PHOTOSENSITIZING ANTIBODY-FLUOROPHORE CONJUGATES

Inventors: Hisataka Kobayashi, Laurel, MD (US); Peter Choyke, Bethesda, MD (US); Makoto Mitsunaga, Rockville, MD (US); Marcelino Bernardo, Germantown, MD (US)

Assignee: The United States of America as represented by the Secretary, Department of Health and Human Services, Washington, DC (US)

Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 0 days.

Appl. No.: 13/180,111
Filed: Jul. 11, 2011

Prior Publication Data

Related U.S. Application Data
Provisional application No. 61/363,079, filed on Jul. 9, 2010.

Int. Cl.
A61K 30/00 (2006.01)
A61K 49/00 (2006.01)
A61B 5/00 (2006.01)

U.S. CL.
USPC ............................. 424/178.1; 424/9.1; 424/9.61

Field of Classification Search
None
See application file for complete search history.

References Cited:

U.S. PATENT DOCUMENTS
6,344,050 B1 * 2/2002 Chen ............................. 607/88
6,534,041 B1 3/2003 Licha et al.
7,005,518 B2 2/2006 Peng et al.

FOREIGN PATENT DOCUMENTS
WO 03/011106 A2 2/2003
WO 03/083811 A1 10/2003
WO 2010/085651 A1 7/2010

OTHER PUBLICATIONS


* cited by examiner

Primary Examiner — Hong Sang

(74) Attorney, Agent, or Firm — Klaquist Sparkman, LLP

ABSTRACT
The present disclosure relates to compositions and methods of killing cells in vitro or in vivo. In particular examples, the method includes contacting a cell having a cell surface protein with a therapeutically effective amount of an antibody-IR700 molecule, wherein the antibody specifically binds to the cell surface protein. In particular examples the antibody recognizes a tumor-specific antigen on the surface of a tumor cell. The cell is subsequently irradiated, such as at a wavelength of 660 to 740 nm at a dose of at least 1 J cm⁻², thereby killing the cell. Also provided are wearable devices that include an article of clothing, jewelry, or covering; and an NIR LED incorporated into the article, which can be used with the disclosed methods.

25 Claims, 31 Drawing Sheets
FIG. 1F

Time after cell seeding (day)

5
3
1

PIT (J/cm²)
0
2.0
0
2.0

TraIR (µg/ml)
0
0
10
10
FIG. 1G
FIG. 1H

<table>
<thead>
<tr>
<th>TraIR (µg/ml)</th>
<th>IRDye only</th>
<th>w/o wash</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>0</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PIT (J/cm²)</th>
<th>IRDye only</th>
<th>w/o wash</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>2.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FIG. 1J

<table>
<thead>
<tr>
<th>Substance</th>
<th>0</th>
<th>10</th>
<th>10</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>TraIR (μg/ml)</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NaN₃ (mM)</td>
<td>0</td>
<td>50</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>PIT (J/cm²)</td>
<td>0</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
</tr>
</tbody>
</table>
FIG. 2A
FIG. 2C
FIG. 4B

Tumor volume (mm$^3$)

Time after MAb injection (d)

- No treatment
- Tra 300 µg i.v., no PIT
- Tra-IR700 300 µg i.v., no PIT
- No Mab, PIT 50 J cm$^{-2}$
- Tra-IR700 300 µg i.v., PIT 50 J cm$^{-2}$
DIC: before  DIC: after treatment

FIG. 5A
FIG. 5B

Percentage of cell death

PanIR (µg/ml) 0 2.0
PIT (J/cm²) 0 2.0 0 0.5 1.0 2.0

*** *** *** ***
Signal intensity (a.u.)

- Pan-IR700 50 µg iv
- Pan-IR700 300 µg iv

Time after MAb injection (day)

FIG. 6B
Tumor to background ratio

- Pan-IR700 50 µg iv
- Pan-IR700 300 µg iv

Time after MAb injection (day)

FIG. 6C
FIG. 6F
No PIT control

Pan-IR700-PIT day 4

FIG. 6G
FIG. 6h
FIG. 7

<table>
<thead>
<tr>
<th>Time after cell injection</th>
<th>White</th>
<th>IR700</th>
<th>Merge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day4 (before PIT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day12 (before PIT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day20</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PC3 flu w/light
head
PC3 pip w/light
tail
PC3 flu w/o light
PC3 pip w/o light
FIG. 8

DIC: before | DIC: after treatment

3T3/HER2 (HER2+)

SHAW (HER2+)

SKOV3 (HER2+)

MDA-MB-453 (HER2+)

A431 (HER1+)

MDA-MB-468 (HER1+)

LNCaP (PSMA+)
PHOTOSENSITIZING ANTIBODY-FLUOROPHORE CONJUGATES

CROSS-REFERENCE TO RELATED APPLICATION

This application claims priority to U.S. Provisional Application No. 61/363,079, filed Jul. 9, 2010, herein incorporated by reference.

FIELD OF THE DISCLOSURE

This application relates to antibody-IR700 conjugates, and methods of their use to kill cells that specifically bind to the antibody following irradiation with infrared (NIR) light. Also provided are devices that incorporate NIR light emitting diodes (LEDs) that can also be used with the disclosed conjugates and methods.

BACKGROUND

Cancer was responsible for about 13% of all human deaths in 2007. Although there are several therapies for cancer, there remains a need for therapies that effectively kill the tumor cells while not harming non-cancerous cells.

In order to minimize the side effects of conventional cancer therapies, including surgery, radiation and chemotherapy, molecular targeted cancer therapies have been developed. Among the existing targeted therapies, monoclonal antibodies (MAb) therapy have the longest history, and to date, over 25 therapeutic MAbs have been approved by the Food and Drug Administration (FDA) (Waldmann, Nat Med 9:269-277, 2003; Reichert et al., Nat Biotechnol 23:1073-1078, 2005). Effective MAb therapy traditionally depends on three mechanisms: antibody-dependent cellular cytotoxicity (ADCC), complement-dependent cytotoxicity (CDC), and receptor blockade and requires multiple high doses of the MAb. MAbs have also been used at lower doses as vectors to deliver therapies such as radionucleotides (Goldenberg et al., J Clin Oncol 24, 823-834, 2006) or chemical or biological toxins (Pastan et al., Nat Rev Cancer 6:559-565, 2006). Ultimately, however, dose limiting toxicity relates to the biodistribution and catabolism of the antibody conjugates.

Conventional photodynamic therapy (PDT), which combines a photosensitizing agent with the physical energy of non-ionizing light to kill cells, has been less commonly employed for cancer therapy because the current non-targeted photosensitizers are also taken up in normal tissues, thus, causing serious side effects, although the excitation light itself is harmless in the near infrared (NIR) range (Fig. 9).

SUMMARY OF THE DISCLOSURE

Provided herein are antibody-IR700 molecules and methods of their use for killing a target cell, such as a tumor cell. In particular examples the methods are specific in that non-target cells, such as normal cells, are not killed in significant numbers (such as less than 1% of normal cells are killed), but the target cells are. In particular examples the method includes contacting a cell having a cell surface protein with a therapeutically effective amount of an antibody-IR700 molecule, wherein the antibody (or other specific binding agent) specifically binds to the cell surface protein. Specific non-limiting examples of antibody-IR700 molecules include Panitumumab-IR700, Trastuzumab-IR700, and Hu5591-IR700. The cell is irradiated at a wavelength of 660 to 740 nm, such as 660 to 710 nm (for example, 680 nm) at a dose of at least 1 J cm⁻² (such as at least 50 J cm⁻²), thereby killing the cell.

Any target cell can be killed with the disclosed antibody-IR700 molecules and methods, for example by using an antibody that binds to a protein on the target cell surface (such as a receptor), wherein the protein on the target cell surface is not significantly found on non-target cells (such as normal healthy cells) and thus the antibody will not significantly bind to the non-target cells. In one example the cell surface protein is a tumor-specific protein, such as HER1, HER2, or PSMA.

In some examples, the cell to be killed is present in a subject. In such examples, the method can include administering a therapeutically effective amount of the antibody-IR700 molecule to the subject and irradiating the subject, for example irradiating a tumor in the subject. In some examples, the method can further include selecting a subject with a tumor that expresses a cell surface protein that can specifically bind to the antibody-IR700 molecule.

Also provided devices, such as those that can be worn by a patient. Such devices can include an article of clothing, jewelry, or a covering, and a near infrared (NIR) light emitting diode (LED) that is incorporated into the article of clothing, jewelry, or covering. Such devices can further include power and/or cooling sources. This permits the patient to wear the device (or be covered by the device) for extended periods of time, thus permitting treatment of tumor cells present in the blood or circulatory system. Methods of using the device are also provided.

The foregoing and other features of the disclosure will become more apparent from the following detailed description of a several embodiments which proceeds with reference to the accompanying figures.

BRIEF DESCRIPTION OF THE FIGURES

FIG. 1A is a digital image showing the labeling of cells with a Trastuzumab-IR700 conjugate (Tra-IR700) at 4°C for 1 hour or 37°C for 6 hours. Light images also shown. Scale bar, 30 μm.

FIG. 1B is a digital image showing the lysosomal localization of Tra-IR700 6 h after incubation. Scale bar, 50 μm.

FIG. 1C is a digital image showing is a digital image showing before and after incubation with Tra-IR700 at 37°C for 6 hours followed by photoimmunotherapy (PIT). Scale bar, 50 μm.

FIG. 1D is a bar graph showing the irradiation dose dependent and target specific cell death in response to Tra-IR700 mediated PIT. Data are mean±s.e.m. (n=at least 4, ** P<0.001 vs. non treatment control, Student’s t test).

FIG. 1E is a bar graph showing the long term growth inhibition in response to Tra-IR700 mediated PIT. Data are mean±s.e.m. (n=3, ** P<0.01 vs. non treatment control, Student’s t test).

FIG. 1F is a digital image showing the microscopic observation of growth inhibition in response to TraIR700 mediated PIT. Scale bar, 100 μm.

FIG. 1G is a bar graph showing that internalization of Tra-IR700 was not required for phototoxic cell death. Data are mean±s.e.m. (n=3).

FIG. 1H is a bar graph showing that target specific membrane binding of Tra-IR700 only induced phototoxic cell death. Data are mean±s.e.m. (n=3).

FIG. 1I is a graph showing that HER2 negatively expressing A431 cells did not show phototoxic effects with Tra-IR700 mediated PIT (n=3).
FIG. 1A is a bar graph showing sodium azide (NaN₃) concentration dependent inhibition of phototoxic cell death induced by Pan-IR700 mediated PDT. Data are means+s.e.m. (n=3, *** P<0.001, ** P<0.01 vs. 2.0 J cm⁻² PDT treatment without NaN₃ control, Student’s t test). DIC: differential interference contrast. PanIR: Pan-IR700.

FIG. 2A is a graph showing that long term growth inhibition was not observed in Balb/3T3 (HER2 negative) cells treated with TralIR700 (TralIR) and exposed to light. Data are means+s.e.m. (n=3).

FIG. 2B is a digital image showing that Free IR700 dye did not incorporate into 3T3/HER2 cells. Fluorescence image was taken without washing the cells. Cells were darker than the media containing free IR700 dye. Scale bar, 50 µm.

FIG. 2C is a graph showing that TralIR700 mediated phototoxicity was dose-dependently blocked by the excess of unconjugated trastuzumab (Tral). Data are means+s.e.m. (n=3).

FIG. 2D is a graph showing that Tral-IR700 binding for 3T3/HER2 cells was blocked by unconjugated trastuzumab dose-dependent manner (n=3). DIC: differential interference contrast.

FIG. 3A is a digital image showing that induction of target specific photoimmunotherapy (PIT) lead to HER2 expressing cell specific necrotic cell death. Scale bar, 50 µm.

FIG. 3B is a digital image showing that HER2 specific cell death was confirmed with fluorescence microscopy with LIVE/DEAD Green staining. Scale bar, 100 µm.

FIG. 3C is a plot showing flow cytometric analysis for detecting HER2-specific cell death induced by Pan-IR700 (TralIR) mediated PDT. Upper left quadrant: TralIR700 positive, live cells; upper right quadrant: TralIR700 positive, dead cells; lower left quadrant: TralIR700 negative, live cells; lower right quadrant: TralIR-700 negative, dead cells (n=3). DIC: differential interference contrast.

FIG. 4A is a digital image showing the biodistribution of Tral-IR700. 3T3/HER2 tumors (both sides of dorsum) were visualized with IR700 fluorescence as early as 1 day after Tral-IR700 injection (300 µg). Right side of the tumor was irradiated with near infrared (NIR) light on day 1, while left side of the tumor was covered with black tape. Tumor shrinkage was confirmed on day 7. Dashed line: irradiated tumor, solid line: non-irradiated tumor. No other specific localization of IR700 was found except for the bladder accumulation on day 1 due to the excretion of unbound dye (n=5 mice).

FIG. 4B is a graph showing mean tumor volume following administration in vivo of Pan-IR700 or carrier alone followed by PIT (30 J cm⁻²). Data are means+s.e.m. (at least n=12 mice in each group, *** P<0.001, ** P=0.01 vs. non treatment control, Kruskal-Wallis test with post-test). Tral: trastuzumab.

FIG. 5A is a digital image showing a microscopic observation of before and after Pan-IR700 mediated PIT. Scale bar, 50 µm.

FIG. 5B is a graph showing irradiation dose dependent and target specific cell death in response to Pan-IR700 (PanIR) mediated PDT. Data are means+s.e.m. (n=at least 4, *** P=0.001 vs. non treatment control, Student’s t test).

FIG. 5C is a digital image showing EGFR expressing cell specific necrotic cell death was induced by Pan-IR700 mediated PIT. Scale bar, 50 µm. DIC: differential interference contrast.

FIG. 6A is a digital image showing specific localization of panitumumab-IR700 conjugate (Pan-IR700) in a mouse previously administered A431 cells. HER1 positive A431 tumor (left dorsum) was selectively visualized as early as 1 day after Pan-IR700 injection (50 µg). HER1 negative 3T3/HER2 tumor (right dorsum) did not show detectable fluorescence (n=5 mice).

FIG. 6B is a graph showing the IR700 signal intensity in A431 tumors over time following injection of two different doses (50 µg and 300 µg) of Pan-IR700. Data are means+s.e.m. (n=4 each mice).

FIG. 6C is a graph showing the tumor to background ratio of IR700 fluorescence intensity in A431 tumors over time following injection of two different doses (50 µg and 300 µg) of Pan-IR700. Data are means+s.e.m. (n=4 each mice).

FIG. 6D is a digital image showing the biodistribution of Pan-IR700. A431 tumors (both sides of dorsum) were selectively visualized with IR700 fluorescence as early as 1 day after Pan-IR700 injection (300 µg). Right side of the tumor was irradiated with near infrared (NIR) light on day 1, while left side of the tumor was covered with black tape. Tumor shrinkage was confirmed on day 7. Dashed line: irradiated tumor, solid line: non-irradiated tumor.

FIG. 6E is a graph showing mean tumor volume following administration in vivo of Pan-IR700 or carrier alone followed by PIT (30 J cm⁻²). PIT was performed on day 1 after Pan-IR700 injection (day 5 after tumor inoculation). Data are means+s.e.m. (at least n=12 mice in each group, *** P<0.001 vs. other control groups, Kruskal-Wallis test with post-test).

FIG. 6F is a graph showing survival time following administration in vivo of Pan-IR700 or carrier alone followed by PIT (30 J cm⁻²) (at least n=12 mice in each group, *** P<0.001 vs. other control groups, log-rank test with Bonferroni’s correction for multiplicity).

FIG. 6G is a digital image showing hematoxylin and eosin stained histology images (×40 and ×200) 4 days after PIT treated (right) and untreated (left) tumors. n=5 mice; Scale bar, 100 µm. Pan: panitumumab.

FIG. 6H is a graph showing that high-dose administration of Pan-IR700 lead to higher antitumor efficacy of Pan-IR700 mediated PIT for A431 tumors in vivo. Tumor growth inhibition by Pan-IR700 mediated PIT was Pan-IR700 dose-dependently observed. Data are means+s.e.m. (at least n=12 mice in each group).

FIG. 7 is a digital image showing the biodistribution of J591-IR700. PC3-PI3 tumors were selectively visualized with IR700 fluorescence after J591-IR700 injection (100 µg). Right side of the tumor was irradiated with near infrared (NIR) light on days 4, 12, and 13 while left side of the tumor was covered with black tape. Tumor shrinkage was confirmed on day 5.

FIG. 8 is a digital image showing the microscopic observation of before and after PIT for various cells in the presence of with Pan-IR700 for HER2+ cells. Pan-IR700 for HER+ cells, and hu591-IR700 for PSMA+ cells. Scale bar, 50 µm. DIC: differential interference contrast.

FIG. 9A is a schematic drawing showing a schema for explaining selective cancer therapy with PIT in the context of other physical cancer therapies employing electro-magnetic wave irradiation. Although other physical cancer therapies induce different types of damages in the normal tissue, PIT dedicatedly damages cancer cells without damaging normal cells or tissues.

FIG. 9B is a schematic drawing showing a schema for explaining photo-physical, chemical and biological basis of PIT. Humanized antibodies are employed as a delivery vehicle because of its highest binding specificity, greatest in vivo target delivery, low immunogenicity among the clinically applicable targeting reagents. A hydrophilic phthalocyanine is employed as an activatable cytotoxic "Nano-dynamite" reagent because of its great absorption of near infrared.
light of 700 nm and strong cytotoxicity induced only when associating with the cell membrane. Near-infrared light of 700 nm is employed as an initiator for activating cytotoxicity because of its high energy among non-harmful non-ionizing photons and great in vivo tissue penetration.

DETAILED DESCRIPTION OF SEVERAL EMBODIMENTS

Unless otherwise explained, all technical and scientific terms used herein have the same meaning as commonly understood by one of ordinary skill in the art to which a disclosed invention belongs. The singular terms “a,” “an,” and “the” include plural referents unless context clearly indicates otherwise. Similarly, the word “or” is intended to include “and” unless the context clearly indicates otherwise. “Comprising” means “including.” Hence “comprising A or B” means “including A or B” or “including A and B.”

Suitable methods and materials for the practice and/or testing of embodiments of the disclosure are described below. Such methods and materials are illustrative only and are not intended to be limiting. Other methods and materials similar to or equivalent to those described herein can be used. For example, conventional methods well known in the art to which a disclosed invention pertains are described in various general and more specific references, including, for example, Sambrook et al., Molecular Cloning: A Laboratory Manual, 2d ed., Cold Spring Harbor Laboratory Press, 1989; Sambrook et al., Molecular Cloning: A Laboratory Manual, 3d ed., Cold Spring Harbor Press, 2001; Ausubel et al., Current Protocols in Molecular Biology, Greene Publishing Associates, 1992 (and Supplements to 2000); Ausubel et al., Short Protocols in Molecular Biology: A Compendium of Methods from Current Protocols in Molecular Biology, 4th ed., Wiley & Sons, 1999; Harlow and Lane, Antibodies: A Laboratory Manual, Cold Spring Harbor Laboratory Press, 1990; and Harlow and Lane, Using Antibodies: A Laboratory Manual, Cold Spring Harbor Laboratory Press, 1999.

The sequences associated with all GenBank Accession numbers referenced herein are incorporated by reference for the sequence available on Jul. 9, 2010.

In order to facilitate review of the various embodiments of the disclosure, the following explanations of specific terms are provided:

Administration: To provide or give a subject an agent, such as an antibody-IR700 molecule, by any effective route. Exemplary routes of administration include, but are not limited to, topical, injection (such as subcutaneous, intramuscular, intradermal, intraperitoneal, intratumoral, and intravenous), oral, sublingual, rectal, transdermal, intranasal, vaginal and inhalation routes.

Antibody: A polypeptide ligand comprising at least a light chain or heavy chain immunoglobulin variable region which specifically recognizes and binds an epitope of an antigen, such as a tumor-specific protein. Antibodies are composed of a heavy and a light chain, each of which has a variable region, termed the variable heavy (VH) region and the variable light (VL) region. Together, the VH region and the VL region are responsible for binding the antigen recognized by the antibody.

Antibodies include intact immunoglobulins and the variants and portions of antibodies well known in the art, such as Fab fragments, Fab' fragments, F(ab')2 fragments, single chain Fv proteins, and disulfide stabilized Fv protein species (dsFv). A scFv protein is a fusion protein in which a light chain variable region of an immunoglobulin and a heavy chain variable region of an immunoglobulin are bound by a linker, while in dsFv's, the chains have been mutated to introduce a disulfide bond to stabilize the association of the chains. The term also includes genetically engineered forms such as chimeric antibodies (for example, humanized murine antibodies), heteroconjugate antibodies (such as, bispecific antibodies). See also, Pierce Catalog and Handbook, 1994-1995 (Pierce Chemical Co., Rockford, Ill.); Kuby, J., Immunology, 3rd Ed., W.H. Freeman & Co., New York, 1997.

Typically, a naturally occurring immunoglobulin has heavy (H) chains and light (L) chains interconnected by disulfide bonds. There are two types of light chain, lambda (λ) and kappa (κ). There are five main heavy chain classes or isotypes which determine the functional activity of an antibody molecule: IgM, IgD, IgG, IgA and IgE.

Each heavy and light chain contains a constant region and a variable region, (the regions are also known as “domains”). In combination, the heavy and the light chain variable regions specifically bind the antigen. Light and heavy chain variable regions contain a "framework" region interrupted by three hypervariable regions, also called “complementarity-determining regions” or “CDRs.” The extent of the framework region and CDRs have been defined (see, Kabat et al., Sequences of Proteins of Immunological Interest, U.S. Department of Health and Human Services, 1991, which is hereby incorporated by reference). The Kabat database is now maintained online. The sequences of the framework regions of different light or heavy chains are relatively conserved within a species, such as humans. The framework region of an antibody, that is the combined framework regions of the constituent light and heavy chains, serves to position and align the CDRs in three-dimensional space.

The CDRs are primarily responsible for binding to an epitope of an antigen. The CDRs of each chain are typically referred to as CDR1, CDR2, and CDR3, numbered sequentially starting from the N-terminus, and are also typically identified by the chain in which the particular CDR is located. Thus, a VH CDR3 is located in the variable domain of the heavy chain of the antibody in which it is found, whereas a VL CDR1 is the CDR1 from the variable domain of the light chain of the antibody in which it is found. Antibodies with different specificities (i.e. different combining sites for different antigens) have different CDRs. Although it is the CDRs that vary from antibody to antibody, only a limited number of amino acid positions within the CDRs are directly involved in antigen binding. These positions within the CDRs are called specificity determining residues (SDRs).

References to "VH" or "VL" refer to the variable region of an immunoglobulin heavy chain, including that of Fv, scFv, dsFv or Fab. References to "VH" or "VL" refer to the variable region of an immunoglobulin light chain, including that of Fv, scFv, dsFv or Fab.

A “monoclonal antibody” is an antibody produced by a single clone of B lymphocytes or a cell into which the light and heavy chain genes of a single antibody have been transfected. Monoclonal antibodies are produced by methods known to those of skill in the art, for instance by making hybrid antibody-forming cells from a fusion of myeloma cells with immune spleen cells. Monoclonal antibodies include humanized monoclonal antibodies.

A “chimeric antibody” has framework residues from one species, such as human, and CDRs (which generally confer antigen binding) from another species, such as a murine antibody that specifically binds mesothelin.

A “humanized” immunoglobulin is an immunoglobulin including a human framework region and one or more CDRs from a non-human (for example a mouse, rat, or synthetic)
immunoglobulin. The non-human immunoglobulin providing the CDRs is termed a “donor,” and the human immunoglobulin providing the framework is termed an “acceptor.” In one embodiment, all the CDRs are from the donor immunoglobulin in a humanized immunoglobulin. Constant regions need not be present, but if they are, they must be substantially identical to human immunoglobulin constant regions, i.e., at least about 85–90%, such as about 95% or more identical. Hence, all parts of a humanized immunoglobulin, except possibly the CDRs, are substantially identical to corresponding parts of natural human immunoglobulin sequences. A “humanized antibody” is an antibody comprising a humanized light chain and a humanized heavy chain immunoglobulin. A humanized antibody binds to the same antigen as the donor antibody that provides the CDRs. The acceptor framework of a humanized immunoglobulin or antibody may have a limited number of substitutions by amino acids taken from the donor framework. Humanized or other monoclonal antibodies can have additional conservative amino acid substitutions which have substantially no effect on antigen binding or other immunoglobulin functions. Humanized immunoglobulins can be constructed by means of genetic engineering (see for example, U.S. Pat. No. 5,585,089).

A “human” antibody (also called a “fully human” antibody) is an antibody that includes human framework regions and all of the CDRs from a human immunoglobulin. In one example, the framework and the CDRs are from the same originating human heavy and/or light chain amino acid sequence. However, frameworks from one human antibody can be engineered to include CDRs from a different human antibody. All parts of a human immunoglobulin are substantially identical to corresponding parts of natural human immunoglobulin sequences.

“Specifically binds” refers to the ability of individual antibodies to specifically immunoreact with an antigen, such as a tumor-specific antigen, relative to binding to unrelated proteins, such as non-tumor proteins, for example β-actin. For example, a HER2-specific binding agent binds substantially only the HER-2 protein in vitro or in vivo. As used herein, the term “tumor-specific binding agent” includes tumor-specific antibodies and other agents that bind substantially only to a tumor-specific protein in that preparation.

The binding is a non-random binding reaction between an antibody molecule and an antigenic determinant of the T cell surface molecule. The desired binding specificity is typically determined from the reference point of the ability of the antibody to differentially bind the T cell surface molecule and an unrelated antigen, and therefore distinguish between two different antigens, particularly where the two antigens have unique epitopes. An antibody that specifically binds to a particular epitope is referred to as a “specific antibody”.

In some examples, an antibody (such as an antibody-IR700 molecule) specifically binds to a target (such as a cell surface protein) with a binding constant that is at least 10^5 M^-1 greater, 10^6 M^-1 greater or 10^7 M^-1 greater than a binding constant for other molecules in a sample or subject. In some examples, an antibody (e.g., monoclonal antibody) and fragments thereof, has an equilibrium constant (Kd) of 1 nM or less. For example, an antibody binds to a target, such as tumor-specific protein with a binding affinity of at least about 0.1×10^-7 M, at least about 0.3×10^-8 M, at least about 0.5×10^-9 M, at least about 0.75×10^-9 M, at least about 1.0×10^-9 M, at least about 1.5×10^-9 M, at least about 2.0×10^-9 M. Kd values can, for example, be determined by competitive ELISA (enzyme-linked immunosorbent assay) or using a surface-plasmon resonance device such as the Biacore T100, which is available from Biacore, Inc., Piscataway, N.J.

**Antibody-IR700 molecule or antibody-IR700 conjugate:** A molecule that includes both an antibody, such as a tumor-specific antibody, conjugated to IR700. In some examples the antibody is a humanized antibody (such as a humanized monoclonal antibody) that specifically binds to a surface protein on a cancer cell.

**Antigen (Ag):** A compound, composition, or substance that can stimulate the production of antibodies or a T cell response in an animal, including compositions (such as one that includes a tumor-specific protein) that are injected or absorbed into an animal. An antigen reacts with the products of specific humoral or cellular immunity, including those induced by heterologous antigens, such as the disclosed antigens. “Epitope” or “antigenic determinant” refers to the region of an antigen to which B and/or T cells respond. In one embodiment, T cells respond to the epitope, when the epitope is presented in conjunction with an MHC molecule. Epitopes can be formed both from contiguous amino acids or noncontiguous amino acids juxtaposed by tertiary folding of a protein. Epitopes formed from contiguous amino acids are typically retained on exposure to denaturing solvents whereas epitopes formed by tertiary folding are typically lost on treatment with denaturing solvents. An epitope typically includes at least 3, and more usually, at least 5, about 9, or about 8-10 amino acids in a unique spatial conformation. Methods of determining spatial conformation of epitopes include, for example, x-ray crystallography and nuclear magnetic resonance.

Examples of antigens include, but are not limited to, peptides, lipids, polysaccharides, and nucleic acids containing antigenic determinants, such as those recognized by an immune cell. In some examples, an antigen includes a tumor-specific peptide (such as one found on the surface of a cancer cell) or immunogenic fragment thereof.

**Cancer:** A malignant tumor characterized by abnormal or uncontrolled cell growth. Other features often associated with cancer include metastasis, interference with the normal functioning of neighboring cells, release of cytokines or other secretory products at abnormal levels and suppression or aggravation of inflammatory or immunological response, invasion of surrounding or distant tissues or organs, such as lymph nodes, etc. “Metastatic disease” refers to cancer cells that have left the original tumor site and migrate to other parts of the body for example via the bloodstream or lymph system. In one example, the cell killed by the disclosed methods is a cancer cell.

**Contacting:** Placement in direct physical association, including both a solid and liquid form. Contacting can occur in vitro, for example, with isolated cells, such as tumor cells, or in vivo by administering to a subject (such as a subject with a tumor).

**Decrease:** To reduce the quality, amount, or strength of something. In one example, a therapeutic composition that includes one or more antibody-IR700 molecules decreases the viability of cells to which the antibody-IR700 molecule specifically binds, following irradiation of the cells with NIR (for example at a wavelength of about 680 nm) at a dose of at least 1 J cm^-2, for example as compared to the response in the absence of the antibody-IR700 molecule. In some examples such a decrease is evidenced by the killing of the cells. In some examples, the decrease in the viability of cells is at least 20%, at least 50%, at least 75%, or even at least 90%, relative to the viability observed with a composition that does not include an antibody-IR700 molecule. In other examples,
decreases are expressed as a fold change, such as a decrease in the cell viability by at least 2-fold, at least 3-fold, at least 4-fold, at least 5-fold, at least 8-fold, at least 10-fold, or even at least 15 or 20-fold, relative to the viability observed with a composition that does not include an antibody-IR700 molecule. Such decreases can be measured using the methods disclosed herein.

IR700 (IRDye® 700DX): A dye having the following formula:

Currently commercially available from LI-COR (Lincoln, Nebr.), IR700 has several favorable chemical properties. Amino-reactive IR700 is a relatively hydrophilic dye and can be covalently conjugated with an antibody using the NHS ester of IR700. IR700 also has more than 5-fold higher extinction coefficient (2.1×10^5 M^-1 cm^-1 at the absorption maximum of 689 nm), than conventional photosensitizers such as the hematoporphyrin derivative Photofrin® (1.2×10^5 M^-1 cm^-1 at 630 nm), meta-tetradecahydroxyphenylchlorin; Foscan® (2.2×10^5 M^-1 cm^-1 at 652 nm), and mono-L-aspartylchlorin 66; NPe6Laserphyrin® (4.0×10^6 cm^-1 at 654 nm).

Pharmaceutical composition: A chemical compound or composition capable of inducing a desired therapeutic or prophylactic effect when properly administered to a subject. A pharmaceutical composition can include a therapeutic agent, such as one or more antibody-IR700 molecules. A therapeutic or pharmaceutical agent is one that alone or together with an additional compound induces the desired response (such as inducing a therapeutic or prophylactic effect when administered to a subject). In a particular example, a pharmaceutical composition includes a therapeutically effective amount of at least one antibody-IR700 molecule.

Pharmaceutically acceptable carriers: The pharmaceutically acceptable carriers (vehicles) useful in this disclosure are conventional. Remington’s Pharmaceutical Sciences, by E. W. Martin, Mack Publishing Co., Easton, Pa., 19th Edition (1995), describes compositions and formulations suitable for pharmaceutical delivery of one or more therapeutic compounds, such as one or more antibody-IR700 molecules.

In general, the nature of the carrier will depend on the particular mode of administration being employed. For instance, parenteral formulations usually comprise injectable fluids that include pharmaceutically and physiologically acceptable fluids such as water, physiological saline, balanced salt solutions, aqueous dextrose, glycerol or the like as a vehicle. For solid compositions (for example, powder, pill, tablet, or capsule forms), conventional non-toxic solid carriers can include, for example, pharmaceutical grades of mannitol, lactose, starch, or magnesium stearate. In addition to biologically-neutral carriers, pharmaceutical compositions to be administered can contain minor amounts of non-toxic auxiliary substances, such as wetting or emulsifying agents, preservatives, and pH buffering agents and the like, for example sodium acetate or sorbitan monolaurate.

Phototherapy (PIT): A molecular targeted therapeutic that utilizes a target-specific photosensitizer based on a near infrared (NIR) phthalocyanine dye, IR700, conjugated to monoclonal antibodies (Mab) targeting cell surface receptors. In one example the cell surface receptor is one found specifically on cancer cells, such as HER1, HER2 or PSMA, and thus PIT can be used to kill such cells. Cell death of the cells occurs when the antibody-IR700 molecule binds to the cells and the cells are irradiated with NIR, while cells that do not express the cell surface receptor recognize the antibody-IR700 molecule are not killed in significant numbers.

Subject or patient: A term that includes human and non-human mammals. In one example, the subject is a human or veterinary subject, such as a mouse. In some examples, the subject is a mammal (such as a human) who has cancer, or is being treated for cancer.

Therapeutically effective amount: An amount of a composition that alone, or together with an additional therapeutic agent(s) (such as a chemotherapeutic agent) sufficient to achieve a desired effect in a subject, or in a cell, being treated with the agent. The effective amount of the agent (such as an antibody-IR700 molecule) can be dependent on several factors, including, but not limited to the subject or cells being treated, the particular therapeutic agent, and the manner of administration of the therapeutic composition. In one example, a therapeutically effective amount or concentration is one that is sufficient to prevent advancement (such as metastasis), delay progression, or to cause regression of a
disease, or which is capable of reducing symptoms caused by the disease, such as cancer. In one example, a therapeutically effective amount or concentration is one that is sufficient to increase the survival time of a patient with a tumor.

In one example, a desired response is to reduce or inhibit one or more symptoms associated with cancer. The one or more symptoms do not have to be completely eliminated for the composition to be effective. For example, administration of a composition containing an antibody-IR700 molecule followed by irradiation can decrease the size of a tumor (such as the volume or weight of a tumor, or metastasis of a tumor), for example by at least 20%, at least 50%, at least 90%, at least 95%, at least 98%, or even at least 100%, as compared to the tumor size in the absence of the antibody-IR700 molecule. In one particular example, a desired response is to kill a population of cells by a desired amount, for example by killing at least 20%, at least 50%, at least 90%, at least 95%, at least 98%, or even at least 100% of the cells, as compared to the cell killing in the absence of the antibody-IR700 molecule and irradiation. In one particular example, a desired response is to increase the survival time of a patient with a tumor (or who has had a tumor recently removed) by a desired amount, for example increase survival by at least 20%, at least 50%, at least 60%, at least 70%, at least 90%, at least 95%, at least 98%, or even at least 100%, as compared to the survival time in the absence of the antibody-IR700 molecule and irradiation.

The effective amount of an agent that includes one of the disclosed antibody-IR700 molecules, that is administered to a human or veterinary subject will vary depending upon a number of factors associated with that subject, for example the overall health of the subject. An effective amount of an agent can be determined by varying the dosage of the product and measuring the resulting therapeutic response, such as the regression of a tumor. Effective amounts also can be determined through various in vitro, in vivo or in situ immunoassays. The disclosed agents can be administered in a single dose, or in several doses, as needed to obtain the desired response. However, the effective amount of can be dependent on the source applied, the subject being treated, the severity and type of the condition being treated, and the manner of administration.

In particular examples, a therapeutically effective dose of an antibody-IR700 molecule is at least 0.5 milligram per 60 kilogram (mg/kg), at least 5 mg/60 kg, at least 10 mg/60 kg, at least 20 mg/60 kg, at least 50 mg/60 kg, at least 10 mg/60 kg, for example 0.5 to 50 mg/60 kg, such as a dose of 1 mg/60 kg, 2 mg/60 kg, 5 mg/60 kg, 10 mg/60 kg, or 20 mg/60 kg, for example when administered intravenously. In another example, a therapeutically effective dose of an antibody-IR700 molecule is at least 10 µg/kg, such as at least 100 µg/kg, at least 500 µg/kg, or at least 1000 µg/kg, for example 10 µg/kg to 1000 µg/kg, such as a dose of 100 µg/kg, 250 µg/kg, about 500 µg/kg, 750 µg/kg, or 1000 µg/kg, for example when administered intravenously or iv. In one example, a therapeutically effective dose is at least 1 µg/ml, such as at least 500 µg/ml, such as between 20 µg/ml to 100 µg/ml, such as 10 µg/ml, 20 µg/ml, 30 µg/ml, 40 µg/ml, 50 µg/ml, 60 µg/ml, 70 µg/ml, 80 µg/ml, 90 µg/ml or 100 µg/ml administered in topical solution. However, one skilled in the art will recognize that higher or lower dosages also could be used, for example depending on the particular antibody-IR700 molecule. In particular examples, such daily dosages are administered in one or more divided doses (such as 2, 3, or 4 doses) or in a single formulation. The disclosed antibody-IR700 molecules can be administered alone, in the presence of a pharmaceutically acceptable carrier, in the presence of other therapeutic agents (such as other anti-neoplastic agents).

Generally a suitable dose of irradiation following administration of the antibody-IR700 is at least 1 J cm⁻² at a wavelength of 660-740 nm, for example, at least 10 J cm⁻² at a wavelength of 660-740 nm, at least 50 J cm⁻² at a wavelength of 660-740 nm, or at least 100 J cm⁻² at a wavelength of 660-740 nm, for example 1 to 500 J cm⁻² at a wavelength of 660-740 nm. In some examples the wavelength is 660-710 nm. In specific examples, a suitable dose of irradiation following administration of the antibody-IR700 molecule is at least 1.0 J cm⁻² at a wavelength of 680 nm for example, at least 10 J cm⁻² at a wavelength of 680 nm, at least 50 J cm⁻² at a wavelength of 680 nm, or at least 100 J cm⁻² at a wavelength of 680 nm, for example 1 to 500 J cm⁻² at a wavelength of 680 nm. In particular examples, multiple irradiations are performed (such as at least 2, at least 3, or at least 4 irradiations, such as 2, 3, 4, 5, 6, 7, 8, 9, or 10 separate administrations), following administration of the antibody-IR700 molecule.

Treating: A term when used to refer to the treatment of a cell or tissue with a therapeutic agent, includes contacting or incubating an agent (such as an antibody-IR700 molecule) with the cell or tissue. A treated cell is a cell that has been contacted with a desired composition in an amount and under conditions sufficient for the desired response. In one example, a treated cell is a cell that has been exposed to an antibody-IR700 molecule under conditions sufficient for the antibody to bind to a surface protein on the cell, followed by irradiation, until sufficient cell killing is achieved.

Tumor, neoplasia, malignancy or cancer: A neoplasm is an abnormal growth of tissue or cells which results from excessive cell division. Neoplastic growth can produce a tumor.

The amount of a tumor in an individual is the "tumor burden" which can be measured as the number, volume, or weight of the tumor. A tumor that does not metastasize is referred to as "benign." A tumor that invades the surrounding tissue and/or can metastasize is referred to as "malignant." A "non-cancerous tissue" is a tissue from the same organ wherein the malignant neoplasm formed, but does not have the characteristic pathology of the neoplasm. Generally, noncancerous tissue appears histologically normal. A "normal tissue" is tissue from an organ, wherein the organ is not affected by cancer or another disease or disorder of that organ. A "cancer-free" subject has not been diagnosed with a cancer of that organ and does not have detectable cancer.

Exemplary tumors, such as cancers, that can be treated with the claimed methods include solid tumors, such as breast carcinomas (e.g. lobular and duct carcinomas), sarcomas, carcinomas of the lung (e.g., non-small cell carcinoma, large cell carcinoma, squamous carcinoma, and adenocarcinoma), mesothelioma of the lung, colorectal adenocarcinoma, stomach carcinoma, prostatic adenocarcinoma, ovarian carcinoma (such as serous cystadenocarcinoma and mucinous cystadenocarcinoma), ovarian germ cell tumors, testicular carcinomas and germ cell tumors, pancreatic adenocarcinoma, biliary adenocarcinoma, hepatocellular carcinoma, bladder carcinoma (including, for instance, transitional cell carcinoma, adenocarcinoma, and squamous carcinoma), renal cell adenocarcinoma, endometrial carcinomas (including, e.g., adenocarcinomas and mixed Mullerian tumors (carcinomas)), carcinomas of the endocervix, ectocervix, and vagina (such as adenocarcinoma and squamous carcinoma of each of same), tumors of the skin (e.g., squamous cell carcinoma, basal cell carcinoma, malignant melanoma, skin appendage tumors, Kaposi sarcoma, cutaneous lymphoma,
skin adnexal tumors and various types of sarcomas and Merkel cell carcinoma), esophageal carcinoma, carcinomas of the nasopharynx and oropharynx (including squamous carcinoma and adenocarcinomas of same), salivary gland carcinomas, brain and central nervous system tumors (including, for example, tumors of glial, neuronal, and meningeval origin), tumors of peripheral nerve, soft tissue sarcomas and sarcomas of bone and cartilage, and lymphatic tumors (including B-cell and T-cell malignant lymphoma). In one example, the tumor is an adenocarcinoma.

The methods can also be used to treat liquid tumors, such as a lymphatic, white blood cell, or other type of leukemia. In a specific example, the tumor treated is a tumor of the blood, such as a leukemia (for example acute lymphoblastic leukemia (ALL), chronic lymphocytic leukemia (CLL), acute myelogenous leukemia (AML), chronic myelogenous leukemia (CML), hairy cell leukemia (HCL), T-cell prolymphocytic leukemia (T-PML), large granular lymphocytic leukemia, and adult T-cell leukemia), lymphomas (such as Hodgkin’s lymphoma and non-Hodgkin’s lymphoma), and myelomas.

Under conditions sufficient for: A phrase that is used to describe any environment that permits the desired activity. In one example, “under conditions sufficient for” includes administering an antibody-IR700 molecule to a subject sufficient to allow the antibody-IR700 molecule to bind to cell surface proteins. In particular examples, the desired activity is killing the cells to which the antibody-IR700 molecule is bound, following therapeutic irradiation of the cells.

Untreated cell: A cell that has not been contacted with a desired agent, such as an antibody-IR700 molecule. In an example, an untreated cell is a cell that receives the vehicle in which the desired agent was delivered.

Disclosure of certain specific examples is not meant to exclude other embodiments. In addition, any treatments described herein are not necessarily exclusive of other treatment, but can be combined with other bioactive agents or treatment modalities.

Overview of Technology

Conventional photodynamic therapy (PDT) for cancer therapy is based on the preferential accumulation of a photosensitizer in tumor to produce phototoxicity with minimal damage to surrounding tissue (Dougherty et al. J Natl Cancer Inst 90:889-905, 1998). Traditionally, PDT is thought to be mediated by the generation of ROS, especially singlet oxygen, in the presence of oxygen (Dougherty et al. J Natl Cancer Inst 90:889-905, 1998). However, to the extent that existing photosensitizers lack tumor selectivity, considerable damage can be seen in normal tissues leading to dose limiting toxicity. Thus, current methods of PDT would be improved if more selective targeting of the photosensitizer and more efficient phototoxicity per photon absorbed was possible.

Disclosed herein are highly targeted photosensitizers, referred to as antibody-IR700 molecules. The photosensitizer, IR700, is excited in the NIR range leading to deeper tissue penetration resulting in successful eradication of subcutaneously xenografted tumors after only a single dose of external NIR light irradiation. Targeted phototoxicity appears to be primarily dependent on binding of the antibody-IR700 molecules to the cell membrane and to a lesser extent on internalization and ROS formation. The fluorescence induced by the conjugate can be used to non-invasively guide both PTT and monitor the results of therapy.

Although a targeted photosensitizer can distribute throughout the body, it is only active where intense light is applied, reducing the likelihood of off-target effects. In contrast, existing photosensitizers are poorly selective small molecules which bind not only to cancer cells but also to normal cells, including the skin and other epithelial surfaces, resulting in unwanted phototoxicity. In addition, target specific delivery of conventional photosensitizers is theoretically difficult because, after reaching the cell, the agent must still be internalized into organelles, such as mitochondria, to be most effective. Various combinations of conventional photosensitizers and MAbs have been tested to improve selectivity (Mew et al., J Immunol 130:1473-1477, 1983; Sobolev et al., Prog Biophys Mol Biol 73:51-90, 2000; Carcenac et al., Br J Cancer 85:1787-93, 2001; Vrouenraets et al., Cancer Res 59:1505-13, 1999; Vrouenraets et al., Cancer Res 61:1970-1975, 2001; Hamblin et al., Cancer Res 56:2505-10, 1996; Mew et al., Cancer Res 45:4380-6, 1985). However, these have had limited success especially by their therapeutic effects, for example because conventional photosensitizers have low extinction coefficients that require conjugation of large numbers of photosensitizers to a single antibody molecule thus, potentially decreasing binding affinity, because conventional photosensitizers are mostly hydrophobic leading to difficulties in conjugating photosensitizers to antibodies without compromising the immunoreactivity and in vivo target accumulation, and because conventional photosensitizers generally absorb light in the visible range reducing tissue penetration.

It is shown herein that antibody-based photosensitizers (such as mAb-based photosensitizers), which are activated by NIR light for targeted photodynamic therapy (PIT) only when bound to the target molecule on the cancer cell membrane. The fluorophore IR700 (Licoir Co. Lincoln, Neb.) can become a photosensitizer when conjugated to an antibody specific for a cell surface receptor and can thus be used for target specific photodynamic therapy of undesired cells, such as tumor or cancer cells. Further, because these agents also emit a diagnostic fluorescence, they can be used to direct the application of light to minimize light exposure to non-relevant tissues and non-invasively monitor therapeutic effects. Based on the similarity of the photosensitivity induced with three different MAbs against several different cells expressing various numbers of respective target molecules and considering the potentially additive benefits from immunotherapy this method can be generally applicable to other Mabs (such as those disclosed in Nunas et al., J Urology 170:S84-S88, 2003 and van Dongen et al., Adv Drug Deliv Rev 56:31-52, 2004).

When IR700 was conjugated with an anti-EGFR antibody (HER1 or HER2) or a PSMA antibody, cells that selectively bound the conjugate were killed upon exposure to 680 nm near-infrared (NIR) light. Based on this novel observation patient therapies are provided. Since this antibody-dependent target-cell specific photodynamic therapy is achieved with NIR light (e.g., 680 nm) excitation and showed highly selectively cytotoxic effects only upon antibody binding, this new antibody-dependent target-cell specific photodynamic therapy using IR700 can be used in cancer patients as a way to personalize cancer therapy with minimal side effects.

The selectivity of the antibody-IR700 conjugate is derived from its activation after binding to the cell membrane of target cells; unbound conjugate does not contribute to phototoxicity. Short term viability assays, as well as long term proliferation assays, demonstrated that the conjugate was capable of inducing specific cell death. When co-cultures of receptor-positive and -negative cells were treated, only the receptor-positive cells were killed despite the presence of unbound antibody-
IR700 in the culture medium. This selective cell killing minimizes damage to normal cells.

The antibody-IR700 molecule must be bound to the cellular membrane to be active. For instance, the rupture of endolysosome occurred within a second of light exposure. Cell death induced by singlet oxygen generally induces a slower apoptotic cell death. Since cell membrane damage was so quickly induced even at 4°C by this method, it is hypothesized that cell death is caused by the rapid expansion of locally heated water with relatively minor effects due to singlet oxygen effects.

Treatment with sodium azide, a redox and singlet oxygen scavenger, only partially reduced the phototoxicity but did not totally eliminate the effectiveness of the conjugate. This indicates that ROS generation is a minor part of the phototoxic effect. The observation that phototoxicity was induced after incubation with antibody-IR700 for only 1 hour at 4°C indicates that internalization of the conjugate is not required for activity. This differs from current PDT agents that require intracellular localization to be effective. Video microscopy demonstrated rapid visible damage to the membrane and lysosomes after exposure to light, following incubation for more than 6 hours at 37°C, when the antibody-conjugate was internalized.

The disclosed antibody-IR700 conjugates permitted detection of targeted tissue. This can permit specific lesions to be identified with OCT rather than irradiating the entire field. Doses required for diagnosis (50 μg) were significantly lower than those required for therapy (300 μg). Improved intratumoral distribution of antibody occurred with the therapeutic dose. Because both bond and unbound antigen fluoresces, there is relatively high background signal at therapeutic doses. Nevertheless, after OCT, the fluorescence of the treated tumor decreased and eventually disappeared, providing a means of monitoring the treatment.

Free IR700 and catabolized IR700, are readily excreted into urine within 1 hour without accumulation in any specific organ. The other component of OCT, light irradiation with NIR (e.g., at 690 nm) is unlikely to be toxic except at thermal doses. There should be no limitations on the cumulative irradiation dose of the NIR light, unlike ionizing radiation such as x-ray or gamma-ray (FIG. 9). Therefore, repeated OCT can be used for long term management of cancer patients. It was observed that repeated OCT with 3 different regimens (3 or 4 fractionated NIRirradiations at a single dose of antibody-IR700 conjugate and 4 cycles of OCT every 2 weeks after multiple doses of antibody) controlled tumor regrowth, resulting in tumor free survival of more than 4 months.

Methods for Killing Cells and Treating Tumors

The present disclosure provides methods for killing a cell, such as a target cell. The cell expresses a protein on its surface, such as a tumor specific antigen, that can specifically bind to an antibody that is conjugated to the dye IR700 (referred to herein as an antibody-IR700 molecule). The cell is contacted with a therapeutically effective amount of one or more antibody-IR700 molecules (for example in the presence of a pharmaceutically acceptable carrier, such as a pharmaceutically and physiologically acceptable fluid), under conditions that permit the antibody to specifically bind to the cell surface protein. For example, the antibody-IR700 molecule can be present in a pharmaceutically effective carrier, such as water, physiological saline, balanced salt solutions (such as PBS/EDTA), aqueous dextrose, sesame oil, glycerol, ethanol, combinations thereof, or the like, as a vehicle. The carrier and composition can be sterile, and the formulation suits the mode of administration.

After administering the one or more antibody-IR700 molecules under conditions that allow the one or more antibody-IR700 molecules to bind to their target on a cell surface, the cell is then irradiated under conditions that permit killing of the cells. For example irradiation at a wavelength of 660 to 710 nm at a dose of at least 1 J cm⁻². The NIR excitation light wavelength allows penetration of at least several centimeters into tissues. For example, by using fiber-coupled laser diodes with diffuser tips, NIR light can be delivered within several centimeters of otherwise inaccessible tumors located deep to the body surface. In addition to treating solid cancers, circulating tumor cells can be targeted since they can be excited when they traverse superficial vessels (for example using the NIR LED wearable devices disclosed herein). The disclosed methods can also be used as a therapy for transplant rejection.

The methods can be used to kill cells in vitro, for example by incubating the cells with the antibody-IR700 molecules in culture, or in vivo, for example, by administering one or more antibody-IR700 molecules to the subject. For example, a subject to be treated can be administered a therapeutically effective amount of one or more antibody-IR700 molecules, followed by irradiating the subject (or a tumor or tumor cell in the subject) with a therapeutic dose of irradiation.

The disclosed methods can be used in combination with other therapies, such as other anti-neoplastic therapies, such as radiation therapy, chemotherapy immunosuppressants (such as Rituximab, steroids), and cytokines (such as GM-CSF). Chemotherapeutic agents are known in the art (see for example, Slapak and Kufe, Principles of Cancer Therapy, Chapter 86 in Harrison’s Principles of Internal Medicine, 14th edition; Perry et al., Chemotherapy, Ch. 17 in Abeloff, Clinical Oncology 2nd ed., 2000 Churchill Livingstone, Inc.; Balzer and Berkery, (eds): Oncology Pocket Guide to Chemotherapy, 2nd ed. St. Louis, Mosby-Year Book, 1995; Fischer Knobf, and Durivage (eds): The Cancer Chemotherapy Handbook, 4th ed. St. Louis, Mosby-Year Book, 1993). Exemplary chemotherapeutic agents that can be used in combination with the methods provided herein include but are not limited to, carboplatin, cisplatin, paclitaxel, docetaxel, doxorubicin, epirubicin, topotecan, irinotecan, gemcitabine, 5-fluouracil, gemcitabine, etoposide, vinorelbine, tamoxifen, valproic acid, cyclophosphamide, methotrexate, fluorouracil, mitoxantrone and vinorelbine. Combination chemotherapy is the administration of more than one agent to treat cancer.

In one example, contacting target cells with one or more antibody-IR700 molecules followed by irradiation kills the target cells that express a cell surface protein that specifically binds to the antibody. For example, the disclosed methods can kill at least 10%, for example at least 20%, at least 40%, at least 50%, at least 80%, at least 90%, or more of the treated cells relative to the absence of treatment with one or more antibody-IR700 molecules followed by irradiation.

In one example, administration of one or more antibody-IR700 molecules to a subject having a tumor, followed by irradiation, kills the cells that express a cell surface protein that can specifically bind to the antibody, thereby treating the tumor. For example, the disclosed methods can decrease the size or volume of a tumor, slow the growth of a tumor, decrease or slow metastasis of the tumor (for example by reducing the number of metastases or decreasing the volume or size of a metastasis), or combinations thereof. For example, the disclosed methods can reduce tumor cell size or volume and/or a metastatic tumor cell volume (or number of metastatic tumors), such as by at least 10%, for example by at
least 20%, at least 40%, at least 50%, at least 80%, at least 90%, or more, relative to the absence of administration of one or more antibody-IR700 molecules followed by irradiation. In addition, the disclosed methods can result in a decrease in the symptoms associated with a tumor and/or a metastatic tumor. In one example, administration of the disclosed compositions slows the growth of a tumor, such as by at least 10%, for example by at least 20%, at least 40%, at least 50%, at least 80%, at least 90%, or more, relative to the absence of administration of the antibody-IR700 molecules followed by irradiation. Methods of monitoring tumor volume/size/metastasis are routine in the art. In some examples, the disclosed methods can increase a subject's (such as a subject with a tumor who has had a tumor previously removed) survival time, for example relative the absence of administration of one or more antibody-IR700 molecules followed by irradiation, such as an increase of at least 20%, at least 40%, at least 50%, at least 80%, at least 90%, or more. For example, the disclosed methods can increase a subject’s survival time by at least 3 months, at least 6 months, at least 12 months, at least 18 months, at least 24 months, at least 36 months or more, relative to average survival time in the absence of administration of an antibody-IR700 molecule followed by irradiation.

Administration of therapeutically effective amounts of antibody-IR700 molecules followed by therapeutically effective doses of irradiation are capable of selectively killing tumor cells in vivo, and are capable of decreasing the weight or volume of a tumor in vivo. By selective killing of tumor cells relative to normal cells is meant that the methods are capable of killing tumor cells more effectively than normal cells such as, for example, cells not expressing the cell surface protein that specifically binds to the antibody administered.

The disclosed methods can be used to treat fixed tumors in the body as well as tumors in the circulation (e.g., leukemia cells, metastases, circulating tumor cells). However, circulating cells, by their nature, cannot be exposed to light for very long. Thus, if the cell to be killed is one that is circulating throughout the body, the methods can be accomplished by using a device that can be worn, or that covers parts of the body. For example, such a device can be worn for extended time periods. Everyday wearable items (e.g., wristwatches, jewelry (such as a necklace or bracelet), blankets, clothing (e.g., underwear, socks, and shoe inserts) and other everyday wearable items) which incorporate NIR emitting light emitting diodes (LEDs) and a battery pack, can be used. Such devices produce light on the skin underlying the device over long periods leading to continual exposure of light to superficial vessels over prolonged periods. Circulating tumor cells are exposed to the light as they transit thru the area underlying the device. As an example, a wristwatch or bracelet version of this device can include a series of NIR LEDs with battery power pack to be worn for most of the day.

After administration of the one or more antibody-IR700 molecules (e.g., intravenously), circulating cells bind the antibody-IR700 conjugate and become susceptible to killing by PIT. As these cells flow within the vessels adjacent to the LED present in the everyday wearable item (e.g., bracelet or wristwatch), they would be exposed to NIR light rendering them susceptible to cell killing. The dose of light may be adjustable according to diagnosis and cell type.

In some examples, the method further includes monitoring the therapy, such as killing of tumor cells. In such examples, the antibody-IR700 conjugate is contacted with the cells and the cells irradiated as described above. However, a lower dose of the antibody-IR700 conjugate and NIR light can be used (as cell killing may not be required, just monitoring of the therapy). In one example, the amount of antibody-IR700 conjugate administered for monitoring is at least 2-fold less (such as at least 3, 4, 5, 6, 7, 8, 9, or 10-fold less than the therapeutic dose). In one example, the amount of NIR light used for monitoring is at least 1/1000 or at least 1/10,000 of the therapeutic dose. This permits detection of the cells being treated. For example, by using such methods, the size of the tumor and metastases can be monitored.

In some examples, the method is useful during surgery, such as endoscopic procedures. For example, after the antibody-IR700 conjugate is contacted with the cells and the cells irradiated as described above, this not only results in cell killing, but permits a surgeon or other medical care provider to visualize the margins of a tumor, and help ensure that resection of the tumor (such as a tumor of the skin, breast, lung, colon, or prostate) is complete and that the margins are clear. In some examples, a lower dose of the antibody-IR700 conjugate can be used for visualization, such as at least 2-fold less (such as at least 3, 4, 5, 6, 7, 8, 9, or 10-fold less than the therapeutic dose).

Exemplary Cells

The target cell can be a cell that is not desired or whose growth is not desired, such as a tumor cell. The cells can be growing in culture, or present in a mammal to be treated, such as a patient with cancer. Any target cell can be treated with the claimed methods. In one example, the target cell expresses a cell surface protein that is not substantially found on the surface of other normal (desired) cells, an antibody can be selected that specifically binds to such protein, and an antibody-IR700 molecule generated for that protein. In one example, the cell surface protein is a tumor-specific protein. In one example, the cell surface protein is CD25, which can be used to target cells associated with undesired transplant rejection.

In one example, the tumor cell is a cancer cell, such as a cell in a patient with cancer. Exemplary cells that can be killed with the disclosed methods include cells of the following tumors: a liquid tumor such as a leukemia, including acute leukemia (such as acute lymphocytic leukemia, acute myelocytic leukemia, and myeloblastic, promyelocytic, myelomonocytic, monocytic and erythroleukemia), chronic leukemias (such as chronic myelocytic (granulocytic) leukemia and chronic lymphocytic leukemia), polycythemia vera, lymphoma, Hodgkin’s disease, non-Hodgkin’s lymphoma, multiple myeloma, Waldenström’s macroglobulinemia, heavy chain disease). In another example the cell is a solid tumor cell, such as sarcomas and carcinomas, fibrosarcoma, myxosarcoma, liposarcoma, chondrosarcoma, osteogenic sarcoma, and other sarcomas, synovial, mesothelioma, Ewing's tumor, leiomyosarcoma, rhabdomyosarcoma, colon carcinoma, pancreatic cancer, breast cancer, ovarian cancer, prostate cancer, hepatocellular carcinoma, lung cancer, colorectal cancer, squamous cell carcinoma, basal cell carcinoma, adenocarcinoma (for example adenocarcinoma of the pancreas, colon, ovary, lung, breast, stomach, prostate, cervix, or esophagus), sweat gland carcinoma, sebaceous gland carcinoma, papillary carcinoma, papillary adenocarcinomas, medullary carcinoma, bronchogenic carcinoma, renal cell carcinoma, hepatoma, bile duct carcinoma, choriocarcinoma, Wilms tumor, cervical cancer, testicular tumor, bladder carcinoma, CNS tumors (such as a glioma, astrocytoma, medulloblastoma, craniopharyngioma, ependymoma, pinealoma, hemangioblastoma, acoustic neuroma, oligodendroglioma, menangiomia, melanoma, neuroblastoma and retinoblastoma).
Exemplary Subjects

In some examples, the disclosed methods are used to treat a subject who has a tumor, such as a tumor described herein. In some examples, the tumor has been previously treated, such as surgically or chemically removed, and the disclosed methods are used subsequently to kill any remaining undesired tumor cells that may remain in the patient. The disclosed methods can be used to treat any mammalian subject, such as a human, who has a tumor, such as a cancer, or has had such previously removed or treated. Subjects in need of the disclosed therapies can include human subjects having cancer, wherein the cancer cells express a tumor-specific protein on their surface that can specifically bind to the antibody-IR700 molecule. For example, the disclosed methods can be used as initial treatment for cancer either alone, or in combination with radiation or other chemotherapy. The disclosed methods can also be used in patients who have failed previous radiation or chemotherapy. Thus, in some examples, the subject is one who has received other therapies, but those other therapies have not provided a desired therapeutic response. The disclosed methods can also be used in patients with localized and/or metastatic cancer.

In some examples the method includes selecting a subject that will benefit from the disclosed therapies, such as selecting a subject having a tumor that expresses a cell surface protein (such as a tumor-specific protein) that can specifically bind to an antibody-IR700 molecule. For example, if the subject is determined to have a breast cancer that expresses HER2, the subject can be selected to be treated with an anti-HER2-IR700 molecule, such as Tru-IR700 described in Example 1, and the subject subsequently irradiated as described herein.

Exemplary Cell Surface Proteins

In one example, the protein on the cell surface of the target cell to be killed is not present in significant amounts on other cells. For example, the cell surface protein can be a receptor that is only found on the target cell type.

In a specific example, the cell surface protein is a tumor-specific protein (also known in the art as a tumor-specific antigen), such as members of the EGF receptor family (e.g., HER1, 2, 3, and 4) and cytokine receptors (e.g., CD20, CD25, IL-13R, CD5, CD52, etc.). Tumor specific proteins are those proteins that are unique to cancer cells or are much more abundant on them, as compared to other cells, such as normal cells. For example HER2 is primarily found in breast cancers, while HER1 is primarily found in adrenocarcinomas, which can be found in many organs, such as the pancreas, breast, prostate and colon.

Exemplary tumor-specific proteins that can be found on a target cell (and to which an antibody specific for that protein can be used to formulate an antibody-IR700 molecule), include but are not limited to: any of the various MAGEs (Melanoma-Associated Antigen E), including MAGE A1 (e.g., GenBank Accession Nos. M77481 and AAI03229), MAGE 2 (e.g., GenBank Accession Nos. L18920 and AAA17792), MAGE 3 (e.g., GenBank Accession Nos. U03735 and AAI17446), MAGE 4 (e.g., GenBank Accession Nos. D32075 and A06841.1), etc.; any of the various tyrosinases (e.g., GenBank Accession Nos. U01873 and AAI03019); mutant ras; mutant p53 (e.g., GenBank Accession Nos. X54156, CA38069 and AA49431); p97 melanoma antigen (e.g., GenBank Accession Nos. M12154 and AAI99992); human milk fat globule (HMFG) associated with breast tumors (e.g., GenBank Accession Nos. S26151 and AAB19777); any of the various IAGEs (Human B melanoma-Associated Antigen E), including BAGE1 (e.g., GenBank Accession No. Q13072) and BAGE2 (e.g., GenBank Accession Nos. NM_182482 and NP_872288), any of the various GAGEs (G antigen), including GAGE1 (e.g., GenBank Accession No. Q13065) or any of GAGE2-6; various gangliosides, CD25 (e.g., GenBank Accession Nos. NP_000488.1 and NM_000417.2).

Other tumor-specific antigens include the HPV 16/18 and E6/E7 antigens associated with cervical cancers (e.g., GenBank Accession Nos. NC_001526, FJ952142.1, ADJ84605, ADJ84606, and U98349), mucin (MUC 1)-KLH antigen associated with breast carcinoma (e.g., GenBank Accession Nos. J03651 and AAA35756), CEA (carcinoembryonic antigen) associated with colorectal cancer (e.g., GenBank Accession Nos. X98311 and CA66955), gp100 (e.g., GenBank Accession Nos. S73003 and AAC06343) associated with for example melanoma, MARTI antigens associated with melanoma (e.g., GenBank Accession No. NP_005302), cancer antigen 125 (CA125, also known as mucin 16 or MUC16) associated with ovarian and other cancers (e.g., GenBank Accession Nos. NM_024690 and NP_078966); alpha-feto-protein (AFP) associated with liver cancer (e.g., GenBank Accession Nos. NM_001314 and NP_001125); Lewis Y, antigen associated with colorectal, biliary, breast, small-cell lung, and other cancers; tumor-associated glycoprotein 72 (TAG72) associated with adenocarcinomas; and the PSA antigen associated with prostate cancer (e.g., GenBank Accession Nos. X14810 and CAA32915).

Other exemplary tumor-specific proteins further include, but are not limited to, PMSA (prostate membrane specific antigen; e.g., GenBank Accession Nos. AAA60209 and AAB81971.1) associated with solid tumor neovascularure, as well prostate cancer; HER-2 (human epidermal growth factor receptor 2, e.g., GenBank Accession Nos. M16789.1, M16790.1, M16791.1, M16792.1 and AAA5637) associated with breast cancer, ovarian cancer, stomach cancer and uterine cancer, HER-1 (e.g., GenBank Accession Nos. NM_005228 and NP_005219) associated with lung cancer, oral cancer, and glioblastoma as well as adenocarcinomas; NY-ESO-1 (e.g., GenBank Accession Nos. U87459 and AAB49693) associated with melanoma, sarcomas, testicular carcinomas, and other cancers, hTERT (aka telomerase) (e.g., GenBank Accession Nos. NM_198253 and NP_937983 (variant 1), NM_198255 and NP_937986 (variant 2)); proteinase 3 (e.g., GenBank Accession Nos. M29142, M75154, M96839, X55668, NM_00277, M96629, X56606, CA39943 and AAA36342), and Wilms tumor 1 (WT-1, e.g., GenBank Accession Nos. NM_000578 and NP_000569 (variant A), NM_024424 and NP_07774 (variant B), NM_024425 and NP_077745 (variant C), and NM_024426 and NP_077744 (variant D)).

In one example the tumor-specific protein is CD52 (e.g., GenBank Accession Nos. AA127495.1 and CA115846.1) associated with chronic lymphocytic leukemia; CD33 (e.g., GenBank Accession Nos. NM_023068 and CAD36509.1) associated with acute myelogenous leukemia; and CD20 (e.g., GenBank Accession Nos. NP_068769 and NP_031667) associated with Non-Hodgkin lymphoma.

Thus, the disclosed methods can be used to treat any cancer that expresses a tumor-specific protein.

Exemplary Antibody-IR700 Molecules

One skilled in the art will recognize that because cell surface protein sequences are publicly available (as for example shown above), that making or purchasing antibodies (or other small molecules that can be conjugated to IR700) specific for such proteins is routine. For example, if the tumor-specific protein HER2 is selected as a target, antibodies specific for HER2 (such as Trastuzumab) can be purchased or generated and attached to the IR700 dye. In one example, a patient is
treated with at least two different antibody-IR700 molecules. For example, antiHER2-IR700 and antiHER2-IR700 could be injected together as a cocktail to facilitate killing of cells bearing either HER1 or HER2. Other specific examples are provided in the table below. In one example, the antibody is a humanized monoclonal antibody. Antibody-IR700 molecules can be generated using routine methods, such as those described in Example 1 below. Thus, the disclosure also provides antibody-IR700 molecules, compositions that include such molecules, and kits that include such molecules (for example a kit that includes one or more antibody-IR700 molecules and a chemotherapeutic agent, or a molecular targeting agent, or combinations thereof).

<table>
<thead>
<tr>
<th>Tumor-Specific Antigen</th>
<th>Exemplary Tumors</th>
<th>Exemplary Antibody/Small Molecules</th>
</tr>
</thead>
<tbody>
<tr>
<td>HER1</td>
<td>Adenocarcinoma (e.g., colorectal cancer, head and neck cancer)</td>
<td>Cetuximab, panitumumab, zalutumumab, nimotuzumab, mertuxumab. Small molecule inhibitors gefitinib, erlotinib, and lapatinib can also be used.</td>
</tr>
<tr>
<td>HER2</td>
<td>Breast cancer, ovarian cancer, stomach cancer, uterine cancer</td>
<td>Trastuzumab (Herceptin®), pertuzumab</td>
</tr>
<tr>
<td>CD20</td>
<td>Non-Hodgkin lymphoma</td>
<td>Tositumomab (Bexxar®); Rituximab (Rituxan, Mabthera); or Brentuximab vedotin (Zevalin, for example in combination with yttrium-90 or indium-111 therapy)</td>
</tr>
<tr>
<td>CD25</td>
<td>T-cell lymphoma</td>
<td>Daclizumab (Zenapax)</td>
</tr>
<tr>
<td>CD33</td>
<td>Acute myelogenous leukemia</td>
<td>Gemtuzumab (Mylotarg), for example in combination with calicheamicin (chemotherapy)</td>
</tr>
<tr>
<td>CD52</td>
<td>Chronic lymphocytic leukemia</td>
<td>Alemtuzumab (Campath)</td>
</tr>
<tr>
<td>CEA</td>
<td>Colorectal cancer, some gastric cancers, biliary cancer</td>
<td>CEA-scan (Fab fragment, approved by FDA), colo101</td>
</tr>
<tr>
<td>Cancer antigen 125</td>
<td>Ovarian cancer, mesothelioma, breast cancer, hepatocellular carcinoma</td>
<td>OC125 monoclonal antibody</td>
</tr>
<tr>
<td>Alpha-fetoprotein (AFP)</td>
<td>Colorectal cancer, biliary cancer</td>
<td>ab757/5 (available from Abcam) and other commercially available AFP antibodies</td>
</tr>
<tr>
<td>Lewis Y</td>
<td>Adenocarcinomas including colorectal, pancreatic, gastric, ovarian, endometrial, mammary, and non-small cell lung cancer</td>
<td>B72.3 (FDA-approved monoclonal antibody)</td>
</tr>
<tr>
<td>Vascular endothelial growth factor</td>
<td>Colorectal cancer</td>
<td>Bevacizumab (Avastin®)</td>
</tr>
</tbody>
</table>

Antibody-IR700 molecules for treating transplant rejection can also be generated using Basiliximab or Daclizumab which target IL-2Rα receptor (CD25).

Administration of Antibody-IR700 Molecules

Antibody-IR700 molecules can be contacted with a cell in vitro, for example by adding the antibody-IR700 molecules to growth media in which the cells or growing, or can be contacted with a cell in vivo, for example by administering the antibody-IR700 molecules to the subject to be treated.

The antibody-IR700 molecules can be administered locally or systemically using any method known in the art, for example to subjects having a tumor, such as a cancer, or who has had a tumor previously removed (for example via surgery). Although specific examples are provided, one skilled in the art will appreciate that alternative methods of administration of the disclosed antibody-IR700 molecules can be used. Such methods may include for example, the use of catheters or implantable pumps to provide continuous infusion over a period of several hours to several days into the subject in need of treatment.

In one example, the antibody-IR700 molecules are administered by parenteral means, including direct injection direct injection or infusion into a tumor (intratumorally). In some examples, the antibody-IR700 molecules are administered to the tumor by applying the antibody-IR700 molecules to the tumor, for example by bathing the tumor in a solution containing the antibody-IR700 molecules or by pouring the antibody-IR700 molecules onto the tumor.

In addition, or alternatively, the disclosed compositions can be administered systemically, for example intravenously, intramuscularly, subcutaneously, intradermally, intraperitoneally, subcutaneously, or orally, to a subject having a tumor (such as cancer).

The dosages of the antibody-IR700 molecules to be administered to a subject are not subject to absolute limits, but will depend on the nature of the composition and its active ingredients and its unwanted side effects (e.g., immune response against the antibody), the subject being treated and the type of condition being treated and the manner of administration. Generally the dose will be a therapeutically effective amount, such as an amount sufficient to achieve a desired biological effect, for example an amount that is effective to decrease the size (e.g., volume and/or weight) of the tumor, or attenuate further growth of the tumor, or decrease undesired symptoms of the tumor.

For intravenous administration of the antibody-IR700 molecules, exemplary dosages for administration to a subject for a single treatment can range from 0.5 to 100 mg/60 kg of body weight, 1 to 100 mg/60 kg of body weight, 1 to 50 mg/60 kg of body weight, 1 to 20 mg/60 kg of body weight, for example about 1 or 2 mg/60 kg of body weight. In yet another example, a therapeutically effective amount of ip or intratumoral administered antibody-IR700 molecules can vary from 10 μg to 5000 μg of antibody-18700 molecule to 1 kg of body weight, such as 10 μg/kg to 1000 μg/kg, 10 μg/kg to 500 μg/kg, or 100 μg/kg to 1000 μg/kg.

In one example, the dose of antibody-IR700 molecule administered to a human patient is at least 50 mg, such as at least 100 mg, at least 300 mg, at least 500 mg, or even 1 g.

Treatments with disclosed antibody-IR700 molecules can be completed in a single day, or may be done repeatedly on multiple days with the same or a different dosage. Repeated treatments may be done on the same day, on successive days, or every 1-3 days, every 3-7 days, every 1-2 weeks, every 2-4 weeks, every 1-2 months, or at even longer intervals.

Irradiation of Cells

After the cells are contacted with one or more antibody-IR700 molecules, they are irradiated. Methods of irradiation are well known in the art. As only cells expressing the cell surface protein will be recognized by the antibody, only those cells will have sufficient amounts of the antibody-IR700 molecules bound to it. This decreases the likelihood of undesired side effects, such as killing of normal cells, as the irradiation will only kill the cells to which the antibody-IR700 molecules are bound, not the other cells.

In some examples, cells are irradiated in vitro, such as in a tissue culture dish. In other examples, a cell is irradiated in vivo, for example irradiating a subject who has previously
been administered antibody-IR700 molecules. In some examples, the subject is irradiated, for example a tumor in the subject can be irradiated.

The cells are irradiated with a therapeutic dose of radiation at a wavelength of 660-710 nm, such as 660-700 nm, 670-690 nm, for example, 680 nm. In particular examples, the cells are irradiated at a dose of at least 1 J cm⁻², such as at least 10 J cm⁻², at least 30 J cm⁻², at least 50 J cm⁻², at least 100 J cm⁻², or at least 500 J cm⁻², for example, 1-1000 J cm⁻², 1-500 J cm⁻², 10-100 J cm⁻², or 10-50 J cm⁻².

Cells (or patients) can be irradiated one or more times. Thus, irradiation can be completed in a single day, or may be done repeatedly on multiple days with the same or a different dosage (such as irradiation at least 2 different times, 3 different times, 4 different times 5 different times or 10 different times). Repeated irradiations may be done on the same day, on successive days, or every 1-3 days, every 3-7 days, every 1-2 weeks, every 2-4 weeks, every 1-2 months, or at even longer intervals.

Exemplary Devices Containing NIR LEDs

Any type of item that can be worn or placed on the body, and is amenable to the incorporation of NIR LEDs, can be used. In one example, the device is a chamber into which the patient is inserted. Such devices can be used in the treatment of tumor cells circulating in the blood or lymph, such as leukemias, lymphomas, as well as metastatic cells present in the blood or lymph. In some examples, such devices can be used in the treatment of tumor cells present on the skin, such as a melanoma.

To kill all the cells circulating in the body it may be necessary to wear the devices for an extended period of time, such as several weeks or months. Thus, these devices can be incorporated into every day clothing, jewelry and nightwear such as blankets. These devices make it possible to expose the patient to NIR light using portable everyday articles of clothing and jewelry so that treatment remains private and does not interfere with everyday activities. For instance, a necklace incorporating NIR LEDs can be customizable to the patient’s tastes, and worn discreetly during the day for PTT therapy (for example by killing tumor cells that pass through the carotid artery and other vasculature in the neck). Multiple devices of a similar “everyday” nature (blankets, bracelets, necklaces, underwear, socks, shoe inserts and the like) could be worn by the same patient during the treatment period. For example while sleeping, a patient could use the NIR blanket. The devices can also include a power supply, such as a battery, and a cooling element to prevent overheating for such devices as blankets.

In one example, the device is jewelry, such as a ring, watch, bracelet, or necklace. In another example, the item is an article of clothing or accessory, such as a shirt, belt, pants, underwear, socks, coat, shoe insert, scarf, hat, wrist guard, gloves, and the like. In another example, the device is an article that can cover the body, such as a blanket or towel. In another example, the device is a whole body light chamber that exposes the skin directly (such a device could also include a power supply and/or cooling supply).

By wearing the device that incorporates one or more NIR LEDs, tumor cells or other cells to be killed that are present in the blood or lymph become exposed to the light generated by the NIR LEDs (such as an NIR LED that emits at 660 to 740 nm, such as 670 to 700 nm or 680 to 720 nm). The light emitted from the NIR LED can penetrate the skin and blood vessels (such as the carotid artery or microvasculature in the skin), thus allowing the light to activate the antibody-IR700 molecule bond to the target cells, thus killing the cells to which the antibody-IR700 molecule is bound. The NIR LEDs can be arranged in the device to ensure that the skin or the blood vessels or lymphatic system are targeted.

NIR LED devices that can be used in the methods provided herein are commercially available. The applicable products from one manufacturer, Marubeni America, are listed below. The first product, a molded LED, has low power but it could be used over a longer exposure time. The other options have higher power and thus may benefit from provisions for additional cooling. Except for the last one, which is packaged in a 25 mm x 18 mm metal case, the others are applicable to wearable devices such as bracelets, necklace, underwear, socks, gloves, hats and other wearable items. All are usable in blankets, handheld devices or chambers.

For example, Marubeni America Corporation (tech-led.com/index.shtml) provides the following NIR LEDs with lens options to set the irradiation pattern: Molded LED (tech-led.com/data/L680-AU.pdf) which is 5 mm in diameter, has a total radiated power of 4 mW, calculated power density of 5 mW cm⁻² and a power requirement of 1.8V 20 mA; Surface Mount LED which is 3.5 mm x 0.7 mm, has a total radiated power of 3 mW, calculated power density of 32 mW cm⁻², and a power requirement of 1.9V 50 mA; Super Beam (tech-led.com/Superbeam_LEDS.shtml) which is 7.6 mm x 7.6 mm, has a total radiated power of 20-52 mW, calculated power density of 34-90 mW cm⁻², and a power requirement of 1.65V 100 mA; High Power Surface Mount (tech-led.com/SMB_BL_LEDS.shtml) which is 5 mm x 5 mm or 7 mm diameter, has a total radiated power of 90 mW, calculated power density of 360 mW cm⁻² and a power requirement of 2.4V 500 mA; and High Power Illuminators (tech-led.com/High_Power_Illuminators.shtml) which is 25 mm x 18 mm, has a total radiated power of 150 mW, a calculated power density of 33 mW cm⁻² and a power requirement of 10V 120 mA. Alternatively, such devices can be made that emit light at 690 nm with a similar power with short intermittent pulse.

During in vitro experimentation, NIR light with a power density of 2.2 mW cm⁻² (or 2.2 mJ s⁻¹ cm⁻²) induced cell death. Assuming an attenuation coefficient for tissue of 4 cm⁻¹, the intensity of the light would be down to 10% at 5.8 mm and 1% at 12 mm. This indicates that for in vivo applications, the power density required needs to be 10-100 times larger. That is, the dose of light emitted by the NIR LED device in some examples is at least 20 mW cm⁻², such as at least 50 mW cm⁻², at least 100 mW cm⁻², at least 150 mW cm⁻², at least 200 mW cm⁻² or, at least 300 mW cm⁻². Multiple NIR LEDs can be arranged in a two-dimensional array to cover larger areas. In one example, a laser is used as the NIR light source as an alternative to an LED.

The NIR LEDs can be powered by using a power supply (which may be directly or indirectly part of the device). The power supply requirement would depend on the number of LEDs in the device. For example, one or more batteries can be used to power the NIR LED. For some LEDs, 4 AA batteries can power 3 LEDs in series. An alkaline AA battery is rated at a maximum of 3000 mAh so this configuration provide powers for up to 150, 60, and 30 hr at 20, 50 and 100 mA.

In some examples, the device further includes a cooling device (which may be directly or indirectly part of the device). For example, heat sinks can be used for passive or active cooling. Another alternative is a thermoelectric effect (Peltier). This would draw additional power but it can be used in applications where the power requirements would need a plug-in AC adapter.

Another type of device that can be used with the disclosed methods is a flash-light like device with NIR LEDs. Such a device can be used for focal therapy of lesions during surgery, or incorporated into endoscopes to apply NIR light to body
surfaces after the administration of PII agent. Such devices can be used by physicians or qualified health personnel to
direct treatment to particular targets on the body.

Treatment Using Wearable NIR LEDs

As described herein, the disclosed methods are highly specific for cancer cells. However, in order to kill the cells circu-
lating in the body or present on the skin, the patient can wear a device that incorporates an NIR LED. In some
elementary the patient uses at least two devices, for example an
article of clothing or clothing during the day, and a blanket at
night. In some example the patient uses at least two devices at
the same time, for example two articles of clothing. These
devices make it possible to expose the patient to NIR light
using portable everyday articles of clothing and jewelry so
that treatment remains private and does not interfere with
everyday activities. In some examples, the device can be worn
discreetly during the day for PII therapy.

In one example, the patient is administered one or more
antibody-IR700 molecules, using the methods described
herein. The patient then wears a device that incorporates an
NIR LED, permitting long-term therapy and treatment of
tumor cells that are present in the blood or lymph or on the
skin. In some examples, the dose is at least 1 J cm⁻²,
at least 10 J cm⁻², at least 20 J cm⁻², or at least 30 J cm⁻²,
such as 20 J cm⁻² or 30 J cm⁻². In some examples, administration
of the antibody-IR700 molecule is repeated over a period of time
(such as bi-weekly or monthly, to ensure therapeutic levels
are present in the body.

In some examples, the patient wears or uses the device, or
combination of devices, for at least 1 week, such as at least 2
weeks, at least 4 weeks, at least 8 weeks, at least 12 weeks, at
least 4 months, at least 6 months, or even at least 1 year. In
some examples, the patient wears or uses the device, or
combination of devices, for at least 4 hours a day, such as at least
12 hours a day, at least 16 hours a day, at least 18 hours a day,
or 24 hours a day. It is quite possible that multiple devices of a
similar “everyday” nature (blanks, bracelets, necklaces,
underwear, socks, shoe inserts) could be worn by the same
patient during the treatment period. At night the patient can
use the NIR LED blanket or other covering.

Additional Treatments

In particular examples, prior to, during, or following
administration of one or more antibody-IR700 molecules, the
subject can receive one or more other therapies. In one
example, the subject receives one or more treatments to
remove or reduce the tumor prior to administration of the
antibody-IR700 molecules.

Examples of such therapies include, but are not limited to,
surgical treatment for removal or reduction of the tumor (such as
surgical resection, cryotherapy, or chemoe-embolization), as
well as anti-tumor pharmaceutical treatments which can include
radiotherapeutic agents, anti-neoplastic chemotherapy,
agents, antibiotics, alkylating agents and antagonists,
kinase inhibitors, and other agents. Particular examples of
additional therapeutic agents that can be used include micro-
tubule binding agents, DNA intercalators or cross-linkers,
DNA synthesis inhibitors, DNA and/or RNA transcription
inhibitors, antibodies, enzymes, enzyme inhibitors, and gene
regulators. These agents (which are administered at a therape-
tically effective amount) and treatments can be used alone
or in combination. Methods and therapeutic dosages of such
agents are known to those skilled in the art, and can be
determined by a skilled clinician.

"Microtubule binding agent" refers to an agent that interacts
with tubulin to stabilize or destabilize microtubule for-
formation thereby inhibiting cell division. Examples of micro-
tubule binding agents that can be used in conjunction with the
disclosed antibody-IR700 molecule therapies include, with-
out limitation, paclitaxel, docetaxel, vinblastine, vin
desine, vinorelbine (nabivin), the epothilones, colchicine, dolasta-
tin 15, nocodazole, podophyllotoxin and rhizoxin. Analogs
and derivatives of such compounds also can be used and are
known to those of ordinary skill in the art. For example,
suitable epothilones and epothilone analogs are described in
International Publication No. WO 2004/018478. Taxoids,
such as paclitaxel and docetaxel, as well as the analogs of
paclitaxel taught by U.S. Pat. Nos. 6,610,860; 5,530,020; and
5,912,254 can be used.

The following classes of compounds can be used in combi-
nation with the methods disclosed herein: suitable DNA
and/or RNA transcription regulators, including, without limita-
tion, actinomycin D, daunorubicin, doxorubicin and deriva-
tives and analogs thereof also are suitable for use in combi-
nation with the disclosed therapies. DNA intercalators and
cross-linking agents that can be administered to a subject
include, without limitation, cisplatin, carboplatin, oxalipl-
atin, mitomycins, such as mitomycin C, bleomycin, chlorambucil,
cyclophosphamide and derivatives and analogs thereof.
DNA synthesis inhibitors suitable for use as therapeutic
agents include, without limitation, methotrexate, 5-fluoro-5-
deoxyuridine, 5-fluorouracil and analogs thereof. Examples of
suitable enzyme inhibitors include, without limitation,
camptothecin, etoposide, fornustane, trichostatin and derivat-
tives and analogs thereof. Suitable compounds that affect
gene regulation include agents that result in increased or
decreased expression of one or more genes, such as rak
pfen, 5-acetylcydide, 5-aza-2'-deoxyctydine, tamoxifen,
4-hydroxytamoxifen, milfeitro and derivatives and ana-
glogs thereof. Kinase inhibitors include Gleveac, Iressa, and
Taceva that prevent phosphorylation and activation of
growth factors.

Other therapeutic agents, for example anti-tumor agents,
that may or may not fall under one or more of the classifica-
tions above, also are suitable for administration in combi-
nation with the disclosed therapies. By way of example, such
agents include adriamycin, epigenin, rapamycin, zebularine,
cimetidine, and derivatives and analogs thereof.

In some examples, the subject receiving the therapeutic
antibody-IR700 molecule composition is also administered,
interleukin-2 (IL-2), for example via intravenous administra-
tion. In particular examples, IL-2 (Chiron Corp., Emeryville,
Calif.) is administered at a dose of at least 500,000 IU/kg as an
intravenous bolus over a 15 minute period every eight hours
beginning on the day after administration of the peptides
and continuing for up to 5 days. Doses can be skipped
depending on subject tolerance.

In some examples, the disclosed antibody-IR700 mole-
cules can be co-administered with a fully human antibody to
cytotoxic T-lymphocyte antigen-4 (anti-CTLA-4). In some
example subjects receive at least 1 mg/kg anti-CTLA-A-4 (such
as 3 mg/kg every 3 weeks or 3 mg/kg as the initial dose with
subsequent doses reduced to 1 mg/kg every 3 weeks).

In one example, at least a portion of the tumor (such as
a metastatic tumor) is surgically removed (for example via
cryotherapy), irradiated, chemically treated (for example via
chemoembolization) or combinations thereof, prior to admin-
istration of the disclosed therapies (such as administration of
antibody-IR700 molecules). For example, a subject having a
metastatic tumor can have all or part of the tumor surgically
excised prior to administration of the disclosed therapies.
In an example, one or more chemotherapeutic agents are admin-
istered following treatment with antibody-IR700 molecules
and irradiation. In another particular example, the subject has
a metastatic tumor and is administered radiation therapy,
chemoembolization therapy, or both concurrently with the administration of the disclosed therapies.

Example 1

Synthesis of IRDye 700-Conjugated Trastuzumab (Anti-Her2)

This example describes methods used to conjugate the monoclonal antibody Trastuzumab to the IRDye 700DX NHS Ester. On skilled in the art will recognize that any antibody, such as any monoclonal antibody specific for a target cell surface protein, can be conjugated to IRDye 700DX NHS Ester using similar methods.

Humanized anti-HER2 antibody, Trastuzumab (Tra; Genentech, San Francisco, Calif.) (1 mg, 6.8 nmol) was incubated with IRDye 700DX NHS Ester (IR700; LI-COR Bioscience, Lincoln, Neb.) (66.8 µg, 34.2 nmol, 5 mmol/L in DMSO) in 0.1 molar NaHPO4 (pH 8.5) at room temperature for 30 to 120 min. Trastuzumab is a recombinant humanized monoclonal antibody (mAb) directed against the extracellular domain of the human epidermal growth factor receptor (EGFR) 2 (HER2) tyrosine kinase receptor. The mixture was purified with a Sephadex G-50 column (PD-10; GE Healthcare, Piscataway, N.J.). The protein concentration was determined with a Coomassie Plus protein assay kit (Pierce Biotechnology, Rockford, Ill.) by measuring the absorbance at 595 nm with a UV-Vis system (8453 Value System; Agilent Technologies, Palo Alto, Calif.). The concentration of IR700 was measured by absorption with the UV-Vis system to confirm the number of fluorophore molecules conjugated to each Trastuzumab molecule. The number of IR700 per Trastuzumab was about 3.

The purity of the Tra-IR700 conjugate was confirmed by analytical size-exclusion HPLC (SE-HPLC) and sodium dodecyl sulfate polyacrylamide gel electrophoresis (SDS-PAGE). SE-HPLC was performed using a Beckman System Gold (Fullerton, Calif.) equipped with model 126 solvent delivery module, a model 168 UV detector, and a JASCO fluorescence detector (excitation 889 nm and emission at 700 nm) controlled by 32 Karat software. SE chromatography was performed on a TSKgel G2000SWx1 (Tosoh Bioscience LLC, Montgomeryville, Pa.) eluted for 45 minutes using phosphate buffered saline (PBS) at 0.5 mL/min. SDS-PAGE was performed with a 4% to 20% gradient polyacrylamide gel (Invitrogen, Carlsbad, Calif.). After separating the proteins, fluorescence intensity was analyzed with a Fujifilm FLA-5100 fluorescence scanner (Vallalla, N.Y.). An internal laser of 670 nm for excitation and 705 nm long pass filter for emission. The fluorescence intensity of each band was analyzed with Multigage software (Fujifilm). The gels were then stained with Colloidal Blue Staining Kit (Invitrogen), and digitally scanned. The protein concentration in each band was analyzed with ImageJ software. The trastuzumab-IR700 (Tra-IR700) and panitumunab-IR700 (Pan-IR700; see Example 8) preparations demonstrated strong association and contained no detectable MAb aggregates as determined by high performance liquid chromatography (HPLC) and sodium dodecyl sulfate polyacrylamide gel electrophoresis (SDS-PAGE).

To determine the in vitro binding characteristics of IR700 conjugates 125I labeling of the conjugates using the Indo-Gen procedure was performed. The specific activities of the radio-labeled antibodies were 8.52 mCi/mg for Trastuzumab and 7.84 mCi/mg for panitumunab (see Example 8 below). It was observed that 73.38±0.39% (125I-Tra-IR700) and 78.61±0.89% (125I-Pan-IR700) of binding was achieved with each MAb conjugate respectively and the specificity of binding was confirmed by blocking with excess native unconjugated MAb (less than 1.4%). Since immunoreactivity of 125I-Tra and 125I-Pan measured with the same method were 78±2%, and 82±3%, respectively, minimal loss of MAb with IR700 conjugation was confirmed. Immunoreactivity assay was performed as described previously. Briefly, after trypsinization, 2×106 of 3T3/HER2 or A431 cells were suspended in PBS containing 1% bovine serum albumin (BSA).

125I-Tra-IR700 or 125I-Pan-IR700 (1 mcg, 0.2 µg) was added and incubated for 1 h on ice. Cells were washed, pelleted, the supernatant decanted, and counted in a 2470 Wizard 2 γ-counter (Perkin Elmer, Shelton, Conn.). Nonspecific binding to the cells was examined under conditions of antibody excess (200 µg of nonlabeled trastuzumab or panitumumab).

Example 2

Selective Killing of HER2+ Cells

This example describes methods used to show that the Trastuzumab-IR700 compound described in Example 1 (referred to herein as Tra-IR700) can be used to selectively kill cells that express HER2 (HER2+), but has minimal negative effects on HER2 negative (HER2−) cells.

HER2 gene-transfected NIH3T3 (3T3/HER2+ cells) were used for target photodynamic therapy (PDT). As a control, Balb/3T3 cells which express DsRed fluorescent protein but not HER2 (Balb/3T3/DsRed) were employed. Cells were grown in RPMI 1640 supplemented with 10% fetal bovine serum and 1% penicillin/streptomycin in tissue culture flasks in a humidified incubator at 37° C. in an atmosphere of 95% air and 5% carbon dioxide.

Fluorescence microscopy was performed with a BX51 or 1x81 microscope (Olympus America, Melville, N.Y.). The filter set was 420-480 nm excitation filter, and a 665-740 nm band pass emission filter. To detect DsRed protein, a filter set consisting of 480-550 nm excitation filter, and a 590 nm long pass emission filter was employed.

Fluorescence microscopy was performed to test the subcellular localization of IR700 in 3T3/HER2+ cells. Cells were seeded on cover glass-bottomed dishes and incubated for 24 hours. Tra-IR700 was added to the culture medium at 10 µg/mL. As shown in FIG. 1a, Tra-IR700 was detected on the cell surface after 1 hour incubation on ice, and was mainly localized to the lysosomes 6 hours after incubation at 37° C., indicating gradual internalization. Co-staining with LysoTracker Green (Invitrogen, Carlsbad, Calif.), which was detected by a filter set consisting of a 420-480 nm excitation filter, and a 520 nm long pass emission filter, revealed colocalization of IR700 with the endolysosomal compartment (FIG. 1b). After 1 h and 6 h of incubation with Tra-IR700, excitation light (fluorescence microscope; power density of 2.2 mW cm−2) induced fluorescence as well as cellular swelling, bleb formation, and rupture of vesicles representing necrotic cell death (FIG. 1c).

For photoimmunotherapy (PIT), cells were seeded on 35 mm cover glass-bottomed dishes and incubated 24 hours. Medium was replaced with fresh culture medium containing Tra-IR700 at 10 ng/mL and incubated for 6 hours at 37° C. Culture medium was replaced with phenol red-free medium after washing with phosphate buffered saline (PBS). Cells were irradiated with light at 670 nm to 690 nm using a red light emitting diode (LED; FluorVivo; INDEC Systems Inc., Capitola, Calif.) with a power density of 2.6 mW cm−2 as measured with optical power meter (PM 100, Thorlabs, New-
Cell viability was assessed 1 hour after treatment with LIVE/DEAD® Fixable Green Dead Cell Stain Kit (Invitrogen). After the treatment, cells were trypsinized and washed with PBS. Green fluorescent reagent dye was added in the cell suspension and incubated at room temperature for 30 minutes. Cells were then analyzed on flow cytometry (FACS Calibur, BD BioSciences, San Jose, Calif.).

As shown in Fig. 1c, irradiation at 1.0 J cm⁻² for 3T3/HER2+ cells resulted in rapid necrotic cell death, representing buckling and swelling of the cell membrane.

**Example 3**

**Identification of Irradiation Dose**

To determine the phototoxicity in response to different doses of light irradiation, PDT-treated 3T3/HER2+ cells were assayed by flow cytometry using the LIVE/DEAD® Fixable Green Dead Cell Stain Kit. The LIVE/DEAD assay, which can detect the cells with damaged membranes, was performed within 1 h after the treatment. As shown in Fig. 1d, cell death in response to Tra-IR700-mediated PDT was light dose dependent 1 hour after PDT. Cells without PDT or Tra-IR700 did not show significant phototoxicity.

**Example 4**

**Measurement of Cell Viability Over Time**

To monitor cell viability over time, cells were labeled and irradiated as described in Example 2, then were monitored subsequently over time (5 days) using microscopy as described in Example 2.

As shown in Fig. 1e, phototoxic cell death was observed only in the treated 3T3/HER2+ cells with Tra-IR700, but not in the un-irradiated group (no PDT) or the group irradiated but did not receive Tra-IR700 (No Tra-IR700).

**Example 5**

**Target Specific Phototoxicity of Tra-IR700**

PIT was performed as described in Example 2. As shown in Fig. 1g, there was no significant difference in phototoxicity between 1 h and 6 h incubation with Tra-IR700, indicating that membrane binding of Tra-IR700 was sufficient to induce cell death. When Tra-IR700 was localized to the endolysosomal compartment (Fig. 1b), it also induced rupture of the vesicle with cellular swelling and bleb formation after irradiation. However, this did not appear to be a major cause of cell death, since cell death was observed without endolysosomal localization of Tra-IR700 within 1 h of incubation at 4°C. Failure to wash the cells prior to irradiation did not influence the phototoxic effect, indicating that cellular membrane binding was important to the phototoxic effects of the conjugate, not merely the presence of the conjugate. Further, the IR700 dye alone (200 nM; equivalent IR700 concentration of Tra-IR700 conjugates) did not incorporate into the cells or induce phototoxicity in cells (Fig. 1a and Fig. 2b). Additionally, phototoxicity was dose-dependently blocked by the excess unconjugated trastuzumab (FIGS. 2c and 2d). Furthermore, Tra-IR700 did not induce therapeutic effect to A431 cells (Fig. 1i). These results confirm that cell death is dependent on specific membrane binding of Tra-IR700.

Reactive oxygen species (ROS) have been implicated in the cell death associated with conventional PDT. To clarify the role of photon-induced redox reactions (e.g. singlet oxygen (¹O₂)) in producing phototoxicity with Tra-IR700, a redox quencher, sodium azide (NaN₃), was added to the medium when cells were irradiated. The percentage of cell death was partially decreased in the presence of sodium azide, in a dose dependent manner (Fig. 1j).

To confirm that the phototoxicity was target specific, 3T3/HER2+ cells and Balb/3T3/DsRed cells (a parental HER2 negative Balb/3T3 transfected with DsRed fluorescent protein) were co-cultured, and irradiated at 1.0 J cm⁻² after 1 or 6 hours of incubation with Tra-IR700 at 37°C. Tra-IR700 was distributed in a HER2 specific manner while DsRed expressing Balb/3T3 cells did not show phototoxicity upon irradiation (FIG. 3a). In addition, LIVE/DEAD Green staining demonstrated HER2 specific induction of cell death as determined by multi-color fluorescence microscopy (FIG. 3b) and flow cytometry analysis (FIG. 3c).

**Example 6**

Tra-IR700 Reduces Proliferation of HER2+ Cells

3T3/HER2 cells were seeded into 35 mm cell culture dishes at a density of 1 x 10⁴. The next day, cells were incubated with or without Tra-IR700 and irradiated as described in Example 2. Cell viability was determined by trypan blue dye exclusion assay at day 1, 3 and 5 after the cell seeding. Viable cells for treated or untreated controls were counted on a hemacytometer after trypan blue staining. Cell growth was also photographed under microscope at each time point.

As shown in Fig. 1e, cells treated with Tra-IR700 and then subjected to PDT 2.0 J cm⁻² had significantly reduced viability as compared to cells only treated with Tra-IR700, only PDT, or no treatment.

**Example 7**

Tra-IR700 Selectively Kills HER2+ Cells In Vivo

This example describes methods used to show that Tra-IR700 can treat HER2+ tumors in vivo. One skilled in the art will appreciate that similar methods can be used with other tumor/antibody-IR700 combinations.

Six- to eight-week-old female homozygote athymic nude mice (Charles River, NCI-Frederick, Frederick, Md.) were anesthetized with isoflurane. 3T3/HER2+ or Balb/3T3 cells (2 million) were injected subcutaneously in the left dorsum of the mice. Four days after cell injection, either 50 or 300 µg of Tra-IR700 was administered intravenously. Her2-specific Tra-IR700 accumulation in tumor xenografts was confirmed with an in vivo fluorescence imaging system (Pearl Imager, LI-COR Biosciences, Lincoln, Nebr.). 3T3/HER2+ tumor, specific IR700-Tra localization was observed. In contrast, Balb/3T3 tumor did not show Her2-specific IR700 fluorescence.

To evaluate the efficacy of targeted PIT with IR700-Tra in vivo, 1 million 3T3/HER2+ or Balb/3T3 cells were injected subcutaneously into the bilateral dorsum of female nude mice. When the volume of both tumors reached ~70 mm³ (about 4 days), animals were randomized into five groups of at least 12 animals per group for the following treatments: (1) no treatment; (2) 300 µg of trastuzumab injected intravenously, no PDT; (3) 300 µg of Tra-IR700 injected intravenously, no PDT; (4) PDT at 50 J/cm² for 3T3/HER2 tumor without Tra-IR700; (5) 300 µg of Tra-IR700 injected intravenously, PDT was performed at 50 J/cm².

Twenty-four hours after administration of Tra-IR700, in mice receiving PIT a 1 cm-diameter area encompassing the
right dorsum including the tumor was irradiated (dose level 50 J cm⁻²). The left dorsum of the tumor was covered with black tape to prevent its exposure to light. Effects in response to P1 were monitored daily and tumor volumes were measured with a caliper twice a week until it reached 500-1000 mm³, at which time mice were euthanized with carbon dioxide gas. In order to determine tumor volume, the greatest longitudinal diameter (length) and the greatest transverse diameter (width) were determined with external caliper. Tumor volume based on caliper measurements were calculated by the following formula; tumor volume = length x width² x 0.5. Data are expressed as means ± SEM from a minimum of three experiments, unless otherwise indicated. Statistical analyses were carried out using a statistics program (GraphPad Prism; GraphPad Software, La Jolla, Calif.). For multiple comparisons, a one-way analysis of variance (ANOVA) with post test (Kruskal-Wallis test with post-test) was used. The cumulative probability of survival, determining herein as the tumor volume was failed to reach 500 mm³, were estimated in each group with the use of the Kaplan-Meier survival curve analysis, and the results were compared with use of the log-rank test with Bonferroni’s correction for multiplicity. P<0.05 was considered to indicate a statistically significant difference.

As shown in FIGS. 4a and 4b, whereas 50 J cm⁻² irradation resulted in significant tumor growth inhibition in 3T3/HER2+ tumors at day 4, 7, 10 and 14 days after treatment, untreated tumors did not exhibit any detectable effect on tumor growth. In addition, irradiation for Balb/3T3 tumors did not show significant therapeutic effect. Furthermore, no lethal side effects were found during or after the treatment.

Example 8

Synthesis of IRDye 700-Conjugated Vectibix® (Anti-Her1)

Panitumumab (Vectibix®), a fully humanized IgG1 MAb directed against the human EGFR was produced from Amgen (Thousand Oaks, Calif.) and conjugated to IR700 using the methods described in Example 1. This compound is referred to as Panitumumab-IR700 or Pan-IR700. The number of IR700 per Panitumumab was about 3.

Example 9

Pan-IR700 Selectively Kills HER1+ Cells

This example describes methods used to show that the Pan-IR700 compound described in Example 8 can be used to selectively kill cells that express HER1 (HER1+ cells), but has minimal negative effects on HER1 negative (HER1-) cells. EGFR-expressing A431 cells were used as the target HER1+ cells. As a control, Balb/3T3 cells which express DsRed fluorescent protein but not express HER1/EGFR (Balb/3T3/DsRed) were used. Cells were grown in RPMI 1640 supplemented with 10% fetal bovine serum and 1% penicillin/streptomycin in tissue culture flasks in a humidified incubator at 37°C in an atmosphere of 95% air and 5% carbon dioxide. A431 or Balb/3T3/DsRed cells were seeded on cover glass-bottomed dishes and incubated for 24 hours. Pan-IR700 was added to the culture medium at 10 μg/mL and incubated either for 1 hour on ice or 6 hours at 37°C, then cells were washed with PBS. Culture medium was replaced with phenol red-free medium after washing with phosphate buffered saline (PBS).

Fluorescence microscopy was performed as described in Example 2 to detect the antigen-specific localization of IR700. Pan-IR700 was detected on the cell surface of A431 cells after 1 hour incubation on ice, and was mainly localized to the lysosome 6 hours after incubation at 37°C. No significant IR700 signal was observed with Balb/3T3/DsRed cells. PIT was performed as described in Examples 2 and 3. As shown in FIG. 5a, irradiation of A431 cells at 0.5 to 2 J cm⁻² resulted in rapid cell death in a dose-dependent manner, representing budding and swelling of the cell membrane. As shown in FIG. 6b, the percentage of cell death in target cells versus untreated control cells was significantly influenced by excitation light dose. In addition, there was no significant cytotoxicity associated with exposure to Pan-IR700 without excitation light or with light exposure without Tram-IR700. However, panitumumab itself had a noticeable treatment effect against A431 cells due to down regulation and signal inhibition of HER1 (Yang et al., Cancer Res 59:1256-43, 1999).

Target-specific phototoxicity was also confirmed with Pan-IR700 mediated PIT in A431 cells and Balb/3T3/DsRed (HER1 negative) co-cultured cells (FIG. 5c). In summary, Tram-IR700 and Pan-IR700 showed identical therapeutic effects to HER2 positive (3T3/HER2) and HER1 positive (A431) cells, respectively, except that unconjugated panitumumab showed noticeable growth inhibition but unconjugated trastuzumab did not reduce growth with the dose used.

Example 10

Pan-IR700 Selectively Kills HER1+ Cells In Vivo

This example describes methods used to show that Pan-IR700 can treat HER1+ tumors in vivo. One skilled in the art will appreciate that similar methods can be used with other tumor/antibody-IR700 combinations.

Six- to eight-week-old female homozygote athymic nude mice (Charles River, NC/Feeder, Frederick, Md.) were anesthetized with isoflurane. One million A431 cells were injected subcutaneously in the left dorsum of the mice. Four days after cell injection, either 50 or 300 μg of Pan-IR700 was administered intravenously.

To confirm antigen specific localization of Pan-IR700, 1x10⁶ of 3T3/HER2 cells (HER1 negative) were injected subcutaneously in the right dorsum at the same time of A431 cells injection. Fluorescence images were obtained at indicated time point with Pearl Imager (L.1-COR Biosciences) using 700 nm fluorescence channel. Regions of interest (ROI) for both tumor and background were placed for equivalent sized areas containing the same number of pixels. Tumor to background ratio (TBR) was calculated using the following formula: TBR = (mean tumor intensity) - (mean background intensity))/[(mean non-tumor intensity) - (mean background intensity)].

As shown in FIG. 6a, Pan-IR700 localized to the A431 tumor. The fluorescence intensity of Pan-IR700 in a A431 tumor decreased gradually over days, while tumor to background ratios (TBRs) increased (FIGS. 6b and 6c). The fluorescence intensity of the 3T3/HER2 tumor was the same as that of background (non-tumor lesions). When 300 μg of Pan-IR700 was administered intravenously, fluorescence intensity of the A431 tumor was more than 3 times higher than 50 μg injection at 1 day after injection, however, TBR was lower because of high background signal (FIGS. 6b and 6c).

As less antitumor activity was found in mice receiving 50 μg (vs. 300 μg) of Pan-IR700 injection following irradiation, the higher injection dose was used (FIG. 6e). Biodistribution of
Tra-IR700 was determined with IR700 fluorescence because tissue levels of radioactivity and fluorescence might be different due to their different excretion routes and catabolism when using dual-labeled radiolabeled-Pan-IR700. There was no specific localization of IR700 except for bladder accumulation on day 1 probably due to excretion of catabolized and unbound dye (Fig. 6d).

As shown in Fig. 6d, PIT treatment following Pan-IR700 administration began to shrink tumors at day 2, in contrast to non-PIT treated tumors which did not shrink. To determine the effect of Pan-IR700 or carrier alone followed by PIT, the following methods were used. In order to determine tumor volume, the greatest longitudinal diameter (length) and the greatest transverse diameter (width) were determined with external caliper. Tumor volume based on caliper measurements were calculated by the following formula: tumor volume = length/width^2/2. After four days, A331 cell injection as described above, tumor volume reaching around 40 mm^3 were selected for the study. Animals were randomized into 8 groups of at least 12 animals per group for the following treatments: (1) no treatment; (2) 300 μg of panitumumab injected intravenously, no PIT; (3) 300 μg Pan-IR700 injected intravenously, no PIT; (4) PIT was performed at 30 J/cm^2 without Pan-IR700; (5) Free IR700 dye, dose equivalent to 300 μg of Pan-IR700, was injected intravenously, and PIT was performed at 30 J cm^-2; (6) 50 μg of Pan-IR700 was injected intravenously, PIT was performed at 30 J cm^-2; (7) 50 μg of Pan-IR700 and 250 μg of panitumumab was injected intravenously, PIT was performed at 30 J cm^-2; and (8) 300 μg of Pan-IR700 was injected intravenously, PIT was performed at 30 J cm^-2. After the treatment, mice were monitored daily, and tumor volume was measured twice a week until the tumor volume reached 500 mm^3, at which time mice were euthanized with carbon dioxide gas. To test a short-term toxicity, 300 μg of Pan-IR700 was repeatedly administered intravenously for non-tumor-bearing mice, twice a week, for 4 weeks.

As shown in Fig. 6e, whereas treatment with Pan-IR700 and 30 J cm^-2 irradiation resulted in significant tumor growth inhibition in A431 (HER1+ tumors at day 3, 7, 10, 14 and 17 days after treatment, untreated tumors did not exhibit any detectable effect on tumor growth. In addition, as shown in Fig. 6f, treatment with Pan-IR700 and 30 J cm^-2 irradiation resulted in significant increases in survival time of mice with A431 (HER1+) tumors. Furthermore, no lethal side effects were found during or after the treatment. Fig. 6g shows microscopic images of cells four days following treatment with Pan-IR700 followed by no PIT therapy or PIT therapy. Pathological analysis revealed that only scant viable A431 tumor cells were present after Pan-IR700 mediated PIT and massive granulation with inflammatory change was observed in the tumor node. It was also observed that tissue edema developed superficially. To assess the acute phase toxicity of Pan-IR700, we repeatedly administrated 300 μg of Pan-IR700 intravenously twice a week for 4 weeks, but there were no adverse effects observed up to 8 w (n=4) compared with the control group.

Example 12
Selective Killing In Vitro by Antibody-IR700 Molecules

This example describes additional results showing that the disclosed antibody-IR700 compounds selectively kill cells that express the appropriate protein. The photoimmunotherapy (PIT) methods are described in Example 2.

As shown in Fig. 8, Tra-IR700 specifically killed HER2 expressing 3T3/1-HER2, SHAW, SKOV3 and MDA-MB-453 cells. Pan-IR700 specifically killed HER1 expressing A431 and MDA-MB-468 cells, and hu591-IR700 specifically killed prostate specific membrane antigen (PSMA) expressing LNCaP cells.

Example 13
Trastuzumab-IR700 Treatment of Metastases

This example describes methods used to show that Tra-IR700 can treat lung metastases. HER2 expressing 3T3/HER2 cells (0.5 to 2 million cells) were injected intravenously into tail vein of female nude mice. Trastuzumab-IR700 (100 μg) was injected intravenously 5 days after the tumor cell injection. As multiple tiny lung metastases were confirmed with Tra-IR700 localization.
in ex vivo imaging, the lungs were treated with 30 J/cm² of NIR light from outside the body 2 days after Trastuzumab-IR700 injection. It was observed that the lung metastases cleared, and there was an observed increase in the overall survival time of the mice as compared to mice that did not receive Tr-at-IR700.

In view of the many possible embodiments to which the principles of the disclosure may be applied, it should be recognized that illustrated embodiments are only examples of the disclosure and should not be considered a limitation on the scope of the invention. Rather, the scope of the invention is defined by the following claims. We therefore claim as our invention all that comes within the scope and spirit of these claims.

We claim:

1. A method of treating a tumor in a subject, comprising: administering to the subject a therapeutically effective amount of one or more antibody-IR700 molecules, wherein the antibody specifically binds to a cell surface protein on the tumor; and irradiating the tumor at a wavelength of 660 to 740 nm and at a dose of at least 1 J cm⁻², thereby treating the tumor in the subject.

2. The method of claim 1, wherein the tumor is a cancer.

3. The method of claim 2, wherein the cancer is a cancer of the breast, liver, colon, ovary, prostate, pancreas, brain, cervix, bone, skin, or lung.

4. The method of claim 2, wherein the cancer is a cancer of the blood.

5. The method of claim 1, wherein the cell surface protein is a tumor-specific protein.

6. The method of claim 5, wherein the tumor-specific protein is HER1, HER2, CD20, CD25, CD33, CD52, or prostate specific membrane antigen (PSMA).

7. The method of claim 6, wherein the one or more antibody-IR700 molecules comprise a Panitumumab-IR700 molecule, Trastuzumab-IR700 molecule, or J591-IR700 molecule.

8. The method of claim 1, wherein the tumor is irradiated at a wavelength of 680 nm.

9. The method of claim 1, wherein the tumor is in a subject's blood, and wherein irradiating the tumor comprises irradiating the blood by using a device worn by the subject, wherein the device comprises a near infrared (NIR) light emitting diode (LED).

10. The method of claim 1, wherein the method further comprises: selecting a subject with a tumor that expresses a cell surface protein that can specifically bind to the antibody-IR700 molecule.

11. The method of claim 1, wherein the method increases survival time of the subject by at least 50% relative to an absence of administration of the antibody-IR700 molecule and irradiation.

12. The method of claim 1, further comprising: contacting the tumor with one or more antibody-IR700 molecules in an amount less than the therapeutically effective amount; and irradiating the tumor at a wavelength of 660 to 740 nm and at a dose of at least 0.001 J cm⁻², thereby permitting detection of the tumor.

13. The method of claim 2, wherein the cancer is a cancer of the head and neck.

14. The method of claim 5, wherein the tumor-specific protein is HER1, and the one or more antibody-IR700 molecules comprise a Cetuximab-IR700 molecule.

15. The method of claim 1, wherein the administering is intravenous.

16. The method of claim 1, wherein the tumor is a human epidermal growth factor receptor 1 (HER1) tumor, the cell surface protein on the tumor is HER1, and the one or more antibody-IR700 molecules comprise a Cetuximab-IR700 molecule.

17. The method of claim 16, wherein the HER1+ tumor is an adenocarcinoma.

18. The method of claim 17, wherein the adenocarcinoma is an adenocarcinoma of the colon, head or neck.

19. The method of claim 1, wherein the tumor is a HER1+ tumor, the cell surface protein on the tumor is HER1, and the one or more antibody-IR700 molecules comprise a Panitumumab-IR700 molecule.

20. The method of claim 19, wherein the HER1+ tumor is an adenocarcinoma.

21. The method of claim 20, wherein the adenocarcinoma is an adenocarcinoma of the colon, head or neck.

22. The method of claim 1, wherein the tumor is a HER2+ tumor, the cell surface protein on the tumor is HER2, and the one or more antibody-IR700 molecules comprise a Trastuzumab-IR700 molecule.

23. The method of claim 22, wherein the HER2+ tumor is a cancer of the breast, ovary, stomach, or uterus.

24. The method of claim 1, wherein the tumor is a prostate-specific membrane antigen (PSMA)+ tumor, the cell surface protein on the tumor is PSMA, and the one or more antibody-IR700 molecules comprise a J591-IR700 molecule.

25. The method of claim 1, wherein the tumor is a metastasis.

* * * * *
It is certified that error appears in the above-identified patent and that said Letters Patent is hereby corrected as shown below:

In the Specifications:

Column 2, line 21, “provided devices” should be --provided are devices--.

Column 2, lines 44-45, “is a digital image showing is a digital image showing” should be --is a digital image showing--.

Column 4, line 30, “multiplicity.” should be --multiplicity).--.

Column 8, line 67, “18700” should be --IR700--.

Column 12, line 5, “18700” should be --IR700--.

Column 21, line 57, “(CD25)” should be --(CD25).--.

Column 22, line 42, “18700” should be --IR700--.

Column 34, lines 18-19, the line spacing is incorrect, “cell injection.” should immediately follow “PC3-PIP”, without a paragraph break or tab in between.

Signed and Sealed this
Eleventh Day of March, 2014

Michelle K. Lee
Deputy Director of the United States Patent and Trademark Office