# Correlation of Tumor Infiltrating CD4+ and CD8+ Lymphocytes and Response to Neoadjuvant Chemotherapy in Locally Advanced Breast Cancer

#### Thesis

Submitted for Partial Fulfillment of the M.D. Degree in Clinical Oncology and Nuclear Medicine

### By

#### Radwa Mohamed Hamed

M.B., B.Ch; M.Sc.
Faculty of Medicine - Ain Shams University
Supervised by

#### Prof. / Zeinab Mohammed Abd Elhafeez Elsayed

Professor of Clinical Oncology and Nuclear Medicine Faculty of Medicine - Ain Shams University

#### Prof. / Manal Mohamed El Mahdy Moahmed

Professor of Pathology Faculty of Medicine - Ain Shams University

#### Dr. / Mohammed Sabry Elkady

Assistant Prof. of Clinical Oncology and Nuclear Medicine Faculty of Medicine - Ain Shams University

#### **Dr. / Waleed Abd Elmmonem Biomy**

Assistant Prof. of Clinical Oncology and Nuclear Medicine Faculty of Medicine - Ain Shams University

#### Dr. / Mai Mohamed Ali Ezz El Din

Assistant Prof. of clinical Oncology and Nuclear Medicine Faculty of Medicine - Ain Shams University

Faculty of Medicine - Ain Shams University
2018



سورة البقرة الآية: ٣٢

### Acknowledgment

#### ALLAH

First and above all, thanks for your great Blessing, giving me the effort to complete and achieve this work.

I would like to express my deep gratitude, thanks, and respect to our eminent **Prof. Dr. Zeinab Abd Elhafeez**, Professor of Clinical Oncology and Nuclear Medicine, Faculty of Medicine, Ain Shams University for her enthusiastic support, encouragement valuable scientific advices, I'm so proud to complete this work under her supervision. May God bless her.

I am really honored by the presence of **Prof. Dr. Tarek Hashim** Professor of Clinical Oncology and Nuclear Medicine, Faculty of Medicine, Menofia University, and **Prof. Dr. Sherif Abd El Wahab** Professor of Clinical Oncology and Nuclear Medicine, Faculty of Medicine – Ain Shams University.

I would like to express my thanks and admiration to **Prof. Dr.**Manal Elmahdy, Professor of pathology Faculty of Medicine, Ain Shams

University for her kind and meticulous supervision, support, help, valuable supervision all through the work.

I am extremely grateful to **Prof. Dr. Mohamed Sabry El Kady,** Professor of Clinical Oncology and Nuclear Medicine Faculty of Medicine, Ain Shams University for his kind supervision, encouragement, wonderful support and meticulous revision of this work.

I am extremely grateful to **Prof. Dr.** Waleed Abd Elmonam, Professor of Clinical Oncology and Nuclear Medicine Faculty of Medicine, Ain Shams University for his kind supervision, encouragement, wonderful support and meticulous revision of this work.

I am extremely grateful to **Prof. Dr. Mai Ezz El Din,** Assistant Professor of Clinical Oncology and Nuclear Medicine Faculty of Medicine, Ain Shams University for her kind supervision, encouragement, wonderful support and meticulous revision of this work.

I am extremely grateful to Colonel. Dr. Hany Samy Attallah, Lecturer of Clinical Oncology Military Medical Academy for his kind supervision, encouragement and wonderful support

I am extremely grateful to Colonel. Dr. Tag Ibrahim Omran, Lecturer of Pathology Military Medical Academy for his kind supervision, encouragement and wonderful support

Radwa Mohamed



**To:** 

My beloved Dad

My wonderful Mom

My amazing Brother and Sisters

Radiation Oncology Department, Maadi Military Medical Compound



### List of Contents

Title	Page No.
List of Abbreviations	i
List of Tables	vi
List of Figures	vii
Introduction	1
Aim of the Study	4
Review of Literature	
Epidemiology and Risk Factors	5
<ul> <li>Breast Cancer is a Heterogeneous Disease</li> </ul>	15
Locally Advanced Breast Cancer	44
<ul> <li>Tumor Infiltrating Lymphocytes in Breast Can</li> </ul>	cer74
Patients and Methods	99
Results	104
Discussion	118
Summary and Conclusion	127
Recommendations	129
References	130
Arabic Summary	

### List of Abbreviations

Abb.	Full term
5-FU	5-fluorouracil
	Doxorubicin
	Androgen receptor
	Antibody Dependent Cell mediated Cytotoxicity
	Aromatase Inhibitors
	American Joint Committee on Cancer
ASCO	American Society of Clinical Oncology
	Area Under the Curve
BC	Breast Cancer
BCI	Breast Cancer Index
BCT	Breast Conservative Treatment
BL1	Basal-Like 1
<i>BL2</i>	Basal-Like 2
BLBC	Basal-Like Breast Cancer
BLIA	Basal-Like Immunoactivated
BLIS	Basal-Like Immunosuppressed
<i>C</i>	Cyclophosphamid
<i>CAP</i>	College of American Pathologists
<i>CBC</i>	Complete blood picture
<i>CDC</i>	Centers for Disease Control and Prevention
<i>CESM</i>	Contrast-Enhanced Spectral Mammography
<i>CISH</i>	Chromogenic in situ hybridization
<i>CRR</i>	Clinical Response Rate
<i>CT</i>	Computerized tomography
CTL	$ Cytotoxic\ T\ lymphocytes$
CTLA	$ Cytotoxic \ T$ -lymphocyte-associated protein
<i>D</i>	Docetaxel
<i>DBT</i>	Digital Breast Tomosynthesis
DCIS	Ductal Carcinoma Insitu

Abb.	Full term
<b>DFS</b>	Disease free survival
dMFS	.Distant metastasis-free survival
<i>E</i>	Epirubicin
<i>EFPE</i>	Formalin-fixed paraffin-embedded
<i>EFS</i>	Levent-Free Survival
<i>EGFR</i>	Epidermal growth factor receptor
<b>EORTC</b>	Luropean Organisation for Research and Treatment of Cancer
EPclin	. Endo Predict
<i>ER</i>	.Estrogen Receptors
FAS-L	.Fas ligand
<i>FDA</i>	Food and Drug Administration
	T.Fluoro-D-glucose positron emission Tomography/Computerized tomography
FGFR-2	Fibroblast growth factor receptors-2
FISH	Fluorescence in situ hybridization
<i>GEP</i>	Gene Expression Profiling
<i>GGI</i>	The Genomic Grade Index
<i>GR</i>	Glucocorticoid Receptor
HER-2	Human Epidermal Growth Factor Receptor- 2
HMGB1	High mobility-group box 1
HR	Hazard ratio
HR	Hormone Receptor
<i>IBC</i>	Invasive Breast Cancer
<i>IFN</i>	Interferon
<i>IFN-γ</i>	Interferon Gamma
<i>IHC</i>	Immunohistochemistry
<i>IL</i>	Interleukin
<i>IM</i>	Immunomodulatory
<i>IQR</i>	Inter quartile range

Abb.	Full term
<b>KFT</b>	Kidney function test
<i>LABC</i>	Locally Advanced Breast Cancer
	luminal Androgen Receptor
<i>LCIS</i>	Lobular Carcinoma Insitu
<i>LFT</i>	Liver function test
	Lymphocyte Predominant Breast Cancer
	Local Recurrence Rate
<i>M</i>	Mesenchymal
<i>M</i>	Methotrexate
M1	Metastasis
<i>MAPK</i>	Mitogen Activated Protein kinase
	Molecular Classification
<i>MDSC</i>	Myeloid-derived suppressor cells
<i>MFS</i>	Metastases-free survival
<i>MG</i>	Mammography
<i>MHC</i>	Histocompitability Complex
<i>MNPI</i>	Modified scores from Nottingham Prognostic
	Index
<i>MRI</i>	Magnetic Resonance Imaging
<i>MSBR</i>	Modified Scarff Bloom Richardson grade
<i>mTOR</i>	Mammalian target of rapamycin
<i>N</i>	Lymph-node
<i>NA</i>	Not applicable
<i>NAC</i>	Neoadjuvant Chemotherapy
<i>NET</i>	Neoadjuvant Endocrine Therapy
	Nuclear Factor Kappa B
<i>NK</i>	Natural Killer
NR	Not Reported
NSABP	National Surgical Adjuvant Breast and Bowel Project

Abb.	Full term
<i>os</i>	Overall survival
P	Pertuzumab
PAM 50	Prediction Analysis of Microarrays 50
<i>pCR</i>	Pathological Complete Responses
PD-1	Programmed cell death-1
PDL-1	Programmed cell death ligand-1
PDL-2	Programmed cell death ligand-1
<b>PFS</b>	Progression free survival
<i>PI3K</i>	Phosphoinositide 3- kinase
<i>PIK3CA</i>	Phosphatidylinositol-4,5-Bisphosphate 3-kinase catalytic subunit alpha
<i>PgR</i>	Progesterone Receptors
<i>PTEN</i>	Phosphatase and tensin enzyme
<i>QNBC</i>	Quadruple Negative Breast Cancer
<i>RCB</i>	Residual Cancer Burden
RECIST	Response Evaluation Criteria in Solid Tumors
<i>RFS</i>	Relapse-free survival
<i>ROR</i>	Risk-of-Recurrence
<i>RS</i>	Recurrence Score
<i>RTK</i>	Receptor tyrosine kinases
<i>SD</i>	Stable disease
SEER	Surveillance, Epidemiology, and End Results program
<i>T</i>	Trastuzumab
<i>TAA</i>	Tumor-Associated Antigens
<i>T-DM1</i>	Trastuzumab Emtansine
<i>TGF-β</i>	Transforming growth factor
Th-1	T helper cell -1
TIL	Tumor Infiltrating Lymhocytes

Abb.	Full term
TLR	Toll-Like Receptor
<i>TNBC</i>	Triple Negative Breast Cancer
<i>TNF</i>	Tumor Necrosis Factor
<i>Tregs</i>	Regulatory T cells
<i>US</i>	Ultrasound
<i>V</i>	Vincristine
Vs	Versus
<i>X</i>	Capecitabine

### List of Tables

Table No.	Title Po	age No.
<b>Table (1):</b>	Estimated New Female Breast Cancer	
	Cases and Deaths by Age	
<b>Table (2):</b>	Age-specific Probability of Developing	
	Invasive Breast Cancer for US Women	
<b>Table (3):</b>	Commercially available prognostic multi-	
	gene signatures for breast cancer patients.	
<b>Table (4):</b>	Trials comparing the same	
	chemotherapeutic regimen preoperative	
	and postoperative	
<b>Table (5):</b>	Clinical trials of neoadjuvant CT with	
	trastuzumab for HER2-positive BC	56
<b>Table (6):</b>	Randomized trials comparing different	
	endocrine agents in the neoadjuvant setting	
<b>Table (7):</b>	Comparison of pathologic response	9
	evaluation system for breast cancer after	
	neoadjuvant therapy	
<b>Table (8):</b>	Neoadjuvant trials that have assessed	l
	tumor-infiltrating lymphocytes	
<b>Table (9):</b>	Tumor-infiltrating lymphocytes (TILs) in	
	residual disease post NAC	
<b>Table (10):</b>	Tumor characteristics	105
<b>Table (11):</b>	CD4 and CD8 Ranges	108
<b>Table (12):</b>	TIL range at diagnosis in both estrogen	
	receptors positive and negative	108
<b>Table (13):</b>	Response to cheotherapy	110
<b>Table (14):</b>	Tumor residual and correlation with CD4	111
<b>Table (15):</b>	By the end of the study 38 patients were	9
	still alive with 7 deaths in low CD4 group	
	vs zero deaths in high CD4 group	
	Tumor residual in correlation to CD8	
<b>Table (17):</b>	Relationship between TILs and clinic	-
	pathological characteristics	116

## List of Figures

Fig. N	lo.	Title Po	age	No.
Figure	(1):	Proportions of familial risk of breast can explained by hereditary variants		14
Figure	(2):	Genes evaluated by multigene assays calculate a recurrence risk score	to	
Figure	(3):	Overlap of Triple-Negative, Basal-like, a BRCA1-Mutant Breast Cancers and histolo	and	
		types		41
<b>Figure</b>	<b>(4):</b>	Assessment response to NEC by CESM and M		
Figure	<b>(5):</b>	Contrast-enhanced, T1-weighted MR images		
		breast cancer cases		68
<b>Figure</b>	<b>(6):</b>	Morphology, definitions, biological a	and	
		diagnostic relevance of different immu		
		infiltrates seen in breast cancer		81
Figure	<b>(7):</b>	Prognostic value of stromal tumor-infiltrat	_	
		lymphocytes (sTILs) in TNBC		85
Figure	(8):	Using the TIL infiltrate and response		20
T31	(0)	frontline treatments to guide patient		
		Immune checkpoint blockade		
_		IQR for presence of CD4 in all cohort		
_		IQR for presence of CD8 in all cohort		
_		Correlation between pCR and CD4 percentag		
_		DFS curve according to high and low CD4		
_		DFS curve according to high and low CD8		
_		correlation between tumor residual and DFS Correlation between molecular subtypes a		113
rigure	(10):	CD4		114
Figure	(17).	Correlation between molecular subtypes a		
riguic	(11).	CD8		115
Figure	(18):	Representative image (high power field) o		
9 0	(10)•	breast cancer tissue sample with CD4 a		
		CD8+ TIL immunostaining		117

### INTRODUCTION

reast cancer is the most common invasive malignancy and the second most common cause of death from cancer in women (Hiatt and Brody, 2018).

Over 1.5 million women (25% of all women with cancer) are diagnosed with breast cancer every year throughout the world. In America, it is estimated that 30% of all new cancer cases among women are breast cancer (Sun et al., 2017).

Breast cancer has not traditionally been considered as an immunogenic disease; however, a large body of evidence has shown the presence of significant immune cell infiltration in patient tumors (West et al., 2013).

Breast cancer is capable of stimulating the immune system. Furthermore, the intensity of tumoral immune response influences the effectiveness of cancer therapy, and is correlated with favorable clinical outcome. Some breast tumors have substantial lymphocytic infiltration, and tumor-infiltrating lymphocytes (TILs) have been recently proposed as a surrogate marker of adaptive immune response. The interaction of the immune system with tumor cells in breast cancer appears to be associated with triple negative breast cancer (TNBC) and HER2-positive breast cancer, and they are thought to be more immunogenic than luminal A carcinomas (García-Teijido et al., 2016).

Several studies have stated that these tumors are infiltrated by a heterogeneous population of immune cells, namely T cells, B cells, natural killer (NK) cells and macrophages. Tumor infiltrating lymphocytes (TIL) are of helper (CD4+) and cytotoxic (CD8+) pheno-types, and express activation markers such as CD25 and the transferrin receptor (Gisterek et al., 2008).

CD8+ cytotoxic T lymphocytes are the primary effector cell type, because they exhibit cytotoxic activity towards tumor cells expressing tumor-associated antigens (TAAs). Where they induce tumor cell death directly upon recognition of tumor peptides presented in association with major histocompitability complex (MHC) class I molecules on tumor cells (Melichar et al., 2014).

CD4+ lymphocytes eliciting its antitumor response through the activation and regulation of many facets of the adaptive immune response as interferon gamma (IFN-γ) production, NK and macrophages activation (Gu-Trantien et al., 2013).

Tumor infiltrating lymphocytes (TILs) is a prognostic indicator for higher rates of pathological complete responses (pCR) to neoadjuvant chemotherapy (NAC) (Dieci, et al., 2014).



Preclinical studies have suggested that cytotoxic agents may partly exert their antitumor activity by inducing immune response against tumor cells (André et al., 2013). Denkert et al., were able first to show in a large-scale analysis of 1058 patients' biopsies that TIL+ tumors achieved a pCR rate of 40-42 % following NAC, whereas TIL- tumors achieved a pCR of only 3–7% (*Denkert et al.*, 2015).