**Name of journal: *World Journal of Clinical Cases***

**Manuscript NO: 47153**

**Manuscript type: Minireviews**

**Antibiotics and immunotherapy in gastrointestinal tumors: friend or foe?**

Yan C *et al*. Association between antibiotics and immunotherapy

Cong Yan, Xiao-Xuan Tu, Wei Wu, Zhou Tong, Lu-Lu Liu, Yi Zheng, Wei-Qin Jiang, Peng Zhao, Wei-Jia Fang, Hang-Yu Zhang

**Cong Yan, Xiao-Xuan Tu, Wei Wu, Zhou Tong, Lu-Lu Liu, Yi Zheng, Wei-Qin Jiang, Peng Zhao, Wei-Jia Fang, Hang-Yu Zhang**, Department of Medical Oncology, First Affiliated Hospital, School of Medicine, Zhejiang University, Hangzhou 310000, Zhejiang Province, China

**ORCID number:** Cong Yan (0000-0002-2550-9095); Xiao-Xuan Tu (0000-0002-5505-0756); Wei Wu (0000-0002-3024-380X); Zhou Tong (0000-0003-0572-9610); Lu-Lu Liu (0000-0002-1762-8529); Yi Zheng (0000-0002-7066-2937); Wei-Qin Jiang (0000-0003-3200-8835); Peng Zhao (0000-0002-5479-899X); Wei-Jia Fang (0000-0001-9849-347X); Hang-Yu Zhang (0000-0003-1325-3915).

**Author contributions:** Yan C performed the majority of the writing and prepared the tables; Zhang HY designed the outline and coordinated the writing of the paper; other coauthors provided the input in writing the paper.

**Supported by** the Major Scientific Project of Zhejiang, No. 2017C03028.

**Conflict-of-interest statement:** There is no conflict of interest associated with any of the senior author or other coauthors who contributed their efforts in this manuscript.

**Open-Access:** This article is an open-access article which was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/

**Manuscript source:** Invited manuscript

**Corresponding author: Hang-Yu Zhang, MD,** **Attending Doctor**, Department of Medical Oncology, First Affiliated Hospital, School of Medicine, Zhejiang University, No. 79, Qingchun Road, Hangzhou 310000, Zhejiang Province, China. zhanghangyu@zju.edu.cn

**Telephone:** +86-15757747033

**Fax:** +86-571-87236858

**Received:** March 15, 2019

**Peer-review started:** March 15, 2019

**First decision:** March 29, 2019

**Revised:** April 7, 2019

**Accepted:** April 18, 2019

**Article in press:**

**Published online:**

**Abstract**

The incidence of gastrointestinal (GI) tumors is increasing year by year, and its pathogenesis is closely related to the intestinal flora. At present, the use of antibiotics is very common in the clinic. And cancer patients with low immunity is vulnerable to all sorts of infections, such as respiratory tract infections and urinary tract infections. Moreover, cancer patients easily run into fever and neutropenia induced by myelosuppression. Therefore, antibiotics are used extensively and even overused in many conditions. However, because of the special anatomical location of the gastrointestinal tract, the antibiotic usage will bring changes to the intestinal flora. Besides, with the expanding popularity of immunotherapy, various factors affecting the efficacy of immune checkpoint inhibitors (ICIs) have been extensively explored, including cancer-associated inflammation and the local and systemic factors that lead to immunosuppression. Some biomarkers for ICIs, including the expression of PD-L1, tumor mutation load, and microbiota, also have been investigated, and many studies have confirmed that gut microbiota can affect the efficacy of immunotherapy. But further studies on the influence of antibiotics directly on immunotherapy are rare. In this review, we discuss the relationship between GI tumors and antibiotics, the current status of immunotherapy in GI tumors, and the influence of antibiotics on immunotherapy.

**Key words:** Antibiotics; Immunotherapy; Gastrointestinal tumor; Microbiota; Immune checkpoint inhibitors

**© The Author(s) 2019.** Published by Baishideng Publishing Group Inc. All rights reserved.

**Core tip:** With the widespread use of immunotherapy for almost all types of cancers and the extensive usage of antibiotics in many countries, the association between antibiotics and immunotherapy deserves an investigation based on some studies which showed that the gut microbiota plays an important role in immunotherapy. We reviewed the relevant papers and found that antibiotics may attenuate the effect of immunotherapy.

Yan C, Tu XX, Wu W, Tong Z, Liu LL, Zheng Y, Jiang WQ, Zhao P, Fang WJ, Zhang HY. Antibiotics and immunotherapy in gastrointestinal tumors: Friend or foe? *World J Clin Cases* 2019; In press

**INTRODUCTION**

Gastrointestinal (GI) tumors, including colorectal cancer (CRC), gastric cancer, pancreatic cancer, hepatocellular carcinoma (HCC), and cholangiocarcinoma, account for a large proportion of all cancers[1,2]. Due to the limited effectiveness of traditional chemotherapy, especially for pancreatic cancer and HCC, great efforts have been made in immunotherapy, which has becomea a potential treatment option for GI tumors in the last decade. In addition, current management strategies and treatments for GI tumors have also been enriched by immune checkpoint inhibitors (ICIs), such as advanced treatment for microsatellite instable CRC and second-line treatment for HCC. However, only a fraction of patients benefited from ICIs and there are some factors affecting their efficacy, such as tumor genomics, PD1 ligand 1 (PD-L1) levels, and gut microbiota[3].

The correlations between the gut microbiota community and clinical response to ICIs have been confirmed by an increasing number of investigations. Early studies found that the effects of CTLA-4 blockade were associated with T cell responses specific for distinct Bacteroides species and tumors in antibiotic-treated or germ-free mice did not respond to CTLA-4 blockade[4]. Cancer immunotherapy may be modulated by manipulating the microbiota[5]. Similarly, the anticancer immunity in mouse models induced by anti-PD-L1 is reported to rely on Bifidobacterium, which might improve the effectiveness of anticancer immunity through augmenting dendritic cell functions and subsequently enhancing CD8+ T cell priming and accumulation in the tumor microenvironment. Furthermore, oral administration of Bifidobacterium can generate a similar effect to anti-PD-L1 treatment on tumor elimination, indicating the potentially important role of Bifidobacterium in strengthening immune functions[5]. Subsequently, an increasing number of studies have revealed a correlation between the response to anti-PD-1 and the abundance of diversified bacteria, including Ruminococcaceae bacteria, *Bifidobacterium longum*, *Collinsella aerofaciens*, and *Enterococcus faecium*[6-8].

Since extensively and overused antibiotics can lead to abnormal intestinal microbiota composition, the effect of antibiotics on immunotherapy has also been explored in several studies. For example, some studies have indicated that antibiotics can weaken the effectiveness of immunotherapy, while others argued that antibiotics have no influence on immunotherapy. In this review, we summarize the relationship between antibiotics, microbiota, and GI tumors, the current status of immunotherapy in GI tumors, and the influence of antibiotics on immunotherapy in a comprehensive manner.

**Antibiotics, Microbiota, and GI Tumors**

The link between antibiotics and cancers has been around for a long time. Several decades ago, the hypothesis that the use of antibiotics may increase the risk of cancer was first proposed[9]. Studies have shown the association between increased use of antibiotics and increased incidence and mortality of breast cancer[10,11]. Antibiotics are also known to influence the development and progression of GI tumors, most notably for colorectal cancer. Cao *et al*[12] reported a study of 1195 newly diagnosed colorectal adenomas in patients who underwent at least one colonoscopy and reported information on antibiotic use. They found that antibiotic use at ages 20–39 and 40–59 was significantly associated with an increased risk of colorectal adenoma after age 60. Two other case-control studies supported this conclusion: one study found a positive association between the use of anti-anaerobic antibiotics and colorectal cancer, but no association was found for anti-aerobic agents[13]; another study found that a high (≥8) number of prescriptions of antibiotics was associated with an increased risk of colorectal cancer (CRC), and when antibiotics were used for ≥ 70 d compared to no use of antibiotics, the risk of CRC significantly increased, and both anti-aerobic agents and anti-anaerobic antibiotics were associated with an increased risk of CRC[14]. Indeed, penicillin can lead to an increased risk of esophageal, gastric, and pancreatic cancers[15], and antibiotic exposure can promote the development of tumors in the liver[16].

However, the effect of the microbiota on cancers further complicates the relationship between antibiotics, bacteria, and cancers. The microbiota is reported to be involved in the initiation, progression, and dissemination of cancer both at epithelial barriers and in sterile tissues, and gut microbiota can modulate the response to cancer therapy and susceptibility to toxic side effects[17]. There are papers showing some microbes associated with GI tumors (table 1), and common examples of microbes involved in cancer include *Helicobacter pylori*, which is associated with gastric cancer, *Clonorchis sinensis* and *Opisthorchis viverrini*, which are associated with bile duct cancer, and enterotoxigenic *Bacteroides fragilis*, which is associated with colon cancer[18,19]. In mice receiving broad-spectrum antibiotics, reductions in microbiota, inflammation, and colonic polyposis, which is a precancerous lesion of colon cancer, were observed[20]. Immune and inflammatory pathways could be regulated by chronic inflammatory conditions, while chronic inflammatory conditions could be affected by microbiota and antibiotics[20,21]. These observations suggested that a further investigation into the influence of antibiotics on the treatment for GI tumors is necessary.

**Immunotherapy and GI Tumors**

Immunotherapy has been a hit in the field of cancer therapy. Unlike melanoma, renal cancer, and non-small cell lung cancer, most GI tumors do not induce effector T-cell responses naturally, which may lead to an unsatisfactory immunotherapy efficacy. Various clinical trials have been conducted to verify the efficacy of ICIs in GI tumors as a single agent or in combination, and tremendous advances have been made (table 2). For esophageal and gastric cancers, a phase II trial confirmed the safety and activity of nivolumab in 64 patients with treatment-refractory esophageal cancer[22]. Nivolumab was approved in Japan after the Asian ATTRACTION 02 study[23], which was a phase III trial performed to compare nivolumab with placebo in patients with unresectable chemorefractory advanced gastric or gastroesophageal junction cancer. Then, the CheckMate-032 phase I/II study evaluated the efficacy and safety of nivolumab and nivolumab plus ipilimumab[24], and the phase II clinical KEYNOTE-059 trial demonstrated promising activity and manageable safety of pembrolizumab[25]. All the above studies suggested that immunotherapy may be a potential approach to treating refractory advanced gastric and esophageal cancers. However, the phase III JAVELIN trial[26] and the KEYNOTE-061 phase III trial[27] showed negative results.

For HCC, an early phase 1/2 dose escalation and expansion trial to assess the safety and efficacy of nivolumab showed a satisfactory survival end-point and treatment response rate[28]. Besides, another study evaluated the efficacy and safety of pembrolizumab in patients who had previously experienced sorafenib[29]. Similarly, small sample clinical trials of camrelizumab (anti-PD-1 antibody)[30] and tremelimumab (anti-CTLA-4 antibody)[31] also yielded promising results. For biliary tract cancer, Bang *et al* performed an interim analysis to evaluate the safety and antitumor activity of pembrolizumab in advanced biliary tract cancer and found that pembrolizumab was generally well tolerated and demonstrated promising antitumor activity among 24 enrolled patients. For pancreatic cancer, early studies on BMS-936559 (anti–PD-L1 antibody)[32] and ipilimumab[33] showed that they were ineffective when treating advanced pancreatic cancer. Hence, further investigations are suggested to perform.

The immunological benefit in patients with colorectal cancer has been limited to those who had a loss of mismatch repair function and had specific germline mutations in the DNA polymerase gene[34,35]. A host of current trials are underway in patients with microsatellite stable (MSS) CRC to evaluate the utility of concurrent chemotherapy, VEGF/EGFR inhibitors, radiotherapy, or MEK inhibitors with ICIs; however, more data are still needed to address the efficacy and tolerability of ICIs in MSS CRC patients[36].

In summary, with respect to advanced gastrointestinal malignancies, ICIs have shown some therapeutic effects. However, for various reasons, such as the stroma providing a formidable barrier to effector T-cell infiltration in pancreatic cancer, the therapeutic effect of ICIs needs to be further improved. Therefore, various clinical trials are planned using combinations of ICIs with chemotherapy, molecular targeted therapy, radiation therapy, or other novel immunomodulatory agents in patients with advanced GI tumors. And the factors affecting the immunotherapeutic efficacy for GI tumors are also worthy of further studying, especially the unclarified but important role of antibiotic usage in patients receiving ICIs treatment.

**Antibiotics and Immunotherapy**

PD-L1 expression in the tumor tissue has been considered to be a biomarker for pembrolizumab in NSCLC[37]; however, some PD-L1-positive patients do not benefit from pembrolizumab, while some PD-L1-negative patients could benefit from nivolumab or other ICIs. How to select the appropriate population for ICIs is still a question. A recent study found that tumor mutation burden or tumor infiltrating lymphocytes might be relevant biomarkers for patients treated with ICIs[38,39], and accumulating evidence supports the hypothesis that the gut microbiota has a great influence on immunotherapy, including ICIs[19]. Therefore, tumor mutation burden, tumor infiltrating lymphocytes, and the gut microbiota are considered potential immunotherapy biomarkers. The gut microbiota plays a crucial role in balancing inflammation, infection, and commensal antigens, which can modulate the host immune system both locally and systemically[40]. As interest in the influence of microbiota on immunotherapy has escalated, microbiota and cancer, specific gut microbes, and administration of antibiotics have also attracted extensive attention.

Early studies focusing on the relationship between immunotherapy and antibiotics were all conducted in murine models. For example, cyclophosphamide (CTX) is a well-known chemotherapy that can stimulate antitumor immune responses, including inducing the death of immunogenic cancer cells, destroying immunosuppressive T cells, and promoting Th1 and Th17 cells to control tumor growth. However, mice treated with antibiotics to kill gram-positive bacteria have been found to have a reduction in the number of pathogenic Th17 cells and a worse treatment response[41]. When pathogenic Th17 cells were transferred to antibiotic-treated mice, the antitumor efficacy of cyclophosphamide was partially restored, which suggests that antibiotics may influence the efficacy of immunotherapy by regulating the gut microbiota. Another study also found that antibiotic-treated mice showed a low response to CpG-oligonucleotides. They found that TNF expression and frequencies of TNF-positive leukocytes induced by CpG-oligonucleotides were significantly impaired[42]. It is mainly because those antibiotics could affect the microbiota and further affected local and systemic inflammation and the tumor immune microenvironment. Further studies showed that immunotherapy CTLA-4 and/or PD-1/PD-L1 efficacy could be improved by transferring patient fecal samples into germ-free (GF) or antibiotic-treated SPF mice[7].

In addition to the above animal experimental findings, several independent retrospective analyses in human cohorts of advanced NSCLC, RCC, and urothelial carcinoma have found contradictory results (table 3). An early study found that antibiotics do not affect the efficacy of nivolumab in NSCLC patients[43]. A total of 74 locally advanced or metastatic NSCLC patients were treated with nivolumab as a second- or third-line therapy, 15 patients were exposed to antibiotics, and the remaining 59 patients were not exposed to antibiotics. No significant difference was found in response rates and progression-free survival (PFS) between the two groups of patients. Subsequently, another two independent studies with larger sample sizes drew inconsistent conclusions. Indeed, Kaderbhai *et al* showed that in RCC patients, antibiotic use compared to no antibiotic use was associated with an increased risk of primary progressive disease (PD), shorter PFS, and shorter overall survival (OS). In NSCLC patients, antibiotic use was associated with similar rates of primary PD but decreased PFS and OS. In a study by Routy, 69 out of 249 patients were prescribed antibiotics. PFS and OS were significantly shorter in the antibiotics-treated patients when all patients were combined. Furthermore, transplantation of fecal microbiota from patients who responded to ICIs into germ-free non-responders restored or enhanced the ICIs responsiveness. In univariate and multivariate Cox regression analyses, antibiotic use was found to be a predictor of resistance to PD-1 blockade, independent of classical prognostic markers in NSCLC and RCC[44]. Gut microbiota composition analysis found that *A. muciniphila* was the most significantly associated bacteria with favorable clinical outcome, which increased the recruitment of CCR9+ CXCR3+ CD4+ T lymphocytes into tumor beds in an IL-12-dependent manner.

The different studies come to different conclusions, which may be due to a combination of several reasons. First, the duration time of antibiotic usage is different. Some studies allowed the use of antibiotics for 3 months before immunotherapy, while other studies used antibiotics for only 1 month before immunotherapy, and there is no unified standard. Second, the cancer type is different. RCC, melanoma, and NSCLC are more sensitive to ICIs. Third, all the studies were retrospective studies, which need to be further confirmed by randomized controlled clinical trials.

**Conclusion**

As is well-known, immunotherapy has become an important weapon in the treatment of GI tumors. However, it still lacks effective biomarkers. Besides, microbiota is known to influence the response to anticancer immunotherapy, and antibiotics have been proven to influence the occurrence and development of GI tumors. In this study, we reviewed a reasonable quantity of papers about the relationship between antibiotics and immunotherapy. Although few studies are directly related to GI tumors, the relevant studies suggest that antibiotics can affect the commensal microbiota and further affect the efficacy of immunotherapy. In a word, according to the current research evidence, it remains inconclusive that the relationship between antibiotics and immunotherapy is friend or foe, and we hope that more studies can focus on this area in the future.

**Acknowledgments**

The authors thank all patients and researchers for their early works.

**REFERENCES**

1 **Bray F**, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA Cancer J Clin* 2018; **68**: 394-424 [PMID: 30207593 DOI: 10.3322/caac.21492]

2 **Siegel RL**, Miller KD, Jemal A. Cancer statistics, 2019. *CA Cancer J Clin* 2019; **69**: 7-34 [PMID: 30620402 DOI: 10.3322/caac.21551]

3 **Havel JJ**, Chowell D, Chan TA. The evolving landscape of biomarkers for checkpoint inhibitor immunotherapy. *Nat Rev Cancer* 2019; **19**: 133-150 [PMID: 30755690 DOI: 10.1038/s41568-019-0116-x]

4 **Vétizou M**, Pitt JM, Daillère R, Lepage P, Waldschmitt N, Flament C, Rusakiewicz S, Routy B, Roberti MP, Duong CP, Poirier-Colame V, Roux A, Becharef S, Formenti S, Golden E, Cording S, Eberl G, Schlitzer A, Ginhoux F, Mani S, Yamazaki T, Jacquelot N, Enot DP, Bérard M, Nigou J, Opolon P, Eggermont A, Woerther PL, Chachaty E, Chaput N, Robert C, Mateus C, Kroemer G, Raoult D, Boneca IG, Carbonnel F, Chamaillard M, Zitvogel L. Anticancer immunotherapy by CTLA-4 blockade relies on the gut microbiota. *Science* 2015; **350**: 1079-1084 [PMID: 26541610 DOI: 10.1126/science.aad1329]

5 **Sivan A**, Corrales L, Hubert N, Williams JB, Aquino-Michaels K, Earley ZM, Benyamin FW, Lei YM, Jabri B, Alegre ML, Chang EB, Gajewski TF. Commensal Bifidobacterium promotes antitumor immunity and facilitates anti-PD-L1 efficacy. *Science* 2015; **350**: 1084-1089 [PMID: 26541606 DOI: 10.1126/science.aac4255]

6 **Gopalakrishnan V**, Spencer CN, Nezi L, Reuben A, Andrews MC, Karpinets TV, Prieto PA, Vicente D, Hoffman K, Wei SC, Cogdill AP, Zhao L, Hudgens CW, Hutchinson DS, Manzo T, Petaccia de Macedo M, Cotechini T, Kumar T, Chen WS, Reddy SM, Szczepaniak Sloane R, Galloway-Pena J, Jiang H, Chen PL, Shpall EJ, Rezvani K, Alousi AM, Chemaly RF, Shelburne S, Vence LM, Okhuysen PC, Jensen VB, Swennes AG, McAllister F, Marcelo Riquelme Sanchez E, Zhang Y, Le Chatelier E, Zitvogel L, Pons N, Austin-Breneman JL, Haydu LE, Burton EM, Gardner JM, Sirmans E, Hu J, Lazar AJ, Tsujikawa T, Diab A, Tawbi H, Glitza IC, Hwu WJ, Patel SP, Woodman SE, Amaria RN, Davies MA, Gershenwald JE, Hwu P, Lee JE, Zhang J, Coussens LM, Cooper ZA, Futreal PA, Daniel CR, Ajami NJ, Petrosino JF, Tetzlaff MT, Sharma P, Allison JP, Jenq RR, Wargo JA. Gut microbiome modulates response to anti-PD-1 immunotherapy in melanoma patients. *Science* 2018; **359**: 97-103 [PMID: 29097493 DOI: 10.1126/science.aan4236]

7 **Matson V**, Fessler J, Bao R, Chongsuwat T, Zha Y, Alegre ML, Luke JJ, Gajewski TF. The commensal microbiome is associated with anti-PD-1 efficacy in metastatic melanoma patients. *Science* 2018; **359**: 104-108 [PMID: 29302014 DOI: 10.1126/science.aao3290]

8 **Frankel AE**, Coughlin LA, Kim J, Froehlich TW, Xie Y, Frenkel EP, Koh AY. Metagenomic Shotgun Sequencing and Unbiased Metabolomic Profiling Identify Specific Human Gut Microbiota and Metabolites Associated with Immune Checkpoint Therapy Efficacy in Melanoma Patients. *Neoplasia* 2017; **19**: 848-855 [PMID: 28923537 DOI: 10.1016/j.neo.2017.08.004]

9 **Setchell KD**, Lawson AM, Borriello SP, Harkness R, Gordon H, Morgan DM, Kirk DN, Adlercreatz H, Anderson LC, Axelson M. Lignan formation in man--microbial involvement and possible roles in relation to cancer. *Lancet* 1981; **2**: 4-7 [PMID: 6113409]

10 **Tamim HM**, Hanley JA, Hajeer AH, Boivin JF, Collet JP. Risk of breast cancer in relation to antibiotic use. *Pharmacoepidemiol Drug Saf* 2008; **17**: 144-150 [PMID: 17943999 DOI: 10.1002/pds.1512]

11 **Velicer CM**, Heckbert SR, Lampe JW, Potter JD, Robertson CA, Taplin SH. Antibiotic use in relation to the risk of breast cancer. *JAMA* 2004; **291**: 827-835 [PMID: 14970061 DOI: 10.1001/jama.291.7.827]

12 **Cao Y**, Wu K, Mehta R, Drew DA, Song M, Lochhead P, Nguyen LH, Izard J, Fuchs CS, Garrett WS, Huttenhower C, Ogino S, Giovannucci EL, Chan AT. Long-term use of antibiotics and risk of colorectal adenoma. *Gut* 2018; **67**: 672-678 [PMID: 28377387 DOI: 10.1136/gutjnl-2016-313413]

13 **Wang JL**, Chang CH, Lin JW, Wu LC, Chuang LM, Lai MS. Infection, antibiotic therapy and risk of colorectal cancer: a nationwide nested case-control study in patients with Type 2 diabetes mellitus. *Int J Cancer* 2014; **135**: 956-967 [PMID: 24470385 DOI: 10.1002/ijc.28738]

14 **Dik VK**, van Oijen MG, Smeets HM, Siersema PD. Frequent Use of Antibiotics Is Associated with Colorectal Cancer Risk: Results of a Nested Case-Control Study. *Dig Dis Sci* 2016; **61**: 255-264 [PMID: 26289256 DOI: 10.1007/s10620-015-3828-0]

15 **Boursi B**, Mamtani R, Haynes K, Yang YX. Recurrent antibiotic exposure may promote cancer formation--Another step in understanding the role of the human microbiota? *Eur J Cancer* 2015; **51**: 2655-2664 [PMID: 26338196 DOI: 10.1016/j.ejca.2015.08.015]

16 **Itoh T**, Moto M, Takahashi M, Sakai H, Mitsumori K. Liver initiation activity of norfloxacin but not nalidixic acid, pipemidic acid, and ciprofloxacin on in vivo short-term liver initiation assay in rats. *Toxicology* 2006; **222**: 240-246 [PMID: 16580113 DOI: 10.1016/j.tox.2006.02.019]

17 **Roy S**, Trinchieri G. Microbiota: a key orchestrator of cancer therapy. *Nat Rev Cancer* 2017; **17**: 271-285 [PMID: 28303904 DOI: 10.1038/nrc.2017.13]

18 **Schwabe RF**, Jobin C. The microbiome and cancer. *Nat Rev Cancer* 2013; **13**: 800-812 [PMID: 24132111 DOI: 10.1038/nrc3610]

19 **Meng C**, Bai C, Brown TD, Hood LE, Tian Q. Human Gut Microbiota and Gastrointestinal Cancer. *Genomics Proteomics Bioinformatics* 2018; **16**: 33-49 [PMID: 29474889 DOI: 10.1016/j.gpb.2017.06.002]

20 **Dennis KL**, Wang Y, Blatner NR, Wang S, Saadalla A, Trudeau E, Roers A, Weaver CT, Lee JJ, Gilbert JA, Chang EB, Khazaie K. Adenomatous polyps are driven by microbe-instigated focal inflammation and are controlled by IL-10-producing T cells. *Cancer Res* 2013; **73**: 5905-5913 [PMID: 23955389 DOI: 10.1158/0008-5472.CAN-13-1511]

21 **De Almeida CV**, de Camargo MR, Russo E, Amedei A. Role of diet and gut microbiota on colorectal cancer immunomodulation. *World J Gastroenterol* 2019; **25**: 151-162 [PMID: 30670906 DOI: 10.3748/wjg.v25.i2.151]

22 **Kudo T**, Hamamoto Y, Kato K, Ura T, Kojima T, Tsushima T, Hironaka S, Hara H, Satoh T, Iwasa S, Muro K, Yasui H, Minashi K, Yamaguchi K, Ohtsu A, Doki Y, Kitagawa Y. Nivolumab treatment for oesophageal squamous-cell carcinoma: an open-label, multicentre, phase 2 trial. *Lancet Oncol* 2017; **18**: 631-639 [PMID: 28314688 DOI: 10.1016/S1470-2045(17)30181-X]

23 **Kang YK**, Boku N, Satoh T, Ryu MH, Chao Y, Kato K, Chung HC, Chen JS, Muro K, Kang WK, Yeh KH, Yoshikawa T, Oh SC, Bai LY, Tamura T, Lee KW, Hamamoto Y, Kim JG, Chin K, Oh DY, Minashi K, Cho JY, Tsuda M, Chen LT. Nivolumab in patients with advanced gastric or gastro-oesophageal junction cancer refractory to, or intolerant of, at least two previous chemotherapy regimens (ONO-4538-12, ATTRACTION-2): a randomised, double-blind, placebo-controlled, phase 3 trial. *Lancet* 2017; **390**: 2461-2471 [PMID: 28993052 DOI: 10.1016/s0140-6736(17)31827-5]

24 **Janjigian YY**, Bendell J, Calvo E, Kim JW, Ascierto PA, Sharma P, Ott PA, Peltola K, Jaeger D, Evans J, de Braud F, Chau I, Harbison CT, Dorange C, Tschaika M, Le DT. CheckMate-032 Study: Efficacy and Safety of Nivolumab and Nivolumab Plus Ipilimumab in Patients With Metastatic Esophagogastric Cancer. *J Clin Oncol* 2018; **36**: 2836-2844 [PMID: 30110194 DOI: 10.1200/JCO.2017.76.6212]

25 **Fuchs CS**, Doi T, Jang RW, Muro K, Satoh T, Machado M, Sun W, Jalal SI, Shah MA, Metges JP, Garrido M, Golan T, Mandala M, Wainberg ZA, Catenacci DV, Ohtsu A, Shitara K, Geva R, Bleeker J, Ko AH, Ku G, Philip P, Enzinger PC, Bang YJ, Levitan D, Wang J, Rosales M, Dalal RP, Yoon HH. Safety and Efficacy of Pembrolizumab Monotherapy in Patients With Previously Treated Advanced Gastric and Gastroesophageal Junction Cancer: Phase 2 Clinical KEYNOTE-059 Trial. *JAMA Oncol* 2018; **4**: e180013 [PMID: 29543932 DOI: 10.1001/jamaoncol.2018.0013]

26 **Bang YJ**, Ruiz EY, Van Cutsem E, Lee KW, Wyrwicz L, Schenker M, Alsina M, Ryu MH, Chung HC, Evesque L, Al-Batran SE, Park SH, Lichinitser M, Boku N, Moehler MH, Hong J, Xiong H, Hallwachs R, Conti I, Taieb J. Phase III, randomised trial of avelumab versus physician's choice of chemotherapy as third-line treatment of patients with advanced gastric or gastro-oesophageal junction cancer: primary analysis of JAVELIN Gastric 300. *Ann Oncol* 2018; **29**: 2052-2060 [PMID: 30052729 DOI: 10.1093/annonc/mdy264]

27 **Shitara K**, Özgüroğlu M, Bang YJ, Di Bartolomeo M, Mandalà M, Ryu MH, Fornaro L, Olesiński T, Caglevic C, Chung HC, Muro K, Goekkurt E, Mansoor W, McDermott RS, Shacham-Shmueli E, Chen X, Mayo C, Kang SP, Ohtsu A, Fuchs CS; KEYNOTE-061 investigators. Pembrolizumab versus paclitaxel for previously treated, advanced gastric or gastro-oesophageal junction cancer (KEYNOTE-061): a randomised, open-label, controlled, phase 3 trial. *Lancet* 2018; **392**: 123-133 [PMID: 29880231 DOI: 10.1016/S0140-6736(18)31257-1]

28 **El-Khoueiry AB**, Sangro B, Yau T, Crocenzi TS, Kudo M, Hsu C, Kim TY, Choo SP, Trojan J, Welling TH Rd, Meyer T, Kang YK, Yeo W, Chopra A, Anderson J, Dela Cruz C, Lang L, Neely J, Tang H, Dastani HB, Melero I. Nivolumab in patients with advanced hepatocellular carcinoma (CheckMate 040): an open-label, non-comparative, phase 1/2 dose escalation and expansion trial. *Lancet* 2017; **389**: 2492-2502 [PMID: 28434648 DOI: 10.1016/S0140-6736(17)31046-2]

29 **Zhu AX**, Finn RS, Edeline J, Cattan S, Ogasawara S, Palmer D, Verslype C, Zagonel V, Fartoux L, Vogel A, Sarker D, Verset G, Chan SL, Knox J, Daniele B, Webber AL, Ebbinghaus SW, Ma J, Siegel AB, Cheng AL, Kudo M; KEYNOTE-224 investigators. Pembrolizumab in patients with advanced hepatocellular carcinoma previously treated with sorafenib (KEYNOTE-224): a non-randomised, open-label phase 2 trial. *Lancet Oncol* 2018; **19**: 940-952 [PMID: 29875066 DOI: 10.1016/S1470-2045(18)30351-6]

30 **Mo H**, Huang J, Xu J, Chen X, Wu D, Qu D, Wang X, Lan B, Wang X, Xu J, Zhang H, Chi Y, Yang Q, Xu B. Safety, anti-tumour activity, and pharmacokinetics of fixed-dose SHR-1210, an anti-PD-1 antibody in advanced solid tumours: a dose-escalation, phase 1 study. *Br J Cancer* 2018; **119**: 538-545 [PMID: 29755117 DOI: 10.1038/s41416-018-0100-3]

31 **Sangro B**, Gomez-Martin C, de la Mata M, Iñarrairaegui M, Garralda E, Barrera P, Riezu-Boj JI, Larrea E, Alfaro C, Sarobe P, Lasarte JJ, Pérez-Gracia JL, Melero I, Prieto J. A clinical trial of CTLA-4 blockade with tremelimumab in patients with hepatocellular carcinoma and chronic hepatitis C. *J Hepatol* 2013; **59**: 81-88 [PMID: 23466307 DOI: 10.1016/j.jhep.2013.02.022]

32 **Brahmer JR**, Tykodi SS, Chow LQ, Hwu WJ, Topalian SL, Hwu P, Drake CG, Camacho LH, Kauh J, Odunsi K, Pitot HC, Hamid O, Bhatia S, Martins R, Eaton K, Chen S, Salay TM, Alaparthy S, Grosso JF, Korman AJ, Parker SM, Agrawal S, Goldberg SM, Pardoll DM, Gupta A, Wigginton JM. Safety and activity of anti-PD-L1 antibody in patients with advanced cancer. *N Engl J Med* 2012; **366**: 2455-2465 [PMID: 22658128 DOI: 10.1056/NEJMoa1200694]

33 **Royal RE**, Levy C, Turner K, Mathur A, Hughes M, Kammula US, Sherry RM, Topalian SL, Yang JC, Lowy I, Rosenberg SA. Phase 2 trial of single agent Ipilimumab (anti-CTLA-4) for locally advanced or metastatic pancreatic adenocarcinoma. *J Immunother* 2010; **33**: 828-833 [PMID: 20842054 DOI: 10.1097/CJI.0b013e3181eec14c]

34 **Le DT**, Uram JN, Wang H, Bartlett BR, Kemberling H, Eyring AD, Skora AD, Luber BS, Azad NS, Laheru D, Biedrzycki B, Donehower RC, Zaheer A, Fisher GA, Crocenzi TS, Lee JJ, Duffy SM, Goldberg RM, de la Chapelle A, Koshiji M, Bhaijee F, Huebner T, Hruban RH, Wood LD, Cuka N, Pardoll DM, Papadopoulos N, Kinzler KW, Zhou S, Cornish TC, Taube JM, Anders RA, Eshleman JR, Vogelstein B, Diaz LA Jr. PD-1 Blockade in Tumors with Mismatch-Repair Deficiency. *N Engl J Med* 2015; **372**: 2509-2520 [PMID: 26028255 DOI: 10.1056/NEJMoa1500596]

35 **Le DT**, Durham JN, Smith KN, Wang H, Bartlett BR, Aulakh LK, Lu S, Kemberling H, Wilt C, Luber BS, Wong F, Azad NS, Rucki AA, Laheru D, Donehower R, Zaheer A, Fisher GA, Crocenzi TS, Lee JJ, Greten TF, Duffy AG, Ciombor KK, Eyring AD, Lam BH, Joe A, Kang SP, Holdhoff M, Danilova L, Cope L, Meyer C, Zhou S, Goldberg RM, Armstrong DK, Bever KM, Fader AN, Taube J, Housseau F, Spetzler D, Xiao N, Pardoll DM, Papadopoulos N, Kinzler KW, Eshleman JR, Vogelstein B, Anders RA, Diaz LA Jr. Mismatch repair deficiency predicts response of solid tumors to PD-1 blockade. *Science* 2017; **357**: 409-413 [PMID: 28596308 DOI: 10.1126/science.aan6733]

36 **Hermel DJ**, Sigal D. The Emerging Role of Checkpoint Inhibition in Microsatellite Stable Colorectal Cancer. *J Pers Med* 2019; **9**: [PMID: 30654522 DOI: 10.3390/jpm9010005]

37 **Reck M**, Rodríguez-Abreu D, Robinson AG, Hui R, Csőszi T, Fülöp A, Gottfried M, Peled N, Tafreshi A, Cuffe S, O'Brien M, Rao S, Hotta K, Leiby MA, Lubiniecki GM, Shentu Y, Rangwala R, Brahmer JR; KEYNOTE-024 Investigators. Pembrolizumab versus Chemotherapy for PD-L1-Positive Non-Small-Cell Lung Cancer. *N Engl J Med* 2016; **375**: 1823-1833 [PMID: 27718847 DOI: 10.1056/NEJMoa1606774]

38 **Biton J**, Ouakrim H, Dechartres A, Alifano M, Mansuet-Lupo A, Si H, Halpin R, Creasy T, Bantsimba-Malanda C, Arrondeau J, Goldwasser F, Boudou-Rouquette P, Fournel L, Roche N, Burgel PR, Goc J, Devi-Marulkar P, Germain C, Dieu-Nosjean MC, Cremer I, Herbst R, Damotte D. Impaired Tumor-Infiltrating T Cells in Patients with Chronic Obstructive Pulmonary Disease Impact Lung Cancer Response to PD-1 Blockade. *Am J Respir Crit Care Med* 2018; **198**: 928-940 [PMID: 29518341 DOI: 10.1164/rccm.201706-1110OC]

39 **Sacher AG**, Gandhi L. Biomarkers for the Clinical Use of PD-1/PD-L1 Inhibitors in Non-Small-Cell Lung Cancer: A Review. *JAMA Oncol* 2016; **2**: 1217-1222 [PMID: 27310809 DOI: 10.1001/jamaoncol.2016.0639]

40 **Belkaid Y**, Naik S. Compartmentalized and systemic control of tissue immunity by commensals. *Nat Immunol* 2013; **14**: 646-653 [PMID: 23778791 DOI: 10.1038/ni.2604]

41 **Viaud S**, Saccheri F, Mignot G, Yamazaki T, Daillère R, Hannani D, Enot DP, Pfirschke C, Engblom C, Pittet MJ, Schlitzer A, Ginhoux F, Apetoh L, Chachaty E, Woerther PL, Eberl G, Bérard M, Ecobichon C, Clermont D, Bizet C, Gaboriau-Routhiau V, Cerf-Bensussan N, Opolon P, Yessaad N, Vivier E, Ryffel B, Elson CO, Doré J, Kroemer G, Lepage P, Boneca IG, Ghiringhelli F, Zitvogel L. The intestinal microbiota modulates the anticancer immune effects of cyclophosphamide. *Science* 2013; **342**: 971-976 [PMID: 24264990 DOI: 10.1126/science.1240537]

42 **Iida N**, Dzutsev A, Stewart CA, Smith L, Bouladoux N, Weingarten RA, Molina DA, Salcedo R, Back T, Cramer S, Dai RM, Kiu H, Cardone M, Naik S, Patri AK, Wang E, Marincola FM, Frank KM, Belkaid Y, Trinchieri G, Goldszmid RS. Commensal bacteria control cancer response to therapy by modulating the tumor microenvironment. *Science* 2013; **342**: 967-970 [PMID: 24264989 DOI: 10.1126/science.1240527]

43 **Kaderbhai C**, Richard C, Fumet JD, Aarnink A, Foucher P, Coudert B, Favier L, Lagrange A, Limagne E, Boidot R, Ghiringhelli F. Antibiotic Use Does Not Appear to Influence Response to Nivolumab. *Anticancer Res* 2017; **37**: 3195-3200 [PMID: 28551664 DOI: 10.21873/anticanres.11680]

44 **Routy B**, Le Chatelier E, Derosa L, Duong CPM, Alou MT, Daillère R, Fluckiger A, Messaoudene M, Rauber C, Roberti MP, Fidelle M, Flament C, Poirier-Colame V, Opolon P, Klein C, Iribarren K, Mondragón L, Jacquelot N, Qu B, Ferrere G, Clémenson C, Mezquita L, Masip JR, Naltet C, Brosseau S, Kaderbhai C, Richard C, Rizvi H, Levenez F, Galleron N, Quinquis B, Pons N, Ryffel B, Minard-Colin V, Gonin P, Soria JC, Deutsch E, Loriot Y, Ghiringhelli F, Zalcman G, Goldwasser F, Escudier B, Hellmann MD, Eggermont A, Raoult D, Albiges L, Kroemer G, Zitvogel L. Gut microbiome influences efficacy of PD-1-based immunotherapy against epithelial tumors. *Science* 2018; **359**: 91-97 [PMID: 29097494 DOI: 10.1126/science.aan3706]

45 **Derosa L**, Hellmann MD, Spaziano M, Halpenny D, Fidelle M, Rizvi H, Long N, Plodkowski AJ, Arbour KC, Chaft JE, Rouche JA, Zitvogel L, Zalcman G, Albiges L, Escudier B, Routy B. Negative association of antibiotics on clinical activity of immune checkpoint inhibitors in patients with advanced renal cell and non-small-cell lung cancer. *Ann Oncol* 2018; **29**: 1437-1444 [PMID: 29617710 DOI: 10.1093/annonc/mdy103]

**P-Reviewer:** Tabll AA, Zhou J **S-Editor:** Gong ZM

**L-Editor:** Wang TQ **E-Editor:**

**Specialty type:** Medicine, research and experimental

**Country of origin:** China

**Peer-review report classification**

Grade A (Excellent): 0

Grade B (Very good): B

Grade C (Good): C

Grade D (Fair): 0

Grade E (Poor): 0

**Table 1 Microbes that may cause gastrointestinal tumors**

|  |  |
| --- | --- |
| **Tumor** | **Microbes involved** |
| Esophageal cancer | *H. pylori*, *Firmicutes*, *Bacteroidetes*, *Proteobacteria*, *Actinobacteria*, and *Fusobacteria phyla*.  |
| Gastric cancer | *H. pylori*, *Porphyromonas*, *Neisseria, Prevotella pallens*, *Streptococcus sinensis, Lactobacillus coleohominis, Klebsiella pneumoniae,* and *Acinetobacter baumannii* |
| Colorectal cancer | *Faecalibacterium prausnitzii, Eubacterium rectale, Proteobacteria, Bacteroidetes, Fusobacterium* |
| Hepatocellular carcinoma | *H. pylori*, *Escherichia coli* |
| Biliary tract cancer | *Pseudomonadaceae, Oxalobacteraceae, Clonorchis sinensis,* and *Opisthorchis viverrini* |
| Pancreatic cancer | *H. pylori* |

*H. pylori*: *Helicobacter pylori.*

**Table 2 Completed clinical trials of immune checkpoint inhibitors on gastrointestinal tumors**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Trial** | **Phase** | **Treatment** | **ORR% (95%CI)** | **DCR% (95%CI)** | **Median PFS months (95%CI)** | **Median OS months (95%CI)** | **Adverse events** |
| **Esophageal and gastric cancers** |
|  | II | Nivolumab (*n* = 64) | 11 (10-28) | 27 (31-54) | 1.5 (1.4-2.8) | 11 (7.3-13) | G3/4 25%; All-grade 73% |
| ATTRACTION02 | II | Nivolumab (*n* = 330)Placebo (*n* = 163) | 11 (8-16)0(0-3.0) | 40 (34-46)25 (18-34) | 1.6 (1.5-2.3)1.5 (1.5-1.5) | 5.3 (4.6-6.4)4.1 (3.4-4.9) | G3/4 27%; All-grade 43%G3/4 4%; All-grade 27% |
| CHECKMATE32 | I/II | Nivolumab 3 (mg/kg)Nivolumab 1 + Iplilimumab 3Nivolumab 3 + Iplilimumab 1 | 12 (5-23)24 (13-39)8.0 (2.0-19) | NRNRNR | 1.4 (1.2-1.5)1.4 (1.2-3.8)1.6 (1.4-2.6) | 6.2 (3.4-12)6.9 (3.7-12)4.8 (3.0-8.4) | G3/4 17%G3/4 47%G3/4 27% |
| KEYNOTE59 | II | Pembrolizumab (*n* = 259) | 12 (8-16) | 27 (21.7-32.9) | 2.0 (2.0-2.1) | 5.5 (4.2-6.5) | G3/4 18%; All-grade 60% |
| JAVELIN Gastric 300 | III | Avelumab (*n* = 185)Chemotherapy (*n* = 186) | 2.2 (0.6-5.4)4.3 (1.9-8.3) | 22 (16-29)44 (37-52) | 1.4 (1.5-2.0)2.7 (1.8-2.8) | 4.6 (3.6-5.7)5.0 (4.5-6.3) | G3/4 9.2%G3/4 32% |
| KEYNOTE61PDL CPS ≥ 1 | III | Pembrolizumab (*n* = 196)Paclitaxel (*n* = 199) | 16 (11-22)14 (9.0-19) | NRNR | 1.5 (1.4-2.0)4.1 (3.1-4.2) | 9.1 (6.2-11)8.3 (7.6-9.0) | G3/4 25%G3/4 35% |
| **Hepatocellular carcinoma** |
| CHECKMATE40 | I/II | Nivolumab (dose-escalation)Nivolumab (dose-expansion) | 15 (6.0-28)20 (15-26) | 58 (43-72)64 | NR5.4 (3.9-8.5) | 15 (9.6-20)NR | G3/4 25%G3/4 63% |
| KEYNOTE224 | II | Pembrolizumab (*n* = 169) | 18 (11-26) | 62 (52-71) | 4.9 (3.4-7.2) | 13 (10-16) | G3/4 25%; All-grade 73% |
| **Biliary tract cancer** |
| KEYNOTE28 | I | Pembrolizumab (*n* = 24) | 17 (5.0-39) | 34 | NR | NR | G3/4 17%; All-grade 63% |
| **Pancreatic cancer** |  |  |  |  |  |  |  |
|  | II | Iplilimumab (*n* = 27) | 0 | 0 | NR | NR | NR |
|  | I | Tremelimumab + gemicitabine (*n* = 34) | NR | NR | NR | 7.4 (5.8-9.4) | All-grade 94% |
|  | Ib/II | Pembrolizumab + gemcitabine + nab-paclitaxel (*n* = 17) | 18 | 76 | 9.1 (4.9-15.3) | 15 (6.8-23) | G3/4 71%; All-grade 100% |
| **Colorectal cancer (dMMR)** |
|  | II | Pembrolizumab (*n* = 10) | 40 (12-74) | 90 (55-100) | NR | NR | G3/4 41%; All-grade 98% |
| KHECKMATE142 | II | Nivolumab (*n* = 74) | 31 (21-43) | 69 (57-79) | NR | NR | G3/4 20%; All-grade 70% |

DCR: disease control rate; ORR: objective response rate; OS: overall survival; PFS: progression free survival; G: grade; NR: not reported; dMMR: mismatch repair deficiency.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Research subjects | Tumor type | Patients No. | Research conclusion | Ref. |
| 1 | patients | NSCLC/RCC/urothelial carcinoma | 249 | ATB use presents a predictor of resistance to ICI | Routy *et al*[44], 2018 |
| mice | Sarcoma/melanoma |  |
| 2 | patients | NSCLC | 74 | ATB use does not affect the efficacy of nivolumab | Kaderbhai *et al*[43], 2017 |
| 3 | patients | RCC/NSCLC | 360 | ATB use reduces clinical benefit from ICI | Derosa *et al*[45], 2018 |
| 4 | mice | Lymphoma/colon cancer/melanoma |  | ATB treated mice respond poorly to CpG-oligonucleotide | Lida *et al*[42], 2013 |
| 5 | mice |  |  | ATB mice are resistant tocyclophosphamide | Viaud *et al*[41], 2013 |

**Table 3 Studies about antibiotics and immunotherapy**

ATB: Antibiotics; ICI: immune checkpoint inhibitor.