Persistence of CTL Clones Targeting Melanocyte Differentiation Antigens Was Insufficient to Mediate Significant Melanoma Regression in Humans


Abstract

Purpose: Adoptive transfer of autologous tumor infiltrating lymphocytes (TIL) can mediate durable cancer regression in selected patients with metastatic melanoma. However, the tumor antigens associated with these favorable responses remain unclear. We hypothesized that a clinical strategy involving the iterative adoptive transfer of selected autologous antigen-specific T-cell clones could help systematically define immunologic targets associated with successful cancer therapy, without the interpretative ambiguity of transferring polyclonal populations. Here, we evaluated the clinical efficacy of CD8+ T-cell clones specific for the melanocyte differentiation antigens (MDA), gp100 and MART-1, respectively.

Experimental Design: We conducted two consecutive phase II clinical trials involving the adoptive transfer of highly selected autologous antigen-specific CD8+ T-cell clones against gp100 and MART-1, respectively. Fifteen patients with HLA-A2+ treatment-refractory metastatic melanoma received highly avid MDA-specific CD8+ T-cell clones specific for either gp100 (n = 10) or MART-1 (n = 5) with or without intravenous interleukin-2 (IL2) after a lymphodepleting myeloablative preparative regimen.

Results: Of the 15 treated patients, we observed immunemediated targeting of skin melanocytes in 11 patients (73%) and clonal engraftment in eight patients (53%) after cell transfer. There were only transient minor tumor regressions observed, but no objective tumor responses based on Response Evaluation Criteria in Solid Tumor (RECIST) criteria.

Conclusions: Despite successful clonal repopulation and evidence of in vivo antigen targeting, the poor therapeutic efficacy after the adoptive transfer of autologous MDA-specific T cells raises significant concerns regarding future immunotherapy efforts targeting this class of tumor antigens. Clin Cancer Res; 21(3); 534–43. ©2014 AACR.

Introduction

Cancer regression in patients with metastatic melanoma can now be achieved with three mechanistically distinct types of immunotherapies that augment naturally existing antitumor T-cell responses: (i) systemic cytokine therapy (1, 2); (ii) checkpoint inhibition (3–6); and (iii) adoptive transfer of autologous tumor-infiltrating lymphocytes (TIL; refs. 7–9). These clinical findings have drawn attention to the significant therapeutic potential of exploiting endogenous T-cell populations for cancer therapy. However, efforts to improve current immunotherapies are hindered by a limited understanding of the specific lymphocyte populations that were responsible for the observed tumor responses. Furthermore, the tumor antigens associated with durable and complete cancer regression remain unclear, thus hindering the development of targeted immunotherapeutics. We hypothesized that a clinical strategy involving the iterative adoptive transfer of highly selected autologous antigen-specific T-cell clones could help systematically define immunologic targets associated with successful cancer therapy, without the interpretative ambiguity of transferring polyclonal T-cell populations. In this approach, T-cell clones could be selected ex vivo based on high avidity recognition of specific tumor antigen epitopes, expanded to large numbers, and reintroduced into the autologous host after a lymphodepleting preparative regimen to eliminate regulatory cells and augment homeostatic expansion.

Here, we report two sequential phase II clinical trials for patients with refractory metastatic melanoma in which the class of melanocyte differentiation antigens (MDA) was targeted with highly avid CD8+ T-cell clones specific for either gp100 or MART-1, respectively. The targeting of these MDAs, which are expressed in both normal melanocytes and melanoma tumors, was prompted by the significant natural immunogenicity of these proteins as evident by the high frequency of primed MDA-specific CD8+ T cells found within the TIL of melanoma metastases (9–12). Furthermore, there has been a long observed association between the development of vitiligo and uveitis due to

Surgery Branch, Center for Cancer Research, National Cancer Institute, Bethesda, Maryland.

Note: Supplementary data for this article are available at Clinical Cancer Research Online (http://clincancerres.aacrjournals.org/).

Corresponding Author: Udai S. Kammula, Surgery Branch, Center for Cancer Research, National Cancer Institute, 10 Center Drive, Building 10-Hattfield CRC, Room 3-5930, Bethesda, MD 20892-1201. Phone: 301-435-8606; Fax: 301-435-5167; E-mail: udai_kammula@nih.gov
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Translational Relevance
Adoptive transfer of autologous tumor-infiltrating lymphocytes (TIL) can mediate durable cancer regression in selected patients with metastatic melanoma. However, the tumor antigens associated with these favorable responses remain unclear. We hypothesized that a clinical strategy involving the iterative adoptive transfer of selected autologous antigen-specific T-cell clones could help systematically define immunologic targets associated with successful cancer therapy, without the interpretative ambiguity of transferring polyclonal populations. Here, we report the findings from two sequential phase II clinical trials evaluating the transfer of CD8\(^+\) T-cell clones specific for the melanocyte differentiation antigens (MDA), gp100 and MART-1, respectively. After clone transfer, we observed immune-mediated targeting of skin melanocytes in 73% of patients and clonal engraftment in 53% of patients. Despite these findings, there were no objective tumor responses. The poor therapeutic efficacy using MDA-specific T cells raises significant concerns regarding future immunotherapy efforts targeting this class of tumor antigens.

Materials and Methods

Patients and clinical protocol
HLA-A2\(^+\) patients with metastatic melanoma were treated with either gp100-specific CD8\(^+\) T-cell clones (n = 10) or MART-1–specific CD8\(^+\) T-cell clones (n = 5) at the Surgery Branch, National Cancer Institute (NCI; Bethesda, MD), between January 2009 and January 2013 on two consecutive phase II clinical protocols (NCT00665470 and NCT01495572) approved by the Institutional Review Board (IRB) and U.S. Food and Drug Administration. All patients gave informed consent for treatment in accordance with the Declaration of Helsinki. The patients were required to be 18 years of age or older and have measurable metastatic melanoma that expressed gp100 or MART-1 and major histocompatibility complex (MHC) class I by immunohistochemistry. Before clone infusion, patients were transiently lymphoablated with a nonmyeloablative lymphodepleting regimen including intravenous administration of cyclophosphamide (60 mg/kg) for 2 days followed by fludarabine (25 mg/m\(^2\)) for 5 days as previously described (9). One day after completion of their lymphodepleting regimen, patients received expanded CD8\(^+\) T-cell clones intravenously, either with or without high-dose interleukin-2 (IL2; 720,000 IU/kg) every 8 hours to tolerance. Patients received baseline computed tomography (CT) and/or magnetic resonance imaging (MRI) and/or positron emission tomography (PET) before treatment. Tumor size was evaluated monthly for 3 months and at regular intervals thereafter by CT, MRI, or documented with photography for cutaneous/subcutaneous lesion. Tumor measurements and patient responses were determined according to Response Evaluation Criteria in Solid Tumor (RECIST).

Media and cell culture
Human cultured cell lines, including T2 cells (HLA-A2\(^+\) peptide transporter–associated protein deficient T-B hybrid) and melanoma tumor lines, 526 mel (HLA-A2\(^+\)/MART-1\(^+\)/gp100\(^+\)), 624 mel (HLA-A2\(^+\)/MART-1\(^+\)/gp100\(^+\)), 888 mel (HLA-A2\(^+\)/MART-1\(^+\)/gp100\(^+\)), 938 mel (HLA-A2\(^+\)/MART-1\(^+\)/gp100\(^+\)), were routinely cultured in complete medium (CM) as previously described (19). T2 cells and the melanoma cell lines, 526mel, 624mel, 938mel, and 888mel, were obtained from the cell production facility in the Surgery Branch, NCI. The melanoma cell lines, 526mel, 624mel, 938mel, and 888mel, were obtained from the cell production facility in the Surgery Branch, NCI (NIH, Bethesda, MD). Human PBMC and CD8\(^+\) T-cell clones were cultured in CM with 10% heat-inactivated human AB serum (Gemini Bio-Products).

Generation of MDA-specific CD8\(^+\) T-cell clones for adoptive transfer
PBMCs from patients with HLA-A2\(^+\) melanoma underwent depletion of CD4\(^+\) lymphocytes by magnetic bead separation (Miltenyi Biotec) and were plated as individual microcultures in 96-well flat-bottomed plates at approximately 1 x 10^5 cells per well. The cells underwent in vitro sensitization for 10 to 14 days in the presence of 1 μg/mL of either gp100(154-162) (KTWGGQYWQV) or the modified 10-mer MART-1\(^+\) (KTWGGQYWQV) (ELAGIGILTV) GMP grade peptide (Multiple Peptide Systems) and IL2 (90 IU/mL) as previously described (19). Individual microcultures that exhibited specific peptide reactivity either by a high-throughput qPCR cytokine screening or a high-throughput flow cytometry tetramer screening assay were selected for further expansion. To derive antigen-specific CD8\(^+\) T-cell clones, limiting dilution was typically performed by plating between 1 and 3 T cells in each well of a 96-well U-bottomed plate in 0.2 mL of conditioned medium containing anti-CD3 monoclonal antibodies (mAb) Orthoclone OKT3 (50 ng/mL; Ortho-Biotech) and IL2 (300 IU/mL) with 5 x 10^5 autologous irradiated (40 Gy) PBMCs. On day 5 and every 3 to 4 days thereafter, half of the medium in each well was replaced with fresh medium containing IL2. Growth-positive culture rate was typically approximately 10% to 12%. Characterization of clone function was performed with enzyme-linked immunosorbent assay (ELISA) to quantify IFN\(\gamma\) secretion in response to limiting concentrations of gp100, MART-1, or the native MART-1\(^+\) (AAGIGILTV) peptide pulsed onto T2 cells and antigen-positive tumor lines. Selected clones were subsequently expanded with anti-CD3 mAb (50 ng/mL), IL2 (300 IU/mL), and 3 x 10^5 irradiated allogeneic PBMCs in upright 25-cm^2 flasks for 14 days. Final large-scale expansion of the clones for patient therapy was...
performed by the Surgery Branch Cell Production Facility using methods previously described (9, 20). The production time for clone generation from in vitro stimulation to the final treatment product was approximately 6 to 7 weeks (18–20).

TCR gene sequencing

Confirmation of CD8+ T-cell clonality and determination of T-cell receptor (TCR) clonotype was performed by purifying RNA from each clone using Qiagen RNEasy kits. 5′ RACE was performed using BD SmartRac e reagents and protocol, using the universal 5′ forward primer, and a 3′ gene-specific reverse primer for the TCR α constant region, or C1 or C2 β constant regions. Results were run on an agarose gel and appropriately sized bands (800–900 bp) were excised, subcloned into pCR2.1 (Invitrogen Life Technologies) vector, and sequenced.

Tetramers, mAbs, and flow cytometric immunofluorescence analysis

Phycoerythrin-conjugated MART-126(27L) (ELAGIGILTV) peptide/HLA-A*0201 tetramer complexes were obtained from Immunotech, Beckman Coulter. Phycoerythrin-conjugated gp100154–162 (KTWGQYWQV) peptide/HLA-A*0201 tetramer complexes were obtained from the NIH Tetramer Facility. Anti-human CD8, CD3, CD45RO, CD62L, and CD95 mAbs were obtained from BD Biosciences. Immunofluorescence, analyzed as the relative log fluorescence of live cells, was measured using a FACSCanto II flow cytometer with FACS Diva software (BD Biosciences) and FlowJo software (TreeStar, Inc.).

ELISA-based cytokine release assay

Responder cells (1 × 10^6 T cells) and stimulator cells (1 × 10^5 peptide pulsed T2 cells or tumor lines) were coincubated in a 0.2-mL volume in individual wells of a 96-well plate. Supernatants of peptide pulsed T2 cells or tumor lines) were coincubated in a 0.2-mL volume in individual wells of a 96-well plate. Supernatants were obtained from BD Biosciences. Immunofluorescence, analyzed as the relative log fluorescence of live cells, was measured using a FACSCanto II flow cytometer with FACS Diva software (BD Biosciences) and FlowJo software (TreeStar, Inc.).

Results

Patient and treatment characteristics

A total of 15 HLA-A*0201+ patients with refractory metastatic melanoma, including 5 patients described in a previous report (19), were enrolled upon two consecutive clinical trials.
(NCT00665470 and NCT01495572) in which they received ex vivo–expanded MDA-specific CD8⁺ T-cell clones in conjunction with a nonmyeloablative lymphodepleting conditioning regimen. The protocol was designed to evaluate the persistence, safety, and therapeutic efficacy of MDA-reactive clones. The characteristics of the patients and their cell therapy are shown in Table 1. At the time of enrollment, all patients had demonstrated progression of their metastatic disease after prior systemic therapy. The first 10 patients were treated with CD8⁺ T-cell clones specific for the gp100₁₅₄₋₁₆₂ epitope and the next 5 patients received CD8⁺ T cells specific for the MART₂₇₋₃₅ epitope. The TCR clonotype for each clone was defined by complete molecular sequencing of the β-chain variable region (Vβ). Each patient received a single clonotype except for patient M2 who received two unique clonotypes. The mean number of infused CD8⁺ T-cell clones was 15.8 × 10⁶ (range, 0.1–58.3 × 10⁶). Patients, who were medically eligible, received concomitant high-dose IL2 infusions that were administered to tolerance. All patients in the MART-1 cohort presented with significant clinical comorbidities and were therefore ineligible for IL2 administration.

Characteristics of infused MDA-specific CD8⁺ T-cell clones

The functional and phenotypic attributes of the isolated MDA-specific CD8⁺ T-cell clones were assessed immediately before infusion. Each of the gp100- and MART-specific CD8⁺ T-cell clones demonstrated highly specific and avid antigen recognition by secreting significant amounts of IFNγ in response to 100 ng/mL cognate peptide pulsed on T2 target cells (Fig. 1A) and naturally

![Figure 1. Peptide and tumor reactivity of the infused MDA-specific CD8⁺ T-cell clones. MDA-specific CD8⁺ T-cell clones (1 × 10⁴) isolated from each patient were stimulated with (A) an equal number of T2 cells pulsed with either gp100₁₅₄₋₁₆₂, MART₂₇₋₃₅ or no peptide (DMSO) or (B) HLA-A₂⁺ and HLA-A₂⁻ melanoma tumor cell lines that express both gp100 and MART-1 in an overnight coculture. IFNγ cytokine levels (pg/mL) were measured in culture supernatants by ELISA. Data shown are the mean ± SEM of replicate cultures assayed. Results are representative of multiple independent assays performed on this set of clones.](https://www.aacrjournals.org/doi/fig/10.1158/1078-0432.CCR-14-2208)
produced peptide on allogeneic HLA-A2+ melanoma tumor lines (Fig. 1B). Analysis of the clone reactivity by intracellular FACS for IL2 and IFNγ production after antigen stimulation revealed an effector cytokine profile with 77% ± 3% of the reactive cells producing only IFNγ, 22% ± 4% of cells producing both IFNγ and IL2, and an insignificant population of cells producing only IL2 (1% ± 1%; Fig. 2A). Furthermore, the transferred clones were found to be highly cytolytic and efficiently lysed tumor in an MHC-dependent manner (Fig. 2B). Phenotypic profiling of the clones demonstrated high cell-surface expression of CD45RO and CD62L and minimal expression of the lymph node homing molecule, CD62L, consistent with a differentiated effector status (Fig. 2C). In summary, the adoptively transferred cells represented a highly selected homogenous population of lytic and differentiated effector CD8+ T cells that specifically targeted MDAs.

Clinical results

Each of the treated patients experienced transient neutropenia and thrombocytopenia induced by the lymphodepleting preparatory chemotherapy regimen. The patients who received postinfusion IL2 were additionally noted to have well-described self-limited toxicities associated with systemic cytokine therapy (7). All of the chemotherapy and IL2-related adverse effects were found to be reversible with clinical symptoms and laboratory test values returning to appropriate levels within 2 weeks. With respect to the MDA-specific CD8+ T-cell clones, within 7 days of infusion, there was evidence of immune-mediated targeting of skin melanocytes. Of the 15 treated patients, 11 patients (73%) developed a diffuse erythematous skin rash (Fig. 3, Table 1) with skin biopsies revealing CD8+ T-cell infiltration into the melanocytic layer consistent with autoimmune dermatitis. These histologic observations, noted at a time when the endogenous lymphocytes had been depleted, strongly suggested that the epidermal melanocytes were the targets of immune attack by the transferred clones. There were no cases of uveitis or ototoxicity detected in any of the patients, indicating that resident melanocytes found in the eyes and inner ears were not targeted. In all cases, the autoimmune dermatitis resolved without treatment after approximately 10 to 14 days, with the exception of patient M2, who developed progressive patchy skin vitiligo, indicating ongoing melanocyte destruction after therapy.

We next sought to evaluate the antitumor effects of the administered clones. Despite evidence of melanocyte targeting in the majority of the patients, none of the treated patients demonstrated an objective tumor response by standard oncologic RECIST criteria (Table 1). We observed mixed and minor biologic activity related to the T-cell clone transfer with radiographic shrinkage of individual tumors in patients GP1, GP5, M1, and M2 (examples shown in Supplementary Fig. S1); however, these findings did not appear to provide meaningful clinical benefit for these patients.

In vivo clonal persistence of MDA-specific CD8+ T-cell clones

In prior adoptive transfer clinical trials, the ability of the transferred cells to persist was strongly associated with tumor regression in patients with metastatic melanoma (21, 22). Thus, to help understand the lack of objective tumor responses in the current trials, we sought to determine whether the MDA-specific CD8+ T-cell clones had successfully engrafted and repopulated
Persistence of MDA Clones Insufficient for Tumor Response

Figure 3. Autoimmune dermatitis after MDA-specific CD8\(^+\) T-cell clone infusion. Representative photographs of autoimmune dermatitis manifesting as a diffuse erythematous rash 5 to 7 days after clone infusion in patients GP5, GP10, and M4. Development of patchy vitiligo in patient M2 two months after clone infusion.

The adoptive transfer of autologous TIL in conjunction with lymphodepleting conditioning regimens can mediate durable complete tumor regression in selected patients with metastatic melanoma (7, 8, 23, 24). However, efforts to further improve upon these clinical findings are currently hindered by an incomplete understanding of the specific lymphocyte populations that were responsible for the tumor responses. The cellular composition of administered melanoma TIL is polyclonal, varies across individual patients, and remains largely unknown. As such, the tumor antigens that were instrumental in inducing sustained and complete immune responses are also unclear. One strategy to provide clarity to these issues involves the iterative isolation and adoptive transfer of tumor reactive T-cell clones with single antigen specificity. The transfer of cloned lymphocytes would allow a precise determination of the in vivo fate and function of a genetically trackable population of antigen-specific T cells. Here, we report the results from two sequential clinical trials in which MDAs were targeted with autologous CD8\(^+\) T-cell clones in patients with metastatic melanoma. The decision to target MART-1 and gp100 stemmed from a number of observations that suggested that these tumor antigens represented favorable therapeutic targets to treat melanoma. First, these antigens have been reported to be commonly and highly expressed in metastases among many patients with melanoma (25, 26). Second, the MDAs are highly immunogenic. Since the original identification of HLA-A2 restricted MART-1 and gp100 epitopes recognized by naturally occurring TIL (10, 11), high frequencies of primed CD8\(^+\) T cells specific for these antigens have been routinely isolated from peripheral blood and tumor derived lymphocyte populations (11, 27, 28). Finally, there has been a long observed and intriguing association between the development of autoimmune against melanoma tumor regression in patients treated with immune therapies (13–17). Collectively, these findings prompted our prospective evaluation of the effectiveness of MART-1 and gp100 as tumor regression antigens.

We previously reported a high-throughput technique that allowed the rapid isolation and expansion of high-avidity MDA-specific CD8\(^+\) T-cell clones from peripheral blood for use in adoptive transfer clinical studies (18, 19). The current report further demonstrates that these clones could be routinely isolated and that they possess potent and specific in vivo lytic capability against MDA-expressing melanoma tumor lines. In vivo evidence of clone activity after adoptive transfer was seen in the targeting of normal melanocytes (for example, uveitis and melanoma) among many patients with melanoma (25, 26). Second, the antigens are highly immunogenic. Since the original identification of HLA-A2 restricted MART-1 and gp100 epitopes recognized by naturally occurring TIL (10, 11), high frequencies of primed CD8\(^+\) T cells specific for these antigens have been routinely isolated from peripheral blood and tumor derived lymphocyte populations (11, 27, 28). Finally, there has been a long observed and intriguing association between the development of autoimmunity against melanoma tumor regression in patients treated with immune ther-apies (13–17). Collectively, these findings prompted our prospective evaluation of the effectiveness of MART-1 and gp100 as tumor regression antigens.

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One potential deficiency of our treatment may reside in the intrinsic nature of the infused cell product. The clones generated in this study were derived from the peripheral blood and as such, these cells may lack necessary tumor trafficking and homing abilities that are present in tumor-derived lymphocytes, such as TIL. Furthermore, although our CTL clones were derived using a rapid cloning approach, the cells still underwent massive in vitro proliferation and differentiation. Murine studies have suggested that CD8\(^+\) T cells that have undergone such extensive in vitro expansion progressively lose in vivo proliferative potential and rapidly undergo apoptosis after adoptive transfer (29). However, this theory is difficult to reconcile with the observation that the
clones in the current study could persist for very long periods in the host (Fig. 4C), suggesting that cell survival was not a limiting factor.

Another possibility is that the degree of clonal persistence noted in our studies may not have been sufficient to mount a sustained antitumor response. The persistence in our treated patients was heterogeneous and ranged from 0.3% to 7.8% of the circulating CD8+ T-cell population (Table 1). Previous clinical trials studying the adoptive transfer of autologous TIL have reported a significant and positive correlation between tumor response and the capability of the transferred cells to persist. However, the magnitude of persistence was not examined as a correlate of clinical response. In an effort to determine whether a threshold of persistence is critical for tumor regression, we are currently evaluating approaches to enhance in vivo persistence after cell transfer in preclinical murine models. Variability in the administration of high-dose IL2 might have also influenced the level of persistence or the activation state of the transferred clones. Unfortunately, our study was not designed to address the impact of IL2 dosing on clonal persistence and activity.

Finally, perhaps the most compelling hypothesis for the results of the current clinical trials is that MDAs are suboptimal tumor regression antigens. In fact, a comprehensive review of published adoptive transfer studies targeting the MART-1 and gp100 antigens in patients with metastatic melanoma over the last decade has, similarly, found poor therapeutic efficacy using either MDA-specific clones (28, 30–35), MDA-enriched polyclonal bulk infusions (36–38), or MDA TCR gene-modified PBL (Table 2;
<table>
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<tr>
<th>Year</th>
<th>Author</th>
<th>Trial phase</th>
<th>Cell population</th>
<th>Target antigen: epitope</th>
<th>Patients (n)</th>
<th>Preparative regimen</th>
<th>Cells (n)</th>
<th>Concomitant therapy</th>
<th>Responses</th>
<th>% CR</th>
<th>% ORR</th>
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<tr>
<td>2002</td>
<td>Dudley et al.</td>
<td>I</td>
<td>CTL clone</td>
<td>MART-1:27</td>
<td>35</td>
<td>2 CY</td>
<td>3.3  10^9</td>
<td>None, FLU, HD IL-2</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>Yee et al.</td>
<td>I</td>
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<td>35</td>
<td>5 None</td>
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<td>0</td>
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<td>Vignard et al.</td>
<td>I/II</td>
<td>CTL clone</td>
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<td>10</td>
<td>10 CY</td>
<td>0.036  10^8</td>
<td>None, IL-2, IFN-a</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
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<td>I</td>
<td>Polyclonal CTL</td>
<td>MART-1:27</td>
<td>11</td>
<td>10 CY</td>
<td>0.11  10^8</td>
<td>None, HD IL-2</td>
<td>1 CR</td>
<td>0</td>
<td>9.1</td>
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<td>Morgan et al.</td>
<td>I</td>
<td>DMF4 TCR transduced</td>
<td>MART-1:27</td>
<td>17</td>
<td>10 CY</td>
<td>0.5-34.4 10^9</td>
<td>None, HD IL-2, HD IL-2</td>
<td>2 PR</td>
<td>0</td>
<td>11.8</td>
<td>39</td>
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<tr>
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<td>Wallen et al.</td>
<td>I</td>
<td>CTL clone</td>
<td>MART-1:27</td>
<td>6</td>
<td>None, FLU</td>
<td>10  10^7</td>
<td>None, LD IL-2</td>
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<td>14</td>
<td>CY 1.43-20 10^8</td>
<td>0.036  10^8</td>
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<td>1 CR, 4 PR</td>
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<td>42.9</td>
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<td>20</td>
<td>CY 1.5-10^7</td>
<td>0.6  4.8  10^9</td>
<td>HD IL-2, pep pulsed</td>
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<td>CY 0.4-58.3 10^9</td>
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<td>12</td>
<td>CY 1.3-12 10^8</td>
<td>4.4  10^9</td>
<td>None, HD IL-2</td>
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<td>0</td>
<td>34</td>
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<tr>
<td>2002</td>
<td>Yee et al.</td>
<td>I</td>
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<td>5</td>
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<td>Powell et al.</td>
<td>I</td>
<td>Polyclonal CTL</td>
<td>gp100:154-162</td>
<td>9</td>
<td>CY 0.4-10^9</td>
<td>0.4  10^9</td>
<td>None, HD IL-2</td>
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<td>2009</td>
<td>Johnson et al.</td>
<td>II</td>
<td>gp100 TCR transduced</td>
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<td>16</td>
<td>CY 2.3-110 10^9</td>
<td>2.3-110 10^9</td>
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<td>2012</td>
<td>Chapuis et al.</td>
<td>I/II</td>
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<td>CY 0.4-58.3 10^9</td>
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<td>None, HD IL-2</td>
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**MART-1 summary**
- 118 patients
- 7 CR, 13 PR
- 3.7% CR, 16.1% ORR

**gp100 summary**
- 69 patients
- 1 CR, 2 PR
- 1.4% CR, 4.3% ORR

**Overall summary**
- 187 patients
- 7 CR, 15 PR
- 3.7% CR, 11.8% ORR

**Abbreviations:** CR, complete response; CY, cyclophosphamide; DTIC, dacarbazine; FLU, fluorouracil; HD, high dose; LD, low dose; ORR, objective response rate; PR, partial response.
Although these trials were conducted by various groups and had differences in their clinical design, the characteristics of the infused cell product, and the use of conditioning regimens and cytokines, they shared the exclusive targeting of either MART or gp100. Our review found few, if any, objective clinical responses by standardized oncologic criteria. The most potent in vivo targeting of MDAs was evident in the trials transferring peripheral blood lymphocytes that were genetically engineered to express high-affinity TCRs against MART and gp100 (17). The transfer of these TCR-transduced cells was associated with severe on target-off tumor toxicity in normal tissues in the eye, inner ear, and skin which all harbor populations of normal melanocytes. Although objective tumor responses in patients were demonstrated in these trials, the tumor shrinkage was typically partial and transient in nature. In reviewing the collective experience of published clinical trials targeting MDAs, we found a low complete tumor response rate of 3.7%, which usually involved regression of small volume lymph node metastases. This complete response rate is significantly lower than the 22% 5-year complete response rate associated with bulk polyclonal TIL therapy in patients with advanced melanoma (9). Thus, the cumulative findings of these published reports, in concert with our current study, raise significant concerns regarding future immunotherapy efforts targeting this class of tumor antigens.

One major biologic limitation of targeting MDAs may be the nonessential role that these proteins play in malignant melanoma transformation and the metastatic phenotype. We recently reported the profiling of over 3,000 biopsies of metastases from 1,514 patients with melanoma using quantitative immunohistochemistry to detect gp100, MART-1, and tyrosinase expression (41). We observed significantly low expression or complete loss of expression of each of these MDAs in approximately 30% of lesions. Furthermore, within metastases with detectable antigen expression, there was significant heterogeneity among the tumor cells within the same metastases. This heterogeneity in MDA antigen expression may explain the partial, transient, and mixed responses observed when MDAs are immunologically targeted.

In an attempt to retrospectively define potentially more immunogenic targets responsible for the durable remissions with TIL transfer, the source tumors from these patients have recently undergone whole-exomic sequencing to identify tumor-specific nonsynonymous mutations. Candidate epitopes containing these mutated amino acids were screened for HLA-class I binding motifs and those predicted by an algorithm (42). These findings provide compelling evidence that somatic mutations in metastatic cutaneous melanoma tumors can generate neo-epitopes that can elicit a robust autologous immunologic response against mutant proteins. The search for more suitable antigenic targets has directed our current efforts toward identifying T cells that target neo-epitopes generated by cancer-specific somatic mutations and, in particular, driver mutations. Classic driver mutations encode for proteins that typically contribute to tumor development and maintenance of the malignant phenotype. Unlike MDAs, the neo-proteins encoded by these mutations may serve as more effective therapeutic targets given their tumor specificity and their essential role in the survival and proliferation of metastatic cells.

Disclosure of Potential Conflicts of Interest
No potential conflicts of interest were disclosed.

Authors’ Contributions
Conception and design: S.S. Chandran, R.M. Sherry, U.S. Kammula
Acquisition of data (provided animals, acquired and managed patients, provided facilities, etc.): S.S. Chandran, B.C. Paria, A.K. Srivastava, L.D. Rothermel, D.J. Stephens, J.R. Wunderlich, J.C. Yang, U.S. Kammula
Writing, review, and/or revision of the manuscript: S.S. Chandran, B.C. Paria, A.K. Srivastava, D.J. Stephens, M.E. Dudley, R.M. Sherry, J.C. Yang, S.A. Rosenberg, U.S. Kammula
Administrative, technical, or material support (i.e., reporting or organizing data, constructing databases): B.C. Paria, D.J. Stephens, R. Somerville, S.A. Rosenberg, U.S. Kammula
Study supervision: S.A. Rosenberg, U.S. Kammula

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References


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