FOUNDATIONONE®CDx

PATIENT
Chen, Ying-Feng

TUMOR TYPE
Brain anaplastic astrocytoma
COUNTRY CODE
TW

REPORT DATE
25 Apr 2022
ORDERED TEST #
ORD-1346475-01

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 Brain anaplastic astrocytoma
NAME Chen, Ying-Feng
DATE OF BIRTH 16 November 1971
SEX Male
MEDICAL RECORD # 42709262

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 Brain
SPECIMEN ID S111-12513B (PF22054)
SPECIMEN TYPE Slide Deck
DATE OF COLLECTION 25 March 2022
SPECIMEN RECEIVED 18 April 2022

Biomarker Findings

Microsatellite status - MS-Stable
Tumor Mutational Burden - 1 Muts/Mb

Genomic Findings

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

IDH1 R132H
ATRX S522fs*39
TP53 I232S

Report Highlights

- Variants with **diagnostic implications** that may indicate a specific cancer type: ***ATRX* S522fs*39** (p. 4), ***IDH1* R132H** (p. 3)
- Targeted therapies with potential clinical benefit **approved in another tumor type**: Ivosidenib (p. 6)
- Variants that may inform **nontargeted treatment approaches** (e.g., chemotherapy) in this tumor type: ***IDH1* R132H** (p. 3)
- Evidence-matched **clinical trial options** based on this patient's genomic findings: (p. 7)
- Variants with **prognostic implications** for this tumor type that may impact treatment decisions: ***IDH1* R132H** (p. 3)

BIOMARKER FINDINGS	THERAPY AND CLINICAL TRIAL IMPLICATIONS	
Microsatellite status - MS-Stable	**No therapies or clinical trials.** see Biomarker Findings section	
Tumor Mutational Burden - 1 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)**
***IDH1* -** R132H	none	Ivosidenib
10 Trials *see p. 7*		

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.

Electronically signed by Erik Williams, M.D. | 25 April 2022
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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].

FREQUENCY & PROGNOSIS

MSI-High has been reported in 3-8% of adult or pediatric astrocytomas and was generally not associated with Lynch syndrome[6-8]. Low-level MSI has been reported in 5-9% of glioblastoma (GBM) samples[9-11]. A large-scale study did not find high-level microsatellite instability (MSI-H) in any of 129 GBM samples[9], although a small-scale study reported MSI-H in 4 of 15 pediatric GBMs and 1 of 12 adult GBMs[12]. The frequency of MSI has been reported to be increased in relapsed compared to primary GBM[9], in GBMs with a previous lower grade astrocytoma[10], and in giant cell GBM compared to classic GBM[11].

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[13]. 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[13-15]. 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[16-18]. MSS status indicates MMR proficiency and typically correlates with intact expression of all MMR family proteins[13,15,17-18].

BIOMARKER

Tumor Mutational Burden

RESULT
1 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[19-21], anti-PD-1 therapies[19-22], and combination nivolumab and ipilimumab[23-28]. In glioma, a lack of association between TMB and clinical benefit from immune checkpoint inhibitors has been reported[19,29-30]. However, multiple case studies have reported that patients with ultramutated gliomas driven by POLE mutations have benefited from treatment with anti-PD-1[31-32] or anti-PD-L1[33] therapies. Therefore, although increased TMB alone may not be a strong biomarker for PD-1 or PD-L1 inhibitors in this cancer type, these agents may have efficacy for patients with glioma harboring both high TMB and POLE mutation.

FREQUENCY & PROGNOSIS

Anaplastic astrocytoma harbors a median TMB of 1.8 mutations per megabase (muts/Mb), and 2% of cases have high TMB (>20 muts/Mb)[34]. For pediatric patients, high TMB has been reported in a subset of high-grade gliomas, frequently in association with mutations in mismatch repair or proofreading genes and in TP53, whereas BRAF alterations or other oncogene fusions were observed more frequently in brain tumors harboring low TMB[35-36]. Increased TMB has been reported to correlate with higher tumor grade in glioma[37] and glioblastoma (GBM) tissue samples with biallelic mismatch repair deficiency (bMMRD)[31], as well as with shorter OS of patients with diffuse glioma[38].

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[39-40] and cigarette smoke in lung cancer[41-42], treatment with temozolomide-based chemotherapy in glioma[43-44], mutations in the proofreading domains of DNA polymerases encoded by the POLE and POLD1 genes[45-49], and microsatellite instability (MSI)[45,48-49]. 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[19,29-33].

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GENE
IDH1

ALTERATION
R132H

TRANSCRIPT ID
NM_005896

CODING SEQUENCE EFFECT
395G>A

VARIANT ALLELE FREQUENCY (% VAF)
41.3%

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

IDH1 mutations that lead to production of 2-HG, most commonly R132 alterations, may predict sensitivity to IDH1-mutation-specific inhibitors such as ivosidenib[50]. A Phase 1b/2 study of the IDH1 inhibitor olutasidenib for patients with IDH1-mutated glioma reported a DCR of 50% (n=24) with 1 PR[51]. A Phase 1 study of the pan-IDH1/IDH2 inhibitor vorasidenib for patients with IDH1- or IDH2-mutated glioma reported an ORR of 18.2% (4/22; RANO criteria) and median PFS of 31.4 months for non-enhancing cases and median PFS of 7.5 months for the overall glioma population (n=52)[52]. Preclinical studies suggested that IDH1 neomorphic mutations may also confer sensitivity to PARP inhibitors[53-56]. In a Phase 1 trial of the PD-L1 inhibitor atezolizumab in patients with glioblastoma (GBM), 2 of the 3 patients with IDH1-mutant tumors experienced clinical benefit (1 PR and 1 long-term SD; the third patient experienced short-term SD), whereas none of the 8 patients with IDH1-wild-type GBM experienced benefit (8/8 PD); significantly longer PFS and a trend toward longer OS were observed in the patients with IDH1-mutated tumors compared to the patients with IDH1-wild-type tumors[33]. Preclinical data indicate that IDH1-mutated glioma may be sensitive to the glutaminase inhibitor telaglenastat in combination with radiotherapy[57].

— Nontargeted Approaches —

IDH1/2 mutations are associated with improved survival outcomes for patients with glioma treated with radiation or alkylating chemotherapy (NCCN CNS Cancers Guidelines, v2.2021).

FREQUENCY & PROGNOSIS

IDH1 mutation is characteristic of low-grade gliomas and secondary glioblastoma, and is relatively rare in primary glioblastoma[58-62]. In the TCGA datasets, IDH1 mutation has been found in 77% of lower grade glioma cases and in 5% of glioblastoma cases[63-64]. IDH1 mutations are highly prevalent in grade 2 and grade 3 astrocytoma, oligodendroglioma, and oligoastrocytoma, reported in 43-100% of grade 2 tumors and 45-93% of grade 3 tumors[65-68]. IDH1/2 mutations are a strong favorable prognostic marker for OS in Grade 2-3 glioma, particularly in combination with 1p/19q codeletion (NCCN CNS Cancers Guidelines, v2.2021). Several studies have found IDH1 mutations to be associated with improved prognosis and longer PFS and OS in patients with various types of glioma including anaplastic astrocytoma and GBM[62,69-75].

FINDING SUMMARY

The isocitrate dehydrogenases IDH1 and IDH2 encode highly homologous enzymes that are involved in the citric acid (TCA) cycle and other metabolic processes, playing roles in normal cellular metabolism and in protection against oxidative stress and apoptosis[76]. R132 is located within the active site of IDH1 and is a hotspot for mutations in cancer[76-80]. Substitutions at IDH1 R132 alter the enzymatic activity of IDH1, resulting in the production of the oncometabolite, D-2-hydroxyglutarate (2-HG)[78-82], which promotes tumorigenesis[78,83-86].

POTENTIAL DIAGNOSTIC IMPLICATIONS

IDH mutation in the absence of TERT mutation is suggestive of astrocytoma (NCCN CNS Cancers Guidelines, v2.2021)[87]. IDH1/2 mutation is associated with Grade 2 and 3 astrocytomas and oligodendrogliomas, and distinguishes secondary glioblastoma (GBM) from primary GBM (NCCN CNS Cancers Guidelines, v2.2021). ATRX mutations often co-occur with IDH1/2 mutations and may be indicative of Grade 2-3 astrocytoma or secondary glioblastoma (GBM) (NCCN CNS Cancers Guidelines, v2.2021)[87-88].

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GENE
ATRX

ALTERATION
S522fs*39

TRANSCRIPT ID
NM_000489

CODING SEQUENCE EFFECT
1564_1567delTCCT

VARIANT ALLELE FREQUENCY (% VAF)
79.0%

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

No targeted therapies are available to directly address ATRX inactivation. Based on preclinical[89-90] and limited clinical data[91], ATRX alterations may confer sensitivity to combination strategies involving WEE1 inhibition. In a Phase 2 study evaluating the WEE1 inhibitor adavosertib plus irinotecan for the treatment of pediatric patients with neuroblastoma, prolonged SD was reported for 44% (4/9) of patients with ATRX-deficient tumors and responses were seen in two tumors that had evidence of ALT[91]. Preclinical evidence also suggests that ATRX deficiency may impart sensitivity to synthetic lethal approaches involving PARP inhibition and irinotecan[92], combined PARP and ATR inhibition[90], or double-strand break-induction with agents such as doxorubicin, irinotecan, and topotecan[93]; however, these approaches have not been demonstrated clinically.

FREQUENCY & PROGNOSIS

Somatic mutation of ATRX has been reported in a number of solid tumor types, often associated with ALT[94]. ATRX mutation correlating with ALT has been reported in 10-20% of pancreatic neuroendocrine tumors (PNETs)[94-96], 12.6% of pheochromocytomas and paragangliomas[97], and 48% of adolescent and young adult (AYA) patients with glioblastoma (GBM) or neuroblastoma[98-102]. ATRX loss in PNET[95,103] and melanoma[104] and mutation in other neuroendocrine tumors[97] is associated with poor prognosis. Pediatric patients with high-grade glioma and ATRX mutation were shown to have more aggressive disease but are more responsive to treatment with double-strand break therapy[93]. ATRX mutation or loss of expression is more frequent in Grade 2/3 astrocytoma and secondary GBM than primary GBM, oligodendroglioma, and oligoastrocytoma[67,105-107] and has been proposed as a distinguishing biomarker[67,106-107]. ATRX mutation has not been detected in concurrence with MYCN amplification in glioma and neuroblastoma[99-102]. Low-grade gliomas with both IDH1/2 mutation and ATRX mutation are associated with worse prognosis than those with IDH1/2 mutation but no ATRX mutation[67]. Loss of ATRX protein expression has been reported in 33-39% of incidences of leiomyosarcoma (LMS) associating with ALT, a poor prognostic factor across all LMS subtypes, and with poor prognosis in extrauterine LMS but not in uterine LMS[108-109].

FINDING SUMMARY

ATRX encodes a SWI/SNF chromatin remodeling protein implicated in histone variant H3.3 deposition, transcriptional regulation, and telomere maintenance[110-111]. ATRX inactivation or loss of expression is associated with alternative lengthening of telomeres (ALT)[94,109,112-113]. Alterations that disrupt the ADD domain (aa 167-270) or helicase domain (aa 2010-2280) of ATRX are predicted to result in loss of ATRX function[114-116]; however, the loss of ATRX function is not sufficient to induce ALT, which requires other undetermined factors[110,117]. Germline mutations in ATRX give rise to alpha-thalassemia X-linked intellectual disability syndrome (ATR-X syndrome)[118].

POTENTIAL DIAGNOSTIC IMPLICATIONS

ATRX mutations often co-occur with IDH1/2 mutations and may be indicative of Grade 2-3 astrocytoma or secondary glioblastoma (GBM) (NCCN CNS Cancers Guidelines, v2.2021)[87-88].

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GENE
TP53

ALTERATION
I232S

TRANSCRIPT ID
NM_000546

CODING SEQUENCE EFFECT
695T>G

VARIANT ALLELE FREQUENCY (% VAF)
83.1%

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[119-122], or p53 gene therapy and immunotherapeutics such as SGT-53[123-127] and ALT-801[128]. 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[129]. 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[130]. 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[131]. 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[132]. 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[133]. 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[134]. 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[135]. 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[127]. Missense mutations leading to TP53 inactivation may also be sensitive to therapies that reactivate mutated p53 such as APR-246[136-138]. 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[139]. 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[140-141]; however, ATR inhibitors as monotherapy had little effect on these parameters in solid tumor models in other preclinical studies[142-143]. Therefore, it is unclear whether TP53 inactivation predicts sensitivity to ATR inhibition.

FREQUENCY & PROGNOSIS

TP53 mutations have been reported in 18-40% of astrocytoma samples, and preferentially in anaplastic astrocytoma; one study reported TP53 loss of function and partially/fully functional mutations in 15% and 25% of anaplastic astrocytomas, respectively[144-149]. Some studies suggest that the presence of a TP53 mutation is correlated with a favorable prognosis in patients with glioblastoma (GBM)[150]. One study reported that TP53 alterations were associated with poorer OS (12.9 months altered vs. 19.7 months wildtype, HR=1.58, p=0.0054) in IDH-wildtype GBM[151]. Mutation of TP53 is thought to be an early step in the tumorigenesis of astrocytomas, which can progress into anaplastic astrocytoma and then glioblastoma through gain of other genetic abnormalities such as loss of CDKN2A or RB1, followed by loss of PTEN[152].

FINDING SUMMARY

Functional loss of the tumor suppressor p53, which is encoded by the TP53 gene, is common in aggressive advanced cancers[153]. Alterations such as seen here may disrupt TP53 function or expression[154-158].

POTENTIAL GERMLINE IMPLICATIONS

Germline mutations in TP53 are associated with the very rare autosomal dominant disorder Li-Fraumeni syndrome and the early onset of many cancers[159-161], including sarcomas[162-163]. Estimates for the prevalence of germline TP53 mutations in the general population range from 1:5,000[164] to 1:20,000[163]. 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[165]. 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[166-171]. 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[166-167]. Clinical management of patients with CH in this gene may include monitoring for hematologic changes and reduction of controllable risk factors for cardiovascular disease[172]. Comprehensive genomic profiling of solid tumors detects nontumor alterations that are due to CH[170,173-174]. Patient-matched peripheral blood mononuclear cell sequencing is required to conclusively determine if this alteration is present in tumor or is secondary to CH.

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Ivosidenib

Assay findings association

IDH1
R132H

AREAS OF THERAPEUTIC USE

Ivosidenib is an isocitrate dehydrogenase 1 (IDH1) inhibitor that is FDA approved to treat patients with a susceptible IDH1 mutation in relapsed or refractory acute myeloid leukemia (AML) or previously treated locally advanced or metastatic cholangiocarcinoma. It is also approved as a first-line treatment for patients with AML and a susceptible IDH1 mutation who are not eligible for intensive induction chemotherapy or who are ≥75 years old. Please see the drug label for full prescribing information.

GENE ASSOCIATION

On the basis of extensive clinical evidence in AML[175] and cholangiocarcinoma[176-177] and limited clinical data in myelodysplastic syndrome (MDS)[175] and glioma[50,178] , IDH1 R132 mutation may confer sensitivity to ivosidenib.

SUPPORTING DATA

In a Phase 1 study of ivosidenib for patients with IDH1-mutated advanced solid tumors, 1 patient achieved PR in the non-enhancing glioma population (ORR=2.9% [1/35]); for patients with non-enhancing glioma and enhancing glioma, SD rates were 85.7% (30/35) and 45.2% (14/31), respectively, and median PFS was 13.6 months and 1.4 months, respectively[50,178] .

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
IDH1

ALTERATION
R132H

RATIONALE
IDH1 mutations may predict sensitivity to IDH1 inhibitors. On the basis of preclinical data, IDH1 mutations may also confer sensitivity to PARP inhibitors in solid tumors. Preclinical data indicate that IDH1 mutations may predict sensitivity to glutaminase inhibitors.

NCT02264678

PHASE 1/2

Ascending Doses of AZD6738 in Combination With Chemotherapy and/or Novel Anti Cancer Agents

TARGETS
ATR, PARP, PD-L1

LOCATIONS: Seongnam-si (Korea, Republic of), Seoul (Korea, Republic of), Goyang-si (Korea, Republic of), Cambridge (United Kingdom), Withington (United Kingdom), Manchester (United Kingdom), Coventry (United Kingdom), Sutton (United Kingdom), Oxford (United Kingdom), Villejuif (France)

NCT04740190

PHASE 2

Talazoparib - Carboplatin for Recurrent High-grade Glioma With DDRd

TARGETS
PARP

LOCATIONS: Hong Kong (Hong Kong)

NCT05035745

PHASE 1/2

Selinexor & Talazoparib in Advanced Refractory Solid Tumors; Advanced/Metastatic Triple Negative Breast Cancer (START)

TARGETS
XPO1, PARP

LOCATIONS: Singapore (Singapore)

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)

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NCT03212274

PHASE 2

Olaparib in Treating Patients With Advanced Glioma, Cholangiocarcinoma, or Solid Tumors With IDH1 or IDH2 Mutations

TARGETS PARP

LOCATIONS: California, Wisconsin, Missouri, Kansas

NCT04056910

PHASE 2

Ivosidenib (AG-120) With Nivolumab in IDH1 Mutant Tumors

TARGETS PD-1, IDH1

LOCATIONS: Pennsylvania

NCT02484404

PHASE 1/2

Phase I/II Study of the Anti-Programmed Death Ligand-1 Antibody MEDI4736 in Combination With Olaparib and/or Cediranib for Advanced Solid Tumors and Advanced or Recurrent Ovarian, Triple Negative Breast, Lung, Prostate and Colorectal Cancers

TARGETS PARP, VEGFRs, PDGFRA, PDGFRB, KIT, PD-L1

LOCATIONS: Maryland

NCT02769962

PHASE 1/2

Trial of CRLX101, a Nanoparticle Camptothecin With Olaparib in People With Relapsed/Refractory Small Cell Lung Cancer

TARGETS PARP, TOP1

LOCATIONS: Maryland

NCT04550494

PHASE 2

Measuring the Effects of Talazoparib in Patients With Advanced Cancer and DNA Repair Variations

TARGETS PARP

LOCATIONS: Maryland

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.

DAXX
Q224H

LTK
C384R

RAF1
R41Q

SPEN
S2594C

TSC2
R245H

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Post-Sequencing Analysis: 150 Second St., 1st Floor. Cambridge, MA 02141 · CLIA: 22D2027531

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)*	*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	*C11orf30 (EMSY)*	*C17orf39 (GID4)*	*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*	*EP300*	*EPHA3*	*EPHB1*
EPHB4	*ERBB2*	*ERBB3*	*ERBB4*	*ERCC4*	*ERG*	*ERRFI1*	*ESR1*	*EZH2*
FAM46C	*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*	*GNA11*	*GNA13*	*GNAQ*	*GNAS*	*GRM3*	*GSK3B*	*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*	*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*	*NSD3 (WHSC1L1)*	*NT5C2*	*NTRK1*	*NTRK2*	*NTRK3*	*P2RY8*	*PALB2*
PARK2	*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*	*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*	*TET2*	*TGFBR2*	*TIPARP*	*TNFAIP3*	*TNFRSF14*	*TP53*
TSC1	*TSC2*	*TYRO3*	*U2AF1*	*VEGFA*	*VHL*	*WHSC1*	*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)

Electronically signed by Erik Williams, M.D. | 25 April 2022
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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

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

Foundation Medicine makes no promises or guarantees that a healthcare provider, insurer or other third party payor, whether private or governmental, will reimburse a patient for the cost of FoundationOne CDx.

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

MR Suite Version 6.1.0

The median exon coverage for this sample is 861x

Electronically signed by Erik Williams, M.D. | 25 April 2022
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