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Patient Name: 정병열 Gender: M Sample ID: N25-99 Primary Tumor Site: lung
Collection Date: 2025.06.24

# Sample Cancer Type: Non-Small Cell Lung Cancer

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# **Relevant Non-Small Cell Lung Cancer Findings**

| Gene        | Finding          |                      | Gene  | Finding       |
|-------------|------------------|----------------------|-------|---------------|
| ALK         | None detected    |                      | MET   | None detected |
| BRAF        | None detected    |                      | NRG1  | None detected |
| EGFR        | None detected    |                      | NTRK1 | None detected |
| ERBB2       | None detected    |                      | NTRK2 | None detected |
| FGFR1       | None detected    |                      | NTRK3 | None detected |
| FGFR2       | None detected    |                      | RET   | None detected |
| FGFR3       | None detected    |                      | ROS1  | None detected |
| KRAS        | None detected    |                      |       |               |
| Genomic Alt | eration          | Finding              |       |               |
| Tumor Mu    | ıtational Burden | 4.73 Mut/Mb measured |       |               |

### **Relevant Biomarkers**

| Tier | Genomic Alteration    | Relevant Therapies<br>(In this cancer type) | Relevant Therapies<br>(In other cancer type) | Clinical Trials |
|------|-----------------------|---|--|-----------------|
| IIC  | CCNE1 amplification   | None*                                       | None*  | 9               |
|      | cyclin E1             |   |  |                 |
|      | Locus: chr19:30303647 |   |  |                 |

<sup>\*</sup> Public data sources included in relevant therapies: FDA1, NCCN, EMA2, ESMO

Line of therapy: I: First-line therapy, II+: Other line of therapy

**Tier Reference:** Li et al. Standards and Guidelines for the Interpretation and Reporting of Sequence Variants in Cancer: A Joint Consensus Recommendation of the Association for Molecular Pathology, American Society of Clinical Oncology, and College of American Pathologists. J Mol Diagn. 2017 Jan;19(1):4-23.

#### Prevalent cancer biomarkers without relevant evidence based on included data sources

MAP2K7 deletion, Microsatellite stable, TP53 p.(Y236D) c.706T>G, PDCD1 deletion, NQ01 p.(P187S) c.559C>T, Tumor Mutational Burden

<sup>\*</sup> Public data sources included in prognostic and diagnostic significance: NCCN, ESMO

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#### **Variant Details**

# **DNA Sequence Variants**

| Gene  | Amino Acid Change | Coding                             | Variant ID | Locus          | Allele<br>Frequency | Transcript  | Variant Effect            |
|-------|-------------------|------------------------------------|------------|----------------|---------------------|-------------|---------------------------|
| TP53  | p.(Y236D)         | c.706T>G                           | COSM43602  | chr17:7577575  | 45.80%              | NM_000546.6 | missense                  |
| NQ01  | p.(P187S)         | c.559C>T                           |            | chr16:69745145 | 34.40%              | NM_000903.3 | missense                  |
| MSH3  | p.(A57_A62del)    | c.162_179delTGCAGC<br>GGCCGCAGCGGC |            | chr5:79950707  | 63.73%              | NM_002439.5 | nonframeshift<br>Deletion |
| LATS2 | p.(T999I)         | c.2996C>T                          |            | chr13:21549280 | 69.99%              | NM_014572.3 | missense                  |
| CIC   | p.(Q940P)         | c.2819A>C                          |            | chr19:42795830 | 42.79%              | NM_015125.5 | missense                  |
| MID2  | p.(S64F)          | c.191C>T                           |            | chrX:107084086 | 43.32%              | NM_012216.4 | missense                  |

| Copy Number Variations |                |             |           |  |
|------------------------|----------------|-------------|-----------|--|
| Gene                   | Locus          | Copy Number | CNV Ratio |  |
| CCNE1                  | chr19:30303647 | 5.13        | 1.94      |  |
| MAP2K7                 | chr19:7968792  | 0.73        | 0.62      |  |
| PDCD1                  | chr2:242793161 | 0.68        | 0.61      |  |
| FGFR3                  | chr4:1801456   | 0.85        | 0.66      |  |
| CD276                  | chr15:73991923 | 0.87        | 0.66      |  |

# **Biomarker Descriptions**

### **CCNE1** amplification

cyclin E1

Background: The CCNE1 gene encodes the cyclin E1 protein, a member of the highly conserved E-cyclin family which also includes CCNE2<sup>60</sup>. CCNE1 facilitates progression from G1 to the S phase of the cell cycle by binding to cyclin dependent kinase 2 (CDK2) which results in phosphorylation and inactivation of the retinoblastoma (RB1) protein<sup>60</sup>. Consequently, RB1 inactivation results in E2F transcription factor activation and cellular G1/S phase transition resulting in cell cycle progression, a common event observed in tumorigenesis<sup>61,62,63</sup>. Additionally, CCNE1 is often deregulated in a variety of cancer types supporting an oncogenic role for CCNE1<sup>60,64</sup>.

Alterations and prevalence: CCNE1 amplification is observed in about 40% of uterine carcinosarcoma, 20% of ovarian cancer, 11% of stomach cancer, 7-8% sarcoma, uterine, and esophageal cancers, 5-6%, adrenocortical carcinoma, squamous lung, and bladder cancers<sup>5</sup>. Additionally, CCNE1 overexpression has been observed in many different tumor types including in 70-80% of Hodgkin's lymphoma.<sup>60,64,65</sup>.

Potential relevance: The FDA has granted fast track designation (2024) to the small molecule PKMYT1 inhibitor, lunresertib<sup>66</sup>, in combination with camonsertib for the treatment of adult patients with CCNE1 amplified endometrial cancer and platinum resistant ovarian cancer. CCNE1 amplification and overexpression has been associated with poor prognosis in certain cancer types including lung and breast cancers<sup>67,68,69</sup>.

#### MAP2K7 deletion

mitogen-activated protein kinase kinase 7

Background: The MAP2K7 gene encodes the mitogen-activated protein kinase kinase 7, also known as MEK7¹. MAP2K7 is involved in the JNK signaling pathway along with MAP3K4, MAP3K12, MAP2K4, MAPK8, MAPK9, and MAPK10<sup>56,57,58</sup>. Activation of MAPK proteins occurs through a kinase signaling cascade<sup>56,57,59</sup>. Specifically, MAP3Ks are responsible for phosphorylation of MAP2K family

# **Biomarker Descriptions (continued)**

members<sup>56,57,59</sup>. Once activated, MAP2Ks are responsible for the phosphorylation of various MAPK proteins whose signaling is involved in several cellular processes including cell proliferation, differentiation, and inflammation<sup>56,57,59</sup>.

Alterations and prevalence: Somatic mutations in MAP2K7 are observed in 7% of stomach adenocarcinoma, 4% of colorectal adenocarcinoma, and 2% of skin cutaneous melanoma and uterine corpus endometrial carcinoma<sup>5,6</sup>. Biallelic deletions are observed in 4% of uterine carcinosarcoma, 2% of esophageal adenocarcinoma, and 1% of uveal melanoma<sup>5,6</sup>.

Potential relevance: Currently, no therapies are approved for MAP2K7 aberrations.

#### Microsatellite stable

Background: Microsatellites are short tandem repeats (STR) of 1 to 6 bases of DNA between 5 to 50 repeat units in length. There are approximately 0.5 million STRs that occupy 3% of the human genome<sup>34</sup>. Microsatellite instability (MSI) is defined as a change in the length of a microsatellite in a tumor as compared to normal tissue<sup>35,36</sup>. MSI is closely tied to the status of the mismatch repair (MMR) genes. In humans, the core MMR genes include MLH1, MSH2, MSH6, and PMS2<sup>37</sup>. Mutations and loss of expression in MMR genes, known as defective MMR (dMMR), lead to MSI. In contrast, when MMR genes lack alterations, they are referred to as MMR proficient (pMMR). Consensus criteria were first described in 1998 and defined MSI-high (MSI-H) as instability in two or more of the following five markers: BAT25, BAT26, D5S346, D2S123, and D17S250<sup>38</sup>. Tumors with instability in one of the five markers were defined as MSI-low (MSI-L) whereas, those with instability in zero markers were defined as MS-stable (MSS)<sup>38</sup>. Tumors classified as MSI-L are often phenotypically indistinguishable from MSS tumors and tend to be grouped with MSS<sup>39,40,41,42,43</sup>. MSI-H is a hallmark of Lynch syndrome (LS), also known as hereditary non-polyposis colorectal cancer, which is caused by germline mutations in the MMR genes<sup>36</sup>. LS is associated with an increased risk of developing colorectal cancer, as well as other cancers, including endometrial and stomach cancer<sup>35,36,40,44</sup>.

Alterations and prevalence: The MSI-H phenotype is observed in 30% of uterine corpus endothelial carcinoma, 20% of stomach adenocarcinoma, 15-20% of colon adenocarcinoma, and 5-10% of rectal adenocarcinoma<sup>35,36,45,46</sup>. MSI-H is also observed in 5% of adrenal cortical carcinoma and at lower frequencies in other cancers such as esophageal, liver, and ovarian cancers<sup>45,46</sup>.

Potential relevance: Anti-PD-1 immune checkpoint inhibitors including pembrolizumab<sup>47</sup> (2014) and nivolumab<sup>48</sup> (2015) are approved for patients with MSI-H or dMMR colorectal cancer who have progressed following chemotherapy. Pembrolizumab<sup>47</sup> is also approved as a single agent, for the treatment of patients with advanced endometrial carcinoma that is MSI-H or dMMR with disease progression on prior therapy who are not candidates for surgery or radiation. Importantly, pembrolizumab is approved for the treatment of MSI-H or dMMR solid tumors that have progressed following treatment, with no alternative option and is the first anti-PD-1 inhibitor to be approved with a tumor agnostic indication<sup>47</sup>. Dostarlimab<sup>49</sup> (2021) is also approved for dMMR recurrent or advanced endometrial carcinoma or solid tumors that have progressed on prior treatment and is recommended as a subsequent therapy option in dMMR/MSI-H advanced or metastatic colon or rectal cancer<sup>41,50</sup>. The cytotoxic T-lymphocyte antigen 4 (CTLA-4) blocking antibody, ipilimumab<sup>51</sup> (2011), is approved alone or in combination with nivolumab in MSI-H or dMMR colorectal cancer that has progressed following treatment with chemotherapy. MSI-H may confer a favorable prognosis in colorectal cancer although outcomes vary depending on stage and tumor location<sup>41,52,53</sup>. Specifically, MSI-H is a strong prognostic indicator of better overall survival (OS) and relapse free survival (RFS) in stage II as compared to stage III colorectal cancer patients<sup>53</sup>. The majority of patients with tumors classified as either MSS or pMMR do not benefit from treatment with single-agent immune checkpoint inhibitors as compared to those with MSI-H tumors<sup>54,55</sup>. However, checkpoint blockade with the addition of chemotherapy or targeted therapies have demonstrated response in MSS or pMMR cancers<sup>54,55</sup>.

#### TP53 p.(Y236D) c.706T>G

tumor protein p53

Background: The TP53 gene encodes the tumor suppressor protein p53, which binds to DNA and activates transcription in response to diverse cellular stresses to induce cell cycle arrest, apoptosis, or DNA repair¹. In unstressed cells, TP53 is kept inactive by targeted degradation via MDM2, a substrate recognition factor for ubiquitin-dependent proteolysis<sup>8</sup>. Alterations in TP53 are required for oncogenesis as they result in loss of protein function and gain of transforming potential<sup>9</sup>. Germline mutations in TP53 are the underlying cause of Li-Fraumeni syndrome, a complex hereditary cancer predisposition disorder associated with early-onset cancers<sup>10,11</sup>.

Alterations and prevalence: TP53 is the most frequently mutated gene in the cancer genome with approximately half of all cancers experiencing TP53 mutations. Ovarian, head and neck, esophageal, and lung squamous cancers have particularly high TP53 mutation rates (60-90%)5.6.12.13.14.15. Approximately two-thirds of TP53 mutations are missense mutations and several recurrent missense mutations are common, including substitutions at codons R158, R175, Y220, R248, R273, and R2825.6. Invariably, recurrent missense mutations in TP53 inactivate its ability to bind DNA and activate transcription of target genes16,17,18,19. Alterations in TP53 are also observed in pediatric cancers5.6. Somatic mutations are observed in 53% of non-Hodgkin lymphoma, 24% of soft tissue sarcoma, 19% of glioma, 13% of bone cancer, 9% of B-lymphoblastic leukemia/lymphoma, 4% of embryonal tumors, 3% of Wilms tumor and leukemia,

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# **Biomarker Descriptions (continued)**

2% of T-lymphoblastic leukemia/lymphoma, and less than 1% of peripheral nervous system cancers (5 in 1158 cases) 5.6. Biallelic loss of TP53 is observed in 10% of bone cancer, 2% of Wilms tumor, and less than 1% of B-lymphoblastic leukemia/lymphoma (2 in 731 cases) and leukemia (1 in 250 cases) 5.6.

Potential relevance: The small molecule p53 reactivator, PC14586<sup>20</sup> (2020), received a fast track designation by the FDA for advanced tumors harboring a TP53 Y220C mutation. The FDA has granted fast track designation to the p53 reactivator, eprenetapopt<sup>21</sup>, (2019) and breakthrough designation<sup>22</sup> (2020) in combination with azacitidine or azacitidine and venetoclax for acute myeloid leukemia patients (AML) and myelodysplastic syndrome (MDS) harboring a TP53 mutation, respectively. In addition to investigational therapies aimed at restoring wild-type TP53 activity, compounds that induce synthetic lethality are also under clinical evaluation<sup>23,24</sup>. TP53 mutation are a diagnostic marker of SHH-activated, TP53-mutant medulloblastoma<sup>25</sup>. TP53 mutations confer poor prognosis and poor risk in multiple blood cancers including AML, MDS, myeloproliferative neoplasms (MPN), and chronic lymphocytic leukemia (CLL), and acute lymphoblastic leukemia (ALL)<sup>26,27,28,29,30,31</sup>. In mantle cell lymphoma, TP53 mutations are associated with poor prognosis when treated with conventional therapy including hematopoietic cell transplant<sup>32</sup>. Mono- and bi-allelic mutations in TP53 confer unique characteristics in MDS, with multi-hit patients also experiencing associations with complex karyotype, few co-occurring mutations, and high-risk disease presentation as well as predicted death and leukemic transformation independent of the IPSS-R staging system<sup>33</sup>.

#### PDCD1 deletion

programmed cell death 1

Background: The PDCD1 gene encodes programmed cell death 1, also known as PD-1 or CD279¹. PDCD1 is a type I transmembrane inhibitory receptor and member of the CD28/CTLA-4 family, which is part of the immunoglobulin superfamily². PDCD1 is an immune checkpoint molecule that acts as a gatekeeper of immune responses through a balance of signaling suppression, which is critical in the facilitation of self and non-self cell recognition³. PDCD1 is expressed in a variety of hematopoietic cells, immune cells, tumor cells, and tumor specific T-cells².⁴. The two main immunoregulatory ligands of PDCD1 are CD274 (PD-L1) and PDCD1LG2 (PD-L2), which are type I transmembrane proteins expressed in many cells including antigen presenting cells and tumor cells². PDCD1 and CD274 act as co-inhibitors and regulate immune tolerance of central and peripheral T-cells and reduce the proliferation of CD8+ T-cells by inhibitor signals².⁴.

Alterations and prevalence: Somatic mutations in PDCD1 are observed in 4% of skin cutaneous melanoma, 3% of uterine corpus endometrial carcinoma, and 2% of uterine carcinosarcoma<sup>5,6</sup>. Deletions in PDCD1 are observed in 8% of sarcoma, 5% of brain lower grade glioma, 3% of cervical squamous cell carcinoma, esophageal adenocarcinoma, bladder urothelial carcinoma, and uveal melanoma<sup>5,6</sup>.

Potential relevance: Currently, no therapies are approved for PDCD1 aberrations. Immune checkpoint inhibitor therapy uses immunotherapy to block receptor-ligand interactions and enhance immunity activity against tumor cells<sup>7</sup>. Although not approved for specific PDCD1 aberrations, approved checkpoint inhibitors targeting PDCD1 include the monoclonal antibodies pembrolizumab, nivolumab, and cemiplimab<sup>2</sup>.

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# **Alerts Informed By Public Data Sources**

#### **Current FDA Information**

Contraindicated

Not recommended



Resistance



Breakthrough



FDA information is current as of 2025-05-14. For the most up-to-date information, search www.fda.gov.

#### **CCNE1** amplification

## camonsertib + lunresertib

Cancer type: Endometrial Carcinoma, Ovarian Cancer

Variant class: CCNE1 amplification

#### Supporting Statement:

- The FDA has granted Fast Track designation to lunresertib in combination with camonsertib for the treatment of adult patients with CCNE1 amplified, or FBXW7 or PPP2R1A mutated platinum resistant ovarian cancer.
- The FDA has granted Fast Track designation to lunresertib in combination with camonsertib for the treatment of adult patients with CCNE1 amplified, or FBXW7 or PPP2R1A mutated endometrial cancer.

#### Reference:

https://ir.reparerx.com/news-releases/news-release-details/repare-therapeutics-announces-fast-track-designation-granted-fda

## **Genes Assayed**

## Genes Assayed for the Detection of DNA Sequence Variants

ABL1, ABL2, ACVR1, AKT1, AKT2, AKT3, ALK, AR, ARAF, ATP1A1, AURKA, AURKB, AURKC, AXL, BCL2, BCL2L12, BCL6, BCR, BMP5, BRAF, BTK, CACNA1D, CARD11, CBL, CCND1, CCND2, CCND3, CCNE1, CD79B, CDK4, CDK6, CHD4, CSF1R, CTNNB1, CUL1, CYSLTR2, DDR2, DGCR8, DROSHA, E2F1, EGFR, EIF1AX, EPAS1, ERBB2, ERBB3, ERBB4, ESR1, EZH2, FAM135B, FGF7, FGFR1, FGFR2, FGFR3, FGFR4, FLT3, FLT4, FOXA1, FOXL2, FOXO1, GATA2, GLI1, GNA11, GNAQ, GNAS, HIF1A, HRAS, IDH1, IDH2, IKBKB, IL6ST, IL7R, IRF4, IRS4, KCNJ5, KDR, KIT, KLF4, KLF5, KNSTRN, KRAS, MAGOH, MAP2K1, MAP2K2, MAPK1, MAX, MDM4, MECOM, MED12, MEF2B, MET, MITF, MPL, MTOR, MYC, MYCN, MYD88, MYOD1, NFE2L2, NRAS, NSD2, NT5C2, NTRK1, NTRK2, NTRK3, NUP93, PAX5, PCBP1, PDGFRA, PDGFRB, PIK3C2B, PIK3CA, PIK3CB, PIK3CD, PIK3CG, PIK3R2, PIM1, PLCG1, PPP2R1A, PPP6C, PRKACA, PTPN11, PTPRD, PXDNL, RAC1, RAF1, RARA, RET, RGS7, RHEB, RHOA, RICTOR, RIT1, ROS1, RPL10, SETBP1, SF3B1, SIX1, SIX2, SLC01B3, SMC1A, SMO, SNCAIP, SOS1, SOX2, SPOP, SRC, SRSF2, STAT3, STAT5B, STAT6, TAF1, TERT, TGFBR1, TOP1, TOP2A, TPMT, TRRAP, TSHR, U2AF1, USP8, WAS, XP01, ZNF217, ZNF429

# Genes Assayed for the Detection of Copy Number Variations

ABCB1, ABL1, ABL2, ABRAXAS1, ACVR1B, ACVR2A, ADAMTS12, ADAMTS2, AKT1, AKT2, AKT3, ALK, AMER1, APC, AR, ARAF, ARHGAP35, ARID1A, ARID1B, ARID2, ARID5B, ASXL1, ASXL2, ATM, ATR, ATRX, AURKA, AURKC, AXIN1, AXIN2, AXL, B2M, BAP1, BARD1, BCL2, BCL2L12, BCL6, BCOR, BLM, BMPR2, BRAF, BRCA1, BRCA2, BRIP1, CARD11, CASP8, CBFB, CBL, CCND1, CCND2, CCND3, CCNE1, CD274, CD276, CDC73, CDH1, CDH10, CDK12, CDK4, CDK6, CDKN1A, CDKN1B, CDKN2A, CDKN2B, CDKN2C, CHD4, CHEK1, CHEK2, CIC, CREBBP, CSMD3, CTCF, CTLA4, CTNND2, CUL3, CUL4A, CUL4B, CYLD, CYP2C9, DAXX, DDR1, DDR2, DDX3X, DICER1, DNMT3A, DOCK3, DPYD, DSC1, DSC3, EGFR, EIF1AX, ELF3, EMSY, ENO1, EP300, EPCAM, EPHA2, ERAP1, ERAP2, ERBB2, ERBB3, ERBB4, ERCC2, ERCC4, ERRFI1, ESR1, ETV6, EZH2, FAM135B, FANCA, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, FANCM, FAT1, FBXW7, FGF19, FGF23, FGF3, FGF4, FGF9, FGFR1, FGFR2, FGFR3, FGFR4, FLT3, FLT4, FOXA1, FUBP1, FYN, GATA2, GATA3, GLI3, GNA13, GNAS, GPS2, HDAC2, HDAC9, HLA-A, HLA-B, HNF1A, IDH2, IGF1R, IKBKB, IL7R, INPP4B, JAK1, JAK2, JAK3, KDM5C, KDM6A, KDR, KEAP1, KIT, KLF5, KMT2A, KMT2B, KMT2C, KMT2D, KRAS, LARP4B, LATS1, LATS2, MAGOH, MAP2K1, MAP2K4, MAP2K7, MAP3K1, MAP3K4, MAPK1, MAPK8, MAX, MCL1, MDM2, MDM4, MECOM, MEF2B, MEN1, MET, MGA, MITF, MLH1, MLH3, MPL, MRE11, MSH2, MSH3, MSH6, MTAP, MTOR, MUTYH, MYC, MYCL, MYCN, MYD88, NBN, NCOR1, NF1, NF2, NFE2L2, NOTCH1, NOTCH2, NOTCH3, NOTCH4, NRAS, NTRK1, NTRK3, PALB2, PARP1, PARP2, PARP3, PARP4, PBRM1, PCBP1, PDCD1, PDCD1LG2, PDGFRA, PDGFRB, PDIA3, PGD, PHF6, PIK3C2B, PIK3CA, PIK3CB, PIK3R1, PIK3R2, PIM1, PLCG1, PMS1, PMS2, POLD1, POLE, POT1, PPM1D, PPP2R1A, PPP2R2A, PPP6C, PRDM1, PRDM9, PRKACA, PRKAR1A, PTCH1, PTEN, PTPN11, PTPRT, PXDNL, RAC1, RAD50, RAD51, RAD51B, RAD51C, RAD51D, RAD52, RAD54L, RAF1, RARA, RASA1, RASA2, RB1, RBM10, RECQL4, RET, RHEB, RICTOR, RIT1, RNASEH2A, RNASEH2B, RNF43, ROS1,

## **Genes Assayed (continued)**

## Genes Assayed for the Detection of Copy Number Variations (continued)

RPA1, RPS6KB1, RPTOR, RUNX1, SDHA, SDHB, SDHD, SETBP1, SETD2, SF3B1, SLCO1B3, SLX4, SMAD2, SMAD4, SMARCA4, SMARCB1, SMC1A, SMO, SOX9, SPEN, SPOP, SRC, STAG2, STAT3, STAT6, STK11, SUFU, TAP1, TAP2, TBX3, TCF7L2, TERT, TET2, TGFBR2, TNFAIP3, TNFRSF14, TOP1, TP53, TP63, TPMT, TPP2, TSC1, TSC2, U2AF1, USP8, USP9X, VHL, WT1, XPO1, XRCC2, XRCC3, YAP1, YES1, ZFHX3, ZMYM3, ZNF217, ZNF429, ZRSR2

## Genes Assayed for the Detection of Fusions

AKT2, ALK, AR, AXL, BRAF, BRCA1, BRCA2, CDKN2A, EGFR, ERBB2, ERBB4, ERG, ESR1, ETV1, ETV4, ETV5, FGFR1, FGFR2, FGFR3, FGR, FLT3, JAK2, KRAS, MDM4, MET, MYB, MYBL1, NF1, NOTCH1, NOTCH4, NRG1, NTRK1, NTRK2, NTRK3, NUTM1, PDGFRA, PDGFRB, PIK3CA, PPARG, PRKACA, PRKACB, PTEN, RAD51B, RAF1, RB1, RELA, RET, ROS1, RSPO2, RSPO3, TERT

## Genes Assayed with Full Exon Coverage

ABRAXAS1, ACVR1B, ACVR2A, ADAMTS12, ADAMTS2, AMER1, APC, ARHGAP35, ARID1A, ARID1B, ARID2, ARID5B, ASXL1, ASXL2, ATM, ATR, ATRX, AXIN1, AXIN2, B2M, BAP1, BARD1, BCOR, BLM, BMPR2, BRCA1, BRCA2, BRIP1, CALR, CASP8, CBFB, CD274, CD276, CDC73, CDH1, CDH10, CDK12, CDKN1A, CDKN1B, CDKN2A, CDKN2B, CDKN2C, CHEK1, CHEK2, CIC, CIITA, CREBBP, CSMD3, CTCF, CTLA4, CUL3, CUL4A, CUL4B, CYLD, CYP2C9, CYP2D6, DAXX, DDX3X, DICER1, DNMT3A, DOCK3, DPYD, DSC1, DSC3, ELF3, ENO1, EP300, EPCAM, EPHA2, ERAP1, ERAP2, ERCC2, ERCC4, ERCC5, ERRF11, ETV6, FANCA, FANCC, FANCD2, FANCE, FANCE, FANCG, FANCI, FANCI, FANCH, FA

# **Relevant Therapy Summary**

CCNE1 amplification

■ In this cancer type ■ In this cancer type ■ In this cancer type and other cancer types ■ No evidence

| CCNE I amplification                 |     |      |     |      |                  |
|--------------------------------------|-----|------|-----|------|------------------|
| Relevant Therapy                     | FDA | NCCN | EMA | ESMO | Clinical Trials* |
| palbociclib                          | ×   | ×    | ×   | ×    | <b>(II)</b>      |
| APR-1051                             | ×   | ×    | ×   | ×    | <b>(</b>  /  )   |
| ARTS-021                             | ×   | ×    | ×   | ×    | <b>(</b>  /  )   |
| ECI-830, hormone therapy, ribociclib | ×   | ×    | ×   | ×    | <b>(</b>  /  )   |
| INX-315, hormone therapy             | ×   | ×    | ×   | ×    | <b>(</b>  /  )   |
| WJB-001                              | ×   | ×    | ×   | ×    | <b>(</b>  /  )   |
| lunresertib, camonsertib, Debio-0123 | ×   | ×    | ×   | ×    | (I)              |
| nedisertib, tuvusertib               | ×   | ×    | ×   | ×    | (I)              |
| NKT-3964                             | ×   | ×    | ×   | ×    | (I)              |

<sup>\*</sup> Most advanced phase (IV, III, II/III, II, I/II, I) is shown and multiple clinical trials may be available.

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#### **HRR Details**

| Gene/Genomic Alteration | Finding                           |
|-------------------------|-----------------------------------|
| LOH percentage          | 34.47%                            |
| BRCA2                   | LOH, 13q13.1(32890491-32972932)x3 |

Homologous recombination repair (HRR) genes were defined from published evidence in relevant therapies, clinical guidelines, as well as clinical trials, and include - BRCA1, BRCA2, ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D, and RAD54L.

Thermo Fisher Scientific's Ion Torrent Oncomine Reporter software was used in generation of this report. Software was developed and designed internally by Thermo Fisher Scientific. The analysis was based on Oncomine Reporter (6.1.1 data version 2025.06(006)). The data presented here are from a curated knowledge base of publicly available information, but may not be exhaustive. FDA information was sourced from www.fda.gov and is current as of 2025-05-14. NCCN information was sourced from www.nccn.org and is current as of 2025-05-01. EMA information was sourced from www.ema.europa.eu and is current as of 2025-05-14. ESMO information was sourced from www.esmo.org and is current as of 2025-05-01. Clinical Trials information is current as of 2025-05-01. For the most up-to-date information regarding a particular trial, search www.clinicaltrials.gov by NCT ID or search local clinical trials authority website by local identifier listed in 'Other identifiers.' Variants are reported according to HGVS nomenclature and classified following AMP/ ASCO/CAP guidelines (Li et al. 2017). Based on the data sources selected, variants, therapies, and trials listed in this report are listed in order of potential clinical significance but not for predicted efficacy of the therapies.

#### References

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