Do thymic malignancies respond to target therapies?

Bin Hu, Hao Rong, Yongtao Han and Qiang Li*

Department of Thoracic Surgery, Sichuan Cancer Hospital and Institute, Chengdu, China

*Corresponding author. Department of Thoracic Surgery, Sichuan Cancer Hospital and Institute, No.55, Sect. 4 Renmin Nan Road, Chengdu, Sichuan Province 610000, China. Tel: +86-28-85420366; fax: +86-28-85420367; e-mail: dletend@sohu.com (Q. Li).

Abstract

A best evidence topic in cardiothoracic surgery was written according to a structured protocol. The question addressed was ‘Do thymic malignancies respond to target therapies?’ Altogether, 347 papers were found using the reported search, of which, in our opinion, 16 papers represented the best evidence to answer the clinical question. The authors, journal, date and country of publication, patient group studied, study type, relevant outcomes and results of these papers were tabulated. We did not find any randomized controlled trials on target therapies for the thymic malignancies, due to the very small incidence of this tumour, and it seems unlikely that there will be any such trials in the foreseeable future. Three studies on target therapies showed that several cases of thymic malignancies were reported to have partial response (PR) to epidermal growth factor receptor tyrosine kinase inhibitors such as cetuximab and erlotinib, whereas, one study on erlotinib and another on gefitinib showed no activity. Proto-oncogene c-KIT (KIT) mutant thymic carcinomas were noted to benefit from target therapies, implying that systematic sequencing of KIT in thymic carcinoma tumours may be warranted for optimal patient selection. A study that investigated the efficacy of cixutumumab, a fully human IgG1 monoclonal antibody that binds to insulin-like growth factor 1 receptor, indicated that relapsed thymomas tended to respond, whereas thymic carcinoma did not. The antiangiogenesis agent belinostat had modest antitumour activity in heavily pretreated thymoma, but no response to thymic carcinoma was found. Several cases with metastatic thymic carcinoma showed that multitargeted kinase inhibitors, such as sunitinib and sorafenib, were effective. We concluded that, as the side-effects of the agents were tolerable in almost all reported cases, target therapies can be an option for patients with heavily pretreated thymoma.

Keywords: Targeted therapies • Thymic malignancies

INTRODUCTION

A best evidence topic was constructed according to a structured protocol. This is fully described in the ICVTS [1].

THREE-PART QUESTION

In [patients with thymoma] does treatment with [targeted therapies] result in [increased survival]?

CLINICAL SCENARIO

During a national thoracic oncology meeting, a case of heavily pretreated thymoma patient is presented. The patient is considered unable to tolerate additional surgery or chemotherapy. One of the oncologists advises that the patient should be commenced on target therapies to improve survival. You resolve to check the literature yourself.

SEARCH STRATEGY

We searched Medline from 1950 to March 2014 using the pubmed interface with the search terms [thymoma OR thymic malignancy OR thymic tumour OR thymic carcinoma] AND [sunitinib OR belinostat OR motesanib OR dasatinib OR sorafenib OR imatinib OR cetuximab OR erlotinib OR gefitinib OR target therapy OR targeted therapy].

SEARCH OUTCOME

A total of 347 papers were found using the reported search. Among them, 16 papers were identified that provided the best evidence to answer the question and these papers are presented in Table 1.

RESULTS

Target molecular therapy is a new paradigm in the treatment of thymus tumours. Several major signalling pathways with potential targets that have been identified as playing important roles in thymus tumours include the epidermal growth factor receptor (EGFR) inhibitors, cetuximab and erlotinib, the KIT/mast/stem-cell growth factor receptor inhibitors, imatinib and sorafenib, the insulin-like growth factor 1 receptor (IGF-1R) cixutumumab, mammalian target of rapamycin (mTOR) inhibitor, antiangiogenesis pathway inhibitor belinostat and multitargeted kinase inhibitors such as sunitinib, sorafenib and dasatinib.
<table>
<thead>
<tr>
<th>Author, date, journal and country</th>
<th>Patient group</th>
<th>Outcomes</th>
<th>Key results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palmieri et al. (2007), Front Biosci, Italy [2]</td>
<td>Two patients with metastatic and chemorefractory thymoma received cetuximab</td>
<td>Response and [18F] FDG uptake</td>
<td>Both patients achieved PR and reduced [18F] FDG uptake in metastases at 3 months</td>
<td>This report showed the metabolic tumour response to cetuximab (EGFR -TKI), though there was no apparent reduction in tumour size</td>
</tr>
<tr>
<td>Farina et al. (2007), Lancet Oncol, Italy [3]</td>
<td>A recurrent patient with metastatic heavily pretreated B2 lymphocytic thymoma received cetuximab</td>
<td>Response</td>
<td>A PR with recession in tumour mass and metastases was detected after 6 weeks, and the treatment continued for SD after 12 months</td>
<td>This report showed the reduction in tumour size of thymoma in response to cetuximab</td>
</tr>
<tr>
<td>Christodoulou et al. (2008), Ann Oncol, Greece [4]</td>
<td>A recurrent patient with mixed epithelial cells, lymphocytes stage IV thymoma and severe myasthenia gravis, received erlotinib</td>
<td>Response</td>
<td>The patient had an excellent response and gained a 12-month survival, and myasthenic symptom improved and a better survival gained on the treatment with erlotinib</td>
<td>Tumour -controlled, myasthenic symptom</td>
</tr>
<tr>
<td>Pedersini et al. (2008), Tumori, Italy [5]</td>
<td>A patient with heavily pretreated type B3 and stage IVb TC received erlotinib</td>
<td>Response</td>
<td>No response was detected after 4 months</td>
<td>Erlotinib showed no activity in the case of TC</td>
</tr>
<tr>
<td>Nakagiri et al. (2014), Ann Thorac Cardiovasc Surg, Japan [6]</td>
<td>A patient heavily pretreated for a thymoma received gefitinib</td>
<td>Response</td>
<td>The 3-month therapy led to no reduction of the tumour size and no improvement in survival</td>
<td>Gefitinib showed no activity in the case of thymoma</td>
</tr>
<tr>
<td>Giaccone et al. (2009), J Thorac Oncol, Netherlands [7]</td>
<td>Seven patients with unresectable B3 (2 patients) thymomas and TC (5 patients) received imatinib</td>
<td>Survival</td>
<td>All 5 patients with TC had rapid PD and died; the 2 patients with B3 thymomas had SD and more than 38-month survival</td>
<td>Imatinib had no activity in TC, but improved survival in cases of thymoma</td>
</tr>
<tr>
<td>Strobel et al. (2004), N Engl J Med, Germany [8]</td>
<td>A c-KIT mutation (c-KIT exon 11 V560del) patient with hepatic metastatic TC received imatinib</td>
<td>Survival</td>
<td>The patient died 20 months after the treatment. The therapy improved clinical performance for 4 months. The tumour progressed after 6 months</td>
<td>Patients with KIT mutation TCs can benefit from imatinib</td>
</tr>
<tr>
<td>Buti et al. (2011), J Clin Oncol, Italy [9]</td>
<td>A c-KIT mutation (c-KIT exon 11 Y553N missense mutation) patient with heavily multiple bilateral pulmonary, hepatic and sternal metastatic TC received imatinib</td>
<td>Response</td>
<td>The treatment improved clinical performance after 1 week, and radiographic responses lasted for 9 months with liver function negative</td>
<td>Treatment with imatinib achieves a partial response with improvement in symptoms and performance status in patients with c-KIT mutation TCs</td>
</tr>
<tr>
<td>Bisagni et al. (2009), J Thorac Oncol, Italy [10]</td>
<td>A patient with heavily pretreated metastatic TC with c-KIT mutation (c-KIT exon 17 missense mutation D820E) received sorafenib</td>
<td>Response</td>
<td>The clinical response was confirmed after 8-week treatment. After 15 months, it was still in PR</td>
<td>Patients with a hitherto unreported c-KIT missense mutation TC can benefit from imatinib</td>
</tr>
</tbody>
</table>
Palmieri et al. [2] evaluated the effect of cetuximab on two metastatic and chemorefractory thymomas. After 3 months of cetuximab treatment, these two patients achieved PR as the [18F] fluorodeoxyglucose uptake was significantly decreased at metastatic sites. Similarly, it has been reported in the study of Farina et al. [3], which showed that a recurrent patient with metastatic heavily pretreated World Health Organization (WHO) international histological classification of tumours of thymus B2 lymphocytic thymoma received cetuximab treatment and a PR was detected after 6 weeks of therapy. In addition, the patient was still treated with cetuximab for stable disease after 12 months.

A report by Christodoulou et al. [4] showed that a patient with a recurrence of malignant mixed stage IV thymoma responded to erlotinib with a confirmed PR for 12 months and with limited side-effects. However, Pedersini et al. [5] reported that erlotinib did not show any beneficial impact on a patient with heavily pretreated thymic carcinoma, and strong EGFR expression, after 4 months of treatment.
Nakagiri et al. [6] reported a 56-year-old woman with heavily pretreated thymoma. After positive evidence of EGFR mutation was obtained, gefitinib was administrated for 3 months, but this led to no reduction in tumour size. In a single institutional report of imatinib treatment by Giaccone et al. [7], 7 patients including unresectable WHO B3 thymomas (2 patients) and thymic carcinoma (5 patients) underwent imatinib treatment. Two patients had stable disease and 5 progressed. Median survival was 4 months and median time to progression (TTP) was 2 months.

Ströbel et al. [8] also showed that the liver metastases shrank within 4 months of imatinib treatment in a thymic carcinoma patient with KIT mutation and multiple liver metastases. A report by Buti et al. [9] found that a heavily pretreated patient with metastatic c-KIT mutated thymic carcinoma received imatinib treatment and improvement of clinical performance was documented with radiographic responses lasting for 9 months. In addition, an earlier report by Bisagni et al. [10] also reported a 15-month PR to sorafenib in a heavily pretreated patient with metastatic thymic carcinoma and with c-KIT missense mutation on exon 17 (D820E). This evidence suggests that screening for activating KIT mutations might identify KIT expressing carcinomas, which could benefit from target therapies.

Rajan et al. [11] investigated the efficacy of cixutumumab, a fully human IgG1 monoclonal antibody targeting IGF-1R in 49 patients with recurrent or refractory thymic epithelial tumours (37 with thymomas and 12 with thymic carcinomas) after failure of previous chemotherapy. With a median follow-up of 24 months, five of 37 (14%) thymoma patients achieved PR. The median TTP was 9.9 months and median survival was 27.5 months. However, none of 12 thymic carcinoma patients had a PR, and the median TTP and overall survival were 1.7 and 8.4 months, respectively. These reports indicate that thymomas can respond to this form of target therapy, whereas thymic carcinoma generally does not.

Evidence shown by Wheler et al. [12] found that, for thymoma patients (with advanced thymoma or metastatic thymic carcinoma) treated on mTOR inhibitor regimens, the time to treatment failure (TTF) was 11.6 vs 2.3 months on their last conventional regimen prior to referral.

There was also a phase II study of belinostat by Giaccone et al. [13] in 41 patients with recurrent or refractory advanced thymic epithelial tumours. Two patients achieved PR, 25 had stable disease and all 13 thymic carcinoma patients had progressive disease after belinostat treatment.

Azad et al. [14] investigated the effect of motesanib in a heavily pretreated thymoma patient. Although there was a modest increase in tumour measurements that reached a maximum after 11 cycles, it achieved a meaningful effect for over 12 months.

Ströbel et al. [15] also reported that four patients with metastatic thymic carcinoma refractory to conventional therapies were treated with sunitinib. A partial remission (lasting 2 to 18+ months) in 3 patients and a stable disease in another one were documented.

Chuah et al. [16] reported a patient with pretreated chronic myeloid leukaemia who developed lymphoid blast crisis and a B2 thymoma. After 2-month treatment with dasatinib, a clinical remission and tumour size reduction was obtained, and the mass was completely resected.

Thomas et al. [17] evaluated the effect of sorafenib in a heavily pretreated patient with widespread metastatic thymic carcinoma. After a few weeks, the general condition of the patient improved and a 50% reduction in tumour size was documented, which lasted 15 months.

**CLINICAL BOTTOM LINE**

The evidence we have presented shows that several cases of thymic malignancy responded to EGFR-TKIs such as cetuximab and erlotinib: these agents can be regarded as a worthwhile treatment option for heavily pretreated thymoma. Evidence also shows that screening for activating KIT mutations can identify KIT expressing carcinomas that may benefit from target therapies. In addition, treatments combined with an mTOR inhibitor have been shown to prolong the TTF in patients with thymic carcinoma. Antiangiogenesis agents, such as bevacizumab, had modest antitumour activity in heavily pretreated thymoma, but no response in thymic carcinoma. Multitargeted kinase inhibitors such as sunitinib and sorafenib seem to be a particularly good choice of second-line therapy for thymic carcinoma. Target therapies can be an option for patients with heavily pretreated thymoma, as the side-effects of the agents have been tolerable in almost all reported cases.

**Conflict of interest:** none declared.

**REFERENCES**


