

Phase 0 trial investigating the intra-tumoural concentration and activity of Sorafenib in Neurofibromatosis type 2

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Introduction

Schwannomas, meningiomas and ependymomas are tumours of the nervous system which occur sporadically or as part of the hereditary disease Neurofibromatosis type 2. Mutations in *Neurofibromin 2/NF2* gene cause all NF2-related schwannomas, meningiomas and ependymomas, 77% sporadic schwannomas, 60% sporadic meningiomas and 30% sporadic ependymomas¹. Schwannomas are the hallmark of NF2 and develop in all NF2 patients. Current treatments for NF2-related tumours are surgery or radiosurgery. Radiation may induce additional mutations and formation of secondary tumours in NF2 whereas surgery has limited use in patients with high tumour load or tumours located at the sites where resection would cause neurological complications¹. Avastin is effective but only in a fraction of patients¹. Published consensus recommendations suggest that the development of effective therapies for NF2 is urgent, with great potential for clinical progress¹.

Platelet-derived growth factor receptor β (PDGFR β) is overexpressed and activated in human primary schwannoma cells leading to increased proliferation². Using orally available, FDA approved cRAF/ VEGFR-2/PDGFR- β inhibitor, Sorafenib this was successfully inhibited *in vitro*².

This was an open label, phase 0, single agent trial (EudraCT: 2011-001789-16, REC: 11/LO/0771) testing Sorafenib in NF2 patients with the aim to determine whether molecular target inhibition occurs with oral sorafenib in NF2 patients and whether target inhibition in plasma with oral sorafenib in NF2 patients can act as a biomarker.

Methods

Per protocol minimal recruitment target depending on the PD response rate was 3 patients (2 out of 3 or 3 out of 5 with 60% PD response⁴). Here five adult NF2 patients with peripheral schwannomas (PS), diagnosed according to NIH Diagnostic Criteria for Neurofibromatosis, were treated with Sorafenib administered orally at maximum tolerated dose (MTD) of 400mg, twice daily, for 10 days, and with a single 400mg dose on day 11 and two different (except 1 patient) peripheral schwannomas biopsied at day 0 and 11 as part of the trial protocol. The steady-state plasma concentrations and intra-tumoural concentrations of Sorafenib (primary outcome) in PS were measured after the treatment (North East Bioanalytical Laboratories, Hamden, CT, USA). The co-primary outcome was efficacy of Sorafenib on target inhibition. This was assessed by determining the levels of active/phosphorylated PDGFR β , ERK1/2, AKT and S6 Ribosomal Protein (ps6), expression of proliferation marker cyclin D1, apoptosis marker cleaved caspase-3 in PS and the levels of active/phosphorylated PDGFR β , ERK1/2, AKT in peripheral blood mononuclear cells (PBMCs) before and after treatment in each patient. Methods used were western blotting and immunohistochemistry (IHC)³. Evidence for a reduction in each molecular target of Sorafenib was sought from one-sided t-tests performed, using R version 3.3.3, on the log-transformed ratios of the before-and-after measurements, which assumed a common variance for each marker pooled from across the patients. According to the phase 0 design of Murgo et al.⁴ the mean logged ratios of at least three out of five patients had to be less than zero to conclude a significant effect of Sorafenib on a particular target.

Results

Most patients experienced mild-moderate adverse events using CTCAE, (Supplementary table 1). Sorafenib was detected at 3316.9 -20792.2 ng/ml in plasma and 1425.9 -6242.1 ng/g in PS samples from all NF2 patients similar to other trials (Supplementary table 2).

Western blot analysis of PS samples from five patients demonstrated non-significant changes of pPDGFR β ^{Y857} in all patients (Figure 1A); non-significant changes of pERK1/2 (Figure 1B) in four patients and significant reduction in one patient; non-significant changes of pAKT^{S473} in all five patients (Figure 1C); non-significant changes of ps6 in three patients and significant reduction in two (Figure 1D); non-significant changes of cyclin D1 (Figure 1E), cleaved caspase-3 (Figure 1F) and total ERK1/2 and AKT (Supplementary figure 1A and C) in all five patients. Results from PBMC: pPDGFR β ^{Y857} (Figure 1G), pERK1/2 (Figure 1H), pAKT^{S473} (Figure 1I), total ERK1/2 and total AKT (Supplementary figure 1B and D) showed no significant changes.

Additional semi-quantitative immunohistochemistry demonstrated decreased pPDGFR β ^{Y857} staining in PS samples from two patients, pERK1/2 in four and cleaved caspase-3 in one (Figure 1J). No changes in pAKT^{S473} (Figure 1J) were observed. Sorafenib increased number of proliferating cells (MIB1) in PS tissues from three patients and had no effect in two (Supplementary figure 1E). It also increased number of intratumoural macrophages (CD68) in PS tissue from one patient and decreased in PS tissues from two patients (Supplementary figure 1E). The number of or tumour-infiltrating CD3+T-cells increased in tissue samples from four patients (Supplementary figure 1E). Double staining for MIB1 and macrophage marker CD63, and MIB1 and T-cell marker CD3 revealed that the majority of proliferating cells were tumour cells although, in two cases, up to 24% were macrophages. No proliferating lymphocytes were observed (Supplementary figure 1E).

No correlation between target inhibition and drug concentrations in PS and in plasma were observed.

Discussion

To select the right drug to take forward into larger clinical trials in NF2 patients we report the first phase 0 clinical trial⁴ allowing rapid assessment of the usefulness of Sorafenib. Our within-patient measurements allowed a direct estimate of patient-specific variability.

We show that at standard MTD (400mg, twice daily), Sorafenib was detected in plasma (3316.9-20792.2 ng/ml) and in tumour tissue (1425.9 -6242.1ng/g) in all patients. At MTD Sorafenib caused adverse events in all patients including fatigue, diarrhoea/constipation and rash which were mostly mild to moderate but in one patient rash was severe. Pharmacodynamics (PD) effects, even at MTD with reasonable bioavailability, were lower than expected from our preclinical *in vitro* studies in human primary schwannoma cells where Sorafenib was highly effective². The primary PD endpoint was negative since samples from only two out of five patients displayed significant results. Immunohistochemistry staining for MIB1/Ki67 revealed no changes in proliferation upon Sorafenib treatment in two patients and a slight increase in three patients. This increase is potentially due to accumulation of MIB1/Ki67-positive macrophages and active tumour-infiltrating CD8+T cells⁵. Post-treatment PS samples demonstrated increased macrophages and T cells which agrees with previous studies⁵. Double staining for MIB1/Ki67, macrophage marker CD63 and, MIB1/Ki67 and T-cell marker CD3 revealed that most of proliferating cells were tumour cells. However, a percentage of CD63 positive macrophages double stained with MIB1. No CD3 positive cells co-stained with MIB1. Thus, lack of reduction or slightly increased proliferation after the treatment could partly be due to increased number of proliferating macrophages.

This study demonstrates that Sorafenib, can be detected in plasma and in PS and its effect on target inhibition can be successfully determined confirming the usefulness of Phase 0 trials in NF2 patients. However, despite some PD effects the trial was negative for the primary outcome and patients experienced relevant side effects.

Conflict of Interest Disclosure: No conflict of interest.

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Figure Legends

Figure 1

Analysis of the efficacy of Sorafenib in target inhibition in peripheral schwannoma samples (PS; western blotting and immunohistochemistry) and peripheral blood mononuclear cells (PBMCs; western blotting) from Neurofibromatosis type 2 (NF2) patients. (A) Sorafenib had no significant effect on pPDGFR β in PS samples of any patients (5/5). (B) No significant changes of pERK1/2 were observed in PS samples from four patients (4/5) and significant reduction of pERK1/2 was detected in PS sample from one patient (1/5). (C) pAKT^{S473} did not significantly change in PS samples from any patients (5/5). (D) No significant changes of ps6 were observed in PS samples from three patients (3/5) and significant reduction was detected in PS samples from two patients (2/5). (E and F) Cyclin D1 and cleaved caspase-3 were not significantly changed in PS samples from any of patients (5/5). (G-I) All results from PBMC: pPDGFR β (G), pERK1/2 (H) and pAKT^{S473} (I) showed no significant change in any of patients. (J) Immunohistochemistry demonstrated decreased pPDGFR β staining in PS samples from two patients (2/5), pERK1/2 in four (4/5) and Cleaved caspase 3 in one (1/5). No significant changes in pAKT^{S473} were observed in any of patients. Technical repeats: Patient1, n=5 (A), n=5 (B), n=3 (C), n=4 (D), n=1 (E), n=3 (F), n=5 (G), n=5 (H), n=5 (J); Patients 2, n=5 (A), n=6 (B), n= 7 (C), n=3 (D), n=3 (E), n=3 (F), n=3 (G), n=4 (I); Patient 3, n=4 (A), n=6 (B), n=6 (C), n=3 (D), n=5 (E), n=4 (F), n=3 (G), n=5 (H), n=5 (I); Patient 4, n=4 (A), n= 3 (B), n=4 (C), n=8 (D), n=6 (E), n=5 (F), n=3 (G), n=1 (H), n=4 (I); Patient 5, n=6 (A), n=3 (B), n=4 (C), n=5 (D), n=7 (E), n=5 (F).

Supplementary figure 1

Expression of AKT^{S473} and ERK1/2 in PS tissues and PBMC samples, and the number of MIB positive cells in PS tissues from NF2 patients before (Day 0) and after (Day 11) treatment with Sorafenib. (A and C) Western blot on fresh biopsy samples demonstrates non-significant changes in ERK1/2 and AKT expression after the treatment in all patients (5/5). (B and D) Western blot on fresh PBMC samples demonstrates non-significant changes of ERK1/2 and non-significant changes of AKT in four out of four patients after the treatment. (E) MIB1 staining increases in three patients (3/5) when estimated in average proliferating area. The number of CD63 and MIB1 positive cells increases in all the patients (5/5) and no CD3 cells are MIB1 positive. (A-D) Technical repeats: Patient 1, n=5 (A), n=3 (B), n=3 (C) and n=4 (D); Patient 2, n=5 (A), n=1 (B), n=4 (C) and n=1 (D); Patient 3, n=5 (A), n=4 (C); n=1 (D). Patient 4, n=5 (A), n=4 (B), n=5 (C), n=5 (D). Patients 5, n=6 (A), n=5 (C).