Neutralizing antibodies to interferon beta: Assessment of their clinical and radiographic impact: An evidence report

Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology

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Abstract—The clinical and radiologic impact of developing neutralizing antibodies (NAbs) to interferon beta (IFNβ) while on this therapy for multiple sclerosis (MS) is assessed. On the basis of Class II and III evidence, it is concluded that treatment of patients with MS with IFNβ (Avonex, Betaseron, or Rebif) is associated with the production of NAbs (Level A). NAbs in the serum are probably associated with a reduction in the radiographic and clinical effectiveness of IFNβ treatment (Level B). In addition, the rate of NAb production is probably less with IFNβ-1a treatment than with IFNβ-1b treatment, although the magnitude and persistence of this difference is difficult to determine (Level B). Finally, it is probable that there is a difference in seroprevalence due to variability in the dose of IFNβ injected or in the frequency or route of its administration (Level B). Regardless of the explanation, it seems clear that IFNβ-1a (as it is currently formulated for IM injection) is less immunogenic than the current IFNβ preparations (either IFNβ-1a or IFNβ-1b) given multiple times per week subcutaneously (Level A). However, because NAbs disappear in some patients even with continued IFNβ treatment (especially in patients with low titers), the persistence of this difference is difficult to determine (Level B). Although the finding of sustained high-titer NAbs (>100 to 200 NU/mL) is associated with a reduction in the therapeutic effects of IFNβ on radiographic and clinical measures of MS disease activity, there is insufficient information on the utilization of NAb testing to provide specific recommendations regarding when to test, which test to use, how many tests are necessary, or which cutoff titer to apply (Level U).

The development of neutralizing antibodies (NAbs) to proteins administered therapeutically is often associated with a reduction in the biologic actions that these proteins exert. It is therefore surprising that the clinical and radiographic impact of NAbs to interferon beta (IFNβ) in the treatment of multiple sclerosis (MS) is controversial. This assessment evaluates the clinical and radiographic impact of NAbs in this setting and considers some of the difficulties in this research area that may explain the ongoing controversy. In this regard, it is useful for readers to appreciate the complexity of this particular biologic system. Thus, a brief overview of IFN biology is provided in the supplementary material to this as-
questions posed by this assessment are as follows: 1) Once NAb-positivity has developed in an individual patient, does this state persist? 2) Are NAb to IFNβ associated with a reduced effectiveness in IFNβ-treated patients with respect to the activity or the severity of MS (measured either clinically or radiographically)? 3) Does the prevalence of NAb-positivity (i.e., the seroprevalence) differ between the different IFNβ products?

Methods. A panel of neurologists analyzed the evidence relating to NAb by using a literature search with the key words antibodies and interferon beta. We used the MEDLINE database from 1966 to 2005. In addition, the reference lists of the articles identified were reviewed to identify articles not found by the computer search. Using these methods we identified 627 articles. Twenty-seven articles in the English language reporting clinical or radiographic outcomes in both antibody positive and antibody negative patients were reviewed. The entire panel classified the level of evidence provided by each article. Several studies were classified as providing Class II evidence (table 1), despite a randomized placebo-controlled trial design (RCTs). This is because evidence associated with NAb status is always post hoc and because patients can never be randomized with respect to their ultimate NAb status. Therefore, one can never exclude the possibility that there are patient-specific factors, which both predispose certain patients to the development of NAbs and, in an unrelated manner, make them either more or less susceptible to MS attacks. If so, this will make NAbs artificially appear to increase or decrease the MS attack rate, underscoring the fact that evidence of an association cannot prove causation.

Detecting and measuring antibodies to IFNβ. Antibodies to IFNβ ultimately develop in many IFNβ-treated patients. Two classes of antibodies are recognized. Binding antibodies (BAbs) may or may not interfere with IFNβ function while neutralizing antibodies (NAbs) interfere with IFNβ function in vitro, presumably by altering (or blocking) binding to the IFNβ receptor. Conceptualized in this manner, NAb is a subset of the BAbs. Nevertheless, this conception may be simplistic. For example, in a recently presented study, some NAb-positivity was measured in IFNβ-treated patients. A two article review identified 627 articles. These analyses have been made by combining the findings from the low-dose and high-dose arms of this trial.

n = number of neutralizing antibody (NAb)-positive patients studied; + = outcome worse in NAb-positive group than NAb-negative group; – = outcome worse in NAb-negative group than NAb-positive group; † = actual outcome not reported; blank cells = no information provided; NS = not significant; MS = multiple sclerosis; MSCRG = Multiple Sclerosis Collaborative Research Group; INCOMIN = Independent Comparison of Interferon.

Table 1 Effect of NAbs on clinical and MRI outcomes in MS therapeutic trials

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Year</th>
<th>Clinical activity</th>
<th>Clinical severity</th>
<th>MRI activity</th>
<th>MRI severity</th>
<th>Drug</th>
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<tr>
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<td>55</td>
<td>1996</td>
<td>– (NS)</td>
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<td>53</td>
<td>1996</td>
<td>+ †</td>
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<td>23</td>
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<td>55</td>
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<td>+ (NS)</td>
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<tr>
<td>North American SPMS IFNβ-1b Study Group35</td>
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<tr>
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<td>7</td>
<td>2005</td>
<td>+ †</td>
<td>+ (NS)</td>
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<td>2005</td>
<td>+ †</td>
<td>+ (NS)</td>
<td>+ (NS)</td>
<td>+ (NS)</td>
<td>IFNβ-1a</td>
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</table>

Clinical activity was assessed by attack rate or attack-free status. MRI activity was assessed by Gd-enhancement, new T2 lesions, or both. Clinical severity was assessed by confirmed Expanded Disability Status Scale progression. MRI severity was assessed by total T2 volume (burden) of disease. Merged cell indicates that groups were combined for the purpose of statistical analysis (post hoc method done to increase statistical power).

* Trials of more than 2 years’ duration.
† p < 0.05; ‡ p < 0.01; § p < 0.001.
* Significant only on interval analysis method (p = 0.03); not significant on the anytime positive method.
* Analysis using combined data from Avonex, Betaseron-, and Rebiq-treated patients.
* These analyses have been made by combining the findings from the low-dose and high-dose arms of this trial.
Both the CPE and the MxA assays depend upon assay conditions and require standardization. Either assay had a 2 to 4% false positive rate as judged by the other in a clinical trial setting. For cost reasons, antibodies are often measured using a two-step method, in which sera is screened by a binding assay for the presence of BAbs, and, if positive, assayed for NABs using the CPE or MxA methods. It is possible that NABs attach to the receptor-binding region of the IFNβ molecule, whereas non-NABs attach to less critical epitopes. Some BABS seem to have little measurable impact on IFNβ activity (as it is measured by current NAB assays) although BABS still might lower serum IFNβ levels by increasing IFNβ-clearance through the reticuloendothelial system. Despite the fact that in vivo IFNβ activity might be affected in these alternative ways, questions are associated with attenuation of many IFNβ-induced proteins, including IFNβ-specific proteins such as TRAIL (see supplementary data on the Neurology Web site at www.neurology.org). Determining NAB-positivity. Varying definitions of NAB-positivity make comparisons between studies problematic. Many use an arbitrary titer of 20 neutralizing units (NU) per milliliter as the cutoff for NAB-positivity. Even though it is evident that higher titers (e.g., more than 100 or 200 NU/mL) are more likely to have an impact on clinical parameters and biomarkers than lower titers, it is likely more with NAB titers of less than 200 NU/mL, although it can happen at titers as high as 3,094 NU/mL.

In considering the effects of NABs, some authors have used the ever positive, always positive method, in which patients who were ever NAB-positive are compared to persistently NAB-negative subjects. Other studies use the so-called once positive, always positive method, in which only observations after the patient has become NAB-positive (often defined as two consecutive positive titers) are compared to observations in NAB-negative subjects. Each of these methods fails to account for subjects who revert to NAB-negative status after becoming NAB-positive. In a reanalysis of the IFNβ-1b (Betaseron) trial, 51% to 65% of the NAB-positive patients in the high-dose arm reverted to NAB-negative status at some time. Inevitably, clinical attacks occurring during a patient’s NAB-negative periods will be attributed inappropriately to the attack rate in the NAB-positive group. Attempts to minimize such errors include measuring NABs every 3 months and assuming that the switch in NAB status occurred at the time of NAB measurement, or measuring NABs at 12-month intervals, presuming subjects were at the measured NAB status from 6 months preceding to 6 months following the NAB determination. Recently, in the so-called interval analysis, investigators asked if subjects were NAB-positive throughout a 6-month interval if they were positive (by a single determination) at the end of the interval. Unfortunately, each of these analysis methods will combine data from both NAB-positive and NAB-negative periods when they are used in a population of patients who are spontaneously switching their NAB status. This will be an even greater problem if there is a delay in the clinical impact of NABs, as suggested by some authors. Most importantly, however, these alternative methods have not particularly clarified the clinical impact of NABs when compared directly to either the once positive, always positive or the ever positive, always positive methods.

Due to small numbers (table 1), data often lack the statistical power to detect a convincing effect of NABs. Sometimes, two different treatment arms of a trial are combined in an attempt to increase statistical power. Because such analyses are done post hoc, they increase the likelihood of bias. Unfortunately, because so little post-marketing information has been acquired, we continue to lack studies with sufficient statistical power to address many important NAB questions, despite more than 150,000 patients being on IFNβ therapy worldwide.

Analysis of the evidence.

General considerations regarding the evidence. As an example of the potential impact of NABs on IFNβ efficacy, 38% of patients in the high-dose arm of the phase III IFNβ-1b (Betaseron) trial became NAB-positive (defined as two consecutive positive titers of ≥20 NU/mL 3 months apart and also as once positive, always positive) after 2 years. When NAB-positive and NAB-negative patients were analyzed separately, the NAB-positive patients seemed to have attack rates similar to placebo-treated patients. There are several reasons why such an observation might not be interpreted as easily as it might seem at first glance and also why, in general, relating NAB titers to outcome (either positive or negative) is fraught with problems.

First, as discussed earlier, many of the patients analyzed in this fashion did not become NAB-positive until late in the course of the trial when attack rates had spontaneously declined in all treatment groups. Even among those patients who became NAB-positive in this study, a large percentage ultimately became NAB-negative, at least temporarily. Both of these circumstances confound any straightforward interpretation of the data.

Second, the relationship of the IFNβ activities neutralized by NABs to the mechanisms whereby IFNβ exerts its therapeutic effects in MS is uncertain. Although it seems reasonable to expect that interference with one receptor-mediated action would translate to an impact on all such actions, this may not be the case. For example, as noted in the supplementary data (www.neurology.org), despite the fact that IFNα and IFNβ bind to the same receptor, each molecule has a distinct pattern of downstream biologic effects. Consequently, receptor binding could be distorted by NABs in such a way that some functions, but not others, are impacted.

Third, antigen-antibody complexes (and thus the mere presence of BABS with or without NABs) can also modulate immune functions. These effects will be independent of the receptor-mediated functions of IFNβ and would be expected to be most conspicuous in patients with high antibody titers.

Fourth, because of the marked intersubject variability in both the clinical course of MS and the response to administered IFNβ, and because IFNβ has only a modest effect on clinical outcomes, it will be very difficult to establish conclusively a deleterious effect of NABs on clinical outcomes using small datasets. To do this will require the study of large numbers of NAB-positive patients although, with over 150,000 patients on therapy worldwide, these numbers should be easily achievable.

Once NAB-positivity has developed in an individual patient, does this state persist? Studies of the natural history of NABs in IFNβ-treated patients suggest that the NAB-positive state is often transient. For example, in a subset of patients from the original IFNβ-1b trial, almost 80% of NAB-positive patients had reverted to NAB-negative status after 8 years despite continued IFNβ-1b therapy. Also, as mentioned earlier, 51 to 65% of NAB-positive patients in the high-dose arm of this trial reverted to NAB-negative status (at least temporarily) within the first 3 years. Similarly, in a recent study of 23
NAb-positive IFNβ-1b treated patients who were switched to IFNβ-1a, only 6 out of 20 (30%) and 3 out of 14 (21%) remained NAb-positive after 2 and 5 years.30 Also, the reversion rate from NAb-positive to NAb-negative status was 50% in a small Italian study after 3 to 4 years41 and it was 54% after 3 years in the North American trial of IFNβ-1b in SPMS.33 It seems that, despite continued treatment with IFNβ, the majority of NAb-positive patients will ultimately revert to NAb-negative status after 3 to 8 years of therapy. Nevertheless, the actual rate of NAb disappearance is difficult to define precisely because the data from long-term studies may be biased from the potential impact of selective drop-out (i.e., patients doing poorly on therapy will stop). This apparently increased tolerance to IFNβ over time may be molecule specific. In a Danish study of 455 patients, the authors reported that the cumulative probability of reverting to definitely NAb-negative status (i.e., two consecutive NAb-negative titers) in IFNβ-1b (Betaseron) treated patients was 57% after 42 months (CI = 0.43 to 0.71) compared to only 19% (CI = 0.07 to 0.30) in IFNβ-1a (Rebiif) treated patients over the same time period.53 Because most patients who revert to NAb-negative status tend to have titers of 100 NU/mL or less,29,32,35,41,48,49 such a difference might reflect higher NAb-titers to IFNβ-1a compared to IFNβ-1b.51

Are NAbS to IFNβ associated with an increase in the activity or the severity of MS (measured either clinically or radiographically) in IFNβ-treated patients? Persistently high NAb titers to IFNβ seem likely to have an impact on the clinical and radiographic efficacy of IFNβ, particularly as assessed by MRI (table 1). The effect of NAbS on clinical measures (especially measures of disease severity such as confirmed Expanded Disability Status Scale progression) is less convincing, although, even for clinical measures of disease activity (i.e., attack rate), the majority of studies greater than 2 years in duration reported a higher attack rate in NAb-positive compared to NAb-negative patients (table 1). Thus, in the larger (or longer) trials, such as the PRISMS,21,22,35 the European SPMS,20,29 and the North American SPMS studies,33 a NAb-associated increase in relapse rate was found (p = 0.05 to 0.01).

Impact of NAb-positivity on clinical decisions. Despite this evidence, however, it is still unclear whether NAbS eliminate or merely attenuate the effect of IFNβ. Some individuals can have an apparently excellent response to IFNβ despite having very high NAb titers. For example, in an NIH study of IFNβ-1b, 3 of the 11 patients with NAbS had both titers >400 NU/mL (including the patient with the second highest NAb titer of 1044 NU/mL) and a greater than 90% suppression of MRI activity over the 36 months following the start of IFNβ-1b.31 In a recent bioactivity study52 the authors reported that, despite a marked reduction of the normalized ratio (NR) for in vivo IFNβ-induced MxA production, the NR was still greater than the normal mean of 1.0 in most (82%) of the NAb-positive patients and, in over half (65%), the NR was more than three times normal even with NAb-titers up to 800 NU/mL.30 Thus, although the IFNβ effect on MxA was attenuated by NAbS, it was not completely eliminated in most patients.32 Because it is unknown whether such a low level of MxA induction is associated with continued clinical benefit, it is also unknown whether it would be wise to switch a NAb-positive patient to a non-interferon when they are otherwise clinically well. Indeed, because of our uncertainty about the relationship of MxA induction to the mechanisms of IFNβ benefit, because of the variability of the clinical data (table 1), and because there is persistent MxA mRNA expression or MxA induction in some persistently NAb-positive individuals,48,49,52 this course of action cannot be recommended. In a NAb-positive patient doing poorly, an alternative therapy should be considered, although such a course of action should probably be considered anyway, regardless of the patient’s NAb status. Because NAb-status might influence the choice of subsequent therapy, well standardized and easily accessible methods for NAb measurement should be available to practicing clinicians. Nevertheless, a cautious interpretation by treating neurologists (considering both clinical and probably also MRI data) is necessary.

It is also uncertain whether the apparently deleterious effect of NAbS is offset by the improved efficacy reported with high-dose (more frequently administered) IFNβ.8 There are only two randomized head-to-head comparative trials which might conceivably answer such a question. These are the 63-week EVIDENCE trial,26,27 which provides Class I comparative data for both clinical and MRI outcomes, and the 2-year Independent Comparison of Interferon (INCOMIN) trial,29 which provides Class I comparative data for MRI outcomes and Class III data for clinical outcomes. Both trials, particularly EVIDENCE, are too short to provide a complete answer in view of the dynamics of NAb-positivity discussed earlier. In both trials, NAb-positive patients (defined as positive after a single positive titer of more than 20 NU/mL) in the high-dose (more frequent) IFNβ arms had lower relapse rates and less MRI activity than the arm receiving low-dose (once weekly) IFNβ regardless of their NAb status.25-27,29 Therefore, within the first 2 years of treatment, the available evidence favors using the more effective therapy, even if this therapy is associated with a greater seroprevalence of NAbS. Whether the relative advantage of high-dose (more frequently administered) therapy is sustained beyond 2 years is unknown, but any such consideration of long-term impact must estimate and take into account both the magnitude of the NAb-effect and the probability of (and time course for) the spontaneous disappearance of NAbS, which occurs in many patients.12,13,25,31,32,50

Does the rate of NAb production differ between the different IFNβ products? Prevalence data for NAbS
(table 2) is confounded by nonuniform definition of the NAb-positive state and by differences in the assays used. In the Multiple Sclerosis Collaborative Research Group (MSCRG) trial of IFNβ-1a (Avonex), 22% of patients developed NAbS (defined as always positive on the basis of a single titer ≥20 NU/mL) after 2 years of therapy.17,18,28 By contrast, using a newly formulated product, NAbS have generally been found in 7% or less of the IFNβ-1a treated patients.25,26,28,37-41 The reason for the difference in seroprevalence between formulations is unknown and demonstrates that efficacy for reformulated products requires a clinical study, not merely an inference from studies using previous formulations.

The seroprevalence of NAbS IFNβ-1b seems higher than with IFNβ-1a (table 2).10,14,16,25,28 However, in a recent survey of 6,698 patients with MS on IFNβ-1b therapy,54 the seroprevalence of NAbS (defined as a single positive test with a titer ≥20 NU/mL) in two clinically deteriorating cohorts (21% in North America and 28% in Europe) was significantly lower ($p < 10^{-28}$ for North America and $p < 10^{11}$ for Europe) compared to NAb seroprevalence in an unselected cohort (37% in Australia). Although these unexpected results raise serious questions about any posited connection between NAb-positivity and reduced efficacy, the findings need replication in a more controlled setting before any strong conclusions can be drawn.

With respect to the effect of dose on seroprevalence, two studies demonstrated greater NAb-positivity among low-dose than high-dose arms.19,21-24 A follow-up trial of placebo patients re-randomized to low or high dose IFNbeta-1a did not confirm this result (table 2). To further confuse matters, the EVIDENCE trial found NAb-positivity in 25% of high-dose Rebif-treated patients after 1 year,26,27 a number almost double that in earlier placebo-controlled trials.19,21-24 By contrast, in the European dose-comparison study of IFNβ-1a IM,37,38 the 60-μg dose resulted in almost three times the seroprevalence of NAbS compared to the 30-μg dose. Despite these conflicting observations, it seems that IFNβ-1a is probably less immunogenic than IFNβ-1b, especially when administered IM. This could be the result of molecular structure. IFNβ-1a is glycosylated, which may reduce its immunogenicity compared to the non-glycosylated IFNβ-1b.55-57 Also, if IFNβ-1b forms aggregates, this may increase immunogenicity. Possibly, differences in IFNβ solubility (caused by the different physical properties of the molecules) or the subcutaneous route might predispose to NAb formation. Regardless, the randomized EVIDENCE trial,26,27 which found a marked difference in NAb prevalence between Avonex and Rebif (2% and 25%), indicates that the dose, the formulation, the route, or the frequency of IFNβ-1a administration make an important difference.

**Conclusions.** 1. Treatment of MS with IFNβ (Avonex, Betaseron, or Rebif) is associated with the production of NAbS to the IFNβ molecule (Level A).
2. It is probable that the presence of NAbs, especially in persistently high titers, is associated with a reduction in the radiographic and clinical effectiveness of IFNβ treatment (Level B).

3. It is probable that the rate of NAb production is less with IFNβ-1a treatment compared to IFNβ-1b treatment (Level B). However, because of the variability of the prevalence data, and because NAbs disappear in the majority of patients even with continued treatment (especially in those with low-titer NAbs), the magnitude and persistence of any difference in seroprevalence between these forms of IFNβ is difficult to determine.

4. It is probable that the seroprevalence of NAb to IFNβ is affected by one or more of the following: its formulation, dose, route of administration, or frequency of administration (Level B). Regardless of the explanation, it seems clear that IFNβ-1a (as it is currently formulated for IM injection) is less immunogenic than the current IFNβ preparations (either IFNβ-1a or IFNβ-1b) given multiple times per week subcutaneously (Level A). Because NAbs may disappear in many patients with continued therapy, the persistence of this difference is difficult to determine (Level B).

5. Although the finding of sustained high-titer NAbs (>100 to 200 NU/mL) has been associated with a reduction in the therapeutic effects of IFNβ on radiographic and clinical measures of MS disease activity, there is insufficient information on the utilization of NAb testing to provide specific recommendations regarding when to test, which test to use, how many tests are necessary, and which cutoff titer to apply (Level U).

**Recommendations for future research.**

1. In order to incorporate NAb testing into clinical practice, future research must specifically address issues such as the assay system applied and the stratification of risk for losing IFNβ-efficacy based on the degree of test abnormality. Despite this need for further research, much is already known. NAbs generally develop between 6 and 24 months after the onset of therapy, and if NAbs have not developed by this time, they are unlikely to develop in the future. Newer methods of analysis (e.g., measuring the IFNβ-induced in vivo production of MxA protein or measuring the amount of IFNβ-induced MxA-mRNA expression) may offer more reliable test results. The utility, sensitivity, and specificity for each of these newer techniques for characterizing the in vivo effects of IFNβ (either in the presence of NAbs or between individuals at baseline) and correlating these changes (or between-subject differences) in the bioactivity of IFNβ with its subsequent clinical and radiographic actions must be determined.

2. The methods of NAb measurement need to be standardized in order to facilitate cross-trial comparisons. Patients with persistent NAb titers of more than 200 NU/mL, those with persistent lower titers, and those who change status during the course of a trial need to have their clinical and MRI statuses analyzed separately, and only from the time of their first NAb-positive test result. These patient-groups should be compared to persistently NAb-negative patients (adjusted to the time at which the comparator group first became NAb-positive). The effects of NAbs in patients using different products or different doses of IFNβ need to be analyzed separately.

3. Future clinical trials need to include a long-term ascertainment of NAb status and its clinical impact.

4. Future clinical trials need to include a determination of IFN-responsiveness in individuals at study onset in order to link the biologic activity in both NAb-positive and NAb-negative groups with clinical and radiographic outcomes.

5. Because of the small number of NAb-positive patients generally available in RCTs, and because patients cannot be randomized with respect to their ultimate NAb status (e.g., table 1), conclusive data will need to be compiled from large-scale postmarketing surveys. The pharmaceutical industry and the physician community need to work together to acquire and share postmarketing surveillance data so as to characterize accurately the prevalence, persistence, and consequence of NAbs.

**Mission statement of TTA.** The Therapeutics and Technology Assessment Subcommittee (TTA) oversees the development of AAN technology assessments and therapeutic assessments, which are evidence-based statements that assess the safety, utility, and effectiveness of new, emerging, or established therapeutic agents or technologies in the field of neurology. Technology assessments and therapeutic assessments are developed through a rigorous process of defining the topic, evaluating and rating the quality of the evidence, and translating the conclusions of the evidence into practical assessments that can be used to guide the use of technologies and therapeutic agents in the practice of neurology.

**Disclaimer.** This statement is provided as an educational service of the American Academy of Neurology. It is based on an assessment of current scientific and clinical information. It is not intended to include all possible proper methods of care for a particular neurologic problem or all legitimate criteria for choosing to use a specific procedure. Neither is it intended to exclude any reasonable alternative methodologies. The AAN recognizes that specific patient care decisions are the prerogative of the patient and the physician caring for the patient, based on all of the circumstances involved.

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have a financial stake in the success or failure of the products appraised in the CPGs and the developers of the guidelines. Conflict of interest forms were obtained from all authors and reviewed by an oversight committee prior to project initiation. AAN limits the participation of authors with substantial conflicts of interest. The AAN forbids commercial participation in, or funding of, guideline projects. Drafts of the guideline have been reviewed by at least three AAN committees, a network of neurologists, Neurology peer reviewers, and representatives from related fields. The AAN Guideline Author Conflict of Interest Policy can be viewed at www.aan.com. With regards to this specific report, all authors have stated that they have nothing to disclose.

Appendix 1

Therapeutics and Technology Assessment subcommittee members: Janis Miyasaki, MD, FAAN (Co-chair); Yuen T. So, MD, PhD (Co-Chair); Carmel Armon, MD, MHS, FAAN (ex-officio); Vinay Chaudhry, MD, FAAN; Richard M. Dubinsky, MD, MPH, FAAN; Douglas S. Goodin, MD (ex-officio, facilitator); Mark Hallett, MD, FAAN; Cynthia L. Harden, MD; Kenneth J. Mack, MD, PhD; Fenwick T. Nichols III, MD, Michael A. Sloan, MD, MS, FAAN; James C. Stevens, MD; Paul W. O’Connor, MD, FAAN.

Appendix 2

AAN classification of evidence for therapeutic intervention

Class I. Prospective, randomized, controlled clinical trial with masked outcome assessment, in a representative population. The following are required: a) primary outcome(s) clearly defined; b) exclusion/inclusion criteria clearly defined; c) adequate accounting for dropouts and cross-overs with numbers sufficiently low to have minimal potential for bias; and d) relevant baseline characteristics are presented and substantially equivalent among treatment groups or there is appropriate statistical adjustment for differences.

Class II. Prospective matched group cohort study in a representative population with masked outcome assessment that meets a–d above OR a RCT in a representative population that lacks one criteria a–d.

Class III. All other controlled trials (including well-defined natural history controls or patients serving as own controls) in a representative population, where outcome is independently assessed, or independently derived by objective outcome measurement.*

Class IV. Evidence from uncontrolled studies, case series, case reports, or expert opinion.

* Objective outcome measurement: an outcome measure that is unlikely to be affected by an observer’s (patient, treating physician, investigator) expectation or bias (e.g. blood tests, administrative outcome data).

Appendix 3

Classification of recommendations

A = Established as effective, ineffective, or harmful for the given condition in the specified population. (Level A rating requires at least two consistent Class I studies.)

B = Probably effective, ineffective, or harmful for the given condition in the specified population. (Level B rating requires at least one Class I study or at least two consistent Class II studies.)

C = Possibly effective, ineffective, or harmful for the given condition in the specified population. (Level C rating requires at least one Class II study or two consistent Class III studies.)

U = data inadequate or conflicting; given current knowledge, treatment is unproven.

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Neurology 2007;68;977-984
DOI 10.1212/01.wnl.0000258545.73854.cf

This information is current as of March 26, 2007
Although calculating ethnicity-based risk in such populations is complex, the availability of panels of genetically characterized specific markers for some ancestral populations will help to resolve the challenges and concerns raised by Dr. Alappat.

Orla Hardiman, Simon Cronin, Bryan J. Traynor, Dublin, Ireland

Disclosure: The authors report no conflicts of interest.

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CORRECTION


For the Special Article “Neutralizing antibodies to interferon beta: Assessment of their clinical and radiographic impact: An evidence report: Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology” by D. S. Goodin, E. M. Frohman, B. Hurwitz, P. W. O’Connor, J. J. Oger, A. T. Reder, and J. C. Stevens (Neurology 2007 68: 977–984), the following Conflict of Interest statement was submitted by the Therapeutics and Technology Assessment Subcommittee during manuscript revision and was inadvertently omitted by the Editorial Office at press time. Since February 2007, the Editorial Office only approves disclosure statements by individual authors. The Editorial Office apologizes for the error.

Financial Disclosure: Most of the panel members who took part in this assessment have participated in (or are currently participating in) industry-sponsored clinical trials in multiple sclerosis. The sponsoring pharmaceutical companies for these trials have included (or do include) Ares-Serono, Berlex Laboratories, Biogen-Idec, Schering AG, Teva-Neuroscience, Sanofi Aventis, BioMS, and Novartis. These same panel members have also lectured at both medical conferences and in public on various aspects of the diagnosis and management of multiple sclerosis. In many cases these talks have been sponsored either directly or indirectly by educational grants from one or another of the above listed companies.