Immunization Using Autologous Dendritic Cells Pulsed with the Melanoma-Associated Antigen gp100-Derived G280-9V Peptide Elicits CD8+ Immunity

Gerald P. Linette,¹ Dongsheng Zhang,¹ F. Stephen Hodi,² Eric P. Jonasch,⁴ Simonne Longerich,¹ Christopher P. Stowell,¹ Iain J. Webb,² Heather Daley,² Robert J. Soiffer,² Amy M. Cheung,¹ Sara G. Eapen,¹ Sharon V. Fee,¹ Krista M. Rubin,¹ Arthur J. Sober,¹ and Frank G. Haluska¹

Abstract

Purpose: To determine the toxicity, maximal tolerated dose, and clinical and immunologic response to autologous dendritic cells pulsed with melanoma-associated antigen gp100-derived G280-9V peptide.

Patients and Methods: Twelve HLA-A*0201+ patients with advanced melanoma were administered dendritic cells pulsed with G280-9V peptide. Cohorts of three patients were administered 5 × 10⁵, 15 × 10⁵, and 50 × 10⁵ cells i.v. every 3 weeks according to a dose escalation scheme. Three additional patients were treated at the highest dose. No additional cytokines or therapies were coadministered. The immunogenicity of G280-9V-pulsed dendritic cells was measured by IFN-γ ELISPOT assay, tetramer assay, and ⁵¹Cr release assay comparing prevaccination to postvaccination blood samples. Response to treatment was assessed by Response Evaluation Criteria in Solid Tumors.

Results: CD8+ immunity to the native G280 was observed in 8 (67%) patients as measured by ELISPOT and in 12 (100%) patients as measured by tetramer assay. Of the 9 patients tested, 9 (100%) had measurable high-avidity CTL activity as defined by lysis of allogeneic melanoma lines, which coexpress HLA-A*0201 and gp100. The median follow-up of the entire cohort is 43.8 months. Two (17%) partial responses were observed and 3 (25%) patients had stable disease. The median survival of the treated population was 37.6 months. At this time, three patients are alive, including one patient who continues to respond without additional treatment.

Conclusion: The high rate of immunization as measured by three independent assays and the occurrence of clinical regression support continued investigation of G280-9V peptide as a candidate epitope in melanoma vaccine formulations.

Melanoma incites an immune response by the host, and a variety of strategies have been pursued in an attempt to take advantage of this observation (1). Some of these strategies involve nonspecific attempts to augment antitumor immunity, such as the cytokines interleukin (IL)-2 and IFN-α2b (2, 3). These are now accepted conventional therapies. However, most recent investigational work has been focused on attempts to induce specific antitumor immunity by engendering responses to defined single or multiple antigens expressed by tumor cells. The central line of this research has been the identification and isolation of the antigens present on melanomas recognized by T cells (4).

The isolation of melanoma-associated antigens has allowed investigators to design peptide vaccines that can be coadministered with a variety of adjuvants (4, 5). Dendritic cells serve a critical role in capturing and presenting antigen in the initiation of immunity against infectious pathogens and neoplasia (6). A variety of technical advances in isolating human dendritic cells as well as an improved understanding of dendritic cell biology have led investigators to propose using autologous dendritic cells as adjuvant for peptide vaccination in cancer (7, 8).

The initial clinical reports conclude that dendritic cell immunization in patients with advanced melanoma is safe and well tolerated; however, response rates are <10% in most studies (9–11). Laboratory correlative studies show that some patients develop T-cell immunity after dendritic cell vaccination with a variety of schedules and routes of administration.
renal, and hepatic function as defined by WBC >3,000/mm³, platelet inclusion criteria included age corticosteroids, chemotherapy, radiotherapy, immunotherapy, or autoimmune disorder, and were >4 weeks from any therapy with using the monoclonal antibody HMB45, had no evidence of proven melanoma metastases confirmed by immunohistochemistry Oncology Group performance status of 0 or 1, had gp100+ biopsy-were eligible. All subjects were HLA-A*0201+, had Eastern Cooperative were longitudinal samples from each patient.

Table 1. Details of subject characteristics, dose, and clinical responses

<table>
<thead>
<tr>
<th>ID</th>
<th>Age*</th>
<th>Sex</th>
<th>Stage (III, 2; IV, 10)</th>
<th>Disease sites</th>
<th>Prior therapy</th>
<th>Dose level</th>
<th>Total dendritic cell dose</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>101</td>
<td>72</td>
<td>F</td>
<td>IV</td>
<td>Soft tissues, mesentery</td>
<td>Surgery</td>
<td>1</td>
<td>30 x 10⁶</td>
<td>SD</td>
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<tr>
<td>102</td>
<td>49</td>
<td>F</td>
<td>IV</td>
<td>Distant lymph nodes</td>
<td>Surgery, IFN</td>
<td>1</td>
<td>30 x 10⁶</td>
<td>SD Now NED</td>
</tr>
<tr>
<td>103</td>
<td>55</td>
<td>M</td>
<td>IV</td>
<td>Soft tissue, lung, mesentery</td>
<td>Surgery, XRT, chemotherapy</td>
<td>1</td>
<td>30 x 10⁶</td>
<td>Twice² PR; then PD</td>
</tr>
<tr>
<td>201</td>
<td>69</td>
<td>M</td>
<td>IV</td>
<td>Lymph node, lung, liver</td>
<td>Surgery, XRT</td>
<td>2</td>
<td>90 x 10⁶</td>
<td>PD</td>
</tr>
<tr>
<td>202</td>
<td>51</td>
<td>F</td>
<td>IV</td>
<td>Skin, soft tissue, adrenal</td>
<td>Surgery, IFN</td>
<td>2</td>
<td>90 x 10⁶</td>
<td>PD</td>
</tr>
<tr>
<td>203</td>
<td>29</td>
<td>F</td>
<td>III</td>
<td>Skin</td>
<td>Surgery, IFN</td>
<td>2</td>
<td>90 x 10⁶</td>
<td>PD Now NED</td>
</tr>
<tr>
<td>301</td>
<td>67</td>
<td>M</td>
<td>IV</td>
<td>Lung</td>
<td>Surgery</td>
<td>3</td>
<td>250 x 10⁶</td>
<td>PD</td>
</tr>
<tr>
<td>302</td>
<td>75</td>
<td>M</td>
<td>III</td>
<td>Skin</td>
<td>Surgery, IFN</td>
<td>3</td>
<td>300 x 10⁶</td>
<td>PR</td>
</tr>
<tr>
<td>303</td>
<td>59</td>
<td>M</td>
<td>IV</td>
<td>Skin, lung, liver, brain</td>
<td>Surgery, XRT</td>
<td>3</td>
<td>300 x 10⁶</td>
<td>PD</td>
</tr>
<tr>
<td>304</td>
<td>71</td>
<td>M</td>
<td>IV</td>
<td>Liver</td>
<td>None</td>
<td>3</td>
<td>300 x 10⁶; SD; then PR³</td>
<td>AWD</td>
</tr>
<tr>
<td>305</td>
<td>60</td>
<td>M</td>
<td>IV</td>
<td>Abdominal mass</td>
<td>Surgery, IFN</td>
<td>3</td>
<td>300 x 10⁶</td>
<td>PD</td>
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<tr>
<td>306</td>
<td>50</td>
<td>F</td>
<td>IV</td>
<td>Lung</td>
<td>Surgery, chemotherapy</td>
<td>3</td>
<td>200 x 10⁶</td>
<td>PD</td>
</tr>
</tbody>
</table>

Abbreviations: PD, progressive disease; SD, stable disease; PR, partial response; NED, no evidence of disease; AWD, alive with disease; XRT, radiation therapy.

*Median age, 59.5; range, 29-75.

Five men, seven women.

*Dose level 1: 10 x 10⁶; 2.15 x 10⁶; 3, 50 x 10⁶.

Subject 103 experienced a PR, underwent a second course of therapy, and then progressed.

Subject 304 experienced a PR, underwent a second course of therapy, but went on to experience a partial response 4.5 months after the last treatment without additional therapy.
Table 2. Dendritic cell phenotype

<table>
<thead>
<tr>
<th>Phenotype</th>
<th>Mean percentage of positive cells (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HLA-DR</td>
<td>0.67 (0.97)</td>
</tr>
<tr>
<td>CD11c</td>
<td>1.24 (0.15)</td>
</tr>
<tr>
<td>HLA-DR/CD11c</td>
<td>96.72 (79.2-99.8)</td>
</tr>
<tr>
<td>CD80</td>
<td>0.12 (2.18)</td>
</tr>
<tr>
<td>CD86</td>
<td>87.29 (54.6-98.6)</td>
</tr>
<tr>
<td>CD80/CD86</td>
<td>6.52 (0.38-4)</td>
</tr>
<tr>
<td>CD14</td>
<td>0.04 (0-1.2)</td>
</tr>
<tr>
<td>CD11c</td>
<td>75.87 (50.7-97.4)</td>
</tr>
<tr>
<td>CD14/CD11c</td>
<td>21.87 (0.2-49.2)</td>
</tr>
<tr>
<td>CD3</td>
<td>3.44 (0.02-29.2)</td>
</tr>
<tr>
<td>CD19</td>
<td>2.28 (0.02-27.2)</td>
</tr>
<tr>
<td>CD3/CD19</td>
<td>0.46 (0-5.84)</td>
</tr>
</tbody>
</table>

NOTE: Release criteria: HLA-DR, >75%; CD11c, >75%; CD86, >75%; CD14, <60%.

Peptides. HLA-A*0201-associated gp100: 280-288 (G280) peptide (YLEEPGPTVA) with modification at the terminal anchor residue (position 9) called G280-9V (YLEEPGVPVT) was used in this study. GMP-grade lyophilized peptide with >99% purity by high-performance liquid chromatography was purchased from Bachem AG (Bubendorf, Switzerland). The peptide for vaccination was dissolved in 5% DMSO in sterile water at 2 mg/mL followed by 0.2 μm filtration. The peptide was divided into aliquots, vialed for single use, and frozen at -80°C. The peptide was tested for sterility, biological activity by T2 target cell assay, and stability before pulsing dendritic cells (data not shown).

Immunologic monitoring

ELISPOT assay. ELISPOT was done against the immunogen G280-9V (the anchor modified), native G280 (the relevant target expressed on melanoma), and HIV-gag (SLNYTVALTL) peptide (background control) in batch to minimize interassay variation. Briefly, 96-well plates (MAHAS4510, Millipore, Bedford, MA) were coated with 100 μL anti-IFN-γ antibody (10 μg/mL, 1-D1k, Mabtech, Mariemont, OH) overnight at 4°C. After six washes with PBS, the plates were blocked with 150 μL/well RPMI 1640 with 5% human AB serum (Valley Biomedical, Inc., Winchester, VA) at 37°C for 2 hours. After removal of the blocking medium, thawed PBMCs were incubated at 2 × 10^6 PBMCs per well in triplicate in a total of 100 μL RPMI 1640 with 5% human AB serum with each of the peptides G280 and G280-9V at 20 μg/mL for 24 hours. Plates were washed thrice with 0.01% Tween 20 in PBS. Next, biotinylated anti-IFN-γ antibody (100 μL/well, 1 μg/mL, 7-B6-1, Mabtech) in PBS with 0.5% bovine serum albumin (Fisher Biotech, Fair Lawn, NJ) was added. After incubation at room temperature for 2 hours, plates were washed thrice with each of 0.01% Tween 20 in PBS and PBS alone. Next, streptavidin-APL (100 μL/well; 1:1,000 dilution in PBS) was added and incubated at room temperature for 1 hour. After four washings with PBS, 5-bromo-4-chloro-3-indolyl phosphate/nitroblue tetrazolium substrate solution (Bio-Rad, Hercules, CA) was added. The plates were incubated at room temperature in the dark to develop. The colorimetric reaction was then stopped by washing with running water. Plates were allowed to dry, and the number of spots was read on an ELISPOT reader (Autoimmune Diagnostika GmbH, Strassberg, Germany). Values are corrected by subtracting background spots caused by PBMC incubation with control peptide HIV-gag. Phytohemagglutinin-positive controls were employed and in all cases yielded >300 spots per well.

To define an ELISPOT response, we determined the mean number of spots at baseline for patients and the between-patient SD. A positive result was designated as an elevation of 2 SDs above baseline. Data from our laboratory (data not shown) have shown that in patients, using the average of duplicate values, the mean and SD were 1.9 ± 1.6 for the G209 peptide in 17 patients and 2.6 ± 2.7 for the G209-2M peptide in 15 patients in an assay using the same conditions as reported here. For this study (see Results), the mean and SD were 6 ± 6.8 spots for G280 and 4.4 ± 3.4 spots for G280-9V. Thus, a positive response to G280 was an increment of 14 spots over baseline. For G280-9V, a positive result was an increment of 7 spots over baseline.

Tetramer assay. PBMCs (1 × 10^9) were washed with 1% fetal bovine serum/PBS and followed by incubation with antigen-presenting cell–labeled G280:HLA-A*0201 tetramers and phycoerythrin-labeled anti-human CD8 antibody (Pharmingen, San Diego, CA) on ice for 30 minutes. In some experiments, G280-9V:HLA-A*0201 tetramers were used. After washing twice with 1% fetal bovine serum/PBS, cells were fixed by 2% paraformaldehyde in PBS and analyzed by a FACSCalibur with CellQuest (BD Biosciences, San Jose, CA). HIV-gag peptide:HLA-A*0201 tetramer (Beckman Coulter Immunomics, San Diego, CA) was used as background control. Data are presented as the percentage of CD8+ cells positive for tetramer binding based on gating variables set with appropriate isotype control nonbinding antibodies. The optimal concentrations of CD8-phycocerythrin and antigen-presenting cell–labeled G280:HLA-A*0201 tetramers with temperature and time of reaction were determined in preliminary experiments.
The mean ± SD staining at baseline was 0.1 ± 0.04%. As for ELISPOT, a positive result was designated at 2 SDs above baseline or results greater than 0.18%.

**Cytolytic assay.** Purified CD8+ T cells were obtained by negative selection (20). Autologous dendritic cells pulsed with 10 μg/mL peptide were added to purified CD8+ cells at a 1:20 ratio and cultured in 48-well trays (Costar 3548, Cambridge, MA) in RPMI 1640 containing 10% autologous plasma. IL-2 (50 units/mL, Chiron, Emeryville, CA) was added to each well beginning on day 1 and every 2 to 3 days thereafter. T cells were harvested on day 7 and assayed for lytic activity in triplicate using a standard 4-hour 51Cr release assay. T2 (TAP1-deficient, A*0201+) cells, DM6 (A*0201 and gp100), DM13 (A*0201+ and gp100+), and A375 (A*0201 and gp100+) cells were used as target cells in lysis assays as described.

**Statistical methods.** The Kaplan-Meier plot was used to present the survival curve of the 12 patients. The Kruskal-Wallis test was used to test differences in the three dose groups with respect to the three immunologic end points. The immunologic end points were defined as the difference between prevaccine and postvaccine readings. In addition, univariate analysis of the signed rank test on the three immunologic end points was done.

**Results**

**Patient characteristics.** From October 1998 to April 2001, we enrolled 12 patients evaluable for clinical and immunologic responses. Fourteen additional patients were deemed ineligible as a consequence of being typed HLA-A2+. Two patients enrolled had unrectable recurrent stage III melanoma and 10 patients had stage IV disease (see Table 1). Five patients had prior adjuvant IFN, whereas two patients had received prior chemotherapy for metastatic melanoma. Two patients had prior brain metastases controlled with radiation therapy and were deemed stable before study entry.

**Feasibility.** The production of dendritic cells for therapeutic administration was feasible and reproducible. The mean yield of dendritic cells from initial PBMC was 6.77% (range, 2.62-17.75%). No dendritic cell lot failed release criteria. Dendritic cell phenotypes as determined by two-color flow cytometry are listed in Table 2.

**Safety.** The overall toxicities of the G280-9V-pulsed dendritic cell vaccine were mild. Five patients reported rashes during the study. Two of these were grade 1 eruptions possibly related to treatment. Two of them were grade 1 and related to contrast administration. One was grade 2 contact dermatitis and unrelated to treatment. Four patients reported upper respiratory or flu-like symptoms; all were grade 1. There were three reports of constitutional symptoms, nausea or vomiting. All were grade 1 in intensity. Generally, the vaccine was well tolerated, and no serious adverse events related to therapy were reported.

**Efficacy.** Using Response Evaluation Criteria in Solid Tumors, patients were evaluated by computed tomography imaging after three vaccinations and again after six vaccinations. Two patients (103 and 302) experienced a partial response after six vaccination cycles. One of these patients (103) had tumor in multiple soft-tissue sites and had already experienced a prior complete response to whole-brain radiation therapy as well as a partial response to prior chemotherapy, whereas the other patient (302) had disease confined to the skin of the scalp that responded after treatment. Three patients (101, 102, and 304) had stable disease after completion of the study. Patient 304 experienced stable disease of a solitary (biopsy-proven) liver metastasis after study but went on to show a near-complete tumor response with additional follow-up in the absence of further treatment and remains alive with disease. Patient 101 had stable disease but ultimately experienced disease progression of pulmonary nodules 11 months after completion of therapy. Patient 102 had stage IV disease with extensive i.p. adenopathy but is currently alive with disease after additional treatment with systemic biochemotherapy and i.p. chemotherapy for mesenteric disease.

The remaining seven patients had documented disease progression. Interestingly, patient 203 had extensive in-transit stage III disease at entry and had a vigorous CTL response as measured by ELISPOT, tetramer, and lysis assays and progressed to stage IV disease involving distant skin. After further investigational therapy with a farnesyl transferase inhibitor (no response) followed by isolated limb perfusion (complete response), the patient is disease free. Remarkably, the latter procedure prompted regression of the regional metastases as well as a distant metastatic lesion on the contralateral (nonperfused) limb.

The median follow-up of the entire cohort is 43.8 months and the median survival of the entire population is 37.6 months. The median survival of the 10 stage IV patients is 21.1 months. Three patients are still alive; two of them having undergone additional treatments as described above. Figure 1 illustrates the overall survival in a Kaplan-Meier plot.

**Immunologic response.** The ELISPOT (IFN-γ) assay was used to measure the frequency of cells reactive to the native G280 peptide as well as the anchor-modified peptide G280-9V used for immunization. Baseline (preimmunization) values were calculated, and the mean and SD for the population were determined. Positive values were those >2 SDs above the pretreatment mean. As shown in Fig. 2A, 8 (67%) patients responded to G280 immunization with a significant increase in ELISPOT number. Figure 2B illustrates the response to the immunizing peptide, G280-9V; 8 (67%) patients responded to the modified peptide. Two patients (202 and 305) show no detectable immunity to either peptide. Two additional patients (103 and 302) mounted weak yet significant responses to G280-9V without significant responses to the native peptide.

To evaluate the frequency of cells specific for the G280:HLA-A*0201 complex, tetramer analysis was done on PBMC from...
12 patients after three vaccinations and after the final (sixth) vaccination. Baseline values were determined as above. As shown in Fig. 2C, all 12 immunized patients showed significant increases in CD8+ cells specific for G280:HLA-A*0201 3 weeks after the third and sixth immunizations. Peripheral blood samples from patient 306 were tested at baseline and after the third immunization only.

Standard 51Cr release assays were done and repeated at least once to measure the lytic activity of CD8+ effector T cells from blood samples obtained at baseline and after study completion. Purified CD3+CD8+ cells from peripheral blood were cultured for 7 days with G280:HLA-A*0201 3 weeks after the third and sixth immunizations. Peripheral blood samples from patient 306 were tested at baseline and after the third immunization only.

Standard 51Cr release assays were done and repeated at least once to measure the lytic activity of CD8+ effector T cells from blood samples obtained at baseline and after study completion. Purified CD3+CD8+ cells from peripheral blood were cultured for 7 days with G280:HLA-A*0201 3 weeks after the third and sixth immunizations. Peripheral blood samples from patient 306 were tested at baseline and after the third immunization only.

Fig. 2. Immunologic monitoring by ELISPOT analysis. Mean number of spots per 2 x 10^5 PBMCs (triplicate determinations) in an IFN-γ assay at baseline (Pre-vaccine), after the fourth immunization (Cycle 4), or after the sixth immunization (Post-vaccine). Background spots (after incubation with HIV-gag peptide) have been subtracted from the number of spots. A, ELISPOT to native peptide G280-9V. B, ELISPOT to immunogen peptide G280-9V. The postvaccination sample for 306 was not obtained. C, Immunologic monitoring by tetramer analysis. Percentage of G280:HLA-A*0201 tetramer+/CD8+ cells at baseline (Pre-vaccine), after the third vaccination (Cycle 3), and after the sixth vaccination (Post-vaccine). The postvaccination sample for 306 was not obtained. The clinical outcome is presented at the bottom and described as in Table 1.
had detectable immunity against G280 peptide-pulsed T2 cells elicited by dendritic cell immunization (Fig. 3B). Moreover, dendritic cell vaccination elicited CTL that lysed DM6 melanoma coexpressing gp100 and HLA-A*0201 (Fig. 3C). As a control, CD8+ T cells were cocultured with influenza A matrix (M1) peptide and tested against T2 cells pulsed with the M1 peptide. Both prevaccination and postvaccination blood samples contained influenza A–specific CTL, suggesting that all patients were immunocompetent at study enrollment and study conclusion based on reactivity to M1 peptide (Fig. 3D). Cultured CD8+ T cells from all donors were tested for natural killer cell activity against K562 target cells and were nonreactive (data not shown).

Patients 103 and 203 were studied in greater detail to confirm the above findings and prove antigen specificity. In separate experiments, CD8+ T cells from both donors were stimulated in vitro for 7 days with G280-9V-pulsed dendritic cells and tested at various E:T ratios using either T2 target cells or additional melanoma cell lines. Postvaccination CTL from each donor lysed T2 target cells pulsed with the G280 native peptide as well as the G280-9V-pulsed targets (data not shown). In a second test of specificity, both donor CTL efficiently lysed DM6 and DM13 (gp100+, A*0201+) melanomas; however, the A375 (gp100+, A*0201+) melanoma target is not recognized supporting the requirement for naturally processed gp100 antigen. Postvaccination CTL from both donors can effectively kill G280-pulsed A375 melanoma cells showing reconstitution with exogenous antigen. As a control, prevaccination and postvaccination CD8+ T cells specific for influenza A M1 peptide are detected from each patient.

As a final test of antigen specificity, CD8+ T cells from 12-day in vitro cultures from postvaccination blood samples are evaluated by tetramer analysis with flow cytometry. At study completion, patient 103 had 0.65% tetramer/CD8+ double-positive PBMC, whereas patient 203 had 0.82% tetramer/CD8+ double-positive PBMC (data not shown). After 12 days of in vitro culture with G280-9V-pulsed dendritic cells, the expansion of peptide-specific CD8+ T cells was significant with detection of 64% tetramer/CD8+ cells seen in donor 103 (Fig. 4B) and 88% tetramer/CD8+ cells seen in donor 203 (Fig. 4D). CTL from these cultures efficiently killed DM6, DM13, and G280-pulsed A375 melanomas as confirmation of specificity as shown for both donors (Fig. 4A and C).

In an effort to evaluate antigen receptor avidity, T2 target cells were pulsed with 10-fold dilutions (range, 10 fmol/L-100 nmol/L) of G280, G280-9V, or M1 peptide before addition of effector CD8+ T cells from postvaccination samples. We calculated the peptide concentration sufficient to render the target cells susceptible to lysis and express this value as 50% half-maximal lysis. A representative experiment is shown with donor 203 using effector T cells obtained by 12-day in vitro culture (Fig. 4E). The 50% half-maximal lysis was calculated as 12.53 pmol/L for G280-9V and 14.32 pmol/L for G280. The flu M1 peptide was not recognized at any concentration tested. A similar analysis was conducted using postvaccination blood from donor 103 and similar results were obtained which support the finding of high-avidity CTL after dendritic cell immunization. We conclude that dendritic cell vaccination of melanoma patients with G280-9V elicits CTL that fully cross-react and retain specificity for the native peptide sequence naturally presented by A*0201+ melanomas.

The Kruskal-Wallis test did not show significant differences between the vaccine dose groups with respect to the three immunologic end points. Because the dose groups did not differ significantly, the effect of the vaccine dose on the end points was assumed to be homogeneous. Next, the signed rank test (one sided P value) was used to evaluate the presence of an effect of the vaccine on the induction of immunity as measured by ELISPOT (P = 0.003), tetramer (P = 0.005), and lysis (P = 0.0005) assays. These data suggest that an increase in the magnitude of the response seen in each assay is due to the vaccine; however, the responses are not affected by the vaccine dose administered.

Discussion

We postulated that immunization with dendritic cells is effectively required to elicit antigen-reactive T cells capable of eradicating melanoma. A phase I dose escalation clinical trial was designed to test the hypothesis that immunization with G280-9V-pulsed dendritic cells can effectively elicit tumor-reactive CTL in patients with advanced melanoma. Results from this study allow us to conclude that peptide-specific CD8+ T cells can be elicited through repeated dendritic cell immunization with a modified peptide designed for improved immunogenicity. Single amino acid substitution of neutral
Immature dendritic cells with detection of SIV-specific CTL and IL-4 (30). Moreover, successful immunization using primate measured in all patients after repeated immunizations with intermediate) were used for the vaccination protocol. We (CD80low, CD83low, CD86+, HLA class I+, HLA class II) dendritic cells are immunogenic (29). In our study, dendritic immature dendritic cells are tolerogenic, whereas mature dendritic cell vaccine efficacy in a murine model (32); at high dose (30 Gy); (b) irradiated immature dendritic cells, although increased CD86 was seen at this time, the effects of irradiation on human dendritic cell maturation and possible effects on vaccine potency remain unclear. Merrick et al. (28) found that (a) irradiation did not change the surface phenotype (MHC class I and II, CD1a, CD80, CD83, CD40, and CCR7) of human PBMC-derived immature dendritic cells, although increased CD86 was seen at high dose (30 Gy); (b) irradiated immature dendritic cells mostly maintain their endocytic, phagocytic, and migratory functions; and (c) irradiation did not increase expression of RelB in immature dendritic cells, a marker of dendritic cell maturation. The significance of this finding is unclear.

Recent studies suggest that CTL avidity is an important factor influencing recognition of malignant and virally infected cells. Alexander-Miller et al. proposed that avidity is defined as the sensitivity to low peptide-MHC complex determinant density on target cells and is useful in characterizing the quality of CTL from immunized patients (33, 34). We evaluated avidity as lysis on target cells and is useful in characterizing the quality of CTL from cryopreserved adherent PBMC for each dose and that strict quality-control measures were employed to ensure immunization with pure dendritic cell populations for each dose. We elected to irradiate all dendritic cell products before reinfusion based on a preclinical study showing improved dendritic cell vaccine efficacy in a murine model (32); at this time, the effects of irradiation on human dendritic cell maturation and possible effects on vaccine potency remain unclear.
secreting CD8+ T cells. Up to 25-fold levels of increase were observed. Fluorescence-activated cell sorting analysis, with tetramers of circulating levels of peptide-specific CD8+ T cells, showed significant responses to vaccination in all patients. Two patients at the highest dose level exhibited >1% circulating CD8+ T cells specific for the native G280. Finally, all nine patients tested had measurable high-avidity CTL that lysed allogeneic melanoma cell lines that coexpressed A*0201 and gp100.

Recently, Cerundolo et al. (35) reviewed progress in the dendritic cell therapy field. They chose as the standard for dendritic cell trials those using characterized peptides and ELISPOT or tetramer assays for measurements of T-cell frequencies in the blood. They compared these with trials done using peptide alone or recombinant viruses alone. There is a very wide variation in T-cell responses. Response to gp100 (209-217M) was 28% in the single trial they analyzed; other melanoma antigen dendritic cell peptide trials report responses ranging from 22% to 73%. The results reported here compare favorably with other studies.

We conclude that dendritic cell–based vaccination with modified class I restricted G280-9V peptide uniformly elicits antitumor immunity and offers the prospect of clinical benefit for some patients (35).

Acknowledgments

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References


Immunity+Peptide Elicits CD8+ Immunity Using Autologous Dendritic Cells Pulsed with the Melanoma-Associated Antigen gp100-Derived G280-9V Peptide Elicits CD8+ Immunity
