**EGFR-mutated pulmonary adenocarcinoma with concurrent PIK3CA mutation, and with acquired RET fusion and EGFR T790M mutation after afatinib therapy**

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Generically, receptor tyrosine kinase (RTK) fusions are mutually exclusive of epidermal growth factor receptor (EGFR) mutations in non-small cell lung cancer (NSCLC). However, RTK fusions have recently emerged as mechanisms of actionable resistance to EGFR–tyrosine kinase inhibitors (TKIs) in EGFR-mutated NSCLC [1]. More than half of the acquired RET fusions following EGFR-TKI therapy occur in response to osimertinib (third-generation) treatment. To the best of our knowledge, only one case of NSCLC with acquired RET fusion following afatinib (second-generation) therapy has been reported in the English literature. Phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutations are found infrequently (approximately 7%) in pulmonary adenocarcinoma [2]. Although other oncogenic driver mutations in NSCLC are mutually exclusive, PIK3CA mutations frequently coexist with other mutations [2,3]. Here, we report a rare case of EGFR-mutated pulmonary adenocarcinoma with concurrent PIK3CA mutation, displaying acquired RET fusion and EGFR T790M mutation following afatinib therapy.

**CASE REPORT**

A 64-year-old man without a known underlying disease was transferred with dyspnea and pleural effusion. He was a smoker with a 30 pack-year history. The clinical course is shown in Fig. 1. The cytological examination of the pleural fluid confirmed the diagnosis as metastatic adenocarcinoma of the lung (Fig. 1A). Chest computed tomography (CT) (Fig. 2A) suggested lung malignancy with pleural and lymph node metastases. Positron emission tomography showed a 3-cm-sized hypermetabolic mass in the right upper lobe of the lung, and the size of the lung mass and amount of pleural fluid were found to be decreased on chest CT after 3 months (Fig. 2B). However, the disease was stable for 6 months, and next-generation sequencing (NGS) was performed on the previous needle biopsy specimen of the lung on an Ion Torrent S5 sequencer (Thermo Fisher Scientific, Waltham, MA, USA) using a commercially available targeted gene panel (Oncomine Comprehensive Assay v3, Thermo Fisher Scientific). The NGS results showed exon 19 deletion. The patient received afatinib treatment, and as a result, the disease was stable for 6 months, and next-generation sequencing (NGS) was performed on the previous needle biopsy specimen of the lung on an Ion Torrent S5 sequencer (Thermo Fisher Scientific, Waltham, MA, USA) using a commercially available targeted gene panel (Oncomine Comprehensive Assay v3, Thermo Fisher Scientific). The NGS results showed exon 19 deletion of EGFR and PIK3CA G118D mutation. The disease progressed in 7.5 months (Fig. 2C) and afatinib had to be discontinued. Video-assisted thoracoscopic wedge resection was performed on the right upper lobe of the lung and after a tumor heterogeneity with solid and cribriform components (Fig. 1C), and acinar and papillary components (Fig. 1D). A second EGFR mutation test showed T790M
mutation and exon 19 deletion. The patient was prescribed with osimertinib, but the disease progressed in 3 months (Fig. 2D). Needle biopsy of the right axillary lymph node was performed for further molecular evaluation of the cancer. Metastatic adenocarcinoma with a solid and cribriform pattern was observed in the lymph node (Fig. 1E). The third EGFR mutation test showed exon 19 deletion but not T790M mutation. The second NGS test on axillary lymph node specimens revealed a new CCDC6-RET fusion in addition to exon 19 deletion of EGFR and PIK3CA G118D mutation. Additionally, a third NGS test was performed on the wedge resection specimen (second biopsy), which showed CCDC6-RET fusion with T790M mutation and exon 19 deletion of EGFR and PIK3CA G118D.

**DISCUSSION**

Viola et al. analyzed 86 cases of RTK fusions as acquired resistance in EGFR-mutated NSCLC [1]. The acquired RTK fusions occurred most frequently (57%) after the third generation EGFR-TKI therapy (first, 24%; second, 12%). The most frequently reported acquired RTK fusion in EGFR-TKI–resistant NSCLC was RET fusion, whereas CCDC6-RET fusion was the most common variant. Combined EGFR and RET inhibition with osimertinib and BLU-667 may be an effective therapeutic strategy in EGFR-TKI–resistant NSCLC with acquired RTK fusion [4]. The concurrent PIK3CA mutation is a known poor prognostic and predictive marker for EGFR-TKI therapy in pulmonary adenocarcinomas [2]. CCDC6-RET fusion and PIK3CA G118D mutation are not the most common variants in NSCLC with a single oncogenic driver mutation [1, 5, 6].

In this case, considering the third NGS result, the CCDC6-RET fusion probably occurred with EGFR T790M mutation after afatinib treatment. In lung wedge specimens resected after afatinib treatment, we observed tumor heterogeneity (Fig. 1C, D). We could not confirm which tumor population had CCDC6-RET fusion or EGFR T790M mutation or both. Considering morphological features (Fig. 1C, E), we assumed that tumor population with solid and cribriform patterns (Fig. 1C) had CCDC6-RET fusion.

In conclusion, we report a rare case of EGFR-mutated pul-
Acquired RET fusion after EGFR-TKI therapy

A pulmonary adenocarcinoma with concurrent PIK3CA mutation, and acquired RET fusion and EGFR T790M mutation after EGFR-TKI therapy. Since NSCLC has a number of well-known oncogenic driver mutations, we believe that NGS is currently one of the best methods to determine the treatment of NSCLC, especially adenocarcinoma.

**Ethics Statement**
This study was approved by the Institutional Review Board of Gyeongsang National University Hospital, and informed consent was waived (IRB No. GNUH 2020-08-005).

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**Conflicts of Interest**
The authors declare that they have no potential conflicts of interest.

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**Fig. 2.** Chest computed tomography. (A) Lung mass (arrow) in right upper lobe with pleural fluid (arrowhead) at diagnosis. (B) Decreased size of lung mass (arrow) and amount of pleural fluid (arrowhead) after 3 months of afatinib therapy. (C) Increased amount of pleural fluid (arrow) after 7.5 months with afatinib therapy. (D) Increased size of axillary (arrow) and mediastinal (arrowhead) lymph nodes after 3 months with osimertinib therapy.
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