

LAG-3 Expression and Outcome of Metastatic Melanoma Patients Treated with Combination Anti-LAG-3 + Anti-PD-1 Immunotherapies



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BACKGROUND

Lymphocyte-activation gene-3 (LAG-3), an immune checkpoint receptor, negatively regulates T-cell function and facilitates immune escape of tumors¹.

Dual inhibition of LAG-3 and programmed cell death receptor-1 (PD-1) significantly improved progression-free survival (PFS) in metastatic melanoma patients compared to anti-PD-1 therapy alone².

Investigating the utility of LAG-3 expression as a biomarker of response to anti-LAG-3 + anti-PD-1 immunotherapy is of great clinical relevance.

OBJECTIVES

To evaluate the association between baseline LAG-3 expression and clinical outcomes following anti-LAG-3 immunotherapy in metastatic melanoma

RESULTS

LAG-3 Expression in Melanoma

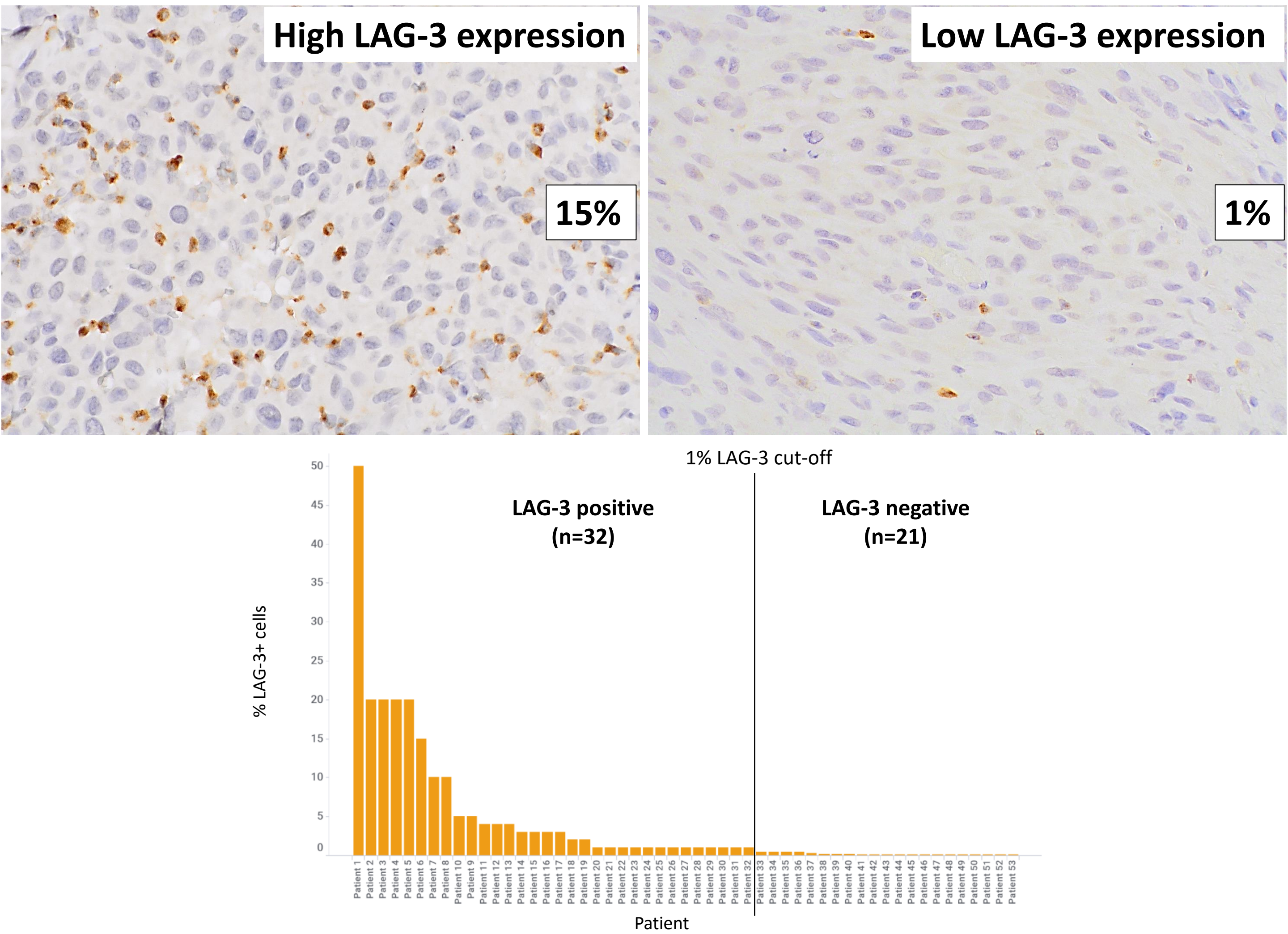


Figure 1. LAG-3 expression in melanoma.

LAG-3 Expression in Different Sites of Metastasis

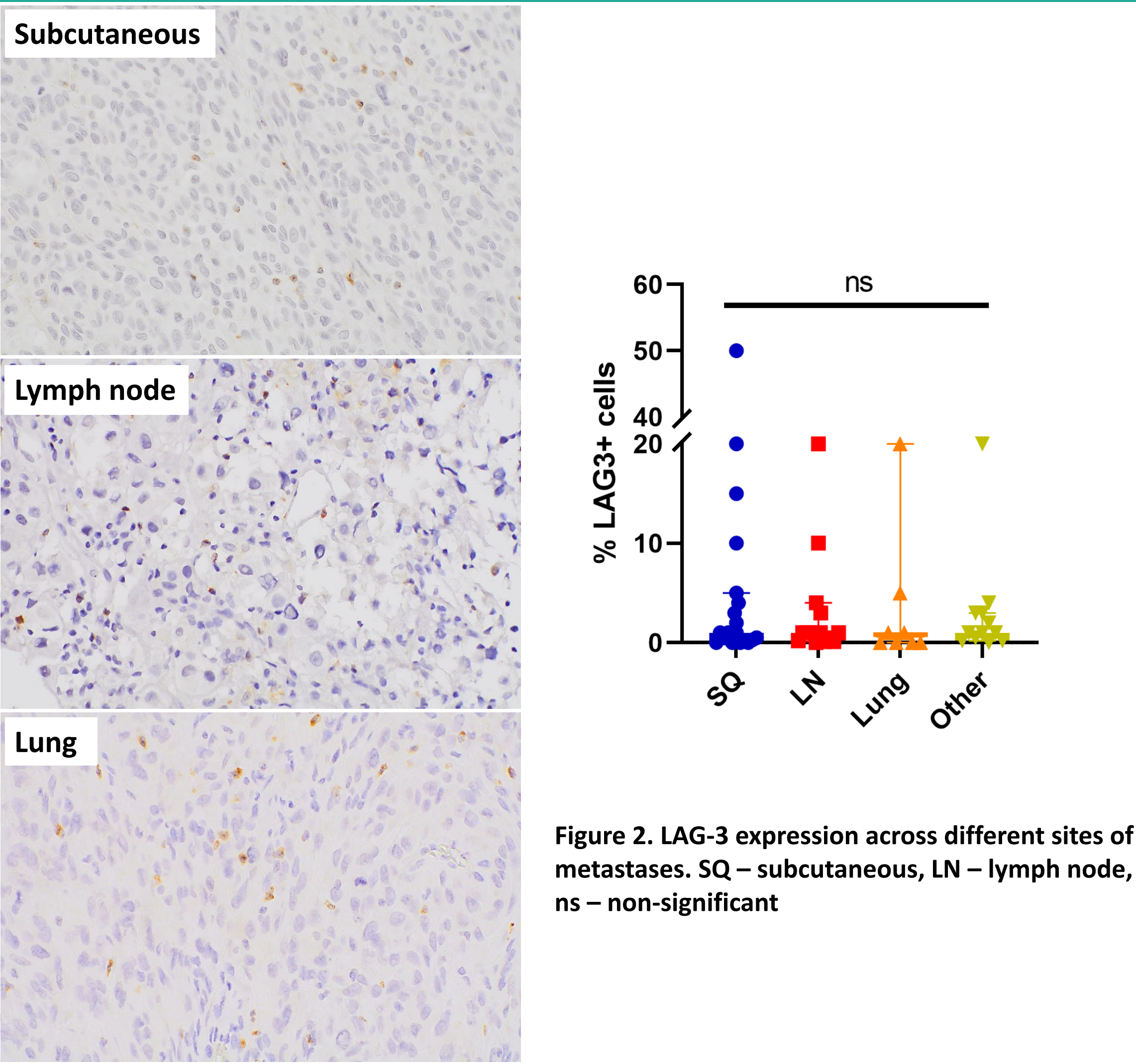


Figure 2. LAG-3 expression across different sites of metastases. SQ – subcutaneous, LN – lymph node, ns – non-significant

CONCLUSIONS

- LAG-3 expression is associated with response to combination anti-LAG-3 and anti-PD-1-based immunotherapy
- Patients with LAG-3 positive tumours have significantly longer PFS compared to those with LAG-3 negative tumours
- Assessment of LAG-3 expression via IHC warrants further evaluation to determine its predictive value in metastatic melanoma

METHODS

- LAG-3 immunohistochemistry (clone D2G4O) was performed on pre-treatment formalin-fixed paraffin-embedded metastatic melanoma specimens from 53 patients treated with combination anti-LAG-3 + anti-PD-1-based therapies
- Patients were categorized as responders (CR or PR; n=37) or non-responders (SD or PD; n=16) based on RECIST
- Tumor-infiltrating lymphocytes (TILs) were scored on hematoxylin and eosin-stained sections using a four tier TIL grading scheme
- LAG-3 was evaluated on lymphocytes expressing punctate, cytoplasmic, or membranous LAG-3 as described previously³
- Samples were classified as LAG-3 positive if the number of LAG-3+ lymphocytes was $\geq 1\%$ of all cells

LAG-3 Expression is Associated with Response

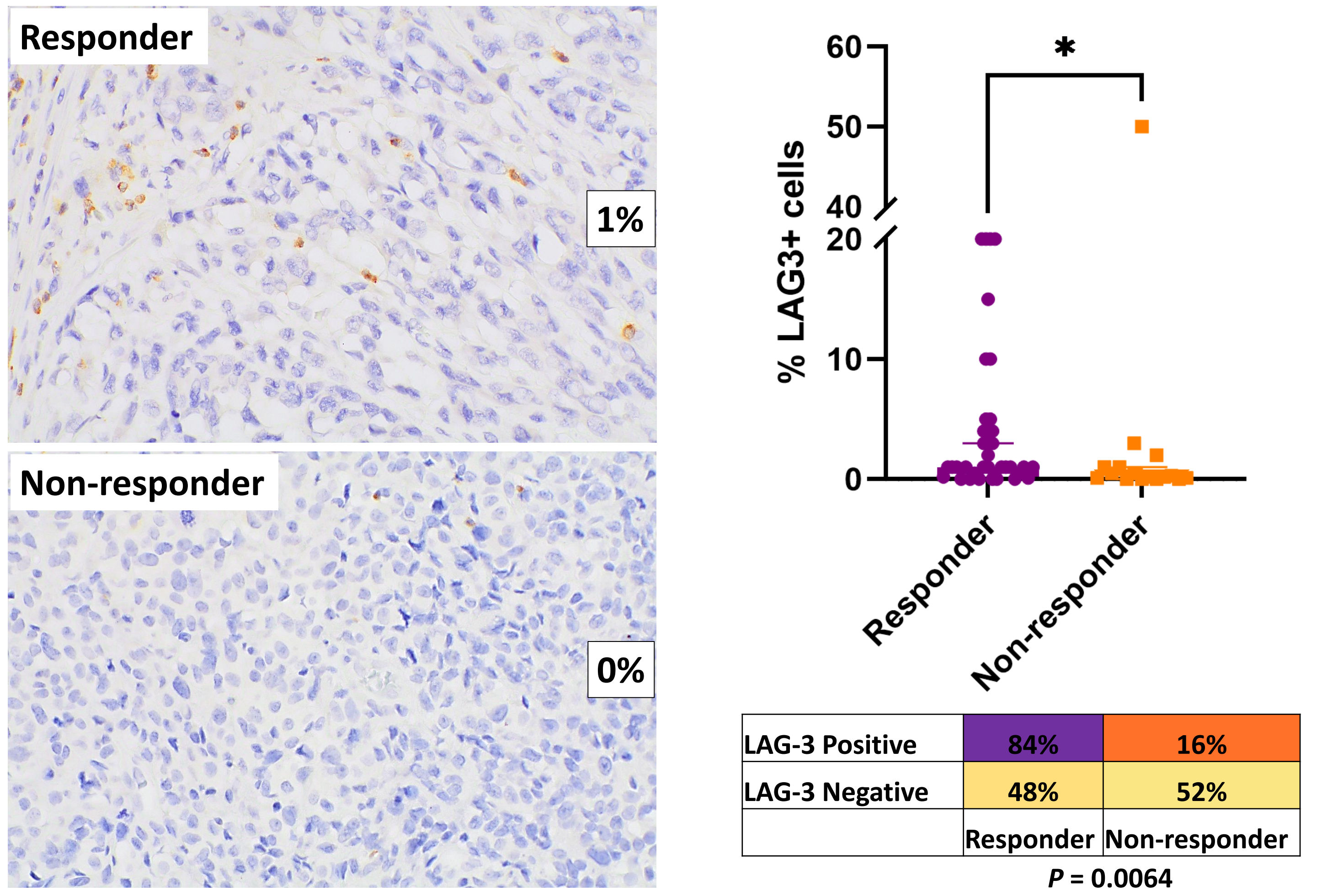


Figure 3. Association between LAG-3 expression and response to anti-LAG-3 + anti-PD-1-based immunotherapy. *P < 0.05

LAG-3 Expression is Associated with PFS

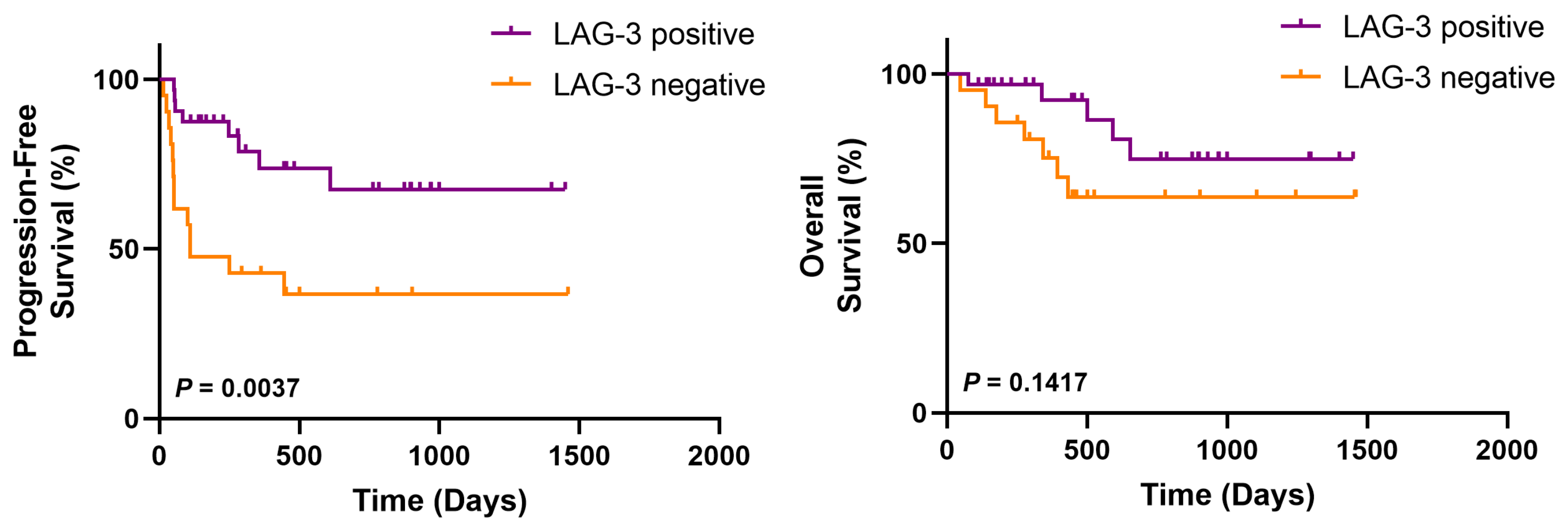


Figure 4. Association between LAG-3 status and progression-free and overall survival.

LAG-3 Expression in Anti-PD-1 Refractory Patients

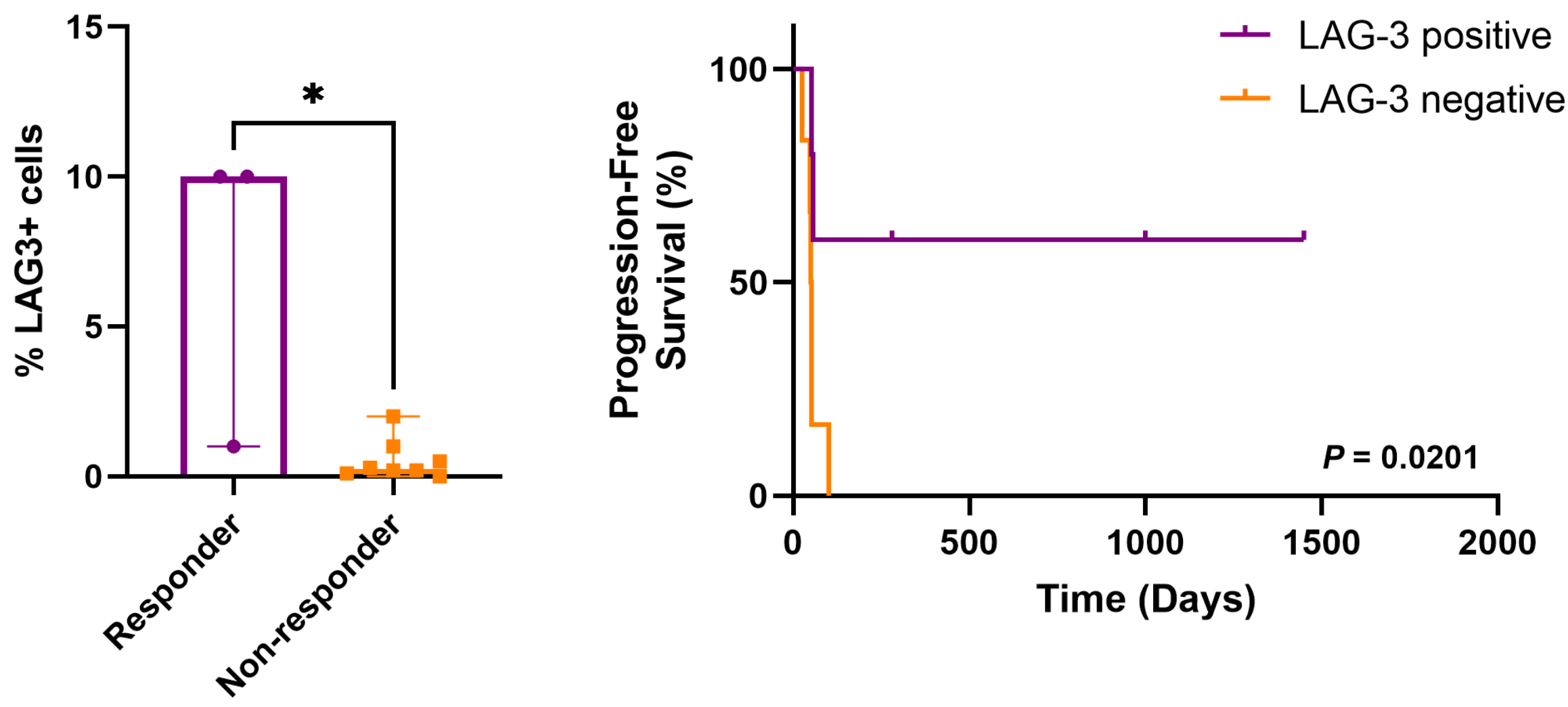


Figure 5. Association between LAG-3 expression, response and PFS in anti-PD-1 refractory cohort. *P < 0.05

References

1. Andrews et al. LAG3 (CD223) as a cancer immunotherapy target. Immunological reviews 2017;276:80-96
2. Tawbi et al. Relatlimab and Nivolumab versus Nivolumab in Untreated Advanced Melanoma. N Engl J Med 2022;386:24-34
3. Johnson et al. Development of a LAG-3 immunohistochemistry assay for melanoma. J Clin Pathol 2022;0:1-8

Acknowledgements

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