Profile of everolimus in the treatment of tuberous sclerosis complex: an evidence-based review of its place in therapy

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Abstract: Tuberous sclerosis complex (TSC) is a relatively rare genetic disorder, affecting one in 6,000 births. Mammalian target of rapamycin (mTOR) inhibitors, such as everolimus, which have been previously used to prevent solid organ transplant rejection, augment anticancer treatment regimens, and prevent neovascularization of artificial cardiac stents, are now approved for treating TSC-related manifestations, such as subependymal giant cell astrocytomas and renal angiomyolipomas. The use of everolimus in treating subependymal giant cell astrocytomas is supported by long-term Phase II and III clinical trials. Seizures are a common feature in TSC, occurring in up to 96% of patients. While mTOR inhibitors currently do not have regulatory approval in treating this manifestation, small clinical studies have demonstrated beneficial outcomes with everolimus. Further evidence from a forthcoming Phase III clinical study may provide additional support for the use of everolimus for this indication. Also, there are no approved treatments for TSC-associated neuropsychiatric disorders, which include intellectual disability, behavioral difficulties, and autism spectrum disorder, but preclinical data and small studies have suggested that some neuropsychiatric symptoms may be improved through mTOR inhibition therapy. More evidence is needed, particularly regarding safety in young infants. This review focuses on the current evidence supporting the use of everolimus in neurologic and neuropsychiatric manifestations of TSC, and the place of everolimus in therapy.

Keywords: everolimus, tuberous sclerosis complex, subependymal giant cell astrocytomas, seizures, TAND

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Since the discovery of rapamycin in the 1960s, mTOR inhibitors, particularly everolimus, have been used to prevent solid organ transplant rejection, augment anticancer treatment regimens, and prevent neovascularization of artificial cardiac stents. Following the identification of the genes involved in TSC in the 1990s, evidence in the 2000s revealed mutations or deletions that allowed mTOR activity to go unchecked (Figure 1). Subsequent clinical trials in patients with TSC led to the approval of the mTOR inhibitor everolimus for TSC-associated subependymal giant cell astrocytoma (SEGA) by US Food and Drug Administration (FDA) in 2010; it became approved treatments for TSC-associated neuropsychiatric disorders, which include intellectual disability, behavioral difficulties, and autism spectrum disorder, but preclinical data and small studies have suggested that some neuropsychiatric symptoms may be improved through mTOR inhibition therapy. More evidence is needed, particularly regarding safety in young infants. This review focuses on the current evidence supporting the use of everolimus in neurologic and neuropsychiatric manifestations of TSC, and the place of everolimus in therapy.

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Everolimus was also approved by the FDA in 2012 to treat renal angiomyolipomas in patients with TSC. A summary of the major clinical studies evaluating everolimus in treating TSC is found in Table 1.11–17 Although additional definitive, well-designed clinical trials are still needed, mTOR inhibitors have been shown to be beneficial for the treatment of several other clinical manifestations of TSC, including epilepsy, facial angiofibromas, cardiac rhabdomyomas, and lymphangioleiomyomatosis (LAM).17–21

This review focuses on the place of everolimus in the treatment of TSC and the evidence supporting its use from a neurologic and neuropsychiatric standpoint.

**Subependymal giant cell astrocytomas**

SEGAs are brain tumors composed of glioneuronal cells, usually found near the foramen of Monro.22,23 They occur in up to 20% of patients with TSC and are often present within the first two decades of life.22,23 Although SEGAs are benign tumors, due to their capacity for serial growth, they pose a risk for increased intracranial pressure, acute hydrocephalus, and death.23

The initial accelerated approval of everolimus for the treatment of growing SEGAs was based on the results of an open-label Phase II study (NCT00411619) in which the effect of everolimus on SEGAgrowth was examined in
Table 1 Currently published clinical trials of everolimus in TSC

<table>
<thead>
<tr>
<th>Study/population</th>
<th>Study design</th>
<th>Efficacy</th>
<th>Adverse events</th>
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<tbody>
<tr>
<td>Krueger et al11/Franz et al12</td>
<td>Core study</td>
<td>• SEGA: Reduction in primary SEGA volume (P&lt;0.001); SEGA reduction of ≥30% in 75% of the patients and reduction of ≥50% in 32% of the patients</td>
<td>• Generally grade 1 or 2</td>
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<tr>
<td>Patients aged ≥3 years with growing TSC-associated SEGA</td>
<td>• N=28</td>
<td>• Seizures: Reduction in seizure (median change, −1 seizure; P=0.02)</td>
<td>• Common adverse events (&gt;25%) were stomatitis (79%), URTI (79%), sinusitis (39%), and otitis media (36%)</td>
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<td></td>
<td>• Single center, prospective, open-label, Phase VII study</td>
<td>• SEGA: SEGA reduction maintained out to 2 years and SEGA reduction of ≥30% in 92.9% of patients and reductions of ≥50% in 82.1% of the patients at some point in study</td>
<td>• Common treatment-related AE-included URTI (92.9%) and stomatitis (89.3%)</td>
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<td></td>
<td>• Everolimus (EVE) 3.0 mg/m² titrated to blood trough 5–15 ng/mL</td>
<td>• Seizures: percentage of the patients with daily seizures decreased from 26.9% at baseline to 11.1% at 60 months</td>
<td>• Frequency of emerging AEs decreased over time</td>
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<td></td>
<td>• Median duration of everolimus 21.5 months</td>
<td>Long-term extension</td>
<td></td>
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<td></td>
<td>• ≈5 years of treatment</td>
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<tr>
<td>EXIST-115,16</td>
<td>Core study</td>
<td>• SEGA response of 35% in patients taking EVE versus 0% in patients given PBO (P&lt;0.0001); SEGA reduction of ≥30% in 78% of the EVE group versus 15% of PBO group at week 24; and SEGA reduction of ≥50% in 42% of the EVE group versus 3% of the PBO group at week 24</td>
<td>• AEs generally grade 1/2 in severity</td>
</tr>
<tr>
<td>Patients of any age with growing TSC-associated SEGA</td>
<td>• N=117 (78 EVE and 39 PBO)</td>
<td>• SEGA response increased to 49%; SEGA reduction of ≥30% in 72% of the patients and reduction of ≥50% in 47% of the patients at week 96</td>
<td>• Most common AEs were mouth ulceration (32% EVE versus 5% PBO), stomatitis (31% EVE versus 21% PBO), convulsions (23% EVE versus 26% PBO), and pyrexia (22% EVE versus 15% PBO)</td>
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<tr>
<td></td>
<td>• Multicenter, prospective, double-blind, placebo-controlled, Phase III study</td>
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<td></td>
<td>• Everolimus 4.5 mg/m² titrated to blood trough 5–15 ng/mL</td>
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<td>• &gt;6-month treatment period</td>
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<td>Long-term extension</td>
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<td></td>
<td>• N=111 (EVE)</td>
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<td></td>
<td>• Open-label</td>
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<td></td>
<td>• ≈2.5-year interim (planned ≈4 years)</td>
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<tr>
<td>EXIST-215,16</td>
<td>Core study</td>
<td>• SEGA response of 35% in patients taking EVE versus 0% in patients given PBO (P&lt;0.0001); SEGA reduction of ≥30% in 78% of the EVE group versus 15% of PBO group at week 24; and SEGA reduction of ≥50% in 42% of the EVE group versus 3% of the PBO group at week 24</td>
<td>• Most AEs grade 1 or 2 in severity</td>
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<tr>
<td>Patients aged ≥18 years with TSC- or sLAM-associated renal angiomyolipoma</td>
<td>• N=118 (79 EVE and 39 PBO)</td>
<td>• SEGA response increased to 49%; SEGA reduction of ≥30% in 72% of the patients and reduction of ≥50% in 47% of the patients at week 96</td>
<td>• Treatment-emergent AEs decreased with time</td>
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<td></td>
<td>• Multicenter, prospective, double-blind, placebo-controlled, Phase III study</td>
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<td>• EVE 10 mg/d</td>
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<td>• &gt;6-month treatment period</td>
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<tr>
<td>Krueger et al17</td>
<td>Core study</td>
<td>• Renal angiomyolipoma response rate 42% (EVE versus 0% (PBO) (P&lt;0.0001))</td>
<td>• AEs were mostly grade 1 or 2 in severity</td>
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<td>Patients aged ≥2 years with medically refractory TSC-associated seizures</td>
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<td>• Renal angiomyolipoma response rate increased to 54%</td>
<td>• Most common AEs were stomatitis (48% EVE versus 8% PBO), nasopharyngitis (24% EVE versus 31% PBO), acne-like skin lesions (22% EVE versus 5% PBO), and headache (22% EVE versus 18% PBO)</td>
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<td></td>
<td>• N=20</td>
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<tr>
<td></td>
<td>• Multicenter, prospective, open-label, Phase I/II study</td>
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<td>• EVE 5 mg/m²/d titrated to blood trough 5–15 ng/mL</td>
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<td></td>
<td>• 12-week treatment duration</td>
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Abbreviations: AEs, adverse events; EVE, everolimus; NCBRF, Nisonger Child Behavior Rating Form; PBO, placebo; SEGA, subependymal giant cell astrocytoma; sLAM, sporadic lymphangioleiomyomatosis; TSC, tuberous sclerosis complex; URTI, upper respiratory tract infection; UTI, urinary tract infection.
Neuropsychiatric disease

Neurocognitive disorders, including intellectual disability and behavioral difficulties, affect ~90% of individuals with TSC.30 Furthermore, up to 50% of those with TSC have autism spectrum disorder (ASD). These neurocognitive and behavioral disorders, combined with psychiatric conditions, together are known as TSC-associated neuropsychiatric disorders (TAND).28 The Tuberous Sclerosis Complex Neuropsychiatry Panel met at the 2012 Tuberous Sclerosis Complex International Consensus Conference and defined the term TAND with the goal of providing accurate terminology to the neuropsychiatric diseases seen in TSC, as well as providing guidance on appropriate evaluation and treatment.28,31 The Neuropsychiatry Panel recommended that individuals with TSC be screened for TAND at least once per year. The panel devised a TAND checklist, which has since been validated (Table 2).28,31

While there are currently no approved medications for the treatment of these symptoms in individuals with TSC, research suggests that mTOR inhibition may provide some benefits. Several preclinical studies have demonstrated that aberrant regulation of mTOR is central to many of the structural, neurophysiologic, and behavioral deficits
of the disorder. Of for example, Tsc1−/+ mice demonstrate impaired learning in hippocampal-dependent learning tasks and abnormal social behavior. Similarly, Tsc2−/− mice show deficits in synaptic plasticity, learning, and memory. These deficits emerge in the absence of gross structural abnormalities and seizures, demonstrating that other disease mechanisms are involved. The neurocognitive deficits in these same mouse models of TSC can be reversed with treatment with mTOR inhibitors. Treatment with the mTOR inhibitor rapamycin in adult mice rescued not only synaptic plasticity but also the behavioral deficits in this animal model. Mouse models demonstrating neurobehavioral deficits, including social impairment and repetitive behaviors, also have shown improvement after treatment with an mTOR inhibitor. These findings indicate that defects in the Tsc1 or Tsc2 gene result in social impairment typically associated with ASD through dysregulated mTOR signaling and that these impairments may be rescued by pharmacologic mTOR inhibitors, such as rapamycin and everolimus.

Retrospective and small pilot prospective studies have identified specific areas of cognitive impairment and autism spectrum behaviors in early childhood similar to that observed in animal models. A longitudinal cohort study of infants with TSC was performed to define early clinical, behavioral, and biologic markers of ASD. Infants with TSC and more typically developing controls were recruited beginning as young as 3 months of age and followed longitudinally until they were aged 36 months. At 6 months, infants with TSC demonstrated delays in nonverbal IQ on the Mullen Scales of Early Learning, both in visual receptive and fine motor domains. Infants with TSC exhibited delays in all developmental domains on the Mullen Scales of Early Learning by the age of 9 months. They also demonstrated more atypical social behaviors as early as 6 months of age in the areas of visual tracking, disengagement of attention, and anticipatory responses, as measured by the Autism Observation Scale for Infants. By the age of 12 months, infants with TSC who were later diagnosed with ASD demonstrated significantly greater cognitive delays compared to infants with TSC without ASD. Developmental trajectories for these groups differed, with a significant decline in nonverbal IQ between 12 months and 36 months in the ASD group only. Although there was no mention of concomitant use of mTOR inhibitors in this study, it is unlikely that any participants were previously or currently exposed to mTOR inhibitors, and therefore, the impact of mTOR inhibitors on cognitive impairment and ASD cannot be determined.

In an open-label Phase II trial that evaluated the efficacy and safety of rapamycin in adults with renal angiomyolipoma and TSC or LAM, eight patients with TSC had neurocognitive assessments. Seven of the eight patients tested showed positive change on immediate recall tasks, including list learning, story recall, and figure recall. These results suggest that mTOR inhibition has the potential to improve certain areas of cognition.

The role of everolimus in treating TAND symptoms in children and adolescents has recently been studied. The RAD001 Neurocognition Trial (NCT01289912) is a Phase II randomized, placebo-controlled trial of everolimus in children and young adults (aged 6–21 years) with TSC. The study was started in 2011 across two sites and evaluated the effect of everolimus on neurocognition over a 6-month period. Neuropsychological measures were given at baseline and 6 months, with additional measures given in the interim at 3 months (www.ClinicalTrials.gov/ct2/show/NCT01289912). Results of the study have not been published to date. Similarly, the Phase III EXIST-3 study (NCT01713946) is evaluating TAND using the Vineland Adaptive Behavior Scales-II and the Wechsler Non-Verbal Scale of Ability and comparing scores at 18 weeks and every 6 months thereafter with baseline scores (www.ClinicalTrials.gov/ct2/show/NCT01713946). Results from these studies are forthcoming.

### Current gaps in knowledge/disease-modifying effects

Single-gene syndromes with a high prevalence of neurodevelopmental disorders, such as TSC, provide us with
opportunities to investigate the underlying biology and identify potential treatments. Pharmacologic mTOR inhibitors are proven to be efficacious against multiple TSC disease manifestations. The mTOR inhibitor everolimus is now FDA-approved to treat SEGAs and renal angiomyolipomas in TSC, but the impact of the treatment on the neurocognitive and neurobehavioral aspects of TSC, particularly in infants and young children, is not yet known nor is the safety of mTOR treatment in this specific population. However, major studies examining these areas, such as EXIST-3, are underway. The severity and underlying causes for neurodevelopmental disorders, such as TAND, are complex and highly variable, which present a major barrier to identification of at-risk infants and development of effective treatments to prevent or alter progression.

All clinical trials with mTOR inhibitors in patients with TSC to date, whether published or in progress, almost exclusively involve or have involved older pediatric and young adult patients. Only EXIST-1, a Phase III clinical trial using everolimus to treat SEGA, reported treating infants under the age of 3 years. Even so, none of the patients treated with everolimus for 6 months were under the age of 1 year. At one of the EXIST-1 sites, four patients were between 1 year and 2 years of age. This center conducted annual neuropsychiatric evaluations outside of the study protocol using the Psycho Cattell test. No significant changes were noted at follow-up compared to baseline. More detailed assessments to evaluate ASD specifically or other aspects of neurodevelopment were not performed. No study to date has evaluated younger infants treated with mTOR inhibitors using direct, detailed observational assessment tools for objective characterization of TAND deficits. This is a critical age when brain development is at the forefront, and early treatment exposure has the potential to exert dramatic effects on developmental trajectory and overall quality of life in patients with TSC.

Despite optimism for potential benefit of early treatment with mTOR inhibitors in TSC, no studies have provided adequate measure of the safety of mTOR inhibitor treatment in very young infants. mTOR inhibitors have been shown to have immunosuppressive effects, leading to an increased risk of infection in treated individuals. In the prospective, open-label Phase II study using everolimus to treat SEGA, URTIs were reported in 86% of the patients after a median treatment exposure of 34 months; however, the majority of AEs were either grade 1 or grade 2, and none led to treatment discontinuation. Furthermore, the incidence of infections and other AEs decreased over time. The youngest enrolled patient was aged 3 years, so no safety data regarding infant use could be generated. An analysis of 18 patients from EXIST-1 aged <3 years at everolimus initiation showed that the most common AEs in this population were stomatitis, cough, pharyngitis, and pyrexia. The youngest patient was aged 1.1 years. Serious AEs occurring in two or more patients included pneumonia (three patients), and pyrexia, bronchitis, URTI, and convulsion (two patients each).

Given the prominent role of the mTOR pathway in many normal physiologic functions, there is also the theoretical risk of adverse effects on growth and development, especially early in life. Currently, long-term analyses (=5 years) of patients from EXIST-1 have not demonstrated an impact of everolimus on growth and sexual maturation. However, it is essential that we establish the basic safety and impact of mTOR inhibitors on neurodevelopment in infants and young children.

An abundance of clinical and basic science evidence suggests that mTOR inhibitors represent a rational candidate for the treatment of TAND. However, mTOR inhibitors have not been adequately evaluated or approved for the treatment of these specific disorders. In a pilot study evaluating everolimus treatment for epilepsy, Krueger et al utilized two standardized, parental survey instruments (Nisonger Child Behavior Rating Form and Quality of Life for Children with Epilepsy), which included many items overlapping or identifiable as features of TAND. It was noted that several domains and overall quality of life improved after 3 months of treatment. However, the study was limited by small sample size, unblended treatment, and no direct, observational assessment tools to objectively characterize specific ASD and neurocognitive changes. An earlier prospective, open-label treatment trial using everolimus for SEGA by the same group also attempted to measure neurocognitive function over a 6-month period using direct assessments but was unable to draw any conclusion, as the majority of patients were unable to perform the prescribed assessment battery.

There has been a longstanding interest in identifying treatment strategies for patients with TSC diagnosed at early ages, where the potential impact of mTOR inhibitors or other therapies could drastically improve or even prevent the neurodevelopmental sequelae of ASD and TAND seen in TSC. A prospective, longitudinal study underway at the TSC Clinic at Cincinnati Children’s Hospital Medical Center is characterizing safety and neurodevelopment, including autism and neurocognition, in infants with TSC treated with everolimus as clinically indicated. The goals of the study are to determine the effects of everolimus on neurocognitive
development, including autism, along with its safety profile in this population.

Other existing prospective human clinical trials already in progress are evaluating developmental precursors of ASD in infants with TSC who have never been exposed to mTOR inhibitors (TSC Autism Center of Excellence Network; NCT01780441) and the effect of everolimus on neurocognition in patients aged 6–21 years with TSC (RAD001 study; NCT01289912). While the TSC Autism Center of Excellence Network study provides a well-characterized control group of TSC-related neurodevelopment in infants and toddlers, few were exposed to an mTOR inhibitor, limiting pilot data regarding the safety and treatment effect of mTOR inhibitors in very young individuals. Conversely, the RAD001 Neurocognition Trial is evaluating treatment safety and effect in older children, but potential differences in a younger population that would be targeted for preventative therapies could be missed if they vary significantly due to age, comorbidities, and concurrent treatment, as well as brain maturation and neuroplasticity. Thus, there is a critical need to evaluate the effects of mTOR exposure in young children to fill these gaps and provide a solid and cohesive research strategy for the next logical step—a true early intervention, prevention-based clinical trial using mTOR inhibitors in infants with TSC for the assessment of optimal neurocognitive, developmental, and behavioral outcomes in patients with TSC.

Conclusion

mTOR inhibitors are already being used to treat several manifestations of TSC, including SEGAs and renal angiomylipomas. However, these medications have the potential to not only treat other manifestations of TSC, such as angiofibromas, cardiac rhabdomyomas, LAM, and epilepsy, but they may also have a role in modifying disease progression at a very young age.

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