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Published in:
The New England journal of medicine

DOI:
10.1056/NEJM19971009371502

Link to publication

Citation for published version (APA):

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A SHORT-TERM STUDY OF CHIMERIC MONOCLONAL ANTIBODY cA2 TO TUMOR NECROSIS FACTOR α FOR CROHN’S DISEASE


ABSTRACT

Background Studies in animals and an open-label trial have suggested a role for antibodies to tumor necrosis factor α, specifically chimeric monoclonal antibody cA2, in the treatment of Crohn’s disease.

Methods We conducted a 12-week multicenter, double-blind, placebo-controlled trial of cA2 in 108 patients with moderate-to-severe Crohn’s disease that was resistant to treatment. All had scores on the Crohn’s Disease Activity Index between 220 and 400 (scores can range from 0 to about 600, with higher scores indicating more severe illness). Patients were randomly assigned to receive a single two-hour intravenous infusion of either placebo or cA2 in a dose of 5 mg per kilogram of body weight, 10 mg per kilogram, or 20 mg per kilogram. Clinical response, the primary end point, was defined as a reduction of 70 or more points in the score on the Crohn’s Disease Activity Index at four weeks that was not accompanied by a change in any concomitant medications.

Results At four weeks, 81 percent of the patients given 5 mg of cA2 per kilogram (22 of 27 patients), 50 percent of those given 10 mg of cA2 per kilogram (14 of 28), and 64 percent of those given 20 mg of cA2 per kilogram (18 of 28) had had a clinical response, as compared with 17 percent of patients in the placebo group (4 of 24) (P < 0.001 for the comparison of the cA2 group as a whole with placebo). Thirty-three percent of the patients given cA2 went into remission (defined as a score below 150 on the Crohn’s Disease Activity Index, as compared with 4 percent of the patients given placebo [P = 0.005]). At 12 weeks, 41 percent of the cA2-treated patients (34 of 83) had had a clinical response, as compared with 12 percent of the patients in the placebo group (3 of 25) (P = 0.008). The rates of adverse effects were similar in the groups.

Conclusions A single infusion of cA2 was an effective short-term treatment in many patients with moderate-to-severe, treatment-resistant Crohn’s disease.

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CROHN’S disease is a chronic inflammatory disorder characterized by patchy granulomatous inflammation of any part of the gastrointestinal tract. Patients have a spectrum of clinical features, with great variation in the course of the disease. Mesalamine is considered first-line therapy. The majority of patients have relapses requiring glucocorticoid treatment. Immunomodulatory agents, including azathioprine or mercaptopurine, methotrexate, and cyclosporine may be used to treat severe, persistent disease that is refractory to treatment with corticosteroids, or symptoms that recur on tapering of the dose of corticosteroids. In animal models, antibodies to tumor necrosis factor α (anti-TNF-α) prevent or reduce inflammation, suggesting that therapy with such antibodies may be useful for disorders in which chronic inflammation may be due to an increase in cytokines produced by the T helper 1 subclass of T cells. In vitro studies have shown that the production of TNF-α is increased in the mucosa of patients with Crohn’s disease and that the mucosal inflammatory process reflects a shift in the balance of cytokine production by T cells toward the T helper 1 subclass. Similar findings were reported in the synovia of patients with rheumatoid arthritis, and anti–TNF-α reduces clinical signs and symptoms of this disease.

The role of TNF-α in the pathogenesis of Crohn’s disease and the successful use of anti–TNF-α in the treatment of rheumatoid arthritis stimulated an open-label trial of chimeric monoclonal antibody cA2 (infliximab, Centocor, Malvern, Pa.) for Crohn’s disease. In that preliminary trial, clinical remission occurred after one infusion of cA2 in eight of nine patients with Crohn’s disease. We report the results of a multicenter randomized, placebo-controlled, double-blind trial of cA2 for the treatment of active Crohn’s disease.

METHODS

Patients

To be eligible for the study, patients had to have had Crohn’s disease for six months, with scores on the Crohn’s Disease Activity Index between 220 and 400. The Crohn’s Disease Activity Index incorporates eight variables related to the disease: the number of liquid or very soft stools, the severity of abdominal pain or cramping, general well-being, the presence of extraintestinal manifestations, the presence of extraintestinal manifestations, the presence of extraintestinal manifestations, the presence of extraintestinal manifestations, the presence of extraintestinal manifestations, the presence of extraintestinal manifestations, the presence of extraintestinal manifestations, the presence of extraintestinal manifestations. The role of TNF-α in the pathogenesis of Crohn’s disease and the successful use of anti–TNF-α in the treatment of rheumatoid arthritis stimulated an open-label trial of chimeric monoclonal antibody cA2 (infliximab, Centocor, Malvern, Pa.) for Crohn’s disease. In that preliminary trial, clinical remission occurred after one infusion of cA2 in eight of nine patients with Crohn’s disease. We report the results of a multicenter randomized, placebo-controlled, double-blind trial of cA2 for the treatment of active Crohn’s disease.

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ifectations, abdominal mass, use of antiinflammatory drugs, hemato-
crit, and body weight. These items yield a composite score rang-
ing from 0 to approximately 600. Higher scores indicate greater
disease activity. Scores below 150 indicate remission, whereas
scores above 450 indicate severe illness. Patients were eligible for
the study if they had been receiving any of the following: me-
salazine for eight or more weeks, with the dose remaining stable
during the four weeks before screening; in all study groups, a maximum of 40 mg of
corticosteroids per day for eight or more weeks, with the dose re-
main ing stable during the two weeks before screening; and mer-
captopurine or azathioprine for six or more months, with the dose re-
main ing stable during the eight weeks before screening. Patients were also excluded
if they met any of the following criteria: symptomatic stenosis or ileal strictures; proctocolectomy or total colectomy; stoma; a his-
tory of allergy to murine proteins; prior treatment with murine,
chimeric, or humanized monoclonal antibodies; or treatment
with parenteral corticosteroids or corticotropin within four weeks before
screening.

Patients were enrolled at 18 centers in North America and Eu-
rope. The protocol was approved by the institutional review
boards and ethics committees at all sites, and all patients gave
written informed consent before enrolling in the trial. The study
began on June 21, 1995, and concluded on March 12, 1996. A
total of 203 patients were screened for the study, 95 of whom
were excluded. The most common reasons for exclusion were a
requirement for contraindicated medications, refusal to give in-
formed consent, or disease activity that did not meet the study
criteria.

Protocol

Subjects were screened one week before the administration of
cA2 to establish base-line scores on the Crohn’s Disease Activity
Index and the Inflammatory Bowel Disease Questionnaire,24 and
base-line C-reactive protein concentrations. The Inflammatory
Bowel Disease Questionnaire, a 32-item questionnaire, evaluates
quality of life with respect to bowel function (e.g., loose stools
and abdominal pain), systemic symptoms (fatigue and altered
sleep pattern), social function (work attendance and the need to
cancel social events), and emotional status (angry, depressed, or
irritable). The score ranges from 32 to 224, with higher scores
indicating a better quality of life. Patients in remission usually
score between 170 and 190.24

Patients were randomly assigned to receive a single dose of ei-
ther placebo or 5 mg of cA2 per kilogram of body weight, 10 mg
of cA2 per kilogram, or 20 mg of cA2 per kilogram in an intra-
venous infusion, administered over a two-hour period. The cA2
monoclonal antibody is a chimeric mouse–human IgG1 that
binds to both soluble25 and transmembrane26 human TNF-α with
high affinity and specificity. It neutralizes the functional activity
of TNF in a variety of bioassays by blocking the binding of the
factor to the p55 and p75 receptors.27 The placebo preparation
contained 0.1 percent human serum albumin instead of cA2 and
was identical in appearance to the cA2 solution. Patients were en-
was performed centrally by an independent organization (PPD
Pharmaco, Austin, Tex.). The cA2 and placebo solutions were
prepared by a pharmacist at each site who was aware of the treat-
ment assignments. The investigators, all other study personnel,
and the patients were blinded to the treatment assignments.

The primary end point was defined before the initiation of the trial
as a reduction of 70 points or more in the score on the Crohn’s Disease Activity Index at the four-week evaluation that
was not accompanied by a change in any concomitant medica-
tion. Patients who did not have a clinical response at that time
to receive a stable dose during the trial period. The dose of
corticosteroids could be tapered beginning eight weeks after
the initiation of the study. Treatment with these drugs or with
methotrexate or cyclosporine could not be initiated during the
trial. After all patients had completed 12 weeks of the trial and
the data were finalized, the treatment assignments were revealed.

Immunologic Investigations

Serum samples were obtained at base line and at 12 weeks for
the evaluation of antinuclear antibodies and human anti-cA2. An-
inuclear antibodies were detected by immunofluorescence on
Hep-2 cells. Serum samples positive by immunofluorescence for an-
inuclear antibodies were tested for antibodies to double-stranded
DNA by an enzyme-linked immunosorbent assay (North Ameri-
can centers) or by Citrihn immunofluorescence (European cen-
ters). Human anti-cA2 was measured by a double-antigen enzyme-
linked immunosorbent assay.

Statistical Analysis

An adaptive stratified design was used to assign patients to a
treatment group, with investigational site and corticosteroid use
as the strata. We calculated that approximately 25 patients were
needed in each treatment group to detect a difference in the
number of patients who responded with 80 percent power (α = 0.05),
as suming a response rate of 30 percent in the placebo
group, 80 percent in the cA2 group with the greatest response,
and 55 percent in the remaining cA2 groups. The original study
protocol did not specify the use of intention-to-treat analysis.
Two patients were assigned to a treatment but did not receive it: one declined to participate and one did not meet eligibility crite-
ria. No further data were collected on these two patients, and
they are not included in the analysis. Otherwise, all patients were
analyzed according to the treatment to which they were assigned.
When we assessed the response or remission rates in all evaluation
periods after the initial blinded infusion, patients who received an
open-label infusion or those with a change in concomitantly ad-
ministered medications were considered to have had no response.

Categorical variables (clinical response and remission) were
compared with use of the Mantel–Haenszel chi-square test for
general association stratified according to investigational site.28

Analyses comparing each of the cA2 treatment groups with pla-
cebo were performed only when the treatment effect was con-
sidered significant (P<0.05). The changes from base line in
continuous variables (Crohn’s Disease Activity Index score, In-
flammatory Bowel Disease Questionnaire score, and C-reactive
protein concentration) were compared with use of analysis of vari-
ance, with the van der Waerden normal scores blocked according
to center.29 If the treatment effect was significant, the cA2 treat-
ment groups were compared with the placebo group with linear
contrasts. All P values are two-sided.

RESULTS

Base-Line Characteristics of the Study Patients

A total of 108 patients were studied, with 25 to 28 patients in each group. There were no significant
differences in age, weight, race (all patients were white), sex, duration of disease, scores on the Crohn’s
Disease Activity Index and Inflammatory Bowel Disease
Questionnaire, or C-reactive protein concentrations at base line among the groups, although patients in the placebo
group had a lower mean concentration of C-reactive protein (Table 1). Signifi-
cantly more patients had ileal disease alone in the placebo
group than in the other three groups (P = 0.02), but there were no significant differences


in the number who had undergone previous segmental resections among the groups. Similar numbers of patients in each group had been treated with oral corticosteroids, mercaptopurine, azathioprine, and oral mesalamine at baseline. All treatment groups had a mean score on the Crohn’s Disease Activity Index of approximately 300, despite concurrent treatment with drugs other than cA2; thus, the patients had moderate-to-severe, treatment-resistant Crohn’s disease.

Clinical Response and Remission

Week 2

Figure 1A demonstrates that clinical response was achieved early: 61 percent of cA2-treated patients had a clinical response by week 2, as compared with 17 percent of patients in the placebo group (P < 0.001). At two weeks, 27 percent of cA2-treated patients were in clinical remission (defined as a score of less than 150 on the Crohn’s Disease Activity Index), as compared to 4 percent of the patients in the placebo group (P = 0.06) (Fig. 1B).

Week 4

Four weeks after the infusion, the primary end point of a reduction of 70 or more points in the score on the Crohn’s Disease Activity Index was reached in 81 percent of those given 5 mg of cA2 per kilogram (22 of 27 patients), 50 percent of those given 10 mg of cA2 per kilogram (14 of 28 patients), and 64 percent of those given 20 mg of cA2 per kilogram (18 of 28 patients), as compared with 17 percent of those given placebo (4 of 24 patients) (Fig. 1A). The overall response of the cA2 groups was 65 percent (P < 0.001 for the comparison with placebo). No dose–response relation was seen during this period. At four weeks, 33 percent of the cA2-treated group were in remission, as compared with 4 percent of the placebo group (P = 0.005). Thus approximately half of the patients who had a clinical response at either two or four weeks also entered remission. Consistent treatment effects were observed when the analyses for both response and remission at week 4 were stratified according to the location of disease or concurrent drug regimens (data not shown).

Changes in Clinical and Inflammatory Measures during the First Four Weeks

The mean change in the scores on the Crohn’s Disease Activity Index in the cA2-treated group as a whole was significant at weeks 2 and 4 of the trial, as compared with the changes in scores in the placebo group (P < 0.001) (Table 2). The mean decrease in the score on the Crohn’s Disease Activity Index

| Table 1. Baseline Characteristics of the 108 Patients.* |
|---------------------------------|--------------------|--------------------|--------------------|
| Characteristic                  | Placebo (N = 28)   | 5 mg of cA2/kg (N = 27) | 10 mg of cA2/kg (N = 28) | 20 mg of cA2/kg (N = 28) |
| Duration of disease — yr       | 10.4 ± 7.7         | 12.5 ± 10.3         | 11.5 ± 9.6          | 13.5 ± 8.8        |
| Involved intestinal area — no. of patients (%) |                     |                     |                    |                    |
| Ileum only                    | 8 (32)†            | 3 (11)              | 4 (14)              | 2 (7)             |
| Ileum and colon               | 10 (40)            | 15 (56)             | 14 (50)             | 19 (68)           |
| Colon only                    | 7 (28)             | 9 (33)              | 10 (36)             | 7 (25)            |
| Previous segmental resection — no. of patients (%) |                     |                     |                    |                    |
| Age — yr                      | 38.5 ± 11.0        | 37.0 ± 11.8         | 39.3 ± 10.6         | 36.0 ± 9.7        |
| Male sex — no. (%)            | 15 (60)            | 14 (52)             | 13 (46)             | 13 (46)           |
| Weight — kg                   | 71.4 ± 14.4        | 68.1 ± 17.7         | 74.2 ± 19.5         | 68.4 ± 16.0       |
| Height — cm                   | 172 ± 11           | 169 ± 8             | 171 ± 10            | 171 ± 9           |
| Medications — no. of patients | Prednisone equivalent |                 |                    |                    |
| <20 mg/day orally             | 10 (40)            | 8 (30)              | 8 (29)              | 10 (36)           |
| ≥20 mg/day orally             | 6 (24)             | 7 (26)              | 8 (29)              | 7 (25)            |
| Mercaptopurine                | 4 (16)             | 4 (15)              | 4 (14)              | 4 (14)            |
| Azathioprine                  | 7 (28)             | 5 (19)              | 4 (14)              | 8 (29)            |
| Oral aminosalicylates         | 17 (68)            | 16 (59)             | 18 (64)             | 13 (46)           |
| Score on Crohn’s Disease Activity Index | 288 ± 54         | 312 ± 56            | 318 ± 59            | 307 ± 50          |
| Score on Inflammatory Bowel Disease | 128 ± 29         | 122 ± 29            | 116 ± 23            | 118 ± 28          |
| C-reactive protein — mg/liter | 12.8 ± 13.9        | 22.1 ± 23.6         | 23.2 ± 24.2         | 22.4 ± 23.9       |

*Plus–minus values are means ±SD. Higher scores on the Crohn’s Disease Activity Index indicate greater disease activity, and higher scores on the Inflammatory Bowel Disease Questionnaire indicate better quality of life.

†P = 0.02 for the comparison with the other three groups.
The differences in the rates of clinical response between the cA2-treated groups and the placebo group remained significant through the 12 weeks of follow-up: it was 48 percent in the group given 5 mg of cA2 per kilogram (13 of 27 patients), 29 percent in the group given 10 mg of cA2 per kilogram (8 of 28 patients), and 46 percent in the group given 20 mg of cA2 per kilogram (13 of 28 patients), for an overall rate of response of 41 percent (34 of 83 patients), as compared with a rate of 12 percent in the placebo group (3 of 25 patients) (P = 0.008). The difference in the percentage of patients who were in remission was not significant at 12 weeks: 30 percent of the group given 5 mg of cA2 per kilogram (8 of 27 patients), 18 percent of the group given 10 mg of cA2 per kilogram (5 of 28 patients), and 25 percent of the group given 20 mg of cA2 per kilogram (7 of 28 patients), for an overall rate of remission achieved of 24 percent (20 of 83 patients), as compared with a rate of 8 percent in the placebo group (2 of 25 patients) (P = 0.31).

Characterization of the Response to Treatment

The magnitude and duration of response were characterized through the 12-week follow-up period in the 54 patients who responded to a single infusion of cA2. The improvement in the scores on the Crohn’s Disease Activity Index (clinical remission was defined as a score below 150) and Inflammatory Bowel Disease Questionnaire (remission was defined as a score between 170 and 190) in patients with a response was maintained. The mean (±SD) score on the Crohn’s Disease Activity Index was 318±52 at base line, 144±67 at week 4, 151±86 at week 8, and 182±91 at week 12, and the mean score on the Inflammatory Bowel Disease Questionnaire was 121±26 at base line, 175±26 at week 4, 165±36 at week 8, and 162±35 at week 12. Concentrations of C-reactive protein (normal, <8 mg per liter) began to rise at 12 weeks, potentially indicating a relapse of disease (from 25.8±2.7 mg per liter at base line to 75.5±1.5 mg per liter at week 4, 11.0±2.1 mg per liter at week 8, and 14.1±2.2 mg per liter at week 12).
Effects of Open-Label cA2 in Patients with No Response
Four Weeks after the Initial Infusion of cA2

Patients who did not have a clinical response after the first infusion were given a second infusion of open-label cA2 in a dose of 10 mg per kilogram and followed for an additional 12 weeks. Among 19 patients who initially received placebo, the response rate was 58 percent and the remission rate was 47 percent four weeks after the second infusion — rates that were similar to those in the initial, blinded study (Fig. 1). By contrast, among the 29 patients who had no response to the initial cA2 infusion, the rates of response and remission after the second infusion were 34 percent (P = 0.14 for the comparison with the patients who received placebo initially) and 17 percent (P = 0.05), respectively, confirming that this group was less responsive to cA2.

Adverse Effects

Adverse effects were recorded at the time of infusion and 2, 4, 8, and 12 weeks after the infusion. In patients who received an open-label infusion 4 weeks after an infusion of placebo or cA2, adverse effects were monitored for an additional 12 weeks. As shown in Table 3, the percentages of patients with adverse effects were similar in the placebo and cA2 groups. Of the 29 patients who received two cA2 infusions, 2 had a reaction (chest pain, dyspnea, or nausea) that led to the discontinuation of the infusion. These reactions resolved spontaneously within minutes after the infusion was discontinued. In addition, complications requiring hospitalization developed in two patients (abdominal abscess in one patient in the placebo group and salmonella colitis in one patient given an infusion of 20 mg of cA2 per kilogram). Both patients were treated successfully. A bowel obstruction occurred in one patient given cA2, and a flare of Crohn’s disease occurred in another.

Immunologic Responses

Serum samples were screened for antibodies to double-stranded DNA at base line and at 12 weeks in 98 patients who received cA2 (in either a blinded

### Table 2. Measures of Clinical Response and Inflammation at Base Line and Weeks 2 and 4.*

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>PLACEBO (N=25)</th>
<th>5 mg of cA2/kg (N=27)</th>
<th>10 mg of cA2/kg (N=28)</th>
<th>20 mg of cA2/kg (N=28)</th>
<th>ALL cA2 GROUPS (N=83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score on Crohn’s Disease Activity Index</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>288±54</td>
<td>312±56</td>
<td>318±59</td>
<td>307±50</td>
<td>312±55</td>
</tr>
<tr>
<td>2 weeks</td>
<td>272±75</td>
<td>182±79†</td>
<td>238±92‡</td>
<td>217±92†</td>
<td>212±90†</td>
</tr>
<tr>
<td>4 weeks</td>
<td>271±82</td>
<td>166±76†</td>
<td>226±115§</td>
<td>211±107†</td>
<td>201±103†</td>
</tr>
<tr>
<td>Score on Inflammatory Bowel Disease Questionnaire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>128±29</td>
<td>122±29</td>
<td>116±23</td>
<td>118±28</td>
<td>118±27</td>
</tr>
<tr>
<td>4 weeks</td>
<td>133±28</td>
<td>168±36†</td>
<td>146±41‡</td>
<td>149±35</td>
<td></td>
</tr>
<tr>
<td>C-reactive protein (mg/liter)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base line</td>
<td>12.8±13.9</td>
<td>22.1±23.6</td>
<td>23.2±34.2</td>
<td>22.4±23.9</td>
<td>22.6±27.4</td>
</tr>
<tr>
<td>2 weeks</td>
<td>16.4±18.9</td>
<td>4.2±3.0†</td>
<td>6.7±7.3**</td>
<td>8.7±13.8††</td>
<td>6.5±9.3‡†</td>
</tr>
<tr>
<td>4 weeks</td>
<td>14.8±18.6</td>
<td>5.7±9.3††</td>
<td>12.1±18.6§</td>
<td>6.9±11.6¶</td>
<td>8.3±13.9¶†</td>
</tr>
</tbody>
</table>

*Plus-minus values are means ±SD. Higher scores on the Crohn’s Disease Activity Index indicate greater disease activity, and higher scores on the Inflammatory Bowel Disease Questionnaire indicate better quality of life. All P values are for the change from base line in cA2-treated groups as compared with the placebo group. See the Methods section for a description of the statistical analyses used.

### Table 3. Adverse Effects.*

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>PLACEBO</th>
<th>ONE DOSE OF cA2</th>
<th>TWO DOSES OF cA2</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients evaluated</td>
<td>25</td>
<td>102</td>
<td>29</td>
</tr>
<tr>
<td>Average length of follow-up — wk</td>
<td>6.9</td>
<td>10.4</td>
<td>12.4</td>
</tr>
<tr>
<td>Adverse effect — no. of patients (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any adverse effect</td>
<td>15 (60)</td>
<td>76 (75)</td>
<td>23 (79)</td>
</tr>
<tr>
<td>Headache</td>
<td>5 (20)</td>
<td>19 (19)</td>
<td>5 (10)</td>
</tr>
<tr>
<td>Nausea</td>
<td>2 (8)</td>
<td>11 (11)</td>
<td>5 (17)</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>3 (12)</td>
<td>8 (8)</td>
<td>4 (14)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>1 (4)</td>
<td>6 (6)</td>
<td>3 (10)</td>
</tr>
<tr>
<td>Myalgia</td>
<td>1 (4)</td>
<td>4 (4)</td>
<td>3 (10)</td>
</tr>
<tr>
<td>Rhinitis</td>
<td>1 (4)</td>
<td>3 (3)</td>
<td>3 (10)</td>
</tr>
<tr>
<td>Pain</td>
<td>0</td>
<td>4 (4)</td>
<td>3 (10)</td>
</tr>
<tr>
<td>Pruritus</td>
<td>1 (4)</td>
<td>1 (1)</td>
<td>4 (14)</td>
</tr>
<tr>
<td>Chest pain</td>
<td>1 (4)</td>
<td>2 (2)</td>
<td>3 (10)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>0</td>
<td>2 (2)</td>
<td>3 (10)</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>0</td>
<td>1 (1)</td>
<td>3 (10)</td>
</tr>
</tbody>
</table>

*Adverse effects that occurred in 10 percent or more of the patients in any of the groups are reported.
or an open-label infusion); all patients were negative for these antibodies at base line, and 3 were positive at 12 weeks. Serum samples from 101 patients treated with cA2 (in either a blinded or an open-label infusion) were also tested for human anti-cA2; 6 patients tested positive. In two thirds of the patients, however, cA2 was still detectable in serum samples taken at 12 weeks, and this may have interfered with the assay.

DISCUSSION

Many of our patients with moderate-to-severe Crohn's disease that was resistant to treatment had a rapid response to cA2. Other treatments for such patients have not had beneficial effects over the long term and may not be well tolerated.30-33 Our short-term study suggests that anti–TNF-α therapy with cA2 may represent a new treatment option for patients with moderate-to-severe Crohn's disease. Further studies will be necessary to determine the long-term efficacy of a single infusion of cA2 as well as the efficacy and safety of repeated treatments.

The mechanisms of the chronic mucosal inflammatory processes manifesting as Crohn's disease are not clear. However, our results add strength to the suggestion that TNF-α may have a central role in the inflammatory process in at least two thirds of the patients with Crohn's disease.22 Studies in rodent models have provided insight into the role of anti–TNF-α in the pathogenesis of Crohn's disease. Studies involving the transfer of CD45RBhi cells to mice with severe combined immunodeficiency have shown that these cells can induce a chronic, transmural inflammatory process in the colon.34 Powrie et al. have demonstrated that this colitis can be reversed or ameliorated by the use of agents, including anti–TNF-α, capable of down-regulating the production of the T helper 1 subclass of T cells.10 These cells produce proinflammatory cytokines including interferon-γ, interleukin-2, and potentially, TNF. A mechanistic role for TNF-α in intestinal inflammation has been suggested on the basis of these studies.

Other studies involving animal models have shown that cytokines produced by the T helper 1 subclass are expressed in the mucosa of people with Crohn's disease.17,28 Anti–TNF-α may participate in the down-regulation of mucosal inflammation in this disease by inhibiting the T helper 1 population of active T cells. Extensive follow-up studies are needed to determine how the elimination of TNF affects mucosal inflammation after treatment with anti–TNF-α.

In this study, a clinical response or remission occurred in 65 percent of patients with severe Crohn's disease after a single infusion of cA2. Furthermore, results in the open-label retreatment phase corroborated the finding that patients with no response to the first infusion of cA2 were less likely to have a response to a second infusion. Thus, this group of patients may differ from those that responded. The similarities among the patients, including age, duration of disease, types of concomitant treatment, and disease activity at base line, suggest that any differences are more likely to be detected subclinically. There was no apparent dose–response relation between a dose of 5 mg of cA2 per kilogram and a dose of 20 mg per kilogram with respect to either the magnitude or the duration of the clinical response. In a previous open-label trial of cA2 doses of 1 mg, 5 mg, 10 mg, and 20 mg per kilogram, the group receiving 1 mg of cA2 per kilogram had a more transient response than the groups given the higher doses.35 This transient response was similar to that in a small trial of a different anti–TNF-α antibody.36 The results of these trials support the use of a dose of 5 mg of cA2 per kilogram in future trials.

In summary, we found that a single infusion of cA2 was an effective short-term treatment for patients with moderate-to-severe Crohn's disease that was resistant to treatment.

Supported by Centocor, Inc., and by a grant (FD-R-001276) from the Food and Drug Administration Orphan Products Development Division. Drs. Hanauer, van Deventer, Present, and Rutgeerts have received honoraria from Centocor for lectures.

APPENDIX


REFERENCES