Conclusions Both bTMB and rTMB are potentially useful biomarkers for enriching responses to D+T in previously untreated, advanced UC. Neither bTMB nor rTMB was associated with better outcomes for D monotherapy. Cut-offs of 24 mut/Mb for bTMB and 10 mut/Mb for rTMB appear optimal in comparison to disease improvement and weight stabilization, improvement in performance status, and decreased pain. PsP was accompanied with clear clinical benefit of disease improvement and weight stabilization, improvement in performance status, and decreased pain bPS-P BAL (N=160) or in combination with ZAL (N=143). Early PsP was observed in 7 patients treated with BAL and 8 with BAL/ZAL while 5 patients experienced delayed PsP (BAL (n=1); ZAL (n=4)). Serial PsP was observed in 1 patient (BAL only) and another (n=1) BAL treated experienced showed PsP (new metastatic lesions) present in 2 consecutive CT scan evaluations before disappearance – hence were classified as PD even by iRECIST. Immune-related sarcoidosis was confirmed histologically in 2 patients following confirmation by mediastinal lymph node biopsy. PsPs were accompanied with clear clinical benefit of disease improvement and weight stabilization, improvement in performance status, and decreased pain PsP BAL (N=160) or in combination with ZAL (N=143). Early 7 (4%) 8 (6%) Delayed 1 (<1%) 4 PsP was defined as radiologic disease progression per RECIST1.1 following by a significant reduction of measurable baseline lesions, disappearance of the non-measurable lesions, or no further progression for at least two tumor assessments after initial progressive disease (PD) by Independent Evaluation Review Committee (IERC). PsP was divided into 3 categories ethically in 2 patients following confirmation by mediastinal lymph node biopsy. PsPs were accompanied with clear clinical benefit of disease improvement and weight stabilization, improvement in performance status, and decreased pain PsP BAL (N=160) or in combination with ZAL (N=143). Early 7 (4%) 8 (6%) Delayed 1 (<1%) 4 PsP was defined as radiologic disease progression per RECIST1.1 following by a significant reduction of measurable baseline lesions, disappearance of the non-measurable lesions, or no further progression for at least two tumor assessments after initial progressive disease (PD) by Independent Evaluation Review Committee (IERC). PsP was divided into 3 categories – early (before or at week 12 of treatment), delayed (after week 12) and serial (at least 2 PsP occurrences).

Results Overall, 313 patients with post-chemotherapy recurrent CC with baseline measurable disease were treated with either BAL (n=160) or in combination with ZAL (n=143). Early PsP was observed in 7 patients treated with BAL and 8 with BAL/ZAL while 5 patients experienced delayed PsP (BAL (n=1); ZAL (n=4)). Serial PsP was observed in 1 patient (BAL only) and another (n=1) BAL treated experienced showed PsP (new metastatic lesions) present in 2 consecutive CT scan evaluations before disappearance – hence were classified as PD even by iRECIST. Immune-related sarcoidosis was confirmed histologically in 2 patients following confirmation by mediastinal lymph node biopsy. PsPs were accompanied with clear clinical benefit of disease improvement and weight stabilization, improvement in performance status, and decreased pain PsP BAL (N=160) or in combination with ZAL (N=143). Early 7 (4%) 8 (6%) Delayed 1 (<1%) 4 PsP was defined as radiologic disease progression per RECIST1.1 following by a significant reduction of measurable baseline lesions, disappearance of the non-measurable lesions, or no further progression for at least two tumor assessments after initial progressive disease (PD) by Independent Evaluation Review Committee (IERC). PsP was divided into 3 categories – early (before or at week 12 of treatment), delayed (after week 12) and serial (at least 2 PsP occurrences).

Conclusions Both bTMB and rTMB are potentially useful biomarkers for enriching responses to D+T in previously untreated, advanced UC. Neither bTMB nor rTMB was associated with better outcomes for D monotherapy. Cut-offs of 24 mut/Mb for bTMB and 10 mut/Mb for rTMB appear optimal in comparison to disease improvement and weight stabilization, improvement in performance status, and decreased pain PsP was defined as radiologic disease progression per RECIST1.1 following by a significant reduction of measurable baseline lesions, disappearance of the non-measurable lesions, or no further progression for at least two tumor assessments after initial progressive disease (PD) by Independent Evaluation Review Committee (IERC). PsP was divided into 3 categories – early (before or at week 12 of treatment), delayed (after week 12) and serial (at least 2 PsP occurrences).

References
1. AstraZeneca. Update on phase III DANUBE trial for IMFINZI and tremelimumab in previously untreated, advanced UC. Neoadjuvant chemoradiotherapy followed by IMFINZI and tremelimumab (NCT03104699) or in combination with zoledronic acid (ZAL; N=137) in patients with locally advanced (LA) or metastatic lung cancer (MC) (NCT03104699). PFS and OS were evaluated at the interim and final analysis. PN=160 vs PNL=15 vs 143. PFS was superior in both studies (HR: 0.67 [0.53–0.84]; p<0.0001) and OS was better in the combination group (HR: 0.74 [0.56–1.00]; p=0.0522). The results were consistent in both line of treatment settings (first- and second-line).


Background Management of patients with recurrent endometrial cancer after failure of platinum therapy remains an important clinical challenge. Tumors characterized by abnormalities in DNA repair are associated with high numbers of neoantigens, making immunotherapy a promising approach. Retifanlimab (INCMGA00012) is an investigational humanized immunoglobulin G4 monoclonal antibody against PD-1. In the dose escalation and tumor expansion portions of the POD1UM-101 phase 1 study, retifanlimab monotherapy demonstrated acceptable tolerability and durable clinical activity in multiple advanced tumor types, including pretreated endometrial cancer. Here we present interim clinical activity and safety data from a preplanned futility assessment in patients with microsatellite instability-high (MSI-H) recurrent endometrial cancer.

Methods Patients eligible for this cohort had histologically proven, unresectable recurrent endometrial cancer that was MSI-H or deficient mismatch repair (dMMR) based on local testing (either by PCR or IHC), ECOG performance status (PS) ≤1, disease progression during or following ≤5 prior systemic treatments, measurable disease per RECIST v1.1, and no prior treatment with immune checkpoint inhibitors. The primary endpoint is safety (using CTCAE v4.03 grading). Confirmed best overall response rate and duration of response were evaluated by RECIST v1.1 (investigator’s assessment). Retifanlimab 500 mg Q4W was administered up to 2 years.

Results As of April 7, 2020, 44 patients who received at least 1 dose of retifanlimab were assessed for safety, including 24 patients who were fully assessable for the planned futility analysis. Median age was 63 (49–86) years, 45.5% had an ECOG PS of 1, and 97.7% had adenocarcinoma (1 had missing histology data at cut-off). Of the 44 patients treated, all but 1 were pretreated with at least 1 prior platinum-based chemotherapy, 72.7% were treated with radiotherapy, and 90.9% underwent surgery. Median drug exposure was 1.9 (0.03–11.1) months. Eight patients (18.2%) experienced Grade (G) 3/4 AEs regardless of causality with anemia being the leading event (n=3, 6.8%). Two patients (4.5%) had immune-related AEs (n=1 each: dry mouth [G3] and myositis [G3]); both patients discontinued study treatment because of the event. No treatment-related deaths occurred. Confirmed responses (7 PR, 1 CR) per RECIST v1.1 were observed, supporting study continuation. Median duration of response was not reached, as no confirmed responders had disease progression or died at time of this analysis.

Conclusions Retifanlimab was generally well tolerated with preliminary evidence of encouraging antitumor activity in MSI-H pretreated advanced endometrial cancer. Enrollment is ongoing.

Acknowledgements This study is sponsored by Incyte Corporation (Wilmington, DE).

Trial Registration NCT03059823, EudraCT 2017-000865-63

Ethics Approval The study was approved by institutional review boards or independent ethics committees of participating institutions.

Consent n/a

http://dx.doi.org/10.1136/jitc-2020-SITC2020.0268

TUMORAL AND PERIPHERAL LANDSCAPE OF VIRAL-VERSUS CARCINOGEN-DRIVEN HEAD AND NECK CANCER

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Background Head and neck squamous cell carcinoma (HNSCC) is composed of a heterogeneous group of tumors arising through environmental carcinogens or infection by human papillomavirus (HPV). Treatment interventions such as immunotherapy and targeted therapy have shown clinical benefit in HNSCC patients. Despite these encouraging results, resistance to treatment is still observed in the majority of patients. Additionally, clinical effectiveness of treatment options has also been shown to be associated with HPV status. Here we investigate the tumoral and peripheral landscape of HPV(-) vs. HPV(+) head and neck cancers to identify features able to expand treatment options for patients with Viral- and Carcinogen-driven Head and Neck Cancer.

Methods Biopsies and serum samples derived from 502 primary and metastatic HNSCC patients were leveraged for genomic, proteomic and immunochemistry evaluations. Tumor biopsies from HNSCC patients commercially obtained (n=143) or derived from patients enrolled in CP1108 trial (n=19, NCT01693562) were profiled by gene expression. Primary tumor biopsies (N=198) from HNSCC have been assessed by Whole Exome Sequence (WES). Expression of immune markers including CD8, NKP46 was evaluated by immunohistochemistry (IHC) on 186 and 214 tumors biopsies, respectively. The expression of 80 immune related soluble factors was evaluated in serum derived from n=285 patients of HNSCC enrolled in EAGLE (NCT02369874), a randomized, open-label, study assessing Durvalumab and Tremelimumab vs. Standard of Care (SoC). Statistical comparison between HPV (+) vs. HPV (-) samples were conducted using R software.

Results Patients with HPV(-) vs. HPV(+) HNSCC were characterized by worse prognosis. Increased levels of immunosuppressive factors including VEGF (p=0.01), IL-8 (p=0.02), IL6 (p=0.07) and macrophages chemo attractive factor CCL4 (p=0.07) was observed in the serum of HPV(-) vs HPV(+) HNSCC patients. In the tumor microenvironment, higher mRNA expression of immune signatures associated with MDSC, Cancer Associated Fibroblast (CAF), and Metalloproteinase (MMP) was observed in HPV(-) vs. HPV (+) HNSCC patients. In contrast, HNSCC HPV(+) patients were characterized by increased mRNA expression of DC signatures and IFNγ related genes (i.e. CXCL9). No differential infiltration of T and NK cells (CD8+ and NKP46+) were found in HPV (-) vs. HPV(+) patients. Enrichments of mutations in EGFR, and DNA repair genes (PMS1, POLK, ATM) was observed in HPV(+) patients. On the contrary, enrichments of mutations in TP53 was observed in HPV(-) patients.

Conclusions Deep evaluation of tumoral and peripheral landscape of viral- versus carcinogen-driven HNSCC might help understanding differential outcome of treatments regimens in HPV(+) vs HPV (-) HNSCC thus leading to novel therapeutic interventions.

Trial Registration NCT01693562,NCT02369874

Ethics Approval The study was approved by AstraZeneca.