Successful Treatment of Melanoma Brain Metastases With Adoptive Cell Therapy

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STATEMENT OF TRANSLATIONAL RELEVANCE

Metastatic melanoma to the brain is a difficult and frequent clinical challenge. Current systemic treatments for patients with melanoma and brain involvement are limited and largely ineffective. Adoptive Cell Therapy (ACT) with a nonmyeloablative preparative regimen using activated lymphocytes and interleukin-2 is an experimental approach that has been shown to be effective for some patients with metastatic melanoma. This report describes our experience using ACT for patients with metastatic melanoma to both the brain and extracranial sites. We document that ACT can mediate complete and durable regression of untreated brain metastasis that can also result in long term survival for some patients. These results suggest that activated lymphocytes can effectively traffic to the CNS. This strategy is important because it affords the opportunity to simultaneously address metastatic melanoma to both the brain and extracranial sites.
ABSTRACT

Purpose. To determine the objective response rate and response duration of melanoma brain metastases to adoptive cell therapy with autologous antitumor lymphocytes plus interleukin-2 following a lymphodepleting preparative regimen.

Methods. Between 2000 and 2009, 264 patients with metastatic melanoma received ACT consisting of cyclophosphamide and fludarabine with or without total-body irradiation followed by the infusion of autologous tumor infiltrating lymphocytes (TIL) or autologous peripheral blood lymphocytes retrovirally transduced to express a T-cell receptor that recognized the melanocyte differentiation antigens gp-100 or MART-1 (TCR). From this group, 26 patients were retrospectively identified to have had untreated brain metastases as well as extracranial disease prior to receiving ACT. The response rate and duration of melanoma brain metastases as well as the overall response rate, response duration, and survival for these patients are presented.

Results. Seventeen of these 26 patients received ACT with TIL. Seven of these patients (41%) achieved a complete response in the brain and six patients achieved an overall partial response. In the 9 patients that received TCR transduced lymphocytes, 2 patients achieved a CR in the brain (22%) and one of these two achieved an overall PR. One patient developed a tumor-associated subarachnoid hemorrhage during the thrombocytopenic phase of therapy and had an uneventful metastatectomy.
**Conclusion.** ACT with a nonmyeloablative preparative regimen using either TIL or TCR gene-transduced cells and interleukin-2 can mediate complete and durable regression of melanoma brain metastases. This strategy can be used safely in selected patients with metastatic melanoma to the brain.

**INTRODUCTION**

Malignant melanoma commonly metastasizes to the brain and it has been estimated that up to 75% of patients with metastatic melanoma ultimately develop brain metastases. Because current systemic treatments for brain metastases are limited and largely ineffective, these patients have a poor prognosis. Current strategies include supportive care, surgical resection, stereotactic radiosurgery, whole brain radiation, chemotherapy, or combinations of these agents. Resection and radiosurgery can produce effective palliation in selected cases, but this is usually restricted to patients with few lesions. Radiation therapy is the current standard of care for individuals with multiple brain metastases; it can improve neurologic symptoms but does not alter survival. Objective responses of melanoma brain metastases are rarely seen with chemotherapy or immunotherapy. Consequently, it is not surprising that brain metastases are the direct cause of death in 60-70% of affected patients.

Over the last decade, a major focus of the Surgery Branch at the National Cancer Institute has been the investigation of adoptive cell therapy (ACT) using tumor infiltrating lymphocytes (TIL) or T-cell receptor transduced lymphocytes (TCR) and interleukin-2 (IL-2) with a nonmyeloablative (NMA) conditioning regimen. The intensity of the preparative regimen was modified in some protocols to include 2-Gy, 6-Gy, or 12-Gy total body irradiation (TBI) and...
autologous stem cell support was added in those cases. We have also used a variety of cell culture techniques to speed TIL growth and to enrich for CD8+ lymphocyte subpopulations. The objective response rates in the NMA, NMA plus 2-Gy TBI, and the NMA plus 12-Gy TBI were 49%, 52%, and 72%, respectively.\(^7\) Tumor regression has been observed at all visceral and soft tissue sites including brain. Because TIL cannot be generated for all patients, we have also investigated the infusion of peripheral blood lymphocytes that were transduced with retroviral vectors to express a T-cell receptor that recognized either gp-100 or MART-1 in HLA-A2+ patients.\(^8\) The objective response rates for these trials have been reported to be 20-30% and durable tumor regression at all disease sites including brain has also been observed.\(^8,9\)

Typically 4 to 6 weeks of cell culture are required to obtain adequate numbers of reactive lymphocytes for any of our clinical protocols. As a consequence, there may be a 6 to 8 week interval between the screening brain MRI evaluation that was generally obtained by the referring oncologist and the protocol baseline images obtained immediately prior to the start of chemotherapy. The majority of patients in this report developed brain metastases during this short interval.

**PATIENTS AND METHODS**

Between 2000 and 2009, 264 patients with metastatic melanoma were enrolled on one of a series of sequential trials designed to investigate ACT with TIL or TCR and high dose IL-2 along with a nonmyeloablating conditioning regimen. All patients had measurable metastatic melanoma and were enrolled on a protocol that was approved by the NCI Investigational Review Board. Eligible patients were 18 years of age or older, had a life expectancy of at least 3 months,
an ECOG score of 0 or 1, had an adequate hepatic, renal and hematopoietic reserve, and had brain lesions ≤ 10 mm associated without significant edema, mass effect, or symptoms. From this population, 26 patients were retrospectively identified to have had untreated and evaluable brain metastases as a component of their disease prior to treatment. For these patients, we elected to proceed with ACT if the brain metastases were asymptomatic, ≤ 10 mm, and demonstrated no mass effect or significant edema. Patient age range, sex, and sites of extracranial disease are noted in Tables 1 and 2.

Conditioning regimen

The conditioning regimens have been previously described in detail. In brief, the regimen consisted of cyclophosphamide (60mg/kg/day on days -7 and -6) and fludarabine (25mg/m2/day on days -5 to -1). In some protocols additional lymphodepletion with 2-Gy, 6-Gy, or 12-Gy was added over the 1 to 3 days immediately prior to cell transfer and chemotherapy was compressed, overlapping the two agents. Patients received the lymphocyte infusion on day 0 along with IL-2 (720,000 IU/kg q8hr) as tolerated to a maximum of 15 doses. Platelet counts were generally maintained by transfusion at ≥ 20,000/µl for patients with known brain metastases. Patients were re-evaluated at all known tumor sites including the brain approximately 4 to 6 weeks after the initiation of treatment and subsequently at 4 to 8 week intervals.

Cell Products used for therapy

Patients received an autologous lymphocyte product manufactured in the Surgery Branch Cell Production Facility that passed a protocol-specific certificate of analysis including potency, safety, and sterility criteria. Patients listed in Table 1 received TIL cultures derived from...
resected metastatic melanoma lesions. TIL cultures for infusion were generated as described previously. Briefly, resected specimens were enzymatically disaggregated into single cell suspensions or small tumor fragments were separated and plated to initiate cultures. TIL were propagated in 6000 IU/ml IL-2 in complete media containing 10% human serum until a homogenous lymphocyte culture evolved. Some cultures (patients 1-4 and 13, “TIL”, Table 1) were highly selected by assessing tumor recognition and other cultures were grown from the entire cell population and were (patients 9-12, 15-17, “CD8 YT”, Table 1) CD8+ enriched prior to final expansion. Bulk, tumor reactive, or CD8+ enriched TIL were rapidly expanded with anti-CD3 antibody, IL-2 and irradiated peripheral blood mononuclear “feeder” cells for 14 days prior to patient infusion. Patients listed in Table 2 received a genetically retargeted product derived from peripheral blood lymphocytes (PBL). PBL from a leukopheresis were stimulated with anti-CD3 and IL-2 then transduced with a recombinant retrovirus encoding the alpha and beta chains of an HLA-A2 restricted, tumor antigen-reactive T-cell receptor (TCR) genes. Cells were monitored for transduction efficiency and tumor reactivity, then further rapidly expanded with anti-CD3, IL-2 and irradiated feeder cells. TCRs used for these studies include the HLA-A2/MART-1:27-35 specific “F4” and “F5”8; HLA-A2/gp100:209-217 specific “gp100”15; and HLA-A2/gp100:154-162 specific “g154”9.

STATISTICAL ANALYSIS

Objective response rates (partial and complete), duration of response and time to progression (time from treatment to disease progression) were calculated and overall survival probabilities (treatment to last follow-up or death) were estimated using the Kaplan-Meier method.
method. Data were analyzed as of March 1st, 2010. Patient response was assessed using standard radiographic studies and physical examination at 4 weeks after cell administration and at regular intervals thereafter. Responses were categorized into complete, partial, or no response based on Response Evaluation Criteria in Solid Tumors (RECIST) guidelines. Although the brain metastases were small (<10 mm), standard RECIST criteria for response was also used to evaluate the in brain response but ultimately no partial responses were encountered. The duration of response was determined from the date patients received the cell infusion.

RESULTS

In Brain Response and Overall Response to TIL

Seventeen patients that received TIL with a lymphodepleting preparative regimen and bolus IL-2 had evaluable brain metastases. Seven (41%) of these patients achieved a complete regression (CR) of all brain disease and five of these responses are ongoing in the brain at 4 to 44 months (Table 1, Figure 1). Patients 1 and 6 who experienced an in-brain CR for 6 months ultimately developed new sites of brain disease as well as at extracranial sites. Five of these 7 patients had at least 2 brain metastases and two individuals had 4 or more metastases. All lesions that responded to ACT were 10 mm or less in size. Although all of the patients had extensive extracranial metastatic disease, 6 of the 7 patients with a CR in the brain achieved an overall partial response (PR). The median survival for these 17 patients was 8.5 months with an estimated actuarial 2-year survival of approximately 40% (Figure 3).
One patient in this group (patient 13) developed a subarachnoid hemorrhage of a 9 mm intracranial lesion located in the right insular cortex during the thrombocytopenic phase of treatment. She had an elective uncomplicated craniotomy and metastatectomy when the thrombocytopenia resolved. She is considered a non-responder in the brain. However, this patient had extracranial regression and achieved an overall PR for nine months and had no neurologic sequelae.

**In Brain Response and Overall Response to TCR**

Nine patients that received TCR gene-transduced lymphocytes with a lymphodepleting preparative regimen and IL-2 had evaluable brain metastases. Two of these patients achieved a complete regression (CR) of brain disease, one lasting 8 months and the other ongoing at 25 months (Table 2, Figure 2). Patient 3 who experienced an in-brain CR for 8 months ultimately developed new sites of brain disease as well as at extracranial sites. One of these patients had two brain lesions and the other had one brain lesion. One of the 2 patients with a complete response in the brain developed an overall objective partial response (PR) while the other patient had a brief minor regression extracranially. None of these patients developed significant neurotoxicity as a result of the preparative regimen or lymphocyte infusion with IL-2. The median survival for these 9 patients was 15 months (Figure 3).

**DISCUSSION**

The treatment of brain metastases from melanoma remains a difficult clinical challenge. The prognosis for patients with brain metastases is poor, with the median survival ranging from
2.8 to 4.0 months after diagnosis. The management of these patients is complicated by the need to treat both the CNS metastases as well as the other systemic disease.

Resection or stereotactic radiosurgery of solitary melanoma brain metastases either with or without whole brain radiation therapy (WBRT) is recognized as the treatment of choice. Retrospective surgical series suggest that the median survival for patients with resected solitary lesions is approximately 5 to 8 months. Retrospective series using WBRT after surgical resection in patients with melanoma brain metastases report no survival benefit. The results with stereotactic radiosurgery appear to be comparable to resection with a median survival for patients with solitary and multiple brain metastases ranging from 5 to 9 months. WBRT in concert with radiosurgery appears to prevent new lesions and neurologic causes of death but has no impact on survival largely due to uncontrolled extracranial disease. Conversely, chemotherapy alone has been largely unsuccessful in treating melanoma brain metastases. A multicenter Phase II study of temozolomide in 151 patients with brain metastases from melanoma reported a 7% response rate in the brain with a median survival of 3.5 months. Similarly, immunotherapy with high dose bolus IL-2 has also been ineffective. One retrospective study at the National Cancer Institute reported an overall response rate of 5.6% for patients with previously untreated brain metastases. Two of thirty-six patients with evaluable brain metastases had objective regression of intracranial and extracranial disease after receiving IL-2. Ipilimumab has recently been reported to cause the complete regression of untreated melanoma brain metastases in two patients. A phase II trial that investigated the treatment of melanoma brain metastases with ipilimumab reported that in 51 patients with melanoma brain metastases, 5 patients developed a partial response in the brain.
We have previously reported that ACT with autologous antitumor lymphocytes plus bolus IL-2 following a lymphodepleting preparatory regimen can cause objective regression of metastatic melanoma in 49-72% of patients. The retrospective analysis of patients with both untreated brain metastasis and uncontrolled extracranial disease confirms that this therapy can mediate complete and durable regression of metastatic melanoma in the brain. Seven of 17 patients that received TIL and 2 of 9 patients that received TCR achieved a complete response in the brain. Of the 26 patients, 15 patients were alive at the time of analysis. Five of these 15 patients survived beyond 12 months without additional CNS or systemic therapy. One patient with 4 brain lesions achieved a complete response that has been durable for over 18 months. The median survival of patients that received TCR and TIL in this analysis was noted to be 15 months and 8.5 months, respectively. A group of similar patients without untreated melanoma brain metastases that received TIL demonstrated a median survival of 16.6 months.

Our patients were carefully selected and we treated only patients with brain lesions ≤ 10 mm that had no evidence of significant edema, mass effect, or symptoms prior to cell therapy. The largest lesion that responded to this therapy was 10 mm. The response rate of larger lesions to this treatment approach is unknown but needs to be investigated. Interestingly, all of the intracranial tumor regressions were complete. In addition, 7 of the 9 patients that responded in the brain also achieved an objective response overall. Conversely, all patients that failed to achieve a response in the brain also failed to achieve an overall objective response at other visceral sites. This fact suggests that brain metastases are as responsive to ACT as extracranial sites. Moreover, it confirms that activated lymphocytes can effectively traffic to the central nervous system (CNS).
ACT is typically associated with a brief period of thrombocytopenia and platelet transfusions are required. One patient (patient 13) developed a subarachnoid hemorrhage during the thrombocytopenic phase of therapy. The platelet count was 26,000/µl when the patient became symptomatic with a severe headache. Workup revealed hemorrhage and no evidence of aneurysm. She had an uncomplicated craniotomy 10 days later when the thrombocytopenia resolved. We suspect that this bleed was caused by tumor necrosis from therapy due to the presence of extensive lymphocytic infiltration in the tumor specimen. Subsequent to this event, we have attempted to maintain a platelet count ≥ 30,000/µl for patients with untreated brain metastases. No other patient experienced neurologic complication from rapid CNS disease progression during TIL or TCR therapy. Patients who did not respond in the brain after ACT ultimately required either resection, SRS, or WBRT depending on the extent of their CNS progression. Interestingly, although 9 patients developed an in-brain CR, it should be noted that none of these patients developed an overall complete response to this treatment.

ACT with autologous antitumor lymphocytes plus high dose IL-2 following a lymphodepleting preparative regimen can mediate complete and durable regression of metastatic melanoma in the brain and can result in long term survival. Furthermore, this therapy is safe in selected patients so that the presence of melanoma brain metastases is not necessarily a contraindication to ACT therapy. These results demonstrate that ACT is unique in its ability to achieve high objective response rates at both intracranial and extracranial sites and many of these responses appear to be durable.

Acknowledgement

Author manuscripts have been peer reviewed and accepted for publication but have not yet been edited.

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**Figure legends**

**Figure 1:** Resolution of multiple brain lesions in two patients treated with CD8 enriched TIL and IL-2 after preparative lymphodepleting regimens of Cy/Flu (A, B) or Cy/Flu + 6-Gy TBI (C, D).

Panels A and C: pretreatment MRI
Panel B: 14 months after cell transfer
Panel D: 6 months after cell transfer

**Figure 2:** Complete regression of a brain metastasis in two patients treated with anti-MART-1 TCR-transduced peripheral blood lymphocytes and IL-2 following a preparative regimen of Cy/Flu.

Panels A and C: pretreatment MRI
Panel B: 6 months after cell transfer
Panel D: 30 months after cell transfer

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Table 1. Patients who received a non-myeloablative (with or without TBI) adoptive cell transfer with TIL

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Abbreviations: Prep, preparative chemotherapy regimen; TBI, total body irradiation; Dur, duration of response; mm, size of largest brain lesion in millimeters. AX, axilla; LI, liver; LU, lung; CL, clavicular; IL, iliac; RP, retroperitoneal; BR, breast; SU, subcutaneous; ME, mediastinal; SK, skin; AD, adrenal; SP, spleen; IN, inguinal; CE, cervical; MT, mesentery; PE, periaortic; KI, kidney; HI, hilar; SB, small bowel; BO, bone; PP, periportal; IP, intraperitoneal; MS, muscle; EA, ear; EY, eye; PL, pleura; PV, pelvis.
Table 2. Patients who received a non-myeloablative (with or without TBI) adoptive cell transfer with TCR.

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Abbreviations: Prep, preparative chemotherapy regimen; TBI, total body irradiation; Dur, duration of response; mm, size of largest brain lesion in millimeters. AX, axilla; LI, liver; LU, lung; CL, clavicular; IL, iliac; RP, retroperitoneal; BR, breast; SU, subcutaneous; ME, mediastinal; SK, skin; AD, adrenal; SP, spleen; IN, inguinal; CE, cervical; MT, mesentery; PE, periaortic; KI, kidney; HI, hilar; SB, small bowel; BO, bone; PP, periportal; IP, intraperitoneal; MS, muscle; EA, ear; EY, eye; PL, pleura; PV, pelvis; PA, pancreas; NK, neck.

The table describes patients who received adoptive cell transfer therapy with TCR. The data includes patient identification (Pt), cells type, preparative chemotherapy regimen (Prep), TBI dose (cGy), age/sex, other disease sites, cell count (10^9), IL2 dose, and response (Res) with duration (Dur) in months.
Fig 3. Kaplan-Meier estimate of overall survival for melanoma patients with untreated brain metastases prior to ACT.
# Clinical Cancer Research

## Successful Treatment of Melanoma Brain Metastases With Adoptive Cell Therapy

Jenny J Hong, Steven A Rosenberg, Mark E Dudley, et al.

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