The Shared and Contrasting Roles of IL2 and IL15 in the Life and Death of Normal and Neoplastic Lymphocytes: Implications for Cancer Therapy

Thomas A. Waldmann

Abstract

IL2 and IL15, members of the 4α-helix bundle family of cytokines, play pivotal roles in the control of the life and death of lymphocytes. Although their heterotrimeric receptors have two receptor subunits in common, these two cytokines have contrasting roles in adaptive immune responses. The unique role of IL2 through maintenance of fitness of regulatory T cells and activation-induced cell death is the elimination of self-reactive T cells to prevent autoimmunity. In contrast with IL2, IL15 is dedicated to the prolonged maintenance of memory T-cell responses to invading pathogens. Blockade of IL2 and IL15 using monoclonal antibodies has been reported to be of value in the treatment of patients with leukemia, autoimmune disorders, and in the prevention of allograft rejection. IL2 has been approved by the FDA for the treatment of patients with malignant renal cell cancer and metastatic malignant melanoma. Clinical trials involving recombinant human IL15 given by bolus infusions have been completed, and studies assessing subcutaneous and continuous intravenous infusions are underway in patients with metastatic malignancy. Furthermore, clinical trials are being initiated that employ the combination of IL15 with IL15Rα/IGFc.

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Learning Objectives

The cytokines interleukin-2 (IL2) and IL15 bind heterotrimeric receptors that share two common subunits. Both cytokines stimulate T-cell proliferation, induce the generation of CTLs, and facilitate the maintenance of natural killer cells. Through its role in maintaining the fitness of regulatory T cells and in activation-induced cell death (AICD), IL2 is involved in the elimination of self-reactive T cells and prevention of autoimmunity. IL15 inhibits AICD and prolongs CD8 memory T-cell responses. IL2 has been approved by the FDA for malignant renal cell cancer and metastatic melanoma. Clinical trials of IL15/IL15Rα are ongoing. Upon completion of this activity, the participant should gain a basic knowledge of the pivotal roles of the IL2 and IL15 cytokine/receptor system in controlling the life and death of lymphocytes and the current therapeutic utility of the IL2/IL15 cytokine/receptor systems.

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Introduction

The immune system is dedicated to a series of goals, including the generation of a rapid innate and adaptive immune response to invading pathogens, the elimination of autoreactive T cells to generate tolerance to self, and the maintenance of specific memory responses to pathogens. Such immune responses are normally regulated by cytokines. The cytokines that share the common gamma-chain (γc) among their receptor subunits, including IL2, IL4, IL7, IL9, IL15, and IL21, play dominant roles in the regulation of immune responses (1, 2). IL2 and IL15 have particularly pivotal roles in the control of the life and death of lymphocytes (3). In addition to the common γc, the heterotrimeric receptors for IL2 and IL15 share another subunit referred to as IL2Rα (also known as IL2Rγc, CD122; refs. 4, 5). Furthermore, the high-affinity forms of IL2R and IL15R contain a third cytokine-specific receptor α subunit IL2Rα (CD25) or
IL15Rα (CD215), respectively (refs. 6, 7; Fig. 1). Additional structural data showed that the signaling complexes they form are topologically nearly identical (8). In light of the common receptor components and the fact that IL2 and IL15 signaling pathways also share JAK1 (Janus kinase 1). JAK3, and STAT3/5 (signal transducer and activator of transcription 3 and 5) molecules, it was assumed that IL2 and IL15 would have similar functions. Indeed, both cytokines stimulate the proliferation of T cells, induce the generation of cytotoxic T lymphocytes (CTL), and facilitate the maintenance of regulatory T cells (Treg) to yield self-tolerance and thereby allow signaling through these complexes. Adapted from Waldman (3).

Table 1. Comparison of IL2 and IL15

<table>
<thead>
<tr>
<th>Properties</th>
<th>IL2</th>
<th>IL15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gene structure and location</td>
<td>Four exons, chromosome 4q26</td>
<td>Eight exons, chromosome 4q31</td>
</tr>
<tr>
<td>Main site of synthesis</td>
<td>Activated CD4 Th1 cells</td>
<td>Activated DCs and monocytes</td>
</tr>
<tr>
<td>Mechanism of regulation of expression</td>
<td>Transcriptional regulation and stabilization of mRNA</td>
<td>Mainly posttranscriptional, during translation and intracellular trafficking</td>
</tr>
<tr>
<td>Receptor</td>
<td>Cis-presentation to IL2/15Rβ, and γc coexpressed on activated T and B cells</td>
<td>IL15Rx/IL15 on the surface of DCs and monocytes trans-presented to NK cells and CD8+ memory T cells expressing IL2/15Rβ and γc</td>
</tr>
<tr>
<td>Unique function</td>
<td>Maintenance of Tregs and elimination of self-reactive T cells mediated by AICD to yield self-tolerance</td>
<td>Maintenance of NK cells and CD8+ CD44hi memory T cells to provide a long-term immune response to pathogens</td>
</tr>
<tr>
<td>Features of mice deficient in gene-encoding cytokine or its private receptor α chain</td>
<td>Marked enlargement of peripheral lymphoid organs, polyclonal expansion of T and B cells associated with autoimmune disorders</td>
<td>Marked reduction in number of NK, NKT gamma/delta, and CD8+ CD44hi memory T cells</td>
</tr>
</tbody>
</table>

NOTE: Data are from refs. 3, 7, 9, 13, 19, 22.

Abbreviations: IL2Rx, IL2 receptor alpha chain; IL2/15Rβ, β chain of the IL2 and IL15 receptor; IL15Rx, IL15 receptor alpha chain; Treg, CD4+ CD25+ regulatory T cell.
maintenance of long-lasting, high-avidity T-cell responses to invading pathogens, a function that it achieves by supporting the survival of CD8 memory T cells (15, 16). This Masters of Immunology primer focuses on the distinct contributions of these cytokines to regulation of the immune response. It also emphasizes efforts to translate insights concerning the biology of these cytokines into novel IL2- and IL15-mediated approaches to the treatment of cancer as well as to the opposite goal that employs antibodies to the cytokine receptors to treat cytokine-dependent malignancies and autoimmune diseases.

**Genomic Organization of IL2 and IL15 and Control of Gene Expression**

The genes encoding IL2 and IL15 are located on chromosomes 4q26-27 and 4q31, respectively (7). The cytokines are short-chain α-helical bundle type 1 cytokines with that of IL2 involving four exons and IL15 eight exons. IL2 synthesis is controlled by several mechanisms, including silencing of the IL2 gene by B lymphocyte–induced maturation protein 1 (Blimp1; ref. 13). Following T-cell interaction with mitogen or antigen–MHC complexes and dendritic cells (DC), IL2 synthesis is regulated at the level of transcription predominantly by CD4 cells and to a lesser extent by CD8 cells, NK cells, and DCs (13). IL15 transcription, translation, and secretion are regulated through multiple complex mechanisms (17, 18). IL15 and IL15Rα proteins are coexpressed simultaneously predominantly by activated monocytes and DCs (3, 13). The transcription of the heterodimer IL15/IL15Rα occurs following the interaction of monocytes/DCs with type 1 or type 2 IFNs, CD40 ligation, or agents that act through Toll-like receptors (TLR) that activate NF-κB. Moreover IL15/IL15Rα protein expression is predominantly controlled at the levels of translation and secretion (17, 18). Three checkpoints have been identified that impede IL15 expression, including multiple start codons (AUG) in the 5′ untranslated region, an unusually long signal peptide (48 amino acids), and a negative regulator near the C terminus of the precursor proteins (17, 18). The systemic elimination of these three checkpoints, including the removal of upstream AUGs, the replacement of the endogenous human IL15 leader with that of IL2, and the fusion of the C terminus of the IL15 mature protein with a FLAG-epitope tag, augmented the synthesis and secretion of IL15 250-fold.

**IL2 and IL15 Receptor Complexes and Signaling**

Three different IL2R complexes exist (7, 10, 12, 13, 19). The isolated IL2Rαα subunit that is transiently expressed following T-cell receptor (TCR) activation or by contact of IL2 with the other subunits binds IL2 with low affinity (dissociation constant \( K_d = 10^{-8} \) mol/L) without transducing a signal. The heterodimeric IL2Rαβγc binds IL2 with intermediate affinity (\( K_d = 10^{-7} \) mol/L), whereas the heterotrimeric IL2Rαββ binds IL2 with high affinity (\( K_d = 10^{-11} \) mol/L). Both the heterodimeric and heterotrimeric receptors signal. In contrast with IL2Rαα, the isolated IL15Rαα has a high affinity for IL15 (\( K_d = 10^{-11} \) mol/L; refs. 6, 19). With the Kit 225 CLL T-cell line, it was demonstrated that the common γc, IL2/IL15Rβ, IL2Rα, IL15Rα as well as class I and II MHCs are associated elements in supramolecular receptor clusters in lipid rafts before the cytokine addition and that IL2 and IL15 compete for the use of γc (19). In addition, IL2 initially binds to IL2Rαα, resulting in a structural change in the element of IL2 that binds to the β chain followed by joining with IL2/IL15Rβ and γc that increases the proximity of its receptor subunits (19). The binding of IL2 or IL15 to the IL2/IL15Rβγc and γc heterodimer induces JAK1 activation via the β chain and JAK3 via the γ chain that together phosphorylate tyrosine on the cytokine receptors and induce the tyrosine phosphorylation of STAT3, STAT5A, and STAT5B that via SH2 domain interactions homodimerize, translocate to the nucleus, and bind to regulatory regions of target genes (3, 10, 20–24). Additional IL2 and IL15 signaling mechanisms include the adaptor protein Shc that binds to a phosphotyrosine residue on IL2/IL15Rβγc, resulting in the activation of Grb2 and Akt via the Shc, Grb2, Gab2, PI3K,PIP3, Akt, mTOR, p70, S6 signaling pathway (20–23). In a third signaling pathway, IL2/IL15 signaling is associated with activation of SOS and Grb2 to form a Grb2/SOS complex that, in turn, activates the Ras, Raf, MEK, MAPK–ERK pathway involved in cellular proliferation. Collectively, these signaling pathways induce the expression and activation of c-myc, c-fos, c-jun, Bcl-2, Bcl-xl, and NF-κB as well as decreasing expression of proapoptotic Bim and PIUMA (25). In addition to the positive signals, lymphocytes have evolved sophisticated mechanisms to prevent excessive responses to IL2 and IL15, including the induction of the expression of suppressors of cytokine signaling (SOCS), including SOCS1, SOCS3, and CIS as well as PIAS (26). SOCS proteins inhibit components of the cytokine signaling cascade via direct binding or by preventing access to the signaling complex. The SOCS proteins also target signal transducers for proteasomal destruction.

**Distinct Functions of IL2 and IL15**

IL2 and IL15 have several similar functions as a consequence of their sharing of receptor components IL2/IL15Rβγc and γc and their use of common JAK and STAT signaling molecules. These functions include stimulating the proliferation of activated CD4+CD8– (double negative), CD4+CD8+ (double positive), CD4+ and CD8+ (single positive) T cells, and their differentiation into defined effector T-cell subsets following antigen-mediated activation (3, 7, 10, 19). Furthermore, the two cytokines facilitate the production of CTLs and immunoglobulin synthesis by B cells that have been stimulated with immunoglobulin M (IgM)–specific antibodies or by CD40 ligation. IL2 and IL15 also stimulate the generation and proliferation of NK cells (27). In addition to these similarities, there are distinctions between the functions of IL2 and IL15 that are crucial in the homeostasis of adaptive immune responses. IL2 has paradoxical functions in T-cell homeostasis. IL2 acts as a T-cell growth factor during the initiation of an immune response, but it has a crucial role in the termination of T-cell responses for the maintenance of self-tolerance. Although IL2 signals are not essential for Treg development in the thymus, they are critical for maintenance of Treg in the periphery (14, 28–31). IL2 and all three IL2 receptor chains (α, β, and γc) are required for high-affinity IL2 binding for Foxp3 (forkhead box P3) expression (28). The transcription factor AML1 (acute myeloid leukemia with AE-1)/Runx1 (Runt-related transcription factor 1) activates IL2 and IFNγ gene expression in conventional CD4+ T cells through binding to their respective promoters (31). In natural Tregs, Foxp3 interacts physically with AML1 (31). Several lines of evidence support a model in which this interaction suppresses IL2 and IFNγ production, upregulates Treg-associated molecules, and exerts suppressive activity (28).
In contrast with IL2, IL15 has no major net effect on the maintenance of the fitness of Foxp3-expressing Tregs. IL2 and IL15 also have distinct roles in AICD (11, 32). IL2 is a critical determinant in the choice between proliferation and death. Both CD4 and CD8 T cells previously exposed to antigen and a high level of IL2 undergo apoptosis after persistent TCR stimulation in a process involving induction of the death receptor FAS (CD95) and FAS ligand (CD95 L32). In contrast, IL15 is an antiapoptotic factor in several systems. In particular, in IL15-transgenic mice, IL2-induced AICD is inhibited (11). Furthermore, IL15 promotes the maintenance of CD8+CD44hi memory T cells (15, 16).

These observations from ex vivo functional studies were supported by analysis of mice with disrupted cytokine or cytokine-receptor genes (33, 34). IL2−, IL2R−, and IL2/IL15Rβ-deficient mice developed a marked enlargement of peripheral lymphoid organs that was associated with polyclonal expansions of T- and B-cell populations, a dysregulated proliferation that reflects the impairment of Treg fitness and AICD (33). IL2R−deficient mice develop autoimmune diseases, such as hemolytic anemia and inflammatory bowel disease. In contrast, mice that are deficient in IL15 or its private receptor, IL15Rα, do not develop lymphoid enlargement, increased serum immunoglobulin concentrations, or autoimmune disease (34). Rather, such mice have a marked reduction in the number of thymic and peripheral NK cells, natural killer T (NKT) cells, γδ T cells, and intestinal intraepithelial lymphocytes. Furthermore, IL15Rβ-deficient mice show a marked reduction in CD8+CD44hi memory T cells.

How do IL2 and IL15, with two receptor subunits and the common receptor genes (33, 34), IL2−, IL2R−, and IL2/IL15Rβ-deficient mice develop a marked enlargement of peripheral lymphoid organs that was associated with polyclonal expansions of T- and B-cell populations, a dysregulated proliferation that reflects the impairment of Treg fitness and AICD (33). IL2R−deficient mice develop autoimmune diseases, such as hemolytic anemia and inflammatory bowel disease. In contrast, mice that are deficient in IL15 or its private receptor, IL15Rα, do not develop lymphoid enlargement, increased serum immunoglobulin concentrations, or autoimmune disease (34). Rather, such mice have a marked reduction in the number of thymic and peripheral NK cells, natural killer T (NKT) cells, γδ T cells, and intestinal intraepithelial lymphocytes. Furthermore, IL15Rβ-deficient mice show a marked reduction in CD8+CD44hi memory T cells.

Disorders of the IL15/IL2 Cytokine Receptor System

The gene encoding γc is mutated in individuals with X-linked SCID who lack T cells and NK cells; B cells are present but nonfunctional (7, 50). Mutations of JAK3 downstream of γc are present in autosomal recessive SCID (51, 52). IL2, IL2γc, and IL2/IL15Rβ deficiencies are associated with polyclonal expansions of T- and B-cell populations and autoimmune diseases. In the absence of IL2 signals, the number of Tregs declines markedly, whereas the number of Th17 cells increases (7, 53). IL2/IL15Rβ deficiency is also associated with the absence of NK cells secondary to defective IL15 signaling.

Excessive dysregulated IL15 expression has been reported in patients with a range of autoimmune inflammatory diseases, including rheumatoid arthritis, multiple sclerosis, ulcerative colitis, type 1 diabetes, psoriasis, and refractory celiac disease (3, 9). IL15, a proinflammatory cytokine, may precede the expression of TNFα and downstream cytokines IL1, IL6, and GM-CSF (3). The retrovirus HTLV-I–encoded tax protein expressed in adult T-cell leukemia (ATL) and the neurologic disease HAM/TSP activates two autocrine systems and one paracrine system involving IL2/IL2Rα, IL15/IL15Rα, and IL9 (54, 55). As a consequence of these stimulatory autocrine/paracrine loops, the ATL cells among ex vivo peripheral blood mononuclear cells proliferate spontaneously.

IL2Rb- and IL15Rα-Directed Immunotherapy

The specific IL2Rb subunit IL2Rα has been an exceptionally valuable target for immunotherapy (9, 56–63). The scientific basis for this is that IL2Rα is not expressed by resting cells other than Tregs and CD56dimCD16lo NK cells, but is constitutively expressed by an array of malignant cells of various T- and B-cell leukemias as well as T cells involved in select autoimmune conditions.
disorders and those that participate in organ allograft rejection (56, 58). One form of IL2 receptor-directed therapy involves the use of unarmed antibodies specific for IL2Rα, including basiliximab (Simulect; Novartis AG) and daclizumab (also known as anti-Tac; Zenapax; Roche), the first humanized anti-body that was approved by the FDA (56, 57, 59, 60). Administration of these antibodies blocks the interaction of IL2 with IL2R, leading to cytokine deprivation and death of IL2-dependent cells. Treatment with daclizumab has provided effective therapy for patients with noninfectious uveitis (59). Furthermore, treatment with daclizumab has resulted in an over 70% reduction in new contrast-enhancing lesions in patients with multiple sclerosis who did not respond to treatment with IFNβ (60). In addition, daclizumab was shown to provide effective therapy for selected patients with human T-cell lymphotropic virus 1-associated (HTLV-1) ATL—which has been viewed as the leukemic counterpart of Tregs (56, 63). In additional clinical trials, daclizumab armed with toxins or β-emitting radionuclides that result in selective delivery of toxins or radionuclides to cells expressing IL2Rα has provided effective therapy for selected patients with ATL and Hodgkin lymphoma (61, 62).

An antibody directed toward IL2/IL2Rβ (Hu-Mik-Beta-1) has been shown to block the trans-presentation of IL15, but not the action of IL1.5, on cis expressed heterotrimeric IL15 receptors (44). Hu-Mik-Beta-1 is being evaluated in patients with T-cell large granular lymphocytic leukemia, the HTLV-1–associated neurologic disease HAM/TSP, and in patients with refractory celiac disease (44). In patients with HTLV-1–associated disorders, the protein-encoding Tα Tactivates two sine pathways (IL2/IL2R, IL15/IL15R) and one paracrine (IL9) pathway that signal through the γc and the Jak1/3–STAT3/5 pathway (54, 55). In light of this multicytokine activation in lieu of a mAb inhibition, utilizing a Jak inhibitor (e.g., ruxolitinib/foxicitinib) or more appropriately a Jak1-specific inhibitor could be of value (55).

**IL2 in the Treatment of Cancer**

Rosenberg (64) first utilized ultra-high doses of IL2 to treat patients with metastatic renal cell carcinoma. Such high-dose IL2 therapy resulted in a significant clinical response (around 15%); however, it also resulted in very significant toxicity. The IL2 doses used amounted to approximately 50 million units per injection, every 8 hours, which resulted in plasma IL2 concentrations more than sufficient to saturate the high-affinity as well as the intermediate-affinity IL2 receptors. The end result was stimulation of a massive secondary release of proinflammatory cytokines IFNγ, IL6, TNFα, and GM-CSF in concert with direct binding of IL2 to CD25+expressing endothelial cells that induced the vascular capillary leak syndrome. IL2 (aldesleukin) was approved for the treatment of metastatic renal cell cancer and malignant melanoma. Despite its accepted role, IL2 has additional negative characteristics. IL2 has a short half-life. Furthermore, IL2 has a dual role as an immunomodulator that stimulates proliferation of effector cells that kill cancer cells but, as noted above, also stimulates checkpoint cells that suppress the immune response by the maintenance of inhibitory CD25+Foxp3+ Tregs that are involved in AICD.

IL2 has also been used in ultra–low dose therapy based on the known affinity of IL2 heterotrimeric receptor components (19, 65). These trials were performed in patients with cancer or following bone marrow transplantation and resulted in selective expansion of CD56+CD3–CD16+ NK cells based on the rationale that such resting cells have a constitutive expression of the high-affinity heterotrimeric IL2Rα, β, γc cells. The ability of low-dose IL2 to expand such NK cells with little or no toxicity has been confirmed in additional patients with cancer and/or immunodeficiency. However, low-dose IL2 therapy for cancer has shown disappointing results presumably due in part to the expansion of Tregs.

In addition to natural IL2, a conformational switch has been exploited to engineer an IL2 ‘superkine’ that allows tight binding to γc in the absence of IL2Rα. The super-IL2 has improved antitumor activity in mice bearing three types of human tumors (66). Furthermore, Boyman and colleagues (67) demonstrated that some IL2/anti-IL2 mAb immune complexes caused massive (>100-fold) expansion of CD8+ T cells and activation of NK cells in vivo due to the markedly augmented activity of IL2. Thus, IL2 antibody complexes have been used to selectively boost the immune response and reduce tumor metastases (67–70). Furthermore, an antibody–IL2 fusion protein has been shown to overcome tumor heterogeneity by induction of a cellular immune response (69). In parallel, IL15/antibody fusion proteins for cancer immunotherapy mimicking IL15 trans-presentation at the tumor site have been generated (71).

**IL15 in the Treatment of Cancer**

A number of studies in murine models, in particular CT26 and MC38 colon adenocarcinoma, P1A+, B-16 melanoma, and TRAMP-C2 prostate cancer, suggested that IL15 may prove to be of value in the therapy of neoplasia (3, 13, 19, 22, 72–81). Intravenous administration of murine IL15 enhanced survival of such tumor-bearing mice (73). Furthermore, Klebanoff and colleagues (72) demonstrated that IL15 enhanced the in vivo activity of tumor-reactive CD8+ T cells in the TCR transgenic mouse (pml-1) whose CD8+ T cells recognized an epitope derived from the melanoma antigen GP-100. In addition, Bessard and colleagues (82) demonstrated high antitumor activity of RLI, an IL15–IL15R fusion protein, in metastatic melanoma and colorectal cancer models. On the basis of the animal preclinical trials with IL15, great interest was generated among leading immunotherapeutic experts participating in the NCI Immunotherapy Agent Workshop, which ranked IL15 as the most promising unavailable immunotherapeutic agent to be brought to human therapeutic trials (83).

The safety of IL15 was evaluated in rhesus macaques by Munger and colleagues (75), Mueller and colleagues (84), Waldmann and colleagues (85), Lugli and colleagues (86), Sneller and colleagues (87), and Berger and colleagues (88). A 12-day bolus of intravenous administration of 20 μg/kg/day of IL15 to rhesus macaques was associated with a 4-fold to 8-fold increase in the number of circulating NK, stem, central, and effector memory CD8 T cells (86). Subsequently, alternative routes of administration were evaluated in rhesus macaques, including continuous intravenous infusion (CIV) and subcutaneous administration of IL15. The administration of IL15 by CIV at 20 μg/day for 10 days led to a 10-fold increase in the number of circulating NK cells, a 15-fold increase in the number of circulating monocytes, and a massive 80-fold to 100-fold increase in the number of circulating effector memory CD8 T cells (87). Subcutaneous infusions at 20 μg/kg/day for 10 days led to a more modest 10-fold expansion in the number of circulating effector memory CD8 T cells.
Clinical Trials Using IL15 in the Treatment of Cancer

Five clinical trials have been initiated using Escherichia coli rIL15 in the treatment of cancer (89–92). The primary goal of the completed trial—a phase I study of recombinant human IL15 in adults with refractory metastatic malignant melanoma and metastatic renal cancer—was to determine the safety, adverse event profile, dose-limiting toxicity, and maximum tolerated dose (MTD) of rIL15 administered as a daily intravenous bolus infusion for 12 days to patients with metastatic malignant melanoma or metastatic renal cell cancer (93). The study was initially planned as a phase I dose-escalation trial starting with an initial dose of 3 μg/kg/d for 12 days. However, after the initial patient developed grade 3 hypotension and another patient developed grade 3 thrombocytopenia, the protocol was amended to add two lower doses of 1.0 and 0.3 μg/kg/d for 12 days. Two of 4 patients given the 1.0 μg/kg/d dose had persistent grade 3 alanine aminotransferase and aspartate aminotransferase elevations that were dose limiting. All 9 patients with IL15 administered at 0.3 μg/kg/d received all 12 doses without DLT. The MTD of rIL15 was determined to be 0.3 μg/kg/d.

There was a consistent temporal pattern of posttreatment adverse events in patients given the 3-μg/kg/day dose of IL15 with fever and rigors beginning 2.5 to 4 hours after the start of IL15 infusions and blood pressure dropping to a nadir of approximately 20 mm/Hg below pretreatment levels 5 to 9 hours after the infusion. These changes were concurrent with a maximum of 50-fold elevations of circulating IL6 and IFNγ concentrations. Flow cytometry of peripheral blood lymphocytes revealed an efflux of NK and memory T cells from the circulating blood within minutes upon IL15 administration followed by influx and hyperproliferation, leading to 10-fold expansions of NK and γδ T cells that ultimately returned to baseline. Furthermore, there were significant increases in the number of CD8 memory phenotype T cells. In this first-in-human phase 1 trial, there were no responses, with stable disease as the best response. However, 5 patients manifested a decrease of between 10% and 30% of their marker lesions, and 2 patients had clearing of lung lesions. Subsequently, alternative dosing strategies including CIV and subcutaneous administration of IL15 were initiated (90, 91).

IL15/IL15Rα

Although IL15 may show efficacy in the treatment of metastatic malignancy in human trials, it has not been optimal when used as a single agent for cancer therapy. A particular challenge is that there is only a low-level expression of IL15Rα on resting DCs (94). Indeed, the true IL15 cytokine may not be an IL15 monomer but rather may be considered as an IL15Rα/IL15 heterodimeric cytokine. Physiologically, IL15 is produced as a heterodimer in association with IL15Rα. Furthermore, in mice, it is the heterodimer alone that is stably produced and transported to the surface of the cell (38, 39). On cleavage from the cell surface, IL15Rα/IL15 elements are associated in the serum as the sole form of circulating IL15 (94). To address the issue of deficient IL15Rα, IL15/IL15Rα, and IL15Rα, IgFc have been produced and entered into clinical trials evaluating patients with metastatic malignancy (95–99).

As an alternative strategy, agents are available that induce IL15Rα expression on DCs that could be given in conjunction with IL15 to circumvent the problem discussed above with IL15 when used in monotherapy. The combination of IL15 with the agonistic anti-CD40 antibody FGK4.5 showed additivity/synergy in the MC38 murine model of colon cancer and the TRAMP-C2 model of prostatic cancer (73, 79). Administration of the anti-CD40 antibody was associated with an increased expression of IL15Rα on CD11+ DCs. Furthermore, in the murine syngeneic tumor model, treatment with IL15 with the agonistic anti-CD40 antibody alone significantly prolonged the survival of the TRAMP-C2 tumor-bearing mice. Moreover, it was demonstrated that the combination of IL15 with anti-CD40 produced markedly additive effects when compared with either agent administered alone. The combination appeared to circumvent the problem of ‘helpless’ CD8 T cells wherein the CD8 T cells produced are not tumor antigen specific (73). The administration of either IL15 or anti-CD40 alone did not augment the number of tumor-specific tetramer-positive CD8 T cells in the TRAMP-C2 model system. However, the administration of the combination of IL15 plus the agonistic anti-CD40 antibody was associated with a meaningful increase in the number of TRAMP-C2 tumor-specific SPAS-1/SCN9-H8 tetramer–positive CD8 T cells (73).

Agents to Relieve Checkpoints on the Immune System to Optimize IL15 Action

As is true with other cytokines, IL15 is associated with the expression of immunologic checkpoints, including the inhibitory cytokine IL10 and the expression of PD-1 on CD8 T cells. In addition, IL15 was shown to be critical in the maintenance of CD122+CD8+–negative Tregs (100, 101). To address the issue of induced checkpoints, IL15 was administered in combination with agents to remove these checkpoints with antibodies to cytotoxic T-lymphocyte antigen 4 (CTLA-4) and programmed death-ligand 1 (PD-L1; refs. 80, 102). In the CT26 or MC38 colon carcinoma or the TRAMP-C2 prostatic cancer syngeneic tumor models, IL15 alone provided modest antitumor activity. The addition of either anti–CTLA-4 or anti–PD-L1 alone in association with IL15 did not increase the action of IL15. However, tumor-bearing mice receiving IL15 in combination with both anti-checkpoint antibodies together manifested a marked prolongation of survival (80, 102).

Combination Therapy with IL2 and IL15 with Anticancer Monoclonal Antibodies to Augment Antibody-Dependent Cell-Mediated Cytotoxicity

The predominant approaches involving IL2 and IL15 are based on the hypothesis that the host is making an immune response, albeit inadequate, to the tumor and that this can be augmented by the administration of an IL2- or IL15-containing agent. However, these cytokines could also be used in drug combinations where an additional coadministered drug provides the specificity directed toward the tumor. In particular, IL2 or IL15 could be used with anticancer vaccines, cellular therapy, or with tumor-directed mAbs (82, 103–110). Given the capacity of IL2 and IL15 to increase the number of activated NK cells, monocytes, and granulocytes, a very attractive antitumor strategy would be to use the optimal IL2 or IL15 agent and dosing strategy in conjunction with antitumor mAbs to augment their antibody-dependent cell-mediated cytotoxicity action (104–109). For example, when low-dose
IL2 therapy with intermediate-dose boluses was combined with administration of R24, a murine mAb that recognizes a malignant melanoma antigen. 3 of the 18 evaluable patients generated clinical responses (107). In addition, IL2 has been given in combination with rituximab for the treatment of B-cell malignancies with varying success (109). An alternative strategy is the direct coupling of a tumor-specific mAb and a cytokine as a fusion protein. Such an agent has been generated that couples IL2 to tumor-specific mAbs (110, 111). In parallel with an IL15 conjugate, Vincent and colleagues (112) reported highly potent anti-

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CD20-RLI immunocytokine targeting established human B-cell lymphoma in SCID mice. It is hoped that with the diverse approaches discussed, IL15 and IL2 will take central places in the combination treatment of cancer.

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