What you know it’s 1202 or why don’t we get started?

And I know there are folks still logging on, so for those of us who are here, thank you for joining cancer grand rounds.

I hope all of you had a restful and enjoyable Thanksgiving and. Obviously, I know we’re all looking forward to year’s end and hopefully celebrating a better 2021, but we’re really very fortunate to have two exceptional speakers today and I’ll start by introducing our first speaker, who frankly needs no introduction.
Doctor Barbara Burtness is professor of Medicine Co, leader of the Developmental Therapeutics research program. And leader of the head neck cancer program.

And Yell Barbara is internationally known for her leadership in clinical development and research and understanding the biology of head cancer among her many accolades.

We can add now only in the past month is the principle investigator of the head and Explorer of which we are just so proud of both Barbara and the entire team being awarded.
this really coveted an elite grant. Of which I think will be from not correct if I'm not mistaken, there only two head neck spores now in the United States are the leader of one of them, which is an extraordinary distinction for the people who work in this space at Yale. So Barbara was kind enough to share with us the work she's doing on head neck cancer and forever. Thank you for joining us today. Well, thank you for the invitation and for. All the support that’s gotten us this far. So what I wanted to do was talk
about P53 mutated head neck cancer, which is something I have a longstanding interest in. And obviously, P53 is a very critical tumor suppressor gene. It’s meant to be the cell way of reacting to cellular stress signals, and ideally in response to these P53 is activated and promotes the transcription of target genes and domains of cell cycle arrest DNA.
repair a pop ptosis and others.

However, in head neck cancer were aware that P53 functionally disrupted in the majority in HPV associated head neck cancer. P53 is wild type, but its degradation is fostered by viral proteins, an in HPV, negative head neck cancer. Over 85% have genomic disruption of P53, including in frame mutations, truncating mutations and missense mutations, and you can see here that many of these are clustered in the DNA binding domain and we know that this type of mutation is Villa terius for the Natural History of head neck cancer.
So this figure comes from a large trial that the legacy Kog Cooperative Group ran over 500 respected head and neck cancers. All respected to margin, and all offered appropriate risk. Standard at the time and then P 50 was sequenced and you can see here that long term outcome. Was worse for those patients who had P53 mutation, if you classified the mutations as disruptive or nondisruptive, it was worse for those with.
disruptive mutation and the definition that was used in this paper. That was for disruptive was a mutation that was either truncating or in the DNA binding domain. So on the basis of these outcome data, we were interested in the cognitive Akron Head Neck Committee, which I chair in studying intensification of therapy for these poor prognosis patients with disruptive P53 mutation. But the first thing we wanted to do was examined how we really should be calling the P53 mutation. So we started with what we called the poeta rule,
so those were the rules from the paper I just showed you and we compared them to 14 other cloud classifiers that are out there, many of which are based on in silico predictions of disruption, some of which are based on experimental evidence actually of the decrease in OIF 1 activation for every specific mutation and then we also examine Dar poeta rules augmented with information about the splice site mutations. And you can see that this very simple definition of truncating or DNA binding domain actually outperformed
in terms of clinical prognosis.

All of the other indicators, and so in our clinical trial.

We moved forward with this poet's rules plus splice site mutations
and the trial that we're now about halfway through
is a randomized phase. Two trial of.

Post operative therapy for patients who meet the criteria for radiation but have negative margins,
don’t meet the criteria for chemotherapy, and then we want to ask in those patients with disruptive mutation,
do we see an advantage for the addition of platinum that we
don’t see in other patients?
This is supported by.
Is Bisquick grant that takes care of
all of the sequencing and we have
two investigators who are doing
the mutation calling in real time.
So continue to support this trial
and see this is kind of an important
resource in terms of all the sequencing
information that we’re going to
have on top of the clinical outcome.
We also have support for a clinical
trials planning meeting at the NCI
which is going to happen in January.
The goal of this is to write trials
both for locally advanced and recurrent metastatic disease, identifying promising therapies for P53 mutated cancer.

We also want to develop a national infrastructure. For the sequencing and mutation, calling with the consensus approach that all of the groups within the NCT and will accept the breakout groups for this have been meeting for about five months now. I can tell you that the focus is very strong and immunotherapy and synthetic lethal strategies and I’ll mention both of those in in
00:06:49.039 --> 00:06:51.490 the remaining minutes of this talk.

00:06:51.490 --> 00:06:54.090 So head neck cancer is one of the

00:06:54.090 --> 00:06:56.556 cancers where it appears that increase

00:06:56.556 --> 00:06:58.736 tumor mutation burden is predictive

00:06:58.736 --> 00:07:01.038 of response to immunotherapy.

00:07:01.040 --> 00:07:03.506 And we know that this is a cancer with

00:07:03.506 --> 00:07:06.670 a higher number of nonsynonymous mutations,

00:07:06.670 --> 00:07:09.538 particularly in the HPV negative cancers.

00:07:09.540 --> 00:07:12.096 And in the platinum refractory setting,

00:07:12.100 --> 00:07:15.468 both for Pember Lizum app in this early

00:07:15.468 --> 00:07:18.421 single ARM trial and for development

00:07:18.421 --> 00:07:21.451 in a randomized phase three trial.

00:07:21.460 --> 00:07:24.202 In the also in the platinum

00:07:24.202 --> 00:07:25.116 refractory setting,

00:07:25.120 --> 00:07:28.214 in both cases we see that as
tumor mutation burden rises,

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the likelihood of benefit

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from immunotherapy increases.

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So working with my long term

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collaborator at Fox Chase Circle,

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Columbus,

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we wanted to examine whether or

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not mutations in not only P.

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53,

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which is the most common most

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commonly mutated tumor suppressor

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and head neck cancer,

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but also CDK into a which is

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mutated in slightly over half

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of HPV negative cancers as well.

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See how these related to DNA damage
as reflected in tumor mutation burden with the idea of establishing whether or not P53 mutated cancers. Would be particularly susceptible or appropriate for study with immunotherapy. We had access to a data set of 1010 HPV negative cancers that have been profiled at Caris Life Sciences. There gene panel is about a 600 gene panel. They exclude HPV associated cancers with standard methods and then the mutations that we saw were almost invariably truncations or deletions. So we included all of those, but for P53 we were interested once.
again in what’s the best way of calling?

Meaningful mutations,

so we started with the American College of Medical Genetics variants calling

this included essentially all the P53 mutations that we SPA.

We then looked for consensus between the ACM G and two other variant calling

We use the International Agency for Research on Cancer guidelines for what was dominant,

negative or loss of function.

We then looked at the variance is defined by the poeta rules that I just alluded to,

and then we called out those patients who seem to have gain of function mutations,
most of which are defined experimentally across a range of publications, and TMB was. Measured just by counting all nonsynonymous missense mutations across the about 1.4 mega bases that are included in this panel. This shows you the patient characteristics so predominantly oral cavity in order. Pharynx cancers as we see in the clinic. Males outnumbering females, and as you see at the bottom, the number of patients who had P53 mutation by the karris was higher than if we looked at the consensus.
calls or the disruptive call gain of function was less than 10% of all of the mutations that we saw in 53, and indeed it turned out that either P. 53 or CDK into a mutation. W as associated with an increase in TMB. Here we looked for threshold of 15 per megabases as being likely predictive of response to immunotherapy. And you can see that across the board having both genes mutated was associated with higher TMB than having one or the other, and The only exception here was that those patients with gain of function mutations in P53 did not have an increase in tumor mutation burden.
So you know, we concluded that mutation of P53 or CDK in two ways associated with increased tumor mutation burden. This is highest when they’re damaging mutations in both jeans and so just to kind of segue to the next part of the talk, where I’m going to talk a little bit more about synthetic lethal strategies. P53 mutated head neck cancer, I think, remains a really important subject for study, because it’s common. It has a poor prognosis. We still don’t,
have agents which directly target mutated P.
And so the increasing evidence that synthetic lethal strategies might have promise in these patients is has kind of attracted our attention in the lab.
And so one of the things that we know about disruptive P53 mutation is that you lose the cell, loses the ability to perform cell cycle arrest at the G1 S transition, and as a result it becomes much more dependent on transition at G2 M and so we I mean obviously many people have been interested in this across many cancers, but we were interested in
examining some of the.
Potential targets that regulate G2
We know that auroras increasing.
I’ll show you a little bit about this.
We know that Aurora expression is increased in head neck
Aurora content
will go up at the end of G2.
Its activity is required to localize
CDK one to the centromere to.
Foster mitotic entry Aurora also,
in addition to its roles
in centrosome maturation.
It also has the property of.
Activating the city.
See 25 phosphatase, which removes an inhibitory phosphorylation from CDK one and on the other hand, it's important to know that that inhibitory phosphorylation is placed by the mitotic checkpoint kinase we want and so both we won an Auror recognized is up regulated and head neck cancer. Both of them are potential Points of synthetic lethality in P53 mutated cancers, but they appear to have kind of contradictory or opposing roles, and so that the data that I'm going to show you now will try to make
the case that by co treating these cancers with an Aurora inhibitor, which will lead to. Abnormal spindle formation. Defective cytokinesis, but by inhibiting the rural will lose the ability to remove the inhibitory phosphorylation from CDK one and that will result in cell cycle arrest that we can counter that by inhibition of we won so that phosphorylation isn’t placed and accelerate these cells into mitosis where given the spindle disruption that’s been
caused by the Aurora inhibition.

They will be unable to complete a normal mitosis and instead will apoptose are undergo mitotic catastrophe.

So, it's been recognized that Aurora content is increased in the face of loss of P53 and their host of publications, which demonstrate that increased Aurora levels are correlated with poor prognosis. I'll show you some of our work.

This is a panel of cell lines that that we use in the lab, all of which have either mutated or P53 null status,
and you can see that all of them increase the expression of arorae relative to either fibroblasts or normal epithelial tissue. And when I was at Fox Chase, we worked on a Aqua essay and insight to fluorescence assay for Aurora that could be applied to tissue microarrays. And so you see here that green is for carrot and defines where these head neck cancer nests are within the tissue core Blues for dampit. So that will be your nucleus and red is for Aurora and in this Aurora high cancer. What you can particularly appreciate.
00:15:28.840 --> 00:15:31.167 is the high level of expression
NOTE Confidence: 0.819094598293304
00:15:31.167 --> 00:15:33.307 of Aurora within the nucleus.
NOTE Confidence: 0.819094598293304
00:15:33.310 --> 00:15:35.452 When we looked at nuclear Aurora
NOTE Confidence: 0.819094598293304
00:15:35.452 --> 00:15:37.285 in the tissue microarray first
NOTE Confidence: 0.819094598293304
00:15:37.285 --> 00:15:39.651 for all cases we saw that high
NOTE Confidence: 0.819094598293304
00:15:39.651 --> 00:15:41.273 Aurora expression was associated
NOTE Confidence: 0.819094598293304
00:15:41.273 --> 00:15:42.590 with worse survival.
NOTE Confidence: 0.819094598293304
00:15:42.590 --> 00:15:43.902 This is also true,
NOTE Confidence: 0.819094598293304
00:15:43.902 --> 00:15:45.870 just is a reflection of Natural
NOTE Confidence: 0.819094598293304
00:15:45.943 --> 00:15:48.109 History in those patients who had
NOTE Confidence: 0.819094598293304
00:15:48.109 --> 00:15:50.072 had no post operative treatments
NOTE Confidence: 0.819094598293304
00:15:50.072 --> 00:15:51.860 and never been exposed.
NOTE Confidence: 0.819094598293304
00:15:51.860 --> 00:15:54.184 Any DNA damaging agents and we were
NOTE Confidence: 0.819094598293304
00:15:54.184 --> 00:15:56.866 able to show that this was entirely
NOTE Confidence: 0.819094598293304
00:15:56.866 --> 00:15:59.278 driven by the HPV negative cancers.
NOTE Confidence: 0.819094598293304
00:15:59.280 --> 00:16:01.576 So on the basis of this these
00:16:01.576 --> 00:16:03.739 data we went to Millennium.
00:16:03.740 --> 00:16:05.246 And argued that.
00:16:05.246 --> 00:16:08.258 Aurora could potentially be a good target in head and neck cancer.
00:16:08.258 --> 00:16:10.926 They were doing a trial of Al assertive, which is in Aurora a inhibitor.
00:16:10.930 --> 00:16:14.074 Val asserted monotherapy across a bunch of solid tumors,
00:16:14.080 --> 00:16:17.140 and we were able to convince them to add a head neck cohort,
00:16:17.140 --> 00:16:18.740 but this was crushingly disappointing because the response rate for Aurora monotherapy in head and neck turned out to be about 9% and given the increasing experimental
evidence that are or inhibition may always be intrinsically limited.

Limited by this kind of compensatory cell cycle arrest.

We were then interested in what would be.

The rational combination with Arorae inhibition that could.

Optimize the targeting of what we continued to think was likely to be an important target in this disease, and so any Mendez and colleagues at the University of Washington together with Dell Yarbrough are former colleague here had undertaken a functional kind, here had undertaken a functional kind, ohmic screen.

In P53,
mutated head and neck cancer and actually Aurora came out of that screen. But another thing that came out was this mitotic checkpoint kinase that I just alluded to. People have been interested in the idea that inhibitors of G1 will abrogate the G2 checkpoint. The G1 checkpoint is already advocated by P53 mutation and that this might accelerate cell death, particularly in the presence of DNA damage such as you might generate with.
cisplatin and they showed in animal models that we one inhibitor MK 1775, which is now known as the data sorted, was synergistic with platinum in P53 mutated head neck cancer models. Eddie Mendez then took this forward as a window trial and head neck cancer, so a small number of patients treated with a DAB assertive together with low dose weekly chemotherapy. And you can see here that the majority of patients had some diminution in tumor size and a number of them had rather major pathologic responses, and most intriguingly, you can see that there was evidence...
of target engagement,

and so among those patients who had responses,

there was a decrease in phosphorylation of CDK.

There was a decrease in fast focus Stone Age 3.

And potentially you could see some increase in gamma, H2, ax.

They also were able to correlate both pathologic and clinical response with the presence of P53 mutation in the HPV negative cancers and across the board.

These P53 mutations are
00:19:02.722 --> 00:19:04.696 disruptive or deletions.
NOTE Confidence: 0.790267467498779
00:19:04.700 --> 00:19:07.166 So we've been exploring whether or
NOTE Confidence: 0.790267467498779
00:19:07.166 --> 00:19:10.530 not you can combine Aurora A and we
NOTE Confidence: 0.790267467498779
00:19:10.530 --> 00:19:12.585 want inhibition and observe synergy
NOTE Confidence: 0.790267467498779
00:19:12.585 --> 00:19:15.278 in P53 mutated head neck cancer,
NOTE Confidence: 0.790267467498779
00:19:15.280 --> 00:19:19.078 and you see here a picture of John Wooley,
NOTE Confidence: 0.790267467498779
00:19:19.080 --> 00:19:21.200 my colleague in the lamp,
NOTE Confidence: 0.790267467498779
00:19:21.200 --> 00:19:24.154 who has done the majority of these
NOTE Confidence: 0.790267467498779
00:19:24.154 --> 00:19:26.698 experiments and so you'll see MLN,
NOTE Confidence: 0.790267467498779
00:19:26.700 --> 00:19:28.500 that's the Aurora inhibitor,
NOTE Confidence: 0.790267467498779
00:19:28.500 --> 00:19:33.610 Azd 1775 that's the wee one
NOTE Confidence: 0.790267467498779
00:19:33.610 --> 00:19:41.569 In terms of cell viability,
NOTE Confidence: 0.790267467498779
00:19:33.610 --> 00:19:36.130 soft auger oncosphere formation and
NOTE Confidence: 0.790267467498779
00:19:36.130 --> 00:19:44.491 HPV negative head neck cancer cell
lines that bear P53 mutations.

Trying to figure out whether or not our guests about the mechanism was correct.

You can see here that when you give the Aurora inhibitor there’s a dramatic increase in phosphorylation of CDK one.

This happens in a slightly different timeline in the two South and the two different cell lines, but seems to be a reproducible phenomenon, and that’s abrogated by the addition of the wee one inhibitor and completely abolished when you give it to together.

This results in an increase in the number
of mitotic figures that’s abnormal to the.

The. Presence of really only

single digit normal mitotic figures

in the presence of the combination.

So if you just walk through here,

these are the normal mitotic figures.

When you give the wee one inhibitor,

you get the formation of these multipolar

spindles three to four spindles,

you get some dis aggregation of

chromatin reflected here in the

fast food Stone Age 3 stain.

When you give the Aurora inhibitor,

you get the formation of these multipolar

spindles three to four spindles,

and when you give the

two together you get a, uh.

Abnormal catastrophic mitotic figure.
We also showed in using Annexin 5 flow and looking for cleaved PARP that there’s an increase in apoptosis. And we wanted to compare this to Aurora B inhibition, which completely cuts off mitotic entry by aggregating the phosphorylation of histone H3 and there was no synergy between these two agents and you can see there. The lack of fastball, histone H3, an increase in DNA damage. Taking this into xenograft models here at either of two doses of the wee one inhibitor, the standard dose of the Aurora
inhibitor tumors continued to grow

not too differently from vehicle,

but when we gave the two together,

there was control of tumor growth and

actually statistically significant

looking at the tumors under the microscope

there was a decrease in proliferation

reflected in decreased Ki 67,

there was increased cleaved caspase and

there was a decrease in fast for CDK,

one within tissue and if we did

Aquaphor phospho CDK one and

counted the amount of phosphorus,

one signal in the tumor leading edge.
You can see this was dramatically decreased.

Ellisor to has been a difficult drug to work within the clinic.

It’s associated with Mila suppression,

and there’s been a negative phase three monotherapy trial,

and lymphoma,

and so we were concerned that the development of that agent might not go forward.

However,

there’s been a number of 2nd generation drugs that have come forward and we’ve had access to a compound from Taiho called task 119 recently been acquired by Bit Track.
And it's gonna be called Vic 1911 moving forward and once again across a range of P53 mutated cell lines we see dramatic synergy for the two agents. Once again, we see synergy in xenograft models. This is confocal microscopy that again shows you the multipolar spindle formation with the use of task 119 is the Aurora inhibitor. But with the cells really arresting in that or becoming quiet sent in that multipolar spindle state an as they then attempt to enter mitosis in the presence of both the wee one
inhibitor and the Aurora inhibitor, developing these very catastrophic
mitotic phenotypes, an notice that I’m sort of running out of time here,
so I won’t March you through this, but the mechanism looks to be identical here,
I’m working with our Columbus is Lambert at Fox Chase.
We undertook a high throughput screen to see if we could find additional partners that would be.
Both hindering and an fostering mitotic entry again with the attempt to exploit these multiple regulators of G2,
M and another hit that appeared

very strong was the check one

inhibitor Prexasertib agent.

It’s not really moving forward in

the clinic because of its toxicity,

but I wanted to show this just

because with very low dose Ng and

a single dose we saw a profound.

Energetic survival effects that make us

hopeful that with a number of these pairs,

we might be able to go to very

low doses in the clinic.

So test 119 has completed

two clinical trials.

There’s a recommended phase two dose.

The toxicity seems to be very manageable
with diarrhea and eye disorders.

Probably the prominent most prominent side effects,

and so we are moving forward with a window trial in HPV,

negative head neck cancer that will have both an initial dose escalation.

Looking at the combination of Vic and DAB assertive.

And followed by a dose expansion and that will be part of Project two of

our head next 4 so I wanted to leave a couple of minutes for questions,

but I didn’t want to end without first of all calling out all of
the fabulous colleagues who were part of the team that they put the head and explore in and then acknowledging all the people whose work I’ve just talked about, particularly John Wooley Jannike Parameshwar on in Teresa Sandoval Schaefer in the lamp. So thank you very much. Barbara, thank you. That’s fabulous work. Congratulations on all of it and and folks can submit questions on the on the chat box of the zoom, but I wanted to ask, you know, with regard as you look through
00:26:10.906 --> 00:26:12.895 the combination of an Aurora kinase and we want inhibitors,
00:26:12.895 --> 00:26:14.765 do you have a sense of 1st what might emerge?
00:26:14.770 --> 00:26:18.680 I’m even when you’re getting response
00:26:18.680 --> 00:26:21.020 because of the complexity of those pathways.
00:26:21.020 --> 00:26:23.758 What might emerges mechanism?
00:26:23.760 --> 00:26:25.436 Resistance that will occur when
00:26:25.436 --> 00:26:27.531 you have dual inhibition of any and
00:26:27.531 --> 00:26:30.186 what do you anticipate will be the toxicity profile or the therapeutic
00:26:30.186 --> 00:26:32.552 then the second question I have is
00:26:32.552 --> 00:26:34.540 therapeutic window for the combination
00:26:34.540 --> 00:26:36.300 clinically. So the we want inhibitors
00:26:36.300 --> 00:26:38.060 been quite tolerable ’cause I’m
00:26:38.060 --> 00:26:40.496 going to take the second question
00:26:40.496 --> 00:26:42.527 NOTE Confidence: 0.827964603900909
00:26:42.527 --> 00:26:44.585 NOTE Confidence: 0.827964603900909
first 'cause I've already wrestled with X and a lot that we want. Inhibitors been quite tolerable in the clinic but when it was combined with PARP inhibition, diarrhea really became the dose limiting. Side effect, and so this second generation Aurora inhibitor did have about a 25% rate of high grade diarrhea at the recommended phase two dose. So the two things that were sort of hoping is 1. That will get away with lower doses as we have in the animal models and second of all, the diarrhea as it dose limiting toxicity is one of the easier ones to
manage and so that if we’re on top of this with an Imodium regimen early on, hopefully that will be helpful in terms of resistance mechanisms with this is not something that we’ve really gone into with the combination yet, but is well studied for both of the agents independently and one of the. Resistance mechanisms to the Aurora agents has been a kind of conformational dependence on the inhibitor, so inhibitor binds to the activated form of Aurora A and if you get a adaptive process where the cell just generates more inactive Aurora,
the current generation of inhibitors may not work as well and there is a group. Kevan Shokat lab has been developing novel Aurora inhibitors that may be more able to bind the inactive confirmation as well. And in terms of we want inhibitors there there is. Suggestions that? The the. Do you need damage effects of? That we want inhibitors may have an S phase. Could actually upregulate some checkpoints that are earlier in the cell cycle. But it’s a good question. Probably something we should devote more effort to. Yeah, well, I’m sure it’ll
it’ll definitely emerge. Emerge as you get samples from your trial. So it’s really exciting. And congratulations so I know we’re at 12:31. Wherever so why don’t we will turn out to people? Can submit questions to Barbara Online, but will turn now to our second speaker and very fortunate to have another valued member of our faculty speaking. Doctor Elizabeth Klaus is a professor of Biostatistics and neurosurgery. Focused not only on brain tumors but also the Epidemiology, most notably the genetic
Epidemiology of these malignancies.

She received her MD and PhD from Yale and completed her surgery here in their surgery and through her work she really has been an international leader in the investigation of the Epidemiology of CNS Malignancy’s, most notably serving as the leader of the Meningioma consortium, that meningioma Genome Wide Association study. also a leader of the AL Acoustic neuroma study, a leader in the investigation of the Meningioma consortium, that meningioma Genome Wide Association study. Also, a leader of the AL Acoustic neuroma study, and we again were so pleased to have talented people who bridge the gap of Epidemiology in biology of cancer.
NOTE Confidence: 0.831635475158691
00:30:10.785 --> 00:30:13.564 and Elizabeth thank you so much for
NOTE Confidence: 0.831635475158691
00:30:13.564 --> 00:30:17.388 sharing your work with us today.
NOTE Confidence: 0.831635475158691
00:30:17.390 --> 00:30:18.326 Thanks very much.
NOTE Confidence: 0.831635475158691
00:30:18.326 --> 00:30:19.892 Can you see my slides?
NOTE Confidence: 0.831635475158691
00:30:19.892 --> 00:30:20.204 OK,
NOTE Confidence: 0.850167512893677
00:30:20.204 --> 00:30:20.828 yes great.
NOTE Confidence: 0.850167512893677
00:30:20.830 --> 00:30:22.090 So I’m going to
NOTE Confidence: 0.850167512893677
00:30:22.090 --> 00:30:24.088 talk a little bit about something
NOTE Confidence: 0.850167512893677
00:30:24.088 --> 00:30:26.403 we’ve been working on an I do want
NOTE Confidence: 0.850167512893677
00:30:26.403 --> 00:30:28.571 to note that this is work done in
NOTE Confidence: 0.850167512893677
00:30:28.571 --> 00:30:30.386 collaboration with Jeff Townsend’s Group
NOTE Confidence: 0.850167512893677
00:30:30.386 --> 00:30:33.040 who I think you all know very well.
NOTE Confidence: 0.850167512893677
00:30:33.040 --> 00:30:34.605 And Vincent Kenna Tarot as
NOTE Confidence: 0.850167512893677
00:30:34.605 --> 00:30:35.857 well as Steven Gaffney.
NOTE Confidence: 0.850167512893677
00:30:35.860 --> 00:30:37.425 So despite all the things
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that we’ve attempted to do, we still don’t know much about risk factors for glioma. And we wanted to take a look and see if they were different methods that we could use. To see if we could tease out both environmental and then also another hot topic is sex specific signatures of glioma causation. So you all know that gliomas are the most common type of malignant brain tumor, accounting for about 1/3 of all brain tumors, and the majority of malignant tumors. But they proved to be very heterogeneous and we have not done a
great job identifying risk factors, be they genetic or environmental for glioma. And so we were interested in doing that, particularly in light of the poor outcomes that we see with this group of patients. So we do know that there are sex specific differences in glioma risk and outcome and the plots I have here are for all gliomas, an then glioblastoma or sort of an IDH positive. Excuse me, IDH negative tumor and then lower grade gliomas. the plots I have here are for all gliomas, an then glioblastoma or sort of an IDH positive. Excuse me, IDH negative tumor and then lower grade gliomas. The males being the blue, the females being the red.
And it’s interesting in that we see this sex specific difference across the entire age range, so it’s a little bit different than we see with meningiomas where we see the women having greater risk, but the risk difference decreasing once women passed through the menopause. Whereas here we see the sex differences for glioma across the age spectrum and across all subtypes, and so that obviously suggests that other mechanisms in addition to a good sex hormones must be.
Are behind the difference men are at greater risk of being diagnosed with the disease. And again, that’s across pretty much all the subtypes and they also have lower survival in general then for females across all subtypes. So we’ve looked at this a little bit and I’ve been lucky enough to collaborate with a group of individuals called the glioma. International Case Controls Consortium, and that’s led by Melissa Bondy, initially at MD Anderson, then it Baylor.
Now she heads up the Epidemiology section at Stanford, but we were able to gather over 10,000 cases and 10,000 controls, and so these are essentially looking at constitutional or germline risk alleles by sex.

So we did certainly find differences at the germline level, males being the blue, an females being the red.
but we were also interested in looking at things at the tumor or their cinematic level.
Sex is a biologic variables I mentioned. This is a very hot topic. Now we obviously know there are biologic differences between males and females. There's also some thought as to whether there's variation in the prevalence of risk factors, and then also whether there's a difference in sort of a gene by environmental interaction. So, for example, and this has long been postulated,
but it’s really been pretty difficult to prove that males in particular are more likely to be exposed to work like toxins that might be associated with risk, and so that was one of the things we wanted to look at as well. And in part, why we divided our analysis. So there’s two goals and what contribution and this is based on some of the work that I know you’ve already appreciated with Jeff Townsend, but we’re applying it specifically now to glioma,
but looking at the relative contribution of cancer cell lineages, proliferation and survival of single nucleotide mutations, and we divided our study subjects up by IDH mutation. And, as most of you know, IDH mutation is one of the key dividers into the. The higher in the lower grade tumors, certainly a prognostic factor, as well as a factor in response to treatment. We also wanted to quantify, and this is something that is a little bit new to Epidemiology.
in terms of how we’ve tried to identify risk exposures. Typically we’ve done things like large case control studies where we look at large numbers of people that have the disease, and compare them to large numbers of people without the disease, and look at things like questionnaire or work pic. Exposure and see if we can figure out differences between the cases and controls. So what we’re doing now, and this is sort of an emerging field in cancer Epidemiology, is to look at the cosmic cancer.
mutational signatures in tumors and see if we can then backtrack match it to possible risk exposures,

and one of the things we’re hoping to do in the future is to go back to our cohorts and studies for which we collected good occupational data and see if we can match it up to. Mutational signatures So the methods I am highlighting here. Jeff’s paper that he had in J&CI two years ago, and I think you’ve seen some of these sorts of methods applied,
in particular to actually head and neck cancer.

So the Cancer Genome Atlas, and others, including the glioma Longitudinal Analysis Consortium, or Glass, which is led by roll. Their Hokage, Jackson Labs and which I'm also a member of. So these groups have identified the most common genetic changes in primary glioma tumors including TP 53, IDH, EGFR with the relative importance of these mutations and how they relate to tumorigenesis. Is not well known,
so one of the things that we’ve been working on, and Jeff has been a leader in defining this cancer affect size. So this metric of the relative overabundance of variance due to their contributions to survival, their indivision versus what you’re actually seeing in the tumor. So we’re quantifying the cancer affect size. We’re using single nucleotide mutations, and then we basically do a scaled selection coefficient for the different variants we look at.
By sex and by IDH subtype.

And so we're trying to get a feel for whether this would help us explain any differences in the glioma, risk and outcome that we see by sex.

And then we're going to move on to the cosmic mutations so I won't go into the gory statistical detail.

This is drawn from Jeff's paper, but basically you're comparing expected to observed so expected number of synonymous mutations, and then we're looking at the rate at which the mutations. Actually occur.

The data that we're using here,
our whole exome sequencing data from a pretty good size data set in terms of glioma, so about 1100 and these are all adult patients. There’s no pediatric patients in here and we drew it from the Cancer Genome Atlas study. And as I mentioned, I know some of you may be aware of what glasses, so it’s an effort. As I mentioned led by role Verhaag, which yell is also a member of looking at not only the initial tumors, but the tumours overtime. So how do they change?
In terms of their genetic makeup, when we do nothing to them when we do chemotherapy or we do radiation, or a combination of all the above and what changes do we see and what do we learn from that in terms of what we should or should not be doing?

And then we also used a lot of data. All of this is readily available off the Internet, but we use tissue specific mutational covariance and this helped. Just figure out what sort of mutation rate calculations we should use. Gave us a little bit of information about replication timing.
And some of the other datasets that are listed here. So here’s some of the results. Just to take you through it a little bit. So I have a divided by tumor type and it’s by seksan by mutation. So the wild type tumors who would be considered the higher grade are primarily the glioblastoma tumors are in the first 2 rows and the IDH mutant, which would more typically be the lower grade tumors. And then I have males versus females, and then there’s sort of a
cancer affect size here.

The blue is non coding region.

And the red is coding so you can see the patterns are quite different for what might be called the low and the high grade, the IDH mutant tumors had few unique recurrent substitutions. All of them were in coding regions, whereas the wild type tumors, and obviously this is in part what makes them so hard to manage is they exhibited many substitutions, but they were primarily in non coding regions.

So here’s another picture.
A little busy but divided once again, the IDH mutant or the lower grade tumors are presented first. The wild types are second, and there's female male, female, male, and So what we're looking at here is that. Items that top the list are the most important. The size of the circle that is attached to them measures the prevalence so there can be kind of this. Disconnect as to what is important and how frequently it occurs so we can see that in the low grades it's pretty much as expected.
Previously reported mutations in IDH one and two TP 53.

Some of the other classics were confirmed, but what’s interesting is if we go here to the IDH.

Wild type tumors the most important with respect to cancer affect. Is this B RAF V 600 E so we know that it’s important.

You can see that the circle that matches up to it is small, not large like we see for IDH.

Is this B RAF V 600 E so we know that it’s important.

It turns out that it looks like it’s the most important, but obviously it doesn’t occur.
that frequently but interesting.

What drives some of these gliomas here?

The other thing we looked at is do males and females show the same pattern of what significantly overburdened,

and there were a lot of similarities the way that we have this broken up here is each panel is a gene.

The mutants come first in each panel and then within each panel we’ve got the females in the mails.

So we did see some differences, although overall most the things the males and females showed were similar, but we did see differences in the P3K
pathway, so an IDH mutant, tumors the PK.

Three CA mutations were located in the helical domain for females, and the kinase domain for the males, and so that's appear. This panel here. OK, so it's the mutant and non mutant and then the variance of import also differed by sex for PK3R1 and so that's interesting in part because we know that the way in which these areas are targeted by various chemotherapies does differ. We looked in the literature and we don't see too much reported honest.
We did find a paper by Dan Cahill at all at mass general and although they didn’t report it as such, they found something similar where the females tended to have. Variations in the he local domain and the males had them in the kinase domain, and obviously there’s different sensitivity to various treatment types depending upon domain.
So back to environmental exposure.

We have searched and not just our group of many groups have searched long and hard for environmental and genetic risk factors for glioma.

In terms of genetic risk factors, we have found small numbers of families with high risk but typically that does not relate to the general population and so no genetic risk factors really explain a large proportion of inherited risk and other than high dose radiation to which not many people are exposed.

We really haven’t found much of an association between environmental
risk factors in glioma risk. There has been reported a fairly consistent but low effect, an inverse Association with history of allergy. So the question comes, why haven’t we found anything? Is it that there is no Association? Or is it basically statistical power that there’s so few cases of glioma relative to other things we’ve looked at? For example, I started my work with breast cancer and even just using the state of Connecticut as a base,
you would have enough cases for a large study for glioma. That is not true and also likely a lot of the exposures that we think are causing risk are themselves rare. So one of the things that people have been thinking about doing, is there another way to do this now? So now that we have these mutational signatures that are listed in the Catalogue of Somatic mutations and cancer or cosmic can use that as a way to match up to exposure, particularly if you have previously obtained environmental or other exposure history in the patients.
So we did that here with the 1100 cases that we mentioned, we group Jack Sonic. SNV and tried to match him up to what is in cosmic, and so you know that the cosmic catalog is rapidly changing. New things are always being added, but we looked at what existed at this point, obviously they have previously found a match up over environmental exposure to signatures not only in head and neck cancer, but smoking and lung cancer, UV exposure, and so we looked at that for glioma.
And so again, here's our slide here again, broken into IDH Mutant, which is the top row IDH, Wildtype bottom row and then females or first column mails or second column with each of these bar charts relates to is the proportion of our cases for whom the majority seem to be associated with a certain signature. And the overall news is a little bit depressing in the sense that the primary molecular signature identified was age related mutagenesis. Basically the older you get, the more at risk you are,
but we did find one thing that was quite interesting, particularly in light of their such a positive risk factors identified for glioma and that was occupational exposure to something called Halo alkanes. Pretty much true across whether you are male or female. And whether you were IDH, mutant or not, we did find a little greater rate of the signature showing up in the males versus the females. But we certainly saw them in both and then we also saw which we
haven’t quite figured out how to explain yet. These UV light signatures are interesting because glioma has been associated in the number of instances with Melanoma and also with the B RAF. So we’re trying to sort out whether that. Has anything to do with why we’re just seeing some of those signatures? So hello, alkanes are basically used for many industrial and day-to-day purposes. Of interest there seen in refrigerants, fire extinguishers, flame retardants, and we thought this was very interesting because there’s always sort of been this theory that in some of these. Occupations including for firemen
and that has been reported that there is an increased risk of glioma, so whether or not this ties things together or not is unclear, so the signature was basically developed by looking at cholangio carcinoma in a group of workers that were exposed, known, exposed to hello Alkins in Japan and so essentially they had 111 workers that were exposed, 17 developed, Would you all know to be a pretty rare? Cancer, so it was quite unusual that this number of individuals was diagnosed with it.
They all were working in printing companies and they all were known to have occupational exposure and so essentially what they did was they took the tumors from these individuals, looked at the molecular pattern and developed this signature. So that’s essentially how that signature was initially identified, and so that’s what we’re seeing. Basically in our data. So conclusions here that the majority of cancer causing mutations in these gliomas we’re seeing primarily as a consequence of endogenous, rather than actual, exogenous exposures.
We did think was interesting that different domains of jeans in the P3K pathway were different for males and females. For those of us that have searched long and hard for some of these risk factors for glioma, we are excited that at least potentially, there’s a new means to try and identify even if rare, these environmental risk factors and it’s sort of a whole new aspect of glioma that were looking at so some of our future directions.
Both in the meningioma consortia man, the Glioma international Case Control Consortium. And we also in our international low grade glioma registry. So the San Francisco Bay Area Adult Glioma study, which is led by Margaret Wrench and John Winky, they collected extremely detailed occupational history for their cohort, and they have all the tumors. So we’re going to try and go back and genotype those tumors and see if...
we can confirm these associations, which they found with firefighters. And glioma. And also they found it with painters as well. And so we are also collecting glioma patients with occupational histories and just sort of throwing it out to people. If you’re aware of any firefighters or similar occupied individuals with glioma would love to try and get a cohort together. The other thing that was just sort of luck this past semester. So I teach over at the school, public health and everything has been remote.
And so as I was meeting via zoom with one of my students for her final project, she revealed that she was actually the principle project director for the Firefighters Cancer Cohort study. So we’re also hoping to partner with some of these folks to look at individuals, either living or dead, that may have undiagnosed glioma. So thank you all for your time. I wanted to also thank Jeff Townsend.
Vinston, Canna Terra, who was a postdoc in Jeff’s lab but now as an assistant professor of biology up the road, a little bit of Emmanuel College and I have to thank him. He made all the beautiful pictures an Steven Gaffney, who also works in Jeff Slab. Thank the various. Brain tumor associations, including the ABCA in the NBTS as well as Luglio Anna, a Dutch group called Stop Brain for their support and then also thank you for Doctor Rolled.
their hacking the Glass consortium

who allowed us access to the data.

So happy to take any questions.

That was a terrific summary of your

work and obviously will open it

up to questions on the chat line.

But let me ask.

I found it interesting the the

observation I guess from Asia

about the Association of Halo

alkanes with cholangiocarcinoma.

As you may know,

there’s there’s a biologic

difference between intrahepatic,
where extra panic actually gave
IDH mutations but insured don’t wear the cases that they found
in Asia with a extra paddock.
You know, I don’t know the answer to that.
I gave a similar talk at UCSF and they mentioned this as well,
so we’re trying to gain access to some of that information,
but I don’t know at present.
And then. With regard to the finding of the potential differential in mutations
within pick three CA by gender by sex,
is there an understanding of
why those two domains would be different between men and women?
No, and you know, we started to look at that a little bit and we collaborate a bit with Dan Cahill. As I mentioned up at mass general so we don’t know yet, but he’s going to try to take a look into that he he presented the data but didn’t note the differences, so he’s going to try to take a look and see what that. Might entail. And then my last question, and this is gonna show my naivete
and understanding brain tumors. But instead of the Natural History of the low grades. Is there an evolution of the semantic events such that they look more like high grades? So it depends. They generally remain quite different. The IDH mutation stays constant throughout and so that’s sort of been one of the issues is what you show up to the party with you tend to be what you stay within. That makes it a little bit different to manage them.
We didn’t find in some of the glass consortium work that we’ve looked at that really things changed that much whether you gave them treatment or whether you didn’t give them treatment. Is a little bit disheartening, but we’re going to try to look a little bit further at that.

For the presence of Halo alkanes, you could imagine they may be more ubiquitous in our environment than we might otherwise appreciate given.
all the things they are in absolutely and it doesn’t have to just relate to glioma. 

You know could relate to lots of different things so.

Well, very interesting. 

You know we’re just about out of time.

An really appreciate.

Oh actually, JoJo contest hasn’t question, forgive me.

So Joe’s question is high dose 

radiation therapy delivered to pediatric patients can lead to glioma? 

Have you found evidence that medical imaging and radiation exposure in
00:53:51.988 --> 00:53:53.980 this setting is associated? So
NOTE Confidence: 0.861393511295319
00:53:53.980 --> 00:53:55.805 there's actually, and you probably
NOTE Confidence: 0.861393511295319
00:53:55.805 --> 00:53:58.210 even know of these two studies.
NOTE Confidence: 0.861393511295319
00:53:58.210 --> 00:54:00.583 There's a big cohort from Australia as
NOTE Confidence: 0.861393511295319
00:54:00.583 --> 00:54:03.580 well as a second cohort from England,
NOTE Confidence: 0.861393511295319
00:54:03.580 --> 00:54:06.612 and they did find that even exposure to
NOTE Confidence: 0.861393511295319
00:54:06.612 --> 00:54:09.826 head CT’s at an early age in children
NOTE Confidence: 0.861393511295319
00:54:09.826 --> 00:54:12.029 was associated with the I mean.
NOTE Confidence: 0.861393511295319
00:54:12.030 --> 00:54:14.718 It’s a very small increase in risk,
NOTE Confidence: 0.861393511295319
00:54:14.720 --> 00:54:16.760 but a definite increase in risk
NOTE Confidence: 0.861393511295319
00:54:16.760 --> 00:54:18.940 of both glioma and meningioma,
NOTE Confidence: 0.861393511295319
00:54:18.940 --> 00:54:21.076 and then anything we looked at
NOTE Confidence: 0.861393511295319
00:54:21.076 --> 00:54:24.237 we did find it was a fairly hotly
NOTE Confidence: 0.861393511295319
00:54:24.237 --> 00:54:26.302 contested topic we did find.
NOTE Confidence: 0.861393511295319
00:54:26.310 --> 00:54:28.711 And exposure to bite wings was associated
NOTE Confidence: 0.861393511295319
00:54:28.711 --> 00:54:30.908 with an increased risk of meningioma,
but that's sort of exposure level in terms of dental X-rays generally doesn't exist now. But yeah, in terms of head CT's, anyone to do suggest that, although you know, the absolute numbers are small. And then Antonio Murray asks, is great talk. Have you looked at thyroid hormones, thyroid disease and differences between men and women? So we haven't but one thing that
00:54:59.939 --> 00:55:02.438 is very interesting, and it relates
NOTE Confidence: 0.837125480175018
00:55:02.438 --> 00:55:04.934 a little bit more to meningioma.
NOTE Confidence: 0.837125480175018
00:55:04.940 --> 00:55:07.448 Is a gene that we found,
NOTE Confidence: 0.837125480175018
00:55:07.450 --> 00:55:09.530 and this is a constitutional
NOTE Confidence: 0.837125480175018
00:55:09.530 --> 00:55:11.194 gene on chromosome 10.
NOTE Confidence: 0.837125480175018
00:55:11.200 --> 00:55:14.119 We’ve found to be associated with meningioma,
NOTE Confidence: 0.837125480175018
00:55:14.120 --> 00:55:16.200 breast, ovarian and also now
NOTE Confidence: 0.837125480175018
NOTE Confidence: 0.886166334152222
00:55:20.270 --> 00:55:21.176 Elizabeth, thank you.
NOTE Confidence: 0.886166334152222
00:55:21.176 --> 00:55:23.690 We are at the top of the hour.
NOTE Confidence: 0.886166334152222
00:55:23.690 --> 00:55:25.245 Appreciate both your talk and
NOTE Confidence: 0.886166334152222
00:55:25.245 --> 00:55:26.489 Barbara’s really extending work.
NOTE Confidence: 0.886166334152222
00:55:26.490 --> 00:55:28.770 Thank you for sharing all of it with
NOTE Confidence: 0.886166334152222
00:55:28.770 --> 00:55:31.470 us and to everyone who joins us today.
NOTE Confidence: 0.886166334152222
00:55:31.470 --> 00:55:33.528 Thank you for taking the time
NOTE Confidence: 0.886166334152222
00:55:33.528 --> 00:55:35.623 to join grand rounds and we’ll
see you all again next week.

Have a good day.