

Effect of administration of Neoadjuvant Chemotherapy to newly diagnosed early breast cancer patients on the depressed plasma levels of soluble co-stimulatory and co-inhibitory immune checkpoint molecules

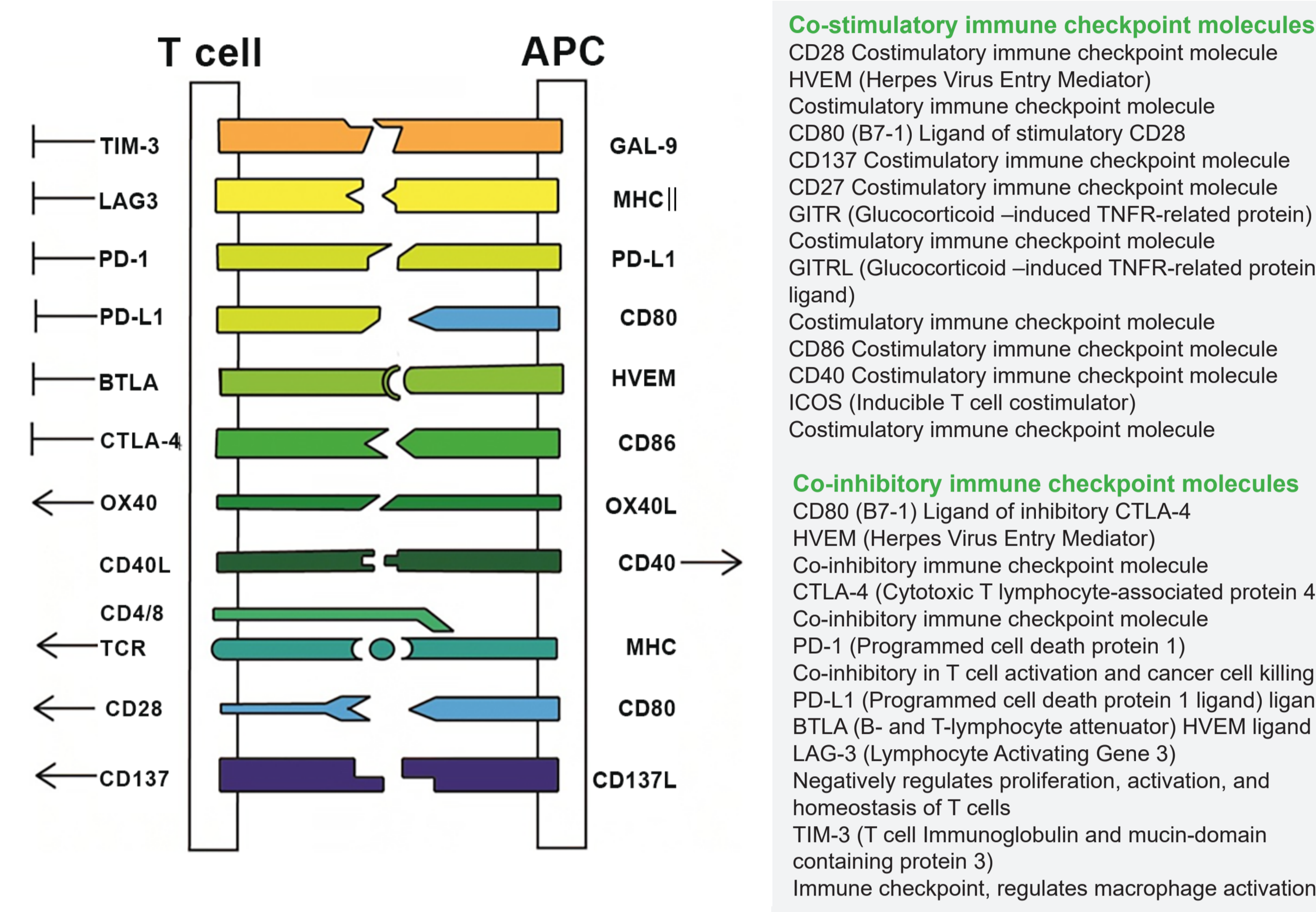
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Background

- For effective killing of cancer cells in an anticancer immune response, a series of events involving different immune cells needs to be initiated and allowed to proceed. The steps in the cancer immunity cycle start with the release of tumor cell antigens, which are recognized by and lead to the killing of cancer cells by cytotoxic T cells. This immune response is modulated by a variety of stimulatory and inhibitory factors;
- T cells need two signals for activation: binding of the TCR (T-cell receptor) to the MHC (major histocompatibility complex) and activation of co-stimulatory molecules;
- Immune checkpoints can stimulate or inhibit these events thereby regulating the functions of immune cells;
- Accordingly, checkpoints play important roles in the maintenance of immune homeostasis;
- Examples of stimulatory molecules include TCR/MHC, CD137L/CD137 and OX40L/CD40, while CTLA-4/CD80 or CD86 and PD-1/PD-L1 are potent inhibitory checkpoints. Increasing numbers of novel regulatory receptors and ligands have recently been described and are summarized in figure 1;
- Recently, a series of soluble systemic immune checkpoint molecules (ICM) such as sCTLA-4 (soluble CTLA-4), sPD-1 (soluble PD-1) and others have been identified that can be measured in plasma.

Figure 1. Stimulatory and inhibitory immune checkpoint molecules.



Reference

Gu, D., Ao, X., Yang, Y. et al. Soluble immune checkpoints in cancer: production, function and biological significance. *J. immunotherapy cancer* 6, 132 (2018).

Methods

Aim

- The circulating levels of 16 immune checkpoint-related proteins panel (BTLA, GITR, GITRL, HVEM, LAG-3, PD-1, PD-L1, TIM-3, CD27, CD28, CD80, CD86, CD40, ICOS, TLR-2 and CTLA-4) were profiled in 72 early breast cancer patients (patient characteristics are summarized in table 1) and compared to those of 45 healthy controls.

Laboratory Method

- Plasma levels of immune-oncology checkpoints were assayed using Bio-Plex Suspension Bead Array platforms (Milliplex® or Bio-Rad® human magnetic bead panels). The methods were followed according to the manufacturers specifications and the data analysed using Bio-Plex Manager software 6.0 and results reported as pg/mL.

Statistical Methods

- The primary hypothesis was that there was a significant difference in the plasma levels of soluble immune checkpoints between early breast cancer patients' pre-treatment, post-neoadjuvant chemotherapy (NAC), and post-surgery.
- Data was prospectively obtained, and levels compared between pre-treatment, post-NAC, post-surgery, and healthy controls using non-parametric tests (Mann-Whitney & Kruskal-Wallis).
- Descriptive statistics were used to tabulate patient characteristics. The Mann-Whitney U-test was used to compare levels of the various test biomarkers between breast cancer patients and healthy controls. $P < .05$ was considered statistically significant.
- NCSS software version 11 for Windows (USA) was used for statistical analyses.

Results

- Patient characteristics are shown in table 1.

Table 2. Pathological complete response for the entire patient cohort and by biological type.

Pathological Complete Response (pCR)	
Yes	44 (61.11%)
No	28 (38.89%)
pCR by Biological Type	
Her-2 Positive	
Yes	8 (80%)
No	2 (20%)
Luminal	
Yes	3 (30%)
No	7 (70%)
TNBC	
Yes	33 (65%)
No	18 (35%)
TNBC & Luminal	
Yes	0 (0%)
No	1 (100%)

Table 1. Patient Characteristics.

Age	
Median Age	54
Range	29-85
Menopausal Status	
Peri-menopausal	46 (64%)
Pre-menopausal	25 (35%)
Post-menopausal	1 (1%)
Grade	
1	1 (1%)
2	20 (28%)
3	49 (68%)
Unknown	2 (3%)
Tumor Size	
T1	21 (29%)
T2	42 (58%)
T3	6 (8%)
T4	3 (4%)
Nodal Status	
Positive	36 (50%)
Negative	36 (50%)
Stage	
1	12 (17%)
2A	32 (44%)
2B	20 (28%)
3	8 (11%)
Biological Type	
Her-2 Positive	10 (14%)
Luminal A	1 (1%)
Luminal B	9 (13%)
TNBC	51 (71%)
TNBC & Luminal B	1 (1%)
Ki-67	
≤ 14%	3 (4%)
15 - 39%	23 (32%)
≥ 40%	45 (63%)
Unknown	1 (1%)

Table 3. The effect of treatments on soluble, systemic ICMs

ICM	Control	Diagnosis (Pre-)	Post-NAC	Post-surgery	p-value (Diagnosis vs Post NAC)	ICM	Control	Diagnosis (Pre-)	Post-NAC	Post-surgery	p-value (Diagnosis vs Post NAC)
BTLA	18 147	13 022	9 987	12 777	0,0367	CD27	4 577	3 342	5 351	5 427	0,0000
CD80	2 329	1 678	3 048	3 611	0,0000	CD28	46 135	32 914	44 277	50 058	0,0416
CD86	14 297	11 585	9 922	12 439	0,2789	CD40	1 977	1 523	2 030	2 054	0,0003
CTLA-4	2 618	1 566	598	687	0,0000	GITR	3 797	1 497	4 035	4 434	0,0000
LAG-3	150 416	131 275	464 880	500 133	0,0000	GITRL	7 151	5 886	5 339	5 927	0,8044
PD-L1	3 342	1 647	4 794	5 215	0,0000	ICOS	26 506	15 123	26 586	29 746	0,0002
PD-1	14 917	12 305	13 350	15 076	0,7859	HVEM	2 290	1 865	4 047	3 950	0,0000
TIM-3	5 047	3 897	9 975	9 615	0,0000	TLR-2	30 477	26 631	33 837	37 042	0,0258

Figure 2. Comparison of ICM's between breast cancer patients at diagnosis, post-NAC, post-surgery and a control group.

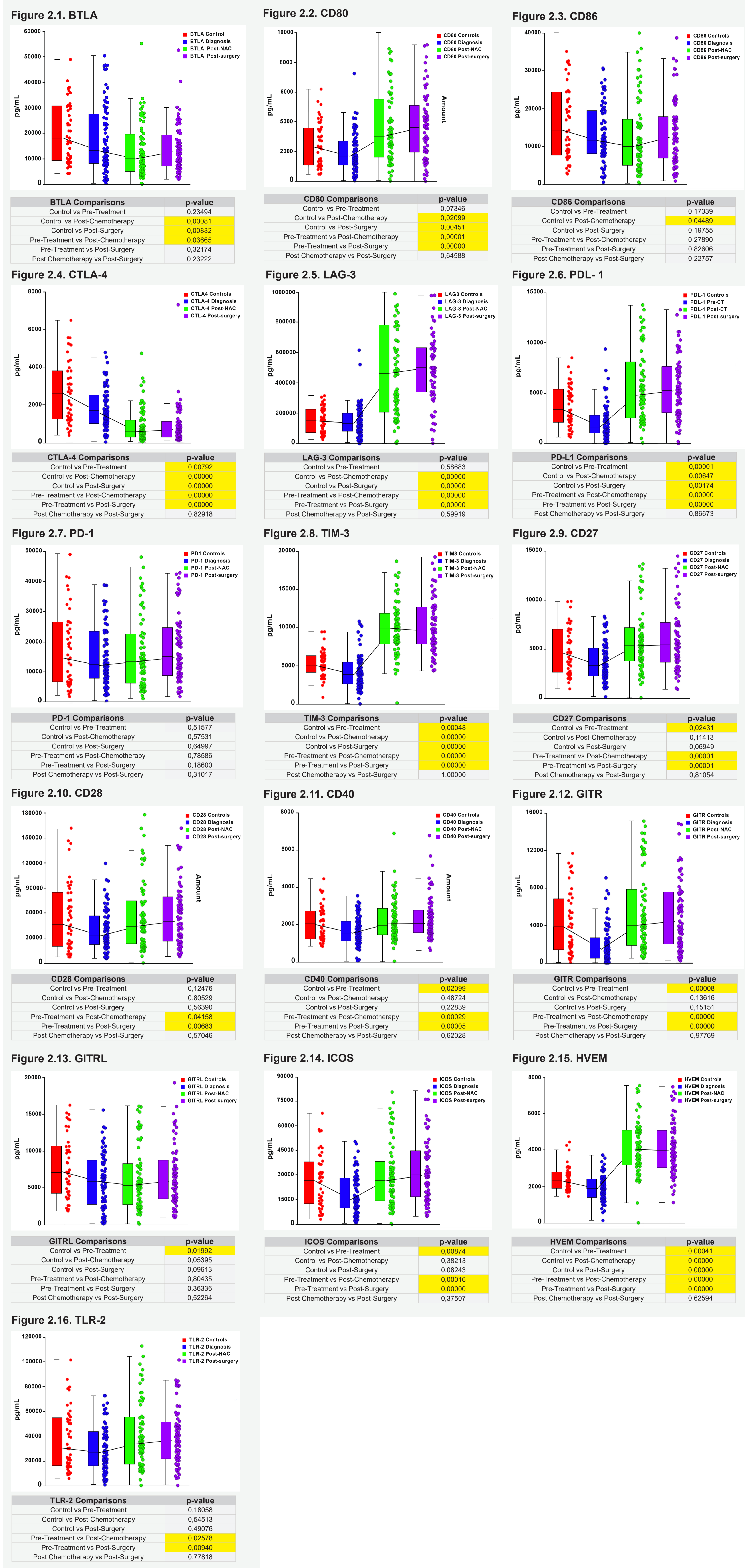


Table 4. Comparison between the median pre-treatment ICM levels of the patients attaining a pCR and patients not attaining a pCR.

ICM	Pre-Treatment pCR (median pg/ml)	Pre-Treatment n pCR (median pg/ml)	p-value	ICM	Pre-Treatment pCR (median pg/ml)	Pre-Treatment n pCR (median pg/ml)	p-value
BTLA	11158,79	20805,06	0,09381	CD27	3150,51	3440,615	0,32575
CD80	1587,38	1758,04	0,37104	CD28	31785,36	40785,61	0,24131
CD86	11140,02	12806,83	0,35118	CD40	1440,05	1730,97	0,24132
CTLA-4	1567,38	1959,23	0,3447	GITR	1264,8	1566,92	0,46494
LAG-3	123654,2	144059,1	0,33199	GITRL	5158,15	6925,995	0,09258
PD-L1	1625,73	1966,8	0,27858	ICOS	14399,75	15777,33	0,31959
PD-1	11086,85	13265,72	0,23135	HVEM	1858,66	1802,72	0,60547
TIM-3	3909,58	3422,375	0,90972	TLR-2	23846,32	30018,63	0,25684

There was no significant difference between the median pre-treatment ICM levels of the patients that attained a pCR compared to those patients that did not attain a pCR.

Conclusions

- Normalization of soluble co-stimulatory immune checkpoints is seemingly indicative of reversal of systemic immune dysregulation following administration of neo-adjuvant chemotherapy in early breast cancer, independent of response to treatment, while recovery of immune homeostasis may explain the increased levels of several negative checkpoint proteins, albeit with the exceptions of CTLA-4 and PD-1.