Selinexor is effective in acquired resistance to ibrutinib and synergizes with ibrutinib in chronic lymphocytic leukemia

Zachary A. Hing1,2, Rose Mantel2, Kyle A. Beckwith1,2, Daphne Guinn2, Erich Williams2, Lisa L. Smith2, Katie Williams2, Amy J. Johnson2,4, Amy M. Lehman3, John C. Byrd2,4, Jennifer A. Woyach2±, and Rosa Lapalombella2±

1Medical Scientist Training Program,
2Division of Hematology, Department of Internal Medicine, and
3Center for Biostatistics, The Ohio State University, Columbus, OH, USA
4Division of Medicinal Chemistry, College of Pharmacy, The Ohio State University, Columbus, OH, USA

±These two senior authors contributed equally to this work

Address correspondence and reprint requests to:

Rosa Lapalombella PhD.
Research Assistant Professor
460 OSUCCC
410 West 12th Avenue
The Ohio State University
Columbus, Ohio 43210
Phone 614-685-6919
Fax: (614) 292-3312
E-mail: rosa.lapalombella@osumc.edu

Scientific category: Lymphoid Neoplasia

Text: 1,386 words

Abstract: 169 words

Number of figures: 2

Running Title: Selinexor synergizes with ibrutinib

KEY POINTS
- Selinexor exhibits synergy with ibrutinib in CLL.
- Selinexor is effective in vitro in ibrutinib-resistant CLL.
ABSTRACT

Despite the therapeutic efficacy of ibrutinib in CLL, complete responses are infrequent and acquired resistance to BTK inhibition is being observed in an increasing number of patients\textsuperscript{1,2}. Combination regimens that increase frequency of complete remissions, accelerate time to remission, and overcome single agent resistance are of considerable interest. We have previously shown that the XPO1 inhibitor selinexor is pro-apoptotic in CLL cells and disrupts BCR signaling via BTK depletion. Herein we show the combination of selinexor and ibrutinib elicits a synergistic cytotoxic effect in primary CLL cells. The combination increases overall survival compared to ibrutinib alone in a mouse model of CLL. Selinexor is effective in cells isolated from patients with prolonged lymphocytosis following ibrutinib therapy. Finally, selinexor is effective in ibrutinib-refractory mice and in a cell line harboring the BTK C481S mutation. This is the first report describing the combined activity of ibrutinib and selinexor in CLL, which represents a new treatment paradigm and warrants further evaluation in clinical trials of CLL patients including those with acquired ibrutinib resistance.
INTRODUCTION

Chronic lymphocytic leukemia (CLL) is a lymphoid malignancy of clonal B-cells that exhibit aberrant activation of the B-cell receptor (BCR) signaling pathway. A critical component of this pathway is Bruton agammaglobulinemia tyrosine kinase (BTK), a non-receptor tyrosine kinase expressed predominantly in B-lymphocytes. Ibrutinib, which irreversibly binds and inhibits BTK activity, has shown promising results in CLL, MCL, and a subset of DLBCL driven by BCR signaling. Despite encouraging results, complete responses are infrequent. Additionally, acquired resistance to ibrutinib represents an important clinical challenge wherein no standard treatment approach currently exists. Mechanisms of ibrutinib resistance were elucidated by our group and others and involve mutations at the C481S site of BTK or in the immediate downstream target, PLCγ2.

Exportin-1 (CRM1/XPO1) is the sole nuclear exporter of tumor suppressor proteins such as p53, I kB, and FOXO3a. Selective inhibitors of nuclear export (SINEs) inhibit XPO1 and restore subcellular localization of dysregulated molecules. Our previous published work showed XPO1 is a therapeutic target for CLL, and has facilitated translation of selinexor, a SINE, to a Phase I clinical trial (NCT01607892) where anti-tumor activity has been observed in lymphoma, CLL, multiple myeloma, and acute myeloid leukemia. We recently showed that selinexor inhibits activation of downstream BCR targets such as ERK and AKT and suppresses BTK gene expression. Based on these observations, we hypothesized that i) targeting XPO1 via selinexor might be effective in patients with acquired resistance to ibrutinib, and ii) dual targeting of XPO1 alongside BTK function might produce synergistic activity in CLL and prevent onset of ibrutinib-resistant clones.

METHODS
Human CLL and normal B-cells were isolated and cultured as previously described\textsuperscript{11}. Blood was obtained from CLL patients under an IRB–approved protocol with informed consent according to the Declaration of Helsinki. Cell death was assessed using either Annexin-V/PI staining as previously described\textsuperscript{11}. Chicken DT40 BTK null cell lines (RCB1468) were obtained from the Riken bioresource, Japan. Lentiviral constructs pReceiver-LV125 and A0534-Lv125 were obtained from Genecopoeia and were used to stably transfect DT40 BTK null cells with empty vector and BTK. The mutation was made using QuikChange site directed mutagenesis (Stratagene) in the kinase domain at cysteine 481 to serine (see the primer sequence in Supplemental Materials on the Blood Web site). Confirmation of the DNA sequence and infection of the DT40 cell lines was performed as previously described\textsuperscript{16}. Cells were selected with puromycin. All animal experiments were carried out under protocols approved by the OSU Institutional Animal Care and Use Committee. C57BL/6 were engrafted with CD19+CD5+ leukemia cells from an E\textsubscript{μ}-TCL1 mouse with active CLL-like leukemia. Leukemia onset was defined as >10\% CD45+CD5+CD19+ B cells in peripheral blood by flow cytometry. At leukemia onset, engrafted mice were randomly assigned to treatment groups. Overall survival was the primary endpoint. An in vivo model of ibrutinib resistance was developed using C57BL/6 mice engrafted with splenocytes derived from ibrutinib-refractory E\textsubscript{μ}-TCL1 mice that were passaged through two C57BL/6 animals. Ibrutinib-refractory E\textsubscript{μ}-TCL1 mice were generated by continuous dosing of animals with ibrutinib in drinking water from the time of weaning. Ibrutinib-resistant E\textsubscript{μ}-TCL1 mice with active leukemia were injected intraperitoneally with 100 \( \mu \)g EdU (5-ethynyl-2'-deoxyuridine) and single-cell suspensions were prepared from spleen and bone marrow and EdU incorporation was detected by flow cytometry according to manufacturer protocol (Life Technologies). All statistical analyses were performed by the OSU Center for Biostatistics using previously
described models\textsuperscript{11}. Selinexor was provided by Karyopharm, Inc. Ibrutinib for in vivo studies was provided by Pharmacyclics, Inc. and for in vitro studies was purchased from Selleck.

RESULTS AND DISCUSSION

We have previously shown that selinexor exhibits pro-apoptotic activity against CLL cells via inhibition of nuclear export of tumor suppressor proteins\textsuperscript{11}. Additionally we have shown that selinexor counteracts BCR signaling partially through the down-modulation of BTK protein expression\textsuperscript{15}. We therefore hypothesized selinexor would synergize with ibrutinib as it targets BTK through a completely different mechanism. We examined this hypothesis in primary CLL patient samples and found that ibrutinib and selinexor in combination exhibit significant synergistic cytotoxicity (Figure 1A). We repeated this assay in patient samples stimulated via TLR9 using synthetic CpG oligodeoxynucleotides and in patient samples co-cultured with the human bone marrow-derived fibroblast cell line HS-5 that induces survival of normal B-cells and CLL cells ex vivo\textsuperscript{17,18}. Synergistic cytotoxicity of ibrutinib and selinexor was maintained with CpG stimulation (Figure 1B). The combination showed a significant increase in cytotoxicity compared to each agent alone during stromal cell co-culture (Figure 1C). It is well established that CLL cells rely on pro-survival signals from the microenvironment to resist cytotoxic agents. This suggests dual inhibition of BTK kinase function by ibrutinib and BTK protein expression by selinexor may be an effective strategy to target CLL cells localized to many different compartments including peripheral blood, bone marrow, and other secondary lymphoid tissues.

Our prior studies with ibrutinib\textsuperscript{19} and selinexor\textsuperscript{15} in the Eµ-TCL1 engraftment mouse model of CLL showed that each of drug alone can inhibit the expansion phase of CLL in
this model. To see if selinexor has potential to improve upon ibrutinib therapy in vivo, since this agent is a current standard of care, we monitored overall survival in a cohort of engrafted mice randomized to receive either ibrutinib alone or selinexor and ibrutinib. As shown in Figure 1D, mice treated with the combination had significantly better survival compared to mice given ibrutinib alone. Similar to reports of other active agents in the Eμ-TCL1 model, disease eradication was not achieved for any treatment group due to the aggressive nature of this model. We next examined the efficacy of selinexor in the common clinical scenario of prolonged lymphocytosis following ibrutinib treatment in patients with CLL. Our previous data indicate that while BTK is inhibited, downstream mediators of BCR signaling are activated in the persistent lymphocytes, and treatment with targeted kinase inhibitors shows that these cells are not addicted to a single survival pathway. Lymphocytes collected at baseline and 9 months after beginning of ibrutinib therapy from the same patients were treated with targeted kinase inhibitors or selinexor. While all the other inhibitors remain equally active at both time points, selinexor was significantly more effective in persistent lymphocytosis (post-ibrutinib) samples (Figure 1E), providing additional evidence for therapeutic combination of these two agents.

Selinexor targets multiple BCR signaling nodes, including BTK, in a manner independent of BTK kinase activity, suggesting that selinexor may possess the ability to overcome or prevent ibrutinib-mediated resistance in CLL by blocking adaptive signaling responses in resistant subclones. Our group previously identified a major mechanism of acquired ibrutinib resistance in CLL patients involving mutation of the BTK cysteine residue where ibrutinib binding occurs (C481S), changing the binding of ibrutinib from irreversible to reversible. To focus on this important resistance mechanism, we cloned human wild-type or C481S BTK into DT40 cells lacking endogenous BTK (Supplementary Materials).
Viability was assessed after treating DT40 cells with selinexor for 24 hours. Selinexor remains active in the presence of the BTK C481S mutation (Figure 2A). To test our hypothesis in vivo, C57BL/6 mice were engrafted with CD19+CD5+ leukemia derived from ibrutinib-refractory Eµ-TCL1 mice. While these mice are not known to possess the C481S mutation, they maintain functionally resistant disease as a result of selective pressure from ibrutinib exposure, mimicking acquired resistance in patients. At leukemia onset, mice were randomized to receive vehicle, ibrutinib alone or selinexor alone. As expected, mice retained their resistance to ibrutinib. However, treatment with selinexor induced a significant improvement in survival (Figure 2B). We further demonstrated that selinexor effectively inhibited the fraction of proliferating leukemic cells, based on a significant decrease in the percentage of 5-ethynyl-2’-deoxyuridine-(EdU)-positive leukemic cells of ibrutinib-resistant mice treated with selinexor (Figure 2C). The ability of selinexor to overcome acquired resistance to ibrutinib was confirmed in vitro in primary CLL cells derived from patients on ibrutinib that have relapsed with BTK C481S mutations (n=3), as confirmed by Ion Torrent deep sequencing performed at the time of ibrutinib relapse (Figure 2D). These data show that selinexor has single-agent activity in ibrutinib-resistant CLL in vitro, suggesting it may be effective in ibrutinib-resistant CLL patients, and may have the potential to prevent expansion of ibrutinib-resistant subclones when used in combination with ibrutinib.

Together our data suggest the combination of selinexor and ibrutinib as a promising new therapeutic paradigm in CLL that may elicit more robust initial responses and provide activity in the setting of acquired resistance to ibrutinib.

AKNOWLEDGEMENTS
We are grateful to the patients who provided blood for the above-mentioned studies, research support from The Leukemia and Lymphoma Society in the form of a translational grant (SCORE LLS 7080-06/7004-11), and the National Cancer Institute (R01 5R01CA177292). We would like to thank Pharmacyclics Inc. for providing the ibrutinib for the in vivo studies and Karyopharm Inc. for providing selinexor used in these studies.

**AUTHORSHIP CONTRIBUTIONS**

ZAH, RL, JAW and JCB designed the experiments, analyzed the data, wrote the paper and reviewed and approved the final version. RM, EW, LLS, KAB, AJJ, DG, and AML planned and contributed to components of the experimental work presented (chemistry, biologic, clinical, statistical or animal studies), reviewed and modified versions of the paper, and approved the final version.

**CONFLICT OF INTEREST DISCLOSURE**

The authors declare no competing financial interests.
REFERENCES


FIGURE LEGENDS

Figure 1. Selinexor synergizes in vitro and in vivo with ibrutinib. (A) CD19+ cells from CLL patients (n=6) were isolated from peripheral blood and incubated with vehicle, 0.5 μM selinexor (SEL), 1 μM ibrutinib (Ibr) or selinexor + Ibrutinib. Ibr was given as a 1h pulse exposure followed by washout and SEL was given continuously for 24h. Viability was determined by annexin-V/propidium iodide (PI) flow cytometry, and is shown relative to time-matched DMSO controls for each group. Horizontal bars represent averages. Each agent alone (SEL or Ibr) significantly decreased cell viability compared to vehicle (P<0.03). The combination produced a synergistic effect on viability (P=0.041). (B) CD19+ cells from CLL patients (n=6) were unstimulated or 3.2µM CpG-stimulated in the presence of vehicle, 0.5 μM SEL (24h continuous exposure), 1 μM Ibr (1h pulse exposure with washout) or SEL + Ibr. Cytotoxicity was measured by annexin/PI. Horizontal bars represent averages. Each agent alone (SEL or Ibr) significantly decreased cell viability compared to vehicle (P=0.001). The combination produced a synergistic decrease in viability (P=0.005). (C) CD19+ cells from CLL patients were incubated with 0.5 μM SEL (24h continuous exposure), 1 μM Ibr (1h pulse exposure with washout) or SEL + Ibr on an HS5 human bone marrow stromal cell layer for 24 hours. Cytotoxicity was measured by Annexin/PI flow based assay. Horizontal bars represent averages. SEL and Ibr together resulted in significantly more cytotoxicity than either agent alone (P<0.001). (D) Overall survival (OS) curves for C57BL/6 mice engrafted with spleen lymphocytes derived from the Eμ-TCL1 transgenic mouse. Mice with active leukemia (defined as ≥10% CD5+/CD19+ cells in the leukocyte population) were randomized to treatment with ibrutinib (~30 mg/kg/day via drinking water) or ibrutinib + selinexor (15 mg/kg on two consecutive days each week via oral gavage) (n=6 per group). (E) Persistent lymphocytes collected at baseline and 9 months after beginning of ibrutinib from the same patients were treated in vitro with selinexor at 0.5 μM (n=13). Cytotoxicity was measured by annexin/PI flow cytometry after 72 hours.

Figure 2. Selinexor is active in the setting of acquired resistance to ibrutinib. (A) DT40 BTK null cells with WT or C481S BTK were exposed to 1 μM ibrutinib for 1 hour, 0.5 μM selinexor for 24 hours, or DMSO (vehicle) for 24 hours. Cytotoxicity after 24 hours was measured by AnnexinV/PI flow cytometry. Viable populations were calculated as a percent of viability of vehicle control. Three biological replicates were performed.
Selinexor induced significantly more cell death compared to vehicle in cells expressing C481S (P=0.042), WT (P=0.027), or empty vector (P=0.011). (B) C57BL/6 mice were engrafted with spleen lymphocytes derived from an Eμ-TCL1 transgenic mouse with acquired resistance to ibrutinib. Mice were followed for leukemia development (defined as ≥10% CD5+/CD19+ cells in the leukocyte population), and once leukemic, randomized to treatment with ibrutinib alone (~30 mg/kg/day via drinking water), selinexor alone (15 mg/kg on two consecutive days each week via oral gavage) or vehicle. As expected, mice treated with ibrutinib did not show any survival advantage compared to vehicle control, while mice treated with selinexor showed improved survival (n=12-14 per group). (C) In vivo EdU labeling was performed in a cohort of mice engrafted as described in (B). Mice were treated for 2 days with vehicle, SEL or Ibr (n=5 for each group). EdU was injected on day 3. Spleens were analyzed by flow cytometry for percentage of Edu-positive cells within the leukemic population (CD45+/CD19+/CD5+ cells). (D) CLL cells derived from ibrutinib resistant patients (n=3) were treated in vitro with selinexor at 0.5 μM. Cytotoxicity was measured by annexin/PI after 48 hours.
Figure 1

A) Graph showing % Alive (normalized to vehicle no CPG) for different treatments: Vehicle, Ibr, SEL, Ibr+SEL. The p-values are 0.002, 0.005, and 0.006, respectively.

B) Graph showing % Alive (normalized to vehicle no stroma) for different treatments: Vehicle, Ibr, SEL, Ibr+SEL, + CPG, + HS5 stroma cells. The p-values are 0.001 for Ibr+SEL and 0.006 for Vehicle.

C) Graph showing % Alive (normalized to vehicle no CPG) for different treatments: Vehicle, Ibr, SEL, Ibr+SEL, + CPG, + HS5 stroma cells. The p-values are not provided.

D) Kaplan-Meier survival curve showing percent survival over time (days) for Ibrutinib and Ibrutinib+Selinexor treatments. The p-values are 0.014 for Ibrutinib and 0.0126 for Ibrutinib+Selinexor.

E) Graph showing % Viable normalized to Vehicle for different treatments: Selinexor baseline and 9 months post ibrutinib. The p-value is 0.0126.
Figure 2

A

![Graph showing viability of different groups over time](image)

B

![Graph showing percent survival over time](image)

C

![Graph showing Edu incorporation](image)

D

![Graph showing viability of different groups](image)
Selinexor is effective in acquired resistance to ibrutinib and synergizes with ibrutinib in chronic lymphocytic leukemia

Zachary A. Hing, Rose Mantel, Kyle A. Beckwith, Daphne Guinn, Erich Williams, Lisa L. Smith, Katie Williams, Amy J. Johnson, Amy M. Lehman, John C. Byrd, Jennifer A. Woyach and Rosa Lapalombella