These results raise several questions. Should we screen and monitor MDS patients for de novo/pan-AML mutations in an attempt to identify early progression prior to clinical development of secondary AML? Does it matter whether secondary-type vs de novo/pan-AML mutations occur in the founding clone or a subclone at clinical diagnosis of de novo AML? Is relapse inevitable in patients with secondary AML who have persistent secondary-type mutations in remission, and what mutations and clones emerge at relapse? Do elderly patients with clinically defined de novo AML and secondary-type mutations have worse overall survival? Do clinically defined de novo AML patients with secondary-type mutations also have persistence of mutations in remission similar to that observed in secondary AML patients? Future studies with longer follow-up will be necessary to address these questions.

Although the authors use conservative mutation-calling criteria to identify sequence variants, the use of matched normal DNA from patients in future trials would allow somatic mutations to be definitively identified. If replicated in independent cohorts, these results have clinical implications. The presence of specific gene mutations could help risk stratify clinically defined de novo AML patients and reduce the heterogeneity in treatment response that is currently observed, especially in elderly AML patients. The absence of secondary-type mutations in AML may identify a group of chemosensitive patients that have better clinical outcomes. Ultimately, serial monitoring of mutations and tumor clones in patients may be necessary to fully understand the impact that gene mutations have on the clinical heterogeneity observed in AML.

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REFERENCES


CD30: seeing is not always believing

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Although most investigators are well aware of the incredible success of brentuximab vedotin in the treatment of patients with Hodgkin lymphoma (HL) and anaplastic large-cell lymphoma (ALCL), the study by Jacobsen and colleagues in this issue of Blood demonstrates surprising activity of this agent in patients with B-cell non-Hodgkin lymphoma (NHL).

In a planned subset analysis of a phase 2 multicenter trial of brentuximab vedotin in patients with relapsed/refractory CD30+ NHL, overall response (OR) and complete response (CR) rates of 44% and 17%, respectively, were observed in 49 patients with diffuse large B-cell lymphoma (DLBCL). Although only 20% of the enrolled DLBCL patients had a prior autologous transplant, 82% were refractory to prior therapy and 24% were transformed from low-grade NHL. OR was 44% and 50% in the patients with refractory and transformed DLBCL, respectively. This efficacy rivals that of other single agents in DLBCL, namely lenalidomide and ibritinib, where ORs of 22% to 53% have been described.

Nineteen patients with B-cell NHL other than DLBCL were also enrolled. Seventy-four percent of these patients were refractory to their last therapy, and OR in this group was 26%, with responses observed in patients with gray-zone lymphoma (n = 3), primary mediastinal B-cell lymphoma (PMBCBL, n = 1), and posttransplant lymphoproliferative disorder (n = 1).

Three questions arise in reviewing this study: (1) Can we predict response based on CD30 expression; (2) Why is the activity in PMBCBL so low (overall response rate 17%), particularly when this disease is typically CD30+; and (3) Are certain subsets (ie, myc+, activated B-cell, or germinal-center subtype) of DLBCL more likely to respond to brentuximab vedotin than others?

With respect to question 1, patients who entered this study were required to have visible CD30 expression by immunohistochemistry (IHC) analysis in a relapse biopsy sample reviewed by a local pathologist. This tissue was also sent for central pathology review, where CD30 expression on the neoplastic cells was visually quantified, and for analysis using computer-assisted quantification of CD30 expression on all cells (malignant and nonmalignant) in a specimen. Surprisingly, no statistical correlation between response and CD30 expression by central visual IHC or by computer-assisted review was observed. Specifically, in 48 DLBCL patients, the median percent of CD30+ cells by visual central review was 25% (0, 90) in the responders vs 25% (0, 100) in the nonresponders. Twenty-one percent of the responders had <10% CD30 expression. Two patients with DLBCL with ≤1% detectable CD30 expression by central pathologist review achieved CR.

By computer-assisted CD30 quantification, all responding patients had quantifiable CD30 expression, and the median percentage of CD30 found using the computer-assisted technique was 58.5%, 37.4%, and 20.7% in the CR, CR + partial response, and nonresponding patients, respectively. This trend to higher CD30 expression levels in the responding patients by using the computer quantification method rather than by pathologist inspection may reflect an accounting for CD30 expression in all cells.

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rather than just the malignant cells. Therefore, it is unclear whether CD30 expression in the malignant cells is necessary for brentuximab vedotin’s activity in NHL or whether some minimum level of background staining must be present. The authors postulate that in the setting of CD30 positivity of the inflammatory infiltrate, a bystander effect may be responsible for brentuximab vedotin’s activity in patients where limited CD30 is visually detected on the malignant cell. Specifically, this bystander effect occurs with the release of monomethyl auristatin E into the surrounding tissue upon binding of the anti-CD30 antibody, killing the adjacent malignant cells.

As a result of the provocative findings of CRs observed in patients with very low CD30 expression, Bartlett and colleagues amended this phase 2 clinical trial to permit enrollment of an additional 50 patients with DLBCL with undetectable CD30 by IHC and reported these results at the American Society of Hematology 2014 meeting. At the time of the meeting, 13 responses (OR 31%, 4 CR) in 42 evaluable patients had been observed. Although the OR is lower than that observed in patients with IHC-detectable CD30, this study demonstrates activity of brentuximab vedotin in CD30− patients and is indicative that more sensitive techniques (computer-assisted CD30 visualization or CD30 mRNA detection by gene expression profiling) may have a future role in identifying patients who could benefit from brentuximab-based therapy.

In regards to the second question, the authors acknowledge that only 1 of 6 responses in patients with PMBCL is unexpectedly low, and that further correlative studies will need to be analyzed from the undetectable CD30 DLBCL trial5 to determine which patients without visible CD30 by IHC respond to this agent. Recent studies have confirmed the safety of brentuximab vedotin in combination with chemotherapy including rituximab, cyclophosphamide, Adriamycin, vincristine, and prednisone (RCHOP). A phase 2 study of RCHOP with brentuximab vedotin in patients with newly diagnosed DLBCL is ongoing (NCT01925612), and preliminary data in 12 response-evaluable patients demonstrate an overall response rate of 92%, with 58% of those CR, although long-term follow-up correlation with CD30 expression by IHC or mRNA, myc and bcl-2 expression, and cell of origin will be necessary to determine whether this agent should be incorporated into front-line DLBCL regimens.

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REFERENCES
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