Phase I Hepatic Immunotherapy for Metastases
Study of Intra-Arterial Chimeric Antigen Receptor–Modified T-cell Therapy for CEA\textsuperscript{+} Liver Metastases

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Abstract

**Purpose:** Chimeric antigen receptor–modified T cells (CAR-T) have demonstrated encouraging results in early-phase clinical trials. Successful adaptation of CAR-T technology for CEA-expressing adenocarcinoma liver metastases, a major cause of death in patients with gastrointestinal cancers, has yet to be achieved. We sought to test intrahepatic delivery of anti-CEA CAR-T through percutaneous hepatic artery infusions (HAIs).

**Experimental Design:** We conducted a phase I trial to test HAI of CAR-T in patients with CEA\textsuperscript{+} liver metastases. Six patients completed the protocol, and 3 received anti-CEA CAR-T HAIs alone in dose-escalation fashion (10\textsuperscript{8}, 10\textsuperscript{9}, and 10\textsuperscript{10} cells). We treated an additional 3 patients with the maximum planned CAR-T HAI dose (10\textsuperscript{10} cells \times 3) along with systemic IL2 support.

**Results:** Four patients had more than 10 liver metastases, and patients received a mean of 2.5 lines of conventional systemic therapy before enrollment. No patient suffered a grade 3 or 4 adverse event related to the CAR-T HAIs. One patient remains alive with stable disease at 23 months following CAR-T HAI, and 5 patients died of progressive disease. Among the patients in the cohort that received systemic IL2 support, CEA levels decreased 37\% (range, 19\%–48\%) from baseline. Biopsies demonstrated an increase in liver metastasis necrosis or fibrosis in 4 of 6 patients. Elevated serum IFNy levels correlated with IL2 administration and CEA decreases.

**Conclusions:** We have demonstrated the safety of anti-CEA CAR-T HAIs with encouraging signals of clinical activity in a heavily pretreated population with large tumor burdens. Further clinical testing of CAR-T HAIs for liver metastases is warranted.

Introduction

Liver metastases are a significant cause of morbidity and mortality in patients with gastrointestinal adenocarcinoma. Tumor infiltrating lymphocyte (TIL) studies have revealed that host T-cell responses to liver metastases are significant correlates of survival (1–5). Although those who mount effective immune responses to liver metastases tend to have prolonged survival, the vast majority of patients succumb to their disease in the context of endogenous immune failure. The immunosuppressive nature of the intrahepatic milieu (6–9) may promote the development of liver metastases and contribute to aggressive disease biology. Given the favorable effects of robust liver TIL responses and the inherent suppressive nature of the intrahepatic space, delivery of highly specific T-cell products for the treatment of liver metastases is a rational approach.

T cells engineered with chimeric antigen receptors (CAR) to enable highly specific tumor recognition and killing have gained considerable attention (10–12). Reprogramming T cells with CAR genes provides an MHC-independent mechanism for docking with and lysing tumor cells. Such modified T cells have been alternatively termed “designer T cells,” “T-bodies,” or “CAR-T cells” (13–15). Carcinoembryonic antigen (CEA) is an attractive target for CAR-T treatment of adenocarcinoma liver metastases given high levels of CEA expression and the ability to measure CEA in serum (16, 17). Upon antigen recognition, anti-CEA CAR-Ts proliferate, produce cytokines, and kill target cells (18). Previous clinical studies, which evaluated systemic delivery of anti-CEA T cells for metastatic adenocarcinoma, demonstrated both promise and dose-limiting toxicity (19). To improve the tolerability of anti-CEA CAR-Ts for liver metastases in addition to enhancing tumor killing within the liver, we studied a regional delivery strategy.

Regional intra-arterial delivery of chemotherapy for liver metastases has been demonstrated to yield superior response rates and limited systemic morbidity (20). Prior reports of...
regionally infused adoptive cell therapy products have demonstrated the safety of this approach (21–23). We propose that hepatic artery infusion (HAI) of anti-CEA CAR-Ts will limit extrahepatic toxicity while optimizing efficacy for treatment of liver metastases. To test the safety and in vivo activity of anti-CEA CAR-Ts in patients with liver metastases, we conducted the phase I Hepatic Immunotherapy for Metastases (HITM) trial (NCT01373047). We utilized a second-generation anti-CEA CAR (18), containing the CD28 costimulatory and CD3ζ signaling domains. We treated an initial cohort with CAR-T HAI intrapatient dose escalations without IL2 support and a second cohort that received fixed CAR-T doses with continuous IL2 infusions.

Six patients with liver metastases completed our protocol and we demonstrated that HAs of anti-CEA CAR-Ts were well tolerated with and without IL2 infusion. We also demonstrated in vivo activity of CAR-T HAs in patients with large volume liver metastasis refractory to conventional treatment. In addition to exploring the safety and efficacy of CAR-T HAs, we examined immunologic correlates of intrahepatic and systemic responses. Our findings support testing of CAR-T HAs for liver metastases in future trials.

Materials and Methods

Study design

In this phase I study (NCT01373047, RWH 11-335-99) we treated two cohorts of 3 patients with anti-CEA CAR-T HAs without or with systemic IL2 support (Fig. 1). Cohort 1 was treated with CAR-T HAs in intrapatient dose escalation fashion (10⁴, 10⁵, and 10⁶) cells) without IL2. Those in the cohort 2 received 3 HAI of 10⁶ CAR-Ts in addition to continuous systemic IL2 infusion at 75,000 U/kg/d via an ambulatory infusion pump.

Eligible patients had measurable unresectable CEA-positive liver metastasis or detectable serum CEA levels and failed one or more lines of conventional systemic therapy. Minimal extra-hepatic disease in the lungs or abdomen was permitted. No commercial sponsor was involved in the study. Clinical assessments were scheduled on infusion days, and on days 1, 2, 4, and 7 postinfusion. Liver MRI and PET examinations were performed within 1 month before the first infusion and then within 1 month following the third CAR-T HAI. The study radiologist (B.F. Stainken) graded responses according to modified RECIST (mRECIST) and immune-related response criteria (26).

Safety evaluation was performed per protocol. Severity of adverse events was graded using the National Cancer Institute Common Terminology Criteria for Adverse Events version 4.0. The study was performed after approval by the institutional review board of the Roger Williams Medical Hospital in accordance with an assurance filed with and approved by the U.S. Department of Health and Human Services. Informed consent was obtained from each subject enrolled in the study.

Human CAR-T cell production

The second-generation anti-CEA scFv-CD28/CD3ζ (Tandem) CAR was cloned into the MFG retroviral backbone as previously described (FDA BB IND 10791; ref. 18). Briefly, the tandem molecule was generated by fusing the hMN14 scFv-CD8 hinge segment of the IgTcR (IgCEA) in the MFG retroviral backbone with a hybrid CD28/CD3ζ molecule. The construct was verified by sequencing. The clinical retroviral vector supernatant was produced using PG13 cells to generate gibbon ape leukemia virus pseudotyped viral particles as described (27). All clinical batches were prepared at Indiana University vector production facility (Indianapolis, IN) and stored at −80°C.

Rhode Island Blood Center personnel performed leukapheresis at the Roger Williams Medical Center (RWMC, Providence, RI). Anti-CEA CAR-Ts were prepared at the RWMC Cell Immunotherapy and Gene Therapy (CITGT) Good Manufacturing Practice (GMP) Facility with standard operating procedures (SOP) for processing, manufacturing, expansion, dose harvesting, labeling, storage, and distribution. Briefly, patient peripheral blood mononuclear cells (PBMC) were isolated from leukapheresis product using Ficoll (Sigma). We then activated PBMCs for 48 to 72 hours in tissue culture flasks (BD Falcon) containing AIM V media (Life Technologies) supplemented with 5% sterile human AB serum (Valley Biomedical), 50 ng/mL of anti-CD3 monoclonal antibody (OKT3; Ortho Biotech), and 3,000 U/mL of IL2 (Prometheus).

Using the spinoculation method (28), 7.2 to 14.4 × 10⁶ T cells were transfused in retronectin (TakaRa Bio Inc.) coated 6-well plates in AIM V media with 5% human AB serum, 3,000 U/mL of IL2, and protamine sulfate (Mp Biomedicals) at low-speed centrifugation for 1 hour at room temperature. Three transductions were carried out over 24 hours. After transduction, cells were washed and incubated for 48 to 72 hours at 37°C. CAR-Ts were further expanded in Lifecell tissue culture bags (Baxter) for 10 to 14 days. CAR-T growth curves and cell viability were examined periodically and cell growth media were replaced as required. CAR-Ts were examined by flow cytometry with fluorescently labeled antibodies specific for CD3 (UCHT1; Invitrogen), CD4 (SK3; BD Biosciences), CD8 (3B5; Invitrogen), and CAR expression (W12 antibody; Immunomedics). The W12 antibody was prepared as an APC conjugate (W12-APC; Molecular Probes). Flow cytometry was performed on a CyAn (Beckman Coulter) or LSRII (BD Biosciences) machine. In vitro activity of patient products was measured by bioluminescence cytotoxicity assay. Luciferase-expressing CEA+ tumor cells were mixed with anti-CEA CAR-T at various ratios in 96-well round bottom plates and loss of bioluminescence from each well measured (29).

We prepared clinical doses using a Fenwal cell harvester system (Baxter) in freezing media containing Plasmalyte (Baxter), 20% human bovine albumin (Valley Biomedicals), 10% DMSO (Bioniche Pharma) and IL2. Bacterial and fungal cultures were monitored for 14 and 28 days, respectively. We performed assays for endotoxin with LAL Endotoxin assay kits (Lonza). The clinical dose was stored in liquid nitrogen and thawed immediately before infusion.
Hepatic Artery CAR-T Infusions

Figure 1.

**A** HITM trial design and CAR-T cell trafficking data. A. patient treatment and evaluation schedule. B. quality control data for the CAR-T products is shown. The percentage of cells that expressed CD3 and the anti-CEA CAR, in addition to the viability fraction, are illustrated for each patient (left). Flow cytometry histogram of preinfusion product from patient 7 demonstrating CAR⁺ percentage, with the dashed line representing the FMO control and lymphocyte gating demonstrated in the inset dot plot (right). C. flow cytometry data from HITM patient 7 to illustrate detection of CD3⁺ CAR⁺ cells within normal liver and liver metastasis 2 weeks following the second CAR-T HAI. CAR gating was set based on the illustrated FMO control. Plot on right demonstrates CAR mean fluorescence intensity (MFI) values from each specimen for patient 7. D. Blood (B), normal liver (L), and liver metastasis (M) biopsies were harvested and analyzed by flow cytometry as illustrated for patient 7. CAR-T percentages among lymphocytes are shown. Percentages were adjusted by subtracting background staining values obtained from FMO control samples. All values represent samples taken 2 weeks following the second infusion. The second dose for cohort 1, -IL2, was 10⁷ cells and for cohort 2, +IL2, was 10⁸ cells.

**Product delivery**

At baseline, a mapping angiogram was performed via a common femoral artery approach. The gastroduodenal and right gastric arteries, in addition to other potential sources of extrahepatic perfusion, were embolized with microcoils. For CAR-T infusions, the same arterial access procedure was carried out and the cells were hand injected via a 60-mL syringe at a rate of <2 mL/second with a total volume of 100 mL. Angiography with calibrated contrast rate was performed after the first 50 mL and at completion of the CAR-T infusion to confirm preserved arterial flow. Infusions were delivered into the proper hepatic artery when possible. In cases of aberrant hepatic arterial anatomy, where either the right or left hepatic artery did not arise from the proper hepatic artery, the dose was split based upon lobar volume calculations. In such cases, split doses were delivered separately into the right and left hepatic arteries to ensure proportionate CAR-T delivery to both lobes.

**Correlative studies**

Normal liver and liver metastasis core needle (16-gauge) biopsies were obtained under sonographic guidance at baseline and at the time of the third CAR-T HAI. Three cores were obtained for normal liver and liver metastases, with each confirmed by cytology. For each case, 4- to 5-μm sections were stained with hematoxylin and eosin (H&E) and additional unstained slides were stained with anti-CEA antibody (TF 3H8-1; Ventana). All
immunohistochemical stains were performed on the Ventana Medical System at Our Lady of Fatima Hospital (Providence, RI). All slides were reviewed in blinded fashion and graded for necrosis and fibrosis. Fibrosis was scored as follows: 0%, grade 0; 5% to 10%, grade 1; 11% to 50%, grade 2; >50%, grade 3. Necrosis was scored as follows: 0%, grade 0; 0% to 10%, grade 1; 11% to 50%, grade 2; >50%, grade 3. Flow cytometry was performed on fresh biopsy tissue for CAR-T cells and peripheral blood as described above.

We measured serum IFNγ levels in all patients by ELISA (eBioscience). Samples were purified with the Purelink DNA isolation Kit (Life Technologies) according to the manufacturer’s instructions. Patient serum was screened for anti-CAR antibodies 1 month after treatment by flow cytometry. We mixed CAR+ or CAR- Jurkat cells with 100 μL of 1:1 diluted patient serum and then stained with secondary goat anti-human immunoglobulin.

CAR DNA was measured from patient whole-blood genomic DNA by qPCR performed at the Boston University Analytical Core Facility. SYBR Green technology was used and CAR-positive samples were identified using 100 μmol/L 28F2 forward (5'-GCAAGCATTCGACCCCTAT-3') and zr2 reverse (5'-GTTCGT-GCCCTGCTGGTA-3') primers (custom, Sigma Aldrich). Plasmid DNA containing the CAR gene was used as a positive control qPCR. Additional primers were used to amplify CD3, GAPDH, and RPL13A (Bio-Rad). Raw cycle threshold (Ct) values were normalized to the average of the two reference genes (RPL13A and GAPDH) and we used the DeltaDelta Ct method to analyze the results. Wet-lab validated and MIQE-compliant primers were purchased from Bio-Rad.

Results

Study design and patient characteristics

We enrolled 8 patients with unresectable CEA+ adenocarcinoma liver metastases who progressed on an average of 2.5 (range, 2–4) lines of conventional systemic therapy (Table 1). Six patients completed the protocol (Fig. 1A), 1 patient withdrew due to an unrelated infection before treatment, and another patient withdrew due to extrahepatic disease progression before his third CAR-T HAI. Of the patients that completed the protocol, 4 were male and 2 were female. Five patients had stage IV colorectal carcinoma and 1 patient had pancreatobiliary ampullary carcinoma. The average age was 57 (range, 51–66). Patients presented with substantial disease burdens, with the average size of the liver metastases who progressed on an average of 2.5 (range, 2–4) lines of conventional systemic therapy (Table 1).

Table 1. Patient characteristics

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<th>DFI</th>
<th>EHD</th>
<th>No. LM</th>
<th>Size (cm)</th>
<th>CEA (ng/mL)</th>
<th>IL2</th>
<th>CAR-T doses</th>
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</tr>
<tr>
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</tr>
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<td>M</td>
<td>55</td>
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<td>362</td>
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<td>2</td>
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<td>3</td>
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<tr>
<td>6</td>
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<td>Colon</td>
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<tr>
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<td>9.8</td>
<td>72</td>
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</table>

Abbreviations: DFI, disease-free interval from diagnosis of primary to liver metastases; IL2, continuous IL2 infusion with CAR-T; LM, liver metastases; size, largest LM before CAR-T treatment; RPN, retroperitoneal nodes; CHEMO, number of lines of systemic therapy prior to enrollment.

*Pancreatobiliary subtype of ampullary carcinoma.

NOTE: Patient 2 experienced grade 3 abdominal pain and dehydration; he was taken off protocol after the second HAI and died due to disease progression 23 days later. Patient 3 was withdrawn before CAR-T infusion due to an unrelated medical condition. Liver function test adverse events reflect values outside of normal range and not necessarily change from baseline.

Table 2. Adverse events

<table>
<thead>
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<th>ID</th>
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<th>Description</th>
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<tbody>
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<td>1</td>
<td>12</td>
<td>Fever, myalgias, abdominal pain, nausea, emesis, and tachycardia</td>
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<tr>
<td>2</td>
<td>1</td>
<td>2</td>
<td>Abdominal wall muscle spasm and AST</td>
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</tr>
<tr>
<td>3</td>
<td>1</td>
<td>3</td>
<td>AST and alk phos</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>1</td>
<td>Aci tes, edema, thrombocytopenia, AST, AST</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>1</td>
<td>Fever, rash</td>
<td></td>
</tr>
<tr>
<td>6</td>
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<td>1</td>
<td>5</td>
<td>AST, ALT, thrombocytopenia, dyspea, rash</td>
</tr>
<tr>
<td>7</td>
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<td>Lower extremity edema</td>
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<td>2</td>
<td>6</td>
<td>Fever, tachycardia, diarrhea, dehydration, lower extremity edema</td>
<td></td>
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</tbody>
</table>

NOTE: Patient 2 experienced grade 3 abdominal pain and dehydration; he was taken off protocol after the second HAI and died due to disease progression 23 days later. Patient 3 was withdrawn before CAR-T infusion due to an unrelated medical condition. Liver function test adverse events reflect values outside of normal range and not necessarily change from baseline.

Death due to disease progression 28 days after third infusion.

*Death due to disease progression 28 days after third infusion.

*Death due to unrelated medical condition.
largest liver metastasis being 8.4 cm (range, 1.7–14.4) and 5 patients having more than 10 liver metastases. The mean CEA level upon enrollment was 807 ng/ml (range, 2–3,265). Five of 8 patients had synchronous colorectal liver metastases, and the mean disease-free interval was 27.3 months (range, 9–37) for patients with metachronous liver metastases. All further analyses include only the 6 patients who completed the study.

CAR-T cell product assessment
The leukapheresis product from each patient was analyzed by flow cytometry before and following transduction with anti-CEA CAR construct. For all patients, the mean percentage of CD3⁺ cells following leukapheresis was 55% (range, 12.0–82.0) and increased to 91% (range, 72–97) following activation and transduction (Fig. 1B). The mean CD4:CD8 ratio was 2.4 (range, 1.4–4.7) in the leukapheresis samples and 0.8 (0.2–2.2) in the final products (not shown). The transduction efficiency (CAR⁺) ranged from 10% to 64%, with a mean of 45% (Fig. 1B). Negligible FoxP3 staining was detected among CAR⁺ cells as described in the methods section.

CAR-T cell trafficking following regional infusion
We obtained CT guided percutaneous biopsies to sample liver metastasis and normal liver before the first CAR-T HAI and at the time of the final HAI. The proportions of CAR-T (CAR⁺/total lymphocyte %) in liver metastasis biopsy, normal liver biopsy, and peripheral blood samples were determined by flow cytometry. Samples from patient 7 demonstrated that 0.8% of normal liver mononuclear cells were CAR⁺ following HAI of CAR-T and 6.6% of intratumoral mononuclear cells were CAR⁺ (Fig. 1C). CAR-T accounted for 5%–20% of liver metastases compared with normal liver in 5 of 6 patients. In patient 5, CAR-T were found to comprise 2% of liver metastasis mononuclear cells in a sample obtained during a microwave ablation procedure 12 weeks following his first CAR-T infusion (not shown). In 4 patients, CAR-T were not detectable in peripheral blood but were transiently present in patient 7 and patient 8 at the time of the final infusion, and the levels dropped below detection 3 days later. We also performed qPCR on peripheral blood samples taken at day 2 following the final infusion; only patient 7 had a measurable increase (1.1-fold) in CAR DNA relative to baseline (not shown).

Anti-CAR antibodies were not detected in patient sera 1 month following CAR-T infusion. This was confirmed by screening sera against CAR⁺ and CAR⁻ target cells and staining for anti-human Ig on the CAR⁺ cells as described in the methods section.

Safety data
Adverse events (AE) of any grade attributable to any cause were observed in all patients who completed the trial (Table 2). The dose in cohort 1 reached the planned maximal HAI CAR-T infusion level at 10¹⁰ cells. No CAR-T dose reductions were required in cohort 1 and, therefore, all patients in cohort 2 received 3 doses at the 10¹⁰ level with IL2 support. There were no grade 4 or 5 adverse events. Febrile AEs were observed in 4 patients. Patient 7 experienced grade 3 fever and tachycardia, with a temperature peak of 104°F. The fever and tachycardia resolved in patient 7 after a 50% dose reduction in her systemic IL2 infusion. Of note, patient 7 also experienced an increase in her peripheral eosinophil count with a peak of 20% and absolute count of 3,740 per ml. Given the reported association between IL2 infusion and cardiac thrombosis with other features of Loeffler syndrome (30), we obtained an echocardiogram and electrocardiogram that were normal. The eosinophil count returned to normal limits without specific intervention.

Clinical activity
At last follow-up, 5 of the 6 heavily pretreated patients who completed the trial died due to disease progression (Table 3). MRI and PET scans were performed in 5 of 6 patients at baseline and 2 to 4 weeks following the third CAR-T HAI. Patient 8 did not obtain final imaging following a return to his native country and ultimately died of disease progression. All patients except patient 5 were determined to have radiographic disease progression. Patient 5 was found to have stable disease by MRI and PET (Supplementary Fig. S3A, arrow). Patient 7 developed new lesions and demonstrated an increase in size of some preexisting lesions, whereas other lesions decreased in size. The lesion in the posterior sector of patient 7 that decreased in size on MRI was not visible on PET (Supplementary Fig. S3B). More medial disease that was decreased in size on MRI was noted to become hypometabolic on the postinfusion PET for patient 7.

As we anticipated limited utility for short follow-up conventional imaging following infusion of CAR-T, we measured serum CEA levels at multiple time points following each of the three HAIs for each patient. Among the patients in cohort 1, transient decreases in serum CEA were demonstrated in 2 patients following each CAR-T HAI (Fig. 3A). CEA kinetics were closely paralleled by changes in serum CA19-9 levels (not shown). Patient 4, who presented with hepatobiliary subtype ampullary carcinoma, was the only patient without a CEA decrease at any point during the trial and he also had the shortest survival time.

The patients in cohort 2 who received systemic IL2 along with anti-CEA CAR-T had more favorable CEA responses to treatment. As each of the three patients in cohort 2 required an IL2 interruption or dose reduction, which would likely impact CAR-T function, we compared CEA levels at baseline with the time point just before IL2 dose change. When using these time points, all 3 patients in cohort 2 had decreases in serum CEA concentrations (Fig. 3A and Table 3). Patients 7 and 8 had a 48% and 43% decrease at any point during the trial and he also had the shortest survival time.

The patients in cohort 2 who received systemic IL2 along with
A

Preinfusion

Postinfusion

-IL2

+IL2

P#1

P#4

P#5

P#6

P#7

P#8

B

Alkaline phosphatase (-IL2)

Total bilirubin (-IL2)

AST (-IL2)

Alkaline phosphatase (+IL2)

Total bilirubin (+IL2)

AST (+IL2)

C

Platelets

D

INR
decrease in serum CEA concentrations, respectively, before IL2 dose interruption or reduction. The mean overall survival time for the 6 patients who completed the trial was 30 weeks with a median of 15 weeks (range, 8–102). Patient 5 is alive with disease at 23 months (102 weeks) following his final CAR-T HAI. Following completion of the HITM trial, patient 5 was determined to have stable disease and we performed a microwave ablation of residual unsectetable tumor (Supplementary Fig. S3).

Detecting radiographic responses in heavily pretreated patients with advanced metastatic disease is challenging, and even more so with immunotherapy where intratumoral inflammation and edema may minimize the relevance of standard RECIST criteria (26). As such, we obtained liver metastasis biopsies before and following CAR-T HAIAs to assess degrees of intratumoral necrosis and fibrosis. After review by a blinded pathologist, 4 patients had an increase in intratumoral fibrosis and 3 patients were scored as having an increase in necrosis within their liver metastases (Fig. 3B). An increase in liver metastasis fibrosis is demonstrated for patient 1 and a decrease in CEA+ tumor cells by immunohistochemistry for patient 8 (Fig. 3C).

**Serum IFNγ concentrations and CEA responses correlate with IL2 administration**

We measured serum IFNγ levels by ELISA at multiple time points. Spikes in IFNγ were noted to occur 24 to 48 hours after doses in all patients, without or with systemic IL2 (Supplementary Fig. S4). Serum CEA changes were compared with peak change in IFNγ for each patient (Fig. 3D, top). The inverse correlation between peak IFNγ levels and CEA change was significant (R = −0.94; P = 0.02). All patient HAI CAR-T doses contained a quantity of IL2 (600,000 UI). The three patients (6, 7, and 8) with continuous systemic IL2 exposure and largest CAR-T doses had the best CEA responses and the highest mean IFNγ levels (P = 0.03, Fig. 3D, bottom).

**Table 3. Patient outcomes**

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<th>PET</th>
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<td>DOD</td>
</tr>
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NOTE: Patient 2 withdrawn after 2 CAR-T doses due to extrahepatic progression and was DOD 23 days after second CAR-T infusion. Patient 3 withdrawn after cell collection due to unrelated medical condition. IL2 CAR*T infusion time points and the dotted vertical lines. Spikes in IFNγ levels and CEA change was significantly related to the CAR-T HAI but did not result in clinically significant consequences. Systemic infusion of T cells expressing anti-CEA TCR was reported to result in dose-limiting toxicity (19).

**Discussion**

Our interest in immunotherapy for liver metastases is based upon studies that have demonstrated liver metastasis patients with robust T-cell responses have significantly improved outcomes. However, most liver metastasis patients fail to mount effective intrathepatic antitumor immunity (1). CAR-T technology has advanced considerably in recent years and holds tremendous promise (10, 11) as an immunotherapeutic tool. We chose HAI of CAR-T to minimize immune-mediated damage to CEA-expressing extracellular tissues and based upon the favorable therapeutic index of chemotherapy HAIAs (20, 31). We established the safety of anti-CEA CAR-T HAIAs with and without systemic IL2 support, reaching the maximum planned dose of 10^11 cells. Systemic IL2 support was associated with increased serum IFNγ levels and improved CEA responses, at the expense of more severe but manageable adverse events. Although there were no radiographic partial or complete responses, 1 of 6 patients had stable disease and is alive at 23 months follow-up. Importantly, histologic evidence of increased liver metastasis necrosis and fibrosis were seen in the majority of subjects following CAR-T HAI.

The safety of CAR-T HAIAs is in line with reports from other groups (21, 23, 25, 32) that infused non-CAR cellular products into the hepatic circulation. The limited systemic exposure of CAR-T in our study subjects likely accounted for the favorable adverse event profile. HAI led to preferential accumulation of CAR-T within liver metastases in 5 of 6 HITM patients, compared with normal liver and peripheral blood. CAR-Ts were not detected in the peripheral blood in 4 of 6 patients and only transiently in patients 7 and 8. Moderate elevations of liver function test values were not likely related to the CAR-T HAI but did not result in clinically significant consequences. Systemic infusion of T cells expressing anti-CEA TCR was reported to result in dose-limiting toxicity (19).

Similar toxicities have been seen with our CAR-T when systemically infused, particularly with IL2 support (R.P. Junghans;
unpublished data). Our continuous ambulatory infusion dose of IL2, 75,000 U/kg/d, is several-fold lower than what is given in other protocols (33). Despite the low daily dose of the IL2 in this study, 2 patients experienced grade 3 events requiring IL2 dose reductions. We attributed these adverse events, including severe pyrexia and colitis, to the IL2 based upon the fact that the symptoms resolved promptly upon IL2 dose reduction. We cannot completely exclude the possibility that the IL2 activated a small number of systemically circulating anti-CEA CAR-T that mediated fever and colitis. Overall, our IL2 infusion strategy was...

Figure 3.
Assessments of clinical activity of anti-CEA CAR-T HAIs. A, serum CEA levels are illustrated for patients who were treated with CAR-T HAIs alone (top row) or CAR-T with systemic IL2 support (bottom row). CAR-T infusion time points are indicated by dotted vertical lines and IL2 dose interruptions by black arrows. The first data point represents the baseline value before CAR-T infusion. B, a blinded pathologist, comparing baseline to postinfusion, scored fibrosis and necrosis from normal and liver metastasis biopsies. For each patient, baseline and postinfusion scores are shown from left to right. C, routine H&E staining for patient 1 (left) and CEA staining for patient 8 (right) are shown, comparing baseline with postinfusion. D, we measured serum IFN\(\gamma\) concentrations by ELISA before and after each hepatic artery CAR-T infusion. Peak IFN\(\gamma\) levels were correlated with the percentage change in CEA concentration from baseline to the time point before IL2 dose interruptions or reductions (top). Mean IFN\(\gamma\) values were calculated for each patient and compared among those who did or did not receive systemic IL2 support in addition to hepatic artery CAR-T infusions (bottom).
well tolerated and the adverse events easily managed by dose reductions.

MRI and PET scans did not demonstrate a response in any patient, while 1 patient had stable disease and is alive more than 23 months following his final CAR-T HAIs. Our patients were heavily pretreated with profound disease burdens, with 4 of 6 patients presenting with more than 10 liver metastases. Due to rapid disease progression following cessation of CAR-T infusions and IL2, we were unable to follow up 5 of the 6 patients beyond 2 months, when responses to immunotherapy may manifest radiographically (26). We are encouraged by the CEA responses in the cohort that received IL2 and by the evidence of necrosis and fibrosis following CAR-T HAIs in several patients. Based on the timing of the biopsies, we cannot determine if IL2 alone or IL2 in combination with a higher CAR-T dose in cohort 2 contributed to histologic findings (34). We also cannot reach definitive conclusions about the efficacy of our approach, but speculate that responses would be more favorable in patients with lower disease burdens. Interestingly, CEA declines may be inherently beneficial given the recently reported proangiogenic effects of CEA (35).

To assess trafficking, we performed image-guided core biopsies of pre- and postinfusion liver metastases and surrounding liver. We analyzed biopsy specimens for CAR+ cells and studied the cell populations by flow cytometry. CAR+ T cells were present in detectable numbers in both tumor and normal liver after HAIs, with numbers passing through liver being undetectable or only minimally detectable in peripheral blood. Similarly, in a parallel study with systemic administration of the same anti-CEA CAR-T, we demonstrated the presence of CAR+ cells by immunohistochemistry in normal liver and in tumor after infusion (Junghans and colleagues; data not shown), thus confirming trafficking by this independent method.

As to intrahepatic T-cell distribution after HAIs, Takayama and colleagues found a preferential localization in tumor versus normal liver after infusion of radiolabeled tumor infiltrating lymphocytes (TIL; ref. 36). Our own flow cytometric analyses of core specimens in this study are also consistent with a conclusion of preferential tumor distribution of CAR T cells in 4 of 6 subjects after HAIs. However, further directed assessments will be required to independently confirm this association on a statistical level.

Performing detailed assessments of CAR-T phenotype and function can be challenging when working with a small subpopulation of mononuclear cells isolated from core needle biopsy specimens. Given the technical limitations related to detecting CAR-T in liver biopsies following infusion, alternative strategies, including molecular imaging with MRI or PET scans (37), or radiolabeling as done by Takayama and colleagues (36) above, should receive consideration for future trials.

Effective delivery of anti-CEA CAR-T to CEA+ tumor deposits also correlated with histologic evidence of tumor killing and serum cytokine surges (38). CEA responses were noted in 3 patients, all of whom received systemic IL2. IL2 alone is not expected to affect CEA levels, which presumptively implicates this fraction of CAR T cells that traffic to tumor as mediating this effect. Prior work in this laboratory has shown tumor responses in animals (34) and in humans (Junghans and colleagues; unpublished results) with CAR-T cells that are dependent upon IL2 supplementation.

One potential limitation on the activity of CAR-T in vivo would be the development of anti-CAR antibodies that could lead to rapid elimination of CAR+ cells. In the present instance, no patient developed an anti-CAR response. In many cases, the CAR includes foreign protein with a murine antibody domain that can elicit an immune response. In the current anti-CEA CAR, however, a CDR-grafted humanized version of the murine MN14 antibody (39) was selected for CAR engineering; such humanized antibodies are known to have much reduced immunization potential with only 4% incidence of anti-immunoglobulin responses in human clinical trials (40). Thus, the absence of anti-CAR antibody reaction in our patients is reassuring but not surprising.

We speculate that improved CAR-T delivery by HAI may decrease the need for lymphodepleting or myeloablative preconditioning (41). In the absence of preconditioning or enhanced cytokine support strategies, multiple CAR-T HAI doses will be necessary. As such, defining surrogates of early response will be important to identify patients who are likely to benefit from serial CAR-T HAIs. Intratumoral necrosis and fibrosis are meaningful correlates of antitumor efficacy, but obtaining liver biopsies at multiple time points is not without risk.

IFNγ correlated with CEA response in the present study. Whereas IL2 likely directly affected systemic IFNγ levels (42), activation of CAR-T within the liver may have also contributed to IFNγ surges. Of note, HAI of CAR-T also led to an increase in serum levels of IL6 and IL17 in patients who did and did not receive IL2 (38), suggesting that CAR-T activity in the intrahepatic space can be detected by peripheral cytokine changes. Increases in serum IFNγ were also noted in the cohort 1 patients, who received an initial HAI bolus of IL2 with their CAR-T doses. This was more prominent in cohort 2 patients with sustained systemic IL2 exposures, in addition to higher CAR-T doses. These findings are compatible with a systemic IL2 effect on T-cell IFNγ production. Interestingly, the highest IFNγ levels in patient 1 and patient 5 were noted after the maximal CAR-T dose (1010). CAR-T that were activated by CEA+ tumor were also likely to have contributed to increases in serum IFNγ.

Our study design does not permit us to conclude that IFNγ changes were solely related to CAR-T activity. Even so, serum IFNγ is an attractive candidate biomarker of clinical responsiveness to CAR-T HAI for liver metastases.

We propose that addressing immunosuppression within the intrahepatic space can enhance the clinical efficacy of CAR-T HAIs (6–8, 43, 44). Based on our findings, further clinical study of CAR-T HAIs is warranted to establish an optimal combinatorial approach. Checkpoint blockade antibodies are an attractive option for use in combination with CAR-T HAIs (45, 46). Immune checkpoint blockade is particularly appealing given that we have found high levels of PD-L1 expression among suppressive liver immune cells, along with PD-1 expression among anti-CEA CAR-T (S.C. Katz; unpublished data). Finally, future HAI CAR-T trials may include alternative methods of CAR-T expansion, including activation with anti-CD3/CD28-coated beads (11, 47). The results from our initial phase I HFTM trial demonstrate the safety of CAR-T HAIs and encouraging signals of clinical activity. CAR-T HAIs may prove to be a valuable component of a combinatorial immunotherapeutic approach for liver metastasis refractory to conventional treatments.

Disclosure of Potential Conflicts of Interest

S.C. Katz is a consultant/advisory board member for InCytu and SureFire Medical. No potential conflicts of interest were disclosed by the other authors.
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