxillin, resulting in the reduction of HepG2 cell migration, whereas PKC $\epsilon$  and  $\zeta$  are required for phosphorylation of paxillin [276]. However, high levels of PKC $\alpha$  mRNA in HCC tissues are correlated with poor survival in patients [277].

The expression of factors associated with certain hepatic viruses can also affect the development and progression of liver carcinomas. Hepatitis B virus (HBV) envelop glycoproteins, for instance, which are collectively known as HBV surface antigens, are divided into three types, the large (LHBs), middle (MHBs), and small surface proteins (SHBs) [278]. The PreS2, which is a 55 hydrophilic amino

acid chain located at the N-terminal of SHBs, is found in LHBs and MHBs [278] and stimulates the Raf1/MEK pathway through PKC $\alpha$  and  $\beta$  signaling pathways [279]. Further, LHBs can promote carcinogenesis and proliferation of HCC cells through the c-Src/PI3K/Akt pathway, which is triggered by PKC $\alpha$ /Raf1 activation. Stable LHB expression in HuH-7 cells also increases G<sub>1</sub>/S cell cycle progression and antiapoptosis via c-Src activation [280].

PKC $\delta$  is involved in caspase-3-dependent apoptosis induced by the synthetic sphingosine immunosuppressant FTY720 [281]. Moreover, activation of the c-Abl/PKC $\delta$  signaling pathway results in claudin-1-induced MMP-2 expression as well as cell invasion and migration [282]. Further, PKC $\delta$  also increases phosphorylation of heat shock protein-27 (HSP-27) via p38 MAPK [283] and this may be correlated with cell migration and invasion [284].

In addition, PKC $\epsilon$  may be involved in growth and migration of HCC cells [276, 285], while the PKC $\beta$ -specific inhibitor LY317615 or siRNA significantly reduces migration and invasion of HCC cells [286].

### 3.8. Lung Cancer

**3.8.1. Small and Nonsmall Cell Lung Carcinoma.** The two major types of lung cancer are nonsmall cell lung cancer (NSCLC) (85%) and small cell lung cancer (SCLC) (15%); NSCLC can be further divided into three subtypes: squamous-cell carcinoma, adenocarcinoma, and large-cell lung cancer [287]. NSCLCs show significantly higher survival and anticancer drug resistance than SCLCs; as they have been shown to have enhanced anticancer drug transport activity [288] and/or JNK activation [289]. Although expression of PKC $\alpha$ ,  $\beta$ ,  $\epsilon$ ,  $\eta$ ,  $\iota$ , and  $\zeta$  is identified in NSCLCs and SCLCs, it seems that the important isozymes for therapeutic use are PKC $\alpha$ ,  $\beta$ ,  $\epsilon$ , and  $\iota$ .

PKC $\alpha$  is highly expressed in patients with NSCLCs, which higher levels being found for adenocarcinoma compared to squamous cell carcinoma [290]. PKC $\alpha$  exerts an important effect on antiapoptosis and metastasis of NSCLC cells. Metastasis of NSCLC cells can be stimulated by the activation of PKC $\alpha$  through a C-terminal class I PDZ-dependent interaction with its substrate, discs large homology-1 [291]. In addition, an increase in the activity of PKC $\alpha$  and nuclear PKC $\beta$  has been detected in lung metastatic nodules originating from other cancers such as HCC [292].

In regard to the antiapoptotic function of PKC $\alpha$ , PKC $\alpha$ -mediated phosphorylation of RLIP76 at Thr-297 increases doxorubicin (DOX)-transport activity, resulting in lower levels of apoptosis. This phenomenon is higher in NSCLC cells than in SCLC cells [288]. Moreover, miR-203 can regulate the expression of PKC $\alpha$  in NSCLC, where downregulation of PKC $\alpha$  by the miR-203 induces apoptosis of A549 cells while also reducing PKC $\alpha$ -mediated cell migration and proliferation [293]. PKC $\alpha$ , along with survival, is also involved in inhibition of FGF2-induced apoptosis by the stimulation of FGF2-mediated surviving expression [294]. Interestingly, a recent study has demonstrated that PKC $\alpha$ , through the activation of a p38 MAPK/TGF- $\beta$  axis, has

a suppressor function in NSCLC formation and its loss enhances K-Ras-mediated cancer initiation and progression of bronchioalveolar stem cells [295].

These data all indicate that PKC $\alpha$  is an important target for treatment of SCLCs and NSCLCs, but clinical trials using PKC $\alpha$ -specific antisense oligonucleotides show no or low efficacy in patients [296–298]. Further, clinical trials using PKC $\alpha$ -targeted antisense oligonucleotides aprinocarsen [296, 297] and LY900003 [298] in combination with anticancer drugs (either gemcitabine and cisplatin or gemcitabine and carboplatin) did not enhance survival and other efficacy measures in patients with advanced NSCLC.

PKC $\epsilon$  is abnormally upregulated in human NSCLCs and is known to regulate growth and survival of NSCLC cells [299]. PKC $\epsilon$ -depleted NSCLC cells show low growth rates *in vitro* and *in vivo*, as well as upregulation of proapoptotic genes, such as *BIRC2*, *CASP4*, *CASP1*, *CD40*, and *FAS*, and downregulation of prosurvival genes, such as *Bcl2*, *BIRC3*, and *CD27* [300]. PKC $\epsilon$  also enhances the proliferation of NSCLCs through the reduction of p21<sup>Cip1</sup>, suggesting that the p21<sup>Cip1</sup> serves as a negative effector in the PKC $\epsilon$ -mediated proliferation of NSCLCs [299]. The antiapoptotic functions of PKC $\epsilon$  in lung cancer cells involve the inhibition of TRAIL-induced cell death [301] and mitochondrial caspase signaling [302], as well as the upregulation of antiapoptotic proteins (e.g., XIAP or Bcl-XL) through S6K2, but not S6K1 signaling [303].

During metastasis of NSCLC cells, PKC $\epsilon$  acts as a positive effector by enhancing the activation of Rac1, a Rho family member of the small GTPases, and the secretion of extracellular matrix protease (e.g., MMP-9) and protease inhibitors (e.g., tissue inhibitor of metalloproteinase 1 and 2) [304]. PKC $\epsilon$ -dependent formation of the  $\alpha_5$ /tight junction protein zonula occludens-1 complex enhances migration and invasion of lung cancer cells [305].

PKC $\iota$  is expressed in both SCLCs and NSCLCs and is associated with their carcinogenesis, survival and antiapoptosis [306–309]. The survival mechanisms of SCLCs and NSCLCs through PKC $\iota$  involve upregulation of the antiapoptotic protein Bcl-XL [310] and S-phase kinase-associated protein 2-mediated anoikis resistance via the PI3K/Akt pathway [308]. PKC $\iota$  also regulates transformed growth and invasion of NSCLC cells mainly through the Rac1/PAK/MEK/ERK signaling pathway [307, 311, 312]. After PKC $\iota$  phosphorylation of epithelial cell transforming sequence 2 (Ect2) at Thr-328, binding of activated Ect2 to the PKC $\iota$ -Par6 complex enhances Rac1 activity [312]. In this process, MMP-10 acts as a critical effector of the PKC $\iota$ -Par6/Rac1 signaling axis that is required for anchorage-independent growth and invasion of NSCLC cells [313]. In PKC $\iota$ -dependent adenocarcinoma transformation, PKC $\iota$  induces four target genes, *COPB2*, *ELF3*, *RFC4*, and *PLS1*, whose expression has been correlated with PKC $\iota$  activity [314]. Therefore, overexpression of PKC $\iota$  is connected with poor survival in patients with NSCLC and can be used as a prognostic indicator [306].

Among oncogenic *Ras* genes (*H-Ras*, *K-Ras*, and *N-Ras*), activating mutations in *K-Ras* are the most frequently found

in NSCLCs [315, 316] and PKC $\iota$  is required for *K-Ras*-mediated bronchioalveolar stem cell expansion and lung cancer growth. This suggests that PKC $\iota$  may be an attractive therapeutic target for the protection of lung cancer-initiating stem cells. In fact, aurothiomalate, which is a potent inhibitor of PKC $\iota$ -Par6 interactions [317], can target lung cancer-initiating stem cell niches and efficiently inhibit *K-Ras*-mediated bronchioalveolar stem cell expansion [318]. In addition, aurothiomalate decreases the proliferation of lung cancers by inhibition of MEK/ERK signaling [311]. Interestingly, oncrasin-1, a small molecule RNA polymerase II inhibitor, requires K-Ras or PKC $\iota$  for its apoptosis induction in lung cancer cells [319].

PKC $\eta$  overexpression may be related to the advanced stages of NSCLC because its highest levels are identified in patients with clinical stage IV NSCLC [320]. Inhibition of PKC $\eta$  enhances caspase-3 activity in NSCLC A549 cells after treatment with anticancer drugs [321]. On the other hand, EGF-mediated PKC $\zeta$  activation is required in NSCLC cell chemotaxis, which plays a critical role in NSCLC cell metastasis [322].

PKC $\delta$  may be a potential therapeutic target for lung cancer because of the close relationship between its expression and antiapoptosis and cell survival. In fact, inhibition of PKC $\delta$  suppresses anchorage-independent growth, invasion, and migration in K-Ras-dependent NSCLC cells [323] and promotes chemotherapy-induced apoptosis [324]. Interaction of HSP-27 with PKC $\delta$ , especially amino acid residues 668–674 (EFQFLDI) of the V5 region, increases radioreistance and chemoresistance of NSCLC cells [325]. PS-341 (bortezomib), a proteasome inhibitor, upregulates PKC $\delta$ -dependent death receptor 5 (DR5) expression and apoptosis of NSCLC cells through the activation of ERK/RSK2 and ER stress pathways [326]. On the other hand, PKC $\delta$  also triggers the upregulation of p21 and downregulation of Rb hyperphosphorylation and cyclin A expression, resulting in PMA-induced G<sub>1</sub> arrest of NSCLC cell lines H441 and H358 [327].

**3.8.2. Role of PKC Isozymes in Cigarette Smoke-Induced Lung Cancer.** Cigarette smoke exposure, including secondhand (passive or environmental) smoke exposure, causes damage and/or apoptosis of lung cells and increases the risk of lung cancer [328]. PKC signaling has been shown to be involved in smoke-induced cell damage and apoptosis [328–330], but there is very little data specifically on the role of PKC isozymes in causing cigarette smoke-induced lung cancer. In a recent study, smoke exposure induces the phosphorylation of tumor necrosis factor-converting enzyme (TACE; also known as ADAM17), which is a metalloprotease disintegrin. PKC $\epsilon$  expression, activated by c-Src/ROS pathways, is required for TACE phosphorylation and EGFR activation, leading to the hyperproliferation of lung cells [329]. Further, nitrosamine 4-(methylnitrosamino)-1-(3-pyridyl)-1 butanone (NNK) is the most potent carcinogen that is formed by nitrosation of nicotine. A recent study has suggested that NNK can induce migration and invasion of human lung cancer cells through the cooperation with c-Src/PKC $\iota$  and PKC $\iota$ /focal



adhesion kinase (FAK) pathways [331]. PKC $\iota$  can also stimulate nicotine-induced migration and invasion of human lung cancer cells through phosphorylation of  $\mu$ - and m-calpains that are major members of the calpain family and can regulate cell motility [309]. Therefore, although there is not an overwhelming amount of evidence, it is likely that cigarette smoke can in fact promote invasion and migration of lung cancer cells through PKC signaling [309, 331, 332].

**3.9. Melanoma.** PKC $\alpha$ ,  $\delta$ ,  $\epsilon$ ,  $\zeta$ , and  $\lambda/\iota$  are the PKC isozymes expressed in melanoma [333, 334]. Among them, PKC $\alpha$  is the most important as it is involved in differentiation, proliferation, survival, metastasis, and antiapoptosis of melanoma cells [333, 335]. Further,  $\alpha$ v-integrin expression and  $\alpha$ v-mediated relocalization of p53 by PKC $\alpha$  enhance melanoma cell survival [336]. In addition, expression of PKC $\alpha$  plays a critical role in the invasion and migration of melanoma cells [337, 338] as it can stimulate  $\alpha$ v $\beta$ 3-integrin-mediated invasion of melanoma cells by increasing the GTPase activity of Rac [337]. PKC $\alpha$  also induces melanoma vasculogenic mimicry [339] or the formation of de novo vascular networks by highly aggressive cancer cells thereby promoting the aggressive, metastatic phenotype of cancer cells [340]. However, the cellular activity of PKC $\alpha$  may vary, even in the same melanoma tissues (e.g., samples collected from the center of a B16 melanoma compared to those from its edge show lower PKC $\alpha$  activity) [341].

PKC $\epsilon$  can participate in antiapoptosis of melanoma cells. For example, expression of PKC $\epsilon$  attenuates the sensitization of melanoma cells to TRAIL-induced apoptosis [342], docetaxel-induced apoptosis through the activation of ERK1/2 pathway [343], and genotoxic stress-induced apoptosis by blocking the transcription factor ATF2 nuclear export and localization in the mitochondria [344].

PKC $\beta$  is detected in normal melanocytes, but is not found in isolated primary or metastatic melanoma cells [333, 334]. Introduction of PKC $\beta$ II into melanoma cells suppresses HGF-induced activation of PI3K, tyrosine phosphorylation of adapter protein Gab1, and invasion activity of melanoma cells [345]. Reexpression of PKC $\beta$  in melanoma cells inhibits melanoma growth and elevates UV-induced ROS production [346]. These results indicate that PKC $\beta$  has cancer suppressive functions and its activation in melanoma can be a potential treatment option for melanoma.

Melanoma cells overexpressing PKC $\delta$  have enhanced cell metastatic capacity, likely through the release and activation of TGF- $\beta$ 1 [347, 348], but reduce proliferative capacity because of reduced sphingomyelinase activity [348, 349]. Furthermore, high levels of activated PKC $\delta$  enhance docetaxel-induced apoptosis via JNK activation [350].

**3.10. Myeloid and Lymphocytic Leukemia.** Leukemia is cancer of the blood cells and is classified as lymphocytic (lymphoid or lymphoblastic) or myeloid (myelogenous or myeloblastic) leukemia according to the type of cell that it starts in. These classifications are further broken down into four types, acute lymphocytic leukemia (ALL), CLL, AML, and chronic myeloid leukemia (CML).

**3.10.1. CLL and ALL.** Several PKC isozymes (PKC $\alpha$ ,  $\beta$ I,  $\beta$ II,  $\delta$ ,  $\epsilon$ ,  $\zeta$ , and  $\iota$ ) are detected in CLL, but PKC $\beta$ II shows the highest expression [351–353] and plays a more important role in cell proliferation, differentiation, survival, and anticancer drug resistance. Overexpression of PKC $\beta$ II in CLL is also associated with poor prognosis and patient survival [354–357]. For these reasons, PKC $\beta$ II is considered a useful therapeutic target for the treatment of CLL; however, inhibition of a PKC $\beta$ II activity with PKC $\beta$ II-specific inhibitor (e.g., LY379196) has a minimal effect on the viability of CLL cells [351, 358]. The presence of LY379196 also failed to induce a spontaneous decrease of PKC $\beta$ II mRNA and activity levels in CLL cells [358]. These data strongly suggest the existence of other critical survival signals and PKC $\beta$ II activation signals in CLL cells. In fact, treatment with the PKC inhibitor RO32-0432, which can inhibit cPKCs, nPKCs, and aPKCs, markedly reduced the cell viability [351]. Further, growth factors, such as VEGF and bFGF, also appear to play an important role in maintaining PKC $\beta$ II activity, because while LY379196 does not inhibit PKC $\beta$ II under normal (i.e., growth factor rich) cellular condition, PKC $\beta$ II is inhibited by this drug in the absence of VEGF [358].

Increased PKC $\beta$ II expression also induces Akt phosphorylation, known to be a survival signal, independent of PI3K [359, 360], and controls the B cell-activating factor of the TNF family (BAFF; also known as BLyS) that is responsible for the Akt activation in response to PI3K activation [361]. During apoptosis, PKC $\beta$ II downregulates proapoptotic B-cell receptor signaling in CLL cells [351]. Further, phosphorylation of antiapoptotic Bcl-2 protein at serine 70 by PKC $\beta$ II increases the survival of CLL cells, but PKC $\beta$ II-mediated phosphorylation of a proapoptotic BH3 only protein, Bim<sub>EL</sub>, which is essential for the initial stimulation of apoptosis, leads to its proteasomal degradation [362]. A recent study has demonstrated that PKC $\beta$ -dependent activation of NF- $\kappa$ B in bone marrow stromal cells is also essential for the survival of CLL cells [363]. Taken together, PKC $\beta$ II appears to participate in CLL cell survival by inhibiting proapoptotic signals and activating prosurvival signals.

PKC $\delta$  also plays an important role in CLL survival through the activation of PI3K [364], stabilization of Mcl-1 [365], and activation of NOTCH2 with an antiapoptotic function [366].

In ALL, PKC $\beta$ -specific inhibitors reduce cell viability in a dose-dependent manner [357]. Overexpression of PKC $\alpha$  has no influence on cell proliferation or cell cycle in the ALL cell line REH, but does induce anticancer drug resistance via Bcl-2 phosphorylation [367].

**3.10.2. CML and AML.** High levels of PKC $\alpha$  and PKC $\beta$ II expression have been reported in myeloid leukemia and both isozymes have been shown to regulate cell differentiation, proliferation, and survival [368–370]. In CML cells, PKC $\beta$ II activation is essential for cell proliferation and survival [362]. A recent study has reported that WK234, an inhibitor of PKC $\beta$ , decreases proliferation of CML K562 cells and enhances their apoptosis [371]. Furthermore, a farnesyltransferase inhibitor, BMS-214662, was determined to stimulate



mitochondrial apoptosis in CD34<sup>+</sup> CML cells during the early upregulation of PKC $\beta$  [372].

CML K562 cells can resist ionizing radiation through activation of the PKC $\delta$ /NF- $\kappa$ B pathway [373]. PKC $\delta$  is also involved in IFN- $\alpha$ -induced growth inhibition of CML cells through phosphorylation of Stat1 [374]. On the other hand, PKC $\delta$  may also participate in K562 cell death because of a close relationship between activation of the PKC $\delta$ /ERK pathway and high levels of Bax at hypoxia-induced apoptosis [375].

In AML cells, PKC $\alpha$  may play an important role in the inhibition of anticancer drug-induced apoptosis. Blocking PKC $\alpha$  activation enhances apoptosis in the AML cell line OCI-AML3 [370] and NB cells [376]. Furthermore, AML patients with active PKC $\alpha$  and PKC $\alpha$ -mediated Bcl-2 phosphorylation, which modulates the antiapoptotic ability of Bcl-2, have much shorter survival [377–379]. However, PKC $\beta$  may not be involved in AML cell death because PKC $\beta$  inhibitors show no effect on AML cell apoptosis [380].

Expression of PKC $\delta$  in AML cells induces cell death through the downregulation of heterogeneous nuclear ribonucleoprotein K [380], phosphorylation of eIF2 $\alpha$  [381] and  $\beta$ -actin [382], and activation of MAPKs (JNK and p38) [383] and caspase-3 [384, 385]. In addition, when wogonin, a natural monoflavonoid, is added to AML U937 cells, cell differentiation and G<sub>1</sub> phase arrest are induced through PKC $\delta$ -mediated upregulation of p21 proteins [386]. Statin-induced AML NB4 cell differentiation [387] and ATRA-induced antileukemic responses in AML cells also require activation of PKC $\delta$  [387, 388].

**3.11. Ovarian Cancer.** Expression of PKC $\alpha$ ,  $\iota$ , and  $\zeta$  has been found in ovarian cancer. PKC $\alpha$  can activate cell growth and DNA synthesis through follicle-stimulating hormone [389] and lysophosphatidic acid-induction in ovarian cancer cell invasion [390]. PKC $\iota$  shows a significant correlation with cancer stage, histopathological grading, and proliferation index, but PKC $\alpha$  is only correlated (negatively) with histopathological grading [391]. PKC $\iota$  does not directly affect ovarian cancer cell response to chemotherapy and proliferation, but it may indirectly participate in cell proliferation [392, 393].

On the other hand, PKC $\zeta$  in ovarian cancer cells can act as a negative regulator of cell survival via regulation of the proapoptotic functions of protein phosphatase 2A (a survival phosphatase) and HRSL3 (a class II tumor suppressor family; also known as H-REVI07-1) [394].

PKC $\delta$  is not expressed in primary and recurrent ovarian cancers [391]. However, gonadotropin-induced ovarian cancer cell proliferation requires PKC $\delta$ -mediated activation of ERK1/2 signaling [395]. Furthermore, activation of PKC $\delta$  may be associated with enhanced apoptosis in the ovarian cancer cell line COC1 [392].

**3.12. Pancreatic Cancer.** As mentioned above, EMT plays a critical role in promoting metastasis and invasion of cancer cells [253, 396]. Overexpression of PKC $\alpha$  in poorly differentiated human pancreatic cancer tissues and cell line

PANCI downregulates the activation of claudin-1 through Snail- and ERK-dependent pathways during EMT. In the well-differentiated pancreatic cancer cell line HPAC, PKC $\alpha$  activation reduces not only claudin-1 but also claudin-4, -7, and occludin, while Snail signaling is not changed. These signaling responses stimulated by PKC $\alpha$  activation lead to the downregulation of tight junction functions and enhanced antiapoptosis capabilities, which may increase cell invasion and metastasis [397, 398]. TGF- $\beta$ -mediated PKC $\alpha$  activation reduces the sensitivity of pancreatic cancer cells to cisplatin through overexpression of P-gp [399], stimulates cell migration, and reduces the expression of a putative tumor suppressor, phosphatase, and tensin homology [400]. In addition, PKC $\alpha$  has been shown to be involved in growth and differentiation of pancreatic cancer cells as the selective downregulation of PKC $\alpha$  enhances TNF $\alpha$ -induced growth arrest and differentiation in HPAC cells [401] and blocks retinoic acid-stimulated growth of the pancreatic cancer cell line AsPc1 [402]. PKC $\alpha$ -selective inhibition reduces carcinogenesis of pancreatic cancer and enhances the survival of tumor-bearing animals [403]. However, one study has shown that activation of PKC $\alpha$  can inhibit growth of the pancreatic cancer cell line DanG through the inhibition of p21<sup>Cip1</sup>-mediated G<sub>1</sub>/S cell-cycle transition [404].

PKC $\zeta$  participates in survival and metastasis of pancreatic cancer cells through the Stat3-dependent pathway [405–407] and Sp1-dependent VPE/VEGF expression, which is associated with cancer angiogenesis [408].

Pancreatic ductal adenocarcinoma (PDAC), the most common type of pancreatic cancer, shows higher expression of PKC $\iota$  than intraductal papillary mucinous neoplasm. Overexpression of PKC $\iota$  has also been correlated with poor survival in PDAC patients [409]. High expression of PKC $\iota$  in intraductal papillary mucinous neoplasm is also significantly associated with a worsening histological grade and advanced stage cancer [410]. PKC $\iota$  is required for angiogenesis and metastasis of PDAC through Rac1-MEK/ERK1/2 pathway [409] and TGF- $\alpha$ - and K-Ras<sup>G12D</sup>-mediated pancreatic acinar-to-ductal metaplasia [411].

PKC $\beta$ 1 may play an important role in migration and antiapoptosis of pancreatic cancer cells [412]. Treatment with the PKC $\beta$  inhibitor enzastaurin reduces cancer growth, phosphorylation of GSK3 $\beta$ , and microvessel density in pancreatic cancer-bearing mice when combined with radiation therapy, but enzastaurin alone failed to affect cell survival, proliferation, or xenograft growth [413, 414]. On the other hand, in a study using the pancreatic endocrine cancer cell line DON1, enzastaurin (5 and 10  $\mu$ M) increased caspase-mediated apoptosis, reduced phosphorylation of GSK3 $\beta$  and Akt, and blocked cell proliferation through the inhibition of insulin-like growth factor-1 (IGF-1) [415].

PKC $\delta$  can increase anchorage-independent growth, resistance to treatment of cytotoxic drugs, and metastasis of PANCI [416]. Activation of the PKC $\delta$ /TG2 signaling pathway is also associated with enhanced drug resistance, metastatic phenotype, and poor patient prognosis with pancreatic cancer cells [417].

3.13. *Prostate Cancer.* In early prostate cancer specimens, PKC $\alpha$  and  $\zeta$  are significantly increased, but PKC $\iota$  expression shows no difference between the benign and malignant groups. Attenuation of PKC $\beta$  in early prostate cancer is associated with an increase in PKC $\epsilon$  expression [418]. High expression of PKC $\delta$  in both low- and high grade prostate cancer has been reported [419, 420]. Furthermore, significantly high levels of PKC $\alpha$ ,  $\beta$ ,  $\epsilon$ , and  $\eta$  have been detected in malignant prostatic carcinoma [421].

The levels of PKC $\alpha$  are lower in hormone-sensitive cell lines (e.g., LNCaP) compared to hormone-insensitive cell lines (e.g., PC3 or DU145) [422, 423]. PKC $\alpha$  activation by the arachidonic acid metabolite 12(S)-hydroxyeicosatetraenoic acid induces the motility of AT2.1 rat prostate cancer cells [424], but the reduced activation of PKC $\alpha$  by TGF- $\beta$ 1 leads to the inhibition of PC3 cell growth [425]. PKC $\alpha$  is also required for EGFR transactivation and ERK1/2 activation in androgen-independent human prostate cancer cells [426]. Further, these signaling responses are linked to multiple biological responses, such as proliferation, migration, and antiapoptosis, occurring in prostate cancer cells [427]. In prostate cancer progression and angiogenesis, osteopontin, a multifunctional glycosylated phosphoprotein, activates PKC $\alpha$ , which then plays a critical role in COX-2 expression, ultimately resulting in enhanced cell migration and invasion and angiogenesis [428].

Prostate cancer cells show PKC $\alpha$ -dependent proapoptotic and antiapoptotic functions. When the anticancer drug cisplatin introduced to prostate cancer cells, PCPH/ENTPD5 expression increases antiapoptosis through PKC $\alpha$ -mediated Bcl-2 stabilization [429]. In addition, resveratrol (3,4',5-trihydroxystilbene), a natural stilbene with anticancer activity, induces p53-mediated apoptosis, but this apoptotic process is inhibited by PKC $\alpha$  activation via EGF [430].

On the other hand, PKC $\alpha$  activation by TPA or a methoxyflavone derivative WJ9708012 was shown to enhance apoptosis of the prostate cancer cells through the downregulation of the serine/threonine kinase ataxia telangiectasia mutated [431], Bcl-2, and Bcl-XL in association with the degradation of the proapoptotic proteins Bid and Bad [432]. However, removal of TPA leads to the downregulation of PKC $\alpha$  [422]. Furthermore, LNCaP cells overexpressing PKC $\alpha$  had increased sensitivity to bryostatin 1-induced apoptosis [433]. Toll-like receptors (TLRs) have important roles in host defense and tissue homeostasis during carcinogenesis through the immune system [434, 435]. The TLR3-specific ligand poly (I:C) induces apoptosis of human prostate cancer cell lines through the upregulation of JNK and p38 MAPK by PKC $\alpha$  activation, resulting in caspase-8-dependent apoptosis [436].

However, in a phase II clinical trial, PKC $\alpha$ -specific antisense oligonucleotides, ISIS 3521 and ISIS 5132, did not show clinical significant anticancer efficacy in patients with hormone-refractory prostate cancer [437].

PKC $\epsilon$  may be the most useful therapeutic target to treat prostate cancers because it plays a key role in growth, survival, and antiapoptosis in this type of cancer. When PKC $\epsilon$  is genetically deleted in the transgenic mouse model of prostate adenocarcinoma, proliferation, antiapoptosis, and metastasis

of prostate cancer cells are dramatically reduced [438]. PKC $\epsilon$  promotes growth and enhances survival of protein kinase D3-induced prostate cancer cells through stimulation of Akt and ERK1/2 [439], enhances cell survival of recurrent CWR-R1 prostate cancer cells through activation of the Akt survival pathway [440], and promotes growth and enhances survival of androgen-independent prostate cells through stimulation of cell proliferation-related protein synthesis (e.g., caceolin-1) and signaling (e.g., Raf1/ERK1/2) [441, 442]. In contrast, one study suggested that overexpression of PKC $\epsilon$  does not alter the sensitivity of LNCaP cells to either PMA or androgen and the expression of caceolin-1 [423]. In addition, PKC $\epsilon$  is required for constitutive activation of Stat3 through phosphorylation at serine 727 that is essential for prostate cancer cell invasion [438, 443].

Furthermore, PKC $\epsilon$ -mediated antiapoptotic properties are obtained through the effects on multiple signaling pathways, such as phosphorylation and inactivation of proapoptotic Bad [444], inhibition of TNF $\alpha$ -induced JNK activation [444], inhibition of I $\kappa$ B $\alpha$  phosphorylation and degradation [445], and interaction of PKC $\epsilon$  with proapoptotic Bax, all of which result in the neutralization of apoptotic signals [446]. Furthermore, PKC $\epsilon$  increases P-gp-mediated drug resistance [447].

Several groups have also demonstrated that anticancer agents that downregulate PKC $\epsilon$  can efficiently induce apoptosis in prostate cancer cells and inhibit their growth *in vivo* and *in vitro*. These drugs include wedelolactone, a medicinal plant-derived coumestan [448]; a second-generation selenium compound, methylseleninic acid [449]; a specific inhibitor of 5-LOX activity, MK591 [450]; and plumbagin (5-hydroxy-2-methyl-1,4-naphthoquinone) [451]. One study, however, has suggested that prostate cancer cells overexpressing PKC $\epsilon$  exhibit sensitivity to bryostatin 1-induced cell death [423].

In prostate cancer cells, PKC $\zeta$  acts as a cancer suppressor through the regulation of c-Myc function [452]. Spisulosine (ES-285), which is a marine compound that has an anticancer activity, induces the death of prostate cancer cells through ceramide accumulation and PKC $\zeta$  activation [453]. In a recent study, PKC $\zeta$  was also shown to be involved in promoting the aggressive phenotype of LNCaP cells [454], while another study postulated that its overexpression inhibits invasive and metastatic activity in Dunning R-3327 rat prostate cancer cells [455]. Further, PKC $\zeta$  activation is required for androgen-dependent cell proliferation in prostate cancer LNCaP cells and during the transition of androgen-dependent to androgen-independent prostate cancer cells [456].

In addition, downregulation of PKC $\eta$  efficiently enhances TRAIL-induced apoptosis [457] and inhibition of centrosomal PKC $\beta$ II expression reduces angiogenesis and prostate cancer cell growth [458].

PKC $\delta$  expression is associated with apoptosis of prostate cancer cells. The proapoptotic role of the protein tyrosine phosphatase PTPL1 in PC3 and LNCaP prostate cancer cells is PKC $\delta$ -dependent and induces inhibition of I $\kappa$ B $\alpha$  degradation and suppression of NF- $\kappa$ B activity [420]. Several mechanisms are involved in PKC $\delta$ -dependent apoptosis, which is

triggered by PMA, anticancer drugs, or androgens; these mechanisms include upregulation of DRs (e.g., DR5) [459], activation of DR downstream effectors (e.g., caspase-8 and -3, p38, and JNK) [459–462], enhanced release of death factors (e.g., TNF $\alpha$  and/or TRAIL) [463, 464], upregulation of ROCK (mediated by depletion of type I transmembrane protein p23/Tmp21) [460], and ROCK-mediated upregulation of p21<sup>Cip1</sup> [465]. Furthermore, activation of neutral endopeptidase (NEP) and PKC $\delta$  correlates with TPA-induced apoptosis of androgen-independent prostate cancer cells. The NEP inhibits neuropeptide-induced and c-Src-mediated PKC $\delta$  degradation [466]. In anticancer drug-induced apoptosis, PKC $\delta$  and ceramide are required for cytochrome C release and caspase-9 activation in mitochondria [467].

In addition, PKC $\delta$  is overexpressed in invasive prostate cancer cell lines (e.g., DU145) and plays a critical role in migration and invasion [468]. BK-mediated migration of prostate cancer cells involves upregulation of MMP-9 and activation of the B2 receptor/PKC $\delta$ /c-Src/NF- $\kappa$ B signaling pathway [469]. PCPH/ENTPD5-mediated invasion of prostate cancer cells is also PKC $\delta$ -dependent [419]. Furthermore, activation of PKC $\delta$  in mice xenografted with PC3 cells can increase angiogenic activity through enhanced NADPH oxidase activity and increased levels of hypoxia-inducible factor (HIF)-1 $\alpha$  [470].

**3.14. Renal Cell Carcinoma (Kidney Cancer).** Renal cell carcinomas (RCCs) are divided into four types: clear cell (70~80%), papillary (10~20%), chromophobe (5%), and collecting duct (1%) [471, 472]. Different types of RCC show significantly different patterns in the expression of PKC isozymes. PKC $\beta$ I,  $\beta$ II,  $\delta$ , and  $\epsilon$  are expressed in RCCs, while PKC $\alpha$ ,  $\beta$ I,  $\beta$ II,  $\eta$ , and  $\iota$  are found in oncocytoma, the most common benign solid renal tumor [473]. Moreover, PKC $\alpha$ ,  $\beta$ I,  $\beta$ II,  $\gamma$ ,  $\delta$ ,  $\epsilon$ ,  $\eta$ ,  $\theta$ , and  $\lambda$  have been detected in the human RCC cell line CCF-RC1 [474]. In human clear cell RCC cell lines clearCa-5, clearCa-19, clearCa-28, and clearCa-39 and PKC $\alpha$ ,  $\epsilon$ ,  $\zeta$ , and  $\iota$  are found, while PKC $\beta$ I,  $\beta$ II,  $\gamma$ ,  $\delta$ ,  $\eta$ , and  $\theta$  are absent [475]. Notably, lower levels of PKC $\alpha$  are detected in clear cell RCCs than in normal tissue [473, 476]. Furthermore, clear cell RCCs collected from patients show expression of PKC $\alpha$ ,  $\beta$ I,  $\beta$ II,  $\delta$ ,  $\epsilon$ ,  $\eta$ ,  $\zeta$ , and  $\iota$ , but not PKC $\gamma$  and  $\theta$ . A 3-fold increase in PKC $\eta$  and a slight increase in PKC  $\zeta$  (20%) in grades III and IV carcinomas are common in all clear cell RCCs, suggesting that these PKCs are correlated with increased cancer progression [476]. On the other hand, Pu et al. [477] have reported a significant increase of PKC $\zeta$  as cancer grade increases in addition to a significant association between increased PKC $\zeta$  and poor patient survival, likely because of increased resistance to the anticancer drug cisplatin. PKC $\zeta$  can also activate HIF-2/HIF- $\alpha$  in the RCC cell line 786-O by inhibiting mRNA expression of FIH-1 [478].

PKC $\epsilon$  is involved in growth, migration, and invasion in the clear cell RCC 769P cell line. Further, inhibition of PKC $\epsilon$  has been shown to induce the activity of caspase-3 after adding chemotherapeutic drugs (sunitinib or 5-fluorouracil) [479]. PKC $\epsilon$  is also associated with the regulation of  $\beta$ 1-integrin expression [473]. PKC $\alpha$  and  $\epsilon$  both play a key role

in invasion of human clear cell RCC cell lines, especially the more highly invasive RCC cell lines clearCa-5 and clearCa-19 [475]. In addition, expression of netrin-1 is higher in the invasive human RCC cell line ACHN than in the weakly invasive cell line 769P, but expression of UNC5B is found to be the opposite. Stimulation of PKC $\alpha$  by PMA increases the expression of netrin-1 and netrin receptor UNC5B in ACHN cells, but expression of netrin-1 is much higher than that of UNC5B [480]. These results may be related with to the enhanced antiapoptosis, cell proliferation, and migration observed in these cells [481].

Expression of CUB-domain-containing protein 1 can elevate RCC migrations through PKC $\delta$  activation and correlates with poor survival of patients [482]. PKC $\delta$  activation also increases RCC migration by reducing expression and activity of  $\beta$ 1-integrin and FAK [483]. Similar to its role in pancreatic cancer cells, IGF-1 receptor activation via PKC $\delta$  induces IGF-1-mediated invasion of RCC cells, but this invasion can be blocked by the tumor suppressor von Hippel-Lindau [484].

**3.15. Thyroid Cancer.** Sphingosine 1-phosphate (S1P)-mediated migration of thyroid cancer ML-1 cells is dependent on PKC $\alpha$ , ERK1/2, and sphingosine kinase 1 (SK1). SK1 activates S1P secretion and the activated S1P stimulates ERK1/2 phosphorylation through PKC $\alpha$  and  $\beta$ I signaling. Downregulation of PKC $\alpha$  reduces both VEGF-A- and S1P-induced haptotaxis, while downregulation of PKC $\beta$ I only reduces S1P-induced haptotaxis [485, 486]. Furthermore, the PKC $\alpha$ -D294G mutant in the V3 region is found not only in thyroid cancers with more invasive phenotype [487–489], but also in pituitary adenomas [487, 489] and breast cancers [490]. This mutant reduces the transduction of extracellular signals that can suppress cancer cell growth and increase apoptosis thereby leading to a more malignant phenotype [487]. However, to date, the pituitary mutants PKC $\alpha$ -A294G [491] and PKC $\alpha$ -A881G [492] have not been identified in thyroid cancers.

Similar to the microRNA functions mentioned for other cancers (e.g., miR-31 in breast cancer or miR-203 in lung cancer), overexpression of miR-146a in the papillary thyroid cancer cell line NPA-187 decreases cell survival and induces apoptosis by suppressing PKC $\epsilon$  expression [493]. In contrast, inhibition of PKC $\epsilon$  in PCCL3 cells blocks p53 expression and increases the levels of murine double minute clone 2, while it has an oncogene function and antiapoptosis activity through the activation of Bcl-2 expression and reduction of Bax expression [494]. In addition, downregulation of PKC $\epsilon$  by prolonged expression of RET/PTC increases cell survival and resistance to DOX-induced apoptosis in the thyroid cancer cell line PCCL3, while acute expression of RET/PTC activates PKC $\epsilon$  [495]. Reduction of PKC $\epsilon$  in papillary thyroid cancers can occur through either translational or posttranslational mechanisms [492].

Furthermore, PKC $\beta$ II inhibition by enzastaurin leads to the reduction of medullary thyroid carcinoma cell proliferation and survival, indicating that PKC $\beta$ II is required in these processes [496].



PKC $\delta$  activation shows an arrest in papillary thyroid cancer cell (NPA) growth at G<sub>1</sub> phase through the ERK/p27<sup>Kip1</sup>/cyclin E/pRb pathway [497] as well as antiproliferative effects in the anaplastic (FRO and ARO) and follicular (ML-1) thyroid cancer cell lines through MAPK/Akt and FOXO signaling [498]. Enhanced FRO cell migration through phosphorylation of Bcl-2 associated athanogene 3 (BAG3) was also observed in some cases [498, 499].

#### 4. PKC Isozymes as Diagnostic or Prognostic Biomarkers

PKC isozymes that are overexpressed or hyperactivated in cancer tissues can be used as immunohistochemical biomarkers during cancer diagnosis by comparing the expression in cancer tissues to that in normal tissues. For example, PKC $\theta$  has been used as a biomarker for GIST, especially GIST that is immunohistochemically negative for KIT and/or DOG1 [176–178]. Furthermore, PKC $\iota$  has been used as a diagnostic biomarker for ovarian [500] and NSCLC [306], while PKC $\alpha$  and PKC $\beta$ II have been used for breast cancer [49, 60] and diffuse large B-cell lymphoma (DLBCL; also known as non-Hodgkin's lymphoma) [354–356], respectively.

However, in spite of usefulness of immunohistochemical biomarkers, cancer biomarkers in blood, urine, feces, or saliva have received much greater interest recently as they are easier to sample and handle; the amount of pain is reduced in patients during sampling, and the detection techniques are, overall, much less invasive compared to the analysis of tissue samples. There is currently very little data on the existence of PKC isozymes in blood, urine, feces, or saliva, but recently activated PKC $\alpha$ , which can act as a biomarker for cancer, was identified in blood samples collected from cancer-bearing mice as well as human patients [22, 501, 502]. Furthermore, fecal PKC $\beta$ II and  $\zeta$  mRNA levels significantly increase in these types of samples collected from colon cancer-bearing rats as compared with normal rats, meaning that the detection of PKC $\beta$ II and  $\zeta$  mRNA may apply to the diagnosis of colon cancer [503, 504].

Overexpression of PKC biomarkers is closely related to poor prognosis, poor response to chemotherapy, and poor survival. In breast cancer progression, PKC $\alpha$  overexpression in breast cancer exhibits poor prognosis and survival because of a decreased response to chemotherapy and the high aggressiveness of the cancer [49, 60]. Further, after endocrine therapy of breast cancer, PKC $\alpha$  expression (PKC $\alpha^+$ /PKC $\delta^-$ ) correlates to estrogen receptor negativity and poor endocrine responsiveness and patient survival, but PKC $\delta$  expression (PKC $\alpha^-$ /PKC $\delta^+$ ) increases endocrine responsiveness and patient survival [49]. A previous study has also reported that increase in PKC $\epsilon$  correlates to positive Her2/neu receptor status, negative estrogen and progesterone receptor status, and poor survival [505]; however, this finding has recently been challenged by another study suggesting that there is no correlation between PKC $\epsilon$  expression and clinicopathological parameters (tumor grade and estrogen/progesterone receptor negativity) and recurrence-free or 10-year survival [60]. In DLBCL, PKC $\beta$ II expression is significantly associated

with low response to chemotherapy and poor survival in patients [354–357]. Furthermore, PKC $\iota$  can be used as a prognostic indicator in NSCLC and ovarian cancer [306, 500]. Interestingly, PKC $\iota$  expression is associated with tumor stage in ovarian cancer [500], but not in NSCLC that shows an increase in PKC $\iota$  expression in both early- and late-stage cancers [306].

#### 5. PKC Isozymes and MDR

The ATP-binding cassette transporter family plays a very important role in the relationship between PKC isozymes and MDR. P-gp is a well-studied ATP-binding cassette transporter protein encoded by the *MDR1* (as known as *ABCB1*) gene and is broadly distributed in both cancers and various normal tissues, such as kidney, adrenal, brain vessels, muscle, lung, pancreas, liver, intestine, placenta, and testis [506–508]. Since overexpression of P-gp is typical in cancer cells, P-gp-mediated MDR is one of the most serious problems facing cancer treatment. P-gp-mediated MDR is maintained by several prosurvival and antiapoptosis signals and their targets, including JNK [55], p38 [509], ERK1/2 [509], and Janus kinase [510]. Although inhibition of P-gp may increase the therapeutic effects of anticancer drugs in MDR cancer cells, P-gp inhibitors have been associated with several potential side effects [511, 512].

As mentioned in Section 3. PKC isozymes and cancer, PKC isozymes, especially PKC $\alpha$  and  $\epsilon$ , are involved in the P-gp-mediated MDR in several types of cancer, such as colon cancer [119–121], pancreatic cancer [399], gastric cancer [157], breast cancer [55], leukemia [513], and prostate cancer [447]. In general, inhibition of PKC isozymes that regulate P-gp leads to reduced MDR and enhanced cancer cell apoptosis. For instance, the membrane translocation and expression levels of PKC $\alpha$  are significantly increased in DOX-treated human colon cancer HCT15 cells, but PKC $\alpha$  inhibition leads to reduced MDR and increased DOX-induced apoptosis [120]. The MDR breast cancer cell line MCF-7/ADR also exhibits higher PKC $\alpha$  levels and lower cell growth inhibition and apoptosis after TAM treatment, compared with untreated MCF-7 cells. However, addition of PKC $\alpha$  inhibitor into TAM treated MCF-7/ADR cells results in reduced MDR and enhanced apoptosis through increased JNK activity [55].

#### 6. PKC Isozymes and Cancer Stem Cells

Cancer stem cells (CSCs) have several interesting properties, such as self-renewal, clonal formation, and chemoresistance [514, 515]. Although there is very little data regarding the role of PKC isozymes in CSC function, several studies have recently demonstrated the involvement of PKC isozymes in controlling cellular signaling in these cells.

The interaction between HA and CD44 increases PKC $\epsilon$ -dependent phosphorylation of the stem cell marker, Nanog, in the breast cancer cell line MCF-7 [38]. Nanog activation by HA-CD44 interaction is also known to occur in ovarian cancers and HNSCCs [516–518]. The activated Nanog induces antiapoptotic and proliferative factors, such as P-gp and



the inhibitor of the apoptosis protein (IAP) family (e.g., cIAP-1, cIAP-2, and XIAP), and reduces cancer suppressor proteins, such as PDCD4, resulting in enhanced antiapoptosis and anticancer drug resistance [516–518]. On the other hand, a recent study has suggested that Nanog expression is also upregulated by inhibition of PKC activity, especially PKC $\alpha$  and  $\delta$  activity, in human cancer cell lines [519].

In glioma, combination treatment using proteasome inhibitors and TRAIL decreases the levels of PKC $\epsilon$  mRNA and protein while also reducing PKC $\epsilon$ -dependent activation of Akt and XIAP, resulting in cancer cell (and CSC) apoptosis. These results mean that PKC $\epsilon$  is involved in antiapoptosis and survival of glioma stem cells [206]. Furthermore, PKC $\epsilon$  participates in UV-radiation-induced development of SCC from precursor hair follicle stem cells [520].

As mentioned in Section 3.8, lung cancer PKC $\iota$  plays a critical role in K-Ras-mediated bronchioalveolar stem cell expansion and lung cancer growth. Importantly, the small molecule PKC $\iota$  inhibitor aurothiomalate can target the cancer-initiating stem cell niche and efficiently inhibit these K-Ras-mediated cellular responses [318].

Notch4 signaling activity is higher in breast cancer stem-like cells compared with differentiated cells and increases stem cell activity and cancer formation [521]. PKC $\alpha$  overexpression upregulates activator protein 1, which in turn mediates Notch4 activity. The activated Notch4 is closely associated with the promotion of estrogen-independent, TAM-resistant growth and chemotherapy resistance in breast cancer cells [522]. In a recent study, breast CSCs and nonbreast CSCs show differential utilization of signaling pathways during the EMT. Non-CSCs utilize c-Fos, while CSCs utilize Fra-1 to act as an effector of the EMT program. Phosphorylation of Fra-1 is performed by PKC $\alpha$ . High PKC $\alpha$  and Fra-1 expression is, therefore associated with aggressive triple-negative breast cancers, while high c-Fos expression is associated with better survival [523].

## 7. Summary and Overall Conclusions

In cancer, PKC isozymes play a critical role in cell proliferation, survival, invasion, migration, apoptosis, angiogenesis, and anticancer drug resistance. PKC isozymes can exhibit similar expression patterns and roles in multiple types of cancer, but in some cases, they can show context specific expression and function that is dependent on the type of cancer. Among PKC isozymes, PKC $\alpha$ ,  $\beta$ ,  $\epsilon$ , and  $\delta$  have been the most broadly studied isozymes in relation to cancer. This may be associated with their ubiquitous expression in many tissues [524]. However, several recent studies have reported that aPKCs may also act as novel therapeutic targets for cancer treatment (e.g., PKC $\iota$  in lung, ovarian, and colon cancer).

In general, overexpression of PKC isozymes is closely related to poor prognosis, poor response to chemotherapy, and poor patient survival. These results are likely caused by the high levels of cancer cell migration, invasion, survival, and anticancer drug resistance stimulated by PKC isozymes. Therefore, the overexpression of several PKC isozymes can

serve as a potential cancer diagnostic marker and could be utilized as therapeutic targets.

Several PKC isozyme-specific or broad, nonspecific inhibitors have been developed and applied in phases II and III clinical trials. For example, PKC $\alpha$ -specific inhibitors have been used in combination with anticancer drugs in clinical trials, but satisfactory results have not yet been obtained [296–298, 437]. However, I suspect that these combination therapy trials will most likely be the only way to overcome the problem of MDR. Thus, the development of new PKC isozyme-specific inhibitors, in association with combination treatment to inhibit other non-PKC related cancer signals (e.g., c-Src signal) [45], is required.

Furthermore, there has been increasing interest in CSCs-targeted therapies as a novel treatment of cancers. Recent studies demonstrate the important role of PKC isozymes in controlling cellular signaling of CSCs. However, there is a paucity of data on the role of PKC isozymes in CSCs and further studies are required.

## Abbreviations

ALL:	Acute lymphocytic leukemia
AML:	Acute myeloid leukemia
APC:	Adenomatous polyposis coli
aPKC:	Atypical PKC isozyme
ATM:	Ataxia telangiectasia mutated
ATP:	Adenosine triphosphate
bFGF:	Basic fibroblast growth factor
BK:	Bradykinin
Cdk:	Cyclin dependent kinase
CEC:	Colon epithelial cell
CLL:	Chronic lymphocytic leukemia
CML:	Chronic myeloid leukemia
Cox-2:	Cyclooxygenase type 2
cPKC:	Conventional or classic PKC isozyme
CSC:	Cancer stem cell
DAG:	Diacylglycerol
DLBCL:	Diffuse large B-cell lymphoma
DOX:	Doxorubicin
DR5:	Death receptor 5
Ect2:	Epithelial cell transforming sequence 2
EGF:	Epidermal growth factor
EGFR:	EGF receptor
ER:	Estrogen receptor
ERK:	Extracellular signal-regulated kinase
FAK:	Focal adhesion kinase
FGF:	Fibroblast growth factor
FOXO:	Forkhead box class-O
GIST:	Gastrointestinal stromal tumor
GR:	Glucocorticoid receptor
GSK3 $\beta$ :	Glycogen synthetase kinase 3 $\beta$
HA:	Hyaluronic acid
HBV:	Hepatitis B virus
HCC:	Hepatocellular carcinoma
HGF:	Hepatocyte growth factor
HIF:	Hypoxia-inducible factor
HNSCC:	Head and neck squamous cell carcinomas

HSP:	Heat shock protein
IAP:	Inhibitor of the apoptosis protein
IFIT:	Interferon-induced protein with tetratricopeptide repeats
IGF:	Insulin-like growth factor
IP <sub>6</sub> :	Inositol hexaphosphate
JNK:	c-Jun N-terminal kinase
MAPK:	Mitogen-activated protein kinase
MDR:	Multidrug resistant
MEK:	MAPK kinase
MMP:	Matrix metalloproteinase
mRNA:	Messenger RNA
mTOR:	Mammalian target of rapamycin
NEP:	Neutral endopeptidase
NNK:	Nitrosamine 4-(methylnitrosamino)-1-(3-pyridyl)-1 butanone)
nPKC:	Novel or non-classic PKC isozyme
NSCLC:	Nonsmall cell lung cancer
PAR:	Proteinase-activated receptor
PDAC:	Pancreatic ductal adenocarcinoma
P-gp:	P-glycoprotein
PI3K:	Phosphatidylinositol 3-kinase
PKC:	protein kinase C
PLC:	Phospholipase C
PMA:	Phorbol-myristate-acetate
pRb:	Retinoblastoma protein
PS:	Phosphatidylserine
Raf1:	v-raf-1 murine leukemia viral oncogene homolog 1
Rb:	See pRb
RCC:	Renal cell carcinoma
ROS:	Reactive oxygen species
SCC:	Squamous cell carcinomas
SCLC:	Small cell lung cancer
SIP:	Sphingosine 1-phosphate
SK:	Sphingosine kinase
Stat3:	Signal transducers and activators of transcription3
TACE:	Tumor necrosis factor-convertase
TAM:	Tamoxifen
TGF:	Transforming growth factor
TLR:	Toll-like receptor
TNF:	Tumor necrosis factor
TPA:	12-O-tetradecanolyphorbol 13-acetate
TRAIL:	TNF-related apoptosis-inducing ligand
uPA:	Urokinase-type plasminogen activator
UV:	Ultraviolet
VEGF:	Vascular endothelial growth factor
XIAP:	X-linked inhibitor of apoptosis.

## Conflict of Interests

The author declares that there is no conflict of interests regarding the publication of this paper.

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