PERCHERON THERAPEUTICS CORPORATE PRESENTATION

Melbourne, Australia – 18 February 2026: Percheron Therapeutics Limited (ASX: PER) ('the Company'), an international biotechnology company focused on the development of novel therapies for oncology and rare diseases, is pleased to provide shareholders with a copy of an updated non-confidential corporate presentation. The presentation will be delivered by CEO Dr James Garner at Emergence 2026 Investment Conference to be held today at the Four Seasons Hotel Sydney.

The attached presentation supersedes the corporate presentation released to the market on 5 November 2025 and includes expanded information on the Company's lead program, HMBD-002, together with an updated overview of the Company's financial position following the release of its latest Quarterly Activities report and Appendix 4C.

~ ENDS ~

About Percheron Therapeutics Limited

Percheron Therapeutics Limited [ASX: PER | US OTC: PERCF] is a publicly listed biotechnology company focused on the development and commercialisation of novel therapies for oncology and rare diseases. The company's lead program is HMBD-002, a monoclonal antibody targeting the immune checkpoint regulator, VISTA. HMBD-002 has completed a phase I clinical trial in patients with advanced cancer, which has shown the drug to be generally safe and well-tolerated, and Percheron aims to commence further clinical trials in CY2026.

For more information, please contact info@PercheronTx.com.

This announcement has been authorized for release to the Australian Securities Exchange by the Board of Directors.

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Developing a Next Generation Immune Checkpoint Inhibitor for the Treatment of Patients with Cancer

Corporate Overview

February 2026

Forward-Looking Statements

This presentation contains **forward-looking statements** within the meaning of the safe-harbor provisions such as the Private Securities Litigation Reform Act of 1995. These statements do not relate strictly to historical or current facts and may be accompanied by words such as ‘could,’ ‘would,’ ‘may,’ ‘potentially,’ ‘suggest,’ ‘believes,’ ‘expects,’ ‘should,’ ‘intends,’ ‘plans,’ ‘forecasts,’ and similar words or expressions.

Such statements involve substantial risks and uncertainties, not all of which may be known at the time. All statements contained in this presentation, other than statements of historical fact, including without limitation statements regarding our strategy, research and development plans, collaborations, future operations, future financial position, future revenues, projected costs, pricing, prospects, plans, and objectives of management, are forward-looking statements. Not all forward-looking statements in this presentation are explicitly identified as such.

The Company does not warrant any of the forward-looking statements in this presentation, and investors are advised to interpret such statements in the context of other available sources of information and with the assistance of expert advisors as appropriate.

Many factors could cause the actual results of the Company to differ materially from the results expressed or implied herein, and you should not place undue reliance on the forward-looking statements. Drug development is inherently risky, and only a small proportion of research and development programs lead to a marketed product. Factors which could change the Company’s expected outcomes include, without limitation, our ability to: advance the development of our programs, and to do so within any timelines that may be indicated herein; the safety and efficacy of our drug development candidates; our ability to replicate experimental data; the ongoing validity of patents covering our drug development candidates, and our freedom to operate under third party intellectual property; our ability to obtain necessary regulatory approvals; our ability to enter into and maintain partnerships, collaborations, and other business relationships necessary to the progression of our drug development candidates; changes in the competitive landscape pertaining to our drug development candidates; the timely availability of necessary capital to pursue our business objectives; changes in the public policy environment in one or more countries in which we operate or may seek to operate which disfavour our business; our ability to attract and retain qualified personnel; changes from anticipated levels of customer acceptance of existing and new products and services; and other factors.

Although the Company believes that the expectations reflected in such forward-looking statements are reasonable, and although they reflect our current views as at the date of this presentation, there can therefore be no assurance that such expectations will prove to be correct. The Company has no obligation as a result of this presentation to pursue any specific strategy or plan outlined herein, or to deliver any specific outcome that may be implied or inferred.

Any forward-looking statements contained in this presentation speak only as of the date this presentation is made, and we expressly disclaim any obligation to update any forward-looking statements, whether because of new information, future events or otherwise, except as may be required by law.

Percheron is developing HMBD-002, a novel, mid-clinical-stage, immuno-oncology therapy with applicability to multiple forms of cancer and high combination potential

THE SCIENCE

Percheron is developing HMBD-002, a next generation immune checkpoint inhibitor, with the potential to treat many forms of cancer

- HMBD-002 targets VISTA, a novel immune checkpoint, similar in many respects to PD-1, the target of Keytruda® (pembrolizumab)
- Previous attempts to drug VISTA have been limited by toxicity; HMBD-002 is built on a different antibody scaffold, substantially reducing potential toxicity
- HMBD-002 has potential as a monotherapy, but also appears synergistic with other checkpoint inhibitors such as Keytruda®

THE COMPANY

Percheron is listed on the ASX (ASX: PER), with a market cap of ~$9 million, and cash at 31DEC25 of ~$4.5 million

- The company trades at a substantial discount to ASX-listed peers, following a corporate transformation during CY2025
- Enterprise value largely reflects acquisition cost of HMBD-002 (~$4.5 million), currently imputing no value to future positive data
- Percheron's cash reserves and low burn imply 3.7 quarters of funding

THE OPPORTUNITY

With phase 1 successfully completed in CY2025, Percheron aims to take HMBD-002 into an international phase 2 human trial in CY2026

- US-based phase 1 study, conducted under IND with US FDA, showed very favourable safety profile, both as monotherapy and in combination with Keytruda® (pembrolizumab)
- Adaptive, modular phase 2 study design can be launched with very modest cash resources and is designed to provide early validating read-outs
- Keytruda® patent expiry in 2028 creates substantial opportunity for novel immune checkpoint inhibitors to expand and extend US$ ~100 billion market

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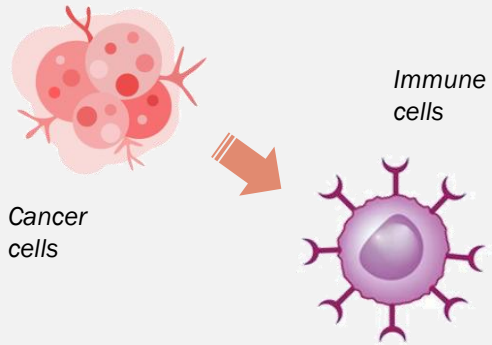
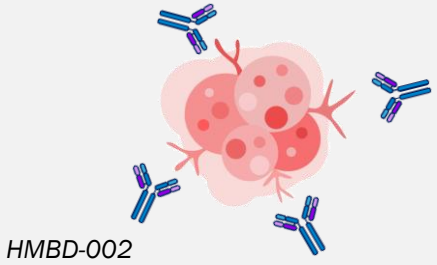
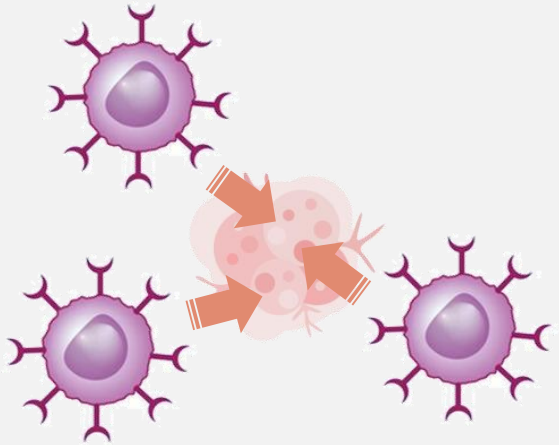
Immune checkpoint inhibitors such as HMBD-002 work by reactivating the body's immune response so that it can attack the tumour



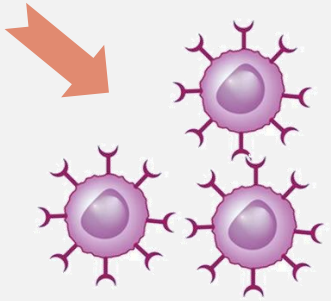
- Ordinarily, our immune system protects us against tumour cells in the same way that it protects against bacteria and viruses
- Growing tumours need to inhibit the patient's immune system to avoid being attacked by normal defences
- One of the ways tumours accomplish this is via 'immune checkpoints' such as PD-1 (the target of Keytruda®) and VISTA (the target of HMBD-002)



- Immune checkpoint inhibitors such as HMBD-002 block these inhibitory signals on the surface of the cancer cell
- A number of such immune checkpoint inhibitor drugs have been approved by FDA in recent years, including Keytruda®, Opdivo®, Tecentriq®, Yervoy® and others
- There are not yet any commercial VISTA inhibitors, partly because the target is relatively newly discovered



- Removal of the inhibitory signals allows the body's own immune system to attack the cancer cells
- The reinvigorated immune system can be potent in its own right, but can also work synergistically with other cancer treatments such as chemotherapy and radiotherapy
- In some cancers, inhibiting multiple immune checkpoints is more effective than just one (e.g. PD-1 and CTLA-4 in melanoma)



- In addition to making the cancer cells vulnerable to the immune system, VISTA inhibition helps to attract more immune cells into the 'tumour microenvironment,' potentially amplifying its effects by turning 'cold tumours' into 'hot tumours'
- In particular, VISTA inhibition appears to attract myeloid cells, which are less susceptible to other immune checkpoint inhibitors

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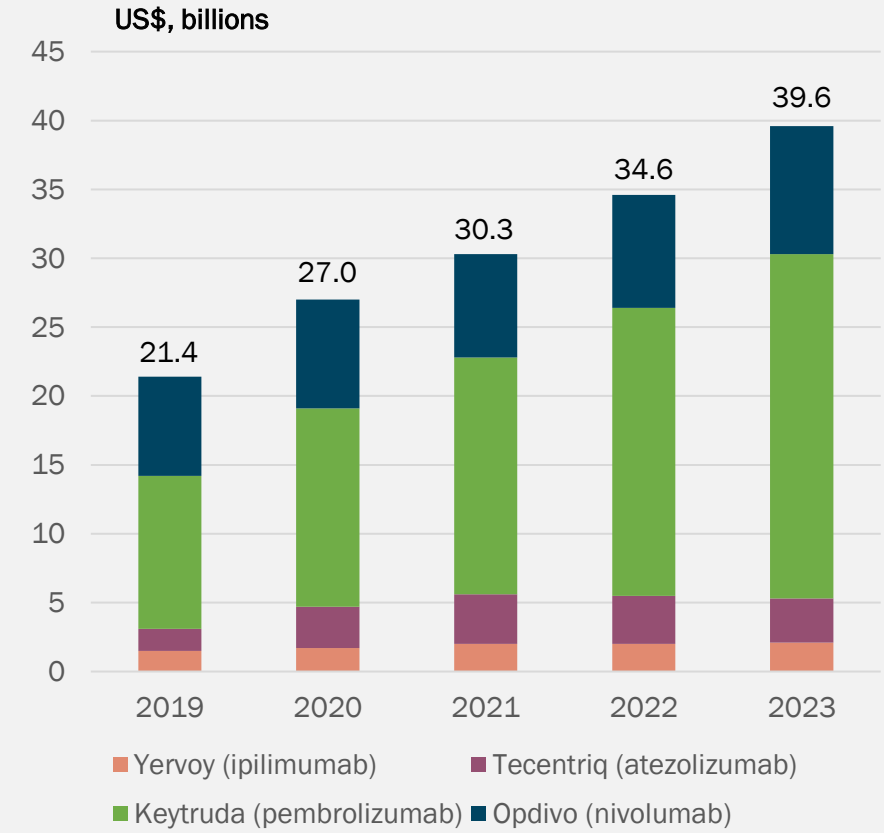
Immune checkpoint inhibitors have been one of the fastest growing classes of medicine in the immuno-oncology field, with more than US$ 40 billion in annual sales

Immuno-oncology therapies target the interaction between tumours and the immune system to enhance the immunological response to cancer

Immuno-oncology has grown to a ~US$ 40+ billion market



Source: Company filings

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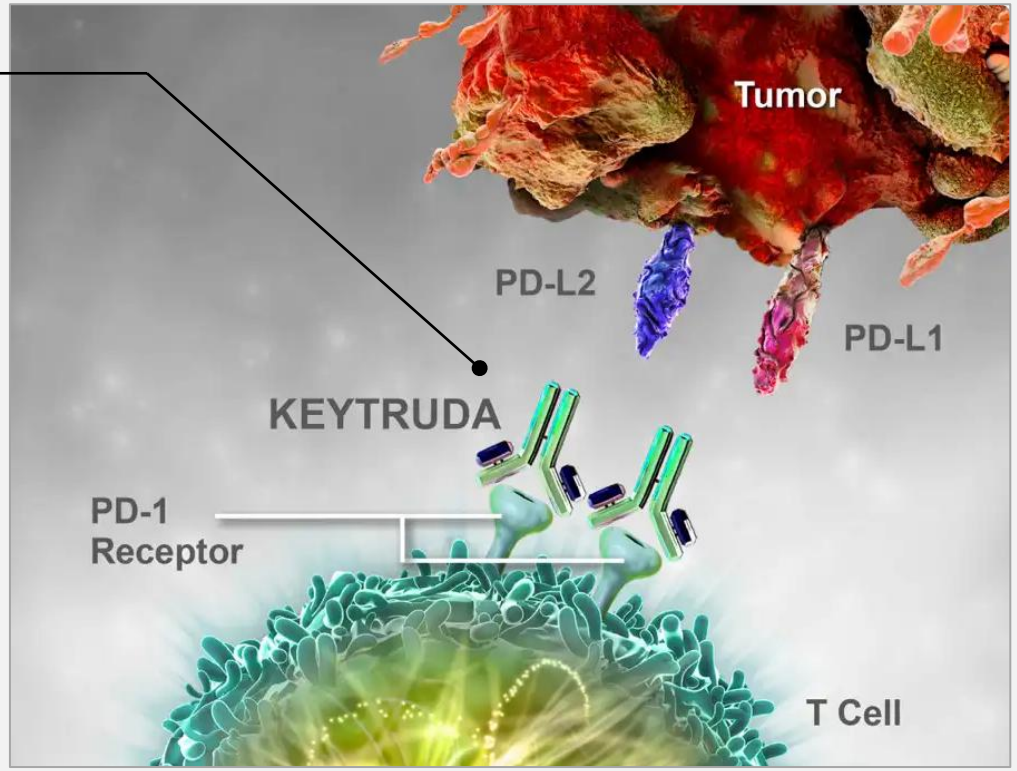
Keytruda® (pembrolizumab), one of the first-generation immune checkpoint inhibitors, has grown to become the largest cancer product in history

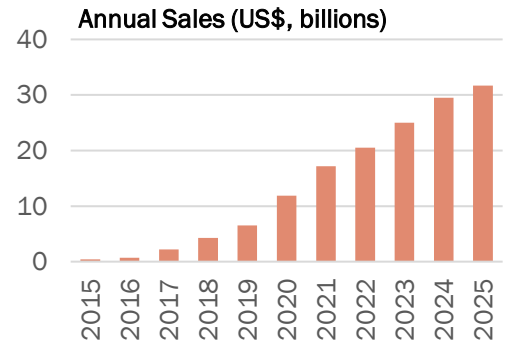
Like Percheron's HMBD-002, Keytruda works by blocking the immune checkpoint on immune cells, so that the tumour cannot 'deactivate' them



Since its first FDA approval in melanoma in 2014, Keytruda has gone on to secure approval in more than a dozen tumours

- Melanoma
- Non-Small Cell Lung Cancer
- Bladder Cancer
- Gastric Cancer
- Oesophageal Cancer
- Cervical Cancer
- Biliary Tract Cancer
- Cutaneous Squamous Cell Carcinoma
- Renal Cell Carcinoma
- Endometrial Carcinoma
- Triple-Negative Breast Cancer
- Merkel Cell Carcinoma
- High Tumour Mutational Burden Cancers (TMB-H)
- High Microsatellite Instability Cancers (MSI-High)

Keytruda has become the best-selling cancer medicine in history



Although a game-changer, most patients ultimately become unresponsive to Keytruda

~40% of melanoma patients never respond

~30% of responders eventually show disease relapse

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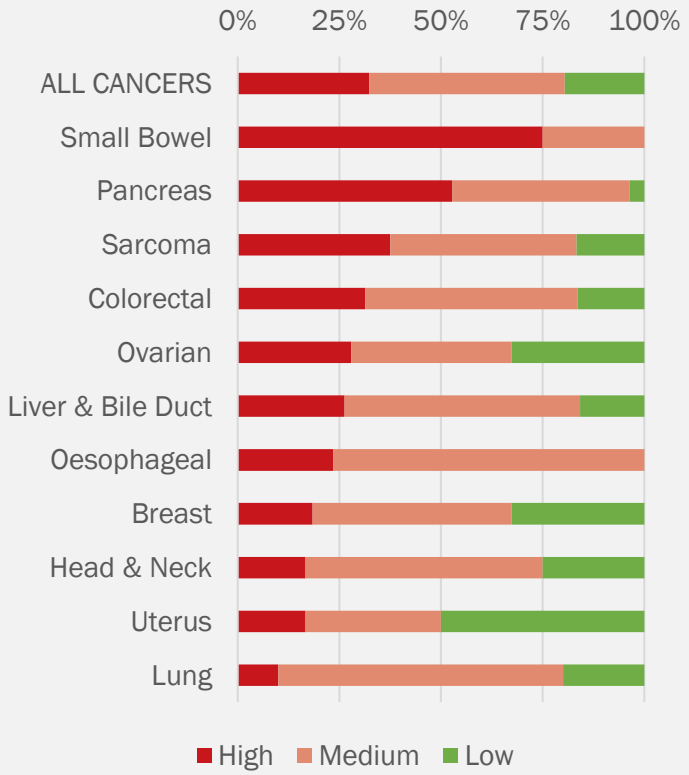
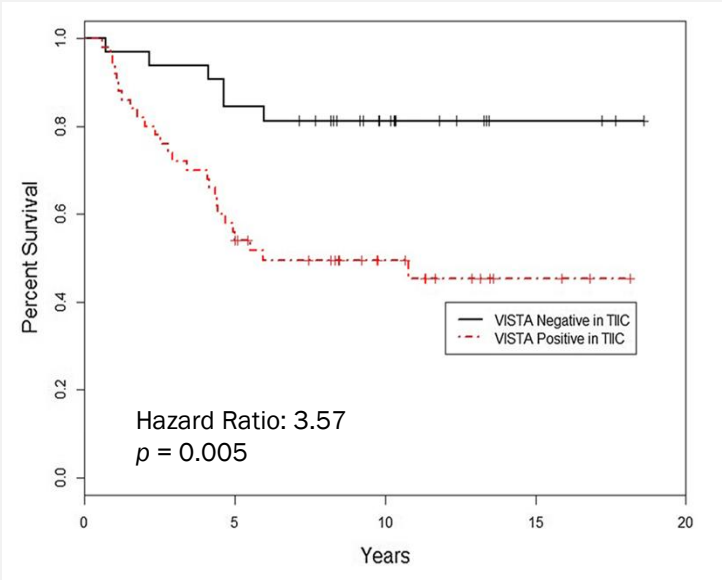
VISTA is a highly attractive target for novel oncology therapies, showing high expression on many tumours and clear correlation with prognosis

VISTA is expressed on a wide range of tumours



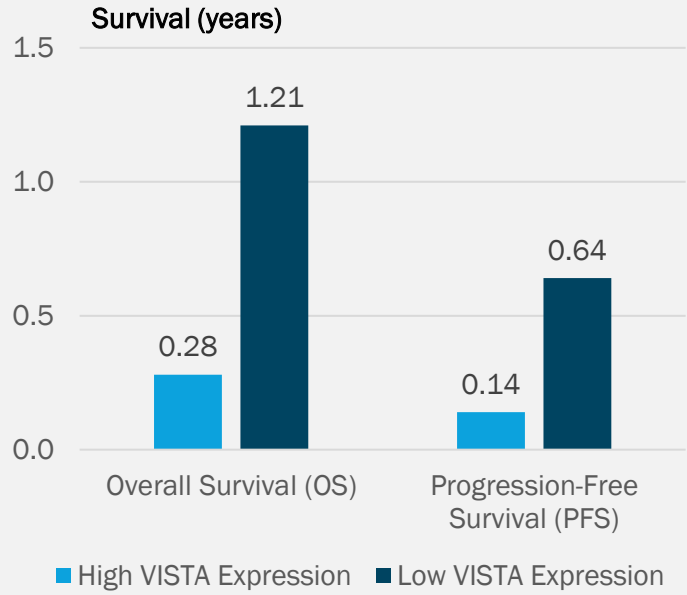
High expression of VISTA is associated with worse prognosis

Survival of 85 melanoma patients comparing those with VISTA positive tumour-infiltrating inflammatory cells (TIICs) and those with VISTA negative TIICs



High VISTA expression is associated with resistance to PD-1 inhibition

Survival of 16 pancreatic cancer patients, all treated with immunotherapy, comparing those with high and low VISTA expression



Sources: D Nishizaki et al. (2024) *ESMO Open* 9(4):102942 (panels 1 & 3); LF Kuklinski et al. (2018) *Cancer Immunol. Immunother.* 67:1113-1121 (panel 2)

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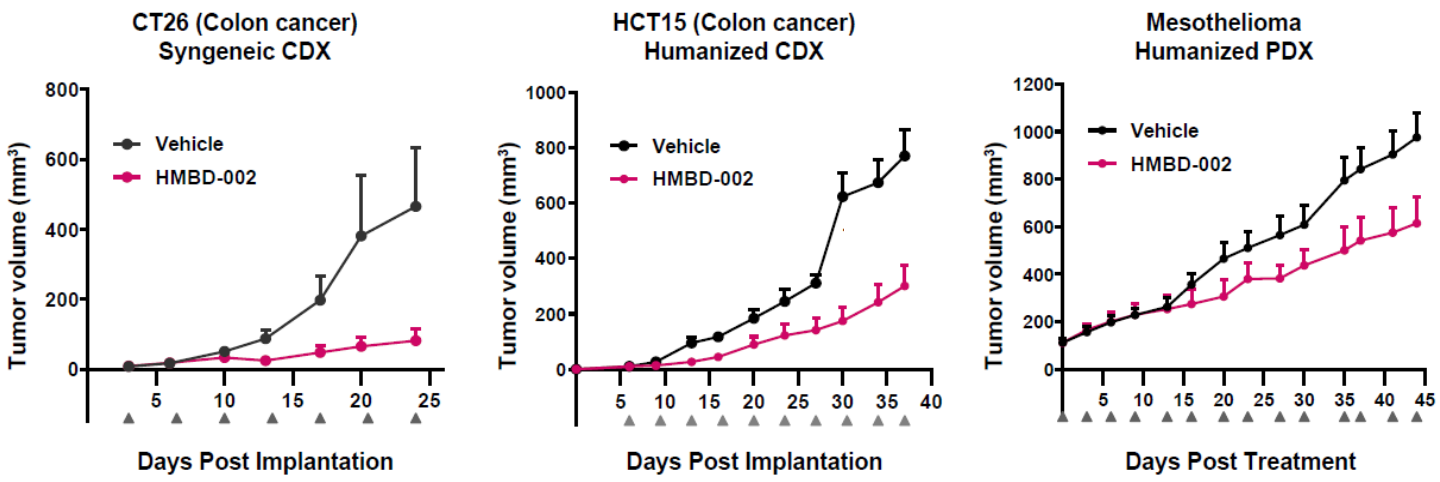
HMBD-002 has shown compelling evidence of activity in a range of preclinical tumour models, and is synergistic with PD-1 inhibition

Monotherapy administration yields up to 80% tumour growth inhibition, depending on tumour type

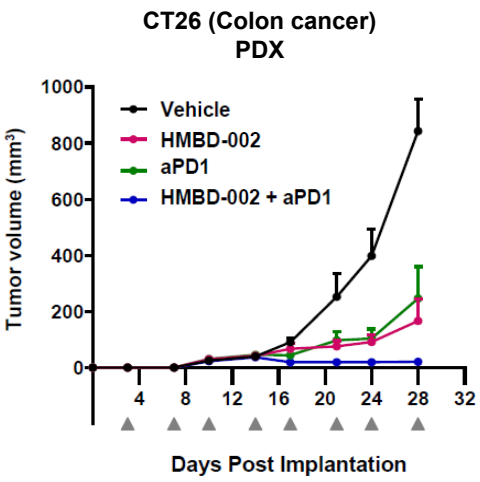


Tumour Growth Inhibition (TGI): ~84%

Tumour Growth Inhibition (TGI): ~65%

Tumour Growth Inhibition (TGI): ~40%

Combination with PD-1 inhibition provides substantial synergy



Tumour Growth Inhibition (TGI): ~94%

Source: B Dharmadhikari et al. (2022) *J Immunother. Cancer* 10(Suppl 2):A558-A558 (poster presentation to SITC 37th Annual Meeting)

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HMBD-002 is arguably the most advanced VISTA antibody in clinical development, and likely the only active member of the IgG4 class

Program	HMBD-002	CI-8993	JNJ-61610588	SNS-101	W0180
Company	Hummingbird Bioscience / percheron THERAPEUTICS	CURIS / ImmuNext	janssen	sensei BIO	Pierre Fabre
Isotype	IgG4	IgG1	IgG1	IgG1	IgG1
Stage	Phase I Complete	Phase I Complete	Phase I Terminated	Phase I Terminated	Phase I Terminated
Exposure to Date	48 patients	26 patients	12 patients	-	33 patients
Combination Data Available	Monotherapy & Combination with Pembrolizumab	Monotherapy	Monotherapy	Monotherapy & Combination with Cemiplimab	Monotherapy & Combination with Pembrolizumab
Status	**Ongoing**	Inactive	Discontinued	Discontinued	Discontinued
Notes				pH-sensitive antibody	

In general, IgG1 antibodies activate antibody-dependent cellular cytotoxicity (ADCC), recruiting immune cells such as natural killer (NK) cells to destroy the target.

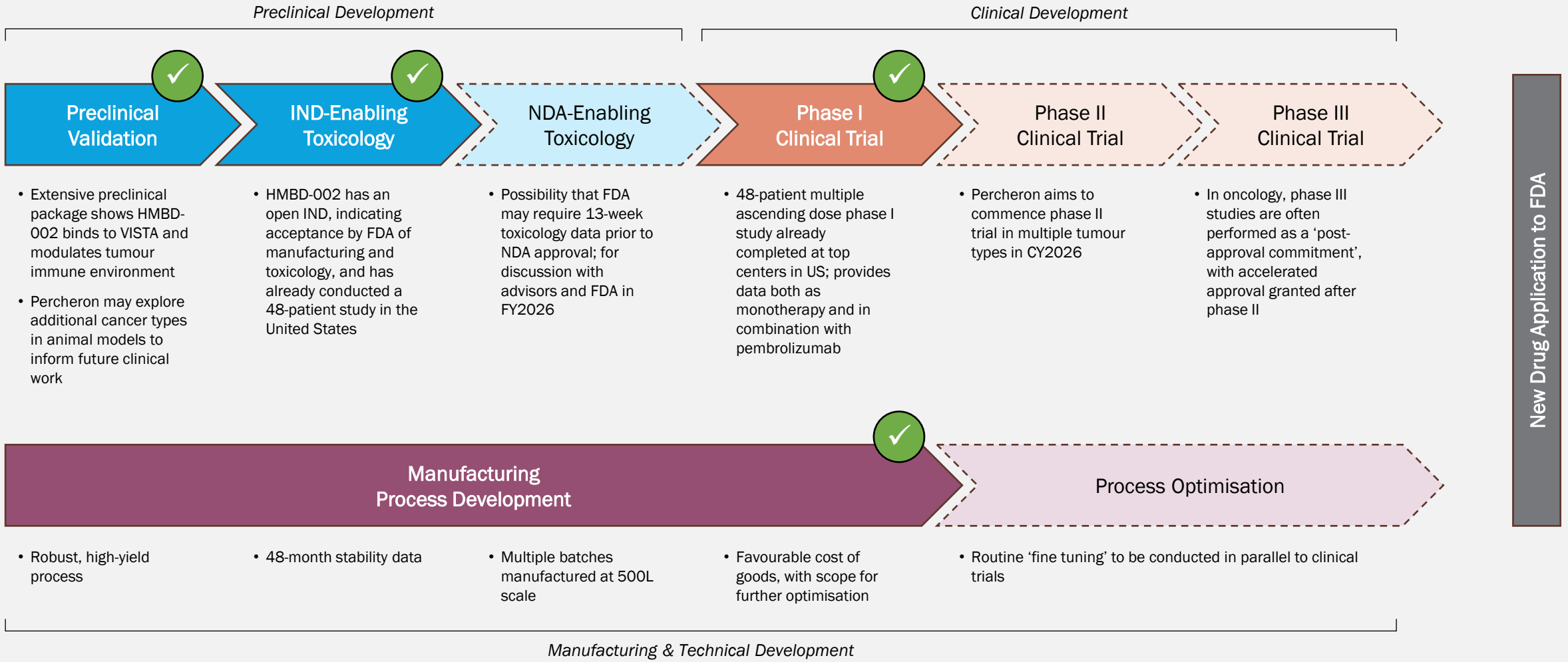
This can be a very effective approach in cancer, but can also lead to significant toxicity, including cytokine release syndrome (CRS).

Expert feedback indicates that the key challenge with other VISTA antibodies, which are almost exclusively IgG1, is that they have often proven toxic in clinical trials.

HMBD-002 is an IgG4 antibody, so it blocks VISTA signalling, but does not necessarily destroy VISTA-positive cells. This is likely to make it significantly less toxic in clinical use.

Sources: Company filings; Clinicaltrials.gov

HMBD-002 is well-advanced in clinical development, with a clear path towards commercialisation

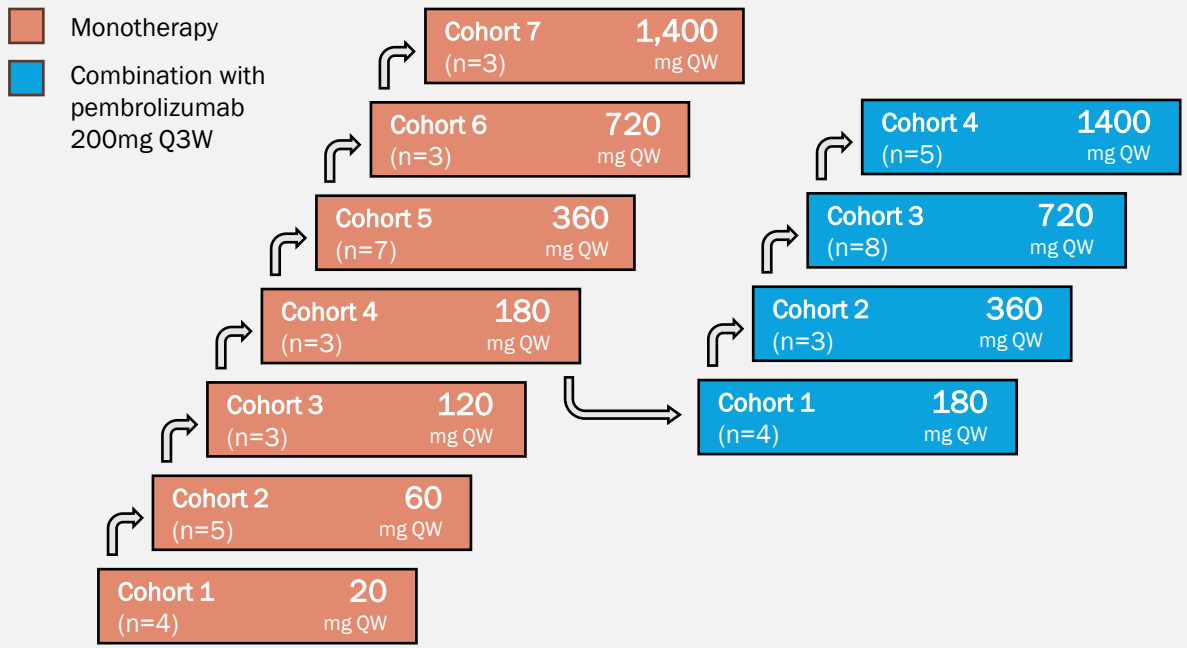


The HMBD-002 phase I study adopted a standard '3+3' design, with an initial monotherapy group (*n*=28) followed by a pembrolizumab combination group (*n*=20)

Patient Population & Study Design

- Advanced cancer patients with no available treatment options known to confer clinical benefit
- ECOG performance status ≤ 1
- 3+3 dose escalation design, with a 21-day observation period for dose limiting toxicities
- HMBD-002 administered weekly via 60-minute iv infusion
- 28 patients on monotherapy and 20 patients in combination with pembrolizumab

Dose Escalation



City of Hope
Cedars Sinai
Stanford Cancer Institute
Yale Cancer Center
A Comprehensive Cancer Center Designated by the National Cancer Institute
UT Southwestern Medical Center
The University of Texas MD Anderson Cancer Center
Making Cancer History®

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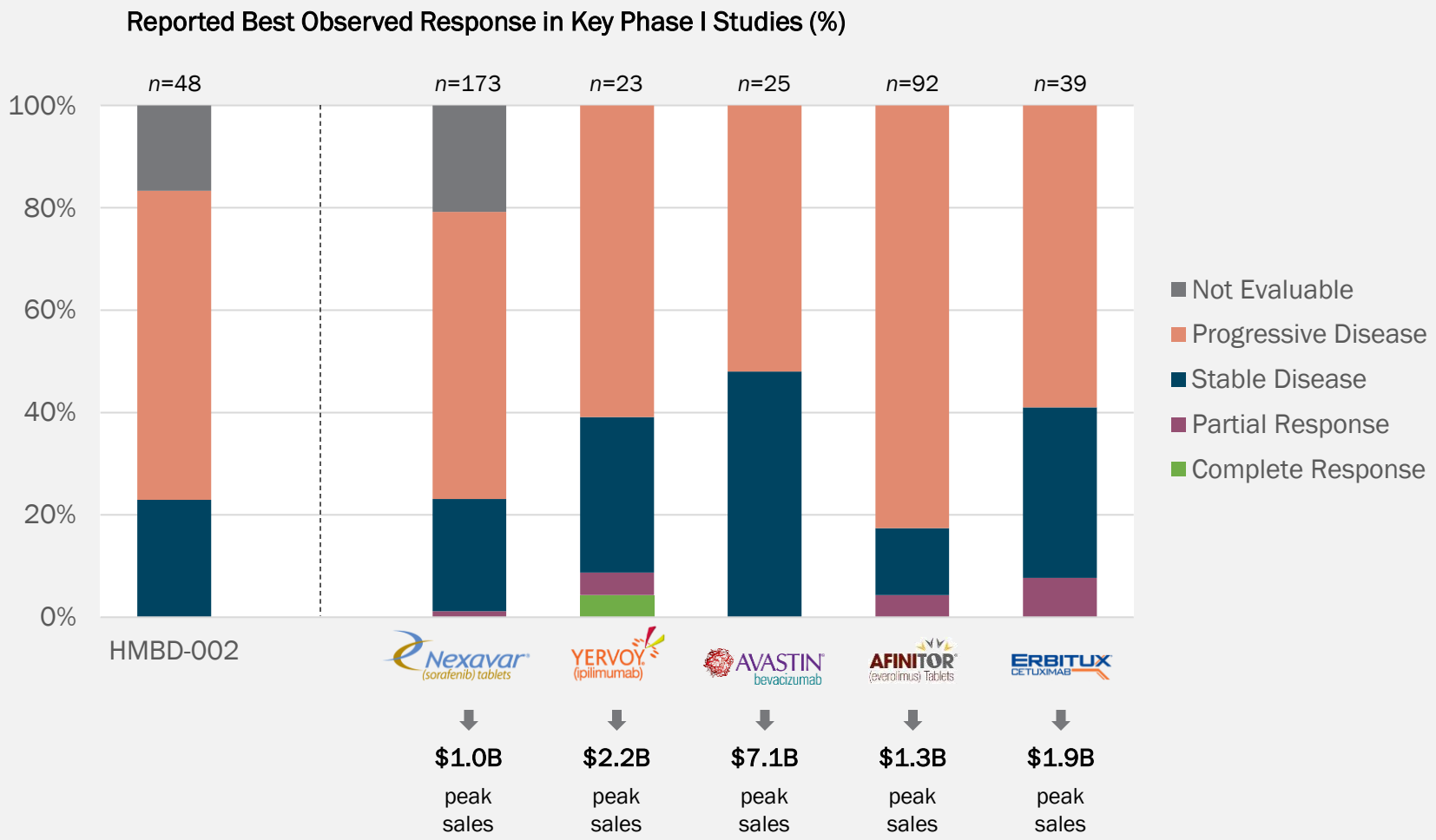
Overall response rates such as were seen in this study are common for targeted and cytostatic therapies



Commentary

- Many targeted therapies have shown similar response profiles in early-phase studies, and some have gone on to become blockbuster commercial products.
- There are several reasons why ORR in phase I sometimes primarily demonstrates a stabilisation effect:
  1. Phase I studies are typically performed in very advanced patients, who may be resistant to almost any therapeutic intervention.
  2. ORR can be a reasonable measure of cytotoxicity and is therefore more useful in the context of cytotoxic chemotherapy, but it often performs less well when measuring the primarily cytostatic effects of targeted therapies.
  3. Immunotherapies in particular can take longer to show benefit, whereas ORR is typically a relatively early-focused measure.

Sources: D Strumberg et al. (2007) *Oncologist* 12(4):426-437; MS Gordon et al. (2001) *J Clin Oncol.* 19(3); A O'Donnell et al. (2008) *J Clin Oncol.* 26(10); JS Weber et al. (2008) *J Clin Oncol.* 26(36); PM Fracasso et al. (2007) *Clin Cancer Res* 13(3):986-993; company and analyst reports

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A number of patients in the study showed evidence of clinical benefit, providing a positive signal of potential future efficacy

Patient	Diagnosis	Time Since Diagnosis	Prior Lines of Therapy	Treatment Group	Maximum Tumour Reduction	Time on Therapy
27M	Metastatic dedifferentiated liposarcoma	5.1 years	3	360mg Monotherapy	↓ 17.2%	53 weeks
67F	Metastatic triple-negative breast cancer	2.8 years	3	360mg Monotherapy	↓ 6.2%	26 weeks
49M	Metastatic non-small-cell lung cancer	2.5 years	5	360mg Combination	↓ 1.1%	30 weeks
45F	Metastatic triple-negative breast cancer	2.7 years	5	720mg Combination	↓ 26.9%	5 weeks
59M	Metastatic squamous cell carcinoma of the head & neck	2.9 years	4	720mg Combination	↓ 13.2%	15 weeks

Patients in the study were very late-stage and heavily pre-treated

Tumour shrinkage and prolonged periods of stable disease are positive markers of potential future efficacy

The phase II study will commence in one tumour type, but will have the ability to expand to additional tumour types at the company's discretion

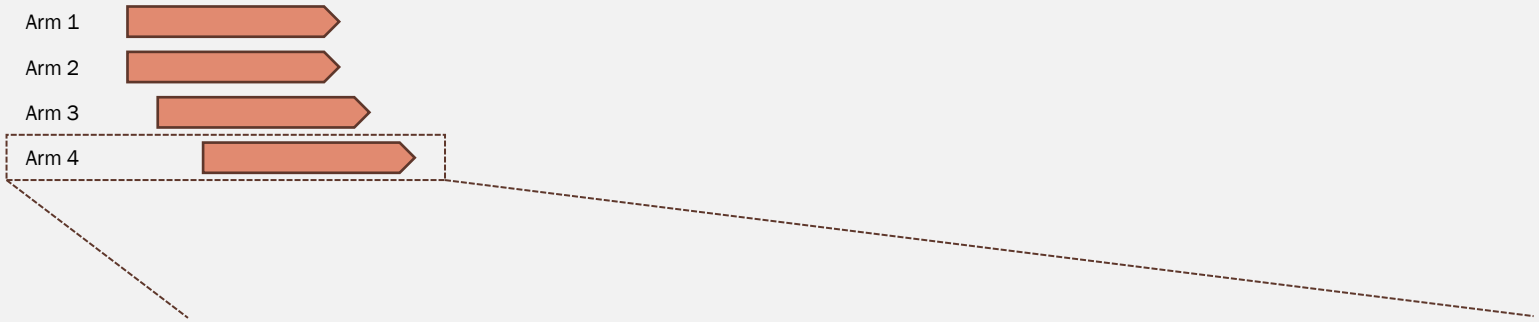
1. Each arm resembles a standalone study in a specific patient population

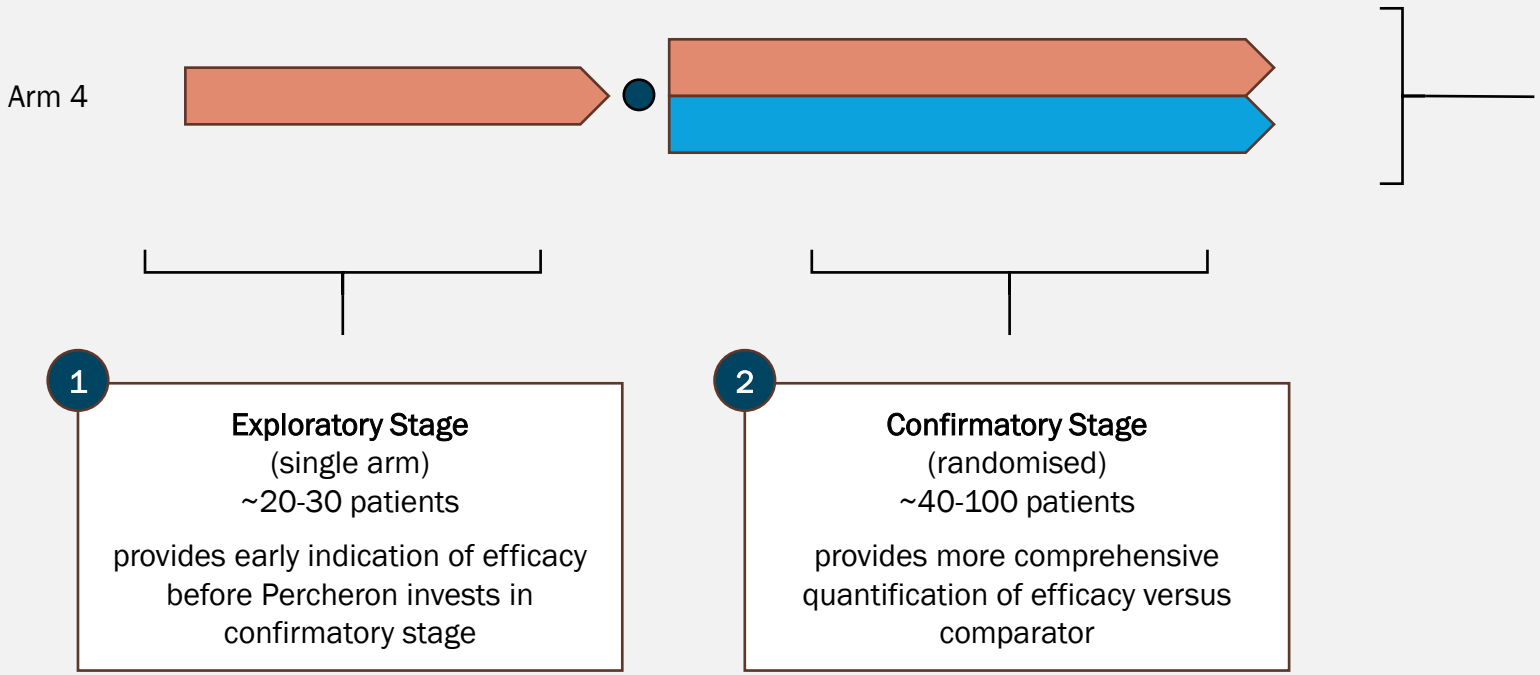
2. Combining the arms into a single study achieves very substantial efficiencies and economies of scale

3. Arms may start and finish at different times, allowing substantial operational flexibility

4. Results of each arm are delivered as they emerge, independently of the other arms

Each arm will potentially have two stages, allowing for an early read-out of activity before investing in confirmatory data





1 **Exploratory Stage**
(single arm)
~20-30 patients

provides early indication of efficacy before Percheron invests in confirmatory stage

2 **Confirmatory Stage**
(randomised)
~40-100 patients

provides more comprehensive quantification of efficacy versus comparator

3 Decision to 'graduate' from exploratory to confirmatory stage is under company's control and may take many inputs into consideration

4 Not all arms will graduate – the study is designed to select only the most promising patient populations

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Four patient groups have been identified as high priority targets, with selection of the first arm anticipated in Q2 CY2026

Triple-Negative Breast Cancer (TNBC)	EGFR-Mutant Non-Small Cell Lung Cancer (NSCLC)	HER2-Negative Oesophageal Adenocarcinoma	Endometrial Cancer
~36,000 patients per annum in United States	**~15,000 patients** per annum in United States	**~10,000 patients** per annum in United States	**up to ~65,000 patients** per annum in United States*
• TNBC lacks surface receptors for estrogen, progesterone, or HER2, which are common targets for therapies, making it very resistant to drug treatment • TNBC disproportionately affects younger women • Pembrolizumab provides only marginal survival benefit	• EGFR-mutant NSCLC is driven by a mutation in a growth signaling pathway • It is more common in women, non-smokers, and Asian patients • EGFR-mutant NSCLC is relatively less responsive to immunotherapy such as pembrolizumab	• Adenocarcinoma is the most common form of oesophageal cancer in the Western world • HER2-negative disease is generally unresponsive to trastuzumab, a common therapy used in HER2-positive cases	• Endometrial cancer is the most common form of uterine cancer • Pembrolizumab is approved but only partially effective, with typical progression-free survival of 6-11 months

Note: endometrial cancer population subject to further refinement in consultation with advisors

INDICATIVE
PRELIMINARY

The plan provides the potential for significant news flow from CY2026 onwards

2026	2027	2028
Design and set-up of study; selection of CRO & sites	Enrol patients to open-label exploratory stage for initial arm(s)	Graduate one or more initial arms to randomised confirmatory stage
Complete manufacture of study drug	Initiate additional arms, guided by scientific rationale, and in line with company's resources	

1H 26	Selection of CRO
Mid 26	Initiation of sites
Mid 26	First patient in to Arm 1
2H 26	First patient in to subsequent arms
Mid 26	Potential grant of orphan designation
2H 26	Award of international non-prop. name
Late 26	Possible initial data

1H 27	Efficacy data from Arm 1
Mid 27	Efficacy data from subsequent arms
2H 27	Graduation of arm(s) to confirmatory
Mid 27	Potential initiation of new arms
2H 27	Potential grant of Fast Track

Mid 28	Confirmatory data from Arm 1
Mid 28	Confirmatory data from other arms
Mid 28	Efficacy data from other arms
2H 28	Potential grant of Breakthrough
2H 28	Possible New Drug Application

Indicative Cost Estimates

Approximate Cost per Patient

~US$ 150,000
(industry-wide benchmark)

Estimated Number of Patients in Exploratory Stage

20 - 25

Estimated Cost of Exploratory Stage for Each Arm

~US$ 3.0 - 3.5 million
(~AU$ 5 million)

(not including impact of R&D Tax Incentive Rebate)

Potential timeframe for partnering discussions with 'big pharma'

Potential timeframe for accelerated approval discussions with FDA

Note: all timelines, costs, forecasts, and other estimates are preliminary, and subject to ongoing revision

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A high-level estimate of market opportunity suggests enormous commercial potential for HMBD-002; only one indication needs to be successful for a profitable product

	Triple-Negative Breast Cancer	EGFR-Mutant Non-Small-Cell Lung Cancer	HER2-Negative Oesophageal Cancer	Endometrial Cancer	
Estimated incident patients in United States, pa	36,000	15,000	10,000	6,500*	
Annualised treatment cost, US$	$250K	$250K	$250K	$250K	Median treatment cost in 2020-24 was $350K; reduced to $250K for conservative estimate
Estimated time on treatment, months	6 months	4 months	4 months	6 months	Earlier stage patients, and patients in combination, may result in longer treatment durations
US addressable market, US$ pa	$4.5 billion	$1.2 billion	$0.8 billion	$0.8 billion	
Global addressable market, US$ pa	**$9.0 billion**	**$2.4 billion**	**$1.6 billion**	**$1.6 billion**	Assume that US represents 50% of global sales

* Endometrial cancer patients estimated at 10% of total pending further analysis of target sub-population

Successful immuno-oncology assets are highly partnerable, with comparable deals suggesting attractive valuations

Date	Asset	Licensor	Licensee	Target	Stage	Deal Terms
Early-Mid Clinical						
Oct 2018	COM701	COMPUGEN	Bristol Myers Squibb	PVRIG	Phase I / II	$20M upfront; $200M milestones; royalties
Jun 2021	EOS-448	iTEOS THERAPEUTICS	GSK	TIGIT	Phase I / II	$625M upfront; $1.45B milestones; royalties
Dec 2022	XTX-101	xilio THERAPEUTICS	GILEAD	CTLA-4	Phase I / II	$30M upfront; $604M milestones; royalties
Jan 2023	ICB-01	ImCheck	maruho medical	BTN3A	Phase I / II	*Japan rights only* €15M upfront; milestones; royalties
Late Clinical						
Jan 2021	Tislelizumab	BeiGene	NOVARTIS	PD-1	Phase III	*Ex-China rights only* $650M upfront; $1.55B milestones; royalties
Dec 2021	Ociperlimab	BeiGene	NOVARTIS	TIGIT	Phase III	$300M upfront; $700M milestones; royalties
Jul 2022	Cemiplimab	REGENERON	sanofi	PD-1	Phase III	$900M upfront; $1.5B milestones; profit split

Source: Company filings

The Percheron Board and Management Team bring extensive international experience in drug development, commercialisation, and partnering

Dr Charmaine Gittleson
Non-Executive Chair of the Board

25 years of drug development experience, including 15-year tenure with CSL in international roles

Dr James Garner
Chief Executive Officer
& Managing Director

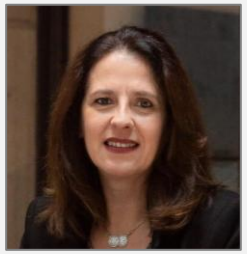
20+ year track record of international drug development, including ten years as a public company life sciences CEO

Deborah Ambrosini
Chief Financial Officer
& Company Secretary

Over 20 years of strategic financial experience with a diverse range of ASX-listed companies

Dr Gil Price
Non-Executive Director
& Chair of Audit

Experienced biotech executive and entrepreneur with extensive experience in drug development



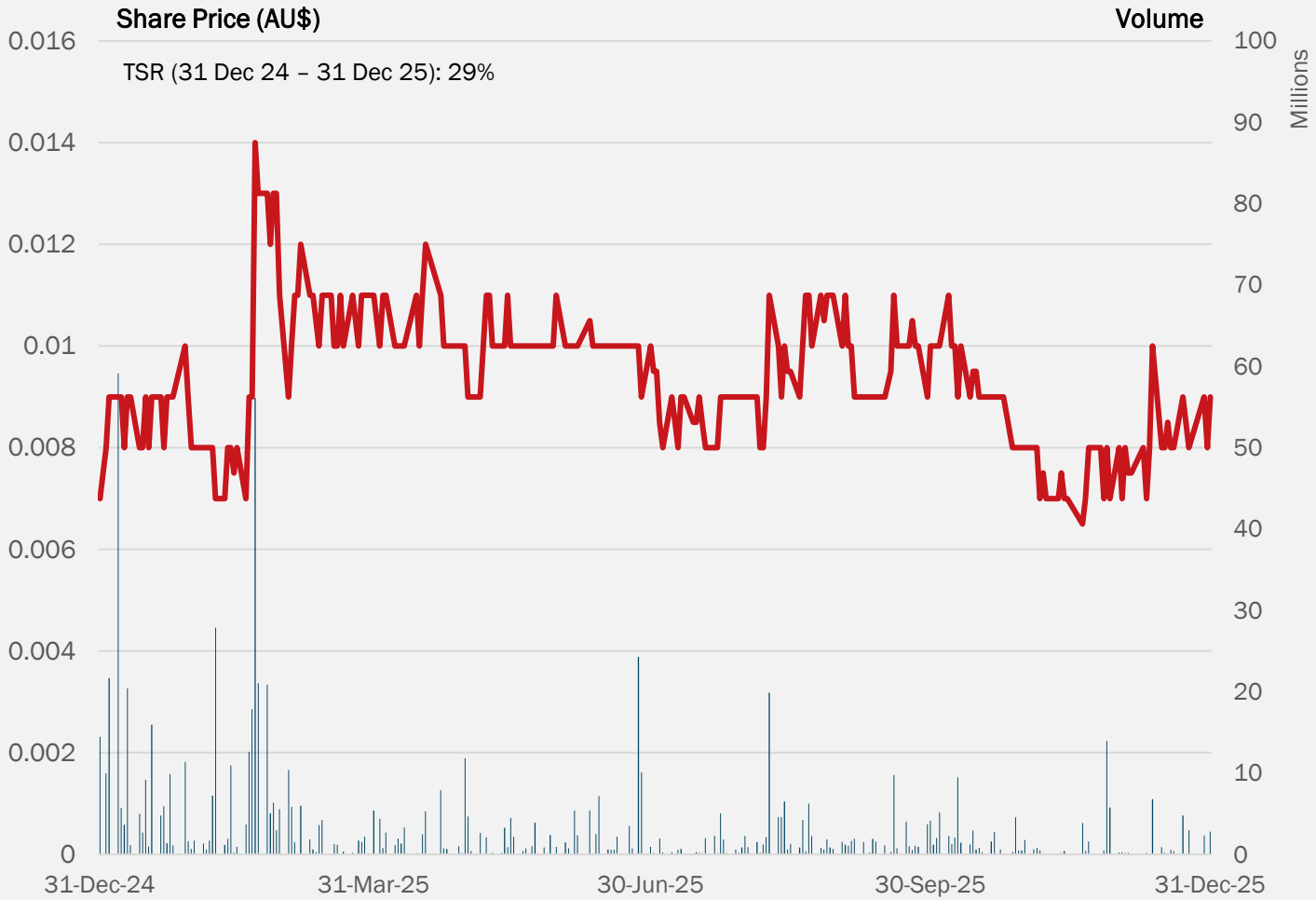
Valentina Dubljevic
Chief Technical Officer

20-year track record of international drug development in multinational companies

Dr Eugene Kennedy
Chief Medical Officer

Johns Hopkins-trained cancer surgeon with over ten years of experience in immuno-oncology drug development

Percheron benefits from an ultra-lean operating model, with the majority of cash outlays being applied directly to R&D



Corporate Fundamentals (as at 31 December 2025)	
Market Capitalisation:	AU$ 9M
Primary Listing:	ASX: PER
Secondary Quotations:	OTC: PERCF
Shares on Issue:	1,087 Million

Financial Position (as at 31 December 2025)	
Cash Balance:	AU$ 4.5 million
Runway (per Appendix 4C):	3.7 quarters

Key Shareholders	
Mutual Investments Limited	5.4%
Non-Correlated Capital Limited	4.6%
Directors and Management	5.6%

Asset Economics	
Acquisition Cost (includes manufacture of one batch of drug substance)	~$4.5 Million
Confidential, substantially back-ended participation for licensor in success of product	

Percheron is competitively valued in comparison to peer ASX-listed companies

Indicative List of Comparator ASX-Listed Oncology Companies

Company	Ticker	Number of Programs	Highest Stage of Development	Cash at 30 June 25	Market Cap at 30 June 25
immutep LAG-3 IMMUNOTHERAPY	IMM	4	Phase III	$67.4M	$350.5M
RACE ONCOLOGY	RAC	1	Phase II	$13.6M	$204.1M
arovella THERAPEUTICS	ALA	2	Preclinical	$20.9M	$118.9M
IMUGENE Developing Cancer Immunotherapies	IMU	5	Phase II	$21.9M	$97.1M
Amplia THERAPEUTICS	ATX	1	Phase II	$7.0M	$77.6M
RAD RADIOPHARM THERANOSTICS	RAD	6	Phase II	$29.1M	$52.0M
Prescient Therapeutics	PTX	3	Phase II	$6.9M	$35.4M
percheron THERAPEUTICS	**PER**	**1**	**Phase II – CY2026**	**$10.2M**	**$10.9M**

Source: ASX; Company filings

Percheron is focused on moving its pipeline forward expeditiously, with potential for rich, value-generating news flow over FY2026

CY2025		
Release of full phase I data	2H CY2025	✓
Initiate manufacture of new batch of drug substance for clinical trial use	2H CY2025	✓
Publication of new preclinical data in head & neck cancer and in triple-negative breast cancer	2H CY2025	✓
Clinician consultation to determine optimal path(s) forward for HMBD-002 in phase II	2H CY2025	✓
Disclosure of phase II study design and target tumours	2H CY2025	✓
CY2026		
Appointment of CRO for phase II clinical trial of HMBD-002	1H CY2026	
Presentation of data at scientific conference(s)	1H CY2026	
Potential application for international non-proprietary name for HMBD-002	1H CY2026	
Ethics Committee approval for phase II clinical trial of HMBD-002	CY2026	
First Patient In to phase II clinical trial of HMBD-002	CY2026	

Note: All timelines are indicative and subject to ongoing review

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GLOSSARY

Cold Tumours	Tumours with few immune cells in the tumour microenvironment. They are typically relatively resistant to immuno-oncology therapies. Some cancers, such as ovarian cancer and brain cancer, are usually considered to be generally 'cold' tumours. By implicit contrast, a 'hot tumour' or inflammatory tumour is one with a large and active population of immune cells in the tumour microenvironment.
Expression (*of an immune checkpoint*)	In the contect of immuno-oncology, a tumour with, on average, a lot of a given immune checkpoint on the surface of its cells is said to highly express that immune checkpoint. For example, a tumour with high PD-1 expression has a lot of PD-1 on the surface of its constituent cancer cells.
Immune Checkpoint	A control mechanism that allows cells, including tumour cells, to inhibit the local activity of the immune system. Analogous to the brake pedal on a car. Examples of immune checkpoints include PD-1, CTLA-4, LAG3, and VISTA.
Immune Checkpoint Inhibitor (ICI)	A drug which inhibits an immune checkpoint, releasing the 'brake' on the local activity of the immune system. Examples of immune checkpoint inhibitors include Keytruda(R) (pembrolizumab), Opdivo(R) (nivolumab), Yervoy(R) (ipilimumab), and Tecentriq(R) (atezolizumab).
Ligand	Generally, a molecule which connects to another molecule to bring about a biological effect. In the context of immuno-oncology, a ligand is typically the molecule on the immune cell to which the immune checkpoint binds (e.g. PD-1 to PDL-1, CTLA-4 to CD80, LAG3 to Gal3, and VISTA to VSIG-3).
Monoclonal Antibody	A class of genetically engineered drugs which utilise the structure of natural human antibodies to generate new molecules which can either block signalling or attack cells. Approximately 40% of cancer drugs are monoclonal antibodies. Monoclonal antibodies are manufactured in living cells under carefully controlled laboratory conditions. They are more challenging to manufacture than 'small molecule' (chemical) drugs but generally simpler than cell therapies.
Myeloid Cells	Myeloid cells are one type of cells involved in the immune system. They exert a range of effects, some of which can be immunosuppressive.
Overall Survival (OS)	A measurement of the average time to death from any cause in a clinical trial. When treated patients are compared to a control group, an improvement in OS is considered the 'gold standard' for FDA approval.
Progression-Free Survival (PFS)	A measurement of the average time to disease progression (20% increase in size of tumour) or death in a clinical trial. When treated patients are compared to a control group, PFS is often a swifter and more sensitive measure of efficacy than OS, and can often provide a basis for approval.
RECIST / Overall Response Rate (ORR)	A standardised way of measuring the early activity of cancer therapies. A complete response (CR) describes 100% reduction in a specific lesion on MRI or CT scan. A partial response (PR) means a 30% or greater reduction in size. Stable disease (SD) means no material change in the size of the tumour. Progressive disease (PD) occurs when a lesion grows by more than 20%. ORR is traditionally a useful way to assess early-stage cancer therapies but rarely provides a basis for FDA approval and is often less sensitive for targeted therapies such as immune checkpoint inhibitors.
Resistance	In oncology, a tumour is said to be resistant to a given therapy if it does not meaningfully respond to that therapy. Resistance may be primary, if the tumour is unresponsive from the outset, or secondary / acquired if the tumour becomes unresponsive after a period of initially successful treatment.
T-Cell / T-Lymphocyte	T-cells are one type of cells involved in the immune system. There are many subtypes, and their effects range from control and coordination ('helper T-cells')to direct attack of infectious organisms and cancer cells ('cytotoxic T-cells').
Tumour Microenvironment (TME)	The TME includes the tumour itself, along with the surrounding tissues, including structural support ('stroma'), small blood vessels, etc. The TME is typically also infiltrated with immune cells. When considering the immune cells specifically, it is sometimes referred to as the tumour immune microenvironment (TIME).
VISTA	V-domain immunoglobulin suppressor of T-cell activation. A novel immune checkpoint, first identified in the 2010s, and the target of HMBD-002.