The fibroblast growth factor receptor pathway in hepatocellular carcinoma

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Abstract

Hepatocellular carcinoma is the third most common cause of cancer-related death globally and portends a poor prognosis. The fibroblast growth factor receptor (FGFR) pathway is increasingly acknowledged to play a role in the pathogenesis of hepatocellular carcinoma (HCC) and is postulated to be upregulated as a mechanism of resistance to anti-VEGF treatment. We attempt to review the importance of the FGFR pathway in HCC oncogenesis, as well as the current clinical evidence on the efficacy and safety of FGFR pathway inhibitors in HCC.

Keywords: Hepatocellular carcinoma, targeted therapy, fibroblast growth factor

INTRODUCTION

Hepatocellular carcinoma (HCC) is the third most common cause of cancer-related death globally. Most patients have advanced disease on diagnosis. In unresectable advanced disease, sorafenib used to be the only available systemic therapy option available and prognosis was poor with a one-year survival rate of less than 50%.

HCC tumours harbour an average of 30-40 mutations, of which 20% may be driver mutations. The molecular complexity and heterogeneity of HCC likely underlies the reason for failure of multiple phase III trials of targeted agents over the years. With improving technologies, we have been able to learn more about the molecular mechanisms underlying the oncogenesis of HCC, and in recent past have seen breakthroughs with several new drugs being added to our armamentarium both in the front-line and second-line setting, and many more compounds showing great promise on the horizon.
One signaling pathway that is increasingly recognized to play a role in the carcinogenesis of HCC is the fibroblast growth factor (FGF)/fibroblast growth factor receptor (FGFR) pathway, which has roles in oncogenesis, mediating cell proliferation and neo-angiogenesis [6,7]. Preclinical models suggest that inhibition of the FGFR pathway is a feasible therapeutic strategy [7] and many clinical trials using FGF/FGFR pathway inhibitors have since been conducted or are ongoing in hepatocellular carcinoma.

We attempt to review the importance of the FGF/FGFR pathway and current clinical evidence to date for use of the pathway inhibitors in HCC.

**FGF/FGFR PATHWAY AND ITS ABBERRATIONS IN CANCER**

The human FGF family consists of 22 structurally related molecules that interact with four FGFRs. Each FGFR comprises three components, an extracellular domain which interacts with the FGF ligand, a transmembrane domain, and an intracellular domain. FGFs act as ligands which can bind to more than one kind of FGFR, causing downstream activation of several pathways including the mitogen-activated protein kinase pathway regulating cellular proliferation, and the phosphoinositide-3 kinase-Akt pathway controlling cellular survival [8]. FGF/FGFR signaling is involved in normal embryonic development of the liver and lungs [9] as well as adult wound healing and angiogenesis [10].

FGFRs are widely expressed in adult tissue, although their relative levels differ in the various organ systems. Under normal conditions, hepatocytes express high levels of FGFR3 and FGFR4 and have lower levels of FGFR1 and FGFR2 [11].

FGFR signaling has significant effects on tumour neo-angiogenesis, both via the direct promotion of endothelial cell proliferation through effects on the tumour microenvironment [12], as well as indirectly via interactions and synergism with the vascular endothelial growth factor (VEGF) and platelet-derived growth factor (PDGF) pathways [13].

FGFR pathway activation has also been shown to be an important resistance mechanism in response to therapeutic pressure with use of anti-VEGF therapy [6,14]. In both the preclinical [15] and clinical [16] settings, tumours progressing on anti-VEGF treatment have been shown to have a higher level of expression of FGF2. As such, upfront dual inhibition of VEGFR and FGFR, or introduction of FGFR inhibition after progression on a VEGF pathway inhibitor [17] can potentially result in greater clinical benefit compared to inhibition of the VEGF pathway alone.

FGFR aberrations occur in approximately 7% of all solid tumours and in almost every tumour type, though the frequency and type of aberration differ [18]. Pathway aberrations identified include: (1) gene amplification, or post-transcriptional changes giving rise to receptor overexpression; (2) gene mutations, resulting in constitutionally activated receptors or receptors that have a reduced dependence of ligand binding for activation; (3) translocations, resulting in expression of FGFR-fusion proteins with constitutive FGFR kinase activity; (4) alternative splicing of FGFR and isoform switching, changing ligand specificity and increasing the range of FGFs that can activate the FGFR; (5) upregulation of FGF ligand expression.

Overall the most common aberration seen in solid tumours is FGFR gene amplification, most commonly in FGFR1. FGFR mutations in cancer differ from those seen in hereditary disorders in that they are not limited to the kinase domains, but may occur in any part of the gene [18].

**RELEVANCE OF THE FGF PATHWAY IN HCC**

The importance of the FGF/FGFR pathway in HCC can be seen in the fact that more than 80% of HCCs
overexpress at least one FGF and/or FGFR\textsuperscript{[20]}. The main FGFRs expressed in liver tissue are FGFR3\textsuperscript{[21]} and FGFR4\textsuperscript{[22]}.

Whilst healthy hepatocytes express minimal levels of FGF1 or FGF2, these levels increase when there is cirrhosis and increasing levels correlate with the progression of cirrhosis into HCC. Higher levels of FGF1 and FGF2 are also seen in more advanced tumour stages\textsuperscript{[23]}. There is hence interest in using FGF1 and FGF2 expression levels as a prognostic marker\textsuperscript{[24]}, though its utility as a diagnostic marker or for follow-up of HCC patients is limited by its non-specificity\textsuperscript{[25]}.

In preclinical models, FGF1 and FGF2 were shown to stimulate proliferation of HCC cell lines\textsuperscript{[26]} through the activation of tumour invasion and angiogenesis resulting in an increase in capillarised sinusoids\textsuperscript{[27]}. There is however substantial redundancy in FGF1- and FGF2-mediated signaling, suggesting that direct targeting of these ligands may have limited therapeutic efficacy\textsuperscript{[28]}.

The FGF8 subfamily, comprising FGFs 8, 17 and 18, also promotes oncogenesis through stimulating hepatocyte proliferation. At least one member of the FGF8 subfamily or its corresponding receptors FGFR2, FGFR3 and FGFR4 is upregulated in more than 50% of HCCs\textsuperscript{[29]}. The use of small interfering RNA (siRNA) targeting FGF18 has been shown to reduce the viability and proliferation of HCC cells\textsuperscript{[30]}.

The FGF19 subfamily, comprising FGFs 19, 21 and 23, act as endocrine factors mediating metabolic effects through FGFR signaling. FGF19, which comes mainly from the ileum, plays a role in the physiological regulation of bile acid and cholesterol metabolism as well as insulin sensitivity. FGF19 binds exclusively to FGFR4 with the co-receptor β-Klotho (KLB) stabilising the interaction. FGF19/FGFR4 signaling is thought to be of particular importance in the carcinogenesis of HCC\textsuperscript{[29]}, with FGF19 expression increased, through focal amplification of 11q, in approximately 6%-12% of HCC cases\textsuperscript{[30]}. FGF19 expression is also upregulated in almost half of HCCs\textsuperscript{[31]}. In addition, FGF19 levels may be prognostic, with higher expression in resected HCC specimens being associated with larger tumour size and stage and higher risk of recurrence after hepatectomy\textsuperscript{[32]}.

In vitro studies show that FGF19 induces HCC cell proliferation\textsuperscript{[26]} and inhibits apoptosis\textsuperscript{[33]}. Mice models also confirm that the ectopic expression of FGF19 promotes hepatocyte proliferation, dysplastic change and precipitates the formation of HCC\textsuperscript{[34]}. Similarly, FGFR4 knockout mice showed increased hepatocyte injury when challenged with the hepatotoxin carbon tetrachloride\textsuperscript{[35]}. Targeting the FGF19/FGFR4 interaction through various approaches appears to be effective in inhibiting hepatocarcinogenesis and HCC growth in preclinical models, be it through the use of a neutralizing antibody against FGF19\textsuperscript{[36]}, through genetic knockout\textsuperscript{[30]}, or though siRNA\textsuperscript{[33]}. Using siRNA to knockdown FGFR4 also showed similar results in mice models, which had impaired regeneration and increased liver injury after partial hepatectomy\textsuperscript{[37]}.

As previously mentioned, the FGF/FGFR pathway has been shown to be upregulated after initial blockade of the anti-VEGF pathway\textsuperscript{[38]}, and may be an important resistance mechanism to anti-VEGF therapy including that of sorafenib. For a long time, sorafenib was the only systemic treatment option for advanced HCC, having demonstrated an improvement in overall survival of 2-3 months in two large phase III trials\textsuperscript{[39,40]}. Whilst having inhibitory effects on multiple targets including VEGFR, PDGFR and Raf kinases, sorafenib has no anti-FGFR activity\textsuperscript{[41]}. Concomitant dual blockade of FGF/FGFR and VEGF pathways are hence a potentially attractive approach in the efforts to overcome this resistance\textsuperscript{[38]}.

**OVERVIEW OF FGF/FGFR PATHWAY INHIBITORS AND THEIR TOXICITIES**

Current available inhibitors against the FGF/FGFR pathway can be classified into Figure 1: (1) monoclonal antibodies which competitively inhibit FGF binding to the FGFR extracellular domain; (2) FGF-ligand traps; and (3) small molecule tyrosine kinase inhibitors (FGFR TKIs).
Most of the FGF/FGFR pathway inhibitors currently in development belong to the last category. These TKIs can be further divided into multi-kinase inhibitors and the selective FGFR TKIs.

Most of the multi-kinase inhibitors have inhibitory effects on both VEGFR and FGFR because of the structural similarities in the kinase domains of both receptors, though they may vary in their relative potency for inhibition for the two groups of receptors, with the majority having a higher potency for VEGFR than FGFR. Whilst multi-kinase inhibitors may potentially increase therapeutic efficacy by simultaneously disrupting resistance pathways, toxicity and off-target effects inevitably increase, which may limit the ability to achieve doses required for effective FGFR inhibition.[19, 42]

Selective FGFR inhibitors on the other hand, may have unique on-target dose-limiting toxicities. Preclinical models with selective FGFR TKIs caused hyperphosphataemia-mediated tissue calcification through the inhibition of FGF23 signaling in the kidney and bone, where it plays a critical role in vitamin D and phosphate homeostasis.[43, 44]. This was replicated in the clinical setting with 83% of patients treated at the maximum tolerated dose in the BGJ398 phase I trial developing hyperphosphataemia.[45]. This resulted in repeated dose interruptions and reductions, and ultimately prompted trial sponsors to explore an alternative intermittent dosing schedule.[45]. An increase in serum FGF23, phosphate and vitamin D levels is being studied as potential on-target biomarkers for effective FGFR inhibition.[46]. Other mechanism-based toxicities observed in preclinical models and clinical studies include cutaneous toxicities such as nail toxicities, xerostomia, stomatitis, as well as dose-dependent keratopathy and retinal pigment epithelial detachment. Although multikinase VEGFR/FGFR inhibitors may cause hypertension and proteinuria, these problems seem to occur with a lesser frequency with selective FGFR inhibitors.

COMPLETED CLINICAL STUDIES OF FGF/FGFR PATHWAY INHIBITORS IN HCC

An overview of the completed clinical studies of FGF/FGFR pathway inhibitors in HCC is given below [Table 1].

Brivanib

Brivanib is a selective inhibitor of VEGFR2 and FGFR1. In preclinical studies, it attenuated hepatic fibrosis in vivo[47] and hence was postulated to be useful in slowing the progression of cirrhosis to HCC.[48]. In a single-
arm phase II study in advanced HCC, brivanib was shown to have anti-tumour activity in both the frontline and second-line setting, reporting a 6-month progression free survival rate of 18% when used as first line treatment. The registration phase III trial (BRISK-FL) however was a negative trial, with brivanib failing to demonstrate non-inferiority to sorafenib in the first-line setting, though it had similar anti-tumour activity albeit a less well-tolerated safety profile with higher rates of drug discontinuation.

A second-line phase III study of brivanib against placebo after sorafenib failure or intolerance (BRISK-PS) also failed to show an overall survival advantage though it had a better improved time to progression and overall response rate.

Following the results of these two trials, the phase III trial of brivanib as adjuvant therapy to transarterial chemoembolization (TACE) was prematurely terminated though analysis similarly suggested no improvement in survival with brivanib use.

Dovitinib
Dovitinib is a non-selective FGFR inhibitor which also has effects on VEGFR, PDGFR, FGFR, c-KIT and other targets. In HCC xenograft models, dovitinib inhibited tumour growth and angiogenesis, and reduced the development of metastases and prolonged mouse survival. In other preclinical work, it also induced apoptosis in sorafenib-resistant cell lines. When translated to the clinical setting however, the randomized phase II study comparing dovitinib versus sorafenib as first-line treatment in advanced HCC in Asian-Pacific populations showed no significant difference in overall survival.

Table 1. Summary of completed clinical trials of FGFR multikinase inhibitors in hepatocellular carcinoma (adapted and updated from Lee et al. Hepatoma Res 2018;4:52)

<table>
<thead>
<tr>
<th>FGFR Multikinase Inhibitor</th>
<th>Trial</th>
<th>Endpoints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brivanib</td>
<td>PII: 1L systemic therapy in advanced HCC</td>
<td>6m PFS 18.2%</td>
</tr>
<tr>
<td></td>
<td>n = 55</td>
<td>mPFS 2.7m</td>
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<tr>
<td></td>
<td>NCT00355238</td>
<td>mOS 10 m</td>
</tr>
<tr>
<td></td>
<td>PII: 2L systemic therapy in advanced HCC</td>
<td>mTTP 2 m</td>
</tr>
<tr>
<td></td>
<td>n = 41</td>
<td>mOS 9.5 m (brivanib) vs. 9.9 m (sorafenib)</td>
</tr>
<tr>
<td></td>
<td>NCT00355238</td>
<td>PIII: 1L systemic therapy in advanced HCC (non-inferiority trial)</td>
</tr>
<tr>
<td></td>
<td>n = 1155</td>
<td>mOS 9.5 m (brivanib) vs. 9.9 m (sorafenib)</td>
</tr>
<tr>
<td></td>
<td>NCT00858871</td>
<td>PIII: 2L systemic therapy in advanced HCC</td>
</tr>
<tr>
<td></td>
<td>n = 295</td>
<td>mOS 9.4 m (brivanib) vs. 8.2 m (placebo) (NS)</td>
</tr>
<tr>
<td></td>
<td>NCT00825955</td>
<td>mTTP 4.2 m (brivanib) vs. 2.8 m (placebo) (SS)</td>
</tr>
<tr>
<td></td>
<td>PIII: in combination with TACE as adjuvant</td>
<td>ORR 10% (brivanib) vs. 2% (placebo) (SS)</td>
</tr>
<tr>
<td></td>
<td>NCT00908752</td>
<td>mOS 26.4 m (TACE/brivanib) vs. 26.1 m (TACE/placebo)</td>
</tr>
<tr>
<td>Dovitinib</td>
<td>RPII: 1L systemic therapy in advanced HCC in Asia-Pacific population</td>
<td>mOS 8.0 m (dovitinib) vs. 8.4 m (sorafenib)</td>
</tr>
<tr>
<td></td>
<td>n = 165</td>
<td>mTTP 4.1 m (dovitinib) vs. 4.1 m (sorafenib)</td>
</tr>
<tr>
<td></td>
<td>NCT0123296</td>
<td>RPII: any line systemic therapy advanced HCC</td>
</tr>
<tr>
<td></td>
<td>n = 12 (PI) n = 35 (RPII)</td>
<td>ORR: 2.9% CR, 5.7% PR, 42.8% SD</td>
</tr>
<tr>
<td></td>
<td>NCT00784290</td>
<td>mTTP 2.1 m, mOS 13.1 m</td>
</tr>
<tr>
<td></td>
<td>PIII: in combination with TACE as adjuvant</td>
<td>mOS 31.1 m (TACE/orantinib) vs. 32.3 m (TACE/placebo)</td>
</tr>
<tr>
<td></td>
<td>NCT01465464</td>
<td>Nintedanib (BIBF 1120)</td>
</tr>
<tr>
<td></td>
<td>RPII: 1L systemic therapy in advanced HCC in Western population</td>
<td>mTTP 5.5 m (nintedanib) vs. 4.6 m (sorafenib)</td>
</tr>
<tr>
<td></td>
<td>n = 93 (RPII)</td>
<td>mOS 11.9 m (nintedanib) vs. 11.4 m (sorafenib)</td>
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<tr>
<td></td>
<td>NCT010004003</td>
<td>mPFS 5.3 m (nintedanib) vs. 3.9 m (sorafenib)</td>
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<tr>
<td></td>
<td>PIII: 1L systemic therapy in advanced HCC in Asian patients</td>
<td>G3 or higher AE 68% (nintedanib) vs. 90% (sorafenib)</td>
</tr>
<tr>
<td></td>
<td>n = 95 (RPII)</td>
<td>mTTP 2.8 m (nintedanib) vs. 3.0 m (sorafenib)</td>
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<tr>
<td></td>
<td>NCT00987935</td>
<td>mOS 10.2 m (nintedanib) vs. 10.7 m (sorafenib)</td>
</tr>
<tr>
<td></td>
<td>PIII: in combination with TACE as adjuvant</td>
<td>G3 or higher AE 56% (nintedanib) vs. 84% (sorafenib)</td>
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<tr>
<td></td>
<td>NCT01761266</td>
<td>Nintedanib (BIBF 1120)</td>
</tr>
<tr>
<td></td>
<td>RPII: 1L systemic therapy in advanced HCC in Asian patients</td>
<td>mTTP 7.4 m</td>
</tr>
<tr>
<td></td>
<td>n = 46</td>
<td>mOS 18.7 m</td>
</tr>
<tr>
<td></td>
<td>NCT00946153</td>
<td>ORR 37% DCR 78%</td>
</tr>
<tr>
<td></td>
<td>RPIII: 1L systemic therapy in advanced HCC (non-inferiority trial)</td>
<td>mOS 13.6 m (lenvatinib) vs. 12.3 m (sorafenib)</td>
</tr>
</tbody>
</table>

HCC: hepatocellular carcinoma.
ic patients failed to show improved overall survival and anti-tumour activity with dovitinib. Of note though, subgroup analysis showed that the subset of patients with higher baseline plasma soluble VEGFR1 (sVEGFR1) levels had longer median overall survival, and although inconclusive, it suggests that the enrichment of a patient population through biomarker selection may be a feasible approach for future studies. No phase III trials were or are being conducted using dovitinib for the indication of HCC.

**Orantinib (TSU-68)**
Orantinib, a multi-kinase inhibitor of FGFR, VEGFR and PDGFR, showed promising efficacy in pretreated patients with advanced HCC, with 51% of patients achieving disease control, and a good safety profile in phase I/II HCC studies. Following a similarly designed phase II study suggesting prolonged progression free survival, a randomized phase III trial was conducted in Asia in patients with unresectable HCC studying either orantinib or placebo after TACE. This study was however terminated early for futility after interim analysis showed no improvement in overall survival with the use of orantinib.

**Nintedanib (BIBF 1120)**
Nintedanib, a multikinase VEGFR/PDGFR/FGFR inhibitor, showed inhibition of HCC cell line growth in vitro and decreased tumour growth and angiogenesis in a xenograft mouse model of HCC. Two phase I/II trials comparing nintedanib and sorafenib in patients with unresectable HCC were performed in the Western population and the Asian population with similar results. Both trials reported similar overall survival and time to progression results with both drugs, with fewer serious drug-related adverse events but higher drug discontinuation rates. We await further studies of this compound in patients with advanced HCC.

**Lenvantinib (E7080)**
Lenvantinib is a multi-kinase inhibitor with inhibitory effects against VEGFR, FGFR1 - 4, KIT and RET. Although higher doses have been tested in other solid tumour types, a lower dose of 12 mg was tested in a phase I trial of lenvatinib in HCC patients, and used subsequently in a Phase II trial conducted in Japan and South Korea. This led to the phase III study comparing lenvatinib and sorafenib in patients with unresectable HCC (REFLECT), showing non-inferiority of lenvatinib in terms of overall survival, and improvements in secondary endpoints of progressive free survival and objective response rate with lenvatinib. Following this study, further studies of lenvatinib in advanced HCC are being conducted or planned, such as a trial studying the combination of lenvatinib and anti-programmed death 1 (anti-PD1) inhibitors in the first line setting (NCT03418922, NCT03006926), as well as a trial studying the safety and efficacy of subsequently second-line treatment after initial lenvatinib use (NCT03433703).

**ONGOING CLINICAL STUDIES OF OTHER FGF/FGFR INHIBITORS IN HCC**
Although most of the completed clinical studies in HCC used multi-kinase inhibitors, several ongoing clinical studies are being conducted with promising selective FGFR inhibitors.

**Erdafinitib (JNJ-4276493)**
Erdafinitib is an oral selective pan-FGFR inhibitor which has shown a manageable safety profile in a phase I study in advanced or refractory solid tumours. Common drug-related adverse events encountered in the phase I study included hyperphosphataemia, nausea, stomatitis and dysguesia, with one dose-limiting toxicity of bilateral retinal pigment epithelium detachment necessitating treatment discontinuation. An ongoing phase I/IIa study is currently recruiting targeting Asian patients with advanced HCC with FGFr9 amplification (NCT02421185). Phase II and III trials are also being conducted with the drug in other tumour types, and notably, the drug received FDA breakthrough therapy designation in the treatment of FGFR-alteration positive urothelial cancer recently, following promising results in a phase II clinical trial.

**BLU-554**
BLU-554, a selective and potent inhibitor of FGFR4, was derived from an earlier compound BLU9931 which suppressed proliferation in HCC tumour xenograft models with an activated FGFR4 signaling pathway. A
phase I first-in-human study of BLU-554 in patients with HCC (NCT02508467) is ongoing, and preliminary results reported suggest promising clinical activity in FGFR19 immunohistochemistry positive (IHC+) patients who have failed prior systemic therapy\[46\].

OTHER PROMISING FGF/FGFR INHIBITORS IN CLINICAL STUDIES

**BGJ398**

BGJ398 is a selective and potent pan-FGFR inhibitor which has shown to have preliminary clinical activity in a variety of solid tumours including FGFR3-mutant bladder and urothelial cancers, FGFR1-dependent squamous lung and head and neck cancers\[45\] as well as FGFR-altered cholangiocarcinoma\[69\]. Ongoing clinical trials are being conducted and/or planned in the above tumour types.

**AZD4547**

AZD4547 is a selective FGFR1 - 3 inhibitor with activity in FGFR2-amplified gastric cancer models\[70\] as well as FGFR1-amplified NSCLC models\[71\]. The randomised phase II trial in FGFR2-amplified gastric cancer did not show an improved progression free survival for AZD4547 compared to paclitaxel though exploratory biomarker analyses suggests that marked intratumoural heterogeneity of FG2 amplification could have contributed to the negative results\[72\]. The phase II/III study of AZD4547 as second-line therapy in treating FGFR-positive patients with stage IV squamous cell lung cancer is ongoing (NCT02965378).

**Anti-FGFR antibodies**

GP369, a monoclonal antibody against the extracellular domain of the FGFR2-IIIB receptor has shown potent anti-tumour activity in breast and gastric cancer cell lines with FGFR2 amplification\[73\]. MFGFR1877S (R3Mab) (NCT01363024) and B-701, both monoclonal antibodies targeting FGFR3, show promise in urothelial cancers, with the latter compound being tested in combination with pembrolizumab in the second line setting (NCT03123055).

On the other hand, the auristatin-based antibody drug conjugate BAY 1187982 also shows significant tumour growth inhibition in models of FGF2 amplified human gastric and breast cancers\[74\], which led to a phase I dose-escalation trial in FGFR2-expressing solid tumours (NCT02368951) though the trial had to be terminated early due to concerns over toxicity.

**FGF-ligand traps**

FP-1039 comprises of a soluble fusion protein consisting of extracellular FGFR1-IIIc fused to the Fc domain of IgG1 hence acting as a ligand trap of FGF1, FGF2 and FGF4. A phase II trial is currently recruiting to study FP-1039 alone and in combination with chemotherapy (docetaxel or paclitaxel and carboplatin) in solid tumours (NCT01868022).

CONCLUSION

Although the majority of clinical studies with FGF/FGFR pathway inhibitors have been negative in hepatocellular carcinoma aside from REFLECT, the results suggest that these compounds do have anti-tumoural activity and better biomarker-based enrichment of a target population is likely the key in planning more successful future trials\[75\]. Several ongoing clinical trials of FGF/FGFR pathway inhibitors in a biomarker-enriched population are ongoing and we await the results of these promising studies.

DECLARATIONS

Authors’ contributions

The two authors are responsible for all the work of this article.
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