A review of bispecific antibodies and antibody constructs in oncology and clinical challenges

Frans V. Suurs, Marjolijn N. Lub-de Hooge, Elisabeth G.E. de Vries, Derk Jan A. de Groot

Department of Medical Oncology, University of Groningen, University Medical Center Groningen, Groningen, the Netherlands
Department of Clinical Pharmacy and Pharmacology, University of Groningen, University Medical Center Groningen, Groningen, the Netherlands
Nuclear Medicine and Molecular Imaging, University of Groningen, University Medical Center Groningen, Groningen, the Netherlands

Abstract

Bispecific antibodies (bsAbs) are antibodies that bind two distinct epitopes to cancer. For use in oncology, one bsAb has been approved and 57 bsAbs are in clinical trials, none of which has reached phase 3. These bsAbs show great variability in design and mechanism of action. The various designs are often linked to the mechanisms of actions. The majority of bsAbs engage immune cells to destroy tumor cells. However, some bsAbs are also used to deliver payloads to tumors or to block tumor signaling pathways. This review provides insight into the choice of construct for bsAbs, summarizes the clinical development of bsAbs in oncology and identifies subsequent challenges.

Keywords:
Bispecific antibody (bsAb)
Antibody constructs
Oncology
Cancer immunotherapy
Clinical trials

1. Introduction

Advances in biotechnology leading to improved antibody production and recombination techniques have fueled the development of antibodies and myriad antibody constructs. Currently, 72 antibodies are approved by the Food and Drug Administration (FDA) of which 30 are registered for the treatment of cancer patients. Antibodies are playing an increasing role in cancer treatments. The understanding of antibodies and how to modify their pharmacokinetic and physicochemical properties has grown. After being established as standard treatments, increasingly complex antibody constructs have been developed. Besides intact immunoglobin...
G (IgG) antibodies, the first antibody drug conjugates and bispecific antibodies (bsAb) have been approved for the treatment of cancer patients, and other antibody constructs are in clinical trials (Carter & Lazar, 2017) (Fig. 1).

Standard human antibodies are monospecific antibodies in which both binding sites are directed against the same target. A bsAb is a more complex construct in which the binding sites are directed to different targets. This enables novel and unique mechanisms of actions (Chames & Baty, 2009; Fan, Wang, Hao, & Li, 2015) such as engaging immune cells to tumor cells, delivering payloads to tumors, and blocking signaling important for the tumor (Fig. 2). Each mechanism of action can require pharmacokinetic properties that can be obtained by modifying the bsAb. An abundance of preclinical data has been published about these bsAb constructs and their mechanisms of action (Brinkmann & Kontermann, 2017).

In oncology, two bsAbs have been approved for use in the clinic. Catumaxomab, targeting Epithelial cell adhesion molecule (EpCAM) and CD3, was approved by the European Medicines Agency (EMA) in 2009 for the treatment of malignant ascites (Seimetz, Lindhofer, & Bokemeyer, 2010). However, at the request of the marketing authorization holder market authorization was withdrawn in June 2017. Blinatumomab, targeting CD19 and CD3, was approved by the FDA in December 2014 and by the EMA in December 2015 for the treatment of Philadelphia chromosome negative B cell acute lymphoblastic leukemia (ALL) (Przepiorka et al., 2015). Outside of oncology the bsAb emicizumab, which binds clotting factors IXa and X, was approved by the FDA in November 2017 and by the EMA in March, 2018 for the treatment of hemophilia A.

Currently, 57 bsAbs, including blinatumomab, are in clinical trials in cancer patients (Table S1) of which 38 use the same mechanism of action: engagement of immune cells with tumor cells. Of the remaining 19 bsAbs in clinical trials, five deliver a payload to tumors and 14 are blocking signaling in the cancer environment.

This review has two aims: 1) to summarize the ongoing clinical development of bsAbs in oncology by evaluating their choice of construct, and 2) to identify the challenges bsAbs are facing in this clinical development.

2. Search strategy

Articles published in English until September 5 2018 were searched using PubMed. The search strategy was based on the terms bispecific antibody, T cell engager, immune cell engager, antibody constructs, targeted delivery and variations of these terms.

The ClinicalTrials.gov database was searched for trials evaluating bsAbs until September 5 2018, based on the abovementioned terms and the names of known bsAbs found in literature. BsAbs were considered to be approaching the clinic if their clinical trials were not all terminated, withdrawn or completed before 2014 without reporting results. Additionally, bsAbs were also excluded when press releases stated that their development had ceased.

Registered drugs were verified on FDA.gov and ema.europa.eu. Reference lists of articles were manually searched for relevant articles missed in the PubMed or ClinicalTrials.gov searches.

3. Bispecific antibody formats and modifications

3.1. Antibody format

An antibody consists of heavy and light domains that connect to form chains. Light chains consist of two light domains and heavy chains of four heavy domains. A light and heavy chain together form a pair, and two heavy-light chain pairs comprise an antibody (Fig. 1A). The region where the two pairs connect is called the hinge region. IgG is the most abundant antibody in the blood and it is the backbone most often used for antibody therapeutics. Endogenous IgGs have small variations in their hinge regions, resulting in IgG subtypes (Irani et al., 2015).

An antibody can be also divided into functional parts: the tail (Fc region) and the binding sites (Fab regions). The Fc region mediates the effector functions that lead to immune-mediated target-cell killing (Scott, Wolchok, & Old, 2012). The Fc region can also be recognized by a receptor called the neonatal receptor, which is involved in regulating the IgG serum levels and actively prolongs the biological half-life (Roopenian & Akilesh, 2007). This process is called neonatal recycling. Connected to the Fc region are the Fab regions containing the variable fragments that make up the binding sites.

3.2. Producing bsAbs

The two binding regions of an antibody target the same epitope. An antibody is therefore bivalent but monospecific. In contrast, bsAbs that

![Image](36x93 to 551x314)

Fig. 1. Schematic overview of the antibody structure and bsAb constructs currently being evaluated in clinical trials. (A) The IgG antibody construct consists of Fab and Fc regions. The binding part of the Fab region is called the single chain variable fragment (scFv). The antibody exists of two heavy chains (VH and CH) and two light chains (VL and CL). These chains can be subdivided by variable (VH and VL) and constant domains (CH and CL). (B) Random heavy-light chain pairing. Two possibilities yield the desired outcome. (C) BsAb constructs currently approved or in clinical trials.
have affinities for two different epitopes bind to two targets, either monovalently or bivalently depending on the construct. Antibodies are generally produced from hybridoma cell lines, which are a fusion of an antibody-secreting B cell and an immortal myeloma cell line (Köhler & Milstein, 1975). BsAbs can be produced by fusing two hybridoma cell lines to form a quadroma, which results in a mixture of IgG molecules (Jain et al., 2007). They can also be produced by conjugating two existing antibodies or their fragments. Another option, which is popular for its flexibility, is using recombinant proteins. Using genetically engineered recombinant proteins creates options regarding origin, composition, and production system (Kontermann, 2012). For example, such proteins can be used to control the association of heavy and light chains. A basic bsAb comprises one heavy-light chain pair from one antibody and another heavy-light chain pair from another antibody. When the four individual chains are combined, they associate randomly, and 16 combinations of IgG molecules can arise. Two of those combinations result in the desired bsAbs with a heterodimerized heavy chain bound to their specific light chains stemming from the same antibody (Fig. 1B). Chimeric quadromas, common light chains and recombinant proteins can provide solutions by limiting the options for association. Chimeric quadromas have species-restricted heavy-light chain pairing. Moreover, using common light chains also prevents undesired heavy-light chain association. Recombinant proteins can force the correct association of heavy-light chains and the heavy chains by multiple means. Examples are the knob-in-holes approach where one heavy chain is engineered with a knob consisting of relatively large amino acids and the other heavy chain is engineered with a hole consisting of relatively small amino acids (A. M. Merchant et al., 1998). Other examples are the constructs with their fragments connected by peptide chains, such as bispecific T cell engagers (BiTE) molecules, thereby circumventing random association of the chains (Mack, Riethmüller, & Kufer, 1995).

3.3. Rational design

Like an antibody, a bsAb can be modified in countless ways to customize its functionality and enhance its efficacy, such as by modulating the immunogenicity, effector functions and half-life of an antibody (Brinkmann & Kontermann, 2017; Carter, 2006).

As regards modulating the immunogenicity, the immunogenic parts of antibody constructs that arise from production in mice are often replaced by human counterparts to reduce auto-immunogenicity (Birch & Racher, 2006; Khazaelli, Conry, & LoBuglio, 1994). This results in the production of chimeric and humanized antibody constructs. Fully human antibody constructs are increasingly being produced, usually by phage display or by immunizing mice that are transgenic for human IgG (Carter, 2006). With phage display, a library of phages expressing antibody parts is screened for affinity to an antigen. Other parts of antibody constructs that can elicit immunogenicity are foreign amino acid sequences, possibly introduced by novel protein engineering (Tovey & Lallemand, 2011).

As regards the effector function of an antibody, the Fc region plays a central role in mediating this process. The region is involved in the immune-mediated cell-killing mechanisms such as complement-dependent cytotoxicity and antibody-dependent cellular cytotoxicity (Scott et al., 2012). In contrast to tumor-cell targeting antibodies, for which a functional Fc region is desired for target cell killing, antibodies binding immune cells are designed to mitigate this cell killing. The immune-mediated cell-killing mechanisms can be influenced by glycoengineering and changing the amino acid sequence of the Fc region (Jiang et al., 2011; Shields et al., 2001). These techniques can enhance or diminish the immune-mediated cell killing via the antibody, depending on the location and the function of the glycans and the amino acids of the antibody that are modified. Besides abolishing
immune-mediated cell killing, the entire Fc region can also be deleted, leading to the distinction between Fc region-bearing and Fc region-lacking antibodies (Kontermann & Brinkmann, 2015). This elimination also drastically reduces the size of an antibody which affects pharmacokinetics including its clearance and tumor penetration (Schmidt & Wittrup, 2009).

An intact IgG antibody is 150 kDa and is cleared by the liver, while proteins with a molecular weight below ~60 kDa are cleared by the kidneys. Renal clearance is faster than hepatic clearance (Wittrup, Thuber, Schmidt, & Rhoden, 2012). The size of an antibody can also be altered by removing domains in the non-binding region of the Fab-region, the C\_1 and C\_2 domains (Fig. 1A). If the non-binding domains are deleted from the construct only the essential binding sites, i.e. the variable fragments remain. These variable fragments linked together by a single peptide chain are called a single chain variable fragment (scFv) (Weisser & Hall, 2009). ScFvs are cleared rapidly from the circulation due to their small size and the lack of the neonatal receptor. Therefore, continuous administration of scFvs may be necessary when a constant blood level is required for treatment of patients (Portell, Wenzell, & Advani, 2013). Moreover, scFvs can serve as building blocks to create bsAbs (Fig. 1C).

Besides increasing the size, others options to extend the half-life of an antibody construct are fusing with or binding to albumin, conjugating to polyethylene glycol fragments and fusing a Fc region to the construct (Kontermann, 2016). Several bispecific constructs when fused to human serum albumin, show increased in half-life in mouse models (Müller et al., 2007). Also, adding a Fc region to bispecifics can circumvent the continuous administration that is required for small constructs due to rapid clearance (L. Liu et al., 2017; Lorenzewski et al., 2017; Moore et al., 2018). In non-human primates, the serum half-life of various BITEs was extended from 6 to 44–167 h by fusing Fc region to them (Arvedson et al., 2017).

BsAbs, in contrast to the standard antibody, do not always bind bivalently to one target. Bivalent binding increases the avidity and can affect the pharmacodynamics of the construct. Bivalent antibodies can induce antibody-dependent dimerization. One example is the development of an antibody that blocks mesenchymal epithelial transition factor (MET) kinase signaling. A monovalent antibody was engineered to prevent dimerization of the MET receptors and downstream activation (M. Merchant et al., 2013). Bivalent antibodies targeting CD3 can also induce crosslinking between T cells leading to T cell lysis (Wong, Eylath, Ghobrial, & Colvin, 1990). In contrast, a one-armed antibody targeting CD3 failed to induce T cell lysis in vitro (Wong et al., 1990). To prevent rejection in patients receiving a renal transplant, a bivalent antibody targeting CD3 depleted T cells but also provoked serious cytokine release (Gaston et al., 1991). With immune cell-engaging bsAbs in oncology, immune cell depletion is not desired, so most of these bsAbs bind CD3 monovalently.

4. Engagement of immune cells

The growing interest in cancer immunotherapy is also driving the development of immune cell engaging bsAbs (Wu & Cheung, 2018). The bsAb blinatumomab engages immune cells to B cell ALL (Kantarjian et al., 2017). It engages the immune cell with the CD3 antigen, a general marker of T cells. The T cell is bound to the tumor by targeting a tumor-associated antigen (TAA). For blinatumomab this TAA is CD19, a marker of B cells. Generally, a TAA should be specific for tumor cells, leaving healthy tissue unharmed. The TAA does not have to play a role in the pathogenesis of the cancer; its primary role in case of immune cell-engaging bsAbs is to provide a binding place at the tumor cell membrane.

The use of immune cell-engaging bsAbs has been explored for over 30 years (Songsivilai & Lachmann, 1990; Staerz, Kanagawa, & Bevan, 1985). Recently, blinatumomab has confirmed the potential of immune cell-engaging bsAbs for the treatment of hematological malignancies (Kantarjian et al., 2017; Topp et al., 2015). In a randomized study, patients with heavily pretreated B cell precursor ALL treated with blinatumomab had a median survival of 7.7 months compared to 4.0 months for the chemotherapy treated group (Kantarjian et al., 2017) (Table 2).

Most bsAbs in clinical trials are immune cell-engaging; 38 of the 57 oncology-related bsAbs reported on ClinicalTrials.gov are of this type (Fig. 3).

4.1. CD3 + T cell-engaging bsAbs

Of the 38 immune cell-engaging bsAbs found in clinical trials, 36 engage T cells by binding to T cell receptor CD3: 18 target hematological malignancies and the remaining 16 target solid cancers.

When both T cell and tumor cell are bound by the bsAb, a cytolytic synapse is formed. In this cytolytic synapse the T cell releases the poreforming perforin and cytotoxic granyme-B, leading to killing of the target cell, as was proven in vitro (Offner, Hofmeister, Romanuik, Kufer, & Baueuerle, 2006) and has been visualized by confocal microscopy (Haas et al., 2009). Binding to a T cell in the absence of a target cell does not activate the T cell as shown in in vitro T cell activation and cytotoxicity assays with human peripheral blood mononuclear cells (PBMCs) and BITEs (Amann et al., 2009; Brischwein et al., 2007).

However, when epidermal growth factor receptor (EGFR) positive and negative cancer cells were mixed in vitro and used to create human xenograft mouse models, a BITE binding CD3 and EGFR also induced killing in the EGFR-negative cells (Ross et al., 2017). This illustrated that BITE treatment can provoke killing of non-TAA expressing tumor cells as well.

Preclinical research has suggested the involvement of immune checkpoints in the response to immune cell-engaging bsAbs in hematological cancers. Addition of AMC330, a BITE targeting CD33 and CD3, to a co-culture of primary acute myeloid leukemia (AML) cells and PBMCs collected from patients resulted in upregulation of programmed death ligand 1 (PD-L1) on predominantly AML cells (Krupka et al., 2016). Addition of anti-PD-1 and/or anti-PD-L1 antibody enhanced lysis of AML cells in these patient samples (Krupka et al., 2016). In cycnomolous monkeys, a CD3 and B cell lineage marker FcRHS targeting full-length bsAb for the treatment of multiple myeloma induced PD1 + CD8 + T cells measured in blood, spleen, lymphnodes and bone marrow and depleted their B cells (Li et al., 2017). Combining this bsAb with an anti-PD-L1 antibody in vitro increased lysis of tumor cells transfected with a PD-L1 encoding plasmid (Li et al., 2017).

In many solid tumor mouse models, with functional immune systems, tumor responses have been observed with immune cell-engaging bsAbs (Yu et al., 2017). For these studies, a broad range of TAAAs were chosen, including established tumor markers such as carcinoembryonic antigen (CEA), EpCAM, human epidermal growth factor receptor 2 (HER2) and EGFR. However, clinical efficacy data on immune cell-engaging bsAbs in solid cancers is scarce (Table 2).

A noteworthy bsAb is IMCgp100, which engages CD3 to glycoprotein-100 (gp100), an antigen associated with melanoma. The construct used for IMCgp100, ImmTAC, targets the surface protein gp100 with a T cell receptor (TCR) instead of the Fab region of an antibody (Liddy et al., 2012) (Fig. 1C). The use of TCRs can enable targeting of intracellular oncoproteins presented by major histocompatibility complex molecules. However, a polyclonal T cell response, such as that generated by CD3-engaging bsAbs, is precluded. A TCR specific for the intracellular WT1 protein coupled to a scFv targeting CD3 (Dao et al., 2015), inhibited xenograft mouse models of human leukemias and solid cancers.

A slightly different approach is the use of bsAb armed T cells (Lum et al., 2015). An example is HER2Bi, a bsAb consisting of two linked antibodies targeting HER2 and CD3. In a phase 1 study, T cells were harvested from the patient and cultured together with the bsAb. The T cells plus the bsAb were then re-infused (Lum et al., 2015).
controlled binding to the T cells ex vivo, less bsAb is potentially required and chance of side effects might be reduced (Bhutani & Lum, 2015). This phase 1 study confirms relatively mild side effects, and showed increased levels of cytokines generally involved in anti-tumor immune responses (Table 2).

4.2. Interplay of CD3+ T cell-engaging bsAbs with the immune system

In general, T cell engaging bsAbs destroy their target independent of co-stimulation, as shown in in vitro cytotoxicity assays with human PBMCs inducing cell death in a human lymphoma cell line in the presence of an anti-CD3 × anti-CD19 bsAb (Dreier et al., 2002). However, addition of a co-stimulatory signal, in this case interleukin-2, can enhance the potency, especially when the PBMCs are co-cultured with the co-stimulatory signal (Dreier et al., 2002). Likewise, targeting co-stimulatory molecules CD137 and CD28 as a co-treatment improved tumor cell killing of immune engaging bsAbs (Liu et al., 2010). Combining a bsAb binding anti-CD137 and anti-CD20 with a bsAb binding anti-CD3 and anti-CD20, showed a synergistic effect in mice bearing human lymphoma xenografts (Liu et al., 2010). However, the CD137 × CD3 bsAb alone did not reduce tumor growth.

Besides co-stimulatory molecules, co-inhibitory molecules are also thought to hamper the effect of immune cell-engaging bsAbs. BsAb RO6958688, the 2:1 CrossMab construct targeting CEA and CD3, increased T cell infiltration into a xenograft colon carcinoma in mice co-grafted with PBMCs as shown with intravital microscopy (Bacac et al., 2016). Moreover administration of this bsAb converted a PD-L1 negative tumor in a PD-L1 positive tumor (Bacac et al., 2016). Similar results were reported for transgenic mouse models with human CD3 and lung and liver carcinoma transduced with human glypican-3 when treated with ERY974, an IgG format bsAb targeting glypican-3 and CD3 (Ishiguro et al., 2017). In in vitro co-cultures of T cells and a panel of tumor cell lines, a BiTE targeting CD3 and CEA induced PD1 expression on T cells and PD-L1 expression on the tumor cells regardless of their initial expression levels (Osada et al., 2015). Cytotoxicity of this BiTE was enhanced by addition of anti-PD1 and anti-PD-L1 antibodies.

HEK293 tumor cells transplanted with PD-L1 limited cytotoxic activity in vitro of HER2-TBD, an anti-HER2 x anti-CD3 bsAb (Junttila et al., 2014). In that study, administration of this bsAb combined with a PD-L1 blocking antibody restored the cytotoxic potential of the bsAb (Junttila et al., 2014). The combination treatment also controlled the tumor growth more potently (Junttila et al., 2014). An Fab(2)-scFv construct engaging CD3 to TROP-2 was synergistic when combined with an anti-PD1 antibody to inhibit tumor growth in spheroid models of the MDA-MB-231 breast cancer cell line and when xenografted in mice (Chang et al., 2017).

The potential of immune cell engaging bsAbs to increase T cell infiltration into solid tumors (Ji Li et al., 2018) and the emerging evidence that inhibition of the PD1/PD-L1 axis could potentiate the effect of bsAbs, is leading to an increase in phase 1 trials evaluating immune cell engaging bsAbs in combination with checkpoint inhibitors, especially anti-PD-L1 antibodies (Table 3). Early results show enhanced activity of RO6958688, the CEA and CD3 targeting bsAb, when combined with anti-PD-L1 antibody atezolizumab in patients with metastatic colorectal cancer (Argilés et al., 2017; Segal et al., 2017). Two of 31 patients treated with RO6958688 alone had a partial response, compared to 14 of 31 patients treated with the combination (Argilés et al., 2017).
niques to deliver payloads to a tumor could potentially circumvent and for a payload, and then injecting the payload. Pretargeting tech-
can be incubated with the payload before injection. Pretargeted delivery
pling to an antibody, a bsAb with af
internalized and the payload is trapped in the cell and can exert its
effect.

breast cancer, and brentuximab vedotin is registered for the treatment
for the treatment of patients with metastatic HER2 overexpressing

soluble CD30 were seen in the peripheral blood, and three out of 26 pa-
(Rothe et al., 2015). In that study, activated NK cells and a decrease of
(TandAb) construct targeting CD30 and CD16, has been completed
in patients with Hodgkin’s lymphoma of AFM13, a tandem diabody
tent cytotoxic lymphocytes of the innate immune system. A phase 1 trial
was completed in 2007 (NCT00204594), but results are not available.

(PTable S1).

trial with AFM13 is now ongoing in patients with Hodgkin’s lymphoma

has entered the clinic (Moek, de Groot, de Vries, & Fehrmann, 2017).

Payload delivery

BsAbs are also options for payload delivery. Payload delivery via anti-
bodies, such as radioimmunotherapy and antibody-drug-conjugates,
has entered the clinic (Moek, de Groot, de Vries, & Fehrmann, 2017).
In this approach, a payload containing an isotope or a drug is directly
coupled to an antibody. The radioimmunotherapy 111In-ibritumomab
tiuxetan is registered for the treatment of non-Hodgkin lymphoma,
the antibody-drug-conjugate adatoxotumab emansine is registered for
the treatment of patients with metastatic HER2 overexpressing
breast cancer, and brentuximab vedotin is registered for the treatment
of Hodgkin lymphoma and systemic anaplastic large cell lymphoma.
They deliver their payload directly to the tumor by binding the anti-
body to the TAA. The antibody, with payload, bound to the TAA is then
internalized and the payload is trapped in the cell and can exert its
effect.

Using a bsAb enables new targeting methods. Instead of direct cou-
pling to an antibody, a bsAb with affinity for the TAA and the payload
can be incubated with the payload before injection. Pretargeted delivery
could also be achieved by first injecting the bsAb with affinity for a TAA
and for a payload, and then injecting the payload. Pretargeting tech-
niques to deliver payloads to a tumor could potentially circumvent
prolonged exposure of healthy tissue to the payload, thus mitigating
toxicity and adverse effects (Boerman, van Schaijk, Oyen, & Corstens,
2003).

Connecting the payload and the bsAb is achieved by directing one
arm of the bsAb to a hapten of the payload (Goldenberg et al., 2012;
Goldenberg & Sharkey, 2007; Knight & Cornelissen, 2014). Haptens
are molecules that are not immunogenic by themselves, but can act as
an antigen and can be bound by an antibody.

The first paper reporting a clinical trial using a bsAb for delivery of a
payload was published in 1993 (Le Doussal et al., 1993). Currently, five
bsAbs delivering payloads are in clinical trials, four of which target solid
tumors. BsAb TF2, existing of three Fab fragments of which two target
CEA and one the payload, is most advanced with a phase 2 trial (Fig. 3).

5.1. Pretargeted delivery of a radioactive payload

Patients with medullary thyroid cancer expressing CEA were
 injected with bsAb TF2, targeting CEA and the payload (Schoffelen
et al., 2013). After 24 h, the payload, a small peptide labeled with
111indium, was administered. Tumor-to-tissue ratios >1:20 were ob-
served 24 h after administering this small peptide showing the feasibil-
ity of pretargeting with bsAbs (Schoffelen et al., 2013). In theory, the
unbound payload will be cleared rapidly due to its small size, minimiz-
ing damage to not-targeted tissues (van de Watering, Rijpkema,
Robillard, Oyen, & Boerman, 2014).

When the payload is a therapeutic radiometal, the hapten can be the
chelator of the radiometal (Cheal et al., 2014). Another option is the use
of two haptens to create one large bivalent hapten that favors the bind-
ing to two tumor-bound bsAbs, which would stabilize binding to the
tumor (Barbet et al., 1999). This system is called affinity enhancement
system (Le Doussal, Martin, Gautheret, Delage, & Barbet, 1989) and
has been used in clinical studies (Table 2).

For the pretargeted delivery of yttrium-90 for radioimmunotherapy,
A bsAb with affinity for CD38 and the DOTA-yttrium complex was com-
pared with an antibody binding the radiometal via a streptavidin-biotin
bond. In mice xenografted with non-Hodgkin lymphoma, or multiple
myeloma, the bsAb approach showed a superior antitumor effect com-
pared to the streptavidin-biotin approach (Green et al., 2018).

Pretargeting can also be achieved with alternatives for linking the
payload and the antibody. These include streptavidin-biotin, oligonucle-
otides or click-chemistry, such as the cycloaddition reaction between a
tetrazine and a trans-cyclooctene (Altai, Membreino, Cook, Tolmachev,
& Zeglis, 2017). However the approach with bsAbs is the only one that
has been tested in the clinic so far (Altai et al., 2017) (Table 2).

5.2. Delivery of other payloads

Pretargeted delivery of other toxic payloads by bsAbs, such as doxo-
rubicin, has been explored in animal models by binding a chelator-
hapten (Gada, Patil, Panwar, Hatefi, & Khaw, 2012; Khaw et al., 2014).
In these studies, the chelator was loaded with the radioisotope
technetium-99 to validate target-specific binding. Other haptons, such
as digoxigenin, can also be conjugated to the payload and are used for
drug delivery (Dengi, Sustmann, & Brinkmann, 2016). Several payloads,
such as doxorubicin and the fluorescent dye Cy5 conjugated to
digoxigenin, showed specific targeting in human xenograft mouse
models (Metz et al., 2011).

A direct targeting approach, in which the bsAb and the payload are
incubated prior to administration is being tested in the clinic
(MacDiarmid et al., 2007) (Table 2 and S1). In this approach, the payload
is encapsulated in a bacterially-derived nanocell, which is called an
genecic delivery vehicle (EDV), and the bsAbs are two antibodies
linked together via their Fc regions (MacDiarmid et al., 2007). The pay-
load can be a chemotherapeutic drug such as doxorubicin or paclitaxel,
but also silencing microRNA. Results of three trials that tested EDVs
Table 1
Constructs of the bsAbs in clinical trials.

<table>
<thead>
<tr>
<th>Construct</th>
<th>Structure</th>
<th>Characteristics</th>
<th>bsAbs</th>
</tr>
</thead>
<tbody>
<tr>
<td>TrioMab</td>
<td>Produced in a rat/mouse quadroma (Chelius et al., 2010). One heavy-light chain is rat, the other heavy-light chain is mouse.</td>
<td>Species restricted heavy-light chain pairing</td>
<td>Catumaxomab</td>
</tr>
<tr>
<td>IgG-like, common light chain.</td>
<td>IgG like with each Fab binding another epitope.</td>
<td>Heterodimerization of heavy chains is based on the knob-in-holes or another heavy chain pairing technique. Randomly pairs light chains to heavy pairs. Often a common light chain is used (Dovedi et al., 2018), (E. J. Smith et al., 2015), (Yen et al., 2016), (de Vries Schultzink et al., 2018).</td>
<td>ERY972, BTCT4465A, MCLA-117, MCLA-128, MEDIS572, OMFP058B3, REGN1979, ZW25</td>
</tr>
<tr>
<td>CrossMab</td>
<td>Uses the knob-in-holes technique for the heavy chain pairing. The Cα1 domain of the heavy chain is switched with the constant domain of the light chain (εG) (Klein, Schafer, &amp; Regula, 2016).</td>
<td>Ensures specific pairing between the heavy-light chains. No side products possible.</td>
<td>Vanucizumab</td>
</tr>
<tr>
<td>2:1 CrossMab</td>
<td>An additional Fab-fragment is added to the N-terminus of its VH domain of the CrossMab (Klein et al., 2016), (Bacac et al., 2018).</td>
<td>The added Fab-fragment to the CrossMab increases the avidity by enabling bivalent binding.</td>
<td>R06958688, R07082859</td>
</tr>
<tr>
<td>2:2 CrossMab</td>
<td>A tetravalent bispecific antibody generated by fusing a Fab-fragment to each C-terminus of a CrossMab (Klein et al., 2016). These Fab-fragments are crossed: their CH1 is switched with their CL VH is fused to their CL and the VH to the CH1 (Brünger et al., 2016).</td>
<td>CrossMab technology in Fab-fragments ensure specific pairing. Avidity is enhanced by double bivalent binding.</td>
<td>R06874813</td>
</tr>
<tr>
<td>Duobody</td>
<td>The Fab-exchange mechanism naturally occurring in IgG4 antibodies is mimicked in a controlled matter in IgG1 antibodies, a mechanism called controlled Fab exchange (Labrijn et al., 2013).</td>
<td>Ensures specific pairing between heavy-light chains and heterodimerization of heavy chains.</td>
<td>JN1-61186372, JN1-64007957</td>
</tr>
<tr>
<td>Dual-variable-domain antibody (DVD-Ig)</td>
<td>Additional Vα and variable light chain (Vβ) domain are added to each N-terminus for bispecific targeting (Jakob et al., 2013).</td>
<td>This format resembles the IgG-scFv, but the added binding domains are bound individually to their respective N-termini instead of a scFv to each heavy chain N-terminus.</td>
<td>ART165</td>
</tr>
<tr>
<td>scFv-IgG</td>
<td>Two scFv are connected to the C-terminus of the heavy chain (Cγ3) (Xu et al., 2013).</td>
<td>Has two different bivalent binding sites and is consequently also called tetravalent. No heavy-chain and light-chain pairing problem.</td>
<td>MM-141, NOV1501/ABL001</td>
</tr>
<tr>
<td>IgG-IgG</td>
<td>Two intact IgG antibodies are conjugated by chemically linking the C-terminals of the heavy chains (Ma et al., 2013).</td>
<td>Facile development using available antibodies.</td>
<td>EGR881, HER2Bi, Cerebral EDV, KIDEV, TargetMir</td>
</tr>
<tr>
<td>Fab-scFv-Fc</td>
<td>Assembly of a light chain, heavy chain and a third chain containing the Fc region and the scFv (Moretti et al., 2013), (Chu et al., 2014), (de Zafra et al., 2017).</td>
<td>Efficient manufacturing and purification.</td>
<td>XmAb14045, XmAb13676, XmAb18087, XmAb20717, AMG424, GBR1302, GBR1342, TF2</td>
</tr>
<tr>
<td>TF</td>
<td>Three Fab fragments are linked by disulfide bridges (Rossi et al., 2006). Two fragments target the tumor associated antigen (TAA) and one fragment targets a hapten.</td>
<td>Lacks an Fc region.</td>
<td></td>
</tr>
<tr>
<td>ADAPTIR</td>
<td>Two scFv bound to each sides of an Fc region (Hernandez-Hoyos et al., 2016).</td>
<td>Abandons the intact IgG as a basis for its construct, but conserves the Fc region to extend the half-life and facilitate purification.</td>
<td>ES414</td>
</tr>
<tr>
<td>Bispecific T cell Engager (BiTE)</td>
<td>Consists of two scFvs, VαA VβA and VβB VαB on one peptide chain (Mack et al., 1995).</td>
<td>Has only binding domains, no Fc region.</td>
<td>Blinatumomab, AMG110, AMG211, AMG330, BAY2010112, BFCR4350A and BIB36909/AMG420</td>
</tr>
<tr>
<td>BiTE-Fc</td>
<td>An Fc region is fused to the BiTE construct (Lorenczewski et al., 2017).</td>
<td>Addition of Fc region enhances half-life leading to longer effective concentrations, avoiding continuous IV (Arvedson et al., 2017).</td>
<td>AMG757</td>
</tr>
<tr>
<td>Dual affinity retargeting (DART)</td>
<td>Two peptide chains connecting the opposite fragments, thus VαA with VβB and VβB with VαA, and a sulfur bond at their C-termini fusing them together (Moor et al., 2018), (Root et al., 2016). Four peptide chains are assembled. Basically, two DART molecules are created with half an Fc region and will dimerize (La Motte-Mohs et al., 2017).</td>
<td>Sulfur bond supposed to improve stability over BiTEs.</td>
<td>MCD006</td>
</tr>
<tr>
<td>DART-Fc</td>
<td>An Fc region is attached to the DART structure. Generated by assembling three chains. Two via a disulfide bond, as with the DART. One chain contains half of the Fc region which will dimerize with the third chain, only expressing the Fc region (Moor et al., 2018), (Root et al., 2016).</td>
<td>Addition of Fc region enhances half-life leading to longer effective concentrations, avoiding continuous IV.</td>
<td>MCD007, MCD009, PF-06671008</td>
</tr>
<tr>
<td>Tetravalent DART</td>
<td>Four peptide chains are assembled. Basically, two DART molecules are created with half an Fc region and will dimerize (La Motte-Mohs et al., 2017).</td>
<td>Bivalent binding to both targets, thus a tetravalent molecule</td>
<td>MCD013</td>
</tr>
<tr>
<td>Tandem diabody (TandAb)</td>
<td>Two diabodies. Each diabody consists of an VαA and VβB fragment and a VαA and VβB fragment covalently associating. Two diabodies are linked with a peptide chain (Kipriyanov et al., 1999).</td>
<td>Designed to improve stability over the diabody consisting of two scFvs (Kipriyanov et al., 1999). Has two bivalent binding sites.</td>
<td>AFM11, AFM13, AMV564</td>
</tr>
<tr>
<td>scFv-scFv-toxin</td>
<td>Toxin and two scFv with a stabilizing linker (Valera, Chen, Sicheneder, Panoskaltsis-Mortari, &amp; Taras, 2009).</td>
<td>Specific delivery of payload</td>
<td>DT2219ARL</td>
</tr>
<tr>
<td>Modular scFv-scFv-scFv</td>
<td>One scFv directed against the TAA is tagged with a short recognizable peptide is assembled to a bsAb consisting of two scFvs, one directed against CD3 and one against the recognizable peptide (Ardnt et al., 2014).</td>
<td>Modular system, thus flexible, built around the recognizable peptide.</td>
<td>GEM33</td>
</tr>
</tbody>
</table>

(continued on next page)
have been published (Table 2). The phase 1 data showed an acceptable safety profile.

The bsAb DT2219 has a directly conjugated payload and targets both CD22 and CD19 to enhance specific delivery. The payload is the toxin diphtheria and enters the cytosol after internalization by CD19 and/or CD22 (Bachanova et al., 2015). This bsAb has been studied in patients with refractory B cell malignancies and one complete and one partial response were reported out of 25 patients (Table 2).

### 6. Signaling blockade

Targeting multiple epitopes or receptors in cancer with combination therapies is a popular approach and many combinational approaches to antibody treatments are being evaluated in clinical trials (D. S. Chen & Mollman, 2017; Henricks, Schellens, Huitema, & Beijnen, 2015; Smyth, Ngioi, Ribas, & Teng, 2016).

A combination of nivolumab, an anti-PD-1 antibody, with ipilimumab, an anti-CTLA4 antibody, has been approved by the FDA and EMA for metastatic melanoma (Postow et al., 2015). Recently, this combination was also approved for the treatment of advanced renal cell carcinoma by the FDA (Motzer et al., 2018). A slightly different combination treatment is a multi-epitope approach with pertuzumab and trastuzumab, both targeting HER2 but on different epitopes. It has been approved as a combination treatment for patients with metastatic HER2-positive tumors (Swain et al., 2015).

Theoretically, the targets of two antibodies could be incorporated into a single bsAb, which could yield various benefits. The specificity of such a drug might be enhanced by co-localization of receptors on cancers, thus minimizing on-target toxicity of healthy tissues. Also, improvements of binding affinity might be achieved by targeting different epitopes of one antigen. Potential disadvantages of such a bsAb are that it would limit itself to one combination of antigens, while antibodies can be combined freely, and it would prevent the sequential administration or personalized dosing of two antibodies. According to ClinicalTrials.gov, 14 bsAbs that block signaling important for the tumor are being studied in clinical trials.

#### Table 1 (continued)

<table>
<thead>
<tr>
<th>Construct</th>
<th>Structure</th>
<th>Characteristics</th>
<th>bsAbs</th>
</tr>
</thead>
<tbody>
<tr>
<td>ImmTAC</td>
<td>A stabilized and soluble T cell receptor is fused to a scFv recognizing CD3 (Oates, Hassan, &amp; Jakobsen, 2015). Two single variable domains (nanobodies) with an additional module for half-life extension (I. Hofmann et al., 2015).</td>
<td>By using a TCR, the ImmTAC is suitable to target processed, e.g. intracellular, proteins. Extra module added to enhance half-life.</td>
<td>IMCgp100, IMCyneso</td>
</tr>
<tr>
<td>Tri-specific nanobody</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trispecific Killer Engager (TrisKE)</td>
<td>Two scFs connected via polypeptide linkers incorporating human IL-15 (Valera et al., 2016).</td>
<td>Linker to IL-15 added to increase survival and proliferation of NKs</td>
<td>161,533</td>
</tr>
</tbody>
</table>

6.2. Immune receptors

Following the establishment of immune checkpoint inhibitors and combinations thereof as therapies in oncology, bsAbs are being explored as additions or improvements to these existing therapies. Tetravalent dual affinity retargeting (DART) construct MGD013 targets both lymphocyte activation gene 3 (LAG-3) and PD-1 bivalently; it will be evaluated in a clinical trial in patients with advanced solid tumor (LaMotte-Mohs et al., 2016). In vitro, MGD013 gave rise to increased cytokine release by T cells compared to monotherapies or combination therapies, indicating increased T cell activation (LaMotte-Mohs et al., 2016). MEDI5752 is a monovalent antibody combining PD-1 and CTLA-4 inhibition preferentially on tumor-infiltrated lymphocytes (Dovedi et al., 2018). This will be tested in a clinical trial in patients with advanced solid tumors (Table S1).

IgG-like construct FS118 also blocks two pathways by targeting PD-L1 via its Fab-fragments and LAG-3 via its fc region (Kraman et al., 2017). A murine counterpart of FS118, targeting murine LAG-3 and PD-L1, induced dose-dependent anti-tumor activity (Kraman et al., 2017) and changed the composition of immune infiltrating lymphocytes by increasing the ratio CD8:Tregs (Kraman et al., 2018). This construct is being tested in a clinical trial in patients with advanced cancer (Table S1).

6.3. Inhibiting angiogenesis

Instead of binding two cell membrane epitopes, the tumor environment itself can also be a target. The CrossMab construct vanucizumab...
<table>
<thead>
<tr>
<th>bsAb (CD19 x CD3)</th>
<th>Phase</th>
<th>Indication</th>
<th>Dose</th>
<th>Key results</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blinatumomab (CD19 x CD3)</td>
<td>III</td>
<td>Adults with heavily pretreated B cell precursor ALL (n = 376)</td>
<td>9 μg/d cIV over 1 week, followed by 28 μg/d cIV for 3 weeks</td>
<td>Blinatumomab treated: OS: 7.7 months, CR:44%; grade 3 + AE: 87%. Chemotherapy treated: OS: 4.0 months, CR:25%, grade 3 + AE: 92%.</td>
<td>(Kantarjian et al., 2017)</td>
</tr>
<tr>
<td>Blinatumomab (CD19 x CD3) + tyrosine kinase inhibitor</td>
<td>Retrospective</td>
<td>Adults with relapsed/refractory Ph + acute lymphoblastic leukemia (n = 9) and chronic myeloid leukemia in blast crisis (n = 3)</td>
<td>blinatumomab and a TKI (ponatinib, n = 8; dasatinib, n = 3; bosutinib, n = 1)</td>
<td>OS: not reached after 14 months, CR: 9/12, AE: 2/12 grade 2 cytokine release syndrome.</td>
<td>(Assi et al., 2017)</td>
</tr>
<tr>
<td>Catumaxomab (EpCAM x CD3)</td>
<td>II/III</td>
<td>Malignant ascites secondary to epithelial cancers (n = 258)</td>
<td>10, 20, 50 and 150 μg/day on day 0, 3, 7, 10, respectively, via IP infusion</td>
<td>Catumaxomab plus paracentesis treated: OS:72 days, puncture free survival: 46 days. Paracentesis treated: OS: 68 days, puncture free survival: 11 days. AE: 23% of patients had a serious adverse event. AE: pyrexia (60.5%), abdominal pain (42.7%), nausea (33.1%), vomiting (27.4%).</td>
<td>(Heiss et al., 2010)</td>
</tr>
<tr>
<td>MEHD7945A/Duligotuzumab (EGFR x HER3)</td>
<td>II</td>
<td>RAS wild-type metastatic colorectal cancer (n = 134)</td>
<td>Duligotuzumab 1100 mg IV every 2 weeks + FOLFIRI (n = 68)</td>
<td>Patient outcomes not improved, development stopped. PFS: 7.3 vs 5.7 months, OS: 14 vs 12.4 months, CR: 0% vs 3%, Duligotuzumab vs cetuximab, respectively. AE: rash (84%), diarrhea (79%), fatigue (62%), and nausea (50%). Similar G ≥ 3 AEs between treatment groups.</td>
<td>(Hill et al., 2018)</td>
</tr>
<tr>
<td>MEHD7945A/Duligotuzumab (EGFR x HER3)</td>
<td>II</td>
<td>Head and neck squamous cell carcinoma (n = 121)</td>
<td>Duligotuzumab: 1100 mg iv every 2 weeks (n = 59)</td>
<td>PFS: 4.2 vs 4.0 months, OS: 7.2 vs 8.7 months, CR: 2% vs 18%, Duligotuzumab vs cetuximab, respectively. AE: rash, infections diarrhea, fatigue, and nausea. G ≥ 3 AEs in the duligotuzumab arm (61%) versus cetuximab arm (51%)</td>
<td>(Fayette et al., 2016)</td>
</tr>
<tr>
<td>AFM13 (CD30 x CD16A)</td>
<td>I</td>
<td>Relapsed or refractory Hodgkin’s lymphoma (n = 28)</td>
<td>Weekly infusion for 4 weeks. 0.01, 0.04, 0.15, 0.5, 1.5, 4.5, and 7.0 mg/kg body weight</td>
<td>PR: 11.5%, SD: 50%; AE: fever (53.6%), chills (39.3%), headache (28.6%), nausea and nasopharyngitis (17.9%), and infusion reaction, rash, vomiting, and pneumonia (14.3%). MTD not reached.</td>
<td>(Rothe et al., 2015)</td>
</tr>
<tr>
<td>AMG110 (EpCAM x CD3)</td>
<td>I</td>
<td>Relapsed or refractory solid tumors (n = 65)</td>
<td>1–96 μg/day cIV for ≥28 days MTD: 24 μg/day. SD: 18/64. AE: Diarrhea (46%), pyrexia (43%), peripheral edema (40%), nausea (39%), vomiting (34%), abdominal pain (32%), AE ≥ G: 95%.</td>
<td>PR: 7%, SD: 31%; AE: Hypertension (86%), asthenia (75%), pyrexia and diarrhea.</td>
<td>(Kebenko et al., 2018)</td>
</tr>
<tr>
<td>AMG221 (CEA x CD3)</td>
<td>I</td>
<td>Relapsed or refractory gastrointestinal adenocarcinoma (n = 44)</td>
<td>0.2–12.8 μg/day cIV for 1–3 weeks.</td>
<td>Disease progression in 33/44 pts. AE: fatigue, nausea, abdominal pain, pyrexia and diarrhea.</td>
<td>(Moek et al., 2018)</td>
</tr>
<tr>
<td>BIB36880 (VEGF x Ang-2)</td>
<td>I</td>
<td>Advanced or metastatic solid cancer (n = 29)</td>
<td>Schedule 1: 40–1000 mg every three weeks. Schedule 2:40–180 mg every week.</td>
<td>MTD/RP2D: 720 mg every three weeks. PR: 7%, SD: 31%; AE: Hypertension (83%), asthenia (48%), nausea (45%) and vomiting (38%).</td>
<td>(Le Tourneau, Clau, et al., 2018; Le Tourneau, Tabernero, et al., 2018)</td>
</tr>
<tr>
<td>BIS-1 (EpCAM x CD3)</td>
<td>I</td>
<td>Malignant peritoneal or pleural effusion (n = 9)</td>
<td>Autologous activated T lymphocytes in the presence of BIS-1 were locally infused in patients with peritoneal or pleural effusion.</td>
<td>Effusions showed a reduction or complete disappearance of tumor cells 24 h after start of treatment.</td>
<td>(Kroesen et al., 1997)</td>
</tr>
<tr>
<td>Renal cell cancer (RCC) (n = 14)</td>
<td></td>
<td></td>
<td>RCC patients received 1, 3 or 5 μg/kg BIS-1 (without Fc region) accompanied with SC interleukin-2 therapy.</td>
<td>For BIS-1 without Fc region, no responses were seen. AE: Severe toxicity observed at 3 and 5 μg/kg</td>
<td></td>
</tr>
</tbody>
</table>

(continued on next page)
<table>
<thead>
<tr>
<th>bsAb</th>
<th>Phase</th>
<th>Indication</th>
<th>Dose</th>
<th>Key results</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD20Bi (CD20 x CD3)</td>
<td>I</td>
<td>Lymphoma and myeloma (n = 12)</td>
<td>5, 10, 15, 20 or 40 × 10^9 T cells incubated with CD20Bi per infusion</td>
<td>AE: chills, fever, hypotension, fatigue. MTD not reached.</td>
<td>(Lum et al., 2013)</td>
</tr>
<tr>
<td>DT2219 (CD19 x CD22)</td>
<td>I</td>
<td>Refractory B cell malignancies (n = 25)</td>
<td>0.5, 1.25, 2.5, 5, 10, 20, 40, 60, 80 µg/kg/day every other day for 4 total doses (days 1, 3, 5, and 8)</td>
<td>CR: 1/25, PR: 1/25, RP2D: 40–80 µg/kg/day. AE: weight gain (range, 5%–14% of baseline), peripheral edema, and hypoalbuminemia consistent with capillary leak syndrome, grade 1–2 fever, and fatigue.</td>
<td>(Bachanova et al., 2015)</td>
</tr>
<tr>
<td>EGFRBi (EGFR x CD3)</td>
<td>I</td>
<td>Advanced pancreatic and colon cancer (n = 5)</td>
<td>10, 20 or 40 × 10^9 T cells incubated with EGFRBi by infusion</td>
<td>MTD not reached.</td>
<td>(Lum, 2015)</td>
</tr>
<tr>
<td>EGFR-nanocell-paclitaxel</td>
<td>I</td>
<td>Advanced solid tumors (n = 28)</td>
<td>1 × 10^9, 2 × 10^9, 5 × 10^9, 2, 5 × 10^10 nanocells per weekly infusion, 5 weeks</td>
<td>SD:10/22 patients, MTD: 1 × 10^10, RP2D: 5 × 10^9 nanocells per infusion. AE: grade 4 lymphopenia (2/28), grade 4 elevated aminotransferase (1/28) and grade 4 elevated alanine transaminase (1/28), Common AE: transient chills (16/28, 57%) and pyrexia (13/28, 46%).</td>
<td>(Solomon et al., 2015)</td>
</tr>
<tr>
<td>EGFR-nanocell-doxorubicin</td>
<td>I/II</td>
<td>Recurrent glioblastoma (n = 16)</td>
<td>1 × 10^8, 2 × 10^8, 5 × 10^8, and 8 × 10^10 nanocells per weekly infusion, 8 weeks</td>
<td>OS: 9 months and 21 days, SD: 28%, RP2D: 8 × 10^9 nanocells per infusion. No DLT observed. AE: nausea (7/16), fever (5/16), and chills or rigors (5/16).</td>
<td>(Whittle et al., 2006)</td>
</tr>
<tr>
<td>F6–734/HMN14–734 (CEA x DTPA)</td>
<td>Retrospective</td>
<td>Metastatic medullary thyroid cancer (n = 29) versus control metastatic medullary thyroid cancer (n = 39)</td>
<td>20–50 µg of anti-CEA/anti-DTPA-indium murine BsMAb F6–734, 4 days later the hapten labeled with 1.4 to 4.1 GBq of 111Iodine. Or 40 or 75 mg/m² humanized anti-CEA/murine anti-DTPA-indium BsMAb (HM1N14–734), 5 days later 2.7 GBq of 111Iodine labeled hapten.</td>
<td>100% increase in serum calcitonin doubling times (defined as biologic responder) and bone-marrow involvement are prognostic indicators in patients. OS biologic responders: 159 months, OS non-responders: 109 months, OS untreated: 61 months. AE: grade 4 thrombocytopenia (5/29) and grade 4 neutropenia (4/29)</td>
<td>(Chatal et al., 2006)</td>
</tr>
<tr>
<td>FBTA05 (CD20 x CD3)</td>
<td>I</td>
<td>Recurrent or refractory B cell malignancies Recurrent or refractory B cell malignancies Pediatric recurrent or refractory B cell malignancies (n = 10)</td>
<td>Individual treatment schedules. Doses from 10 to 300 µg weekly or 10–100 µg daily.</td>
<td>CR: 5/10, PR: 1/10, SD: 3/10. AE: acute infusion reactions, fatigue, hypotension.</td>
<td>(Schuster et al., 2015)</td>
</tr>
<tr>
<td>HER2Bi (HER2 x CD3)</td>
<td>I</td>
<td>Metastatic breast cancer (n = 22)</td>
<td>5, 10, 20 or 40 × 10^9 T cells incubated with HER2Bi per infusion</td>
<td>SD: 13/22, PD: 9/22, OS HER2 3+ patients: 36.2 months, OS HER2 0–2+ : 27.4 months, AE: grade 3 chills and grade 3 headaches. Nausea/diarrhea: 9/22 patients. MTD not reached. MTD/RP2D: 75 µg.</td>
<td>(Lum et al., 2015)</td>
</tr>
<tr>
<td>IMCgp100 (gp100 x CD3)</td>
<td>I</td>
<td>Metastatic uveal melanoma (n = 19)</td>
<td>Week 1: 20 µg iv, once. Week 2: 30 µg iv, once. Week 3 and beyond: 60, 70, 80, 75 µg per week</td>
<td>MTD/RP2D: 75 µg. SD: 12/19. AE: pruritus (84%), pyrexia (84%), fatigue (74%), hypotension (15%), peripheral edema (63%).</td>
<td>(Sato et al., 2017)</td>
</tr>
<tr>
<td>IMCgp100 (gp100 x CD3)</td>
<td>I</td>
<td>Advanced melanoma (n = 31)</td>
<td>5 ng/kg to 900 ng/kg IV every week or daily</td>
<td>MTD: 600 ng/kg weekly IV PR: 4/26, SD: 12/26, AE: rash (100%), pruritus (64%), pyrexia (50%), and periorbital edema (46%).</td>
<td>(Middleton et al., 2016)</td>
</tr>
<tr>
<td>LY3164530 (MET x EGFR)</td>
<td>I</td>
<td>Advanced or metastatic cancer (n = 29)</td>
<td>Schedule 1: 300–1250 mg every 2 weeks. Schedule 2: 500–600 mg weekly.</td>
<td>Development stopped due to toxicity and lack of potential predictive biomarker.</td>
<td>(Patnaik et al., 2015)</td>
</tr>
<tr>
<td>MCLA–128 (HER2 x HER3)</td>
<td>I/II</td>
<td>Advanced solid tumors (n = 28)</td>
<td>40–900 mg every 3 weeks IV over 1–2 h Phase 2 part, at RP2D</td>
<td>MTD schedule 1:1000 mg MTD schedule 2: 500 µg CR: 10.3%, SD: 17.2%. AE: Acneiform (84%), hypomagnesemia (55.2%), paronychia (34.5%). No DLT observed. RP2D: 750 mg every 3 weeks. Phase 2: 8 patients with HER2 amplified metastatic breast cancer. PR:1/8, SD: 5/8, AE: infusion related effects (40%), G1–2</td>
<td>(Alsina et al., 2017)</td>
</tr>
<tr>
<td>bsAb</td>
<td>Phase</td>
<td>Indication</td>
<td>Dose</td>
<td>Key results</td>
<td>Ref</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>------------</td>
<td>------</td>
<td>-------------</td>
<td>-----</td>
</tr>
<tr>
<td>MDX-447 (EGFR x CD64)</td>
<td>I</td>
<td>Advanced solid tumors (n = 64)</td>
<td>1–40 mg/m², IV weekly, 1 to 15 mg/m² in combination with G-CSF (3 μg/kg) sc</td>
<td>diarrhea (13%), rash (13%), fatigue (13%). MTD MDX-447 alone: 30 mg/m² CR: 0, PR: 0. AE: 633 administrations, 41 grade 3 or 4 event containing: hypotension (7%), dyspepsia (5%), pain (3%), hypertension (3%), headache (2%), fever (2%), diarrhea (2%), thrombocytopenia (2%), and hyperglycemia (2%).</td>
<td>(Fury, Lipton, Smith, Winston, &amp; Pfister, 2008)</td>
</tr>
<tr>
<td>MM-111 (HER2 x HER3)</td>
<td>I</td>
<td>HER2+ cancers (n = 86)</td>
<td>10, 20, 30 and 40 mg/kg, weekly</td>
<td>MTD not reached. RP2D: 20 mg/kg weekly and 40 mg every 3 weeks.</td>
<td>(Richards et al., 2014)</td>
</tr>
<tr>
<td>MM-141 (IGF-1R x HER3)</td>
<td>I</td>
<td>Hepatocellular carcinoma, relapsed or refractory solid tumors (n = 42)</td>
<td>Weekly doses of 6, 12 or 20 mg/kg, or biweekly doses of 40 mg/kg. Cohort expansion at 20 mg/kg/week group</td>
<td>Patients with detectable serum levels of free IGF-1 prior to the start of therapy remained on study longer than those with undetectable levels (9 vs 15.7 weeks). SAE in 20% of patients: nausea, vomiting, decreased appetite and headache.</td>
<td>(Isakoff et al., 2016)</td>
</tr>
<tr>
<td>OMP-3058B3 (DLL4 x VEGF)</td>
<td>I</td>
<td>Previously treated solid cancers (n = 49)</td>
<td>0.5–10 mg/kg every 3 weeks</td>
<td>PR: 1/3, SD: 14/39. AE: systemic hypertension (54%), fatigue (20%), headache (24%), anemia (13%), dyspepsia (11%).</td>
<td>(Jimeno et al., 2016)</td>
</tr>
<tr>
<td>RG7802, RO6958688 (CEA x CD3)</td>
<td>I</td>
<td>Advanced CEA+ solid tumors (n = 118)</td>
<td>Group 1: 0.05–600 mg, Group 2: combined with 1200 mg atezolizumab (anti-PDL1): 5–160 mg per week</td>
<td>Group 1: PR: 2/31, AE: pyrexia (56%), infusion related reaction (50%), diarrhea (40%). DLTs: G3 dyspepsia, G3 diarrhea, G4 colitis and G5 respiratory failure. Group 2: PR: 3/14, no additive toxicities.</td>
<td>(Argilés et al., 2017; Segal et al., 2017; Tabernerо et al., 2017)</td>
</tr>
<tr>
<td>ROS674813 (FAP x DR5)</td>
<td>I</td>
<td>Advanced solid tumors (n = 32)</td>
<td>0.5–45 mg/kg every week or every other week</td>
<td>MTD: not reached. PR: 1/31, SD: 6/31. AE: fatigue (21.9%), nausea (15.6%), and infusion-related reactions (9.4%). AEs ≥ G3: anemia (3.6%) and asthenia (3.6%).</td>
<td>(Bendell et al., 2018)</td>
</tr>
<tr>
<td>TargomiRs (EGFR x EDV-miR16)</td>
<td>I</td>
<td>Malignant pleural mesothelioma (n = 27)</td>
<td>5 × 10⁸, 7 × 10⁸, and 9 × 10⁸ TargomiRs either once or twice weekly IV. After eight patients, all subsequent patients 1 × 10⁹ TargomiRs.</td>
<td>Rapid imaging possible, tumor to tissue ratio &gt; 20:1 after 24 h. No tumor responses observed. AE: grade 3/4 thrombocytopenia (1/20), and grade 3 lymphopenia (1/20).</td>
<td>(van Zandwijk et al., 2017)</td>
</tr>
<tr>
<td>TF2 + IMP288 (CEA x IMP288)</td>
<td>I</td>
<td>CEA+ colorectal cancers (n = 20)</td>
<td>Imaging with ¹¹¹Indium to confirm tumor targeting. If targeting confirmed, then treated with 2.5–7.4 GBq ¹⁷⁷Lutetium TF2: 75–150 mg, 1 or 5 days later IMP288: 25–100 μg TargomiRs.</td>
<td>Rapid imaging possible, tumor to tissue ratio &gt; 20:1 after 24 h. No tumor responses observed. AE: grade 3/4 thrombocytopenia (1/20), and grade 3 lymphopenia (1/20).</td>
<td>(Schoffelen et al., 2013)</td>
</tr>
<tr>
<td>TF2 + IMP288 (CEA x IMP288)</td>
<td>I</td>
<td>Medullary thyroid carcinoma (n = 15)</td>
<td>60–120 nmol TF2, 3–6 nmol IMP288, 24–48 h between injections. Positron emission tomography: 1–2 h after injection</td>
<td>Imaging protocol. 30 h between injection and TF2/IMP288 ratio of 20 is optimal.</td>
<td>(Bodet-Milin et al., 2016)</td>
</tr>
<tr>
<td>Vanucizumab (Ang-2 x VEGF-A)</td>
<td>I</td>
<td>Cisplatin resistant ovarian cancer (n = 41)</td>
<td>30 mg/kg IV every 2 weeks</td>
<td>PR: 29% (12/41), SD: 53% (21/41). AE: hypertension (53%), asthenia (39%), constipation (34%), abdominal pain (32%), peripheral edema (19%), nausea (19%), AEs ≥ G3: hypertension (10/24%), pyelonephritis (3/7%), G1-perforation, peritonitis, intestinal obstruction, pulmonary embolism, dyspnea (2/93), PR: 2/8, SD: 1/8. AE: infusion reaction (5/9), diarrhea (4/9), fatigue (3/9).</td>
<td>(Meric-Bernstam et al., 2017)</td>
</tr>
<tr>
<td>ZW25 (HER2 x HER2)</td>
<td>I</td>
<td>HER2+ cancers (n = 9)</td>
<td>5, 10 mg/kg, 15 mg/kg planned</td>
<td>MTD maximum tolerable dose; AE, adverse event; RP2D, recommended phase 2 dose; G1–4, grade 1–4.</td>
<td></td>
</tr>
</tbody>
</table>
inhibits angiogenesis by depleting angiogenin-2 (Ang-2) and vascular endothelial growth factor-A (VEGF-A) in the tumor environment. The bsAb OMP-305B83 targets delta-like ligand 4 and VEGF. In this construct, both bsAbs are Fc-bearing since a long half-life is paramount to effective depletion of factors.

Vanucizumab inhibited tumor growth and metastasis in mice bearing multiple syngeneic, patient-derived and xenograft tumor models (Kienast et al., 2013). It also increased activation of intratumoral immune cells leading to upregulated PD-L1 expression by endothelial cells (again in multiple syngeneic mouse models) (Schmittnaegel et al., 2017). In this approach, adding anti-PD-1 antibody treatment to vanucizumab increased survival providing further rational to evaluate this bsAb in combination with immunotherapies (Table 3).

6.4. Increasing specificity

The bsAb RO6874813, a 2:2 CrossMab, involves a different approach. It has affinity for the death receptor (DR) 5, one of the activating TNF-related apoptosis-inducing ligand receptors on tumor cells, and for fibroblast activation protein (FAP) on cancer-associated fibroblasts. In contrast to previous attempts with antibodies to activate DR5 on tumor cells, this bsAb enhances specificity to the tumor by using the affinity for the cancer-associated fibroblasts (Brünker et al., 2016). In in vitro and in human xenograft mouse models with fibroblasts combined with different carcinomas or a patient-derived sarcoma, the efficacy of this bsAb depended on the presence of cancer-associated fibroblasts. In in vivo models, the bsAb inhibited tumor growth more effectively than the anti-DR5 therapy (Brünker et al., 2016).

7. Remaining challenges

The approval of blinatumomab and emicizumab have stimulated the influx of bsAbs into clinical trials (Fig. 4). Continuous administration of small bsAbs, like blinatumomab, is necessary to maintain a constant blood level when treating patients (Portell et al., 2013). One way to circumvent this drawback is by prolonging the half-life of the bsAbs by adding an Fc region (Arvedson et al., 2017; L. Liu et al., 2017; Lorenzewsiki et al., 2017).

At present, two popular small bsAb platforms, the BiTE and the DART construct, both have an Fc region extended version in clinical trials (Fig. 1C). AMG757, targeting DLL3 and CD3, is a BiTE-Fc; MGD007 and MGD009, targeting glycoprotein A33 and CD3 and B7-H3 and CD3, respectively, are DART-Fc constructions. All these bsAbs target solid tumors. MGD007 has recently completed a phase 1 clinical trial in patients with relapsed or refractory metastatic colorectal carcinoma (NCT02248805). The results have not been published. However, the study design of the MGD007 illustrates the advantage of a longer half-life; weekly and three-weekly treatment regimens are used, while the DART molecule MGD006, targeting CD123 and CD3, is administered via continuous IV infusion to patients with AML (NCT02152956). An increasing number of novel bsAbs entering clinical trials have an Fc region (Fig. 4).

Moreover, blinatumomab is administered via stepwise dosing to mitigate toxicity (Topp et al., 2015). The severe toxicity of this construct is caused by systemic cytokine release called cytokine release syndrome and is commonly found in T cell-engaging therapies (Maude, Barrett, Teachey, & Grupp, 2014). Besides stepwise dosing, corticosteroids are needed to manage cytokine release syndrome.

Table 3

<table>
<thead>
<tr>
<th>bsAb</th>
<th>Immunotherapy</th>
<th>Phase</th>
<th>Indication</th>
<th>NCT number</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABT–165 (DLL4 x VEGF)</td>
<td>ABVR-181 (anti-PD-1 mAb)</td>
<td>I</td>
<td>Advanced solid tumors</td>
<td>NCT01946074</td>
<td>Active, not recruiting</td>
</tr>
<tr>
<td>AFM13 (CD30 x CD16A)</td>
<td>Pembrolizumab (anti-PD-1 mAb)</td>
<td>I</td>
<td>Hodgkin lymphoma</td>
<td>NCT02665650</td>
<td>Active, not recruiting</td>
</tr>
<tr>
<td>BIB30880 (Ang2 x VEGF)</td>
<td>BI754091 (anti-PD-1 mAb)</td>
<td>I</td>
<td>Non-squamous, Non-small-cell lung cancer</td>
<td>NCT03468426</td>
<td>Recruiting</td>
</tr>
<tr>
<td>Blinatumomab (CD19 x CD3)</td>
<td>Nivolumab (anti-PD-1 mAb) ipilimumab (anti CTLA4 mAb)</td>
<td>I</td>
<td>B acute lymphoblastic leukemia</td>
<td>NCT02879695</td>
<td>Recruiting</td>
</tr>
<tr>
<td>Blinatumomab (CD19 x CD3)</td>
<td>Pembrolizumab (anti-PD-1 mAb)</td>
<td>I</td>
<td>B acute lymphoblastic leukemia</td>
<td>NCT03160079</td>
<td>Recruiting</td>
</tr>
<tr>
<td>Blinatumomab (CD19 x CD3)</td>
<td>Pembrolizumab (anti-PD-1 mAb)</td>
<td>I</td>
<td>Relapsed or refractory diffuse large B cell lymphoma</td>
<td>NCT03340766</td>
<td>Recruiting</td>
</tr>
<tr>
<td>Blinatumomab (CD19 x CD3)</td>
<td>Pembrolizumab (anti-PD-1 mAb)</td>
<td>I/II</td>
<td>Recurrent of refractory acute lymphoblastic leukemia</td>
<td>NCT03512405</td>
<td>Not yet recruiting</td>
</tr>
<tr>
<td>Blinatumomab (CD19 x CD3)</td>
<td>Pembrolizumab (anti-PD-1 mAb)</td>
<td>I</td>
<td>Pediatric and young adult patients with relapsed or refractory acute leukemia or lymphoma</td>
<td>NCT03605589</td>
<td>Not yet recruiting</td>
</tr>
<tr>
<td>BTCT4465A (CD20 x CD3)</td>
<td>Atezolizumab (anti-PD-1 mAb)</td>
<td>I</td>
<td>Chronic lymphocytic leukemia, Non-Hodgkin lymphoma</td>
<td>NCT02500407</td>
<td>Recruiting</td>
</tr>
<tr>
<td>HERZB1 (HER2 x CD3)</td>
<td>Pembrolizumab (anti-PD-1 mAb)</td>
<td>I/II</td>
<td>Metastatic breast cancer</td>
<td>NCT03272334</td>
<td>Recruiting</td>
</tr>
<tr>
<td>IMCgp100 (gp100 x CD3)</td>
<td>Durvalumab (anti-PD-L1 mAb) tremilolizumab (anti-CTLA4 mAb)</td>
<td>II</td>
<td>Prostate cancer</td>
<td>NCT03406858</td>
<td>Recruiting</td>
</tr>
<tr>
<td>MGD007 (gpA33 x CD3)</td>
<td>MGA012 (anti PD-1 mAb)</td>
<td>I</td>
<td>Malignant melanoma</td>
<td>NCT02533078</td>
<td>Recruiting</td>
</tr>
<tr>
<td>MGD009 (B7-H3 x CD3)</td>
<td>MGA012 (anti PD-1 mAb)</td>
<td>I</td>
<td>Relapsed or refractory metastatic colorectal cancer</td>
<td>NCT03513612</td>
<td>Recruiting</td>
</tr>
<tr>
<td>REGN1979 (CD20 x CD3)</td>
<td>REGN2810 (anti-PD-1 mAb)</td>
<td>I</td>
<td>Lymphoma</td>
<td>NCT02651662</td>
<td>Recruiting</td>
</tr>
<tr>
<td>Vanucizumab (Ang-2 x VEGF-A)</td>
<td>Selicrelumab (anti-CD40 mAb)</td>
<td>I</td>
<td>Advanced/metastatic solid tumors</td>
<td>NCT02665416</td>
<td>Recruiting</td>
</tr>
<tr>
<td>Vanucizumab (Ang-2 x VEGF-A)</td>
<td>Atezolizumab (anti-PD-L1 mAb)</td>
<td>I</td>
<td>Neoplasms</td>
<td>NCT01688206</td>
<td>Completed</td>
</tr>
<tr>
<td>RO0958688/RG7802 (CEA x CD3)</td>
<td>Atezolizumab (anti-PD-L1 mAb)</td>
<td>I</td>
<td>Advanced/metastatic solid tumors</td>
<td>NCT02650713</td>
<td>Recruiting</td>
</tr>
<tr>
<td>RO0958688/RG7802 (CEA x CD3)</td>
<td>Atezolizumab (anti-PD-L1 mAb)</td>
<td>I</td>
<td>Metastatic non-small-cell lung cancer</td>
<td>NCT03337698</td>
<td>Recruiting</td>
</tr>
<tr>
<td>RO07082859 (CD20 x CD3)</td>
<td>Atezolizumab (anti-PD-L1 mAb)</td>
<td>I</td>
<td>Relapsed refractory B non-Hodgkin’s lymphoma</td>
<td>NCT03532832</td>
<td>Recruiting</td>
</tr>
</tbody>
</table>
also used to reduce cytokine release syndrome (Lee et al., 2014; Maude et al., 2014).

Recently, in humanized mice bearing a B cell lymphoma, pretreatment with an anti-CD20 antibody led to decreased toxicity after administration of a CD20- and CD3-targeting CrossMab bsAb, as measured by cytokine levels (Bacac et al., 2018). In that study design, the B cells in the peripheral blood and secondary lymphoid organs are depleted by the pretreatment, thus preventing their undesired activation and avoiding cytokine release by the immune-cell engaging bsAb (Bacac et al., 2018).

In addition, a recent study with a syngeneic mouse tumor model has shown a difference in distribution of HER2-targeting bsAbs with different affinity for CD3 (Mandikian et al., 2018). High affinity for CD3 reduced the systemic exposure and shifted uptake towards lymphoid tissues (Mandikian et al., 2018). Another study showed that the side effects of a bsAb engaging CD3 and C-type lectin-like molecule-1 are dependent on the CD3 affinity: the high-affinity variant induced high levels of cytokine release in cynomolgus monkeys (Leong et al., 2017).

These findings highlight the need for extensive pharmacokinetic studies of novel constructs like bsAbs, for example by means of molecular imaging. The design of bispecific antibody constructs is a challenge because the biodistribution of the drug is determined by both parts of the construct in combination with all other pharmacodynamics properties of the construct. Although there are many ways to measure pharmacokinetics of new drugs, molecular imaging the only non-invasive way.

Molecular imaging studies could be used to make predictive models for the pharmacokinetics of parts of bispecific constructs and develop optimal dosing strategies. This is especially relevant for all the differing constructs that have yet to be evaluated in clinical trials. An example of molecular imaging used for pharmacokinetics research is the development of a zirconium-89 labeled AMG211 tracer for positron emission tomography (Waaijer et al., 2018). AMG211 is a BiTE targeting CEA and CD3. In a phase I trial with patients with advanced gastrointestinal adenocarcinomas, metastases were imaged using this approach. There was heterogeneous tumor uptake within and between patients as well as CD3-specific uptake in lymphoid tissue (Moek et al., 2019).

8. Conclusion

As evidenced by the clinical trials evaluating these drugs, there is major interest in bsAbs as a treatment for cancer given. One bsAb is currently used in clinical practice, but none are undergoing phase 3 clinical trials for the treatment of cancer. Most of these bsAbs under evaluation have the same mechanism of action: the engagement of immune cells with tumor cells. For delivering payloads, the enthusiasm for using bsAbs seems to have been tempered due to the advent of facile conjugation methods such as click-chemistry. Preclinical studies suggest that antitumor efficacy of immune-cell engaging bsAbs will increase when combined with immune modulators such as anti-PD1 and anti-PD-L1 antibodies. The first clinical results confirm this, but more data is needed. The differing and novel constructs of bsAbs that will enter clinical trials also constitute a strong argument for the use of molecular imaging to reveal its in-vivo behavior. In recent history, the bsAb has been a versatile tool but besides blinatumomab it has not yet resulted in a clinical breakthrough. However, due to the increasing ease of production and their unique mechanisms of action, bsAbs can potentially be tailored to become a valuable addition to the oncology arsenal.
Conflict of interest statement

E.G.E.D.V. reports consulting/advisory fees from Sanofi, Pfizer, Daichi Sankyo, NSABP and Merck, and research funding from Amgen, Genentech, Roche, Chugai Pharma, Synthion, CytoX Therapeutics, Nordic Nanovector, Regeneron, G1 Therapeutics, AstraZeneca, Radius Health, Servier and Bayer; all payments to the institution.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.pharmthera.2019.04.006.

References


Bhutani, D., & Lum, L. G. (2015). Activated T cells armed with bispecific antibody directed to the epidermal growth factor receptor directed bispecific antibody MDX-447 without costimulation.


Braun-Falco, O., Ritter, J., Burger, M., & Dienes, H. P. (1999). When IgG antibodies are not to be considered as "hammocks": Histopathological and functional characterization of the trifunctional antibody catumaxomab.


Cancer Therapy 13(7), 1803–1812.


F. V. Suurs et al. / Pharmacology & Therapeutics 201 (2019) 103–119

Why, what, how, and which.

Annals of Oncology 29 (Suppl. 1), S1–S11.


F. V. Suurs et al. / Pharmacology & Therapeutics 201 (2019) 103–119

Why, what, how, and which.


Tovey, M. G., & Lallemand, C. (2011). Immunogenicity and other problems associated with the use of biopharmaceuticals. Therapeutic Advances in Drug Safety 2(3), 113–128.


