Advances in immunotherapy for cervical cancer: recent developments and future directions

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ABSTRACT
There is an unmet need for novel therapies to improve clinical outcomes for patients with locally advanced, recurrent, or metastatic cervical cancer. Most cases of cervical cancer are driven by infection with human papillomavirus (HPV), which uses multiple mechanisms to avoid immune surveillance. Several classes of agents have been developed that seek to activate the immune system in order to overcome this resistance and improve treatment outcomes. These include immune checkpoint inhibitors, therapeutic vaccines, engineered T cells, and antibody-drug conjugates. Here, we review the immune landscape of cervical cancer and the growing clinical data regarding the use of immunotherapy. Checkpoint inhibitors are the best studied treatments, with encouraging phase II studies available in the definitive setting and recently published phase III data defining a new standard of care for patients with recurrent or metastatic disease. Vaccines and engineered T cells are generally in earlier phases of development but use unique mechanisms of immune activation. It is possible that combination of immunotherapy, with either conventional systemic therapy or multiple immunomodulatory agents, may provide further benefit. We also discuss possible synergies between immunotherapy and radiation therapy, which is frequently used in the management of cervical cancer. Ultimately, immunotherapy represents an emerging treatment option for patients with cervical cancer. It is an appropriate component of first-line treatment in the recurrent or metastatic setting and may soon be incorporated into definitive management of locally advanced disease.

INTRODUCTION
Cervical cancer is the most common gynecologic malignancy, with over 500,000 estimated cases annually worldwide, resulting in 311,000 deaths. The burden is highest in developing countries with limited access to appropriate screening and treatment resources. However, even with optimal treatment, there are significant opportunities to improve outcomes. Patients with locally advanced disease are typically treated with a combination of chemoradiation and brachytherapy, both of which have been demonstrated to improve survival compared with external beam radiation treatment alone. However, long-term survival rates remain approximately 50% for those with FIGO stage IIIA–C disease and are even worse for patients with para-aortic lymph node involvement (stage IIIC2). For those with recurrent or metastatic disease, treatment with combination chemotherapy and bevacizumab results in a median overall survival of 17 months.

The pathogenesis of cervical cancer is typically driven by infection with high-risk strains of human papillomavirus (HPV). The role of the immune system in clearing HPV infection and increased incidence of cervical cancer in patients with HIV provide a strong rationale for the use of immunomodulatory therapies in cervical cancer. The recent success of immunotherapy across many cancer types, including in other HPV-driven malignancies, also offers hope. Here, we review the mechanisms underlying the immunogenicity of cervical cancer, the available clinical data regarding immunotherapy use, and postulated synergies with existing treatment strategies.

IMMUNOMODULATION OF CERVICAL CANCER
Infection with oncogenic strains of HPV results in the production of E6 and E7 proteins, which inhibit critical tumor suppressor genes p53 and Rb, respectively. In addition to oncogenesis, these proteins may also contribute to the ability of infected cells to escape detection and elimination by the immune system. For example, E7 is known to be ‘tolerogenic’—it will be taken up by local dendritic cells and presented to the immune system in a manner similar to a non-inflamatory self-antigen, resulting in tolerance rather than an adaptive immune response. Pre-cancerous and malignant cells may also affect cytokine balance in the tumor microenvironment, resulting in immune suppression. Finally, the majority of cervical cancers express the programmed cell death ligand 1 (PD-L1), which helps to downregulate the host immune response as seen in Figure 1.

These mechanisms play an important role in the development of cervical cancer, but probably also influence the response to treatment. Analysis of the tumor microenvironment from patients who responded well (n=11) or poorly (n=10) to standard therapy demonstrated that adequate responders had higher pre-treatment levels of CD8+ tumor-infiltrating lymphocytes and higher expression of PD-L1.
and programmed cell death protein (PD-1) increased following chemoradiation and was sustained or further increased during the subsequent ipilimumab therapy.

In addition to sequential treatment, there is interest in using immunotherapy concurrently with standard chemoradiation to take advantage of potential synergies between radiation and immune therapy as discussed below. However, this approach may carry a higher risk of toxicity, such as colitis. These risks were evaluated in a phase II randomized trial from the University of Virginia, where patients were randomized to receive the PD-1 inhibitor pembrolizumab either sequentially after chemoradiation or concurrently. Pembrolizumab was given at 200 mg every 3 weeks for three cycles. Eligible patients had biopsy-proven FIGO 2009 stage IB–IVA disease with positive pelvic and/or para-aortic lymph nodes. Initial acute toxicity data have been published from 52 patients (24 treated sequentially, 28 concurrently). The overall rate of grade 2+ toxicity was 88%, grade 3+ 44%, and grade 4 21%. There was no grade 5 toxicity. No significant differences were found in side effect rates or profiles between the concurrent and sequential immunotherapy arms. The most common toxicities in both arms were nausea/vomiting and cytopenias. The authors were particularly concerned about diarrhea as this can be a common side effect of both pelvic radiation treatment and pembrolizumab; however, only two cases of grade 3 diarrhea were noted, one in each arm of the trial. These data suggest that concurrent immunotherapy with chemoradiation is well tolerated without excessive synergistic toxicity. Oncologic outcomes from the trial are not yet available.

These results have led to the activation of larger trials, which are currently accruing. These include two large multicenter phase III randomized trials, the CALLA study (NCT03830866) and GOG-3047 (NCT04221945). Complete study titles, primary endpoints, and planned enrollment for these and other studies investigating immunotherapy in the definitive management of cervical cancer are shown in Table 1. These two placebo-controlled studies test concurrent and adjuvant durvalumab and pembrolizumab, respectively, in addition to standard chemoradiation. Inclusion criteria for both trials are similar, with patients eligible if they have FIGO 2014 stage IB–IIA disease with more lymph nodes or FIGO 2014 stage III–IVA disease regardless of lymph node status.

Other ongoing studies include a randomized French phase II trial studying chemoradiation ± the PD-L1 inhibitor atezolizumab for locally advanced disease (NCT03612791). Lastly, NRG-GY017 (NCT03738228) uses concurrent atezolizumab and chemoradiation in both arms, with a randomization to with or without a ‘priming’ dose of immunotherapy 3 weeks before the start of chemoradiation-immunotherapy. The results of these and the other pending studies in Table 5 will help to refine the role of immunotherapy in the definitive management of cervical cancer. If checkpoint inhibitors are successful at improving long-term clinical outcomes, they will probably represent a new standard of care for patients with locally advanced disease.

**CLINICAL TRIALS: METASTATIC DISEASE**

Immune checkpoint inhibitors targeting both the PD-L1 and CTLA-4 axes have also been studied in the setting of recurrent or metastatic cervical cancer. A phase I/II dose escalation study of ipilimumab
monotherapy for patients with recurrent or metastatic disease whose disease had progressed on platinum chemotherapy found that treatment was well tolerated with mild toxicity. 

Ipilimumab was delivered at 10 mg/kg every 3 weeks for four cycles, followed by four cycles of maintenance therapy every 12 weeks. Unfortunately, clinical responses were disappointing, with only 1 out of 34 evaluable patients displaying a partial response while the remainder had stable or progressive disease. Median progression-free survival was 2.5 months. These data suggest that anti-PD-1/PD-L1 antibodies such as nivolumab, pembrolizumab, and cemiplimab, which all target the PD-1 receptor on immune cells, could potentially be useful as part of a combined regimen.

More encouraging data in the metastatic setting is available for pembrolizumab, nivolumab, and cemiplimab, which all target the PD-1 receptor on immune cells. In the phase II KEYNOTE-158 study, pembrolizumab 200 mg every 3 weeks was given for up to 2 years to 98 heavily pre-treated patients, most of whom had PD-L1 positive tumors. 

While the objective response rate was only 12%, responses were durable, with 75% lasting for more than 9 months. All responders had PD-L1 positive tumors. In the phase I/II Checkmate-358 study, patients were treated with nivolumab 240 mg every 2 weeks and an even higher overall response rate of 26% was found among 19 patients with cervical cancer. 

The median duration of response was not reached at 19 months of follow-up. Unfortunately, these findings were not replicated in the multicenter NRG-GY002 study of nivolumab monotherapy, where the response rate was only 4%. The reason for the discrepancy is unclear, although the authors note that response rate as defined by Response Evaluation Criteria In Solid Tumors (RECIST) may not be ideal in the setting of immunotherapy.

Building on these studies, the first phase III data for checkpoint immunotherapy in patients with recurrent or metastatic disease is beginning to emerge. In the second-line setting, the recently presented EMPOWER-Cervical 1 trial enrolled patients whose disease had progressed on a platinum-based regimen and randomized them to cemiplimab versus investigator's choice chemotherapy.

The trial was discontinued early after an interim analysis demonstrated that cemiplimab met the primary endpoint of the study and improved overall survival (median 12 months vs 8.5 months with chemotherapy, p<0.001). The KEYNOTE-826 trial studied the addition of pembrolizumab 200 mg q3 weeks to chemotherapy (±bevacizumab) as first-line therapy for 617 patients with recurrent or metastatic disease. The addition of pembrolizumab significantly improved the 2-year overall survival in the intention-to-treat population from 40.4% to 50.4%. Improved outcomes were seen among nearly all subgroups except perhaps those with PD-L1 combined positive scores of <1, although this was a small subset of patients. Similar to the studies discussed above for localized disease, there was no evidence of excess synergistic toxicity between checkpoint blockade and other systemic agents. These compelling results suggest that upfront treatment with chemoinmunotherapy is an appropriate standard of care for patients with recurrent or metastatic disease.

Other studies have also attempted to combine immunotherapy with traditional systemic agents, particularly angiogenesis inhibitors such as bevacizumab, which was shown to be effective in the GOG-240 trial. A small study of 10 patients testing the combination of atezolizumab 1200 mg every 3 weeks and bevacizumab failed to show any responses. However, a larger recent Chinese phase
Il study tested the combination of camrelizumab (an anti-PD-1 antibody) and apatinib (a tyrosine kinase inhibitor of the vascular endothelial growth factor-2 receptor). Thirty-five patients were enrolled, including 10 who had previously received bevacizumab. Camrelizumab was given at a dose of 200 mg every 2 weeks and apatinib 250 mg orally once per day. The overall response rate was 36%, including two complete responses and 17 partial responses. However, the toxicity of combined therapy was significant as more than two-thirds of patients experienced grade 3+ toxicity. The most common side effects included high blood pressure, anemia, and fatigue. Similar to KEYNOTE-158, median progression-free survival was significantly higher in patients with PD-L1 positive tumors.

Another possible avenue for combination therapy involves using two separate checkpoint inhibitors. Data presented in abstract form at European Society of Medical Oncology (ESMO) 2020 found that the combination of balstilimab (anti-PD-1) and zalifrelimab (anti-CTLA-4) for patients with recurrent or metastatic disease resulted in an overall response rate of 22%, better than the 14% with single-agent balstilimab. Responses were again more likely in PD-L1 positive patients but were also seen in approximately 10% of PD-L1 negative patients.

In summary, there is an increasing role for immunotherapy in the treatment of metastatic cervical cancer, particularly for patients with PD-L1 positive tumors. Response rates with immune monotherapy as second-line therapy are low but show promising durability. In the upfront setting, recently published randomized phase III data support the addition of pembrolizumab to chemotherapy as first-line treatment. Further research will continue to define appropriate patient selection and determine if combination immunotherapy may further improve outcomes. Ongoing trials using checkpoint blockade immunotherapy in the metastatic setting are summarized in Table 2.

### BEYOND CHECKPOINT BLOCKADE: EMERGING IMMUNOTHERAPEUTIC APPROACHES

Checkpoint inhibitors are the best studied class of immunotherapy for cervical cancer, but numerous other strategies to activate the immune system have been proposed. Some of the most promising solutions include immunologic vaccines, infusion of tumor infiltrating lymphocytes, infusion of genetically engineered T cells targeting HPV-associated proteins, and antibody-drug conjugates. Ongoing trials using these approaches are summarized in Table 3.

One of the leading vaccine strategies for treatment of cervical cancer uses a bacterial vector (attenuated *Listeria monocytogenes*), which infects host antigen-presenting cells and secretes a fusion HPV E7 protein. Known as AXAL, the virus thus stimulates a CD4- and CD8-mediated adaptive immune response targeting HPV-infected cells. Initial phase I data showed that the vaccine was well tolerated, although all patients were noted to have a flu-like syndrome, which ultimately did not require prescription treatment.

Two phase II trials have since been completed. The GOG phase II study enrolled 50 patients with metastatic disease whose disease had progressed on at least one prior systemic therapy and administered three doses of the vaccine. The 12-month overall survival was 38%, which represented an improvement compared with historical controls. In India, 110 patients with recurrent disease were randomized to three to four doses of AXAL with or without weekly cisplatin 40 mg/m². More than a third of patients had stable disease or responses (including five complete responses) and 2-year overall survival was 56%, including two complete responses and 23 partial responses.

**Table 2** Selected ongoing studies using checkpoint blockade immunotherapy in treatment of recurrent or metastatic cervical cancer

<table>
<thead>
<tr>
<th>NCT identifier</th>
<th>Title</th>
<th>Phase</th>
<th>Planned enrollment</th>
<th>Primary endpoint(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT03257267</td>
<td>Study of Cemiplimab in Adults With Cervical Cancer</td>
<td>III</td>
<td>590</td>
<td>Overall survival</td>
</tr>
<tr>
<td>NCT03912415</td>
<td>Efficacy and Safety of BCD-100 (Anti-PD-1) in Combination With Platinum-Based Chemotherapy With and Without Bevacizumab as First-Line Treatment of Subjects With Advanced Cervical Cancer (FERMATA)</td>
<td>III</td>
<td>316</td>
<td>Overall survival</td>
</tr>
<tr>
<td>NCT03556839</td>
<td>Platinum Chemotherapy Plus Paclitaxel With Bevacizumab and Atezolizumab in Metastatic Carcinoma of the Cervix (BEATcc)</td>
<td>III</td>
<td>404</td>
<td>Overall survival</td>
</tr>
<tr>
<td>NCT03192059</td>
<td>Study of Pembrolizumab, Radiation and Immune Modulatory Cocktail in Cervical/Uterine Cancer (PRIMMO)</td>
<td>II</td>
<td>43</td>
<td>Objective response rate</td>
</tr>
<tr>
<td>NCT03614949</td>
<td>SBRT and Atezolizumab in the Management of Recurrent, Persistent, or Metastatic Cervical Cancer</td>
<td>II</td>
<td>26</td>
<td>Overall response rate</td>
</tr>
<tr>
<td>NCT01693783</td>
<td>Ipiilimumab in Treating Patients With Metastatic or Recurrent Human Papilloma Virus-Related Cervical Cancer</td>
<td>II</td>
<td>44</td>
<td>Adverse events, objective response rate</td>
</tr>
<tr>
<td>NCT03277482</td>
<td>Durvalumab, Tremelimumab+Radiotherapy in Gynecologic Cancer</td>
<td>I</td>
<td>32</td>
<td>Maximum tolerated dose</td>
</tr>
<tr>
<td>NCT03452332</td>
<td>Stereotactic Body Radiation Therapy, Tremelimumab and Durvalumab in Treating Participants With Recurrent or Metastatic Cervical, Vaginal, or Vulvar Cancers</td>
<td>I</td>
<td>20</td>
<td>Adverse events</td>
</tr>
</tbody>
</table>
Table 3  Selected ongoing studies using vaccines, antibody-drug conjugates, or engineered T-cell therapies in the treatment of cervical cancer

<table>
<thead>
<tr>
<th>NCT identifier</th>
<th>Title</th>
<th>Phase</th>
<th>Planned enrollment</th>
<th>Primary endpoint(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT04697628</td>
<td>Tisotumab Vedotin vs Chemotherapy in Recurrent or Metastatic Cervical Cancer (innovaTV 301)</td>
<td>III</td>
<td>482</td>
<td>Overall survival</td>
</tr>
<tr>
<td>NCT04646005</td>
<td>Cemiplimab and ISA101b Vaccine in Adult Participants With Recurrent/Metastatic Human Papillomavirus (HPV)16 Cervical Cancer Who Have Experienced Disease Progression After First-Line Chemotherapy</td>
<td>II</td>
<td>103</td>
<td>Objective response rate</td>
</tr>
<tr>
<td>NCT04580771</td>
<td>A Vaccine (PDS0101) and Chemoradiation for the Treatment of Stage IB3–IV A Cervical Cancer, the IMMUNOCERV Trial</td>
<td>II</td>
<td>35</td>
<td>Grade 3+ acute toxicity</td>
</tr>
<tr>
<td>NCT04405349</td>
<td>Investigating the Combination of VB10.16 and Atezolizumab in Patients With HPV 16-positive Cervical Cancer</td>
<td>II</td>
<td>50</td>
<td>Adverse events, overall response rate</td>
</tr>
<tr>
<td>NCT03444376</td>
<td>The Combination of GX-188E Vaccination and Pembrolizumab in Patients With HPV 16 and/or 18+ Advanced Cervical Cancer</td>
<td>I/II</td>
<td>60</td>
<td>Overall response rate</td>
</tr>
<tr>
<td>NCT02858310</td>
<td>E7 TCR T Cells for Human Papillomavirus-Associated Cancers</td>
<td>I/II</td>
<td>180</td>
<td>Overall response rate</td>
</tr>
<tr>
<td>NCT03260023</td>
<td>Phase Ib/II of TG4001 and Avelumab in HPV16 Positive R/M Cancers</td>
<td>I/II</td>
<td>150</td>
<td>Overall response rate and progression-free survival</td>
</tr>
<tr>
<td>NCT02379520</td>
<td>HPV-16/18 E6/E7-Specific T Lymphocytes, Relapsed HPV-Associated Cancers, HESTIA (HESTIA)</td>
<td>I</td>
<td>32</td>
<td>Dose-limiting toxicity</td>
</tr>
<tr>
<td>NCT02172911</td>
<td>A Study of INO-3112 DNA Vaccine With Electroporation in Participants With Cervical Cancer</td>
<td>I</td>
<td>10</td>
<td>Adverse effects</td>
</tr>
<tr>
<td>NCT03578406</td>
<td>HPV-E6-Specific Anti-PD1 TCR-T Cells in the Treatment of HPV-Positive NHSCC or Cervical Cancer</td>
<td>I</td>
<td>20</td>
<td>Maximum tolerated dose</td>
</tr>
</tbody>
</table>

Survival was 18% across both treatment arms. The addition of cisplatin did not appear to improve outcomes compared with AXAL alone. Based on these encouraging data, a larger phase III trial was initiated in the definitive setting (NCT02853604). Unfortunately, the trial was closed prematurely in 2019, and no results have been presented or published to date.

Another novel immunotherapeutic approach uses a patient’s own tumor-reactive T cells. These are cultured from samples of a metastatic tumor or draining lymph node and tested for activity against E6 and E7 proteins. Cultures that show high T-cell content and purity with good reactivity are further propagated and then administered to the patient in a single-dose IV infusion after preparatory lymphocyte depleting chemotherapy. Initial data from nine patients with metastatic disease showed three responses, including two complete responses. The cohort was expanded to 18 patients and longer-term follow-up data were recently published. The two patients with a complete response remained free of disease at 53 and 67 months after treatment. Factors predictive of treatment response included the HPV reactivity of the cultured T cells prior to infusion as well as the number of HPV reactive T cells in the peripheral blood post-infusion, as quantified by flow cytometry.

Genetically engineered T-cell therapy has resulted in several breakthroughs for treatment of hematologic malignancies and is now being investigated for the treatment of HPV-associated epithelial cancers. This technique isolates a patient’s peripheral mononuclear blood cells and then uses a retrovirus encoding HPV-related genes to engineer the T cells to target infected cells. These cells are engineered and propagated over several weeks and then infused back into the patient after preparative chemotherapy. Phase I data are now available for engineered T cells targeting both the E6 and E7 proteins. In the latter study, which included 12 patients with metastatic HPV-associated cancer from multiple primary sites (including five with cervical primaries), 50% of patients demonstrated tumor response, including several who had previously been given anti-PD-1 immunotherapy.

Lastly, a recently published phase II study showed an encouraging objective response rate of 24% after treatment of patients with recurrent or metastatic disease with an antibody drug conjugate. The antibody targets a protein known as tissue factor, which is highly prevalent in cervical cancers, ultimately resulting in the intracellular delivery of a microtubule disrupting agent. In addition to direct cytotoxicity, multiple mechanisms of immune activation are also thought to contribute to the effectiveness of the treatment. Toxicity was grade 3 or higher in more than a quarter of patients, and there was one treatment-related fatality due to septic shock. These encouraging results overall have led to the initiation of a randomized phase III study (NCT04697628).

**Radiation and Immunotherapy**

Since radiation therapy is frequently used as a component of cervical cancer management, potential synergies between radiation...
treatment and immunotherapy are another exciting area of ongoing investigation. Pre-clinical data show an improved response to treatment with combination therapy including both anti-CTLA-4 and PD-1 agents as well as radiation. The improved response with all three therapies suggests complementary mechanisms, with the CTLA-4 inhibition reducing immunosuppressive Treg cells, anti-PD-1 therapy preventing immune exhaustion of CD8 positive cells, and radiation treatment enhancing the diversity of T-cell receptors present on tumor-infiltrating lymphocytes. Similar data suggest that the release of tumor-associated antigens with radiation treatment may also be beneficial for enhancing the efficacy of infused T cell therapies.

A clinical phenomenon known as the abscopal effect (regression of tumors outside the radiation field after treatment) is thought to be immune mediated, and may be promoted in the setting of immunotherapy. For example, anti-CD40 treatment and single-fraction radiation significantly improved tumor control and survival in a mouse model of cervical cancer. Radiation also changes the tumor microenvironment, even in non-radiated distant tumors. However, the abscopal effect is controversial and is a rare phenomenon, with clinical data largely limited to case reports. Further research is ongoing to understand the treatments and patients for whom this is most likely to occur (eg, NCT03614949). Another important question still under investigation is the optimal sequencing of immune therapy with radiation to achieve the optimal therapeutic ratio.

CONCLUSION

Immunotherapy represents an emerging treatment option for patients with cervical cancer. Checkpoint blockade therapy is now an appropriate component of first-line treatment in the metastatic setting and is used under investigation in several phase III trials that may change the standard of care for definitive management of locally advanced disease. Other immunotherapies, including vaccines and engineered T cells, are in earlier phases of development, with promising initial results. All these treatments may synergize with radiation therapy to provide an optimal immune response.

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