**Chinese perspectives on clinical efficacy and safety of alectinib in patients with ALK-positive advanced non-small cell lung cancer**

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**Abstract:** The incidence of lung cancer is increasing in China, in contrast to trends in Western countries, due to the increasing numbers of smokers and high levels of air pollution. Non-small-cell lung cancer (NSCLC) is the most common form of lung cancer, accounting for approximately 85% of lung cancers. Better understanding of the pathogenesis of NSCLC has led to the identification of multiple genetic mutations and chromosomal translocations such as those in the anaplastic lymphoma kinase (ALK) gene. To facilitate the identification of treatment targets, multiple guidelines (European Society for Medical Oncology, National Comprehensive Cancer Network, and American Society of Clinical Oncology) now recommend screening for genetic factors to help guide treatment decisions. In recent years, multiple ALK inhibitors have been developed to treat NSCLC, including the first-generation tyrosine kinase inhibitor (TKI) crizotinib; second-generation TKIs such as ceritinib, ensartinib, brigatinib, and alectinib; the third-generation TKI lorlatinib; and the fourth-generation TKI repotrectinib. These agents differ in structure, potency, and activity, both systemically and their effects on central nervous system (CNS) metastases. Recently, alectinib was approved in China to treat patients with locally advanced or metastatic NSCLC that were ALK+. Alectinib has demonstrated activity against NSCLC, including metastases within the CNS, with better tolerability than crizotinib. These ALK inhibitors represent significant advances in the treatment of NSCLC and yet patients will likely still exhibit disease progression. Alectinib offers greater potency with greater specificity as well as a better toxicity profile than many other TKIs that are currently available. Here, we review the role of ALK as a therapeutic target in NSCLC, the testing methods for identifying ALK-rearranged NSCLC, and the various TKIs currently being used or explored for treatment in this setting, with a focus on alectinib from a Chinese perspective.

**Keywords:** NSCLC, anaplastic lymphoma kinase, alectinib, tyrosine kinase inhibitor

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**Introduction**

In China, the incidence of cancer is on the rise with lung cancer being the most common cancer type diagnosed and the most common cause of cancer-related deaths.¹⁻⁵ It is known that lung cancer morbidity and mortality trends reflect the prevalence of tobacco exposure 20–30 years earlier.⁶⁻⁷ Therefore, due to the ongoing high levels of tobacco exposure and air pollution in China, both of which are significant risk factors in the development of lung cancer, the health burden of lung cancer is expected to increase in the future.⁸⁻¹⁰
Non-small-cell lung cancer (NSCLC) is the most common type of lung cancer, accounting for 85–90% of all lung cancer cases globally, and is associated with high rates of mortality.\(^1\)\(^-\)\(^5\)\(^,\)\(^11\)\(^-\)\(^12\) According to the most recently released SEER Cancer Statistics Review, the 5-year survival rate (2009–2015) for NSCLC is 25.1%.\(^13\) Improved understanding of the pathogenesis of NSCLC has resulted in the development of treatments that target various genetic mutations that drive the development and progression of NSCLC. This includes translocations of the anaplastic lymphoma kinase (ALK) gene\(^14\) and the ROS1 proto-oncogene 1 receptor tyrosine kinase (ROSI) gene;\(^14\) rearrangements in kinase-encoding genes such as epidermal growth factor receptor (EGFR);\(^14\) Kirsten ras (KRAS),\(^14\) v-raf murine sarcoma viral oncogene homolog B (BRAF),\(^14\) neurotrophic tyrosine receptor kinase (NTRK),\(^14\) and rearranged during transfection (RET);\(^14\) fusions of neuregulin 1 (NRG1)\(^15\) and fibroblast growth factor receptor 1/3 (FGFR1/3);\(^16\) human epidermal growth factor receptor 2 (HER2) insertion;\(^16\) and AKT serine/threonine kinase 1 (AKTI) mutation.\(^17\) Some reports show that these mutations are mutually exclusive, while other reports show that some tumors can have concomitant mutations.\(^18\)\(^-\)\(^21\) These mutations are capable of influencing responses to targeted therapy.\(^14\) It has, therefore, become standard clinical practice to test for gene mutations and fusions in patients with NSCLC and to tailor treatment strategies accordingly.\(^22\)

In the present review, we briefly discuss the role of ALK mutations and translocations in NSCLC, the testing methods for identifying ALK-positive (ALK+) NSCLC, and present the evidence for approved ALK-targeted therapies. This review focuses on alectinib in Chinese patients due to its recent and rapid approval (August 2018) as a monotherapy for locally advanced or metastatic ALK+ NSCLC in China.

### Mechanism of action of ALK

The ALK gene is a member of the insulin receptor superfam-ily. It is located on the short arm of chromosome 2 (2p23) and encodes a receptor tyrosine kinase;\(^23\)\(^,\)\(^24\) Similar to other receptor tyrosine kinases, ALK contains an extracellular domain, a transmembrane segment, and a cytoplasmic receptor kinase segment.\(^24\) ALK mutations have been implicated in tumorigenesis, with involvement in the initiation and progression of several cancer types, including lymphomas, neuroblastoma, and NSCLC.\(^25\)\(^-\)\(^26\) ALK translocations typically cause an increase in tyrosine kinase activity, resulting in increased cell proliferation and survival via their effects on signaling pathways that include phospholipase C\(\gamma\) (PLC\(\gamma\)), phosphatidylinositol 3-kinase (PI3K)–protein kinase B (AKT), mammalian target of rapamycin (mTOR), and mitogen-activated protein kinase (MAPK) signaling cascades, among others.\(^26\) Translocation events at the ALK locus generate a variety of ALK fusion proteins, such as NPM1–ALK, that are found in multiple types of cancers.\(^26\) ALK activation in cancer may also arise through overexpression and point mutation of full-length ALK.\(^27\)\(^-\)\(^29\)

Anaplastic lymphoma kinase was first identified as the receptor tyrosine kinase in a novel fusion gene arising from chromosomal translocation t(2;5) in anaplastic large-cell lymphoma.\(^30\) This rearrangement results in a nucleophosmin (NPM1)–ALK fusion protein\(^30\)\(^,\)\(^31\) and subsequent constitutive activation of the ALK kinase, which is normally regulated by the extracellular ligand-binding domain of the full-length receptor.\(^30\)\(^,\)\(^25\) Although ALK is highly expressed during embryogenesis and appears to be involved in brain and neural development,\(^32\) its precise physiological role in mammals remains unclear. ALK, however, is not critical for viability as Alk\(^{-/-}\) mice are viable.\(^33\)

### NSCLC and ALK

In 2007, the fusion oncogene echinoderm microtubule-associated protein-like 4 (EML4)–ALK was shown to be present in 3% to 6% of patients with NSCLC.\(^34\) This fusion oncogene is the result of a chromosome inversion (inv[2][p21;p23]) in which EML4 fuses with the juxta membranous portion of ALK and replaces the extracellular and intramembranous portions.\(^34\) EML4-ALK fusions form ligand-independent dimers via the coiled-coil of EML4;\(^35\) this ligand-independent dimerization results in constitutive downstream signaling of canonical ALK pathways.\(^34\) The EML4–ALK oncogene was shown to induce tumor formation in nude mice.\(^26\)\(^,\)\(^34\) Figure 1 shows an overview of the EML4–ALK pathways involved in tumorigenesis.

ALK gene rearrangements appear to arise more frequently in specific NSCLC patient populations. Demographic characteristics associated with more frequent rearrangements include young, female, never- or light-smoker status, or the presence of tumors with an adenocarcinoma histology.\(^23\)\(^,\)\(^36\)\(^-\)\(^39\) The reported prevalence of ALK rearrangements in Chinese patients ranges between 3.3% and 11.6%, compared with 30% of patients with EGFR mutations;\(^40\)\(^-\)\(^42\) however, the prevalence of ALK rearrangements in the Chinese population is similar to that reported in other Asian populations (for
example, 7% in Japanese patients). In general, the prevalence of ALK rearrangements in Asian populations is slightly greater than that in non-Asian populations. It has been reported that the clinicopathologic features of ALK-rearranged lung adenocarcinoma in Western patients may differ from those in other populations. However, there are suggestions that this discrepancy may result from differing pathologic interpretations rather than actual ethnicity-related genetic differences in patients with ALK fusion oncogene-positive lung cancer.

**Testing methods for ALK-rearranged NSCLC**

The general consensus of the International Association for the Study of Lung Cancer Atlas is that all patients presenting with advanced NSCLC should be screened for the presence of ALK gene rearrangements. ALK–EML4 gene fusions and ALK rearrangements in NSCLC can be identified in clinical specimens using several techniques: immunohistochemistry (IHC), fluorescence in situ hybridization (FISH), reverse transcriptase polymerase chain reaction (RT-PCR), and next generation sequencing (NGS). Figure 2 shows the currently recommended testing methods for ALK-rearranged NSCLC.

FISH was clinically validated in studies with the first-generation tyrosine kinase inhibitor (TKI), crizotinib, prior to its approval by the US Food and Drug Administration (FDA) for ALK-rearranged NSCLC. The ALK FISH approach is the gold standard and uses ALK break-apart probes that label the 5′ and 3′ ends of the ALK gene with fluorescent probes. Rearrangements in ALK result in a split appearance of the signal or loss of the 5′ signal in at least 15% of the cells counted. FISH can be performed on formalin-fixed paraffin-embedded tissue or snap-frozen samples, but its use is limited by high costs, suboptimal reliability, and technical complexity.

IHC is a widely available, cost-effective, and rapid technique for ALK screening that can be performed before FISH analysis. In 2013, China was the first country to approve the VENTANA ALK (D5F3) CDx Assay, which uses IHC to identify the presence of ALK+ gene rearrangements. This
assay is a key step in qualitative identification, which is used to assess the presence of ALK protein in samples from patients with $ALK^+$ NSCLC, and is often subsequently confirmed by FISH analysis. At present, Ventana IHC (D5F3) remains the most widely used testing method for $ALK^+$ NSCLC. Furthermore, it was recommended by Chinese guidelines as the first choice for $ALK^+$ NSCLC diagnosis in 2018. Quantitative RT-PCR represents a highly sensitive method capable of detecting ALK mRNA that has both fusions and mutations. However, it has some limitations including (1) the requirement for frozen or fresh tissues or cells for RNA extraction, and (2) the existence of many variants of $EML4$-$ALK$, which raises the possibility of additional variant fusions, making multiplexed RT-PCR assays difficult to optimize for clinical use.

Emerging technologies for testing include NGS and liquid biopsy. NGS is based on highly multiplexed PCR amplicon-based targeted sequencing for oncogenic fusions and represents a viable alternative to FISH because it can be performed on formalin-fixed paraffin-embedded samples, with minimal RNA input needed. Although NGS requires a supporting e-infrastructure to be performed, it offers the advantage of being able to test for a broader range of mutations simultaneously as well as for both somatic and germline mutations. Liquid biopsy involves examining cell-free DNA or circulating tumor DNA, a process that is advantageous when testing for metastatic cancers, but this method offers less sensitivity than tissue-testing for early stage cancers.

The aforementioned techniques differ in their relative sensitivities and specificities, their usefulness for detecting a given type of mutation (eg, whether it involves a fusion or not), and their ease of conduct and affordability. One study assessed patients whose samples were tested by both Ventana IHC and RT-PCR; in addition, some of the samples were also tested by NGS. In this study, it was determined that Ventana IHC was both a reliable and rapid method to identify suitable candidates for $ALK$ gene-targeted therapy. An economic analysis from a Chinese healthcare system perspective investigated the cost-effectiveness of three $ALK$ rearrangement testing methods: Ventana IHC, qRT-PCR, and IHC following FISH confirmation. Here, it was shown that gene-guided therapy was a cost-effective option with or without Chinese patient-assisted programs. The results of this economic analysis were supported in a more recent follow-up study, which compared the cost-effectiveness and quality-

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**Figure 2** Testing methods for $ALK$-rearranged NSCLC as used in China, Europe, and the United States.

**Notes:** a) Preferred method. Conducted in a laboratory meeting the qualifications of the National Center for Clinical Laboratories. b) Only performed when the Ventana ALK (D5F3) CDx assay is not reasonably available, primary screening only. c) Any IHC assay that has been validated against FISH.

**Abbreviations:** NSCLC, non-small cell lung cancer; ALK, anaplastic lymphoma kinase; FISH, fluorescent in situ hybridization; RT-PCR, reverse transcription polymerase chain reaction; IHC, immunohistochemistry.
adjusted life-years when using NGS or multiplex PCR testing to guide therapy. Furthermore, ALK testing under real-world settings across 31 hospitals around China is currently under investigation.

Chinese guidelines on the diagnosis and treatment of ALK+ NSCLC, set by the Chinese Society of Clinical Oncology Cancer Markers Expert Committee and the Chinese Expert Consensus Opinion of the diagnosis of ALK-positive NSCLC, provide guidance on choosing the most suitable technique for identifying ALK gene fusions and rearrangements. As per their assessment, the highest level of evidence supports the use of Ventana IHC to screen for ALK+ NSCLC, which became widely accepted based on findings from later clinical studies, including the ASCEND-4 and ALEX studies of alectinib. In contrast, the RT-PCR technique was recognized as being able to detect known fusion genes, but its performance requires an appropriately qualified laboratory. Lastly, the committee determined that the blood sample testing was still considered experimental and should only be performed in certain circumstances.

In China, a multicenter survey of 932 patients with advanced NSCLC showed that 71.4% of patients were tested for EGFR gene mutations, 44.7% were tested for ALK gene fusions, and 13.7% were tested for ROS1 gene fusions. The clinical assays most used in China to determine ALK involvement in NSCLC are IHC and RT-PCR, with IHC being the most widely used testing method for ALK. The use of FISH is still rare due to the high cost and extensive operational requirements. To date, the China National Medical Products Administration (NMPA) has approved three FISH kits, two IHC kits, six RT-PCR kits, and four NGS solutions, and current Chinese guidelines recommend NMPA-approved kits and methods in clinical ALK+ NSCLC diagnosis. Although various options to test for ALK rearrangements are available, the 2018 Chinese guidelines state that their highest recommendation is for the Ventana IHC. However, in acknowledging that this test may not be available at all sites, the guidelines committee recommends either forwarding samples to laboratories that could perform the Ventana IHC, or performing a primary screening locally using routine IHC and subsequently sending positive samples to other laboratories for confirmation by recommended methods, including FISH, Ventana IHC, or RT-PCR.

**ALK-targeted therapy in NSCLC**

**Overview of NSCLC treatment and the role of ALK inhibitors**

During recent years, several ALK inhibitors that demonstrate significant benefits in the treatment of ALK+ NSCLC compared with conventional chemotherapy have become available in clinical practice around the world or are under clinical investigation. Although the first generation TKI crizotinib is effective in patients with NSCLC compared with standard chemotherapy, it is limited by the relatively shorter progression-free survival (PFS), its associated toxicities, and the disease progression of central nervous system (CNS) metastases due to its poor penetration of the blood–brain barrier. Subsequent generations of TKIs were developed to achieve improved outcomes and fewer toxicities including second generation TKIs such as ceritinib, ensartinib, brigatinib, and alectinib. The pharmacokinetic properties of the ALK inhibitors crizotinib, ceritinib, ensartinib, brigatinib, and alectinib are shown in Table 1, which outlines the absorption, distribution, metabolism, and excretion rates of each agent. Efficacy results for ALK inhibitors are presented in Table 2.

**Limitations of ALK inhibitors**

A limitation of the use of some members of this class of TKIs is the emergence of treatment resistance. Several mechanisms of resistance to each targeted therapy have been identified, but these can be broadly categorized into two main classes: (1) alteration of the driver oncogene, or (2) activation of a critical parallel or downstream signaling pathway(s) that promotes pro-survival signaling. Resistance to crizotinib involves mechanisms such as secondary mutations within the ALK tyrosine kinase domain and activation of alternative signaling pathways. Ceritinib, more potent than crizotinib, is active against multiple ALK mutations that appear to result in resistance to crizotinib. In the case of ceritinib, the increased potency appears to be associated with a higher rate of adverse events. Alectinib is a second-generation ALK inhibitor that has both high selectivity and efficient blood–brain barrier penetration; these characteristics are believed to contribute to the prevention of treatment resistance in naïve patients. In addition, alectinib can overcome crizotinib treatment resistance in patients who have relapsed.

Each TKI can target different oncogenic drivers, which can affect the likelihood of treatment resistance occurring through secondary mutations or bypass mechanisms.
Targets for each TKI are as follows: alectinib (inhibitor of ALK tyrosine kinase and RET kinase, including the ALK L1196M mutant); ensartinib (ROS proto-oncogene 1 receptor tyrosine kinase, ROS1; MET protocol-oncogene receptor tyrosine kinase, MET; STE20 like kinase, SLK; AXL receptor tyrosine kinase, AXL; leukocyte receptor tyrosine kinase, LTK; ABL proto-oncogene 1 non-receptor tyrosine kinase, ABL1; and EPH receptor A2, EPHA2); brigatinib (inhibitor of ALK and EGFR, including ALK L1196M and EGFR T790M mutants); lorlatinib (ALK and ROS1); and repotrectinib (ALK, ROS1, and TRK).14,23,75–87

### The treatment landscape in China

The first Chinese guidelines for the diagnosis and treatment of primary lung cancer were published in 2003, and then updated in 2011, 2015, and 2018.57,88 First-line drug regimens in cases of advanced NSCLC include platinum-doublet chemotherapy and targeted molecular therapy drugs, such as gefitinib, erlotinib, or icotinib if EGFR mutations are detected; or crizotinib if ALK fusion genes are detected. Treatment of NSCLC in China is characterized by many factors, which include the accessibility and availability of diagnostic assays and treatments, insurance reimbursement rates,89 and the accuracy of decision making in the Chinese healthcare system.90

More recently, Chinese guidelines for the treatment and diagnosis of ALK+ and ROS1+ NSCLC were published.57 The first TKI to be approved by the Chinese FDA for advanced ALK+ NSCLC was crizotinib in 2013.91 Global studies have shown that treatment resistance to crizotinib is inevitable;70,73 however, a retrospective study observed that continuation of crizotinib therapy in Chinese patients beyond the initial disease progression may provide further benefits.92 The first second-generation TKI to be developed was ceritinib, which initially showed efficacy in the ASCEND-1 trial, and was approved by the US FDA shortly thereafter, in 2015.93 However, a subsequent phase III study showed inferior efficacy of ceritinib compared with the results of a phase II study.95 Furthermore, with the publication of the ALEX66 and J-ALEX96 trials, alectinib achieved a median PFS of 34.8 months (95% CI: 17.7–not estimable) compared with 10.9 months (95% CI: 9.1–12.9) with crizotinib, making it the drug of choice for advanced ALK+ NSCLC (HR 0.43 [95% CI: 0.32–0.58]).97

Following priority review, alectinib was approved for use in China in August 2018 as a monotherapy to treat patients with locally advanced or metastatic ALK+ NSCLC.98 This approval allows the use of alectinib for both ALK-inhibitor naïve or treated patients. Other second-generation TKIs, ensartinib and brigatinib; the third-generation TKI lorlatinib; and the fourth-generation TKI repotrectinib are not currently available in China.

### Alectinib

Alectinib (CH5424802/RO5424802) is a potent and highly selective second-generation inhibitor of ALK tyrosine kinase that acts only on ALK+ NSCLC.99,100 It also inhibits RET kinase activity and, thus, may prove efficacious against RET fusion+ tumors.101 Furthermore, alectinib exhibits activity against multiple gate-keeper mutations that impart resistance to crizotinib, and can
Table 2  Clinical outcomes of phase I–III studies of ALK inhibitors in crizotinib-naïve or crizotinib resistant patients, with or without chemotherapy

<table>
<thead>
<tr>
<th>Drug</th>
<th>Study phase</th>
<th>Study name</th>
<th>Previous crizotinib</th>
<th>Crizotinib-naive</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>ORR     mPFS (months)</td>
<td>ORR     mPFS (months)</td>
</tr>
<tr>
<td>Alectinib</td>
<td>Phase I/II</td>
<td>AF-001JP/JapicCTI-101264</td>
<td>–       –</td>
<td>94% (43/46)      NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Naïve to ALK inhibitors</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phase II</td>
<td>AF-002JG/NCT01588028</td>
<td>55% (24/44) NA</td>
<td>–     –</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crizotinib pretreated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phase II</td>
<td>NP28761/NCT01871805</td>
<td>52% (35/67) 8.0</td>
<td>–     –</td>
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<tr>
<td></td>
<td></td>
<td>Crizotinib pretreated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phase II</td>
<td>NP28673/NCT01801111</td>
<td>45% (61/96) 8.9</td>
<td>–     –</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crizotinib pretreated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phase III</td>
<td>global ALEX//NCT02075840</td>
<td>–       –</td>
<td>83% (126/152)    Not reached</td>
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<tr>
<td></td>
<td></td>
<td>Untreated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phase III</td>
<td>J-ALEX/JapicCTI-132316</td>
<td>–       –</td>
<td>92% (76/83)      Not reached</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Naïve to ALK inhibitors, Asian Patients</td>
<td></td>
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</tr>
</tbody>
</table>
|          | Phase I     | ALLUR, MO29750/NCT02604342     | 54%  

a (13/24) 9.6 | – | – |
| Phase III | Crizotinib pretreated | 91% (114/125) Not reached | 77% (48/62) 11.1 |  
| Phase III | ALESIA/NCT02838420     | 52%  

b [46–58] 9.36   

b [7.38–11.34] 87% [81–92] Not reported |  
| Phase III | Crizotinib Phase I | PROFILE 1001/NCT00585195 | – | – | 61% (87/143) 9.7 |
| Phase II  | PROFILE 1005/NCT00932451 | – | – | 54% (491/908) 8.4 |
| Phase III | PROFILE 1007/NCT0093283 | – | – | 65% (113/173) 7.7 |
| Phase III | PROFILE 1014/NCT01154140 | – | – | 74% (128/172) 10.9 |
| Phase III | PROFILE 1029/NCT01639001 | – | – | 88% (91/104) 11.1 |
| Ceritinib | Crizotinib Phase I | PROFILE 1001/NCT00585195 | 56% (92/163) 6.9 | 72% (60/83) 18.4 |
| Phase II  | PROFILE 1005/NCT00932451 | 39% (54/140) 5.7 | – | – |
| Phase III | PROFILE 1007/NCT0093283 | – | – | 64% (79/124) 11.1 |
| Phase III | PROFILE 1014/NCT01154140 | – | – | 73% (137/189) 16.6 |
| Phase III | PROFILE 1029/NCT01639001 | 39% (45/115) 5.4 | – | – |
| Phase III | ALESIA/NCT02838420 | 52%  

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| Phase II  | PROFILE 1005/NCT00932451 | – | – | 54% (491/908) 8.4 |
| Phase III | PROFILE 1007/NCT0093283 | – | – | 65% (113/173) 7.7 |
| Phase III | PROFILE 1014/NCT01154140 | – | – | 74% (128/172) 10.9 |
| Phase III | PROFILE 1029/NCT01639001 | – | – | 88% (91/104) 11.1 |
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| Phase III | PROFILE 1007/NCT0093283 | – | – | 64% (79/124) 11.1 |
| Phase III | PROFILE 1014/NCT01154140 | – | – | 73% (137/189) 16.6 |
| Phase III | PROFILE 1029/NCT01639001 | 39% (45/115) 5.4 | – | – |
| Phase III | ALESIA/NCT02838420 | 52%  

b [46–58] 9.36   

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| Phase II  | PROFILE 1005/NCT00932451 | – | – | 54% (491/908) 8.4 |
| Phase III | PROFILE 1007/NCT0093283 | – | – | 65% (113/173) 7.7 |
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(Continued)
Table 2 (Continued).

<table>
<thead>
<tr>
<th>Drug</th>
<th>Study phase</th>
<th>Study name</th>
<th>Previous crizotinib</th>
<th>Crizotinib-naive</th>
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<td></td>
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<td>ORR (n)</td>
<td>mPFS (months)</td>
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<td>Ensartinib</td>
<td>Phase I/II</td>
<td>NCT01622523</td>
<td>69% (20/29)</td>
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<td>Brigatinib</td>
<td>Phase I/II, phase II portion</td>
<td>NCT01444961</td>
<td>71% (50/70)</td>
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<td></td>
<td>Phase III</td>
<td>ALTA-1L/NCT02737501</td>
<td>–</td>
<td>–</td>
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<tr>
<td>Lorlatinib</td>
<td>Phase I, dose escalation component</td>
<td>NCT01970865</td>
<td>53% (17/32)</td>
<td>NA</td>
</tr>
<tr>
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<td>Phase II</td>
<td>NCT01970865</td>
<td>70% (41/59)</td>
<td>Not reached</td>
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</tbody>
</table>

Notes: aRepresents CNS ORR in patients with measurable baseline CNS disease. bRepresents all patients in analysis set: analysis not performed by previous crizotinib exposure.

Abbreviations: ALK, anaplastic lymphoma kinase; CNS, central nervous system; ORR, objective response rate; mPFS, median progression-free survival; NA, not available.

Note, parentheses enclose fractions of patients and square brackets enclose 95% confidence intervals.

Mode of action

The unique chemical structure of alectinib means it 1) targets both ALK rearrangements and RET fusion+ tumors, but not MET or ROS1 kinase activity, and 2) overcomes acquired resistance to crizotinib through its ability to target the mutations that develop with crizotinib treatment.83,102–106 Its features include a scaffold-like structure with lipophilic properties and an ability to cross the blood–brain barrier, possibly because it is not a substrate of the key efflux transporter that delays blood–brain barrier penetration. Additionally, an increased potency over crizotinib is evident in the three-fold increase in in vitro ALK inhibition (53 nM alectinib versus 150.8 nM crizotinib).99 Together, these characteristics may contribute to its ability to overcome resistance to other ALK inhibitors caused by mutations83,84,100,102,111 and its increased potency over crizotinib for treating CNS metastases.83,84 Successful treatment of CNS metastases is demonstrated based on a pooled analysis of data from two phase II studies (NCT01871805 and NCT01801111) that reported a 64.0% CNS objective response rate (95% confidence interval [CI]: 49.2–77.1) and a median CNS duration of response of 10.8 months (95% CI: 7.6–14.1) in crizotinib-refractory ALK+ NSCLC patients with measurable CNS disease (n=50) at baseline.112

Metabolism and pharmacokinetics

Alectinib is primarily metabolized by the cytochrome P450 (CYP) 3A4 enzyme, producing its major active metabolite M4 (Table 1).113 Most of the drug is excreted in the feces.113 The pharmacokinetics of alectinib relative to other ALK inhibitors are presented in Table 1. Alectinib exhibits a time to maximum concentration of 3–5 hrs, and a half-life of 33 hrs.114 The maximum steady-state concentration for alectinib is higher than that of crizotinib, by approximately 4-fold, while alectinib achieves this concentration earlier than crizotinib (Table 1).114,115 It is important to note that the pharmacokinetics of alectinib does not appear to differ by race. Analyses of pharmacokinetic data from the phase III ALEX trial of alectinib, which was prospectively stratified by Asian and non-Asian patients, did not exhibit any notable differences116.
Clinical efficacy of alectinib

The global phase III ALEX study demonstrated prolonged PFS in newly diagnosed patients receiving alectinib versus those receiving crizotinib.97 The study reported a median PFS of 34.8 months (95% CI: 17.7–not estimable), with only 12% of patients developing brain metastases, as compared with 10.9 months (95% CI: 9.1–12.9) and 45%, respectively, in patients treated with crizotinib. In another phase III trial (ALUR) across 13 countries in Europe and Asia, alectinib versus platinum-based chemotherapy in crizotinib-pretreated patients exhibited prolonged median PFS, both investigator assessed and independent review committee assessed: 9.6 months (95% CI: 6.9–12.2) with alectinib and 1.4 months (95% CI: 1.3–1.6) with chemotherapy (investigator assessed) with a hazard ratio (HR) of 0.15 (95% CI: 0.08–0.29; p<0.001).85 Therefore, the long-term benefits of alectinib in ALK inhibitor-naïve patients have been demonstrated in a number of different populations.117

A systematic meta-analysis of eight alectinib trials was published recently and presented the overall pooled efficacy and safety results, and results stratified by prior treatment status.118 The pooled overall response rate (ORR) was 70% (95% CI: 57–82), with ALK-inhibitor naïve patients having an ORR of 87% (95% CI: 81–92) versus crizotinib-resistant patients, who had an ORR of 52% (95% CI: 46–58).118 Table 2 summarizes clinical efficacy results from individual trials of alectinib.

A recent report of the pooled efficacy data after 15- and 18-month follow-up of two key phase II studies (NCT01871805 and NCT01801111; n=255) showed that alectinib has a durable response rate (median =14.9 months; 95% CI: 11.1–20.4) with a 78.8% disease control rate (95% CI: 72.3–84.4) and median PFS of 8.3 months (95% CI: 7.0–11.3).119 There were also no specific ethnic differences in the efficacy of alectinib observed.

Clinical evidence in Chinese patients

The superior efficacy of alectinib compared with crizotinib has been reported in an Asian versus non-Asian patient subgroup analysis in the global phase III ALEX study,66,116 and in the ALESIA phase III randomized clinical trial, which comprised patients from China, South Korea, and Thailand.120 The ALESIA study reported a significant improvement in both investigator-assessed (HR: 0.22; 95% CI: 0.13–0.38; p<0.0001; median PFS not estimable [alectinib] vs 11.1 months [crizotinib]) and independent review committee-assessed (HR: 0.37; 95% CI: 0.22–0.61; p=0.0001) PFS in the alectinib vs crizotinib groups.120 The percent of patients experiencing disease progression or death was higher with crizotinib versus alectinib treatment (60% vs 21%, respectively).120 Although patients receiving alectinib were treated for a longer period than those receiving crizotinib (14.7 vs 12.6 months, respectively), fewer grade 3–5 adverse events (alectinib, 36 [29%] of 125; crizotinib, 30 [48%] of 62) and serious adverse events (alectinib, 19 [15%] of 125; crizotinib, 16 [26%] of 62) were reported in the alectinib vs crizotinib groups.120 Pharmacokinetic results from a subset of 20 frequently sampled Chinese patients (600 mg alectinib, twice daily) demonstrated nearly identical pharmacokinetic profiles to white patients (historical data from a phase II global study).120,121 These clinical data are consistent with data reported for the ALEX study,66 suggesting that alectinib could be suitable to treat both crizotinib-naïve and crizotinib-refractory patients with ALK+ NSCLC, irrespective of ethnicities.

The ALEX trial also included 43 Chinese patients, of which 25 received alectinib and 18 received crizotinib, and results were reported at ESMO-Asia 2017.116 Median PFS (independent review committee-assessed) was longer in alectinib-treated patients (25.7 vs 14.8 months; HR: 0.57, 95% CI: 0.24–1.38; p=0.16), suggesting the efficacy of alectinib in Chinese patients is consistent with that in the global population.

Activity in the CNS

Brain metastases are a common complication during the advanced stages of NSCLC, particularly in patients who have ALK gene rearrangements.122 Therefore, systemic therapies with intracranial efficacy are the preferred long-term treatment option for patients with ALK+ NSCLC. Alectinib has a unique physical structure that contributes to its potency, including an improved ability to penetrate the blood–brain barrier compared to other TKIs.83,84 Alectinib has shown potential efficacy against brain metastases as reported in the pooled analysis of data from two phase II studies (NCT01871805 and NCT01801111) involving crizotinib-refractory ALK+ NSCLC patients with measurable CNS disease (n=50) at baseline, which reported a 64.0% CNS ORR (95% CI: 49.2–77.1) and a median CNS duration of response of 10.8 months (95% CI: 7.6–14.1).110 In a retrospective study of patients with advanced ALK+ NSCLC treated with alectinib, the ORR...
was 73.3% and the disease control rate was 100.0%, with a median CNS duration of response of 19.3 months.123 Patients receiving alectinib in the phase III study, ALEX, exhibited longer times to CNS progression than those patients receiving crizotinib, and the two groups were balanced in CNS disease levels at baseline.111 A recently published update of the phase III ALEX study supports the superior CNS efficacy of alectinib over crizotinib.124 Here, it was reported that alectinib had a significantly longer time to CNS progression, regardless of the presence of CNS metastases at baseline. Notably, when evaluating the cumulative incidence rate (CIR) of CNS progression in patients without baseline CNS metastases, it was shown that the 12-month CIR was only 4.6% in the alectinib group compared with 31.5% in the crizotinib group.125 In addition, the CIR of CNS progression in patients with brain metastases at baseline was 16.0% and 58.3%, respectively. These data demonstrate a superior efficacy and capability of delaying CNS progression for patients treated with alectinib, even in patients without brain metastases at baseline.

A systematic meta-analysis has also described the clinical outcomes among patients with ALK+ NSCLC and brain metastases.89 Patients who received alectinib exhibited a pooled ORR of 52.0% (95% CI: 45.0–59.0), with an ORR of 59.0% (95% CI: 47.0–71.0) among ALK-inhibitor-naïve patients versus 48.0% (95% CI: 38.0–57.0) among crizotinib-resistant patients.89 In the phase III ALUR study of European and Asian patients previously treated with crizotinib, it was shown that there was a greater CNS ORR in patients receiving alectinib versus those receiving chemotherapy (54.2% vs 0%, p<0.001).85 Similarly, Asian patients receiving alectinib in the ALESIA study exhibited larger CNS ORR compared with patients receiving crizotinib: 73% vs 22%, respectively, in patients with and without measurable CNS lesions at baseline.120

The observed efficacy of alectinib in ALK+ NSCLC patients without brain metastases suggests that alectinib may also prevent NSCLC progression to the brain. Therefore, alectinib is a CNS active ALK TKI that is not only active against baseline brain metastases but may also provide long-term benefits to the patient through its ability to potentially prevent the development of further brain metastases.

Safety profile of alectinib

Alectinib is generally well tolerated and has been reported to have a good toxicity profile.119,126,127 The incidence of adverse events in clinical trials is relatively low and this has been reported in both patients with and without baseline brain metastases.85,112 A systematic meta-analysis of eight clinical trials reported that the most common adverse events were constipation (29%), anemia (25%), myalgia (18%), peripheral edema (18%), dysgeusia (18%), and blood creatine phosphokinase increased (18%).118 This meta-analysis also reported a pooled discontinuation rate of 7% (95% CI: 4–10) and a pooled dose reduction or interruption rate of 33% (95% CI: 24–42) among alectinib-treated patients.118

The Japanese J-ALEX clinical trial compared alectinib (300 mg b.i.d) to crizotinib (250 mg b.i.d) and showed that alectinib had a better safety profile than crizotinib.96 In comparison to crizotinib, the incidence of grade 3/4 adverse events (26% versus 52%) and proportion of patients who discontinued treatment (9% versus 20%) were lower in alectinib-treated patients. Furthermore, the phase III ALEX trial also reported fewer grade 3–5 adverse events in treatment-naïve patients receiving alectinib relative to those receiving crizotinib.66 The phase III ALEX trial was a global study and showed that at a dose of 600 mg (b.i.d), grade 3–5 adverse events were reported in 41% of patients, with 11% of patients discontinuing treatment. In both the J-ALEX and ALEX trials, the incidence of adverse events was consistently lower compared to crizotinib except for myalgia and anemia, which were more frequent after alectinib treatment. Similar results were also observed in the phase III ALUR trial of crizotinib-pretreated patients and in the phase III ALESIA trial in Asian patients: fewer grade ≥3 adverse events and fewer adverse events leading to discontinuation occurred in patients receiving alectinib versus those receiving the other treatment.85,120

Conclusions

NSCLC has a very poor prognosis; however, the development of treatments that target pathways involved in tumorigenesis can improve patient survival. Targeting the NSCLC oncogenic-driver gene ALK has resulted in the development of various ALK inhibitors with notable effects in prolonging patient survival. Currently recommended testing methods for identifying ALK gene rearrangements in NSCLC patients include the use of Ventana IHC, which is recommended by the Chinese guidelines.57,65 Once the ALK gene mutation status has been assessed, current TKI therapies confer efficacy, albeit with the risk of toxicities or eventual regression in some cases. Several of these agents, however, have multiple targets that may contribute to the development of resistance (eg, crizotinib) or that may result
in greater toxicity (e.g., cetinib). Alectinib, a TKI that potently and selectively targets the ALK and MET pathways, results in prolonged PFS, even in patients with CNS involvement or patients with or without previous exposure to crizotinib, with lower rates of adverse events and dose reductions or interruptions due to adverse events. Recently approved in China, alectinib may prove to be the best first-line agent to help improve the outcomes of ALK+ locally advanced or metastatic NSCLC patients.

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All authors contributed to data analysis, drafting and revising the article, gave final approval of the version to be published, and agree to be accountable for all aspects of the work.

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Jinjing Xia is an employee of Shanghai Roche Pharmaceuticals Ltd. All other authors report no conflicts of interest in this work.

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