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Vaccine-Induced CD4⁺ T Cell Responses to MAGE-3 Protein in Lung Cancer Patients

Djordje Atanackovic,* Nasser K. Altorki,† Elisabeth Stockert,* Barbara Williamson,* Achim A. Jungbluth,* Erika Ritter,* Darren Santiago,* Cathy A. Ferrara,‡ Mitsutoshi Matsuo,‡ Annamalai Selvakumar,‡ Bo Dupont,‡ Yao-Tseng Chen,*§ Eric W. Hoffman,* Gerd Ritter,* Lloyd J. Old,* and Sacha Gnjatic²*

MAGE-3 is the most commonly expressed cancer testis Ag and thus represents a prime target for cancer vaccines, despite infrequent natural occurrence of MAGE-3-specific immune responses in vivo. We report in this study the successful induction of Ab, CD8⁺, and CD4⁺ T cells in nonsmall cell lung cancer patients vaccinated with MAGE-3 recombinant protein. Two cohorts were analyzed: one receiving MAGE-3 protein alone, and one receiving MAGE-3 protein with adjuvant AS02B. Of nine patients in the first cohort, three developed marginal Ab titers and another one had a CD8⁺ T cell response to HLA-A2-restricted peptide MAGE-3 271–279. In contrast, of eight patients from the second cohort vaccinated with MAGE-3 protein and adjuvant, seven developed high-titered Abs to MAGE-3, and four had a strong concomitant CD4⁺ T cell response to HLA-DP4-restricted peptide 243–258. One patient simultaneously developed CD8⁺ T cells to HLA-A1-restricted peptide 168–176. The novel monitoring methodology used in this MAGE-3 study establishes that protein vaccination induces clear CD4⁺ T cell responses that correlate with Ab production. This development provides the framework for further evaluating integrated immune responses in vaccine settings and for optimizing these responses for clinical benefit.


The MAGE-3 Ag was identified during analysis of CD8⁺ T cell reactivity against an autologous melanoma cell line and was found to be encoded by a member of a multigene family located on the X chromosome (1). MAGE-3 belongs to the growing class of cancer testis (CT) Ags that are expressed only in testicular germ cells and no other normal tissue, yet aberrantly found in a broad variety of tumors (2). A major characteristic of many CT Ags is their capacity to elicit spontaneous immune reactions in cancer patients (3, 4). However, even though ~40% of nonsmall cell lung cancers express MAGE-3 (1, 2, 5, 6), patients with naturally occurring immune responses to MAGE-3 actually appear to be very rare (7–9).

Still, several CD8⁺ T cell epitopes of MAGE-3 have been identified in vitro (10–18), including HLA-A1-restricted epitope 168–176 (1) and HLA-A2-restricted epitope 271–279 (19). Based on these findings, synthetic peptides corresponding to these epitopes have been introduced into clinical vaccination studies in which they were associated with regression of melanoma in individual cases (20). However, circulating anti-MAGE-3 CD8⁺ T cells have been very difficult to detect, even in patients with tumor regressions (21–24).

Studies have indicated that CD4⁺ Th cells in vivo have the capacity to enhance CD8⁺ T cell activity (25–27) and, most importantly, help to maintain the immune response for sustained periods of time (27–29). Therefore, it seems likely that optimal antitumor activity can only be achieved if both CD4⁺ and CD8⁺ tumor-specific T cells are induced (30, 31). The inclusion of CD4⁺ epitopes into MAGE-3 vaccination studies has recently been facilitated by the identification of several HLA-DR-restricted (32–35) and one HLA-DP4-restricted epitope (36, 37).

Clinical vaccination studies using full-length recombinant proteins have the advantage that this form of Ag potentially includes the full range of epitopes for CD4⁺ and CD8⁺ T cells. In addition, it is likely that protein vaccination leads to presentation of epitopes in the context of various HLA alleles, and therefore this type of vaccine should be applicable to any patient regardless of HLA restriction. To date, only one clinical study using MAGE-3 protein as a vaccine has been reported (38). Using a cloning approach, one patient was shown to have a CD4⁺ T cell response to HLA-DR1-restricted peptide 267–282 (39).

We have recently introduced new methodologies for monitoring CD8⁺ (3) and CD4⁺ (4, 40) T cell responses in uncloned populations at the single cell level, to explore the repertoire of naturally occurring T cells against another CT Ag, NY-ESO-1. This is particularly important in the analysis of CD4⁺ T cells, in which high background precluded the interpretation of the specificity of responses. We now applied our experience to MAGE-3 monitoring and show that vaccination with rMAGE-3 protein results in the production of anti-MAGE-3 Ab and the generation of peptide-specific CD4⁺ and CD8⁺ T cells in patients with nonsmall cell lung cancer.

Materials and Methods

Patients

Seventeen patients with MAGE-3-expressing stage I or II nonsmall cell lung cancer were analyzed in this study. All patients had undergone surgical resection of their primary lung tumor at the Department of Cardio-Thoracic Surgery, Weill Medical College of Cornell University, and had no
evidence of disease at the onset of the study. Tumor expression of the gene MAGE-3 was assessed by RT-PCR. Patients provided informed consent to participate in the experimental vaccination study and to donate blood for immunological monitoring. The study was approved by the Institutional Review Board of Weill Medical College of Cornell University and sponsored by the Ludwig Institute for Cancer Research under a Ludwig Institute IND (Investigational New Drug).

**Vaccine**

The MAGE-3 protein preparation used in this trial was a DNA recombinant fusion protein (ProteinD MAGE-3/His) expressed in *Escherichia coli* AR58 (GlaxoSmithKline, Rixensart, Belgium), as described (38). This experimental vaccine was injected alone or in combination with adjuvant AS02 (GlaxoSmithKline). Adjuvant AS02 contains monophosphoryl lipid A and QS21, a saponin extracted from the South American tree Quillaja Saponaria Molina.

**Study design**

The first nine consecutive patients received 300 µg of MAGE-3 protein alone; the remaining eight patients received MAGE-3 protein combined with AS02B adjuvant containing 100 µg of monophosphoryl lipid A and 100 µg of QS21 in oil/water emulsion in a final formulation volume of 500 µL. The vaccination schedule of this phase II study was as follows: four intradermal injections (protein alone cohort) or four i.m. injections (protein with adjuvant cohort) at 3-wk intervals (days 1, 22, 43, and 64). Blood for immunomonitoring purposes was drawn at 30 days (days 22, 43, 64, and 85).

**MAGE-3 Ab**

Serum IgG Ab against MAGE-3 protein was measured by ELISA using MAGE-3 full-length protein (GlaxoSmithKline) and rMAGE-3 truncated protein (aa 57–219) purified from *E. coli*, as described before (7). We used a protein from a different source than the vaccine agent, to avoid potential reactivity with protein D, and found consistent results when cotyping reactivity against the MAGE-3 protein used for vaccination. MAGE-3 and NY-ESO-1 recombinant proteins were used as negative controls, to rule out reactivity against bacterial contaminants (7). Positive results were defined from titration curves, as described before (7). In summary, figures to facilitate comparison of Ab responses between patients, all sample OD values at 1/400 serum dilution were normalized to positive and negative control sera using the following formula: (ODsample – ODnegative control)/(ODpositive control – ODnegative control). Positive control serum from patient A25 ranged from 100 to 300 absorbance units and negative control )/(OD positive control

**Peptides and viral vectors**

MAGE-3-DP4 peptide 243–258 (KKLLTQHFHVQENYELY) was provided by M. Herradura, Laufanger, Switzerland. MAGE-3.A1 peptide 168–176 (EVDPIGHLY) and MAGE-3.A2 peptide 271–279 (FLGWPRALV) were synthesized by Multiple Peptide Systems (San Diego, CA). In a study performed on day 10 of presensitizing culture for CD8+ T cells and on day 20 for CD4+ T cells. Flat-bottom, 96-well nitrocellulose plates (MultiScreen-96-HA; Millipore, Bedford, MA) were coated with IFN-γ mAb (2 µg/ml, 1-D1K; Mabtech, Stockholm, Sweden) and incubated overnight at 4°C. After washing with RPMI 1640, plates were blocked with 10% human AB-type serum for 2 h at 37°C. Target cells were pulsed with 300 µl of serum-free medium with 10 µM peptide for 1 h (target cells for CD8+ effectors) or overnight (target cells for CD4+ effectors). In some assays, target cells were infected overnight with 20 PFU/cell vaccinia virus recombinant either for NY-ESO-1 or for MAGE-3. Target cells were washed twice and were resuspended in RPMI 1640 medium without serum. A total of 5 × 10^4 or 1 × 10^5 presensitized CD4+ or CD8+ T effector cells and 1 × 10^5 targets cells (T2 cells, T-APC, or EBV-B cells) was added to each well and incubated for 20 h. Plates were then washed thoroughly with water containing 0.05% Tween 20, and anti-IFN-γ mAb (0.2 µg/ml, 7-B6-1-hi; Mabtech) was added to each well. After incubation for 2 h at 37°C, plates were washed and developed with streptavidin-alkaline phosphatase (1 µg/ml; Mabtech) for 1 h at room temperature. After washing, plates were incubated for 10 min with 3,5-diaminobenzidine substrate (Histofine; Fujirebio). Target cells were incubated with peptide-pulsed CD4+ T-APC at a 1:2 ratio in 200 µl of X-VIVO-15 at 37°C for 2 h. Brefeldin A (Sigma-Aldrich) at 10 µg/ml was added to each sample and cells were incubated for an additional 5-h period. Cells were then fixed using FACS Lysing Solution (BD Biosciences) diluted 1/10, permeabilized using Permeabilizing Solution 2 (BD Biosciences), and stained with Tri-color-labeled anti-CD4 mAb (Caltag Laboratories), APC-labeled anti-IFN-γ mAb, and PE-labeled anti-IL-2, anti-TNF-α, anti-IL-4, anti-IL-5,
and anti-IL-10 mAb (BD PharMingen, San Diego, CA) at room temperature for 15 min. Cells were subsequently analyzed by flow cytometry with gating on morphologically defined lymphocytes and CD4-positive and CFSE-negative cells.

**Results**

**Vaccination with MAGE-3 protein in combination with adjuvant AS02B results in the generation of anti-MAGE-3 Abs**

Of nine patients who had been vaccinated with MAGE-3 protein in the absence of adjuvant, three (WS-07, AS-08, and SG-09) developed a modest, but significant increase in Abs against MAGE-3 protein, as measured by ELISA (Fig. 1, left). In contrast, of eight patients who received MAGE-3 protein in combination with adjuvant AS02B, seven showed a marked increase in serum concentrations of anti-MAGE-3 (Fig. 2, left). Increases in Ab titer usually became significant on sample day 43, 3 wk after the patients had received the vaccine for the second time (see Fig. 3 for representative patients in titration experiments). Maximum serum levels were reached at day 85, the end of the observation period after four vaccine injections.

**Vaccination with MAGE-3 protein in combination with adjuvant AS02B evokes a strong CD4+ T cell response**

We have previously introduced activated T cells (T-APC) as targets in a modified IFN-γ ELISPOT assay (40). In this highly sensitive assay, Ag-specific CD4+ T cells can be detected on the basis of their cytokine secretion over a very low background. Using the same technique, we analyzed CD4+ T cell responses against MAGE-3 in all patients.

To examine whether these patients had in principle the capacity to develop a CD4+ T cell response, or whether T cell immunity might have been compromised by malignant disease, we first examined CD4+ T cell responses directed against a promiscuous epitope of influenza NP. All patients, with the exception of DS-03, showed good responses (mean: 399 spots/50,000 CD4+ T cells) against T-APC pulsed with NP peptide 206–229 (data not shown).

We then examined CD4+ T cell responses against peptide MAGE-3.DP4 in all 17 patients. This epitope was chosen for the frequent distribution of its restriction allele HLA-DP4 and its proven immunogenicity (37). We observed that only one of the patients who had received MAGE-3 protein without adjuvant AS02B showed a CD4+ T cell response against MAGE-3.DP4 in ELISPOT assays (Fig. 1, middle). It seemed that in this patient (ST-04) expressing the HLA-DP4 haplotype (Table I), a pre-existing immunity against MAGE-3 was present, because his CD4+ T cells secreted IFN-γ in response to MAGE-3.DP4-pulsed T-APC even before he had received the first vaccination. Also, the same patient had low-titered pre-existing Ab titers against MAGE-3 protein. However, repeated immunizations with MAGE-3 protein in the absence of AS02B adjuvant did not have a boosting effect on the level of MAGE-3.DP4-specific T cell immunity or the level of anti-MAGE-3 Abs in this specific patient.

All eight patients who had received MAGE-3 protein in combination with adjuvant AS02B were found to have the HLA-DP4 allele (Table I). Of these patients, four (WG-13, ER-14, GT-15, and GO-17) showed a marked increase in CD4+ T cell responses against MAGE-3.DP4 (Fig. 2, middle). All responding patients had

![FIGURE 1. Monitoring of Ab and CD4+ T cell responses in patients vaccinated with MAGE-3 protein without adjuvant. Left, Ab responses to MAGE-3 by ELISA at different vaccination time points. To facilitate comparison between patients, all sample OD values at 1/400 serum dilution were normalized according to positive and negative controls. Middle, CD4+ T cell responses as measured by IFN-γ ELISPOT. Presensitized CD4+ T cells (50,000) were tested against T-APC pulsed with MAGE-3.DP4 (●) or irrelevant peptide (■). Right, CD4+ T cell responses as measured by staining of intracellular cytokines (CYTOSPOT). Percentage of presensitized CD4+ T cells specifically producing TNF-α (■), IFN-γ (▲), IL-2 (●), IL-10 (□), IL-4 (▲), or IL-5 (○) against MAGE-3.DP4.](http://www.jimmunol.org/DownloadedFrom)
a concomitant humoral response against MAGE-3. CD4⁺ T cells specific for the tumor Ag appeared between days 43 and 64 and were always clearly detectable until day 85, the last sampling date. A presensitization with the irrelevant peptide NY-ESO-1 80–109 as a specificity control did not lead to the generation of effector cells specific for this epitope in any of the patients (data not shown). Numbers of IFN-γ-producing spots after presensitization with positive control peptide NP 206–229 were comparable to number of spots for MAGE-3.DP4 in responding patients (mean = 866 spots for NP/50,000 CD4⁺ T cells for patient WG-13; 921 spots for ER-14; 71 spots for GT-15; 733 spots for GO-17).

CD4⁺ T cells induced by vaccination with MAGE-3 protein in combination with adjuvant AS02B produce Th1-, but no Th2-type cytokines

We next performed a more detailed analysis of the pattern of cytokines produced by patients’ CD4⁺ T cells in response to MAGE-3.DP4. We had previously determined that our in vitro culture conditions were likely to reflect the pre-existing cytokine profile of effectors (40). Using T-APC as targets, we performed a flow cytometry analysis of a variety of intracellular Th1-type (IFN-γ, IL-2, TNF-α) or Th2-type (IL-4, IL-5, IL-10) cytokines in all but two patients (Figs. 1 and 2, right).

Table I. HLA type of all patients included into the MAGE-3 protein vaccination study

<table>
<thead>
<tr>
<th>Patient</th>
<th>MHC Class I HLA-A</th>
<th>MHC Class II HLA-DP4 status</th>
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</tr>
<tr>
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<td>+</td>
</tr>
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</tr>
<tr>
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<td>0301</td>
<td>2402</td>
</tr>
<tr>
<td>DG-06</td>
<td>0201</td>
<td>3001</td>
</tr>
<tr>
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<td>0201</td>
<td>3001</td>
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<td>3101</td>
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</tr>
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<td>0304</td>
</tr>
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<td>GO-17</td>
<td>0201</td>
<td>6801</td>
</tr>
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</table>

* Shown are the HLA-A alleles and the status of HLA-DP4 expression by the given patient. Bold characters highlight patients with HLA-A1 or HLA-A2 expression.
We found that results in the ELISPOT assay were closely paralleled by those observed after staining of intracellular cytokines. Of the eight patients who received MAGE-3 protein in combination with adjuvant, the same four patients that had clear CD4+ responses in the ELISPOT assays also showed MAGE-3.DP4 peptide-induced increase in intracellular cytokines (Fig. 2).

The cytokines that were produced in response to MAGE-3.DP4 Ag were almost exclusively of Th1 type. None of the patients showed significant increases in the intracellular concentrations of IL-4, IL-5, or IL-10 in response to MAGE-3. In contrast, we observed marked increases in the intracellular concentration of IFN-γ and IL-2 following exposure to T-APC pulsed with the MAGE-3.DP4 peptide. TNF-α, however, seemed to be by far the most sensitive parameter for the detection of MAGE-3-specific CD4+ T cells, as shown in a representative patient (Fig. 4).


We looked for the presence of MAGE-3.A1- or MAGE-3.A2-specific T cells in patients that had been vaccinated with MAGE-3 protein by performing tetramer analyses (Table II) and ELISPOT assays (Table III).

Of nine HLA-A2+ patients analyzed, one (DG-06) showed a significant increase in tetramer-positive MAGE-3.A2-specific CD8+ T cells on day 85. These T cells were negative for CD62L and CCR7, and therefore expressed an effector phenotype (Fig. 5A). When an ELISPOT assay was performed using these effector cells, they recognized T2 cells or T-APC pulsed with the HLA-A2-restricted epitope of MAGE-3 (Fig. 5B).

Of five HLA-A1+ patients analyzed, one (GT-15) showed a marked increase in tetramer-positive MAGE-3.A1-specific CD8+ T cells from day 43 onward. These T cells expressed intermediate levels of CD62L and were negative for CCR7 (Fig. 6A). However, an IFN-γ ELISPOT assay performed using this effector cell line revealed that these CD8+ T cells did not recognize EBV-B cells, whether they were pulsed with MAGE-3.A1 peptide or infected with vaccinia virus recombinant for MAGE-3. Furthermore, the same CD8+ T cells did not recognize a MAGE-3-expressing HLA-A1+ melanoma cell line even after this tumor cell line had been pulsed with MAGE-3.A1 peptide (Fig. 6B).

**Discussion**

Successful vaccination of animals with tumor Ags has been shown to be largely dependent on CD8+ T cells, and adoptive transfer of purified CD8+ T cell fractions can mediate tumor regression in mice (42). However, it has recently become clear that CD4+ T cells play an important role in the antitumor response following vaccination (43, 44). Although CD4+ T cells seem to also possess the potential for an immediate effector function against tumor targets, in vitro (45–47) and in vivo (48), their main role is still widely believed to be that of a helper cell. Thus, activated CD4+ T cells help to initiate, amplify, and maintain CD8+ T cell responses. They do so by providing important costimulation via a variety of surface molecules (49), by secretion of a network of cytokines (50), and by activating professional APC (51–56). In addition, studies have suggested that CD4+ T cells have the capability to recruit eosinophils as well as macrophages into the tumor tissue. These cells, activated by neighboring tumor-specific CD4+ T cells, might then contribute to an effective antitumor function by producing factors such as superoxide and NO (57).

We have used a rMAGE-3 protein as a vaccine in patients with nonsmall cell lung cancer. This approach, in addition to the generation of MAGE-3-specific CD8+ T cells, theoretically allows the introduction of specific CD4+ T cell help into the T cell-mediated antitumor reaction. We show in this study that vaccination with a peptide of a CT Ag indeed provides a strong peptide-specific CD4+ T cell response. The occurrence of CD4+ T cell responses correlated with Ab responses. Importantly, we monitored this protein-based vaccination study using peptides as Ag in our assays. This excludes the possibility of T cell responses against contaminants in the protein batch that have been observed in assays using MAGE-3 protein as stimulating Ag and in the readout assay (32).

The MAGE-3 protein-induced CD4+ T cell responses were of the Th1 type, suggesting a supporting role of these Th cells for anti-MAGE-3 CD8+ T cell responses in vivo. In addition, it has previously been shown that MAGE-3.DP4-specific CD4+ T cells are in principle capable of lysing HLA-DR4+ tumor cells expressing MAGE-3.DP4.

**Table II. CD8+ responses against MAGE-3 as indicated by tetramer analysis**

<table>
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<th>Day 64</th>
<th>Day 85</th>
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*All five HLA-A1+ patients and eight HLA-A2+ patients were analyzed. CD8+ T cells were expanded by a single peptide-driven stimulation with peptide MAGE-3.A1 (168–176) or MAGE-3.A2 (271–279), respectively. Effector cells were tested on day 10 against using the given tetramer. Numbers given indicate the percentage of tetramer-positive CD8+ T cells. Bold numbers represent significant positive responses.*
Table III. \( CD^8^+ \) responses against MAGE-3, as indicated by ELISPOT analysis

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<td>3 (0)</td>
<td>0 (4)</td>
<td>2 (0)</td>
<td>1 (8)</td>
</tr>
<tr>
<td></td>
<td>GO-17 4 (16)</td>
<td>4 (5)</td>
<td>8 (54)</td>
<td>8 (3)</td>
<td>16 (14)</td>
</tr>
</tbody>
</table>

\( ^a \) All five HLA-A*01 native patients and nine HLA-A*201 native patients were analyzed. CD8\(^+\) T cells were expanded by a single peptide-driven stimulation with peptide MAGE-3-A1 (168–176) or MAGE-3-A2 (271–279), respectively. Effector cells were tested on day 10 against the HLA-A\(^*\) EBV-transformed B cell line from healthy donor NC 32 or T2 cells, respectively. Targets were pulsed with the relevant MAGE-3 peptide. Numbers given indicate specific IFN-\( \gamma \) spots per 50,000 CD8\(^+\) effector T cells. Numbers in brackets indicate background reactivity against unpulsed targets (for HLA-A\(^*\)01 native patients). Bold numbers represent significant positive responses.

MAGE-3 (36), indicating that this epitope, in contrast to other class II MAGE-3 epitopes (32), may be presented on the surface of tumor cells.

In addition to the strong CD4\(^+\) T cell responses in 50% of patients receiving MAGE-3 protein plus adjuvant, we also observed peptide-specific CD8\(^+\) T cell responses in two patients. Previous in vitro studies have indicated that the HLA-A1-restricted MAGE-3 peptide 168–176 is naturally processed by professional (58) and nonprofessional APC (1, 59), and the same peptide has been eluted from cancer cell lines (60). In this study, we show that the MAGE-3.A1 peptide is naturally processed in vivo and that this leads to a strong increase in peripheral numbers of CD8\(^+\) T cells specific for this epitope, in coordination with MAGE-3 CD4\(^+\) T cells and Ab responses. The vaccine-induced MAGE-3.A1-specific CD8\(^+\) T cells could easily be expanded using a single cycle of peptide-driven stimulation. De novo CD8\(^+\) T cells were not generated during this in vitro expansion phase because reactivity to MAGE-3.A1 was not detected before the second vaccination.

Rather, CD8\(^+\) T cells appeared as a result of vaccination, concomitantly to Ab and CD4\(^+\) T cell responses in an individual patient. Following this 10-day culture period, the MAGE-3.A1 tetramer-positive cells expressed an effector cell phenotype. However, these CD8\(^+\) T cells did not produce IFN-\( \gamma \) in response to target cells pulsed with MAGE-3.A1 peptide or MAGE-3-expressing HLA-A1 tumor cells. We did not examine whether the MAGE-3.A1-specific T cells produced other cytokines (i.e., T cytotoxic type 2 cytokines) in response to their respective epitope, and it remains to be further examined whether these cells have to be considered partially nonresponsive. MAGE-3.A1-specific CD8\(^+\) T cells have previously been shown to kill MAGE-3-expressing tumor cells (1, 59), and future vaccination studies will

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A Tetramers

B ELISPOT

CD8\(^+\) T cells from GT-15 d64 presensitized with MAGE-3.A1 peptide

FIGURE 6. MAGE-3 protein vaccination-induced generation of non-IFN-secreting MAGE-3.A1-specific CD8\(^+\) T cells. PBL of patient GT-15 were obtained on day 64 after study onset, and MAGE-3.A1-specific CD8\(^+\) T cells were expanded in a single cycle of peptide-driven stimulation. Tetramer analysis (A) was performed on day 10 postculture initiation. The CD8\(^+\) T cells were costained for CD62L and CCR7. An ELISPOT assay (B) was performed on the same day using the tetramer-positive CD8\(^+\) T cell line. Effector cells were tested against autologous EBV-transformed B cells unpulsed or pulsed with MAGE-3.A1 peptide. The same tetramer-positive line was also tested against autologous EBV-B cells infected with vaccinia virus recombinant for full-length MAGE-3 or recombinant for NY-ESO-1 as irrelevant Ag. Finally, reactivity of the MAGE-3.A1-specific CD8\(^+\) T cell line was tested against the peptide-pulsed or unpulsed HLA-A1\(^*\), MAGE-3-expressing melanoma cell line SK-MEL-128.
show whether stronger adjuvants delivered with MAGE-3 protein or more prolonged immunization might lead to in vivo generation of fully functional T cytotoxic type I MAGE-3.A1-specific CTL.

In vitro studies have indicated that the HLA-A2-restricted MAGE-3 epitope 271–279 is not naturally processed by nonprofessional APC, including most tumor cells (61). This seems to be caused by cleavage of the MAGE-3 protein at position 278 during its processing by the proteasome (62, 63). In contrast, it has been shown that professional APC using the immunoproteasome are capable of generating antigenic MAGE-3 peptides that are not produced by a standard proteasome (18), possibly including MAGE-3.A2. Accordingly, it has been shown that the processing of MAGE-3-expressing tumor cells by dendritic cells may result in the generation of CD8+ T cells specific for peptide MAGE-3 271–279 (64–66).

We observed that the MAGE-3.A2 epitope seems to be naturally processed in vivo because the vaccination with rMAGE-3 protein resulted in the appearance of MAGE-3.A2-specific CD8+ T cells in the peripheral blood of one patient. These CD8+ T cells could easily be expanded using a single peptide-driven stimulation and were only detected after vaccination. Although MAGE-3.A2-specific CD8+ T cells were seen in the absence of CD4+ T cell or Ab response to MAGE-3, they were fully functional in the sense that they secreted IFN-γ in response to target pulsed with their respective peptide. Therefore, we suggest that in vivo MAGE-3 protein might have been taken up and processed in patients by professional APC, resulting in the generation of CD8+ T cells specific for MAGE-3.A2 peptide 271–279. It remains questionable, however, whether these T cells will have clinical efficacy against nonprofessional APC, such as autologous tumor cells, even if these cells express the MAGE-3 gene.

In conclusion, we show in this study that vaccination with the recombinant protein of a CT Ag provides strong Ag-specific CD4+ T cell help along with Ab and CD8+ T cell responses, and leads to integrated immunity comparable to what is observed in patients with spontaneous responses to NY-ESO-1 (4). It is likely that responses against a range of CD4+ and CD8+ epitopes other than the ones we examined in this study were generated, and application of general methodologies (40, 41) will allow the identification of this repertoire.

The current study design included patients with no evidence of disease at the onset of the trial, precluding assessment of clinical efficacy at this early stage. The data presented in this work lay the grounds for the design of vaccine constructs and immunization protocols to define conditions for maximal immunogenicity and answer the most important question in tumor immunology: can immunization affect the course of human cancer?

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