Adaptive cell transfer: a clinical path to effective cancer immunotherapy

Steven A. Rosenberg, Nicholas P. Restifo, James C. Yang, Richard A. Morgan and Mark E. Dudley

Abstract | Adaptive cell therapy (ACT) using autologous tumour-infiltrating lymphocytes has emerged as the most effective treatment for patients with metastatic melanoma and can mediate objective cancer regression in approximately 50% of patients. The use of donor lymphocytes for ACT is an effective treatment for immunosuppressed patients who develop post-transplant lymphomas. The ability to genetically engineer human lymphocytes and use them to mediate cancer regression in patients, which has recently been demonstrated, has opened possibilities for the extension of ACT immunotherapy to patients with a wide variety of cancer types and is a promising new approach to cancer treatment.

Adaptive cell therapy (ACT) has emerged as the most effective treatment for patients with metastatic melanoma. ACT-based immunotherapy was first described in 1988 [Ref. 1], but the decisive improvement in efficacy came in 2002 with the introduction of an immunodepleting preparative regimen given before the adoptive transfer, which could result in the clonal repopulation of patients with anti-tumour T cells. Of patients with metastatic melanoma refractory to all other treatments, 50% will experience an objective response, some with complete responses. Responses can be durable and are seen in all organ sites, including the brain. Recent studies demonstrating that normal human lymphocytes can be genetically engineered to recognize cancer antigens and mediate cancer regression in vivo have opened opportunities for enhancing and extending the ACT approach to patients with a wide variety of cancer types. These studies provide a valuable guide to the immunological principles that form the basis of effective immunotherapies for patients with cancer.

The role of ACT in human cancer immunotherapy

Current efforts in the immunotherapy of human solid cancers fall into three main categories.

Non-specific immunomodulation. This is mediated by the administration of the T-cell growth factor interleukin 2 (IL2) and can activate endogenous tumour-reactive cells in vivo and reproducibly cause the regression of some human solid cancers. The durability of the cancer regressions induced by IL2 led to its approval by the US Food and Drug Administration for the treatment of patients with metastatic renal cancer in 1992 and metastatic melanoma in 1998. Although IL2 administration leads to toxicity owing to a capillary leak syndrome, experience with the administration of this cytokine has resulted in treatment-related mortalities of <1%. More recently, antibody-mediated blockade of a cell surface inhibitory molecule, cytotoxic T-lymphocyte-associated 4 (CTLA4), has resulted in objective clinical responses in 10–20% of patients, but again only consistently in those with metastatic melanoma or renal cancer, suggesting that these two tumour types are exceptional in their ability to naturally generate endogenous anti-tumour cells of sufficient avidity and in sufficient numbers to mediate cancer regression when appropriately stimulated in vivo. Investigations are underway to evaluate other general immune modulators such IL15, anti-transforming growth factor-β (anti-TGFβ) and anti-programmed death 1 (anti-PD-1) antibodies.

Active immunization approaches (cancer vaccines). These are based on immunizing cancer patients against their autologous cancers using either whole cells, proteins, peptides or a wide variety of immunizing vectors. The identification of a large number of human cancer antigens beginning in 1991 fuelled a resurgence of interest in this area. Currently, only rare and highly sporadic regressions of solid cancers have been achieved using active immunization. Several recent findings have further tempered enthusiasm for this approach. Even though up to 30% of circulating anti-melanoma CD8+ T cells could be induced by immunization of...
At a glance

- Adoptive cell therapy (ACT) is a treatment that uses a cancer patient’s own T lymphocytes with anti-tumour activity, expanded in vitro and reinfused into the patient with cancer.
- ACT using autologous tumour-infiltrating lymphocytes is currently the most effective treatment for patients with metastatic melanoma and can mediate objective tumour regressions in 50% of patients.
- Lymphodepletion before ACT is an important component of the treatment because it eliminates T regulatory cells and eliminates lymphocytes, which compete with the transferred cells for homeostatic cytokines such as interleukin 7 (IL7) and IL15.
- ACT can be effective in treating selected patients with post-transplant lymphoproliferative diseases (PTLD) resulting from Epstein–Barr virus, which can cause PTLD during the immunosuppressed state.
- Recent studies have shown that genetic modification of lymphocytes using retroviruses that encode T-cell receptors can convert normal lymphocytes into lymphocytes with anti-cancer activity. The adoptive transfer of these lymphocytes into patients with metastatic melanoma can mediate tumour regression.

Avidity

The relative intensity of reactivity of lymphocytes when interacting with antigen

Allogeneic

Inter-individual genetic variation at the MHC locus. In a partially matched transplant, for example, some MHC antigens are shared by donor and recipient, but in addition the donor has some MHC antigens that the recipient does not.

patients with melanoma, tumour progression can occur, suggesting that the cells induced are of low avidity and/or subject to inhibition by endogenous factors. Although increases in anti-tumour T cells have been suggested in some active immunization protocols in patients with cancers other than melanoma, it has been possible to isolate and grow only rare anti-tumour T cells from these tumour types, again suggesting that T-cell precursors reactive with non-melanoma antigens are present at low frequency.

ACT. This approach involves the identification ex vivo of autologous or allogeneic lymphocytes with anti-tumour activity, which are then infused into cancer patients, often along with appropriate growth factors to stimulate their survival and expansion in vivo. ACT has substantial theoretical and practical advantages over the approaches discussed above. It is necessary to identify only a small number of anti-tumour cells with the appropriate properties that can then be expanded to large numbers ex vivo for treatment. In vitro tests can identify the exact populations and effector functions required for cancer regression, which can then be selected for expansion. The cells can be activated in the laboratory free from endogenous inhibitory factors and thus can be induced to exhibit the required anti-tumour effector functions. Perhaps most importantly, it is possible to manipulate the host before cell transfer to provide an optimal environment for the transferred cells. This approach has proved to be highly effective for the treatment of cancer in experimental animals as well as in cancer patients.

Adoptive cell transfer in animal models

Shortly after the demonstration that the cellular arm of the immune system was responsible for tissue rejection, attempts were made to treat established rodent tumours by the transfer of immune cells. Examples of the development of ACT in animal models are summarized in Timeline 1. As T lymphocytes could not be grown in vitro, early efforts at ACT in the 1960s were limited to the use of cells obtained directly from immunized animals. Studies by Alexander and colleagues in the mid-1960s showed that sarcomas a few millimetres in size could be treated in rats by the administration of large numbers of lymphocytes from immunized syngeneic animals. Extensive studies by Fefer and colleagues beginning in 1969 showed that intraperitoneal instillation of immune lymphocytes along with chemotherapy could effectively treat mice bearing intraperitoneal virus-induced lymphomas. The ability to expand populations of anti-tumour immune cells using in vitro sensitization techniques in the mid-1970s freed these studies from the constraints imposed by the need for fresh cells from immunized hosts. Eberlein et al. took this a step further by showing that the intravenous injection of immune cells grown in culture in IL2 could treat disseminated tumours in mice and subsequent studies...
showed that the concurrent administration of IL2 could further enhance the effectiveness of these IL2-dependent cells in vivo.

The need for immunization of lymphocyte donors limited the application of this approach until 1986 when it was shown that tumour-infiltrating lymphocytes (TIL) from non-immunized mice bearing sarcomas or melanomas could be expanded in vitro in IL2 and used to successfully treat established lung and liver tumours.

More recently, T-cell receptor (TCR) transgenic mice, all of whose lymphocytes express anti-EB100 tumour antigen TCRs, have provided a constant source of anti-tumour T cells that are valuable for defining host factors and cell properties associated with effective ACT of large, vascularized, subcutaneous tumours in mice. The importance of host immunosuppression as a part of ACT was shown to be due to both the elimination of T regulatory cells as well as the elimination of "cytokine sinks" that compete with the transferred cells for homeostatic cytokines, such as IL7 and IL15, that are produced by host stromal cells. The greater the degree of host lymphodepletion the more effective was the treatment. The characteristics of the transferred cells themselves had a profound effect: anti-tumour T cells with a CD62L+ CD27+ CD28+ CD45RA phenotype is characteristic of central memory cells that are more effective than highly differentiated cells that lost these markers. Immunization of the host with a vaccine expressing a tumour antigen recognized by the transferred cells enhanced their therapeutic effect. Antigen-presenting cells (APCs) also have a role in effective ACT as the injection of APC-stimulating molecules such as Toll-like receptor agonists enhanced the efficacy of treatment.

Recently, it was demonstrated that normal murine splenocytes transduced with a retrovirus encoding an anti-melanoma TCR resulted in the generation of lymphocytes that recognized the melanoma in vitro and, when adoptively transferred, could mediate tumour regression in vivo.

ACT is currently the most effective immunotherapy capable of mediating the rejection of large tumours in mice and optimization of the treatment in mouse models has had an important role in the design of ACT approaches in the human.

**ACT in metastatic melanoma**

Selected highlights in the development of ACT in patients with cancer are shown in **Timeline 2**.

An important step in the development of human ACT was the finding in 1987 that lymphocytes infiltrating melanomas could be grown in IL2 and exhibit major histocompatibility complex (MHC)-restricted recognition of the autologous melanoma. Over 50 different antigenic epitopes either unique to the autologous tumour or widely shared among melanomas were characterized using these TIL. Studies using improved culture methods capable of generating up to $10^{11}$ TIL showed that melanoma-specific activity could be detected in TIL from 81% of 36 consecutive patients.

The infusion of autologous TIL grown from the resected tumour nodules of patients with metastatic melanoma represents the clearest example of the effectiveness of ACT for the treatment of patients with a metastatic solid cancer and has helped to elucidate the cellular and host characteristics required for effective treatment in humans. The original reports of this approach, first published in 1988 and summarized in 1994, described an overall objective response rate of 34% in 86 patients treated with autologous TIL plus high-dose IL2. Patients received two cycles of treatment separated by 2 weeks. Eighty-eight percent of patients received $>10^{11}$ cells in the first cycle. Response rates were similar in patients treated alone (31%) or with low-dose cyclophosphamide (35%) and in patients who had not received prior IL2 (34%) or in patients refractory to prior IL2 therapy (32%). In this trial, TIL were administered regardless of their in vitro activity, although a retrospective analysis revealed that there was a highly

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**Timeline 2: Examples of ACT in patients with cancer**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>Use of autologous TIL to treat patients with metastatic melanoma using shared and unique melanoma antigens</td>
</tr>
<tr>
<td>1990</td>
<td>Fresh donor leukocytes to treat EBV-associated PTLD after bone marrow transplantation using EBV immunodominant nuclear antigens EBNA 1A, 1B, 3C</td>
</tr>
<tr>
<td>1994</td>
<td>Cultured donor EBV-specific T-cell lines to prevent PTLD using EBV antigens EBNA 1A, 1B, 3C</td>
</tr>
<tr>
<td>1995</td>
<td>Cultured partially matched allogeneic cell lines to treat PTLD after solid organ transplantation using EBV antigens EBNA 1A, 1B, 3C</td>
</tr>
<tr>
<td>1998</td>
<td>Cultured autologous EBV-specific T-cell lines, to treat Hodgkin disease using EBV poorly immunogenic antigens LMP1, LMP2 and EBNA A1</td>
</tr>
<tr>
<td>1999</td>
<td>Use of genetically modified autologous normal lymphocytes transduced with TCR that are reactive with the MART1 melanoma antigen to treat metastatic melanoma</td>
</tr>
<tr>
<td>2001</td>
<td>Fresh donor leukocytes to treat relapsed chronic myeloid leukaemia after bone marrow transplantation using minor histocompatibility antigens</td>
</tr>
<tr>
<td>2002</td>
<td>Cultured EBV-specific T-cell lines to treat PTLD and avoid graft-versus-host disease using EBV antigens EBNA 1A, 1B, 3C</td>
</tr>
<tr>
<td>2004</td>
<td>Cultured autologous EBV-specific cell line to treat PTLD after solid organ transplantation using EBV antigens EBNA 1A, 1B, 3C</td>
</tr>
<tr>
<td>2005</td>
<td>Prior lymphodepletion enhanced the therapeutic effect of ACT with TIL in metastatic melanoma using shared and unique melanoma antigens</td>
</tr>
<tr>
<td>2006</td>
<td>Cultured autologous EBV-specific T-cell lines, to treat nasopharyngeal cancer using EBV poorly immunogenic antigens LMP1, LMP2, EBNA A1</td>
</tr>
</tbody>
</table>

**EBV, Epstein–Barr virus; PTLD, post-transplant lymphoproliferative disease; TCR, T-cell receptor; TIL, tumour-infiltrating lymphocytes.**
significant correlation between clinical response and the ability of the TIL to lyse the autologous fresh tumour ($P = 0.0008$)$^{32,33}$. Traffic of indium-111-labelled TIL to tumour deposits correlated with clinical response ($P = 0.022$). Shorter times in culture and shorter doubling times were also positively associated with response ($P = 0.0001$ and 0.03)$^{34}$, in accord with the findings in mouse models that increased proliferative potential was an important property of clinically active cells.

Several shortcomings became apparent in these initial studies of ACT using TIL. Persistence of the transferred cells in vivo was short. Studies using retroviral insertion of the neomycin phosphotransferase gene to mark TIL and sensitive PCR assays to detect the transgene revealed that at 1 week barely 0.01% of cells in the circulation were the transferred cells$^{34}$. Of the 29 patients that exhibited an objective clinical response, five were complete though only two were ongoing at 21 and 46 months. The median duration of the partial responders was 4 months$^{34}$.

Emerging information from murine models of ACT emphasized the need for prior lymphodepletion to eliminate regulatory T cells as well as normal endogenous lymphocytes that compete with the transferred cells for homeostatic cytokines$^{35,36}$. Studies using highly selected tumour reactive CD8$^+$ clones administered following lymphodepletion did not result in objective tumour regression, suggesting that the polyclonal nature of tumour reactivity and possibly the presence of CD4$^+$ cells were necessary to mediate tumour rejection$^{13,34}$. This led to a new generation of ACT clinical protocols with altered techniques for cell growth and with profound host lymphodepletion before cell transfer$^{35}$.

In the latest Surgery Branch, National Cancer Institute trials multiple TIL cultures were initiated from freshly resected metastatic melanomas (a mass of $\geq 1$ cm$^3$ was required) and as soon as anti-tumour activity could be detected in vitro against specific unique or shared antigens, cells underwent a rapid expansion using the T-cell-stimulating antibody OKT3 and IL2 (Fig. 1). Approximately $5 \times 10^{10}$ cells were infused immediately following a non-myeloablative preparative regimen consisting of 60 mg/kg cyclophosphamide for 2 days followed by 5 days of fludarabine at 25 mg/m$^2$. Twenty-five patients each also received either 2 Gy or 12 Gy plus the chemotherapy regimen. IL2 was administered for 2–3 days at $7.2 \times 10^5$ IU/kg every 8 h.

Objective responses by standard response evaluation criteria in solid tumours (RECIST) were seen in 21 of 43 patients (49%), who received no total body irradiation, in 13 of 25 patients (52%) who received 2 Gy and 18 of 25 patients (72%) who received 12 Gy (Table 1). Patients with stable disease were not considered as responders as it is not possible to evaluate this criterion in the absence of randomized patient comparisons. Examples of anti-tumour responses in melanoma patients treated with ACT are shown in Fig. 2. Many of these responses at multiple metastatic sites are durable. None of the 10 complete responders have recurred at times from 8 to 63 months. Fifteen of the partial responders have ongoing responses from 4 to 64 months. The actuarial 3-year survival of patients receiving ACT with the chemotherapy non-myeloablative regimen alone or with 2 Gy total body irradiation is 25% and 42% respectively, compared with 14% for the no lymphodepletion group. The trend for increasing survival as a function of increasing lymphodepletion is highly significant ($P = 0.007$), but this should be interpreted with caution as this was not a randomized comparison$^{39}$.

There were no added toxicities in these trials owing to the cell administration, although the expected toxicities of IL2 administration were seen most often owing to the capillary leak syndrome caused by IL2. Neutropenic fevers that subsided when white cells recovered were seen in several patients.

Several findings in this trial are of note. The transferred cells expanded in vivo and persisted in the peripheral blood in many patients, sometimes achieving levels of 75% of all CD8$^+$ T cells at 6–12 months after infusion$^{1}$. Persistence of the transferred T-cell clonotypes correlated with cancer regression$^{40}$. Eleven of 13 responding patients had $\geq 25\%$ persistence of transferred clonotypes compared with only 1 of 12 non-responders ($P = 0.001$). In accord with this, the telomere length of the infused TIL correlated with cancer regression$^{41}$. The mean telomere length in TIL administered to responding patients was 6.3 kb compared with 4.9 kb in TIL given to non-responders ($P < 0.01$). TIL clonotypes that persisted in vivo had mean telomeres of 6.2 kb compared with 4.5 kb in non-persisting clonotypes ($P < 0.001$). Telomere length is related to the proliferative history of the cell. Each time the cell divides telomeres at the
Figure 2 | Examples of objective tumour regressions in patients receiving adoptive cell transfer of autologous anti-tumour lymphocytes following a lymphodepleting preparative regimen. In each case the pretreatment scans and photos are shown on the left and the post-treatment on the right. a | A 45-year-old male with metastatic melanoma to the liver (upper) and right adrenal gland (middle) who was refractory to prior treatment with high dose α interferon as well as high-dose interleukin 2 (IL2). He underwent a rapid regression of metastases and developed vitiligo (lower). b | A 55-year-old male with rapid tumour growth in the axilla as well as multiple brain metastases from metastatic melanoma that was refractory to prior treatment with high dose IL2 who underwent rapid regression of nodal and brain metastases.

Minor histocompatibility antigens such as HA1 and HA2 can represent strong ‘foreign’ targets for effective ACT in cancer patients receiving allogeneic haematopoietic stem cell transplantation (HSC). In 1990, Kolb et al. reported cytogenetic remissions in three patients with relapsed chronic myeloid leukaemia treated withuffy coat cells from the HSC marrow donor. Later studies showed that infusion of donor lymphocytes could mediate complete molecular remissions in 70–80% of patients with relapsed chronic myeloid leukaemia in chronic phase, in 20–30% of patients in blast crisis and in a minority of patients with relapsed multiple myeloma following treatment with allogeneic HSC transplantation. Cloned CTL lines have induced responses, although the apparent lack of persistence of these lines in vivo has limited their effectiveness.

The treatment of patients with cancers expressing viral antigens. ACT can mediate cancer regression in humans with Epstein–Barr virus (EBV)-related lymphomas, which occur in patients receiving immunosuppressive drugs. Approximately 90% of humans have lymphocytes latently infected with EBV and the cellular immune response against these viral proteins is essential for the control of infected cells. Approximately 1% of individuals undergoing allogeneic HSC transplants who receive immunosuppressive drugs to prevent graft-versus-host disease develop post-transplant lymphoproliferative diseases (PTLD) in cells of donor origin and as many as 20% of solid organ transplant patients can develop PTLD in cells of recipient origin. These lymphomas express latent EBV antigens, including the immunodominant EBV nuclear antigens (EBNA) EBNA-3A, EBNA-3B and EBNA-3C, that are targets for immunotherapy.
In 1994 O’Reilly and colleagues demonstrated that the infusion of small numbers of normal non-irradiated donor lymphocytes (10⁶/kg) achieved complete responses in five patients with lymphomas occurring following the treatment of leukaemia with chemotherapy and T-cell-depleted allogeneic HSC grafts. Shortly thereafter, Rooney et al. demonstrated that infusion of long-term cultured EBV-specific T-cell lines generated by repeated in vitro sensitization and expanded in IL2 could effectively prevent and treat PTLD and thus avoid the graft-versus-host disease that is caused by transfer of whole T-cell populations. Donor-derived EBV-specific CTL lines were infused into 60 patients at high risk of developing EBV PTLD and none developed the malignancy, compared with 11.5% of historical controls. Five of six patients treated for overt PTLD experienced a complete regression. These long-term cultured cells could be detected in patients up to 3 years after infusion. These studies have been widely reproduced using EBV-specific donor cell lines to treat donor PTLD in patients undergoing allogeneic HSC transplantation.

PTLD in solid organ transplant patients is a more difficult problem as it is difficult to raise autologous EBV-specific cells in patients on high doses of immunosuppressive drugs and cells from the organ donor are rarely available. Thus treatment of these patients has used EBV-specific cell lines from partially matched unrelated (allogeneic) donors. Recently Haque and colleagues reported a multicentre clinical trial using a bank of 60 long-term allogeneic EBV-reactive T-cell lines to treat PTLD patients. Of 33 patients, 52% achieved a partial or complete response at 6 months after treatment.

The success in treating EBV PTLD led to the use of autologous anti-EBV cell lines to treat patients with stage 4 nasopharyngeal cancer (NPC) that was refractory to conventional treatments. Virtually all poorly differentiated nasopharyngeal cancer express the less immunogenic EBV latent proteins, LMP-1 and LMP-2, as well as the EBV EBNA-1 antigen. The infusion into six patients of anti-EBV cell lines targeting these antigens led to two complete remissions ongoing at 11 and 23 months and one partial remission lasting 12 months. In a second series two partial responses were seen in ten treated patients. These weak EBV antigens are also expressed in the malignant Reed–Sternberg cells found in about 40% of patients with Hodgkin disease. ACT using autologous EBV-reactive cell lines mediated objective responses in 3 of 11 evaluable patients with Hodgkin disease.

These studies demonstrating the effectiveness of ACT directed against EBV and allogeneic antigens, as well as studies showing that the infusion of IL2-expanded cytomegalovirus (CMV)-reactive autologous T-cell lines grown long-term in IL2 could prevent CMV infection in immunosuppressed patients, have profound implications for the development of ACT approaches to the treatment of patients with solid cancers. Administration of an anti-tumour T cell targeting a highly expressed antigen can result in cancer regression.

**ACT using gene-modified lymphocytes**

The success of ACT for the treatment of patients with metastatic melanoma has formed a foundation on which to build improvements of this approach. TIL with high avidity for tumour antigens can only be generated from some patients with melanoma and a need exists for the generation of T cells with broad reactivity against shared cancer-associated antigens present on multiple tumour types. The ability to introduce genes into circulating human lymphocytes provides the flexibility to introduce antigen receptors as well as molecules that can provide the cell with enhanced properties required for effective ACT therapy (reviewed in Refs 55, 56).

Genes encoding TCRs can be isolated from high avidity T cells that recognize cancer antigens and retroviral or lentiviral vectors can be used to redirect lymphocyte specificity to these cancer antigens. Mispairing of the inserted chains with endogeneous TCR chains can be greatly reduced by insertion of murine constant region sequences or by insertion of cystine residues that favour pairing of only the transduced chains. High-affinity TCRs can be obtained from rare reactive human clones or from transgenic mouse cells following immunization against human cancer antigens, which thus avoids the tolerance that can limit the generation of these cells in the cancer patient. High-affinity TCR against a p53 epitope and against carcinoembryonic antigen (M. R. Parkhurst, personal communication) that is present on common epithelial cancers have been generated in transgenic mice and used to redirect the specificity of human lymphocytes. Phage display techniques have been used to generate TCRs with affinity of a natural TCR directed against the cancer–testis antigen NY-ESO-1, which is expressed on many common cancers. Chimeric TCR that use the combining site of antibodies genetically fused to intracellular T-cell signalling chains such as CD3ζ can

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**Table 1 | Adoptive cell therapy in patients with metastatic melanoma**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Patients (n)</th>
<th>Response (n (%))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PR</td>
<td>CR</td>
</tr>
<tr>
<td>No TBI</td>
<td>43</td>
<td>17 (39.5)</td>
</tr>
<tr>
<td>2 Gy TBI</td>
<td>25</td>
<td>11 (44.0)</td>
</tr>
<tr>
<td>12 Gy TBI</td>
<td>25</td>
<td>14 (56.0)</td>
</tr>
</tbody>
</table>

All patients received cyclophosphamide 60 mg/kg for 2 days then fludarabine 25 mg/m² for 5 days. Includes all patients who received expanded tumour-infiltrating lymphocytes (TIL) plus the full preparative regimen as a first TIL treatment. CR, complete response; OR, objective response; PR, partial response; TBI, total body irradiation.
redirect the recognition specificity of lymphocytes to cell surface tumour-associated antigens and thus avoid the limitations of MHC restriction imposed by the use of α–β TCRs67–71.

The steps involved in this process are shown in FIG. 3. Highly avid anti-tumour T cells are identified and the genes encoding their T-cell receptors (TCRs) are cloned and inserted into retroviruses. Retroviral supernatants are then produced under good manufacturing practice (GMP) conditions and used to insert the T-cell receptors into normal lymphocytes. Expression of the T-cell receptor is then compared in untransduced (UnTd) and transduced (Td) cells by fluorescence-activated cell sorting analysis and by recognition in vitro of HLA-A2+ 526 melanoma line and not the HLA-A2− 888 melanoma line. The effector cells were the anti-MART JKF6 line and untransduced (PBL) and transduced (TCR) lymphocytes. C, constant; IRES, internal ribosome entry site; LTR, long terminal repeat; SA, splice acceptor site; SD, splice donor site; V, variable. Steps 3 and 5 reproduced, with permission, from REF. 4 © American Association for the Advancement of Science (2006).

The first clinical trial to successfully mediate the regression of human cancer by ACT using genetically engineered autologous lymphocytes has recently been published1. Sixteen patients were treated with a TCR that was reactive with the MART1 melanoma antigen isolated from highly reactive TIL. Two patients with metastatic melanoma who received ACT of their autologous normal lymphocytes transduced with genes encoding this MART1 TCR underwent regression of liver and lung hilum metastases respectively and both are currently disease free over 2 years later. Two of 15 additional patients subsequently experienced objective tumour regressions (S.A.R., unpublished observation). TCRs with far greater affinity for the MART1 melanoma antigen have been identified and are now being evaluated in clinical gene therapy trials72. TCRs are now available against a broad array of cancer antigens present on common epithelial cancers and we have recently begun a trial treating patients with epithelial cancers using autologous T cells transduced with a TCR that recognizes a p53 epitope65 (FIG. 4).

As mouse models clearly indicated that increased lymphodepletion could improve the efficacy of ACT72 we are performing clinical trials in which patients receive non-myeloablative chemotherapy plus either 2 Gy or 12 Gy whole body irradiation. Other improvements in ACT are being studied (see TABLE 2 for selected examples). Murine models have shown that CD4+CD25+FOX3+ regulatory T cells can inhibit ACT and thus the regimen can be modified to deplete CD4+ cells or...
selectively eliminate T-regulatory cells. Lymphocyte function may be improved using antibodies or genetic approaches that block inhibitory signals on lymphocytes such as CTLA4, PD-1 or TGFβ. Increased persistence and function of the transferred cells may be accomplished by the administration of alternative cytokines such as IL15, or by stimulating the cells in vivo by the administration of a vaccine or by activating host APCs with Toll-like receptor agonists.

**The future of ACT**

In contrast to common epithelial cancers, melanoma appears to be a tumour that naturally gives rise to anti-tumour T cells. However, other cancers are equally susceptible as the targets of reactive T cells. The susceptibility of melanoma to ACT provides optimism for the application of ACT to common epithelial cancers using TCR gene-modified lymphocytes. A major problem with the application of ACT is that it is a highly personalized treatment and does not easily fit into current modes of oncological practice. The treatment is labour-intensive and requires laboratory expertise. In essence, a new reagent is created for each patient and this patient-specific nature of the treatment makes it difficult to commercialize. Pharmaceutical and biotechnology companies seek off-the-shelf drugs, easy to produce, vial and administer. From a regulatory standpoint, ACT might be more appropriately delivered as a service rather than as a 'drug'. Blood banks have been instrumental in providing CD34+ haematopoietic stem cells for clinical studies and might be the ideal location for the generation of the anti-tumour T cells needed for ACT.

As modern science increasingly provides the physician with sophisticated information about the unique aspects of an individual cancer, changes in the modes of care delivery need to accommodate this. The ability to use this patient-specific information can lead to a new era of personalized medicine in which individual treatments, such as ACT, are devised for each patient.

Studies of ACT have clearly demonstrated that the administration of highly avid anti-tumour T cells directed against a suitable target can mediate the regression of large, vascularized, metastatic cancers in humans and provide guiding principles as well as encouragement for the further development of immunotherapy for the treatment of patients with cancer.

**Table 2 | Opportunities for improving ACT for the treatment of human cancer**

<table>
<thead>
<tr>
<th>Method</th>
<th>Approach</th>
<th>Example refs</th>
</tr>
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<tbody>
<tr>
<td>Genetic modification of lymphocytes to introduce new recognition specificities</td>
<td>αβ TCR, chimeric TCR</td>
<td>4</td>
</tr>
<tr>
<td>Genetic modification of lymphocytes to alter function of T cells</td>
<td>Use of co-stimulatory molecules (CD28, 41BB); cytokines (IL2, IL15); homing molecules (CD62L, CCR7); prevention of apoptosis (BCL2)</td>
<td>76</td>
</tr>
<tr>
<td>Modify host lymphodepletion</td>
<td>Selective depletion of CD4+ cells or T regulatory cells</td>
<td>23</td>
</tr>
<tr>
<td>Block inhibitory signals on reactive lymphocytes</td>
<td>Antibodies to CTLA4 or PD-1</td>
<td>9</td>
</tr>
<tr>
<td>Administer vaccines to stimulate transferred cells</td>
<td>Recombinant virus encoding antigen</td>
<td>22</td>
</tr>
<tr>
<td>Administer alternative cytokines to support cell growth</td>
<td>IL15, IL21</td>
<td>77</td>
</tr>
<tr>
<td>Stimulate APCs</td>
<td>Use of Toll-like receptor agonists</td>
<td>27</td>
</tr>
<tr>
<td>Generate less differentiated lymphocytes</td>
<td>Alternate culture conditions and growth promoting cytokines in vitro</td>
<td>26</td>
</tr>
<tr>
<td>Overcome antigen escape variants</td>
<td>Use of natural killer cells</td>
<td>78</td>
</tr>
</tbody>
</table>

ACT, adoptive cell therapy; APC, antigen-presenting cell; CTLA4, cytotoxic T-lymphocyte-associated 4; IL, interleukin; PD-1, programmed death 1; TCR, T-cell receptor.
The first paper demonstrating the adoptive cell transfer of lymphocytes transduced with a retrovirus encoding TCIDRs that recognize a cancer antigen can mediate anti-tumor responses in patients with metastatic melanoma.


The demonstration that peptide vaccines are capable of generating large numbers of anti-tumor lymphocytes in vivo, but these lymphocytes do not appear to have any in vivo ability to prevent disease progression.


A seminal paper demonstrating the role of the cellular immune response in the rejection of tumor transplants.


65. Cohen, C. J. et al. Recognition of fresh human tumor by human peripheral blood lymphocytes transduced with a bialisteric retroviral vector encoding a marine anti-p53 TCR. J. Immunol. 175, 5799–5808 (2005). References 58–65 demonstrate that TCRs can be identified that recognize cancer antigens and that transduction of these TCRs into normal human cells can transfer this antigen recognition.

DATABASES
CCBR | CD25 | CD27 | CD28 | CD44 | CD55 | CD62L | IL2RA | TETRA | TLR1A | TLR1B | TLR2 | TLR3 | TLR4 | TLR7 | TLR8 | TLR9 | LMP1 | MART1 | NYESO-1 | p55 | PD-L1 | TCR
National Cancer Institute: http://www.cancer.gov/chronicmyeloidleukemia | melanoma | myeloidmyeloma | nasopharyngealcancer | renalcancer
cyclophosphamide | fludarabine
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