Emerging Therapies for Relapsing Multiple Sclerosis

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Six agents are currently approved by regulatory agencies to treat relapsing multiple sclerosis. Although these agents are effective and generally safe, some patients have continued disease activity or adverse effects. A sizable number of new agents are under investigation currently. This article reviews emerging agents that have shown promise in phase 2 trials.

Six agents are approved by regulatory agencies to treat relapsing multiple sclerosis (MS). First-line agents include interferon beta-1b, intramuscular or subcutaneous interferon beta-1a, and glatiramer acetate. Pivotal trials and postmarketing experience support the efficacy, tolerability, and safety of these agents. However, all have modest efficacy for patients as a group and are administered by injection. Two agents, mitoxantrone and natalizumab, are more potent and generally well tolerated but typically are second line because of potential safety concerns. In addition, some patients treated with interferon beta or natalizumab develop neutralizing antibodies that abrogate efficacy.

Multiple sclerosis treatment priorities include (1) better understanding of MS pathogenesis and heterogeneity to guide development of better therapies and monitoring methods; (2) additional treatment options for relapsing-remitting MS (RRMS) that are more effective, convenient, and/or tolerable; (3) effective therapies for purely progressive MS; (4) neuroprotective and repair strategies; and (5) more effective treatments for common symptoms such as fatigue, pain, tremor, and cognitive impairment. Potential approaches to improve therapy in relapsing MS are summarized in Table 1. This review summarizes emerging therapies for relapsing MS, with a focus on agents with promising phase 2 study results (Table 2 and Table 3).

MS TREATMENT AGENTS

Alemtuzumab

Alemtuzumab is a humanized monoclonal antibody (mAb) directed against the surface antigen CD52, which is expressed by T cells, B cells, monocytes, natural killer cells, macrophages, eosinophils, and spermatozoa. Intravenous administration produces rapid, profound, and prolonged lymphopenia via complement-mediated lysis and antibody-dependent cellular cytotoxicity. T cells recover for 16 months, while B cells recover for 3 to 6 months. Alemtuzumab is approved to treat B-cell chronic lymphocytic leukemia.

Single-center pilot studies at the neurology unit of the University of Cambridge demonstrated potent suppression of MS relapses and lesion activity on magnetic resonance imaging (MRI) by alemtuzumab but no benefit on disability accrual in progressive MS. A multicenter, randomized, evaluator-blind, active-comparator, phase 2 study enrolled 334 treatment-naive participants with early (onset within 36 months of screening and Expanded Disability Status Scale [EDSS] score ≤3.0), active (≥2 relapses in the previous 2 years) RRMS. Participants were randomized 1:1:1 to receive 44 µg of subcutaneous interferon beta-1a thrice weekly or high-dose (24 mg per day) or low-dose (12 mg per day) in-
travenous alemtuzumab for 5 days at month 0, 3 days at month 12, and for some participants, 3 days at month 24. Coprimary outcome measures were EDSS progression sustained for 6 months and relapse rate. There were no significant differences between results of the 2 alemtuzumab doses. Alemtuzumab significantly reduced the rate of sustained disability progression vs interferon beta-1a (9.0% vs 26.2%; hazard ratio, 0.29; P < .001). Mean EDSS scores improved 0.39 points vs baseline scores in alemtuzumab-treated participants compared with mean worsening of 0.38 points with interferon beta-1a (P < .001). The relapse rate was significantly reduced (0.10 vs 0.36; hazard ratio, 0.26; P < .001). A significant benefit was demonstrated for proportion of relapse-free participants, T2-hyperintense MRI lesion volume change, and brain volume.

Infusion reactions and cytokine release syndrome (fever, headache, hypotension, malaise, and urticaria) occur with alemtuzumab treatment initiation but can be attenuated with concomitant administration of antipyretic, acetaminophen, and corticosteroid drugs. Serious infusion reactions occurred in 1.4% of subjects treated with alemtuzumab in the phase 2 study. With prolonged lymphopenia, infection is a potential concern. In the phase 2 study, infections were more common with alemtuzumab treatment, but to date increased serious infection-related adverse effects have not been seen in the MS population. The most significant adverse effect is antibody-mediated autoimmunity. Thyroid disorders, particularly Graves disease, were more common with alemtuzumab treatment, but to date increased serious infection-related adverse effects have not been seen in the MS population. The most significant adverse effect is antibody-mediated autoimmunity. Thyroid disorders, particularly Graves disease, occurred in up to 30% of alemtuzumab-treated patients with MS in earlier studies and in 23% in a phase 2 study. In addition, immune thrombocytopenia purpura developed in 6 alemtuzumab-treated participants (2.8%) in a phase 2 study vs 1 participant treated with interferon beta-1a (0.9%) and was fatal in 1 participant who did not seek medical attention. The other 5 participants recovered with medical treatment.

Two randomized, evaluator-blind, 3-arm phase 3 trials of alemtuzumab in early RRMS currently are enrolling subjects. Both trials compare 12 mg of intravenous alemtuzumab per day for 5 consecutive days at month 0 and 3 days at month 12 with 44 µg of subcutaneous interferon beta-1a thrice weekly; time to sustained disability accumulation is the primary outcome measure. One phase 3 study will enroll approximately 525 treatment-naïve participants, and another phase 3 study will enroll approximately 1200 participants with continued disease activity while undergoing interferon beta or glatiramer acetate therapy.
Daclizumab was generally safe and well tolerated in the relatively short studies to date; long-term safety with chronic use needs to be determined. In the phase 2 study, the main adverse effects were cutaneous reactions and possibly increased severity of common infections. The overall incidence of infection was similar in the daclizumab and placebo groups, and there were no opportunistic infections. There were no malignancies or increases in interferon beta toxicity or incidence of anti–interferon beta–neutralizing antibodies. Although IL-2 plays a role in eliminating autoreactive T cells through activation-induced cell death and maintenance of FoxP3+ regulatory T cells, no autoimmunity phenomena were observed. The frequency and significance of anti-daclizumab antibodies need further study.

In an ongoing multicenter, randomized, double-blind, placebo-controlled phase 2 study evaluating subcutaneous daclizumab as monotherapy, approximately 297 participants with RRMS will receive 1 of 2 doses of subcutaneous daclizumab or placebo every 4 weeks for 48 weeks.5

**Rituximab**

Rituximab is a chimeric murine/human mAb directed against CD20, a surface antigen expressed on pre–B cells and mature B cells. Intravenous rituximab leads to rapid depletion of circulating B cells by complement-mediated lysis, cell-mediated cytotoxicity, and apoptosis. Rituximab currently is approved to treat non-Hodgkin lymphoma and, combined with methotrexate, to treat rheumatoid arthritis with an inadequate response to anti–tumor necrosis factor agents.

Although MS is traditionally postulated to be a T cell-mediated autoimmune disorder, several lines of evidence support involvement of B cells and humoral immune mechanisms, including intrathecal antibody production, autoreactive antibody in cerebrospinal fluid, complement deposition associated with vesicular myelin disruption in MS lesions, and the presence of B cells in perivascular cuffs and meningeal lymphoid follicles. However, the lack of CD20 expression by plasma cells (the principal source of antibodies) and the rapidity of the clinical and MRI response in MS (circulating antibodies have a relatively long half-life) suggest that rituximab benefit is not mediated by decreasing antibody titers.12,13 Rather, these observations suggest that the initial benefit results from loss of antigen presentation or production of proinflammatory mediators by B cells.

In a multicenter, randomized, double-blind, placebo-controlled phase 2 trial, 104 participants with RRMS received 1000 mg of intravenous rituximab (n=69) or placebo (n=35) on days 1 and 5 and were followed up for 48 weeks.14 Benefit favoring rituximab was demonstrated on the primary outcome measure, total GdE lesions at weeks 12, 16, 20, and 24 (mean, 5.5 vs 0.5 lesions, P < .001). Benefit was also shown for total new GdE lesions at weeks 12 to 24 (mean 4.5 vs 0.2 lesions, P < .001), GdE lesions at 48 weeks (P < .001), and proportion of relapsing participants at weeks 24 (14.5% vs 34.3%, P = .02) and 48 (20.3% vs 40.0%, P = .04). Gadolinium-enhancing lesion inhibition on MRI was apparent as early as week 12.

Initial rituximab infusions produce fever, rigors, tachycardia, dyspnea, headache, pruritus, and rashes, probably due to B-cell lysis and cytokine release. The infusion reactions rarely are severe with acute respiratory distress syndrome, myocardial infarction, or anaphylaxis. Concomitant corticosteroid administration reduces these symptoms. In the phase 2 trial, rituximab was associated with rapid circulating B-cell depletion that remained nearly complete (>95%) until week 24, with gradual partial return thereafter. Therefore, increased risk of infection is a potential concern. Most infections were mild and occurred equally in treatment groups. No opportunistic infections were seen. However, progressive multifocal leukoencephalopathy was reported in patients treated for malignancy, hematologic disorders, systemic lupus erythematosus, and rheumatoid arthritis, typically in the setting of concomitant chemotherapy, immunosuppression, or stem cell transplantation.15

In the phase 2 trial, 16 of 65 participants (24.6%) who received rituximab had human antichimeric antibodies at week 48 or early termination. Although there was no relationship to adverse effects or efficacy, these antibodies may be an issue with repeated administration. Therefore, future development in MS will use ocrelizumab, a humanized anti-CD20 mAb. A 6-month phase 2 study comparing 2 doses of intravenous ocrelizumab, pla-

**Table 3. Oral Multiple Sclerosis Therapies With Positive Phase 2 Results**

<table>
<thead>
<tr>
<th>Agent</th>
<th>Postulated Mechanism of Action</th>
<th>Potential Adverse Effects</th>
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<tbody>
<tr>
<td>Cladribine</td>
<td>Purine analogue, lymphocytotoxic agent</td>
<td>Myelosuppression and infection</td>
</tr>
<tr>
<td>Dimethyl fumaric acid</td>
<td>Nuclear factor E2-related factor-2 transcriptional pathway activator, immunomodulation</td>
<td>Hepatotoxicity</td>
</tr>
<tr>
<td>Estriol</td>
<td>Immunomodulation</td>
<td>Vascular events</td>
</tr>
<tr>
<td>Fringolimod</td>
<td>Myricin derivative, S1P receptor agonist/antagonist, altered lymphocyte recirculation</td>
<td>Lymphopenia, infection, increased airway resistance, macular edema, hepatotoxicity</td>
</tr>
<tr>
<td>Laquinimod</td>
<td>Roquinimex derivative, immunomodulation</td>
<td>Hepatotoxicity, proinflammation</td>
</tr>
<tr>
<td>Minocycline</td>
<td>Matrix metalloproteinase inhibition</td>
<td>None</td>
</tr>
<tr>
<td>Statins</td>
<td>3-Hydroxy-3-methyl-glutaryl coenzyme A reductase inhibitor, immunomodulation</td>
<td>Rhabdomyolysis, hepatotoxicity</td>
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<tr>
<td>Temsirolimus</td>
<td>Rapamycin analogue, cell cycle inhibition</td>
<td>Leukopenia, thrombocytopenia, mucous membrane ulcers</td>
</tr>
<tr>
<td>Teriflunomide</td>
<td>Dihydropyridine dehydrogenase inhibitor (pyrimidine synthesis), inhibition of T- and B-cell proliferation</td>
<td>Pancytopenia, hepatotoxicity</td>
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Abbreviation: S1P, sphingosine-1-phosphate.
Dirucotide

Dirucotide is a synthetic peptide corresponding to amino acids 82 through 98 of human myelin basic protein, an immunodominant T- and B-cell epitope in MS patients with the HLA-DR2 haplotype. Intravenous administration is postulated to induce high-dose tolerance.

Dirucotide is of interest, as it is being tested in secondary progressive MS (SPMS). In a single-center, 24-month, placebo-controlled, double-blind phase 2 trial, 32 participants with progressive MS received 500 mg of intravenous dirucotide or placebo every 6 months. By contingency analysis of EDSS score progression, there was a nonsignificant trend favoring dirucotide on relative rate of progression for the overall study population (relative rate of progression = 0.56; n = 32). There was a significant benefit favoring dirucotide in HLA-DR2–positive and/or DR4-positive participants (relative rate of progression = 0.23, n = 20). All but 3 dirucotide-treated participants had reduced cerebrospinal fluid anti–myelin basic protein antibody levels, but antibody changes did not predict clinical outcome.

In general, dirucotide was well tolerated with no serious treatment-related adverse effects in this study or previous pilot studies. The most common drug-related adverse effects were injection-site reactions with intermittent injection, facial flushing, and mild blood pressure decrease. There were no clinical or MRI findings suggesting disease activation.

Subject recruitment is complete in 2 ongoing 2-year phase 3 studies comparing dirucotide and placebo in HLA-DR2–positive and/or DR4-positive participants with SPMS. A 15-month, double-blind, placebo-controlled phase 2 study in RRMS will enroll approximately 215 participants.

BHT-3009

BHT-3009 is a DNA vaccine, a plasmid encoding the 18.5-kDa isoform of full-length human myelin basic protein that is intended to generate immune tolerance, both antigen-specific and generalized to other myelin antigens, by bystander suppression. In a multicenter, randomized, double-blind, placebo-controlled, dose-escalation phase 1/2 trial, 30 participants with RRMS or SPMS were treated with BHT-3009. BHT-3009 plus 80 mg of oral atorvastatin daily, or placebo. BHT-3009 plus 80 mg of oral atorvastatin daily, or placebo. BHT-3009 was administered in 0.5-, 1.5-, or 3-mg doses intramuscularly at weeks 1, 3, 5, and 9 after randomization. The vaccine was safe and well tolerated, with no indication of disease activation clinically or radio graphically. There were favorable trends of GdE lesion number and volume. Immunologic changes included a marked decrease in proliferation of interferon γ–producing myelin-reactive CD4+ T cells in peripheral blood and decreased titers of myelin-specific cerebrospinal fluid antibodies measured by protein microarray. There was no additional benefit from combination with atorvastatin.

In a randomized, double-blind, placebo-controlled phase 2 trial, 289 participants with RRMS were randomized to receive 0.5 mg (n = 104) or 1.5 mg (n = 89) of BHT-3009 intramuscularly or placebo (n = 96) at weeks 0, 2, and 4, and then every 4 weeks until week 44. In the analysis of 267 participants, GdE lesions seen on monthly MRI from weeks 28 to 48, the primary outcome measure, were reduced 50% by the 0.5-mg dose relative to placebo (P = .07), which was associated with a dramatic reduction in 23 myelin-specific antibodies measured by protein microarray. Interestingly, the higher dose was ineffective on GdE lesions and antibody titers. The DNA vaccine was well tolerated, with no evidence of disease activation by clinical or MRI parameters. Plans for future studies of BHT-3009 in MS have not been announced.

Cladribine

Cladribine is an adenosine deaminase-resistant purine nucleoside analogue. The phosphorylated triphosphate deoxynucleotide accumulates in lymphocytes, leading to apoptosis of resting and dividing lymphocytes and long-lasting lymphocyte depletion preferentially affecting CD4+ T cells. Cladribine is approved to treat hairy cell leukemia. Several trials supported some aspects of efficacy of parenteral cladribine in RRMS and progressive MS. In general, parenteral cladribine is well tolerated. Infectious complications are the principal concern with prolonged lymphocyte depletion. This issue has been less prominent in MS than in the oncology experience.

Recent development of cladribine has examined an oral formulation. A randomized, double-blind, 3-arm, placebo-controlled phase 3 study assessed oral cladribine for 96 weeks in approximately 1300 participants with RRMS. Participants were randomized to high-dose (1.4 mg/kg in year 1 and 0.7 mg/kg in year 2) or low-dose (0.7 mg/kg in years 1 and 2) oral cladribine or placebo. The primary outcome measure was relapse rate throughout 96 weeks. The results of this completed trial have not yet been reported.

One ongoing 2-year phase 2 study is evaluating the safety, tolerability, and efficacy of oral cladribine combined with interferon beta. There were approximately 200 participants with relapsing MS and at least 1 relapse within 48 weeks of screening during treatment with interferon beta. Participants continue taking interferon beta and are randomized 2:1 to undergo up to 4 cycles of clad ribine treatment (0.875 mg/kg per cycle) or placebo at weeks 0, 5, 48, and 52. There is also a randomized, double-blind, placebo-controlled phase 3 trial of oral cladribine in approximately 642 participants with a clinically isolated syndrome at high risk of converting to MS. Participants are randomized to low-dose (1.75 mg/kg per year) or high-dose (3.5 mg/kg/year) cladribine or placebo once a week for 24 weeks each year. The primary outcome measure is time to conversion to MS by revised McDonald criteria.

Dimethyl Fumarate

Oral fumaric acid esters have a long history of use in treating psoriasis. Dimethyl fumarate is a second-generation fumarate derivative with improved tolerability. The primary metabolite, monomethyl fumarate, activates the nuclear factor E2–related factor-2 transcriptional path-
way, which is involved in regulating both immune function and the response to oxidative stress. Immuno-
logic actions include inhibition of T-cell activity by inducing apoptosis in activated T cells and stimulating a Th1 to Th2 shift in cytokine profile. Methyl hydrogen fumarate and dimethyl fumarate inhibit clinical and histopathologic features of EAE through both anti-
inflammatory and neuroprotective actions.

In a randomized, double-blind, placebo-controlled, dose-ranging phase 2b study, 257 participants with RRMS were randomized to receive oral placebo (n = 65) or 120 mg (n = 64), 360 mg (n = 64), or 720 mg (n = 64) of di-
methyl fumarate per day. Seventy-four percent of the 120-mg and 360-mg doses vs placebo on some outcome measures.

Dimethyl fumarate was generally well tolerated. The most common adverse effects were flushing, feeling hot, gastrointestinal symptoms (abdominal pain, nausea, vomiting, and diarrhea), headache, and fatigue. There was rare elevation of liver enzymes that resolved with drug dis-
continuation. There was no increase in infections and no opportunistic infections. During the double-blind ex-
extension, participants who continued active treatment had decreased adverse effects.

There are 2 ongoing 2-year phase 3 trials of dimethyl fumarate. One phase 3 study will randomize approximately 1101 participants with RRMS to receive 720 or 480 mg of dimethyl fumarate per day or placebo. The primary outcome measure is the proportion of relapsing par-
ticipants. The other phase 3 study will randomize approximately 1232 participants to treatment with 720 or 480 mg of dimethyl fumarate per day, oral placebo, or 20 mg of subcutaneous glatiramer acetate daily. The primary outcome measure is relapse rate.

Methyl hydrogen fumarate and dimethyl fumarate inhibit clinical and histopathologic features of EAE through both anti-
inflammatory and neuroprotective actions.

Estriol

Multiple sclerosis disease activity decreases during preg-
nancy. A variety of pregnancy-related factors are probably involved, including estrogens, which have immuno-
modulatory effects in vitro and ameliorate EAE. In an open-label pilot study of 12 women with RRMS or SPMS, the number and volume of GdE lesions on monthly scans were reduced from week 12 to 24 compared with placebo (1.4 vs 4.5 lesions, 69% reduction, P < .001). The 720-mg dose also produced a 48% reduction in new or enlarging T2 lesions at 24 weeks (P = .006), 53% reduction in T1-hypointense lesion number (P = .01), and a nonsignifi-
cant 32% reduction in relapses. There were nonsignificant trends favoring the 120-mg and 360-mg doses vs pla-
lice on some outcome measures.

Fingolimod

Glycerol- and sphingosine-based phospholipids are ab-
dant structural components of cellular membranes plus pleiotropic-soluble mediators of a variety of biologic func-
tions. Sphingosine is generated by deacylation of ce-
ramide by ceramidase then phosphorylated by sphingo-

sine kinase, forming sphingosine-1-phosphate (SIP). Actions of SIP are mediated by 5 G protein–coupled re-
ceptors with 7 membrane-spanning domains. The SIP receptor subtype 1 predominates in lymphoid tissue and is highly expressed by resting T cells and B cells. Lam-
phocyte egress from secondary lymphoid organs is de-
pendent on detection of a chemottractant SIP gradient mediated by SIP receptor subtype 1.

Fingolimod, an orally active myriocin derivative, is phosphorylated in vivo by sphingosine kinase, forming fingolimod phosphate, a structural analogue of SIP. Fin-
 golimod-phosphate binding leads to aberrant internal-
ization of SIP receptor subtype 1, rendering lympho-
cytes insensitive to the SIP gradient and blocking egress from secondary lymphoid organs. Fingolimod admin-
istration produces a rapid, reversible decrease in circu-
lating lymphocytes (approximately 70%). Interruption of lymphocyte recirculation between central nervous sys-
tem and secondary lymphoid organs is probably respon-
sible for clinical benefit in MS. Fingolimod does not affect lymphocyte activation or memory T-cell and B-cell re-
sponses, so general immunosuppression is not pro-
duced. In addition, fingolimod is lipophilic, allowing cen-
tral nervous system penetration. The SIP receptors are widely expressed by central nervous system cells and me-
diate a variety of actions that potentially lead to neuro-
protective or reparative effects. Interaction of fingoli-
mod with widely expressed SIP receptors in other tissues probably accounts for its adverse effects.

In a randomized, double-blind, placebo-controlled phase 2 trial, 281 participants with RRMS were random-
ized to 1.25 or 5 mg of oral fingolimod daily or placebo for 6 months. Median total number of GdE lesions on monthly MRI was reduced with 1.25 mg (1 lesion, P < .001) and 5 mg (3 lesions, P = .006) of fingolimod vs placebo (5 lesions). The annualized relapse rate was also reduced (1.25 mg of fingolimod, 0.35; P = .009; and 5 mg of fingolimod, 0.36; P = .01; vs placebo, 0.77). In the exten-
sion study, benefits were maintained in participants who continued to take fingolimod and were reproduced in participants who switched from placebo.

Adverse effects included nasopharyngitis, dyspnea, headache, diarrhea, nausea, and asymptomatic elevations of liver enzymes. There was 1 case of posterior reversible encepha-
lopathy in the 5-mg group. Fingolimod treatment pro-
duced bradycardia with the first dose and a mild decrease in forced expiratory volume in 1 second. As with any im-
munomodulatory treatment, infections are a potential con-
cern with fingolimod, though no opportunistic infections were seen in the phase 2 study. Possible increased inci-
dence and severity of herpes infections have occurred in ongoing phase 3 studies. Macular edema was seen in the studies of fingolimod in renal transplant.

Ongoing phase 3 studies will evaluate a 1.25-mg and a 0.5-mg dose. A double-blind, double-dummy, random-
ized, 3-arm trial compares 1.25- and 0.5-mg daily doses of oral fingolimod and 30 µg of weekly intramuscular interferon beta-1a in 1292 participants with RRMS. The primary outcome measure is annualized relapse rate during 12 months. The core study is complete, but the results have not yet been reported. A randomized, double-blind, placebo-controlled phase 3 trial of fingolimod in RRMS randomized 1272 participants with RRMS to 1.25 or 0.5 mg of daily oral fingolimod or placebo. The primary outcome measure is annualized relapse rate during 24 months. A parallel placebo-controlled phase 3 study is being conducted in the United States with a 1080-participant target.

Laquinimod

Laquinimod is a once-daily oral immunomodulatory agent derived from linomide. Promising results with linomide were demonstrated in EAE and preliminary clinical trials. However, a phase 3 trial of linomide was terminated shortly after enrollment completion owing to unanticipated toxicity, including pericarditis, pleural effusion, myocardial infarction, possible pulmonary embolism, pancreatitis, and death. Other common adverse effects included arthralgia, myalgia, bursitis, and edema. Laquinimod was identified by extensive screening of linomide derivatives for efficacy in EAE and lack of proinflammatory effects in beagles.

A multicenter, randomized, double-blind, placebo-controlled phase 2 study in RRMS and SPMS demonstrated that daily doses of 0.3 mg of laquinimod reduced cumulative active MRI lesion number during 24 weeks, the primary outcome measure, in the per-protocol cohort (n = 187; mean, 5.2 vs 9.4 lesions; 44% reduction; P = .0498), with a nonsignificant trend in the intention-to-treat cohort (n = 209; mean, 5.5 vs 9.3 lesions; 41% reduction; P = .17). The 0.1-mg daily dose was ineffective. Benefit was more prominent in the subgroup of participants with at least 1 GdE lesion at baseline (approximately 70% of the per-protocol group), with a 52% reduction in cumulative active MRI lesions during 24 weeks (P = .005).

In a multicenter, randomized, double-blind, placebo-controlled phase 2b trial with 306 participants, a higher laquinimod dose (0.6 mg per day) significantly reduced mean cumulative GdE lesions per scan at weeks 24, 28, 32, and 36 compared with placebo (2.6 vs 4.2 lesions; 40.4% reduction; P = .005), while the 0.3-mg/day dose was not effective. Benefit was seen on several other MRI measures with a nonsignificant trend on relapse rate. In an open-label extension study, benefit of 0.6 mg of laquinimod per day was recapitulated in participants who switched from placebo and persisted in participants who continued taking laquinimod. No new safety issues were identified.

In general, laquinimod has been well tolerated. Mild self-limited dose-dependent increases with liver enzymes were seen in both phase 2 studies. A single case of Budd-Chiari syndrome developed after 1 month of exposure in the phase 2b study in a participant with the factor V Leiden mutation. No clinical evidence of a proinflammatory effect was seen.

Two phase 3 trials of 0.6-mg doses of laquinimod per day in RRMS are under way. One study compares laquinimod with placebo in 1000 participants. A second study compares laquinimod with placebo with an internal comparator (weekly intramuscular interferon beta-1a) in 1200 participants.

Minocycline

Minocycline is a semisynthetic tetracycline antibiotic with extensive clinical experience supporting safety and tolerability. Minocycline crosses the blood-brain barrier, and biologic actions of minocycline potentially of benefit in MS include inhibition of microglial activation, apoptosis, inducible nitrous oxide and free radicals, mitogen-activated kinases, proinflammatory cytokine production by T cells, and matrix metalloproteinase activity.

In a pilot study of 10 participants with active RRMS, 100 mg of oral minocycline twice daily reduced GdE lesions during 6 months compared with 3 months before therapy. This result was driven by activity in 5 participants. A small, randomized, placebo-controlled phase 2 study assessed minocycline combined with glatiramer acetate in 44 participants with RRMS. At months 8 and 9, GdE lesions were reduced by 63% in the glatiramer acetate plus minocycline group compared with the glatiramer acetate group (mean 1.47 vs 2.95 lesions, P = .08) and the number of new T2 lesions were reduced by 65% (mean, 1.84 vs 5.14 lesions, P = .06). Future studies will assess the efficacy of minocycline monotherapy following a clinically isolated demyelinating syndrome and minocycline combined with subcutaneous interferon beta-1a in RRMS.

Statins

Several attributes make statins, 3-hydroxy-3-methylglutaryl-coenzyme A inhibitors, attractive MS therapy candidates. They are administered orally, and extensive clinical experience with long-term treatment of hyperlipidemia indicates excellent tolerability and safety. In addition to lipid-lowering actions, statins have many immunomodulating effects that might be beneficial in MS, including decreased production of Th1 cytokines (IL-2, IL-12, interferon γ, and tumor necrosis factor α), increased production of Th2 cytokines (IL-4, IL-5, IL-10, and transforming growth factor β), generation of Th2 cells, decreased major histocompatibility complex class II expression by antigen-presenting cells, decreased costimulatory molecule expression, decreased antigen-specific T-cell activation, and decreased adhesion molecule and chemokine receptor expression by activated lymphocytes.

Oral statin treatment prevents or reverses EAE.

An open-label, single-arm cross-over study of 30 participants with RRMS showed a 44% reduction in the number of GdE lesions on MRI at months 4, 5, and 6 of treatment with 80 mg of simvastatin daily vs pretreatment (mean, 1.30 vs 2.31 lesions, P < .001). A second study with a similar design evaluated 41 participants with RRMS, including 16 taking interferon beta. Treatment with 80 mg of atorvastatin daily produced a 24% reduction in GdE lesions on monthly MRI at
months 6 to 9 compared with months −2 to 0 (mean, 1.52 vs 2.00 lesions, \( P = .003 \)).

The principal adverse effects of statins are gastrointestinal symptoms, hepatotoxicity, and rhabdomyolysis. There has also been concern that aggressive lowering of serum cholesterol may increase risk for hemorrhagic stroke. A recent small, randomized, double-blind, placebo-controlled pilot study compared daily oral atorvastatin (40 or 80 mg) with placebo combined with 44 µg of subcutaneous interferon beta-1α 3 times weekly in 26 participants with RRMS. Prior to the study, participants received interferon beta-1α on average for 2 years and were clinically stable for at least 6 months. Surprisingly, during the 9-month study, participants treated with either dose of atorvastatin exhibited significantly increased risk of new T2-hyperintense or GdE MRI lesions, or clinical relapse. Whether this observation reflects potential proinflammatory effects of statins or is an artifact resulting from the small sample size remains to be determined.

Additional studies will be necessary to confirm the utility of statins in RRMS both alone and in combination. Enrollment in an ongoing study of atorvastatin in clinically isolated syndrome was closed before reaching the target of 152 subjects because of slow accrual.

**Temsirolimus**

Temsirolimus is an esterified derivative of sirolimus, a cytostatic rapamycin analogue widely used as an immunosuppressant following organ transplantation. In a multicenter, randomized, double-blind, placebo-controlled phase 2 trial, 296 participants with active RRMS and SPMS received 2, 4, or 8 mg of oral temsirolimus or placebo once daily for 9 months. The 8-mg dose produced a 48% decrease in the mean number of cumulative new GdE lesions (\( P = .01 \)), a 51% reduction in relapses (\( P = .02 \)), and a trend to reduced brain volume loss vs placebo. Adverse effects more frequent in temsirolimus-treated participants included nasopharyngitis, alopecia, nausea, limb pain, diarrhea, and arthralgia. Hepatic necrosis and pancytopenia were reported in patients with rheumatoid arthritis who were taking temsirolimus. An additional potential safety issue is teratogenicity in animals. Female subjects are advised not to become pregnant and males are cautioned not to father a child during therapy. Without washout with cholesteryamine or activated charcoal, it may take up to 2 years for plasma levels to reach less than 0.02 mg/L, the level expected to present minimal teratogenic risk.

A 2-year, double-blind, placebo-controlled phase 3 study in relapsing MS is in progress. The primary outcome measure is relapse rate. Enrollment was closed with 1088 participants. Other ongoing or planned studies of temsirolimus include a phase 2 study of combination with interferon beta, a phase 2 study of combination with glatiramer acetate, and a placebo-controlled phase 3 trial in clinically isolated syndrome.

**COMMENT**

A sizable number of promising therapies for relapsing MS are being tested. Anticipated advantages include improved tolerability and convenience, particularly for oral agents, and efficacy that is comparable with or greater than the current standard agents. However, when these agents initially become available, there will be a relative lack of long-term safety and efficacy data. Many of these agents already have potential safety concerns, and, as with all new agents, there is the possibility of unanticipated safety issues. Cost of these agents will include not only the medication but also required monitoring. Which agent has the optimal balance of efficacy, safety, tolerability, and convenience is not clear at present and will depend on results of pivotal trials and clinical experience. It is likely that different agents will be appropriate for different settings.

**REFERENCES**


