ACT Onco®+ Report

PATIENT		
Identifier: 陳*全		Patient ID: ***38019
Date of Birth: Aug **, 1965		Gender: Male
Diagnosis: Prostate adenocarcinoma		
ORDERING PHYSICIAN		
Name: 陳志學醫師		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: S11279565	Collection site: Prostate	Type: FFPE tissue
Date received: Jan 26, 2024	Lab ID: AA-24-00573	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	
PTEN Homozygous deletion	-	-	Capivasertib

VARIANTS/BIOMARKERS WITH POTENTIAL CLINICAL SIGNIFICANCE

Genomic Alterations/Biomarkers	Possibly Sensitive	Possibly Resistant
PTEN Homozygous deletion	Olaparib, Rucaparib	Erlotinib, Gefitinib, Cetuximab, Panitumumab, Trastuzumab

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
TP53	L201fs	22.0%

- Copy Number Alterations

Chromosome	Gene	Variation	Copy Number
Chr10	*PTEN*	Homozygous deletion	0
Chr18	*SMAD4*	Heterozygous deletion	1
Chr22	*CHEK2, NF2*	Heterozygous deletion	1

- 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)	1.3 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 42% 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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SUPPLEMENTARY INFORMATION FOR THERAPEUTIC IMPLICATIONS

TARGETED THERAPIES

Genomic Alterations	Therapies	Effect
Level 3A		
PTEN Homozygous deletion	Capivasertib	**sensitive**
Level 3B		
PTEN Homozygous deletion	Olaparib, Rucaparib	**sensitive**
Level 4		
PTEN Homozygous deletion	Erlotinib, Gefitinib, Cetuximab, Panitumumab, Trastuzumab	**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

Pharmacogenomic implication

Gene	Detection Site	Genotype	Drug Impact	Level of Evidence*
DPYD	rs59086055	AG	Fluorouracil	Level 1A

Clinical Interpretation:
Patients with the AG genotype and cancer who are treated with fluorouracil, a fluoropyrimidine-based chemotherapy, may have increased risk of drug toxicity as compared to patient with the GG genotype. Other genetic and clinical factors may also influence risk of drug toxicity.

* Level of evidence was defined by PharmGKB (https://www.pharmgkb.org/page/clinAnnLevels)

Level 1A: Clinical annotations describe variant-drug combinations that have variant-specific prescribing guidance available in a current clinical guideline annotation or an FDA-approved drug label annotation.
Level 1B: Clinical annotations describe variant-drug combinations with a high level of evidence supporting the association but no variant-specific prescribing guidance in an annotated clinical guideline or FDA drug label.
Level 2A: Variants in Level 2A clinical annotations are found in PharmGKB's Tier 1 Very Important Pharmacogenes (VIPs). These variants are in known pharmacogenes, implying causation of drug phenotype is more likely.

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.

VARIANT INTERPRETATION

TP53 L201fs

Biological Impact

TP53 encodes the p53 protein, a crucial tumor suppressor that orchestrates essential cellular processes including cell cycle arrest, senescence and apoptosis[1]. TP53 is a proto-typical haploinsufficient gene, such that loss of a single copy of TP53 can result in tumor formation[2].

L201fs mutation results in a change in the amino acid sequence beginning at 201, likely to cause premature truncation of the functional p53 protein (UniProtKB). This mutation is predicted to lead to a loss of p53 protein function, despite not being characterized in the literature.

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)[3].

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[4]. 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[5].

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[6][7][8]. 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)[9]. TP53 mutations were correlated with poor survival of advanced breast cancer patients receiving tamoxifen or primary chemotherapy[10][11]. 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[12].

CHEK2 Heterozygous deletion

Biological Impact

The checkpoint kinase 2 (CHEK2 or CHK2) gene encodes a serine/threonine protein kinase involved in transducing DNA damage signals that are required for both the intra-S phase and G2/M checkpoints[13]. CHEK2 heterozygosity has been shown to cause haploinsufficient phenotypes that can contribute to tumorigenesis through inappropriate S phase entry, accumulation of DNA damage during replication, and failure to restrain mitotic entry[14][15]. CHEK2 aberrations are associated with glioblastoma, breast, ovarian, prostate, colorectal, gastric, thyroid, and lung cancers[16][17][18][19][20].

Therapeutic and prognostic relevance

Olaparib and talazoparib are FDA-approved for treating mCRPC patients harboring mutations in homologous recombination repair (HRR) genes, including CHEK2.

CHEK2 mutation has been determined as an inclusion criterion for the trials evaluating olaparib, rucaparib, niraparib, and talazoparib efficacies in various types of solid tumors (NCT03297606, NCT01968213, NCT03840967, NCT02401347, NCT03148795).

In TBCRC 048 trial, olaparib treatment did not show response in 7 metastatic breast cancer patients with germline

mutations in CHEK2 (SD: n=3, PD: n=4)[21]. In TRITON2 trial, rucaparib treatment had limited response in 12 mCRPC patients with CHEK2 alterations[22].

NF2 Heterozygous deletion

Biological Impact

The neurofibromin (NF2) gene encodes the protein Merlin, a tumor suppressor that functions as a negative regulator of the PI3K/AKT/mTOR pathway[23][24][25]. NF2 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[26]. Inactivation germline mutations in the NF2 are associated with the hereditary neurofibromatosis type 2, a disorder characterized by the growth of noncancerous tumors in the nervous system[23][27]. Somatic mutations or deletion of NF2 are frequently observed in human cancers, including 20-50% of pleural mesotheliomas[28], 6% papillary renal cell carcinoma, 5% pancreas cancer, and 4% melanoma (cbioPortal; June 2015), and less frequently in other cancers[29].

Therapeutic and prognostic relevance

Genomic alterations with activating effects on the mTOR signaling pathway have been identified to confer sensitivity to everolimus across multiple cancer types[30][31][32][33]. There are at least two case studies indicating the clinical efficacy of everolimus in bladder cancer and urothelial carcinoma[34][35], both harboring NF2 truncating mutations. Preclinical evidence has shown the efficacy of MEK1/2 inhibitor selumetinib in KRAS-mutant thyroid cancer model with NF2 loss[36]. Moreover, another preclinical study showed that NF2-knockout in cancer cell lines resulted in resistance to a CDK4/6 inhibitor, abemaciclib, possibly due to increased expression of CDK6 in vitro[37].

Analysis of afatinib-plus-cetuximab-resistant biopsy specimens revealed a loss-of-function alteration in genes that modulate mTOR signaling pathway, including NF2 and TSC1[38].

PTEN Homozygous deletion

Biological Impact

The phosphatase and tensin homolog deleted on chromosome ten (PTEN) gene encodes a lipid/protein phosphatase that is important for the regulation of cell proliferation, survival, homologous recombination and maintenance of genomic integrity[39][40]. PTEN acts as an essential tumor suppressor by antagonizing the PI3K/AKT/mTOR signaling pathway[41]. PTEN is a haploinsufficient tumor suppressor gene, in which having only one copy of the wild-type allele does not produce enough protein product to execute wild-type functions[2][42][43]. Germline loss-of-function PTEN mutations are found in approximately 80% of patients with Cowden syndrome, a disorder that is associated with high-penetrance breast and thyroid cancer[44][45][46]. Somatic mutations or monoallelic loss of PTEN is regularly observed in a significant fraction of human cancers, including sporadic breast cancer, colon cancer, endometrial cancer, prostate cancer, and glioblastoma[47][48][49][50][51].

Therapeutic and prognostic relevance

FDA approved capivasertib with fulvestrant for HR+, HER2-, locally advanced or metastatic breast cancer with one or more PIK3CA/AKT1/PTEN-alterations, as detected by an FDA-approved test, following progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy.

Somatic loss of PTEN results in aberrant activation of PI3K/AKT/mTOR signaling pathway and provides a mechanistic rationale for PI3K pathway inhibitors treatment[52][53]. Preclinical studies demonstrated that PTEN deficiency was associated with increased sensitivity to PI3K pathway inhibitors in selected cancer subtypes[54][55][56][57][58][59]. Although early clinical data indicated that PTEN loss was associated with improved response and survival in solid tumor patients treated with mTORC1 inhibitor, everolimus[30][60][61], several phase II trials showed no clinical benefit of everolimus or temsirolimus treatment in patients with advanced solid tumors harboring PTEN loss[62][63][64].

Several groups found that PTEN loss was generally associated with poor response to trastuzumab therapy, whether this agent was administered in the neoadjuvant, adjuvant, or metastatic settings[65][66][67][68][69]. Also, loss of PTEN expression in advanced colorectal cancer (CRC) has been linked with resistance to anti-EGFR mAbs like cetuximab and panitumumab[70][71][72][73][74][75].Preclinical studies showed that loss of PTEN expression in EGFR mutant cells was associated with decreased sensitivity to EGFR TKIs, erlotinib and gefitinib[76][77]. Inhibition of the PI3K/AKT/mTOR signal pathway has been shown to be an effective strategy to radiosensitize NSCLC cells harboring the EGFR activating mutation that acquires resistance to both TKIs due to PTEN loss or inactivation mutations[78].Loss or biallelic inactivation of PTEN is associated with resistance to anti-PD-1 checkpoint blockade therapies, including pembrolizumab and nivolumab in melanoma and leiomyosarcoma patients[79][80][81].

PTEN loss of function mutation has been determined as an inclusion criterion for the trial evaluating olaparib efficacy in metastatic biliary tract cancer (NCT04042831); talazoparib efficacy in HER2-negative solid tumors (NCT02401347); rucaparib efficacy in prostate cancer (NCT02952534, NCT03533946), and niraparib efficacy in breast cancer (NCT04508803) or any malignancy (except prostate) cancer (NCT03207347). Clinical data also suggested that PTEN deficient cancers may be sensitive to olaparib[82]. However, in a phase II trial (NCT02286687), 13 patients with advanced solid tumors harboring PTEN mutation or loss (by IHC) had limited response to talazoparib treatment; only one patient with PTEN mutation had prolonged SD (Mol Cancer Ther 2018;17(1 Suppl):Abstract nr A096; NCT02286687). Besides, in a phase I trial (NCT00749502), no association between loss of PTEN expression and the efficacy of niraparib was identified in patients with castration-resistant prostate cancer[83].

In a preclinical study, PTEN null cancer cells were sensitive to rucaparib treatment in vitro[84].

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[85]. 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[86]. SMAD4 germline mutations are associated with juvenile polyposis syndrome (JPS)[87][88][89][90]. Somatic mutations of SMAD4 are commonly observed in pancreatic cancer[91], colorectal cancer (CRC)[89][92][93], and less frequently seen in other cancers such as lung adenocarcinoma[94], head and neck cancer[95][96], and cutaneous squamous cell carcinoma[97].

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[98]. 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[99].

SMAD4 is also suggested as a predictive marker for 5-fluorouracil-based chemotherapy in colorectal cancer (CRC)[100][101]. 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[102].

Results from clinical and meta-analyses showed that loss of SMAD4 in CRC, pancreatic cancer was correlated with poor prognosis[103][104][105][106][107][108][109][110]. 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[111].

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US FDA-APPROVED DRUG(S)

Capivasertib (TRUQAP)

Capivasertib is developed and marketed by AstraZeneca Pharmaceuticals under the trade name TRUQAP.

- FDA Approval Summary of Capivasertib (TRUQAP)

CAPItello-291 NCT04305496	**Her2-receptor negative breast cancer** (Approved on 2023/11/16)
	PIK3CA/AKT1/PTEN-alterations
	Capivasertib + fulvestrant vs. Placebo + fulvestrant [investigator-assessed PFS(M): 7.3 vs. 3.1]

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[112] NCT01524783	**Lung or gastrointestinal neuroendocrine tumor** (Approved on 2016/02/26)
	-
	Everolimus vs. Placebo [PFS(M): 11 vs. 3.9]
BOLERO-2[113] 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[60] NCT00510068	**Pancreatic neuroendocrine tumor** (Approved on 2011/05/05)
	-
	Everolimus vs. Placebo [PFS(M): 11 vs. 4.6]
EXIST-1[114] NCT00789828	**Subependymal giant cell astrocytoma** (Approved on 2010/10/29)
	-
	Everolimus vs. Placebo [ORR(%): 35.0]
RECORD-1[115] 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)

MAGNITUDE NCT03748641	**Prostate cancer** (Approved on 2023/08/11)
	BRCA mutation
	Niraparib and abiraterone acetate plus prednisone vs. placebo and abiraterone acetate plus prednisone [rPFS(M): 16.6 vs. 10.9]
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[116] 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)

PROpel NCT03732820	**Prostate cancer** (Approved on 2023/05/31)
	BRCA mutation
	Olaparib + abiraterone + prednisone vs. Placebo + abiraterone + prednisone [rPFS(M): not reached vs. 8]
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[117] 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[118] NCT02477644	**Ovarian cancer** (Approved on 2020/05/08)
	HRD+
	Olaparib + bevacizumab vs. Placebo + bevacizumab [PFS(M): 37.2 vs. 17.7]
POLO[119] 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[120] 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[121] NCT02000622	**Breast cancer** (Approved on 2018/02/06)
	HER2-/gBRCA mutation
	Olaparib vs. Chemotherapy [PFS(M): 7 vs. 4.2]

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SOLO-2/ENGOT-Ov21[122] 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[123] 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[124] 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)

TALAPRO-2 NCT03395197	**Prostate cancer** (Approved on 2023/06/20)
	HRR genes mutation
	Talazoparib + enzalutamide vs. Placebo + enzalutamide [rPFS(M): Not reached vs. 13.8]
EMBRACA[125] 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)

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

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

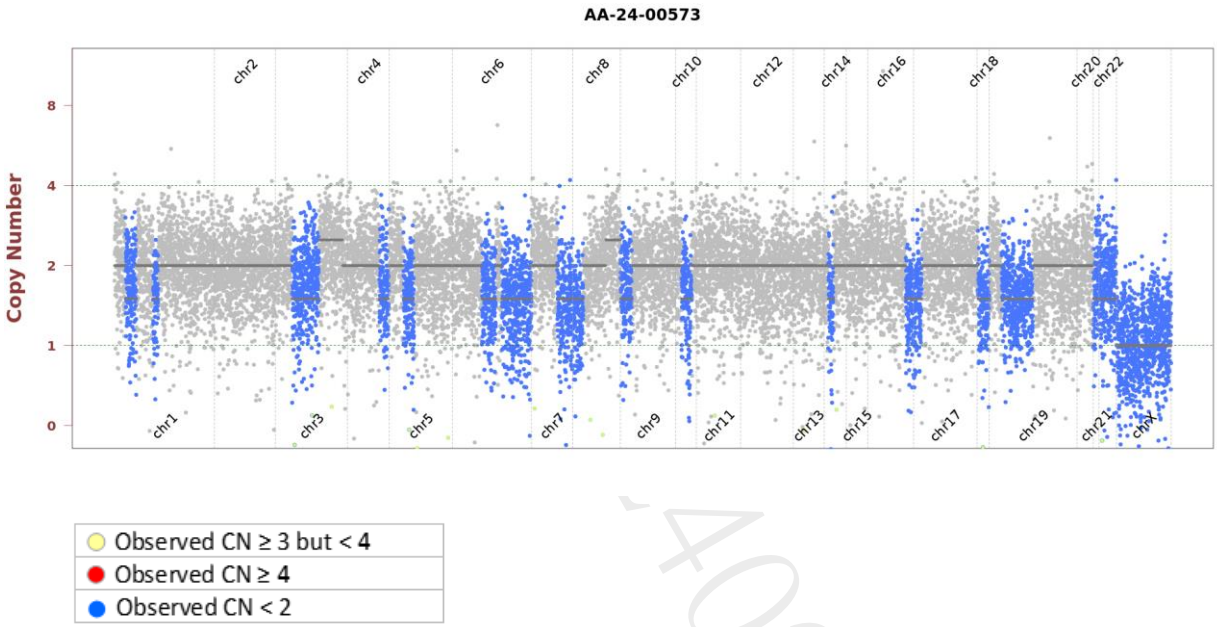
DETAILED INFORMATION OF VARIANTS WITH CLINICAL RELEVANCE

- Single Nucleotide and Small InDel Variants

Gene	Amino Acid Change	Exon	cDNA Change	Accession Number	COSMIC ID	Allele Frequency	Coverage
TP53	L201fs	6	c.602dup	NM_000546	COSM437516	22.0%	469

- 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
CHEK2	R180C	4	c.538C>T	NM_007194	-	42.2%	934
CTCF	L40F	3	c.120A>T	NM_006565	-	50.4%	1644
EPHA5	S673T	11	c.2017T>A	NM_001281765	-	52.6%	3297
IRS2	S828Y	1	c.2483C>A	NM_003749	-	48.8%	473
JAK3	D324G	7	c.971A>G	NM_000215	-	49.3%	668
KMT2C	A1685S	34	c.5053G>T	NM_170606	COSM249560	5.3%	528
PMS1	T451M	9	c.1352C>T	NM_000534	-	31.8%	220

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 23, 2023
- Facility retrieved: 臺北榮總
- H&E-stained section No.: S11279565
- Collection site: Prostate
- Examined by: Dr. Yeh-Han Wang
    1. The percentage of viable tumor cells in total cells in the whole slide (%): 60%
    2. The percentage of viable tumor cells in total cells in the encircled areas in the whole slide (%): 60%
    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: NA
- Manual macrodissection: Not performed
- The outline highlights the area of malignant neoplasm annotated by a pathologist.

RUN QC

- Panel: ACTOnco®+

DNA test

- Mean Depth: 881x
- Target Base Coverage at 100x: 94%

RNA test

- Average unique RNA Start Sites per control GSP2: 159

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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).

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.

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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:
醫檢師陳韻仔 博士
Yun-Yu Chen Ph.D.
檢字第 015647 號

Yun Yu Chen

Sign Off
醫檢師陳韻仔 博士
Yun-Yu Chen Ph.D.
檢字第 015647 號

Yun Yu Chen

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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

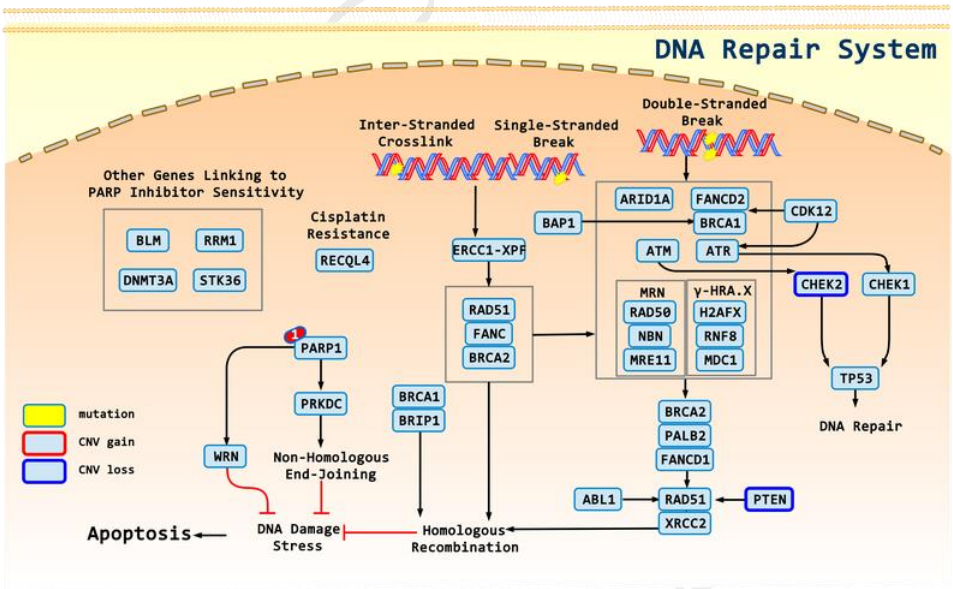
ALK	BRAF	EGFR	FGFR1	FGFR2	FGFR3	MET	NRG1	NTRK1	NTRK2	NTRK3	RET	ROS1

APPENDIX

POSSIBLE THERAPEUTIC IMPLICATIONS FOR HETEROZYGOUS DELETION

Gene	Therapies	Possible effect
NF2	Everolimus, Temsirolimus	**sensitive**
CHEK2	Niraparib, Olaparib, Rucaparib, Talazoparib	**sensitive**
NF2	Abemaciclib, Palbociclib, Ribociclib	**resistant**
SMAD4	Cetuximab	**resistant**

SIGNALING PATHWAYS AND MOLECULAR-TARGETED AGENTS



1: Olaparib, Niraparib, Rucaparib, Talazoparib

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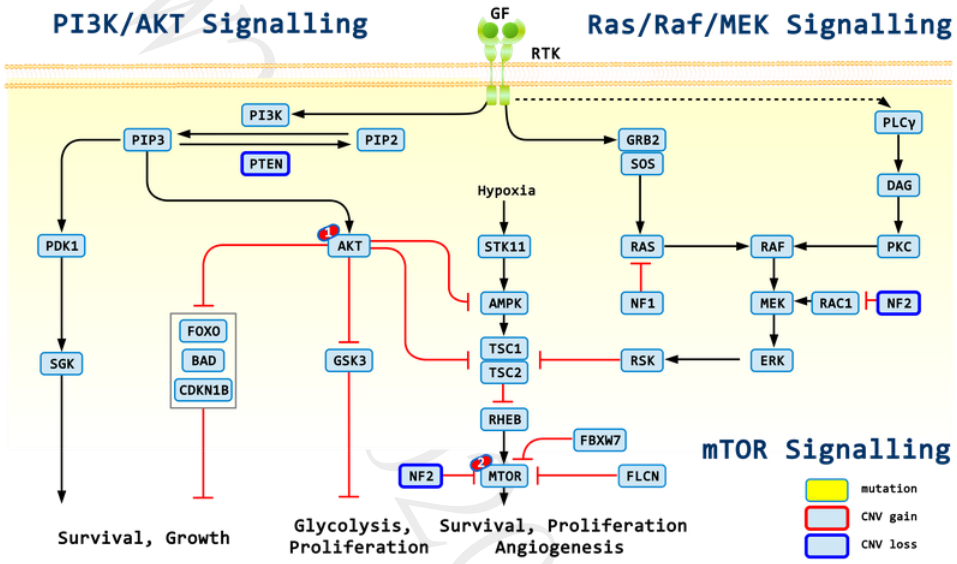

1: Capivasertib; 2: Everolimus, Temsirolimus

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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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