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ADVANCES IN Cancer IMMUNOTHERAPY™

Basic Principles of Cancer Immunotherapy

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AAEM AMERICAN ACADEMY OF EMERGENCY MEDICINE CHAMPION OF THE EMERGENCY PHYSICIAN

ACCC Association of Community Cancer Centers

HOPA Hematology/Oncology Pharmacy Association

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Disclosures

- I have no disclosures
- I will not be discussing non-FDA approved indications during my presentation.

The Premise of Cancer Immunotherapy

- Normally, the immune system eliminates damaged cells, including precancerous and cancer cells.

- To escape this normal immune surveillance, tumors evolve mechanisms to locally disable the immune system.

The goal of immunotherapy is to restore the full capacity of the immune system to recognize and eliminate cancer.

Two major mechanisms of tumor-immune system escape

- **A dysfunctional immune response (as mediated by the tumor):** Cytotoxic ($CD8^+$) T cells often become dysfunctional or exhausted during chronic stimulation (chronic viral responses or responses against tumors). To enhance T cell dysfunction, the tumor microenvironment upregulates a suite of immuno-suppressive molecules.

- **Immune evasion/exclusion (as mediated by the tumor):** A state in which the cancer remains invisible to the immune system. Many features of tumors can result in immune exclusion/avoidance including lack of antigens (T cells don't "see" anything on the tumor) or active immune repellents.

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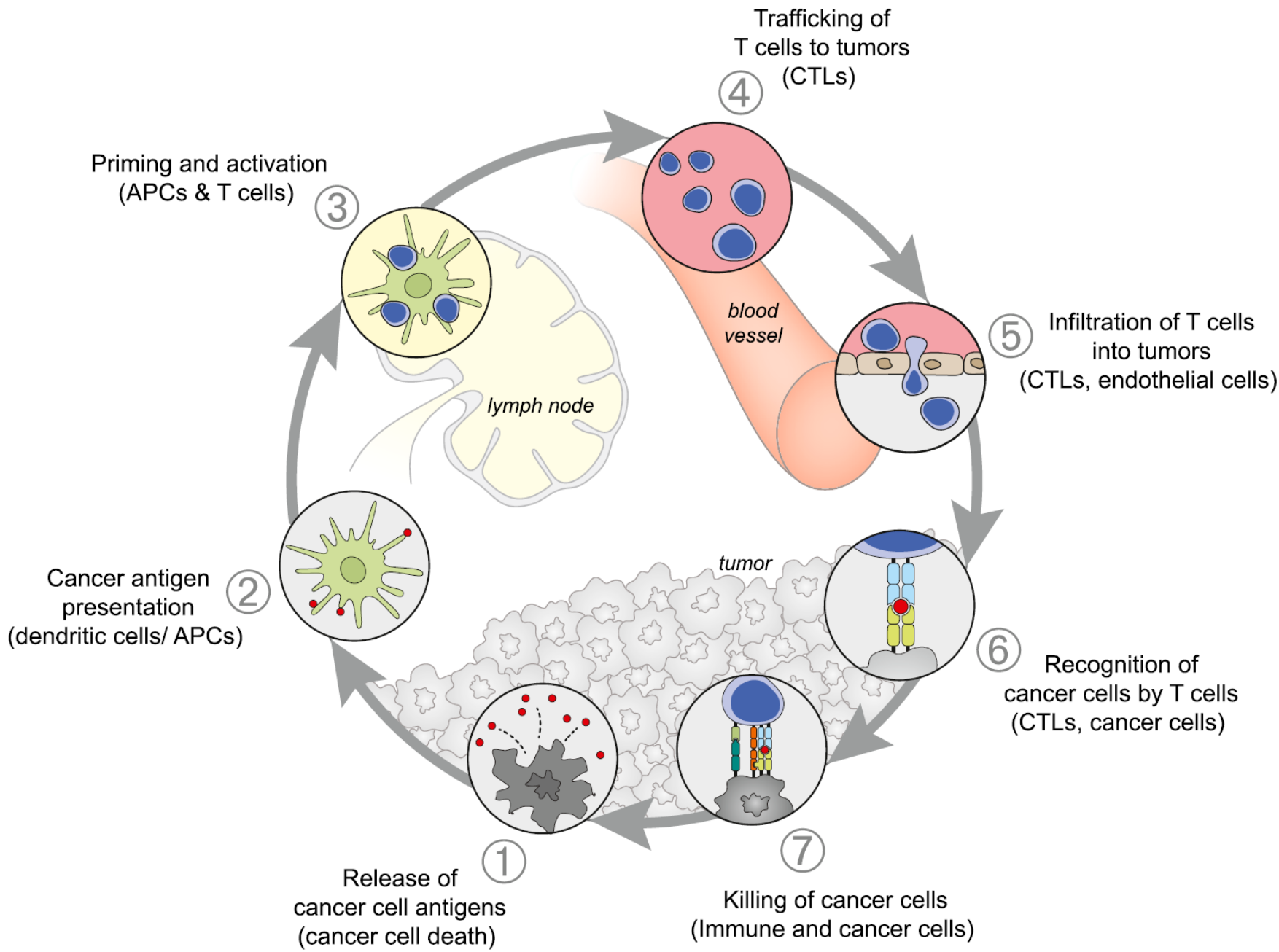
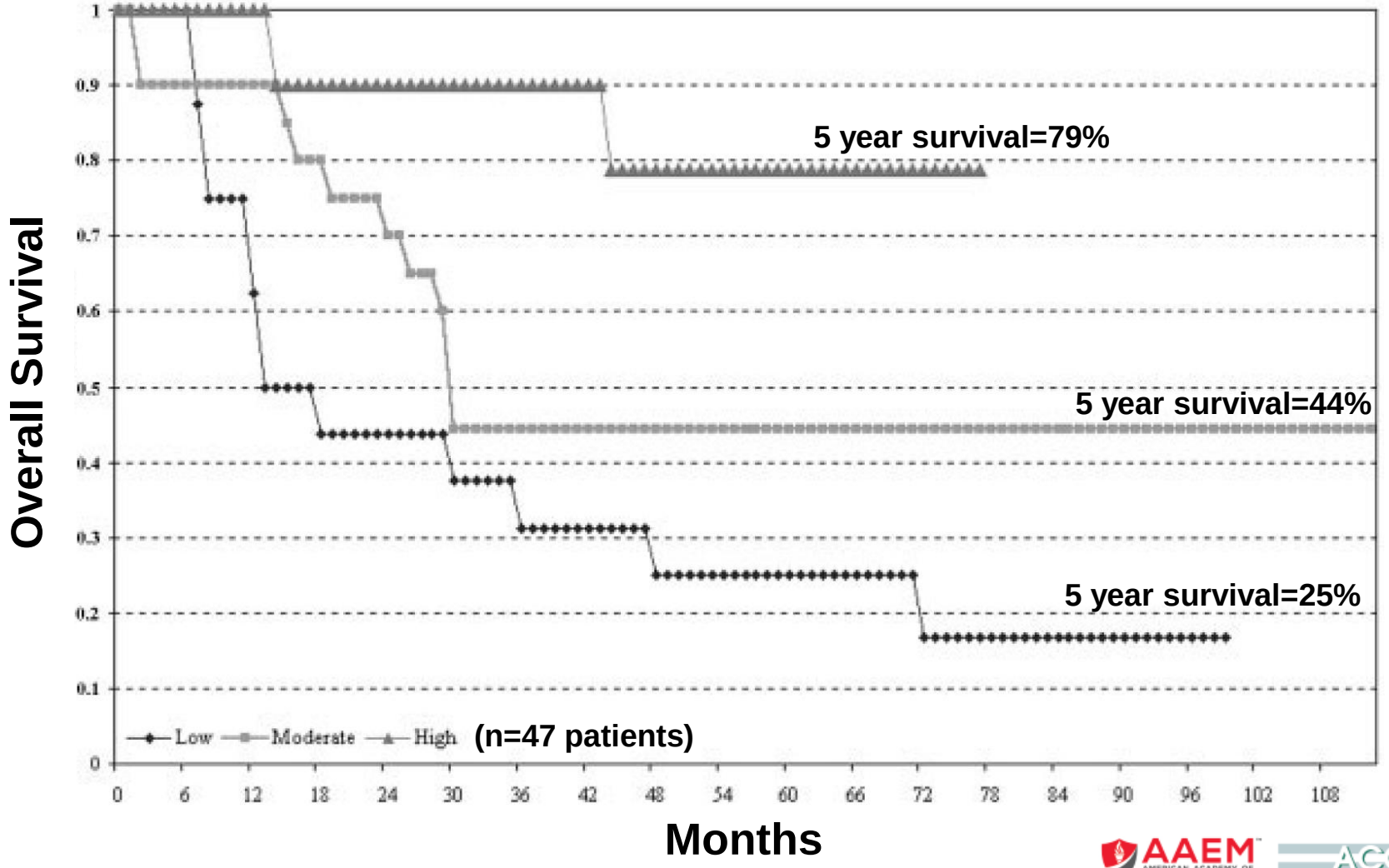
The cancer immunity cycle



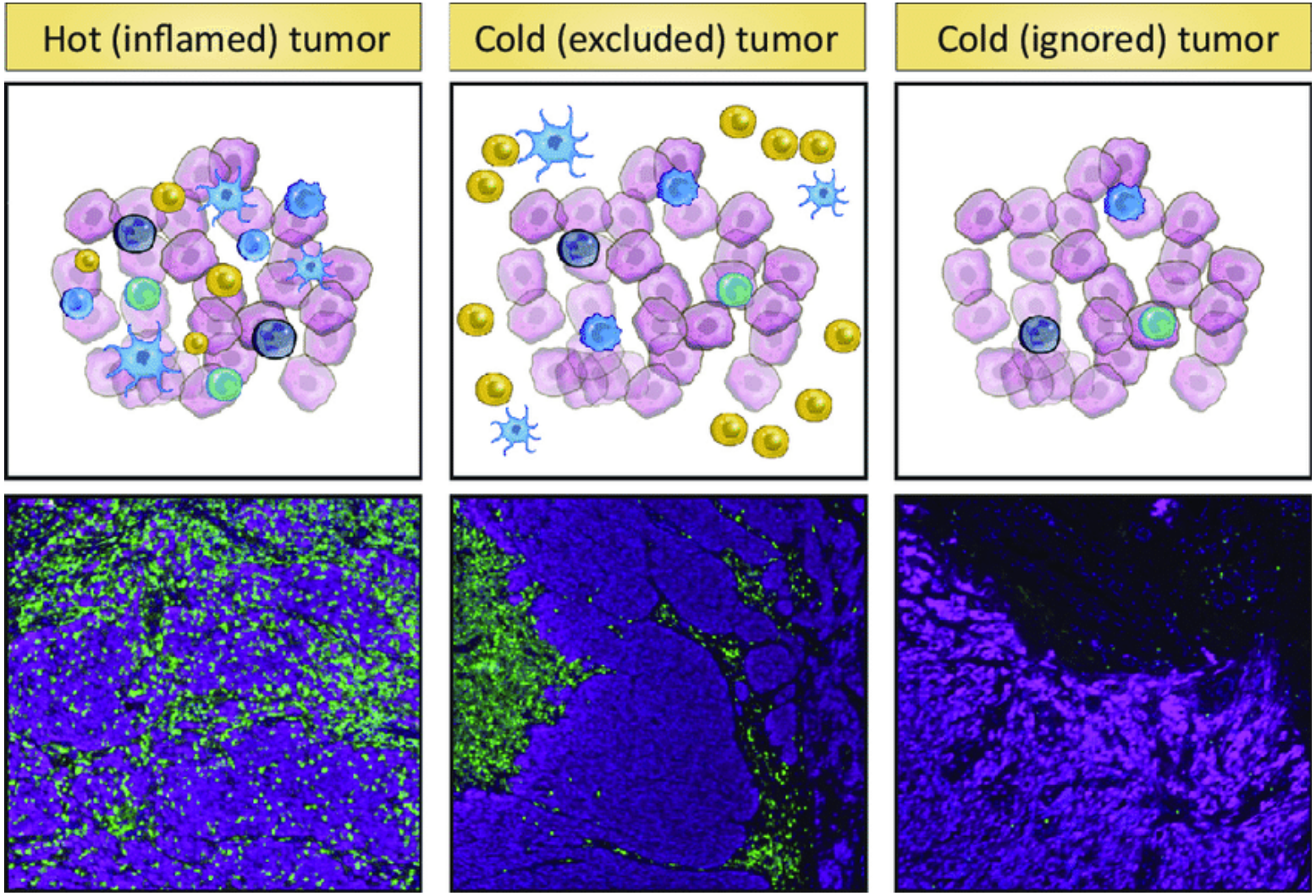
Chen and Mellman , 2013; Immunity

Increased CD8$^+$ cytolytic T cells is associated with increased cutaneous melanoma patient survival

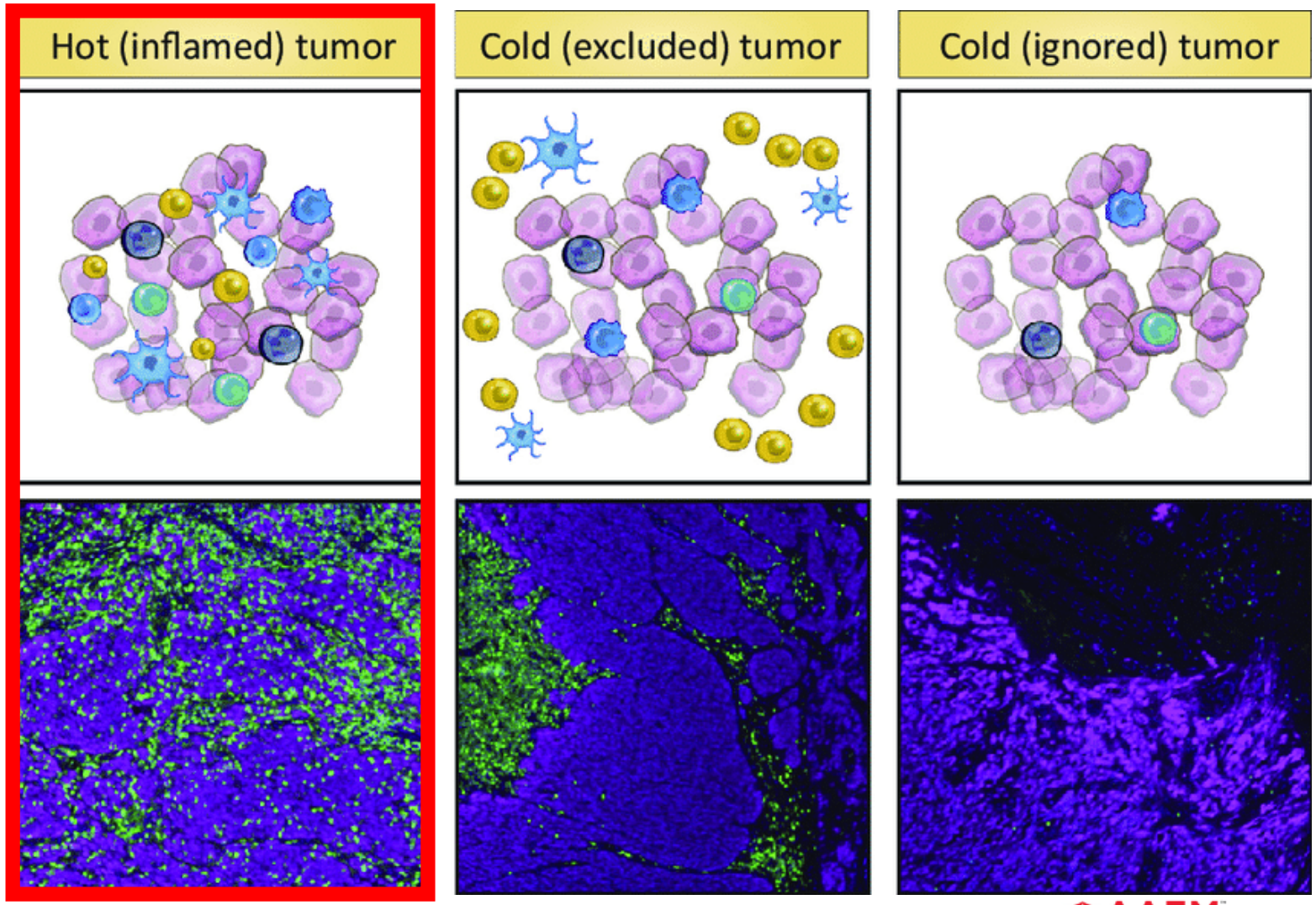


Piras *et al*. 2005; Cancer. 104(6):1246-54.

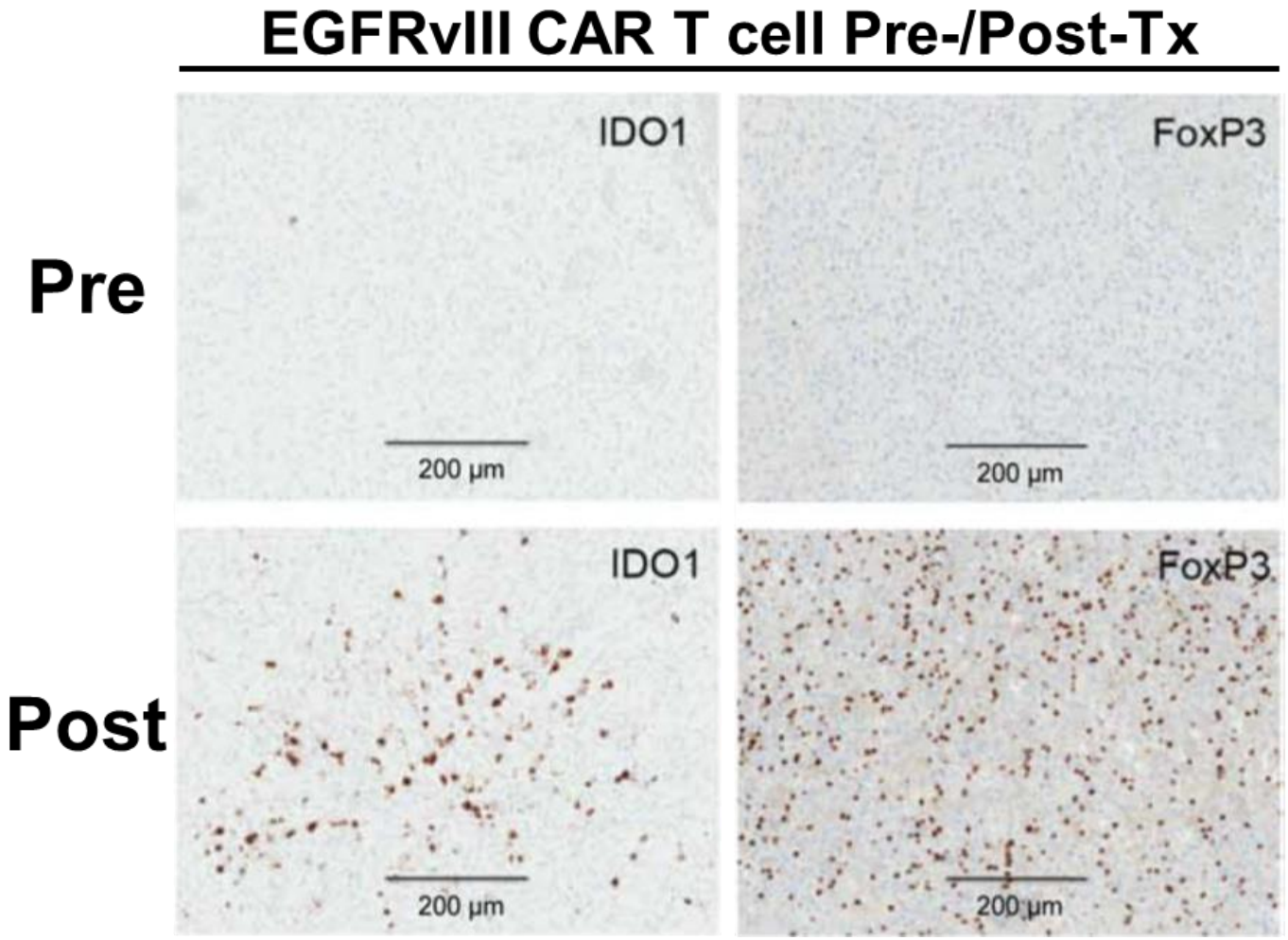
Immune suppression versus exclusion



Immune evasion versus exclusion

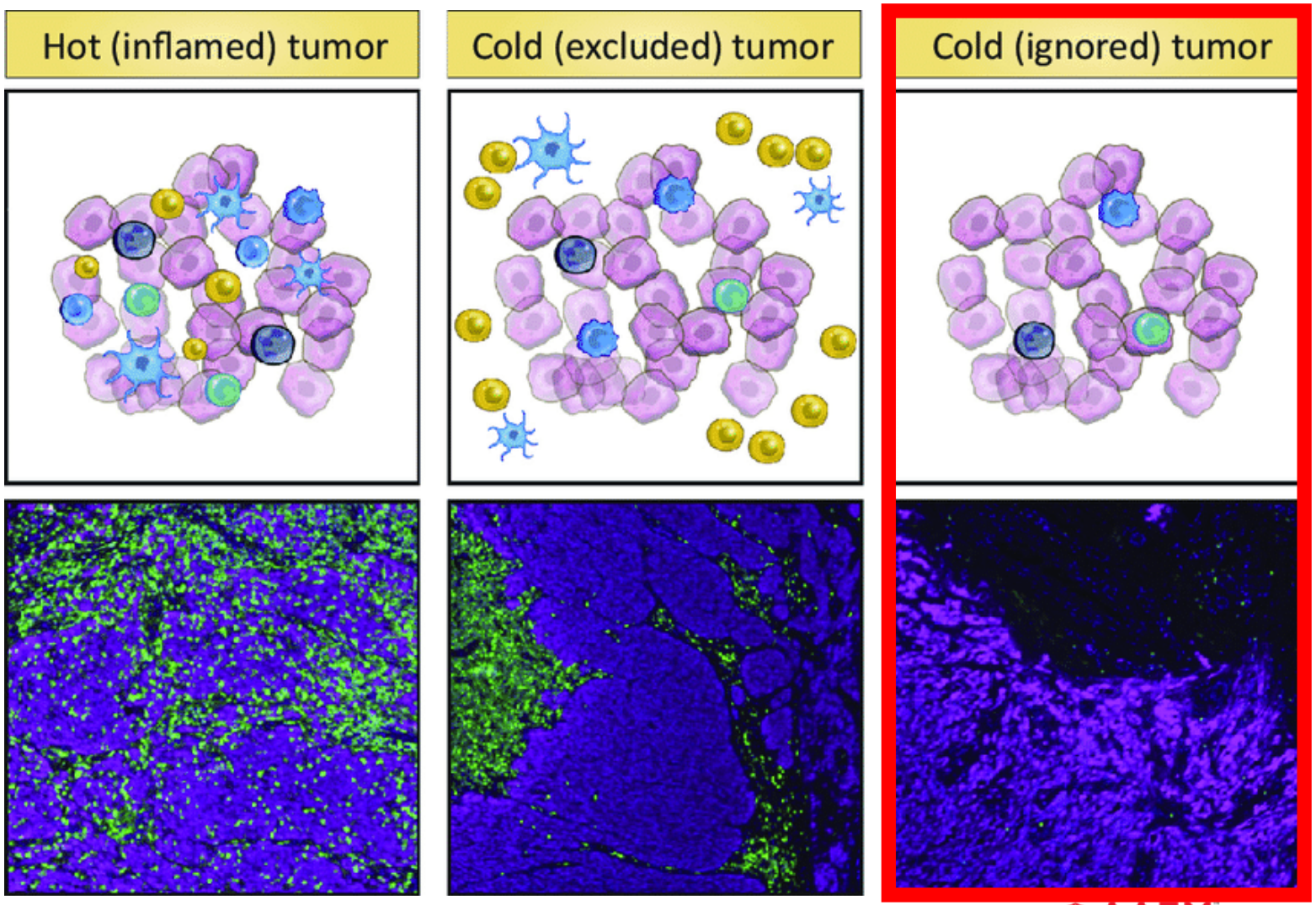


T cell inflamed tumor microenvironment is immune suppressive



O'Rourke *et al*., 2017; Sci. Trans. Medi. 9(399). pii: eaaa0984.

Immune evasion versus exclusion



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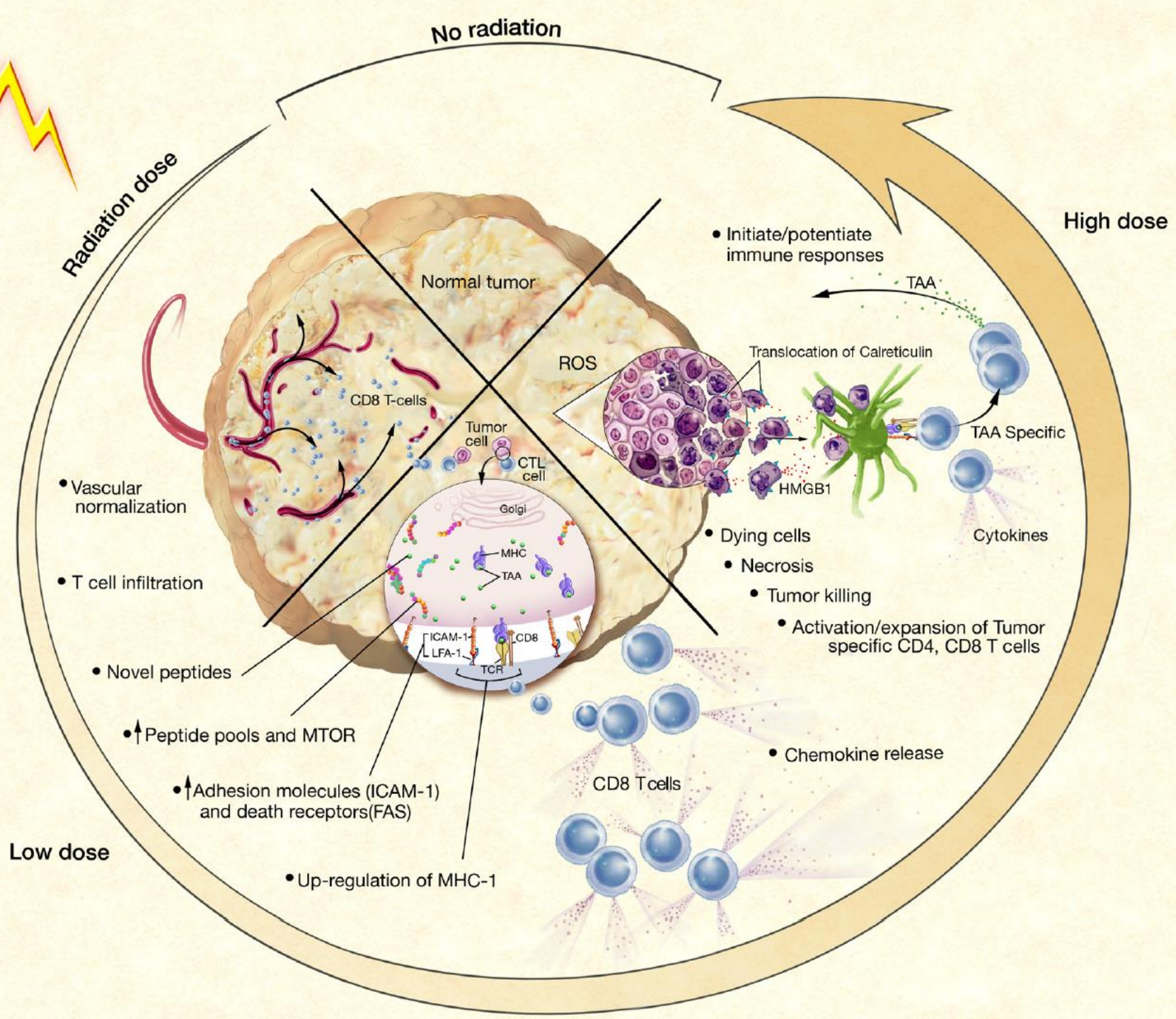
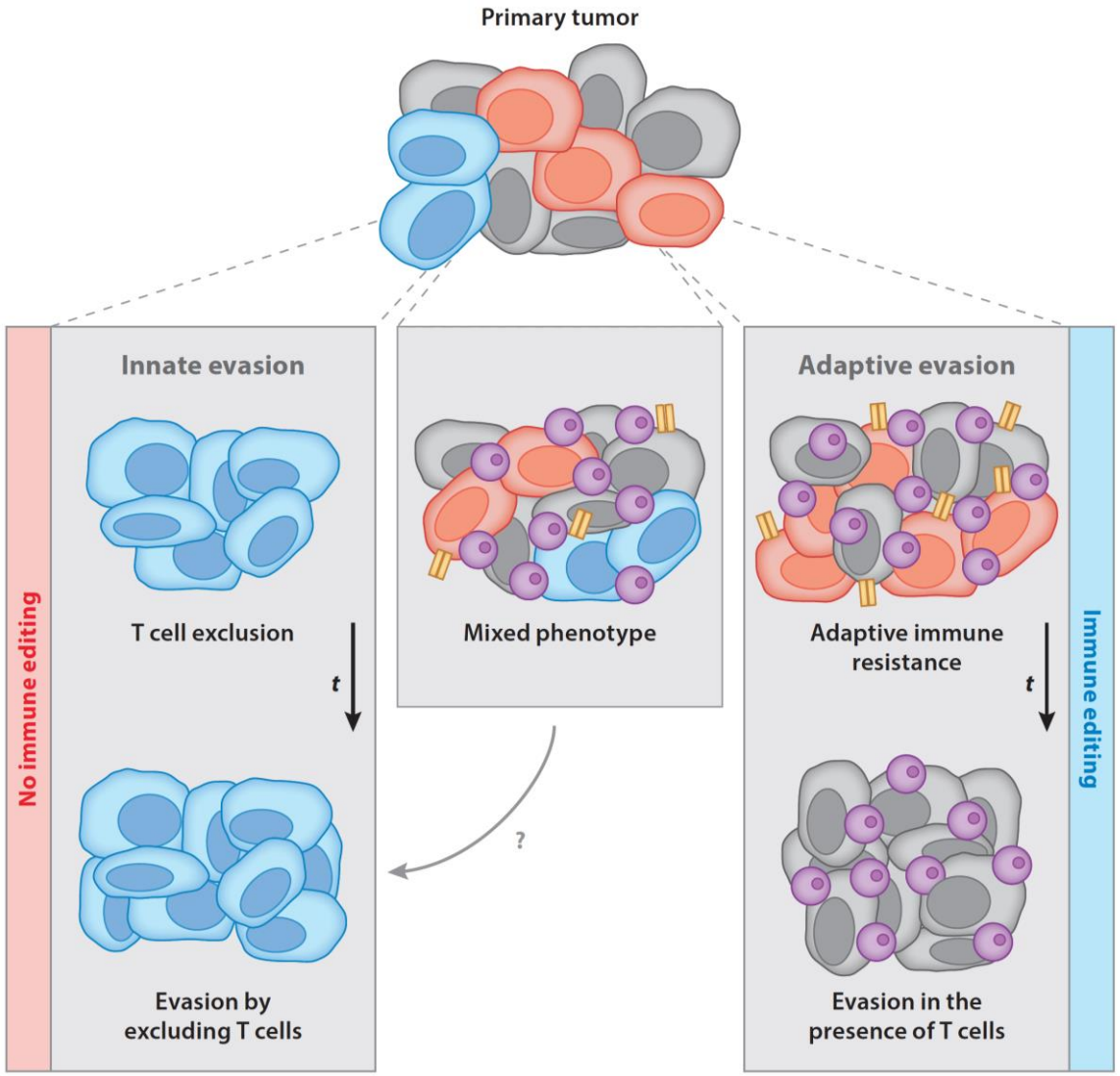
Radiation can "warm up" cold tumors

Kwilas *et al*., 2012; Frontiers in Oncology



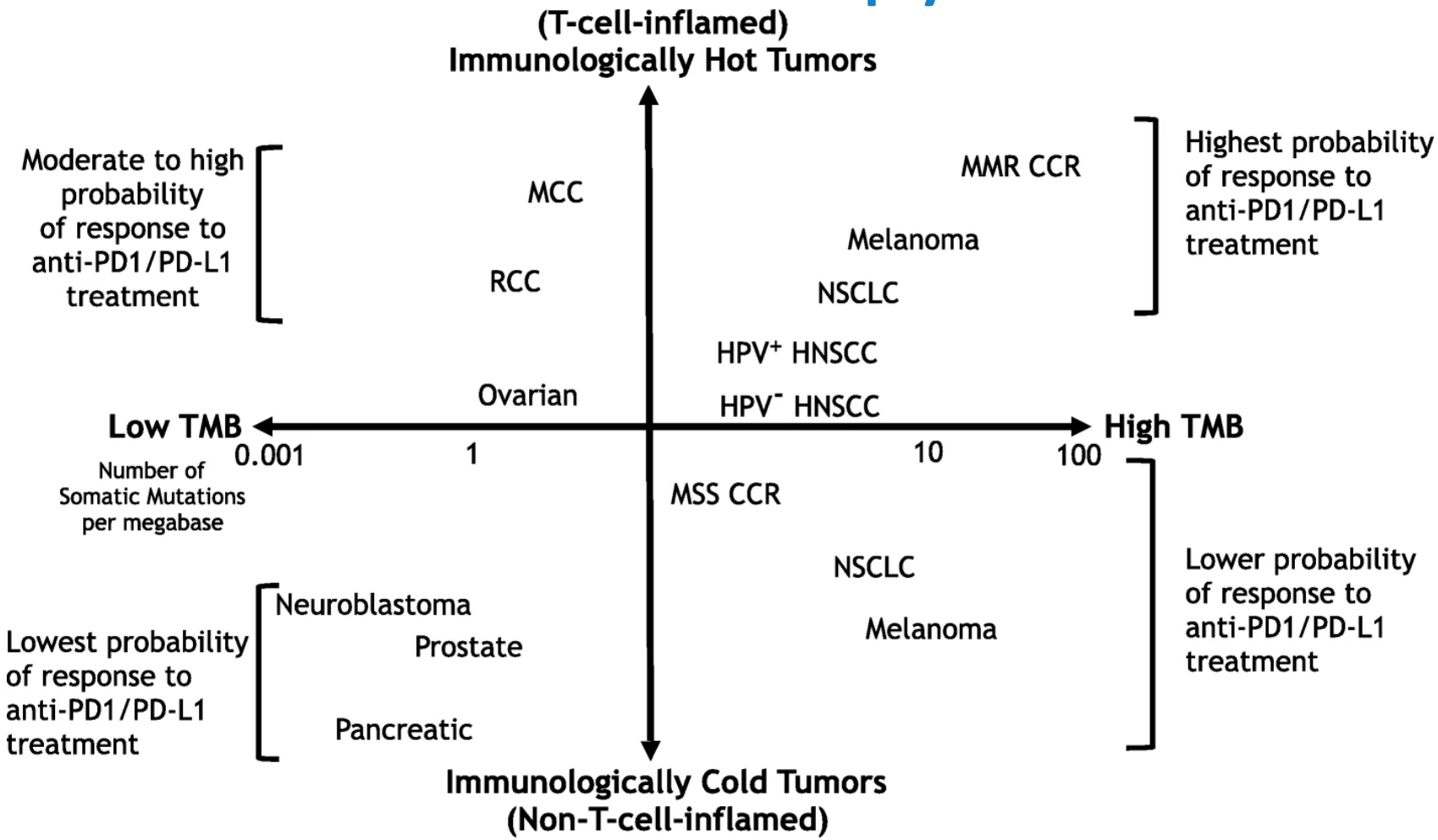
Immune evasion mechanisms



Immunogenic tumor cell
Nonimmunogenic tumor cell
Immune-excluding tumor cell
T cell
PD-L1

Spranger, AR Cancer 2018

Mutational burden and immunotherapy



Vareki *et al*., 2018; J Immunother Cancer. 2018 Dec 27;6(1):157.

Types of Immunotherapy

- Checkpoint blockade immunotherapy
- Cancer vaccines
- Adoptive cell transfer
- Effector antibodies
- Innate immune activation

The CTLA-4 Checkpoint

Cytotoxic **T**-**L**ymphocyte **A**ssociated Protein **4**

Up-regulated in response to T cell activation

Limits positive stimulation by competition

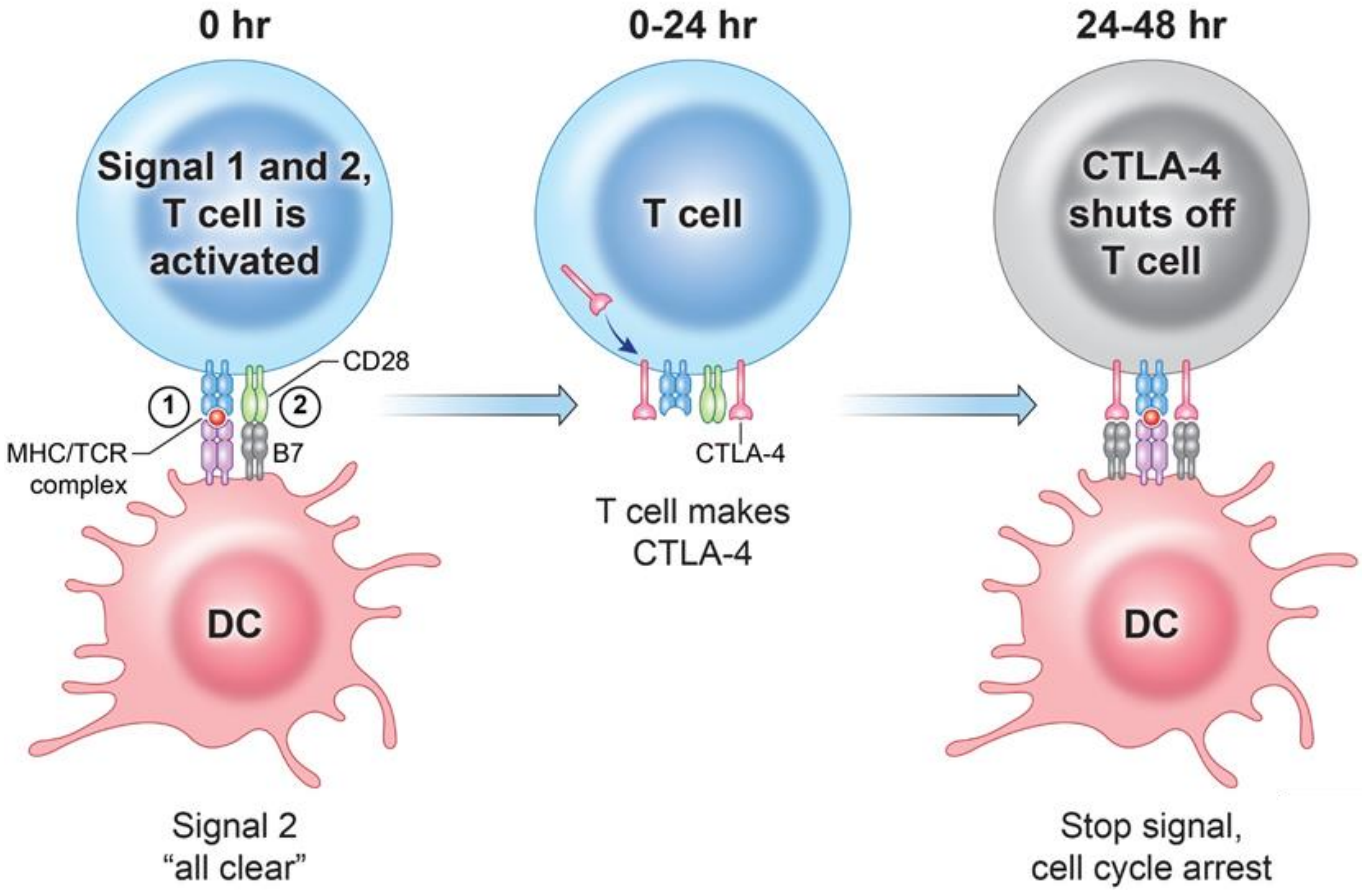


Image courtesy of NCI

The PD-1/PD-L1 Checkpoint

Programmed **D**eath **1**

Up-regulated in response to T cell activation

Ligands PD-L1 and PD-L2 are up-regulated following inflammation (IFNγ)

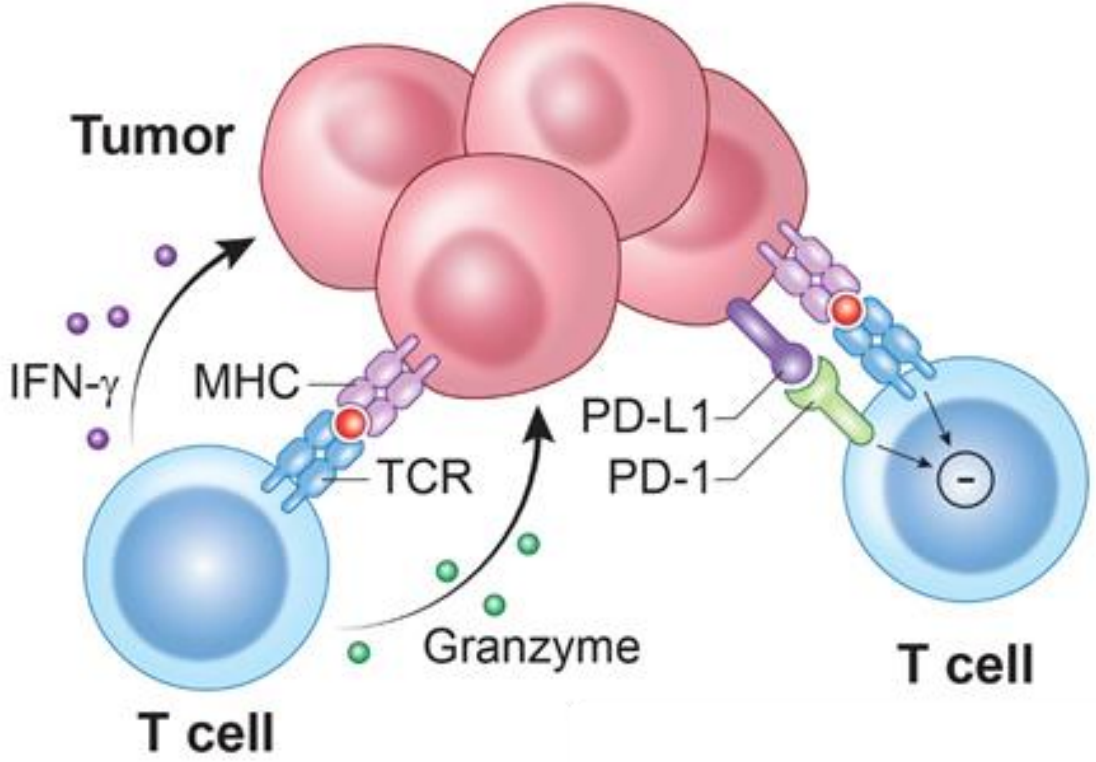
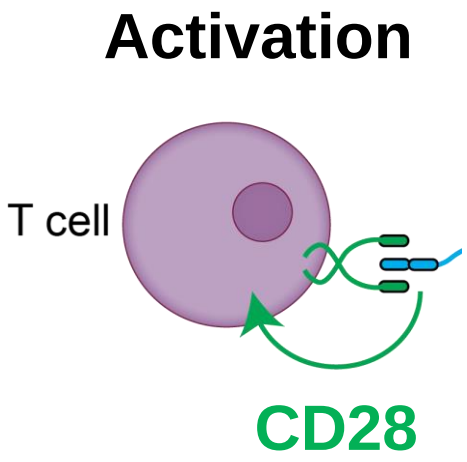


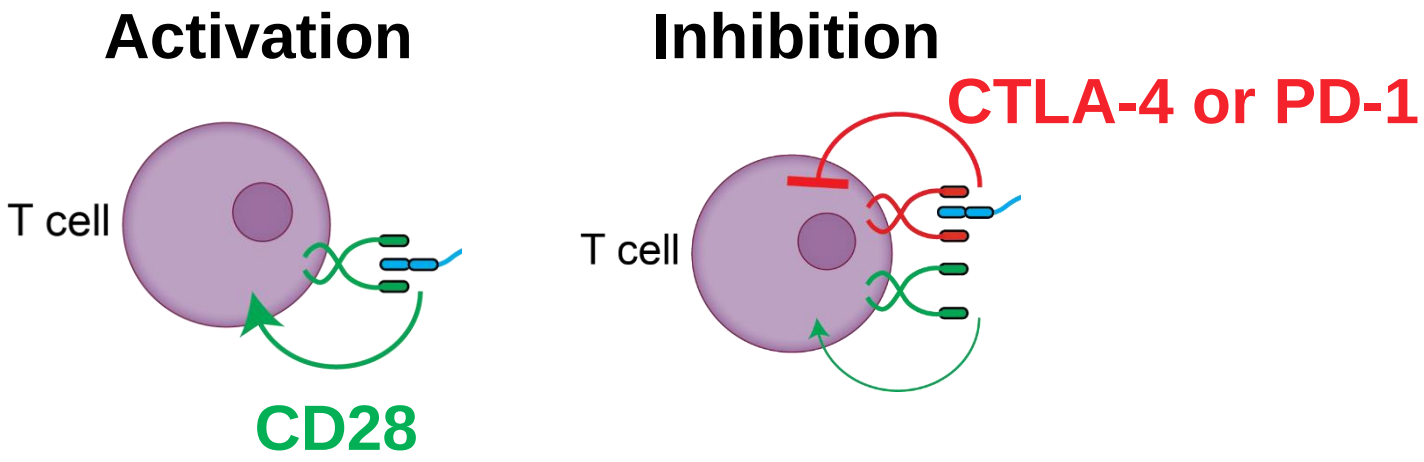
Image courtesy of NCI

Checkpoint blockade therapy unleashes the “brakes” on T cells



Goal: to reduce immune inhibitory signals and/or enhance stimulatory signals to allow T cells to regain effector functions.

Checkpoint blockade therapy unleashes the “brakes” on T cells



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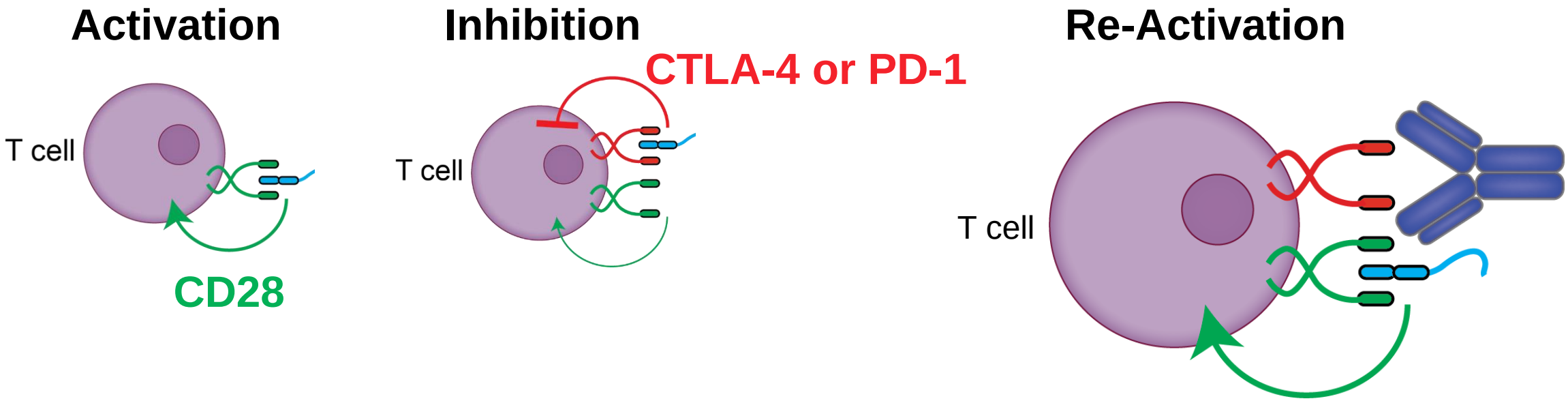


Goal: to reduce immune inhibitory signals and/or enhance stimulatory signals to allow T cells to regain effector functions.

T Cell Checkpoint Modulation

- First generation of checkpoint modulation: blocking inhibitory checkpoints
- Second generation of checkpoint modulation: activating stimulatory checkpoints

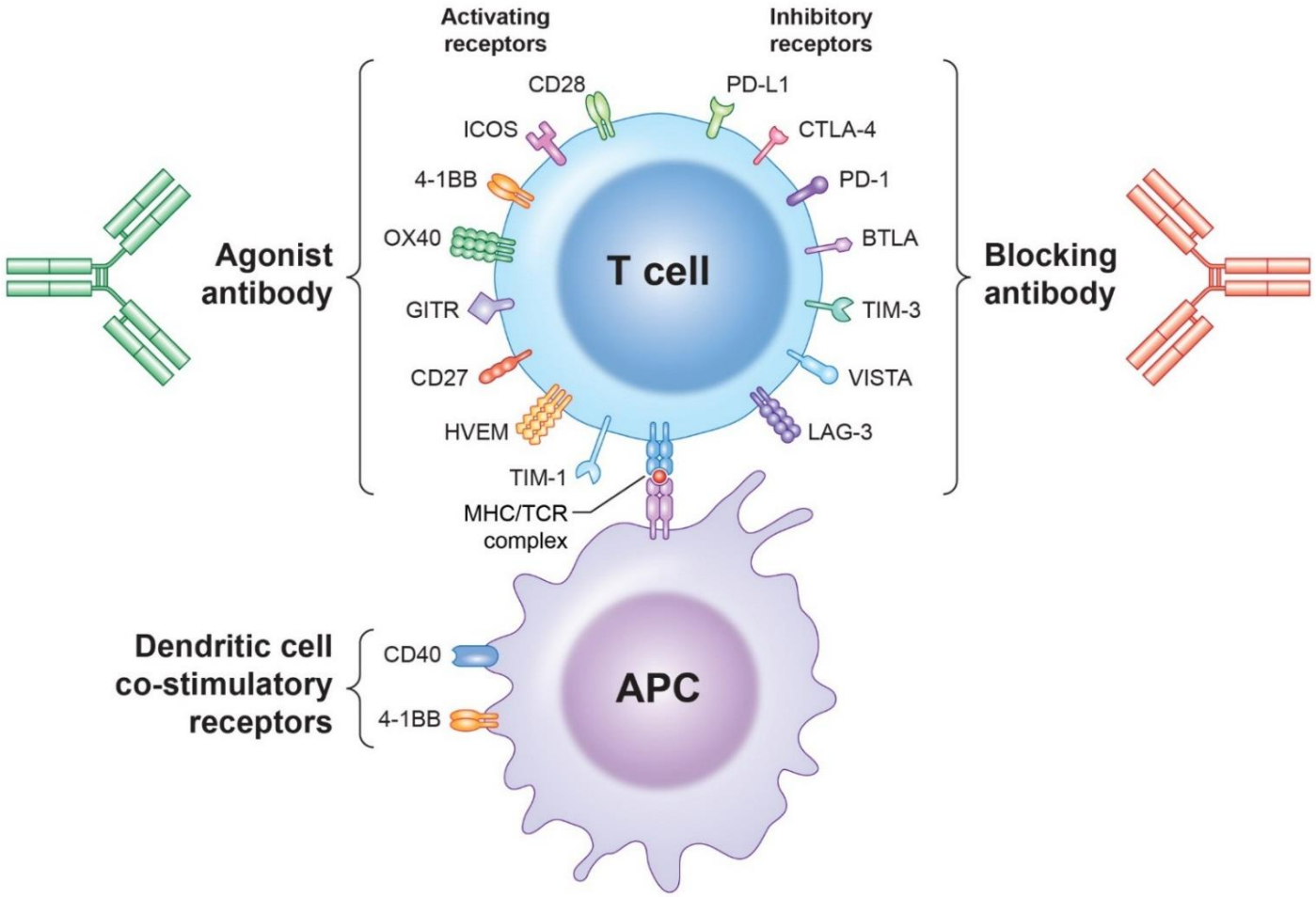


Image courtesy of NCI

Therapeutic Cancer Vaccines

Goal: to increase the immunogenicity of tumor antigens for generating a high frequency of tumor-specific T cells.

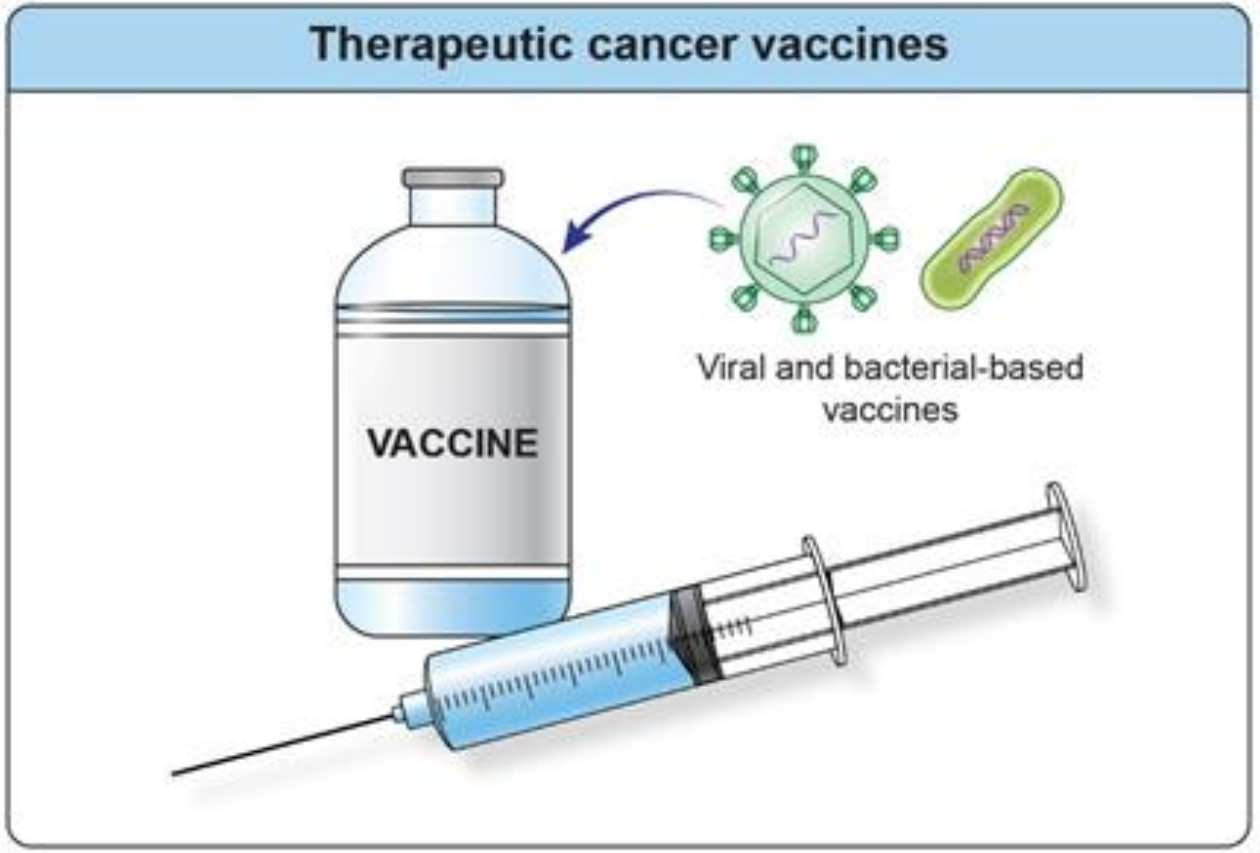


Image courtesy of NCI

Adoptive Cell Therapy

Goal: overwhelm the tumor with a higher frequency of tumor-specific immune cells and/or engineer immune cells to target cancer.

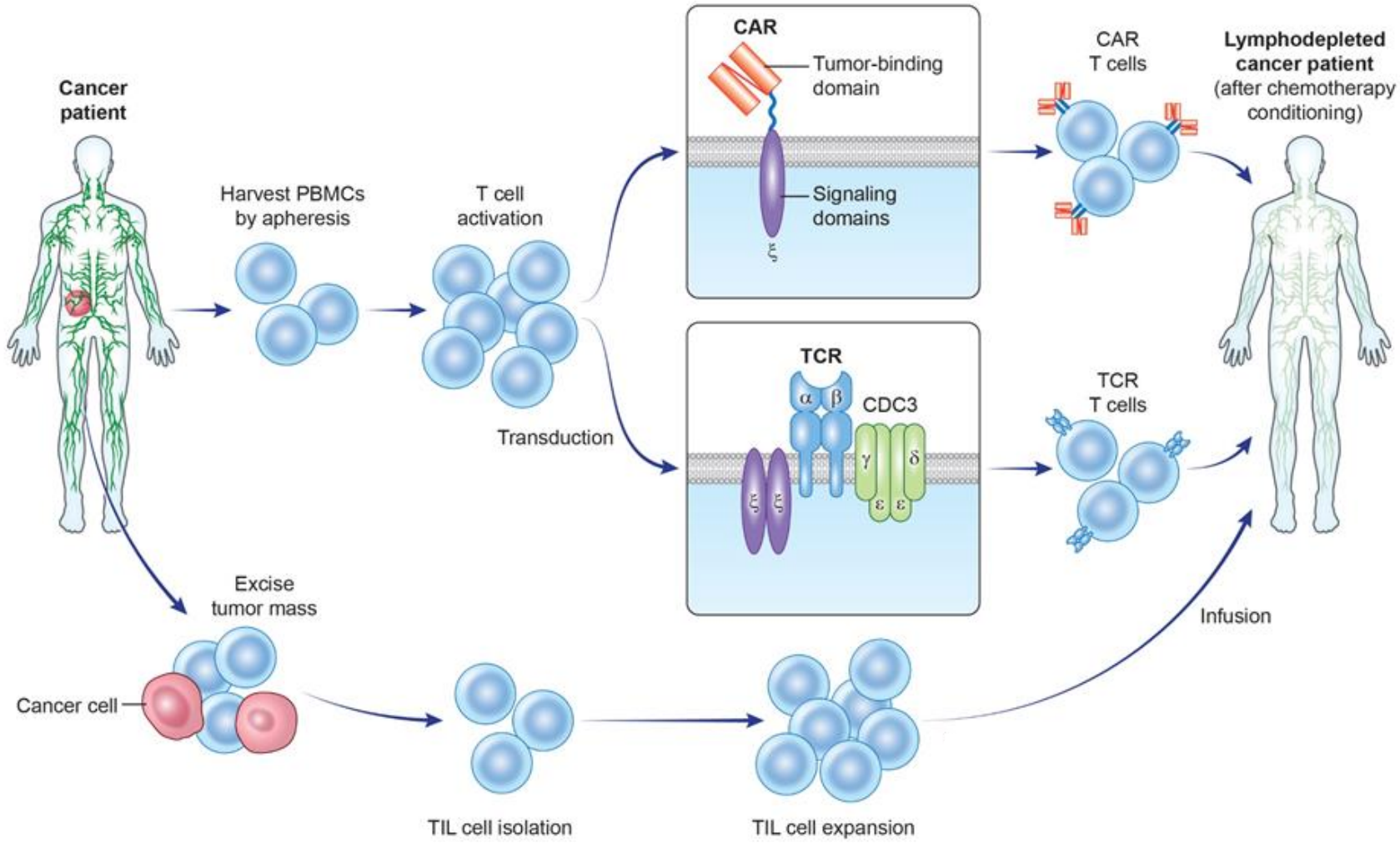


Image courtesy of NCI

Effector Antibodies and Antibody-Drug Conjugates (ADCs)

Goal: specifically target and kill tumor cells using innate mechanisms which are difficult to evade or suppress and/or through delivery of cytotoxic agents

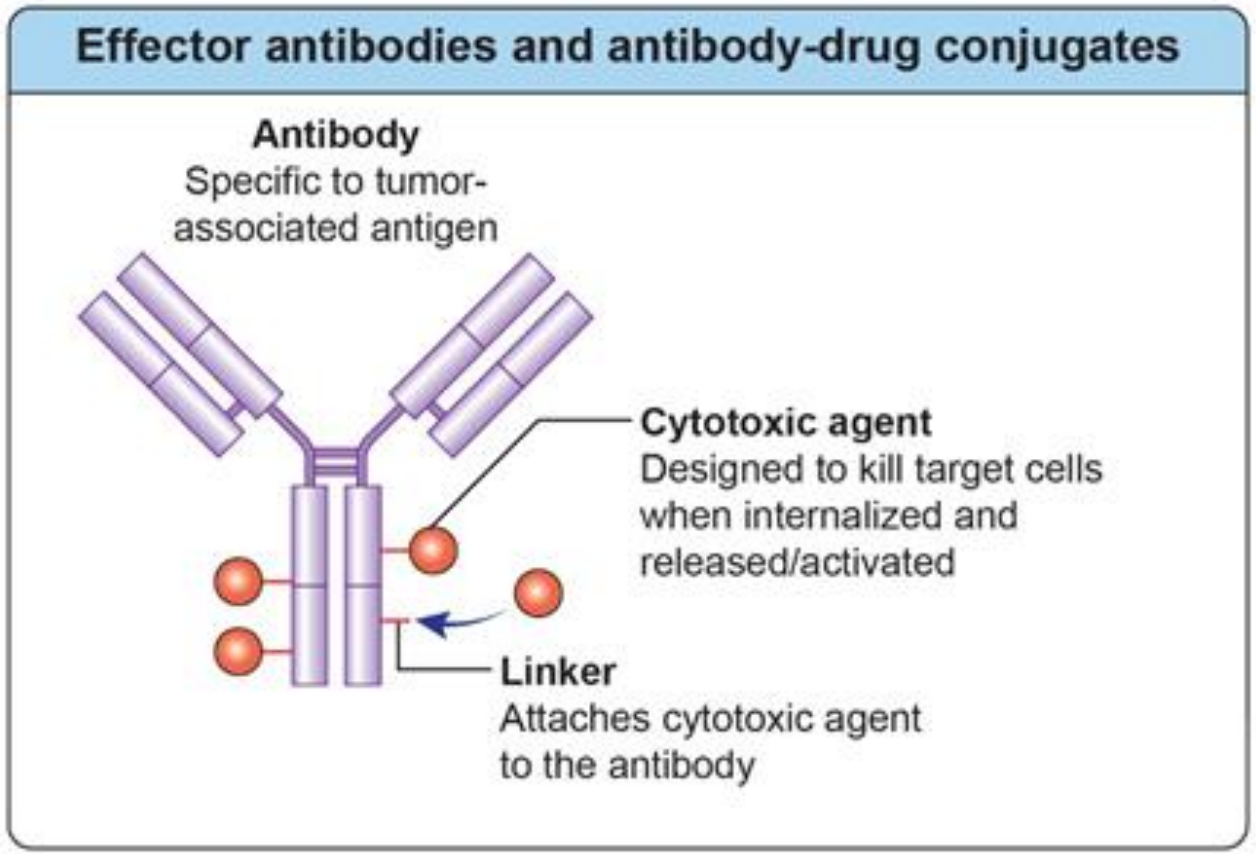
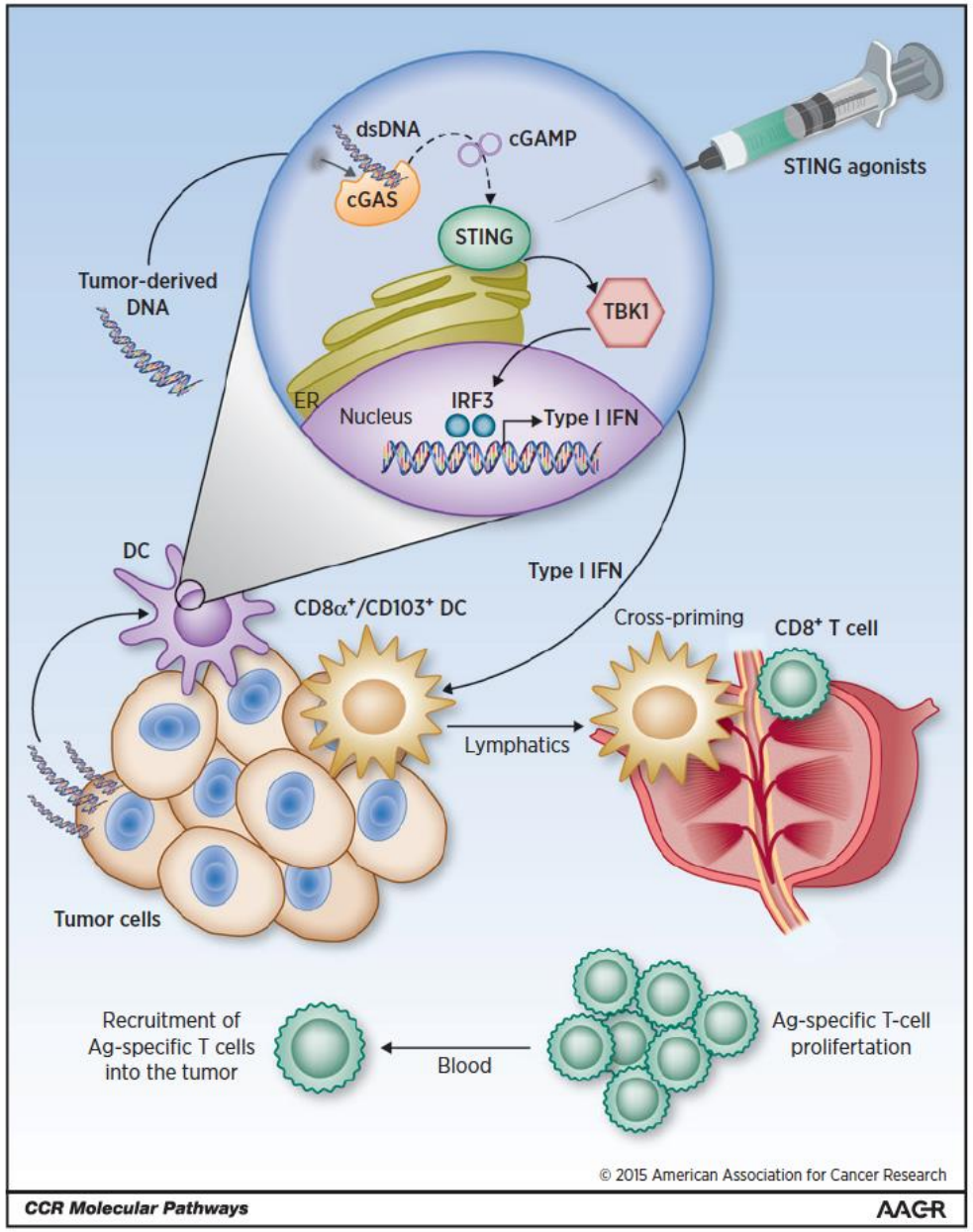


Image courtesy of NCI

Innate immune activation

Goal: enhance innate immune sensing by providing stimulatory agents (frequently into the tumor itself)



Agents:

Sting agonists

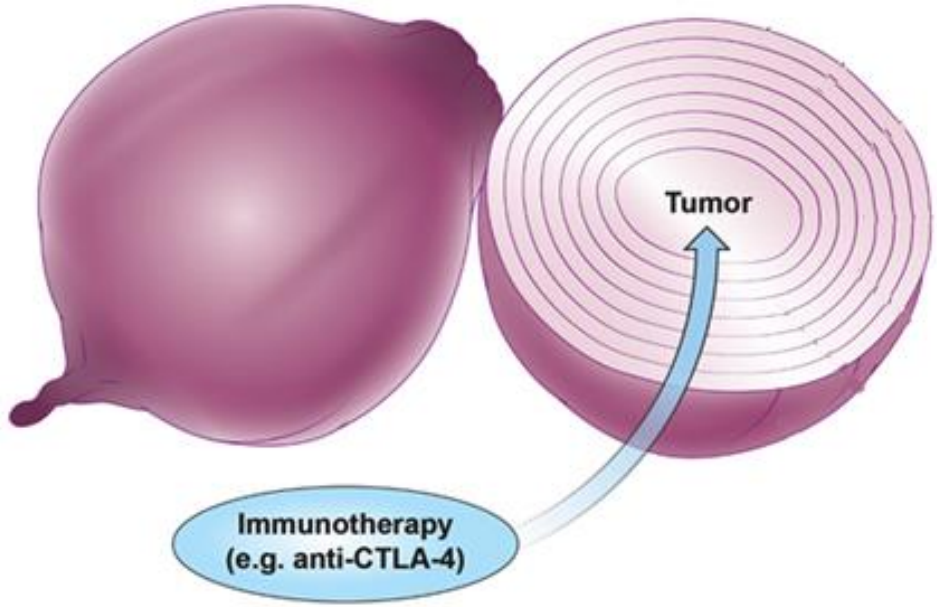
TLR agonists

Immunogenic RNA

Corrales, Clin Can Res 2015

Multi-layered Immunosuppression

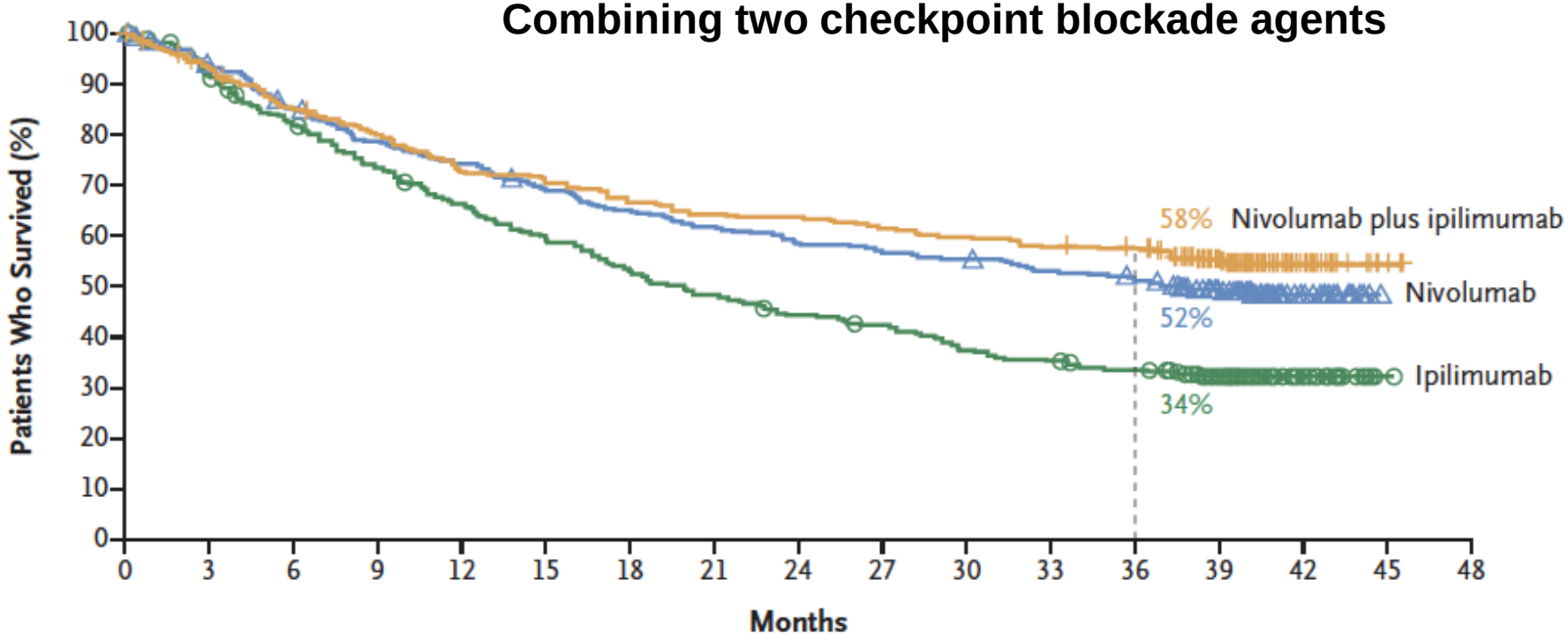
- Tumors insulate themselves with dense layers of immune-suppression
- Overcoming the many layers of interconnected and often functionally redundant immune suppressive mechanisms represents a daunting challenge for tumor-specific T cells
- Immunotherapy can “peel back” the layers of local immune suppression
- Combination therapy might be needed to overcome all layers



Combination Immunotherapy

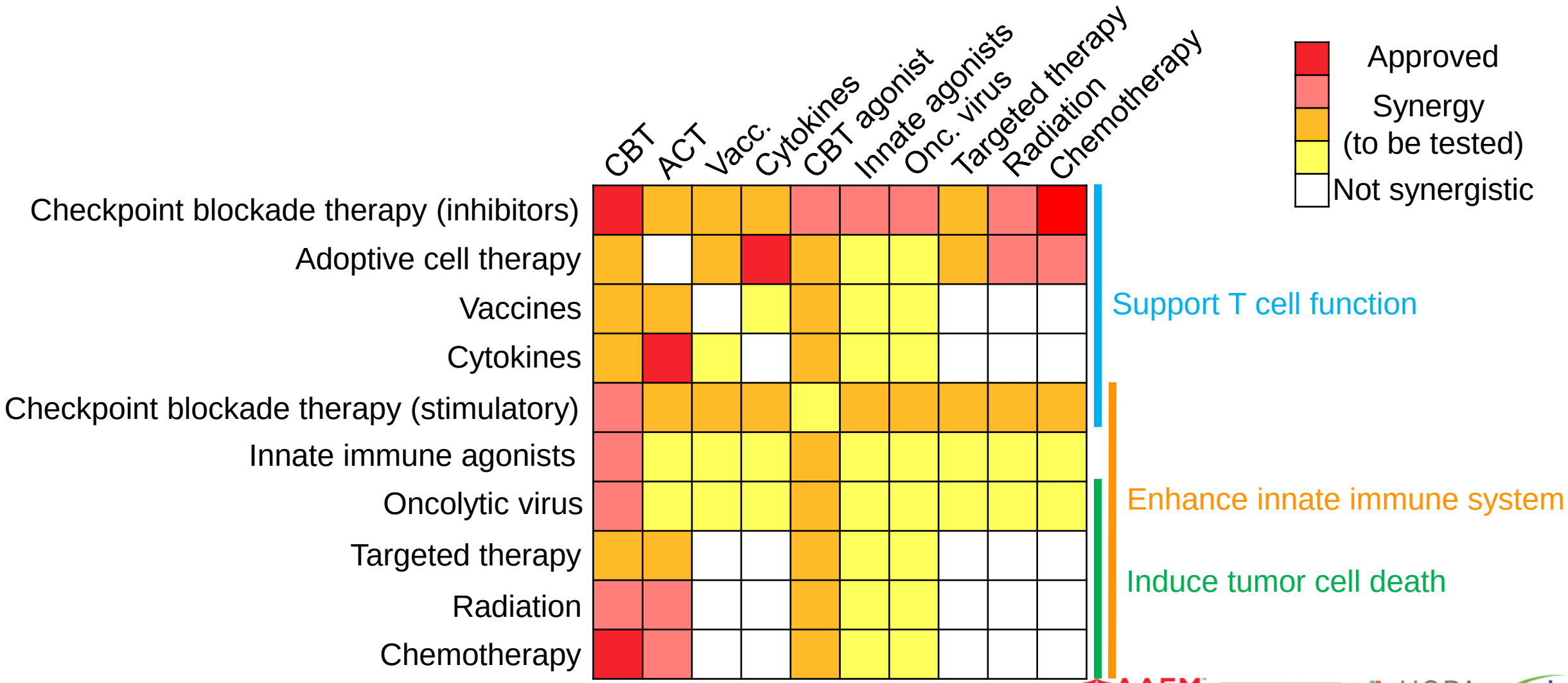
Dual CTLA-4 and PD-1 inhibition

Combining two checkpoint blockade agents

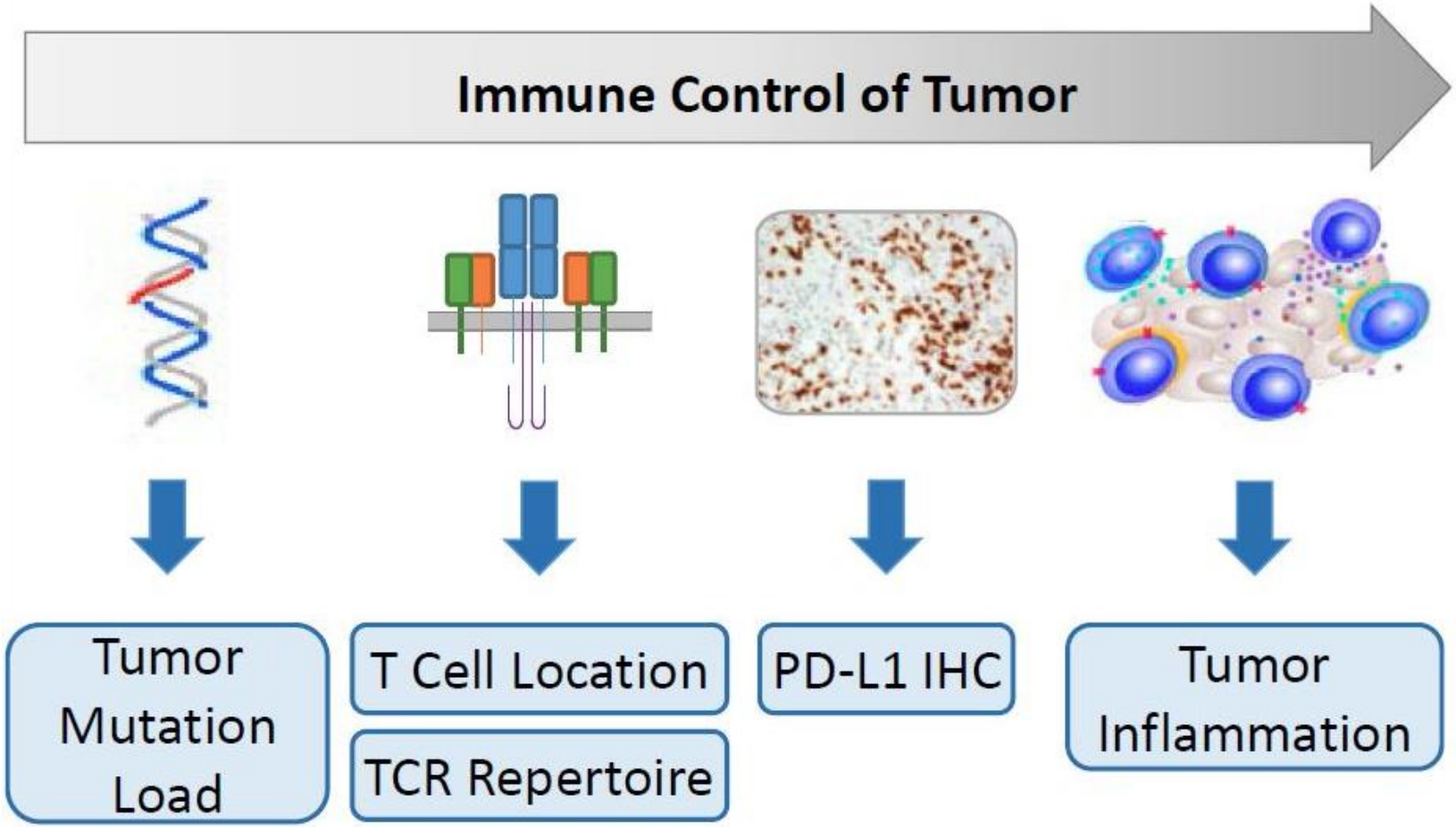


Wolchok et al., NEJM 2017

Combination Immunotherapies

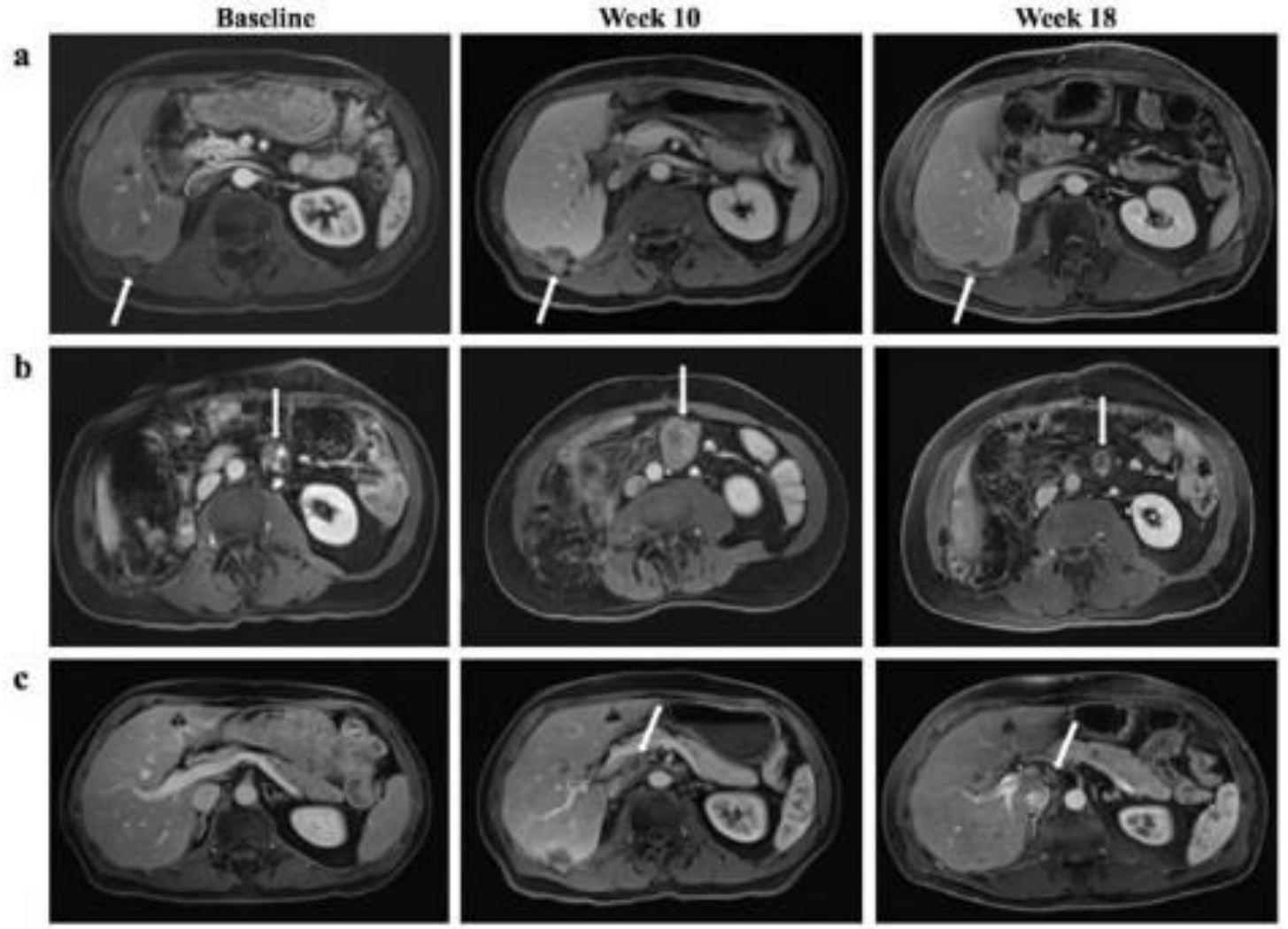


Immunotherapy Biomarkers



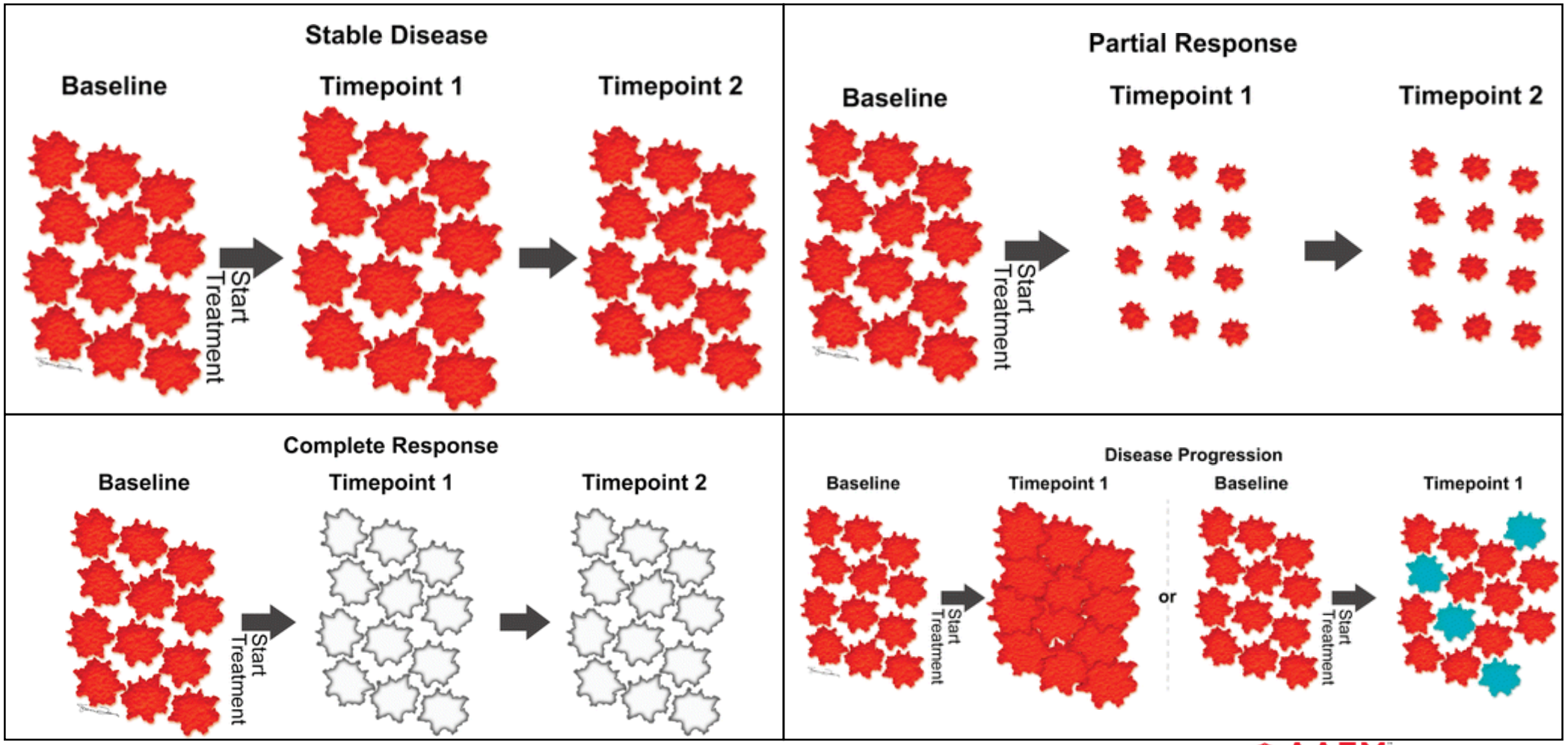
Cesano et al. Biomedicines 2018

Assessment of response



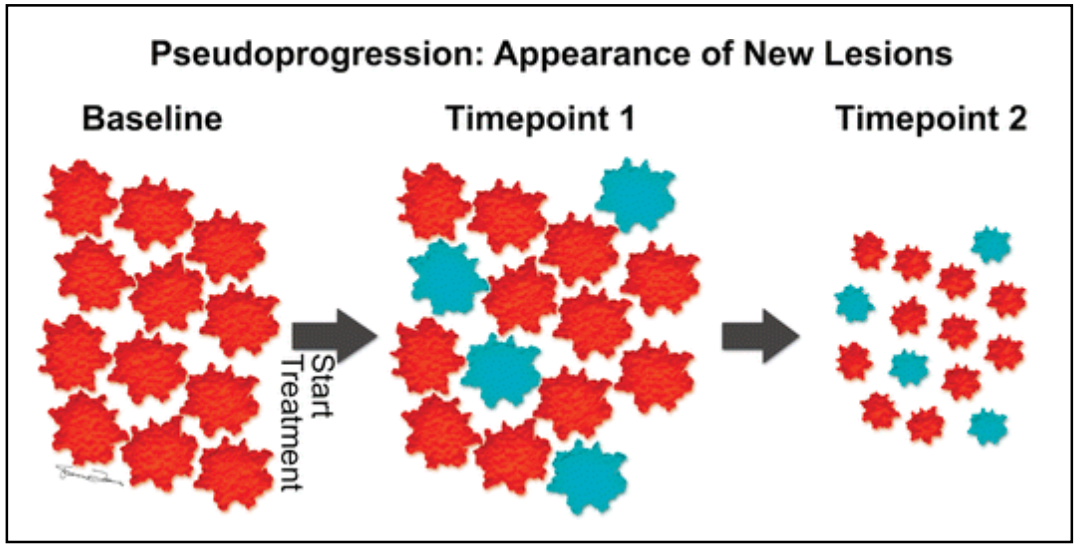
Chae, Oncotarget 2017.

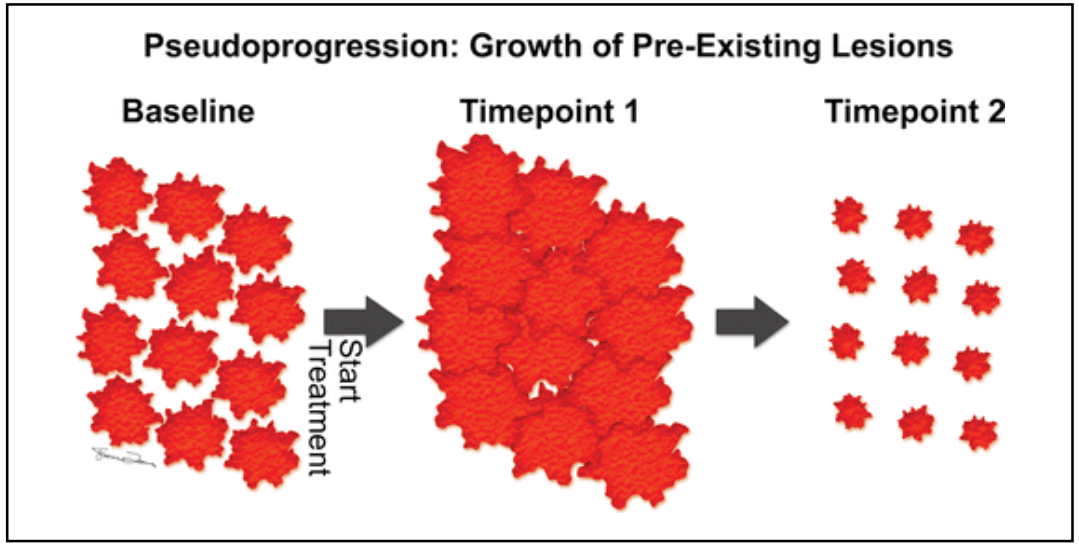
Many possible imaging findings



Wang, RadioGraphics 2017.

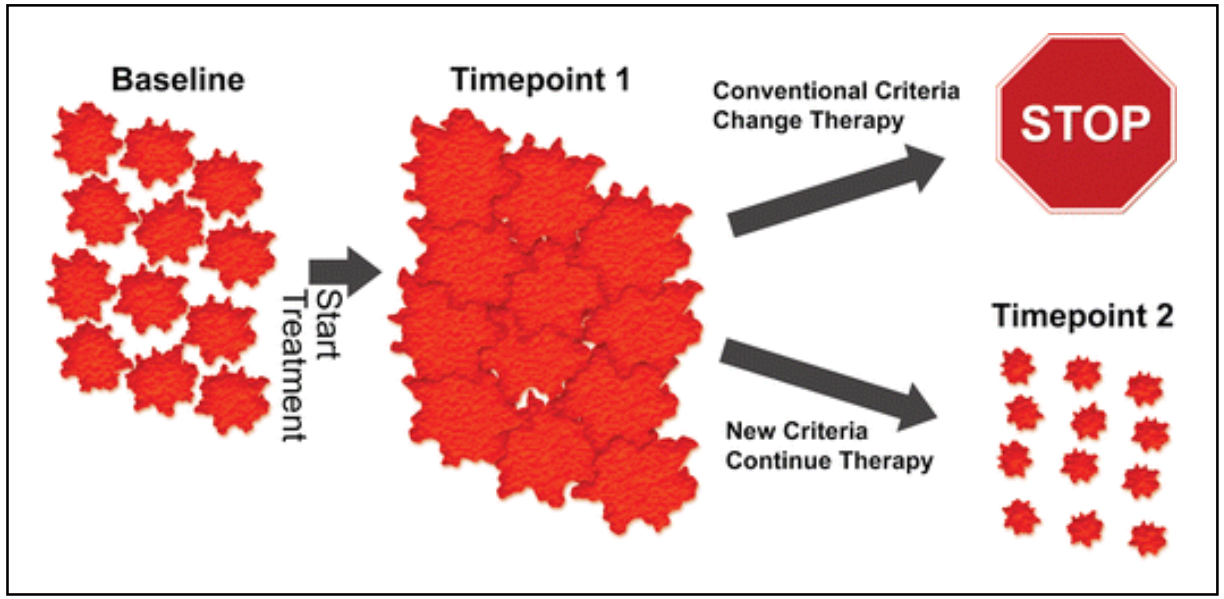
Many possible imaging findings

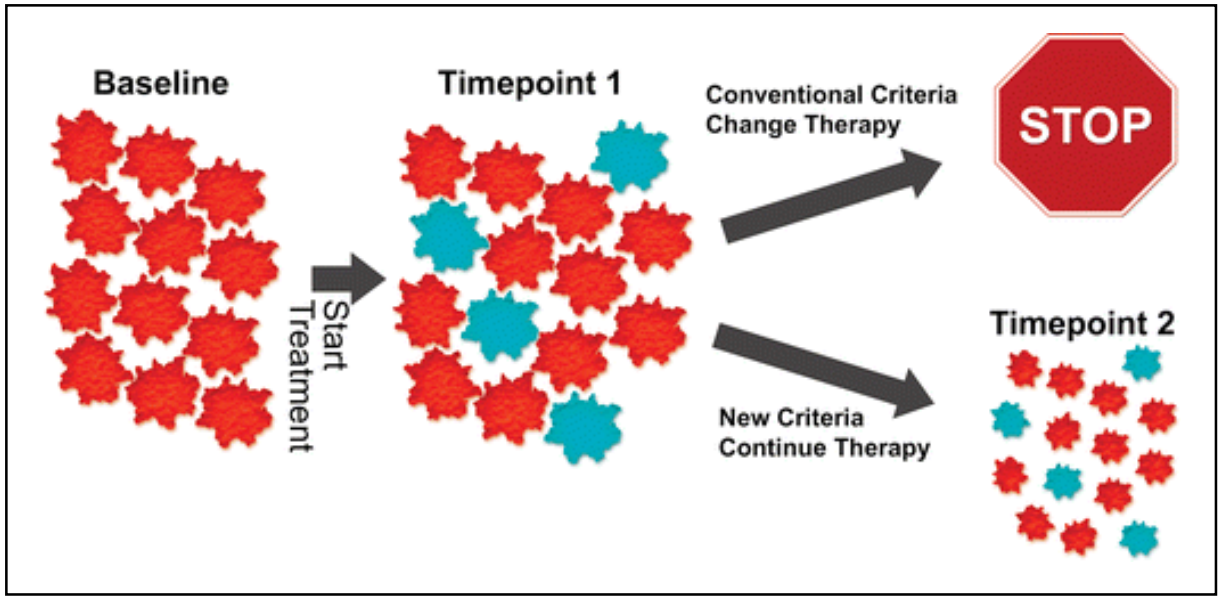




Wang, RadioGraphics 2017.

Assessment of response – unique considerations for immunotherapy





Wang, RadioGraphics 2017.

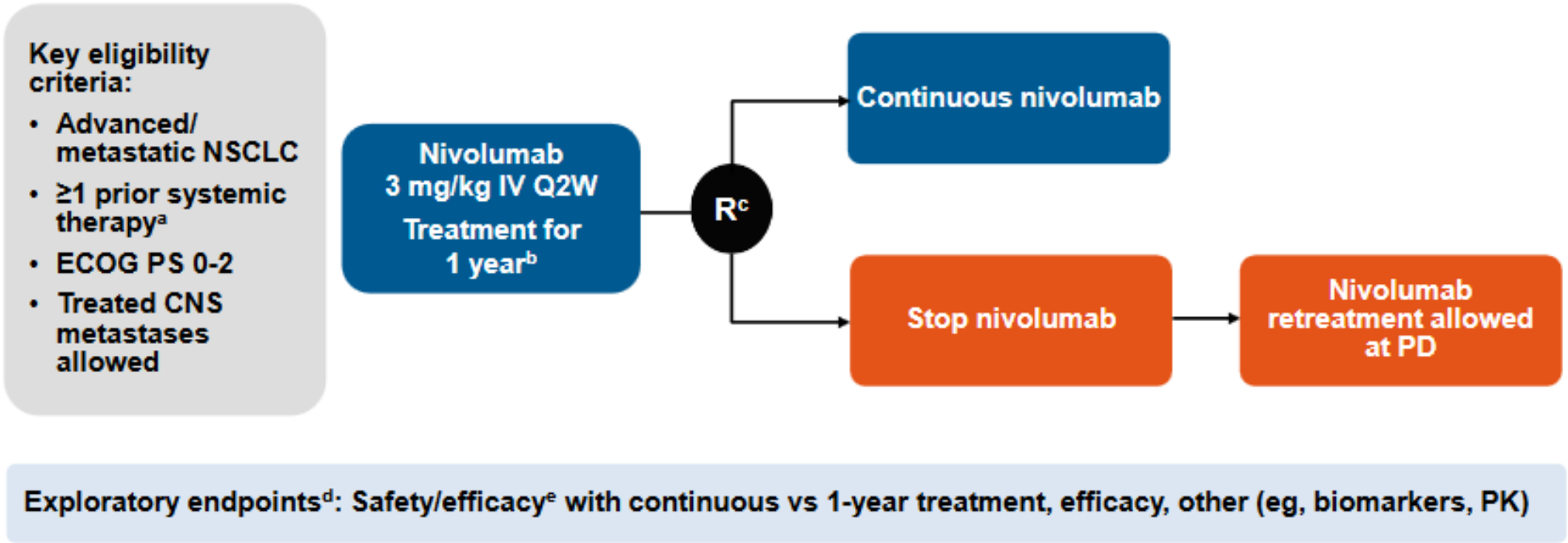
Comparison of disease progression by conventional and immune-related criteria

Treatment Response	RECIST 1.1	irRC
Progressive disease	≥20% increase in lesion sum* (absolute size increase ≥5 mm) or 1+ new lesions at any single observation	≥25% increase in tumor burden[+] versus nadir in two consecutive observations ≥4 weeks apart
New measurable lesions[#]	Always represent progressive disease	Incorporated into disease burden
New non-measurable lesions	Considered equivocal; followed at future examinations to clarify whether it is truly new disease	Does not define progression but precludes complete response

*Sum of lesion diameters: sum of the longest diameter in the plane of measurement for non-nodal target lesions and short-axis diameter for target nodal lesions.
[+]Based on the sum of the products of the two largest perpendicular diameters of all index lesions.
[#]Measurable lesion for RECIST1.1 is ≥10mm at CT; irRC is ≥10x10mm at CT. Smaller lesions are considered non-measurable.

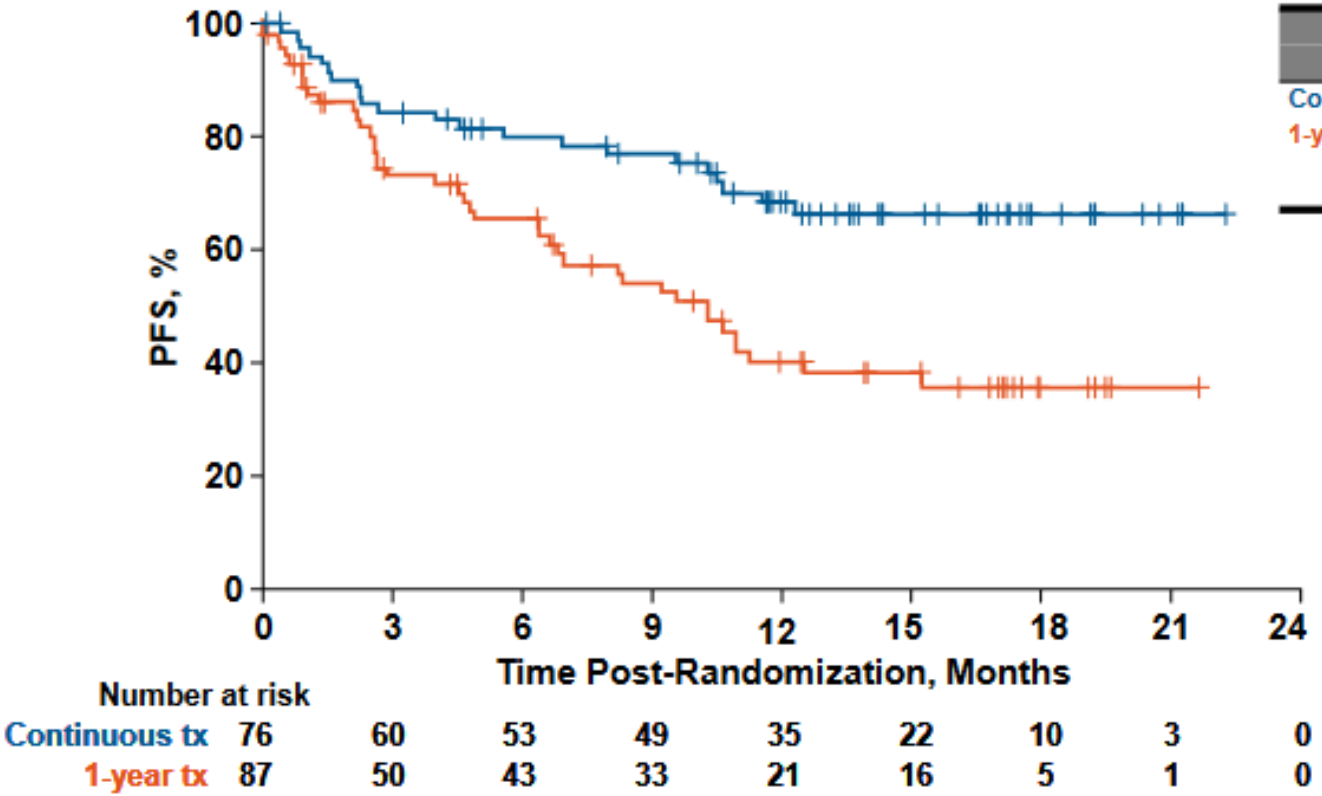
Wang, RadioGraphics 2017.

When to stop immunotherapy: Checkmate 153



Spigel, Ann Oncol 2017.

When to stop immunotherapy: Checkmate 153



	Median, Months (95% CI)	PFS Rate, % 6-Month	1-Year
Continuous tx	NR (NR)	80	65
1-year tx[b]	10.3 (6.4, 15.2)	69	40

HR: 0.42 (95% CI: 0.25, 0.71)

Conclusion: >1 year of treatment may be necessary

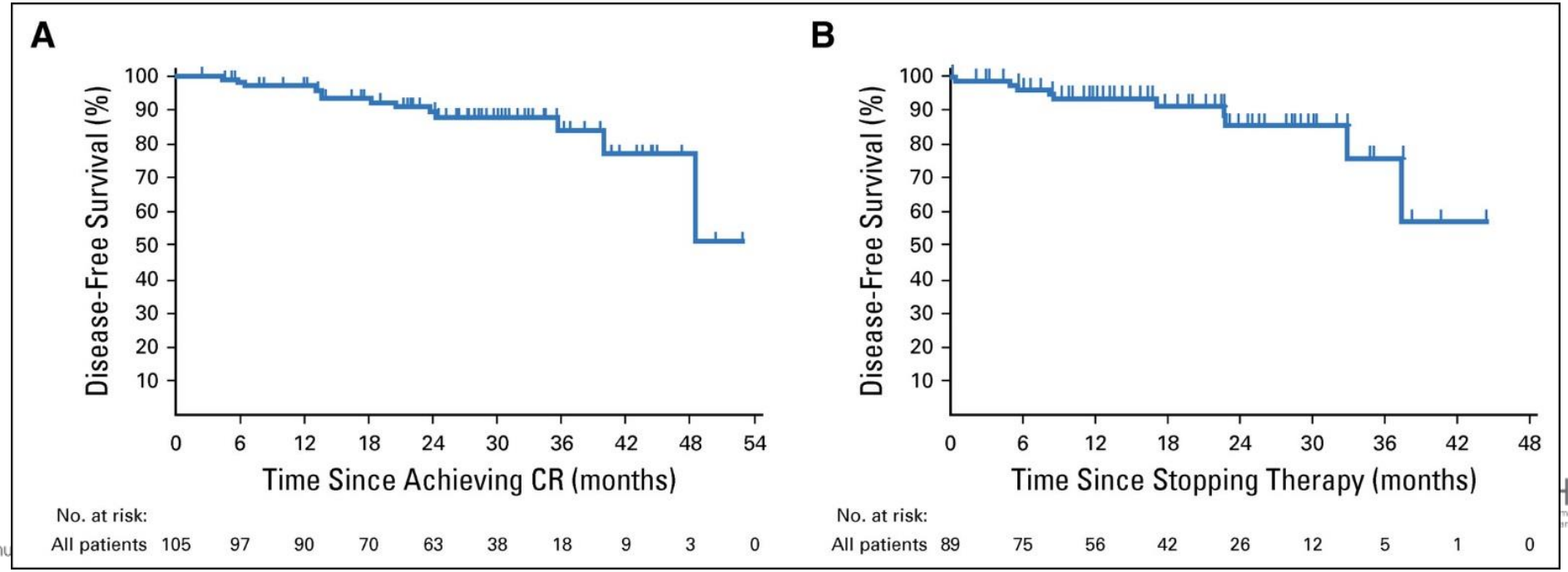
Spigel, Ann Oncol 2017.

When to stop immunotherapy: KEYNOTE-006

- Pembrolizumab (anti-PD-1 mAb) 10 mg/kg Q2W or Q3W or ipilimumab 3 mg/kg Q3W for 4 doses
- Could stay on pembrolizumab for up to 2 years
- Of patients who completed 2 y pembro treatment, **86%** did not progress after 20 months follow-up
- More responders with pembrolizumab, but duration of response was similar for pembrolizumab and ipilimumab

When to stop immunotherapy: KEYNOTE-001

- 16% of patients achieved complete response
- Disease-free survival at 24 months after complete response:
  - In all CR patients: 90.9%
  - In patients who discontinued cancer therapy: 89.9%

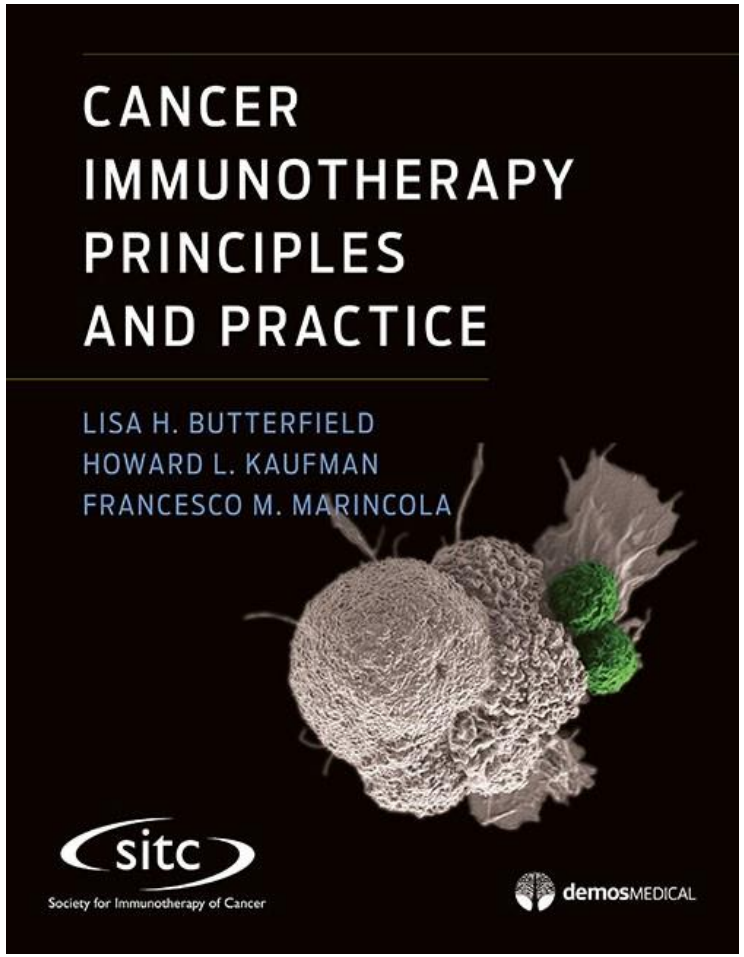


Robert, J Clin Oncol 2018.

When to stop immunotherapy: clinical measures

- PET-based metabolic response
  - Metabolic response may precede anatomical changes on CT or MRI
- Achievement of CR

Additional Resources



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Cancer Immunotherapy CONNECT