High Immune Response Rates and Decreased Frequencies of Regulatory T Cells in Metastatic Renal Cell Carcinoma Patients after Tumor Cell Vaccination

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Our previously reported phase I clinical trial with the allogeneic gene–modified tumor cell line RCC-26/CD80/IL-2 showed that vaccination was well tolerated and feasible in metastatic renal cell carcinoma (RCC) patients. Substantial disease stabilization was observed in most patients despite a high tumor burden at study entry. To investigate alterations in immune responses that might contribute to this effect, we performed an extended immune monitoring that included analysis of reactivity against multiple antigens, cytokine/chemokine changes in serum and determination of the frequencies of immune suppressor cell populations, including natural regulatory T cells (nTregs) and myeloid-derived suppressor cell subsets (MDSCs). An overall immune response capacity to virus-derived control peptides was present in 100% of patients before vaccination. Vaccine-induced immune responses to tumor-associated antigens occurred in 75% of patients, demonstrating the potent immune stimulatory capacity of this generic vaccine. Furthermore, some patients reacted to peptide epitopes of antigens not expressed by the vaccine, showing that epitope-spreading occurred in vivo. Frequencies of nTregs and MDSCs were comparable to healthy donors at the beginning of study. A significant decrease of nTregs was detected after vaccination (p = 0.012). High immune response rates, decreased frequencies of nTregs and a mixed T helper 1/T helper 2 (Th1/Th2)-like cytokine pattern support the applicability of this RCC generic vaccine for use in combination therapies.

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Over the last decade, the development of targeted molecular therapies as both first- and second-line treatments has substantially improved the prognosis for patients with mRCC. These molecular agents are mostly directed against signaling pathways that foster angiogenesis. They include receptor tyrosine kinase inhibitors (for example, sunitinib, sorafenib, pazopanib, axitinib, cediranib and tivozanib), monoclonal antibodies (for example, bevacizumab) and mammalian target of rapamycin (mTOR) inhibitors (for example, temsirolimus and everolimus). Although some tumors show regression, most patients develop therapy resistance over time. Interestingly, some molecular therapies may enhance antitumor responses; therefore, immunotherapy in combination with tyrosine kinase inhibitors has become a recent research focus (1–3).

Among cancer patients with solid tumors, individuals with mRCC showed some of the most favorable responses to immunotherapy (4). Tumor cell vaccines are of special interest, and there is evidence that immunization against tumors can reduce or even eliminate some lesions and induce long-lasting T-cell memory responses, with a capacity to control tumor relapse. One approach is to use autologous tumor cells, either alone or combined with adjuvants, often after introduction of immunologically relevant genes to enhance tumor cell immunogenicity. The first phase I trial in RCC implementing this strategy, by expressing the gene encoding granulocyte-macrophage colony stimulating factor (GM-CSF) in autologous tumor cells, demonstrated induction of specific T-cell immunity and clinical benefit (5,6). An autologous gene-modified tumor cell vaccine expressing the costimulatory molecule CD80 was tested in patients with mRCC in combination with systemic IL-2 (7). Even fusion vaccines of autologous tumor cells and allogeneic dendritic cells (DCs) induced immune responses in a significant number of patients (8,9). Severe toxicities were not seen; however, strong limitations in feasibility and high costs were incurred with the production of individualized vaccines. Generic tumor cell vaccines that could be applied to many patients would reduce production costs, thereby enabling treatment of more patients. Our previously reported clinical trial used an allogeneic gene–modified RCC tumor cell vaccine that acquired improved immunogenicity through coexpression of CD80 and IL-2 (10). Vaccination was well tolerated, and substantial disease stabilization was observed in most patients. Preliminary immune monitoring demonstrated vaccine-induced responses against tumor lysates and a small set of tumor-associated antigens (TAAs) in the majority of the patients.

Here we report extended immune monitoring of these study patients, including assessment of enzyme-linked immunosorbent spot (ELISPOT) reactivity against numerous new RCC-associated antigens, and analyses of cytokines/chemokines in serum and culture supernatants of skin biopsies taken from vaccine challenge sites. Immune suppression in cancer patients often result from high numbers of immune suppressor cell populations, including natural regulatory T cells (nTregs) and myeloid-derived suppressor cells (MDSCs). For this reason, we also determined the frequencies of Tregs and MDSC subsets throughout vaccination.

MATERIALS AND METHODS

Patients
Fifteen patients with histologically proven clear-cell RCC and at least one evaluable metastasis were enrolled in the clinical trial (10). Immune monitoring was done for 12 patients. The study is registered with the German Somatic Gene Transfer Clinical Trial Database (DeReG, reference number 47) and the German Clinical Trial Register, partner register of the World Health Organization primary register (reference number DRKS00000249). Only patients with an HLA-A*02:01 allotype were included, matching one major histocompatibility complex class I molecule with the vaccine. Patients gave written informed consent before the study. The clinical protocol was approved by the Ethics Committee of the Ludwig Maximilians University Munich, and good manufacturing practice (GMP)-certified vaccine production was approved by local, state and national authorities.

Vaccination and Study Schedule
The vaccine cell line RCC-26/CD80/IL-2 was generated as described previously (11). Vaccine cells were thawed immediately before intradermal injection into the inguinal region. Graded doses of cells were applied up to 10 times over a 22-wk period (Supplementary Figure S1). Clinical examination and routine blood checks were performed at every visit. Patients were withdrawn from the study if evidence of tumor progression appeared according to RECIST criteria (response evaluation criteria in solid tumors). In four patients (MR-6, MR-7, MR-8 and MR-9), the lowest vaccine dose (2.5 × 10⁶ cells) was omitted and vaccination was initiated with a dose of 1 × 10⁶ cells.

Enzyme-linked Immunosorbent Spot (ELISPOT)
Patient blood samples for ELISPOT were obtained at wks 1, 6, 14, 22 and 36 (see Supplementary Figure S1), and peripheral blood mononuclear cells (PBMCs) were isolated and cryopreserved. Additional samples from five patients were taken on d 15 after the tenth vaccination, and samples were available from two patients during longer follow-up. The IFN-γ ELISPOT assay was performed as described (10). PBMCs were directly stimulated with selected peptides (each peptide, 5 μg/mL) in serum-free medium (CTL Test medium; Cellular Technology Europe, Bonn, Germany), supplemented with anti-CD28 antibody (1 μg/mL; BD Biosciences, San Jose, CA, USA) and recombinant IL-2 (Proleukin, 2 U/mL; Chiron, Emeryville, CA, USA). Spots were counted with the AID reader system ELR03 with software versions 4.0 and 5.0 (Autoimmun Diagnostika [AID], Strassberg, Germany) and controlled by human audit. The mean spot number of
quadruplicates for a given peptide had to be at least two-fold over the mean background spot number. A response was considered to be vaccine induced, if the ratio of peptide mean to background mean for a given vaccination time point was at least two-fold over the corresponding pre-vaccination ratio. Surrogate peptides for immune monitoring were selected from sequences of TAAs shown to be overexpressed in metastatic RCC lesions and/or the vaccine cells, by using HLA-A*02:01 motif-based epitope predictions available on the web (http://www.syfpeithi.de), or as published in the literature. Several peptides were identified by elution from the RCC-26 cell line. Peptide sequences are given in the supplementary Material and Methods section ELISPOT.

Flow Cytometry
Surface immunostaining used directly labeled monoclonal antibodies (mAbs) from BD Biosciences: CD3, CD4, CD8, CD25, CD39, CD127, CD11b, CD15, CD14, CD33, CD124, HLA-DR and CD19. The FoxP3 mAbs (eBiosciences, Frankfurt, Germany) was used for nTreg analysis. The LIVE/DEAD® Fixable Blue Dead Cell Stain Kit, for UV excitation (Molecular Probes®; Life Technologies, Carlsbad, CA, USA) was applied for discrimination of live/dead cells.

Flow cytometry was performed as described in detail in the supplementary Material and Methods section Flow Cytometry. Briefly, isolated PBMCs were incubated first with the LIVE/DEAD® Fixable Blue dye, washed and stained with directly labeled mAbs. Fix/Perm buffer (eBiosciences) was used for intracellular staining with FoxP3 antibody. Cells were analyzed by using an LSRII (BD Biosciences). Data were processed by using FlowJo software (version 8.8.6; Tree Star, Ashland, OR, USA).

Cytokine/Chemokine Assays
Commercial ELISA kits and protocols (R&D Systems, Wiesbaden, Germany) were used for vascular endothelial growth factor (VEGF), VEGF-C, VEGF-D, transforming growth factor (TGF)-β1 and prostaglandin E2 (PGE2). For all other cytokines (IL-1β, IL-2, IL-4, IL-5, IL-6, IL-10, IL-12p70, IL-13, IL-17, tumor necrosis factor [TNF]-α, IFN-γ, GM-CSF, G-CSF) and chemokines (CXCL8 [IL-8], CXCL9 [monokine induced by gamma-interferon {MIG}], CXCL10 [IP-10], CCL2 [monocyte chemotactic protein-1 {MCP-1}], CCL4 [macrophage inflammatory protein-1β {MIP-1β}] and CCL5 [regulated upon activation normal T cell expressed and presumably secreted {RANTES}], the Luminex (BioPlex; Bio-Rad, Munich, Germany) and the multiplex cytokine bead array systems from BD Biosciences (CBA kit for chemokines and CBA Flex Set) were used according to the manufacturers’ instructions.

Serum samples were obtained before and after the first, fourth, fifth, eighth, ninth and tenth vaccinations (see Supplementary Figure S1).
PBMCs (wk 1) and PBMCs from wk 22 were cultured with parental RCC-26 cells and with RCC-26/C80/IL-2 vaccine cells. Skin-infiltrating lymphocytes grown from biopsies (wks 6, 14 and 22) for 10–19 d were measured for cytokine/chemokine secretion at 24–48 h after stimulation with RCC-26 and vaccine cells. The FACSCalibur was used for the CBA assays. The Luminex 100 Reader was used for the BioPlex assays. Details for sample processing, culturing and analysis are described in the supplementary Material and Methods section Cytokine/Chemokine Assays.

Analysis of the Demethylation of the Foxp3 Gene

Genomic DNA was isolated by using the DNeasy blood and tissue kit (Qiagen, Hilden, Germany). Bisulphite treatment of genomic DNA was performed as described (12) with minor modifications. A quantitative real-time (qRT) polymerase chain reaction (PCR)-based methylation assay with methylation- and demethylation-specific amplification primers was used to analyze the Foxp3 Treg-specific demethylated region DNA, as described (13). Samples were analyzed in triplicate by using a LightCycler 480 System (Roche, Mannheim, Germany). Cycling conditions and data analysis are described in the supplementary Material and Methods section Analysis of the Demethylation of the Foxp3 Gene.

Microarray Analysis

Tissue samples from 32 patients with clear-cell RCC metastases were collected, snap-frozen and stored in liquid nitrogen after written informed consent was obtained. The study was approved by the ethics committee of the Ludwig Maximilians University Munich. Cryostat sections were made, and laser microdissection was used to isolate tumor cells (PALM MicroBeam; Zeiss, Munich, Germany). Processing of the probes is described in detail in the supplementary Material and Methods section Microarray Analysis.

All supplementary materials are available online at www.molmed.org.

RESULTS

Study Patients Had Advanced Disease

Characteristics of study patients, individual vaccination courses and some clinical parameters are summarized in Table 1 and Supplementary Table S1. Study details were described previously (10). More than half of the patients had poor prognosis scores (>0) according to Palmer et al. (14), revealing their advanced states of disease. All patients had good performance status (Eastern Cooperative Oncology Group scores of 0 or 1; data not shown). Of the 12 patients evaluated here, 8 were treated before study entry with other immunotherapies, with the majority receiving subcutaneous IFN-α and IL-2, with or without 5-fluorouracil. The interval between the last therapy course and enrollment in this study was at least 3 months. All patients progressed

<table>
<thead>
<tr>
<th>Patient</th>
<th>TYMS</th>
<th>IGF-BP3</th>
<th>RGS-5</th>
<th>VEGF</th>
<th>MMP7</th>
<th>CA IX</th>
<th>PRUNE</th>
<th>TIF1</th>
<th>NY-ESO</th>
<th>Pool C</th>
<th>Pool E</th>
<th>DTH</th>
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<td>43/32</td>
<td>-16</td>
<td>45/85</td>
<td>14/43</td>
<td>-24</td>
<td>nd/nd</td>
<td>22/nd</td>
<td>81/112</td>
<td>/-15</td>
<td>12/51</td>
<td>+</td>
</tr>
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<td>40/63</td>
<td>66/71</td>
<td>99/97</td>
<td>+</td>
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<td>-60</td>
<td>19/41</td>
<td>32/41</td>
<td>24/42</td>
<td>-23</td>
<td>nd/nd</td>
<td>-37</td>
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<td>+</td>
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<td>-/--</td>
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<td>-/13</td>
<td>-/46</td>
<td>-/28</td>
<td>nd/nd</td>
<td>13/55</td>
<td>-/--</td>
<td>22/126</td>
<td>15/46</td>
<td>+</td>
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<td>-/--</td>
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<td>99/57</td>
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<td>77/33</td>
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<td>32/19</td>
<td>89/57</td>
<td>69/29</td>
<td>69/54</td>
<td>123/155</td>
<td>(+)</td>
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<td>MR-13</td>
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<td>71/80</td>
<td>40/62</td>
<td>61/32</td>
<td>111/17</td>
<td>-/--</td>
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<td>80/32</td>
<td>41/74</td>
<td>157/125</td>
<td>++</td>
</tr>
<tr>
<td>MR-14</td>
<td>23/36</td>
<td>76/141</td>
<td>39/49</td>
<td>-/126</td>
<td>-/64</td>
<td>28/33</td>
<td>-/14</td>
<td>52/67</td>
<td>16/44</td>
<td>-/63</td>
<td>12/70</td>
<td>++</td>
</tr>
</tbody>
</table>

DTH, delayed-type hypersensitivity reaction; nd, not determined (not enough cells).

aPool C contains the peptides for ORMDL3, AHNAK-rel, BTG1, PIG10, LENG4, CP and PRAME.
bPool E contains the peptides for TIF1, CLIC1, ELAC2 and TMP1.
cThe values represent absolute numbers of spots for pre- and postvaccination (pre/post) responses. These values are given irrespective of the time point postvaccination (that is, at 6, 14, 22 or 36 wks).

dNo values mean no reactivity (≥10 spots above background, which corresponds to a frequency of ≥1 × 10⁴ IFN-γ-secreting peptide-specific T cells).
eValues representing a greater than two-fold increase in reactivity against the peptides post- versus prevaccination are indicated in bold. With the larger peptide pools, a reactivity of ≥40 spots above background was considered positive.

fShort protocol of vaccination starting with the middle dose of 10⁷ vaccine cells. DTH reactivity: –, negative; (+), weak; +, positive; ++, positive (>2 cm redness and/or induration).
during the study, except for patients MR-11 and MR-15.

Routine blood parameters and common side effects were described previously (10). Peripheral blood leukocyte populations were not changed significantly during vaccination (Supplementary Figure S2). Patients MR-5, MR-11 and MR-14 showed transient increase of eosinophils (>500 cells/μL blood). Most patients (67%) showed transiently increased neutrophil granulocyte to lymphocyte ratios during vaccination (ratio >4). Two patients demonstrated extremely high ratios at the end of their vaccination courses, at time of progression (MR-7, MR-10; ratio >21; data not shown).

**High Rates of Immune Response Occurred after Vaccination**

PBMCs were obtained throughout vaccination for IFN-γ ELISPOT analyses to compare lymphocyte responses to a variety of peptide antigens before and after vaccination (see Supplementary Figure S1). Three patients (MR-3, MR-8 and MR-12) were not included because of early progression and removal from study.

In our previous trial report, we demonstrated that all patients responded before vaccination to pooled control peptides from cytomegalovirus, Epstein-Barr virus and influenza virus (CEF peptides) and to vaccine cell lysate, with increases in responses to tumor cell lysate noted in 66% of patients after vaccination (10). Here, additional ELISPOT responses after vaccination were analyzed by using surrogate peptides derived from numerous TAAs that are overexpressed in RCC or other tumors. Selected TAAs were tested for prevalence and expression by using microarray analysis of 32 mRCC tumors, parental RCC-26 cells and vaccine cells (Supplementary Table S2). Nearly all selected TAAs were expressed in the majority of tumor samples. Two TAAs (carbonic anhydrase IX [CAIX] and PRUNE2) were present in metastatic lesions but were not detected in parental RCC-26 or vaccine cells. Matrix metalloproteinase 7 (MMP7) was not detected in the vaccine and NY-ESO1 was missing throughout. Several HLA-A2–restricted peptides (transcriptional intermediary factor 1 [TIF1], chloride intracellular channel protein 1 [CLIC1], ElaC homolog-2, putative prostate cancer susceptibility protein 2 or heredity prostate cancer protein 2 [ELAC2], tropomyosin 1 [TPM1], ORM1-like protein 3 [ORMDL3], AHNAK-related protein [AHNAK-rel], B cell translocation gene 1 protein [BTG1], p53-induced gene 10 protein [PIG10] and LENG4) were eluted from RCC-26 cells, identifying additional TAAs. All peptides selected from these TAAs carried anchor residues for HLA-A*02:01, matching the HLA-A2 allelotype of patients (see supplementary Material and Methods section ELISPOT).

The summary of ELISPOT results for 12 patients is shown with values before treatment juxtaposed to the strongest recorded responses detected at any time after vaccination (Table 2). The delayed-type of hypersensitivity reactions (DTH) are also indicated here. All patients except MR-6 developed DTH responses after a challenge with 2.5 × 10⁷ vaccine cells, applied intradermally in the alternate inguinal region at wks 6, 14 and 22. In previous studies, we demonstrated patient ELISPOT responses to peptides derived from survivin, cyclin D1, adipopphilin, c-Met and vimentin (10).

Here, our analyses were extended to include thymidylate synthetase (TYMS), insulin-like growth factor binding protein 3 (IGF-BP3), PRUNE2, transcriptional intermediary factor 1 (TIF1), regulator of G protein signalling 5 (RGS5), VEGF, MMP7, CAIX and NY-ESO1, in addition to two pools, including 10 additional peptides. Interestingly, 100% of the patients reacted to at least one peptide in the entire set of analyzed epitopes. Greater than two-fold increases in reactivity to at least two peptides were detected in 75% of patients after vaccina-

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Peptide reactivity (number of tested peptides)</th>
<th>TTP (wks)</th>
<th>Survival (wks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MR-1</td>
<td>10/15</td>
<td>7/13 2</td>
<td>7</td>
</tr>
<tr>
<td>MR-2</td>
<td>12/16</td>
<td>15/17 11</td>
<td>23</td>
</tr>
<tr>
<td>MR-4</td>
<td>13/14</td>
<td>15/17 7</td>
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</tr>
<tr>
<td>MR-5d</td>
<td>3/14</td>
<td>15/17 11</td>
<td>7</td>
</tr>
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<td>MR-6d</td>
<td>8/16</td>
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<td>2/16</td>
<td>5/15 5</td>
<td>28</td>
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<tr>
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<td>3/18</td>
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<td>39</td>
</tr>
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<td>23</td>
</tr>
<tr>
<td>MR-11</td>
<td>7/17</td>
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</tr>
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<td>33</td>
</tr>
<tr>
<td>MR-14</td>
<td>9/19</td>
<td>17/19 9</td>
<td>35</td>
</tr>
<tr>
<td>MR-15</td>
<td>6/19</td>
<td>15/19 8</td>
<td>151</td>
</tr>
<tr>
<td>Immune response rate (%)</td>
<td></td>
<td>100 100 (75)</td>
<td></td>
</tr>
<tr>
<td>Clinical response (wks)</td>
<td></td>
<td>25.5 77.5</td>
<td></td>
</tr>
</tbody>
</table>

TTP: time to progression; SD, stable disease.

*Numbers of peptides to which reactivity was observed (>10 spots above background).

**Numbers of peptides tested (surivin, cyclin D1, adipolphilin, c-MET, vimentin, PRUNE2, VEGF, NY-ESO, MMP7, TYMS, IGF-BP3, RGS-5, CA IX, CPTIF-1, ORMDEL3, CLIC1, ELAC2 and PIG-10).

**Numbers of peptides (in bold) to which a greater-than-two-fold increase after versus before vaccination was detectable.

Short protocol of vaccination starting with the middle dose of 10⁷ vaccine cells.

SD (7) and SD (131) indicate stable disease at wks 7 and 131, respectively.

Patients reacting to more than one peptide in %.

Median PD and median survival in weeks.
tion (Table 3). The time course of responses varied as illustrated for three patients (Supplementary Figure S3). Faster responses in MR-13 and MR-14 may be due to prior multi-peptide vaccination given more than 4 months before study entry. MR-2 showed a pattern representative of most patients, whereby immune responses increased later in treatment.

Figure 1A shows the total number of IFN-γ-secreting T cells, given as total number of spots for all tested antigens. This result demonstrates the magnitude of vaccine-induced immune responses. In general, patients with a higher total number of spots showed a longer survival, and the same was observed for patients recognizing higher numbers of peptides (Figure 1B). The survival probability of the patients with immune responses to 0–2 peptides (dashed line) and immune responses to ≥3 peptides (solid line), p = 0.066; log-rank test.

**Frequencies of Tregs Decreased after Vaccination**

Immune suppression in cancer patients is often discussed to result from higher numbers of Tregs or MDSCs. For this reason, we analyzed frequencies of CD4+CD25highCD127low/negativeFoxp3+CD39+ cells in patient PBMCs. Supplementary Figure S4 shows the gating strategy for patient MR-1. In general, frequency of Tregs before vaccination (median 2.60, minimum 0.93, maximum 3.56) was similar to that in healthy controls (median 2.71). A decrease of Tregs was observed after vaccination (p = 0.065, Supplementary Table S3). This change with respect to vaccination could even be demonstrated with absolute numbers of Tregs (p = 0.034, Figure 2A). To quantify nTregs more precisely, we used a real-time PCR-based methylation assay using methylation- and demethylation-specific primers. Baseline levels of stable Foxp3-expressing nTregs in the patient cohort did not differ from healthy controls. Interestingly, significant decreases of nTregs (p = 0.012) were detected in patients after vaccination, as illustrated in Figure 2B. A combined analysis of total numbers of responding T cells before and after vaccination (Figure 3A) and absolute numbers of Tregs before and after vaccination (Figure 3B) suggests a reciprocal relationship, as might be expected, but this result did not reach significance owing to the small number of patients (Figure 3C; p = 0.243, r = -0.365).

**Patients with Fewer MDSCs Tended to Longer Survival**

MDSCs represent a second cell population with suppressive function, which was also described in RCC patients (15). These cells were immunophenotyped by using antibodies specific for CD3, CD19, CD14, CD15, CD11b, CD33, HLA-DR and CD124. Supplementary Figure S5 shows the gating strategy for different MDSC cell subpopulations for patient MR-1, as a representative example. Five subpopulations were detected in RCC patients and healthy donors: MDSC1 (CD14+ CD124+), MDSC2 (CD15+ CD124+), MDSC3 (Lin+ HLA-DR+, CD33+, SSC-high), MDSC4 (SSCmean CD14+ HLA-DR+) and MDSC5 (CD14+ CD15+ CD11b+). Results for all patients are given in Supplementary Table S4. Slightly increased frequencies of MDSC4 and MDSC5 were observed in 58% of patients compared with healthy donors. Significant increases or decreases in any of the five MDSC subpopulations were not observed before
and after vaccination, even when calculated for absolute numbers. However, there was a trend for better immune responses in patients with lower frequencies of MDSC4 and MDSC5. Figure 4 indicates a slightly higher survival probability for patients with lower frequencies of MDSC4 ($p = 0.091$), although these differences did not reach significance because of the small number of patients.

**Effector T Cells Displayed Mixed TH1/TH2-Like Cytokine Profiles**

Cytokine profiles also provide useful information about the effects of immunotherapeutic vaccination. Therefore, we analyzed the general cytokine profile in PBMC responses to vaccine cells. In unstimulated controls, a predominant secretion of IL-10 and the proinflammatory cytokines IL-1β, IL-6, IL-8 and TNF-α was found, whereas there was no or only low detection of IL-2, IL-4, IL-5 and IFN-γ (Supplementary Table S5). After stimulation with vaccine cells, much more IFN-γ, IL-2, IL-4 and IL-5 were measured, which increased further after a second restimulation. Also, IL-10 increased after a second stimulation. In contrast, secretion of IL-1β, IL-6, IL-8 and TNF-α decreased after stimulation. This result can be interpreted as a mixed T helper 1/T helper 2 (TH1/TH2)-like profile, reflecting decreases of proinflammatory cytokines after in vitro restimulation with vaccine cells.

**Challenge Site Infiltrating Lymphocytes Produced IL-10 and IFN-γ-Dependent Chemokines**

Cytokines secreted by skin-infiltrating lymphocytes were analyzed in skin biopsies taken 48 h after an intradermal (i.d.) vaccine challenge at wks 6, 14 and 22. Small pieces of biopsies were cultured for 10–19 d, depending on the number of outgrowing cells. The composition of infiltrating cell populations differed from biopsy to biopsy and depended on the cultivation period. After 10 d, up to 95% of infiltrating cells were T cells and NK cells with residual B cells, eosinophils, macrophages and monocytes (data not shown).

Substantial differences were noted in the cytokine/chemokine profiles of the skin-infiltrating lymphocytes taken at different times (Supplementary Table S6). IL-5 and IL-13 were greatest in the first biopsy at 6 wks and declined substantially thereafter. Most factors were at a maximum in cells isolated from wk 14 biopsies, after patients had received eight vaccine doses. IL-10 increased throughout vaccination for most patients, in addition to three other factors (RANTES, IP-10 and MIG), all of which are induced by IFN-γ.

**Multiple Serum Cytokines Increased During Vaccination**

Supplementary Table S7 shows serum cytokine levels. All cytokines increased slightly during vaccination, however, sometimes only transiently. Small increases in IFN-γ were observed in 64% of patients, with maximum levels reaching $>20$ pg/mL for several patients (MR-11, MR-13 and MR-15 [data not shown]). These same patients also showed increases of IL-10. Enhanced IL12p70 secretion was only detected in patients who had longer survival times (MR-13, MR-14 and MR-15). IL-5 but not IL-4 was slightly enhanced in most patients, whereas IL-17 was only detected in one
survival time of 15.6 months (10). Studies
5.3 months and median tumor-specific
with a median time to progression of
50% of patients achieved a state of stable
advanced state of disease. Nevertheless,
prognosis scores (10,14), revealing their
ment, and 42% of patients had poor
metastases at two or more sites at enroll-
fied RCC-26 cells (10).
HLA-A2–matched patients with modi-
phase I vaccine trial was performed in
its improved stimulatory capacity, a
and to secrete IL-2 (11). On the basis of
26 vaccine cells to express surface CD80
munogenic potential that was enhanced
strated that RCC-26 displays strong im-
C-reactive protein, which have been re-
showed enhanced levels of IL-6, IL-8 and
eosinophils (Supplementary Figure S6).
40% and 60% of patients
advanced disease. Changes were not de-
tected in levels of VEGF-C, VEGF-D and
median (solid line) and MDSC4 in
%/lymphocytes < median (dashed line).
Median = 12.13%; p = 0.091; log-rank test.
patient (MR-11). Increases in IL-5 were
not associated with higher numbers of
cytotoxic T cells (Supplementary Table S8).
Between 40% and 60% of patients
showed enhanced levels of IL-6, IL-8 and
C-reactive protein, which have been re-
ported to be elevated in patients with ad-
vanced disease. Changes were not de-
tected in levels of VEGF-C, VEGF-D and
PGF2, whereas VEGF-A and TGF-β1 de-
creased slightly over time (Supplemen-
tary Table S8).

DISCUSSION
Extensive preclinical studies demon-
strated that RCC-26 displays strong im-
munogenic potential that was enhanced
by gene modification to allow the RCC-
26 vaccine cells to express surface CD80
and to secrete IL-2 (11). On the basis of
its improved stimulatory capacity, a
phase I vaccine trial was performed in
HLA-A2–matched patients with modi-
fied RCC-26 cells (10).
The majority of patients had multiple
metastases at two or more sites at enroll-
ment, and 42% of patients had poor
prognosis scores (10,14), revealing their
advanced state of disease. Nevertheless,
50% of patients achieved a state of stable
disease ranging from 23 to 131 wks,
with a median time to progression of
5.3 months and median tumor-specific
survival time of 15.6 months (10). Studies
of larger numbers of patients with simi-
lar advanced disease showed progres-
sion-free survival of 5.5 months with the
angiogenesis inhibitor sorafenib (16) and
5.0 months with IFN-α (17); however, the
side effects of these therapies were much
greater.
All patients but one showed DTH re-
actions that increased in magnitude over
time, indicating strong induction or reac-
tivation of T-cell responses in vivo
through vaccination. To better under-
stand the basis of vaccine-induced im-
mune responses that may have con-
tributed to stable disease, we analyzed
numerous immune parameters in patient
blood lymphocytes, serum and vaccine-
site biopsy samples. Among the numer-
ous parameters that were assessed, the
results of antigen-specific T-cell re-
sponses and the frequencies of Tregs and
MDSCs were most informative.
IFN-γ–secreting cells were measured
after ex vivo stimulation with numerous
new RCC-associated antigens. Here, a
large panel of surrogate peptides, repre-
senting epitopes derived from TAAs
known to be overexpressed in RCC, were
used in addition to several peptides eluted from RCC-26 cells. Peripheral
blood lymphocytes (PBL) of all but one
patient responded to more than one pep-
tide, and the vaccine-induced immune
response rate was 75%. Some patients re-
acted to epitopes (for example, PRUNE2
tide, and the vaccine- induced immune
response rate was <200. In contrast, seven of
patients responding to fewer than three
longer survival. Thus, three of four pa-
tients who survived longer. Likewise, complex
responses to several different peptides
were more common in patients with
longer survival. Thus, three of four pa-
tients responding to fewer than three
peptides survived <15 months; their total
number of T cells responding to the pep-
tide panel was <200. In contrast, seven of
eight patients responding to three or
more peptides survived beyond 15
months and had total T-cell responses
ranging from 200 to 1,138 spots.

Poor clinical outcome in many cancer
patients is associated with higher num-
bers of Tregs or MDSCs. Thus, elevated
Treg numbers in peripheral blood, tu-
mors or lymph nodes were associated
with poor prognosis (18,19). In some
cases, decreased numbers of Tregs were
observed after sunitinib treatment, and
this result correlated with improved
overall survival (20,21). Treg depletion
may support enhanced vaccine-induced
antitumor immunity (22). In our cohort,
baseline levels of stable Foxp3-express-
ing nTregs in patients did not differ from
healthy controls, as reported for a related
cancer vaccine study (23). In contrast, significant
decreases of nTregs (p = 0.012) were de-
tected in this patient cohort after vaccina-
tion, and to some degree, these decreases
were matched with increases in antigen-
specific T-cell responses. Thus, this IL-2-
secreting vaccine did not cause higher
frequencies of nTregs, as seen with sys-
temic IL-2 treatment in melanoma and
RCC (24,25) or during treatment of
mRCC patients with dendritic cells and
low-dose IL-2 (26). Our vaccine strategy
appears to have a favorable profile with
respect to impact on Treg frequencies.
The mechanism underlying this effect is
unknown but may be related to the effect
of vaccination on the cytokine network.
Furthermore, the IL-2 from our vaccine is
unlikely to have systemic effects, since
the cells are applied intradermally.
MDSCs can also interfere with im-
mune responses by several different
mechanisms (15,27–32), and increased
numbers of MDSCs have been correlated
with cancer stage and metastatic spread
(33). MDSCs were reported in RCC (15),
and enhanced antitumor immunity was
obtained by reversing MDSC-mediated
immune suppression after treatment
with sunitinib or all-trans-retinoic acid
(34,35). In our patient cohort, increased
levels of MDSC4 and MDSC5 were
found in 58% of patients compared with
healthy donors. These values did not sig-
nificantly change before and after vac-
cination. A trend for better survival was
seen for patients who had lower frequen-
cies of the MDSC4 subset.

Figure 4. Survival probability of patients
with high versus low frequencies of
MDSC4. Survival probability of the patients
(n = 12) with MDSC4 in %/lymphocytes <
median (solid line) and MDSC4 in
%/lymphocytes > median (dashed line).
Median = 12.13%; p = 0.091; log-rank test.
Cytokine profiles may also provide useful information for understanding clinical effects of immunotherapy. The presence of elevated systemic levels of proinflammatory cytokines may indicate unfavorable clinical outcomes in patients with advanced solid tumors (36). The cytokine balance gives an indication of the overall inflammatory milieu. Kyte et al. (37) reported that mixed T\textsubscript{H}1/T\textsubscript{H}2 cytokine patterns in vaccinated melanoma patients, even at the clonal T-cell level, were associated with long-term survival.

In this cohort, 64% of patients showed increases in serum IFN-\(\gamma\) during vaccination, but the same patients also demonstrated a T\textsubscript{H}2-like profile. In general, associations of particular serum cytokine profiles with immune response rates or survival times were not obvious, with the exception that IL-12p70 was only detected in patients who survived longer. IL-12 is known to activate T\textsubscript{H}1 cells and NK cells, and it was described by others that higher levels of IL-12p70 were associated with better survival in mRCC (38). The mechanisms by which vaccination led to increases in this cytokine are unknown, but it is possible that T cells producing IFN-\(\gamma\) led to IL-12p70 production by dendritic cells.

Four T\textsubscript{H}2 cytokines were prominent in cohort samples. The slightly enhanced IL-10 secretion, as measured both in serum and in skin-infiltrating lymphocytes during vaccination, did not necessarily mean immune suppression. The role of IL-10 in immune response against cancer is still controversial. One report suggests that IL-10 may favor immunemediated rejection of cancer (39). Persistent, moderate threshold levels of IL-10 seem to be necessary for inhibition of tumor growth by activated effector T\textsubscript{H}1 cells (40).

Chemokines play a major role in leukocyte trafficking to sites of inflammation. An increase of chemokines induced by IFN-\(\gamma\) (RANTES, IP-10 and MIG) was observed in skin-infiltrating cells after stimulation with vaccine cells in vitro. IP-10 plays an important role in DTH reactivity and is chemotactic for T cells, NK cells, dendritic cells, macrophages and monocytes. Schwaab et al. (41) observed a treatment-related induction of IP-10 and a relationship between outcome and pretreatment serum IP-10 levels (41). IP-10 expression in RCC tumors has been described as a predictor of good outcome and was shown to be induced by IL-2 and implicated as a component of T\textsubscript{H}1 responses (42). MIG is a chemoattractant for T cells, and RANTES is chemotactic for T cells, monocytes and eosinophils and plays a role in recruiting these cells into inflamed tissues. Thus, induction of these factors may reflect a positive impact of vaccination on immune responses in patients showing this response profile.

In general, the complexity of cytokine networks makes it difficult to determine the relationships between immune response rates, systemic cytokine/chemokine levels and clinical outcome, particularly in a small cohort. It will be necessary to analyze larger patient cohorts to understand how these complex networks regulate immune responses during vaccination.

CONCLUSION

In summary, these extensive immune monitoring studies demonstrate that most patients in this trial acquired increased T-cell reactivity during vaccination to several epitopes derived from shared TAAs and vaccine-eluted peptides. Despite its allogeneic nature, this generic vaccine induced TAA-associated T-cell responses that may elicit significant immune attack of autologous tumor cells in better clinical settings. In future combination therapies or in adjuvant therapies for RCC patients with minimal residual disease, preanalysis of patients for general immune response capacity and prevalence of suppressor cell populations might guide the better use of vaccines. Only patients with an overall good immune response capacity and normal numbers of suppressor cells may benefit from tumor vaccine approaches.

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DISCLOSURE

T Schwachula and S Olek are members of the company Epiontis; and S Walter is a member of the company Immatics Biotechnologies; but being part of these companies has not influenced the results and discussion in this paper.

REFERENCES


