Immunotherapy and small cell lung cancer (SCLC)

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Abstract

Lung cancer is the leading cause of cancer death worldwide. Lung cancers are mainly of two types: non-small cell lung cancer (NSCLC) and small cell lung cancer (SCLC). Small cell lung cancer accounts for about 15% of all the types of lung cancers. The SCLC is also known as small cell undifferentiated carcinoma, oat cell carcinoma and oat cell cancer. Neuroendocrine tumors are another group of tumors that are found in lungs and show a spectrum of tumors, ranging from slow growing non metastatic carcinoid tumors to highly malignant small cell resembling cancers. SCLC has a unique biology with specific molecular and cellular changes. Chromosomal alterations, tumor suppressor genes, oncogenes, aberrant signaling pathways, receptor tyrosine kinases and growth factors are known to occur in SCLC. Immunotherapy might be beneficial for small cell lung cancer (SCLC). There is no immunotherapeutic, which is approved by FDA approved for SCLC. However, a wide variety of immunotherapeutics care under clinical trials for the treatment of SCLC.

Pathophysiology/Molecular basis

SCLC has a unique biology with specific molecular and cellular changes. Chromosomal alterations, tumor suppressor genes, oncogenes, aberrant signaling pathways, receptor tyrosine kinases and growth factors are known to occur in SCLC.

Chromosomal alterations

The majority of SCLCs have deletions, affecting multiple chromosomal sites, with recurrent losses at 3p, 5q, 13q and 17p, which are the loci for tumor suppressor genes, including p53. Comparative genomic hybridization analyses (CGH) have revealed that a large number of SCLCs harbor gains of 1p, 2p, 3q, 5p, 8q and 19p. These regions encode well-known oncogenes, such as MYC and KRAS. SCLC cell lines are found to have amplifications of 1p, 2p and 3q, with the deletions of 18q, displaying a more aggressive phenotype of the disease [5]. Allelic loss on chromosome 3p occurs with a frequency greater than 90% in SCLC, and is believed to be an early event in lung cancer [6]. Distinct areas of loss that have been identified, include 3p12, 3p14.2 and 3p24 [7]. Several genes on these regions have tumor suppressor activity and often lose their expression by epigenetic mechanisms. The 3p21 tumor suppressor genes, 3p12, 3p14.2 and 3p24 [7].

Etiology/Predisposing factors

Small cell lung cancer accounts for about 15% of all the types of lung cancers. Neuroendocrine tumors are another group of tumors that are found in lungs and show a spectrum of tumors, ranging from slow growing non metastatic carcinoid tumors to highly malignant small cell resembling cancers. The common signs and symptoms of SCLC are voice change, recurrent bronchitis or pneumonia, chest pain, hemoptysis, and persistent cough. The most common risk factors of SCLC are smoking cigarettes, cigars, or pipes, radiation therapy to the chest or breast, air pollution, family history of lung cancer, exposure to chromium, asbestos, arsenic, radon, and nickel in the workplace, and HIV [3]. About 87% cases of lung cancer occur due to smoking in the United States [4].

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Key words: non-small cell lung cancer (NSCLC), small cell lung cancer (SCLC), undifferentiated carcinoma, oat cell carcinoma, oat cell cancer, chromosomal alterations, oncogenes, aberrant signaling pathways, tumor suppressor genes (TSGs), comparative genomic hybridization analyses (CGH), xenograft models, phosphotyrosine 3-kinase signaling pathway, receptor tyrosine kinases, check point inhibitors, cytokine-induced killer (CIK), major histocompatibility complex, minimal residual disease (MRD), lymphokine-activated killer (LAK), tumor microenvironment

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suppressor genes include RASSF1A, FUS1, SEMA3B and SEMA3F. RASSF1A gene is inactivated by tumor acquired promoter hypermethylation. It encodes a protein similar to RAS effectors proteins and is inactivated in greater than 90% of SCLC [8]. The 3p24 region contains the RARβ gene, which is methylated in 72% of SCLC, leading to the loss of its expression. RARβ plays an important role in the growth regulation of epithelial cells and suppression of tumorigenesis [9].

Tumor suppressor genes (TSGs)

The tumor suppressor gene p53, located on chromosome 17p13, is the gatekeeper of the cell and protects the cell against genetic instability by regulating cell survival and damage response pathways. It acts as a negative regulator of cellular proliferation by targeting downstream genes, involved in cell cycle arrest (G1 andG2) [p21], DNA repair (GADD45) and apoptosis (BAX) [10]. Inactivating mutations of p53 are seen in approximately 90% of SCLC, of which most of the mutations are missed mutations in the DNA binding domain, while some of them being, homozygous deletions [6].

Non-receptor oncogenes

Bcl-2 genes

The up regulation of Bcl-2 is present in 75–95% of SCLC [11]. Inhibition of bcl-2 shows antitumor activity in SCLC cell lines and in xenograft models [12-14].

MYC-genes

Amplification of the chromosomal bands, 1p32, 2p23 and 8q24.1 regions, encoding for C-MYC, N-MYC and L-MYC, respectively, has been detected through CGH. The use of genespecific probes has confirmed that C-MYC, N-MYC and L-MYC genes are amplified in small cell lung cancer. The MYC gene encodes for a transcription factor, which aids cell proliferation. This proliferation is induced by the activation of growth-promoting genes and occasionally by repression of growth suppressing sequences [15]. MYC activation has been reported in 18–31% of SCLC and correlates with decreased survival [7].

Phosphoinositide 3-kinase (PI3K)/AKT/mTOR signaling pathway

The mTOR is a major downstream mediator of PI3K/AKT that targets eukaryotic ribosomal translation establishment factor 4E-binding protein 1 (4EBP1) and ribosomal protein S6 kinase 1 (S6K1) [16], which targets eukaryotic translation establishment factor 4E-binding protein 1 (4EBP1) and ribosomal protein S6 kinase 1 (S6K1) [16], which controls the protein synthesis [17,18]. The PI3K/AKT/mTOR signaling pathway is an imperfect pathway in small cell lung cancer (SCLC). The SCLC cells keeps an essentially active PI3K and port PTEN pathway is an imperfect pathway in small cell lung cancer (SCLC). The phosphorylated AKT exists in 70% of the tumors in SCLC patients [21]. The protein expression of 4EBP1, S6K1 and mTOR are raised in the SCLC cells as compared to the type-2 epithelial cells [22].

Receptor tyrosine kinases and growth factors

There are various tyrosine kinase receptors, which are overexpressed in the SCLC. They are also associated with the activation of downstream signaltransduction molecules, migration and survival, cell proliferation, and modification of reactive oxygen group. The numerous defective tyrosine kinase receptors and their particular growth factors comprise FGFR/FGF, c-Kit/SCF, IGF-1R/IGF, c-MET/HGF, and VEGFR/VEGF in SCLC. Throughout the activation of several pathways, as well as the activation of the PI3K/AKT/mTOR, these signaling pathways are recognized to be dys-regulated in SCLC. These are also concerned in the translation, apoptosis, survival, and cell cycle regulation [7]. The inhibitors of tyrosine kinase receptors have developed into probable anti-tumor agents in the SCLC.

Immunotherapy

Current immunotherapy option for SCLC are discussed in following categories: kinase inhibitors, monoclonal antibodies, mTOR inhibitors, Proteosome inhibitors and vaccine therapy.

Kinase inhibitors

Mammalian target of rapamycin (mTOR) Immunotherapy

Non-FDA approved Kinase Inhibitors: (Table 1)

Mammalian target of rapamycin (mTOR) Immunotherapy

Non-FDA approved Mtor Inhibitors: (Table 2)

Monoclonal antibody drugs (MABs) and check point inhibitors (CPIs)

Non-FDA Approved drugs: (Table 3)

Proteasome inhibitors

Non-FDA Approved proteasome inhibitors: (Table 4)

Vaccines

Non-FDA Approved vaccines: (Table 5)

Miscellaneous

Cytokine-induced killer (CIK) cells: A preparation of autologous lymphocytes with potential immunopotentiating and anticancer activities. Cytokine-induced killer (CIK) cells are CD3- and CD56-positive, non-major histocompatibility complex (MHC) -restricted, natural killer (NK) -like T lymphocytes, generated ex-vivo by

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**Table 1.** Non-FDA approved tyrosine kinase drugs [23-28].

<table>
<thead>
<tr>
<th>Drug</th>
<th>Clinical trial identifier number</th>
<th>Phase</th>
<th>Study design</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunitinib</td>
<td>NCT00453154</td>
<td>Phase 2</td>
<td>Randomized, Double blind, Safety/Efficacy Study</td>
<td>VEGF</td>
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<td>NCT01182689</td>
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<td>Open label, Efficacy Study</td>
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<td>VEGFR, PDGFR, FGFR</td>
</tr>
<tr>
<td>Pazopanib</td>
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<td>Open label, Efficacy Study</td>
<td>VEGFR, PD-GFR</td>
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<td>Bcr-Abl</td>
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</tbody>
</table>

**Table 2.** Non-FDA approvedmTOR drugs [29,30].

<table>
<thead>
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<th>Phase</th>
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<th>Target</th>
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<td>mTOR</td>
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<td>ME-344</td>
<td>NCT02100007</td>
<td>Phase 1, 2</td>
<td>Open Label, Safety Study</td>
<td>mTOR</td>
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</tbody>
</table>
and a Th1-mediated immune response. By activating the immune cell (Th1) production, leading to the production of memory T-cells (NK) cells, initiating immune signaling pathways and inducing T-helper plasmacytoidal and myeloid dendritic cells (DCs), and natural killer stimulating activity. TLR9 agonist MGN1703 binds to and activates a marker for Hsp90 inhibition. Elevation of heat shock protein 72 (Hsp72); it may inhibit the activity of oncogenic client proteins, the inhibition of cell proliferation and the apoptotic functions; its up-regulation may be used as a surrogate marker for human cancer antigen NY-ESO-1, may result in potent antibody, antigen-delivery and immunostimulatory activities. This saponin-based adjuvant in combination with various antigens, including those for human papilloma virus (HPV), hepatitis C virus (HCV), and the human cancer antigen NY-ESO-1, may result in potent antibody, CD4+ T-helper-cell, and CD8+ cytotoxic T-cell responses against the targeted antigen. In addition, this agent may reduce the amount of antigen necessary to induce an efficient immune response in the host.

**In conclusion,** Immunotherapy might be beneficial for small cell lung cancer (SCLC). There is no immunotherapeutic, which is approved by FDA for SCLC. However, a wide variety of immunotherapeutic was under clinical trials for the treatment of SCLC. The recent activities have increased our understanding of the tumor microenvironment, various immunotherapeutic modalities or combination therapy (like chemotherapy with immunotherapy). Proper preclinical and clinical designs are the important pillars in understanding the future of immunotherapy in treating patients, suffering from lung cancer.

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