

Re-Evaluating the Use of IFN- β and Relapsing Multiple Sclerosis: Safety, Efficacy and Place in Therapy

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Abstract: The advent of interferon therapy for the treatment of multiple sclerosis (MS) was a massive advancement in the field and changed the course of the disease. While the exact mechanism of interferon therapy in MS is unknown, disease control is likely mediated by reducing Th1 and Th17 cells while increasing regulatory T cells and altering the cytokine profile. Interferon therapy not only gave physicians and patients an evidence-based treatment option to treat MS by decreasing relapses and the accrual of disability but it also provided valuable insight into disease pathophysiology that allowed for the development of further treatments. Currently, there are 18 disease-modifying therapies available for the treatment of MS with varying efficacies, routes of administration, and mechanisms. As treatment options in the field have evolved, interferon therapy is less commonly prescribed as first-line therapy, because the newer therapies are more effective and better tolerated. That being said, interferons still have a place in the field in both clinical practice and clinical trial research. In this review, we will summarize the safety and efficacy of interferon therapy and discuss its current place in MS care.

Keywords: multiple sclerosis, interferon-beta therapy, disease-modifying therapy

Introduction

Multiple sclerosis (MS) is an inflammatory demyelinating disease of the central nervous system that leads to neuronal damage and irreversible disability, thought to be mediated by a T-cell autoimmune process. This theory of pathogenic T-cell involvement has become the target of many of the disease-modifying therapies (DMTs). Interferon (IFN) γ -secreting helper T cells (Th1), interleukin-17 secreting Th17 cells, and regulatory T cells (Tregs) are the most studied types of T cells in the pathogenesis and modulation of MS. With the more recent success of anti-B cell monoclonal antibody therapies in the treatment of MS, the role of B cells appears to be important in the pathogenesis of MS as well. It has been shown that the number of B cells, not the amount of antibody, correlates with relapse rates.¹ This led to the theory that it is B cell-T cell interactions such as antigen presenting and modulation of cytokine secretion that are important drivers of the disease.

Interferons are a family of cytokines that are involved in the regulation of innate and adapted immunity, and therefore became an attractive target for immunomodulation therapy in MS. Interferons were initially studied for the treatment of multiple sclerosis on the basis of three rationales: 1) reports that intrathecal injections of natural interferon beta

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(IFN β) significantly reduced exacerbations, 2) that intercurrent viral infections trigger new attacks, and 3) that interferons had immunomodulatory functions including inhibition of IFN γ synthesis, augment defective suppressor activity, and inhibit class II major histocompatibility complex antigen expression.² Since these initial theories were proposed, it has been demonstrated that IFN β has pleiotropic effects on the peripheral immune system including reducing pathogenic Th1 and Th17 cells and increasing Tregs that produce IL-10 via the JAK-STAT signaling pathway.^{3–5} Additionally, IFN β has been shown to reduce CD27+ memory B cells and increase IL-10 producing transitional B cells, which is thought to be beneficial on disease activity.³ Finally, IFN β may downregulate adhesion molecules suppressing the ability of pro-inflammatory cells to enter the CNS.⁵

There are currently multiple formulations of IFN β that are approved for use in clinically isolated syndrome, relapsing remitting MS (RRMS), and secondary progressive MS (SPMS) with relapses. These include IFN β -1b (Betaseron[®] and Extavia[®]) that are administered subcutaneously every other day at a dose of 250 μ g, IFN β -1a that is administered intramuscularly once a week (Avonex[®]) at a dose of 30 μ g, IFN β -1a (Rebif[®]) that is administered subcutaneously three times weekly at a dose of 22 or 44 μ g, and pegylated IFN β -1a (Plegridy[®]) that is administered subcutaneously every 2 weeks at a dose of 125 μ g.⁵

Interferons effect on disease activity in MS is multifactorial and not fully understood. Since the pivotal approval of IFN β , the therapeutic landscape has rapidly and continuously expanded with 18 FDA-approved DMTs for MS to date (Figure 1).⁶ The efficacy of interferons is now considered modest as newer therapies have demonstrated more potent disease control. There is also an

increased adaptation of the use of highly effective therapy earlier in the disease course and a subsequent change in sequencing medications. In this increasingly complex treatment landscape, we will review the safety and efficacy of interferons and discuss their current role in the treatment of MS.

Pivotal Phase III Trials of RRMS

Prior to 1993 when IFN β -1b became the first FDA-approved treatment for RRMS, there was nothing available that significantly impacted relapse rates, lesion accumulation, or disability accrual in MS. The first IFN β trial that was published in 1993 represented a landmark in the history of MS treatment and led to a sea-change in the field. Further studies were subsequently performed looking at different formulations of IFN β . Overall, the initial phase III trials of the first three interferon products showed a reduction in relapse rate by 18–34% in patients with relapsing-remitting MS.⁷ The results of these pivotal trials are summarized below and in Table 1.

The IFN β -1b multiple sclerosis study group published the results of their multicenter, randomized, double-blind, placebo-controlled trial in 1993, based on two identical trials from 1988 to 1990. In this trial, placebo was compared to two different doses of IFN β -1b (1.6 million international units (MIU) and 8.0 MIU), both administered by subcutaneous injections every other day. The primary endpoints of this trial were differences in the rates of exacerbations and the proportion of patients remaining exacerbation free. Results showed dose-dependent outcomes in significantly reducing the annual rate of exacerbation for patients receiving intermediate-dose and high-dose IFN β -1b compared to placebo at 2 years (1.14 vs 0.84 vs 1.27, respectively). Additionally,

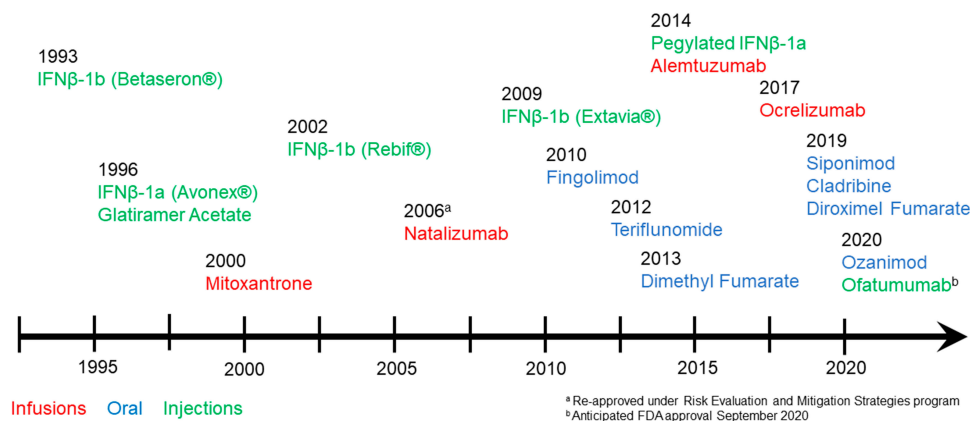


Figure 1 Timeline of FDA approval for currently available disease-modifying therapies. Brand names only used for IFN β formulations for clarity. Infusion therapies are in red text, oral therapies are in blue text and injectable therapies are in green text.

Table 1 Summaries of Pivotal Trials of Interferons in RRMS

Trial	Primary Outcome	Secondary Outcome	Intervention	Significant Results	Adverse Events
IFNB MS Study Group, ² 1993 (2 years)	<ul style="list-style-type: none"> Differences in ARR Proportion of patients exacerbation-free 	<ul style="list-style-type: none"> Time to exacerbation MRI lesion load Severity of exacerbations Change in EDSS 	1.6MIU IFNB 1b or 8.0 MIU IFNB-1b SC every other day vs placebo	<ul style="list-style-type: none"> ARR lower in both treatment groups (placebo: 1.27; 1.6MIU 1.17; 8.0MIU 0.84) More patients in 8.0MIU group exacerbation-free (did not remain significant at 3 years) Prolongation of time to first and second exacerbations in 8.0MIU group Benefit in MRI lesion burden (placebo with 20% increase, 1.6MIU with 10.5% increase, 8.0MIU with 0.1% decrease) Less moderate and severe exacerbations in 8MIU group No significant change in EDSS in any group 	<ul style="list-style-type: none"> Mild, intermittent lymphopenia, neutropenia anemia, thrombocytopenia Abnormal liver enzymes Injection site pain Flu-like illness Muscle aches Fever Chills Neutralizing antibodies: 11% in placebo, 47% in 1.6MIU, 45% in 8.0MIU
MSCRG, ⁸ 1996 (2 years)	<ul style="list-style-type: none"> Time to sustained disability progression 	<ul style="list-style-type: none"> Exacerbations MRI 	6.0 MIU IFNB-1a IM weekly vs placebo	<ul style="list-style-type: none"> Delay in time to sustained EDSS progression (34.9% in placebo vs 21.9% with progression at 104 weeks) Decreased number of exacerbations and annual relapse rates (0.90 in placebo and 0.61 in IFN) Decreased number and volume gadolinium enhancement 	<ul style="list-style-type: none"> Mild anemia Flu-like illness Muscle aches Chills Fever Asthenia Neutralizing antibodies: 4% in placebo, 22% in IFN
PRISMS, ⁹ 1998 (2 years)	<ul style="list-style-type: none"> Annualized relapse rate 	<ul style="list-style-type: none"> Times to first and second relapse Proportion of relapse-free patients Progression in disability MRI activity 	IFNB-1a 22µg or 44 µg SC three times weekly vs placebo	<ul style="list-style-type: none"> Decreased relapse rates in both treatment groups (2.56 in placebo, 1.82 in 22µg and 1.73 in 44 µg) Median time to first relapse delayed by 3 and 5 months in 22µg and 44µg respectively Longer time to sustained progression Decreased T2 and gadolinium-enhancing lesions in both treatment groups 	<ul style="list-style-type: none"> Leukopenia Elevated liver enzymes Depression Injection-site reactions Flu-like illness Neutralizing antibodies: 23.8% in 22µg and 12.5% in 44µg
ADVANCE, ¹⁰ 2014 (48 weeks)	<ul style="list-style-type: none"> Annualized relapse rates 	<ul style="list-style-type: none"> Number of new or enlarging T2 lesions Proportion of patients who relapsed Proportion of patients with disability progression 	Peginterferon beta-1a 125µg every 2 weeks or every 4 weeks, vs placebo	<ul style="list-style-type: none"> Decreased annualized relapse rates (0.397 in placebo, 0.256 in every 2-week group, 0.288 in every 4-week group) Decreased proportion of patients who relapsed (0.291 in placebo, 0.187 in every 2-week group, and 0.222 in every 4-week group) Decreased sustained disability (0.105 in placebo and 0.068 in both treatment groups) Decreased number and volume of T2 lesions 	<ul style="list-style-type: none"> Injection site reactions Flu-like illness Fever Headache

there were significantly more patients who were relapse-free at 2 years in the high-dose IFN β -1b groups compared to placebo (36 vs 18, respectively), though this was no longer significant at 3 years. Secondary outcomes demonstrated a significant prolongation of time to exacerbation in the group receiving high-dose IFN β -1b compared to placebo, and significantly fewer hospitalizations and hospital days in the IFN β -1b groups.² The MRI data was also favorable in the IFN β -1b groups compared to placebo in terms of T2 lesion load: at the end of the first year, the lesion load compared to baseline increased by 12.25% in the placebo group, increased by 4.1% in the intermediate dose group and decreased by 1.1% in the high-dose group.² There was no significant change in the mean Expanded Disability Status Scale (EDSS) score in any of the arms at 3 years, though all three arms increased from baseline.

Adverse events included abnormal laboratory tests (elevated liver enzymes, neutropenia, anemia, thrombocytopenia), injection site reactions, and flu-like syndrome (fever, chills, myalgias, sweating). Mild, transient lymphopenia was the most common laboratory abnormality (65% of placebo patients, 76% in the intermediate dose group, and 80% in the high-dose group). Additionally, neutralizing antibodies were found in 47% of the intermediate dose and in 45% of the high-dose patients; however, there did not appear to be a relationship with exacerbation severity or time between exacerbations.

In 1996, the Multiple Sclerosis Collaborative Research Group published their study regarding the efficacy of intramuscular IFN β -1a in decreasing disability progression. This study was a multi-center, double-blind, placebo-controlled trial, with 6.0MIU administered intramuscularly weekly.⁸ This trial's primary endpoint evaluated time to sustained disability progression (at least 1.0 increase in baseline EDSS for at least 6 months) and showed a decrease in disability progression in the treated group compared to the placebo group (at 104 weeks 33.3% of placebo recipients had progression of disability vs 21.2% of IFN β -1a recipients), and a significantly longer time to sustained disability progression in the treatment group. Additionally, the IFN β -1a group had significantly fewer exacerbations (annual relapse rate 0.82 in the placebo group vs 0.67 in the treatment group), and a longer time to first exacerbation (47.3 weeks vs 36.1 weeks). Fewer gadolinium enhancing lesions were seen in the IFN β -1a group and a larger within-person percent change in T2 lesions volume at 2 years (-6.5% in placebo group vs -13.2% in interferon group). They also found a significantly

greater change in the EDSS scores in the placebo group compared to the treatment group.

Adverse events of the interferon in this trial were similar to the previous trial including flu-like symptoms, injection site reactions, and mild anemia. Depression was seen in both groups equally. Neutralizing antibodies were seen in 22% of the interferon recipients at week 104.

The PRISMS trial was published in 1998 to evaluate the efficacy of subcutaneous IFN β -1a. This study looked at 2 different doses (22 μ g and 44 μ g) of IFN β -1a injected three times weekly compared to placebo.⁹ This study showed a 27% and 33% risk reduction for the two doses of IFN β -1a, respectively. It also showed a delayed median time to first relapse by 3 and 5 months, respectively. Additionally, the time to sustained progression was significantly longer in both IFN β -1a groups compared to placebo, and there was a significant decrease in T2 MRI disease burden (increase of 10.9% in placebo group compared to decreases by 1.2% and 3.8% in the two treatment groups, respectively). Adverse events in the IFN β -1a group included flu-like symptoms, injection site reactions, lymphopenia, and elevated liver enzymes. Depression was again seen in the placebo and treatment groups equally. Neutralizing antibodies were seen in 23.8% of the low-dose recipients and in 12.5% of the high-dose recipients and did not affect the mean relapse count. Overall, the reduction of relapse rates in this study were consistent with the first IFN β -1b study and slightly favorable to the IFN β -1a intramuscular study.

The ADVANCE trial was published in 2014, looking at the safety and efficacy of pegylated IFN β -1a (PEG IFN β -1a) injected subcutaneously every 2 or 4 weeks compared to placebo. A polyethylene glycol (PEG) side chain was attached to the interferon molecule in order to prolong its half-life and increase systemic exposure without changing its biological properties.¹⁰ They found that adjusted annualized relapse rates at 48 weeks were significantly lower compared to placebo (0.397 in placebo vs 0.256 in the every 2-week group vs 0.288 in the every 4-week group). The trial also showed a significantly reduced risk of progression on disability compared to placebo, and fewer new or enlarging T2 lesions on MRI. Overall, every 2-week dosing was superior to every 4-week dosing, which was confirmed when the results of the 2-year study were published in 2015.¹¹ Adverse events were similar to previous interferon studies including flu-like symptoms, injection site reactions and lab abnormalities included elevated liver enzymes. A 2-year extension study

(ATTAIN) confirmed the long-term efficacy and safety of the medication.¹² Less frequent injections with PEG IFN β -1a was an important step in the advancement of DMT in terms of patient satisfaction and compliance.

Trials Looking at Time to Clinically Definite MS After First Event

Jacobs et al¹³ published the results of their CHAMPS trial in 2000 regarding the development of clinically definite MS after a first demyelinating event with MRI evidence of prior demyelination on weekly intramuscular IFN β -1a therapy vs placebo. The results of this trial showed that there was a significantly lower probability of developing clinically definite MS in the interferon group during the 3-year study period (rate ratio of 0.49 when adjusted for age, type of event, and MRI characteristics). The interferon group also had favorable MRI outcomes.

Another study published in 2001 by the Early Treatment of Multiple Sclerosis study group looking at the effects of low-dose subcutaneous IFN β -1a on the occurrence of relapses after a first neurologic event with a brain MRI suggestive of MS.¹⁴ The results showed that 34% of the participants in the interferon group vs 45% of the participants in the placebo group converted to clinically definite MS at 2 years and that the time to 30% of the patients converting to clinically definite MS was 569 days in the interferon group vs 252 days in the placebo group. Additionally, the annual relapse rate was lower, and the MRI characteristics were favorable in the interferon group. However, only 16% of the patients in the placebo group and 6% in the interferon group were free of accumulating new lesions on MRI in the 2-year period.

Pivotal Trials in Progressive MS

The European study group on IFN β -1b in secondary progressive MS published their multi-center, double-blinded, randomized, placebo-controlled study in 1998, evaluating the role of subcutaneous IFN β -1b every other day on disability progression in SPMS patients (EDSS 3.0–6.5).⁷ The primary outcome was progression of disability, measured by a 1.0 increase on the EDSS sustained for at least 3 months after all patients had been in the study for at least 2 years. Superimposed relapses were allowed in the study and were treated with IV steroids for 3 days. They found a significant difference in the time to confirmed progression of disability, in favor of the IFN β -1b group, with progression delayed for 9–12 months during the study period, and

a 30% reduction in annual relapse rate. Additionally, there was a 32.1% reduction in the proportion of patients becoming wheelchair-bound in the IFN β -1b group during the study period. There were also significant effects on the MRI lesion volume in favor of the IFN β -1b group. Adverse effects were similar to those seen in the previous interferon studies.

The secondary progressive efficacy clinical trial of recombinant IFN β -1a in MS study group (SPECTRIMS) published the results of their multi-center, randomized, placebo-controlled study in 2001.¹⁵ They looked at two different doses of subcutaneous IFN β -1a injected three times weekly (250 μ g dose and a body surface area adjusted dose of 160 μ g [5 MIU]/m²). Their findings showed no significant difference in time to sustained disability between the placebo and low-dose IFN β -1a group, however, when broken down by sex, women showed a delay in progression at both doses while men did not. There was a significant benefit on the rate of exacerbations in both IFN β -1a groups compared to placebo. Additionally, patients with pre-study relapses did better on IFN β -1a compared to those without pre-study relapses. Side effects were similar to those seen in previous trials, including depression and suicide attempts in both groups.

A study published in 2003 looked at weekly intramuscular IFN β -1a at two doses compared to placebo in patients with primary progressive MS. This study did not show any significant effect on the primary endpoint of time to sustained progression in disability, but did show a lower rate of MRI lesion accumulation in the lower dose group compared to placebo.¹⁶

With the overall mixed results in these progressive trials, it could not be clearly stated that interferons were effective in SPMS, as they were in RRMS. The difference in results was suggested to be due to the shorter length of the European study, with patients that were younger, with a shorter disease duration, more contrast-enhancing lesions, and the higher rate of pre-study relapses in that trial suggesting a more inflammatory disease process.^{15,17} All of these studies demonstrated more of a benefit of treatment in the subgroup with more active disease, suggesting that patients with more inflammatory diseases were more likely to benefit from IFN β therapy.¹⁷

Long-Term Experience with Interferon Therapy

As Bayas and Gold¹⁷ point out in their article summarizing 10 years of experience with interferon in 2003, the published

data at that time demonstrated that IFN β -1b was an effective treatment for patients with RRMS and SPMS with inflammatory components. The IFN β treatment effect was dose and frequency-dependent and early treatment was beneficial. A recent systemic review by Melendez-Torres et al confirms the benefits of IFN β therapy demonstrating comparative effectiveness on relapses and disability, and adherence rates when compared to glatiramer acetate.¹⁸ While interferon therapy was considered overall a safe treatment, patient support was needed to ensure compliance.¹⁷ Sabido-Espin and Munschauer evaluated discontinuation rates using Market Scan Commercial and Medicare Supplemental healthcare claims databases, which revealed that in a cohort of 5956 patients treated with IFN β , 36.9% discontinued at 1 year, and 55.8% discontinued by 3 years.¹⁹ Mitigating adverse effects was considered especially important to foster patient compliance including thoroughly counseling patients on the benefit vs risk of the therapy, expected adverse effects, and that adverse effects tend to subside with longer duration of therapy. Additionally, the use of the “two-needle technique,” an automated injection device, helped to decrease injection site reactions.¹⁷ IFN β therapy, along with glatiramer acetate, remained the mainstay of DMTs for over 15 years until the first oral DMTs were approved.

Changing Treatment Landscape

The Oral DMTs

In 2010 the first Phase 2 and Phase 3 studies of oral fingolimod were published, leading to the first FDA-approved oral DMT therapy for RRMS.²⁰ While these trials were placebo-controlled, the TRANFORMS trial published in 2010 compared oral fingolimod to intramuscular IFN β -1a.²¹ This study showed a significantly lower annualized relapse rate and improved MRI outcomes with fingolimod compared to IFN β -1a. Shortly thereafter, two randomized, double-blind, placebo-controlled phase 3 studies, TOWER²² and TEMSO,²³ led to the approval of teriflunomide in 2012, and DEFINE²⁴ and CONFIRM²⁵ looking at the safety and efficacy of dimethyl fumarate were published leading to its approval in 2013.^{24,26} Further, oral DMTs have since been approved including cladribine,²⁷ siponimod,²⁸ ozanimod,²⁹ and diroximel fumarate.³⁰ These trials and subsequent FDA approvals started the shift in clinical practice to using oral medications as first-line treatment. Patients had improved compliance with pills over injections, as well as superior efficacy, as demonstrated in real-world studies.^{31–34}

Additionally, when there were no approved DMTs for pediatric use prior to 2018, many pediatric onset MS patients were started on IFN β because of the safety history and extensive experience in adult patients. Since the PARADIGMS³⁵ study was published showing fingolimod’s superior efficacy to intramuscular IFN β -1a, and the medication’s subsequent FDA approval for use in pediatric patients, the practice has also been shifting away from starting IFN β therapy in this younger group.

Early Highly Effective Therapy

There has been a recent shift in the MS field to use the highly effective, infusion-based monoclonal antibody treatments such as natalizumab, rituximab, and ocrelizumab as first-line treatments, and accordingly, fewer and fewer newly diagnosed patients are started on IFN β therapy. This is especially true in patients that appear to have highly inflammatory disease. There is increasing evidence to support a critical time window where treatment has a greater impact on long-term disability which may be missed in a traditional escalation approach.³⁶ Harding et al³⁷ reported on a real-world study comparing outcomes on those who received early intensive treatment (EIT) with monoclonal antibody treatments (n=104) vs those who received injectables or oral therapies (escalation group, n=488). They found that even though patients who received EIT have more active disease, this group had better long-term outcomes compared to those in the escalation group. A recent real-world multi-center study of 741 pediatric patients also revealed better outcomes when using newer oral or monoclonal antibody treatment compared to injectables.³⁸ There are two concurrent randomized, multi-centered trials (TREAT-MS (NCT03500328) and DELIVER-MS (NCT03535298)) that are actively enrolling patients to either escalation therapy vs early highly effective therapy looking at safety, efficacy, and cost-effectiveness.

Current Role for Interferon Use

Disease Stability

One of the main reasons for persistence use of IFN β despite increased availability of treatment options is patients who had started IFN β therapy before the approval of newer options and continue to do well in terms of clinical and MRI stability, and side effects profile. Patients should be continually monitored for disease activity, tolerability and compliance, and the topic of switching therapies should be considered if concerns arise. When

both the patient and treating neurologist are comfortable with continuing IFN β therapy then there is no compelling indication to switch or escalate therapy.

Adverse Events or Intolerability on Other DMTs

Some patients may experience adverse events or are unable to tolerate non-interferon therapy. Common adverse events with many DMTs including oral and infusion therapies are laboratory abnormalities including elevated liver enzymes and leukopenia. While these abnormalities can be seen with IFN β therapy, they tend to be asymptomatic, transient, and are rarely clinically significant.^{39,40}

Though the field is transitioning towards using early, highly effective therapy, there are limitations to the use of these agents, and it is not clear for how long patients can remain on these therapies. The use of natalizumab is limited by JC virus status, and if a patient converts to a positive titer, natalizumab should be switched to an alternate DMT due to the risk of progressive multifocal leukoencephalopathy. Additionally, there may be limitations to the long-term use of B-cell therapy, such as decreased immunoglobulins and increased incidence of infections.^{41,42}

IFN β is an important option for patients who are very risk-averse, given the favorable safety profile and lengthy experience with this class of medication in the field.

De-Escalation

While the field is trending towards early highly effective therapy, it is not clear how long these patients need to remain on this type of therapy, and if or when the topic of treatment de-escalation should be considered. After a period of disease stability, it is not clear if the benefits of continuing these highly effective therapies outweigh the potential risks such as infections. This de-escalation concept is used in oncology and rheumatology where potent treatments are used initially, and then patients are maintained on safer therapies long term.^{43,44}

A small study by Rieckmann et al⁴⁵ looked at patients who had previously been on mitoxantrone therapy and had stable disease activity (relapse free for at least 6 months and no confirmed disability progression for at least 9 months prior to screening) and were subsequently put on either IFN β -1a or no treatment. While the IFN β -1a group had more patients who were relapse-free at 96 weeks, due to the small sample size there were no significant results.

Some evidence suggests that IFN β therapy may be a superior option to teriflunomide when considering a lower-efficacy treatment. A recent study by Newsome et al⁴⁶ performed a matching-adjusted comparison of patient data from the ADVANCE and ATTAIN trials evaluating PEG IFN β -1a to the TEMSO and TOWER studies evaluating teriflunomide. The results showed that the proportion of patients with confirmed disability worsening at 108 weeks was significantly lower in the PEG IFN β -1a group than the teriflunomide group, and that patients treated with PEG IFN β -1a had lower annualized relapse rates at 108 weeks and 5 years compared to teriflunomide.⁴⁶ While these outcomes have been supported by other meta-analyses, there have been no randomized, head-to-head trial proving this.

More studies evaluating de-escalation are needed to guide clinical practice; however, with their long-term safety record, interferons may be a good option for de-escalation once patients have transitioned from the highly inflammatory phase to the progressive stages of the disease where relapses are reduced in frequency, and the patient wishes to remain on therapy.

The Role of Interferons in Clinical Trials

One of the more common uses of interferons currently is as an active comparator in clinical trials for novel DMTs. While placebo-controlled trials are now considered unethical due to the plethora of effective medications available, interferons are commonly used as an active comparator under the umbrella of clinical equipoise. Trials including SUNBEAM²⁹ and RADIANCE²⁹ evaluating ozanimod, TENERE⁴⁷ evaluating teriflunomide (no difference found in a primary composite endpoint), TRANSFORMS²¹ and PARADIGMS³⁵ evaluating fingolimod in adults and children, respectively, OPERA I/II¹ and OPERETTA (NCT01412333) evaluating ocrelizumab in adults and children, respectively, and CARE-MS I/II^{48,49} evaluating alemtuzumab have used or are using IFN β therapy as a comparator for subsequent FDA approval.

Discussion

The advent of IFN β therapy for the treatment of multiple sclerosis was revolutionary and changed the course of disease for a multitude of patients and their families. The study and development of IFN β therapy has also been crucial to the further understanding of the pathogenesis of multiple sclerosis and the development of novel DMTs. The initial trials showed that early intervention is

important for long-term outcomes and that groups with more active and inflammatory disease respond better to therapy. These points have been re-demonstrated in many subsequent clinical trials and have helped shape the use of DMTs in the field. The most recent 2017 revision to the McDonald Criteria allows for earlier diagnosis of MS and subsequently earlier treatment, because of these studies showing the importance of early treatment.⁵⁰

Since the development of oral and infusion DMTs, fewer newly diagnosed patients are started on IFN β due to increased efficacy, better patient satisfaction, and improved compliance with the newer DMTs. In the current treatment landscape with 18 choices for DMT, there is still a role for IFN β in both clinical practice and in clinical research. There will likely always be a subset of patients who cannot tolerate oral or infusion DMTs due to adverse events, and IFN β therapy will remain an option for this group. Additionally, patients who are highly risk-averse and want to proceed with the safest option will be comforted by the long history of favorable safety outcomes with IFN β therapy. Another important role of IFN β has been in the field of clinical trials. Because it is generally considered unethical to design a placebo-controlled trial for active MS, IFN β has been critical in its role of an active comparator for novel DMTs to show efficacy for FDA approval.

IFN β has played an important role in the treatment of multiple sclerosis since their development, and their role will likely remain important and will continually evolve as the field evolves.

Disclosure

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