MDNA11 Demonstrates Clinical Activity as Monotherapy and in Combination with Pembrolizumab in Biomarker-Enriched Gastrointestinal Malignancies, Including ICI-Refractory Disease

André Mansinho, MD[1,2,3], Victoria Atkinson, MBBS, FRACP[4], Philippe L. Bedard, MD[5], Pablo Gajate, MD[6], Jacqueline T. Brown, MD[7], Luis Cabezón-Gutiérrez, MD, PhD[8,9], Austin Duffy, MD[10], Victor Moreno, MD, PhD[11], Kim A. Margolin, MD, FASCO[12], Przemyslaw Twardowski[12], Irene Moreno[13], Hong Shue[14], Ira Winer, MD[15], Michael J. Chisamore, PhD[16], Marc Oliva, MD, PhD[17], Amy Prawira[17], Fahar Merchant, PhD[18], Rosemina Merchant[18], William D. Gwynne, PhD[18], Minh D. To, PhD[18], Nageatte Ibrahim, MD[18], Arash Yavari, MB BS, DPhil[18], Melissa Coello[18], Hussein A. Tawbi, MD, PhD[19], Sara Coelho[20], Igor Medic[21], Tatiana Hernandez-Guerrero[22], and **Paolo A. Ascierto, MD[23]**

(1) START Lisbon, ULSSM – Hospital de Santa Maria, Lisbon, Portugal
(2) Gulbenkian Institute for Molecular Medicine, Lisbon, Portugal
(3) Faculty of Medicine, University of Lisbon, Lisbon, Portugal
(4) Gallipoli Medical Research, Greenslopes, QLD, Australia
(5) University Health Network, Toronto, ON, Canada
(6) Hospital Universitario Ramón y Cajal, Madrid, Spain
(7) Emory University School of Medicine, Atlanta, GA, United States
(8) Universidad Francisco de Vitoria, Madrid, Spain
(9) Hospital Universitario de Torrejón, Madrid, Spain
(10) START Dublin, Mater Misericordiae University Hospital, Dublin, Ireland
(11) START Madrid-Fundación Jiménez Díaz (FJD), Hospital FJD, Madrid, Spain
(12) Saint John's Cancer Institute, Providence Saint John's Health Center, Santa Monica, CA
(13) START Madrid - Integral Oncológico Clara Campal (CIOCC) Hospital HM Sanchinarro, Madrid, Spain
(14) University of the Sunshine Coast, Sunshine Coast, QLD, Australia
(15) Karmanos Cancer Center, Wayne State University, Detroit, MI
(16) Merck & Co., Inc., Rahway, NJ
(17) Obatica Pty Ltd., Sydney, NSW, Australia
(18) Medicenna Therapeutics, Toronto, ON, Canada,
(19) The University of Texas MD Anderson Cancer Center, Houston, TX,
(20) Instituto Português de Oncologia do Porto Francisco Gentil, E.P.E., Porto, Portugal,
(21) Sharp Healthcare, La Mesa, CA,
(22) START - Barcelona HM Nou Delfos, Barcelona, Spain,
(23) Istituto Nazionale Tumori IRCCS Fondazione G. Pascale, Naples, Italy

Society for Immunotherapy of Cancer
sitc2026

MDNA11 ‘β-enhanced not-α’ IL-2 superkine

Engineered for preferential immune effector activation and extended exposure

Abolished α binding

Reduce Treg activation

Minimizes vascular leak

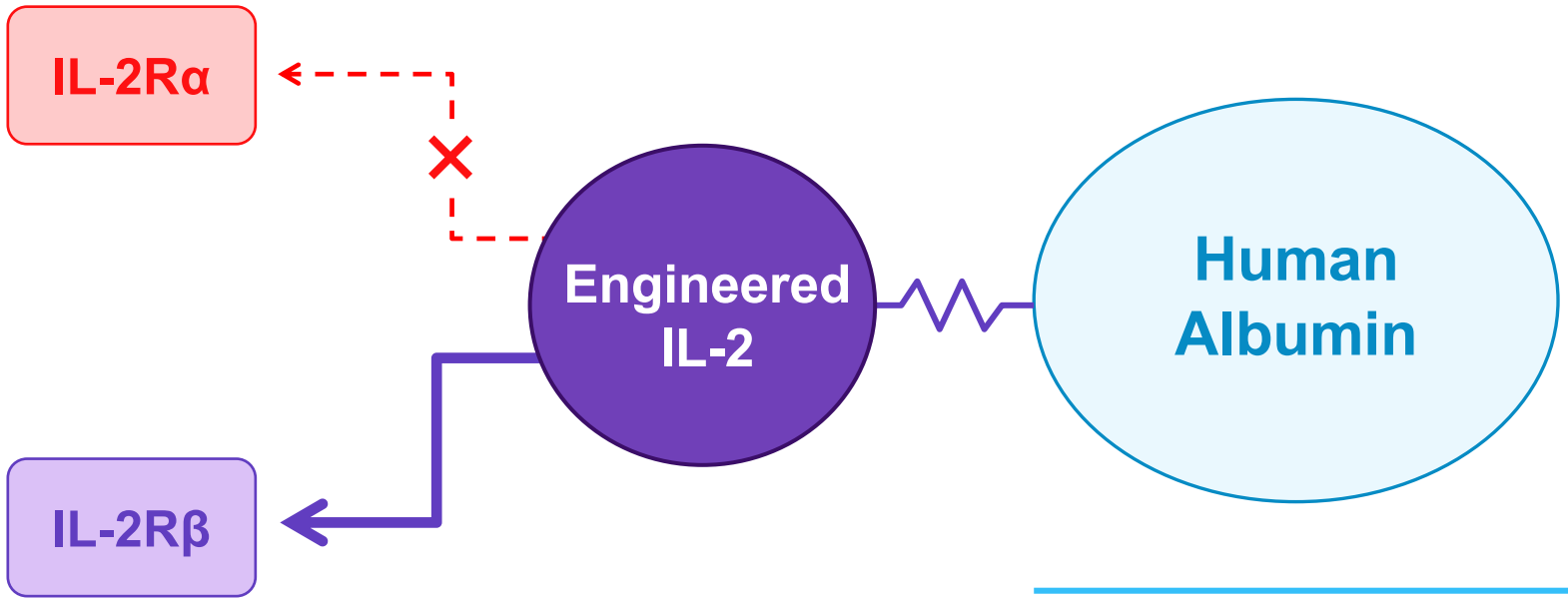
Enhanced β binding

Activate immune effectors

CD8⁺ T cells

NK cells

Promotes immune memory and stemness



Prolonged exposure

Extends half-life and reduces dosing frequency

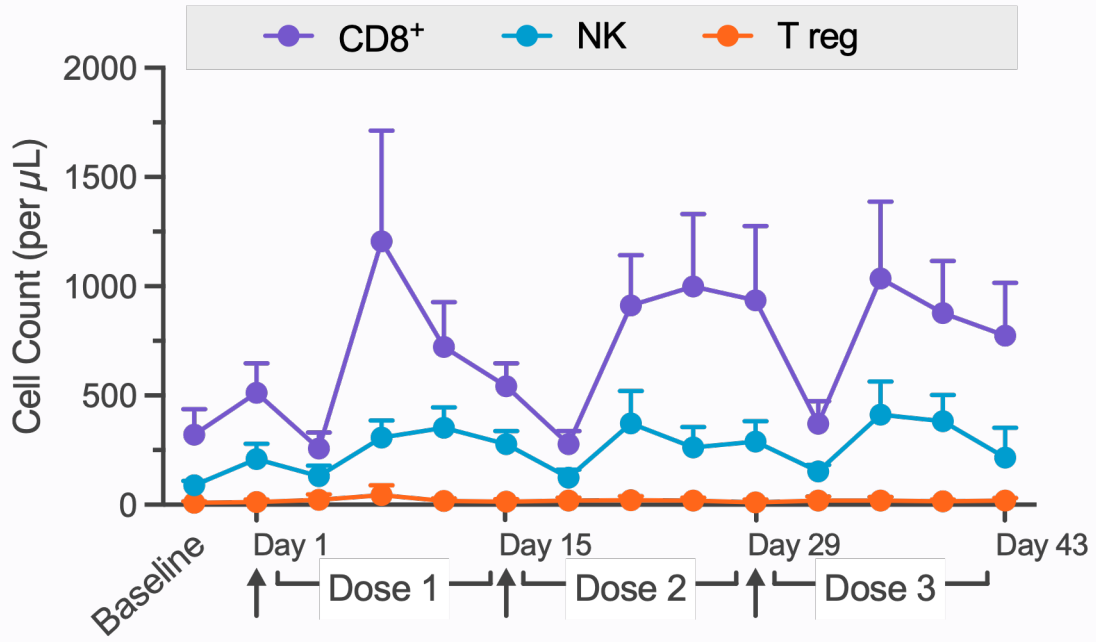
Promotes accumulation within tumor and lymph nodes

Society for Immunotherapy of Cancer sitc2026

MDNA11 Drives Sustained Immune Effector Cell Expansion and Broad CD8⁺ T Cell Activation

SUSTAINED EXPANSION WITH REPEAT DOSING

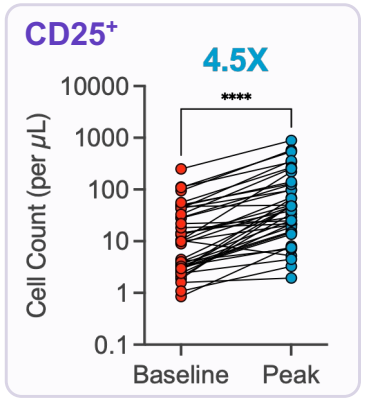
RDE | 90 µg/kg

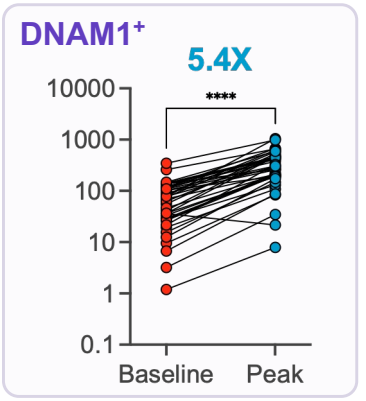


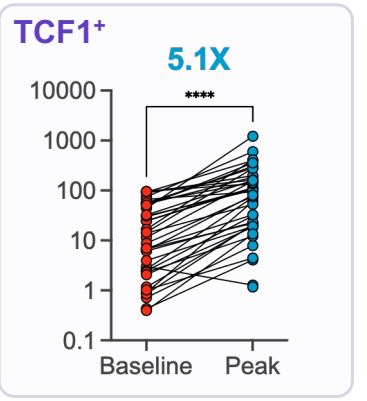
Flow cytometry of peripheral blood mononuclear cells.

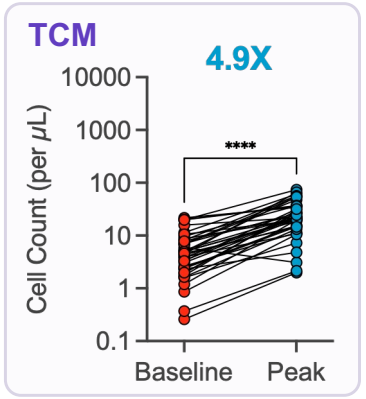
SIGNIFICANT EXPANSION OF CD8⁺ T-CELL SUBSETS

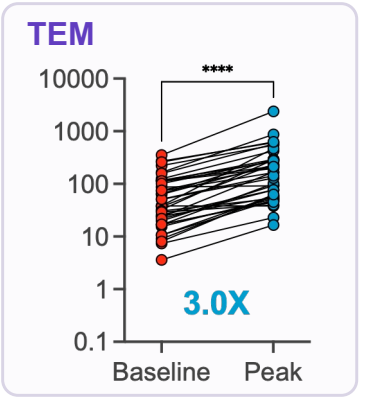
BEDR population | Peak vs baseline











Peak vs Baseline:
Median fold change
Paired t-tests†
**** p<0.0001
N = 40

Society for Immunotherapy of Cancer
sitc2026

Sustained effector-cell kinetics • Expansion of activated, stem-like, central- and effector-memory CD8+ T cells

†Median fold change; paired t-tests on log-transformed counts

Limited Treatment Options after ICI Progression in MSI-H or TMB-H Gastrointestinal Cancers

ICI-NAÏVE SETTING

Response benchmarks with pembrolizumab

45% (N = 153)
MSI-H CRC
1L pembrolizumab[1]

18% (N = 22)
MSI-H PDAC
Previously Treated[1]

20% (N = 35)
TMB-H GI Cancers
Previously Treated
TMB ≥13 mut/Mb[2]

Lower responses with liver metastases

Patient-level ORR by liver-met status in selected **ICI-naïve** cohorts

Cohort	Without liver mets	With liver mets
MSI-H CRC / Mayo[3]	**63%** (N = 27)	**21%** (N = 14)
MSI-H CRC / MoTriColor[4]	**76%** (N = 17)	**33%** (N = 6)
MSI-H CRC / nivo + rela[5]	**56%** (N = 32)	**39%** (N = 18)
TMB-H* / nivo[6]	**33%** (N = 24)	**9%** (N = 46)

AFTER ICI PROGRESSION

Limited treatment options

11%
ORR (N = 41)

ICI rechallenge
MSI-H/dMMR GI cancers[7]

12–13%
ORR (N = 25 and 31)

Chemotherapy ± targeted therapy
Selected GI cohorts[8,9]

An unmet need for therapies that **restore antitumor activity** after ICI progression.

Society for Immunotherapy of Cancer
sitc2026

Cross-trial context only. Populations, prior therapy and response assessment differ. ORR, objective response rate.

[1] Diaz, Lancet Oncol 2022 (KN177) / Marabelle, JCO 2020 (KN158); [2] QLEX PI 2026; [3] Saberzadeh-Ardestani, JAMA Netw Open 2023; [4] Elez, ESMO Open 2025; [5] Overman, JITC 2024; [6] Nakamura, ESMO Open 2026; [7] Mercier, JCO 2025; [8] Chen, Cancers 2022; [9] Bui, Cancers 2022.
*Blood-based TMB-H (bTMB-H) status was determined using circulating tumor DNA (ctDNA).

Overview of ABILITY-1: Phase 1/2 Study Design of MDNA11

MDNA11 monotherapy (N=74)

Dose escalation
Assess safety
Advanced tumors: all-comers

MTD not reached

- 120 µg/kg — Q2W/Q3W, IV
- **90 µg/kg** — **Q2W, IV (RDE)**
- 60 µg/kg — Q2W, IV
- 3–30 µg/kg — Q2W, IV

Backfill → BEDR

Dose expansion
Efficacy and safety
ICI-resistant tumors

90 µg/kg

- **Cutaneous melanoma** — 2° ICI resistant
- **MSI-H/dMMR or TMB-H** — Tumor-agnostic/GI

MDNA11 + pembrolizumab (N=78)

Dose escalation
Assess safety
Advanced tumors: all-comers

MTD not reached

- 120 µg/kg — Q2W/Q3W, IV
- **90 µg/kg** — **Q2W, IV (cRDE)**
- 60 µg/kg — Q2W, IV

Backfill → BEDR

Dose expansion
Efficacy and safety
ICI-resistant tumors

90 µg/kg

- **Cutaneous melanoma** — 1° ICI resistant
- **MSI-H/dMMR or TMB-H** — Tumor-agnostic/GI
- **MSS endometrial** — 2° ICI resistant

Pembrolizumab IV 400 mg Q6W

7 patients rolled over

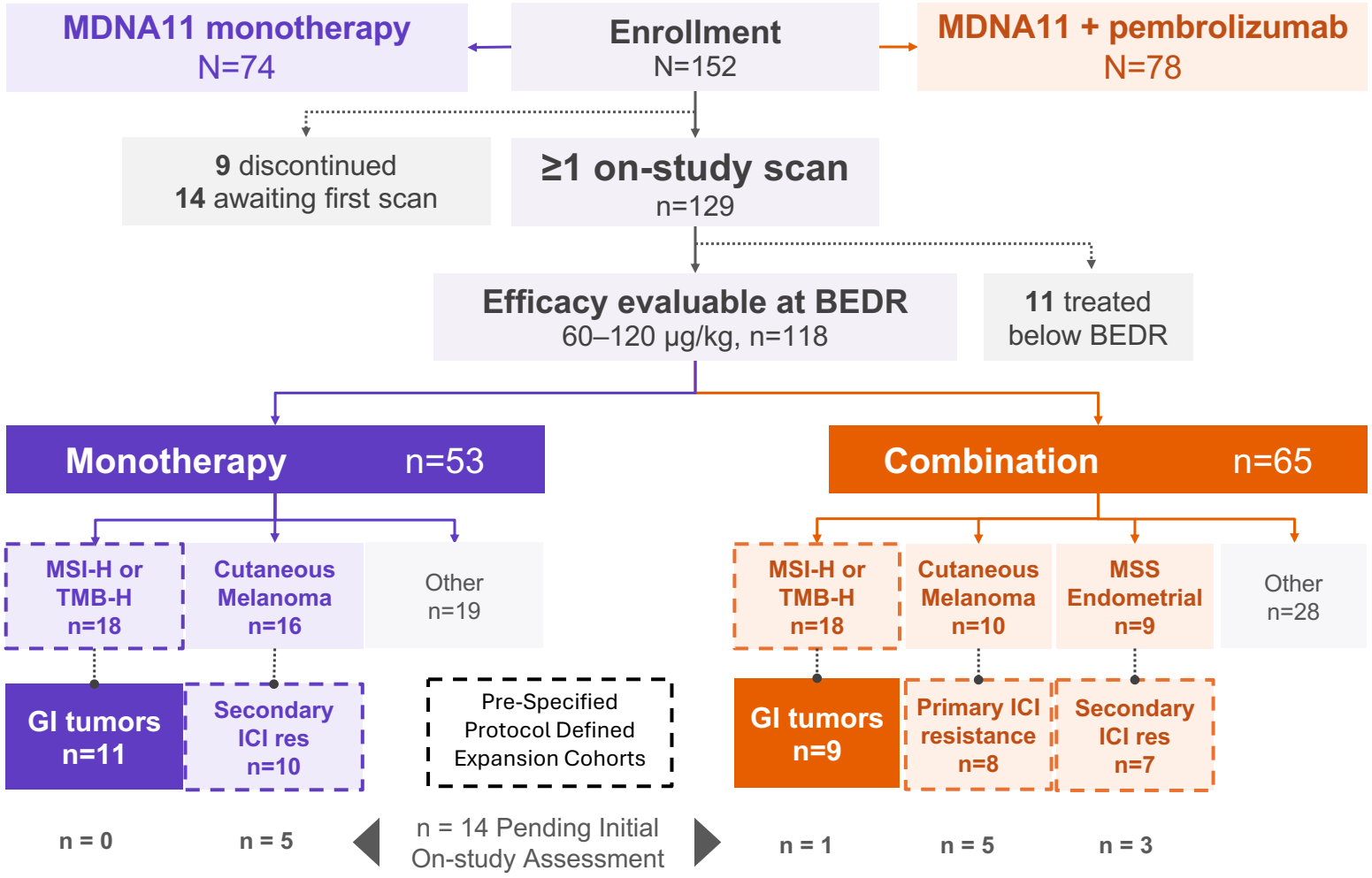
This study is in collaboration with Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA.

BEDR, biologically effective dose range; RDE, recommended dose for expansion. cRDE, combination recommended dose for expansion; MTD, maximum tolerated dose. Enrollment numbers as of **28-Oct-2026.**

Society for Immunotherapy of Cancer sitc2026

ABILITY-1: Safety, Dose Optimization, and Efficacy Signal-finding

PATIENT DISPOSITION



TUMOR TYPES AT ENROLLMENT (N=152)

Tumor type	Mono N=74	Combo N=78
Melanoma	31 (41.9)	15 (19.2)
Endometrial	1 (1.4)	16 (20.5)
Colorectal	8 (10.8)	10 (12.8)
Ovarian	4 (5.4)	7 (9.0)
NSCLC	3 (4.1)	7 (9.0)
Gastric/esophageal/GEJ	4 (5.4)	3 (3.8)
Pancreatic†	6 (8.1)	0 (0.0)
Nonmelanoma skin	4 (5.4)	1 (1.3)
Breast	0 (0.0)	5 (6.4)
Renal cell carcinoma	4 (5.4)	1 (1.3)
Other‡	9 (12.2)	13 (16.7)

Values are n (%). Grouped by primary site.

Biomarker Definitions

MSI-H	MSI-H irrespective of TMB status
TMB-H	MSS and TMB-H

Society for Immunotherapy of Cancer
sitc2026

†Includes one pancreatic neuroendocrine carcinoma. Melanoma includes all subtypes (acral, mucosal, cutaneous). Nonmelanoma skin includes BCC and cSCC. ICI: immune checkpoint inhibitor.

‡Other: Monotherapy, cholangiocarcinoma (2), sarcoma (2), testicular germ cell tumor (1), bladder neuroendocrine carcinoma (1), cervical (1), tonsillar SCC (1), HNSCC (1). Combination, nasopharyngeal (2), pleural mesothelioma (2), adrenal (1), thymic (2), salivary gland (1), SCLC (1), urothelial (1), peritoneal carcinosarcoma (1), anal SCC (1), testicular Sertoli cell tumor (1).

NCI classified GI tumors include colorectal, pancreatic, cholangiocarcinoma, gastric/GEJ and anal SCC. Enrollment as of **28-Oct-2026**

MDNA11 Continues to Demonstrate a Manageable Safety Profile as Monotherapy or in Combination with Pembrolizumab

No DLTs
Through 120 µg/kg

>90% of TRAEs Grade 1–2
Events were predominantly transient (median duration **1–2 days**)

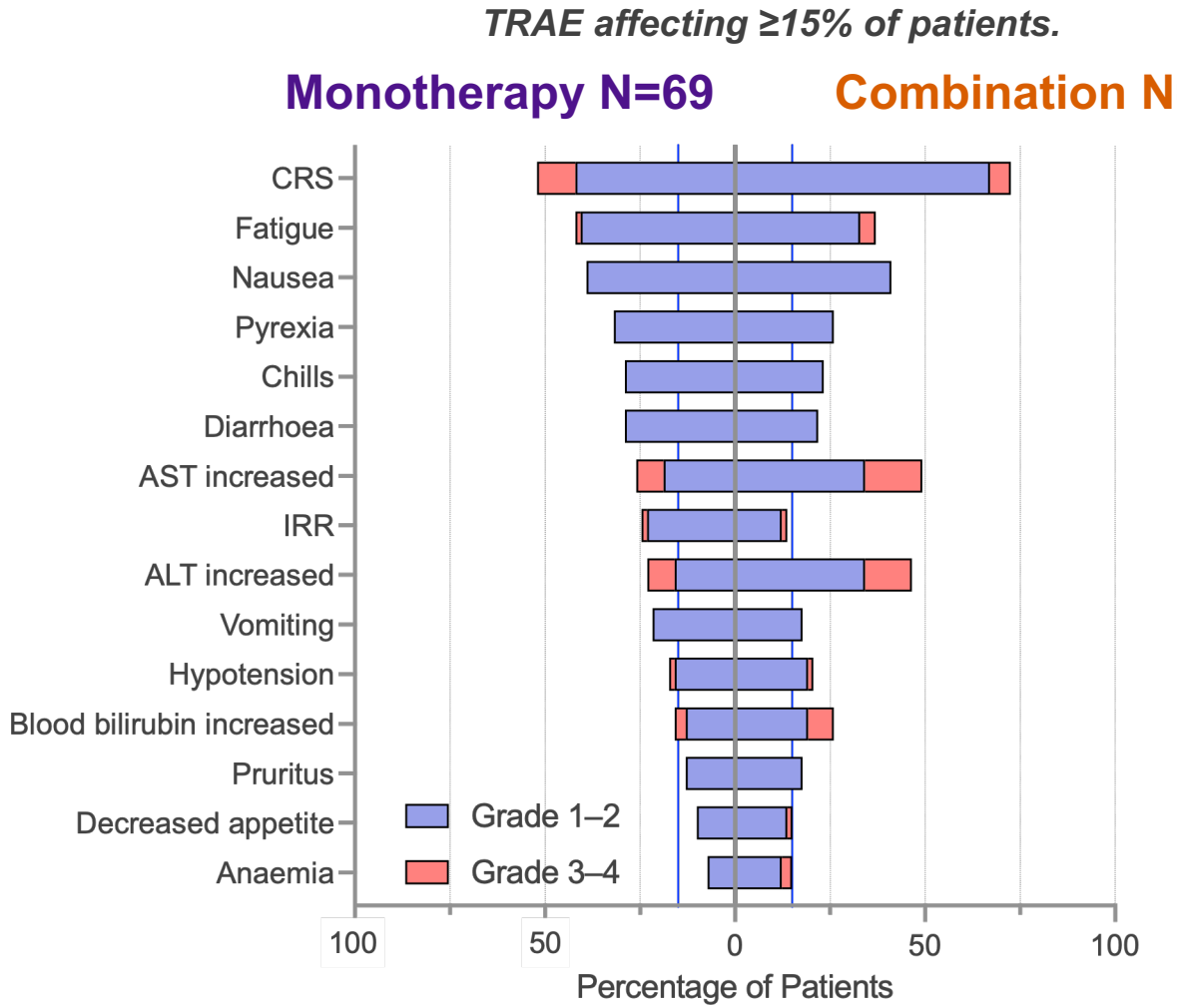
Higher-grade TRAEs were **predominantly laboratory abnormalities**

One transient Grade 4 CRS event in a patient with baseline hypotension, **resolved within 4 days**

No Grade 5 TRAE

No new safety signals in combination with pembrolizumab

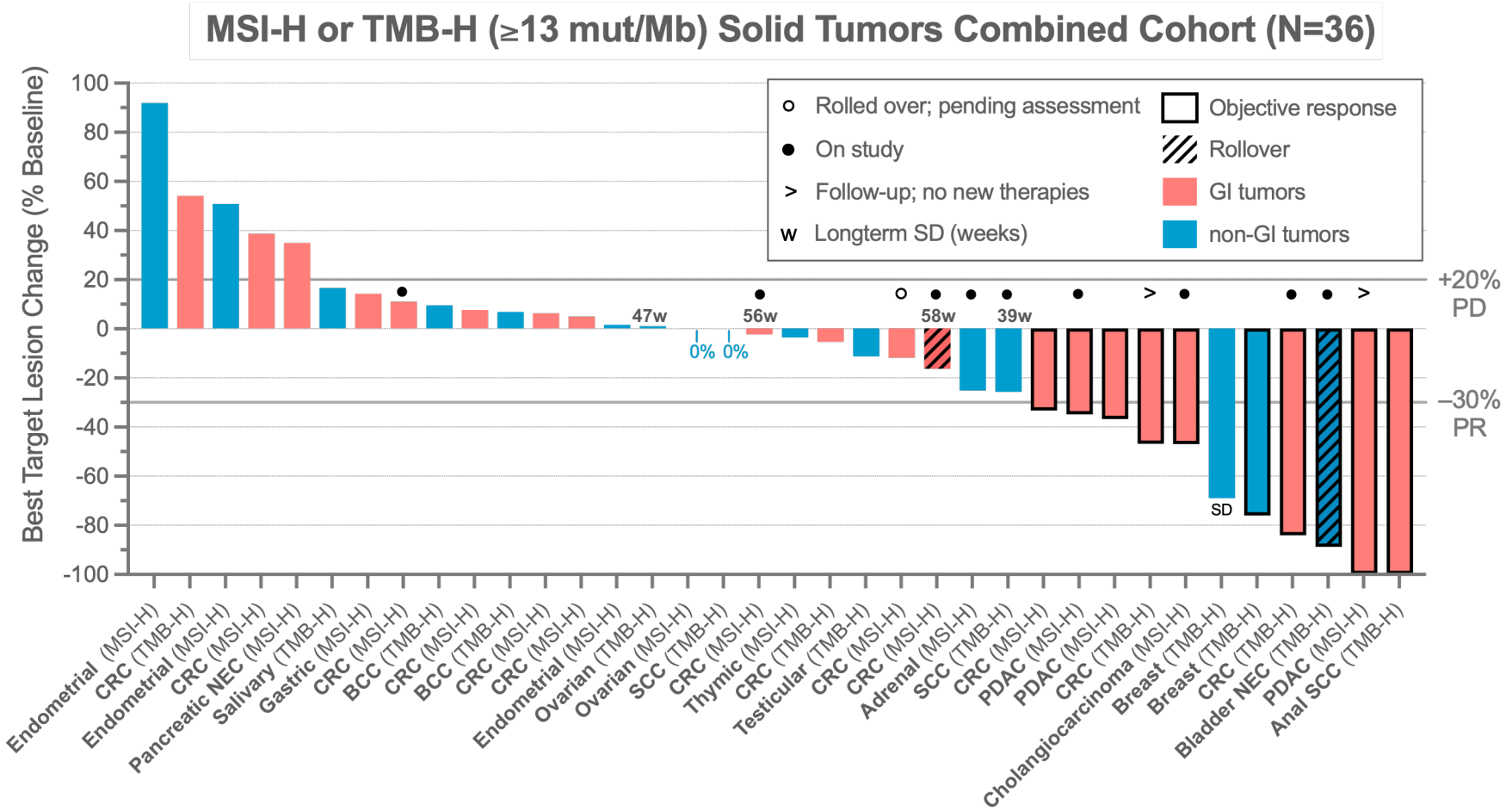
TRAE affecting ≥15% of patients.



Society for Immunotherapy of Cancer sitc2026

TRAE, MDNA11 treatment-related adverse event. CRS, cytokine release syndrome.
N=73 comprises six rollover patients evaluated for safety plus 67 combination–treated patients.
Safety Data Cut: **15 June 2026.**

Objective Responses Were More Frequent in the Gastrointestinal Subset of MSI-H or TMB-H Solid Tumors



GI TUMORS

ORR (95% CI)	40% (19.1–63.9)	8/20
DCR (95% CI)	80% (56.3–94.3)	16/20

NON-GI TUMORS

ORR (95% CI)	12.5% (1.6–38.3)	2/16
DCR (95% CI)	75% (47.6–92.7)	12/16

Combined Cohort

ORR (95% CI)	28% (14.2–45.2)	10/36
DCR (95% CI)	78% (60.8–89.9)	28/36

Responses in 6 different MSI-H or TMB-H solid tumor types:
CRC, PDAC, Cholangiocarcinoma, anal SCC, breast, and bladder NEC

Society for Immunotherapy of Cancer
sitc2026

Patients counted once using best overall response across monotherapy and combination treatment, including post-rollover assessments.
Efficacy population as of 01 September 2026; includes post-cut new and confirmed responses.

Baseline Characteristics of Patients Enrolled with MSI-H or TMB-H GI tumors

N = 20 | Majority ICI-refractory population

Characteristic		MDNA11 Monotherapy N = 11	MDNA11 + Pembrolizumab N = 9	Combined Cohort N = 20
Demographics	**Age, years**, median (range)	55.0 (38.0–85.0)	55.0 (38.0–76.0)	55.0 (38.0–85.0)
	Sex, female, n (%)	8 (72.7)	3 (33.3)	11 (55.0)
	ECOG performance status, 0, n (%)	9 (81.8)	5 (55.6)	14 (70.0)
Prior treatments	**Prior systemic lines of therapy[1],** median (range)	2 (1–6)	5 (1–10)	3 (1–10)
	Prior systemic lines of therapy, ≥4, n (%)	3 (27.3)	6 (66.7)	9 (45.0)
	Prior ICI therapy, n (%)	9 (81.8)	4 (44.4)	13 (65.0)
Baseline laboratories	**LDH ≥ ULN (240 IU/L)**, n (%)	2 (18.2)	5 (55.6)	7 (35.0)
	CRP ≥ ULN (5 mg/L), n (%)	6 (54.5)	6 (66.7)	12 (60.0)
	Lymphocytes, ×10⁹/L, median (range)	1.81 (1.27–2.84)	1.67 (0.80–2.60)	1.80 (0.80–2.84)
Tumor burden	**Target lesion SOD, mm**, median (range)	85.0 (38.0–185.0)	48.7 (20.0–183.0)	75.5 (20.0–185.0)
	Number of target lesions, median (range)	2 (1–5)	2 (1–5)	2 (1–5)
	Number of non-target lesions, median (range)	2 (0–4)	1 (0–5)	1.5 (0–5)
	Liver metastasis, n (%)	4 (36.4)	3 (33.3)	7 (35.0)
MDNA11 exposure	**60 µg/kg**, n (%)	2 (18.2)	2 (22.2)	4 (20.0)
	90 µg/kg (RDE), n (%)	9 (81.8)	7 (77.8)	16 (80.0)
	120 µg/kg, n (%)	0 (0.0)	0 (0.0)	0 (0.0)

[1]Includes adjuvant therapy.

Society for Immunotherapy of Cancer SITC 2026

Antitumor Activity with MDNA11 ± Pembrolizumab in MSI-H or TMB-H Gastrointestinal Tumors

Monotherapy

36% ORR (4/11)

95% CI: 10.9–69.2%

82% DCR (9/11)

95% CI: 48.2–97.7%

Combination

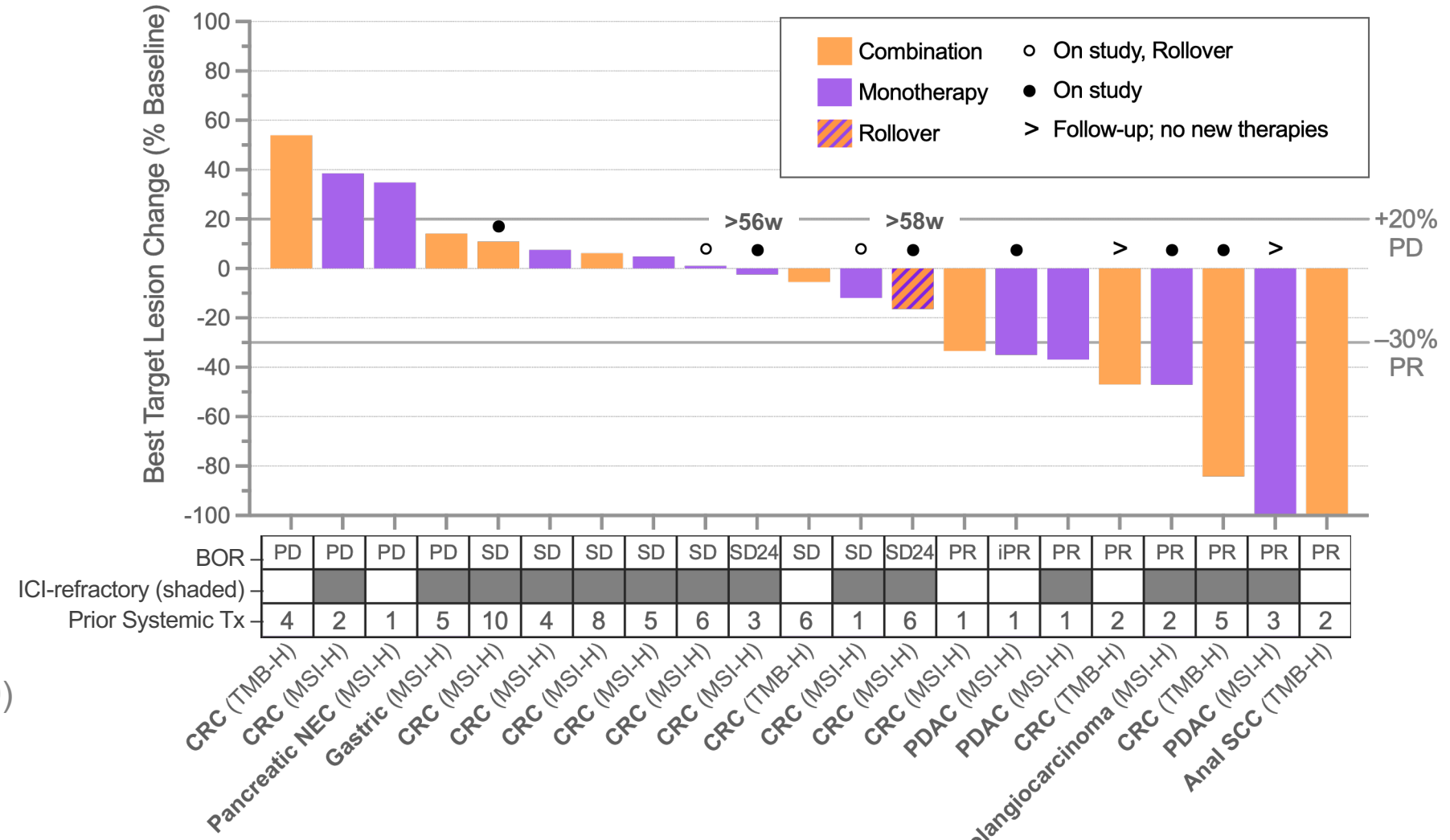
44% ORR (4/9)

95% CI: 13.7–78.8%

78% DCR (7/9)

95% CI: 40.0–97.2%

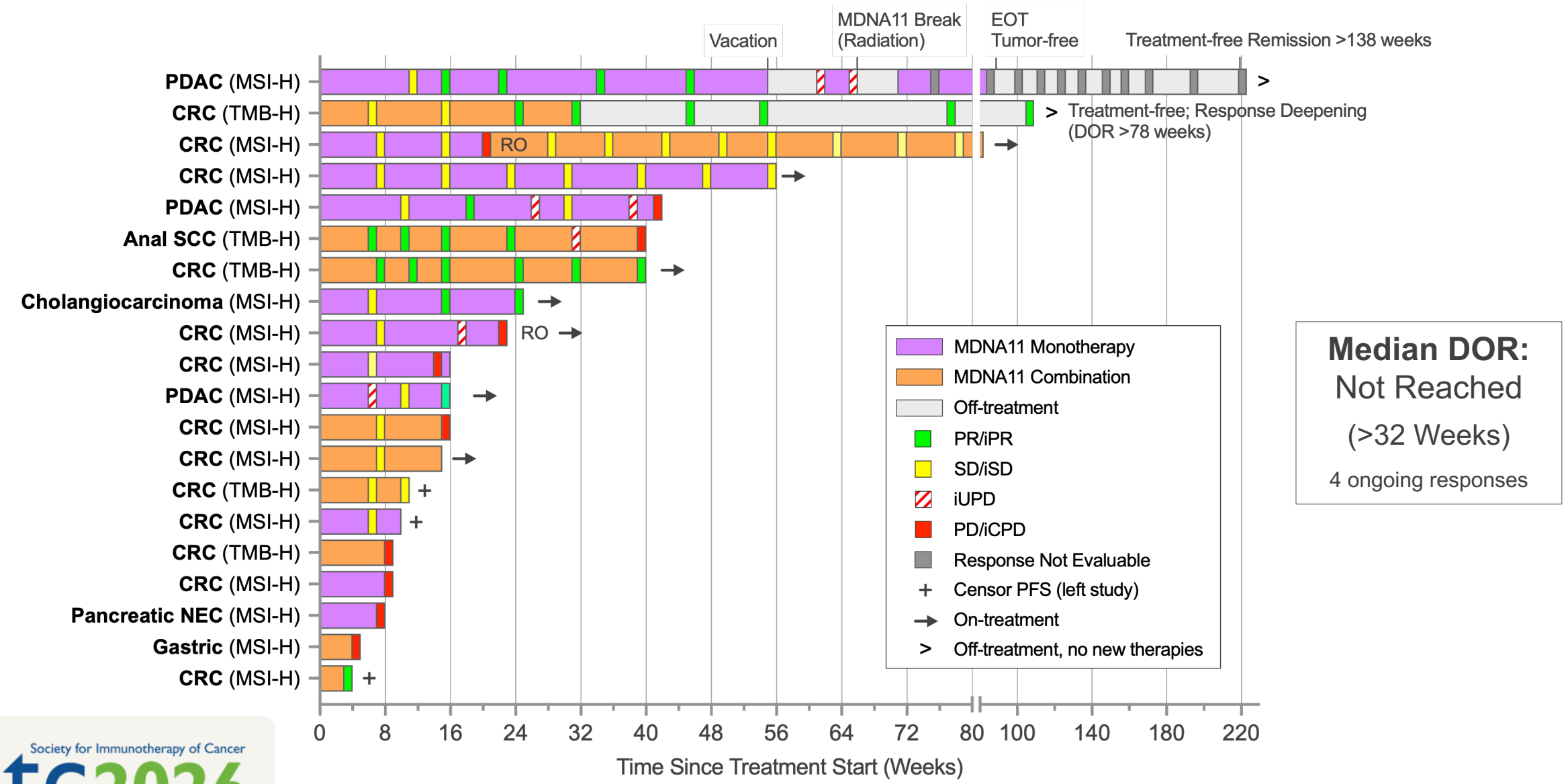
55% of evaluable patients (11/20) experienced tumor regression



Society for Immunotherapy of Cancer
sitc2026

20 unique evaluable patients; 21 bars shown, including one rollover assessment.
Post-rollover treatment outcomes excluded from ORR; patients counted once in their original cohort.
Patients efficacy-evaluable at 01 September 2026; includes new responses and response confirmations after cutoff.

Durable Response and Disease Control with MDNA11 ± Pembrolizumab in MSI-H or TMB-H Gastrointestinal Tumors



Median DOR:
Not Reached
(>32 Weeks)
4 ongoing responses

Patients efficacy-evaluable at 01-September-2026; includes new responses and response confirmations after cutoff.

Society for Immunotherapy of Cancer
sitc2026

Limited Treatment Options Following ICI Progression in MSI-H or TMB-H GI Cancers

Approved therapies, ICI rechallenge after progression, and emerging agents

Population / regimen	Evidence population / prior treatment	N	ORR
ICI rechallenge after progression			
MSI-H/dMMR GI cancers[1] ICI monotherapy or dual ICI (INFLATE)	ICI-refractory	41	**11%**
Current standards of care: selected chemotherapy benchmarks			
MSI-H/dMMR GI Cancers[2,3] Chemotherapy ± targeted therapy	ICI-refractory	25/31	**12/13%**
Emerging therapies			
MSI-H CRC subgroup[4] VVD-214 / RO7589831 (WRN inhibitor)	ICI-refractory	41	**7.3%***
MSI-H/dMMR, TMB-H or viral GI tumors[5] Invikafusp alfa (START-001)	Mostly ICI-refractory Active liver mets excluded	18	**22.2%**
MSI-H or TMB-H GI tumors MDNA11 MDNA11 + Pembrolizumab	Mostly ICI-refractory Enrollment of patients with active liver mets	20	**40%**

Society for Immunotherapy of Cancer
sitc2026

Cross-trial context only. Populations, prior therapy and response assessment differ. *Confirmed ORR.

MDNA11 and invikafusp alfa ORRs include unconfirmed responses. MDNA11 patients counted once using best overall response across monotherapy and combination treatment, including after rollover.

[1]Mercier, ASCO 2025 #3569; [2]Bui, Cancers 2022; [3]Chen, Cancers 2022; [4]Yap, Nat Med 2026; [5]Elez, ESMO GI 2025 #479MO.

Durable Response to MDNA11 Monotherapy in MSI-H PDAC with Liver Metastasis and Primary Resistance to Pembrolizumab

Adj. Folfirinox (**PD**)
03-AUG-2021 → 11-NOV-2021

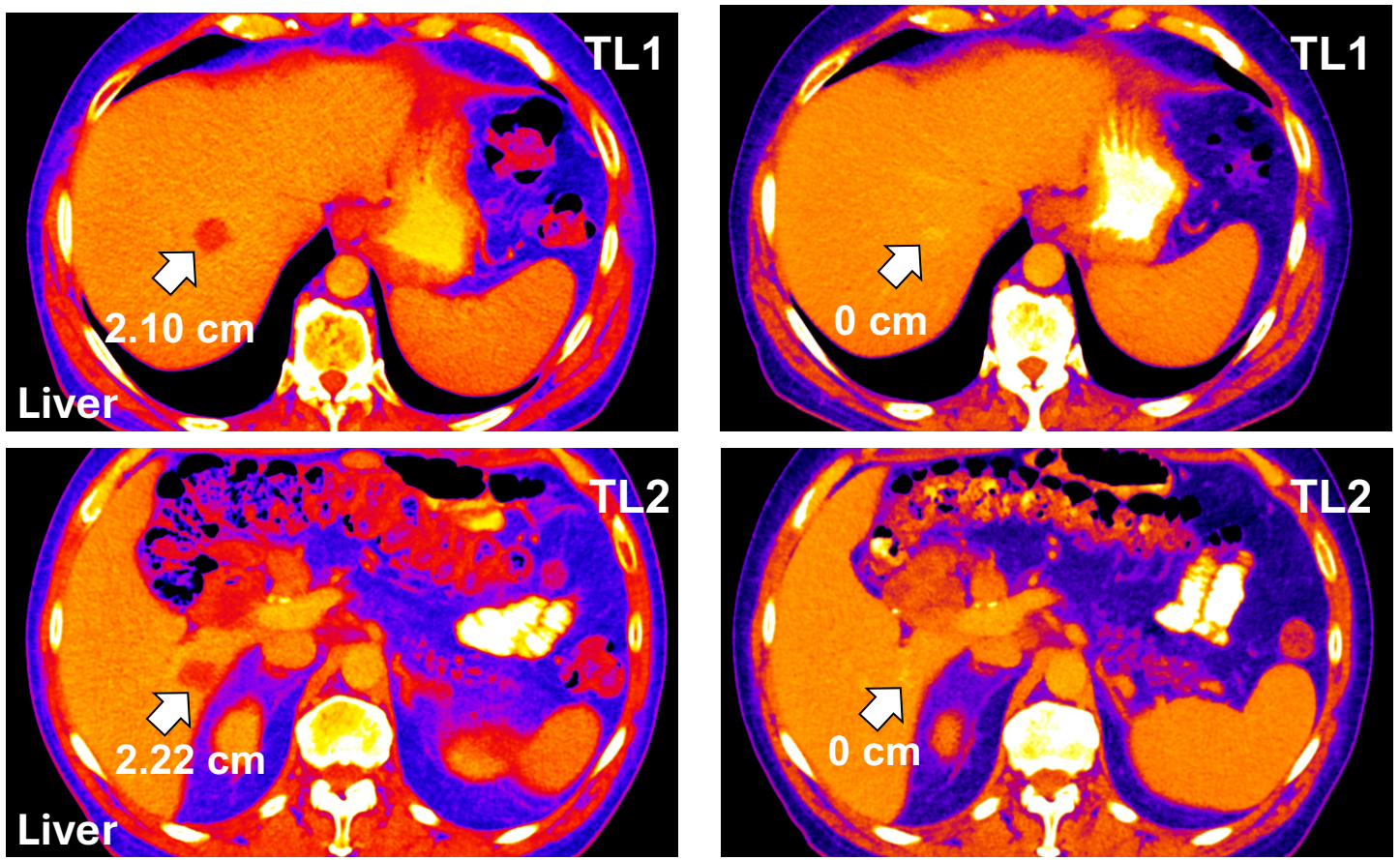
1L Gemcitabine + Abraxane (**SD**)
23-NOV-2021 → 07-DEC-2021

2L Pembrolizumab (**PD**)
20-JAN-2022 → 03-MAR-2022

3L **MDNA11 Monotherapy (PR)**
12-APR-2022 (6 weeks post-pembrolizumab)

Stage IV PDAC | 4th Systemic Therapy

43 mm Target Lesion SOD



Screening **Week 66**

Confirmed PR

PFS 66+ weeks | DOR 50 weeks | DOT 91 weeks

Complete Tumor Regression (–100%)

Remission Ongoing >138 weeks since EOT

As of 01-Sept-2026

Society for Immunotherapy of Cancer
sitc2026

Complete regression of target and non-target lesions. However, unconfirmed iUPD due to new lesion after treatment break (vacation). MDNA11 restart + RT to new lesion followed by complete radiologic remission. RECIST non-evaluable due to RT, DOR censored at iUPD.

Confirmed Response to MDNA11 Monotherapy in MSI-H Cholangiocarcinoma with Liver Metastasis and Primary Chemoimmunotherapy Resistance

Stage IV Cholangiocarcinoma | 3rd Systemic Therapy

119 mm Target Lesion SOD

Adj. Capecitabine + VMAT (**Completed**)
06-DEC-2023 → 02-MAY-2024

1L Gemcitabine + Cisplatin + Durvalumab (**PD**)
04-SEPT-2025 → 12-MAR-2026

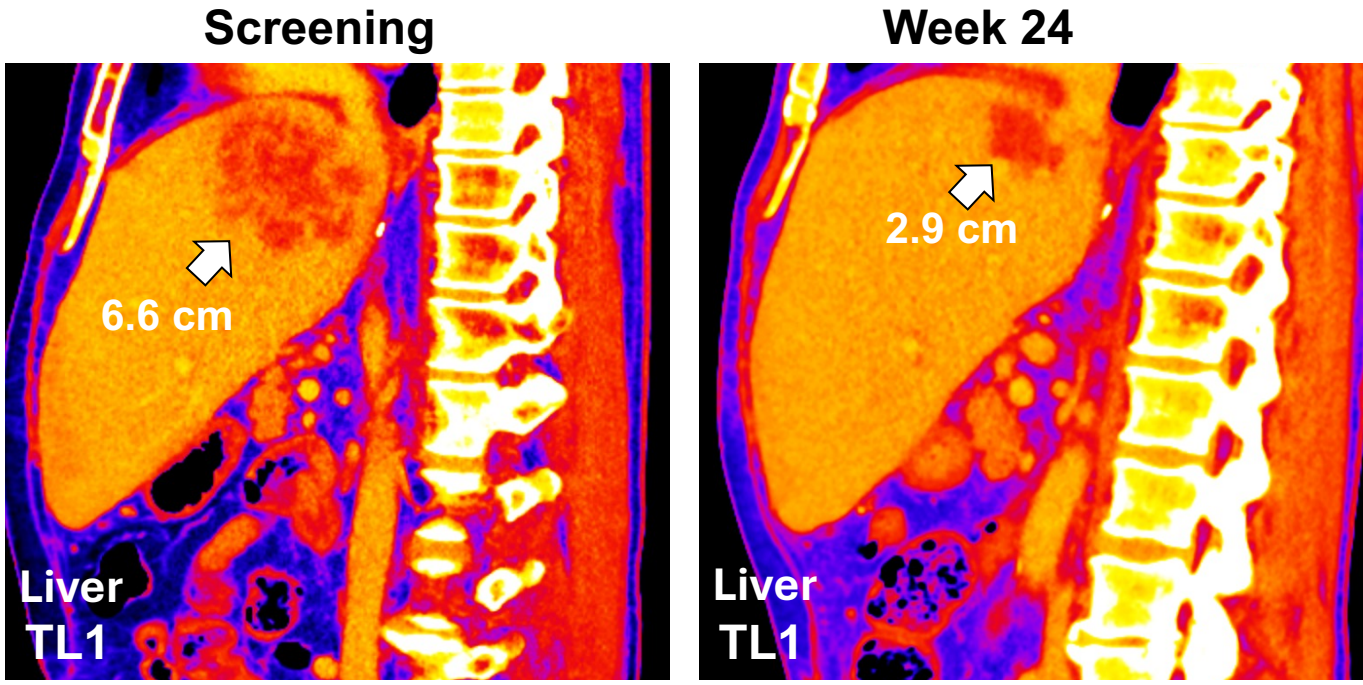
2L **MDNA11 Monotherapy (PR)**
22-APR-2026 (6 weeks post-durvalumab) → ONGOING

Confirmed PR*

PFS >24 weeks | DOR >8 weeks | DOT >24 weeks

−47%*

Best overall target-lesion change



Society for Immunotherapy of Cancer
sitc2026

TL, target lesion | TL1 CT scan shown | -47% refers to change in SOD
*PR confirmed on scan after 01-Sept-2026 efficacy cut

Confirmed PR with MDNA11 + Pembrolizumab in MSS TMB-H Stage IV CRC Following No Objective Response to Five Prior Systemic Therapies, Including ICI

Adj. XELOX chemotherapy and radiation (**PD**)
MAY-2022 → OCT-2022

1L FOLFOX + bevacizumab (**SD**)
JUN-2023 → JUN-2024

2L FOLFIRI + panitumumab (**SD**)
JUN-2024 → DEC-2024

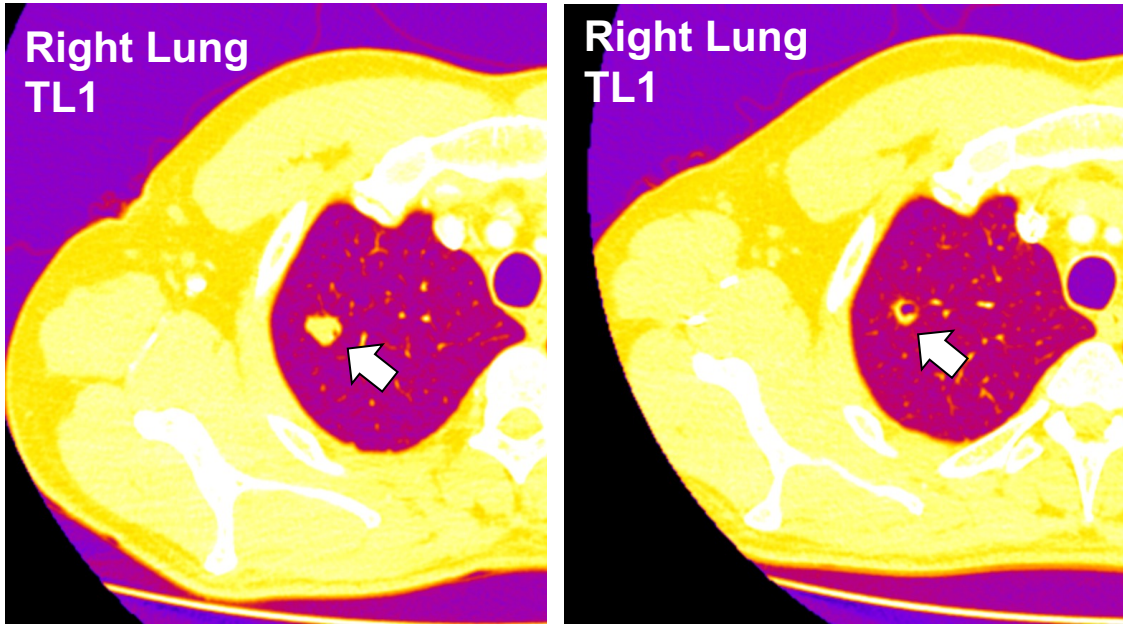
3L Pembrolizumab (**SD 4.5 months**; primary ICI resistance)
DEC-2024 → MAY-2025

4L Alpelisib + capecitabine (**PD**)
MAY-2025 → 01-JUL-2025

5L **MDNA11 + Pembrolizumab (PR)**
16-DEC-2025 → ONGOING

Stage IV MSS TMB-H CRC | 6th Systemic Therapy

38 mm Target Lesion SOD



Baseline | Week 16 (PR)

Confirmed PR

PFS >40 weeks | DOR >32 weeks | DOT >40 weeks

−84%

Best overall target-lesion change
Complete response in non-target lesions

Society for Immunotherapy of Cancer
sitc2026

Liver Lesion Shrinkage Following Pseudoprogression in Stage IV Chemotherapy-resistant PDAC Treated with Single-Agent MDNA11

Adj

5-FU, Irinotecan, Oxaliplatin (**PD**)

04-Mar-2026 → 28-Apr-2026

1L

MDNA11 Monotherapy (iPR)

10-Jun-2026 → ONGOING

iPR*

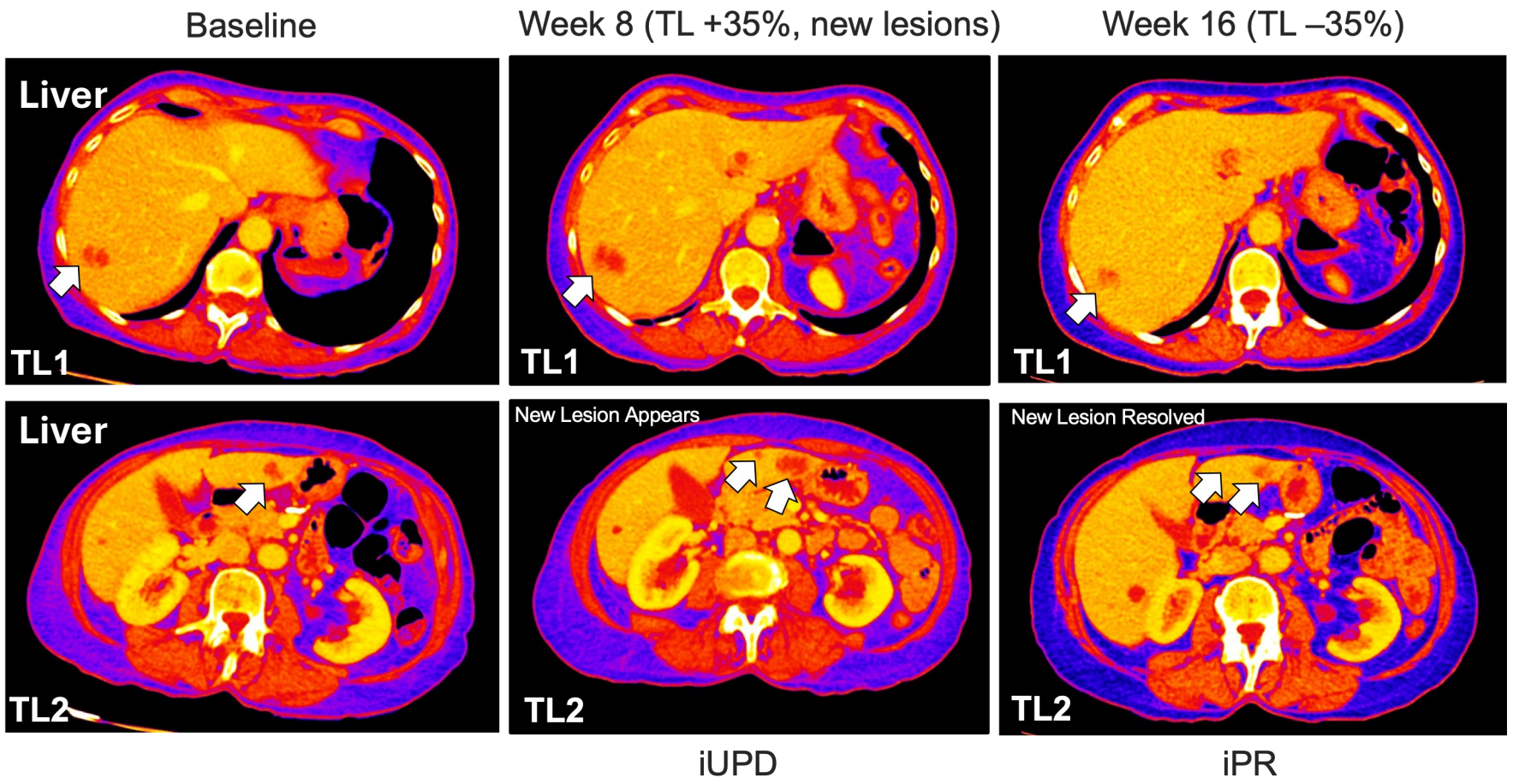
Confirmatory Scan Pending

PFS >16 weeks | DOT >16 weeks

−35%

Best overall target-lesion change

MDNA11 single-agent activity without prior ICB exposure.

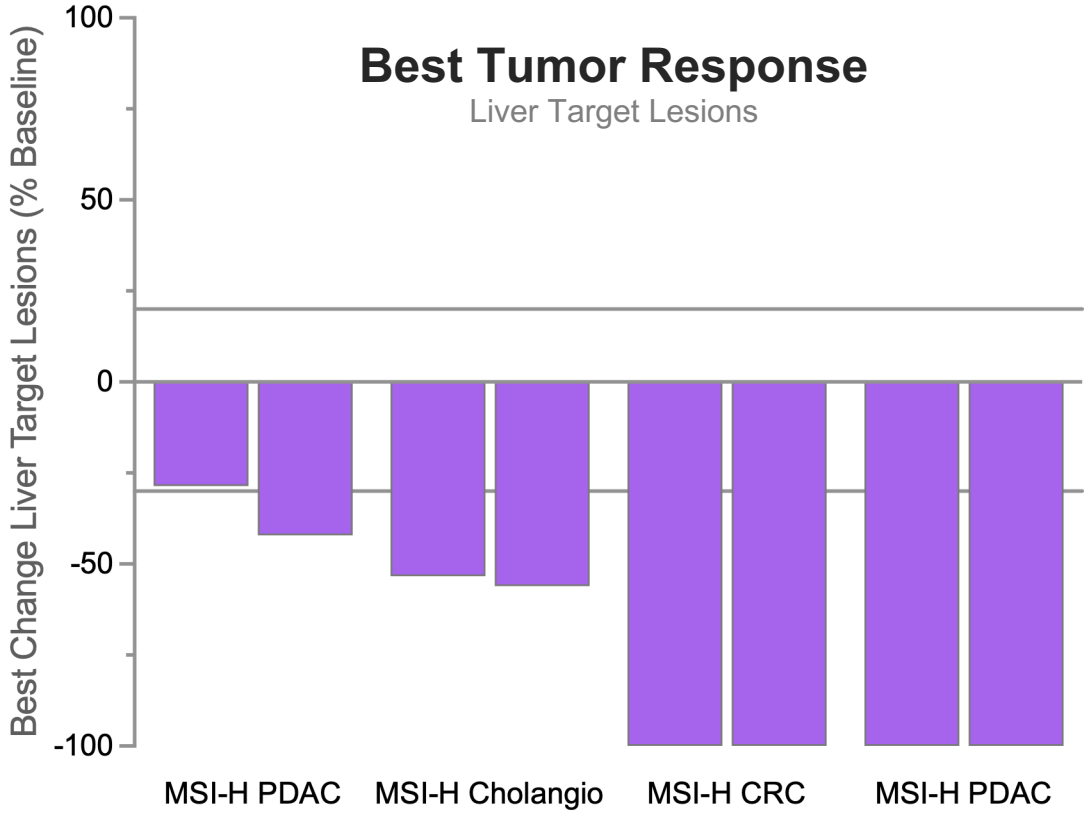


Pseudoprogression on monotherapy: initial enlargement of target and non-target lesions and appearance of new liver lesions, followed by tumor regression.

Society for Immunotherapy of Cancer sitc2026

*iPR on scan after 01-Sept-2026 efficacy cut

Regression of All Measurable Liver Lesions in Patients with GI Tumors Treated with MDNA11 Monotherapy



MSI-H PDAC

Initial increase (pseudoprogression) followed by iPR

BOR: iPR awaiting confirmation

MSI-H CHOLANGIOCARCINOMA

Regression of both hepatic target lesions

BOR: Confirmed PR

MSI-H CRC

Complete regression of hepatic target lesions

BOR: SD

MSI-H PDAC

Complete regression of hepatic target lesions

BOR: Confirmed PR

Consistent response of liver metastasis to MDNA11 monotherapy
Regression in 4/4 patients and 8/8 measurable liver targets

Society for Immunotherapy of Cancer
sitc2026

Four GI MSI-H patients with measurable liver target lesions. Liver-lesion regression and BOR are separate assessments. iPR (MSI-H PDAC) was reached after data cutoff.

Antitumor Activity with MDNA11 ± Pembrolizumab in ICI-refractory Cutaneous Melanoma

Monotherapy

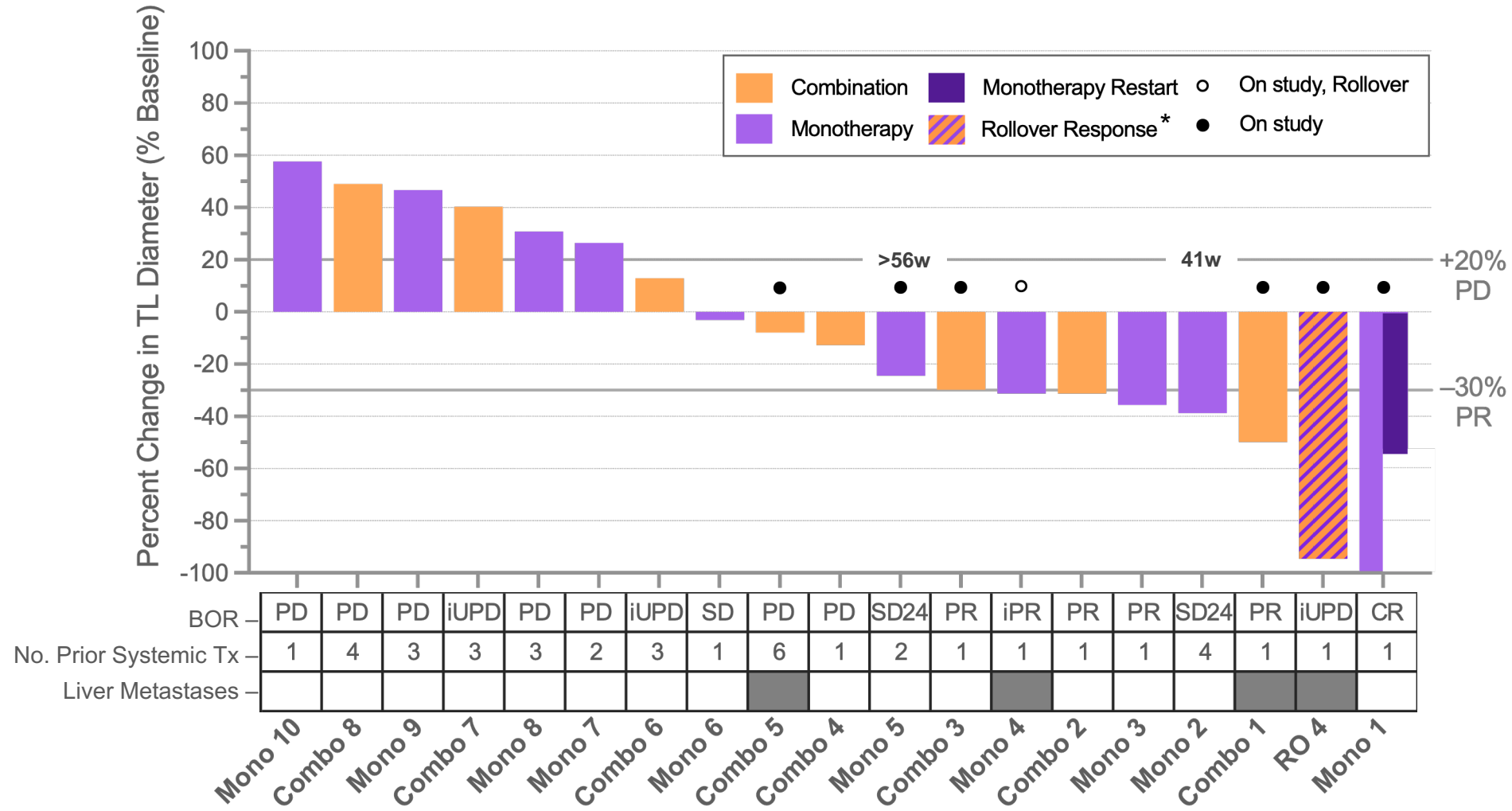
Secondary ICI Resistance
n=10

ORR = 30% (95% CI 6.7–65.2)
DCR = 60% (95% CI 26.2–87.8)

Combination

Primary ICI Resistance
n=8

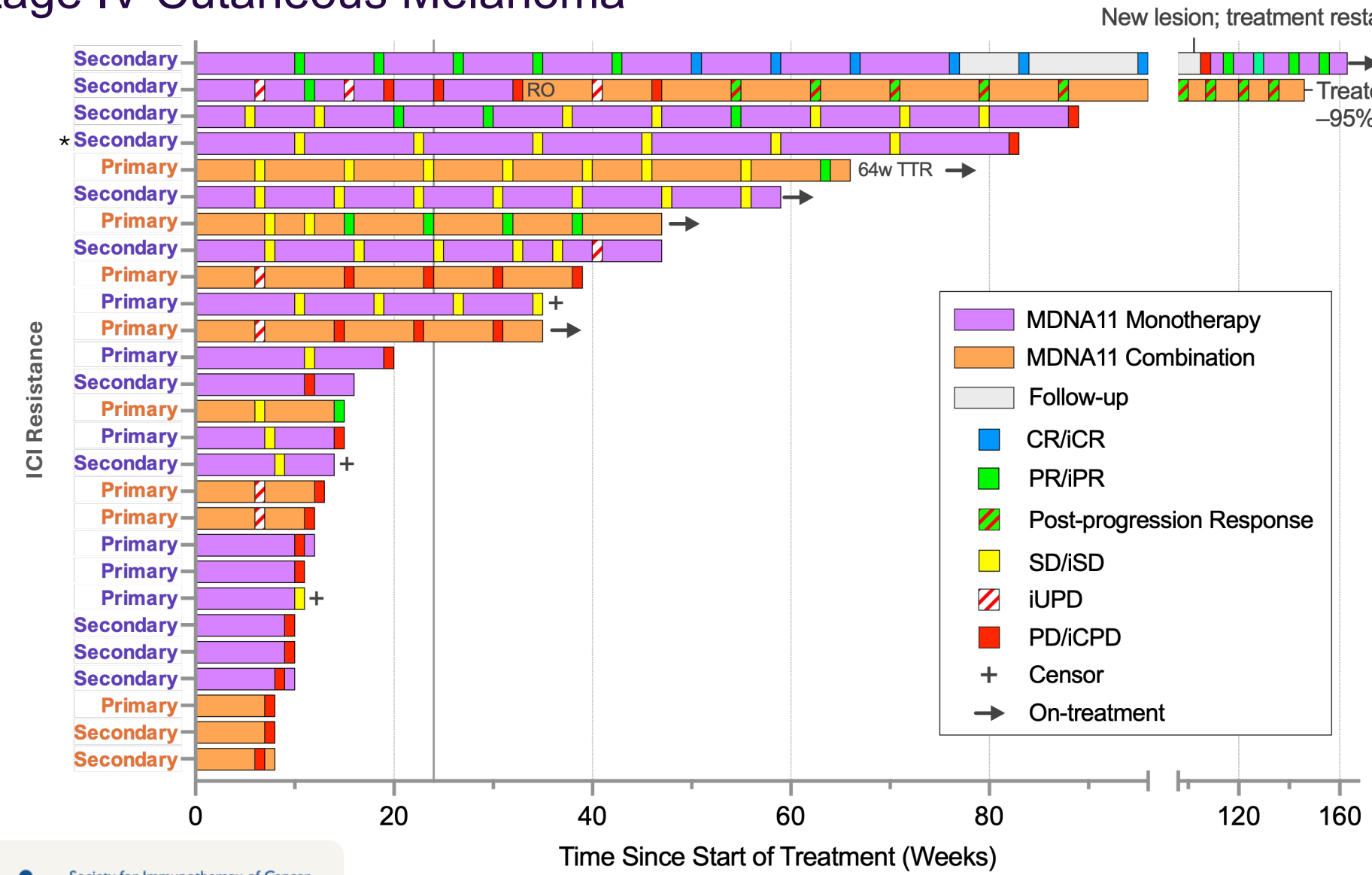
ORR = 38% (95% CI 8.5–75.5)
DCR = 38% (95% CI 8.5–75.5)



Society for Immunotherapy of Cancer
sitc2026

*Following a **confirmed CR (DOR 98 weeks)**, new lesions appeared after 33 weeks off treatment. MDNA11 monotherapy was restarted, resulting in a **confirmed PR (DOR 38 weeks; response ongoing).**

Durable Responses with MDNA11 ± Pembrolizumab in ICI-refractory Stage IV Cutaneous Melanoma



All BEDR

Monotherapy
n=16

Combination
n=10

Median DOR:
68 Weeks
(23–98 weeks)
3 responses ongoing

Society for Immunotherapy of Cancer
sitc2026

*Intrapatient dose-escalation, not in BEDR total

Regression of Liver Metastases Extends Beyond GI Tumors; **Cutaneous Melanoma** with Primary Ipilimumab/Nivolumab Resistance

Stage IVM1c Cutaneous Melanoma

131 mm Target Lesion SOD

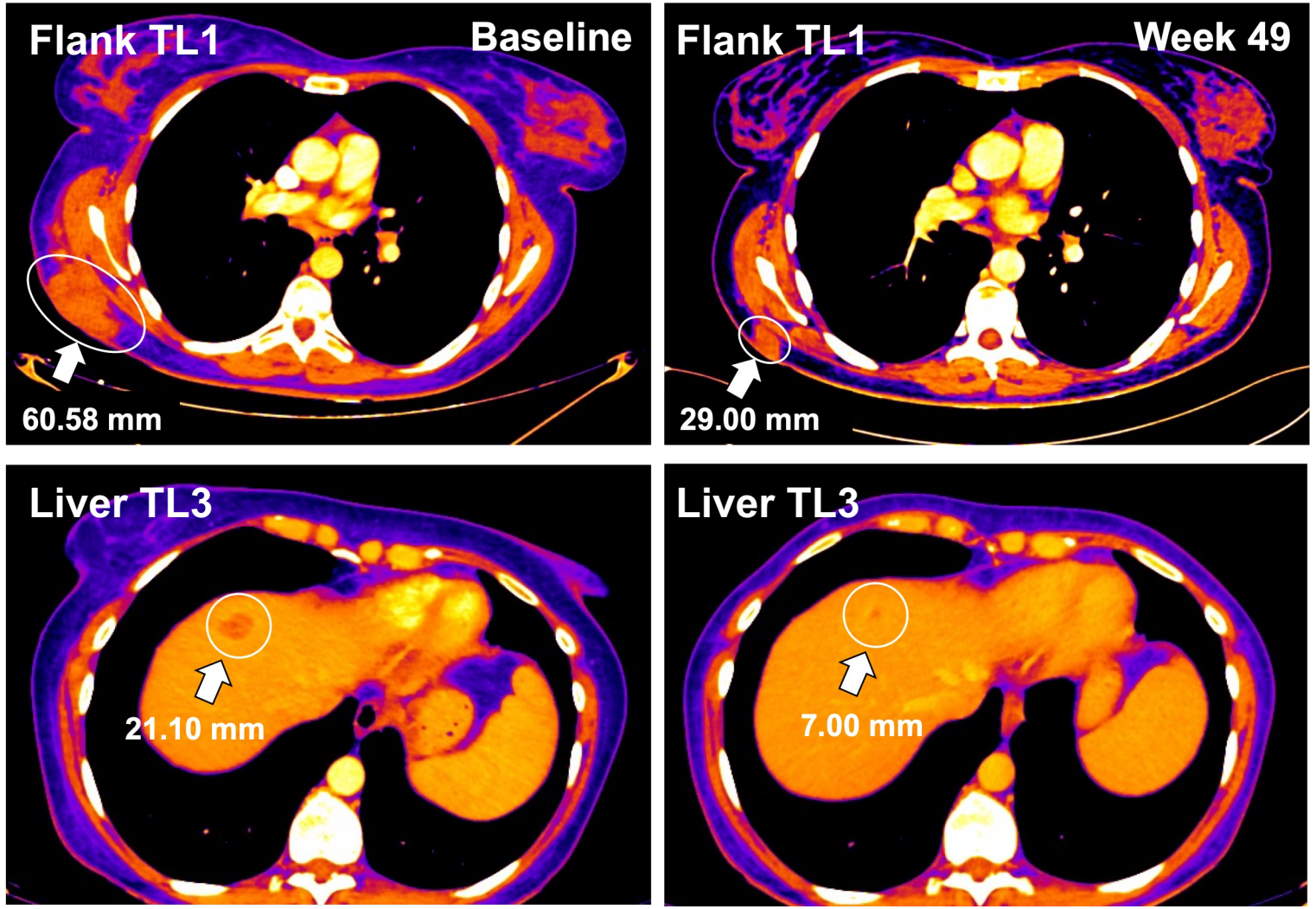
1L Ipilimumab + Nivolumab (**PD**)
06-2025 → 07-2025

2L **MDNA11 + Pembrolizumab (PR)**
10-2025 → ONGOING

Confirmed PR

PFS >49 weeks | DOR >33 weeks | DOT >49 weeks

−55%
Overall target-lesion change



Society for Immunotherapy of Cancer
sitc2026

Key Takeaways

Manageable safety and selective immune activation

- No DLTs through 120 µg/kg with monotherapy and combination therapy
- Expansion of key T-cell populations, including central and effector memory CD8+ T cells, stem-like TCF1+ CD8+ T cells, and activated CD25+ T cells

Durable activity in biomarker-enriched GI tumors with a combined ORR of 40%

- ORR* of 36% with MDNA11 monotherapy and 44% with MDNA11 + pembrolizumab (versus 11-13% with select post-ICI benchmarks)
- Responses occurred after prior ICI progression

Deep regression of liver metastases

- All 8 measurable liver targets regressed across 4 MSI-H GI patients
- Additional responses in liver metastases observed in cutaneous melanoma

Durable responses with MDNA11 ± pembrolizumab in ICI-refractory cutaneous melanoma

- ORR* 30% with MDNA11 monotherapy in secondary ICI-resistant tumors
- ORR* 38% with MDNA11 + pembrolizumab in primary ICI-resistant tumors

These findings support further development of MDNA11-based regimens in ICI-refractory MSI-H or TMB-H GI cancers, and ICI-refractory cutaneous melanoma

Society for Immunotherapy of Cancer
sitc2026

*ORR includes unconfirmed responses.
Rollover excluded from ORR calculation.

Acknowledgements

Zdenka Segota, MD
Warren Brenner, MD
Boca Raton Regional Hospital

Sajeeve Thomas, MD
Orlando Health (formerly)

Jacqueline Brown, MD
Emory Winship Cancer Institute

Przemyslaw W. Twardowski, MD
Kim A. Margolin, MD
Saint John's Cancer Institute

Ira Winer, MD
Wasif Saif, MD
Karmanos Cancer Institute

Igor Medic, MD
Sharp Healthcare

Philippe Bedard, MD
Princess Margaret Hospital

Victoria Atkinson, MBBS, FRACP
Gallipoli Medical Research Foundation

Charlotte Lemech, MD
Scientia Clinical Research

John Park, MD
Macquarie University

Jim Coward, MD
ICON Cancer Centre

Hong Shue, MD
University of Sunshine Coast

Luis Cabezón-Gutiérrez, MD
Hospital Universitario de Torrejón

Pablo Gajate, MD
Ainara Soria-Rivas, MD
Hospital Universitario Ramón y Cajal

Cinta Hierro Carbó, MD MSc PhD
Maria Ochoa de Olza Amat, MD
Catalan Institute of Oncology (ICO)-Badalona

Tatiana Hernandez-Guerrero, MD
START – Barcelona

Victor Moreno, MD
START – Madrid, FJD

Irene Moreno, MD
START – Madrid, CIOCC

André Mansinho, MD
START – Lisbon

Sara Coelho, MD
Instituto Português de Oncologia do Porto

Austin Duffy, MD
START – Dublin

Dr. med. Dr. sc. med. Egle Ramelyte
Universitätsspital Zürich

Keun-Wook Lee, MD, PhD
Seoul National University Bundang Hospital

Do-Youn Oh, MD, PhD
Seoul National University Hospital

Seung Tae Kim, MD, PhD
Samsung Medical Center

Hussein A. Tawbi, MD, PhD
MD Anderson Cancer Center

Nageatte Ibrahim, MD
Arash Yavari, MB BS, DPhil
Fahar Merchant, PhD
William Gwynne, PhD
Minh To, PhD
Melissa Coello, BSc
Nina Merchant, MESc
Medicenna Therapeutics

Amy Prawira, MD
Marc Oliva, MD
Medical Monitors – Obatica Pty Ltd

.....And most of all, to the patients & their families

Study Funding: Medicenna Therapeutics
NCT: 05086692

Contact: Paolo A. Ascierto, MD at *p.ascierto@istitutotumori.na.it*

Society for Immunotherapy of Cancer
sitc2026