KIF5B-EGFR Fusion: A Novel EGFR Mutation in Lung Adenocarcinoma

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Abstract: With the rapid development of detection methods, next-generation sequencing (NGS) technology as a new technology, some novel epidermal growth factor receptor (EGFR) gene fusions comprising the EGFR linked to various fusion partners, most commonly RAD51, are detected in the non-small cell lung cancer (NSCLC). We described a case of an unreported kinesin family member 5B (KIF5B)-EGFR in NSCLC and the efficacy of EGFR tyrosine kinase inhibitors (TKIs) to this specific fusion. Considering this rare EGFR fusion and remarkable response to EGFR-TKI, we should realize the importance of these rare EGFR fusions, the advances in diagnostic techniques and personalized care for lung cancer patients.

Keywords: non-small cell lung cancer, adenocarcinoma, KIF5B-EGFR, EGFR-TKIs, next-generation sequencing

Introduction
Oncogenic mutations in the epidermal growth factor receptor (EGFR) gene serve as important predictive biomarkers in the non-small cell lung cancer (NSCLC). Most of these mutations commonly occur as in-frame deletions, insertions, or point mutations within exons 18–21 consisted of the kinase domain in EGFR and confer constitutive activity and sensitivity to EGFR tyrosine kinase inhibitors (TKIs).1 For EGFR wild-type patients, EGFR-TKIs still had a low ORR (1–9%).2 Uncommon EGFR mutation may be existing in these wild-type patients. Currently, next-generation sequencing (NGS) emerged as a new diagnostic approach for detection, more and more rare or atypical EGFR mutations have been identified. EGFR fusions are detected which are rare events in NSCLC.3 Several EGFR fusion partner genes have been reported, including RAD51 recombinase gene (RAD51), purine-rich element binding protein B gene (PURB), tensin 3 gene (TNS3), zinc finger CCHC-type containing 6 gene (ZCCHC6) and septin 14 gene (SEPTIN14) in NSCLC, most commonly EGFR-RAD51.3–6 Herein, we reported for the first time, the presence of EGFR fusion, kinesin family member 5B (KIF5B)-EGFR in NSCLC. Moreover, we have demonstrated that the patient experienced a remarkable response to EGFR-TKIs. Institutional approval was required to publish the case details. The informed consent was obtained from the patient prior to study commencement and the patient provided informed consent to have their case details, and accompanying images, published. The case report was approved by the ethics committee of Ningbo Medical Center Lihuili Hospital.

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Case Report

A 45-year-old Chinese woman presented with half a month history of cough and expectoration to our hospital in May 2019. Physical examinations were unremarkable. No obvious abnormalities were found in laboratory tests, including blood routine, serum biochemistry and tumor biomarkers. A computed tomography (CT) scan of the chest on May 25 revealed a high-density shadow in inferior lobe of right lung (Figure 1A). The enhanced CT was performed after 2 weeks’ treatment with oral moxifloxacin on June 7, which revealed a little progress of the lesion (Figure 1B). The patient underwent bronchoscopy and aspergillus fumigatus was detected in bronchoalveolar lavage fluid. Therefore, the patient was treated with oral voriconazole (200mg q12h) for more than 1 months. However, the patient’s symptoms worsened. The re-checked CT on July 27 demonstrated marked progression of the lesion in inferior lobe of right lung (Figure 1C) and a new lesion of ground glass opacity (GGO) was also found in the lower left lobe (Figure 1D). Then, voriconazole treatment was discontinued and the patient underwent CT-guided percutaneous lung biopsy and pathological results showed lung adenocarcinoma (Figure 2). The tumor tissue was subjected to next-generation sequencing (NGS), using a commercial gene panel targeting 168 cancer-related genes (Burning Rock Biotech Ltd, Guangzhou, China). The NGS reports revealed the KIF5B-EGFR, a novel rearrangement of the EGFR gene that has not been reported previously (Figure 3). The patient began treatment with afatinib (40mg qd po) and bevacizumab (400mg q3w ivgtt) since August 14. She experienced sustained clinical improvement after anti-tumor therapy and a CT scan on October 13 revealed marked decrease of the infiltrations on the lower right lung (Figure 1E) and the absence of GGO on the left lung, assessed as partial remission. The patient had mild rash and diarrhea during treatment, which was considered an adverse reaction associated with EGFR-TKI. Encouragingly, the lesion on the right lower lung continued to shrink during the treatment (Figure 1F–H). Thus far, the patient feels well and the disease has remained stable. She has been continuing treatment with afatinib and bevacizumab and will be followed up regularly.

Discussion

In clinical practice, EGFR fusions are rare in NSCLC. Previously, EGFR fusions were observed in large cohorts such as Memorial Sloan Kettering–Integrated Mutation Profiling of Actionable Cancer Targets (MSK-IMPACT), Foundation Medicine (FM), which are found at a frequency of 0.05% to 0.13% in the MSK-IMPACT and FM cohorts. EGFR-RAD51 is the most common type of EGFR fusions. It is oncogenic, able to mediate downstream signaling through the MAPK and PI3K/AKT pathways and can be therapeutically targeted with available EGFR-TKIs. Other EGFR
fusion partner genes have also been reported, including P Urb, TNS3, Z CCHC6 and SEPTIN14 in NSCLC. In this case, we provided the first report of a patient with the fusion of KIF5B exon15 to EGFR exon 18 in a primary lung adenocarcinoma through NGS. She responded well to treatment with afatinib and bevacizumab.
We identified the novel KIF5B-EGFR rearrangement through NGS. Traditional methods for detection of EGFR fusion have limitations. Immunohistochemistry and fluorescence in situ hybridization depend on diagnostic expertise, and reverse-transcriptase polymerase chain reaction is unable to detect novel chromosomal rearrangements. Compared with traditional methods, NGS allows for multiplex testing and enables the detection of known as well as uncommon genomic events. More and more rare or atypical EGFR mutations have been identified through NGS. KIF5B is located on the short arm of human chromosome 10 and encodes member 5B of the kinesin family of proteins. Its product is a component of a motor protein complex that is associated with microtubules and mediates the transport of organelles within eukaryotic cells. There is currently no report on KIF5B-EGFR. In this case, we provided the first report of a patient with the fusion of KIF5B exon15 to EGFR exon 18 that contains the EGFR tyrosine kinase domain in a primary lung adenocarcinoma. Konduri et al described five patients with metastatic lung cancer whose tumors harbored EGFR fusions and verified that Ba/F3 cells expressing EGFR-RAD51 were sensitive to different first-third generation EGFR-TKI drugs in vitro. Afatinib is an irreversible inhibitor of the ErbB family that is expected to inhibit tumors with activating EGFR mutations more strongly than are reversible EGFR-TKIs. Several clinical trials have shown favorable PFS with acceptable toxicity profiles for combination therapy consisting of bevacizumab and EGFR-TKIs in untreated EGFR-mutant tumors. In consideration of the synergistic effects of afatinib and bevacizumab, we experimentally treated the KIF5B-EGFR patient with afatinib and bevacizumab. The patient exhibited a significant partial response after treatment with afatinib and bevacizumab for 2 months.

It is worth noting that in this patient, although the lesion progressed after treatments of moxifloxacin and voriconazole, co-infection cannot be ruled out absolutely. Besides, the possibility of delayed absorption of lung infiltrations caused by fungal infection should not be neglected. In addition, the favorable response of the patient to anti-tumor therapy should be attributed to the combined effects of afatinib and bevacizumab. We did not explore the mechanism of EGFR-TKI on this new target, which can be a direction for future efforts.

**Conclusion**

In the present case, the patient of lung adenocarcinoma with KIF5B-EGFR fusion achieved a remarkable remission from treatment with EGFR-TKIs and the monoclonal antibody to vascular endothelial growth factor A. We provided case experiences supporting the use of afatinib and bevacizumab for treatment of the patients with NSCLC who are harboring KIF5B-EGFR fusion.

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**Disclosure**

The authors report no conflicts of interest in this work.

**References**

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