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Title Page

A Phase III Clinical Trial of the Epidermal Growth Factor Vaccine CIMAvax-EGF as Switch Maintenance Therapy in Advanced Non-Small-Cell Lung Cancer Patients.

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Running title: Phase III Clinical Trial of Epidermal Growth Factor Vaccine CIMAvax-EGF in Non-Small-Cell Lung Cancer Patients.

Keywords: Cancer vaccine, Non-Small-Cell Lung Cancer, phase III clinical trial, Epidermal Growth Factor.

Statement of translational relevance: The EGF vaccine consists of a different approach when compared with other active immunotherapies. CIMAVax-EGF is built on the induction of a specific immune response, aiming to sequester EGF, a molecular driver of cancer cells proliferation. The significantly largest benefit of CIMAvax-EGF in the subpopulation of patients with high pre-treatment concentration of EGF is differentiating our cancer vaccine when compared with other modalities of active immunotherapy or targeted therapy. CIMAvax-EGF is a very safe drug that could be a feasible intervention for long-term control of

those NSCLC patients with tumors depending on the EGF, capable to mount a rapid and durable response.

Abstract

Purpose: Epidermal Growth Factor Receptor (EGFR) is a well validated target for Non-Small-Cell-Lung-Cancer (NSCLC) patients. CIMAvax-EGF is a therapeutic cancer vaccine composed by human-recombinant EGF conjugated to a carrier protein and Montanide ISA51, as adjuvant. The vaccine is intended to induce antibodies against self EGF that block EGF-EGFR interaction.

Experimental design: To evaluate overall survival, safety, immunogenicity and EGF concentration in serum after CIMAvax-EGF, a randomized phase III trial was done in advanced NSCLC patients. Four to 6 weeks after first-line chemotherapy, 405 stage IIIB/IV NSCLC patients were randomly assigned to a vaccine group, which received CIMAvax-EGF or a control group, treated with best supportive care.

Results: Long-term vaccination was very safe. Most frequent adverse reactions were *grade 1 or 2* injection-site pain, fever, vomiting and headache. Vaccination induced anti-EGF antibodies and decreased serum EGF concentration. In the safety population, median survival time (MST) was 10.83 months in the vaccine arm vs. 8.86 months in the control arm. These differences were not significant according the standard log-rank (HR 0.82; $p=0.100$) but according a weighted log-rank ($p=0.04$), that was applied once the non-proportionality of the hazard ratio was verified. Survival benefit was significant (HR 0.77; $p=0.036$) in the per-protocol setting (patients receiving at least 4 vaccine doses): MST was 12.43 months for the vaccine arm vs. 9.43 months for the control arm. MST was larger (14.66 months) for vaccinated patients with high EGF concentration at baseline.

Conclusions: Switch maintenance with CIMAvax-EGF was well tolerated and significantly increased MST of patients that completed induction vaccination.

Baseline EGF concentration predicted survival benefit.

Introduction

Lung cancer remains one of the leading causes of cancer-related death in men and women, provoking approximately 1.6 million deaths, 19.4% of the total deaths per year, worldwide (1). In Cuba for instance, lung cancer is the leading cause of death in both genders with more than one-quarter of all cancer deaths. Non-small cell lung cancer (NSCLC) is the most common form of the disease (87%) and approximately 60% of the patients present advanced disease at diagnosis (2).

Treatment of advanced NSCLC has undergone a rapid evolution along the last 30 years with three major advances: the platinum-based doublets, maintenance and second-line chemotherapy with docetaxel, pemetrexed or erlotinib and targeted therapies with small molecules such as gefitinib, erlotinib, afatinib, crizotinib or ceritinib for tumors with sensitizing mutations (3-6). Nevertheless, 1-year survival rate is approximately 35% for patients with wild type tumors whereas 5-year survival rate is still around 5% (2).

Epidermal Growth Factor Receptor (EGFR) is overexpressed in approximately 40%-80% of non-small-cell lung cancers (7). The oncogenic addiction of the malignancies to this signaling pathway triggers its inappropriate activation and promotes the uncontrolled growth, proliferation and survival of cancer cells (8). Thus, EGFR overexpression is associated with poor prognosis, lower survival and resistance to therapy (9).

The EGF-based cancer vaccine CIMAvax-EGF is an active immunotherapy, intended to prevent binding of the endogenous EGF to the receptors, by inducing anti-EGF antibodies that clear the growth factor from circulation (10). CIMAvax-EGF is composed by human recombinant EGF coupled to a carrier

protein, recombinant P64. The EGF-P64 chemical conjugate is emulsified in Montanide, an oily adjuvant. The carrier protein and the adjuvant are required to break the tolerance against EGF, which is a self-protein. Previous phase I/II clinical trials evidenced the immunogenicity and safety of vaccination in patients with advanced stage NSCLC (11-13). In a randomized phase 2 trial using CIMAvax-EGF as switch maintenance or second-line therapy versus best supportive care in subjects with stage IIIB or IV NSCLC, a trend toward survival benefit was found. Patients younger than 60 years, those with good antibody response against EGF and subjects in whom serum EGF concentration ([EGF]) decreased below a pre-established threshold, achieved a significant survival benefit with vaccination. Post-immune serum hampered the binding between EGF and EGFR in a radio-receptor assay and abrogated EGFR phosphorylation (14, 15).

In the present article, we show the results of a randomized phase III trial in advanced NSCLC patients. The primary endpoint was overall survival, while safety, immunogenicity and serum EGF concentration before and after therapy, were secondary endpoints.

Patients and methods

Eligibility Criteria

Eligible patients were 18 years or older, with histologically or cytological proven stage IIIB/IV NSCLC and an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2. Patients with all histological NSCLC subtypes and life expectancy of at least 3 months were trial candidates. Other inclusion criteria included hemoglobin values above 90 g/L, leukocytes count $\geq 3.0 \times 10^9/L$, platelets count $\geq 150 \times 10^9/L$, serum glutamic oxalo-acetic transaminase

(SGOT) and serum glutamate-pyruvate transaminase (SGPT) up to 2.5 times the upper institutional limit and creatinine, up to 2 times the upper institutional reference value. All patients received 4 to 6 cycles of platinum-based chemotherapy (mostly cisplatin/carboplatin in combination with vinblastine, etoposide or paclitaxel) and had stable disease or objective response.

The trial protocol, informed consent, investigator brochure and case report forms were approved by the ethic boards from all participating institutions and by the National Regulatory Agency. Informed consent was obtained from each subject before entering to the study. The study was done in compliance with the principles of Good Clinical Practices (according the International Conference of Harmonization) and the Declaration of Helsinki.

Treatment Schedule

Four to 6 weeks after finishing first-line chemotherapy, patients were randomly assigned (2:1) to the vaccine group, which received the EGF cancer vaccine plus best supportive care, or the control group, that was treated with best supportive care. Patients in the vaccine arm were given a low-dose of cyclophosphamide (200 mg/m²) intravenously, 72 hours before the first immunization. Each vaccine dose was administered at 4 injection sites (2 deltoid and 2 gluteus regions), every two weeks for four doses (induction period) and then, monthly.

CIMAvax-EGF was manufactured at the industrial facility of the Centre for Molecular Immunology (Havana, Cuba), in compliance with the Good Manufacturing Practice standards for biopharmaceutical products. The vaccine is composed of human recombinant EGF manufactured in yeast (hu-recEGF), and it is chemically conjugated to the P64K Neisseria meningitides recombinant

protein (recP64k), manufactured in *Escherichia coli*. The final formulation of the cancer vaccine (0.6 mg hu-recEGF/recP64k) is then mixed in a water-in oil emulsion with Montanide (Seppic, Paris, France) immediately before injection. At each immunization, patients received 2.4 mg of human recombinant EGF/recombinant P64k/ Montanide (16).

Patient Assessment

Patient assessment was performed at baseline and every 4 weeks, and included physical exam and clinical laboratory tests, as described in the inclusion criteria. Additionally, chest radiography, computed tomography (CT) scan, and abdominal ultrasound were performed at baseline and every 3 months to assess clinical response according the Response Evaluation Criteria in Solid Tumors, version 1.1 (RECIST1.1).

Toxicity was graded according to the National Cancer Institute Common Toxicity Criteria (NCI-CTC; version 3) at each visit. Criteria for discontinuing vaccination included voluntary withdrawal, unmanageable toxicity, or severe worsening of the patient general conditions. Progressive disease according RECIST 1.1 was not an interruption criterion.

Measurements of Antibody Titers

Blood samples were collected at baseline (pre-treatment) and every 14 days for 60 days and monthly, thereafter. Anti-EGF antibody titers were measured through an enzyme linked immunosorbent assay (ELISA), as described in previous studies. Patients were classified in good antibody responders (GAR) if they developed anti-EGF antibody titers equal or higher than 1:4000, and super-good antibody responders (SGAR) if they reached anti-EGF antibody titers

equal or higher than 1:64000. Those vaccinated patients that did not have titers above 1:4000 were classified as poor antibodies responders (PAR) (12-15).

EGF concentration in serum was measured with a commercial ELISA (Quantikine EGF; R&D Systems Inc, Minneapolis, MN) in 50 % of the enrolled patients. Subjects were classified according their pre-treatment (baseline) serum EGF concentration, in high EGF ([EGF] > 870 pg/mL) or low EGF ([EGF] ≤ 870 pg/mL). The selected cut-off (870 pg/ml) corresponded to the median EGF concentration for all patients, at day 0.

Statistical Analysis

The projected sample size was 579 considering that a two-sided log-rank test with 386 vaccinated patients and 193 controls achieves 90 % power at a 0,05 % significance level to detect a hazard ratio of 0,7. The proportion dropping out of the treatment and control groups was anticipated to be 10 %. *First and second interim analyses were done after 40 % and 60 % of the patients were enrolled.* The trial was stopped before reaching the intended sample size, after the marketing approval of CIMAvax-EGF by the National Regulatory Agency, at the second interim analysis.

Survival time (date of random assignment to date of death or last contact) was estimated by the Kaplan-Meier method in the safety population (patients receiving at least 1 vaccine dose) and in the per-protocol population (PP), as established in the trial protocol. The per-protocol population included those patients that completed 4 doses of CIMAvax-EGF (induction period). Control patients that did not survive for 6 weeks (time interval needed to complete CIMAvax-EGF induction period) were excluded from the survival comparison. Regarding serum EGF, a prospectively defined sub-group was retrospectively

analyzed using the analytically validated test for EGF concentration. The evaluation of the EGF concentration as predictive or prognostic biomarker was classified as exploratory.

Survival comparison was done with a standard log-rank test and a weighted log-rank test (Harrington-Fleming), according the proportionality of the hazards (17). The hazard proportionality was checked graphically in agreement with the methodology proposed by Lambert PC and co-workers (18). The Pearson correlation coefficient and Fisher's exact tests were used to estimate the correlation between anti-EGF titers and [EGF], and to assess the uniform distribution of baseline variables between groups, respectively.

PFS was not a secondary objective since it is not a recommended endpoint for evaluating vaccines efficacy. Because of their immunological mechanisms of action, cancer vaccines may require considerable time after administration to induce immunity. Therefore, tumors in subjects treated with cancer vaccines may show early progression followed by subsequent response.

The statistical system SPSS (version 15.1) and R (version 2) were used for modelling and verifying the hypothesis in all population sets. This study was registered in the National Public Registry of Clinical Trials; a WHO validated Public Registry (<http://www.who.int/ictcp/network/rpcec/en>, Trial number RPCEC00000161)

Results

From July 5, 2006 to January 3, 2012, 1 336 patients were evaluated for eligibility in 19 Cuban clinical research centers. Four-hundred-five (405) patients with histology or cytology proven NSCLC at stage IIIB and IV were enrolled in the trial: 270 in the vaccine arm and 135 in the control group. Two hundred

forty-six (246) patients received at least one vaccine dose (safety population), 219 subjects received four doses (per-protocol population), 85 patients received more than 14 CIMAvax-EGF doses (1-year vaccination), 39 patients were vaccinated 26 times or more (2-years vaccination), while 12 subjects received more than 50 vaccine doses (4-years vaccination). Three control patients were vaccinated, as compassionate use, upon trial withdrawal (Supplementary figures S1). Control patients that received CIMAvax-EGF were excluded from the analysis.

Twenty-four patients (8.8 %) from the vaccine arm did not receive any vaccine dose while 27 patients (10.9 %) that started vaccination did not complete CIMAvax-EGF induction (4 doses). The main causes of early dropout were rapid worsening of the performance status, consent withdrawal, uncompensated comorbidities, schedule violations and rapid onset of death. Eighteen patients, 10 vaccinated (3.7 %) and 8 controls (5.9 %), died before day 45 (time needed to complete induction vaccination). No significant differences were found between both arms regarding early death.

The two arms were well matched for baseline demographic and tumor variables such as sex, ethnic origin, age, smoking status, ECOG, disease stage, histology and response to initial chemotherapy (Table 1).

Most patients did not receive further chemotherapy at progression (in consonance with the national treatment guideline), since the recommended second line drugs pemetrexed, docetaxel and erlotinib were not widely available in the country at the time of trial execution. In the vaccine arm, 16 patients (5.9 %) received additional chemotherapy including carboplatin, cisplatin, paclitaxel, etoposide, vinblastine, cyclophosphamide and docetaxel. In the control group, 9

subjects (6.6 %) were treated with other chemotherapies comprising paclitaxel, carboplatin, vinblastine, etoposide, vincristine and docetaxel. Overall, only 2 patients, one from each arm, received docetaxel, one of the drugs accepted to increase survival after progressive disease.

CIMAvax-EGF Efficacy

In the safety population (patients receiving at least 1 CIMAvax-EGF dose), vaccinated patients had a survival benefit that did not reach statistical significance according the standard log-rank test (HR 0.82, 95% CI 0.661-1.03, $p=0.100$). Median survival time (MST) in the vaccine arm was 10.83 months (95% CI 8.95-12.71) while MST in the control group was 8.86 months (95% CI 6.69-11.03). Five-year survival rate was 14.4% for vaccinated patients and 7.9 % for controls. Since a delayed-separation of the survival curves and a non-proportional hazard ratio between the 2 groups was verified, the Harrington-Fleming test was applied. The survival difference was significant according this weighted log-rank test (HF $p= 0.04$).

In addition, overall survival was evaluated in the per-protocol population, as established in the trial protocol. The median survival in the vaccine arm (*patients completing 4 vaccine doses*) was 12.43 months (95% CI 10.42-14.45) vs. 9.43 months (95% CI 7.53-11.33), in the control arm (*patients surviving for at least 6 weeks*). Five-year survival rate was 16.62 % for those vaccinated patients that received 4 vaccine doses vs. 6.2 % for non-vaccinated patients. Survival differences in the per-protocol population were significant according the standard, unweighted log-rank test: (HR 0.77 95% CI 0.61-0.98, $p=0.036$) (Figure 1B).

Serum EGF at baseline might be a prognostic and predictive factor of vaccine efficacy.

Serum EGF was quantified in 188 patients. Mean and median EGF concentration was 1195 pg/ml and 873 pg/ml, respectively. There were not differences in the serum EGF levels between vaccinated and control patients. Mean and median EGF concentration was 1194 pg/ml and 930 pg/ml for the vaccine arm and 1197 pg/ml and 820 pg/ml for controls (p=0.98).

Median EGF concentration (870 pg/ml) was established as a cutoff to classify patients in high or low [EGF] at enrollment, as pre-specified in the protocol. Survival according [EGF] at baseline was evaluated in control and vaccinated patients to preliminary assess the prognostic and predictive value of the referred biomarker.

In the control group, patients with high [EGF] had a worse survival as compared to patients with low [EGF] (HR 0.38 95% CI 0.20-0.70, p=0.002) (Figure 2A). Median OS was 8.63 months (95% CI 1.15- 28.28) for controls with high [EGF] vs. 15.06 months (95% CI 1.67- 15.59) for subjects with low [EGF]. *According to this analysis, high EGF levels may be a poor prognostic factor while low EGF may be a good prognostic factor for NSCLC patients.* The association between EGF levels and prognosis remained significant when other prognostic variables (gender, smoking history, performance status, and staging) were included in the multivariate analysis. In the multivariate analysis, the most significant variables were EGF concentration and ECOG.

On the contrary, patients with serum [EGF]>870 pg/ml had a better survival as compared to controls with the same EGF serum levels, if vaccinated with CIMAvax-EGF (HR 0.41 95% CI 0.25-0.67, p=0.0001). Median survival time for

vaccinated patients was 14.66 months (95% CI 8.34-20.98) vs. 8.63 months (95% CI 1.67-15.59) for non-vaccinated patients. Five-year survival rate was 23% for vaccinated patients while no controls were alive after 60 months. According to this retrospective analysis (predefined in the protocol), [EGF] above the 870 pg/ml threshold, could be a predictive biomarker of CIMAvax-EGF efficacy (Figure 2B). The interaction between EGF levels and treatment was checked and was statistically significant ($p < 0.0001$).

Vaccination with CIMAvax-EGF induced anti-EGF antibodies and decreased EGF concentration in sera.

Anti-EGF antibody titers were evaluated in 112 patients (40 % of subjects enrolled in the vaccine arm). Eighty-nine patients (79.4 %) were classified as good responders while 24 patients (21.4 %) were categorized as super-good responders, since they developed anti-EGF antibody titers above 1:64000 sera dilution. The percentage of patients reaching the GAR condition after 1, 2, 3 or 4 vaccine doses was 0, 7 %, 39 % and 56 %, respectively. Four doses was the minimum number of injections after which 50 % of the patients met the GAR status. Patients that met the GAR criterion after the induction period had a significant survival benefit: MST was 14.90 months vs 8.86 months for the controls (HR 0.638 95% CI 0.44-0.92, $p = 0.017$). Overall, the geometric mean of the maximal antibody titer was 1:12646 while the highest antibody titer was 1:1024000.

In addition, serum EGF was measured before and after vaccination. A significant inverse correlation was observed (spearman $r = -0.523$; $p < 0.01$) between the anti-EGF antibody titers and serum EGF concentration in

vaccinated patients (Figure 3). In control patients, there was no association between antibody titers and serum EGF.

A subgroup exploration including the most important demographic and tumor variables was done in the safety population (Figure 4). In addition to high serum EGF concentration, patients with the largest benefit after vaccination were those bearing squamous cell carcinoma histology, smokers, and with stage IV.

Long-term vaccination with CIMAvax-EGF was safe

The safety evaluable population consisted of 246 patients who received at least one dose of CIMAvax-EGF. Adverse events were reported in 78.3% of the safety evaluable population and 1200 vaccine-related events were reported in 59.4% of the treated patients. Most frequent related adverse events were injection-site pain (46.6 %), fever (36.5%), vomiting (23.3 %) and headache (22.5 %). Grade 3 related adverse events were seen in 3.6% of the vaccinated patients and consisted on headache (2 patients), dyspnea (2 patients), injection site reactions (2 patients), eosinophilia (2 patients), fever (1 patient), chills (1 patient), tremors (1 patient) and arthralgia (1 patient). No patient developed grade 4 adverse events (Table 2 and Supplementary Tables S2 and S3).

Discussion

The treatment of advanced NSCLC has undergone a rapid evolution along the last 30 years: from a dark landscape in the 80s to the demonstration of survival gain after the combination of platinum doublets, maintenance and second line therapy with docetaxel, pemetrexed and erlotinib for patients with EGFR and ALK wild type tumors (3-5).

Another big wave of improvement came with targeted therapies with tyrosine kinase inhibitors like gefitinib, erlotinib and afatinib for tumors carrying EGFR

mutations and crizotinib and ceritinib for tumors carrying ALK activating translocations (19). The median survival in patients with metastatic disease and defined mutations ranged from 23 to 27 months (20). Unfortunately the population bearing EGFR or ALK mutations and thus, benefiting from the approved targeted therapies, is small (~15-20 %) (6).

The next wave of progress is coming from immunotherapy. Long lasting responses have been reported after the use of the anti-PD1 antibodies (nivolumab, pembrolizumab) and the anti-PD1L antibodies (MPDL3280A, BMS936559, MEDI4736). Moreover, nivolumab has recently demonstrated to increase survival of patients bearing metastatic squamous and adenocarcinoma NSCLC that progressed on or after platinum-based chemotherapy, as compared with docetaxel (21, 22). Pembrolizumab showed remarkable antitumor activity in patients with advanced NSCLC and PD-L1 expression in at least 50% of tumor cells (23). FDA recently approved both checkpoint inhibitors for the treatment of metastatic NSCLC, as second line therapy.

Active immunization might also improve lung cancer survival, if the vaccine successfully triggers a strong immune response and if used in the right population. Clinical studies with three vaccine candidates in advanced population such as tecemotide, TG4010, and Belagenpumatucel-L had not meet their primary endpoint but showed *possible* benefits in patient subpopulations: for tecemotide, a potential role of vaccination was seen in patients treated with concurrent chemo-radiotherapy; for TG4010, the lymphocyte phenotype and concomitance with chemotherapy were reported as potential predictors of outcome and for Belagenpumatucel-L the number of circulating tumor cells appears to correlate with overall survival (24-26).

The EGF vaccine consists of a different approach when compared with other active immunotherapies. CIMAvax-EGF is built on the induction of a specific immune response, aiming to sequester EGF, a molecular driver of cancer cells proliferation (11-15). Its mechanism of action is based on the “hormone deprivation theory” that has proven to be effective for sexual hormones dependent tumors (10). The rationale of CIMAvax-EGF is based on the finding that EGF concentration is higher in NSCLC patients than in normal donors. The preliminary role of [EGF] as a negative prognostic marker for advanced NSCLC reinforces the validity of the “removal” approach (9).

In this phase III study, CIMAvax-EGF was very safe even in patients that received very prolonged vaccination (more than 2 years) and did not show cumulative toxicity.

Immunogenicity assessment was a secondary endpoint of this Phase III clinical trial. The protocol projected the evaluation of 40 % of the patients for anti-EGF response since a full characterization of the immunogenicity was done in all previous trials (5 exploratory and 1 phase II trials). This protocol evaluated a different vaccine dose and schedule, as compared to the controlled Phase II, that yielded a good antibody response in 53 % of the vaccinated patients. After vaccinating with a high antigen dose, at 4 injection sites (current Phase III protocol), 78.8 % of the patients had a good response (anti-EGF antibody titers >4000). Still, only 21.2 % of the vaccinated patients achieved a super good response (anti-EGF>1:64 000). CIMAvax-EGF was not only immunogenic but also reduced the EGF concentration to undetectable levels. There was an inverse correlation between serum EGF and the anti-EGF antibody titers.

Regarding efficacy, patients that received at least 4 doses of CIMAvax-EGF had a significant survival advantage. For active immunotherapy, where the target is the immune system and not the tumor, it is mandatory to administer a minimum number of vaccine doses to break the tolerance against self-antigens (27, 28). Moreover, in a post-hoc analysis in the safety population, CIMAvax-EGF significantly increased overall survival, when a weighted log-rank test was used. The Harrington-Fleming test is very sensitive to detect a delayed effect in the survival curves, when the HR is not proportional. The “delayed benefit” and the survival advantage in a population completing the induction period, indicate that there is a time lag before CIMAvax-EGF can be effective (17, 28). A rational combination with chemotherapy can allow the vaccine to “buy” that time. The immunogenicity of CIMAvax-EGF has been already demonstrated in combination with platinum-doublets.

PFS was not a secondary goal of the study, since endpoints based on tumor assessments (response rate, PFS), may not be appropriate for a late phase clinical trial for a cancer vaccine. Previously, other vaccines and immunomodulatory antibodies have not shown improvement in PFS: sipuleucel-T and prostrvac-vf in prostate cancer and ipilimumab and eltrapuldencel-T in melanoma were associated with no improvement in PFS and response rate, but statistically significant benefit in overall survival (29).

The incidence of activating EGFR and ALK translocations was not evaluated in the trial, since the TKI targeting the referred mutations were not accessible. However, theoretically, CIMAvax-EGF would be effective in patients lacking EGFR mutations. EGFR is constitutively activated in tumors with mutations at the intracellular domain which do not require EGF binding for signal

transduction. According our preliminary data, CIMAvax-EGF is more active in Caucasian, smoker males bearing squamous cell carcinomas. Patients benefiting largely from EGFR TKI are Asian, female, non-smoker with adenocarcinomas. These demographic characteristics correspond with EGFR sensitizing mutations at exons 19 and 21. The actual correlation between EGFR mutations and efficacy of CIMAvax-EGF will be addressed in the forthcoming trials.

Particularly, our data suggest that survival gain occurs mainly in patients having high EGF concentration after front line chemotherapy. Median survival time in this patient population (14.66 months) is comparable with the survival of patients receiving other drugs recommended as continuation or switch maintenance. This result is more relevant provided that 94 % of patients did not receive second line chemotherapy upon progression. This observation highlights the importance of a predictive biomarker to maximize the therapeutic value of CIMAvax-EGF. A new clinical trial enrolling patients with [EGF] above the 870 pg/ml threshold is already ongoing (30).

In summary, CIMAvax-EGF is a very safe drug that could be a feasible intervention for long-term control of those NSCLC patients with tumors depending on the EGF, capable to mount a rapid and durable response.

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Figure legends

Figure 1A. Kaplan-Meier curve in the safety population. MST for the vaccine arm was 10.83 months (95% CI 8.95-12.71) vs. 8.86 months (95% CI 6.69-11.03) for the control arm. HR 0.82 (95% CI 0.661-1.03, $p=0.100$).

Figure 1B. Kaplan-Meier curve in the per-protocol population. MST for the vaccine arm was 12.43 months (95% CI 10.42-14.45) vs. 9.43 months (95% CI 7.53-11.33) for the control arm. HR 0.77 95% CI 0.61-0.98, $p= 0.036$.

Figure 2A. Kaplan-Meier curve in non-vaccinated patients (control arm). MST for patients with low [EGF] was 15.06 months (95% CI 1.15-28.28) vs. 8.63 months (95% CI 1.67-15.59) for patients with high [EGF] at day 0. HR 0.38 (95% CI 0.20-0.70) $p=0.002$.

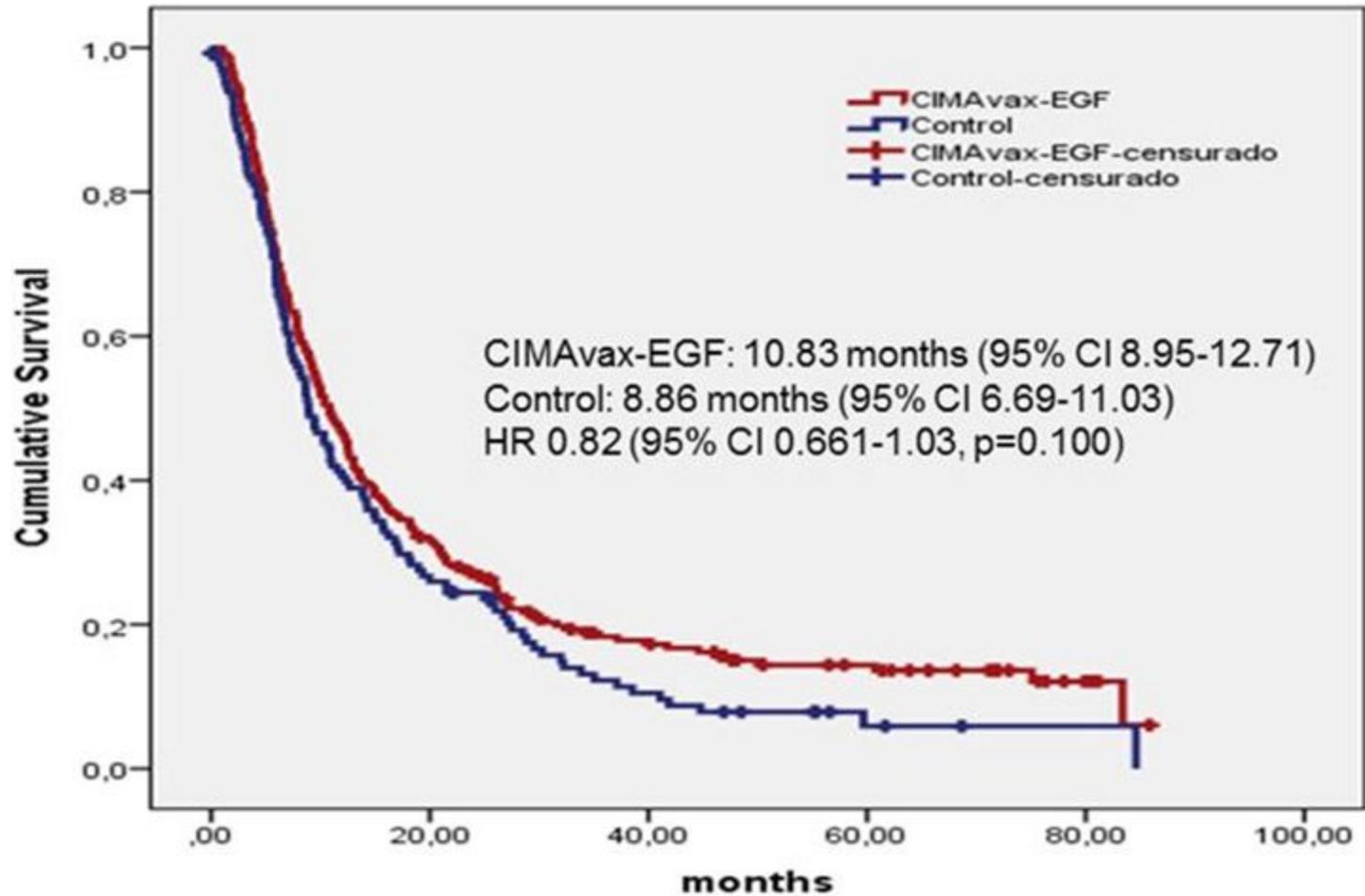
Figure 2B. Kaplan-Meier curve in patients with high [EGF] at day 0. MST for vaccinated patients was 14.66 months (95% CI 8.34-20.98) vs. 8.63 months (95% CI 1.67-15.59) for controls. HR 0.38 (95% CI 0.20- 0.70) $p=0.002$.

Figure 3. Kinetics of the anti-EGF antibody titers and serum EGF concentration in vaccinated patients. Blood samples were collected at baseline, every 14 days for 60 days and monthly thereafter. Anti-EGF antibody titers were measured through an ELISA. EGF concentration in serum was measured with a commercial ELISA (Quantikine; R&D Systems Inc, Minneapolis, MN).

Figure 4. Cox regression analysis: Subgroup analysis considering the most important demographic and tumor variables.

Figure 1A

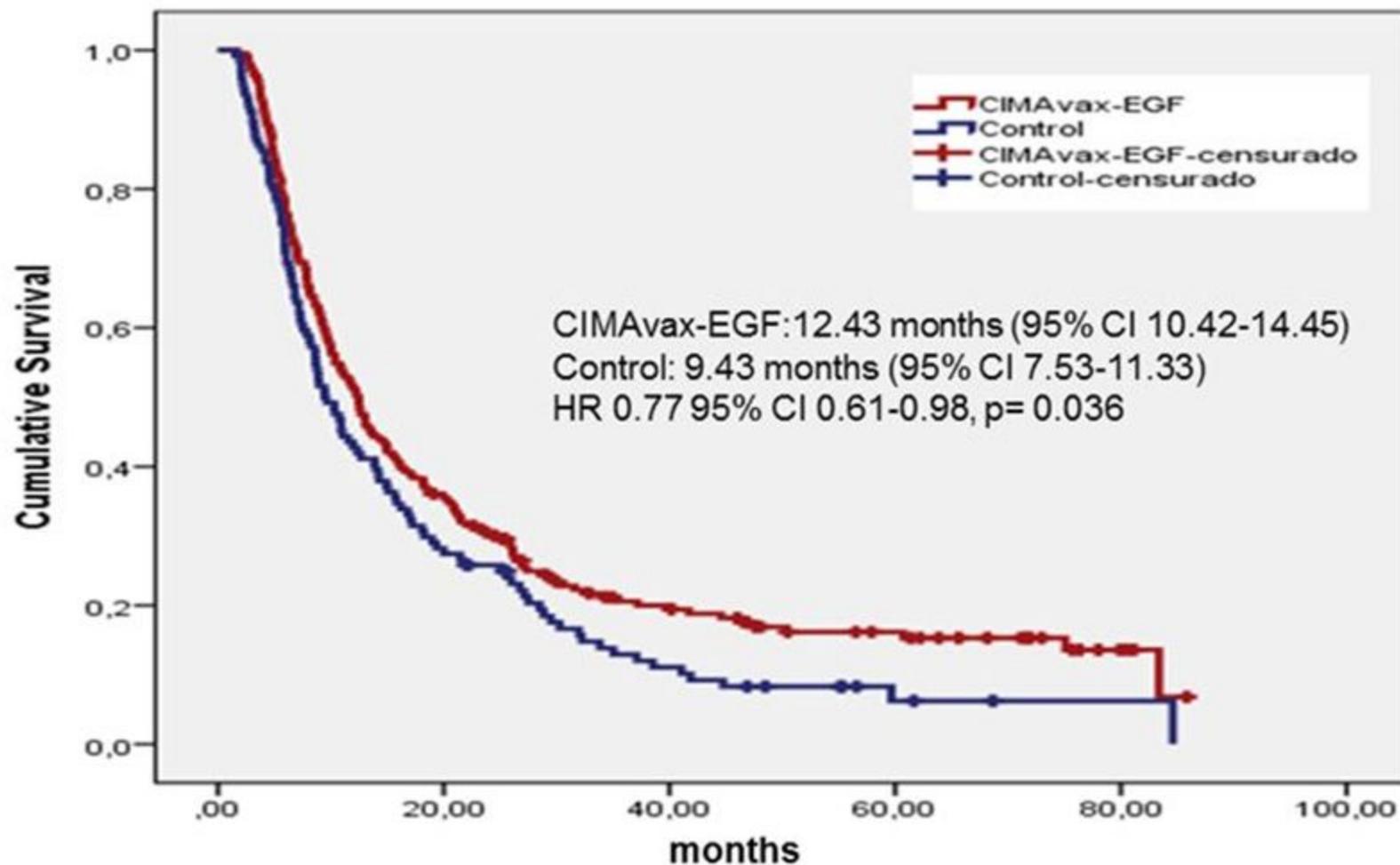
A



Number at risk	0	6	12	24	36	48	60	72	84
CIMAvax-EGF	246	173	114	64	35	24	19	10	1
Control	132	88	53	30	14	8	3	1	0

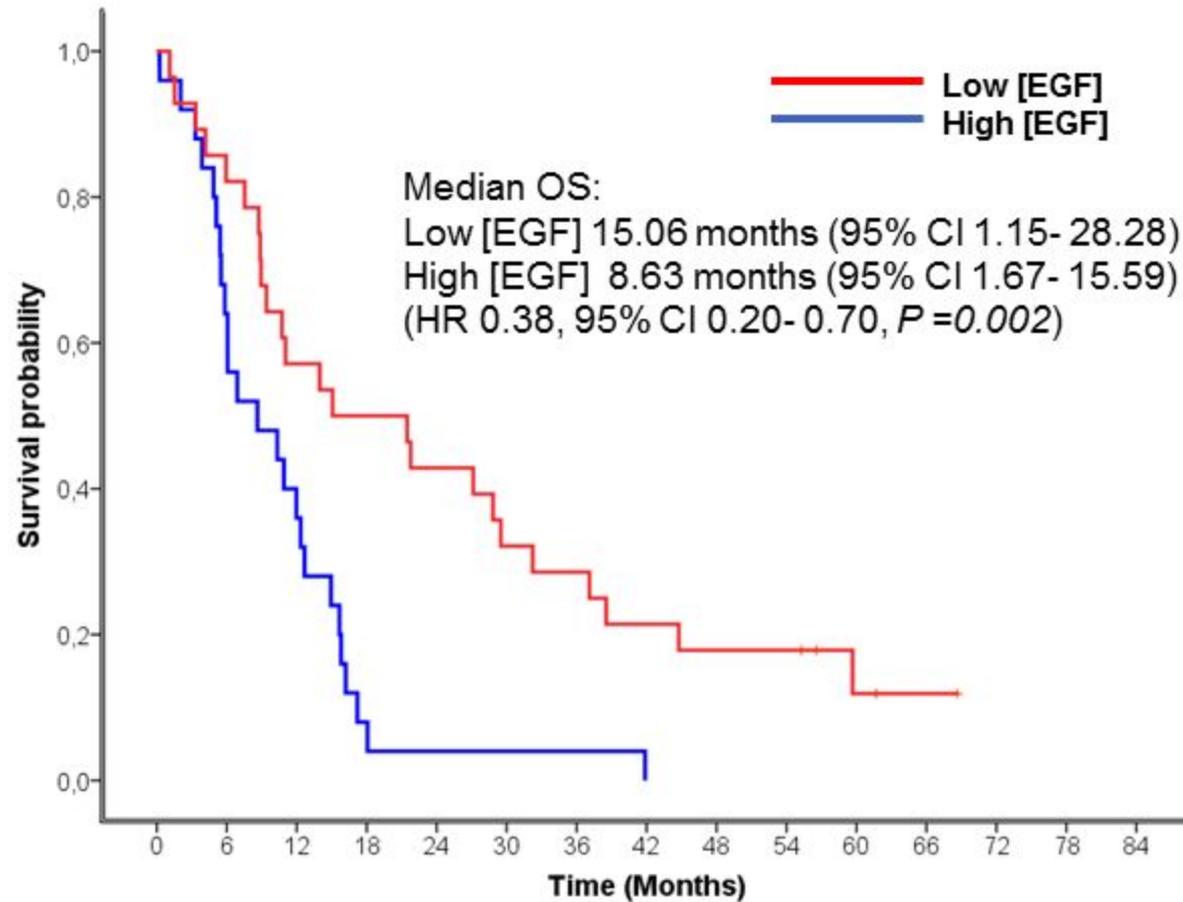
Figure 1B

B



Number at risk	0	6	12	24	36	48	60	72	84
CIMAvax-EGF	219	168	112	64	35	24	18	10	1
Control	124	88	53	30	14	8	3	1	0

A

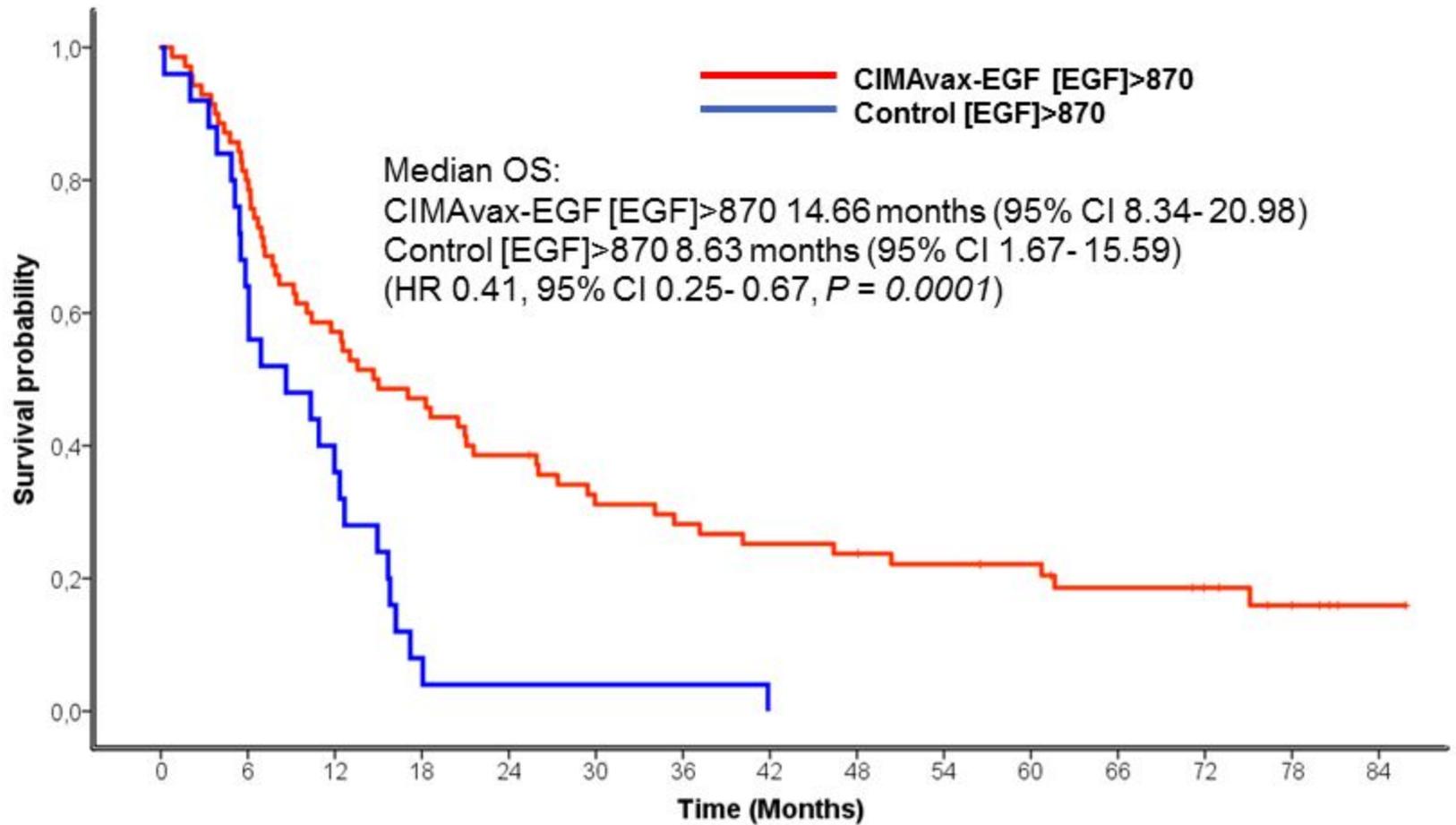


Number at risk

	0	6	12	24	36	48	60	72
Low [EGF]	25	23	16	12	8	5	2	0
High [EGF]	28	16	9	1	0	0	0	0

Figure 2B

B



Number at risk

	0	6	12	24	36	48	60	72	84
Low [EGF]	70	56	40	27	19	16	12	8	1
High [EGF]	25	16	9	1	0	0	0	0	0

Figure 3

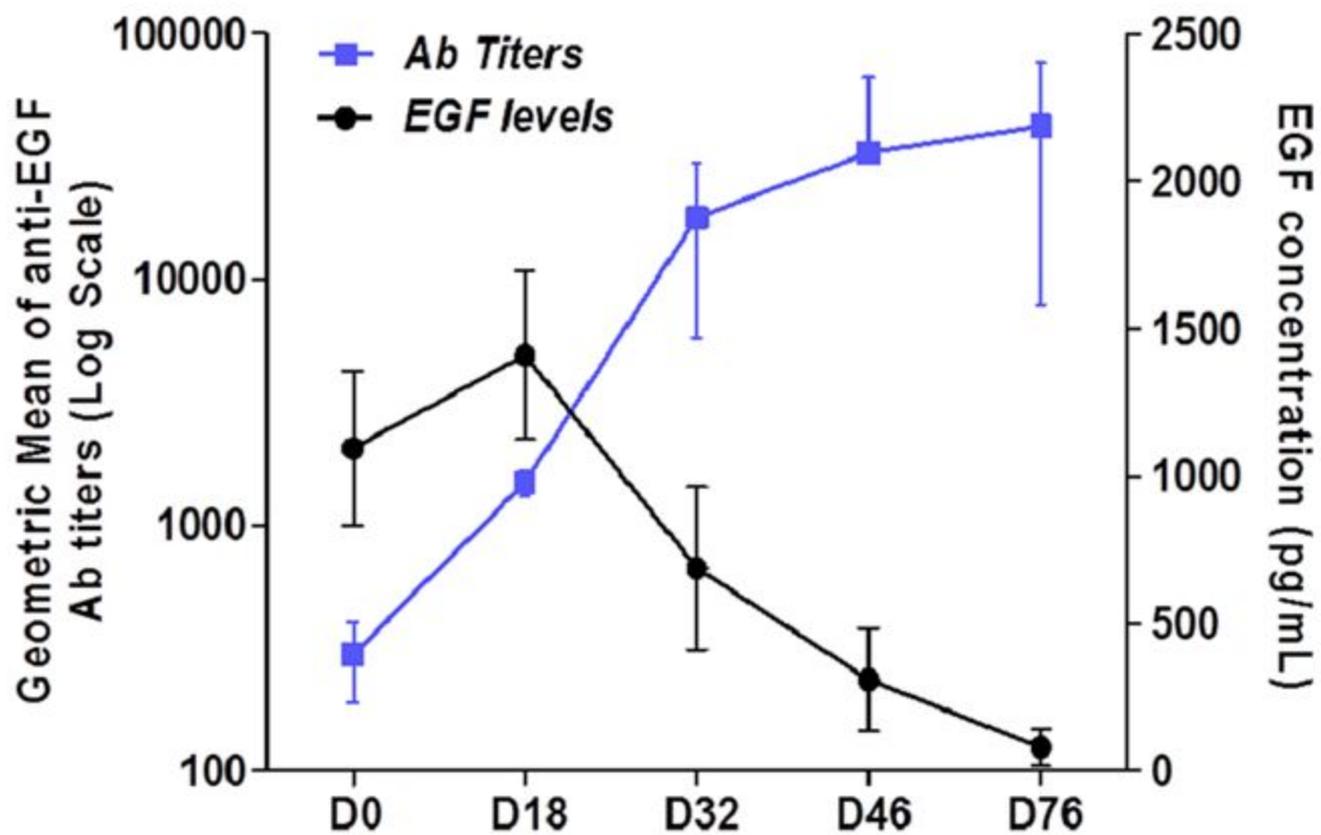


Figure 4

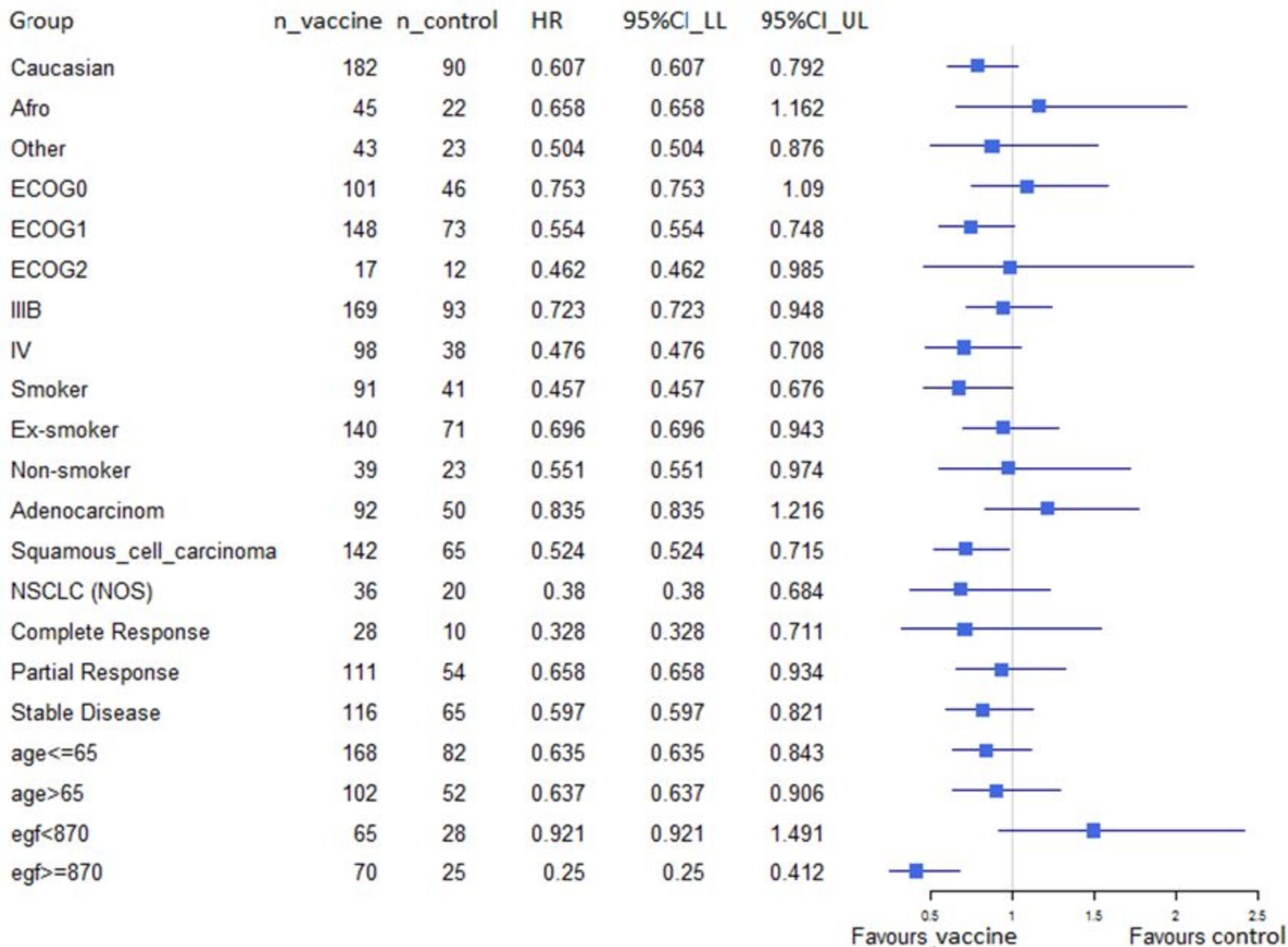


Table 1 Demography

	Vaccine Arm (n= 270)	Control Arm (n= 135)
Sex		
Men	178 (65.9%)	86 (63.7%)
Women	92 (34.1%)	49 (36.3%)
Ethnic origin		
White	182 (67.4)	90 (66.7)
African	45 (16.7)	22 (16.3)
Others	43 (15.9)	23 (17.0)
Smoking history		
Current	91 (33.7%)	41 (34.1%)
Pass	140 (51.9%)	71 (52.6%)
Never	39 (14.4%)	23 (17.0%)
ECOG		
0	101 (37.4%)	46 (34.0%)
1	148 (54.8%)	73 (54.1%)
2	17 (7.0%)	12 (8.9%)
Missing	4 (1.4%)	4 (3.0%)
Disease stage		
IIIB	169 (62.3%)	88 (65.2%)
IV	98 (36.3%)	36 (26.6%)
Missing	3 (1.1%)	4 (3.0%)
Tumor histology		
Adenocarcinoma	92 (34.1%)	46 (34.0%)
Squamous Cell carcinoma	142 (52.6%)	73 (54.0%)
NSCLC NOS	36 (13.3)	20 (14.8%)
Response to first-line treatment		
Complete response	28 (10.4%)	10 (7.4%)
Partial response	111 (41.1%)	54(40.0%)
Stable disease	116 (43.0%)	65 (48.1%)
Progressive disease	15 (5.6%)	6 (4.4%)

Abbreviation: NOS, not otherwise specified.

Table 1. Demographic and baseline characteristics

Table 2 Adverse Events

EA	Vaccine (n= 246)	%	Controls (n= 132)	%
Injection site reactions	116	46.6	0	0
Fever	91	36.5	10	7.6
Dyspnea	79	31.7	38	28.8
Vomiting	58	23.3	5	3.8
Headache	56	22.5	9	6.8
Nausea	45	18.1	11	8.3
Anorexia	38	15.3	21	15.9
Anemia	35	14.1	13	9.8
Asthenia	29	11.6	13	9.8
Hypertension	25	10.0	4	3
Fatigue	19	7.6	6	4.5
Arthralgia	18	7.2	17	12.9
Hypotension	15	6.0	4	3
Myalgia	15	6.0	2	1.5
Bones pain	13	5.2	14	10.6
Flu like symptoms	13	5.2	5	3.8
Dry skin	7	2.8	0	0
Mouth dryness	6	2.4	0	0
Bronchospasm	5	2.0	1	0.8
Blurred vision	4	1.6	0	0
Urticarial reactions	3	1.2	0	0

Table 2 Number of patients with more frequent Adverse Events by study arm

Clinical Cancer Research

A Phase III Clinical Trial of the Epidermal Growth Factor Vaccine CIMAvax-EGF as Switch Maintenance Therapy in Advanced Non-Small-Cell Lung Cancer Patients

Pedro C Rodriguez, Xitlally Popa, Odeth Martinez, et al.

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