Safety and Tolerability of Subcutaneous Cladribine Therapy in Progressive Multiple Sclerosis

R.Selby, J.Brandwein and P. O'Connor

ABSTRACT: Objective: To evaluate the safety and tolerability of subcutaneous (s.c.) cladribine therapy in patients with chronic progressive multiple sclerosis (CPMS), and to evaluate the effects on lymphocyte subsets. Background: Cladribine, a synthetic antineoplastic agent with immunosuppressive effects, may favourably affect the course of CPMS. However results of a previous reported clinical trial showed significant myelosuppression in some patients. Design/Methods: 19 patients with severe (mean extended disability status score [EDSS] = 6.7) CPMS were treated on a compassionate basis with cladribine 0.07 mg/kg/day s.c. for 5 days per cycle, repeated every 4 weeks for a total of 6 cycles. Patients underwent clinical evaluation, EDSS, and hematologic analysis before, during, and following therapy. Results: The treatment was very well tolerated with no clinically significant side effects observed. Between baseline and the end of cycle 6, mean decreases were noted in absolute lymphocyte count from 1697 to 463 (p = 0.0000012), CD4 count from 865 to 187 (p = 0.0000008), CD8 from 418 to 165 (p = 0.005) and CD19 from 197 to 26 (p = 0.000002). Platelet, granulocyte and RBC counts were unaffected. Approximately one year after completion of therapy, some recovery of CD4 and CD8 counts had occurred although both counts remained suppressed compared to baseline (302 and 227 respectively); the CD19 count had recovered essentially to normal by one year. EDSS scores post-therapy revealed some deterioration in 8 patients and stable scores in the remaining 11. Global patient evaluations of the treatment were mixed. Conclusions: Cladribine therapy, at lower doses than previously reported, was remarkably well tolerated in CPMS, with no significant myelosuppression. Profound effects occurred in total lymphocyte count and CD4, CD8 and CD19 subsets.


BACKGROUND

There is considerable evidence that cell mediated immunity plays an important role in the pathogenesis of multiple sclerosis (MS). Helper (CD4) T lymphocytes are found in MS lesions

From the Division of *Hematology, (R.S., J.B.) The Toronto Hospital and Division of Neurology, (P.O.) St. Michael’s Hospital, University of Toronto, Toronto, Ontario, Canada.


Reprint requests to: Dr. P. O’Connor, Division of Neurology, St. Michael’s Hospital, 30 Bond Street, Suite 3133-D, Toronto, Ontario, Canada MSB 1W8
along with abnormal MHC class II expression. In experimental allergic encephalomyelitis (EAE), injection of myelin basic protein (MBP) and other myelin proteins results in T-cell infiltration into the CNS, accompanied by CNS lesions similar to those seen in MS. T lymphocytes specific to such myelin antigens have been shown to induce CNS inflammation in several mammalian species. T lymphocyte clones reactive to MBP have also been found in the blood of patients with MS. Despite these observations the exact mechanisms of demyelination are unclear.

Beta interferons have been shown to reduce the frequency and severity of exacerbations in the relapsing remitting form of MS. However, little progress has been made in altering the natural history of the disease particularly in patients with chronic progressive MS. Despite early encouraging results, immunosuppressive agents such as cyclophosphamide, azathioprine, and cyclosporin have demonstrated, at best, only marginal activity in double blind controlled trials.

Cladribine (2-chlorodeoxyadenosine) is a purine analog which is incorporated into DNA and is resistant to the enzyme adenosine deaminase. It has demonstrated considerable antineoplastic activity in hairy cell leukemia, chronic lymphocytic leukemia and certain forms of non-Hodgkin’s lymphoma. It has significant immunosuppressive effects, with reduction in the numbers of CD4 and CD8 lymphocytes which persist for 6-12 months or more after a course of therapy. The drug is generally well tolerated with the major toxicity being myelosuppression.

Recently a small (n = 51), randomized, double-blind, placebo controlled, cross-over trial was reported using intravenous cladribine in patients with CPMS. 48 patients entered as matched pairs and the trial was stopped after one year of treatment before the cross-over occurred. Treatment consisted of four monthly cycles of 0.7 mg/kg cladribine given through a central line. Cladribine appeared to favourably influence the course of CPMS, with improvement or stabilization in neurologic scores, lesion volumes on MRI, and concentrations of oligoclonal bands in cerebrospinal fluid in treated patients, compared to placebo. However, although the treatment was generally well tolerated, significant hematologic toxicity was reported, in addition to several viral infections.

Subcutaneous cladribine has shown good bioavailability compared to the intravenous route, with a similar pharmacokinetic profile. Our objective was to evaluate the safety and tolerability of subcutaneous cladribine therapy in patients with chronic progressive multiple sclerosis, and to assess if lower doses than those previously used would be immunosuppressive with less myelosuppression.

**Patients and Methods**

19 patients (13 females and 6 males) with chronic progressive MS (CPMS) attending the MS Clinic at St. Michael’s Hospital in Toronto were treated. EDSS scores ranged from 5.5 to 8, and ages from 31 to 60 years (mean age 43). Patients were selected for treatment on compassionate grounds based primarily on rapid progression in the two years prior to therapy.

The average disease duration in these patients was 12.6 years. 15 patients had no comorbid medical conditions. The following conditions were found in one patient each: asthma, insulin-dependent diabetes mellitus (IDDM), depression, and IDDM with depression. Most patients had at some point in their disease been treated with short term high dose corticosteroids for MS exacerbations. Apart from brief courses of corticosteroids, no patient had received immunosuppressive therapy in the year prior to the study. No patient received concomitant corticosteroid or other immunosuppressive therapy while on cladribine. Cladribine (Leustatin®, Ortho-Biotech) was administered at a dose of 0.07 mg/kg/day by subcutaneous injection for 5 days per cycle, or 0.35 mg/kg/cycle, repeated every 4 weeks for 6 cycles in total. Complete blood count (CBC) and differential, as well as clinical assessment, were done prior to each treatment cycle; CBC was repeated at day 14 following at least the first cycle to assess the nadir counts. Total lymphocyte counts and CD4, CD8 and CD19 positive lymphocyte subsets were determined prior to initiation of treatment, then at Cycle 3 and 6, and (in most instances) at one year following completion of therapy. Lymphocyte subset analysis was done by immunophenotyping using a FACSscan flow cytometer. The normal reference ranges for total lymphocyte count, CD4, CD8 and CD19 subsets were 1500 – 2900, 535 – 1125, 300 – 810 and 135 – 447 x 10^6/L respectively.

Neurologic assessments and EDSS scores were performed by neurologists at the MS clinic at baseline, during therapy, after completion of the 6 cycles, and in follow-up over the next 21 months. Because of difficulties involved in getting significantly disabled patients to return for follow-up, the exact timing of the EDSS assessment varied somewhat.

Data are presented as mean ± standard deviation. The Student’s t-test for paired data was used to compare observations; a significance level of 0.05 was used to indicate statistical significance.

**RESULTS**

Of the 19 treated patients, 13 received all six cycles of cladribine. Six patients chose not to complete therapy, 2 patients after 5 cycles, 3 after 4 cycles and 1 after 3 cycles. The primary reasons patients gave for not completing therapy were perceived lack of efficacy together with the medication cost. Toxicity did not limit treatment in any of the cases.

Laboratory data from 4 patients (patients 2, 8, 10 and 13 on Table 3) were excluded from analysis because of absent baseline lymphocyte subset data in two cases, and insufficient follow-up data in the other two. The total lymphocyte count and CD4, CD8 and CD19 lymphocyte subsets at baseline (prior to the start of therapy) were determined prior to initiation of treatment, then at Cycle 3 and 6, and (in most instances) at one year following completion of therapy. Lymphocyte subset analysis was done by immunophenotyping using a FACSscan flow cytometer. The normal reference ranges for total lymphocyte count, CD4, CD8 and CD19 subsets were 1500 – 2900, 535 – 1125, 300 – 810 and 135 – 447 x 10^6/L respectively.

**Table 1: Lymphocyte subset analysis during therapy (n = 15).**

<table>
<thead>
<tr>
<th>Lymphocyte count</th>
<th>Baseline</th>
<th>3 Months</th>
<th>p value*</th>
<th>6 months</th>
<th>p value**</th>
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</thead>
<tbody>
<tr>
<td><strong>Lymphocyte count</strong></td>
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<tr>
<td>Baseline</td>
<td>1697 ± 570f</td>
<td>801 ± 350</td>
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<td>463 ± 207</td>
<td>0.00012</td>
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<tr>
<td>CD4 count</td>
<td>865 ± 313</td>
<td>411 ± 170</td>
<td>0.000005</td>
<td>187 ± 94</td>
<td>0.0000008</td>
</tr>
<tr>
<td>CD8 count</td>
<td>418 ± 170</td>
<td>248 ± 145</td>
<td>0.000002</td>
<td>165 ± 127</td>
<td>0.005</td>
</tr>
<tr>
<td>CD19 count</td>
<td>197 ± 104</td>
<td>25 ± 27</td>
<td>0.000002</td>
<td>26 ± 16</td>
<td>0.4</td>
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<tr>
<td>p value derived from Student’s t test for paired data</td>
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<tr>
<td>*Baseline vs. 3 months</td>
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<td>**3 months vs. 6 months</td>
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<td>†All values expressed as mean ± standard deviation, x 10^6/L.</td>
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</table>
of cladribine therapy), and at 3 and 6 months on therapy in the 15 evaluable patients are summarized in Table 1. As shown, significant decreases in total lymphocyte counts as well as in helper (CD4+) and cytotoxic/suppressor (CD8+) lymphocyte subsets were seen during cladribine therapy. There was a continuing decline in T lymphocyte subsets from 3 to 6 months; this was particularly true for the CD4 subset. Highly significant decreases in the B lymphocyte (CD19+) subset was also seen with trough values attained at 3 months.

Follow up laboratory data, one year after completion of cladribine, were available on 12 of these 15 patients and are summarized in Table 2. The mean total lymphocyte, CD4 and CD 8 counts had shown some recovery compared to the values at the end of therapy, but were still significantly below baseline level. The mean CD19 count had recovered to normal levels.

Table 2: Lymphocyte subset analysis following completion of therapy (n=12).

<table>
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<tr>
<th></th>
<th>6 Months</th>
<th>1 year post therapy</th>
<th>p value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Lymphocyte count</td>
<td>475 ± 200†</td>
<td>895 ± 367</td>
<td>0.0003</td>
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<tr>
<td>CD4 count</td>
<td>199 ± 97</td>
<td>302 ± 133</td>
<td>0.018</td>
</tr>
<tr>
<td>CD8 count</td>
<td>156 ± 91</td>
<td>227 ± 142</td>
<td>0.047</td>
</tr>
<tr>
<td>CD19 count</td>
<td>28 ± 16</td>
<td>179 ± 110</td>
<td>0.00014</td>
</tr>
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</table>

*P value derived from Student’s t test for paired data
†All values expressed as mean ± standard deviation, x 10^9/L.

DISCUSSION

The original report of cladribine treatment in MS, a statistically significant drop in blood counts was observed. In 7 patients, the platelet count dropped below 80 x10^9/L, while a substantial and sustained decrease in granulocytes was seen. Two patients developed severe and prolonged aplastic anemia requiring red cell and platelet transfusions. In one case, the patient had experienced prior therapy with chlorambucil and was receiving phenytoin while on cladribine. The second patient had previously received extensive therapy with chlorambucil. Both recovered after several months of marrow suppression. Two patients developed severe and persistent hepatitis B requiring treatment with acyclovir. One patient presented with acute fulminant hepatitis B infection 3 days after her second cladribine infusion and died 5 days after admission. She had negative hepatitis B serology at start of therapy and a history of probable recent exposure.

Our series of patients received a lower total treatment dose (total of 2.1 vs 2.8 mg/kg, as well as a lower treatment dose per cycle (0.35 mg/kg vs. 0.7 mg/kg). Using this dosing regimen, patients experienced no significant myelosuppression or infectious problems despite achieving profound lymphocyte suppression. When compared to the higher dose regimen, the rate of decline in the CD4 count using our regimen was less rapid, although the trough CD4 count at six months into treatment was similar. In contrast, the rate of decline, nadir and post-therapy levels of CD8 and CD19 counts were similar in the two groups. At approximately 1 year post-therapy, we noted a partial but incomplete recovery in CD4 counts, while CD4 levels remained severely depressed in the higher-dose study. View of the presumed pathogenetic role of T helper cells in MS, the slower decline and earlier recovery in these cells could have implications.
regarding therapeutic efficacy. However, since only a small subset of T cells is likely involved in producing MS, these implications are unclear. Measuring T lymphocytes reactive to myelin basic protein could address this question in vitro, although only a randomized trial could accurately assess the clinical relevance of the effects of the different dosing regimens.

In addition to the lower cladribine dose, none of our patients were on concomitant immunosuppressive or myelosuppressive therapy which may have contributed to the lack of toxicity. Concomitant use of corticosteroids and purine analogs has been associated with opportunistic infections. Whether cladribine is safe to use along with or soon after medications such as beta-interferon, methotrexate, azathioprine or cyclophosphamide is unclear and requires further study. The long-term safety of cladribine in MS is also unknown.

The subcutaneous route of administration has been shown to have a favorable pharmacokinetic profile, with 100% bioavailability and no local toxicity. Such treatment is easy to administer, not requiring intravenous access. Although given in our Medical Day Care outpatient unit, there is no reason in principle why patients could not be trained in self-administration of the medication. Subcutaneous cladribine therapy, at the doses used in this study, is remarkably well tolerated in chronic progressive multiple sclerosis, with no significant toxicity despite achieving profound and long lasting immunosuppression. The degree of suppression of lymphocytes was similar to the higher-dose regimens, although differences were noted in the rate of decline and recovery of CD4 counts.

As this was a safety and tolerability study with no control group, nothing meaningful can be stated regarding the observed EDSS changes, given the unpredictable course of MS. Although no objective improvements were noted in any patient, we cannot exclude the possibility that cladribine may have contributed to disease stabilization in some instances. We await the results of a large appropriately powered randomized blinded trial of this medication with interest. Although safe and easy to use, the therapeutic effectiveness of cladribine in chronic progressive MS remains to be established.

ACKNOWLEDGEMENTS

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REFERENCES


