

Brief report

Eradication of B-lineage cells and regression of lymphoma in a patient treated with autologous T cells genetically engineered to recognize CD19

James N. Kochenderfer,¹ Wyndham H. Wilson,² John E. Janik,² Mark E. Dudley,¹ Maryalice Stetler-Stevenson,³ Steven A. Feldman,¹ Irina Maric,⁴ Mark Raffeld,³ Debbie-Ann N. Nathan,¹ Brock J. Lanier,¹ Richard A. Morgan,¹ and Steven A. Rosenberg¹

¹Surgery Branch, ²Metabolism Branch, and ³Laboratory of Pathology, National Cancer Institute, Bethesda, MD; and ⁴Department of Laboratory Medicine, Clinical Center, National Institutes of Health, Bethesda, MD

Adoptive transfer of genetically modified T cells is an attractive approach for generating antitumor immune responses. We treated a patient with advanced follicular lymphoma by administering a preparative chemotherapy regimen followed by autologous T cells genetically engineered to express a chimeric antigen receptor (CAR) that recognized the B-cell antigen CD19. The patient's lymphoma underwent a dramatic regression, and B-cell

precursors were selectively eliminated from the patient's bone marrow after infusion of anti-CD19-CAR-transduced T cells. Blood B cells were absent for at least 39 weeks after anti-CD19-CAR-transduced T-cell infusion despite prompt recovery of other blood cell counts. Consistent with eradication of B-lineage cells, serum immunoglobulins decreased to very low levels after treatment. The prolonged and selective elimination of B-

lineage cells could not be attributed to the chemotherapy that the patient received and indicated antigen-specific eradication of B-lineage cells. Adoptive transfer of anti-CD19-CAR-expressing T cells is a promising new approach for treating B-cell malignancies. This study is registered at www.clinicaltrials.gov as #NCT00924326. (*Blood*. 2010;116(20): 4099-4102)

Introduction

T cells can be genetically modified to express chimeric antigen receptors (CARs).¹⁻⁵ CARs consist of an antigen-recognition moiety, such as antibody-derived, single-chain variable fragments, coupled to T-cell activation domains.¹⁻⁴ T cells have been genetically engineered to express CARs that can recognize a variety of tumor-associated antigens, including the B-lineage antigen CD19, in a non-human leukocyte antigen-restricted manner.^{4,15} Expression of the cell-surface protein CD19 is restricted to normal mature B cells, malignant B cells, B-cell precursors, and plasma cells.¹⁶⁻¹⁹ We have designed a CAR that targets CD19 and initiated a clinical trial of autologous T cells expressing this CAR (www.clinicaltrials.gov; #NCT00924326).

tal Materials link at the top of the online article). The T cells were 66% CD8⁺ and 34% CD4⁺. The anti-CD19-CAR-transduced T cells specifically recognized CD19⁺ target cells (supplemental Table 1). Methods of T-cell preparation, flow cytometry, polymerase chain reaction, and immunohistochemistry are in the supplemental data. For the immunohistochemistry images in Figures 1 and 2, images were obtained via digital microscopy using an Olympus BX51 microscope (Olympus America) equipped with a UPlanFL 10×/0.3 numeric aperture and UPlanFL 40×/0.75 numeric aperture objectives. Images were captured using an Olympus DP70 digital camera system. Imaging software was Adobe Photoshop CS3 (Adobe Systems).

Methods

This clinical trial was approved by the National Cancer Institute Institutional Review Board. Design and construction of the mouse stem cell virus-based splice-gag retroviral vector MSGV-FMC63-28Z encoding the anti-CD19 CAR used in our clinical trial have been described (GenBank HM852952).⁷ The anti-CD19 CAR contains an antigen-recognition moiety consisting of the variable regions of the FMC63 monoclonal antibody joined to part of the CD28 molecule and the signaling domains of the CD3ζ molecule.

Peripheral blood mononuclear cells were transduced with retroviruses encoding the anti-CD19 CAR and cultured in an almost identical manner as previously described.²⁰ As measured by flow cytometry, the CAR was expressed on 64% of the infused cells, which were 98% CD3⁺ T cells (supplemental Figure 1, available on the *Blood* Web site; see the Supplemental

Results and discussion

The patient was diagnosed with grade 1, stage IVB follicular lymphoma in 2002. Before enrollment on our protocol, he had received the following treatments for his lymphoma: PACE (prednisone, doxorubicin, cyclophosphamide, and etoposide), an idiotype vaccine, the anti-CTLA-4 monoclonal antibody ipilimumab, and EPOCH-R (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin, and rituximab). The last cycle of EPOCH-R was administered in January 2008. The EPOCH-R caused a partial remission; however, progressive disease was noted in July 2008. The patient received no further treatment before he was evaluated for enrollment on our trial of anti-CD19-CAR-transduced T cells.

When we evaluated the patient in May 2009, he had progressive lymphoma that involved all major lymph node areas (Figure 1A). He had bilateral pleural effusions, night sweats, and a recent weight loss of 10 pounds. Flow cytometry of a fine needle aspirate from an

Submitted April 23, 2010; accepted July 20, 2010. Prepublished online as *Blood* First Edition paper, July 28, 2010; DOI 10.1182/blood-2010-04-281931.

The online version of this article contains a data supplement.

The publication costs of this article were defrayed in part by page charge payment. Therefore, and solely to indicate this fact, this article is hereby marked "advertisement" in accordance with 18 USC section 1734.

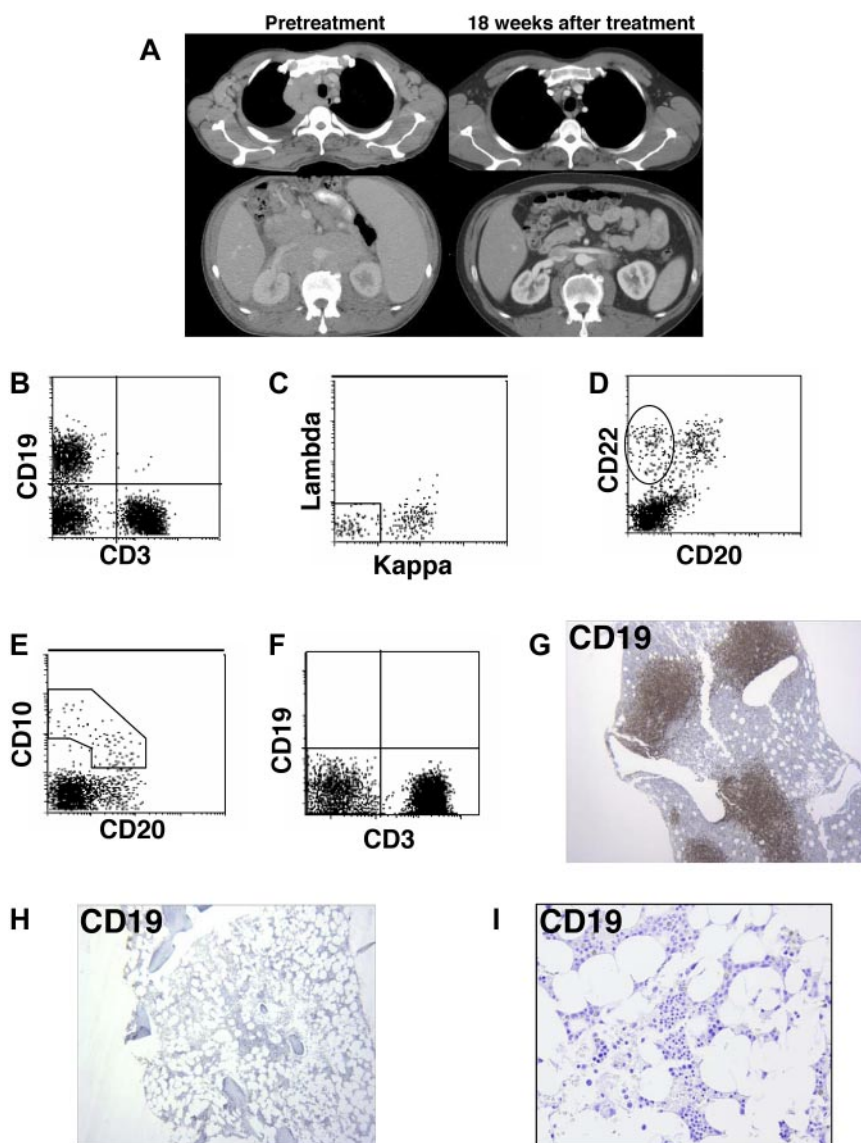


Figure 1. B-lineage cells, including B-cell precursors, were eradicated from the bone marrow after treatment with anti-CD19-CAR-transduced T cells. (A) Representative pretreatment computed tomography scan images and images from 18 weeks after treatment demonstrate regression of lymphoma masses in the chest and abdomen after treatment with chemotherapy followed by anti-CD19-CAR-transduced T cells plus IL-2. (B) Flow cytometric evaluation of a pretreatment bone marrow aspirate was conducted with a forward versus side light scatter analysis gate of lymphoid cells. The left upper quadrant contains CD19⁺ B-lineage cells (35% of lymphoid cells), and the right lower quadrant contains CD3⁺ T cells. (C) Flow cytometric evaluation of a pretreatment bone marrow aspirate with a CD19⁺ analysis gate is shown. κ - and λ -negative, CD19⁺, mostly immature B-lineage cells that are not part of the malignant lymphoma clone are in the rectangle. The cells outside the rectangle are mostly lymphoma cells. (D) Flow cytometric evaluation of a pretreatment bone marrow aspirate with a forward versus side light scatter analysis gate of lymphoid cells. Immature B-cell precursors in the oval are CD22⁺ and CD20⁻. (E) Flow cytometric evaluation of a pretreatment bone marrow aspirate with a forward versus side light scatter analysis gate of lymphoid cells. Immature B-cell precursors in the polyhedral demonstrate decreasing CD10 correlating with increasing CD20 expression. (F) Flow cytometric evaluation of a bone marrow aspirate from 36 weeks after treatment with a forward versus side light scatter analysis gate of lymphoid cells. CD19⁺ B-lineage cells are absent. (G) Immunohistochemistry staining of a pretreatment bone marrow biopsy reveals a large population of CD19⁺ cells that includes lymphoma cells as well as nonmalignant B-lineage cells. (H) Immunohistochemistry staining of a bone marrow biopsy from 36 weeks after infusion of anti-CD19-CAR-transduced T cells demonstrates a complete absence of CD19⁺ cells. (I) High-power view of the same anti-CD19 staining shown in panel H.

enlarged cervical lymph node demonstrated a monoclonal B-cell process consistent with follicular lymphoma that uniformly expressed CD19, CD20, CD22, CD10, and IgM-kappa. Flow cytometry showed that 14.5% of the blood lymphoid cells had a phenotype that was consistent with the lymphoma and 0.7% of the blood lymphoid cells were normal polyclonal B cells (data not shown). Before treatment, 35% of bone marrow lymphoid cells expressed CD19 (Figure 1B). A total of 55% of these CD19⁺ cells were monoclonal κ -positive and λ -negative lymphoma cells; 45% of the bone marrow CD19⁺ cells were normal surface-immunoglobulin (Ig)-negative immature B-cell precursors (Figure 1C). The immature B-cell precursors demonstrated a pattern of antigen expression consistent with normal maturation, namely, CD22⁺ B cells with decreasing CD10 expression correlating with increasing CD20 expression (Figure 1D-E).^{21,22} Large numbers of bone marrow CD19⁺ cells and CD79a⁺ cells were detected by immunohistochemistry before treatment (Figures 1G, 2A).

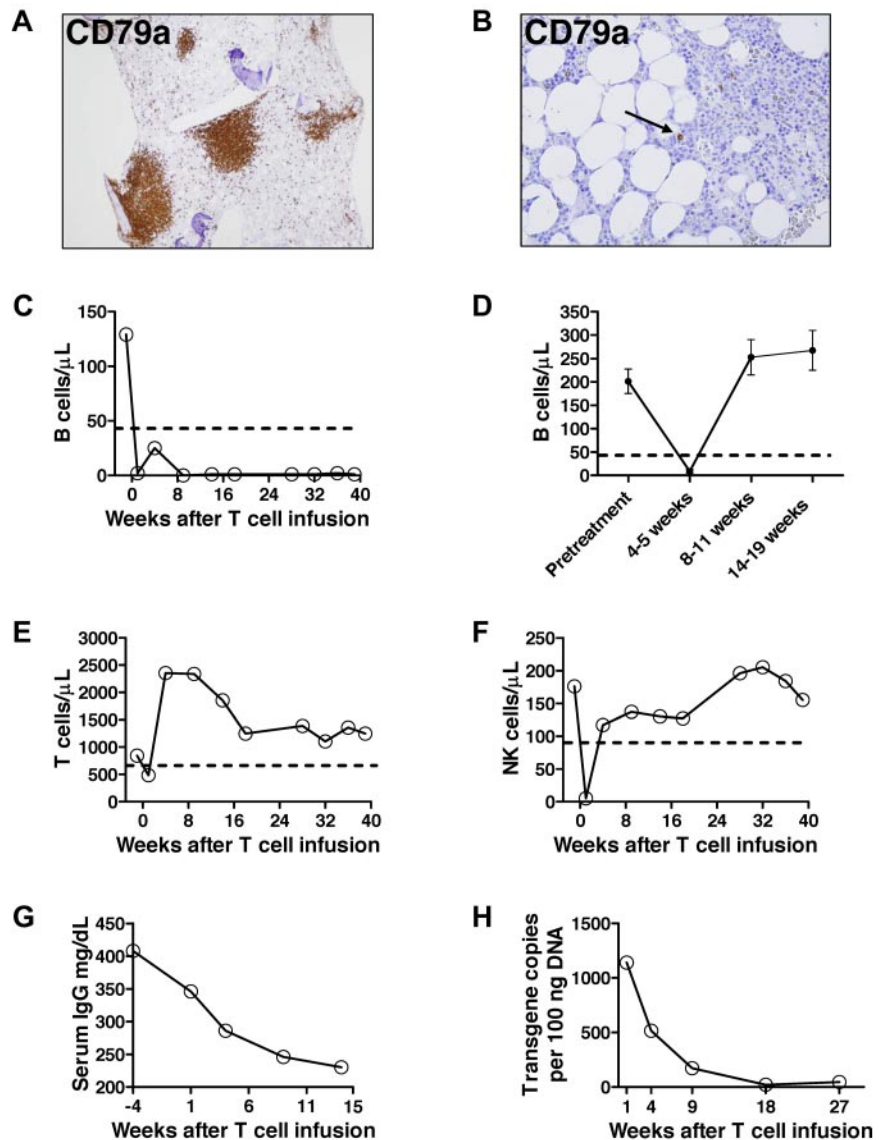
The patient underwent apheresis, and peripheral blood mononuclear cells were used to prepare anti-CD19-CAR-transduced T cells. The patient received a lymphocyte-depleting regimen consisting of 60 mg/kg cyclophosphamide daily for 2 days followed by 5 daily doses of 25 mg/m² fludarabine. The

day after the last fludarabine dose, the patient received 1×10^8 anti-CD19-CAR-transduced T cells intravenously. The next day, he received 3×10^8 anti-CD19-CAR-transduced T cells intravenously. After the second anti-CD19-CAR-transduced T-cell infusion, the patient received 720 000 IU/kg interleukin-2 (IL-2) intravenously every 8 hours. Eight doses of IL-2 were administered. The only acute toxicities that the patient experienced were cytopenias that were attributable to chemotherapy and a fever that lasted 2 days (maximum temperature, 38.5°C). The patient was discharged 11 days after his second anti-CD19-CAR-transduced T-cell infusion, and he resumed full-time employment.

After therapy, computed tomography scans revealed an impressive partial remission of the lymphoma that lasted 32 weeks (Figure 1A); 32 weeks after treatment, progressive CD19⁺ lymphoma was noted in right cervical and retroperitoneal lymph nodes.

Blood B cells were absent from 9 weeks after anti-CD19-CAR-transduced T-cell infusion until at least 39 weeks after anti-CD19-CAR-transduced T-cell infusion (Figure 2C; supplemental Figure 2). This prolonged B-cell depletion cannot be attributed to the chemotherapy that the patient received. Neither the New York esophageal squamous cell carcinoma antigen-1 (NY-ESO) nor the melanoma antigen gp100 is expressed by B cells.^{23,24} In prior clinical trials, patients treated with the

Figure 2. Prolonged B-cell depletion after anti-CD19-CAR-transduced T-cell infusion. (A) Immunohistochemistry staining of a pretreatment bone marrow biopsy shows a large population of CD79a⁺ cells. (B) Thirty-six weeks after anti-CD19-CAR-transduced T-cell infusion, rare CD79a⁺ cells were detected by immunohistochemistry staining of a bone marrow biopsy. The cells did not appear to be plasma cells morphologically. The number of CD79a⁺ cells was substantially below normal limits. The arrow indicates one of the rare CD79a⁺ cells. (C) The blood B-cell count of the patient treated with anti-CD19-CAR-transduced T cells is shown before treatment and at multiple time points after treatment. B cells were measured by flow cytometry for CD19. The dashed line indicates the lower limit of normal. Day 0 is the day of the second anti-CD19-CAR-transduced T-cell infusion. (D) The mean \pm SEM blood B-cell count is shown for patients who received infusions of T cells targeted to either the NY-ESO antigen or the gp100 antigen. The patients all received the same chemotherapy and IL-2 regimen as the patient who received anti-CD19-CAR-transduced T cells. NY-ESO and gp100 are not expressed by B cells. Day 0 is the day of T-cell infusion. All available B-cell counts were included for each time point (pretreatment, n = 28; 4-5 weeks after T-cell infusion, n = 29; 8-11 weeks after T-cell infusion, n = 31; 14-19 weeks after T-cell infusion, n = 20). All patients with available samples had a B-cell count in the normal range by 14 to 19 weeks after T-cell infusion. (E) The blood CD3⁺ T-cell count of the patient treated with anti-CD19-CAR-transduced T cells is shown before treatment and at multiple time points after treatment. (F) The blood NK cell count of the patient treated with anti-CD19-CAR-transduced T cells is shown before treatment and at multiple time points after treatment. NK cells were measured by flow cytometry as CD3⁺, CD16⁺, CD56⁺ cells. (E-F) Day 0 is the day of the second anti-CD19-CAR-transduced T-cell infusion, and the dashed line indicates the lower limit of normal. (G) The serum IgG level of the patient treated with anti-CD19-CAR-transduced T cells is shown before treatment and at multiple time points after treatment. Day 0 is the day of the second anti-CD19-CAR-transduced T-cell infusion. (H) Real-time polymerase chain reaction was performed with a primer and probe set that was specific for the anti-CD19 CAR. Anti-CD19-CAR-transduced T cells were undetectable in pretreatment blood samples. The anti-CD19 CAR transgene was detected in the peripheral blood of the patient who received anti-CD19-CAR-transduced T cells from 1 to 27 weeks after anti-CD19-CAR-transduced T-cell infusion.



same chemotherapy and IL-2 regimen as the patient described in this report along with T cells retrovirally transduced with receptors that recognized either NY-ESO or gp100 did not experience prolonged B-cell depletion (Figure 2D).

Except for B cells and a mild thrombocytopenia, all blood cell counts, including neutrophils, erythrocytes, T cells, and NK cells, of the patient treated with anti-CD19-CAR-transduced T cells recovered to normal levels by 9 weeks after treatment (Figure 2E-F).

Thirty-six weeks after anti-CD19-CAR-transduced T cells were infused, CD19⁺ cells were absent from the bone marrow as measured by flow cytometry (Figure 1F) and immunohistochemistry (Figure 1H-I). CD79a⁺ cells were undetectable in the bone marrow by immunohistochemistry 14 weeks after treatment (data not shown). CD79a⁺ cells were detected at greatly below normal frequency 36 weeks after anti-CD19-CAR-transduced T-cell infusion (Figure 2B). CD79a is expressed earlier in B-cell development than CD19,²⁵ so the presence of a small number of CD79a⁺ cells while CD19⁺ cells were absent suggests early recovery of B-lineage cells.

A decrease in serum IgG levels occurred after treatment (Figure 2G). Serum IgM was undetectable from 9 to at least 39 weeks after treatment. Serum IgA was 66.8 mg/dL before treatment. Serum IgA decreased to below the detectable limit of 10 mg/dL after treatment (supplemental Figure 3). Five months after treatment, the patient

developed pneumonia of unknown etiology that required hospitalization. After a course of antibiotics, the patient recovered completely. The patient has subsequently received intravenous Ig replacement, and he has not had further infections.

The anti-CD19 CAR transgene was detected in peripheral blood mononuclear cells from one to 27 weeks after anti-CD19-CAR-transduced T-cell infusion with a quantitative real-time polymerase chain reaction assay (Figure 2H).

This is the first patient treated on our trial and the only patient with long enough follow-up to evaluate B-cell depletion. The prolonged elimination of CD19⁺ cells in this patient indicates *in vivo* antigen-specific activity of anti-CD19-CAR-expressing T cells. Our findings should encourage continued study of anti-CD19-CAR-transduced T cells.

Acknowledgments

The authors thank Margaret Brown for flow cytometry, Manuel Van Deventer for Ig assays, Laura Devillier for T-cell preparation, and Hui Xu, Mary Black, and Zhili Zheng for technical assistance.

This work was supported by the Center for Cancer Research, National Cancer Institute, National Institutes of Health (intramural funding).

Authorship

Contribution: J.N.K. designed the protocol, provided patient care, conducted experiments, analyzed data, and wrote the paper; W.H.W., J.E.J., D.-A.N.N., and B.J.L. provided patient care,

assisted protocol design, and edited the paper; S.A.F. and R.A.M. provided reagents and interpreted data; M.E.D. conducted experiments and edited the paper; M.S.-S., I.M., and M.R. conducted experiments, interpreted data, and edited the paper; and S.A.R. designed the protocol, interpreted data, and edited the paper.

Conflict-of-interest disclosure: The authors declare no competing financial interests.

Correspondence: James N. Kochenderfer, National Institutes of Health, 10 Center Dr, CRC Rm 3-3888, Bethesda, MD 20892; e-mail: kochendj@mail.nih.gov.

References

- Eshhar Z, Waks T, Gross G, Schindler DG. Specific activation and targeting of cytotoxic lymphocytes through chimeric single chains consisting of antibody-binding domains and the gamma or zeta subunits of the immunoglobulin and T-cell receptors. *Proc Natl Acad Sci U S A*. 1993;90(2):720-724.
- Kershaw MH, Teng MWL, Smyth MJ, Darcy PK. Supernatural T cells: genetic modification of T cells for cancer therapy. *Nat Rev*. 2005;5(12):928-940.
- Irving BA, Weiss A. The cytoplasmic domain of the T cell receptor zeta chain is sufficient to couple to receptor-associated signal transduction pathways. *Cell*. 1991;64(5):891-901.
- Sadelain M, Brentjens R, Riviere I. The promise and potential pitfalls of chimeric antigen receptors. *Curr Opin Immunol*. 2009;21(2):215-223.
- Vera JF, Brenner MK, Dotti G. Immunotherapy of human cancers using gene modified T lymphocytes. *Curr Gene Ther*. 2009;9(5):396-408.
- Kowolik CM, Topp MS, Gonzalez S, et al. CD28 costimulation provided through a CD19-specific chimeric antigen receptor enhances in vivo persistence and antitumor efficacy of adoptively transferred T cells. *Cancer Res*. 2006;66(22):10995-11004.
- Kochenderfer JN, Feldman SA, Zhao Y, et al. Construction and preclinical evaluation of an anti-CD19 chimeric antigen receptor. *J Immunother*. 2009;32(7):689-702.
- Lamers CH, Langeveld SC, Groot-van Ruijven CM, Debets R, Sleijfer S, Gratama JW. Gene-modified T cells for adoptive immunotherapy of renal cell cancer maintain transgene-specific immune functions in vivo. *Cancer Immunol Immunother*. 2007;56(12):1875-1883.
- Hwu P, Yang JC, Cowherd R, et al. In vivo antitumor activity of T cells redirected with chimeric antibody/T-cell receptor genes. *Cancer Res*. 1995;55(15):3369-3373.
- Brentjens RJ, Latouche JB, Santos E, et al. Eradication of systemic B-cell tumors by genetically targeted human T lymphocytes co-stimulated by CD80 and interleukin-15. *Nat Med*. 2003;9(3):279-286.
- Till BG, Jensen MC, Wang J, et al. Adoptive immunotherapy for indolent non-Hodgkin lymphoma and mantle cell lymphoma using genetically modified autologous CD20-specific T cells. *Blood*. 2008;112(6):2261-2271.
- Pule MA, Savoldo B, Myers GD, et al. Virus-specific T cells engineered to coexpress tumor-specific receptors: persistence and antitumor activity in individuals with neuroblastoma. *Nat Med*. 2008;14(11):1264-1270.
- Milone MC, Fish JD, Carpenito C, et al. Chimeric receptors containing CD137 signal transduction domains mediate enhanced survival of T cells and increased antileukemic efficacy in vivo. *Mol Ther*. 2009;17(8):1453-1464.
- Brentjens RYR, Bernal Y, Riviere I, Sadelain M. Treatment of chronic lymphocytic leukemia with genetically targeted autologous T cells: a case report of an unforeseen adverse event in a phase I clinical trial. *Mol Ther*. 2010;18(4):666-668.
- Jensen MC, Popplewell L, Cooper LJ, et al. Anti-transgene rejection responses contribute to attenuated persistence of adoptively transferred CD20/CD19-specific chimeric antigen receptor redirected T cells in humans. *Biol Blood Marrow Transplant*. 2010;16(9):1245-1256.
- Nadler LM, Anderson KC, Marti G, et al. B4, a human B lymphocyte-associated antigen expressed on normal, mitogen-activated, and malignant B lymphocytes. *J Immunol*. 1983;131(1):244-250.
- Pontvert-Delucq S, Breton-Gorius J, Schmitt C, et al. Characterization and functional analysis of adult human bone marrow cell subsets in relation to B-lymphoid development. *Blood*. 1993;82(2):417-429.
- Uckun FM, Jaszcz W, Ambrus JL, et al. Detailed studies on expression and function of CD19 surface determinant by using B43 monoclonal antibody and the clinical potential of anti-CD19 immunotoxins. *Blood*. 1988;71(1):13-29.
- Harada H, Kawano MM, Huang N, et al. Phenotypic difference of normal plasma cells from mature myeloma cells. *Blood*. 1993;81(10):2658-2663.
- Johnson LA, Morgan RA, Dudley ME, et al. Gene therapy with human and mouse T-cell receptors mediates cancer regression and targets normal tissues expressing cognate antigen. *Blood*. 2009;114(3):535-546.
- van Lochem EG, van der Velden VHJ, Wind HK, te Marvelde JG, Westerdal NAC, van Dongen JJM. Immunophenotypic differentiation patterns of normal hematopoiesis in human bone marrow: reference patterns for age-related changes and disease-induced shifts. *Cytometry B Clin Cytom*. 2004;60(1):1-13.
- Lucio P, Parreira A, van den Beemd MW, et al. Flow cytometric analysis of normal B cell differentiation: a frame of reference for the detection of minimal residual disease in precursor-B-ALL. *Leukemia*. 1999;13(3):419-427.
- Kawakami Y, Eliyahu S, Delgado CH, et al. Identification of a human melanoma antigen recognized by tumor-infiltrating lymphocytes associated with in vivo tumor rejection. *Proc Natl Acad Sci U S A*. 1994;91(14):6458-6462.
- Chen YT, Scanlan MJ, Sahin U, et al. A testicular antigen aberrantly expressed in human cancers detected by autologous antibody screening. *Proc Natl Acad Sci U S A*. 1997;94(5):1914-1918.
- Blom B, Spits H. Development of human lymphoid cells. *Annu Rev Immunol*. 2006;24:287-320.



blood[®]

2010 116: 4099-4102
doi:10.1182/blood-2010-04-281931 originally published
online July 28, 2010

Eradication of B-lineage cells and regression of lymphoma in a patient treated with autologous T cells genetically engineered to recognize CD19

James N. Kochenderfer, Wyndham H. Wilson, John E. Janik, Mark E. Dudley, Maryalice Stetler-Stevenson, Steven A. Feldman, Irina Maric, Mark Raffeld, Debbie-Ann N. Nathan, Brock J. Lanier, Richard A. Morgan and Steven A. Rosenberg

Updated information and services can be found at:
<http://www.bloodjournal.org/content/116/20/4099.full.html>

Articles on similar topics can be found in the following Blood collections

[Brief Reports](#) (1946 articles)
[Clinical Trials and Observations](#) (4598 articles)
[Gene Therapy](#) (585 articles)
[Immunobiology and Immunotherapy](#) (5503 articles)
[Lymphoid Neoplasia](#) (2609 articles)

Information about reproducing this article in parts or in its entirety may be found online at:
http://www.bloodjournal.org/site/misc/rights.xhtml#repub_requests

Information about ordering reprints may be found online at:
<http://www.bloodjournal.org/site/misc/rights.xhtml#reprints>

Information about subscriptions and ASH membership may be found online at:
<http://www.bloodjournal.org/site/subscriptions/index.xhtml>