

The tumor microenvironment and immune infiltration landscape of *KRAS* mutant pancreatic ductal adenocarcinoma (PDAC) compared to colorectal adenocarcinoma (CRC).

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Background

The composition of the tumor microenvironment (TME) in PDACs is more heavily driven by mutant (mt) *KRAS* than any other cancer. How genomic alterations of PDAC including *KRAS* status affect the immune cell (IC) landscape remains unclear. Thus, we characterized IC types and the prevalence of immuno-oncologic (IO) biomarkers in PDAC by genomic and transcriptomic analysis and investigated associations of mt *KRAS* with IC estimates in the TME. Our findings were compared to our previous study in CRC.

Methods

A total of 4,142 PDAC and 3,727 CRC with *KRAS*-mts were analyzed using next-generation DNA sequencing (NextSeq, 592 gene panel or NovaSeq, WES), IHC, and whole transcriptome RNA sequencing (NovaSeq) (Caris Life Sciences, Phoenix, AZ). MSI/MMR was tested by FA, IHC and NGS. TMB-H was classified based on a cut-off of ≥ 10 mutations per MB. ICs were estimated by QuantiSeq (Finotello 2019, *Genome Medicine*) or MCP counter (Betcht 2016, *Genome Biology*). Significance was determined by χ^2 and Fisher-Exact and p-adjusted for multiple comparisons ($q < 0.05$).

Results

Table 1: patient demographics

	PDAC			
	Male	Female	Total (%)	Median age
<i>KRAS</i> MT	2205	1937	4142 (81.7%)	68
<i>KRAS</i> WT	506	424	930 (18.3%)	67
	CRC			
	Male	Female	Total (%)	Median age
<i>KRAS</i> MT	1969	1758	3727 (49.9%)	61
<i>KRAS</i> WT	2134	1602	3736 (50.1%)	62

Figure 1a – *KRAS* mutational distribution in PDAC

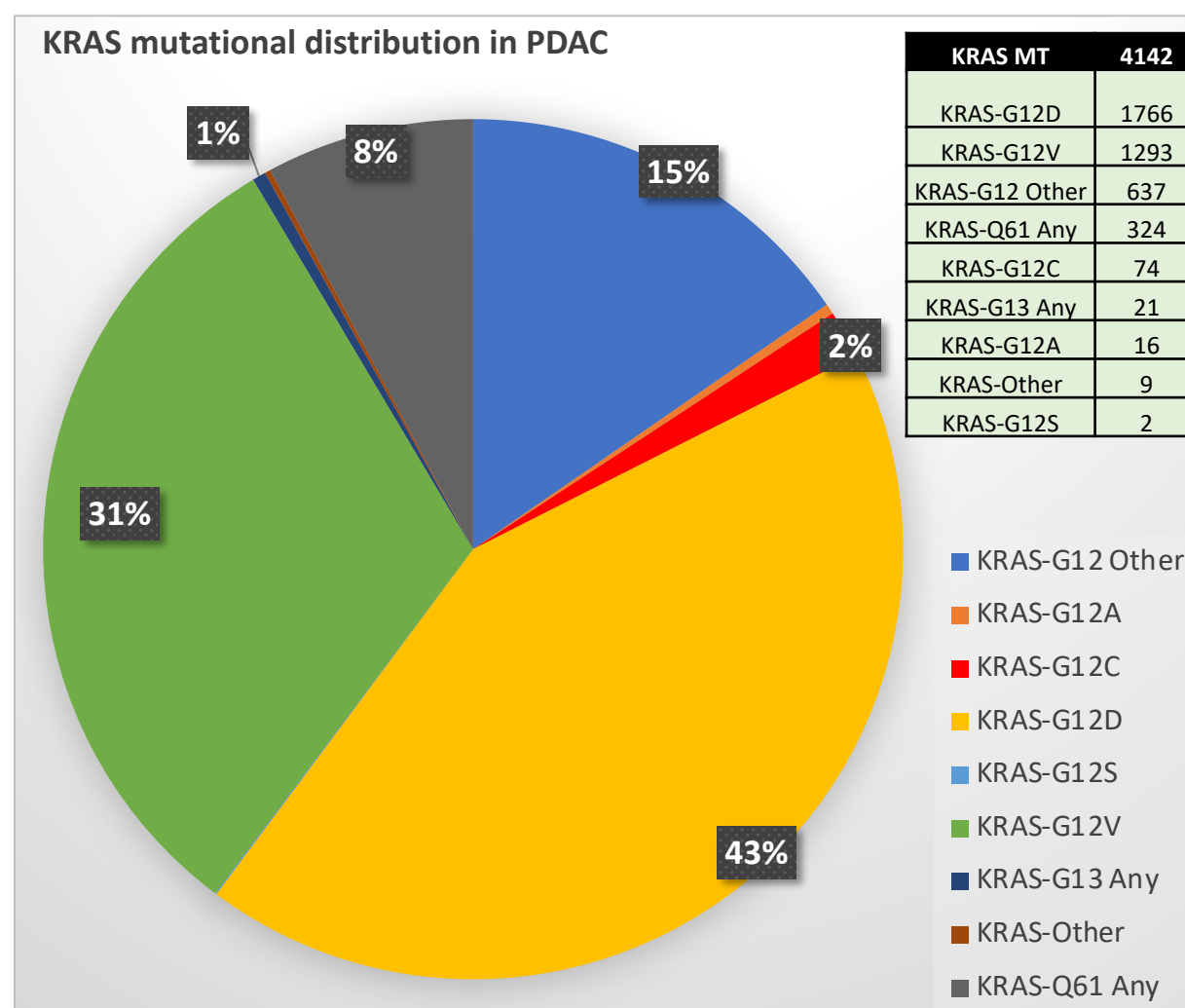


Figure 1b – *KRAS* mutational distribution in CRC

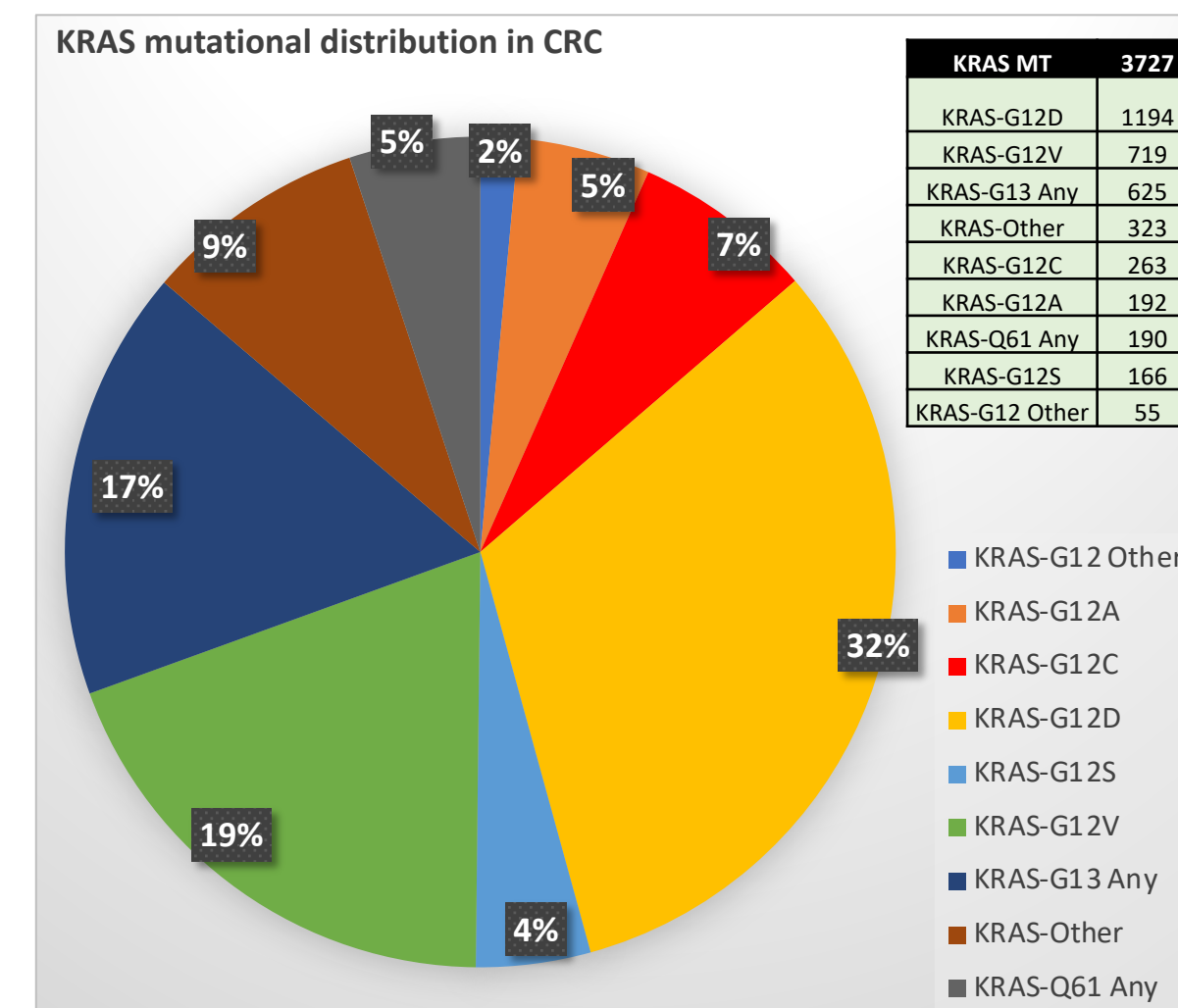


Figure 2 – IO markers in *KRAS* mt vs WT PDAC

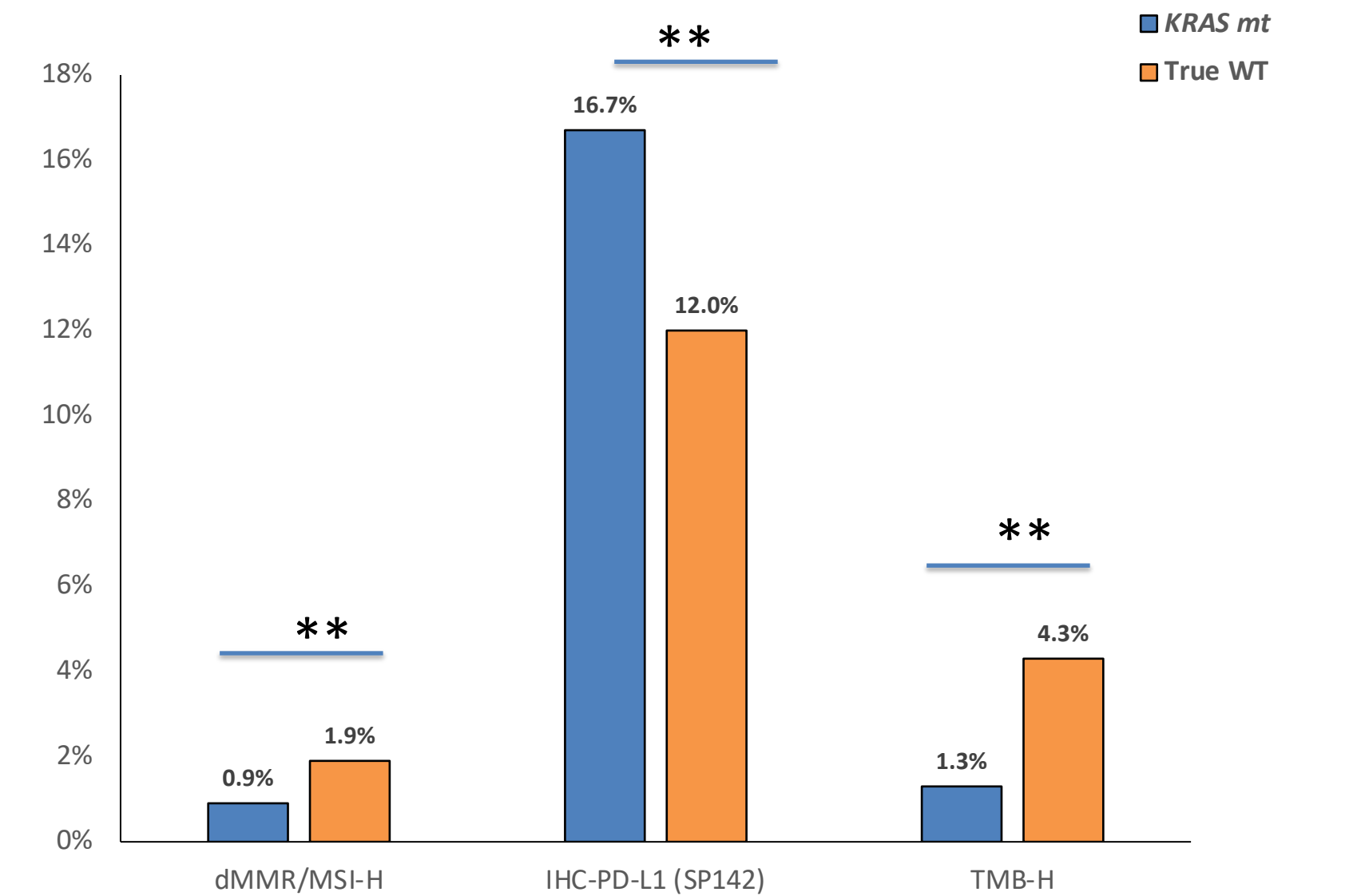


Table 2 – IO marker median expression for *KRAS* mt subtypes compared to *KRAS* WT. Bold/highlighted values represent $q < 0.05$ compared to WT tumors.

Gene	True WT	G12X	G12A	G12C	G12D	G12S	G12V	G13X	Other	Q61X
<i>CD80</i>	6.49	5.81	6.90	6.47	6.76	4.29	6.13	7.95	6.51	5.86
<i>CD86</i>	9.40	9.12	11.66	9.29	10.00	5.11	9.59	11.30	9.22	8.99
<i>CD274</i>	5.87	4.73	5.69	5.86	5.86	12.50	5.33	7.31	6.54	5.10
<i>CTLA4</i>	2.48	1.69	2.60	1.81	1.85	2.06	1.85	2.46	1.87	1.63
<i>HAVCR2</i>	22.22	19.64	26.51	20.01	22.04	4.91	21.60	25.23	20.72	19.68
<i>IFNG</i>	0.80	0.39	0.42	0.39	0.44	0.19	0.43	0.57	0.52	0.37
<i>IDO1</i>	5.79	4.05	4.42	3.67	5.18	7.45	4.33	5.85	5.83	3.64
<i>LAG3</i>	1.32	0.78	0.93	0.95	0.89	2.63	0.89	0.83	1.11	0.78
<i>PDCD1</i>	1.06	0.67	0.84	0.75	0.72	0.48	0.67	0.73	0.67	0.64
<i>PDCD1LG2</i>	1.35	1.13	1.52	1.22	1.36	1.30	1.28	1.48	1.10	1.24

Figure 3 – Immune cell environment of *KRAS* mt PDAC compared to WT. Arrows show significant increase/decrease of infiltration in *KRAS* mt compared to WT tumors.

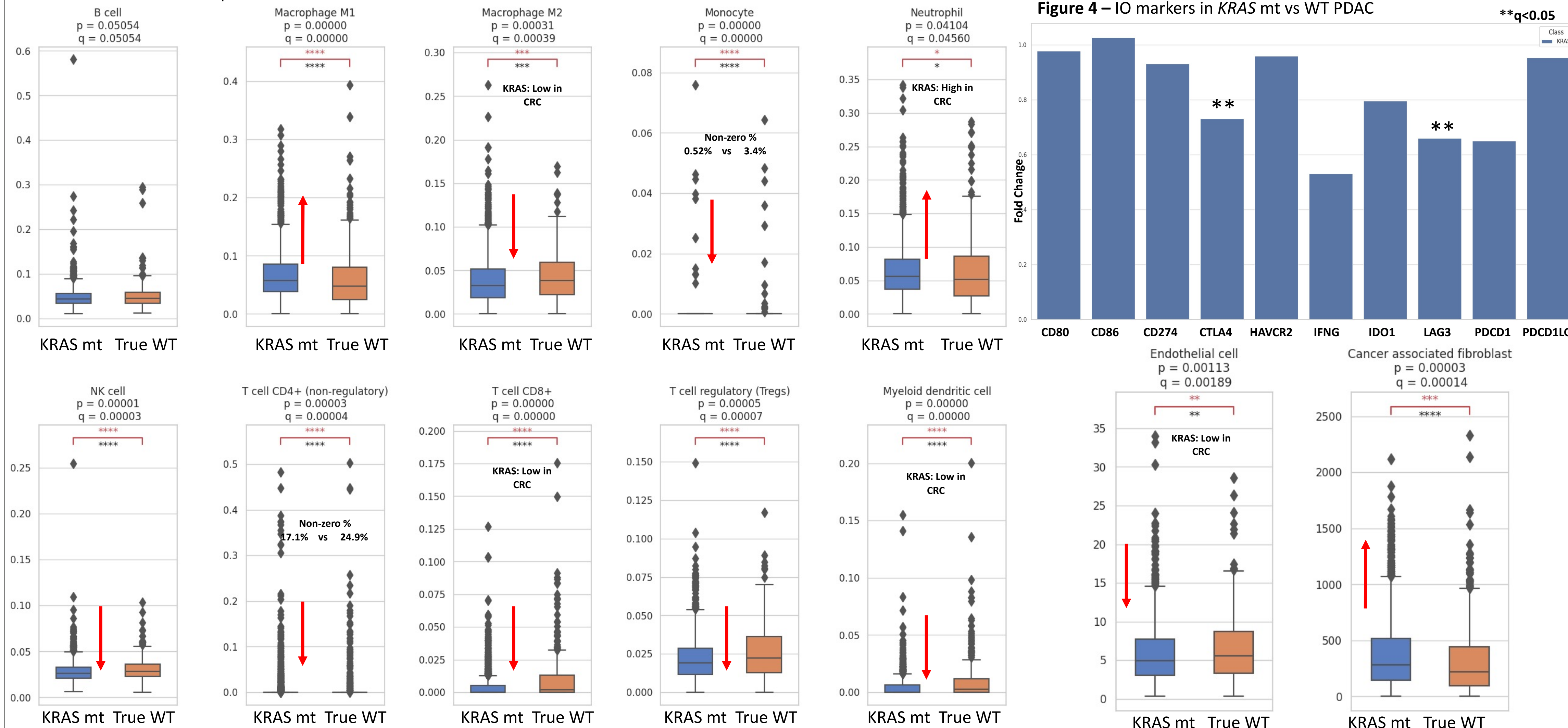
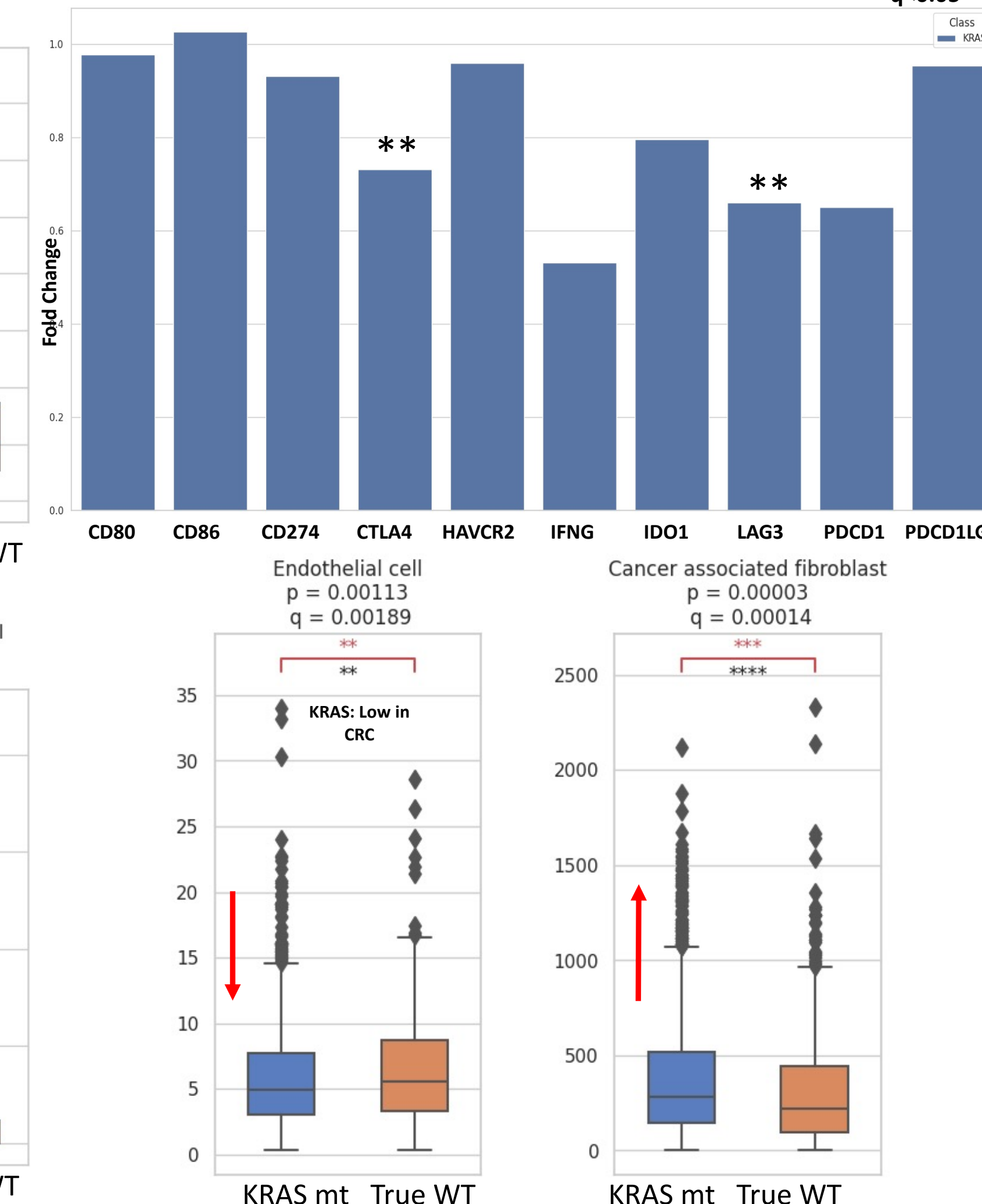


Figure 4 – IO markers in *KRAS* mt vs WT PDAC



Conclusions

- KRAS* mutants were seen in 81% of PDAC and 48% of CRC.
- G12D was the most common *KRAS* variant and was seen in 43% of PDAC and 32% of CRC while *KRAS* G12C variant comprised 2% of PDAC and 7% of CRC.
- For IO related markers: In PDAC, *KRAS* mt were associated with lower prevalence of MSI-H/dMMR when compared to *KRAS* WT (0.9% vs 1.9%, $p=0.027$). PDL1 expression was significantly lower in *KRAS* wt (12%) compared to G12D (19%) and G13X (33%), similar to previous observations in CRC. However, when considering TMB, in PDAC, G12D (1%), G12V (1%) and Q61 (1%) mutations had significantly lower TMB-H than *KRAS* wt tumors (4%); in contradiction to CRC.
- The TME of *KRAS* mt PDAC showed significantly higher infiltration with M1 macrophages and cancer-associated fibroblasts (CAFs), as well as lower M2 macrophages, CD4+ & CD8+ T cells, T-reg, NK, myeloid dendritic and endothelial cells compared to *KRAS* wt (CRC showed similar but more pronounced in PDAC).
- Immune regulatory markers such as CTLA-4 and LAG3 are downregulated in *KRAS* mt PDAC (significant in *KRAS* mutants harboring G12D, G12V, Q61 and some rare variants).
- These results demonstrate that the TME of PDAC and CRC shows immune-cold features. Tailored immunotherapeutic strategies would have to overcome these barriers in *KRAS* mt PDAC and CRC, possibly in combination with molecularly targeted treatment strategies.