Immuno-oncology Combinations: A Review of Clinical Experience and Future Prospects

Scott J. Antonia¹, James Larkin², and Paolo A. Ascierto³

¹Moffitt Cancer Center and Research Institute, Tampa, FL, USA; ²The Royal Marsden, London, UK; ³Istituto Nazionale Tumori Fondazione G. Pascale, Naples, Italy

Corresponding Author: Scott J. Antonia, Moffitt Cancer Center and Research Institute, Tampa, FL 33612. Phone: 813-745-8470; E-mail: Scott.Antonia@moffitt.org

Note: S.J. Antonia and P.A. Ascierto share senior authorship.

Running Title: Immuno-oncology Combinations

Disclosure of Potential Conflicts of Interest

S.J. Antonia is a consultant/advisory board member for Bristol-Myers Squibb and MedImmune/AstraZeneca. J. Larkin reports receiving commercial research grants from Bristol-Myers Squibb, Novartis, and Pfizer, and is a consultant/advisory board member for Bristol-Myers Squibb, GlaxoSmithKline, Merck (uncompensated since 2012), Novartis, Pfizer, and Roche/Genentech (uncompensated since 2012). P.A. Ascierto reports receiving commercial
research grants from Bristol-Myers Squibb, Merck, Roche/Genentech, and Ventana; speakers bureau honoraria from Bristol-Myers Squibb, GlaxoSmithKline, and Roche/Genentech; and is a consultant/advisory board member for Bristol-Myers Squibb, GlaxoSmithKline, Merck, Novartis, Roche/Genentech, and Ventana.
Abstract

Immuno-oncology is an evolving treatment modality that includes immunotherapies designed to harness the patient’s own immune system. This approach is being studied for its potential to improve long-term survival across multiple tumor types. It is now important to determine how immunotherapies may be most effectively used to achieve the best possible patient outcomes.

Combining or sequencing immunotherapies that target distinct immune pathways is a logical approach, with the potential to further enhance the magnitude of the antitumor immune response over single agents. Early clinical data in patients with melanoma treated with two immune checkpoint inhibitors, ipilimumab and nivolumab, suggest support for this combination approach. Numerous other combination approaches are being evaluated in early phase clinical trials; however, their clinical activity remains unknown.

Clinical experience to date has shown that when combining an immuno-oncology agent with an existing therapeutic modality, it is important to determine the optimal dose, schedule, and sequence.
**Introduction**

Tumors avoid immune destruction by a range of complex and often overlapping mechanisms that disrupt key components of the immune system involved in mounting an effective antitumor response (1–4). Tumors can avoid recognition and elimination by the immune system by disrupting antigen presentation mechanisms, either through downregulation of major histocompatibility complex (MHC) class I molecules or by disabling antigen processing machinery. Alternatively, or additionally, tumors may suppress the immune system by disrupting pathways involved in controlling T-cell inhibition (checkpoint) and activation (3, 5), or by recruiting immunosuppressive cell types, such as regulatory T cells (Tregs) and myeloid-derived suppressor cells (MDSCs). The release of factors, including adenosine and prostaglandin E2, and the enzyme indoleamine 2,3-dioxygenase (IDO), is another mechanism that tumors may use to suppress immune activity (3).

The idea of targeting the immune system as a therapeutic approach in cancer is not new. Cytokines (interleukin-2 [IL-2] and interferon-alpha [IFN-α]) have been used for decades, predominantly in patients with renal cell carcinoma (RCC) and melanoma. However, these cytokines are not target specific, and have been associated with significant toxicity and limited efficacy; these factors restrict use to healthy patients, and only a select group of these patients will derive benefit (6, 7).

Immuno-oncology is an evolving treatment modality that includes immunotherapies designed to target and harness the patient’s immune system.
directly to kill tumor cells (8, 9). Numerous strategies for overcoming tumor immune evasion are under evaluation (Table 1). Because these approaches directly target the patient’s immune system, they have the potential for activity across multiple types of cancer. Examples of immunotherapeutic approaches under clinical investigation include T-cell checkpoint inhibitors or agonists for T-cell activating pathways, novel cytokines such as IL-12 and IL-15, therapeutic vaccines, elimination of immunosuppressive cells, and other agents and approaches designed to enhance immune-cell function (Table 1; refs. 10–12).

Since the approval of IL-2, sipuleucel-T (a therapeutic vaccine composed of recombinant antigen protein designed to stimulate T-cell responses) and ipilimumab (a cytotoxic T-lymphocyte antigen 4 [CTLA-4] immune checkpoint inhibitor) were the first immunotherapies to be approved for cancer patients; sipuleucel-T in 2010 for asymptomatic or minimally symptomatic metastatic castrate resistant prostate cancer (CRPC) and ipilimumab in 2011 for unresectable or metastatic melanoma. Both agents were shown to significantly improve overall survival (OS) in phase III clinical trials (Fig. 1; 13–16).

Monoclonal antibodies targeting programmed death-1 (PD-1) ligand (PD-L1) interaction, another immune checkpoint pathway, are the most advanced in clinical development after ipilimumab and sipuleucel-T, and various agents are being tested in clinical trials across a range of tumor types.

One of the more exciting aspects of immunotherapies is demonstrated with data from ipilimumab, nivolumab, and pembrolizumab clinical trials that show the potential for long-term survival. In a phase III study of ipilimumab in
previously treated patients with metastatic melanoma (study MDX010-020), the survival rate at 2 and 3 years was 25% for each (17). Additionally, in a pooled analysis of data from 12 ipilimumab clinical studies with follow-up of up to 10 years in some patients, an OS plateau started at approximately 3 years and the 3-year survival rate was 22% (18). The PD-1 immune checkpoint inhibitors nivolumab and pembrolizumab have also shown durable responses in phase I studies (19–21).

Although targeting the immune system has emerged as an effective treatment approach for patients with CRPC and metastatic melanoma (17, 18), for the development of this treatment modality to progress, it is important to determine how agents should be used to achieve the best possible patient outcomes. Combining immunotherapies with other established and investigational cancer therapies is a field of active investigation, with a multitude of approaches under consideration. This review will focus on (1) combining or sequencing immunotherapies that target distinct immune pathways, particularly T-cell checkpoints, and (2) combining immunotherapies with existing therapeutic modalities, specifically BRAF-targeted therapies, chemotherapies, and radiotherapy (RT).

**Combining immunotherapies that target distinct immune pathways**

Combining or sequencing immunotherapies that target distinct immune pathways is a rational strategy to determine whether the magnitude of the antitumor immune response may be improved over that generated with a single agent. Potential combination approaches undergoing clinical evaluation include dual T-
cell checkpoint inhibition, T-cell checkpoint inhibition combined with immunomodulatory antibodies designed to enhance T-cell activity through agonistic interaction with costimulatory receptors (aiming to switch on adaptive immunity), T-cell checkpoint inhibition combined with approaches to improve the function of innate immune cells, and T-cell checkpoint inhibition combined with other approaches to enhance the immune response (Table 2; refs. 3, 5, 12).

**Dual T-cell checkpoint inhibition**

Given that T-cell checkpoint inhibitors (e.g., ipilimumab, nivolumab, pembrolizumab) have shown single-agent clinical activity in several tumor types (5, 13), and preclinical data suggest checkpoint molecules may act synergistically to regulate T-cell function and promote tumor immune escape, it is rational to evaluate if combining checkpoint inhibitors improves activity, achieving an OS benefit in a greater proportion of patients compared with either agent alone (Fig. 2; refs. 16, 22–24). Initial support for dual T-cell checkpoint inhibition has come from a phase I study in which patients with advanced stage III or IV melanoma were treated with both ipilimumab (1 or 3 mg/kg) and nivolumab (0.3, 1, or 3 mg/kg) in a concurrent or sequenced regimen (16, 25). An objective response rate (ORR) rate of 40% was achieved in patients treated with the concurrent regimen (ORR was 53% at the maximum tolerated dose, nivolumab 1 mg/kg, ipilimumab 3 mg/kg). The preliminary 1-year OS rate with the concurrent regimen was 82% (95% confidence interval [CI] 69.0–94.4) (Fig. 1; ref. 16). These promising results prompted the initiation of a phase III study (CheckMate 067) to further evaluate concurrent ipilimumab/nivolumab (12).
Phase I studies are in progress to evaluate ipilimumab plus nivolumab in patients with a range of solid tumors (including RCC, non-small cell lung cancer [NSCLC], colon cancer, triple-negative breast cancer, gastric cancer, pancreatic cancer, and small cell lung cancer [SCLC]); ipilimumab plus pembrolizumab (anti-PD-1) in patients with melanoma, RCC, and NSCLC; tremelimumab (an anti-CTLA-4 agent) plus MEDI 4736 (anti-PD-L1 agent) in NSCLC; and an anti-lymphocyte activation gene 3 (LAG-3) monoclonal antibody BMS-986016 plus nivolumab (anti-PD-1) in patients with solid tumors (Table 2; ref. 12). The latter combination is supported by preclinical data which showed strong synergistic antitumor activity when both the PD-1 and LAG-3 immune checkpoint pathways were blocked (23). Dual anti–LAG-3/anti–PD-1 antibody treatment cured most mice of established fibrosarcoma and colon adenocarcinoma tumors that were largely resistant to single antibody treatment (22).

**T-cell checkpoint inhibition combined with agonistic antibodies against T-cell costimulatory receptors**

In theory, if agents designed to release the checkpoint-mediated inhibition of T cells were combined with agonist antibodies designed to enhance costimulatory T-cell signaling, a more effective immune response may be generated (5). To date, no data are available from clinical trials evaluating these combinations, but studies are in progress. CD40 plays a key role in the development of T-cell-dependent antitumor immunity, and is essential in enabling antigen-presentation cells to process and present antigen effectively to T cells (26–28). Combining T-cell checkpoint blockade (using anti-CTLA-4 agent tremelimumab) with an agent
that targets the costimulatory molecule CD40 (CP-870,893) is being investigated in a phase I trial in patients with melanoma (12).

Other agonist antibodies designed to target receptors, including OX-40, CD27, GITR, and CD137, are in development. The clinical evaluation of these agents as monotherapy is at an early stage, although the limited data available suggest they can be safety administered to patients. Data from a large phase I trial with urelumab (anti-CD137) in over 100 patients did show liver toxicity, with 2 deaths reported at higher doses. Clinical evaluation of urelumab is continuing at lower doses in advanced solid tumors and hematologic malignancies (29).

Evaluating combinations of these antibodies with checkpoint inhibitors and other immunotherapies is an exciting possibility, but one that should be evaluated with caution.

Another agonistic therapeutic approach that was evaluated with catastrophic effects was the CD28 agonist TGN1412. In a first-in-human phase I trial, TGN1412 administration resulted in a cytokine storm that caused severe adverse events in the six volunteers (30). As explained by Dr Curran and colleagues (31), CD28 is widely expressed on all mature T-cell populations; therefore, an agonistic CD28 antibody may be expected to have a polyclonal "super agonist" effect—this is in contrast to other costimulatory modules, such as CD137 or OX-40, which are only expressed on a proportion of T cells, so agonist antibodies are likely to have a more selective effect.

**T-cell checkpoint inhibition combined with approaches to improve the function of innate immune cells**
Adaptive immune responses to cancer involve various components of innate immunity. In view of this, combining therapies designed to enhance T-cell function with agents designed to improve innate immune-cell function are worthy of evaluation. Natural killer (NK) cells are innate effector cells that maintain tolerance to self-tissue via the expression of killer cell immunoglobulin-like receptors (KIR), which negatively regulate NK-cell activity by binding to the MHC class I molecules expressed on most "normal" cells (32–35). Tumor cells may appear like normal cells by retaining or upregulating MHC class I in order to escape immunosurveillance by NK cells (33). Lirilumab is an anti-KIR antibody that blocks the inhibitory KIR signal, thereby potentiating NK-cell killing of tumor cells, despite expression of MHC I. A regimen designed to enhance innate and adaptive immunity, respectively, could theoretically achieve more favorable biologic and clinical activity compared with either agent alone (36, 37). This could be achieved in a variety ways, such as by using an anti-KIR agent (lirilumab) in combination with PD-1 or CTLA-4 immune checkpoint inhibitors. Clinical trials are underway evaluating such combinations (Table 2; ref. 12).

**Other immunotherapy combination partners**

**Cytokine therapy**

Cytokines have the capacity to stimulate an immune response, although arguably less specifically compared with other immunotherapeutic approaches (3). IL-21 has a role in NK and T-cell activation, and systemic administration of a recombinant IL-21 (rIL-21) has demonstrated antitumor activity in tumors, including metastatic melanoma (38). Based on preclinical studies in mouse tumor
models which showed enhanced antitumor activity when rIL-21 was combined with either anti-CTLA-4 or anti-PD-1 agents (39), phase I dose-escalation studies are evaluating these combinations in patients with advanced or metastatic melanoma (ipilimumab) (40) or solid tumors (nivolumab) (41).

Other cytokines are under evaluation as monotherapy for cancer therapy, but a phase II trial is ongoing with IL-7, which has a wide range of biological activities, including a role in T-cell development, after standard therapy with sipuleucel-T for patients with asymptomatic or minimally symptomatic metastatic CRPC (12).

**IDO inhibition**

IDO is an immunosuppressive enzyme that is involved in maintaining peripheral immune tolerance by suppressing the function of both innate and adaptive immune cells. Data from preclinical studies suggest that inhibiting IDO can promote the proliferation, survival, and function of various immune cells (e.g., T cells, NK cells, and dendritic cells [DCs]), reduce the generation of Tregs, and significantly inhibit tumor growth (42, 43). Furthermore, studies in murine models showed that host-derived IDO can suppress the antitumor activity of an anti-CTLA-4 antibody. However, inhibition or absence of IDO combined with therapies targeting immune checkpoints, such as CTLA-4, PD-1/PD-L1, and GITR, act synergistically to control tumor growth and improve OS (44). Thus, combining an agent that inhibits IDO with another immunotherapy would appear to be a rational approach and is being evaluated in several clinical trials (Table 2). A phase II trial
is evaluating the IDO inhibitor indoximod in combination with the therapeutic vaccine sipuleucel-T in patients with prostate cancer (Table 2; 12).

Adoptive cell transfer (ACT) and T-cell engineering

ACT involves the collection of tumor-infiltrating lymphocytes (TILs) from patients, the \textit{in vitro} expansion of autologous lymphocytes with reactivity to tumor antigens, and the subsequent transfer back to the patient, with the expectation that the tumor-specific lymphocytes will attack the tumor (11, 45). ACT has demonstrated durable complete responses in patients with melanoma (45). In a phase II study, 20 of 93 patients with metastatic melanoma (22\%) had durable, complete remissions (>3 to 7 years) after treatment with IL-2 and ACT of tumor infiltrating lymphocytes.

In addition to the expansion and transfer of TILs, approaches to modify the patient's T cells are under evaluation. These include engineering T cells using chimeric antigen receptors (CARs) to redirect them to specific tumor-antigen targets prior to reinfusion. T-cell receptor (TCR) gene therapy is another strategy in development; the objective is to induce immune reactivity against tumors by introducing genes encoding a tumor-reactive TCR into patients' T cells, improving immune reactivity. Combining these types of approaches with other immunotherapies may further improve clinical efficacy. Trials of ACT, CARs, and TCR gene therapy in combination with immune checkpoint inhibitors or other approaches are ongoing or under consideration.

Therapeutic vaccines
Although the various mechanisms of action of therapeutic vaccines are beyond
the scope of this review (46, 47), most vaccines are designed to (1) present
tumor antigens to the immune system and (2) provide immune modulation.

Because of their differing mechanisms of action, vaccines and other
immunotherapies are potential combination partners. Clinical data have shown
promising results with some combinations e.g., gp100 peptide vaccine and IL-2
in melanoma, and ipilimumab combined with granulocyte macrophage-colony
stimulating factor (GM-CSF) cell-based vaccine (GVAX) in pancreatic cancer (48,
49). However, no survival advantage was seen in patients with melanoma treated
with gp100 plus ipilimumab versus those given ipilimumab alone in a phase III
trial (13, 17).

Various phase I and II clinical trials combining a vaccine with a checkpoint
inhibitor are ongoing in patients with melanoma or prostate cancer (Table 2; ref.
12). However, a clear demonstration of the vaccine’s ability to induce clinically
relevant antitumor responses in patients is required, as historically, the clinical
translation of cancer vaccines into efficacious therapies has been challenging
(with the exception of sipuleucel-T, the only approved therapeutic cancer
vaccine) (47). Data suggest that T cells activated at the vaccine site are “shut
down” when they enter the tumor microenvironment, most likely due to tumor-
mediated T-cell suppressive mechanisms (50, 51). With tools such as PD-1
immune checkpoint inhibitors that are designed to block tumor-mediated T-cell
suppression in the tumor microenvironment, it is worth evaluating whether
vaccines may improve clinical efficacy when combined with a checkpoint
inhibitor. However, data from the only published vaccine/PD-1 checkpoint inhibitor study showed the addition of a vaccine did not improve the efficacy of PD-1 inhibition (52).

**Integrating immunotherapies with existing therapeutic modalities**

Existing treatment modalities, (e.g., chemotherapy, RT, and molecularly targeted therapies) cause tumor reduction, not only through cytotoxic/cytostatic effects, but also through mechanisms which may potentiate immune activity, including modification of the tumor microenvironment and release of tumor antigens. This activity may be complementary, even synergistic, to the immunotherapies designed to support an antitumor immune response.

The immune effects of chemotherapy and RT are widely recognized and reviewed (53–62). Immune potentiating mechanisms include release of tumor antigens for immune presentation, depletion of immune suppressive cells (e.g., MDSC, Treg), activation of immune effectors (NK cells, DCs, B cells, conventional effector T cells), and sensitization of tumor cells to lysis.

Targeted therapies may also sensitize tumor cells to immune-mediated killing by a variety of mechanisms. These have been reviewed by Vanneman et al (58), and include promoting effective DC maturation, T-cell priming, activation and differentiation into long-lived memory T cells, increasing expression of death receptors or “distress” ligands, reducing expression of pro-survival signals, abrogating the production of tumorigenic inflammation, and inhibiting immunosuppressive cell types (63). BRAF inhibitors may also increase TILs and enhance antigen presentation (64, 65). Interestingly, while the BRAF inhibitors
have a potentiating effect on the immune system, MEK inhibitors have a possible reverse effect, reducing the secretion of cytokines (66) and reducing the activity of T lymphocytes (65) and DCs (67).

**Clinical experience and considerations in combining novel immunotherapies with existing treatment modalities**

Ipilimumab is the most widely studied combination partner for existing treatment modalities and data highlight the need for careful consideration in the choice of combination partner and approach to treatment. Preliminary data for ipilimumab in combination with chemotherapy, RT, and targeted therapy with BRAF inhibitors, are discussed below, alongside data with other immunotherapies. Table 2 provides a summary of ongoing clinical trials with immunotherapies (excluding ipilimumab) in combination studies with chemotherapy, RT, and targeted therapies (12).

**Chemotherapy combinations**

Ipilimumab has shown promising results when combined with chemotherapy in patients with melanoma and lung cancer; however, data indicate that careful consideration of the combination approach is going to be important in regard to tolerability and optimizing patient outcomes.

Patients with previously untreated melanoma who received ipilimumab (10 mg/kg) plus chemotherapy (dacarbazine) had significantly improved OS compared with those who received chemotherapy alone (11.2 months vs. 9.1 months) (15). However, the benefit of the combination relative to ipilimumab alone remains unclear, as there was not an ipilimumab-alone arm in the trial. The
combination was also less well-tolerated compared with dacarbazine alone. Grade 3 or 4 adverse events occurred in 56.3% of patients treated with ipilimumab/dacarbazine compared with 27.5% treated with dacarbazine/placebo ($P < 0.001$) (15). Similarly, data from a three-arm, phase I study showed that ipilimumab could be safety combined with either dacarbazine or carboplatin/paclitaxel in patients with melanoma (68).

Combining ipilimumab with paclitaxel and carboplatin significantly improved immune-related progression-free survival (irPFS) compared with chemotherapy alone in a phase II study in patients with NSCLC and extensive-disease SCLC (69, 70). However, the improvement in irPFS was only evident when the drugs were given on a phased schedule (e.g., two doses of placebo plus paclitaxel/carboplatin followed by four doses of ipilimumab plus paclitaxel/carboplatin), not when they were given concurrently. Phased ipilimumab, concurrent ipilimumab, and control, respectively, were associated with median irPFS of 5.7, 5.5, and 4.6 months in patients with NSCLC, and 6.4, 5.7, and 5.3 months in patients with SCLC. The overall incidence of treatment-related grade 3/4 adverse events was similar across the arms, and ipilimumab did not appear to exacerbate the adverse events associated with chemotherapy (69, 70).

Ongoing trials are further evaluating ipilimumab/chemotherapy combinations in melanoma and lung cancer, as well as in various other solid tumors, and will hopefully provide information about how best to combine these treatment modalities.
Nivolumab is being investigated in combination with a variety of agents in a large phase I trial (CheckMate 012, NCT01454102) in chemotherapy-naïve patients with NSCLC. Treatment arms include nivolumab monotherapy and nivolumab in combination with three, platinum-based doublet chemotherapy regimens, bevacizumab given after at least four cycles of platinum doublet chemotherapy, and erlotinib (epidermal growth factor receptor [EGFR]-mutation positive non-squamous NSCLC patients). Preliminary data indicate that nivolumab plus platinum-based chemotherapy has a manageable safety profile with no drug-related deaths reported so far. Objective responses have been observed in each arm, and 1-year OS rates ranged from 50% to 87% (71).

RT combinations

Ipilimumab has been evaluated in combination with RT in patients with metastatic CRPC and melanoma. Promising activity with manageable tolerability was observed in a phase I/II trial in patients with CRPC who had progressed after anti-androgen therapy (72); however, results from a phase III trial showed no significant improvement in OS with the addition of ipilimumab to RT in post-docetaxel CRPC. A subgroup analysis did suggest benefit for patients with less advanced disease (73). An analysis of clinical data from 21 patients with advanced melanoma who had received RT after ipilimumab progression on the Italian Expanded Access Program indicated that RT after ipilimumab treatment may further potentiate its effect (74). A local response to RT was detected in 13 patients (62%), while 8 patients (38%) did not show any local regression. The median OS for all 21 patients was 13 months (range 6–26). Eleven (85%) out of
13 patients with local response showed an abscopal effect, suggesting that local response to RT may be predictive for the abscopal response and outcome. The median OS for patients with and without abscopal responses was respectively of 22.4 months (range 2.5–50.3) and 8.3 months (range 7.6–9.0). There are now over 15 clinical trials alone in progress to evaluate ipilimumab plus RT.

Initial data from a phase I trial of MPDL3280A, an anti-PD-L1 monoclonal antibody, in combination with local RT showed evidence of activity in the five patients treated (75). Overall, case reports and data from several small clinical studies showing successful, sometimes dramatic, outcomes with RT/immunotherapy combinations in patients with melanoma provide additional support for further evaluation; these are comprehensively discussed by Barker and Postow (2014, 76).

**Targeted therapy combinations**

Clinical data are limited on the efficacy of combining ipilimumab with targeted agents, although numerous trials are ongoing, particularly in melanoma, where three targeted therapies are now approved in the United States for patients with melanoma and mutated BRAF (dabrafenib, vemurafenib, and trametinib).

Immunotherapy and BRAF inhibitor combinations are extensively reviewed by Hu-Lieskovan and colleagues (77). Some data indicate that the sequencing of BRAF inhibitors and ipilimumab has a marked effect on the efficacy and tolerability of the combination in patients with BRAF-mutant melanoma, and indicate that the drugs should be sequenced (78–80). Data from a recent retrospective analysis of a cohort of patients treated with
immunotherapy and then a BRAF inhibitor (with or without a MEK inhibitor) showed prior immunotherapy did not appear to have an adverse effect on response to a BRAF inhibitor. However, outcomes were poor when ipilimumab was given after BRAF inhibitor discontinuation (81). More data are needed, but there is some rationale to use either agent first in a sequencing approach, depending on the disease kinetics: in more rapid progressors, a BRAF inhibitor may be used first to reduce tumor load followed by ipilimumab to maintain a response; in patients with more indolent disease, ipilimumab may be given first followed by vemurafenib to reduce tumor burden (78).

In a phase I trial, concurrent administration of vemurafenib and ipilimumab at the approved monotherapy doses or with a lower dose of vemurafenib resulted in hepatotoxicity that was greater than expected for either agent alone (80). These safety analyses demonstrate the risk of using vemurafenib and ipilimumab concurrently, and these drugs should not be used in combination outside of a clinical trial. Ongoing studies are evaluating the optimal sequence of these agents in patients with BRAF-mutant metastatic melanoma. Severe cutaneous and neurologic toxicity has also been reported in two patients with melanoma during therapy with vemurafenib after receiving treatment with a PD-1 immune checkpoint inhibitor (nivolumab or pembrolizumab) (82). It is also noteworthy that dose-limiting toxicities have been observed in RCC patients treated with the targeted agent sunitinib and either rhIL-21 (hematological toxicity) or the anti-CTLA-4 agent tremelimumab (renal failure), further emphasizing the need for caution when evaluating combinations (83, 84).
RCC is a tumor where combining immunotherapy and targeted therapy is of substantial interest. Preliminary data from a phase II trial of nivolumab in combination with pazopanib or sunitinib in patients with metastatic RCC showed evidence of activity with ORRs of 45% and 52%, respectively, and a manageable safety profile (85). This trial and others evaluating various combinations in RCC continue.

The anti-CD137 agents urelumab and PF-05082566 are both in phase I trials in combination with rituximab in patients with non-Hodgkin's lymphoma (Table 2). Clinical study of these agents with rituximab is based on preclinical data which have shown enhanced tumor regression when an anti-CD137 agent is used after a therapeutic monoclonal antibody (86, 87). The anti-CD-137 antibody is proposed to enhance rituximab-dependent cytotoxicity through antigen-dependent cell-mediated cytotoxicity (86). Recent preclinical data showing enhanced anti-lymphoma activity with rituximab combined with KIR blockade (lirilumab) also support clinical investigation of this combination (34).

Conclusions

Immuno-oncology is an evolving treatment modality, with agents being studied for their potential to provide long-term survival across a broad range of tumor types, and for their synergistic activity when combined with other treatment modalities. It is important now to determine how to advance this field and how to use these new immunotherapies most effectively to achieve the best patient outcomes. Areas of investigation are broad, and include combining or sequencing immunotherapies that target distinct immune pathways, combining or
sequencing an immunotherapeutic agent with existing treatment modalities, and determining the optimal schedule of therapies in combination regimens. At present, it is difficult to identify the best combination approaches to pursue given the limited data and the somewhat unexpected occurrence of toxicity with some combinations (e.g., ipilimumab and vemurafenib). Future data from preliminary clinical studies will help to direct research.

Combining immunotherapies has the potential to overcome more than one of the barriers that tumor cells develop to evade the immune system, and may provide an OS benefit in a greater portion of patients compared with either agent alone (Fig. 1). However, the ideal sequence, schedule, and combination of immunotherapies need to be determined. Likewise, it is important to determine optimal dose, schedule, and sequence when combining an immunotherapy with RT, chemotherapy, or targeted agents, as these therapies all have different mechanisms of action. A final consideration for combining immunotherapies will be to identify the regimens with the best risk-benefit profile. We can expect improvements in overall clinical efficacy as new agents targeting alternative or overlapping tumor-associated immunosuppressive mechanisms are developed and used in combination or sequentially.

Grant Support

J. Larkin is supported by the National Institute for Health Research Royal Marsden Hospital/Institute of Cancer Research Biomedical Research Centre for Cancer.

Acknowledgments
The authors wish to acknowledge Rebecca Turner of StemScientific, a healthcare communications firm funded by Bristol-Myers Squibb, for providing writing and editorial support.

References


17. McDermott D, Haanen J, Chen TT, Lorigan P, O'Day S; MDX010-20 Investigators. Efficacy and safety of ipilimumab in metastatic melanoma


23. Woo SR, Tumis ME, Goldberg MV, Bankoti J, Selby M, Nirschl CJ, et al. Immune inhibitory molecules LAG-3 and PD-1 synergistically regulate T-


through a caspase-independent mechanism mediated through AIF.

Anticancer Res 2011;31:3193–204.


66. Shindo T, Kim TK, Benjamin CL, Wieder ED, Levy RB, Komanduri KV.


Inhibition of both BRAF and MEK in BRAF(V600E) mutant melanoma restores compromised dendritic cell (DC) function while having differential direct effects on DC properties. Cancer Immunol Immunother 2013;62:811–22.


Randomized phase I pharmacokinetic study of ipilimumab with or without


metastatic castration-resistant prostate cancer that had progressed after
docetaxel chemotherapy (CA184-043): a multicentre, randomised, double-

74. Grimaldi AM, Simeone E, Giannarelli D, Muto P, Falivene S, Borzillo V, et
al. Abscopal effects of radiotherapy on advanced melanoma patients who
progressed after ipilimumab immunotherapy. Oncoimmunology
2014;3:e28780.

al. Local tumor irradiation combined with α-PDL-1 immune checkpoint
inhibition results in local and systemic anti-tumor responses: successful
translation of a mouse model to a human case series [abstract]. In:
Proceedings of the 105th Annual Meeting of the American Association for
Cancer Research; 2014 Apr 5–9; San Diego, CA. Philadelphia (PA):
AACR; 2014. Abstract nr 2941.

76. Barker CA, Postow MA. Combinations of radiation therapy and
immunotherapy for melanoma: a review of clinical outcomes. Int J Radiat

77. Hu-Lieskovan S, Robert L, Homet Moreno B, Ribas A. Combining targeted
therapy with immunotherapy in BRAF-mutant melanoma: promise and

78. Ascierto PA, Simeone E, Giannarelli D, Grimaldi AM, Romano A, Mozzillo
N, et al. Sequencing of BRAF inhibitors and ipilimumab in patients with


Table 1. Potential strategies for overcoming tumor immune evasion mechanisms and examples of agents in clinical development (12)

<table>
<thead>
<tr>
<th>Treatment strategy</th>
<th>Examples of agents in clinical development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reversing the inhibition of adaptive immunity</strong></td>
<td></td>
</tr>
<tr>
<td>- Inhibiting the CTLA-4 checkpoint molecule^a</td>
<td>Ipilimumab: approved for melanoma</td>
</tr>
<tr>
<td></td>
<td>Tremelimumab: phase II for malignant mesothelioma, HCC, melanoma</td>
</tr>
<tr>
<td>- Inhibiting the interaction between PD-1 checkpoint and its ligands^a</td>
<td>Nivolumab (anti-PD-1): phase III for melanoma, NSCLC, RCC</td>
</tr>
<tr>
<td></td>
<td>Pembrolizumab (MK-3475; anti-PD-1): phase III for NSCLC, melanoma</td>
</tr>
<tr>
<td></td>
<td>MPDL3280A (RG7446; anti-PD-L1): phase III for NSCLC</td>
</tr>
<tr>
<td></td>
<td>Pidilizumab (CT-011; anti-PD-1): phase II for FL, prostate, pancreatic, melanoma</td>
</tr>
<tr>
<td></td>
<td>AMP-514 (MEDI0680; anti-PD-1): phase I for solid tumors</td>
</tr>
<tr>
<td></td>
<td>MEDI4736 (anti-PD-L1): phase I for solid tumors</td>
</tr>
<tr>
<td></td>
<td>AMP-224 (recombinant PD-L-Fc fusion protein): phase I for solid tumors</td>
</tr>
<tr>
<td></td>
<td>rHIgM12B7 (anti-PD-L2): phase I for melanoma</td>
</tr>
<tr>
<td>- Inhibiting the LAG-3 checkpoint molecule</td>
<td>IMP321: phase I for breast, RCC; phase II for melanoma</td>
</tr>
<tr>
<td></td>
<td>BMS-986016: phase I for solid tumors</td>
</tr>
<tr>
<td>- Inhibiting the TIM-3 checkpoint</td>
<td>No agent undergoing clinical evaluation</td>
</tr>
<tr>
<td>- Inhibiting the adenosine A2A receptor</td>
<td>No agent undergoing clinical evaluation</td>
</tr>
<tr>
<td><strong>Switching on adaptive immunity</strong></td>
<td></td>
</tr>
<tr>
<td>- Promoting CD137 signalling</td>
<td>Urelumab: phase I for B-cell NHL, CLL, solid tumors</td>
</tr>
<tr>
<td></td>
<td>PF-05082566: phase I for NHL</td>
</tr>
<tr>
<td>- Enhancing OX-40 signalling</td>
<td>MEDI6469: phase II for breast, prostate, solid tumors</td>
</tr>
<tr>
<td>- Promoting GITR signalling</td>
<td>TRX518: phase I for melanoma, solid tumors</td>
</tr>
<tr>
<td>Enhanced Function</td>
<td>Medication/Approach</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Enhancing CD27 signalling</td>
<td>CDX-1127</td>
</tr>
<tr>
<td>CD40 activation</td>
<td>CP-870,893, Chi Lob 7/4</td>
</tr>
<tr>
<td>Systemic recombinant IL-21 administration (range of effects that enhance immune cell function)</td>
<td>Denenicokin</td>
</tr>
<tr>
<td>Systemic recombinant IL-15 administration (range of effects that enhance immune cell function)</td>
<td>rhIL-15</td>
</tr>
<tr>
<td>Systemic recombinant IL-7 administration (range of effects, including on T-cell development)</td>
<td>rhIL-7</td>
</tr>
</tbody>
</table>

### Improving the function of innate immune cells

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Medication/Approach</th>
<th>Phase and Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manipulating the activation of NK-cell inhibitory receptors (KIRs)</td>
<td>Lirilumab</td>
<td>phase II for AML (maintenance); phase I for solid tumors</td>
</tr>
<tr>
<td>Stimulating macrophages and DCs</td>
<td>Toll-like receptor agonists:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bacillus Calmette-Guérin (TLR 2/4 agonist)</td>
<td>approved for bladder carcinoma</td>
</tr>
<tr>
<td></td>
<td>Hiltonol (TLR7 agonist)</td>
<td>phase II various solid and hematologic malignancies</td>
</tr>
<tr>
<td></td>
<td>Imiquimod (TLR7 agonist)</td>
<td>approved basal cell carcinoma</td>
</tr>
<tr>
<td></td>
<td>Resiquimod (TRL7/8 agonist)</td>
<td>phase 1/II various solid and hematologic malignancies</td>
</tr>
<tr>
<td></td>
<td>CpG 7909 (TLR 9 agonist)</td>
<td>phase II various solid tumors</td>
</tr>
</tbody>
</table>

### Activating the immune system (potentiating immune-cell effector function)
| Approaches where there are approved compounds or investigational compounds being studied in phase III trials. | Abbreviations: ADCC, antibody-dependent cell-mediated cytotoxicity; AML, acute myeloid leukemia; CLL, chronic lymphocytic leukemia; CTLA-4, cytotoxic T-lymphocyte antigen 4; DCs, dendritic cells; EOC, epithelial ovarian cancer; FL, follicular lymphoma; FTC, fallopian tube cancer; GITR, glucocorticoid-induced tumor necrosis factor related gene; HCC, hepatocellular carcinoma; IDO, indoleamine 2,3-dioxygenase; IFN, interferon; IL, interleukin; KIRs, killer-cell Ig-like receptors; LAG-3, lymphocyte activation gene-3; NHL, non-Hodgkin’s lymphoma; NK, natural killer; NSCLC, non-small cell lung cancer; PD-1, programmed death protein 1; PD-L1/2, programmed death ligand-1/2; PPC, primary peritoneal cancer; RCC, renal cell cancer; SCHN, squamous cell head and neck cancer; TGF, transforming growth factor; TIM, T cell immunoglobulin mucin; TLR, toll-like receptor |
| --- |
| • IDO inhibition | INCB024360: phase II for melanoma, EOC, PPC, FTC
Indoximod: phase II for breast, prostate |
| • Inhibition of TGF-β signalling | GC1008: phase I for melanoma, RCC
LY2157299: phase 1/2 various solid tumors
TEW 7197: phase I solid tumors
IMC-TR1 (LY3022859): phase I solid tumors |
| • Systemic IL-2 or IFN-α administration<sup>a</sup> | Agents approved |
| • Various vaccine-based strategies<sup>a</sup> | Various approaches under clinical evaluation |

<sup>a</sup>Approaches where there are approved compounds or investigational compounds being studied in phase III trials.
Table 2. Combination approaches in clinical development (12)

Selected clinical trials of immunotherapies

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Target</th>
<th>Development phase/tumor type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dual T-cell checkpoint blockade</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ipilimumab + nivolumab</td>
<td>CTLA-4 + PD-1</td>
<td>Phase III: melanoma; Phase I/II: RCC, colon, NSCLC, triple-negative breast cancer, gastric cancer pancreatic cancer and small cell lung cancer</td>
</tr>
<tr>
<td>Ipilimumab + pembrolizumab</td>
<td>CTLA-4 + PD-1</td>
<td>Phase I: melanoma, RCC and NSCLC</td>
</tr>
<tr>
<td>Tremelimumab + MEDI4736</td>
<td>CTLA-4 + PD-L1</td>
<td>Phase I: NSCLC, solid tumors</td>
</tr>
<tr>
<td>Nivolumab + BMS-986016</td>
<td>PD-1 + LAG-3</td>
<td>Phase I: solid tumors</td>
</tr>
<tr>
<td><strong>T-cell blockade + costimulatory receptor agonists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP-870,893 + tremelimumab</td>
<td>CTLA-4 + CD40</td>
<td>Phase I: metastatic melanoma</td>
</tr>
<tr>
<td><strong>T-cell blockade + improving the function of innate immune cells</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lirilumab + ipilimumab</td>
<td>CTLA-4 + KIR</td>
<td>Phase I: solid tumors</td>
</tr>
<tr>
<td>Lirilumab + nivolumab</td>
<td>PD-1 + KIR</td>
<td>Phase I: solid tumors</td>
</tr>
<tr>
<td><strong>T-cell blockade + other immune system activators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denenicokin + ipilimumab</td>
<td>CTLA-4 + IL-21</td>
<td>Phase I: melanoma</td>
</tr>
<tr>
<td>Denenicokin + nivolumab</td>
<td>PD-1 + IL-21</td>
<td>Phase I: solid tumors</td>
</tr>
<tr>
<td>INCB024360 + ipilimumab</td>
<td>CTLA-4 + IDO</td>
<td>Phase I: melanoma</td>
</tr>
<tr>
<td>Indoximod + sipuleucel-T</td>
<td>IDO + vaccine</td>
<td>Phase II: prostate</td>
</tr>
<tr>
<td>Nivolumab + gp100, NY-ESO-1</td>
<td>PD-1 + vaccine</td>
<td>Phase I: melanoma</td>
</tr>
<tr>
<td>Ipilimumab + sipuleucel-T</td>
<td>CTLA-4 + vaccine</td>
<td>Phase II: prostate cancer</td>
</tr>
<tr>
<td>Ipilimumab + TriMix-DC</td>
<td>CTLA-4 + vaccine</td>
<td>Phase II: melanoma</td>
</tr>
<tr>
<td>Ipilimumab + NY-ESO-1 vaccine</td>
<td>CTLA-4 + vaccine</td>
<td>Phase II: melanoma</td>
</tr>
<tr>
<td>Ipilimumab + adoptive cell transfer</td>
<td>CTLA-4 + passive</td>
<td>Phase I/II: melanoma</td>
</tr>
<tr>
<td></td>
<td>immunotherapy</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>Target</td>
<td>Combination treatment modality</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Tremelimumab</td>
<td>CTLA-4</td>
<td>Gefitinib</td>
</tr>
<tr>
<td>Nivolumab</td>
<td>PD-1</td>
<td>Chemotherapy&lt;sup&gt;a&lt;/sup&gt;, Dasatinib, Bevacizumab, Erlotinib, Sunitinib or pazopanib</td>
</tr>
<tr>
<td>Pembrolizumab (MK-3475)</td>
<td>PD-1</td>
<td>Pazopanib, Lenalidomide + dexamethasone</td>
</tr>
<tr>
<td>MPDL3280A (RG7446)</td>
<td>PD-L1</td>
<td>Bevacizumab, Erlotinib, Vemurafenib, Trametinib ± dabrafenib</td>
</tr>
<tr>
<td>MEDI14736</td>
<td>PD-L1</td>
<td>Pembrolizumab, Pazopanib, Lenalidomide + dexamethasone</td>
</tr>
<tr>
<td>Pembrolizumab (CT-011)</td>
<td>PD-1</td>
<td>Rituximab, Gemcitabine, FOLFOX, Sipuleucil-T + cyclophosphamide</td>
</tr>
<tr>
<td>IMP321</td>
<td>LAG-3</td>
<td>Paclitaxel</td>
</tr>
<tr>
<td>Urelumab</td>
<td>CD137</td>
<td>Rituximab</td>
</tr>
<tr>
<td>PF-05082566</td>
<td>CD137</td>
<td>Rituximab</td>
</tr>
<tr>
<td>CP-870,893</td>
<td>CD40</td>
<td>Paclitaxel/carboplatin</td>
</tr>
<tr>
<td>Denenicokin</td>
<td>IL-21</td>
<td>Sunitinib, Sorafenib, Rituximab</td>
</tr>
<tr>
<td>Indoximod</td>
<td>IDO</td>
<td>Docetaxel</td>
</tr>
</tbody>
</table>

<sup>a</sup>Chemotherapies include: gemcitabine/cisplatin; pemetrexed/cisplatin; carboplatin/paclitaxel.
**Figure 1.** Targeting two distinct immune checkpoint pathways: interim data from a phase I study of concurrent ipilimumab and nivolumab. Patients with advanced melanoma treated with ipilimumab in combination with nivolumab had a preliminary 1-year OS rate of 82%. These data provided the rationale for initiation of a phase III trial of the ipilimumab/nivolumab combination in previously untreated patients with metastatic melanoma (16). Reprinted with permission from Wolchok et al. (16).

**Figure 2.** Hypothetical effect on OS of blocking two T-cell checkpoint pathways. Adapted with permission from Urba (24).
Figure 1:

1-year survival of 82% (95% CI 69.0%–94.4%) for 1 mg/kg nivolumab + 3 mg/kg ipilimumab in all concurrent regimen. Patients at risk and censored/died/treated are as follows:

- 1 mg + 3 mg: 17 patients at risk, 2 censored, 10 died/treated
- All concurrent: 53 patients at risk, 9 censored, 44 died/treated
Figure 2:

Combination
PD-1 pathway blockade
CTLA-4 pathway blockade

Percentage alive vs. Years

CCR Reviews
Immuno-oncology Combinations: A Review of Clinical Experience and Future Prospects

Scott J Antonia, James Larkin and Paolo A Ascierto

Clin Cancer Res  Published OnlineFirst October 23, 2014.

Updated version
Access the most recent version of this article at:
doi:10.1158/1078-0432.CCR-14-1457

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

E-mail alerts
Sign up to receive free email-alerts related to this article or journal.

Reprints and Subscriptions
To order reprints of this article or to subscribe to the journal, contact the AACR Publications Department at pubs@aacr.org.

Permissions
To request permission to re-use all or part of this article, contact the AACR Publications Department at permissions@aacr.org.