

Idiotypic vaccination: why we have failed ~~20~~ years ago

25

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Immunotherapy in Hematological Malignancies 2018
Cuneo, May 17-19, 2018***



AO S.Croce e Carle
Cuneo



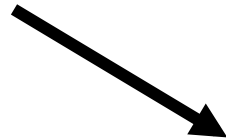
serum IgG



ionic exchange chromatography



affinity chromatography



serum IgA



ammonium sulphate precipitation



gel filtration



dialysis against 0.9% NS



Idiotype



vol/vol conjugation

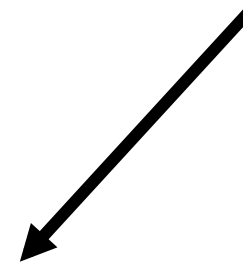
endotoxin removal X 2



Id/KLH



Bence Jones



KLH
(clinical grade)



sterile vialing
(-20 ° C)

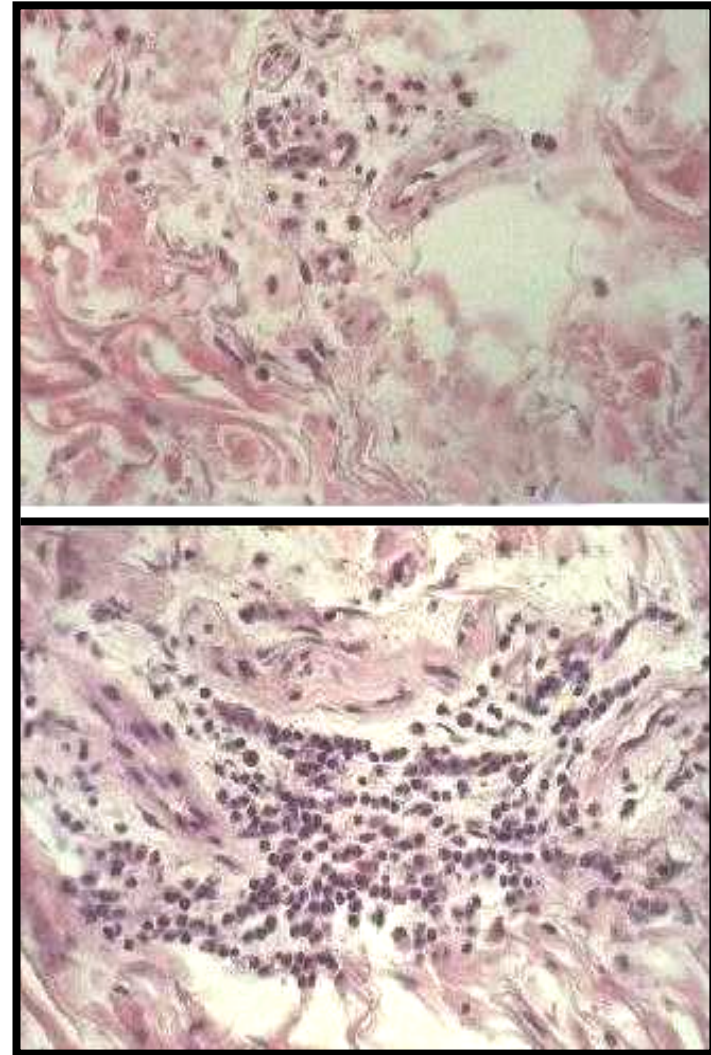
Protocol 9401

week	0	2	6	10	14	24	28
<i>Id/KLH</i> <i>(0.5 mg + 0.5 mg)</i>							
<i>IL-2</i> <i>(1.2 x 10⁶ IU/ m²)</i>							
<i>GM-CSF</i> <i>(150 µg/m²)</i>							

DTH responses in MM receiving Id/KLH conjugates

IL-2
(1.2×10^6 IU/sqm for 5 days)

GM-CSF
(150 μ g/sqm for 5 days)

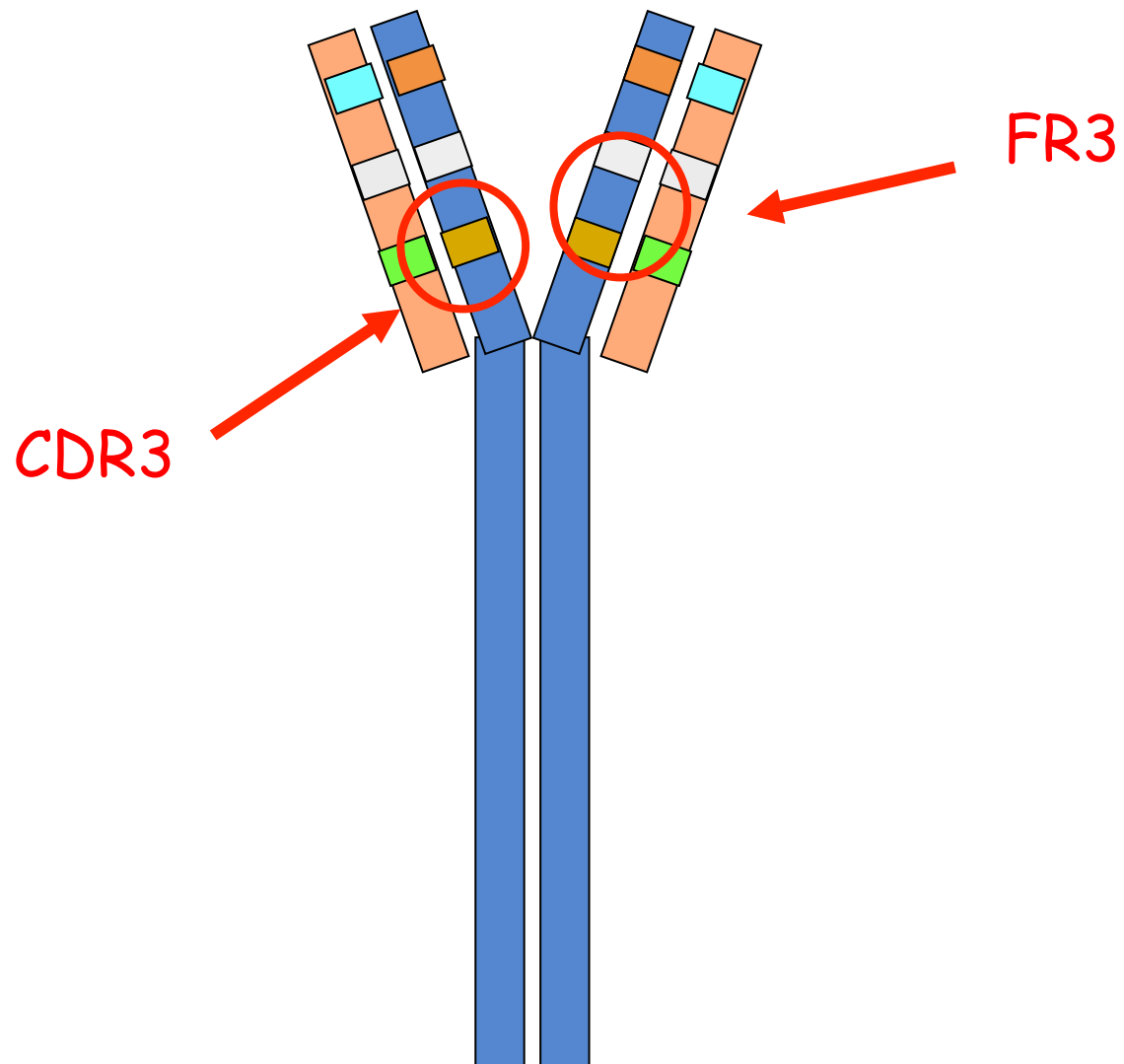


Protocol 9402

<i>week</i>	<i>0</i>	<i>2</i>	<i>6</i>	<i>10</i>	<i>14</i>	<i>24</i>	<i>28</i>
<i>Id/KLH</i> <i>(0.5 mg + 0.5 mg)</i>							
<i>GM-CSF</i> <i>(150 µg/sqm)</i>							

- 15 MM in first remission after HDS and PBPC infusion;

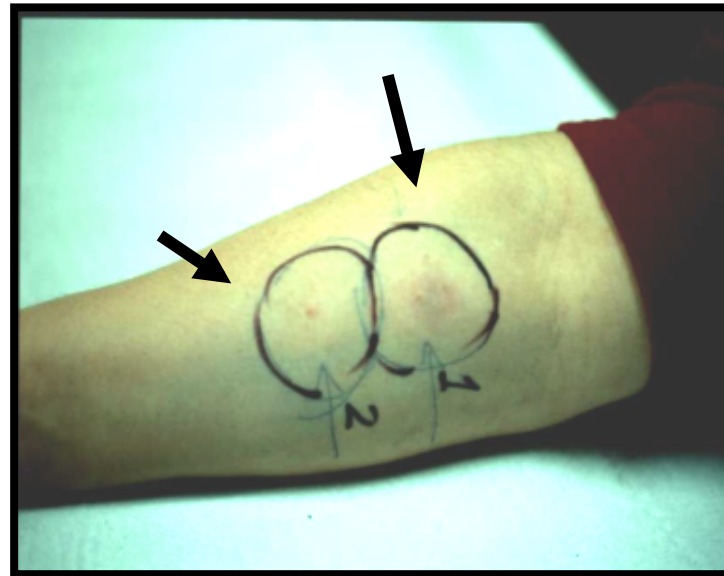
tumor-derived immunoglobulin



DTH responses in MM receiving Id/KLH conjugates

CDR3-derived peptide (1)

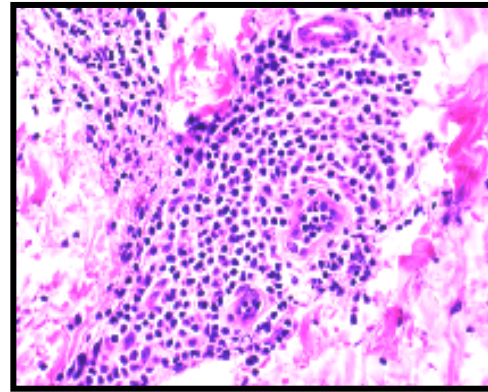
FR3-derived peptide (2)



Late DTH responses

post-vax

lymph.



CD4

CD8

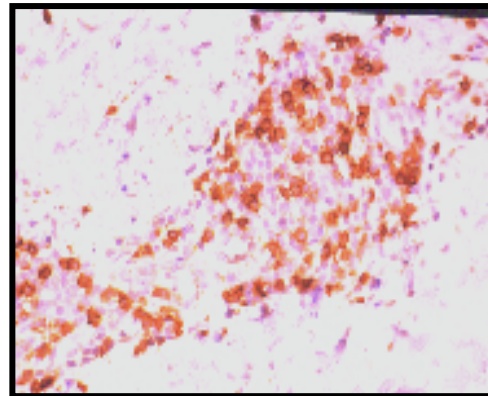
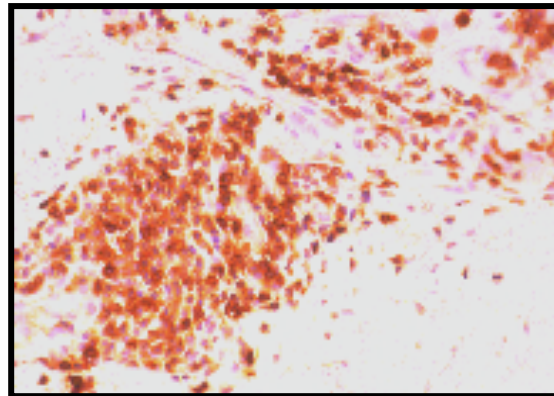
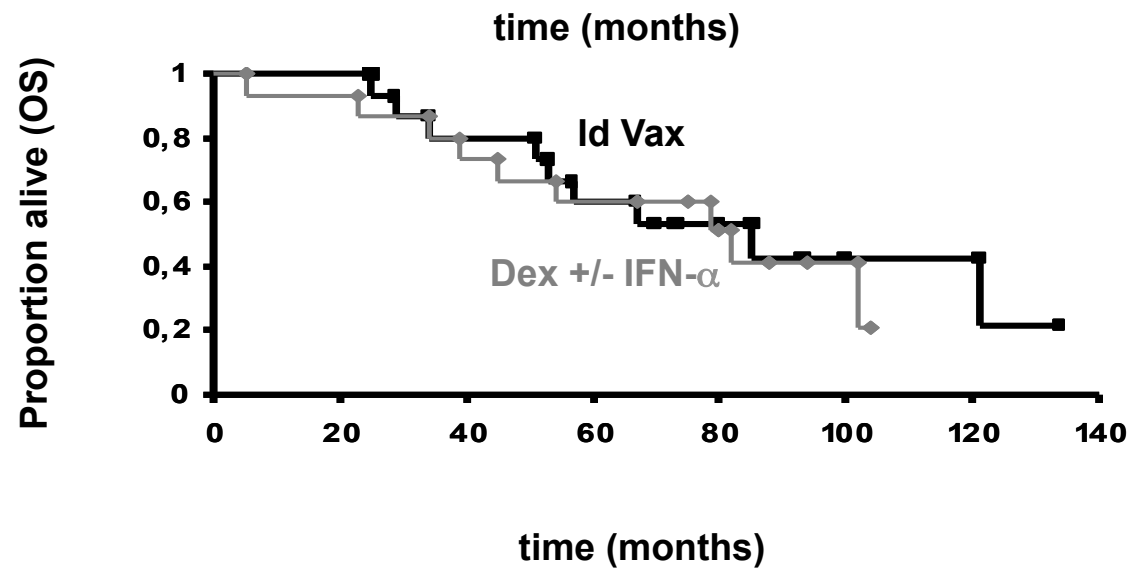
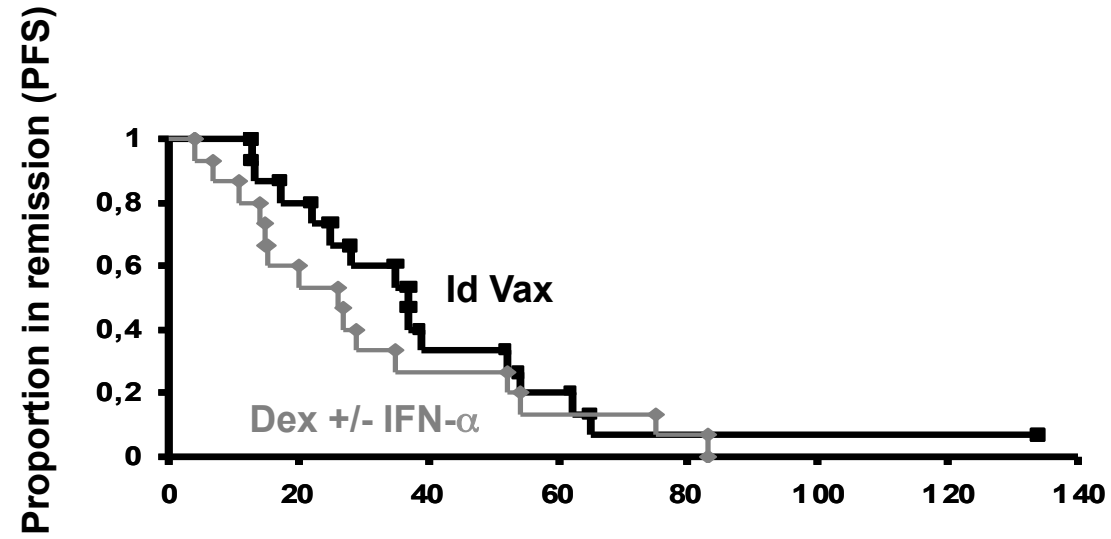


Table 2. Antibody responses to vaccine components

ant-KLH			anti-Id ^a			anti-Id ^b			Anti-GM-CSF		
IgM	IgG	IgE	IgM	IgG	IgE	IgM	IgG	IgE	IgM	IgG	IgE
9/10 ^c	9/10	5/15	0/15	3/15	5/15	0/15	3/15	4/15	nd ^d	3/15	nd

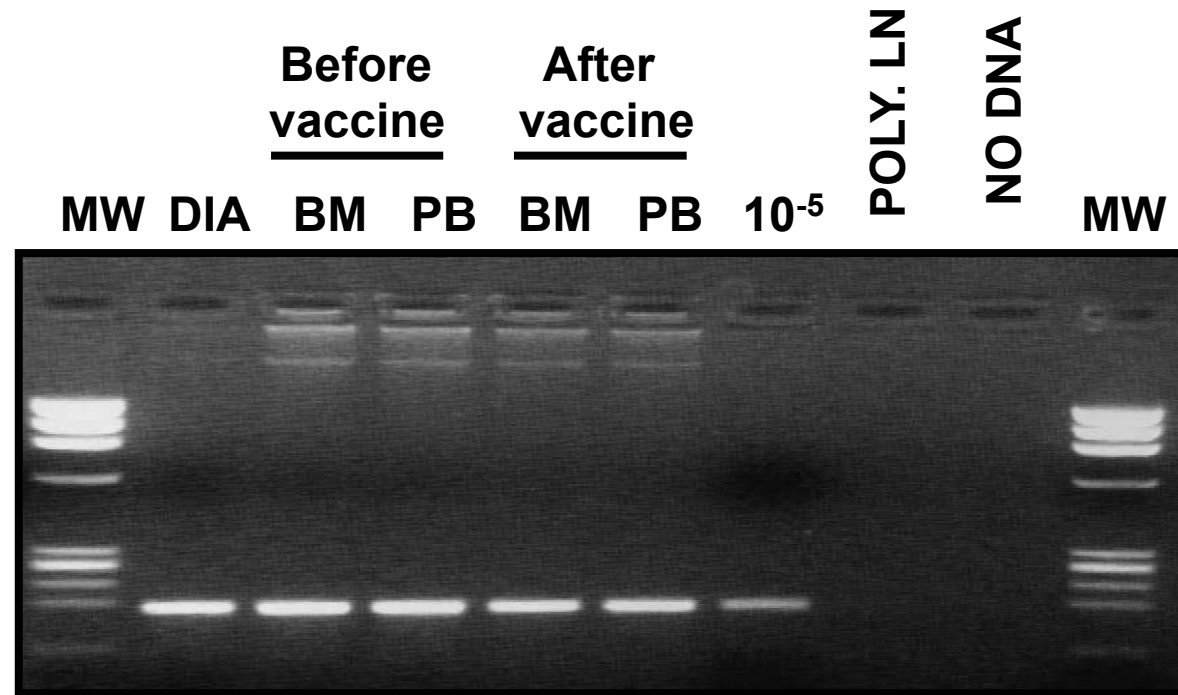
^a autologous Id
^b isotype-related allogeneic Id
^c positive/tested patients
^d not done



minimal residual disease detection

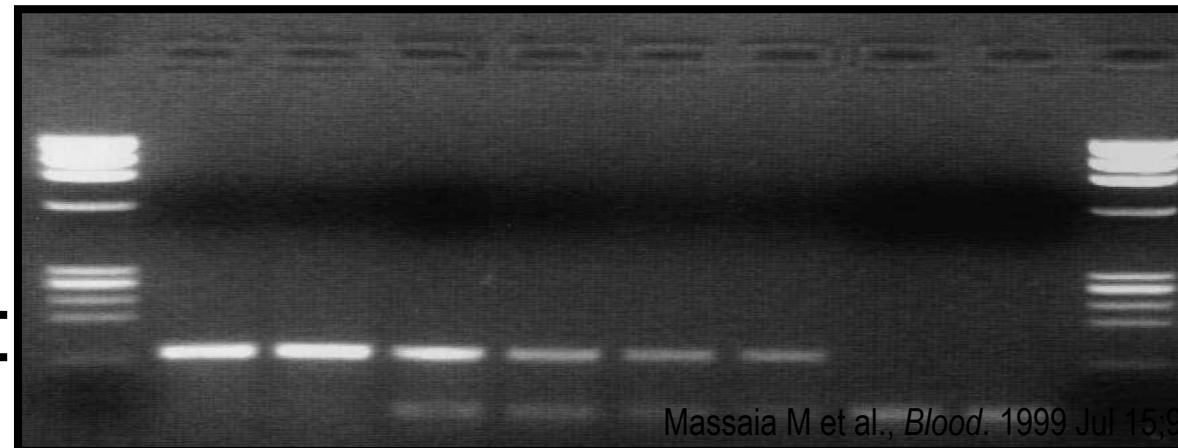
plasma cells

194
118



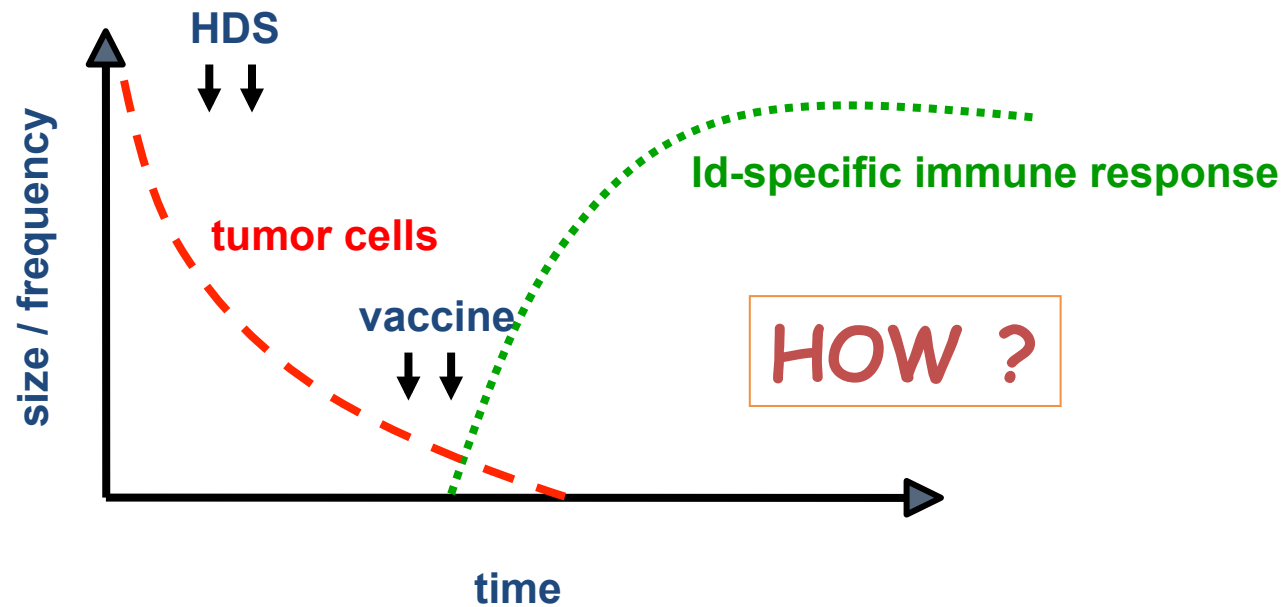
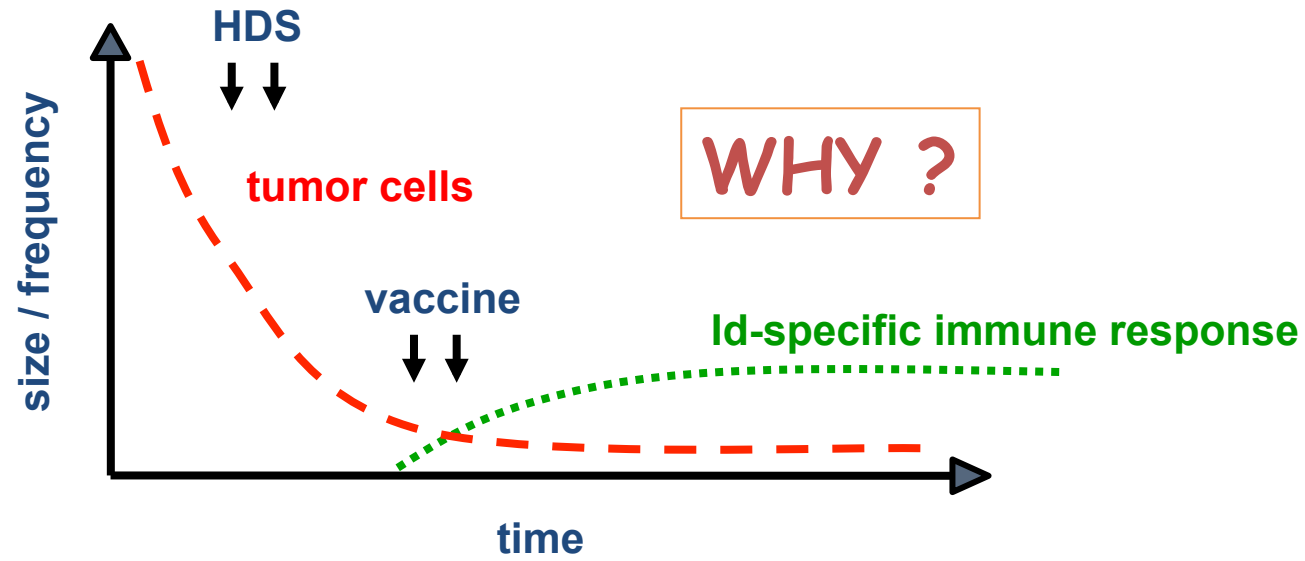
B cells

194
118



Massaia M et al., *Blood*. 1999 Jul 15;94(2):673-83.

Coscia M et al., *Leukemia*. 2004 Jan;18(1):139-45.



Bullet points:

- Better TAAs than Id?
- Early & persistent immune suppressive TME commitment
- Redundancy of ICP/ICP-L pairs in TME
- Is hot or cold the TME in MM (rem vs dia etc)?

Idiotyp

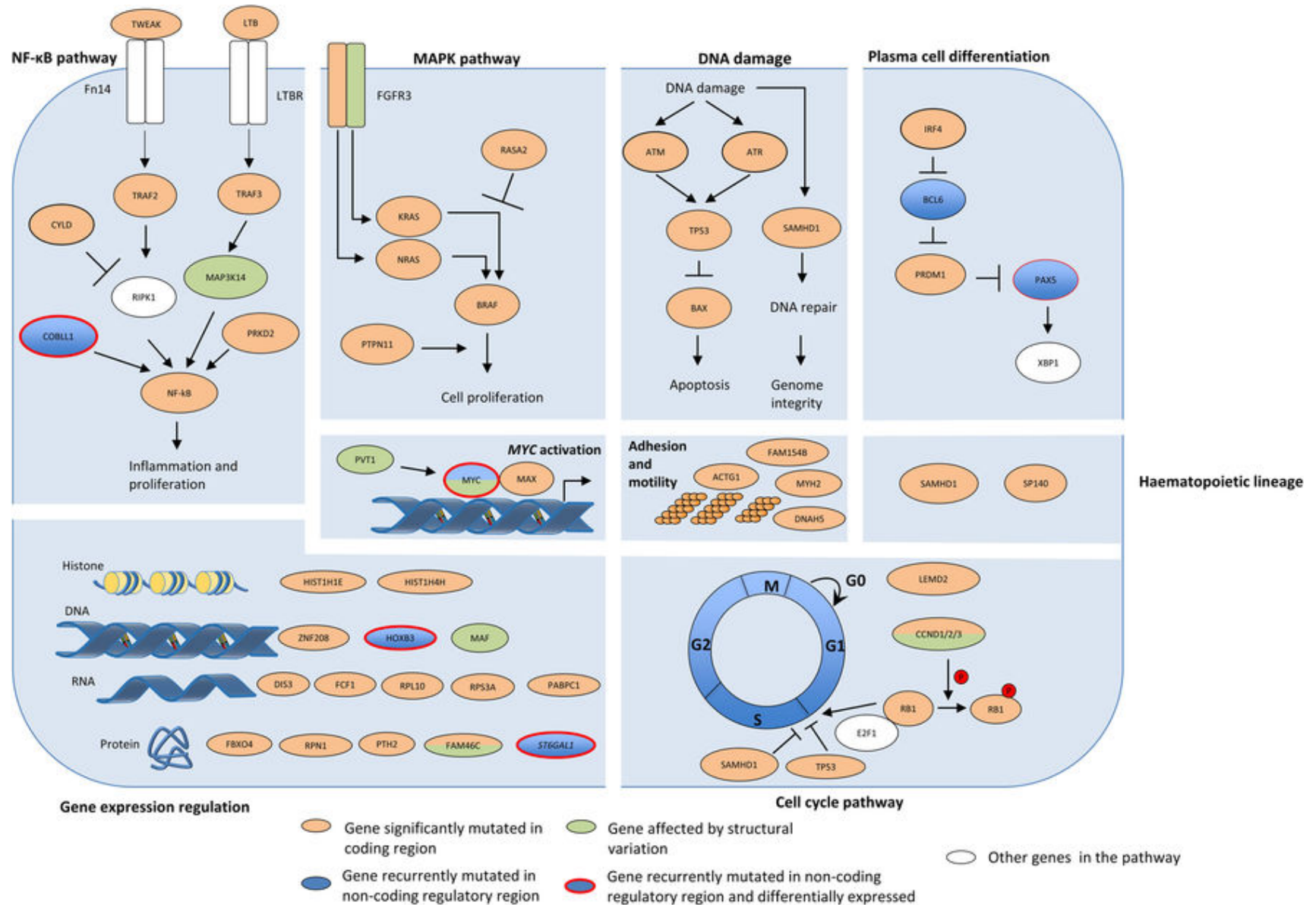
Pros:

- highly tumor specific

Cons:

- surface expression?
- myeloma cell progenitors?
- self-antigen
- pathogenic role?

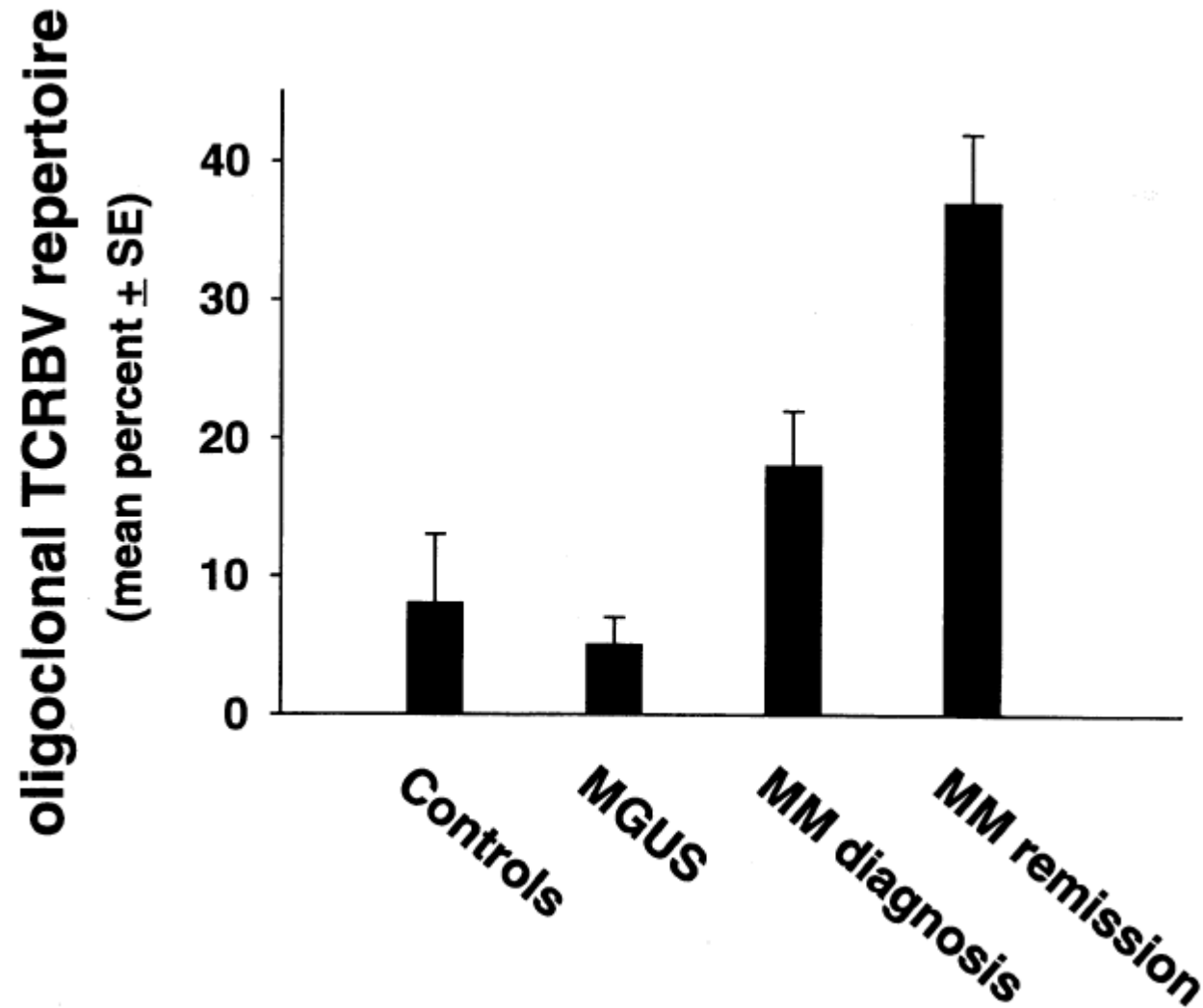
Oncogenic pathways disrupted by coding and non-coding mutations in MM



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Severe and long-lasting disruption of TCR diversity after ASCT in MM

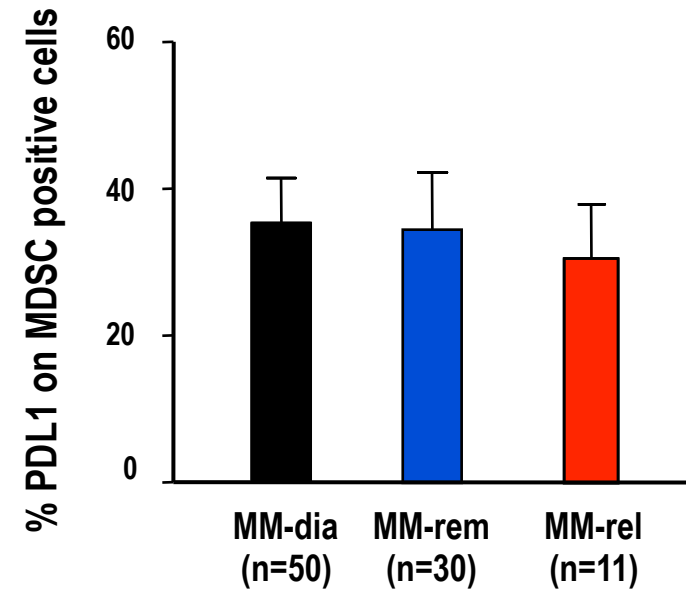
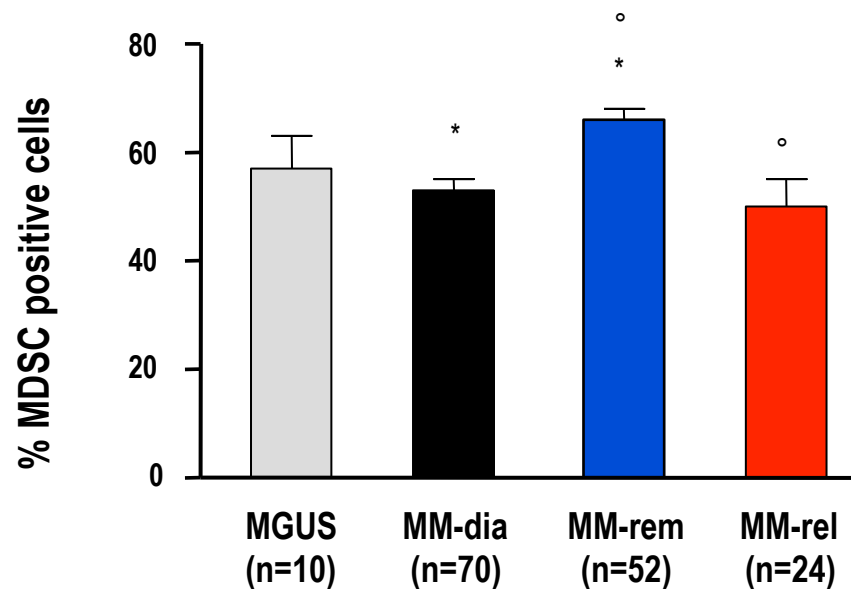
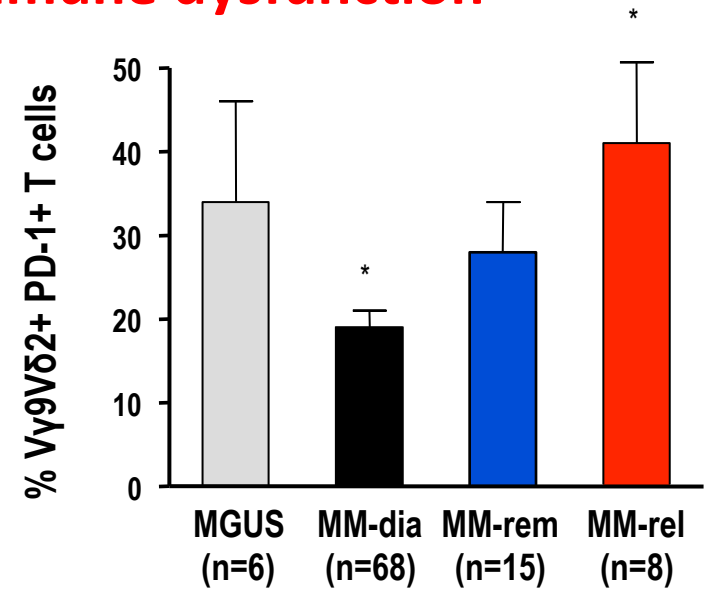
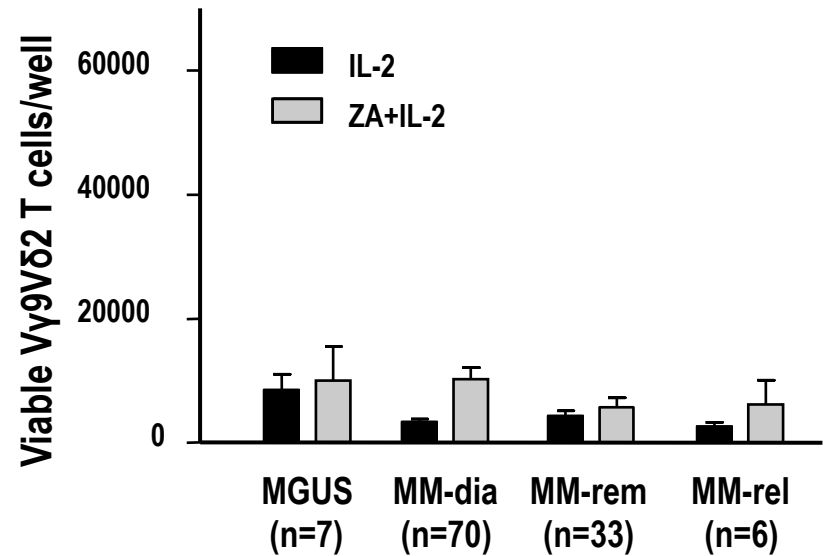


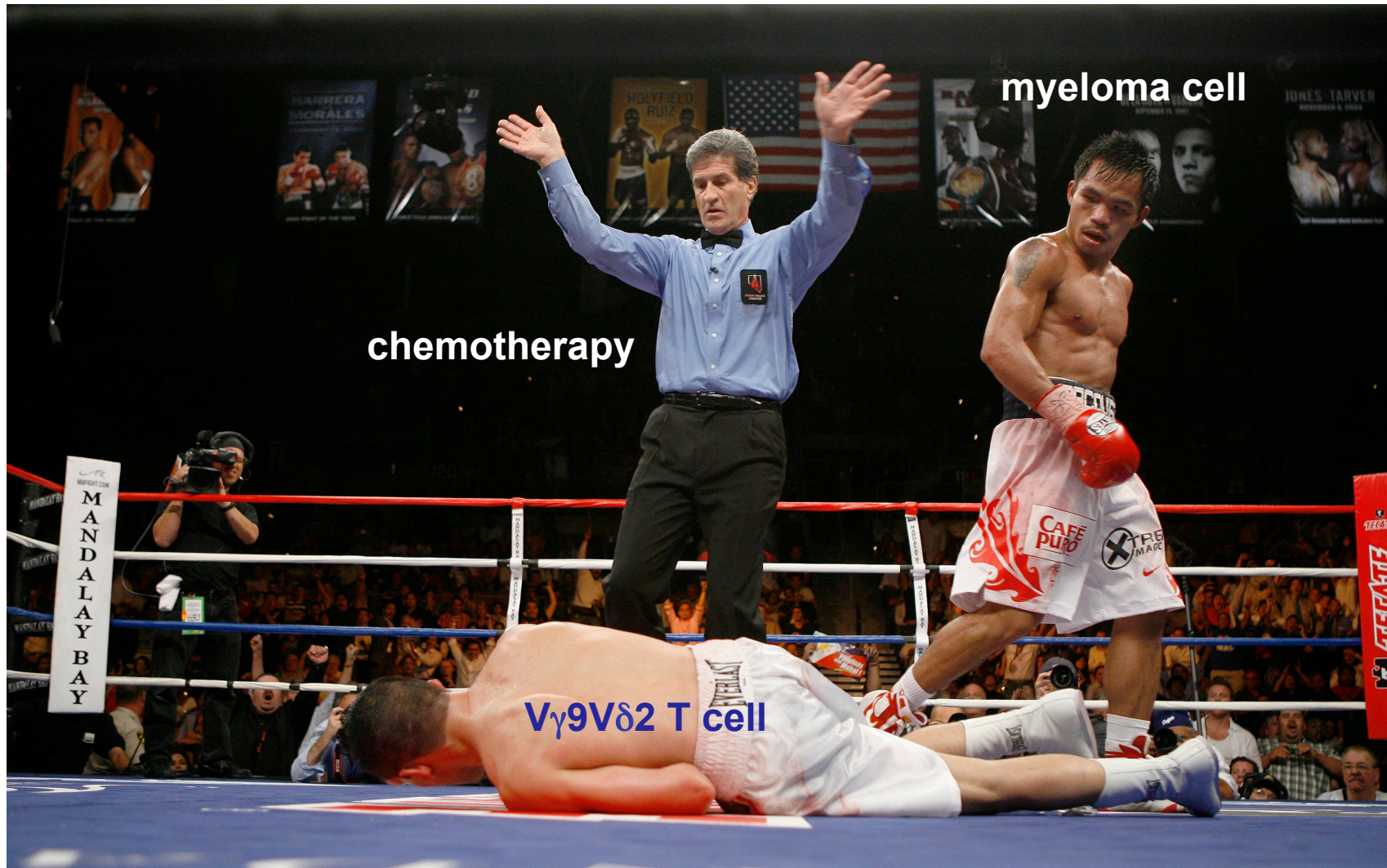
V γ 9V δ 2 T cells: early sensors of immune pollution in TME



**What we find depends on the tools we use
(i.e. microscope vs PCR/flow to detect MRD)**

Defective ZA-reactivity of BM $V\gamma 9V\delta 2$ T-cell is an early and long-lasting immune dysfunction





myeloma cell

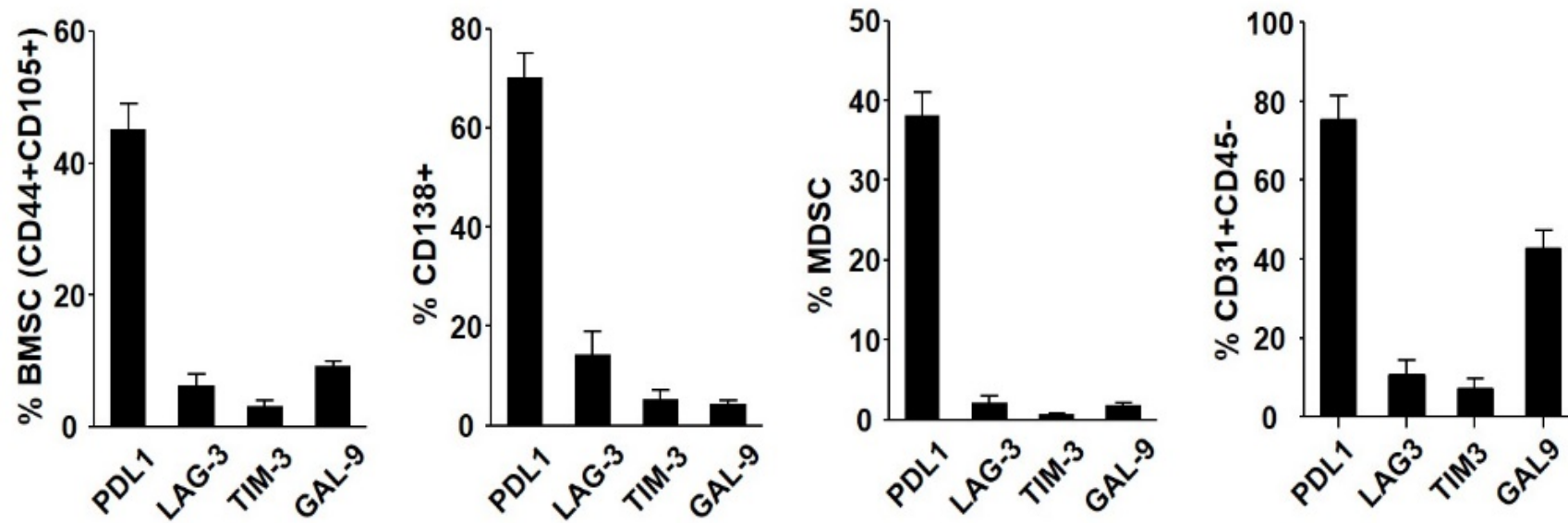
chemotherapy

$V_{\gamma 9V\delta 2}$ T cell

Bullet points:

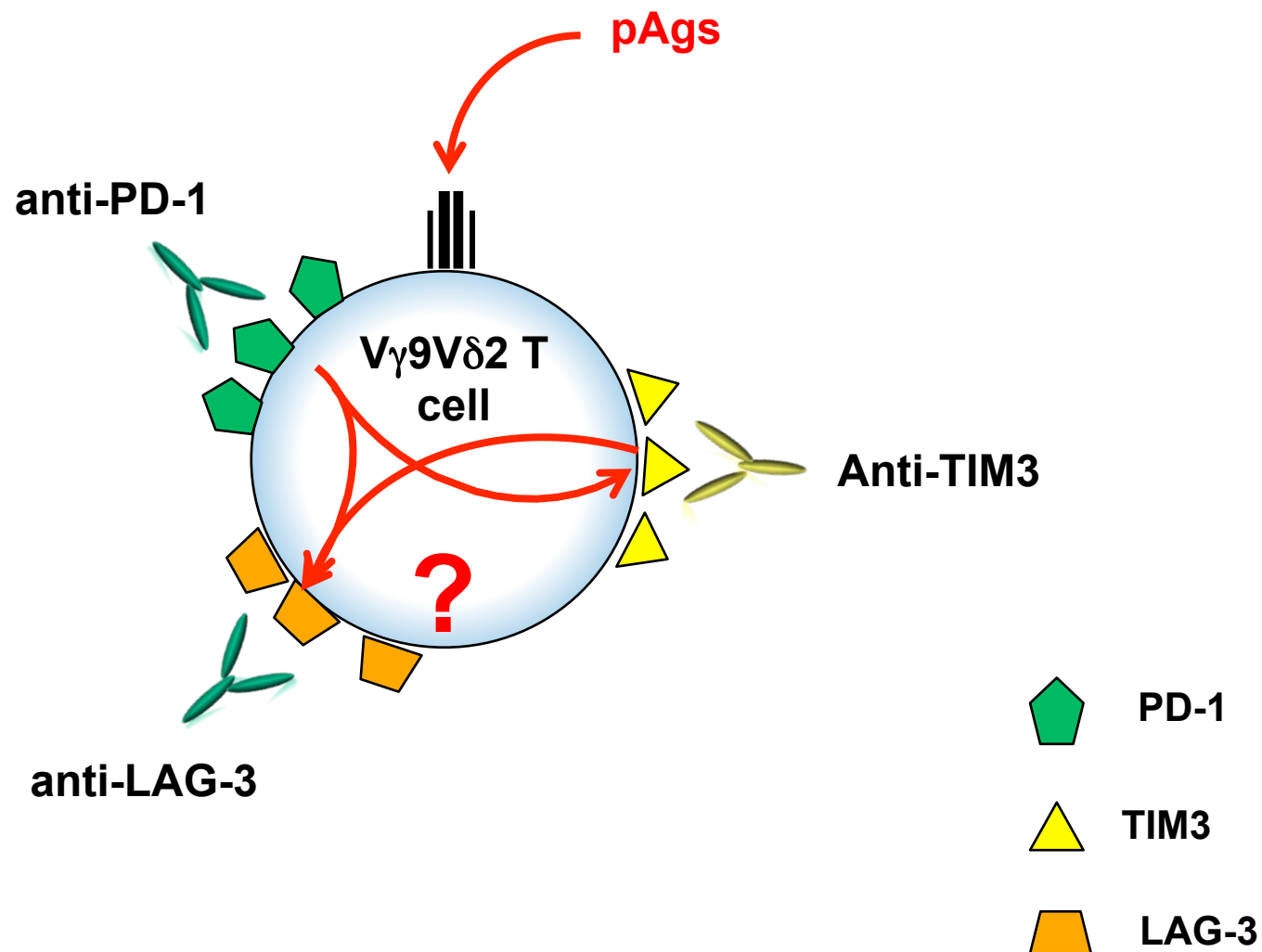
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Immune suppressor engagers in the TME of MM patients

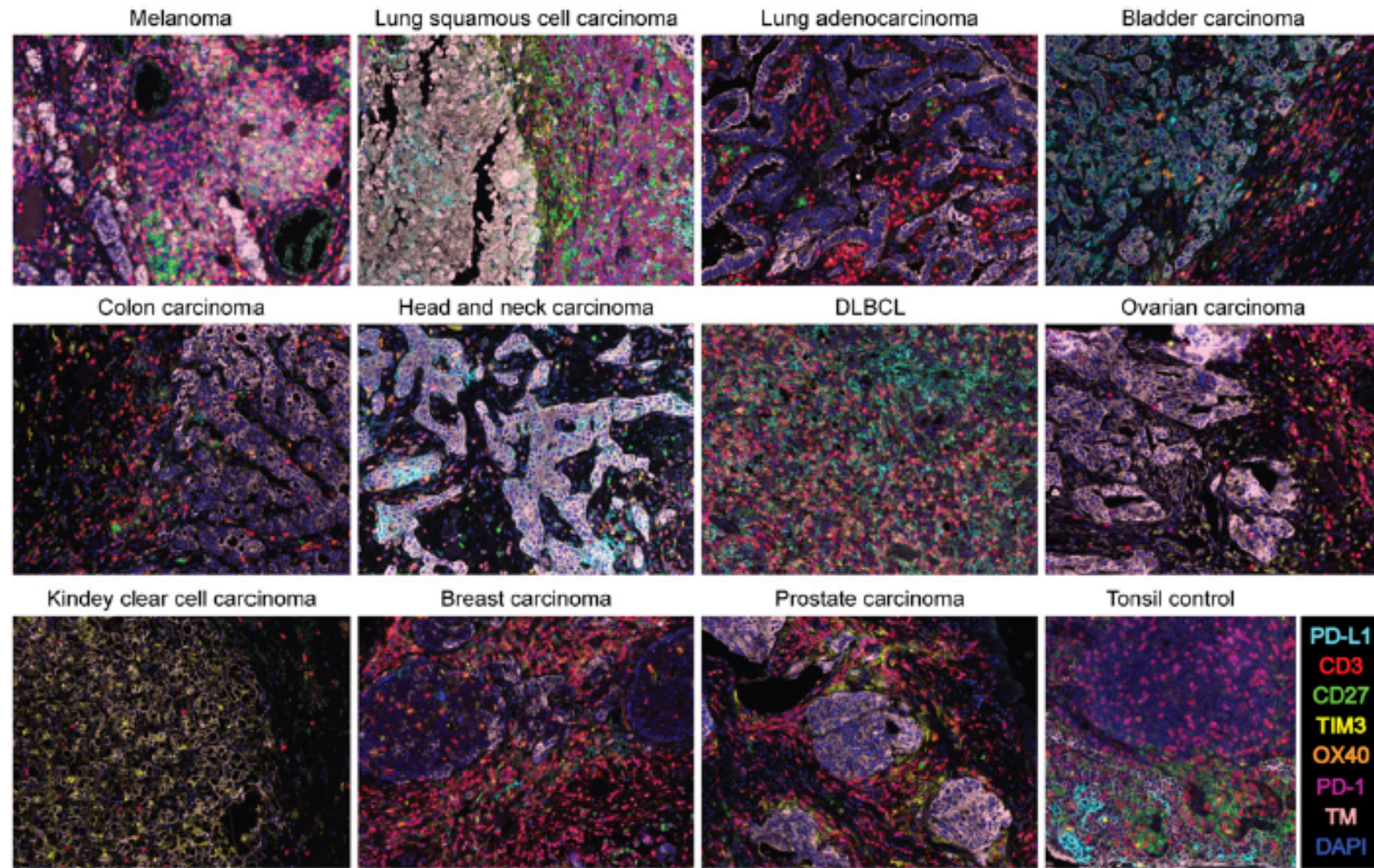


unpublished

$V_{\gamma}9V_{\delta}2$ T cells as tools to dissect mechanisms of adaptive resistance to ICP inhibition



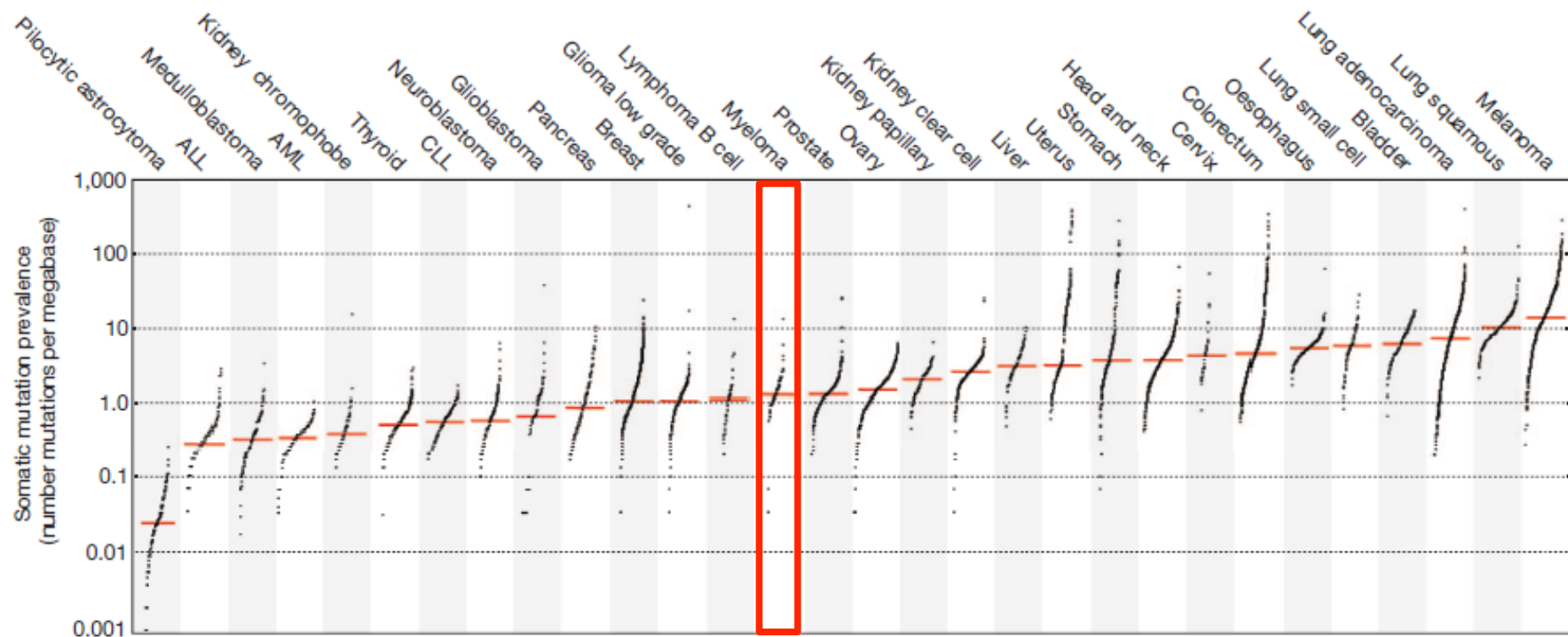
Eight-color multiplex IHC in different tumor types.



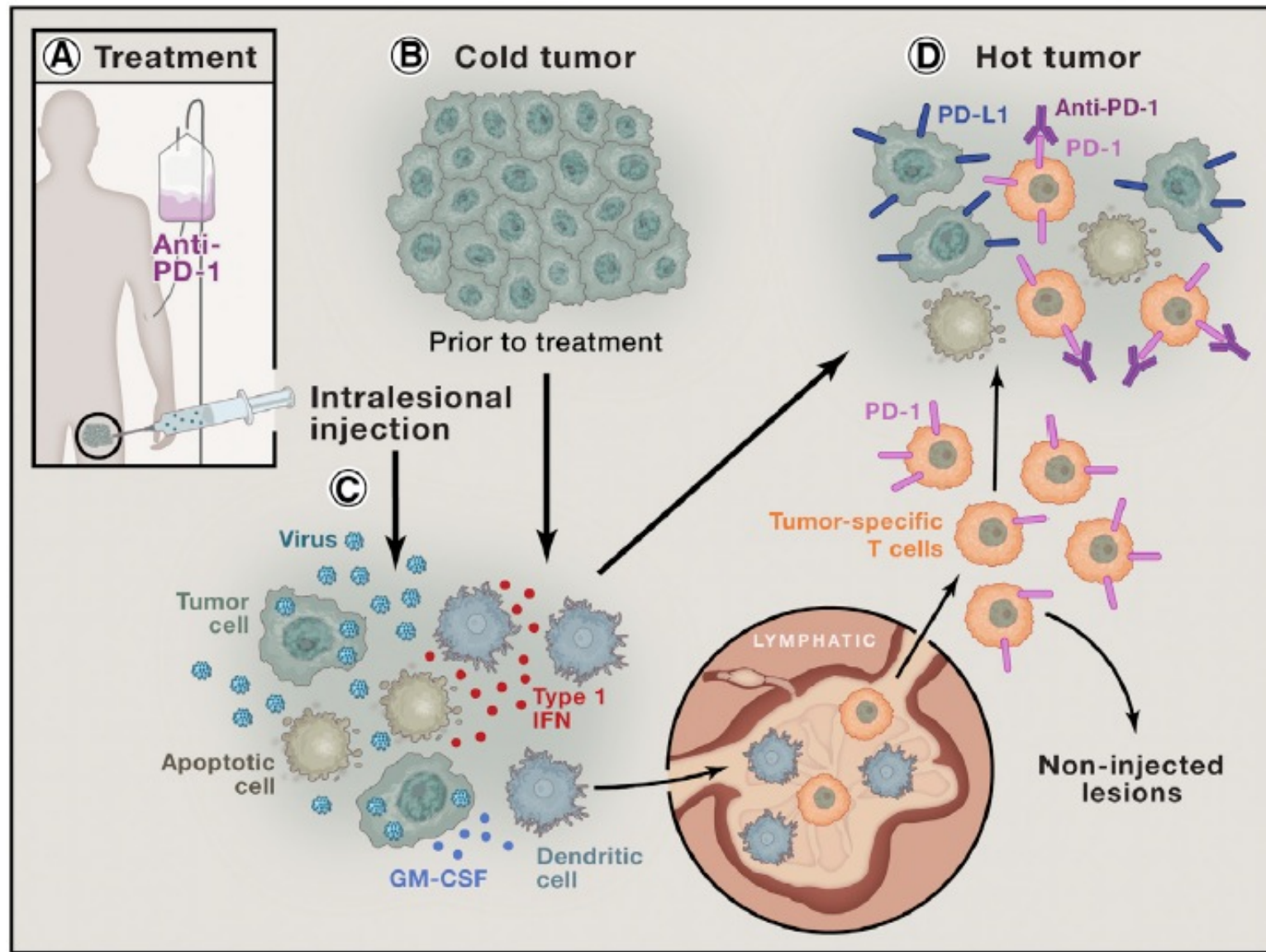
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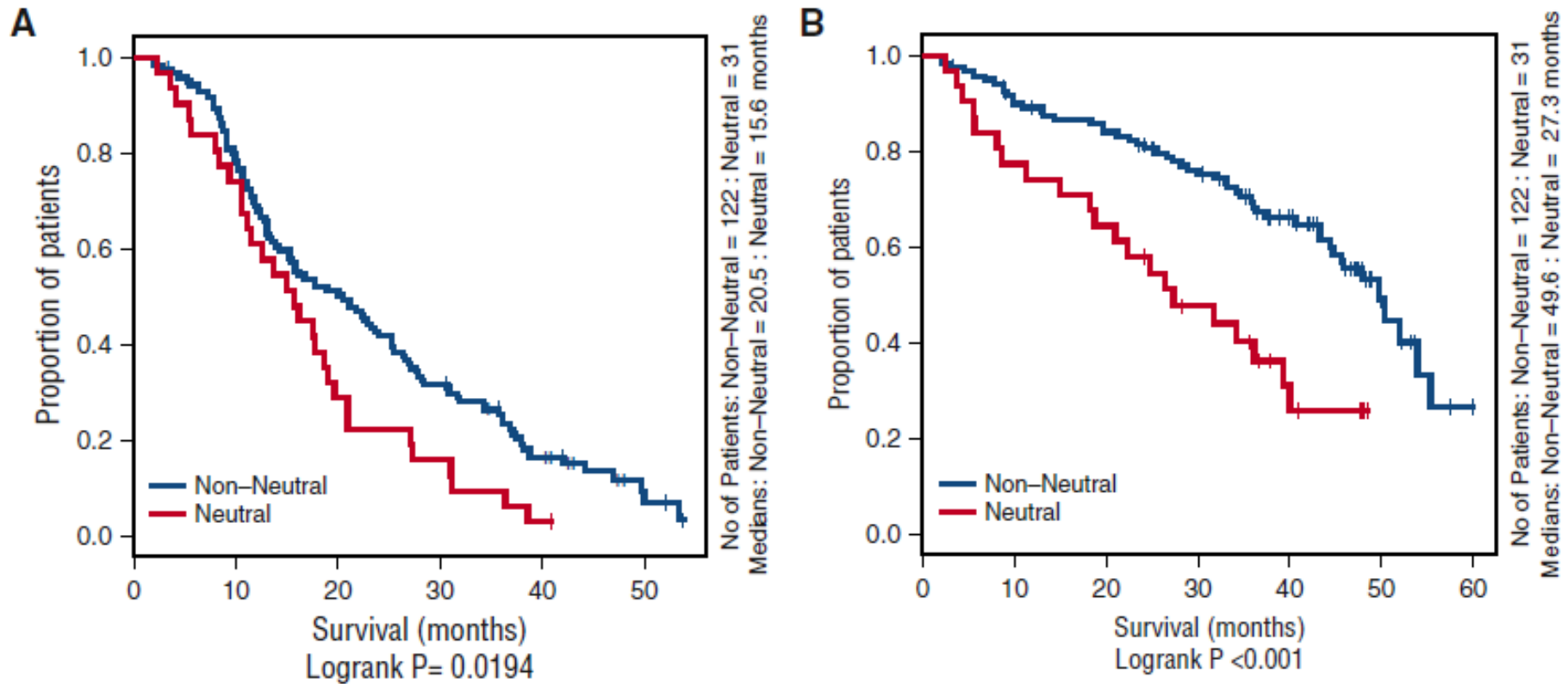
Mutation burden and immune responses



Converting Cold into Hot Tumors

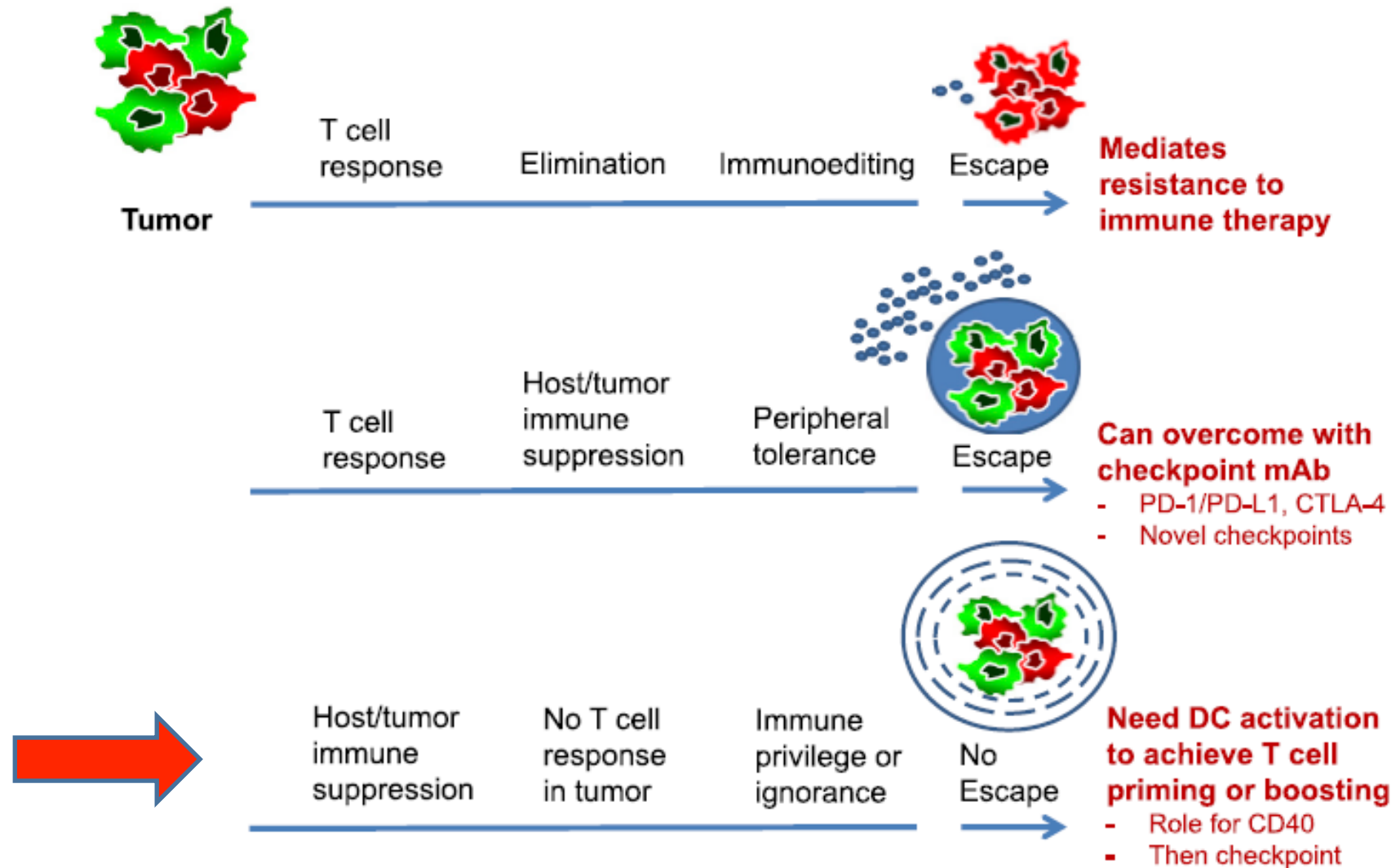


Influence of neutral evolutionary dynamics on OS and PFS in the Myeloma XI and CoMMpass studies



Neutral tumors tend to confer poorer patient survival in the context of microenvironment modulating therapies.

The Immune Revolution: A Case for Priming, Not Checkpoint



Credits

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Ada Funaro

