Oncolytic viruses (OV) are a promising immunotherapeutic modality in number of cancers. OV administration leads to profound changes in tumor immune contexture by inducing a shift towards a pro-immune tumor microenvironment and to immunogenic cancer cell death resulting in the onset of an adaptive anti-tumor T-cell response. Effective use of OV in clinical setting is limited by the requirement of intra-tumoral administration. Hence, there is a great need to develop OV able to localize to tumor tissue following intravenous delivery. TG6002 is a vaccinia virus deleted for Thymidine Kinase/Ribonucleotide Reductase and encoding the FCU1 enzyme that converts the pro-drug 5-Fluorocytosine (5-FC) to its active metabolite 5-Fluorouracil (5-FU). Herein, we report preliminary results from a dose-escalation phase I study combining intravenous TG6002 and oral 5-FC in patients with advanced gastrointestinal (GI) carcinomas. Exploratory analyses were performed to document TG6002 pharmacokinetic (PK), biodistribution, and conversion of 5-FC to 5-FU.

**METHODS**

A total of 15 patients received TG6002 infusions on days 1, 8 and 15 at the dose of 3x10^8 pfu (n=3), 1x10^9 pfu (n=10) or 3x10^9 pfu (n=2) combined with 5-FC (4 times 50 mg/kg/day) from days 5 to 7, 12 to 14, and 19 to 28. Blood was sampled 30 min, 3h and 24h after TG6002 infusion on day 1 and 15 for plasma TG6002 PK and one hour after intake of 5-FC at screening (single dose of 50 mg/kg) and on days 5, 7, 14 and 28 for serum 5-FC and 5-FU measurements. A 18g metastasis biopsy was performed on day 5 along with synchronous blood sampling. Virus presence was assessed by qPCR and plaque assay, and 5-FC and F-BAL were quantified using HPLC-MS. Urine, saliva and feces samples were collected on day 2 and 7 for viral shedding assessment. Neutralizing antibodies (NAb) titers were assessed at baseline, days 28 and 43 using a plaque inhibition assay.

**RESULTS**

TG6002 was transiently detected in the plasma following administration and was not found in urine, saliva or feces, suggesting that plasma clearance was essentially driven by the entry of virus in cells. In 3 patients we observed a rebound on day 5, in line with preclinical experience with TG6002 (Fig A).

Depending on the dose-level cohort, 30% to 50% of patients showed direct evidence of the virus in the tumor by qPCR or plaque assay (Fig B). Sensitivity of these analyses was limited by the scarcity and the histologic heterogeneity of the tumor samples (Fig C).

We detected 5-FU and its final metabolite F-BAL in tumor tissue (Fig D) and in peripheral blood (Fig E) in most of the evaluable patients across the 3 dose-level cohorts.

Plasma and tumor levels of 5-FU were correlated on day 5 (Fig F). Interestingly, patients with the highest levels of 5-FU in blood and tumor were patients for which there was direct evidence of TG6002 in the tumor.

Neutralizing antibodies were detected in all patients 28 days and 43 days after administration of TG6002. None of the patients had detectable levels at baseline (Fig G).

**CONCLUSIONS**

- Our data demonstrate that TG6002 localizes to the tumor after IV administration, replicates in tumor cells and is able to express a functional payload.
- FCU1 activity was associated with high virus concentration in tumor tissue suggesting a selective replication of TG6002 in tumor cells.
- We did not detect viral shedding in urine feces or saliva samples.