ACT Onco® + Report

PATIENT		
Identifier: 陳政琦		Patient ID: 49032533
Date of Birth: Jun 06, 1960		Gender: Male
Diagnosis: Lung cancer		
ORDERING PHYSICIAN		
Name: 沈佳儀醫師		Tel: 886-228712121
Facility: 臺北榮總		
Address: 臺北市北投區石牌路二段 201 號		
SPECIMEN		
Specimen ID: S11143542A	Collection site: Bone	Type: FFPE tissue
Date received: Nov 08, 2022	Lab ID: AA-22-06744	D/ID: NA

ABOUT ACTOnco®+

The test is a next-generation sequencing (NGS)-based assay developed for efficient and comprehensive genomic profiling of cancers. This test interrogates coding regions of 440 genes associated with cancer treatment, prognosis and diagnosis. Genetic mutations detected by this test include small-scale mutations like single nucleotide variants (SNVs), small insertions and deletions (InDels) (≤ 15 nucleotides) and large-scale genomic alterations like copy number alterations (CNAs). The test also includes an RNA test, detecting fusion transcripts of 13 genes.

SUMMARY FOR ACTIONABLE VARIANTS

VARIANTS/BIOMARKERS WITH EVIDENCE OF CLINICAL SIGNIFICANCE

Genomic Alterations/Biomarkers	Probable Effects in Patient's Cancer Type		Probable Sensitive in Other Cancer Types
	Sensitive	Resistant	
MET Amplification	Capmatinib, Crizotinib, Tepotinib	Afatinib, Dacomitinib, Erlotinib, Gefitinib, Osimertinib	-

VARIANTS/BIOMARKERS WITH POTENTIAL CLINICAL SIGNIFICANCE

Genomic Alterations/Biomarkers	Possibly Sensitive	Possibly Resistant
MET Amplification	Cabozantinib	Cetuximab, Panitumumab

Note:

- The above summary tables present genomic variants and biomarkers based on the three-tiered approach proposed by US FDA for reporting tumor profiling NGS testing. "Variants/biomarkers with evidence of clinical significance" refers to mutations that are widely recognized as standard-of-care biomarkers (FDA level 2/AMP tier 1). "Variants/biomarkers with potential clinical significance" refers to mutations that are not included in the standard of care but are informational for clinicians, which are commonly biomarkers used as inclusion criterial for clinical trials (FDA level 3/AMP tier 2).
- The therapeutic agents and possible effects to a given drug are based on mapping the variants/biomarkers with ACT Genomics clinical knowledge database. The mapping results only provide information for reference, but not medical recommendation.
- Please refer to corresponding sections for more detailed information about genomic alteration and clinical relevance listed above.

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TESTING RESULTS

VARIANT(S) WITH CLINICAL RELEVANCE

- Single Nucleotide and Small InDel Variants

Gene	Amino Acid Change	Allele Frequency
ERCC4	C723*	41.6%
TP53	L130V	56.7%

- Copy Number Alterations

Chromosome	Gene	Variation	Copy Number
Chr17	*FLCN, TP53*	Heterozygous deletion	1
Chr18	*SMAD4*	Heterozygous deletion	1
Chr4	*FBXW7*	Heterozygous deletion	1
Chr5	*RAD50*	Heterozygous deletion	1
Chr7	*MET*	Amplification	8
Chr5	*TERT*	Amplification	10

- Fusions

Fusion Gene & Exon	Transcript ID
No fusion gene detected in this sample	

- Immune Checkpoint Inhibitor (ICI) Related Biomarkers

Biomarker	Results
Tumor Mutational Burden (TMB)	3.8 muts/Mb
Microsatellite Instability (MSI)	Microsatellite stable (MSS)

Note:
- Variant(s) enlisted in the SNV table may currently exhibit no relevance to treatment response prediction. Please refer to INTERPRETATION for more biological information and/or potential clinical impacts of the variants.
- Loss of heterozygosity (LOH) information was used to infer tumor cellularity. Copy number alteration in the tumor was determined based on 63% tumor purity.
- For more therapeutic agents which are possibly respond to heterozygous deletion of genes listed above, please refer to APPENDIX for more information.
- TMB was calculated by using the sequenced regions of ACTOnco®+ to estimate the number of somatic nonsynonymous mutations per megabase of all protein-coding genes (whole exome). The threshold for high mutation load is set at ≥ 7.5 mutations per megabase. TMB, microsatellite status and gene copy number deletion cannot be determined if calculated tumor purity is < 30%.

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THERAPEUTIC IMPLICATIONS

TARGETED THERAPIES

Genomic Alterations	Therapies	Effect
Level 2		
MET Amplification	Capmatinib, Crizotinib, Tepotinib	**sensitive**
MET Amplification	Afatinib, Dacomitinib, Erlotinib, Gefitinib, Osimertinib	**resistant**
Level 3B		
MET Amplification	Cabozantinib	**sensitive**
Level 4		
MET Amplification	Cetuximab, Panitumumab	**resistant**

Therapies associated with benefit or lack of benefit are based on biomarkers detected in this tumor and published evidence in professional guidelines or peer-reviewed journals.

Level	Description
1	FDA-recognized biomarkers predictive of response or resistance to FDA approved drugs in this indication
2	Standard care biomarkers (recommended by the NCCN guideline) predictive of response or resistance to FDA approved drugs in this indication
3A	Biomarkers predictive of response or resistance to therapies approved by the FDA or NCCN guideline in a different cancer type
3B	Biomarkers that serve as inclusion criteria for clinical trials (minimal supportive data required)
4	Biomarkers that show plausible therapeutic significance based on small studies, few case reports, or preclinical studies

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IMMUNE CHECKPOINT INHIBITORS (ICIs)

No genomic alterations detected to confer sensitivity or lack of benefit to immune checkpoint therapies.

- Other Biomarkers with Potential Clinical Effects for ICIs

Genomic Alterations	Potential Clinical Effects
Not detected	

Note: Tumor non-genomic factors, such as patient germline genetics, PDL1 expression, tumor microenvironment, epigenetic alterations or other factors not provided by this test may affect ICI response.

CHEMOTHERAPIES

No genomic alterations detected in this tumor predicted to confer sensitivity or lack of benefit to chemotherapies.

HORMONAL THERAPIES

No genomic alterations detected in this tumor predicted to confer sensitivity or lack of benefit to hormonal therapies.

OTHERS

No genomic alterations detected in this tumor predicted to confer sensitivity or lack of benefit to other therapies.

Note:
Therapeutic implications provided in the test are based solely on the panel of 440 genes sequenced. Therefore, alterations in genes not covered in this panel, epigenetic and post-transcriptional and post-translational factors may also determine a patient's response to therapies. In addition, several other patient-associated clinical factors, including but not limited to, prior lines of therapies received, dosage and combinations with other therapeutic agents, patient's cancer types, sub-types, and/or stages, may also determine the patient's clinical response to therapies.

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VARIANT INTERPRETATION

ERCC4 C723*

Biological Impact

The ERCC4 (XPF) gene encodes a subunit of the ERCC1-XPF nuclease which plays an essential role in DNA repair and maintaining genomic stability. Loss-of-function mutations in ERCC4 are associated with several rare inherited human disorders such as Fanconi anemia which leads to bone marrow failure and predisposition to cancer[1].

C723* mutation results in a premature truncation of the ERCC4 protein at amino acid 723 (UniProtKB). This mutation is predicted to lead to a loss of ERCC4 function, despite not having characterized in the literature.

Therapeutic and prognostic relevance

A patient with stage IIIC high-grade serous ovarian cancer harboring inactivation mutation of ERCC4 was sensitive to platinum-based chemotherapy. However, ERCC4 inactivation does not confer sensitivity to rucaparib and doxorubicin in vitro[2]. ERCC4 mutation has been determined as an inclusion criterion for the trials evaluating niraparib efficacy in solid tumors (NCT03207347) and olaparib efficacy in metastatic urothelial cancer (NCT03448718).

TP53 L130V, Heterozygous deletion

Biological Impact

TP53 encodes the p53 protein, a crucial tumor suppressor that orchestrates essential cellular processes including cell cycle arrest, senescence and apoptosis[3]. TP53 is a proto-typical haploinsufficient gene, such that loss of a single copy of TP53 can result in tumor formation[4].

Therapeutic and prognostic relevance

Despite having a high mutation rate in cancers, there are currently no approved targeted therapies for TP53 mutations. A phase II trial demonstrated that Wee1 inhibitor (AZD1775) in combination with carboplatin was well tolerated and showed promising anti-tumor activity in TP53-mutated ovarian cancer refractory or resistant (< 3 months) to standard first-line therapy (NCT01164995)[5].

In a retrospective study (n=19), advanced sarcoma patients with TP53 loss-of-function mutations displayed improved progression-free survival (208 days versus 136 days) relative to patients with wild-type TP53 when treated with pazopanib[6]. Results from another Phase I trial of advanced solid tumors (n=78) demonstrated that TP53 hotspot mutations are associated with better clinical response to the combination of pazopanib and vorinostat[7].

Advanced solid tumor and colorectal cancer patients harboring a TP53 mutation have been shown to be more sensitive to bevacizumab when compared with patients harboring wild-type TP53[8][9][10]. In a pilot trial (n=21), TP53-negative breast cancer patients demonstrated increased survival following treatment with bevacizumab in combination with chemotherapy agents, Adriamycin (doxorubicin) and Taxotere (docetaxel)[11]. TP53 mutations were correlated with poor survival of advanced breast cancer patients receiving tamoxifen or primary chemotherapy[12][13]. In a retrospective study of non-small cell lung cancer (NSCLC), TP53 mutations were associated with high expression of VEGF-A, the primary target of bevacizumab, offering a mechanistic explanation for why patients exhibit improved outcomes after bevacizumab treatment when their tumors harbor mutant TP53 versus wild-type TP53[14].

FBXW7 Heterozygous deletion

Biological Impact

The F-box/WD repeat-containing protein 7 (FBXW7) gene encodes a protein that belongs to the SCF (SKP1-CUL1-F-box protein) E3 ligase complex. FBXW7 is recognized as a tumor suppressor which is involved in the negative regulation of oncogenes such as c-Myc[15][16], c-Jun[17], cyclin E[18], Notch family members[19][20], Aurora-A[21], mTOR[22],

KLF5[23], and MCL-1[24]. Inactivating FBXW7 mutation or copy number loss may result in the accumulation of oncoproteins and therefore lead to malignant transformation[25]. FBXW7 is a haploinsufficient tumor suppressor gene with one copy loss may lead to weak protein expression and is insufficient to execute its original physiological functions[23][24][26].

Therapeutic and prognostic relevance

Clinical efficacy of mTOR inhibitors was seen in patients harboring aberrations in the FBXW7 gene (one patient with refractory fibrolamellar hepatocellular carcinoma, and one patient with lung adenocarcinoma)[27][28]. Moreover, in vitro assay also suggested that loss or inactivation of FBXW7 may confer sensitivity to mTOR inhibitor[22].

Preclinical studies suggested that mutations or loss of FBXW7 were associated with regorafenib and oxaliplatin resistance in CRC cell lines and gefitinib resistance in lung cancer cells[29][30][31][32].

Retrospective studies have indicated that a relatively low expression level of FBXW7 is an independent prognostic marker of poor survival for patients with hepatocellular carcinoma, lung adenocarcinoma and squamous cell carcinoma[33][31].

FLCN Heterozygous deletion

Biological Impact

The FLCN gene encodes the tumor suppressor, Folliculin, a GTPase activating protein (GAP) for RagC/D GTPase proteins involved in amino acid sensing and signaling to mTORC1[34]. FLCN has been implicated as a haploinsufficient gene with one copy loss may lead to weak protein expression and is insufficient to execute its original physiological functions[35][36]. Inactivation of the FLCN gene by mutation or deletion results in the activation of the mTOR pathway and AKT signaling[37][38]. Germline mutation of the FLCN gene causes the Birt-Hogg-Dubé syndrome, a rare disorder that is characterized by benign hamartomatous skin lesions and an increased risk of pneumothorax and renal tumors[39].

Therapeutic and prognostic relevance

In a prospective Phase 2 study, four anaplastic thyroid cancer (ATC)/ poorly differentiated thyroid cancer (PDTC) patients who had PI3K/mTOR/AKT alterations, including TSC2, FLCN or NF1, showed impressive progression-free survival (PFS) of 15.2 months after receiving everolimus[40]. mTOR inhibition via rapamycin also demonstrated potential in inhibiting the growth of renal cells deficient in FLCN in the preclinical setting[41].

MET Amplification

Biological Impact

The Mesenchymal-Epithelial Transition (MET) is an oncogene that encodes the MET receptor tyrosine kinase (c-MET, also called HGFR, hepatocyte growth factor receptor). Binding of HGF leads to autophosphorylation and activation of MET and downstream effectors through the PI3K/AKT and RAS/RAF/MEK pathways, which regulates cell growth, proliferation, migration, and angiogenesis[42][43]. Gene amplification or overexpression of the MET occur in a wide range of cancers, including breast cancer[44], non-small cell lung cancer (NSCLC)[45], prostate cancer[46], renal papillary carcinoma[47][48], glioblastoma[49], hepatocellular carcinoma[50], and gastric cancer[51].

Therapeutic and prognostic relevance

MET amplification is known as an acquired mechanism conferring resistance to 1) EGFR-directed tyrosine kinase inhibitors including gefitinib, afatinib, erlotinib, and osimertinib, in patients with NSCLC[52][53][54][55]; 2) anti-EGFR mAb therapies in colorectal cancer (CRC) and head and neck cancer[56][57][58][59][60]; and 3) sunitinib, a multi-targeted tyrosine kinase inhibitor in renal cell carcinoma cells[61][62]. Furthermore, MET amplification and overexpression has been implicated as a causative factor in acquired cetuximab resistance in head and neck squamous cell carcinoma.

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In NCCN guidelines for NSCLC, high-level MET amplification has been suggested as an emerging biomarker for crizotinib, capmatinib and tepotinib in patients with metastatic NSCLC[63](DOI: 10.1200/jco.2014.32.15_suppl.8001). In the phase 2 GEOMETRY mono-1 study (NCT02414139), patients with high-level MET-amplified advanced NSCLC showed responses to capmatinib in both treated and treatment naïve cohorts. The DOR, PFS, and OS were similar in both treated and treatment naïve patients (DOR: ~8 months; PFS: ~4 months. OS: ~10 months)[64]. The results of the phase II VISION trial (NCT02864992) indicated that tepotinib showed meaningful efficacy in advanced NSCLC patients with MET amplification. The overall response rate is 41.7% and the mPFS is 4.2 months (Journal of Clinical Oncology 39, no. 15_suppl 9021-9021). In addition, results from clinical studies of squamous cell carcinoma of lung (SCC), and esophagogastric adenocarcinoma also showed that patients with MET-amplified tumors responded to crizotinib[65][66].

Combinations of EGFR TKIs like gefitinib, erlotinib, osimertinib, and icotinib with c-MET inhibitor crizotinib were proposed to overcome the acquired resistance induced by EGFR-directed TKIs mediated MET amplification and were successfully evaluated in clinical settings[67][68][69][70][71][72]. Besides, there is a case report showed that EGFR-mutated NSCLC patients with acquired MET amplification responded to combination therapy with bevacizumab and erlotinib[73]. A phase Ib/II trial in NSCLC patients who failed EGFR inhibitor therapy showed that patients with mutated EGFR and MET amplification (copy number >6) responded to the combination treatment with capmatinib and gefitinib (Overall response rate: 47%, disease control rate: 75%)[74].

Cabozantinib is a small molecule inhibitor of MET, VEGFR2, KIT and RET and was approved by the U.S. FDA for the treatment of progressive, metastatic medullary thyroid cancer[75][76]. MET amplification has been selected as an inclusion criteria for the trial examining cabozantinib in NSCLC (NCT01639508) (NCT03911193).

MET amplification and exon 14 splice site mutations are associated with higher c-Met protein expression and poor prognosis in patients with NSCLC and esophageal squamous cell carcinoma[77][78]. Besides, the plasma level of c-MET was associated with poor outcome in patients with hepatocellular carcinoma[79].

RAD50 Heterozygous deletion

Biological Impact

The RAD50 gene encodes a highly-conserved DNA double-strand break (DSB) repair factor. It forms MRN complex with NBS1 and MRE11 protein and is involved in sensing and early processing of DSB, cell cycle checkpoints, DNA recombination and maintenance of telomeres[80][81]. Mutations in the components of the MRN complex could increase susceptibility to familial breast cancer[82][83], gastric cancer[84], colorectal cancer[85], and urothelial cancer[86]. RAD50 has been implicated as a haploinsufficient gene with one copy loss may lead to weak protein expression and is insufficient to execute its original physiological functions[87]. Besides, RAD50 deletion was also suggested as a marker of BRCAness, a phenotype shared between non-BRCA1/2-mutated ovarian cancers and BRCA1/2-mutated ovarian cancers[88].

Therapeutic and prognostic relevance

Preclinical data showed that knockdown of the RAD50 gene in ovarian cancer cell lines was significantly associated with better responses to two PARP inhibitors, olaparib and rucaparib[88]. RAD50 has been selected as an inclusion criterion for the trials examining talazoparib efficacy in HER2-negative breast cancer, olaparib efficacy in breast cancer, rucaparib efficacy in metastatic prostate cancer and niraparib efficacy in any malignancy (except prostate) (NCT02401347, NCT03207347, NCT03344965, NCT03413995).

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SMAD4 Heterozygous deletion

Biological Impact

The SMAD family member 4 (SMAD4) gene encodes a transcription factor that acts as a downstream effector in the TGF-β signaling pathway. Upon phosphorylated and activated by serine-threonine receptor kinase, Smad4 is the Co-Smad which recruits other activated R-Smad proteins to the Smad transcriptional complex and regulate TGF-β-targeted genes[89]. Smad4 has been identified as a haploinsufficient gene with one copy loss may lead to a weak protein expression and is insufficient to execute its original physiological function[90]. SMAD4 germline mutations are associated with juvenile polyposis syndrome (JPS)[91][92][93][94]. Somatic mutations of SMAD4 are commonly observed in pancreatic cancer[95], colorectal cancer (CRC)[93][96][97], and less frequently seen in other cancers such as lung adenocarcinoma[98], head and neck cancer[99][100], and cutaneous squamous cell carcinoma[101].

Therapeutic and prognostic relevance

In Chinese patients with metastatic colorectal cancer, SMAD4 or NF1 mutations are suggested as a potential biomarker for poor prognosis to cetuximab-based therapy[102]. Preclinical data demonstrated that depletion of SMAD4 by shRNA knockdown increased clonogenic survival and cetuximab resistance in HPV-negative head and neck squamous cell carcinoma cells[103].

SMAD4 is also suggested as a predictive marker for 5-fluorouracil-based chemotherapy in colorectal cancer (CRC)[104][105]. CRC patients with normal SMAD4 diploidy exhibited three-fold higher benefit of 5-FU/mitomycin-based adjuvant therapy when compared with those with SMAD4 deletion[106].

Results from clinical and meta-analyses showed that loss of SMAD4 in CRC, pancreatic cancer was correlated with poor prognosis[107][108][109][110][111][112][113][114]. In cervical cancer patients, weak cytoplasmic SMAD4 expression and absent nuclear SMAD4 expression were shown to be significantly associated with poor disease-free and overall 5-year survival[115].

TERT Amplification

Biological Impact

The TERT gene encodes the catalytic subunit of telomerase, an enzyme that maintains telomere length and genomic integrity[116]. Upregulation of TERT promotes cancer development and progression via modulation of Wnt-catenin and nuclear factor kappa B signaling[117][118], and mitochondrial RNA processing[119]. Activating mutations in the TERT promoter have been identified in a number of cancer types including melanoma, hepatocellular carcinoma, urothelial carcinoma, medulloblastoma, and glioma whereas TERT gene amplification is implicated in lung cancer, cervical cancer, breast cancer, Merkel cell carcinoma, neuroblastoma and adrenocortical carcinoma[120][121][122][123][124].

Therapeutic and prognostic relevance

Imetelstat (GRN163L), a telomere inhibitor which has been shown to inhibit cell proliferation in various cancer cell lines and tumor xenografts is currently in clinical trials[116].

TERT gene amplification is an independent poor prognostic marker for disease-free survival in non-small cell lung cancer (NSCLC) and breast cancer[125][126][127].

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US FDA-APPROVED DRUG(S)

Cabozantinib (COMETRIQ)

Cabozantinib is a small molecule inhibitors of multiple tyrosine kinases, including RET, MET, VEGFR-1, -2 and -3, KIT, TRKB, FLT-3, AXL, and TIE-2. Cabozantinib is developed and marketed by Exelixis under the trade names COMETRIQ (capsule) and CABOMETYX (tablet).

- FDA Approval Summary of Cabozantinib (COMETRIQ)

EXAM[128] NCT00704730	**Thyroid cancer** (Approved on 2012/11/29)
	-
	Cabozantinib vs. Placebo [PFS(M): 11.2 vs. 4]

Cabozantinib (CABOMETYX)

Cabozantinib is a small molecule inhibitors of multiple tyrosine kinases, including RET, MET, VEGFR-1, -2 and -3, KIT, TRKB, FLT-3, AXL, and TIE-2. Cabozantinib is developed and marketed by Exelixis under the trade names COMETRIQ (capsule) and CABOMETYX (tablet).

- FDA Approval Summary of Cabozantinib (CABOMETYX)

COSMIC-311 NCT03690388	**Differentiated thyroid cancer (dtc)** (Approved on 2021/09/17)
	-
	Cabozantinib vs. Placebo [PFS(M): 11 vs. 1.9, ORR(%): 18.0 vs. 0]
CHECKMATE-9ER NCT03141177	**Renal cell carcinoma** (Approved on 2021/01/22)
	-
	Nivolumab + cabozantinib vs. Sunitinib [ORR(%): 55.7 vs. 27.1, PFS(M): 16.6 vs. 8.3, OS(M): NR vs. NR]
CELESTIAL [129] NCT01908426	**Hepatocellular carcinoma** (Approved on 2019/01/14)
	-
	Cabozantinib vs. Placebo [OS(M): 10.2 vs. 8]
CABOSUN[130] NCT01835157	**Renal cell carcinoma** (Approved on 2017/12/09)
	-
	Cabozantinib vs. Sunitinib [PFS(M): 8.6 vs. 5.3]
METEOR[131] NCT01865747	**Renal cell carcinoma** (Approved on 2016/04/25)
	-
	Cabozantinib vs. Everolimus [PFS(M): 7.4 vs. 3.8]

Capmatinib (TABRECTA)

Capmatinib is an orally bioavailable inhibitor of the proto-oncogene c-Met (also known as hepatocyte growth factor receptor (HGFR)) with potential antineoplastic activity. Capmatinib is developed and marketed by Novartis under the trade name TABRECTA.

- FDA Approval Summary of Capmatinib (TABRECTA)

GEOMETRY mono-1[64] NCT02414139	**Non-small cell lung carcinoma** (Approved on 2020/05/06)
	MET exon 14 skipping
	Capmatinib [ORR (Treatment naive) (%): 68, ORR (Previously treated)(%): 41]

Crizotinib (XALKORI)

Crizotinib is an inhibitor of the tyrosine kinases anaplastic lymphoma kinase (ALK) and c-ros oncogene 1 (ROS1), by competitively binding with the ATP-binding pocket. Crizotinib is developed and marketed by Pfizer under the trade name XALKORI.

- FDA Approval Summary of Crizotinib (XALKORI)

ADVL0912, A8081013 NCT00939770, NCT01121588	**Inflammatory myofibroblastic tumor** (Approved on 2022/08/05)
	ALK+
	Crizotinib [ORR(pediatric patients)(%): 86.0, ORR(adult patients)(%): 71.0]
ADVL0912 NCT00939770	**Alk fusion-positive anaplastic large cell lymphoma (alcl)** (Approved on 2021/01/14)
	ALK fusion
	Crizotinib [ORR(%): 88.0, DOR(M): 39 (maintained response for at least 6 months) vs. 22 (maintained response for at least 12 months)]
PROFILE 1001[132] NCT00585195	**Non-small cell lung carcinoma** (Approved on 2016/03/11)
	ROS1+
	Crizotinib [ORR(%): 66.0]
PROFILE 1014[133] NCT01154140	**Non-small cell lung carcinoma** (Approved on 2015/03/20)
	ALK+
	Crizotinib vs. Pemetrexed + cisplatin or pemetrexed + carboplatin [PFS(M): 10.9 vs. 7]
PROFILE 1007[134] NCT00932893	**Non-small cell lung carcinoma** (Approved on 2013/11/20)
	ALK+
	Crizotinib vs. Pemetrexed or docetaxel [PFS(M): 7.7 vs. 3]

Everolimus (AFINITOR)

Everolimus, a derivative of sirolimus, works as an inhibitor of mammalian target of rapamycin complex 1 (mTORC1) and blocks mTORC1-mediated downstream signals for cell growth, proliferation, and survival. Everolimus is developed and marketed by Novartis under the trade name AFINITOR.

- FDA Approval Summary of Everolimus (AFINITOR)

RADIANT-4[135] NCT01524783	**Lung or gastrointestinal neuroendocrine tumor** (Approved on 2016/02/26)
	-
	Everolimus vs. Placebo [PFS(M): 11 vs. 3.9]
BOLERO-2[136] NCT00863655	**Breast cancer** (Approved on 2012/07/20)
	ER+/HER2-
	Everolimus + exemestane vs. Placebo + exemestane [PFS(M): 7.8 vs. 3.2]
EXIST-2 NCT00790400	**Tuberous sclerosis complex (tsc)-associated renal angiomyolipoma** (Approved on 2012/04/26)
	-
	Everolimus vs. Placebo [ORR(%): 41.8 vs. 0]
RADIANT-3[137] NCT00510068	**Pancreatic neuroendocrine tumor** (Approved on 2011/05/05)
	-
	Everolimus vs. Placebo [PFS(M): 11 vs. 4.6]
EXIST-1[138] NCT00789828	**Subependymal giant cell astrocytoma** (Approved on 2010/10/29)
	-
	Everolimus vs. Placebo [ORR(%): 35.0]

RECORD-1[139] NCT00410124	**Renal cell carcinoma** (Approved on 2009/05/30)
	-
	Everolimus vs. Placebo [PFS(M): 4.9 vs. 1.9]

Niraparib (ZEJULA)

Niraparib is an oral, small molecule inhibitor of the DNA repair enzyme poly (ADP-ribose) polymerase-1 and -2 (PARP-1, -2). Niraparib is developed and marketed by Tesaro under the trade name ZEJULA.

- FDA Approval Summary of Niraparib (ZEJULA)

PRIMA NCT02655016	**Ovarian cancer, Fallopian tube cancer, Peritoneal carcinoma** (Approved on 2020/04/29)
	-
	Niraparib vs. Placebo [PFS (overall population)(M): 13.8 vs. 8.2]
NOVA[140] NCT01847274	**Ovarian cancer, Fallopian tube cancer, Peritoneal carcinoma** (Approved on 2017/03/27)
	-
	Niraparib vs. Placebo [PFS (overall population)(M): 11.3 vs. 4.7]

Olaparib (LYNPARZA)

Olaparib is an oral, small molecule inhibitor of poly (ADP-ribose) polymerase-1, -2, and -3 (PARP-1, -2, -3). Olaparib is developed by KuDOS Pharmaceuticals and marketed by AstraZeneca under the trade name LYNPARZA.

- FDA Approval Summary of Olaparib (LYNPARZA)

OlympiA NCT02032823	**Her2-negative high-risk early breast cancer** (Approved on 2022/03/11)
	HER2-/gBRCA mutation
	Olaparib vs. Placebo [invasive disease-free survival (IDFS)(M):]
PROfound[141] NCT02987543	**Prostate cancer** (Approved on 2020/05/19)
	HRR genes mutation
	Olaparib vs. Enzalutamide or abiraterone acetate [PFS(M): 5.8 vs. 3.5]
PAOLA-1[142] NCT02477644	**Ovarian cancer** (Approved on 2020/05/08)
	HRD+
	Olaparib + bevacizumab vs. Placebo + bevacizumab [PFS(M): 37.2 vs. 17.7]
POLO[143] NCT02184195	**Pancreatic adenocarcinoma** (Approved on 2019/12/27)
	gBRCA mutation
	Olaparib vs. Placebo [ORR(%): 23.0 vs. 12.0, PFS(M): 7.4 vs. 3.8]
SOLO-1[144] NCT01844986	**Ovarian cancer, Fallopian tube cancer, Peritoneal carcinoma** (Approved on 2018/12/19)
	gBRCA mutation or sBRCA mutation
	Olaparib vs. Placebo [PFS(M): NR vs. 13.8]
OlympiAD[145] NCT02000622	**Breast cancer** (Approved on 2018/02/06)
	HER2-/gBRCA mutation
	Olaparib vs. Chemotherapy [PFS(M): 7 vs. 4.2]
SOLO-2/ENGOT-Ov21[146] NCT01874353	**Ovarian cancer, Fallopian tube cancer, Peritoneal carcinoma** (Approved on 2017/08/17)
	gBRCA mutation
	Olaparib vs. Placebo [PFS(M): 19.1 vs. 5.5]

Study19[147] NCT00753545	**Ovarian cancer, Fallopian tube cancer, Peritoneal carcinoma** (Approved on 2017/08/17)
	-
	Olaparib vs. Placebo [PFS(M): 8.4 vs. 4.8]

Rucaparib (RUBRACA)

Rucaparib is an inhibitor of the DNA repair enzyme poly (ADP-ribose) polymerase-1, -2 and -3 (PARP-1, -2, -3). Rucaparib is developed and marketed by Clovis Oncology under the trade name RUBRACA.

- FDA Approval Summary of Rucaparib (RUBRACA)

TRITON2 NCT02952534	**Prostate cancer** (Approved on 2020/05/15)
	gBRCA mutation or sBRCA mutation
	Rucaparib [ORR(%): 44.0, DOR(M): NE]
ARIEL3[148] NCT01968213	**Ovarian cancer, Fallopian tube cancer, Peritoneal carcinoma** (Approved on 2018/04/06)
	-
	Rucaparib vs. Placebo [PFS (All)(M): 10.8 vs. 5.4, PFS (HRD)(M): 13.6 vs. 5.4, PFS (tBRCA)(M): 16.6 vs. 5.4]

Talazoparib (TALZENNA)

Talazoparib is an inhibitor of poly (ADP-ribose) polymerase (PARP) enzymes, including PARP1 and PARP2. Talazoparib is developed and marketed by Pfizer under the trade name TALZENNA.

- FDA Approval Summary of Talazoparib (TALZENNA)

EMBRACA[149] NCT01945775	**Breast cancer** (Approved on 2018/10/16)
	HER2-/gBRCA mutation
	Talazoparib vs. Chemotherapy [PFS(M): 8.6 vs. 5.6]

Temsirolimus (TORISEL)

Temsirolimus is a soluble ester of sirolimus (rapamycin, brand-name drug Rapamune) and functions as an inhibitor of mammalian target of rapamycin complex (mTORC). The inhibitory molecular mechanism is similar to Everolimus. Temsirolimus is developed by Wyeth Pharmaceuticals and marketed by Pfizer under the trade name TORISEL.

- FDA Approval Summary of Temsirolimus (TORISEL)

[150] NCT00065468	**Renal cell carcinoma** (Approved on 2007/05/30)
	-
	Temsirolimus vs. Ifn-α [OS(M): 10.9 vs. 7.3]

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Tepotinib (TEPMETKO)

Tepotinib is a potent and selective c-Met inhibitor. Tepotinib is developed and marketed by EMD Serono, Inc. under the trade name TEPMETKO.

- FDA Approval Summary of Tepotinib (TEPMETKO)

VISION NCT02864992	**Non-small cell lung carcinoma** (Approved on 2021/02/03)
	MET exon 14 skipping
	Tepotinib [ORR (Treatment naive)(%): 43, ORR (Previously treated)(%): 43]

D=day; W=week; M=month

ONGOING CLINICAL TRIALS

Trials were searched by applying filters: study status, patient's diagnosis, intervention, location and/or biomarker(s). Please visit https://clinicaltrials.gov to search and view for a complete list of open available and updated matched trials.

No trial has been found.

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SUPPLEMENTARY INFORMATION OF TESTING RESULTS

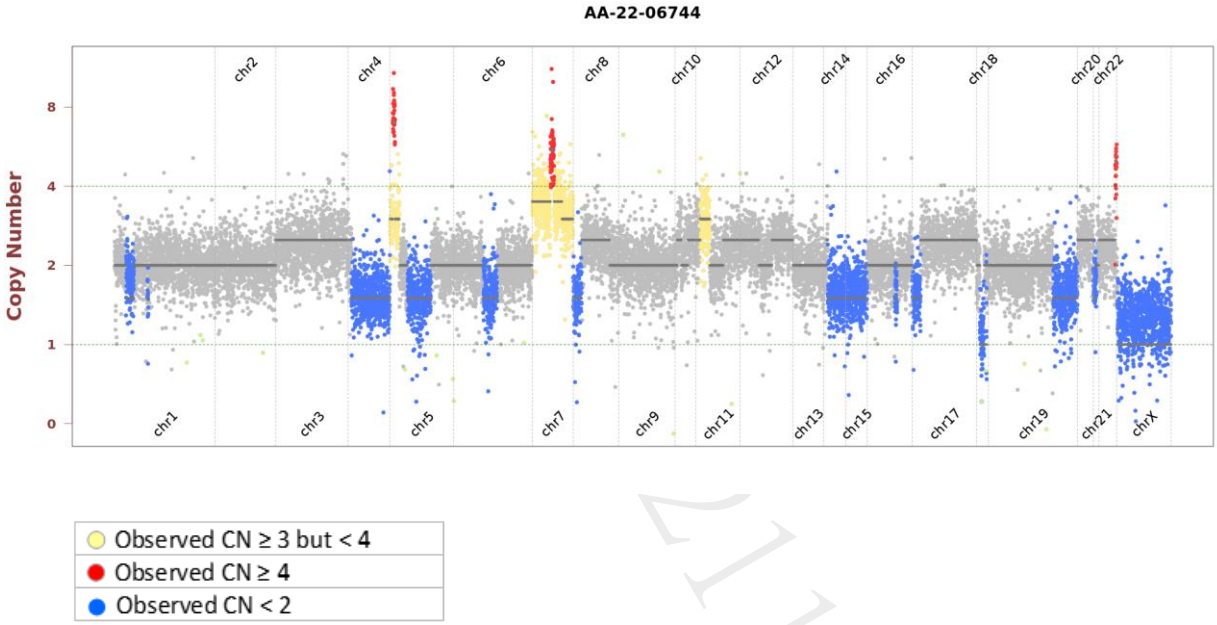
DETAILED INFORMATION OF VARIANTS WITH CLINICAL RELEVANCE

- Single Nucleotide and Small InDel Variants

Gene	Amino Acid Change	Exon	cDNA Change	Accession Number	COSMIC ID	Allele Frequency	Coverage
ERCC4	C723*	11	c.2169C>A	NM_005236	-	41.6%	2445
TP53	L130V	5	c.388C>G	NM_000546	COSM11462	56.7%	633

- Copy Number Alterations

Observed copy number (CN) for each evaluated position is shown on the y-axis. Regions referred to as amplification or deletion are shown in color. Regions without significant changes are represented in gray.



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OTHER DETECTED VARIANTS

Gene	Amino Acid Change	Exon	cDNA Change	Accession Number	COSMIC ID	Allele Frequency	Coverage
ABL2	R78H	3	c.233G>A	NM_007314	-	36.8%	1247
ALK	T1012M	18	c.3035C>T	NM_004304	-	64.1%	1778
APC	G2383V	16	c.7148G>T	NM_000038	-	76.2%	602
DDR2	V327I	9	c.979G>A	NM_006182	-	58.5%	1848
ESR2	L413V	8	c.1237C>G	NM_001437	COSM7637015	79.3%	1263
IKBKE	Splice region	-	c.1734-3T>C	NM_014002	-	63.7%	1199
IL7R	W217*	5	c.651G>A	NM_002185	-	24.3%	1713
KIT	T734S	15	c.2201C>G	NM_000222	-	28.9%	933
KMT2C	V924M	17	c.2770G>A	NM_170606	-	63.0%	327
MTOR	A1134V	23	c.3401C>T	NM_004958	-	39.9%	2372
MUC16	K1884M	1	c.5651A>T	NM_024690	-	83.2%	1199
MUC6	Splice region	-	c.1453+4C>T	NM_005961	COSM2108620	29.4%	476
PRKDC	T4000I	85	c.11999C>T	NM_006904	-	50.4%	1905
PTPRT	A68T	2	c.202G>A	NM_007050	-	48.5%	1891
PTPRT	V764M	14	c.2290G>A	NM_007050	COSM6975856	51.8%	3109
REL	N424S	11	c.1271A>G	NM_002908	-	57.6%	1275
RET	R67C	2	c.199C>T	NM_020975	COSM6958548	48.4%	759
TERT	T1110A	16	c.3328A>G	NM_198253	-	7.1%	2168
TSC2	R1369Q	34	c.4106G>A	NM_000548	-	45.3%	813

Note:

- This table enlists variants detected by the panel other than those with clinical relevance (reported in Testing Result section). The clinical impact of a genetic variant is determined according to ACT Genomics in-house clinical knowledge database. A negative result does not necessarily indicate absence of biological effect on the tumor. Some variants listed here may possibly have preclinical data or may show potential clinical relevance in the future.

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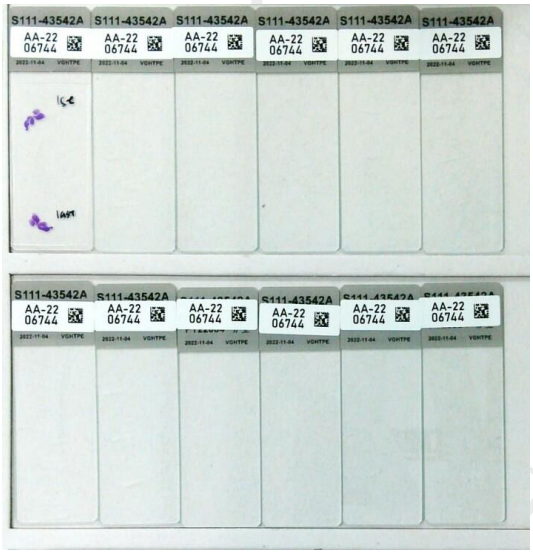
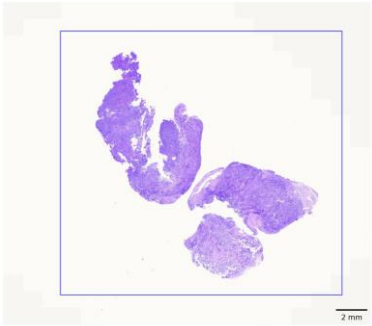
TEST DETAILS

SPECIMEN RECEIVED AND PATHOLOGY REVIEW





- Collection date: Oct 25, 2022
- Facility retrieved: 臺北榮總
- H&E-stained section No.: S11143542A
- Collection site: Bone
- Examined by: Dr. Yun-An Chen
    1. The percentage of viable tumor cells in total cells in the whole slide (%): 70%
    2. The percentage of viable tumor cells in total cells in the encircled areas in the whole slide (%): 70%
    3. The percentage of necrotic cells (including necrotic tumor cells) in total cells in the whole slide (%): 0%
    4. The percentage of necrotic cells (including necrotic tumor cells) in total cells in the encircled areas in the whole slide (%): 0%
    5. Additional comment: N/A
- Manual macrodissection: Not performed
- The outline highlights the area of malignant neoplasm annotated by a pathologist.

RUN QC

- Panel: ACTOnco®+

DNA test

- Mean Depth: 1014x
- Target Base Coverage at 100x: 95%

RNA test

- Average unique RNA Start Sites per control GSP2: 122

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LIMITATIONS

1. This test does not provide information of variant causality and does not detect variants in non-coding regions that could affect gene expression. This report does not report polymorphisms and we do not classify whether a mutation is germline or somatic. Variants identified by this assay were not subject to validation by Sanger or other technologies.
2. The possibility cannot be excluded that certain pathogenic variants detected by other sequencing tools may not be reported in the test because of technical limitation of bioinformatics algorithm or the NGS sequencing platform, e.g. low coverage.
3. This test has been designed to detect fusions in 13 genes sequenced. Therefore, fusion in genes not covered by this test would not be reported. For novel fusions detected in this test, Sanger sequencing confirmation is recommended if residue specimen is available.

NEXT-GENERATION SEQUENCING (NGS) METHODS

DNA test

Extracted genomic DNA was amplified using primers targeting coding exons of analyzed genes and subjected to library construction. Barcoded libraries were subsequently conjugated with sequencing beads by emulsion PCR and enriched using Ion Chef system. Sequencing was performed according to Ion Proton or Ion S5 sequencer protocol (Thermo Fisher Scientific).

Raw reads generated by the sequencer were mapped to the hg19 reference genome using the Ion Torrent Suite. Coverage depth was calculated using Torrent Coverage Analysis plug-in. Single nucleotide variants (SNVs) and short insertions/deletions (InDels) were identified using the Torrent Variant Caller plug-in. VEP (Variant Effect Predictor) was used to annotate every variant using databases from Clinvar, COSMIC and Genome Aggregation database. Variants with coverage ≥ 20, allele frequency ≥ 5% and actionable variants with allele frequency ≥ 2% were retained. This test provides uniform coverage of the targeted regions, enabling target base coverage at 100x ≥ 85% with a mean coverage ≥ 500x.

Variants reported in Genome Aggregation database with > 1% minor allele frequency (MAF) were considered as polymorphisms. ACT Genomics in-house database was used to determine technical errors. Clinically actionable and biologically significant variants were determined based on the published medical literature.

The copy number alterations (CNAs) were predicted as described below:
Amplicons with read counts in the lowest 5th percentile of all detectable amplicons and amplicons with a coefficient of variation ≥ 0.3 were removed. The remaining amplicons were normalized to correct the pool design bias. ONCOCNV (an established method for calculating copy number aberrations in amplicon sequencing data by Boeva et al., 2014) was applied for the normalization of total amplicon number, amplicon GC content, amplicon length, and technology-related biases, followed by segmenting the sample with a gene-aware model. The method was used as well for establishing the baseline of copy number variations.

Tumor mutational burden (TMB) was calculated by using the sequenced regions of ACTOnco®+ to estimate the number of somatic nonsynonymous mutations per megabase of all protein-coding genes (whole exome). The TMB calculation predicted somatic variants and applied a machine learning model with a cancer hotspot correction. TMB may be reported as “TMB-High”, “TMB-Low” or “Cannot Be Determined”. TMB-High corresponds to ≥ 7.5 mutations per megabase (Muts/Mb); TMB-Low corresponds to < 7.5 Muts/Mb. TMB is reported as “Cannot Be Determined” if the tumor purity of the sample is < 30%.

Classification of microsatellite instability (MSI) status is determined by a machine learning prediction algorithm. The change of a number of repeats of different lengths from a pooled microsatellite stable (MSS) baseline in > 400 genomic loci are used as the features for the algorithm. The final output of the results is either microsatellite Stable (MSS) or microsatellite instability high (MSI-H).

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RNA test

Extracted RNA was reverse-transcribed and subjected to library construction. Sequencing was performed according to Ion Proton or Ion S5 sequencer protocol (Thermo Fisher Scientific). To ensure sequencing quality for fusion variant analysis, the average unique RNA Start Sites (SS) per control Gene Specific Primer 2 (GSP 2) should be ≥ 10.

The fusion analysis pipeline aligned sequenced reads to the human reference genome, identified regions that map to noncontiguous regions of the genome, applied filters to exclude probable false-positive events and, annotated previously characterized fusion events according to Quiver Gene Fusion Database, a curated database owned and maintained by ArcherDX. In general, samples with detectable fusions need to meet the following criteria: (1) Number of unique start sites (SS) for the GSP2 ≥ 3; (2) Number of supporting reads spanning the fusion junction ≥ 5; (3) Percentage of supporting reads spanning the fusion junction ≥ 10%; (4) Fusions annotated in Quiver Gene Fusion Database.

DATABASE USED

- Reference genome: Human genome sequence hg19
- COSMIC v.92
- Genome Aggregation database r2.1.1
- ClinVar (version 20210404)
- ACT Genomics in-house database
- Quiver Gene Fusion Database version 5.1.18

Variant Analysis:
醫檢師張筑芃 博士
Chu-Yuan Chang Ph.D.
檢字第 020115 號

Sign Off
解剖病理專科醫師王業翰
Yeh-Han Wang M.D.
病解字第 000545 號

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GENE LIST

SNV & CNV

ABCB1*	ABCC2*	ABCG2*	ABL1	ABL2	ADAMTS1	ADAMTS13	ADAMTS15	ADAMTS16	ADAMTS18	ADAMTS6	ADAMTS9
ADAMTSL1	ADGRA2	ADH1C*	AKT1	AKT2	AKT3	ALDH1A1*	ALK	AMER1	APC	AR	ARAF
ARID1A	ARID1B	ARID2	ASXL1	ATM	ATR	ATRX	AURKA	AURKB	AXIN1	AXIN2	AXL
B2M	BAP1	BARD1	BCL10	BCL2*	BCL2L1	BCL2L2*	BCL6	BCL9	BCOR	BIRC2	BIRC3
BLM	BMPR1A	BRAF	BRCA1	BRCA2	BRD4	BRIP1	BTG1	BTG2*	BTK	BUB1B	CALR
CANX	CARD11	CASP8	CBFB	CBL	CCNA1	CCNA	CCNB1	CCNB2	CCNB3	CCND1	CCND2
CCND3	CCNE1	CCNE2	CCNH	CD19	CD274	CD58	CD70*	CD79A	CD79B	CDC73	CDH1
CDK1	CDK12	CDK2	CDK4	CDK5	CDK6	CDK7	CDK8	CDK9	CDKN1A	CDKN1B	CDKN2A
CDKN2B	CDKN2C	CEBPA*	CHEK1	CHEK2	CIC	CREBBP	CRKL	CRLF2	CSF1R	CTCF	CTLA4
CTNNA1	CTNNB1	CUL3	CYLD	CYP1A1*	CYP2B6*	CYP2C19*	CYP2C8*	CYP2D6	CYP2E1*	CYP3A4*	CYP3A5*
DAXX	DCUN1D1	DDR2	DICER1	DNMT3A	DOT1L	DPYD	DTX1	E2F3	EGFR	EP300	EPCAM
EPHA2	EPHA3	EPHA5	EPHA7	EPHB1	ERBB2	ERBB3	ERBB4	ERCC1	ERCC2	ERCC3	ERCC4
ERCC5	ERG	ESR1	ESR2	ETV1	ETV4	EZH2	FAM46C	FANCA	FANCC	FANCD2	FANCE
FANCF	FANCG	FANCL	FAS	FAT1	FBXW7	FCGR2B	FGF1*	FGF10	FGF14	FGF19*	FGF23
FGF3	FGF4*	FGF6	FGFR1	FGFR2	FGFR3	FGFR4	FH	FLCN	FLT1	FLT3	FLT4
FOXL2*	FOXP1	FRG1	FUBP1	GATA1	GATA2	GATA3	GNA11	GNA13	GNAQ	GNAS	GREM1
GRIN2A	GSK3B	GSTP1*	GSTT1*	HGF	HIF1A	HIST1H1C*	HIST1H1E*	HNF1A	HR	HRAS*	HSP90AA1
HSP90AB1	HSPA4	HSPA5	IDH1	IDH2	IFNL3*	IGF1	IGF1R	IGF2	IKBKB	IKBKE	IKZF1
IL6	IL7R	INPP4B	INSR	IRF4	IRS1	IRS2*	JAK1	JAK2	JAK3	JUN*	KAT6A
KDM5A	KDM5C	KDM6A	KDR	KEAP1	KIT	KMT2A	KMT2C	KMT2D	KRAS	LCK	LIG1
LIG3	LMO1	LRP1B	LYN	MALT1	MAP2K1	MAP2K2	MAP2K4	MAP3K1	MAP3K7	MAPK1	MAPK3
MAX	MCL1	MDM2	MDM4	MED12	MEF2B	MEN1	MET	MITF	MLH1	MPL	MRE11
MSH2	MSH6	MTHFR*	MTOR	MUC16	MUC4	MUC6	MUTYH	MYC	MYCL	MYCN	MYD88
NAT2*	NBN	NEFH	NF1	NF2	NFE2L2	NFKB1	NFKBIA	NKX2-1*	NOTCH1	NOTCH2	NOTCH3
NOTCH4	NPM1	NQO1*	NRAS	NSD1	NTRK1	NTRK2	NTRK3	PAK3	PALB2	PARP1	PAX5
PAX8	PBRM1	PDCD1	PDCD1LG2	PDGFRA	PDGFRB	PDIA3	PGF	PHOX2B*	PIK3C2B	PIK3C2G	PIK3C3
PIK3CA	PIK3CB	PIK3CD	PIK3CG	PIK3R1	PIK3R2	PIK3R3	PIM1	PMS1	PMS2	POLB	POLD1
POLE	PPARG	PPP2R1A	PRDM1	PRKAR1A	PRKCA	PRKCB	PRKCG	PRKCI	PRKCQ	PRKDC	PRKN
PSMB8	PSMB9	PSME1	PSME2	PSME3	PTCH1	PTEN	PTGS2	PTPN11	PTPRD	PTPRT	RAC1
RAD50	RAD51	RAD51B	RAD51C	RAD51D	RAD52	RAD54L	RAF1	RARA	RB1	RBM10	RECQL4
REL	RET	RHOA	RICTOR	RNF43	ROS1	RPPH1	RPTOR	RUNX1	RUNX1T1	RXRA	SDHA
SDHB	SDHC	SDHD	SERPINB3	SERPINB4	SETD2	SF3B1	SGK1	SH2D1A*	SLC19A1*	SLC22A2*	SLCO1B1*
SLCO1B3*	SMAD2	SMAD3	SMAD4	SMARCA4	SMARCB1	SMO	SOCS1*	SOX2*	SOX9	SPEN	SPOP
SRC	STAG2	STAT3	STK11	SUFU	SYK	SYNE1	TAF1	TAP1	TAP2	TAPBP	TBX3
TEK	TERT	TET1	TET2	TGFBR2	TMSB4X*	TNF	TNFAIP3	TNFRSF14	TNFSF11	TOP1	TP53
TPMT*	TSC1	TSC2	TSHR	TYMS	U2AF1	UBE2A*	UBE2K	UBR5	UGT1A1*	USH2A	VDR*
VEGFA	VEGFB	VHL	WT1	XIAP	XPO1	XRCC2	ZNF217				

*Analysis of copy number alterations NOT available.

FUSION

ALK	BRAF	EGFR	FGFR1	FGFR2	FGFR3	MET	NRG1	NTRK1	NTRK2	NTRK3	RET	ROS1

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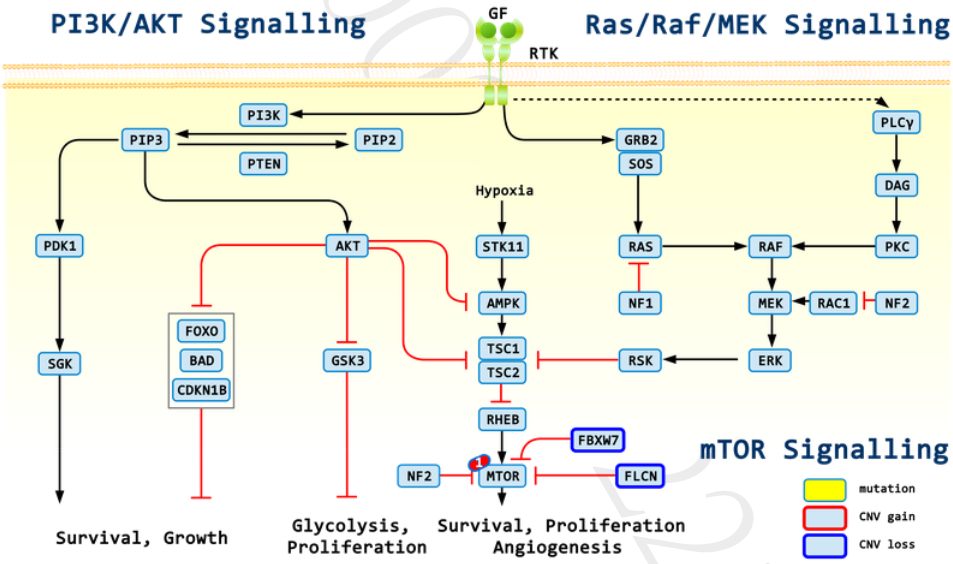
APPENDIX

POSSIBLE THERAPEUTIC IMPLICATIONS FOR HETEROZYGOUS DELETION

Gene	Therapies	Possible effect
FBXW7	Everolimus, Temsirolimus	**sensitive**
FLCN	Everolimus, Temsirolimus	**sensitive**
RAD50	Niraparib, Olaparib, Rucaparib, Talazoparib	**sensitive**
SMAD4	Cetuximab	**resistant**
FBXW7	Gefitinib, Regorafenib	**resistant**

SIGNALING PATHWAYS AND MOLECULAR-TARGETED AGENTS



1: Everolimus, Temsirolimus

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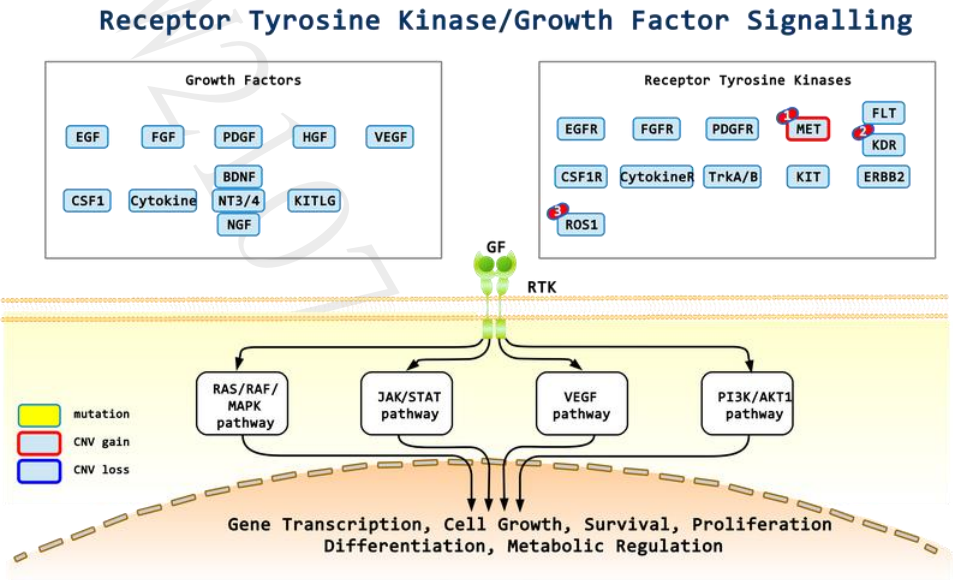
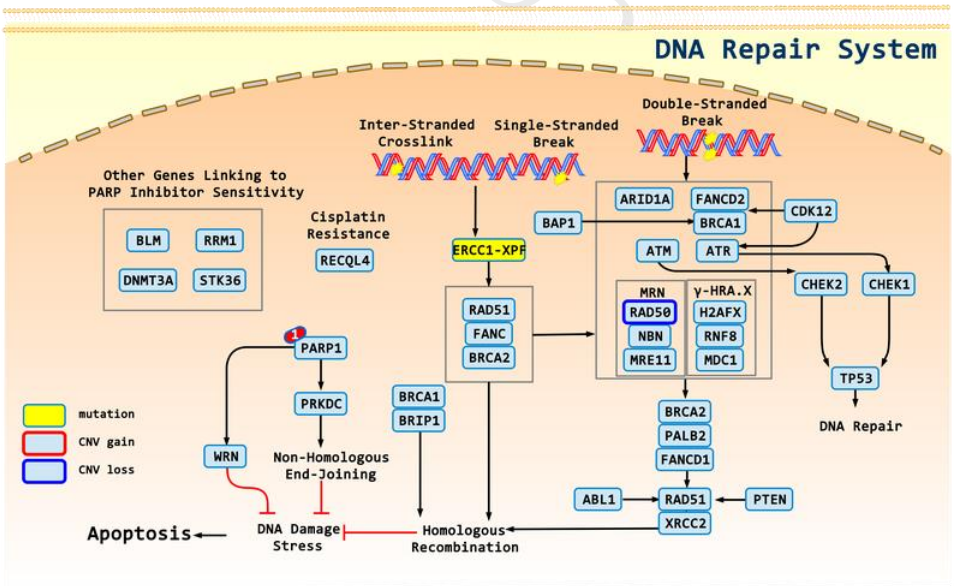


1: Crizotinib, Cabozantinib, Capmatinib, Tepotinib; 2: Cabozantinib; 3: Crizotinib



1: Olaparib, Niraparib, Rucaparib, Talazoparib

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DISCLAIMER

法律聲明

本檢驗報告僅提供專業醫療參考，結果需經專業醫師解釋及判讀。基因突變資訊非必具備藥物或治療有效性指標，反之亦然。本檢驗報告提供之用藥指引不聲明或保證其臨床有效性，反之亦然。本基因檢測方法係由本公司研究開發，已經過有效性測試。
本檢驗報告非經本公司許可，不得私自變造、塗改，或以任何方式作為廣告及其他宣傳之用途。
本公司於提供檢驗報告後，即已完成本次契約義務，後續之報告解釋、判讀及用藥、治療，應自行尋求相關專業醫師協助，若需將報告移件其他醫師，本人應取得該醫師同意並填寫移件申請書，主動告知行動基因，行動基因僅能配合該醫師意願與時間提供醫師解說。

醫療決策需由醫師決定

任何治療與用藥需經由醫師在考慮病患所有健康狀況相關資訊包含健檢、其他檢測報告和病患意願後，依照該地區醫療照護標準由醫師獨立判斷。醫師不應僅依據單一報告結果(例如本檢測或本報告書內容)做決策。

基因突變與用藥資訊並非依照有效性排序

本報告中列出之生物標記變異與藥物資訊並非依照潛在治療有效性排序。

證據等級

藥物潛在臨床效益(或缺乏潛在臨床效益)的實證證據是依據至少一篇臨床療效個案報告或臨床前試驗做為評估。本公司盡力提供適時及準確之資料，但由於醫學科技之發展日新月異，本公司不就本報告提供的資料是否為準確、適宜或最新作保證。

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REFERENCE

1. PMID: 26074087; 2015, Gene;569(2):153-61
The ERCC1 and ERCC4 (XPF) genes and gene products.

2. PMID: 25634215; 2015, Cancer Res;75(4):628-34
A unique subset of epithelial ovarian cancers with platinum sensitivity and PARP inhibitor resistance.

3. PMID: 24739573; 2014, Nat Rev Cancer;14(5):359-70
Unravelling mechanisms of p53-mediated tumour suppression.

4. PMID: 21125671; 2011, J Pathol;223(2):137-46
Haplo-insufficiency: a driving force in cancer.

5. PMID: 27998224; 2016, J Clin Oncol;34(36):4354-4361
Phase II Study of WEE1 Inhibitor AZD1775 Plus Carboplatin in Patients With TP53-Mutated Ovarian Cancer Refractory or Resistant to First-Line Therapy Within 3 Months.

6. PMID: 26646755; 2016, Ann Oncol;27(3):539-43
TP53 mutational status is predictive of pazopanib response in advanced sarcomas.

7. PMID: 25669829; 2015, Ann Oncol;26(5):1012-8
Phase I study of pazopanib and vorinostat: a therapeutic approach for inhibiting mutant p53-mediated angiogenesis and facilitating mutant p53 degradation.

8. PMID: 27466356; 2016, Mol Cancer Ther;15(10):2475-2485
TP53 Alterations Correlate with Response to VEGF/VEGFR Inhibitors: Implications for Targeted Therapeutics.

9. PMID: 23670029; 2013, Oncotarget;4(5):705-14
P53 mutations in advanced cancers: clinical characteristics, outcomes, and correlation between progression-free survival and bevacizumab-containing therapy.

10. PMID: 17145525; 2006, Semin Oncol;33(5 Suppl 10):S8-14
Bevacizumab in combination with chemotherapy: first-line treatment of patients with metastatic colorectal cancer.

11. PMID: 21399868; 2011, Int J Oncol;38(5):1445-52
p53, HER2 and tumor cell apoptosis correlate with clinical outcome after neoadjuvant bevacizumab plus chemotherapy in breast cancer.

12. PMID: 20549698; 2011, Int J Cancer;128(8):1813-21
p53 status influences response to tamoxifen but not to fulvestrant in breast cancer cell lines.

13. PMID: 10786679; 2000, Cancer Res;60(8):2155-62
Complete sequencing of TP53 predicts poor response to systemic therapy of advanced breast cancer.

14. PMID: 25672981; 2015, Cancer Res;75(7):1187-90
VEGF-A Expression Correlates with TP53 Mutations in Non-Small Cell Lung Cancer: Implications for Antiangiogenesis Therapy.

15. PMID: 15498494; 2004, Curr Biol;14(20):1852-7
A nucleolar isoform of the Fbw7 ubiquitin ligase regulates c-Myc and cell size.

16. PMID: 15103331; 2004, EMBO J;23(10):2116-25
Phosphorylation-dependent degradation of c-Myc is mediated by the F-box protein Fbw7.

17. PMID: 16023596; 2005, Cancer Cell;8(1):25-33
The v-Jun point mutation allows c-Jun to escape GSK3-dependent recognition and destruction by the Fbw7 ubiquitin ligase.

18. PMID: 11533444; 2001, Science;294(5540):173-7
Phosphorylation-dependent ubiquitination of cyclin E by the SCFFbw7 ubiquitin ligase.

19. PMID: 11461910; 2001, J Biol Chem;276(38):35847-53
The Notch intracellular domain is ubiquitinated and negatively regulated by the mammalian Sel-10 homolog.

20. PMID: 11425854; 2001, J Biol Chem;276(37):34371-8
Functional interaction between SEL-10, an F-box protein, and the nuclear form of activated Notch1 receptor.

21. PMID: 16863506; 2006, Cancer Sci;97(8):729-36
Fbxw7 contributes to tumor suppression by targeting multiple proteins for ubiquitin-dependent degradation.

22. PMID: 18787170; 2008, Science;321(5895):1499-502
FBXW7 targets mTOR for degradation and cooperates with PTEN in tumor suppression.

23. PMID: 20484041; 2010, Cancer Res;70(11):4728-38
The Fbw7 tumor suppressor targets KLF5 for ubiquitin-mediated degradation and suppresses breast cell proliferation.

24. PMID: 21368833; 2011, Nature;471(7336):104-9
SCF(FBW7) regulates cellular apoptosis by targeting MCL1 for ubiquitylation and destruction.

25. PMID: 18094723; 2008, Nat Rev Cancer;8(2):83-93
FBW7 ubiquitin ligase: a tumour suppressor at the crossroads of cell division, growth and differentiation.

26. PMID: 23032637; 2012, Cancer Inform;11():157-71
Haploinsufficiency of Tumor Suppressor Genes is Driven by the Cumulative Effect of microRNAs, microRNA Binding Site Polymorphisms and microRNA Polymorphisms: An In silico Approach.

27. PMID: 24586741; 2014, PLoS One;9(2):e89388
FBXW7 mutations in patients with advanced cancers: clinical and molecular characteristics and outcomes with mTOR inhibitors.

28. PMID: 24360397; 2014, Lung Cancer;83(2):300-1
Temsirolimus therapy in a patient with lung adenocarcinoma harboring an FBXW7 mutation.

29. PMID: 27399335; 2017, Oncogene;36(6):787-796
FBW7 mutations mediate resistance of colorectal cancer to targeted therapies by blocking Mcl-1 degradation.

30. PMID: 25860929; 2015, Oncotarget;6(11):9240-56
FBXW7-mutated colorectal cancer cells exhibit aberrant expression of phosphorylated-p53 at Serine-15.

31. PMID: 29633504; 2018, Mol Oncol;12(6):883-895
FBXW7 deletion contributes to lung tumor development and confers resistance to gefitinib therapy.

32. PMID: 28522751; 2017, Cancer Res;77(13):3527-3539
Targeting FBW7 as a Strategy to Overcome Resistance to Targeted Therapy in Non-Small Cell Lung Cancer.

33. PMID: 24884509; 2014, Mol Cancer;13():110
Fbxw7 is an independent prognostic marker and induces apoptosis and growth arrest by regulating YAP abundance in hepatocellular carcinoma.

34. PMID: 24095279; 2013, Mol Cell;52(4):495-505
The folliculin tumor suppressor is a GAP for the RagC/D GTPases that signal amino acid levels to mTORC1.

35. PMID: 26342594; 2016, Fam Cancer;15(1):127-32
Birt-Hogg-Dubé syndrome: novel FLCN frameshift deletion in daughter and father with renal cell carcinomas.

36. PMID: 23223565; 2013, J Clin Pathol;66(3):178-86
Birt-Hogg-Dube syndrome: clinicopathological features of the lung.

37. PMID: 19850877; 2009, Proc Natl Acad Sci U S A;106(44):18722-7
Homozygous loss of BHD causes early embryonic lethality and kidney tumor development with activation of mTORC1 and mTORC2.

38. PMID: 24908670; 2014, Hum Mol Genet;23(21):5706-19
Folliculin (Flcn) inactivation leads to murine cardiac hypertrophy through mTORC1 deregulation.

39. PMID: 15956655; 2005, J Natl Cancer Inst;97(12):931-5
High frequency of somatic frameshift BHD gene mutations in Birt-Hogg-Dubé-associated renal tumors.

40. PMID: 29301825; 2018, Clin Cancer Res;24(7):1546-1553
Genomic Correlates of Response to Everolimus in Aggressive Radioiodine-refractory Thyroid Cancer: A Phase II Study.

41. PMID: 26418749; 2015, Oncotarget;6(32):32761-73
Flcn-deficient renal cells are tumorigenic and sensitive to mTOR suppression.

42. PMID: 25770121; 2015, J Biochem;157(5):271-84
Hepatocyte growth factor and Met in drug discovery.

43. PMID: 23867513; 2013, Cancer J;19(4):316-23
Targeting the hepatocyte growth factor/c-Met signaling pathway in renal cell carcinoma.

44. PMID: 15455388; 2005, Int J Cancer;113(4):678-82
C-Met overexpression in node-positive breast cancer identifies patients with poor clinical outcome independent of Her2/neu.

45. PMID: 9699182; 1998, Lung Cancer;20(1):1-16
Differential expression of Met/hepatocyte growth factor receptor in subtypes of non-small cell lung cancers.

46. PMID: 10454259; 1999, Cancer Lett;141(1-2):173-8
Progression-linked overexpression of c-Met in prostatic intraepithelial neoplasia and latent as well as clinical prostate cancers.

47. PMID: 24812413; 2014, Clin Cancer Res;20(13):3361-3
MET as a target in papillary renal cell carcinoma.

48. PMID: 24658158; 2014, Clin Cancer Res;20(13):3411-21
MET is a potential target across all papillary renal cell carcinomas: result from a large molecular study of pRCC with CGH array and matching gene expression array.

49. PMID: 18772890; 2008, Nature;455(7216):1061-8
Comprehensive genomic characterization defines human glioblastoma genes and core pathways.

50. PMID: 24222167; 2013, Anticancer Res;33(11):5179-86
A survey of c-MET expression and amplification in 287 patients with hepatocellular carcinoma.

51. PMID: 9759658; 1998, Lab Invest;78(9):1143-53
Amplification of c-myc, K-sam, and c-met in gastric cancers: detection by fluorescence in situ hybridization.

52. PMID: 25806347; 2015, Transl Lung Cancer Res;4(1):67-81
Known and putative mechanisms of resistance to EGFR targeted therapies in NSCLC patients with EGFR mutations-a review.

53. PMID: 18093943; 2007, Proc Natl Acad Sci U S A;104(52):20932-7
MET amplification occurs with or without T790M mutations in EGFR mutant lung tumors with acquired resistance to gefitinib or erlotinib.

54. PMID: 17463250; 2007, Science;316(5827):1039-43
MET amplification leads to gefitinib resistance in lung cancer by activating ERBB3 signaling.

55. PMID: 30676858; 2019, J Clin Oncol;37(11):876-884
Clonal MET Amplification as a Determinant of Tyrosine Kinase Inhibitor Resistance in Epidermal Growth Factor Receptor-Mutant Non-Small-Cell Lung Cancer.

56. PMID: 24913799; 2014, Mol Oncol;8(6):1084-94
Acquired resistance to EGFR-targeted therapies in colorectal cancer.

ACT Onco® + Report

57. PMID: 23729478; 2013, Cancer Discov;3(6):658-73
Amplification of the MET receptor drives resistance to anti-EGFR therapies in colorectal cancer.

58. PMID: 24714091; 2014, Int J Mol Sci;15(4):5838-51
Cetuximab-induced MET activation acts as a novel resistance mechanism in colon cancer cells.

59. PMID: 25293556; 2014, Cancer Discov;4(11):1269-80
Resistance to anti-EGFR therapy in colorectal cancer: from heterogeneity to convergent evolution.

60. PMID: 30694565; 2019, Int J Cancer;145(3):748-762
MET activation confers resistance to cetuximab, and prevents HER2 and HER3 upregulation in head and neck cancer.

61. PMID: 26434595; 2016, Oncogene;35(21):2684-6
TAMing resistance to multi-targeted kinase inhibitors through Axl and Met inhibition.

62. PMID: 26364599; 2016, Oncogene;35(21):2687-97
Targeting MET and AXL overcomes resistance to sunitinib therapy in renal cell carcinoma.

63. PMID: 21623265; 2011, J Thorac Oncol;6(5):942-6
Activity of crizotinib (PF02341066), a dual mesenchymal-epithelial transition (MET) and anaplastic lymphoma kinase (ALK) inhibitor, in a non-small cell lung cancer patient with de novo MET amplification.

64. PMID: 32877583; 2020, N Engl J Med;383(10):944-957
Capmatinib in MET Exon 14-Mutated or MET-Amplified Non-Small-Cell Lung Cancer.

65. PMID: 22042947; 2011, J Clin Oncol;29(36):4803-10
MET amplification identifies a small and aggressive subgroup of esophagogastric adenocarcinoma with evidence of responsiveness to crizotinib.

66. PMID: 24192513; 2014, Lung Cancer;83(1):109-11
Major partial response to crizotinib, a dual MET/ALK inhibitor, in a squamous cell lung (SCC) carcinoma patient with de novo c-MET amplification in the absence of ALK rearrangement.

67. PMID: 30638795; 2019, Clin Lung Cancer;20(3):e251-e255
Combined Use of Crizotinib and Gefitinib in Advanced Lung Adenocarcinoma With Leptomeningeal Metastases Harboring MET Amplification After the Development of Gefitinib Resistance: A Case Report and Literature Review.

68. PMID: 30797494; 2019, Lung Cancer;129():72-74
Mutation tracking of a patient with EGFR-mutant lung cancer harboring de novo MET amplification: Successful treatment with gefitinib and crizotinib.

69. PMID: 30791921; 2019, J Transl Med;17(1):52
Crizotinib with or without an EGFR-TKI in treating EGFR-mutant NSCLC patients with acquired MET amplification after failure of EGFR-TKI therapy: a multicenter retrospective study.

70. PMID: 30881166; 2019, Lung Cancer (Auckl);10():21-26
Differential response to a combination of full-dose osimertinib and crizotinib in a patient with EGFR-mutant non-small cell lung cancer and emergent MET amplification.

71. PMID: 30915273; 2019, Front Oncol;9():132
Phase II Trial of Cabozantinib Plus Erlotinib in Patients With Advanced Epidermal Growth Factor Receptor (EGFR)-Mutant Non-small Cell Lung Cancer With Progressive Disease on Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitor Therapy: A California Cancer Consortium Phase II Trial (NCI 9303).

72. PMID: 29571987; 2018, Lung Cancer;118():105-110
Clinical analysis by next-generation sequencing for NSCLC patients with MET amplification resistant to osimertinib.

73. PMID: 30792648; 2019, Case Rep Oncol;12(1):91-97
Promising Combination Therapy with Bevacizumab and Erlotinib in an EGFR-Mutated NSCLC Patient with MET Amplification Who Showed Intrinsic Resistance to Initial EGFR-TKI Therapy.

74. PMID: 30156984; 2018, J Clin Oncol;36(31):3101-3109
Phase Ib/II Study of Capmatinib (INC280) Plus Gefitinib After Failure of Epidermal Growth Factor Receptor (EGFR) Inhibitor Therapy in Patients With EGFR-Mutated, MET Factor-Dysregulated Non-Small-Cell Lung Cancer.

75. PMID: 23902240; 2013, Future Oncol;9(8):1083-92
Cabozantinib (XL184) for the treatment of locally advanced or metastatic progressive medullary thyroid cancer.

76. PMID: 28192597; 2017, Cancer;123(11):1979-1988
A phase 2 and biomarker study of cabozantinib in patients with advanced cholangiocarcinoma.

77. PMID: 26847053; 2016, Clin Cancer Res;22(12):3048-56
MET Amplification and Exon 14 Splice Site Mutation Define Unique Molecular Subgroups of Non-Small Cell Lung Carcinoma with Poor Prognosis.

78. PMID: 30855149; 2019, Org Lett;21(7):2139-2142
Trematosphones A and B, Two Unique Dimeric Structures from the Desert Plant Endophytic Fungus Trematosphaeria terricola.

79. PMID: 30738047; 2019, Gastroenterology;156(6):1731-1741
Biomarkers Associated With Response to Regorafenib in Patients With Hepatocellular Carcinoma.

80. PMID: 9315668; 1997, Mol Cell Biol;17(10):6087-96
hMre11 and hRad50 nuclear foci are induced during the normal cellular response to DNA double-strand breaks.

81. PMID: 16467875; 2006, Cell Res;16(1):45-54
The role of NBS1 in DNA double strand break repair, telomere stability, and cell cycle checkpoint control.

82. PMID: 16385572; 2006, Int J Cancer;118(11):2911-6
Evaluation of RAD50 in familial breast cancer predisposition.

83. PMID: 24894818; 2014, Breast Cancer Res;16(3):R58
Rare key functional domain missense substitutions in MRE11A, RAD50, and NBN contribute to breast cancer susceptibility: results from a Breast Cancer Family Registry case-control mutation-screening study.

84. PMID: 18440592; 2008, Hum Pathol;39(6):925-32
Gastric cancer with high-level microsatellite instability: target gene mutations, clinicopathologic features, and long-term survival.

85. PMID: 11196187; 2001, Cancer Res;61(1):36-8
Frameshift mutations at coding mononucleotide repeats of the hRAD50 gene in gastrointestinal carcinomas with microsatellite instability.

86. PMID: 24934408; 2014, Cancer Discov;4(9):1014-21
Synthetic lethality in ATM-deficient RAD50-mutant tumors underlies outlier response to cancer therapy.

87. PMID: 16474176; 2006, Carcinogenesis;27(8):1593-9
RAD50 and NBS1 are breast cancer susceptibility genes associated with genomic instability.

88. PMID: 27016230; 2016, Gynecol Oncol;141(1):57-64
Copy number deletion of RAD50 as predictive marker of BRCAness and PARP inhibitor response in BRCA wild type ovarian cancer.

89. PMID: 25935112; 2015, Trends Biochem Sci;40(6):296-308
Structural determinants of Smad function in TGF-β signaling.

90. PMID: 19014666; 2008, Pathogenetics;1(1):2
Smad4 haploinsufficiency: a matter of dosage.

91. PMID: 9545410; 1998, Am J Hum Genet;62(5):1129-36
A gene for familial juvenile polyposis maps to chromosome 18q21.1.

92. PMID: 8553070; 1996, Science;271(5247):350-3
DPC4, a candidate tumor suppressor gene at human chromosome 18q21.1.

ACT Onco® + Report

93. PMID: 8673134; 1996, Nat Genet;13(3):343-6
Evaluation of candidate tumour suppressor genes on chromosome 18 in colorectal cancers.

94. PMID: 18662538; 2008, Cell;134(2):215-30
TGFbeta in Cancer.

95. PMID: 9135016; 1997, Cancer Res;57(9):1731-4
Tumor-suppressive pathways in pancreatic carcinoma.

96. PMID: 23139211; 2013, Cancer Res;73(2):725-35
SMAD2, SMAD3 and SMAD4 mutations in colorectal cancer.

97. PMID: 22810696; 2012, Nature;487(7407):330-7
Comprehensive molecular characterization of human colon and rectal cancer.

98. PMID: 25890228; 2015, World J Surg Oncol;13():128
Clinical outcome and expression of mutant P53, P16, and Smad4 in lung adenocarcinoma: a prospective study.

99. PMID: 19841540; 2009, J Clin Invest;119(11):3208-11
Smad4: gatekeeper gene in head and neck squamous cell carcinoma.

100. PMID: 15867212; 2005, Clin Cancer Res;11(9):3191-7
Differences in Smad4 expression in human papillomavirus type 16-positive and human papillomavirus type 16-negative head and neck squamous cell carcinoma.

101. PMID: 25589618; 2015, Clin Cancer Res;21(6):1447-56
Genomic analysis of metastatic cutaneous squamous cell carcinoma.

102. PMID: 29703253; 2018, BMC Cancer;18(1):479
SMAD4 and NF1 mutations as potential biomarkers for poor prognosis to cetuximab-based therapy in Chinese metastatic colorectal cancer patients.

103. PMID: 28522603; 2017, Clin Cancer Res;23(17):5162-5175
SMAD4 Loss Is Associated with Cetuximab Resistance and Induction of MAPK/JNK Activation in Head and Neck Cancer Cells.

104. PMID: 16144935; 2005, Clin Cancer Res;11(17):6311-6
SMAD4 levels and response to 5-fluorouracil in colorectal cancer.

105. PMID: 24384683; 2014, Br J Cancer;110(4):946-57
Loss of Smad4 in colorectal cancer induces resistance to 5-fluorouracil through activating Akt pathway.

106. PMID: 12237773; 2002, Br J Cancer;87(6):630-4
SMAD4 is a predictive marker for 5-fluorouracil-based chemotherapy in patients with colorectal cancer.

107. PMID: 25749173; 2015, Transl Oncol;8(1):18-24
A Meta-Analysis of SMAD4 Immunohistochemistry as a Prognostic Marker in Colorectal Cancer.

108. PMID: 19478385; 2009, Cell Oncol;31(3):169-78
Presence of a high amount of stroma and downregulation of SMAD4 predict for worse survival for stage I-II colon cancer patients.

109. PMID: 25681512; 2015, J Clin Pathol;68(5):341-5
Smad4 inactivation predicts for worse prognosis and response to fluorouracil-based treatment in colorectal cancer.

110. PMID: 26861460; 2016, Clin Cancer Res;22(12):3037-47
Reduced Expression of SMAD4 Is Associated with Poor Survival in Colon Cancer.

111. PMID: 26947875; 2016, Transl Oncol;9(1):1-7
Prognostic Value of SMAD4 in Pancreatic Cancer: A Meta-Analysis.

ACT Onco® + Report

112. PMID: 25760429; 2015, Pancreas;44(4):660-4
SMAD4 expression predicts local spread and treatment failure in resected pancreatic cancer.

113. PMID: 22504380; 2012, Pancreas;41(4):541-6
SMAD4 genetic alterations predict a worse prognosis in patients with pancreatic ductal adenocarcinoma.

114. PMID: 19584151; 2009, Clin Cancer Res;15(14):4674-9
SMAD4 gene mutations are associated with poor prognosis in pancreatic cancer.

115. PMID: 18425078; 2008, Mod Pathol;21(7):866-75
Expression of Smad2 and Smad4 in cervical cancer: absent nuclear Smad4 expression correlates with poor survival.

116. PMID: 21332640; 2011, J Cell Mol Med;15(7):1433-42
Targeting telomerase-expressing cancer cells.

117. PMID: 19571879; 2009, Nature;460(7251):66-72
Telomerase modulates Wnt signalling by association with target gene chromatin.

118. PMID: 23159929; 2012, Nat Cell Biol;14(12):1270-81
Telomerase directly regulates NF-κB-dependent transcription.

119. PMID: 19701182; 2009, Nature;461(7261):230-5
An RNA-dependent RNA polymerase formed by TERT and the RMRP RNA.

120. PMID: 23348506; 2013, Science;339(6122):957-9
Highly recurrent TERT promoter mutations in human melanoma.

121. PMID: 23530248; 2013, Proc Natl Acad Sci U S A;110(15):6021-6
TERT promoter mutations occur frequently in gliomas and a subset of tumors derived from cells with low rates of self-renewal.

122. PMID: 11103775; 2000, Cancer Res;60(22):6230-5
Frequent amplification of the telomerase reverse transcriptase gene in human tumors.

123. PMID: 12007187; 2002, Genes Chromosomes Cancer;34(3):269-75
Amplification of the telomerase reverse transcriptase (hTERT) gene in cervical carcinomas.

124. PMID: 25301727; 2014, Oncotarget;5(20):10048-57
TERT promoter mutations and gene amplification: promoting TERT expression in Merkel cell carcinoma.

125. PMID: 16641908; 2006, Br J Cancer;94(10):1452-9
Amplification of telomerase (hTERT) gene is a poor prognostic marker in non-small-cell lung cancer.

126. PMID: 27982019; 2017, Cancer Gene Ther;24(1):20-27
The associations of TERT-CLPTM1L variants and TERT mRNA expression with the prognosis of early stage non-small cell lung cancer.

127. PMID: 29100407; 2017, Oncotarget;8(44):77540-77551
TERT promoter status and gene copy number gains: effect on TERT expression and association with prognosis in breast cancer.

128. PMID: 24002501; 2013, J Clin Oncol;31(29):3639-46
Cabozantinib in progressive medullary thyroid cancer.

129. PMID: 29972759; 2018, N Engl J Med;379(1):54-63
Cabozantinib in Patients with Advanced and Progressing Hepatocellular Carcinoma.

130. PMID: 28199818; 2017, J Clin Oncol;35(6):591-597
Cabozantinib Versus Sunitinib As Initial Targeted Therapy for Patients With Metastatic Renal Cell Carcinoma of Poor or Intermediate Risk: The Alliance A031203 CABOSUN Trial.

131. PMID: 26406150; 2015, N Engl J Med;373(19):1814-23
Cabozantinib versus Everolimus in Advanced Renal-Cell Carcinoma.

132. PMID: 25264305; 2014, N Engl J Med;371(21):1963-71
Crizotinib in ROS1-rearranged non-small-cell lung cancer.

133. PMID: 25470694; 2014, N Engl J Med;371(23):2167-77
First-line crizotinib versus chemotherapy in ALK-positive lung cancer.

134. PMID: 23724913; 2013, N Engl J Med;368(25):2385-94
Crizotinib versus chemotherapy in advanced ALK-positive lung cancer.

135. PMID: 26703889; 2016, Lancet;387(10022):968-977
Everolimus for the treatment of advanced, non-functional neuroendocrine tumours of the lung or gastrointestinal tract (RADIANT-4): a randomised, placebo-controlled, phase 3 study.

136. PMID: 22149876; 2012, N Engl J Med;366(6):520-9
Everolimus in postmenopausal hormone-receptor-positive advanced breast cancer.

137. PMID: 21306238; 2011, N Engl J Med;364(6):514-23
Everolimus for advanced pancreatic neuroendocrine tumors.

138. PMID: 23158522; 2013, Lancet;381(9861):125-32
Efficacy and safety of everolimus for subependymal giant cell astrocytomas associated with tuberous sclerosis complex (EXIST-1): a multicentre, randomised, placebo-controlled phase 3 trial.

139. PMID: 18653228; 2008, Lancet;372(9637):449-56
Efficacy of everolimus in advanced renal cell carcinoma: a double-blind, randomised, placebo-controlled phase III trial.

140. PMID: 27717299; 2016, N Engl J Med;375(22):2154-2164
Niraparib Maintenance Therapy in Platinum-Sensitive, Recurrent Ovarian Cancer.

141. PMID: 32343890; 2020, N Engl J Med;382(22):2091-2102
Olaparib for Metastatic Castration-Resistant Prostate Cancer.

142. PMID: 31851799; 2019, N Engl J Med;381(25):2416-2428
Olaparib plus Bevacizumab as First-Line Maintenance in Ovarian Cancer.

143. PMID: 31157963; 2019, N Engl J Med;381(4):317-327
Maintenance Olaparib for Germline BRCA-Mutated Metastatic Pancreatic Cancer.

144. PMID: 30345884; 2018, N Engl J Med;379(26):2495-2505
Maintenance Olaparib in Patients with Newly Diagnosed Advanced Ovarian Cancer.

145. PMID: 28578601; 2017, N Engl J Med;377(6):523-533
Olaparib for Metastatic Breast Cancer in Patients with a Germline BRCA Mutation.

146. PMID: 28754483; 2017, Lancet Oncol;18(9):1274-1284
Olaparib tablets as maintenance therapy in patients with platinum-sensitive, relapsed ovarian cancer and a BRCA1/2 mutation (SOLO2/ENGOT-Ov21): a double-blind, randomised, placebo-controlled, phase 3 trial.

147. PMID: 27617661; 2016, Lancet Oncol;17(11):1579-1589
Overall survival in patients with platinum-sensitive recurrent serous ovarian cancer receiving olaparib maintenance monotherapy: an updated analysis from a randomised, placebo-controlled, double-blind, phase 2 trial.

148. PMID: 28916367; 2017, Lancet;390(10106):1949-1961
Rucaparib maintenance treatment for recurrent ovarian carcinoma after response to platinum therapy (ARIEL3): a randomised, double-blind, placebo-controlled, phase 3 trial.

149. PMID: 30110579; 2018, N Engl J Med;379(8):753-763
Talazoparib in Patients with Advanced Breast Cancer and a Germline BRCA Mutation.

ACT Onco® + Report

150. PMID: 17538086; 2007, N Engl J Med;356(22):2271-81
Temsirolimus, interferon alfa, or both for advanced renal-cell carcinoma.