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### 961MO Safety, efficacy, immunogenicity of arenavirus-based vectors HB-201 and HB-202 in patients with HPV16+ cancers

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961MO

### Safety, efficacy, immunogenicity of arenavirus-based vectors HB-201 and HB-202 in patients with HPV16+ cancers

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**Background:** Human papillomavirus 16 positive (HPV16+) cancers are caused by stable expression of HPV16-specific E7 and E6 oncoproteins, also a source of immunogenic neoantigens. Replicating arenavirus vectors HB-201 (LCMV) and HB-202 (Pichinde virus), expressing the same non-oncogenic HPV16 E7E6 fusion protein, induce tumour-specific T-cell responses.

**Methods:** A phase I first-in-human study assessed HB-201 monotherapy and HB-201 & HB-202 alternating 2-vector therapy (HB-201/HB-202) intravenously (IV) with or without 1 intratumoural dose (IT/IV) in HPV16+ cancers. Safety, tolerability, and preliminary anti-tumour activity by Response Evaluation Criteria in Solid Tumors (RECIST) 1.1 or immune RECIST were evaluated, as well as immunogenicity and pharmacodynamic biomarkers in blood and tumour tissue samples.

**Results:** The study treated 38 patients (29 with  $\geq 1$  efficacy scan) with confirmed HPV16+ cancers with a median (range) of 3 (1–10) prior anticancer therapies. The most common primary cancer site was oropharynx (76%), followed by cervical (7.9%). Eighteen patients received HB-201 monotherapy IV and 9 IT/IV; 11 patients received HB-201/HB-202 alternating therapy. Treatment was generally well tolerated. Twenty patients (53%) reported treatment-related adverse events (all Grade  $\leq 2$ ). Two of 11 evaluable patients treated with HB-201 IV every 3 weeks had partial response (including 1 unconfirmed immune complete response of target lesion) and 6 had stable disease (SD) lasting 1.2–5.9 months. All 6 evaluable patients that received HB-201/HB-202 had SD. HPV16-specific T-cells in peripheral blood were detected at several time points post-administration through direct ex vivo stimulation. Different schedules, regimens, modes of administration, and doses will be presented with corresponding immunogenicity data. The proposed pathway to the recommended phase II regimen will be discussed.

**Conclusions:** Arenavirus-based vectors HB-201 and HB-201/HB-202 appeared well tolerated and showed preliminary anti-tumour activity as single agents in this heavily pretreated population of patients with HPV16+ cancers. Induction of circulating E7E6-specific activated CD8+ T-cells was observed.

**Clinical trial identification:** NCT04180215.

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962MO

**A phase I clinical trial on intratumoral injection of autologous CD1c (BDCA-1)<sup>+</sup>/CD141 (BDCA-3)<sup>+</sup> myeloid dendritic cells (myDC) in combination with talimogene laherparep (T-VEC) in patients with advanced pretreated melanoma**

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**Background:** Intratumoral (IT) myDC play a pivotal role in initiating antitumor immune responses within the tumor microenvironment. IT injection of the oncolytic virus T-VEC may lead to the release of tumor antigens and maturation signals that can be captured and processed by CD1c (BDCA-1)<sup>+</sup>/CD141 (BDCA-3)<sup>+</sup> myDC, thereby reinvigorating the cancer immunity cycle.

**Methods:** Patients (pts) with ICI-refractory melanoma received IT injections of  $\geq 1$  non-visceral metastases with T-VEC ( $10^5$  PFU/mL; max 4 mL) on day 1 followed by IT injection of CD1c (BDCA-1)<sup>+</sup> (cohort C1) or CD1c (BDCA-1)<sup>+</sup>/CD141 (BDCA-3)<sup>+</sup> myDC (cohort C2) on day 2. Injection of T-VEC ( $10^8$ PFU/mL; max 4 mL) was repeated on day 21, and Q2w thereafter. In C1, the number of CD1c (BDCA-1)<sup>+</sup>myDCs was escalated from  $0.5 \times 10^6$ , to  $1 \times 10^6$ , and  $10 \times 10^6$  cells. In C2, pts received all isolated CD1c (BDCA-1)<sup>+</sup>/CD141 (BDCA-3)<sup>+</sup> myDCs. Primary objectives were safety and feasibility. Immunohistochemistry (IHC), gene expression profiling (GEP), and multiplexed immunofluorescence (mIF) of baseline and on-treatment biopsies was performed.

**Results:** 13 pts were enrolled (C1: n=7 [respectively 2, 2, and 3 pts per dose-level of myDC]; C2: n=6). Pts received the predefined dose of myDCs and a median of 6 (range 3-8) T-VEC injections. Most frequent AEs were fatigue in 11 pts (85%), injection-site pain in 9 pts (69%), fever in 8 pts (62%), and chills and flu-like symptoms in 6 pts (46%). There were no G4 or G5 AEs. AEs of special interest were a G3 eosinophilia and a G2 purpuric rash at the injection-site; 2 pts (C1, dose level 3) developed a pathological complete remission that is ongoing at 24 months following treatment initiation. One pt in C2 had an unconfirmed partial response (iRECIST); a mixed response was observed in 2 pts. Responses were observed in both injected and non-injected lesions. In responder pts, infiltration of lymphocytes was observed on IHC. GEP and mIF on biopsies are ongoing.

**Conclusions:** IT co-injection of CD1c (BDCA-1)<sup>+</sup> +/- CD141 (BDCA-3)<sup>+</sup> myDC plus T-VEC is feasible, tolerable, and resulted in encouraging early signs of durable antitumor activity in pts with ICI-refractory melanoma.

**Clinical trial identification:** NCT03747744.

**Legal entity responsible for the study:** Department of Medical Oncology, Universitair Ziekenhuis Brussel.