Phase I Trial of Subcutaneous Recombinant Human Interleukin-12 in Patients with Advanced Renal Cell Carcinoma

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ABSTRACT

Patients with advanced renal cell carcinoma were treated in a Phase I trial with escalating doses of recombinant human interleukin-12 (rHuIL-12) given on days 1, 8, and 15 of each 28-day cycle. Treatment in the initial dose scheme consisted of a fixed dose with dose levels of 0.1, 0.5, and 1.0 μg/kg given to cohorts composed of three or six patients. On the basis of the toxicity profile, a second scheme (up-titration) was undertaken wherein rHuIL-12 was escalated for each patient from week 1 to week 2, to a target dose given weeks 3 and thereafter; cohort target dose levels were 0.5, 0.75, 1.0, 1.25, and 1.5 μg/kg. Fifty-one patients were treated: 32 (63%) had prior cytokine therapy and 19 (37%) had complete response, 34 patients were stable, 14 patients showed progression, and 1 patient was invaluable.

In conclusion, rHuIL-12 was relatively well tolerated when administered by s.c. injection. The recommended dose according to the up-titration schedule of rHuIL-12 (μg/kg) for Phase II trials was as follows: cycle 1, 0.1 (day 1), 0.5 (day 8), 1.25 (day 15); cycle 2 onwards, 1.25. Phase II trials of rHuIL-12 were initiated in previously untreated patients with renal cell carcinoma and in patients with melanoma.

INTRODUCTION

rHuIL-122 is a heterodimeric protein composed of two disulfide-linked subunits having molecular masses of 40 and 35 kDa, respectively (1, 2). IL-12 as a cytokine has been shown to exert a number of regulatory effects on T lymphocytes and NK cells (3, 4). These include (a) enhancing the lytic activity of NK/LAK-cells; (b) facilitating specific cytolytic T-lymphocyte responses; (c) inducing the secretion of IFN-γ by both T and NK cells; and (d) promoting the development of Th1-type helper T cells, thereby contributing to the development of cell-mediated immune responses (5–8). Other cell types, including monocytes, macrophages, activated B-cells, dendritic cells, and keratinocytes, also contribute to the biological activity of IL-12 (5–8). One activity of IL-12 that may contribute to an antitumor effect is the ability to inhibit angiogenesis, an effect mediated through the induction of IFN-γ (9).

Interest in biological response modifiers as a treatment for metastatic renal cell carcinoma is fostered by the reproducible, albeit infrequent, responses with IFN-α and IL-2 against this chemotherapy-refractory malignancy (10). The antitumor activities of HuhL-2 were demonstrated in a large number of murine tumor models, including Renca, a spontaneously arising renal cell carcinoma (8, 11). Treatment of mice bearing murine Renca renal cell carcinoma resulted in tumor growth inhibition, tumor regression, and prolongation of survival; the antitumor effect was superior to IL-2 and IFN-α (8, 11). These data provided the rationale for a Phase I trial of HuhL-12 in patients with renal cell carcinoma. The schedule of s.c. administration at escalating dose levels of HuhL-12 given once weekly for 3 weeks was based on single- and multiple-dose toxicology studies performed in cynomolgus monkeys and chimpanzees.3 Pharmacokinetic and pharmacodynamic parameters were studied, which included assessment of IFN-γ and serum neopterin, an unconjugated pteridine released by macrophages after activation by IFN-γ (12).

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2 The abbreviations used are: rHuIL-12, recombinant human interleukin-12; IL, interleukin; ASAT, aspartate aminotransferase; ALAT, alanine aminotransferase.

3 Roche, unpublished data.
PATIENTS AND METHODS

Patients. Between April 1995 and November 1996, 51 patients with advanced renal cell carcinoma were entered in this institutional review board-approved Phase I trial. All patients were between 18 and 75 years of age; gave informed consent; had measurable disease; had a Karnofsky performance status ≥80%; had an estimated life expectancy of >4 months; had a WBC count of ≥3000 cells/mm³, a granulocyte count of ≥2000 cells/mm³, a platelet count of ≥75,000 cells/mm³, and a hemoglobin level of ≥10 g/dl; had normal serum bilirubin and transaminase levels and alkaline phosphatase ≤2.5 times normal; had a normal serum creatinine concentration in patients without a prior nephrectomy and ≤1.5 times normal in patients with prior nephrectomy; and had a serum calcium level of ≤12.5 mg/dl (≤3.12 mmol/liter). Exclusion criteria included active brain metastases, history of psychiatric disorders or seizures, clinically significant cardiac abnormalities, chronic obstructive pulmonary disease, prior history of systemic liver disease, active systemic infection, and Th1-mediated autoimmune diseases. Prior systemic therapy was allowed, but patients could not have received more than one previous chemotherapy plus one previous immunotherapy.

rHuIL-12. rHuIL-12 was supplied by Hoffmann-La Roche, Inc. (Nutley, NJ) as ready-to-use HSA-free solution in single-dose glass vials containing 10, 100, 500, or 1000 µg of purified rHuIL-12 in 1 ml of sterile solution containing polysorbate 80 (0.2 mg/ml) and 67 mM PBS adjusted to pH 7.0. The vials were stored at 2–8°C and protected from light. rHuIL-12 was administered by s.c. injection using a 25 gauge needle.

Dose Schedule. All patients were treated with two cycles of therapy lasting 28 days (Table 1). Each cycle consisted of s.c. injections on days 1, 8, and 15. Treatment was given on an outpatient basis, except that patients were hospitalized for pharmacokinetic studies. On the basis of results of the tumor assessment following cycle 2, patients with a response of stable disease or better received additional cycles of therapy until evidence of progression or unacceptable toxicity.

In the initial dose scheme (scheme A), patients were treated with a fixed dose of rHuIL-12 at planned dose levels of 0.1, 0.5, and 1.0 µg/kg. Cohorts included three patients per dose level until a grade 2 or higher toxicity occurred, with the exception of grade 2 fever or leukopenia and grade 3 or 4 lymphopenia or fever; for these levels and subsequent dose-escalated levels, an additional three patients were entered. The maximum tolerated dose was defined as the level at which two of six patients experienced dose-limiting grade 3 or 4 toxicity.

As a result of observations made during the initial phase of the trial regarding treatment tolerability, a second scheme (scheme B) was initiated in August 1995, after patients were treated on the trial. In this scheme, the dose of rHuIL-12 was escalated for each patient on days 8 and 15 of cycle 1 (Table 1). Subsequent cycles were administered at the day 15 dose level. Target (day 15) dose levels were 0.5, 0.75, 1.0, 1.25, and 1.5 µg/kg. Patients weighing more than 80 kg received a maximum total dose corresponding to a body mass of 80 kg. The number of patients treated per dose level and the maximum tolerated dose was defined as described for dose scheme A.

Patients were monitored by physical examination, complete blood count, and serum chemistry on each day of treatment. Each patient had a reassessment of measurable disease after the second cycle of treatment and then every 4 weeks thereafter. Patients with stable disease had tumor assessments performed every 2 months thereafter. All patients kept a daily log documenting symptoms and medications taken. Response was assessed according to WHO criteria and toxicity according to Common Toxicity criteria.

Pharmacodynamic and Pharmacokinetic Parameters. IFN-γ, tumor necrosis factor-α, and neopterin concentrations were measured in the serum of patients at preselected times. Serum samples were obtained at baseline and 10, 24, 48, 72, 96, and 168 h following treatment on day 1 of cycle 1 of treatment scheme A and day 15 of cycle 1 of treatment scheme B. IFN-γ concentrations in serum were determined by a commercial assay (R&D Systems, Minneapolis, MN). In brief, 50 µl of the assay diluent were added to each well of the microtiter plate. Two hundred µl of standard or sample was added to each well and incubated for 2.5 h at room temperature. Each well was then washed three times with buffer, and any remaining wash removed by blotting it against a clean paper towel or by aspiration. Two hundred µl of IFN-γ conjugate were added and incubated for 2 h at room temperature. Each well was repeatedly washed/aspirated, 200 µl of substrate solution were added, and the samples were incubated for 20 min. Fifty µl of stop solution were added to each well and tapped to ensure thorough mixing. The absorbance of each well was determined within 30 min.
using a spectrophotometer set at 450 nm. The interassay variability was <10%, and the limit of detection was 3.0 pg/ml.

Neopterin concentration in serum was measured using a radio-immunoassay that used 125I-labeled neopterin as a tracer (Incstar, Stillwater, MN). Antineopterin rabbit antibody was incubated with samples, standards, and 125I-labeled neopterin. After a 1-h incubation at 37°C, antirabbit antiserum from sheep in polyethylene glycol buffer was added and incubated at room temperature for 15 min. Samples were centrifuged, supernatant was decanted, and pellets were counted for radioactivity. The amount of neopterin in sample was inversely proportional to the amount of radioactivity in the pellet. Unknown concentrations were calculated from a standard curve. The assay showed negligible cross-reactivity with other neopterin-like compounds (bipterin, monapterin, and tetrahydroneopterin) and a lower limit of quantitation of 0.2 ng/ml.

Tumor necrosis factor-\(\alpha\) concentrations were determined by a quantitative sandwich enzyme-immunoassay technique (R&D Systems). Tumor necrosis factor-\(\alpha\) standards and study samples were incubated with antibody bound to a microtiter plate. After washing away unbound substances, an enzyme-linked polyclonal antibody specific for tumor necrosis factor-\(\alpha\) was added to the wells. The plates were washed to remove unbound antibody-enzyme reagent, and a substrate solution was added. Color development was proportional to the amount of tumor necrosis factor-\(\alpha\) bound in the initial step. Sample concentrations were determined on a standard curve by plotting the absorbance versus the lower limit of quantitation of the assay was 15.6 pg/ml.

Serum concentrations of rHuIL-12 were measured at baseline and at 2, 4, 8, 10, 16, 24, 30, 34, 48, and 72 h on days 1–3 of cycle 1 of scheme A (fixed dose) and on day 15 of cycle 1 when first maintenance (target) dose was administered in scheme B (up-titration schedule). rHuIL-12 concentration was measured by a two-step method of antibody capture to ensure specificity followed by a cell proliferation assay. rHuIL-12 was isolated from serum by an affinity technique that involved incubation of samples in sterile tissue culture plates precoated with mouse antihuman IL-12 monoclonal antibody (13). Samples and rHuIL-12 standards were incubated with the bound monoclonal antibody for 3 h on an orbital shaker at room temperature. After a sterile wash with PBS to remove all non-specific material, KIT 5/K6 cells were added to each well of the tissue culture plates. After incubation for 66 h, cells were pulsed with [methyl-\(^3\)H]thymidine for six h, and cell proliferation was measured by [methyl-\(^3\)H]thymidine incorporation. Sample values were determined on a standard curve obtained from plotting radioactive counts against IL-12 concentration. The assay had a lower limit of detection of 50 pg/ml of serum using 100-\(\mu\)l aliquots. The interassay precision was 8.0%. rHuIL-12 was stable in serum for 24 h at room temperature. Serum samples were also found to be stable after three freeze/thaw cycles.

Anti-rHuIL-12 antibodies were measured in serum at baseline and periodically thereafter. Anti-rHuIL-12 antibodies were determined by a sandwich enzyme immunological assay. The assay was based on the ability of the multivalent anti-IL-12 antibodies to simultaneously bind rHuIL-12 coated on the wells of microtiter plate and soluble peroxidase-conjugated rHuIL-12. The intra- and interassay variabilities were 11 and 20%, respectively. The level of detection for this assay was 29 ng/ml. The specificity of the assay anti-IL-12 antibodies was confirmed by the absence of any measured response in serum samples containing antibodies against various irrelevant proteins.

### RESULTS

**Patient Characteristics.** Fifty-one patients were treated with rHuIL-12 (Table 2). The median age was 56 years, and 43 (75%) had a prior nephrectomy. Thirty-two (63%) had prior cytokine therapy (IFN-\(\alpha\), IL-2, or IL-6), and 19 (37%) had received no prior systemic therapy.

**Treatment Administered and Toxicity.** Twenty-four patients were treated with a fixed-dose schedule (scheme A) and 27 were treated with the up-titration schedule (scheme B; Table 1). Fever, fatigue, and a rapid, transient decrease in WBC counts after the first injection were common to all dose levels. The decrease in WBC count included a decrease in lymphocytes and neutrophils; the lymphocyte count decreased to a greater extent. Other frequent adverse events at doses equal to or greater than 27 were treated with the up-titration schedule (scheme B; Table 1). Fever, fatigue, and a rapid, transient decrease in WBC counts after the first injection were common to all dose levels. The decrease in WBC count included a decrease in lymphocytes and neutrophils; the lymphocyte count decreased to a greater extent. Other frequent adverse events at doses equal to or greater than 0.5 \(\mu\)g/kg were mild to moderate chills, diaphoresis, anorexia, headaches, transient cough, and nausea and vomiting. There were no treatment-related deaths, and none of the patients required intensive care unit support.

With the fixed-dose regimen, the 0.1 \(\mu\)g/kg dose was well tolerated, and there were no grade 3 toxicities (except fever, which was not dose-limiting). One of three patients treated with 0.1 \(\mu\)g/kg rHuIL-12 had a grade 2 increase in serum transmi-
Table 3  Number of patients experiencing selected adverse events in cycle 1, day 1, versus cycle 2, day 15 (grades 2, 3, or 4), from fixed dosing scheme A

<table>
<thead>
<tr>
<th>Adverse event</th>
<th>0.1 μg/kg (n = 3)</th>
<th>0.5 μg/kg (n = 15)</th>
<th>1.0 μg/kg (n = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cycle 1, day 1</td>
<td>Cycle 2, day 15</td>
<td>Cycle 1, day 1</td>
</tr>
<tr>
<td>Fever</td>
<td>(2, 0)</td>
<td>(8, 2)</td>
<td>(4, 0)</td>
</tr>
<tr>
<td>WBC</td>
<td>(0, 0)</td>
<td>(3, 1)</td>
<td>(2, 1)</td>
</tr>
<tr>
<td>ASAT</td>
<td>(1, 0)</td>
<td>(0, 0)</td>
<td>(1, 1)</td>
</tr>
<tr>
<td>ALAT</td>
<td>(1, 0)</td>
<td>(1, 0)</td>
<td>(0, 1)</td>
</tr>
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</table>

Fig. 1 Changes in ALAT levels following fixed doses of weekly s.c. administration of rHuIL-12 in a patient (patient 103) at 1.0 μg/kg dose. Increases in transaminase levels were highest after the first dose and decreased on subsequent dosing.

Fifteen patients were treated with a fixed-dose schedule of 0.5 μg/kg. All reported a mild to moderate fever within 36 h of the first injection, and all had mild to moderate increases in serum transaminase concentrations after the first injection. One patient had grade 4 gastrointestinal toxicity. This patient had a distant history of recurrent colitis and a family history of ulcerative colitis undisclosed at study entry. He developed bloody diarrhea during the second cycle, and a colonoscopy showed pancolitis. The patient was taken off the study and improved with medical management that included steroids.

Six patients were treated with a fixed-dose schedule of 1.0 μg/kg; two experienced dose-limiting toxicity composed of a grade 3 increase in transaminase concentration plus grade 4 pulmonary toxicity in one patient and a grade 3 leukopenia in one patient. The pulmonary toxicity was characterized by acute onset of shortness of breath in the setting of fever approximately 40 h following day 1 of cycle 1 treatment during hospital stay. With supplemental oxygen, the patient recovered immediately without sequelae. Evaluation included a chest radiograph, electrocardiogram, and ventilation/perfusion scan, which failed to reveal an etiology. The patient weighed 112 kg, and the relatively high dose of 112 μg of rHuIL-12 may have been a factor; subsequent patients treated on the study were dosed according to a maximum 80 kg weight. At the 1.0 μg/kg dose treatment, fever and leukopenia were more persistent with slower recovery. Nearly all patients treated with 1.0 μg/kg had an increase in transaminase levels 5–10 days after the first injection, but only one patient had grade 3 toxicity.

A comparison of the severity of fever, leukopenia, and elevated serum transaminase concentration according to dose in...
cycle 1 versus cycle 2 suggested a dose-effect relationship (Table 3). At all dose levels, the most severe toxicities occurred mainly after the first injection and were milder upon further treatment with rHuIL-12 (Fig. 1). Most patients showed only mild (grade 1) fever and other common adverse events (leukopenia and elevated ALAT and/or ASAT) in cycle 2 at all doses. Therefore, the maximum tolerated dose was reached at 1.0 μg/kg with the first dose. Because tolerability improved with subsequent therapy, a slow escalation dosing scheme was followed for a second cohort of patients.

In the second dose scheme, the dose of rHuIL-12 was up-titrated in two steps for each patient following day 1 and day 8 treatments, and patients were treated with the maintenance dose ranging from 0.5 to 1.5 μg/kg from day 15 of cycle 1 until they were taken off study or required a dose reduction. No dose-limiting toxicity was observed in patients treated at target maintenance dose levels of 1.25 μg/kg or less. The maximum tolerated dose was 1.5 μg/kg. At this dose level, two of the first six patients had dose-limiting toxicity. The one patient had grade 4 serum transaminase (ALAT) concentrations during week 2 of cycle 2 at the maintenance dose of 1.5 μg/kg. A second patient had grade 3 serum transaminase elevations following the first injection of the 1.5 μg/kg dose during cycle 1. An additional six patients were treated at this dose level without any dose-limiting toxicity.

The severity of changes in serum transaminase and leukocyte concentrations, as well as fever, was compared between cycle 1 and cycle 2 following escalation doses (Table 4). In contrast to patients treated with the fixed dosing scheme, the slow escalation of rHuIL-12 was better tolerated, although similar adverse events occurred at later times (cycle 2) and at higher doses (Fig. 2).

An additional toxicity observed, albeit not dose-limiting, was stomatitis. Grade 1 mucositis was first noted in two patients.
treated at the 1.0 μg/kg dose level in the fixed-dose scheme and one patient treated at the 1.0 μg/kg dose level in the up titration dose scheme. When higher doses of rHuIL-12 were given in the up titration dose scheme, the severity increased and reached grade 2 toxicity in two patients treated at 1.25 μg/kg and two patients treated at 1.5 μg/kg.

**Pharmacokinetics/Pharmacodynamics.** Serum concentrations of rHuIL-12 are shown in Fig. 3 at various doses after the first dose (day 1) in fixed dose scheme A or after the first maintenance dose (day 15) in escalation dose scheme B. Serum concentration of IL-12 increased slowly after s.c. administration, with peak serum concentration observed between 8 and 24 h. Serum concentration then decreased gradually with a half-life ranging from 7 to 21 h. Mean pharmacokinetic parameters of IL-12 are described in Table 5 for both dose schemes. The serum concentrations of IL-12 for equivalent target doses were lower after escalation dose scheme B compared to fixed dose scheme A, although the peak time and half-life were unchanged.

After treatment for as long as 8 months, no serum antibodies were identified against rHuIL-12. Serum levels of anti rHuIL-12 antibody were below the detection limit (29 ng/ml) in all patients.

Three different immunological markers (IFN-γ, neopterin, and tumor necrosis factor-α) were followed to investigate Th1 immune stimulation by rHuIL-12. Serum levels of IFN-γ were nonmeasurable (<3.0 pg/ml) at baseline. The mean peak level achieved in patients treated with 1.0 μg/kg by the fixed dose schedule was 250 pg/ml (Fig. 4). Similar to the levels of serum IL-12, IFN-γ increased but to a lesser extent when dosing scheme was changed from fixed to the up titration schedule. The peak level of IFN-γ was 126 pg/ml at 1.0 μg/kg dose in the escalation dose scheme. The levels, however, increased as the dose was increased within the escalation scheme to 205 pg/ml at

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**Table 5** Mean (±SE) pharmacokinetic parameters of rHuIL-12 at various doses (cycle 1, day 1, for fixed dose and cycle 1, day 15, for escalation doses)

<table>
<thead>
<tr>
<th></th>
<th>Fixed Dose</th>
<th>Escalation Dose</th>
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<tbody>
<tr>
<td></td>
<td>0.5 μg/kg</td>
<td>1.0 μg/kg</td>
</tr>
<tr>
<td></td>
<td>(n = 15)</td>
<td>(n = 6)</td>
</tr>
<tr>
<td>(C_{\text{max}}) (pg/ml)</td>
<td>320 (70)</td>
<td>1092 (275)</td>
</tr>
<tr>
<td>(T_{\text{max}}) (h)</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>AUC(^{c}) (pg-h/ml)</td>
<td>7031 (2031)</td>
<td>26589 (6633)</td>
</tr>
<tr>
<td>(t_{1/2}) (h)</td>
<td>13 (2)</td>
<td>10 (2)</td>
</tr>
</tbody>
</table>

\(^{a}\) AUC, area under the curve.

\(^{b}\) Adequate sample in one patient.
1.5 μg/kg dose, demonstrating a dose-related increase in T<sub>H1</sub> stimulation. The onset of such stimulation was relatively rapid, with peak time for IFN-γ occurring at about 24 h after IL-12 administration. The levels then decreased during subsequent days of the cycle to nonmeasurable levels by day 8 of next dose.

Neopterin serum concentration increased more slowly than IFN-γ, with peak concentration reached between 72 and 96 h following treatment with rHuIL-12. The predose baseline neopterin concentration ranged from 1.2 to 8 ng/ml. The mean ± SE peak neopterin concentration after the first dose of 1.0 μg/kg...
was 70 ± 25 ng/ml. For patients treated with the up-titration schedule (scheme B), the mean ± SE peak neopterin levels after the first maintenance (week 3) dose were 15.4 ± 2.7, 19.5 ± 7.9, 35.0 ± 11.2, and 31.0 ± 5.0 ng/ml at 0.5, 1.0, 1.25, and 1.5 μg/kg doses, respectively (Fig. 5). The peak concentration occurred at about 96 h and maintained at higher than predose levels prior to administration of the next dose (168 h). Few sporadic levels of tumor necrosis factor-α were detected during the treatment, but no consistent increase in levels was observed in relation to severity of the measured adverse events.

Response and Survival. Fifty patients were evaluable for response. One patient, who was considered unequivocal, received day 1 of treatment and was removed from study because of pulmonary toxicity. Two patients discontinued treatment because of progression following one month of therapy. At the 2-month tumor assessment following two cycles of therapy, the response was as follows: stable, 34 patients; progressive, 14 patients. One patient with a response of stable disease following the first two cycles had tumor regression and subsequently achieved a complete response. The extent of disease in this patient was confined to lung parenchyma, and he was treated with 1.5 μg/kg of rHuIL-12 according to the up-titration schedule. This patient continues on treatment following 12 cycles of therapy and remains progression-free at >12 months. For the remaining 34 patients with a best response of stable, the median time to progression was 4 months (range, 2–15 months).

DISCUSSION

Common adverse events observed in this study were fever, chills, fatigue, transient leukopenia, and increase in serum concentrations of hepatic transaminase. Other toxicities included stomatitis, respiratory distress in the setting of fever, and colitis. The colitis may have represented reactivation of an autoimmune disorder; rHuIL-12 facilitated the development of autoimmune disease in several murine models (14, 15). The extent and duration of adverse events were influenced by dose and schedule. In the fixed-dose scheme, acute intolerance was observed with the first treatment at doses of 0.5 and 1.0 μg/kg, and decreased with continued treatment. The acute tolerability of rHuIL-12 was improved when the schedule was altered to a two-step, up-titration dose scheme. The maximum tolerated dose increased from 1.0 μg/kg in fixed-dose scheme to 1.5 μg/kg in the up-titration dosing scheme.

Consistent with the improved acute tolerability, pharmacokinetic data showed a lower peak serum concentration and AUC of rHuIL-12 with the up-titration dose escalation compared to the fixed dosing scheme at comparable dose levels. However, to achieve acceptable tolerability, a slow intrapatient dose escalation of this cytokine was important. Although serum levels of IL-12 and the secondary cytokine (IFN-γ) were lower after intrapatient dose escalation compared to fixed dosing, the cytokine levels at the target doses of 1.25 and 1.5 μg/kg in the up-titration schedule were much higher than predose baseline levels. The mechanism producing the observed lower IL-12 and IFN-γ levels with dose escalation compared to fixed dose scheme is not clear. The decreased IL-12 levels could not be explained by production of antibody because no measurable antibody was detected in these patients. One possible explanation would be induction of receptor mediated clearance following an initial dose of rHuIL-12. These parameters were studied during the first cycle and will be further investigated with chronic dosing.

In one other Phase I trial, rHuIL-12 was given by i.v. injection (16). Dose-limiting toxicities included oral stomatitis and liver function test abnormalities. There was one treatment-related death from Clostridia perfringens sepsis. In the subsequent Phase II study in patients with renal cell carcinoma, administration of the same daily dose by i.v. administration produced severe toxicity in most of the 17 patients treated and death in 2 patients (17). A difference between the two studies was that patients in the Phase I study received a predose of rHuIL-12 prior to initiation of the daily i.v. dosing (16), whereas patients in the Phase II study were started immediately on daily i.v. injections of rHuIL-12 (17). Also, in both of these trials, rHuIL-12 was given by i.v. bolus, and severe toxicity resulted, including treatment-related deaths. In contrast, administration by s.c. injection according to schedule in the current trial was relatively well tolerated.

Eligibility was restricted to patients with renal cell carcinoma, based on the high degree of response observed with rHuIL-12 in the mouse Renca renal cell carcinoma model and the modest antitumor activity reported with other cytokines (IFN-α and IL-2) in this highly refractory malignancy (10). In a patient population composed mostly of patients pretreated with IL-2, IFN-α, or both, one patient treated at the maximum tolerated dose had a durable complete response, and several patients treated in this trial had prolonged stable disease. Antitumor activity against renal cell carcinoma and melanoma was reported in a Phase I trial of rHuIL-12 in patients with varied malignancies (16). Therefore, Phase II trials of rHuIL-12 given by s.c. administration were initiated in patients with melanoma and in previously untreated patients with renal cell carcinoma. Moreover, synergistic antitumor effect was demonstrated for combined treatment with HuIL-12 and IL-2 against murine renal cell carcinoma (18).

In conclusion, treatment with rHuIL-12 was tolerable when administered by s.c. injection according to the schedule reported here. The recommended dose according to the up-titration schedule of rHuIL-12 (μg/kg) for Phase II trials was as follows: cycle 1, 0.1 (day 1), 0.5 (day 8), 1.25 (day 15); cycle 2 onwards, 1.25. Phase II trials of rHuIL-12 were initiated in previously untreated patients with renal cell carcinoma and in patients with melanoma.

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