improvement in clinical efficacy (40% objective response rate [ORR]), 5.26 month median progression-free survival [PFS], and 15.2 month median OS) than other subgroups (table 1).

In addition to immune-related genes in the microenvironment, DEG analysis also revealed that tumor-related genes were highly expressed in non-responders, such as intrinsic genes related to angiogenesis (VEGFA [P = 0.07], KDR [P = 0.07]), the mTOR pathway (MTOR [P = 0.015]), and DNA damage repair (REV3L [P = 0.007]). MTOR and REV3L were associated with shorter PFS (P = 0.02; P = 0.003) and OS (P = 0.03; P = 0.008), respectively.

Conclusions By using GEP, T-cell and MHC I GS were identified as potentially predictive biomarkers of response to tislelizumab monotherapy in PD-L1+ UC in this retrospective analysis. By combining these two GS scores, patients with optimal efficacy responses could be identified. Conversely, high expression of tumor intrinsic genes related to angiogenesis and the mTOR pathway may indicate resistance and suggest potential future drug combinations for these patients. Both findings warrant further validation in a phase 3 study (NCT03967977).

Acknowledgements Editorial assistance was provided by Stephanie Lindsey, PhD, and Elizabeth Hermans, PhD (OPEN Health Medical Communications, Chicago, IL), and funded by the study sponsor.

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### Abstract 79 Tumor-immune signatures associated with clinical efficacy of tislelizumab in patients with ESCC

| Subgroup | n=43 | TLR-high (n=27) | TLR-low (n=16) | TLR-high (n=22) | TLR-low (n=21) | Combined signature
<table>
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</thead>
<tbody>
<tr>
<td>ORR (%)</td>
<td>6 (14.4)</td>
<td>6 (23.0)</td>
<td>6 (23.0)</td>
<td>1 (4.3)</td>
<td>4 (18.2)</td>
<td>5 (22.7)</td>
</tr>
<tr>
<td>DCR (%)</td>
<td>16 (37.2)</td>
<td>16 (62.2)</td>
<td>16 (62.2)</td>
<td>10 (45.5)</td>
<td>4 (18.2)</td>
<td>11 (49.6)</td>
</tr>
<tr>
<td>Median PFS (mo)</td>
<td>9 (5, 15.0)</td>
<td>9 (5, 15.0)</td>
<td>9 (5, 15.0)</td>
<td>6 (4, 15.0)</td>
<td>6 (4, 15.0)</td>
<td>6 (4, 15.0)</td>
</tr>
<tr>
<td>Median OS (mo)</td>
<td>15.2</td>
<td>15.2</td>
<td>15.2</td>
<td>15.2</td>
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</tbody>
</table>

Conclusions By using GEP, T-cell and MHC I GS were identified as potentially predictive biomarkers of response to tislelizumab monotherapy in PD-L1+ UC in this retrospective analysis. By combining these two GS scores, patients with optimal efficacy responses could be identified. Conversely, high expression of tumor intrinsic genes related to angiogenesis and the mTOR pathway may indicate resistance and suggest potential future drug combinations for these patients. Both findings warrant further validation in a phase 3 study (NCT03967977).

Acknowledgements Editorial assistance was provided by Stephanie Lindsey, PhD, and Elizabeth Hermans, PhD (OPEN Health Medical Communications, Chicago, IL), and funded by the study sponsor.

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### Abstract 80 Evaluation of the TruSight Oncology 500 Assay for routine clinical testing of tumor mutational burden (TMB) and clinical utility for predicting response to pembrolizumab

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Background Various biomarkers have been investigated for their ability to identify patients more likely to respond to pembrolizumab. In the context of pembrolizumab, high tumor mutational burden (TMB) has been associated with increased clinical benefit. The TruSight Oncology 500 Assay (TSO500) was designed to identify high TMB tumors for pembrolizumab treatment.

Methods In TSO500, 500 cancer-related genes with high-quality sequencing data were sequenced to detect somatic mutations. The TMB was calculated as the number of nonsynonymous mutations per million bases.

Results In a validation cohort of 70 patients with solid tumors, the TSO500 showed high analytical sensitivity for the detection of mutations, with a median TMB of 10 mutations per million bases. In a retrospective analysis of 116 patients with non-small cell lung cancer (NSCLC), patients with high TMB (defined as >10 mutations per million bases) had a significantly higher response rate to pembrolizumab compared to those with low TMB (P = 0.04). In addition, patients with high TMB had significantly longer progression-free survival (PFS) and overall survival (OS) compared to those with low TMB (P < 0.05).

Conclusions The TSO500 is an accurate and reliable assay for detecting high TMB tumors. It may be a valuable tool for identifying patients who are more likely to benefit from pembrolizumab treatment.

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immunotherapy. Recently, the PD-1 inhibitor pembrolizumab was approved by the FDA for treating patients with unresectable or metastatic solid tumors with high TMB (TMB-H) who have no satisfactory alternative treatment options following progression on prior treatment. The FDA contemporaneously approved the FoundationOne®CDx (F1CDx; Foundation Medicine) as the companion diagnostic for TMB assessment for pembrolizumab. However, multiple comprehensive genomic profiling panels that can measure TMB are currently available or in development. We evaluated the performance of TruSight™ Oncology 500 (TSO500; Illumina) for assessing TMB and its clinical utility using F1CDx and whole exome sequencing (WES) as reference methods.

**Methods** Pretreatment archival tumor samples from patients enrolled in 8 clinical trials of pembrolizumab monotherapy were evaluated for TMB by TSO500, F1CDx QSR pipeline v3.2.0, and WES. Correlation was assessed using Spearman’s rank correlation coefficient (ρ). The F1CDx and WES TMB cutpoints were 10 mut/Mb and 175 mut/exome, respectively. The TSO500 cutpoint was selected using the Youden index criterion. Concordance was assessed by calculating area under the receiver-operating curve (AUROC), positive percentage agreement (PPA), and negative percentage agreement (NPA). Statistical significance of the association of TMB measured by TSO500 with ORR was assessed using logistic regression adjusted for ECOG performance status and cancer type. Clinical utility of the selected TSO500 TMB cutpoint for discriminating responders and nonresponders was assessed by calculating sensitivity, specificity, positive predictive value, negative predictive value, ORR enrichment, and prevalence.

**Results** TMB scores were valid for 294/294 patients assessed by TSO500, 269/270 assessed by F1CDx, and 293/294 assessed by WES. TMB assessed by TSO500 had good correlation with TMB assessed by F1CDx (ρ=0.76) and WES (ρ=0.74). Using Youden index criterion, 10 mut/Mb was the TSO500 cutpoint that corresponded with both the F1CDx and WES cutpoints. TSO500 reliably predicted TMB-H and non-TMB-H status as determined by the F1CDx (AUROC=0.99, PPA=97.4%, NPA=93.0%) and WES (AUROC=0.95, PPA=76.2%, NPA=96.1%) cutpoints. TMB measured by TSO500 was significantly associated with ORR (one-sided P<0.0001). Clinical utility metrics were generally similar for TSO500 and F1CDx (table 1) and TSO500 and WES (table 2).

**Conclusions** TMB assessed by TSO500 is highly correlated and concordant with TMB assessed by F1CDx and WES. Similar to the validated and approved F1CDx TMB cutpoint of 10 mut/Mb, the TSO500 TMB cutpoint of 10 mut/Mb is predictive of response to pembrolizumab monotherapy.

**Acknowledgements** This analysis and all included studies were sponsored by Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., Kenilworth, NJ, USA.

**Trial Registration** NA

**Ethics Approval** The protocols and all amendments for the studies included in this analysis were approved by the appropriate ethics committee at each participating institution.

**Consent** NA

**REFERENCE**

http://dx.doi.org/10.1136/jitc-2020-SITC2020.0080

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### Abstract

#### 81. INCLUSION OF PD-L1-EXPRESSING TUMOR CELLS IN THE COMBINED POSITIVE SCORE ALGORITHM YIELDS SUPERIOR IDENTIFICATION OF POSITIVE SPECIMENS AROUND DIAGNOSTIC CUT-OFFS ACROSS MULTIPLE INDICATIONS

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#### Background**

PD-L1 IHC 22C3 pharmDx uses Tumor Proportion Score (TPS) and Combined Positive Score (CPS) scoring algorithms for the immunohistochemical (IHC) evaluation of PD-L1 protein expression in human cancer tissues; both algorithms include PD-L1 staining tumor cells (TC) in scoring and CPS also includes scoring of PD-L1 staining mononuclear inflammatory cells to aid in the identification of patients for treatment with pembrolizumab (KEYTRUDA®) using indication-specific diagnostic cut-offs. This study evaluated contribution of TC in determining specimen diagnostic status based on the CPS scoring algorithm by looking into four tumor indications approved for use with KEYTRUDA®: gastric or gastroesophageal junction (GEJ) adenocarcinoma (GC/GEJ), urothelial carcinoma (UC), head and neck squamous cell carcinoma (HNSCC), and esophageal squamous cell carcinoma (ESCC). Detection of specimens expressing PD-L1 is significantly dependent on the PD-L1 staining TC component.

#### Methods**

A retrospective analysis was done looking at Dako’s internal tumor bank of the mentioned indications that were all stained with PD-L1 IHC 22C3 pharmDx and scored using the TPS, CPS and Quantitative Immune Cell Density (QID) methods described in figure 1. Statistical analysis encompassed looking at the scores generated that met the following criteria: CPS>0, TPS>0 and CPS≠TPS and then evaluating the percentage of those samples that changed from positive to negative diagnostic status upon removal of the TC component from the scoring.

#### Results**

A noticeable downward trend was observed in all four indications in the total number of positives with the removal of the TC component. Table 1 aptly captures this by showing the number of specimens for each indication that had changed from positive to negative around each indication’s diagnostic cut-off(s). The three indications that showed the highest