



# Radiographic Endpoints for Immunotherapy Clinical Trial Design

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Cancer Center

## **Disclosures**

### **Advisory Board:**

» Array BioPharma, Aduro, BMS, Incyte, Merck, NewLink Genetics, Novartis, Eisai, Pfizer

### **Honoraria:**

» BMS and Merck

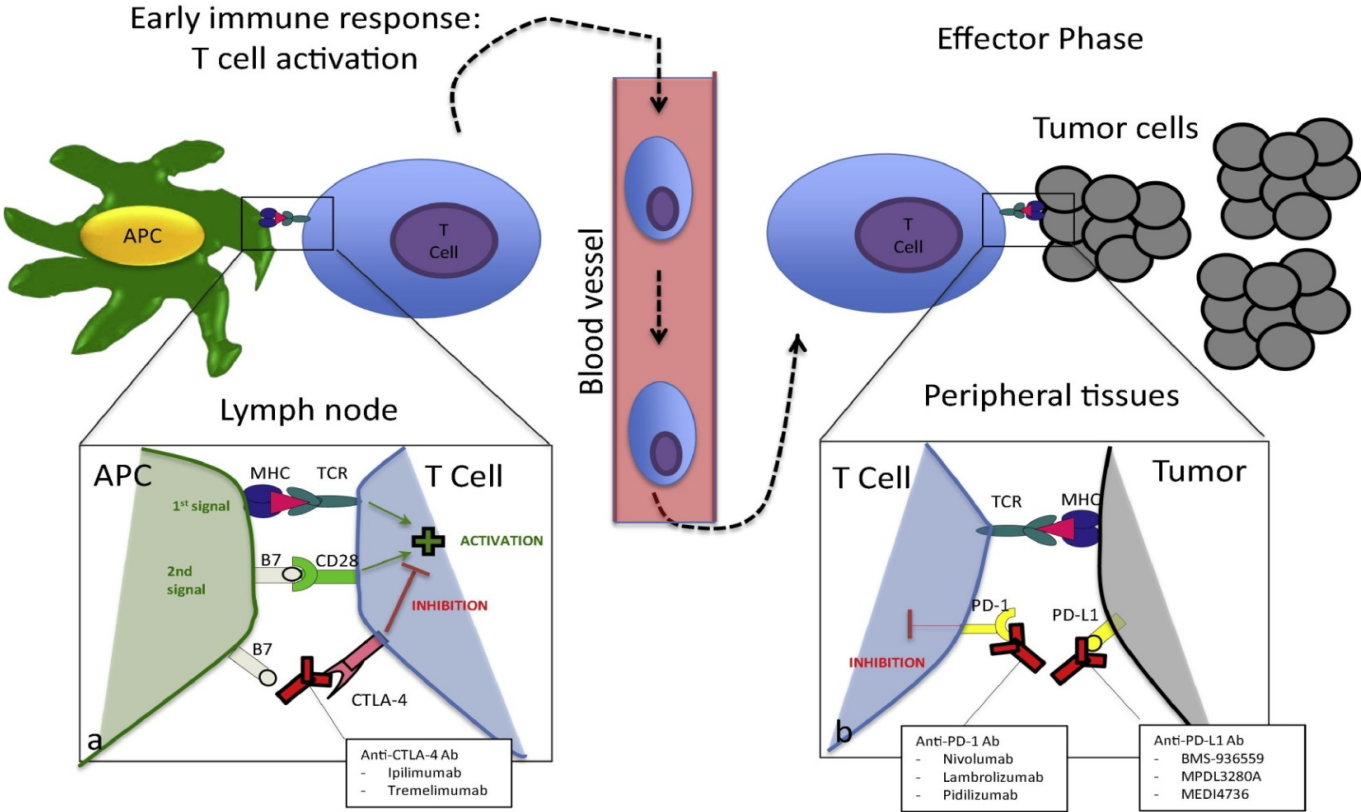
### **Institutional Support:**

» RGenix, Infinity, BMS, Merck, Array BioPharma, Novartis

## **Overview**

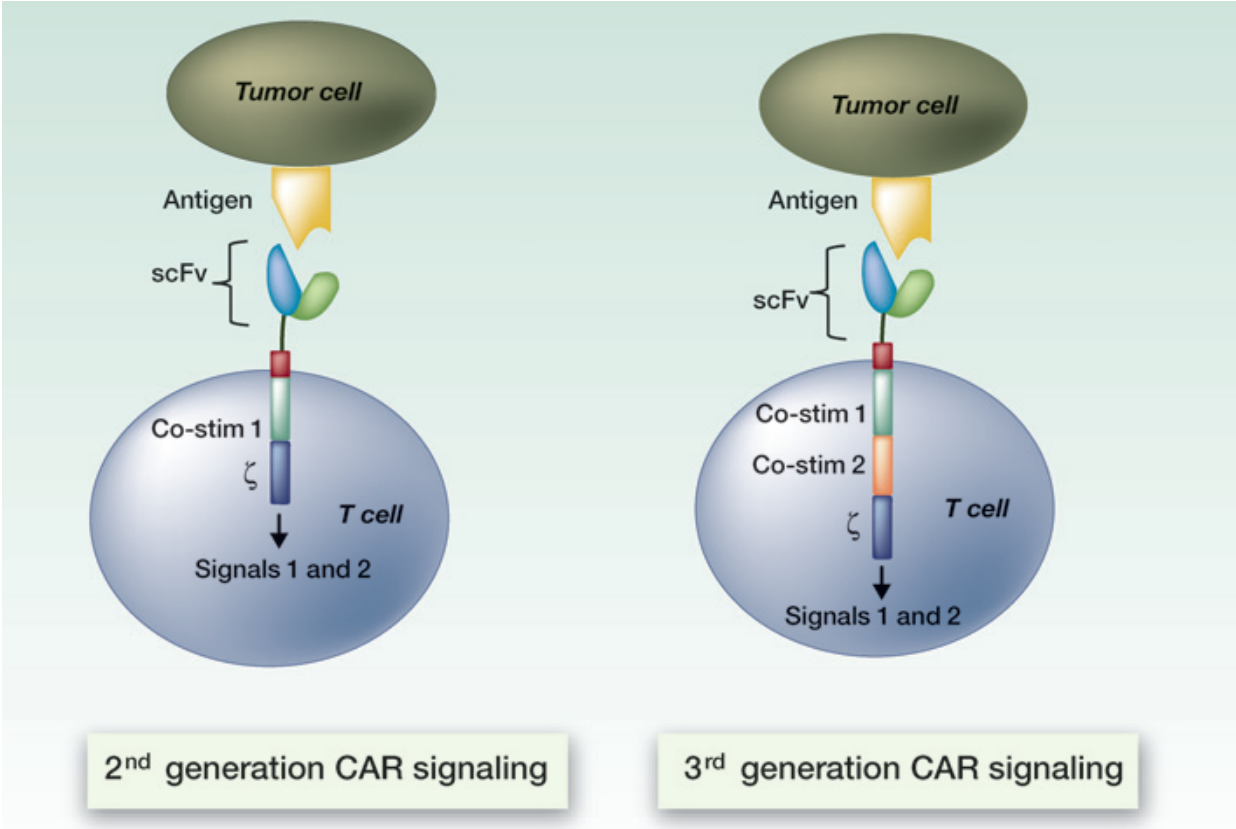
- 1. Types of immunotherapy under consideration**
- 2. Difference radiographically with immunotherapy**
- 3. New ways to consider radiographic assessment**

# Immune Checkpoints

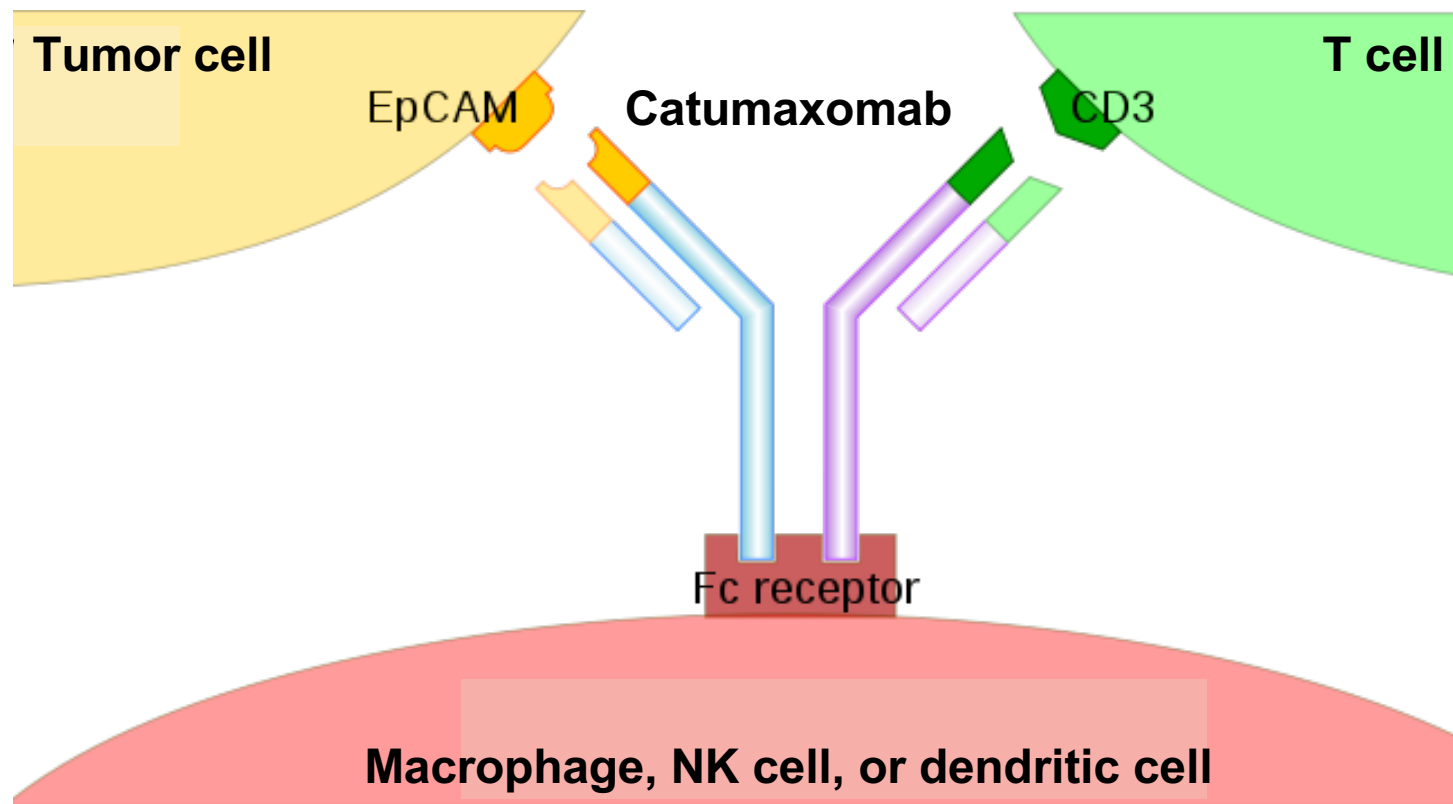


Kyi and Postow FEBS Letters 2014

# CAR T Cells



# Bispecific Antibodies

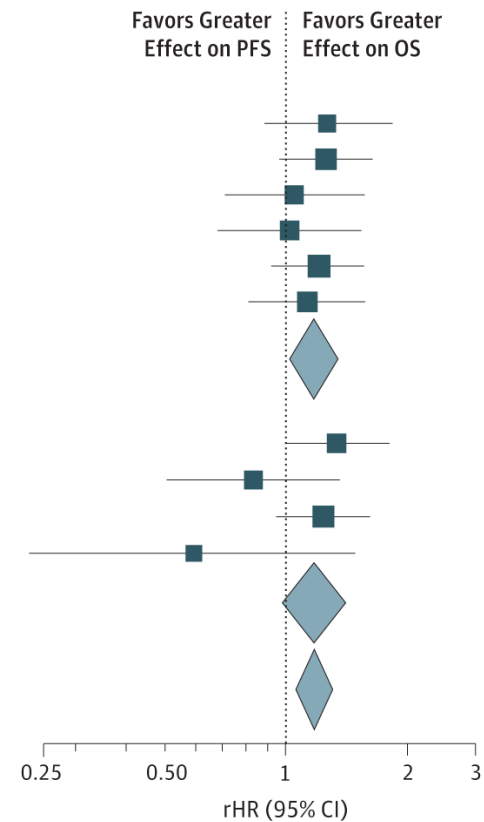


## **Assessing Efficacy**

- 1. Some immunotherapy does not directly treat the tumor, is watching a tumor grow or shrink appropriate?**
- 2. What radiographic endpoints are appropriate?**

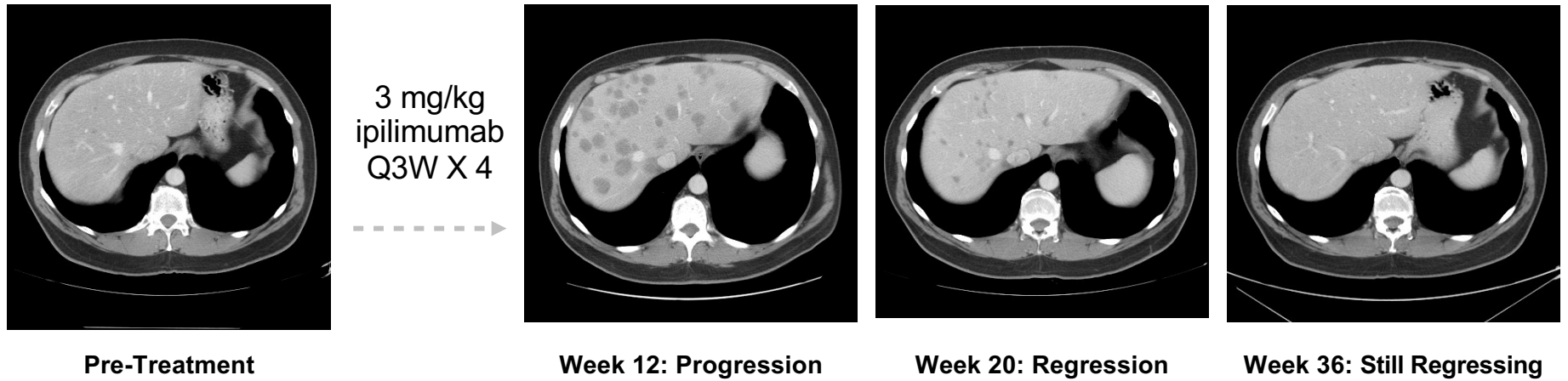
# Immunotherapy has a stronger effect on OS than PFS

Study	rHR (95% CI)
<b>Nivolumab</b>	
Ferris et al, <sup>8</sup> 2016 (Checkmate 141)	1.27 (0.89-1.83)
Borghaei et al, <sup>9</sup> 2015 (Checkmate 057)	1.26 (0.97-1.64)
Brahmer et al, <sup>10</sup> 2015 (Checkmate 017)	1.05 (0.71-1.56)
Robert et al, <sup>11</sup> 2015 (Checkmate 066)	1.02 (0.68-1.54)
Motzer et al, <sup>12</sup> 2015 (Checkmate 025)	1.21 (0.93-1.56)
Carbone et al, <sup>13</sup> 2017 (Checkmate 026)	1.13 (0.81-1.57)
<b>Overall</b>	<b>1.18 (1.03-1.34)</b>
<b>Pembrolizumab</b>	
Bellmunt et al, <sup>14</sup> 2017 (Keynote 045)	1.34 (1.00-1.80)
Reck et al, <sup>15</sup> 2016 (Keynote 024)	0.83 (0.51-1.36)
Herbst et al, <sup>16</sup> 2016 (Keynote 010)	1.24 (0.95-1.62)
Langer et al, <sup>17</sup> 2016 (Keynote 021)	0.59 (0.23-1.49)
<b>Overall</b>	<b>1.18 (0.98-1.41)</b>
<b>Overall</b>	<b>1.18 (1.06-1.31)</b>



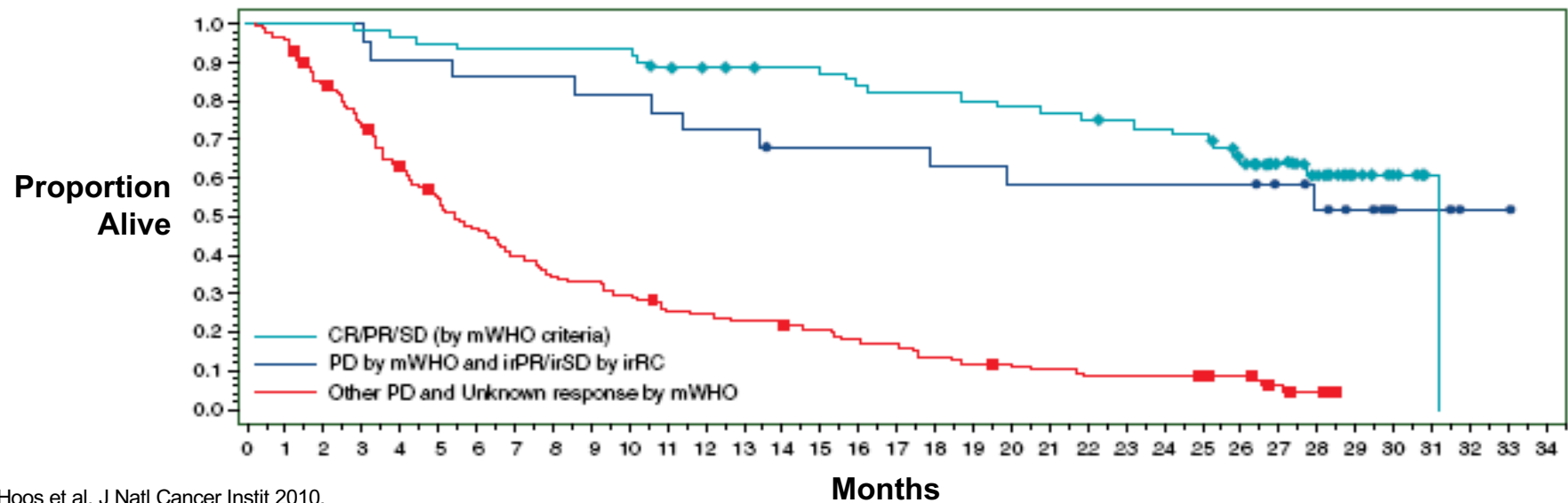


# Immunotherapy (ipilimumab) responses can be delayed



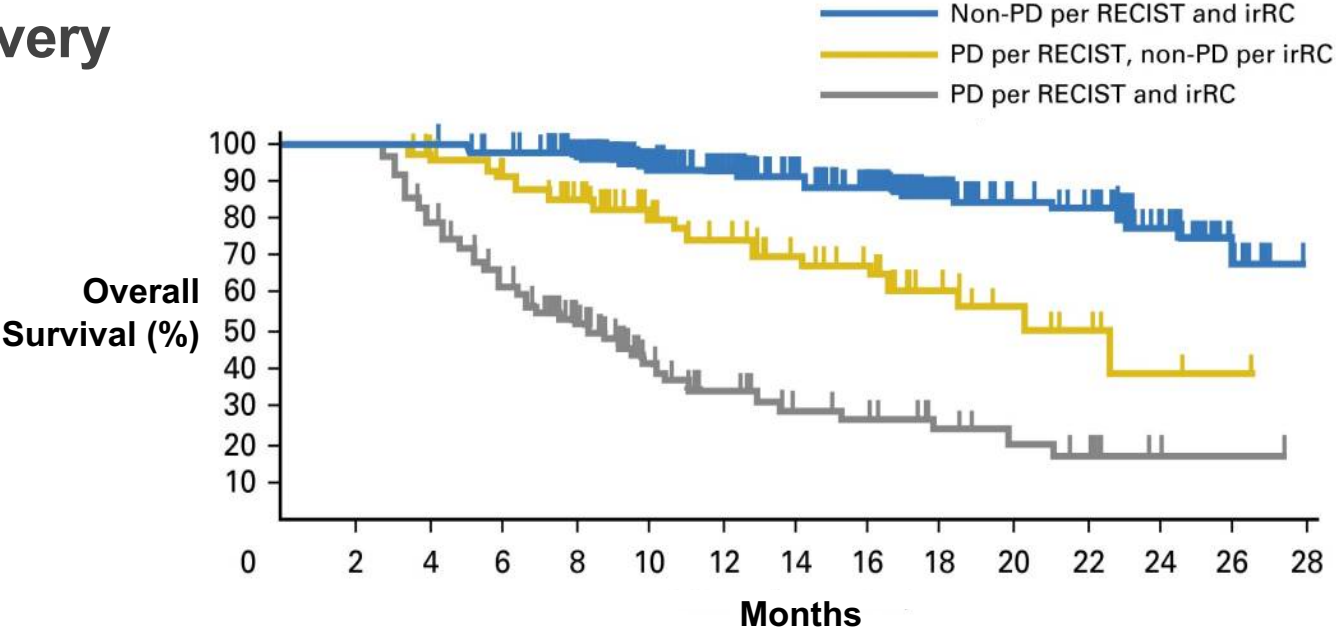
## Some patients who “progress” do well

Pooled data from phase II studies of ipilimumab monotherapy at 10mg/kg (n=227)



Hoos et al, J Natl Cancer Inst 2010,  
Wolchok et al, Clin Cancer Res 2009

# PD by RECIST very heterogeneous

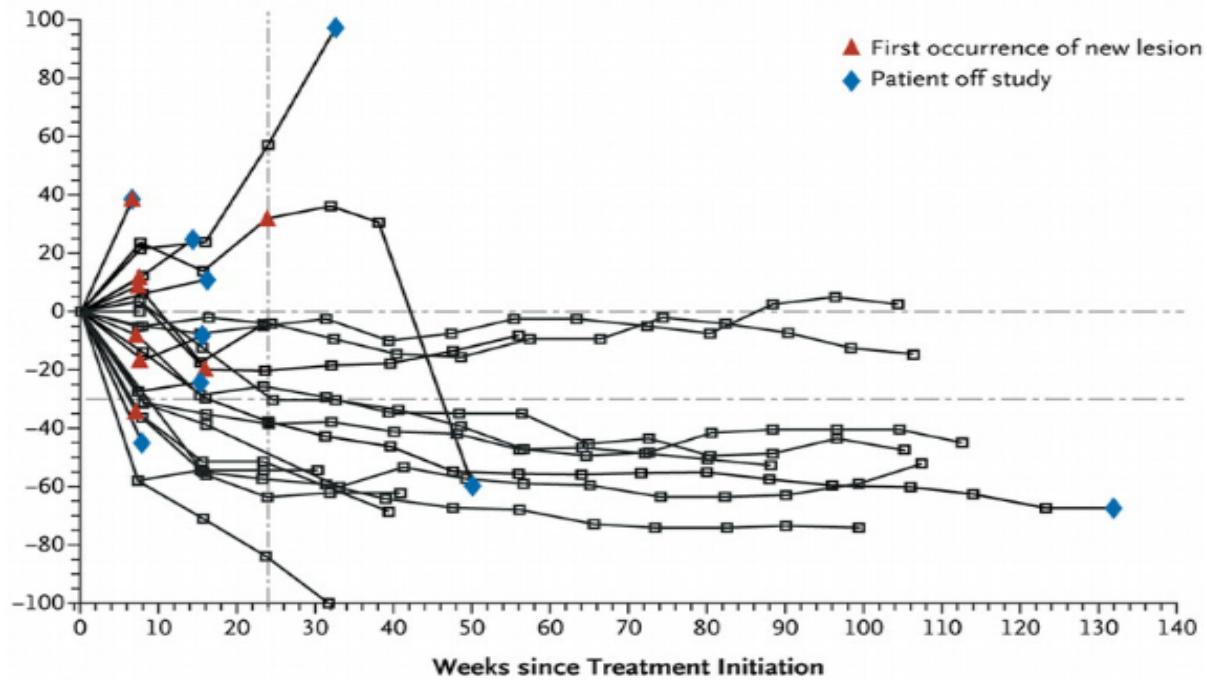


**No. at risk**

Non-PD per RECIST and irRC	331	331	329	321	301	219	192	159	136	79	60	55	31	8	0
PD per RECIST, non-PD per irRC	84	84	79	71	60	44	37	28	22	13	9	6	3	2	1
PD per RECIST and irRC	177	177	139	109	75	48	33	23	20	15	10	8	1	1	0

Hodi et al.  
JCO 2016

# What about PD-1 pseudoprogression?

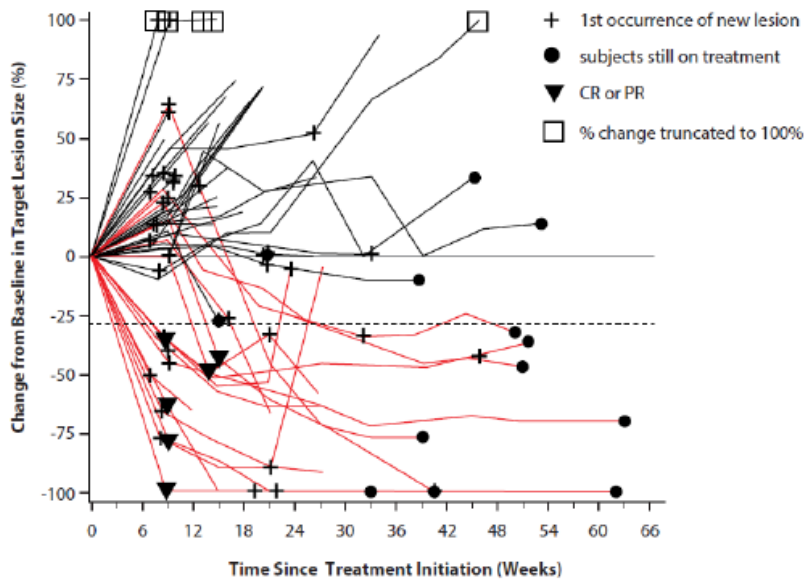


Topalian et al,  
NEJM 2012

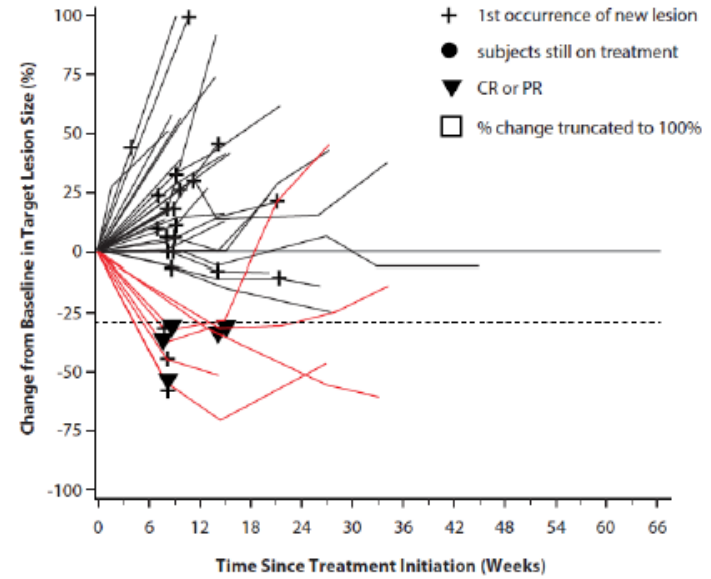
**Pseudoprogression with PD-1 is rare  
(approximately 5-10%)**

Weber et. al Lancet Oncol 2015, Hodi et al. JCO 2016, Beaver et al. Lancet Oncol 2018

**54 nivolumab patients treated beyond POD**  
17 (8% of total pts) eventually had 30% reduction



**49 dacarbazine patients treated beyond POD**  
8 (4% of total pts) eventually had 30% reduction



Robert et al, NEJM 2015

**Major effect of immune criteria  
is on progression free survival  
not overall response rate**



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## Main differences between RECIST and iRECIST is declaration of progression

<b>Outcome</b>	<b>RECIST*</b>	<b>Immune RECIST**</b>
Complete Response	Disappearance of targets	Disappearance of targets
Partial Response	≥30% decrease in targets	≥30% decrease in targets
Stable Disease	Everything else	Everything else
Progressive Disease	≥20% increase in targets <b>Any new lesion</b>	≥20% increase in targets requiring confirmation

\*Eisenhauer et al. Eur J Cancer 2009

\*\*Seymour et al. Lancet Oncol 2018



## Main differences between RECIST and iRECIST is declaration of progression

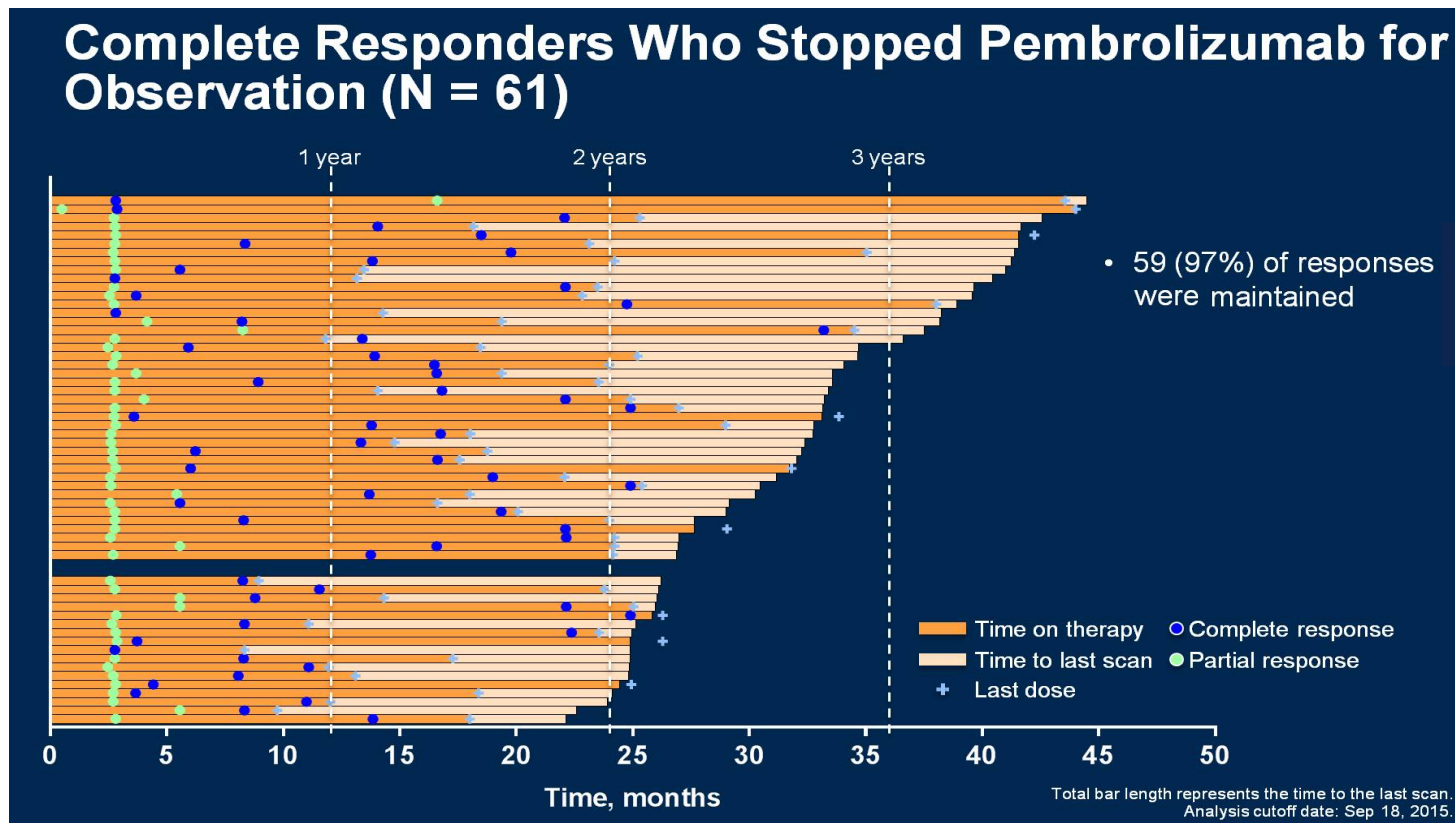
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**Possibility of late response is  
different from pseudoprogession**

Most PD-1 responses occur early but some are late



## Summary of Standard IO Response Criteria

**1. Pseudoprogression rarely happens with PD-1 and PD-1 combos and is distinct from late response**

**2. Immune response criteria redefine PFS**

» Immune related response criteria (irRC)– Bidirectional\*

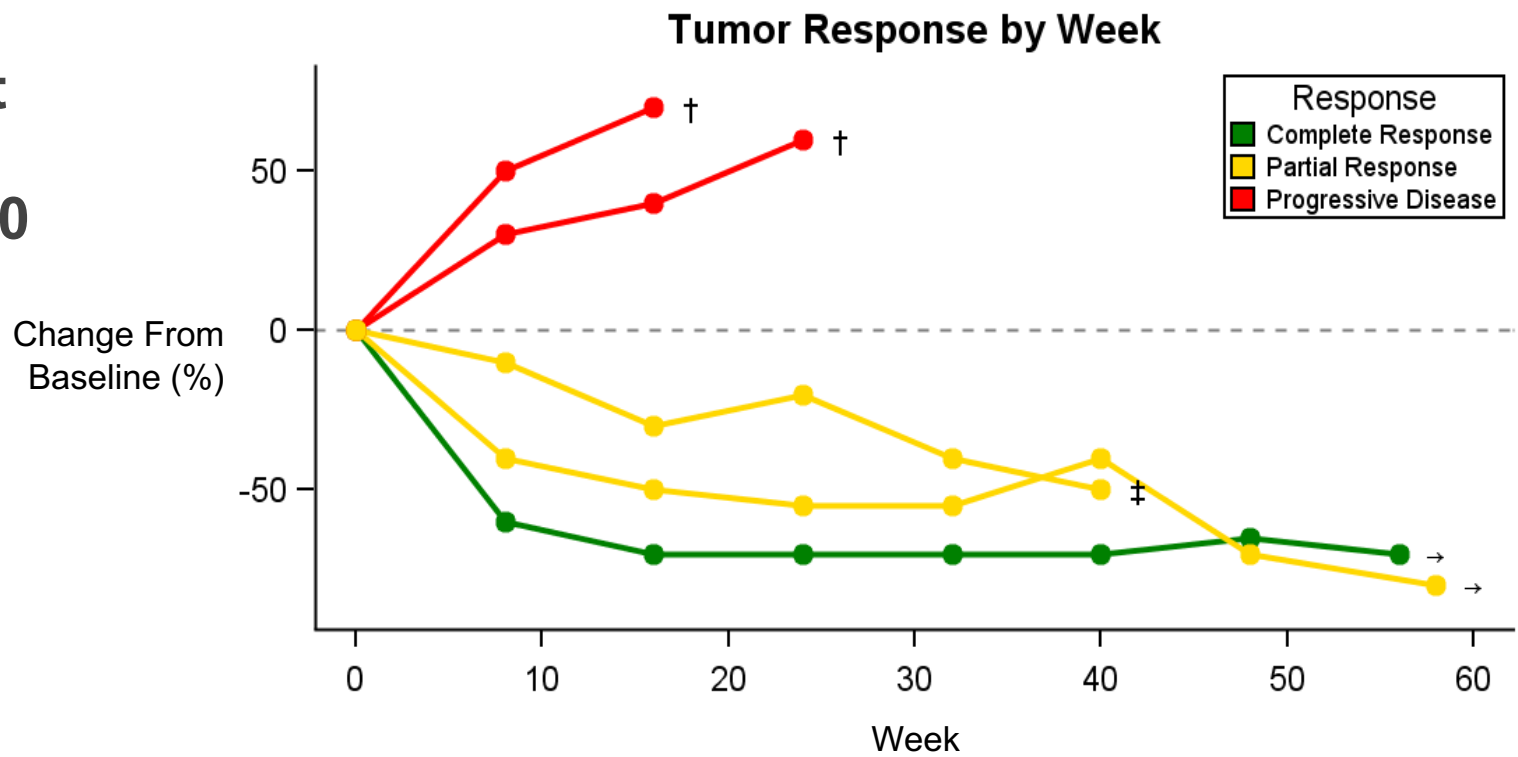
» Immune RECIST (iRECIST)-- Newest/Unidimensional\*\*

\*Wolchok et al. Clin Cancer Res 2009

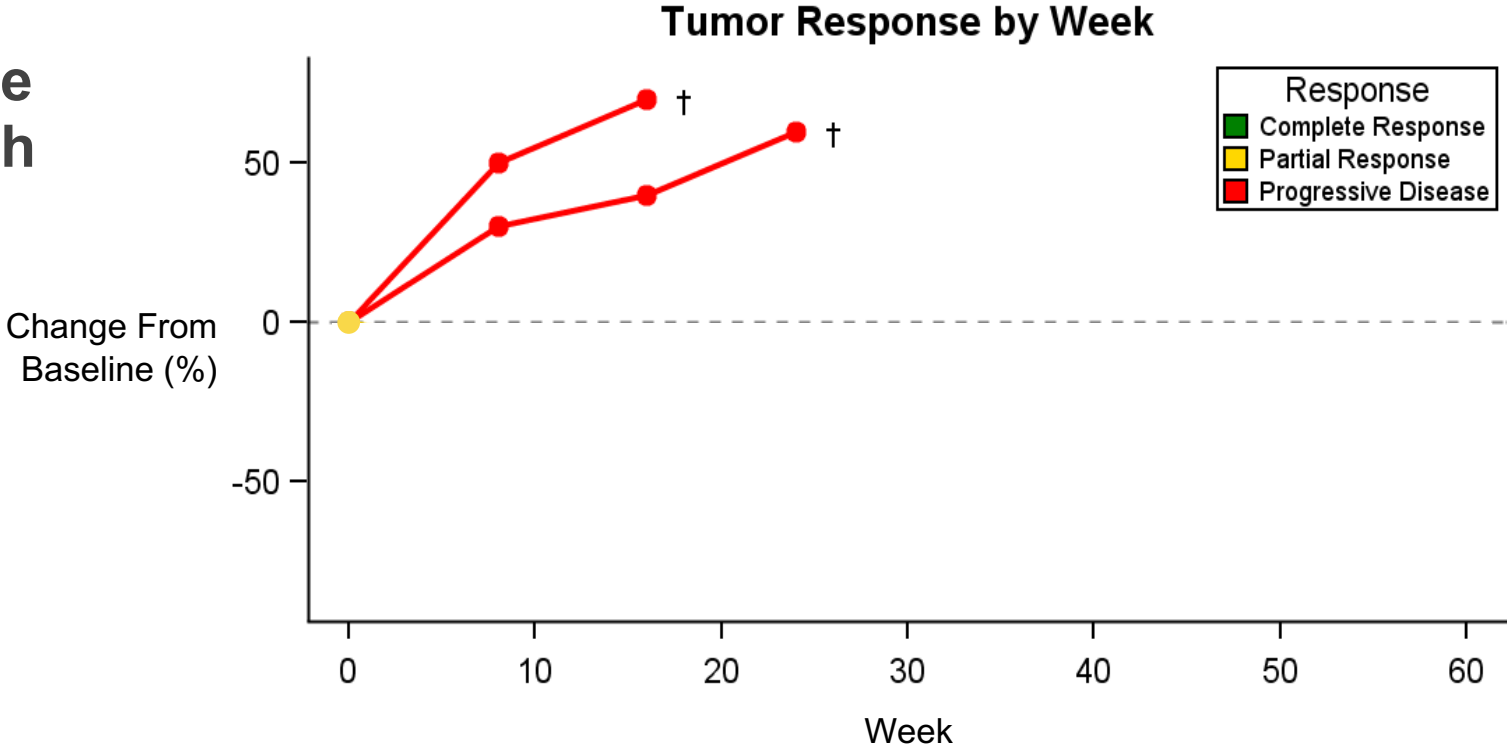
\*\*Seymour et al. Lancet Oncol 2018

**What if you cannot run  
a randomized study?**

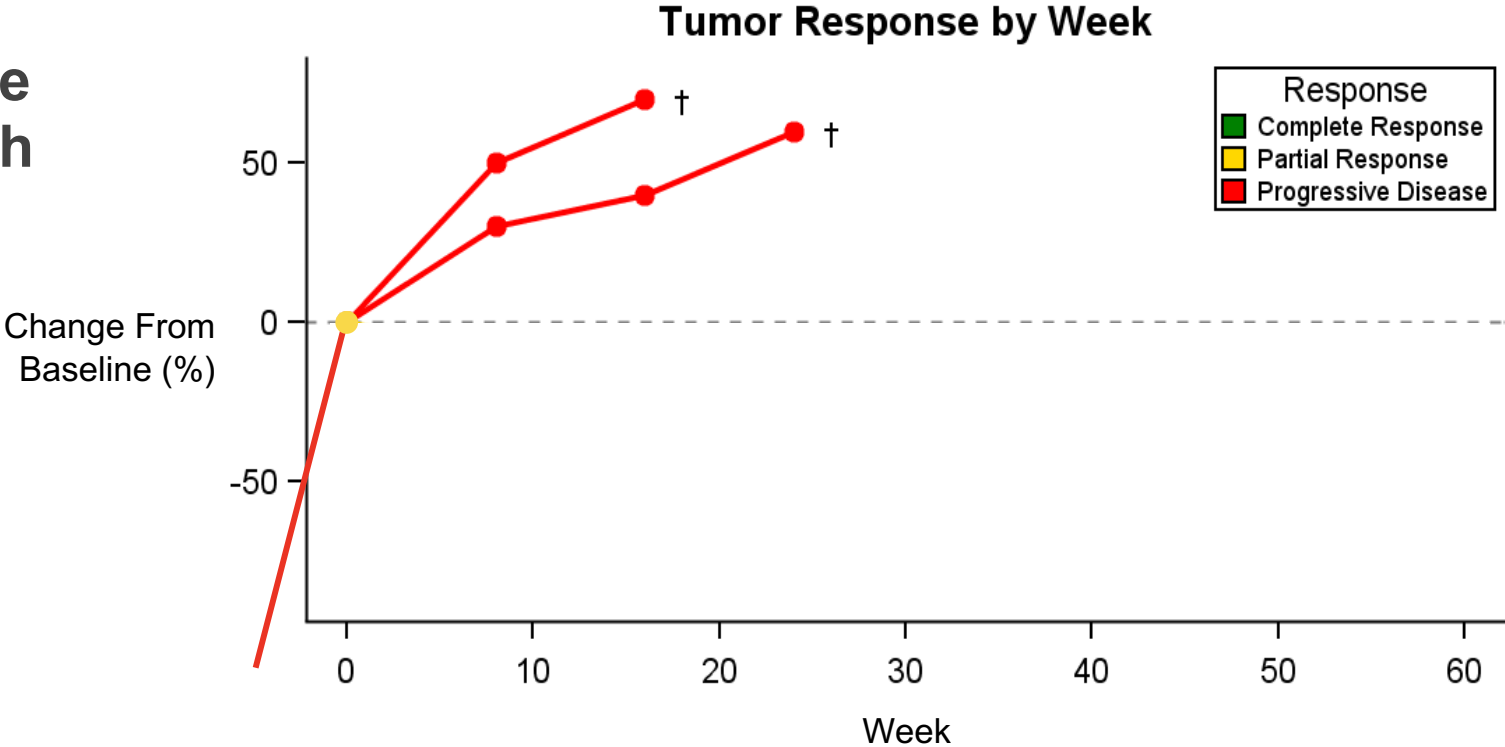
# Traditional Spider Plot Measures from Time 0



Does drug  
"X" improve  
prior growth  
kinetics?



Does drug  
"X" improve  
prior growth  
kinetics?



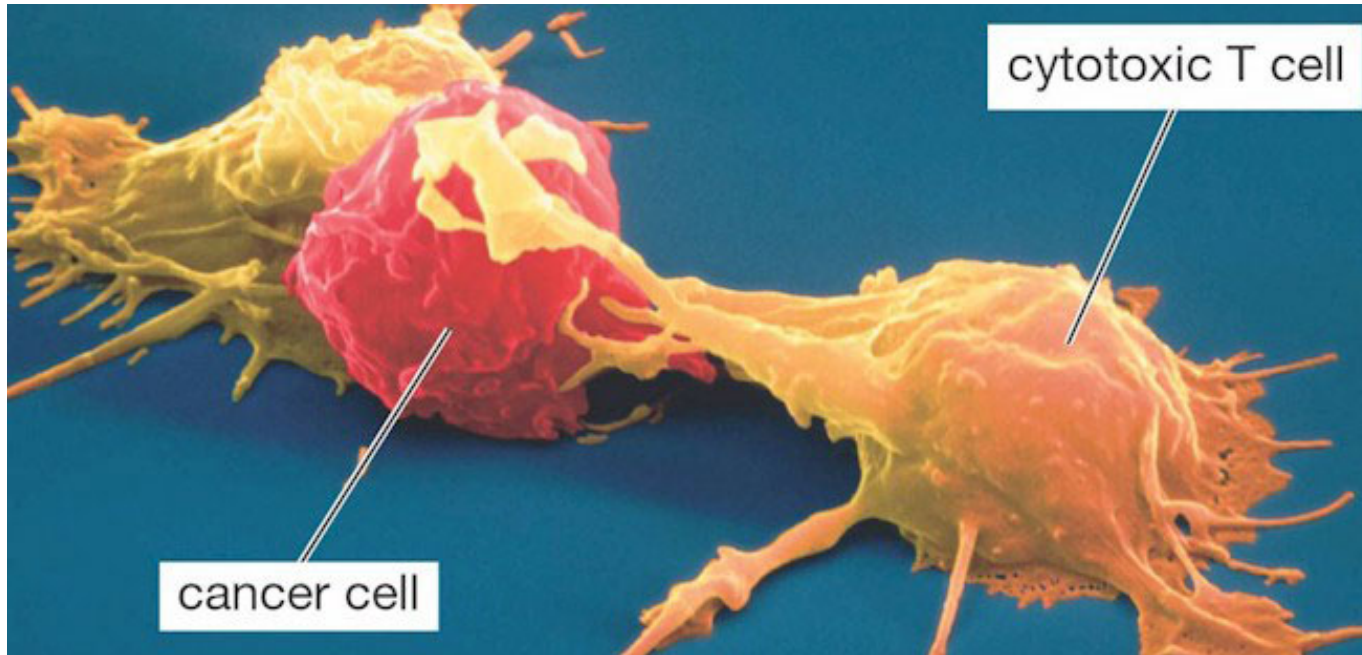


# Exploring New Ways To Image Patients

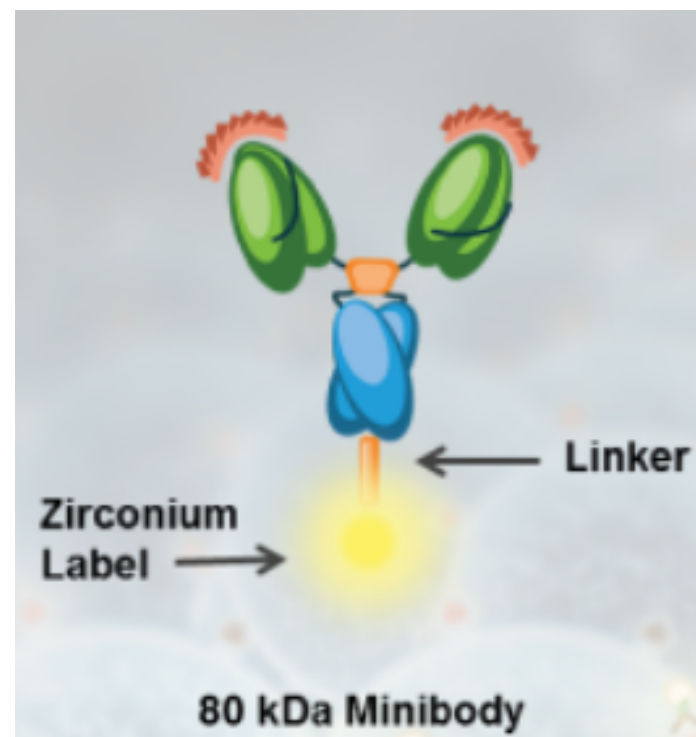
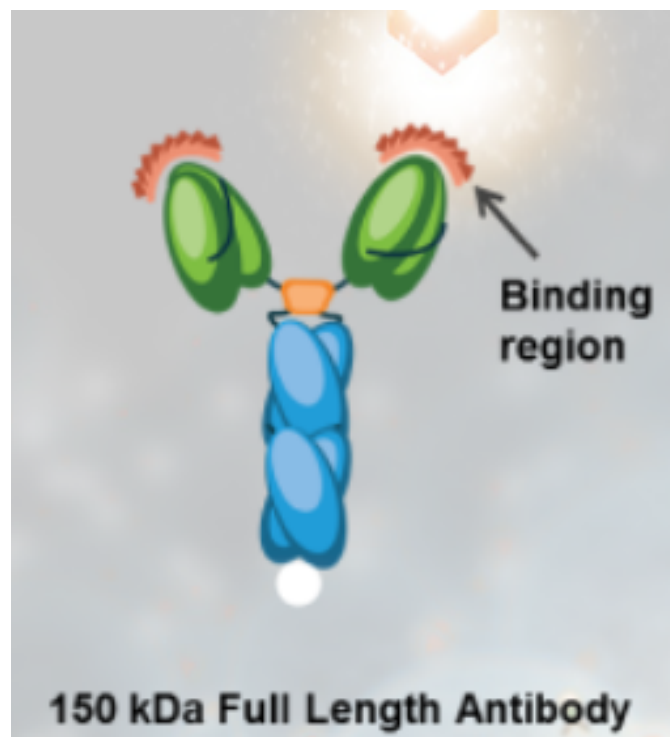


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**Immunotherapy = Immune cell kills a cancer cell**



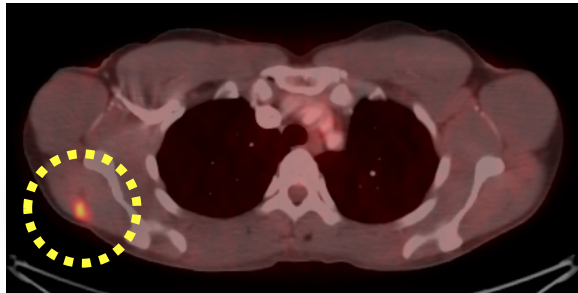
What about  
directly  
imaging CD8  
T cells?



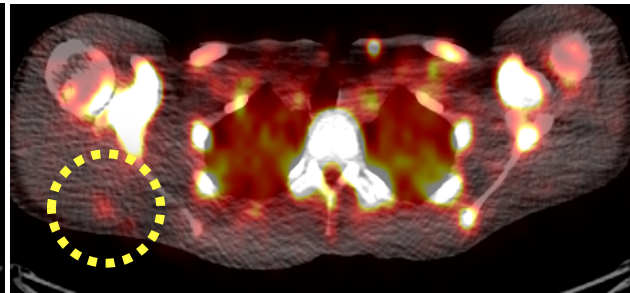
## Non-invasive CD8 T Cell Imaging

37 year old woman with metastatic melanoma on pembrolizumab for 2 years

**FDG PET/CT**

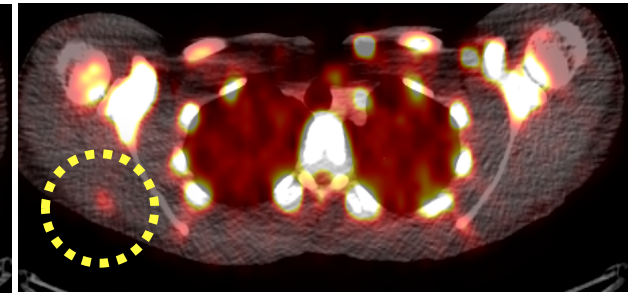


**CD8 T Cell PET**



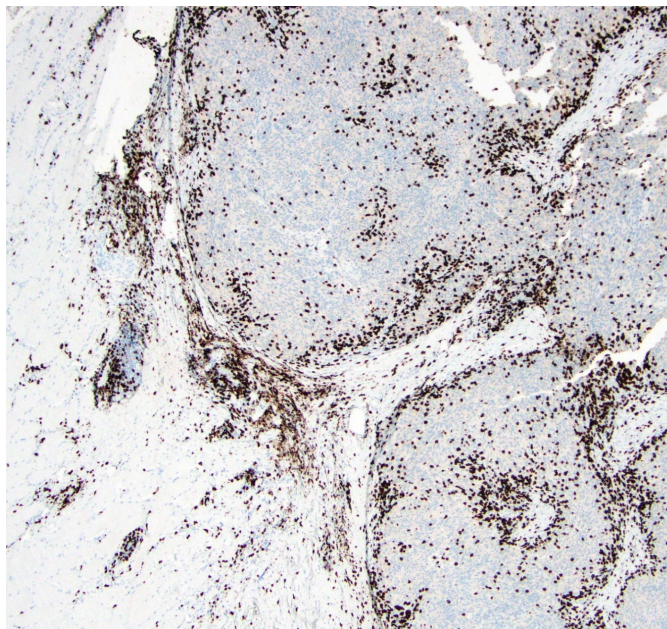
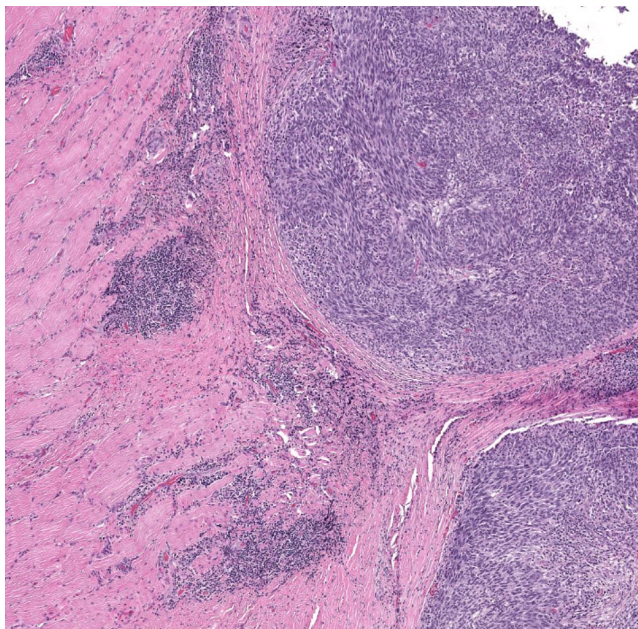
6 hours

**CD8 T Cell PET**



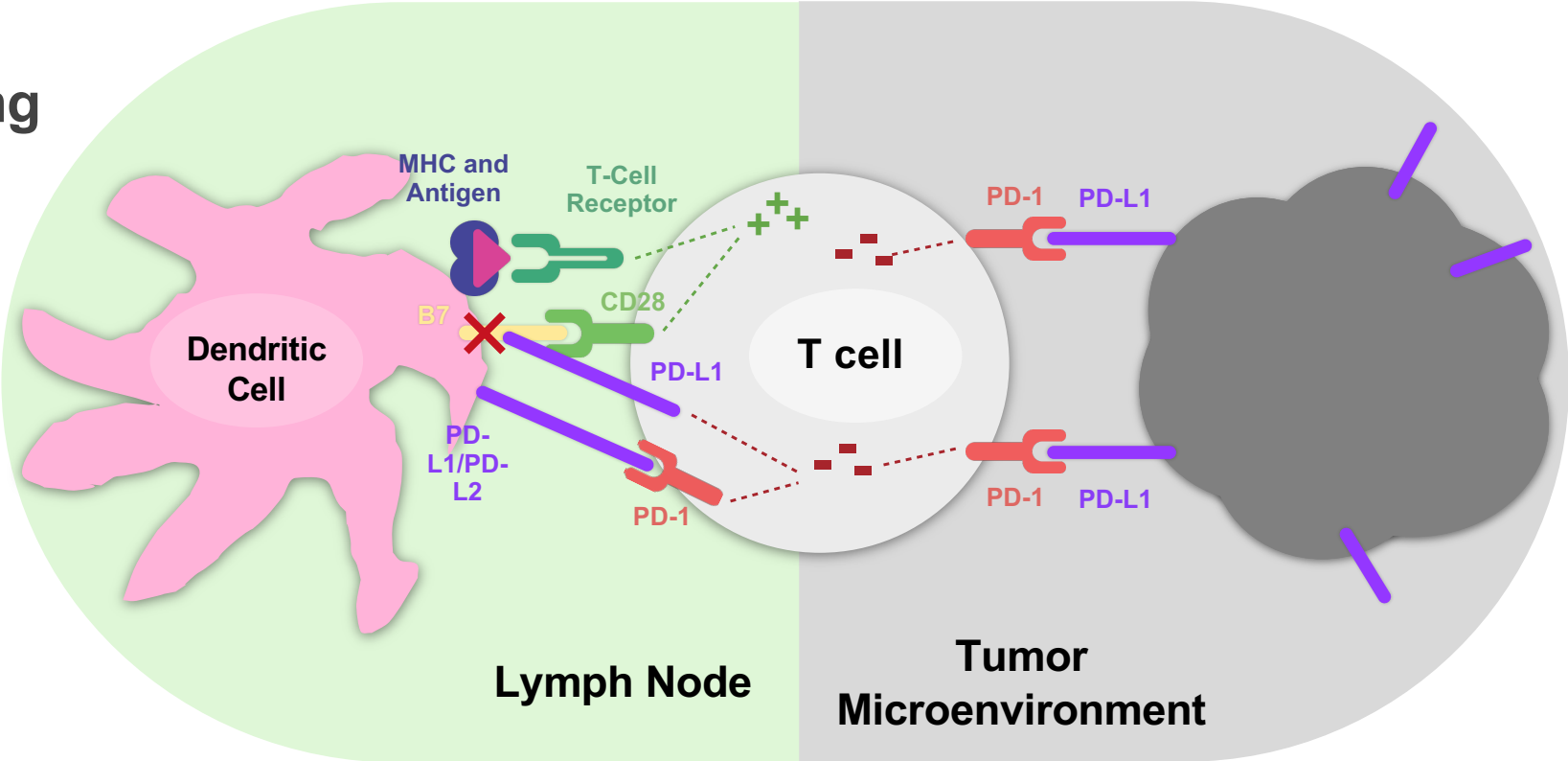
1 day

## CD8 T cells seen on immunohistochemistry



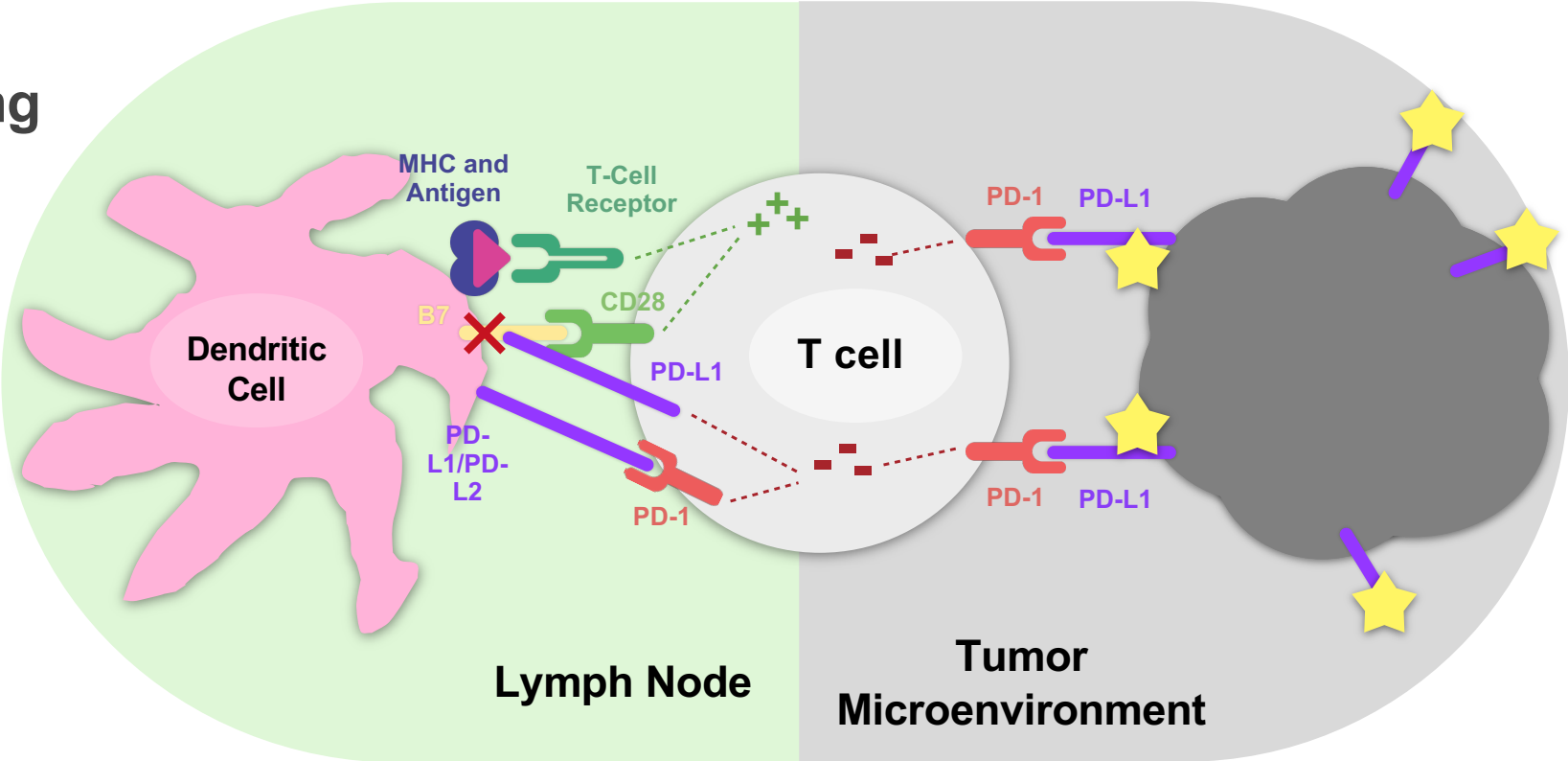
Pandit-Taskar, Postow, Hellmann et. al J Nucl Med 2019

# PD-L1 Imaging



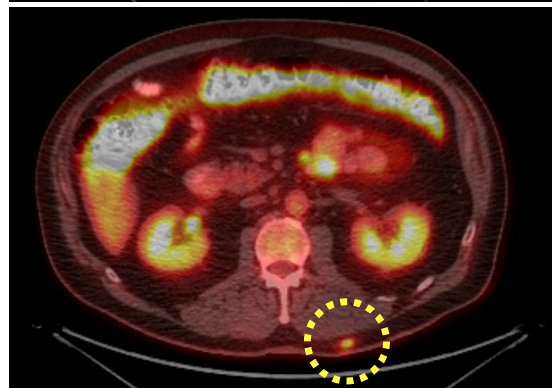
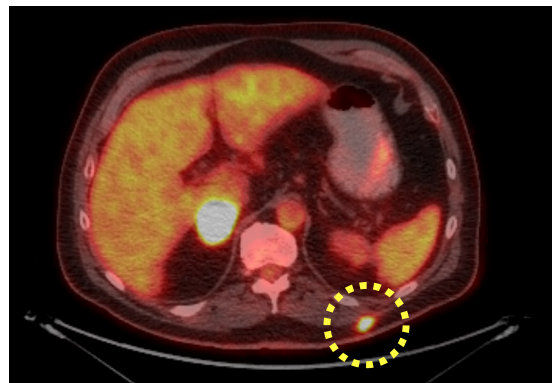
Postow et. al J Clin Oncol 2015

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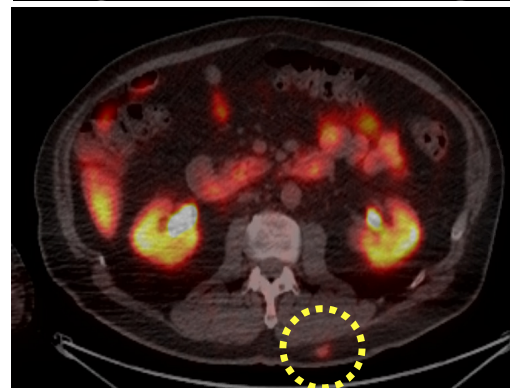
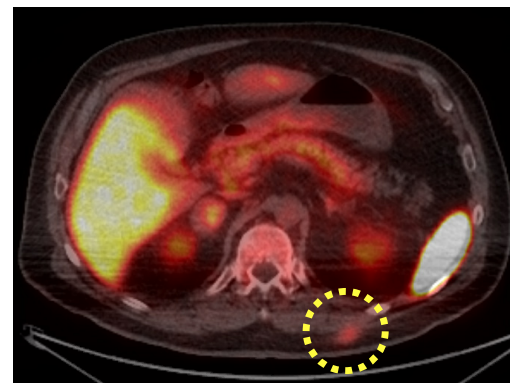


Postow et. al J Clin Oncol 2015

# Non-invasive PD-L1 Imaging



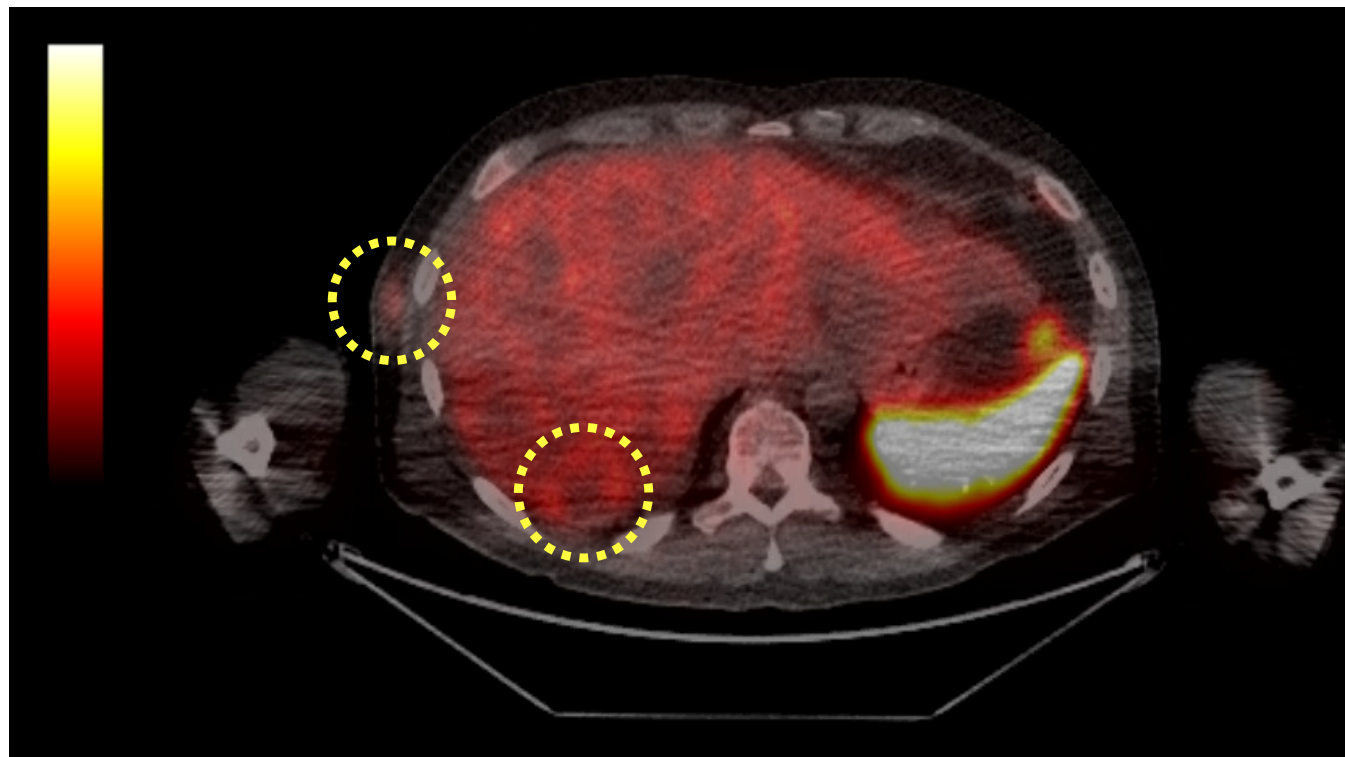
**FDG PET**



**[18F]-BMS-986229 (PD-L1)**

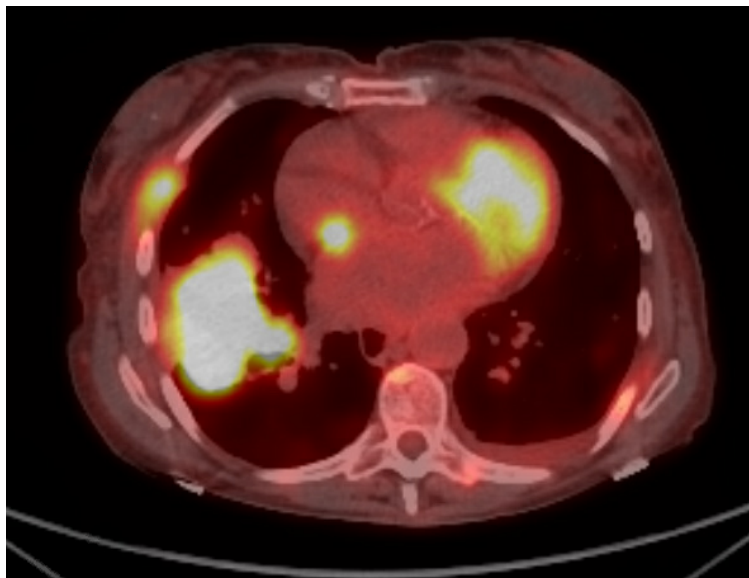


## Non-invasive PD-L1 Imaging

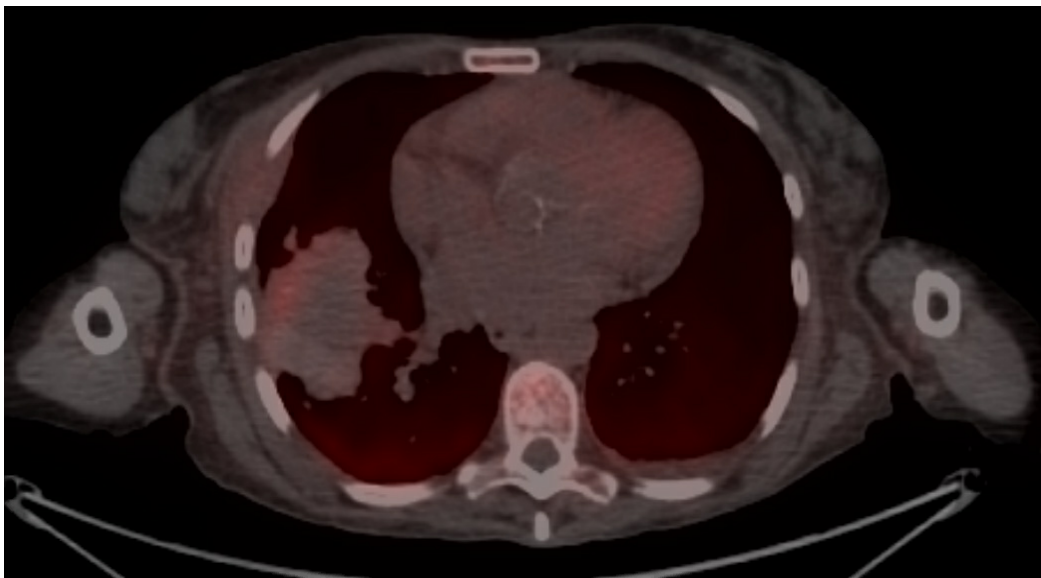


[<sup>18</sup>F]-BMS-986229 (PD-L1)

## Non-invasive PD-L1 Imaging



**FDG PET**



**[18F]-BMS-986229 (PD-L1)**

## Summary

- 1. RECIST has limitations but remains standard for registrational trials**
- 2. New ways of imaging patients will hopefully help**



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NASDC

NCI Awardee Skills Development Consortium

# Radiographic Endpoints for Immunotherapy Clinical Trial Design Questions