Activation of Human Melanoma Reactive CD8+ T Cells by Vaccination with an Immunogenic Peptide Analog Derived from Melan-A/Melanoma Antigen Recognized by T Cells-1

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ABSTRACT

Purpose: As compared with natural tumor peptide sequences, carefully selected analog peptides may be more immunogenic and thus better suited for vaccination. However, T cells in vivo activated by such altered analog peptides may not necessarily be tumor specific because sequence and structure of peptide analogs differ from corresponding natural peptides.

Experimental Design: Three melanoma patients were immunized with a Melan-A peptide analog that binds more strongly to HLA-A*0201 and is more immunogenic than the natural sequence. This peptide was injected together with a saponin-based adjuvant, followed by surgical removal of lymph node(s) draining the site of vaccination.

Results: Ex vivo analysis of vaccine site draining lymph nodes revealed antigen-specific CD8+ T cells, which had differentiated to memory cells. In vitro, these cells showed accelerated proliferation upon peptide stimulation. Nearly all (16 of 17) of Melan-A-specific CD8+ T-cell clones generated from these lymph nodes efficiently killed melanoma cells.

Conclusions: Patient immunization with the analog peptide leads to in vivo activation of T cells that were specific for the natural tumor antigen, demonstrating the usefulness of the analog peptide for melanoma immunotherapy.

INTRODUCTION

The identification and molecular characterization of tumor antigens has opened the opportunity for specific immunotherapy in cancer patients (1–6), but it remains difficult to elicit protective immunity controlling tumor growth. It is important to identify the reasons for failure of immune protection from cancer. Tumor cells may have defects in expression or presentation of antigens (7–11). The weakness of tumor-specific immune activation must also be considered. Both spontaneous- (i.e., disease induced) and immunotherapy-induced activation of tumor antigen-specific T cells is only weak or even undetectable (12–16). This is in marked contrast to protective virus-specific T cells, which are often strongly activated and readily detected in vivo (17, 18). Thus, to obtain an efficient antitumor immune response, it is important to develop reagents activating the immune system more strongly and in a continuous manner (19). The missing piece of immunotherapy may be an early, strong, and continued activation of antitumor T cells (20, 21). How can this be achieved?

One can render tumor peptides more immunogenic by increasing the binding affinity to HLA through selective amino acid replacement (22). We have recently developed an analog to the melanoma differentiation antigen Melan-A/MART-1(23) (hereafter Melan-A) derived peptide Melan-A26–35, which has an Alanine-to-Leucine substitution at position two of the peptide. This analog peptide is strongly immunogenic in vitro (23) and in vivo in HLA-A*0201 transgenic mice (24). CD8+ T cells generated by stimulation of PBL in vitro with this Melan-A peptide analog recognize the natural peptide and Melan-A+/HLA-A2+ tumor cells. The question remained whether patient immunization with this analog peptide selectively activates T cells that are cross-specific for the natural self-peptide presented by tumor cells. It was necessary to address this question in vivo.

The abbreviations used are: MART-1, melanoma antigen recognized by T cells-1; IL, interleukin; LCR, Ludwig Institute for Cancer Research; LN, lymph node; mAb, monoclonal antibody; PBL, peripheral blood lymphocyte; rhIL, recombinant human interleukin; TILN, tumor-infiltrated lymph node; VSSN, vaccine site-sentinel lymph node.
because T cells selected in vivo can reach higher specificity/avidity to antigen than those selected in vitro (25).

Untreated patients with Melan-A-positive melanomas frequently have activated Melan-A-specific T cells in tumor-infiltrated organs (26), and this activation is stronger in tissue with high tumor load (27). Although it is much more difficult to elicit a tumor antigen-specific immune response in absence of (detectable) tumor, vaccine efficiency should be tested in this setting to avoid uncontrolled immunogenicity by endogenous factors. Therefore, we selected melanoma patients with a high likelihood to be tumor free and immunized them with the Melan-A analog peptide in a healthy limb.

As a consequence of intense research in immunology and pharmaceutical production, the number of potential vaccine components (antigens, vectors, adjuvants, and additional immune stimulatory molecules) is steadily increasing. In addition, vaccines may be administered at different body sites, doses, and treatment schedules. A major challenge is to select optimal formulations and strategies for immunization. Therefore, we searched for a reliable method to evaluate the efficiency of experimental vaccines. Our aim was to investigate antigen specific CD8+ T cells at the site of primary activation, i.e., in local lymph nodes. For this, we took advantage of an existing technique allowing to identify and surgically remove the lymph node that drains a defined patient skin area. This so-called sentinel node technique is usually applied with the purpose of detecting metastatic disease (28). Tracing colloids (technetium nanocolloids and patent blue) are injected in the skin in the primary tumor area. These markers subsequently accumulate in one or sometimes several draining lymph node(s), allowing to identify the so-called sentinel lymph node(s) known to bear the highest risk for micrometastases (29).

Patients with resected thick primary melanomas and with resected sentinel lymph node that is invaded by micrometastases have a high risk of progressive disease and must undergo lymph node dissection. Before this was done, the patients were included in the present study, applying the modified sentinel node technique to identify the vaccine site-sentinel node. The study procedure was performed in a lower limb not affected by the disease. HLA-A2-positive patients were injected with a mixture containing Melan-A analog peptide, Influenza peptide, and QS21-based immune adjuvant AS02B. Our aim was to investigate antigen specificity/fine specificity, and to compare local with systemic immunity.

**MATERIALS AND METHODS**

**Clinical Study Protocol.** This Phase I study was performed at the Multidisciplinary Oncology Center, University Hospital of Lausanne and the Division of Clinical Onco-Immunology, LICR, Lausanne Branch, Switzerland, after approval by the LICR Protocol Review Committee (New York, NY) and the Lausanne University Hospital Ethics Committee. It was conducted as study LUD 98-009 under the supervision of the LICR Office of Clinical Trials Management. Endpoints were treatment toxicity and immune response. Eligibility criteria were: written informed consent; older than 16 years of age; HLA-A2 positive; Melan-A-expressed by the melanoma; and histologically proven skin melanoma (initially staged as American Joint Committee on Cancer stage I T1 N0 M0, but upgraded to stage III T2 N1 M0 because of a previously identified positive, i.e., micrometastatic sentinel node).

**Patients.** Melanoma was diagnosed by histology upon excision of the primary tumor. Subsequent sentinel lymph node biopsy revealed presence of micrometastases in all three patients. After this, patients were included in the present study, and the vaccines were injected in a lower limb (Fig. 1). Three patients were studied: patient 1 (code LAU 359) had a primary skin melanoma at the left thigh. The contra-lateral LNs were resected (lymph node dissection) inguinal left and the VSSN inguinal right. Patient 2 (code LAU 371) had a primary melanoma in the left lumbar skin region. The contra-lateral LNs were resected inguinal left and the VSSN inguinal right. Finally, patient 3 (code LAU 445) had a primary melanoma at the right ear. The contra-lateral LNs were resected at the right axilla and the VSSN inguinal left. All resected contra-lateral LNs were found to be tumor negative by histology in all three patients.

**Vaccine Preparation and Treatment Schedule.** Patients received Melan-A analog and Influenza peptides. The Melan-A analog peptide26–35 A27L ELAGIGILTV (with Ala nine-to-Leucine substitution at position two; Ref. 23) and the Influenza matrix peptide58–66 GILGFVFTL were synthesized by Multiple Peptide Systems (San Diego, CA). The lyophilized peptides were diluted in sterile PBS at a concentration of 330 μg/ml and distributed in 0.5-ml vials according to Good Manufacturing Practice quality criteria by the LICR Biological Pro-
duction Facility (Melbourne, Australia). Vials were stored at
−80°C and thawed just before vaccine preparation and injec-
tion. As immune adjuvant, AS02B provided by GlaxoSmith-
Kline Biologicals (Rixensart, Belgium) was used. AS02B
includes the three components QS21 (a natural saponin), mono-
phosphoryl lipid A (MPL), and an oil-in-water emulsion com-
posed of an organic phase made of two metabolizable oils
(a-tocopherol and squalene), an aqueous phase (PBS), and an
emulsifier (TWEEN 80). Patient immunization was done as fol-
lows: 100 µg of each peptide were mixed with 600 µl adjuvant
AS02B and injected i.m. at a limb not affected by the disease.
Each immunization was followed by a booster injection con-
sisting of intradermal peptide injection without adjuvant 2
weeks later. The first immunization was performed on day 0,
followed by a booster injection on day 14 (Fig. 1). Lymph node
dissection and removal of the VSSN were done on day 28: the
skin site of vaccine injection had been marked with a permanent
pen, where tracing colloids (°technetium nanocolloids and
patent blue) were injected, and the VSSN was resected. Patients
received four additional injections on study days 42, 56, 70 and
84. Treatment toxicity was evaluated according to the National
Cancer Institute Common Toxicity Criteria scale. Tumor staging
was carried out by physical examination and computed tomog-
raphy scans.

Lymph Node and Blood Cells. Lymph nodes were dis-
sociated to obtain sterile single cell suspensions in RPMI 1640
supplemented with 10% FCS, washed, and cryopreserved in
RPMI 1640, 40% FCS, and 10% DMSO. Vials containing
5–10 × 10^6 cells were stored in liquid nitrogen. TILNs were
prepared similarly. They were obtained from patient 1 (after
disease progression) and six other HLA-A2-positive melanoma
patients who had no irradiation, chemotherapy, or immunother-
dapy for a minimum of 12 weeks before surgical dissection. PBLs
were separated from heparinized blood by centrifugation over
Ficoll-Paque (Pharmacia), washed three times, and cryopre-
served similarly as the lymph node cells. All experiments were
done with previously frozen cells. This allowed standardization
and repetition of testing, as well as proper comparison between
samples obtained at different dates.

mAbs and Tetramers. The mAbs were obtained from
Becton Dickinson (Mountain View, CA), except anti-CD28°TTC
(Immunotech, Marseille, France) and goat-antirat°APC (Caltag,
Burlingame, CA). The rat IgG2a mAb 3D12 (anti-CCR7) was
kindly provided by Francine Jotereau, U211 Inserm, Nantes,
Laboratory from a surgically excised melanoma metastasis from
patient LAU 203 as described previously (23), and NA8-MEL
(a gift from Dr. Francine Jotereau, U211 Inserm, Nantes,
France). Target cells were radiolabeled with Na°CrO4 for 1 ha-
at 37°C, washed, and coincubated in V-bottomed microwells at the
indicated effector to target ratio (10° target cells/well). After 4 h
at 37°C/5% CO2, supernatants were collected and counted in a
Top count (Canberra Packard) gamma counter. The percentage
of specific lysis was calculated as [experimental release –
spontaneous release] × 100/(total release – spontaneous release).

RESULTS

In Vivo Activation and Expansion of Peptide-specific T
Cells in VSSNs. We prepared single cell suspensions from the
excised lymph nodes and performed flow cytometry ex vivo
with fluorescent HLA-A°201 tetramers. To establish back-
ground values, we applied a tetramer detecting HIV-1 poly-
merase-specific cells and found <0.01% CD8+ tetramer+ cells
as shown in patient 2 (Fig. 2). In the VSSN of this patient, we
found 0.08% Melan-A-specific and 0.96% Influenza-specific
cells, demonstrating that the frequency of Melan-A-specific
cells was at least ×8 and Influenza specific cells at least ×96
above background (Fig. 2). In a contra-lateral lymph node from
the same patient, 0.05% of CD8+ T cells were Melan-A spe-
tetramer-guided cell sorting response, specific T cells from patients 2 and 3 were isolated by to test specificity and function of the induced cells in local draining lymph nodes. Melan-A peptide (Fig. 3a/b) revealed half maximal lysis (EC_{50}) at low peptide concentrations between 10^{-10} and 10^{-13} molar, demonstrating that the tumor reactive T-cell receptors were of high avidity for the Melan-A analog peptide (ELAGIGILT). The natural Melan-A peptides EAAAGIGILT (decamer) and AA-GIGILT (nonamer) were less efficiently recognized, similarly to what had been observed in T-cell clones generated from TILNs or PBLs from untreated melanoma patients (23). Among the total of 17 Melan-A-specific clones tested, 14 were of high avidity similarly as e.g., clone 1B7 or 1E2. The clones 1E6, 1C8, and a third clone (data not shown) were of low avidity. Thus, 3 of 17 clones were of low avidity and 1 of 17 clones (clone 1E6) did not kill melanoma cells expressing the tumor antigen Melan-A. As expected, the Influenza-specific clones had a high avidity of peptide recognition (EC_{50} ≈ 10^{-13} molar), confirming that virus-specific T cells usually reach higher avidity than tumor (self) antigen-specific T cells. Representative clones of both specificities also produced large amounts of IFN-γ upon antigen stimulation (data not shown). In summary, the CD8+ T cells induced in vivo by peptide vaccination and derived from VSSN recognized and killed target cells in an antigen-specific manner, and the Melan-A specific cells showed remarkably efficient killing of tumor cells naturally processing and presenting endogenous Melan-A antigen. Importantly, the T cells efficiently recognized tumor cells, although they had been primed in vivo with the Melan-A analog peptide.

**Phenotypic Characterization of VSSN T Cells ex Vivo.** Influenza-specific and Melan-A-specific T cells from all lymph nodes were analyzed for expression of three different surface molecules (Fig. 4) characteristic for various T-cell differentiation stages (30–37). Antigen experienced T cells may down-regulate CD45RA (32) and undergo additional phenotypic changes in vivo (30–37). We found that Influenza-specific cells were CD45RA negative in contralateral LNs and VSSNs (Fig. 4), which is in agreement with the notion that these cells are antigen experienced in the majority of adult individuals. About half of the Melan-A-specific T cells were CD45RA positive both in contralateral LNs and VSSNs. For comparison, TILNs from seven melanoma patients with more advanced disease were used for similar characterization of Melan-A-specific T cells. Interestingly, many Melan-A-specific cells in TILNs showed down-regulation of the chemokine receptor CCR7 and some had also reduced expression of the co-stimulatory molecule CD28 known to be associated with differentiation toward effector cells (30, 33). No such down-regulation was observed in contralateral LNs and VSSNs. We conclude that contralateral LNs and VSSNs contained significant percentages of antigen experienced T cells, but they remained CCR7^{+} and CD28^{+} in contrast to TILN where the tumor antigen-specific T cells showed down-regulation of CCR7 and in some TILN also of CD28.

**Materials and Methods.**
local pain after injection, and no systemic toxicities were observed. Patients 2 and 3 remained tumor free (current status 24 and 15 months after study termination). Patient 1 had progressive disease after study termination, for which he underwent additional left iliac lymph node dissection, whereby 9 of 10 lymph nodes were found tumor positive (and analyzed as TILNs in this study, Fig. 4). This patient underwent surgery and isolated limb perfusion with Dacarbazin and Fotemustine for numerous in transit metastases. Overall, the clinical results of the patients in this study were comparable with untreated historical controls. However, evaluation of clinical vaccine efficacy was not an aim of this study.

**DISCUSSION**

To characterize the biological effects induced by our vaccine formulation, we measured lymphocyte activation both locally and systemically. We focused on Melan-A- and Influenza-specific T cells in part because they can readily be detected in the majority of adult individuals even in absence of an acute immune response. Melan-A-specific T cells are detectable in the majority of healthy HLA-A2-positive humans despite that these cells are naive and have not undergone antigen driven clonal expansion (38, 39). Influenza-specific T cells are present at low levels in the majority of healthy individuals, and they are detectable in the majority of vaccinated individuals. The biological effects of our vaccine formulation on the immune system were therefore evaluated using the following approach:

**No to Weak Lymphocyte Activation Detectable in Peripheral Blood.** PBLs were obtained before (day 0) and after (days 27, 70, and 98) peptide immunization and analyzed ex vivo by flow cytometry after tetramer staining. The Melan-A-specific cells were detectable but did not significantly change in frequency during the time of observation (Table 3). The percentages for Influenza-specific cells from patients 2 and 3 were slightly increased on day 27, which was however not the case after subsequent vaccines. In patient 1, the percentages of Influenza-specific cells were lower after as compared with before vaccination. We also determined IFN-γ Elispot forming cells after short-term (18 h) stimulation of PBLs with peptides. The results were compatible with tetramer data because no Melan-A specific spots were obtained and only minor changes between pre- and postvaccination were found for the percentages of Influenza-specific spots (data not shown). Thus, activation of circulating T cells was borderline detectable in two patients and only for Influenza but not Melan-A-specific cells, indicating that systemic immune activation was weak to undetectable.

**Clinical Evolution.** The three patients received all six vaccine injections according to the study protocol (two vaccines before and four vaccines after lymph node dissection and VSSN removal). The treatment was well tolerated with no minor

### Table 1 Antigen-specific CD8+ T cells detected ex vivo

<table>
<thead>
<tr>
<th>Antigen</th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Mean</th>
<th>SD</th>
<th>P &lt; 0.05</th>
<th>n.s.</th>
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</thead>
<tbody>
<tr>
<td>A2/Influenza+</td>
<td>0.14</td>
<td>0.17</td>
<td>0.47</td>
<td>0.26</td>
<td>0.18</td>
<td>0.01</td>
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<tr>
<td>VSSN</td>
<td>3.10</td>
<td>0.96</td>
<td>1.40</td>
<td>1.82</td>
<td>1.13</td>
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<tr>
<td>A2/Melan-A+</td>
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<td>0.05</td>
<td>0.09</td>
<td>0.06</td>
<td>0.02</td>
<td>0.01</td>
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<tr>
<td>VSSN</td>
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<td>0.11</td>
<td>0.04</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>A2/HIV+</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>VSSN</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>0.01</td>
<td></td>
</tr>
</tbody>
</table>

*Flow cytometry results obtained with fluorescent tetramers and CD8 specific mAbs (similarly as in Fig. 2) from all lymph node samples from the three patients. The data are individual experimental results or mean values when multiple contralateral LNs/VSSNs per patient were recovered (i.e., 3 contralateral LNs in patient 1, 2 contralateral LNs in patient 2, and 2 VSSNs in patient 3). The results are representative for two repeated experiments. The difference between contralateral LNs and VSSNs was significant for Influenza-specific cells but not for Melan-A- and HIV-1 polymerase-specific cells (the latter allowing to estimate background levels).*
elevated levels because of prior expansion and persistence as so-called memory cells in most adults (31, 40).

One explanation why tumor-specific T-cell activation is absent or only weak may be that most tumor antigen-specific T-cell receptors are of low avidity. However, at least some T cells efficiently recognize tumor antigens such as Melan-A (22). Once activated, T cells may exert their effector functions even against target cells that bear antigens to which they are of relatively low avidity. Analogue peptides such as the Melan-A analog studied here have a stronger potential to activate specific T cells (23). However, when analog peptides are generated, great care must be taken to maintain the original specificity such that the activated T cells are clearly tumor specific. Because T-cell fine specificity is dominantly determined during in vivo priming (25), this issue needs to be tested in vivo.

After vaccination, the VSSN contained activated specific T cells that showed enhanced proliferative responses upon Melan-A and Influenza peptide stimulation in vitro. Melanoma cell recognition was of high specificity, as demonstrated by the fact that 16 of 17 Melan-A-specific clones were able to kill melanoma cells. This is remarkable because Melan-A-specific clones generated from normal individuals frequently fail to kill melanoma cells because of low efficiency in antigen recognition, as revealed by half-maximal lysis requiring natural decamer peptide concentrations of $>10^{-8}$ molar (41). Thus, we provide direct evidence that the T-cell receptor repertoire recruited by the analog peptide is highly specific for the naturally processed antigen leading to efficient melanoma cell killing. This supports the notion that the Alanine-to-Leucine substitution at position two of the Melan-A analog peptide does not significantly alter the T-cell receptor binding sites (42). Rather, the mechanism of enhanced immunogenicity of this analog peptide is the enhanced binding to HLA-A*0201 (23).

Several studies in tumor patients suggest that tumor antigen-specific T-cell responses are usually only detectable in PBLs from patients with multiple and/or large metastases, even after specific vaccination. Thus, tumor tissue and synthetic antigen appear to have a synergistic effect in the activation of specific T cells. In this study, we took the challenge to immunize tumor-free patients because it was important to test vaccine efficacy in a situation with low likelihood of T cells being activated by tumor tissue. Disappointingly, tetramers and IFN-γ Elispot assays did not reveal T-cell activation in PBLs after vaccination. This is similar to our experience in 25 other melanoma patients treated with the same vaccine as used in this study. Disappointingly, tetramers and IFN-γ Elispot assays did not reveal T-cell activation in PBLs after vaccination. This is similar to our experience in 25 other melanoma patients treated with the same vaccine as used in this study. Disappointingly, tetramers and IFN-γ Elispot assays did not reveal T-cell activation in PBLs after vaccination. This is similar to our experience in 25 other melanoma patients treated with the same vaccine as used in this study. Disappointingly, tetramers and IFN-γ Elispot assays did not reveal T-cell activation in PBLs after vaccination. This is similar to our experience in 25 other melanoma patients treated with the same vaccine as used in this study. Disappointingly, tetramers and IFN-γ Elispot assays did not reveal T-cell activation in PBLs after vaccination. This is similar to our experience in 25 other melanoma patients treated with the same vaccine as used in this study. Disappointingly, tetramers and IFN-γ Elispot assays did not reveal T-cell activation in PBLs after vaccination. This is similar to our experience in 25 other melanoma patients treated with the same vaccine as used in this study. Disappointingly, tetramers and IFN-γ Elispot assays did not reveal T-cell activation in PBLs after vaccination. This is similar to our experience in 25 other melanoma patients treated with the same vaccine as used in this study.

Fig. 3 Tumor-specific cytolytic activity by T-cell lines and clones derived from VSSN. Tetramer sorted and in vitro expanded lines and clones specifically and efficiently killed target cells. a, the lytic activity was tested against two different melanoma cell lines, i.e., the HLA-A*0201+ Melan-A+ line Me 290 (circles) and the HLA-A*0201+ Melan-A- line NAI-MEL cells (squares), in absence (closed symbols) or presence (open symbols) of synthetic peptide. b, the efficiency of antigen recognition was assessed with peptide titration experiments. T2 target cells were incubated with the Melan-A analog peptide ELAGIGILTV (circles), the natural decamer EAAGIGILTV (squares), the natural nonamer AAGIGILTV (diamonds), and the Influenza matrix peptide (triangles). The clones are identified by three digit codes (e.g., 1B7). The data are representative for 17 Melan-A and 15 Influenza-specific clones tested.

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analysis strategy, most other groups are analyzing specific T cells after in vitro stimulation for one or more weeks. In fact, none of the published studies with synthetic vaccines (13, 15, 43, 44) showed ex vivo detectable activation of Melan-A-specific T cells in PBLs.

We have withdrawn and analyzed the lymph nodes after only two vaccinations, although additional vaccinations may have increased the likelihood of lymphocyte activation. For medical reasons, lymph node dissection needs to be performed shortly after diagnosis of lymph node metastases, leaving only a short time window for vaccination. Ethical reasons also excluded the possibility to excise the VSSN at a later time point because this would have required an extra surgery session.

Our data confirm that for the assessment of CD8+ T-cell responses to the vaccine, PBLs were less sensitive than vaccine site-draining lymph node cells (45). Thus, immune activation is more readily detectable locally than systemically. This may possibly be explained by dilution of specific T cells taking place when they enter circulation, which significantly reduces the likelihood that they can be revealed by tetramers (detection limit of ~1 in 10,000 CD8+ lymphocytes).

The contralateral LNs were taken from the diseased limb and were tumor free according to histological analysis. We have no definitive proof that they were indeed completely tumor free because small numbers of tumor cells cannot be entirely excluded. However, it is unlikely that small numbers of tumor cells can significantly activate tumor antigen-specific T cells because this can only be detected in presence of substantial tumor infiltration (26, 27). Although one should investigate disease free LNs from multiple body sites and from patients without melanoma, ethical considerations limit the amount of healthy tissue that can be withdrawn from patients.

Besides measuring numbers of antigen-specific T cells, we determined their ex vivo surface phenotype known to be associated with functional stages (30–37). Our data suggest that the T cells from VSSNs were less activated and/or less differentiated as compared with T cells from TILNs because only the latter showed down-regulation of CCR7 (and occasionally of CD28) by Melan-A-specific T cells. Because effector functions (cytokine production and cytotoxicity) are associated with CCR7 down-regulation (30), our results suggest that the vaccines did not induce effector cells in the VSSN. That nearly all of the cells were CCR7+ was, however, not surprising because CCR7 expression is characteristic for T cells residing in lymph nodes (46). One possibility is that vaccine-activated T cells have left the VSSNs and differentiated to effector cells elsewhere.

Immune adjuvants are usually necessary to immunize T cells in vivo, but molecular pathways need to be elucidated in more detail. An important element is activation of dendritic cells, which occurs through various Toll-like receptors triggered by microbial products such as lipoproteins, peptidoglycans, lipopolysaccharides, and bacterial DNA (47, 48). Another way to activate dendritic cells is via CD40, which is triggered by CD40L expressed on activated T cells (49, 50). The consequences on antigen-specific immune responses are intensively studied (51, 52) and will need to be tested in humans. Hopefully, the corresponding immune stimulatory substances become available for clinical use within the near future and will allow to activate human T cells more efficiently.

Taken together, our findings show that T-cell priming in vivo with the analog peptide resulted in highly tumor-specific T cells. However, although the analog peptide is more immunogenic than the natural one, it was not sufficiently strong to induce systemic T-cell activation detectable ex vivo after administration with immune adjuvant. Thus, this Melan-A analog peptide needs to be combined with new generation immune stimulatory molecules that promote immune activation more

Table 3 Antigen-specific CD8+ T cells detected in peripheral blood ex vivo

<table>
<thead>
<tr>
<th>Patient</th>
<th>Day</th>
<th>A2/Influenza+</th>
<th>A2/Melan-A+</th>
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</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>27</td>
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<tr>
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<td>70</td>
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<td>Patient 2</td>
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<tr>
<td>Patient 3</td>
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PBLs were obtained before (day 0) and after (days 27, 70, and 98) vaccination and analyzed ex vivo for positive staining with Influenza- and Melan-A-specific tetramers. One hundred percent is the total CD8+ T lymphocytes.
strongly, resulting in strong systemic immunity and possibly in protection from tumor progression.

In conclusion, the VSSN approach provided detailed information on local and systemic immunity. The technique will be applied to evaluate and compare new vaccine formulations. In addition, it can be used to test immune responses against multiple cancer peptide antigens in individual patients and to adapt the subsequent immunotherapy for each patient by selecting those peptides to which the patient is responsive.

ACKNOWLEDGMENTS

We thank the patients for their cooperation and confidence. We also thank the medical and ethical committees for suggestions and supervision of the clinical trial. We thank Eric Hoffman and Lisa Pugliese from the Office of Clinical Trials Management of the Ludwig Institute for Cancer Research for their help and the crucial contributions to patient clinical management by Angelika Bischof Delaloye, Louis Guillou, Reto Meuli, Jean-Yves Meuwly, Pierre Schnyder, and Jean-Pierre Willi. We thank GlaxoSmithKline Biologicals for the adjuvant AS02B; Roger Murphy for peptide preparation; Reinhold Förster and Martin Lipp for the CCR7-specific mAb; Philippe Guillaume and Immanuel Lüscher for tetramer synthesis; Pascal Batard for cell sorting; and Jean-Marie Tiency for HLA typing. We also thank the excellent technical and secretarial help of Celine Baroffio, Christine Geldhof, Danielle Minnaïdis, Nicole Montandon, Martine van Overloop, and Andréé Poret.

REFERENCES


Activation of Human Melanoma Reactive CD8+ T Cells by Vaccination with an Immunogenic Peptide Analog Derived from Melan-A/Melanoma Antigen Recognized by T Cells-1
