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The Genomic Landscape of SMARCA4 Alterations and Associations with Outcomes in Patients with Lung Cancer

Adam J. Schoenfeld
Chaitanya Bandlamudi
Jessica A. Lavery
Joseph Montecalvo
Azadeh Namakydoust

See next page for additional authors

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Author
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1Thoracic Oncology Service, Division of Solid Tumor Oncology, Department of Medicine, Memorial Sloan Kettering Cancer Center, Weill Cornell Medical College, New York, NY, USA
2Center for Molecular Oncology, Memorial Sloan Kettering Cancer Center, New York, NY, USA
3Department of Epidemiology and Biostatistics, Memorial Sloan Kettering Cancer Center, New York, NY, USA
4Department of Pathology, Memorial Sloan Kettering Cancer Center, New York, NY, USA
5Druckenmiller Center for Lung Cancer Research, Memorial Sloan Kettering Cancer Center, New York, NY, USA
6David H. Koch Institute for Integrative Cancer Research, Massachusetts Institute of Technology, 500 Main Street, Cambridge, MA 02139, USA
7Department of Medicine, New York-Presbyterian Brooklyn Methodist Hospital - Weill Cornell Medicine, New York, NY, USA
8Howard Hughes Medical Institute, Massachusetts Institute of Technology, Cambridge, MA 02139, USA. *Contributed equally. #Co-senior authors

Correspondence to:

Dr. Gregory J. Riely
Thoracic Oncology Service, Division of Solid Tumor Oncology, Department of Medicine, Memorial Sloan Kettering Cancer Center
1275 York Avenue, New York, NY, 10065, USA
+1 646-888-4199
rielyg@mskcc.org

Dr. Natasha Rekhtman
Thoracic Oncology Service, Department of Pathology, Memorial Sloan Kettering Cancer Center
1275 York Avenue, New York, NY, 10065, USA
+1 212-639-6780
rekhtman@mskcc.org

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Statement of translational relevance:

In this study, we characterize the clinical, molecular and histologic relationships of SMARCA4 genomic and protein alterations in lung cancer. SMARCA4 is the most commonly mutated member of the SWI/SNF complex, with mutations occurring in 8% of patients with NSCLC. Genomic, protein expression, and clinical outcome data identify two distinct classes of SMARCA4 alterations. SMARCA4 alterations often co-occur with STK11, KEAP1, and KRAS alterations, but they are a prognostic factor, independent of these alterations. Although patients whose tumors have Class 1 SMARCA4 alterations (associated with protein expression loss) have a very poor prognosis, they may have higher response rates to PD-(L)1 blockade despite low PD-L1 expression.
ABSTRACT

Purpose: SMARCA4 mutations are among the most common recurrent alterations in NSCLC, but the relationship to other genomic abnormalities and clinical impact has not been established.

Experimental Design: To characterize SMARCA4 alterations in NSCLC, we analyzed the genomic, protein expression, and clinical outcome data of patients with SMARCA4 alterations treated at Memorial Sloan Kettering.

Results: In 4813 tumors from patients with NSCLC, we identified 8% (n= 407) patients with SMARCA4-mutant lung cancer. We describe two categories of SMARCA4 mutations: Class 1 mutations (truncating mutations, fusions and homozygous deletion) and Class 2 mutations (missense mutations). Protein expression loss was associated with Class 1 mutation (81% vs 0%, (P < 0.001)). Both classes of mutation co-occurred more frequently with KRAS, STK11, and KEAP1 mutations compared to SMARCA4 wildtype tumors (P < 0.001). In patients with metastatic NSCLC, SMARCA4 alterations were associated with shorter overall survival, with Class 1 alterations associated with shortest survival times (P < 0.001). Conversely, we found that treatment with immune checkpoint inhibitors was associated with improved outcomes in patients with SMARCA4-mutant tumors (P = 0.01), with Class 1 mutations having the best response to ICIs (p = 0.027).

Conclusions: SMARCA4 alterations can be divided into two clinically relevant genomic classes associated with differential protein expression as well as distinct prognostic and treatment implications. Both classes co-occur with KEAP1, STK11, and KRAS mutations, but individually represent independent predictors of poor prognosis. Despite
association with poor outcomes, *SMARCA4*-mutant lung cancers may be more sensitive to immunotherapy.

**Introduction**

Genomic abnormalities in the subunits of the *SWI/SNF* chromatin remodeling complex occur in approximately 20% of solid tumors and emerging data suggests that specific alterations within this complex might affect outcomes in certain solid tumors (1-3). For example, alterations in the *SWI/SNF* complex gene *PBRM1* have been associated with improved outcomes in patients with renal cell carcinoma treated with immune checkpoint inhibitors (ICIs); refs. (3,4). In lung cancer, inactivation of the catalytic subunit *SMARCA4* (BRG1), is the most common alteration within the *SWI/SNF* complex and has been associated with poor patient outcomes (1,5-10). *SMARCA4* is one of two mutually exclusive DNA-dependent ATPases, along with *SMARCA2*, involved in transcriptional regulation of gene expression (11,12). Yet, the relationship between *SMARCA4* and other alterations within the complex genomic landscape of lung cancer remains unclear.

Multiple studies have recently highlighted the importance of considering genes of interest within the context of commonly co-occurring mutations (13-18). For example, the identification of *STK11*, *KEAP1*, and *TP53* mutant subgroups has changed the paradigm of classifying *KRAS*-mutant lung cancers and non-small cell lung cancers (NSCLCs) in general (13-15,18). These distinct subgroups correlate with differential responses to immunotherapy and long-term outcomes (13,14,17,18). Further, in *EGFR*-mutant lung cancer, mutations in *TP53* and *RB1* are associated with shorter response
to TKIs and transformation to small cell carcinoma (15,16). Previous studies have shown that \textit{SMARCA4} alterations can co-occur in \textit{KRAS} mutant tumors, yet they also occur independently and less commonly with other driver oncogenes such as epidermal growth factor receptor (\textit{EGFR}); refs. (5,6). However, there are only limited data on \textit{SMARCA4}'s relationship to these other co-occurring mutations (8,10) and the significance of \textit{SMARCA4} alterations among oncogene driven subsets of lung cancer is unknown.

Increased understanding of the relationship of \textit{SMARCA4} in lung cancer may enable new therapeutic opportunities in the future. Recently, \textit{SMARCA4} alterations have been shown to be oncogenic drivers in a highly aggressive subset of ovarian cancer, small cell carcinoma of the ovary, hypercalcemic type (SCCOHT) that shows increased susceptibility to ICIs (19). Further, there have been case reports of durable responses to ICIs in thoracic \textit{SMARCA4}-deficient undifferentiated tumors and \textit{SMARCA4}-deficient lung carcinoma (20,21), but no studies have comprehensively evaluated treatment outcomes in a large cohort of lung cancer patients. In this study, we characterize the clinical, molecular, and histologic relationships of \textit{SMARCA4} genomic and protein alterations in lung cancer.

\textbf{Methods}

We identified all patients with NSCLC of any stage with \textit{SMARCA4} alterations detected by MSK-IMPACT NGS (22) until April of 2019 who were treated at Memorial Sloan Kettering Cancer Center (MSK) for genomic analysis (Sup. Fig. 1).

\textit{SMARCA4} alterations were classified into two groups: \textit{SMARCA4} truncating mutations, fusions and homozygous deletions were deemed “Class 1 alteration” and 2) \textit{SMARCA4}...
missense mutations or variants of unknown significance, or “Class 2 alteration” based upon categorization in OncoKB (23). Tumors with concurrent Class 1 and Class 2 alterations were classified within the Class 1 category. A retrospective pathologic analysis of expression of SMARCA4 in all cases of with SMARCA4 molecular alterations was performed by immunohistochemistry using the previously described methods (10).

Somatic alterations were identified using the MSK-IMPACT assay as previously described (22). Individual genes were queried for distribution and enrichment among the patients with and without SMARCA4 alterations. Frequencies of gene alterations by SMARCA4 alteration were considered significant with a p-value < 0.05 and, to reduce false discovery in multiple testing, FDR q-value < 0.10. Tumor mutation burden (TMB) was normalized across each version of the MSK-IMPACT panel (341, 410, or 468 genes) and defined as the total number of mutations divided by the coding region captured reported as mutations/megabase in each panel (0.897 megabases (Mb) for 341-, 1.017 Mb for 410-, and 1.139 Mb for 468-gene panel). PD-L1 expression was scored as the percentage of tumor cells with membranous staining using predominantly E1L3N antibody, as previously described (24).

Medical, pharmacy, and pathology records for all patients with metastatic NSCLC and SMARCA4 alterations were reviewed to collect demographic, pathologic, and treatment data. A random sample of patients with metastatic NSCLC who had MSK-IMPACT without SMARCA4 alterations and were tested during the same time period was used as a comparator group. The response to anti-PD-(L)1 therapy was determined (database lock of April 1, 2019) using Response Evaluation Criteria in Solid Tumors.
(RECIST) version 1.1. by thoracic radiologists. This study was approved by the Institutional Review Board/Privacy Board at MSK and was in accordance with the Belmont report for retrospective review of records and waiver of consent.

**Statistical Methods**

Patient and tumor characteristics were compared across SMARCA4 mutation classes (Class 1, Class 2, wild type) using Chi-square tests and Kruskal-Wallis tests. Overall survival (OS) defined from the date of metastatic diagnosis to death and accounted for the left truncation time from metastatic diagnosis to IMPACT biopsy. Patients without events were censored at their last known visit date. Survival curves and estimates of the median survival time were generated using Kaplan-Meier methods and compared across the three mutation classes using log-rank tests. A Cox proportional hazards model was adjusted for age, sex, smoking status (never smoker, former light smoker, former heavy smoker and current smoker), histology (adenocarcinoma, squamous, other), as well as co-occurring STK11 and KEAP1 mutations, and TMB. Hazard ratios (HR) and 95% confidence intervals (CI) are reported. Sub-analyses of OS were performed among patients with KRAS mutations. Patients without follow-up after their IMPACT pathology date were excluded from analyses (n = 5).

The response to immunotherapy as characterized by progression-free survival (PFS), OS, and overall response rate (ORR) was examined among the subset of patients that received immunotherapy. PFS was defined as the time from start of PD-(L)1 inhibitor to clinical or radiographic progression, death, or the end of follow-up, and OS was defined as the time from the start of PD-(L)1 inhibitor to death or the end of follow-up. PFS and
OS were analyzed using Kaplan Meier methods and Cox proportional hazards model accounting for left truncation, again adjusted for age, sex, smoking status, histology, TMB, and co-occurring STK11 and KEAP1 mutations. Best overall response was defined as complete or partial response. Multivariable logistic regression was applied to compare the likelihood of ORRR across SMARCA4 mutation classes adjusted for age, TMB, PD-L1, STK11, and KEAP1.

To assess whether immunotherapy is associated with improved survival among patients with Class 1 or 2 SMARCA4 mutations, we first calculated the propensity score, probability of receipt of ICIs based on available variables (mutation class, age, sex, race, smoking status, histology, TMB, co-occurring STK11 and KEAP1 mutations). We then adjusted for the propensity score when comparing OS for patients that received ICIs versus patients that did not via a Cox proportional hazards model accounting for left truncation. A p-value <0.05 was considered statistically significant for all analyses. Statistical analyses were performed with GraphPad Prism software version 7 (La Jolla, CA, www.graphpad.com) and R version 3.6.1 software (www.r-project.org).(25)

Results

Spectrum of SMARCA4 genomic alterations

In patients with NSCLC tested by comprehensive next-generation sequencing (NGS), 8% (n = 407 of 4813) had a SMARCA4 alteration, with an array of SMARCA4 alterations identified (Fig. 1). SMARCA4 alterations were categorized into two groups based upon the type of genomic abnormality: 1) “Class 1 alterations” included truncating mutations deemed oncogenic, gene fusions, and homozygous deletions and 2) “Class 2
alterations” included all missense mutations and other variants of unknown significance based upon categorization in OncoKB (23). Tumors with concurrent Class 1 and Class 2 SMARCA4 alterations were categorized as Class 1 tumors. In total, 212 patients (4% of total, 52% of SMARCA4 variants) had tumors with Class 1 SMARCA4 alterations and 195 (4% of total, 48% of SMARCA4 variants) had tumors with Class 2 SMARCA4 alterations (Fig. 1).

Relationship between class of SMARCA4 genomic alteration and protein expression

We next explored the relationship between the genomic class of SMARCA4 alteration and protein expression. Sufficient tissue for SMARCA4 immunohistochemical analysis was available for 86 cases, including 62 tumors with Class 1 (truncating) alterations and 24 tumors with Class 2 (missense) alterations. SMARCA4 expression loss was identified in 50 cases, all of which were tumors with Class 1 alterations (81% of Class 1 alterations). Overall, loss of SMARCA4 expression was significantly associated with Class 1 alterations (P < 0.001; Fig. 1).

Molecular landscape associated with SMARCA4 alterations

To evaluate the genomic context of SMARCA4 alterations, we evaluated genomic profiles of tumors harboring SMARCA4 alterations (n=407) and those without SMARCA4 alterations (n=4406). Among commonly altered genes in lung cancer, the most frequent co-occurring mutations with SMARCA4 alterations were TP53 (56%), KEAP1 (41%), STK11 (39%) and KRAS (36%) (Fig. 2A and 2B).
We identified multiple genes that were associated with *SMARCA4* alterations (Fig. 2C).

Mutations in *STK11* and *KEAP1* had the strongest association with *SMARCA4* mutant tumors compared to *SMARCA4* wildtype tumors (*P* < 0.001, q < 0.001; *P* < 0.001, q < 0.001; Fig. 2B and 2C). Conversely *EGFR* alterations were strongly associated within *SMARCA4* wildtype tumors compared to *SMARCA4* mutants (*P* < 0.001, q < 0.001).

*SMARCA4* alterations occurred in the absence of *KRAS*, *STK11*, and *KEAP1* alterations in 38% of cases (Fig. 2D). *STK11* alterations occurred significantly more frequently with Class 1 than Class 2 alterations (*P* < 0.001, q = 0.08, Sup. Table 1).

*NKX2-1* and *KEAP1* alterations also occurred more frequently with Class 1 alterations (*P* = 0.002, q = 0.19; *P* = 0.01, q = 0.34 respectively) and *EGFR* alterations were common with Class 2 alterations (*P* = 0.004, q = 0.19, Sup. Table 1).

**Patient characteristics in advanced NSCLC by *SMARCA4* alteration class**

We then investigated how the findings from our molecular and expression analyses related to clinical outcomes in patients with advanced NSCLC. Patient characteristics among stage IV tumors with Class 1 (n=149) versus Class 2 (n=143) *SMARCA4* alterations were generally similar (Table 1). The presence of a Class 1 or 2 *SMARCA4* alteration was associated with history of smoking (*P* < 0.001) and non-adenocarcinoma histology (*P* < 0.001) compared to patients with *SMARCA4* wildtype NSCLC (n=996) (Table 1). Among patients harboring either class of *SMARCA4* mutation, 85% were smokers and 84% had adenocarcinoma; the rest had predominantly NSCLC, not otherwise classified.
Prognostic impact of Class 1 and Class 2 SMARCA4 alterations in advanced NSCLC

Overall, we found that patients with metastatic NSCLC harboring either Class 1 or Class 2 SMARCA4 alterations had shorter overall survival compared to patients with SMARCA4 wildtype NSCLC (p<0.001; Fig. 3A). Class 1 alterations were associated with the poorest outcomes (Fig. 3A). The differences in outcomes held in the multivariable survival analysis adjusted for age, sex, smoking status, histology, TMB, and the presence of STK11 and/or KEAP1 mutations (Fig. 3A).

Given the heterogeneity of co-occurring mutations, we sought to further isolate the specific impact of SMARCA4 alterations by examining within the context of a single driver oncogene. We focused initially on 374 patients with tumors harboring KRAS mutations. In these patients, the presence of Class 1 or Class 2 SMARCA4 alterations was a poor prognostic factor and remained prognostic when accounting for age, sex, smoking status, histology, TMB, and the presence of STK11 or KEAP1 mutations (Fig. 3B). Further, the addition of STK11 and/or KEAP1 was associated with decreased survival, with patients with all three STK11, KEAP1, and SMARCA4 having the shortest survival (P <0.001, Sup. Fig. 2).

Association with benefit of immunotherapy

Next, we analyzed the impact of ICIs on patient outcomes. Among patients with SMARCA4 alterations, ICI use was associated with significantly improved survival from the start of ICIs (HR 0.67, 95% CI 0.48, 0.92, P = 0.01) (Fig. 4A). When evaluating known factors that predict outcomes to ICI, SMARCA4-mutant tumors had higher TMB...
(P < 0.001, **Fig. 4B**) but were more likely to be PD-L1 low or negative (P = 0.03, **Fig. 4C**). Class 1 alterations had lower expression of PD-L1 and higher median TMB compared to Class 2 alterations (**Fig. 4B-C**).

Finally, we sought to compare outcome among the two *SMARCA4* mutant classes and *SMARCA4* wildtype NSCLC in patients who had received ICI. Overall response was assessed in 445 out of 570 patients that received ICI. In unadjusted analyses, patients who harbored Class 1 alterations had a higher ORR in comparison to Class 2 alterations or *SMARCA4* wild-type tumors (P = 0.027, **Fig. 4D**). There was no difference in progression-free survival (P = 0.74) or overall survival (P = 0.35) on ICIs by *SMARCA4* alteration status (**Fig. 4E-F**).

**Discussion**

Here, we identify two specific classes of *SMARCA4* alterations associated with distinct protein expression and differential negative clinical outcomes in patients with metastatic NSCLC. While both classes of *SMARCA4* alterations are associated with poor clinical outcomes, Class 1 alterations, which are associated with protein loss, are the strongest independent negative prognostic factor for patients, but respond best to ICIs. Despite the negative prognostic impact compared to patients with *SMARCA4* wildtype tumors, patients with *SMARCA4* alterations who received ICIs had better outcomes than those who did not.

This study builds upon recent data that co-occurring *STK11* and *KEAP1* mutations in lung cancer can significantly impact prognosis and responsiveness to therapy. *STK11* and *KEAP1* alterations are linked with poor prognosis and lack of response to
immunotherapy in KRAS-mutant tumors and more recently in all patients with NSCLC. We find that SMARCA4 alterations are associated with STK11 and KEAP1 mutations but are independent predictors of poor prognosis. SMARCA4 abnormalities in combination with STK11 and/or KEAP1 mutations have an additive impact on shortening survival. However, unlike STK11, SMARCA4 appears to be associated with increased sensitivity to immunotherapy. Future studies of STK11 and KEAP1 should incorporate exploration of SMARCA4 to further delineate the role of each co-occurring mutation in influencing patient outcomes and SMARCA4 should be identified and tested as a potential prognostic or predictive variable in prospective trials moving forward.

We observed that the spectrum of SMARCA4 alterations differentially impact protein expression. Our findings are consistent with other recent analyses that assessed the incidence of SMARCA4-mutant lung cancer and frequency of protein expression loss with truncating mutations, supporting our classification schema (8,10). Interestingly, while the effect of Class 1 (truncating) alterations was most profound, we also find that, unexpectedly, patients with Class 2 (mis-sense, non-truncating) SMARCA4 alterations had worse overall prognosis relative to patients with SMARCA4 wild-type tumors, suggesting that function may be compromised in the setting of intact expression. Recent preclinical work provides additional mechanistic support and reveals that missense mutations of SMARCA4 modify the open chromatin landscape and induce pro-oncogenic expression changes in MYC and its target genes, among others (26,27).

Our study is the first to evaluate how SMARCA4 alterations in NSCLC influence sensitivity to ICIs. Recent analyses have shown that SMARCA4 and PBRM1 could be associated with improved response to immunotherapy in subtypes of ovarian cancer
and renal cell cancer (4,19) and case reports have described durable responses to ICIs in a patient with a thoracic SMARCA4-deficient undifferentiated tumor (also referred to as a SMARCA4-deficient thoracic sarcoma) and a patient with NSCLC (20,21). Despite high rates of PD-L1 negativity, patients with SMARCA4-mutant NSCLC appear to derive significant benefit from PD-(L)1 blockade. Therefore, SMARCA4 mutation status should be explored as a potentially novel biomarker of responsiveness to ICIs as a complement to PD-L1 expression and TMB in NSCLC.

While there are no known currently effective targeted treatments for SMARCA4-mutant NSCLCs, our study and others suggest SMARCA4 is a potential target in lung cancer with distinct therapeutic vulnerabilities. For example, CDK4/6, AURKA, ATR, and EZH2 inhibition have recently shown antitumor activity in preclinical models of SMARCA4 deficient tumors (1,16,25,28-33). SMARCA2 could be a synthetic lethal vulnerability in SMARCA4-mutant cancers. Prior reports have shown that SMARCA2 retains expression in SMARCA4-mutant NSCLC and several SMARCA2 inhibitors are currently in development to target this potential vulnerability (10,16). Future trials should explore use of these agents alone or in combination with ICIs given the efficacy of anti-PD-(L)1 antibodies in our analysis.

This study is a single-institution retrospective analysis and therefore has some inherent limitations. Unidentified factors associated with exposure and response to immunotherapy and overall survival could bias our results. Nevertheless, we accounted for all known potential variables that may influence outcomes. For example, we developed and incorporated a risk score to account for a patient’s likelihood of receiving anti-PD(L)1 therapy and used a Cox proportional hazards model for multivariate
analysis using the variables available. Analyses adjusting for PD-L1 expression are
limited by the modest number of patients with sufficient available tissue for retrospective
staining for PD-L1 and SMARCA4. Future studies that incorporate zygosity are also
needed to understand its impact on expression and clinical outcomes.

In sum, our report highlights that SMARCA4 alterations in lung cancer are uniquely
linked to response to immunotherapy and patient outcomes. We found that the
presence of SMARCA4 abnormalities is enriched in patients with KRAS, STK11, and
KEAP1 mutations, but independently contributes to shortened overall survival with these
co-occurring alterations. Despite these poor outcomes, patients with SMARCA4-mutant
lung cancers may also be more sensitive to immunotherapy, which may enable new
therapeutic options in the future.

References

and bioinformatic analysis of mammalian SWI/SNF complexes identifies
10.1038/ng.2628.
Mammalian SWI/SNF complex genomic alterations and immune checkpoint
myofibroblastic tumors harbor multiple potentially actionable kinase fusions.


of clinical oncology: official journal of the American Society of Clinical Oncology


Figure 1. Spectrum of SMARCA4 alterations by class and association with SMARCA4 protein expression. (A) The distribution of Class 1 SMARCA4 alterations (n=212) and protein expression (n=62). (B) The distribution of Class 2 SMARCA4 alterations (n=95) and protein expression (n=24). Green QLQ, Gln, Leu, Gln motif; Red HSA, helicase/SANT-associated domain; Blue BRK, Brahma and Kismet domain; Yellow DEXDc, DEAD-like helicase superfamily domain; Purple SNF2_N, SNF2 family N-terminal domain; Orange HELICc, helicase superfamily C-terminal domain; Pink Bromo, bromodomain.

Figure 2. Genomic context of SMARCA4 alterations. (A) Most frequent co-occurring alterations by SMARCA4 alteration. (B) Distribution of SMARCA4 alteration by commonly altered gene subgroups in NSCLC. (C) Frequency of altered individual genes within SMARCA4 mutant vs SMARCA4 wildtype subgroups. Genes labeled red were associated with significantly differential PD-L1 expression (q value <0.10). (D) Distribution of SMARCA4, STK11, KRAS, and KEAP1 alterations within NSCLC cohort.

Figure 3. Survival by SMARCA4 alteration class. (A) Overall survival among all patients, with multivariate model (right). (B) Overall survival among patients with KRAS mutations, with multivariate model (right).

Figure 4. PD-L1 expression, tumor mutational burden, and immune checkpoint inhibitor (ICI) outcomes. (A) Overall survival among patients with SMARCA4 alterations who did and did not receive ICIs. (B) Tumor mutational burden (TMB) by SMARCA4 alteration...
class. (C) PD-L1 expression frequency by SMARCA4 alteration class. (D) Overall response rate by SMARCA4 alteration class. (E) Progression-free survival by SMARCA4 alteration class. (F) Overall survival by SMARCA4 alteration class.
**Table 1:** Clinical characteristics of patients with advanced NSCLC by *SMARCA4* alteration class.

<table>
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<tr>
<th>Characteristic</th>
<th>SMARCA4 Class 1 (N = 149)</th>
<th>SMARCA4 Class 2 (N = 143)</th>
<th>SMARCA4 Wild type (N = 996)</th>
<th>P-value</th>
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<td>Median Age (Q1, Q3)</td>
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<td>65 (58, 73)</td>
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<td>74 (50%)</td>
<td>78 (55%)</td>
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<td>7 (5%)</td>
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<td>26 (18%)</td>
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<td>Former light (&lt;15 py)</td>
<td>20 (13%)</td>
<td>19 (13%)</td>
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<td>71 (50%)</td>
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<td>131 (13%)</td>
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<td>914 (92%)</td>
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<td>28 (19%)</td>
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<td>82 (8%)</td>
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</table>

py: pack years
Figure 1

A. Class 1 SMARCA4 alterations

B. Class 2 SMARCA4 alterations
Figure 2

A. Genetic Alteration

- Inframe mutation
- Missense mutation
- Truncating mutation
- Fusions
- Amplification
- Deep deletion
- No alterations

B. Frequency in SMARCA4 mutant tumors

C. q value < 0.10

D. Venn Diagram of gene alterations

Author manuscripts have been peer reviewed and accepted for publication but have not yet been edited.

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Figure 3

A. Overall survival probability by Mutation Status:

- Wild type (n = 996)
- Class 1 alteration (n = 149)
- Class 2 alteration (n = 143)

B. Overall survival probability by Mutation Status:

- Wild type (n = 264)
- Class 1 alteration (n = 58)
- Class 2 alteration (n = 52)

**Table 1: Hazard Ratios for Survival**

<table>
<thead>
<tr>
<th></th>
<th>Hazard Ratio</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SMARCA4 mutation type</strong></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Wild type</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Class 2</td>
<td>2.01</td>
<td>1.58, 2.55</td>
<td></td>
</tr>
<tr>
<td>Class 1</td>
<td>1.59</td>
<td>1.25, 2.04</td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td>0.2</td>
</tr>
<tr>
<td>Female</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.12</td>
<td>0.95, 1.31</td>
<td></td>
</tr>
<tr>
<td><strong>Age (10 years)</strong></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>1.22</td>
<td>1.13, 1.32</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Smoking status</strong></td>
<td></td>
<td></td>
<td>0.005</td>
</tr>
<tr>
<td>Never smoker</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Former light (&lt;15 pack-year)</td>
<td>1.58</td>
<td>1.23, 2.03</td>
<td></td>
</tr>
<tr>
<td>Former heavy (&gt;15 pack year)</td>
<td>1.21</td>
<td>0.96, 1.51</td>
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</tr>
<tr>
<td>Current smoker</td>
<td>1.27</td>
<td>0.96, 1.69</td>
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</tr>
<tr>
<td><strong>Histology</strong></td>
<td></td>
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<td>&lt;0.001</td>
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<tr>
<td>Adenocarcinoma</td>
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<td>--</td>
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</tr>
<tr>
<td>Non-adenocarcinoma</td>
<td>1.79</td>
<td>1.38, 2.33</td>
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<tr>
<td><strong>Tumor mutation burden (TMB)</strong></td>
<td>0.98</td>
<td>0.97, 0.99</td>
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</tr>
<tr>
<td><strong>STK11</strong></td>
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<tr>
<td>Negative</td>
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<td>--</td>
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</tr>
<tr>
<td>Positive</td>
<td>1.52</td>
<td>1.23, 1.88</td>
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<tr>
<td><strong>KEAP1</strong></td>
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<td>0.036</td>
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<tr>
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<tr>
<td>Positive</td>
<td>1.26</td>
<td>1.02, 1.55</td>
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</table>

**Table 2: Hazard Ratios for Survival**

<table>
<thead>
<tr>
<th></th>
<th>Hazard Ratio</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SMARCA4 mutation type</strong></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Wild type</td>
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<td>--</td>
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</tr>
<tr>
<td>Class 2</td>
<td>2.75</td>
<td>1.84, 4.11</td>
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<tr>
<td>Class 1</td>
<td>1.59</td>
<td>1.04, 2.41</td>
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</tr>
<tr>
<td><strong>Sex</strong></td>
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<td>0.6</td>
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<tr>
<td>Female</td>
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</tr>
<tr>
<td>Male</td>
<td>0.93</td>
<td>0.70, 1.25</td>
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<tr>
<td><strong>Age (10 years)</strong></td>
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<td>&lt;0.001</td>
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<tr>
<td>1.33</td>
<td>1.13, 1.55</td>
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</tr>
<tr>
<td><strong>Smoking status</strong></td>
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<tr>
<td>Never smoker</td>
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<tr>
<td>Former light (&lt;15 pack-year)</td>
<td>1.03</td>
<td>0.49, 2.16</td>
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<td>Former heavy (&gt;15 pack year)</td>
<td>1.12</td>
<td>0.59, 2.14</td>
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<tr>
<td>Current smoker</td>
<td>0.88</td>
<td>0.43, 1.78</td>
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<tr>
<td><strong>Histology</strong></td>
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<td>0.13</td>
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<tr>
<td>Adenocarcinoma</td>
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<tr>
<td>Non-adenocarcinoma</td>
<td>1.61</td>
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<td><strong>Tumor mutation burden (TMB)</strong></td>
<td>0.97</td>
<td>0.95, 1.00</td>
<td>0.023</td>
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<td><strong>STK11</strong></td>
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<tr>
<td>Positive</td>
<td>1.51</td>
<td>1.08, 2.11</td>
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<tr>
<td>Negative</td>
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<tr>
<td>Positive</td>
<td>1.34</td>
<td>0.95, 1.89</td>
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</tr>
</tbody>
</table>
Figure 4

A. SMARCA4 altered: Did not receive ICI (n = 205) received ICI (n = 87)

B. Overall survival probability

0.00 0.25 0.50 0.75 1.00
0 6 12 18 24 30 36 42 48 54 60

SMARCA4 WT Class 1 Class 2
(n=996) (n=149) (n=143)

C. TMB/Mb

0 20 40 60 80 100
0% 1-49% 50-100%

SMARCA4 WT Class 1 Class 2
(n=294) (n=39) (n=54)

D. Class 1 Class 2

0 25 50 75 100

SMARCA4 WT
(n=358) (n=50) (n=37)

E. Progression-free survival probability

0.00 0.25 0.50 0.75 1.00
0 6 12 18 24 30 36

SMARCA4 WT Class 1 Class 2
(n=325) (n=41) (n=33)

F. Overall survival probability

0.00 0.25 0.50 0.75 1.00
0 6 12 18 24 30 36

SMARCA4 WT Class 1 Class 2
(n=482) (n=50) (n=37)
Clinical Cancer Research

The Genomic Landscape of *SMARCA4* Alterations and Associations with Outcomes in Patients with Lung Cancer

Adam J Schoenfeld, Chaitanya Bandlamudi, Jessica A Lavery, et al.

*Clin Cancer Res* Published OnlineFirst July 24, 2020.

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