To cycle or fight - CDK 4/6 inhibitors at the crossroads of anti-cancer immunity

Malaka Ameratunga[1], Emma Kipps[1,2], Alicia F C Okines[2], and Juanita S Lopez[1]

[1] The Drug Development Unit, Institute of Cancer Research and the Royal Marsden Hospital, Downs Road, Sutton, UK

[2] Breast Unit, Royal Marsden Hospital, Fulham Road, London, UK.

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Corresponding author

Dr Juanita S Lopez MA MBBChir MRCP PhD PgDip (Onc)
Consultant Medical Oncologist Drug Development Phase I Unit
Royal Marsden Hospital and The Institute of Cancer Research

Sycamore House, Downs Road
London SM2 5PT
United Kingdom

Email: Juanita.Lopez@icr.ac.uk
T +44 20 8661 3539 | F +44 20 8642 7979

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Abstract (162 words):

Dysregulation of cell division resulting in aberrant cell proliferation is a key hallmark of cancer, making it a rational and important target for innovative anti-cancer drug development. Three selective CDK4/6 inhibitors are FDA and EMEA approved for hormone receptor positive/HER2 negative advanced breast cancer. A major emerging appreciation is that these inhibitors are not only cytostatic, but also play critical roles in the interaction between tumour cells and the host immune response. However, to trigger an effective immune response, lymphocytes must also proliferate. This review aims to assimilate our emerging understanding on the role of CDK4/6 inhibitors in cell cycle control, as well as their biological effect on T cells and other key immune cells, and the confluence of preclinical evidence of augmentation of anti-cancer immunity by these drugs. We aim to provide a framework for understanding the role of the cell cycle in anti-cancer immunity, discussing ongoing clinical trials evaluating this concept and challenges for developing rational combinations with immune-therapy.

Introduction:

The mammalian cell cycle is a highly organised and regulated process that ensures duplication of genetic material and cell division (1). Key features of this process are cascades of growth-regulatory signals and signalling proteins that monitor genetic integrity. Proliferation depends on progression from the quiescent state (G0) though four distinct phases; G1, the first gap phase, S phase, DNA synthesis, G2, the second gap phase and M, mitosis – which is controlled at checkpoints by cyclins and their associated cyclin-dependent kinases (CDKs) (2). Cyclin-dependent kinases 4 and 6 (CDK4/6) are fundamental drivers of the cell cycle and required for entry into, and progression through G1.

Unsurprisingly, this intricate process is disrupted in most cancers (3), either as a result of mutations in upstream signalling pathways, or by defects in genes encoding cell cycle proteins (reviewed in (4)). Specific inhibitors of CDK4/6 have been touted as paradigm-shifting with recent FDA and EMEA approval for three orally available inhibitors – Palbociclib (PD-0332991; Ibrance©; Pfizer, Inc.), Ribociclib (LEE011; Kisqali©; Novartis) and Abemaciclib (LY2835219; Verzenio©; Lilly) (5-7). In contrast to traditional chemotherapeutic agents, CDK4/6 inhibitors arrest progression through G1, promoting transient quiescence or inducing senescence and have shown significant clinical benefit in combination with aromatase inhibitors, the selective oestrogen receptor degrader, fulvestrant, and tamoxifen (8).

Translational outputs from these ongoing trials have unexpectedly revealed effects of CDK4/6 inhibitors in several critical roles underpinning the interactions of cancer cells with the host immune system (9-11). The cell cycle cascade couples two processes that are required for the generation of an effective adaptive immune response; clonal expansion and differentiation, and consequently, CDK inhibitors have the potential to participate in the decision between tolerance, anergy and the promotion of anti-tumour immunity.

In this review, we discuss the biological functions of the CDK4-CDK6-Retinoblastoma (CDK4/6-Rb) axis - both when pathologically hijacked in cancer and also physiologically in immune cells, with a view to providing a framework for understanding the role of the cell cycle in anti-cancer immunity. We discuss emerging preclinical and clinical data showing effects of CDK4/6 inhibition on promoting various aspects of anti-tumour immunity including enhancing antigen presentation, depleting immunosuppressive regulatory T cells, and

ultimately shifting the balance towards the generation of an efficient anti-tumour immune response. We also ponder the challenges faced by ongoing clinical trials attempting to therapeutically target these together with immunotherapy.

The biology of the Cyclin D-CDK4/6-Rb axis

Numerous detailed reviews of this pathway are available (e.g. (4, 12)). This review will therefore focus on the major principles of this axis. Quiescent cells in G0 can be triggered to re-enter the cell cycle through stimulation by a variety of mitogenic factors that activate intricate intracellular signalling networks that are '*sensed*' by the holoenzyme complex of Cyclin D and CDK4 and/or CDK6 (4) (Figure 1). Evolutionarily highly conserved, there are three mammalian Cyclin Ds that have overlapping functions in a cell-lineage specific manner. These allosterically bind to and regulate cyclin-dependent kinases 4 and 6 - two highly homologous serine/threonine kinases that have unique functions that are cell-type specific as well as being tightly developmentally and temporally regulated (13, 14). CDK6 is expressed at high levels in hematopoietic cells (14, 15) and *Cdk6* deficiency is characterized by subtle defects in the hematopoietic system, such as defects in thymocyte development (13, 16). CDK6 is also a more robust kinase (as compared to CDK4) with distinct affinities for specific modulatory client proteins, and together these two Cyclin D-dependent CDKs allow for the creation of a network of finely tuned interactions to regulate cell cycle progression (17). Activation of the Cyclin D-CDK4/6 complex promotes progression from the G1 phase into S phase by phosphorylating several cellular targets, of which the Retinoblastoma protein (Rb) is key (18). Rb phosphorylation attenuates its inhibition of transcription by the E2F family of transcription factors, leading to the commitment of the cell to DNA replication and progression through the cell cycle (19).

The role of the Cyclin D-CDK4/6-Rb pathway in cancer

In cancer, multiple components of the CDK4/6-Rb axis are commonly dysregulated (20). The Cyclin D1 gene (*CCND1*) represents the second most frequently amplified locus among all human cancer types (21), with the highest prevalence in well-differentiated and dedifferentiated liposarcoma (22), glioblastomas (23), breast cancer (24-26), non-small cell lung cancer (NSCLC), endometrial cancers and pancreatic cancers (24). Copy number variation or overexpression in at least one component of the cyclin D-CDK4/6 pathway is also common and seen in up to 75% of melanoma (27) and gliomas (28). Loss of the negative regulators of the pathway either by genomic deletions, loss-of-function point

mutations or promoter methylation are also frequent, with $p16^{INK4A}$ most commonly lost in breast cancers (29) and head and neck cancers (30). However, other than in mantle cell lymphoma, which is defined by a translocation involving *CCND1* resulting in cyclin D1 overexpression (31), mutations in genes encoding for the pathway are less common than copy number changes (32).

Transcription of Cyclin D and its assembly with CDK4/6 is highly dependent on mitogenic signaling and is therefore an important mechanism of Cyclin D-CDK4/6 upregulation in cancer (32). Oestrogen receptor (ER) signaling upregulates cyclin D1 levels as well as other signaling pathways, which largely culminate in the upregulation of CDK4/6 activity (6, 33, 34). Other upstream oncogenic signal transduction pathways including the PI3K-AKT-mTOR, wnt/β-catenin, mitogen-activated protein kinase (MAPK), and nuclear factor kappa-light-chain-enhancer of activated B cells (NF-κB) pathways, also significantly lead to the induction of cell cycle proteins, and D-type Cyclins in particular (6, 35).

Single agent, CDK4/6 inhibitors *in vitro,* are fundamentally cytostatic, causing downregulation of E2F target genes, loss of proliferation markers and cell cycle arrest in G1 (36). It can therefore be hypothesised that cancer cells addicted to mitogenic signaling pathways and have functional Rb are strongly dependent on Cyclin D-CDK4/6 and thereby more vulnerable to CDK4/6 inhibition; this has been elegantly demonstrated in *vitro* (37). However, only modest clinical benefit has been reported in the various unselected early phase trials of single agent CDK 4/6 monotherapy including in NSCLC, glioblastoma (GBM), melanoma, colorectal and ovarian cancers as well as in mantle cell lymphoma and advanced liposarcoma. One exception to this is abemaciclib (which at clinically efficacious doses also inhibits CDK9) and has shown potentially useful single agent activity in breast cancer leading to licensing as monotherapy in previously treated advanced breast cancer patients (38). Furthermore, the randomized JUNIPER study (NCT02152631) will evaluate its monotherapy efficacy in non-small cell lung cancer.

Given the striking dependence of activated Cyclin D-CDK4/6 complex on mitogenic signals, there has been substantial work developing synergistic combinations of signal transduction inhibitors together with CDK4/6 inhibitors. The most advanced combinations are those in with endocrine therapies in oestrogen-positive breast cancer, which led to the first FDA approvals. The pivotal Phase II PALOMA-1 (NCT 00721409) study randomized post-

menopausal women with advanced ER+/HER2- breast cancer to either Letrozole, an aromatase inhibitor that prevents oestrogen-induction of Cyclin D, in combination with Palboclicib, or Letrozole alone (39). The significant improvement of progression-free survival in the combination arm (20.2 months vs 10.2 months for Letrozole alone; hazard ratio HR=0.48 P<0.001) led to early provisional FDA approval of Palboclicib. Subsequent larger phase III trials have not only confirmed these results (7, 40, 41) but extended the proof-of-principle of synergy in combining other CDK4/6 inhibitors with the selective oestrogen receptor degrader, fulvestrant (42, 43) or the anti-oestrogen, tamoxifen (41, 44).

The concept, that combinatorial therapy with signal transduction inhibitors will amplify the effectiveness of a CDK4/6 inhibitor, is now being extended to other mitogenic pathways and other tumour types. For example, pre-clinical evidence to suggest CDK4/6 inhibitors enhance the effect of RAS–RAF–MEK pathway inhibition in RAS-driven NSCLC (45) and RAS/RAF resistant malignant melanoma (46) has led to early phase trials of combination therapy in KRAS mutant NSCLC (NCT02022982) and NRAS and BRAF mutant melanoma (47, 48). Hyperactivation of the PI3K pathway has also been shown to stabilise the Cyclin D protein and the Cyclin D-CDK4/6 complex (49), and CDK4/6 inhibitors have been shown preclinically to sensitise *PIK3CA* mutant breast cancer to PI3K inhibitors (50). Triplet combinations of CDK4/6 inhibitors together with hormone therapies and PI3K inhibitors are also ongoing in breast cancer (NCT03006172) (51-53).

One really interesting observation that may be pivotal is that in addition to blocking cell proliferation, CDK4/6 inhibitors can induce senescence – an irreversible distinct cellular state characterized by the by absence of proliferation markers, expression of tumour suppressor genes, senescence-associated beta-galactosidase activity and the presence of senescence-associated heterochromatin foci in multiple Rb-proficient cell lines (54, 55). The decision whether to transition from quiescence into senescence is the subject of much ongoing work and the outcome appears to cell-type specific with downregulation of MDM2, redistribution of the chromatin-remodelling enzyme ATRX, repressions of oncogenes as well as upregulation of proteasomal homeostasis necessary for the shift to senescence (56-58). Senescent cells secrete a collection of inflammatory cytokines, chemokines and proteinases, collectively referred to as the senescence associated secretory phenotype (SASP) which recruits and activates distinct cells from the innate and adaptive immune system, such as macrophages and NK cells as well as T cells (59, 60). The SASP is one of the most profound features of senescence with the triggering of immune cell recruitment into the tumour (61, 62), although

on the other hand there are concerns that the inflammatory environment chronically stimulated by SASP could be pro-tumourigenic (59).

This raises several obvious questions about the clinical effect of these inhibitors on host immune cells, and whether this would hinder, or could be leveraged for combination therapies. In the following sections, we review the role of Cyclin D-CDK4/6 in immune cell expansion and differentiation, together with the emerging learnings from the translations studies of CDK4/6 inhibitors.

The role of the Cyclin D- CDK4/6-Rb pathway in immune cell biology

Mouse models provided the first clues to the physiological roles of Cdk4 and Cdk6 *in vivo,* particularly with respect to the immune cell types that critically depend upon the Cyclin D-CDK4/6 pathway during development. Double mutant mice lacking both Cdk4 and Cdk6 (*Cdk4/6*$^{-/-}$ mice) display late embryonic lethality accompanied by a defect in fetal haematopoiesis very similar to the phenotype observed in the triple *D1/2/3-cyclins*$^{-/-}$ mice, including multilineage haematopoietic abnormalities (13, 63).

Myeloid lineage

Myeloid cell development in preclinical models is entirely reliant on Cyclin D2 and Cyclin D3-driven CDK6 (13, 64) and all myeloid progenitor cells populations were also severely reduced in *Cdk4/6*$^{-/-}$ double mutant mice (13).

Not unsurprisingly, neutropenia has been the dose-limiting toxicity of both palbociclib and ribociclib, necessitating intermittent dosing schedules (65, 66). Abemaciclib, being a more-potent inhibitor of CDK4 (as well as inhibiting CDK9 at clinically efficacious doses) seems distinct and causes much lower rates of neutropenia (Table 1) and can be dosed on a continuous schedule (67). An ongoing study of palbociclib is investigating whether a continuous dosing schedule (at 100mg/day) is as effective and tolerable as the approved intermittent dosing schedule (NCT 02630693). Clinical data on the changes in other myeloid cell sub-populations is however scarce at this time, chiefly as multi-parameter data analysis of circulating immune cells or immune cells within the tumour microenvironment was not collected in the initial trials.

Lymphoid lineage

Following antigen exposure, quiescent lymphocytes require intense, prolonged and repeated proliferation to establish a rapid immune response and generate immunological memory. Upon stimulation, T cells exit G0 via an NF-κB dependent pathway (68). Cyclin D is expressed in cells during G1, with significant upregulation of Cyclins D2,D3 and CDK6 during early and late G1 (69, 70) (Figure 2). Deletion of specific Cyclins and CDKs in mice have identified CDK6 and Cyclin D3 to be the key players in hematopoietic stem cells regulation, their proliferation and subsequent commitment to the T-cell lineage (13, 16, 71-73). Loss of CDK6 leads to delayed G1 progression in lymphocytes, but critically, once a cell is committed to proliferation, other Cyclins-CDKs, particularly Cyclin E and CDK2 appear to compensate. As such, despite CDK6 mutant mice having lower numbers of thymocytes early on in development, they have normal/higher than normal levels of CD4+/CD8+ cells later in development (64). This is very consistent with the modest reductions in total lymphocyte numbers seen clinically with the unique differential potency of inhibition of abemaciclib likely to be responsible for the lack of appreciable leukopenia reported clinically for abemaciclib (Table 1) (67).

Commitment to specific cell fates and differentiation with transcriptional activation of specific gene expression programmes are predominantly directed by CDK2 (74), and as such *in vitro* differentiation of naïve CD4+ and CD8+ T cells are not affected by CDK4/6 inhibitors (10). Specific T cell sub-populations however, may be much more selectively suppressed by CDK4/6 inhibition as suggested by flow cytometry analysis of circulating immune cells in pre-clinical models. In tumour-free mice, both abemaciclib and palbociclib significantly reduced FOXP3+ regulatory T cells (10) without affecting other cell sub-types, and this may relate to the higher levels of both Cyclin D as well as CDK4/6 (75, 76) or Rb1 present in these cells (77). Abemaciclib may also have additional epigenetic effects by selectively inhibiting the enzyme DNMT1 in regulatory T cells, resulting in overexpression of the negative regulator p21 (10). The effects of CDK4/6 inhibition on tumour-infiltrating lymphocytes may be more complex with both palboclicib and trilaciclib causing increased infiltration of T cells into lung tumours in an immunocompetent genetically engineered mouse model (GEMM). In this model, absolute numbers of CD4+ and CD8+ cells were unchanged, but proliferation of tumour infiltrating FOXP3+ regulatory cells as well as immunosuppressive myeloid cells were significantly reduced resulting in an increased percentage of effector cells within the tumour microenvironment (9).

In summary, the data thus far reveals that while therapeutic targeting of CDK4/6 can theoretically slow T cell proliferation, *in vivo* it has a preferential effect of promoting cell differentiation while specifically depleting regulatory T cells (9, 10). (Figure 2)

Effects of CDK4/6 inhibition on the tumour microenvironment and the tumour-host immune reaction

Enhancing immune cell infiltration into tumour

Cell cycle arrest and the induction of senescence leads to the activation of the SASP in a subset of cancer cells which can induce the recruitment of innate immune cells including macrophages, neutrophils and natural killer cells into the tumour microenvironment where they are provoked into coordinately attacking tumours through both phagocytosis and direct cytotoxic killing (62, 67). The challenge remains in understanding how tumour cells are directed toward either reversible quiescence or a more stable senescence, as preliminary work in a small subset of abemaclicib-sensitive breast cancer cell lines suggest that genes encoding for the canonical SASP cytokines were not shown to be upregulated in the cell lines tested (11).

Enhancing antigen presentation

The initial studies suggesting links between CDK4/6 inhibition and the immune system came from a Rb proficient transgenic mouse model of breast cancer (10). Treatment with Abemaciclib caused not only cell stasis but also a significant decrease in tumour volume and reduced cell proliferation (10). Gene expression analysis has shown that in addition to downregulating genes related to cell cycle, mitotic and E2F targets, abemaciclib also significantly upregulates genes responsible for antigen processing and presentation including major histocompatibility complex (MHC) class I molecules (10). This was confirmed *in vitro* as well as in patient-derived xenografts. Strikingly, tumour cells treated with CDK4/6 inhibitors show a marked reduction of *DNMT1*, which decreases DNA methylation of genes that regulate immune function, as well as endogenous retroviral genes (ERVs). Expression of double-stranded RNA, triggers ‘viral mimicry’ stimulating the production of an interferon response (10) (Figure 3).

Further support of this model comes from data from the Cancer Genome Atlas (TCGA) showing that breast cancers harbouring *CCND1* amplification (therefore enhanced CDK4/6

activity) display significantly lower expression of major histocompatibility complex (MHC) class I molecules *HLA-A, HLA-B and HLA-C* than non-amplified tumours (10).

Effects on cytokine milieu in tumour microenvironment

Additionally, Deng *et al* used a small molecule screen designed to identify targets that enhanced T cell activity in the setting of PD-1 engagement and found that CDK4/6 inhibitors potently upregulated IL-2 (9). Using short interfering RNAs, they confirmed that CDK6, not CDK4 was responsible for the enhanced IL-2 secretion supporting a predominant role for CDK6 in immune cell function. Careful dissection of the mechanistic basis of this effect found that CDK6 was an upstream regulator of Nuclear Factor of Activated T cells (NFAT) proteins which are critical in regulation of T cell activation and function. CDK4/6 inhibition resulted in increased nuclear levels of NFAT and increased transcriptional activity ultimately resulting in a change in cytokine milieu within the tumour microenvironment and increased effector T cell activity (9, 11). Levels of IL-6, IL-10 and IL-23, three cytokines produced by immunosuppressive myeloid cells, were significantly reduced, while an increase of the Th1 chemokines CXCL9 and CXCL10 which govern the trafficking of effector cells to tumour sites was seen (9, 78).

Effects on PD-L1 and other co-inhibitor molecule expression

PD-L1 protein abundance fluctuates during cell cycle progression in multiple human cancer cell lines, peaking in M and early G1, with a sharp reduction in latter stages of the cell cycle. This is tightly regulated by Cyclin D-CDK4 mediated phosphorylation of the speckle-type POZ protein, a core component of the Cullin3-SPOP E3 ligase responsible for the proteasomal degradation of PD-L1 (79). Inhibition of CDK4/6 in this single paper increases PD-L1 expression, but only in SPOP-proficient cancer cells. The story is far from complete though, as effects of CDK4/6 inhibition on the expression of other co-inhibitory molecules, particularly on immune cells is likely to be complex. For example in the GEMM mouse model used by Deng *et al,* levels of the co-inhibitory molecular PD-1 and CTLA-4 were reduced in both CD4+ and CD8+ T cells after CDK4/6 inhibition (9).

Taken together, these studies illustrate the complex connection between immunity and cell-cycle regulation and constitute an exciting new area of research, which is likely to lead to significant anti-cancer therapeutic opportunities and pharmacodynamic and transalational

outputs from the ongoing clinical trials are eagerly awaited. Combining CDK4/6 inhibitors together with immune checkpoint inhibitors enhance tumour regression in a number of immunocompetent preclinical mice models (9, 79). These effects seem to be at least in part to be tumour-intrinsic, as most potent upregulation of the antigen processing machinery at a gene expression level occurred in CDK4/6 sensitive cell lines (10). Additionally, there are hints that as cancers evolve, and undergo immune-editing thus becoming more immune-refractory, they may be increasingly dependent on Cyclin D-CDK4/6. Oh *et al* studied a highly immune-refractory cancer and found that synaptonemal complex protein 3 (SCP3) is overexpressed in immune-edited cancer cells and upregulates the pluripotency transcriptional factor NANOG by hyperactivation of the Cyclin D-CDK4/6 axis. In this model, the combination of Palbociclib together with adoptive cytotoxic cell transfer showed considerable therapeutic efficacy, suggesting a niche role for CDK4/6 inhibitors in immunotherapy combinations in the resistant/refractory setting (80).

Challenges for the future

The ongoing clinical trials testing combinations of CDK4/6 inhibitors with immune checkpoint inhibitors are listed in Table 2, but a few specific challenges in combining these are worth exploring. Understanding the temporal kinetics of pharmacodynamics effects of CDK4/6 inhibitors on the tumour microenvironment and the immune system would be key to optimising sequencing of any combinations. Schaer *et al* looked at the differences in anti-tumour responses when anti-PD-L1 therapy was given either concurrently, sequentially (after completion of CDK4/6 inhibitor) or in a phased (initiated after 1 week of CDK4/6 inhibitor) manner with abemaciclib (11). Surprisingly, concurrent administration of abemaciclib with immune checkpoint inhibitors showed no significant difference in the anti-tumour response compared to monotherapy. Sequential treatment was additive, but the phased regime was significantly synergistic, with complete responses seen in 2/10 mice (11) highlighting the importance of understanding the biology to direct scheduling of combinations. Furthermore, they analysed the effect of transient vs continuous exposure to abemaciclib on primary T cells during TCR-mediated expansion and found that the greatest effect in upregulating genes indicated of T cell activation was seen with the continuous exposure. This may be pertinent when other CDK4/6 inhibitors that are given intermittently are considered for combinations. Moving forward, it will be absolutely imperative that proof-of-mechanism pharmacodynamics studies utilising paired tumour biopsies as well as in-depth analyses of host immune responses be incorporated into these trials to maximise patient benefit.

Biomarker driven patient selection is also likely to direct these combinations to the patients who are most likely to derive benefit; for example if loss of MHC I expression or markers of T cell exhaustion are seen, combinations of phased in pre-treatment with CDK4/6 inhibitors given with immunotherapy may be therapeutically beneficial. Paraphrasing Shakespeare, much more remains to be learned about how a cell decides whether to cycle or to fight, and future work will reveal if the promise of combining CDK4/6 inhibitors with immunotherapy will be realised and validated.

310 **Table 1.** Myelosuppression seen in the initial early phase trials of single agent CDK4/6 inhibitors.

311 *Indicates dose-limiting toxicity.

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			Palboclicib		**Riboclicib**		**Abemaclicib**	
IC50	**CDK4**		9-11 nmol/L		10 nmol/L		2 nmol/L	
	CDK6		15 nmol/L		39 nmol/L		5 nmol/L	
Dosing			125mg daily 3 weeks on 1 week off		600mg daily 3 weeks on 1 week off		200mg daily continuously	
Effects on immune cells			**All grades**	**G3/4**	**All grades**	**G3/4**	**All grades**	**G3/4**
	neutropenia		95%	**54%***	46%	**29%***	23%	10%
	leukopenia		68%	23%	48%	21%	25%	10%
Reference			NCT00141297		NCT01237236		NCT01394016	

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Table 2. Ongoing clinical trials combining CDK4/6 inhibitors with immune check-point inhibitors

Trial name/ID	Phase	Patient population	Combination agents	Primary objective
Ribociclib + PDR001 in Breast Cancer and Ovarian Cancer/ NCT03294694	I	HR-positive HER2-negative Breast Cancer Epithelial Ovarian Cancer	Ribociclib PDR001 - PD-1 Inhibitor Fulvestrant	MTD/RP2D
PACT/ NCT02791334	I	Solid Tumour Microsatellite Instability-High (MSI-H) Solid Tumors Cutaneous Melanoma Pancreatic Cancer Breast Cancer (HR+HER2-)	LY3300054 - PD-1 Inhibitor Ramucirumab Abemaciclib Merestinib	DLT
A Study of Abemaciclib (LY2835219) in Participants With Non-Small Cell Lung Cancer or Breast Cancer/ NCT02779751	I	Non Small Cell Lung Cancer HR-positive HER2-negative Breast Cancer	Abemaciclib Pembrolizumab	AEs
PAVEMENT – A Phase Ib Study of Palbociclib and Avelumab in Metastatic AR+ triple negative breast cancer (NCT pending)	Ib	Androgen-receptor positive triple negative Breast Cancer	Palbociclib Avelumab	R2PD

AEs, adverse events; ER+, estrogen receptor-positive; DLT, dose-limiting toxicity; HER2, human epidermal growth factor receptor 2; MTD, maximum tolerated dose; RP2D, recommended Phase II dose;

Figure legends

Figure 1 Regulation and functions of cyclin D–CDK4/6 kinases. The Cyclin D-CDK4/6 holoenzyme complex (green boxed) acts as an environmental sensor responding dynamically to mitogenic signals (e.g., oestrogen, Ras-Raf-MEK, EGFR and PI3K signaling pathways), cytokines, and other cues. Upon stimulation, D-type cyclins accumulate in early G_1 phase through both transcriptional and posttranscriptional mechanisms. The activated cyclin D–CDK4/6 complexes initiates the phosphorylation of pRb releasing E2F transcription factors thereby driving the expression of genes required for cellular commitment to enter S-phase, and ultimately mitotic cell division. Growth-inhibitory signals antagonize G1–S progression by upregulating CDK inhibitors of the INK4 family ($p16^{INK4A}$, $p15^{INKB}$, $p18^{INK4C}$ and $p19^{INK4D}$).

Amplification of the *CCND1* gene encoding for Cyclin D or its overexpression, loss of stoichiometric inhibitors of cyclin D–CDK4/6 (members of the INK4A family), or the loss of Rb in tumours aberrantly activate the Cyclin D-CDK4/6 complex thereby driving dysregulated cell cycle progression.

Depending on the cell type, and other mitogenic transforming signals, Rb-positive cells undergo either quiescence or senescence when treated with CDK4/6 inhibitors. In contrast, cells without function Rb are refractory to arrest by chemical inhibitors of CDK4/6.

Figure 2 Cyclin D-CDK4/6 in T cell activation, expansion and differentiation

The figure shows relative levels of CDK4/6 and D type Cyclins at the various stages of the cell cycle as naïve T cells respond to antigen stimulation, enter the cell cycle, undergo clonal expansion followed by maturation and subsequent differentiation. Lilac boxes highlight cells with high levels of CDK4/6 and D type Cyclins, while light green indicates cells with low levels.

Stimulation of the TCR together with costimulatory signals (eg CD28) leads to the induction of a number of cell cycle activators, including cyclin-dependent kinases (CDKs) 4/6 and D-type cyclins which set off a signalling cascade permitting progression through the G_1 phase of the cell cycle. Subsequent progression through S phase is accompanied by downregulation of both CDK4/6 and D type cyclins in an oscillating manner as cells undergo repeated cycles of cell division. As cells differentiate, Cyclin D remain low in the majority of T cells, with the exception of regulatory T cells which retain high expression of both Cyclin D as well as CDK4/6 (75, 76). As such, while therapeutic targeting of CDK4/6 can *theoretically* slow T cell proliferation, *in vivo* it has a preferential effect of promoting cell differentiation while specifically depleting regulatory T cells (9, 10).

Figure 3 To cycle or fight

Tumours with hyperactivation of the Cyclin D-CDK4/6 axis aberrantly progress through the cell cycle and effectively *hide* from the host immune system through multiple mechanisms including down regulation of MHC Class I molecules.

Treatment with CDK4/6 inhibitors both arrests cell cycle but also promotes a 'fight' mode, promoting anti-tumour immunity by stimulating antigen presentation through 1) the upregulation of MHC Class I expression within tumours and 2) the increase in pro-inflammatory cytokine secretion (eg IFNγ) either via inducing the senescence associated secretory phenotype (SASP) or other mechanism resulting in activation of dendritic cells and macrophages. CDK4/6 inhibitors also selectively deplete immunosuppressive regulatory T cells and change the cytokine milleu within the tumour microenvironment, thereby increasing effector T cell infiltration into the tumour. (9, 10, 11)

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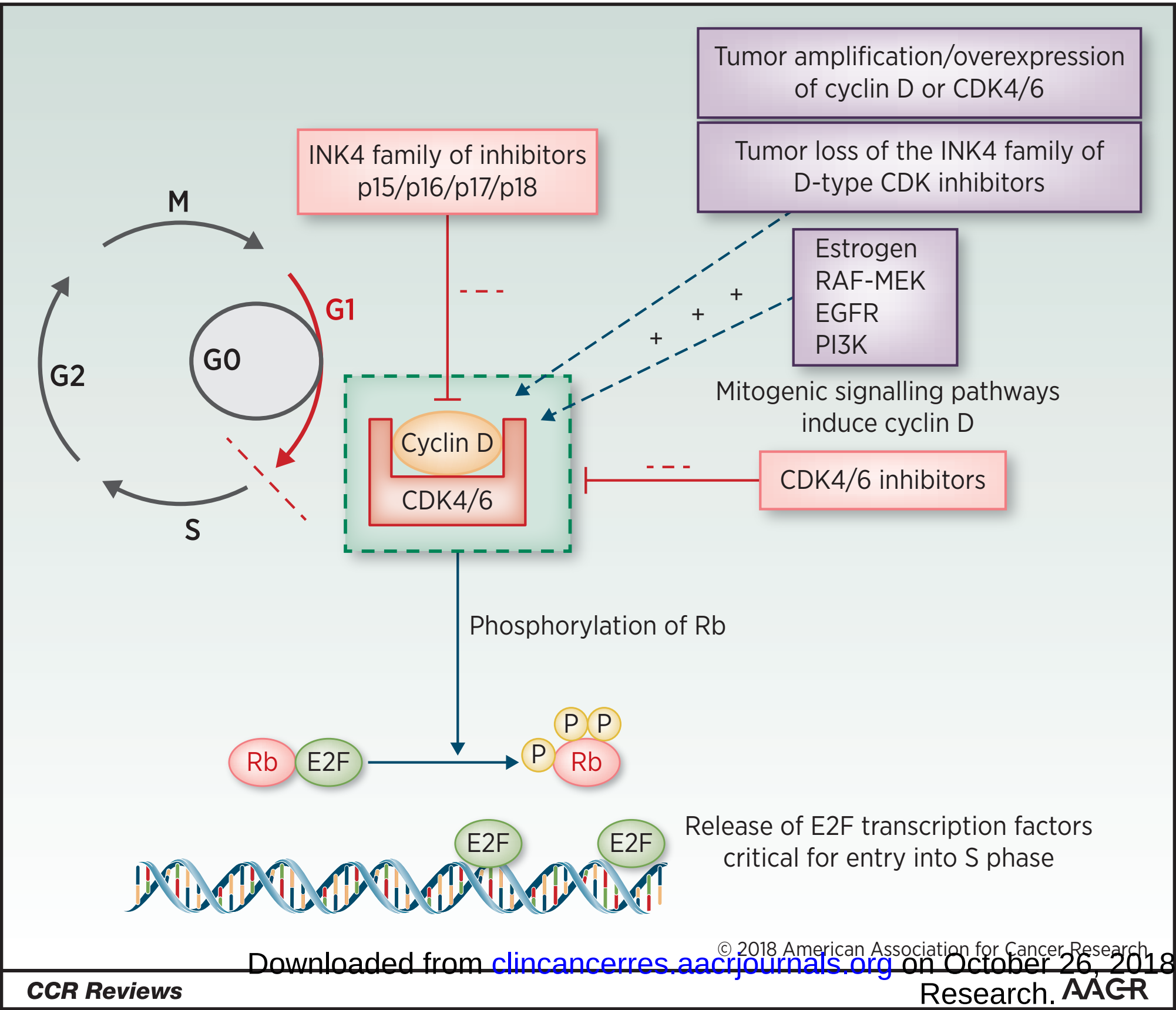
Figure 1:



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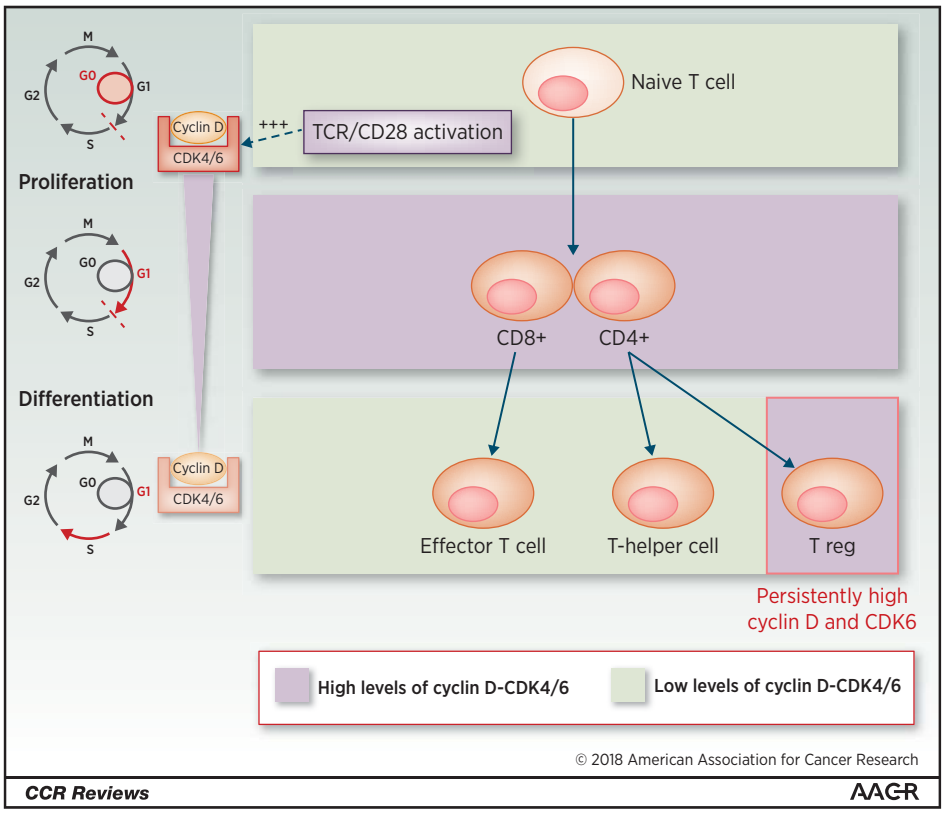

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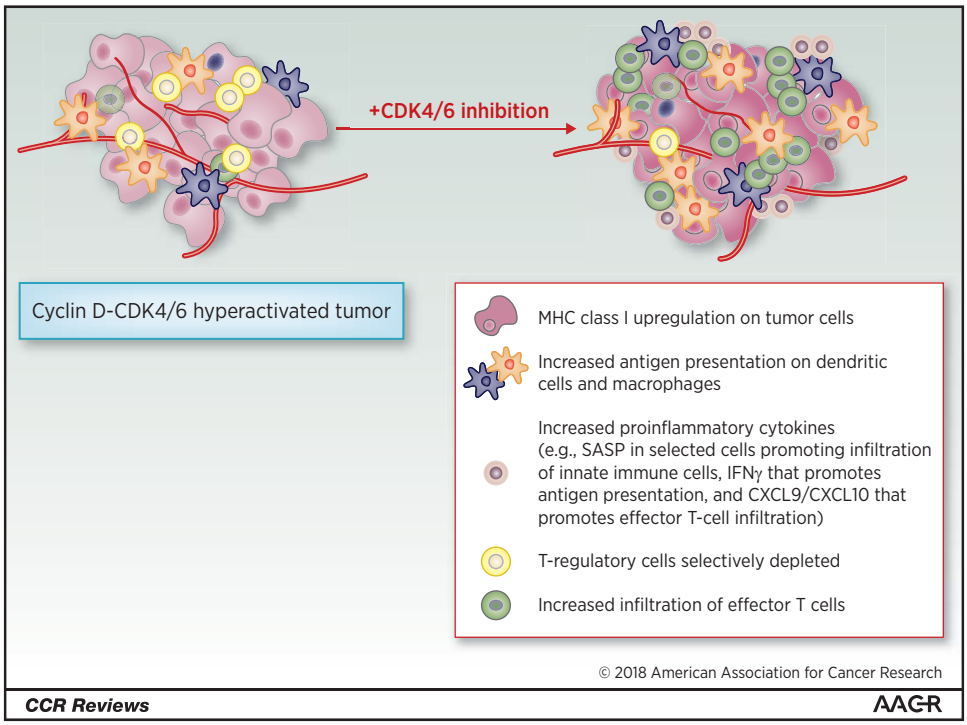

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Malaka Ameratunga, Emma Kipps, Alicia FC Okines, et al.

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