FOUNDATIONONE®CDx

PATIENT
Sung, Hsin-Feng

TUMOR TYPE
Colon adenocarcinoma (CRC)
COUNTRY CODE
TW

REPORT DATE
19 May 2022
ORDERED TEST #
ORD-1362453-01

ABOUT THE TEST FoundationOne®CDx is a next-generation sequencing (NGS) based assay that identifies genomic findings within hundreds of cancer-related genes.

PATIENT
DISEASE Colon adenocarcinoma (CRC)
NAME Sung, Hsin-Feng
DATE OF BIRTH 17 July 1969
SEX Female
MEDICAL RECORD # 35768991

PHYSICIAN
ORDERING PHYSICIAN Yeh, Yi-Chen
MEDICAL FACILITY Taipei Veterans General Hospital
ADDITIONAL RECIPIENT None
MEDICAL FACILITY ID 205872
PATHOLOGIST Not Provided

SPECIMEN
SPECIMEN SITE Colon
SPECIMEN ID S110-60828 G
SPECIMEN TYPE Slide Deck
DATE OF COLLECTION 19 March 2021
SPECIMEN RECEIVED 12 May 2022

Biomarker Findings

Microsatellite status - MS-Stable
Tumor Mutational Burden - 6 Muts/Mb

Genomic Findings

For a complete list of the genes assayed, please refer to the Appendix.

KRAS wildtype
NRAS wildtype
APC E1309fs*4
PIK3CA G1007R - subclonal†
TP53 R273H

3 Disease relevant genes with no reportable alterations: ***BRAF, KRAS, NRAS***

† See About the Test in appendix for details.

Report Highlights

- Targeted therapies with **NCCN categories of evidence** in this tumor type: **Cetuximab** (p. 8), **Panitumumab** (p. 8)
- Evidence-matched **clinical trial options** based on this patient's genomic findings: (p. 9)

BIOMARKER FINDINGS	THERAPY AND CLINICAL TRIAL IMPLICATIONS	
Microsatellite status - MS-Stable	**No therapies or clinical trials.** see Biomarker Findings section	
Tumor Mutational Burden - 6 Muts/Mb	**No therapies or clinical trials.** see Biomarker Findings section	
GENOMIC FINDINGS	**THERAPIES WITH CLINICAL RELEVANCE (IN PATIENT'S TUMOR TYPE)**	**THERAPIES WITH CLINICAL RELEVANCE (IN OTHER TUMOR TYPE)**
***KRAS* -** wildtype	Cetuximab 2A	none
0 Trials	Panitumumab 2A	
***NRAS* -** wildtype	Cetuximab 2A	none
0 Trials	Panitumumab 2A	
***APC* -** E1309fs*4	none	none
4 Trials *see p. 9*		
***PIK3CA* -** G1007R - subclonal	none	none
10 Trials *see p. 10*		

☐ *NCCN category*

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GENOMIC FINDINGS WITH NO REPORTABLE THERAPEUTIC OR CLINICAL TRIAL OPTIONS

For more information regarding biological and clinical significance, including prognostic, diagnostic, germline, and potential chemosensitivity implications, see the Genomic Findings section.

NOTE Genomic alterations detected may be associated with activity of certain approved therapies; however, the agents listed in this report may have varied clinical evidence in the patient's tumor type. Therapies and the clinical trials listed in this report may not be complete and exhaustive. Neither the therapeutic agents nor the trials identified are ranked in order of potential or predicted efficacy for this patient, nor are they ranked in order of level of evidence for this patient's tumor type. This report should be regarded and used as a supplementary source of information and not as the single basis for the making of a therapy decision. All treatment decisions remain the full and final responsibility of the treating physician and physicians should refer to approved prescribing information for all therapies.

Therapies contained in this report may have been approved by the US FDA.

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BIOMARKER

Microsatellite status

RESULT
MS-Stable

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

On the basis of clinical evidence, MSS tumors are significantly less likely than MSI-H tumors to respond to anti-PD-1 immune checkpoint inhibitors[1-3], including approved therapies nivolumab and pembrolizumab[4]. In a retrospective analysis of 361 patients with solid tumors treated with pembrolizumab, 3% were MSI-H and experienced a significantly higher ORR compared with non-MSI-H cases (70% vs. 12%, p=0.001)[5]. For patients with chemotherapy-refractory microsatellite-stable (MSS) metastatic colorectal cancer (CRC), a Phase 3 trial reported no OS advantage from the combination of the PD-L1 inhibitor atezolizumab plus cobimetinib relative to regorafenib (8.9 vs. 8.5 months, HR=1.00); atezolizumab monotherapy similarly did not prolong OS (7.1 vs. 8.5 months, HR=1.19)[6]. For patients with MSS CRC, a Phase 2 study combining ipilimumab and nivolumab reported an overall DCR of 25% (10/40)[7]. Two Phase 1 studies for patients with MSS CRC treated with regorafenib and nivolumab reported PFSs of 7.9 months[8] and 5.7 months[9], and a patient with MSS CRC refractory to chemotherapy treated with the PD-1 inhibitor sintilimab and regorafenib reported a CR[10].

— Nontargeted Approaches —

MSI has not been found to be a predictive biomarker for combination chemotherapy regimens, including FOLFOX[11-12] and FOLFIRI[13-14]. Patients with MSS CRC are more likely to benefit from postsurgical fluorouracil (FU)-based adjuvant therapy[15-16] but less likely to benefit from irinotecan chemotherapy[17].

FREQUENCY & PROGNOSIS

MSS colorectal cancers (CRCs) make up 70-85% of CRC cases[3,18-22]. MSS colorectal cancers are molecularly heterogeneous, driven by diverse mechanisms such as extensive DNA methylation, oncogenic mutations in KRAS or BRAF, or chromosomal instability[22]. Multiple studies have shown that MSS CRCs have a worse prognosis than MSI-high tumors[18,23-29].

FINDING SUMMARY

Microsatellite instability (MSI) is a condition of genetic hypermutability that generates excessive amounts of short insertion/deletion mutations in the genome; it generally occurs at microsatellite DNA sequences and is caused by a deficiency in DNA mismatch repair (MMR) in the tumor[20]. Defective MMR and consequent MSI occur as a result of genetic or epigenetic inactivation of one of the MMR pathway proteins, primarily MLH1, MSH2, MSH6, or PMS2[20,30-31]. This sample is microsatellite-stable (MSS), equivalent to the clinical definition of an MSS tumor: one with mutations in none of the tested microsatellite markers[19,32-33]. MSS status indicates MMR proficiency and typically correlates with intact expression of all MMR family proteins[19-20,31,33].

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BIOMARKER

Tumor Mutational Burden

RESULT
6 Muts/Mb

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

On the basis of clinical evidence in solid tumors, increased TMB may be associated with greater sensitivity to immunotherapeutic agents, including anti-PD-L1[34-36], anti-PD-1 therapies[34-37], and combination nivolumab and ipilimumab[38-43]. In multiple pan-tumor studies, increased tissue tumor mutational burden (TMB) was associated with sensitivity to immune checkpoint inhibitors[34-37,44-48]. In the KEYNOTE 158 trial of pembrolizumab monotherapy for patients with solid tumors, significant improvement in ORR was observed for patients with TMB ≥10 Muts/Mb (as measured by this assay) compared with those with TMB <10 Muts/Mb in a large cohort that included multiple tumor types[44]; similar findings were observed in the KEYNOTE 028 and 012 trials[37]. At the same TMB cutpoint, retrospective analysis of patients with solid tumors treated with any checkpoint inhibitor identified that tissue TMB scores ≥ 10 Muts/Mb were associated with prolonged time to treatment failure compared with scores <10 muts/Mb (HR=0.68)[48]. For patients with solid tumors treated with nivolumab plus ipilimumab in the CheckMate 848 trial, improved responses were observed in patients with a tissue TMB ≥ 10 Muts/Mb independent of blood TMB at any cutpoint in matched samples[49]. However, support for higher TMB thresholds and efficacy was observed in the prospective Phase 2 MyPathway trial of atezolizumab for patients with pan-solid tumors, where improved ORR and DCR was seen in patients with TMB ≥ 16 Muts/Mb than those with TMB ≥ 10 and <16 Muts/Mb[47]. Similarly, analyses across several solid tumor types reported that patients with higher TMB (defined as ≥16-20 Muts/Mb) achieved greater clinical benefit from PD-1 or PD-L1-targeting monotherapy compared with patients with higher TMB treated with chemotherapy[50] or those with lower TMB treated with PD-1 or PD-L1-targeting agents[35]. In CRC specifically, a retrospective analysis of immune checkpoint inhibitor efficacy reported significantly improved OS for patients with tumors harboring TMB ≥9.8 Muts/MB compared with those with tumors with TMB <9.8 Muts/Mb (~ equivalency <12 Muts/Mb as measured by this assay)[34]. Another retrospective study reported that a TMB ≥12 Muts/Mb cutoff identifies >99% of MSI-High CRC cases but only 3% of MSS cases, indicating the utility of this cutoff for identification of patients with CRC likely to benefit from treatment with immune checkpoint inhibitors[51].

FREQUENCY & PROGNOSIS

Elevated tumor mutational burden (TMB) has been reported in 8-25% of colorectal cancer (CRC) samples[21,52-53]. Multiple studies have reported that up to 90% of hypermutated CRC cases exhibit high levels of microsatellite instability (MSI-H) and mismatch repair deficiency (MMR-D)[21,52]. Increased TMB is significantly associated with MSI-H and MMR-D, with studies reporting that 100% of MSI-H CRCs harbor elevated TMB and conversely that 100% of tumors with low TMB harbor intact MMR[52]. A subset of CRCs that harbor increased TMB but not MSI-H are driven by mutations in POLE, which leads to an "ultramutated" phenotype with especially high TMB[21,52]. Tumors with increased TMB harbor BRAF V600E mutations more frequently than those with low TMB[21,52], whereas TMB-low tumors more frequently harbor mutations in TP53 and APC[21]. The prognostic value of tumor mutational burden (TMB) in colorectal cancer (CRC) is context- and therapy-dependent. A study of tissue TMB (tTMB) in 145 CRC samples showed longer OS in TMB-high samples compared with TMB-low ones[54]. Similarly, for patients with metastatic CRC treated with first-line chemotherapy combined with bevacizumab or cetuximab, high tissue TMB (tTMB-H) was associated with longer OS[55]. For patients treated with adjuvant chemotherapy, tTMB-H was associated with better 5-year relapse-free survival[56]. However, for patients with EGFR/BRAF-inhibitor-treated, BRAF-mutated microsatellite stable (MSS) metastatic CRC, intermediate tTMB was associated with significantly poorer PFS and OS compared with TMB-low status; patients with primary resistance to EGFR/BRAF blockage had higher TMB than those sensitive to these therapies[57]. In a study for 61 patients with metastatic, MSS CRC treated with best standard of care, plasma TMB scores ≥28 Muts/Mb (approximately 14 Muts/Mb as measured by this assay) were associated with reduced OS compared with plasma TMB scores <28 Muts/Mb (3.0 vs. 5.3 months, HR=0.76, p=0.007), whereas tTMB was not found to be prognostic in this population[58].

FINDING SUMMARY

Tumor mutation burden (TMB, also known as mutation load) is a measure of the number of somatic protein-coding base substitution and insertion/deletion mutations occurring in a tumor specimen. TMB is affected by a variety of causes, including exposure to mutagens such as ultraviolet light in melanoma[59-60] and cigarette smoke in lung cancer[61-62], treatment with temozolomide-based chemotherapy in glioma[63-64], mutations in the proofreading domains of DNA polymerases encoded by the POLE and POLD1 genes[21,65-68], and microsatellite instability (MSI)[21,65,68]. This sample harbors a TMB below levels that would be predicted to be associated with sensitivity to PD-1- or PD-L1-targeting immune checkpoint inhibitors, alone or in combination with other agents[34,44,51].

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GENE
KRAS

ALTERATION
wildtype

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

Lack of mutations in KRAS or NRAS is associated with clinical benefit of treatment with EGFR-targeting antibodies cetuximab[69-72] or panitumumab[73-75] for patients with CRC. Therefore, these agents are indicated to treat patients with CRC lacking such mutations (NCCN Guidelines v3.2021).

FREQUENCY & PROGNOSIS

Approximately 50-65% of colorectal cancers (CRCs) have been reported to lack KRAS mutations[76-84]. Numerous studies have reported that KRAS wild-type status is associated with decreased metastasis, better clinicopathological features, and longer survival of patients with CRC[78-81,85-86].

FINDING SUMMARY

KRAS encodes a member of the RAS family of small GTPases. Activating mutations in RAS genes can cause uncontrolled cell proliferation and tumor formation[87-88]. No alterations in KRAS were identified in this case.

GENE
NRAS

ALTERATION
wildtype

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

Lack of mutations in KRAS or NRAS is associated with clinical benefit of treatment with EGFR-targeting antibodies cetuximab[69-72] or panitumumab[73-75] for patients with CRC. Therefore, these agents are indicated to treat patients with CRC lacking such mutations (NCCN Guidelines v3.2021).

FREQUENCY & PROGNOSIS

The majority of colorectal cancers (CRCs) (91-98%) have been reported to lack NRAS mutations[21,84,89-94]. NRAS wild-type status has been reported to be associated with decreased frequency of metastasis[84] and longer survival[94-95] of patients with CRC.

FINDING SUMMARY

NRAS encodes a member of the RAS family of small GTPases that mediate transduction of growth signals. Activation of RAS signaling causes cell growth, differentiation, and survival by activating the RAF-MAPK-ERK, PI3K, and other pathways[87]. No alterations in NRAS were identified in this case.

GENE
APC

ALTERATION
E1309fs*4

TRANSCRIPT ID
NM_000038

CODING SEQUENCE EFFECT
3927_3931delAAAGA

VARIANT ALLELE FREQUENCY (% VAF)
32.8%

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

There are no approved drugs targeting APC inactivation in cancer. Loss of APC function leads to accumulation of beta-catenin and upregulation of WNT pathway transcription programs[96], and potential therapeutic approaches to target this pathway include CBP/beta-catenin antagonists, which interfere with the ability of beta-catenin to interact with transcriptional co-activator CBP[97-98]. In a Phase 1 trial of the CBP/beta-catenin antagonist E7386, 1 patient with APC-mutated small bowel adenocarcinoma achieved a PR with tumor shrinkage of -69% and response duration of 165 days[99]; preclinical data support sensitivity of APC-deficient gastric or colorectal cancer models to E7386[100-101].

FREQUENCY & PROGNOSIS

APC alterations have been found in 77% of tumors in the Colorectal Adenocarcinoma TCGA dataset[21]. Inactivation of APC leads to activation of the Wnt/beta-catenin pathway, which is thought to play a role in the adenoma-carcinoma transition in some cancers, including colorectal cancer (CRC)[102]. The prognostic significance of APC mutations in sporadic CRC remains unclear[103]. Solid tumors with WNT/beta-catenin pathway alterations, as seen here, were observed to have significantly less T-cell inflammation in one study[104].

FINDING SUMMARY

APC (adenomatous polyposis coli) encodes a tumor suppressor with critical roles in regulating cell division and adhesion. APC interacts with beta-catenin and controls signaling in the WNT pathway, which regulates embryonic development and cell differentiation[105]. Alterations such as seen here may disrupt APC function or expression[106-110].

POTENTIAL GERMLINE IMPLICATIONS

One or more of the APC variants observed here has been described in the ClinVar database as a likely pathogenic or pathogenic germline mutation (by an expert panel or multiple submitters) associated with familial adenomatous polyposis (ClinVar, Mar 2022)[111]. Follow-up germline testing would be needed to distinguish whether the finding in this patient is somatic or germline. Germline mutations in APC are found in more than 90% of patients with familial adenomatous polyposis (FAP)[112-114]. The prevalence for FAP in the general population is estimated to be 1:8,300 from birth[115], and in the appropriate clinical context germline testing of APC is recommended.

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GENE
PIK3CA

ALTERATION
G1007R - subclonal

TRANSCRIPT ID
NM_006218

CODING SEQUENCE EFFECT
3019G>C

VARIANT ALLELE FREQUENCY (% VAF)
2.3%

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

Clinical and preclinical data in various tumor types indicate that PIK3CA activating alterations may predict sensitivity to therapies targeting PI3K[116-123], AKT[124-125], or mTOR[126-133]. The Phase 2 NCI-MATCH study of copanlisib for patients with refractory solid tumors harboring PIK3CA mutations with or without PTEN loss met its primary endpoint with an ORR of 16% (4/25 PRs); responses (PR or SD >6 months) were seen in patients with ameloblastoma, liposarcoma, and carcinomas of the endometrium, ovary, esophagus, lung, and prostate[123]. However, the Phase 2 study of copanlisib for patients with endometrial carcinoma harboring PIK3CA hotspot mutations failed to report any objective responses (n=11)[122]. Two other studies of copanlisib for patients with genomically unselected tumors reported 1 CR and 2 PRs (1 unconfirmed) among 16 total patients with PIK3CA-mutated solid tumors with or without PTEN alterations[120-121]. Emerging evidence suggests that the glutaminase inhibitor telaglenastat has clinical activity in PIK3CA-mutated colorectal cancer (CRC). A Phase 1 trial of telaglenastat and capecitabine for patients with CRC who progressed on fluoropyrimidine chemotherapy observed numerically increased median PFS for patients with PIK3CA mutation compared with patients with wildtype PIK3CA status (24.8 vs. 16 weeks, n=7 vs. n=4), including SD >30 weeks for 3 patients with PIK3CA mutation[134].

— Potential Resistance —

Multiple clinical studies report that inhibitors of the PI3K-AKT-mTOR pathway have not produced significant clinical benefit as monotherapies to treat CRC, even for tumors that harbor alterations in PIK3CA or PTEN; data are more limited for alterations in other genes in this pathway[130,135-136].

FREQUENCY & PROGNOSIS

PIK3CA mutations have been reported in up to 17%% of colorectal cancers[21,137]. A meta-analysis of 864 patients with colorectal cancer treated with cetuximab- or panitumumab-based therapy showed that PIK3CA mutations, particularly in exon 20 (H1047R), are significantly associated with worse response[138] and shorter progression-free and overall survival[92]. A study of 354 patients with metastatic colorectal cancer observed no difference in overall survival between patients with PIK3CA mutations versus those without (21.7 months vs. 22.4 months, respectively); however, the study did not include treatment information for the patients[139].

FINDING SUMMARY

PIK3CA encodes p110-alpha, which is the catalytic subunit of phosphatidylinositol 3-kinase (PI3K). The PI3K pathway is involved in cell signaling that regulates a number of critical cellular functions, including cell growth, proliferation, differentiation, motility, and survival[140-141]. PIK3CA alterations that have been characterized as activating, such as observed here, are predicted to be oncogenic[142-163].

GENE
TP53

ALTERATION
R273H

TRANSCRIPT ID
NM_000546

CODING SEQUENCE EFFECT
818G>A

VARIANT ALLELE FREQUENCY (% VAF)
45.5%

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

There are no approved therapies to address TP53 mutation or loss. However, tumors with TP53 loss of function alterations may be sensitive to the WEE1 inhibitor adavosertib[164-167], or p53 gene therapy and immunotherapeutics such as SGT-53[168-172] and ALT-801[173]. In a Phase 1 study, adavosertib in combination with gemcitabine, cisplatin, or carboplatin elicited PRs in 9.7% and SDs in 53% of patients with solid tumors; the response rate was 21% (4/19) for patients with TP53 mutations versus 12% (4/33) for patients who were TP53 wildtype[174]. A Phase 2 trial of adavosertib in combination with chemotherapy (gemcitabine, carboplatin, paclitaxel, or doxorubicin) reported a 32% (30/94, 3 CR) ORR and a 73% (69/94) DCR for patients with platinum-refractory TP53-mutated ovarian, Fallopian tube, or peritoneal cancer[175]. A smaller Phase 2 trial of adavosertib in combination with carboplatin achieved a 43% (9/21, 1 CR) ORR and a 76% (16/21) DCR for patients with platinum-refractory TP53-mutated ovarian cancer[176]. The combination of adavosertib with paclitaxel and carboplatin for patients with TP53-mutated ovarian cancer also significantly increased PFS compared with paclitaxel and carboplatin alone[177]. In the Phase 2 VIKTORY trial, patients with TP53-mutated metastatic and/or recurrent gastric cancer experienced a 24% (6/25) ORR with adavosertib combined with paclitaxel[178]. A Phase 1 trial of neoadjuvant adavosertib in combination with cisplatin and docetaxel for head and neck squamous cell carcinoma (HNSCC) elicited a 71% (5/7) response rate for patients with TP53 alterations[179]. The Phase 2 FOCUS4-C trial for patients with TP53- and RAS-mutated colorectal cancer reported improvement in PFS (3.61 vs. 1.87 months, HR=0.35, p=0.0022), but not OS (14.0 vs 12.8 months, p=0.93), following adavosertib treatment compared with active monitoring[180]. In a Phase 1b clinical trial of SGT-53 in combination with docetaxel for patients with solid tumors, 75% (9/12) of evaluable patients experienced clinical benefit, including 2 confirmed and 1 unconfirmed PRs and 2 instances of SD with significant tumor shrinkage[172]. Missense mutations leading to TP53 inactivation may also be sensitive to therapies that reactivate mutated p53 such as APR-246[181-183]. In a Phase 1b trial for patients with p53-positive high-grade serous ovarian cancer, APR-246 combined with carboplatin and pegylated liposomal doxorubicin achieved a 52% (11/21) response rate and 100% DCR[184]. ATR inhibitor treatment of chronic lymphocytic leukemia (CLL) cells with biallelic inactivation of TP53 suppressed cell viability, promoted DNA damage, and attenuated xenograft growth in preclinical studies[185-186]; however, ATR inhibitors as monotherapy had little effect on these parameters in solid tumor models in other preclinical studies[187-188]. Therefore, it is unclear whether TP53 inactivation predicts sensitivity to ATR inhibition.

FREQUENCY & PROGNOSIS

TP53 mutations have been reported in up to 75% of colorectal cancer cases[21,189-194]. A study reported p53 expression in 49% of analyzed colorectal cancer cases[195]. TP53 mutation has not been consistently demonstrated to be a significant independent prognostic marker in the context of CRC[196].

FINDING SUMMARY

Functional loss of the tumor suppressor p53, which is encoded by the TP53 gene, is common in aggressive advanced cancers[197]. Alterations such as seen here may disrupt TP53 function or expression[198-202].

POTENTIAL GERMLINE IMPLICATIONS

One or more of the TP53 variants observed here has been described in the ClinVar database as a likely pathogenic or pathogenic germline mutation (by an expert panel or multiple submitters) associated with Li-Fraumeni syndrome (ClinVar, Mar 2022)[111]. Follow-up germline testing would be needed to distinguish whether the finding in this patient is somatic or germline. Germline mutations in TP53 are associated with the very rare autosomal dominant disorder Li-Fraumeni syndrome and the early onset of many cancers[203-205], including sarcomas[206-207]. Estimates for the prevalence of germline TP53 mutations in the general population range from 1:5,000[208] to 1:20,000[207]. For pathogenic TP53 mutations identified during tumor sequencing, the rate of germline mutations was 1% in the overall population and 6% in tumors arising before age 30[209]. In the appropriate clinical context, germline testing of TP53 is recommended.

POTENTIAL CLONAL HEMATOPOIESIS IMPLICATIONS

Variants seen in this gene have been reported to occur in clonal hematopoiesis (CH), an age-related process in which hematopoietic stem cells acquire somatic mutations that allow for clonal expansion[210-215]. CH in this gene has been associated with increased mortality, risk of coronary heart disease, risk of ischemic stroke, and risk of secondary hematologic malignancy[210-211]. Clinical management of patients with CH in this gene may include monitoring for hematologic changes and reduction of controllable risk factors for cardiovascular disease[216]. Comprehensive genomic profiling of solid tumors detects nontumor alterations that are due to CH[214,217-218]. Patient-matched peripheral blood mononuclear cell sequencing is required to conclusively determine if this alteration is present in tumor or is secondary to CH.

Cetuximab

Assay findings association

KRAS
wildtype

NRAS
wildtype

AREAS OF THERAPEUTIC USE

Cetuximab is a monoclonal antibody that targets EGFR. It is FDA approved for the treatment of head and neck squamous cell carcinoma (HNSCC) and KRAS-wild-type, EGFR-expressing metastatic colorectal cancer (CRC). Please see the drug label for full prescribing information.

GENE ASSOCIATION

Therapies targeting EGFR, including cetuximab, have been shown to have significant clinical activity for patients with CRC[69-72,219-220] ; wild-type KRAS and NRAS are predictive biomarkers for the efficacy of cetuximab in metastatic CRC (NCCN Colon Cancer Guidelines v3.2021).

SUPPORTING DATA

Cetuximab has been shown to improve OS, PFS, and response rate for patients with KRAS-wildtype CRC, both in combination with FOLFIRI, FOLFOX4, or irinotecan[69-70,219-221] and as monotherapy for chemotherapy-refractory patients[72,222] . A prospective study of cetuximab for patients with KRAS/NRAS/BRAF mutation-negative metastatic CRC resulted in limited efficacy, with 11% (2/19) of participants experiencing PRs and 58% (11/19) experiencing SDs[223]. The Phase 2 AVETUX trial of cetuximab combined with avelumab and mFOLFOX6 for patients with RAS- and BRAF-wildtype metastatic CRC resulted in an ORR of 81% (4 CR and 27 PRs, n=37) and a DCR of 89%[224]. In the Phase 3 ASPECCT study, panitumumab was found to be non-inferior to cetuximab with respect to median OS (10.4 vs. 10.0 months, HR=0.97) for patients with previously treated KRAS exon 2 wildtype metastatic colorectal cancer; median PFS was also similar between the two treatment groups (4.4 vs. 4.1 months, HR=1.00)[225]. In a similar patient population, a Phase 2 study of combination panitumumab and irinotecan versus combination cetuximab and irinotecan also demonstrated non-inferiority with respect to median PFS (5.4 vs. 4.3 months, HR = 0.64) and median OS (14.9 vs. 11.5 months, HR=0.66)[226].

Panitumumab

Assay findings association

KRAS
wildtype

NRAS
wildtype

AREAS OF THERAPEUTIC USE

Panitumumab is a monoclonal antibody that targets EGFR. It is FDA approved to treat KRAS wild-type and NRAS wild-type metastatic colorectal cancer (CRC) combined with chemotherapy or as monotherapy for patients who have progressed on prior chemotherapy. Please see the drug label for full prescribing information.

GENE ASSOCIATION

Therapies targeting EGFR, including panitumumab, have been shown to have significant clinical activity for patients with CRC[73,225,227] ; wild-type KRAS and NRAS are predictive biomarkers for the efficacy of panitumumab in metastatic CRC (NCCN Colon Cancer Guidelines v3.2021).

SUPPORTING DATA

Panitumumab has been shown to improve OS, PFS, and ORR for patients with KRAS wildtype CRC, both in combination with FOLFOX4, FOLFIRI, irinotecan, or best supportive care[73,228-230] and as monotherapy for chemotherapy-refractory patients[192,225,227] . A Phase 2 trial reported that for patients with unresectable RAS-wildtype colorectal adenocarcinoma treated with panitumumab plus FOLFOX4, maintenance with a combination of panitumumab plus fluorouracil and leucovorin was superior to panitumumab monotherapy (10-month PFS, 59% vs. 49%)[231]. In the Phase 3 ASPECCT study, panitumumab was found to be non-inferior to cetuximab with respect to median OS (10.4 vs. 10.0 months, HR=0.97) for patients with previously treated KRAS exon 2 wildtype metastatic colorectal cancer; median PFS was also similar between the two treatment groups (4.4 vs. 4.1 months, HR=1.00)[225]. In a similar patient population, a Phase 2 study of combination panitumumab and irinotecan versus combination cetuximab and irinotecan also demonstrated non-inferiority with respect to median PFS (5.4 vs. 4.3 months, HR = 0.64) and median OS (14.9 vs. 11.5 months, HR=0.66)[226].

NOTE Genomic alterations detected may be associated with activity of certain FDA approved drugs, however, the agents listed in this report may have varied evidence in the patient's tumor type.

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NOTE Clinical trials are ordered by gene and prioritized by: age range inclusion criteria for pediatric patients, proximity to ordering medical facility, later trial phase, and verification of trial information within the last two months. While every effort is made to ensure the accuracy of the information contained below, the information available in the public domain is continually updated and should be investigated by the physician or research staff. This is not a comprehensive list of all available clinical trials. Foundation Medicine displays a subset of trial options and ranks them in this order of descending priority: Qualification for pediatric trial → Geographical proximity → Later trial phase. Clinical trials listed here may have additional enrollment criteria that may require medical screening to determine final eligibility. For additional information about listed clinical trials or to conduct a search for additional trials, please see clinicaltrials.gov. Or visit https://www.foundationmedicine.com/genomic-testing#support-services.

GENE
APC

ALTERATION
E1309fs*4

RATIONALE
Based on preclinical and limited clinical data, APC inactivation may be associated with sensitivity to CBP/beta-catenin interaction inhibitors.

NCT03833700

PHASE 1

A Study of E7386 in Participants With Advanced Solid Tumor Including Colorectal Cancer (CRC)

TARGETS
CBP, Beta-catenin

LOCATIONS: Fukuoka (Japan), Nagaizumi-cho (Japan), Chuo Ku (Japan), Kashiwa (Japan)

NCT05091346

PHASE 1/2

A Study of E7386 in Combination With Pembrolizumab in Previously Treated Participants With Selected Solid Tumors

TARGETS
CBP, Beta-catenin, PD-1

LOCATIONS: Osaka (Japan), Tokyo (Japan), Chiba-shi (Japan), Kashiwa (Japan), California

NCT04008797

PHASE 1

A Study of E7386 in Combination With Other Anticancer Drug in Participants With Solid Tumor

TARGETS
CBP, Beta-catenin, FGFRs, RET, PDGFRA, VEGFRs, KIT

LOCATIONS: Osakasayama (Japan), Chuo-Ku (Japan), Kashiwa (Japan)

NCT03264664

PHASE 1

Study of E7386 in Participants With Selected Advanced Neoplasms

TARGETS
CBP, Beta-catenin

LOCATIONS: Glasgow (United Kingdom), Manchester (United Kingdom), Sutton (United Kingdom)

GENE
PIK3CA

ALTERATION
G1007R - subclonal

RATIONALE
PIK3CA activating mutations may lead to activation of the PI3K-AKT-mTOR pathway and may therefore indicate sensitivity to inhibitors of this pathway. Strong clinical data support sensitivity of PIK3CA-mutated solid tumors to the PI3K-alpha inhibitor alpelisib. Several clinical studies have shown that inhibitors of the PI3K-AKT-mTOR pathway have not produced significant clinical benefit when used as a monotherapy in patients with colorectal cancer; combination therapies may be required to overcome this lack of response. On the basis of preclinical and limited clinical data, PIK3CA activating mutations may predict sensitivity to glutaminase inhibitors.

NCT04589845

PHASE 2

Tumor-Agnostic Precision Immuno-Oncology and Somatic Targeting Rational for You (TAPISTRY) Platform Study

TARGETS
TRKB, ALK, TRKC, ROS1, TRKA, RET, PD-L1, AKTs, ERBB2, MDM2, PI3K-alpha

LOCATIONS: Taipei City (Taiwan), Taoyuan County (Taiwan), Tainan (Taiwan), Hong Kong (Hong Kong), Seoul (Korea, Republic of), Xi'an (China), Tianjin (China), Beijing City (China), Beijing (China), Chengdu City (China)

NCT04337463

PHASE NULL

ATG-008 Combined With Toripalimab in Advanced Solid Tumors

TARGETS
mTORC1, mTORC2, PD-1

LOCATIONS: Chongqing (China), Chengdu (China)

NCT04803318

PHASE 2

Trametinib Combined With Everolimus and Lenvatinib for Recurrent/Refractory Advanced Solid Tumors

TARGETS
mTOR, FGFRs, RET, PDGFRA, VEGFRs, KIT, MEK

LOCATIONS: Guangzhou (China)

NCT04929223

PHASE 1

A Study Evaluating the Safety and Efficacy of Targeted Therapies in Subpopulations of Patients With Metastatic Colorectal Cancer (INTRINSIC)

TARGETS
VEGFA, EGFR, PI3K-alpha, CDK7, TIGIT, PD-L1

LOCATIONS: Seongnam-si (Korea, Republic of), Seoul (Korea, Republic of), Padova (Italy), Milano (Italy), London (United Kingdom), Washington, Barcelona (Spain), California, Madrid (Spain)

NCT03772561

PHASE 1

Phase I Study of AZD5363 + Olaparib + Durvalumab in Patients With Advanced or Metastatic Solid Tumor Malignancies

TARGETS
PARP, AKTs, PD-L1

LOCATIONS: Singapore (Singapore)

NCT04801966

PHASE NULL

Safety and Oversight of the Individually Tailored Treatment Approach: A Novel Pilot Study

TARGETS
CDK4, CDK6, PI3K-alpha, PD-L1, MEK, PARP, PD-1, BRAF

LOCATIONS: Melbourne (Australia)

NCT03673787

PHASE 1/2

A Trial of Ipatasertib in Combination With Atezolizumab

TARGETS
AKTs, PD-L1

LOCATIONS: Sutton (United Kingdom)

NCT04317105

PHASE 1/2

Testing the Addition of an Anti-cancer Drug, Copanlisib, to the Usual Immunotherapy (Nivolumab With or Without Ipilimumab) in Patients With Advanced Solid Cancers That Have Changes in the Following Genes: PIK3CA and PTEN

TARGETS
PD-1, CTLA-4, PI3K

LOCATIONS: Toronto (Canada), Massachusetts, Texas, Virginia

NCT03263429

PHASE 1/2

Novel PET/CT Imaging Biomarkers of CB-839 in Combination With Panitumumab and Irinotecan in Patients With Metastatic and Refractory RAS Wildtype Colorectal Cancer

TARGETS
GLS, TOP1, EGFR

LOCATIONS: Tennessee

NCT04495621

PHASE 1/2

MEN1611 With Cetuximab in Metastatic Colorectal Cancer (C-PRECISE-01)

TARGETS
PI3K-alpha, EGFR

LOCATIONS: Warsaw (Poland), Skórzewo (Poland), Berlin (Germany), Dresden (Germany), Munich (Germany), Nijmegen (Netherlands), Tuebingen (Germany), Amsterdam (Netherlands), Maastricht (Netherlands), Rotterdam (Netherlands)

NOTE One or more variants of unknown significance (VUS) were detected in this patient's tumor. These variants may not have been adequately characterized in the scientific literature at the time this report was issued, and/or the genomic context of these alterations makes their significance unclear. We choose to include them here in the event that they become clinically meaningful in the future.

C11ORF30 (EMSY)
V739A

FANCG
A153G

FGFR4
D709G

HRAS
V109M

HSD3B1
G277S

MAP2K2 (MEK2)
A80T

MAP2K4
D289N

MED12
R1262K

P2RY8
C249F

PARP1
V69I

PDCD1LG2 (PD-L2)
splice site 766+2T>C

TSC1
T393A

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APPENDIX Genes Assayed in FoundationOne®CDx

FoundationOne CDx is designed to include genes known to be somatically altered in human solid tumors that are validated targets for therapy, either approved or in clinical trials, and/or that are unambiguous drivers of oncogenesis based on current knowledge. The current assay interrogates 324 genes as well as introns of 36 genes involved in rearrangements. The assay will be updated periodically to reflect new knowledge about cancer biology.

DNA GENE LIST: ENTIRE CODING SEQUENCE FOR THE DETECTION OF BASE SUBSTITUTIONS, INSERTION/DELETIONS, AND COPY NUMBER ALTERATIONS

ABL1	*ACVR1B*	*AKT1*	*AKT2*	*AKT3*	*ALK*	*ALOX12B*	*AMER1 (FAM123B or WTX)*	
APC	*AR*	*ARAF*	*ARFRP1*	*ARID1A*	*ASXL1*	*ATM*	*ATR*	*ATRX*
AURKA	*AURKB*	*AXIN1*	*AXL*	*BAP1*	*BARD1*	*BCL2*	*BCL2L1*	*BCL2L2*
BCL6	*BCOR*	*BCORL1*	*BRAF*	*BRCA1*	*BRCA2*	*BRD4*	*BRIP1*	*BTG1*
BTG2	*BTK*	*CALR*	*CARD11*	*CASP8*	*CBFB*	*CBL*	*CCND1*	*CCND2*
CCND3	*CCNE1*	*CD22*	*CD274 (PD-L1)*	*CD70*	*CD79A*	*CD79B*	*CDC73*	*CDH1*
CDK12	*CDK4*	*CDK6*	*CDK8*	*CDKN1A*	*CDKN1B*	*CDKN2A*	*CDKN2B*	*CDKN2C*
CEBPA	*CHEK1*	*CHEK2*	*CIC*	*CREBBP*	*CRKL*	*CSF1R*	*CSF3R*	*CTCF*
CTNNA1	*CTNNB1*	*CUL3*	*CUL4A*	*CXCR4*	*CYP17A1*	*DAXX*	*DDR1*	*DDR2*
DIS3	*DNMT3A*	*DOT1L*	*EED*	*EGFR*	*EMSY (C11orf30)*	*EP300*	*EPHA3*	*EPHB1*
EPHB4	*ERBB2*	*ERBB3*	*ERBB4*	*ERCC4*	*ERG*	*ERRFI1*	*ESR1*	*EZH2*
FANCA	*FANCC*	*FANCG*	*FANCL*	*FAS*	*FBXW7*	*FGF10*	*FGF12*	*FGF14*
FGF19	*FGF23*	*FGF3*	*FGF4*	*FGF6*	*FGFR1*	*FGFR2*	*FGFR3*	*FGFR4*
FH	*FLCN*	*FLT1*	*FLT3*	*FOXL2*	*FUBP1*	*GABRA6*	*GATA3*	*GATA4*
GATA6	*GID4 (C17orf39)*	*GNA11*	*GNA13*	*GNAQ*	*GNAS*	*GRM3*	*GSK3B*	*H3-3A (H3F3A)*
HDAC1	*HGF*	*HNF1A*	*HRAS*	*HSD3B1*	*ID3*	*IDH1*	*IDH2*	*IGF1R*
IKBKE	*IKZF1*	*INPP4B*	*IRF2*	*IRF4*	*IRS2*	*JAK1*	*JAK2*	*JAK3*
JUN	*KDM5A*	*KDM5C*	*KDM6A*	*KDR*	*KEAP1*	*KEL*	*KIT*	*KLHL6*
KMT2A (MLL)	*KMT2D (MLL2)*	*KRAS*	*LTK*	*LYN*	*MAF*	*MAP2K1 (MEK1)*	*MAP2K2 (MEK2)*	*MAP2K4*
MAP3K1	*MAP3K13*	*MAPK1*	*MCL1*	*MDM2*	*MDM4*	*MED12*	*MEF2B*	*MEN1*
MERTK	*MET*	*MITF*	*MKNK1*	*MLH1*	*MPL*	*MRE11 (MRE11A)*	*MSH2*	*MSH3*
MSH6	*MST1R*	*MTAP*	*MTOR*	*MUTYH*	*MYC*	*MYCL (MYCL1)*	*MYCN*	*MYD88*
NBN	*NF1*	*NF2*	*NFE2L2*	*NFKBIA*	*NKX2-1*	*NOTCH1*	*NOTCH2*	*NOTCH3*
NPM1	*NRAS*	*NSD2 (WHSC1 or MMSET)*		*NSD3 (WHSC1L1)*	*NT5C2*	*NTRK1*	*NTRK2*	*NTRK3*
P2RY8	*PALB2*	*PARP1*	*PARP2*	*PARP3*	*PAX5*	*PBRM1*	*PDCD1 (PD-1)*	*PDCD1LG2 (PD-L2)*
PDGFRA	*PDGFRB*	*PDK1*	*PIK3C2B*	*PIK3C2G*	*PIK3CA*	*PIK3CB*	*PIK3R1*	*PIM1*
PMS2	*POLD1*	*POLE*	*PPARG*	*PPP2R1A*	*PPP2R2A*	*PRDM1*	*PRKAR1A*	*PRKCI*
PRKN (PARK2)	*PTCH1*	*PTEN*	*PTPN11*	*PTPRO*	*QKI*	*RAC1*	*RAD21*	*RAD51*
RAD51B	*RAD51C*	*RAD51D*	*RAD52*	*RAD54L*	*RAF1*	*RARA*	*RB1*	*RBM10*
REL	*RET*	*RICTOR*	*RNF43*	*ROS1*	*RPTOR*	*SDHA*	*SDHB*	*SDHC*
SDHD	*SETD2*	*SF3B1*	*SGK1*	*SMAD2*	*SMAD4*	*SMARCA4*	*SMARCB1*	*SMO*
SNCAIP	*SOCS1*	*SOX2*	*SOX9*	*SPEN*	*SPOP*	*SRC*	*STAG2*	*STAT3*
STK11	*SUFU*	*SYK*	*TBX3*	*TEK*	*TENT5C (FAM46C)*	*TET2*	*TGFBR2*	*TIPARP*
TNFAIP3	*TNFRSF14*	*TP53*	*TSC1*	*TSC2*	*TYRO3*	*U2AF1*	*VEGFA*	*VHL*
WT1	*XPO1*	*XRCC2*	*ZNF217*	*ZNF703*				

DNA GENE LIST: FOR THE DETECTION OF SELECT REARRANGEMENTS

ALK	*BCL2*	*BCR*	*BRAF*	*BRCA1*	*BRCA2*	*CD74*	*EGFR*	*ETV1*
ETV4	*ETV5*	*ETV6*	*EWSR1*	*EZR*	*FGFR1*	*FGFR2*	*FGFR3*	*KIT*
KMT2A (MLL)	*MSH2*	*MYB*	*MYC*	*NOTCH2*	*NTRK1*	*NTRK2*	*NUTM1*	*PDGFRA*
RAF1	*RARA*	*RET*	*ROS1*	*RSPO2*	*SDC4*	*SLC34A2*	*TERC**	*TERT***
TMPRSS2								

*TERC is an NCRNA

**Promoter region of TERT is interrogated

ADDITIONAL ASSAYS: FOR THE DETECTION OF SELECT CANCER BIOMARKERS

Loss of Heterozygosity (LOH) score
Microsatellite (MS) status
Tumor Mutational Burden (TMB)

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FoundationOne CDx fulfills the requirements of the European Directive 98/79 EC for in vitro diagnostic medical devices and is registered as a CE-IVD product by Foundation Medicine's EU Authorized Representative, Qarad b.v.b.a, Cipalstraat 3, 2440 Geel, Belgium. CE

ABOUT FOUNDATIONONE CDX

FoundationOne CDx was developed and its performance characteristics determined by Foundation Medicine, Inc. (Foundation Medicine). FoundationOne CDx may be used for clinical purposes and should not be regarded as purely investigational or for research only. Foundation Medicine's clinical reference laboratories are qualified to perform high-complexity clinical testing.

Please refer to technical information for performance specification details: www.rochefoundationmedicine.com/f1cdxtech.

INTENDED USE

FoundationOne®CDx (F1CDx) is a next generation sequencing based in vitro diagnostic device for detection of substitutions, insertion and deletion alterations (indels), and copy number alterations (CNAs) in 324 genes and select gene rearrangements, as well as genomic signatures including microsatellite instability (MSI), tumor mutational burden (TMB), and for selected forms of ovarian cancer, loss of heterozygosity (LOH) score, using DNA isolated from formalin-fixed, paraffin-embedded (FFPE) tumor tissue specimens. The test is intended as a companion diagnostic to identify patients who may benefit from treatment with therapies in accordance with approved therapeutic product labeling. Additionally, F1CDx is intended to provide tumor mutation profiling to be used by qualified health care professionals in accordance with professional guidelines in oncology for patients with solid malignant neoplasms.

TEST PRINCIPLES

FoundationOne CDx will be performed exclusively as a laboratory service using DNA extracted from formalin-fixed, paraffin-embedded (FFPE) tumor samples. The proposed assay will employ a single DNA extraction method from routine FFPE biopsy or surgical resection specimens, 50-1000 ng of which will undergo whole-genome shotgun library construction and hybridization-based capture of all coding exons from 309 cancer-related genes, one promoter region, one non-coding (ncRNA), and select intronic regions from 34 commonly rearranged genes, 21 of which also include the coding exons. The assay therefore includes detection of alterations in a total of 324 genes.

Using an Illumina® HiSeq platform, hybrid capture–selected libraries will be sequenced to high uniform depth (targeting >500X median coverage with >99% of exons at coverage >100X). Sequence data will be processed using a customized analysis pipeline designed to accurately detect all classes of genomic alterations, including base substitutions, indels, focal copy number amplifications, homozygous gene deletions, and selected genomic rearrangements (e.g.,gene fusions). Additionally, genomic signatures including loss of heterozygosity (LOH), microsatellite instability (MSI) and tumor mutational burden (TMB) will be reported.

THE REPORT

Incorporates analyses of peer-reviewed studies and other publicly available information identified by Foundation Medicine; these analyses and information may include associations between a molecular alteration (or lack of alteration) and one or more drugs with potential clinical benefit (or potential lack of clinical benefit), including drug candidates that are being studied in clinical research. The F1CDx report may be used as an aid to inform molecular eligibility for clinical trials. Note: A finding of biomarker alteration does not necessarily indicate pharmacologic effectiveness (or lack thereof) of any drug or treatment regimen; a finding of no biomarker alteration does not necessarily indicate lack of pharmacologic effectiveness (or effectiveness) of any drug or treatment regimen.

Diagnostic Significance

FoundationOne CDx identifies alterations to select cancer-associated genes or portions of genes (biomarkers). In some cases, the Report also highlights selected negative test results regarding biomarkers of clinical significance.

Qualified Alteration Calls (Equivocal and Subclonal)

An alteration denoted as "amplification – equivocal" implies that the FoundationOne CDx assay data provide some, but not unambiguous, evidence that the copy number of a gene exceeds the threshold for identifying copy number amplification. The threshold used in FoundationOne CDx for identifying a copy number amplification is four (4) for ERBB2 and six (6) for all other genes. Conversely, an alteration denoted as "loss – equivocal" implies that the FoundationOne CDx assay data provide some, but not unambiguous, evidence for homozygous deletion of the gene in question. An alteration denoted as "subclonal" is one that the FoundationOne CDx analytical methodology has identified as being present in <10% of the assayed tumor DNA.

Ranking of Therapies and Clinical Trials

Ranking of Therapies in Summary Table

Therapies are ranked based on the following criteria: Therapies with clinical benefit (ranked alphabetically within each evidence category), followed by therapies associated with resistance (when applicable).

Ranking of Clinical Trials

Pediatric trial qualification → Geographical proximity → Later trial phase.

NATIONAL COMPREHENSIVE CANCER NETWORK® (NCCN®) CATEGORIZATION

Biomarker and genomic findings detected may be associated with certain entries within the NCCN Drugs & Biologics Compendium® (NCCN Compendium®) (www.nccn.org). The NCCN Categories of Evidence and Consensus indicated reflect the highest possible category for a given therapy in association with each biomarker or genomic finding. Please note, however, that the accuracy and applicability of these NCCN categories within a report may be impacted by the patient's clinical history, additional biomarker information, age, and/or co-occurring alterations. For additional information on the NCCN categories, please refer to the NCCN Compendium®. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). © National Comprehensive Cancer Network, Inc. 2022. All rights reserved. To view the most recent and complete version of the guidelines, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.

Limitations

1. In the fractional-based MSI algorithm, a tumor specimen will be categorized as MSI-H, MSS, or MS-Equivocal according to the fraction of microsatellite loci determined to be altered or unstable (i.e., the fraction unstable loci score). In the F1CDx assay, MSI is evaluated based on a genome-wide analysis across >2000 microsatellite loci. For a given microsatellite locus, non-somatic alleles are discarded, and the microsatellite is categorized as unstable if remaining alleles differ from the reference genome. The final fraction unstable loci score is calculated as the number of unstable microsatellite loci divided by the number of evaluable microsatellite loci. The MSI-H and MSS cut-off thresholds were determined by analytical concordance to a PCR comparator assay using a pan-tumor FFPE tissue sample set. Patients with results categorized as "MS-

Stable" with median exon coverage <300X, "MS-Equivocal," or "Cannot Be Determined" should receive confirmatory testing using a validated orthogonal (alternative) method.

2. TMB by F1CDx is determined by counting all synonymous and non-synonymous variants present at 5% allele frequency or greater (after filtering) and the total number is reported as mutations per megabase (mut/Mb) unit. Observed TMB is dependent on characteristics of the specific tumor focus tested for a patient (e.g., primary vs. metastatic, tumor content) and the testing platform used for the detection; therefore, observed TMB results may vary between different specimens for the same patient and between detection methodologies employed on the same sample. The TMB calculation may differ from TMB calculations used by other assays depending on variables such as the amount of genome interrogated, percentage of tumor, assay limit of detection (LoD), filtering of alterations included in the score, and the read depth and other bioinformatic test specifications. Refer to the SSED for a detailed description of these variables in FMI's TMB calculation https://www.accessdata.fda.gov/cdrh_docs/pdf17/P170019B.pdf. The clinical validity of TMB defined by this panel has been established for TMB as a qualitative output for a cut-off of 10 mutations per megabase but has not been established for TMB as a quantitative score.
3. The LOH score is determined by analyzing SNPs spaced at 1Mb intervals across the genome on the FoundationOne CDx test and extrapolating an LOH profile, excluding arm- and chromosome-wide LOH segments. Detection of LOH has been verified only for ovarian cancer patients, and the LOH score result may be reported for epithelial ovarian, peritoneal, or Fallopian tube carcinomas. The LOH score will be reported as "Cannot Be Determined" if the sample is not of sufficient quality to confidently determine LOH. Performance of the LOH classification has not been established for samples below 35% tumor content. There may be potential interference of ethanol with LOH detection. The interfering effects of xylene, hemoglobin, and triglycerides on the LOH score have not been demonstrated.
4. Alterations reported may include somatic (not inherited) or germline (inherited) alterations; however, the test does not distinguish between germline and somatic alterations. The test does not provide information about susceptibility.
5. Biopsy may pose a risk to the patient when archival tissue is not available for use with the assay. The patient's physician should determine whether the patient is a candidate for biopsy.
6. Reflex testing to an alternative FDA approved companion diagnostic should be performed for patients who have an *ERBB2* amplification result detected with copy number equal to 4 (baseline ploidy of tumor +2) for confirmatory testing. While this result is considered negative by FoundationOne®CDx (F1CDx), in a clinical concordance study with an FDA approved FISH test, 70% (7 out of 10 samples) were positive, and 30% (3 out of 10 samples) were negative by the FISH test with an average ratio of 2.3. The frequency of *ERBB2* copy number 4 in breast cancer is estimated to be approximately 2%. Multiple references listed in https://www.mycancergenome.org/content/disease/breast-cancer/ERBB2/238/ report the frequency of HER2 overexpression as 20% in breast cancer. Based on the F1CDx HER2 CDx concordance study, approximately 10% of HER2 amplified samples had copy number 4. Thus, total frequency is conservatively estimated to be approximately 2%.

REPORT HIGHLIGHTS

The Report Highlights includes select genomic and therapeutic information with potential impact on patient care and treatment that is specific to the genomics and tumor type of the sample analyzed. This section may highlight information including targeted therapies with potential sensitivity or resistance; evidence-matched clinical trials; and variants with potential diagnostic, prognostic, nontargeted treatment, germline, or clonal hematopoiesis implications. Information included in the Report Highlights is expected to evolve with advances in scientific and clinical research. Findings included in the Report Highlights should be considered in the context of all other information in this report and other relevant patient information. Decisions on patient care and treatment are the responsibility of the treating physician.

VARIANT ALLELE FREQUENCY

Variant Allele Frequency (VAF) represents the fraction of sequencing reads in which the variant is observed. This attribute is not taken into account for therapy inclusion, clinical trial matching, or interpretive content. Caution is recommended in interpreting VAF to indicate the potential germline or somatic origin of an alteration, recognizing that tumor fraction and tumor ploidy of samples may vary.

Precision of VAF for base substitutions and indels

BASE SUBSTITUTIONS	%CV*
Repeatability	5.11 - 10.40
Reproducibility	5.95 - 12.31
INDELS	**%CV***
Repeatability	6.29 - 10.00
Reproducibility	7.33 - 11.71

**Interquartile Range = 1st Quartile to 3rd Quartile*

VARIANTS TO CONSIDER FOR FOLLOW-UP GERMLINE TESTING

The variants indicated for consideration of follow-up germline testing are 1) limited to reportable short variants with a protein effect listed in the ClinVar genomic database (Landrum et al., 2018; 29165669) as Pathogenic, Pathogenic/Likely Pathogenic, or Likely Pathogenic (by an expert panel or multiple submitters), 2) associated with hereditary cancer-predisposing disorder(s), 3) detected at an allele frequency of >10%, and 4) in select genes reported by the ESMO Precision Medicine Working Group (Mandelker et al., 2019; 31050713) to have a greater than 10% probability of germline origin if identified during tumor sequencing. The selected genes are *ATM, BAP1, BRCA1, BRCA2, BRIP1, CHEK2, FH, FLCN, MLH1, MSH2, MSH6, MUTYH, PALB2, PMS2, POLE, RAD51C, RAD51D, RET, SDHA, SDHB, SDHC, SDHD, TSC2,* and *VHL*, and are not inclusive of all cancer susceptibility genes. The content in this report should not substitute for genetic counseling or follow-up germline testing, which is needed to distinguish whether a finding in this patient's tumor sequencing is germline or somatic. Interpretation should be based on clinical context.

VARIANTS THAT MAY REPRESENT CLONAL HEMATOPOIESIS

Variants that may represent clonal hematopoiesis (CH) are limited to select reportable short variants in defined genes identified in solid tumors only. Variant selection was determined based on gene tumor-suppressor or oncogene status, known role in solid tumors versus hematological malignancies, and literature prevalence. The defined genes are *ASXL1, CBL, DNMT3A, IDH2, JAK2, KMT2D (MLL2), MPL, MYD88, SF3B1, TET2,* and *U2AF1* and are not inclusive of all CH genes. The content in this report should not substitute for dedicated hematological workup. Comprehensive genomic profiling of solid tumors detects nontumor alterations that are due to CH. Patient-matched peripheral blood mononuclear

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cell sequencing is required to conclusively determine if this alteration is present in tumor or is secondary to CH. Interpretation should be based on clinical context.

LEVEL OF EVIDENCE NOT PROVIDED

Drugs with potential clinical benefit (or potential lack of clinical benefit) are not evaluated for source or level of published evidence.

NO GUARANTEE OF CLINICAL BENEFIT

This Report makes no promises or guarantees that a particular drug will be effective in the treatment of disease in any patient. This Report also makes no promises or guarantees that a drug with potential lack of clinical benefit will in fact provide no clinical benefit.

NO GUARANTEE OF REIMBURSEMENT

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TREATMENT DECISIONS ARE RESPONSIBILITY OF PHYSICIAN

Drugs referenced in this Report may not be suitable for a particular patient. The selection of any, all or none of the drugs associated with potential clinical benefit (or potential lack of clinical benefit) resides entirely within the discretion of the treating physician. Indeed, the information in this Report must be considered in conjunction with all other relevant information regarding a particular patient, before the patient's treating physician recommends a course of treatment. Decisions on patient care and treatment must be based on the independent medical judgment of the treating physician, taking into consideration all applicable information concerning the patient's condition, such as patient and family history, physical examinations, information from other diagnostic tests, and patient preferences, in accordance with the standard of care in a given community. A treating physician's decisions should not be based on a single test, such as this Test, or the information contained in this Report. Certain sample or variant characteristics may result in reduced sensitivity. FoundationOne CDx is performed using DNA derived from tumor, and as such germline events may not be reported.

SELECT ABBREVIATIONS

ABBREVIATION	DEFINITION
CR	Complete response
DCR	Disease control rate
DNMT	DNA methyltransferase
HR	Hazard ratio
ITD	Internal tandem duplication
MMR	Mismatch repair
muts/Mb	Mutations per megabase
NOS	Not otherwise specified
ORR	Objective response rate
OS	Overall survival
PD	Progressive disease
PFS	Progression-free survival
PR	Partial response
SD	Stable disease
TKI	Tyrosine kinase inhibitor

REFERENCE SEQUENCE INFORMATION

Sequence data is mapped to the human genome, Genome Reference Consortium Human Build 37 (GRCh37), also known as hg19.

MR Suite Version 6.2.0

The median exon coverage for this sample is 901x

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