**ENDOCRINE TUMORS**

**BRAF V600E mutations in papillary craniopharyngioma**

Priscilla K Brastianos¹ and Sandro Santagata²·³·⁴

¹Division of Neuro-Oncology, Massachusetts General Hospital, Harvard Medical School, Boston, Massachusetts 02114, USA, ²Department of Cancer Biology, Dana-Farber Cancer Institute, Harvard Medical School, Boston, Massachusetts 02215, USA, ³Department of Pathology, Brigham and Women’s Hospital, Harvard Medical School, Boston, Massachusetts, 77 Avenue Louis Pasteur, Boston, Massachusetts 02115, USA and ⁴Department of Pathology, Boston Children’s Hospital, Harvard Medical School, Boston, Massachusetts 02115, USA

Correspondence should be addressed to S Santagata
Email ssantagata@bics.bwh.harvard.edu

Abstract

Papillary craniopharyngioma (PCP) is an intracranial tumor that results in high levels of morbidity. We recently demonstrated that the vast majority of these tumors harbor the oncogenic BRAF V600E mutation. The pathologic diagnosis of PCP can now be confirmed using mutation specific immunohistochemistry and targeted genetic testing. Treatment with targeted agents is now also a possibility in select situations. We recently reported a patient with a multiply recurrent PCP in whom targeting both BRAF and MEK resulted in a dramatic therapeutic response with a marked anti-tumor immune response. This work shows that activation of the MAPK pathway is the likely principal oncogenic driver of these tumors. We will now investigate the efficacy of this approach in a multicenter phase II clinical trial. Post-treatment resection samples will be monitored for the emergence of resistance mechanisms. Further advances in the non-invasive diagnosis of PCP by radiologic criteria and by cell-free DNA testing could someday allow neo-adjuvant therapy for this disease in select patient populations.

Background

Craniopharyngiomas are uncommon epithelial neoplasms that arise above the sella turcica of the skull base, in the suprasellar, infundibulotuberal, and third ventricular areas of the brain (1, 2, 3). Despite their benign histologic appearance, these tumors pose many clinical challenges (4, 5, 6). The tumors arise in proximity to critical structures and can compress or infiltrate these vital neurological areas (4, 5, 6, 7). Visual defects, pan-hypopituitarism, cognitive deficits, personality changes, hyperphagia and morbid obesity are common complications that result not only from the growth of the tumor but also often as a consequence of treatment with surgery, radiation, or both (4, 5, 6, 7, 8, 9, 10, 11). Moreover, scarring and reactive changes occur following surgical resection and radiation treatment. As a result, resecting recurrent tumors is fraught with difficulties. Patient management is further complicated by a lack of effective systemic chemotherapies (12) and by variations in clinical practice algorithms (13).

There are two histopathologic variants of craniopharyngioma. Adamantinomatous craniopharyngioma (ACP)

Invited Author’s profile

S Santagata, MD PhD is an Assistant Professor in pathology at Harvard Medical School and practices neuropathology and molecular pathology at Brigham and Women’s Hospital and Boston Children’s Hospital. His research focuses on understanding a fundamental challenge in tumor biology: how tumor cells develop their most aggressive behaviors and the mechanisms that they use to resist even the most sophisticated therapeutic regimens.
occurs in both children and adults, and papillary craniopharyngioma (PCP) occurs almost exclusively in adults. These variants have distinct histologic features (1, 14, 15).

When resection specimens are large and abundant, and well-preserved tumor epithelium is present, classification is routine on H&E stained sections (1, 14, 15). ACP has epithelium that grows in cords, lobules, and whorls, with palisading peripheral columnar epithelium and loosely arranged epithelium called stellate reticulum. ‘Wet’ keratin is a hallmark of this variant. PCP has well-differentiated monomorphic squamous epithelium covering fibrovascular cores with thin capillary blood vessels and scattered immune cells including macrophages and neutrophils. The epithelium lacks surface maturation and there is no ‘wet’ keratin (14, 15).

In some craniopharyngioma resection specimens, however, the epithelium is sparse or absent and establishing a definite diagnosis can be challenging (16). Some specimens for instance have prominent reactive changes with marked granulomatous inflammation, cholesterol clefts, and prominent lymphocytic inflammation. On small biopsies, some PCP can be difficult to distinguish from other suprasellar and infundibulotuberal masses such as non-neoplastic Rathke’s cleft cysts (16, 17). Some variants have distinct histologic features such as non-neoplastic Rathke’s cleft cysts (RCCs) (17, 26, 27). A recent re-evaluation of 33 suprasellar mass that were diagnosed as RCCs showed that three cases harbored BRAF V600E mutations (27). These cases had an atypical clinical presentation and two had squamous metaplasia. Upon re-evaluation of the pathology and clinical information, these three cases were re-classified as PCP. Hence, determining the BRAF status is likely of significant value when evaluating epithelial suprasellar lesions (17, 26, 27).

One caveat and challenge of using IHC to identify specimens harboring BRAF V600E mutations is that the VE1 antibody can cross-react with certain BRAF WT tissues. For example, endocrine tissues such as normal pituitary are immunoreactive with the VE1 antibody despite these tissues having WT BRAF. The VE1 antibody also cross-reacts with cilia (17, 26, 29) through recognition of epitopes in the axonemal dyneins of cilia that resemble the BRAF V600E peptide sequence used to generate the VE1 antibody (26). The cytosol of ciliated cells shows variable degrees of positivity (26). Thus, VE1 IHC of RCCs, which has ciliated epithelium, should be interpreted cautiously. In some cases where interpretation of the staining may be uncertain, allele-specific genetic testing for BRAF V600E mutation may be required to support the IHC results (17, 26, 27). In some institutions allele specific genetic testing may be the preferred diagnostic modality. Because over 90% of PCPs harbor BRAF V600E mutations, some institutions may find it sufficient to make diagnoses and guide therapy decisions based on review of H&E stained sections alone.

Currently, the WHO classification of craniopharyngioma does not require mutation assessment using surrogates like IHC or direct genetic testing (1). In time
though, the classification of craniopharyngioma could have at least four groups: ACP CTNNB1 mutated, adamantinomatous craniopharyngioma CTNNB1 WT, PCP BRAF V600E mutated, and PCP BRAF WT.

It is possible that the WT tumors may have different ways of activating BRAF or β-catenin that have not yet been identified. Uncovering the genetic drivers of the few CTNNB1 and BRAF WT craniopharyngioma will allow for further refinement of these categories.

Interestingly, a study has suggested that BRAF V600E mutations and mutations in CTNNB1 may co-exist in approximately 10% of ACP (30). While targeted sequencing from the validation set from our original genomic study did not detect ACP samples with BRAF V600E mutations (18), the possibility of co-occurring mutations is very intriguing and requires further exploration. If co-existence of mutations in craniopharyngioma is confirmed, it will be important to determine if either mutation is clonal or subclonal, the clinical course of such tumors as well as the optimal treatment.

**Systemic treatment for BRAF V600E mutated PCP**

While targeting and inhibiting β-catenin directly remains an unsolved challenge, considerable advances in the treatment of BRAF V600E mutant melanoma provide a paradigm for the targeted therapy of PCP (31, 32). Targeted therapy has been successful for treating patients with other BRAF V600E mutated tumors (33) including hairy cell leukemia (33, 34, 35, 36, 37, 38, 39), Erdheim Chester Disease (33, 40), ameloblastoma (41, 42, 43), and pleomorphic xanthoastrocytoma (33, 44, 45, 46, 47).

Using targeted agents that inhibit BRAF and MEK, we recently achieved a dramatic response in a patient with a multiply recurrent BRAF V600E mutated PCP (48). Prior to therapy with BRAF and MEK inhibitors, the patient required several urgent neurosurgical decompressions for a rapidly growing tumor, which had a very large cystic component. The patient suffered from panhypopituitarism and chronic bilateral optic neuropathy. We first treated the patient with the BRAF inhibitor dabrafenib alone. In 17 days, the solid part of the tumor decreased by 50% and the cystic portion by 70%. Because concomitant inhibition of BRAF and MEK has been shown to reduce the emergence of resistance in melanoma (31), we added trametinib for an additional 14 days. During the treatment the solid part of the tumor decreased by 85% and the cystic portion by 81%. The size of the cyst may have decreased as the treatment compromised the tumor epithelium and presumably diminished cyst fluid secretion. The residual tumor was resected and then 3 weeks later the patient was administered radiation therapy. Eight months following the radiation therapy, the patient remains without new symptoms (48).

Review of the histology of the specimens that were resected before and after dabrafenib/trametinib treatment revealed a remarkable effect (Fig. 1). The Ki67 proliferation index decreased from over 20% in the pre-treatment tumor to <0.5% in the on-treatment tumor. Radiation therapy was administered 3 weeks after this final on-treatment tumor resection. The combined dabrafenib and trametinib treatment led to a prominent immune response with foamy macrophages engorging the fibrovascular cores and CD8-positive T cells infiltrating throughout the tumor. This suggests that targeted therapy unleashes a strong anti-tumor immune response in PCP, a phenomenon that also appears to be elicited by BRAF inhibition in melanoma (49, 50, 51).
Development of resistance to BRADF and MEK inhibitors is common in patients with melanoma. Whole exome sequencing data from the pre- and on-treatment tumors from our patient did not identify the emergence of any known genetic drivers of BRADF resistance (18). The low frequency of mutations and limited genomic complexity of these tumors suggest that combined therapy may effectively limit the emergence of resistance but high vigilance for the emergence of treatment resistance mechanisms will be required.

The rationale of concomitantly targeting BRADF and MEK for PCP treatment is supported by a recently published report using single agent vemurafenib treatment in a patient with a BRADF V600E mutant PCP (52). Similar to the response observed in our patient, that tumor was also exceptionally responsive to targeted treatment, with a near complete radiological response after 3 months. When vemurafenib was held, however, the tumor re-grew in 6 weeks. Tumor growth was stabilized when vemurafenib was re-administered but tumor progression subsequently ensued. The tumor progression seen in that patient treated with single agent vemurafenib suggests combining BRADF and MEK inhibition will be preferable for prolonged and durable control of tumor growth.

Phase II clinical trial studying the combination of BRADF and MEK inhibition in patients with PCP

Given these exceptional tumor responses and the consistent occurrence of the BRADF V600E mutation in the vast majority of PCPs, we are now designing a multicenter phase II study evaluating the combination of BRADF and MEK inhibition in patients with PCPs. We will study the effect of dual inhibition because of the improved efficacy of the combination over single agent BRADF inhibitors in other BRADF-mutant tumors. As most resistance to single-agent BRADF inhibitors occurs because of reactivation of the RAF–MEK–ERK (MAPK) pathway, the addition of MEK inhibition delays the emergence of resistant clones. Furthermore, the major complication of RAF inhibitor treatment is the development of cutaneous squamous-cell carcinoma. This complication is significantly reduced in patients receiving the combination of dabrafenib and trametinib compared with those receiving single agent treatment alone (31). Systemic treatment will be administered until definitive therapy with surgery or radiation therapy is indicated. Correlative studies will be performed with a focus on obtaining pre- and post-treatment tissue which will be characterized with whole exome sequencing and RNA-sequencing in an attempt to identify potential mutations, genomic aberrations, or transcriptional mechanisms that might render PCP tumors either refractory or resistant to treatment.

Future outlook

The current standard of care for treating PCP involves surgery and radiation and can lead to substantial morbidity. Therefore, a neo-adjuvant approach for treating these tumors could be of use in selected patient populations. Such strategies are commonly used for prolactin producing pituitary adenomas which are treated with bromocriptine as well as for germ cell tumors. Of note, we were able to detect mutant BRADF V600E DNA circulating in the blood of our exceptional responder patient (48). This finding is encouraging and suggests that confirming the presence of PCP may be achievable through non-invasive “liquid biopsy” methods such as cell-free DNA (cfDNA) detection testing. Our trial will include explorative objectives designed to carefully assess such capabilities. Moreover, the development of validated radiological criteria for discriminating PCP and ACP from one another and from other tumors will be important for evaluating patients with suprasellar masses (3, 53, 54, 55, 56). A combination of improved non-invasive diagnostics coupled with effective targeted therapy could provide a new treatment paradigm that in molecularly selected patient populations reduces the morbidities associated with surgery and radiation and improves the outcomes of patients with PCP and other rare brain tumors (57).

Declaration of interest

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

Funding

This work was supported by the National Institutes of Health (K08 NS064168 and K12 CA093354-11), the Brain Science Foundation, the Conquer Cancer Foundation, the American Brain Tumor Association, the Jared Branfman Sunflowers for Life Fund for Pediatric Brain, and Spinal Cancer Research, A Kid’s Brain Tumor Cure Foundation, Pedals for Pediatrics and the Clark Family, the Stahl Family Charitable Foundation, the Stop & Shop Pediatric Brain Tumor Program, and the Pediatric Brain Tumor Clinical and Research Fund.

References


MEK inhibition in melanoma with BRAF V600 mutations.


41 Sweeney RT, McClary AC, Myers BR, Biscocho J, Neahring I, Kwei KA, Qu K, Gong X, Ng T, Jones CD et al. Identification of recurrent SMO and BRAF mutations in ameloblastomas. Nature Genetics 2014 46 722–725. (doi:10.1038/ng.2986)


