Original Research

Designing Clinical Trials in “Regular” COPD Versus Alpha-1 Antitrypsin Deficiency-Associated COPD: “More Alike than Unalike?”

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Abstract

Alpha-1 antitrypsin deficiency (AATD) predisposes to emphysema, liver disease, and panniculitis. This emphysema risk naturally invites a comparison between “regular” COPD (i.e., unrelated to AATD) and AATD-associated emphysema.

Several features characterize both conditions. Both can be life-limiting and highly debilitating. Both are highly under-recognized.

An important corollary of this comparison between “regular” COPD and AATD-associated COPD is whether both should be treated similarly and whether clinical trials to assess new therapies can be conducted similarly in both. Here the distinctions between “regular” COPD and AATD-associated COPD are quite pronounced. Therapeutically, sparse available data suggest that lung volume reduction surgery confers less improvement in FEV1 in AATD and that such benefits are shorter-lived. Perhaps the most striking contrast between the two conditions is that clinical trials designs and conduct are necessarily very different. The relative scarcity of diagnosed individuals with AATD hampers recruitment to trials. Furthermore, primary outcome measures in trials of “regular” COPD must differ markedly from those of AATD-associated emphysema. Specifically, power calculations show that FEV1, and exacerbation frequency, which are amply represented as endpoints in large COPD trials, are infeasible in studies of AATD-associated emphysema. Rather, in the 3 available randomized controlled trials of intravenous augmentation therapy, the rate of emphysema progression based on serial CT densitometry measurements has been the only feasible primary outcome measure.

These considerations underscore the distinctive challenges and needs of conducting treatment trials in AATD-associated emphysema and emphasize that, with regard to clinical study design, the two conditions are “more unalike than alike.”
Introduction

Alpha-1 antitrypsin deficiency (AATD) predisposes to COPD, which naturally prompts the question about “lumping” vs. splitting” the two entities: COPD associated with AATD vs. “regular” (i.e., alpha-1 antitrypsin-replete) COPD. Do the two conditions have different clinical implications? Should they be treated differently? Should clinical trials in both conditions be conducted similarly? These issues have been especially topical in the ongoing dialog between the patient and clinical/scientific communities and regulatory agencies regarding endpoints for registrational trials of new therapies for AATD.

In this context, the current perspective considers the common and discordant features of both conditions, with a special focus on issues regarding clinical trial design. In her poem, the Human Family, Maya Angelou, the Pulitzer Prize-winning poetess, states: “I note the obvious differences between each sort and type. But we are more like my friends then we are unlike.” The question here is whether "regular" COPD and AATD-associated COPD are “more alike than unalike,” especially regarding the design of clinical trials to assess treatment.

Common Features of “Regular” COPD and COPD Associated with AATD

“Regular” COPD and AATD-associated COPD bear important similarities. Both conditions are life-threatening. "Regular” COPD is currently the fourth leading cause of death in the United States with 38.2 deaths per 100,000. Similarly, data from the recent ETHOS trial in “regular” COPD show a 1-year mortality rate of ~2.5% in study participants. Also, “regular” COPD individuals with the highest BODE quartile (BODE 4) demonstrated only a 20% 1-year survival rate. In AATD, data from the NHLBI Registry for Individuals with Severe Deficiency
of Alpha-1 Antitrypsin\textsuperscript{7} showed a similar 18.6\% mortality rate at 5 years or approximately 3\%/year mortality rate.

Another similarity is that both conditions are severely debilitating. Combining death and disability, "regular" COPD is the fourth leading cause in the United States. Based on data from the NHLBI AATD Registry, 30\% of participants whose mean age was 46 years reported being retired or medically unemployed,\textsuperscript{8} a reminder of the disability burden associated with AATD.

Similarly, both "regular" COPD and AATD are severely under-recognized.\textsuperscript{9-13} Specifically, 2020 estimates suggest that >25 million Americans have "regular" COPD, of whom 12 million are currently undiagnosed.\textsuperscript{3,4} Regarding AATD, estimates suggest that there are approximately 100,000 severely deficient Americans, of whom the vast majority – perhaps \textasciitilde 90,000 - are currently unrecognized.\textsuperscript{1} Under-recognition of AATD has regrettably been longstanding. In a 1989 study sampling 20,000 St. Louis blood bank specimens, Silverman et al.\textsuperscript{12} identified 7 PI*Z individuals, for a prevalence of 1 in 2900. Reasoning that donated blood bank specimens were representative of the overall population of St. Louis (2 million), this prevalence estimate predicted 700 PI*Z St. Louis individuals. However, when the investigators subsequently polled all the pulmonary practices in St. Louis, only 28 (4\%) of the expected 700 individuals were reported.\textsuperscript{12} More recently but similarly, an analysis of 458,164 participants in the UK Biobank showed that only 6.4\% of the 140 PI*ZZ individuals in the Biobank had been previously identified as having AATD.\textsuperscript{13} These observations show that AATD is persistently and severely under-recognized.

Further evidence of under-recognition of AATD is the long diagnostic delay commonly experienced by AATD individuals.\textsuperscript{14-17} A 1994 survey\textsuperscript{10} of 300 self-reported severely AAT
deficient individuals showed that the mean age of onset of lung symptoms, most frequently dyspnea, was 35 years but that individuals reported a mean 7.2-year interval between first onset of dyspnea and first diagnosis of AATD. Furthermore, when asked about the number of physicians they saw between first symptom and first diagnosis of AATD, 25% reported having the diagnosis made on the first physician visit but 12.5% reported seeing 6-10 physicians before initial diagnosis; 44% reported seeing ≥3 physicians before the initial diagnosis of AATD.

This prolonged diagnostic delay interval has persisted over time (Table 1), i.e., was estimated to be 6 years in 2019\textsuperscript{17} vs. 7 years in 1994.\textsuperscript{9} The inescapable conclusion is that, like regular COPD, AATD remains severely under-recognized currently.

Discordant Features of “Regular” COPD and COPD Associated with AATD

Notwithstanding these considerable similarities between both “regular” COPD and AATD-associated COPD, there are substantial differences. First, "regular" COPD demonstrates polygenic inheritance with a strong environmental/lifestyle component. In contrast, AATD is inherited as an autosomal codominant condition where the risk is also amplified by smoking and occupational exposures.\textsuperscript{1}

AATD is also a distinctive endotype of COPD, with different pathogenesis than “regular” COPD, a characteristically different distribution of emphysema, and a markedly higher prevalence of associated bronchiectasis. Pathogenetically, McDonough et al.\textsuperscript{18} proposed that inflammation and subsequent disappearance of small airways leads to the loss of alveolar walls in “regular” COPD. In contrast, in AATD, emphysema results from unopposed proteolytic damage to lung matrix like elastin, causing the destruction of alveolar walls and resultant emphysema.
Radiographically, the craniocaudal distribution of emphysema between “regular” COPD and AATD differs markedly;\textsuperscript{19-21} lower lobe predominance is more frequent in AATD and homogeneous or upper lobe emphysema is more prevalent in “regular” COPD. Specifically, in PI*ZZ individuals, 96% demonstrated lower lobe predominant COPD in contrast to individuals with "regular" COPD, in whom homogeneous or upper lobe emphysema was evident in 84%. Data from Parr et al.\textsuperscript{21} confirm the distinctively lower lobe predominance of emphysema in AATD; specifically, 64% of 102 PI*ZZ individuals undergoing CT chest demonstrated predominantly basilar hyperlucency.

The prevalence of bronchiectasis associated with COPD can also differentiate the two entities. The frequency of bronchiectasis in "regular" COPD ranged from 4 to 69% with a mean of 38.5% in 16 available studies.\textsuperscript{22} While prevalence estimates of bronchiectasis in AATD vary,\textsuperscript{23} one series showed that 95% of PI*ZZ individuals had radiographic evidence of bronchiectasis,\textsuperscript{24} with 31% of individuals demonstrating "clinical" bronchiectasis, e.g., copious phlegm, with exacerbations, hemoptysis, etc. In the UK Biobank study,\textsuperscript{13} though only 4.3% of AATD participants carried the clinical diagnosis of bronchiectasis, the odds ratio for having bronchiectasis in PI*ZZ AATD compared with AAT-replete subjects was 7.3.

Treatment differences also underscore the distinctiveness of these two entities. Absent specific studies in AATD, mainstay treatment of COPD in both conditions – e.g., bronchodilators, supplemental oxygen, rehabilitation – is often similar. Yet, when AATD has been specifically studied, important treatment differences are noteworthy. For example, in a subset analysis from the National Emphysema Treatment Trial,\textsuperscript{25} lung volume reduction surgery conferred smaller and shorter improvements in FEV1 in individuals with AATD-associated COPD than with “regular COPD. Similarly, in a subset analysis from the Long-term Oxygen
Treatment Trial (LOTT [26]), individuals with AATD-associated COPD demonstrated earlier and more profound desaturation than matched individuals with “regular” COPD.

Perhaps the most important dissimilarity between the two conditions regards the feasibility and conduct of clinical trials regarding treatments. While “regular” COPD is common, allowing large-scale recruitment for a large number of clinical trials of various treatments (Table 2), relatively few randomized controlled trials (RCTs) in AATD are available.27-31 For example, only three published RCTs have examined the efficacy of intravenous augmentation therapy,27-29 and one each has examined the efficacy of inhaled AAT31 and the efficacy of the retinoid agonist, palovarotene.30 The largest of the available RCTs of augmentation therapy in AATD, called RAPID, recruited a total of only 180 individuals.29 Notably, recruitment of these 180 individuals took 56 months in 28 centers across 13 countries and actually even longer from study inception to recruitment close (~7 years). The number of subjects in the palovarotene and inhaled AAT RCTs were 262 and 168 respectively, underscoring the challenge of recruiting large number of subjects in RCTs regarding AATD.

In contrast to the experience with AATD, sample sizes from some of the many recent randomized controlled trials in “regular” COPD are summarized in Tables 2 5,25,32-38 and indicate large-scale recruitment success. In some instances, as in TORCH32 and UPLIFT,33 where 6184 and 5993 patients respectively participated, differences between treatment and placebo arms were still inapparent, even in the face of very large numbers of participants. As noted, recruitment experience in studies regarding AATD are orders of magnitude smaller given the infrequency of AATD1,11 and its under-recognition. In this context, "regular" COPD and COPD associated with AATD are distinctly “more unalike than alike.”
Compounding this recruitment challenge, sample size estimates for various primary outcome measures in studies regarding AATD suggest the infeasibility of using many of the conventional outcome measures employed in studies of “regular” COPD, including mortality, spirometry measures, St. George’s Respiratory Questionnaire (SGRQ), and exacerbation frequency. For example, Idell and Cohen\(^3\) estimated the sample size required to detect a reduction in mortality in AATD. The smallest estimated number of participants in a study with mortality as a primary endpoint and an effect size (i.e., mortality benefit) of 50% in individuals followed over 5 years was 192 patients per treatment arm. For less dramatic reductions in mortality related to augmentation therapy and shorter follow-up (e.g., 30% mortality reduction studied over 2 years), the estimated number of participants necessary to show power increased (e.g., to 1757 per treatment arm). The infeasibility of such recruitment numbers led to the recommendation to defer a randomized controlled clinical trial of augmentation therapy but rather for the NHLBI to assemble a registry for individuals with AATD. On the basis of observed mortality data from the resultant NHLBI Registry, Schluchter et al.\(^4\) estimated that 208 patients would be required in each treatment arm for a randomized trial of augmentation therapy showing a 50% reduction in mortality in the subset of individuals whose FEV1 was between 35% and 49% predicted at baseline. With a smaller effect size, i.e., a 30% reduction in mortality, the required sample size rose to 648, which is clearly infeasible (Table 3). Power calculations using SGRQ as a possible primary outcome measure in studies of AATD show similar infeasibility. Even using an enriched population with rapid decline in FEV1, Stockley et al.\(^5\) estimated that 5039 subjects would be needed per treatment arm to show a 25% decrement in decline. The message is clear. As with mortality and SGRQ as endpoints, recruitment requirements based on these estimates make a trial of therapy for AATD using FEV1 or
exacerbation frequency as a primary outcome measure infeasible. Indeed, none of the three available randomized controlled trials of intravenous augmentation therapy have shown significant benefits regarding FEV1 slope or exacerbation frequency. While other endpoints like degree of inflammation in exacerbations or duration of exacerbation could be considered, inexperience with their use as primary outcomes in pivotal trials and the lack of power calculations have blunted enthusiasm for their use. Also, some have advocated using FEV1 % predicted or percent predicted transfer factor in trials in which the subject pool is enhanced by including subjects screened for rapid FEV1 decline. While the proposed numbers of subjects for such trials (86 and 77 per treatment arm, respectively) have appeal for feasibility, it bears emphasis that such rapid decliners comprise a small minority of all AATD individuals, which compounds the recruitment challenge by limiting inclusion to a small subset of an already limited population. For example, in the study by Wencker et al., rapid decliners comprised only 7.3% of the overall population of 96 AATD subjects in that study.

The only primary outcome measure for which recruitment goals for a randomized controlled trial of augmentation therapy for AATD have proven feasible to date is CT densitometry. Based on the first available randomized controlled trial, an observed effect size of loss of lung density at 1.07 g/L/year over a 3-year trial estimated the need for 130 total subjects in a randomized trial using CT densitometry as the primary outcome measure. In the subsequent RAPID trial, although challenging and, as discussed above, requiring protracted recruitment to accrue only 180 participants, the study demonstrated a significant difference between the rate of loss of lung density among augmentation vs. placebo recipients over 2 years using CT densitometry at TLC (but not at TLC or FRC) as the outcome measure. The effect size of 0.74 g/L/year using CT densitometry (measured at TLC alone) achieved statistical
significance at p = 0.03. Finally, data from the RAPID trial have been used to estimate sample size requirements for FEV1 percent predicted, exacerbation frequency, and the St. George's Respiratory Questionnaire data as primary outcome measures in a randomized trial of augmentation therapy in AATD. As suggested above, these estimates (Table 4) suggest a minimum of 1525 subjects per treatment arm, again clearly infeasible in AATD based on the prevalence estimates and under-recognition challenges noted.

In conclusion, the response to Maya Angelou’s question about whether the entities of "regular" COPD and COPD associated with AATD are more alike than unlike is that, while they share commonalities of being under-recognized and very debilitating, they are distinctly unalike in important ways, perhaps most pronouncedly regarding the possibility and needs for clinical trial design. The infeasibility of conducting clinical trials in AATD using conventional outcome measures for “regular” COPD requires innovative thought and design, especially considering CT densitometry as a primary outcome measure. The appeal of CT densitometry as a primary outcome measure is based on its measuring lung integrity⁴³ and, importantly, on the demonstrated feasibility of using it as an outcome in trials regarding treatment of AATD.
References


Table 1. Diagnostic Delay Interval Estimates For Alpha-1 Antitrypsin Deficiency

<table>
<thead>
<tr>
<th>Authors (Reference)</th>
<th>Publication Year</th>
<th>Country</th>
<th>Diagnostic Delay (Years ± SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoller et al. (9)</td>
<td>1994</td>
<td>USA</td>
<td>7.2 years ± 8.3</td>
</tr>
<tr>
<td>Stoller et al. (10)</td>
<td>2005</td>
<td>USA</td>
<td>5.6 years ± 8.5</td>
</tr>
<tr>
<td>Campos et al. (14)</td>
<td>2005</td>
<td>USA</td>
<td>8.3 years ± 6.9</td>
</tr>
<tr>
<td>Kohnlein et al. (15)</td>
<td>2010</td>
<td>Germany</td>
<td>6 years</td>
</tr>
<tr>
<td>Greulich et al. (16)</td>
<td>2013</td>
<td>Germany Italy</td>
<td>7 years (0-73, IQR 13)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6 years (0-40, IQR 11)</td>
</tr>
<tr>
<td>Tejwani et al. (17)</td>
<td>2019</td>
<td>USA</td>
<td>Median 6 years (25-75% CI = 2.9-15.4 yrs) for subjects with symptoms</td>
</tr>
</tbody>
</table>
Table 2. Summary of Selected Key Trials in “Regular” COPD

<table>
<thead>
<tr>
<th>Trial/Author (Date) (Reference)</th>
<th>Intervention</th>
<th>PrimaryOutcome</th>
<th>Number of Subjects</th>
<th>Summary of Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>NETT (2003) (25)</td>
<td>LVRS vs. usual care</td>
<td>Survival</td>
<td>N = 1,218 (of 3,777 assessed)</td>
<td>Long-term survival with LVRS &gt; usual care, RR death with LVRS 0.85 (p = 0.02)</td>
</tr>
<tr>
<td>TORCH (2007) (32)</td>
<td>Salmeterol (Sal) + Fluticasone Propionate (FP) vs. Placebo or single agents</td>
<td>Time to death over 3 years</td>
<td>N = 6,184 (of 8,555 recruited)</td>
<td>2.6% reduction in death risk with Sal + FP, HR 0.825, p = 0.052</td>
</tr>
<tr>
<td>UPLIFT (2008) (33)</td>
<td>Tiotropium vs. Placebo</td>
<td>Rate of FEV1 decline over 4 years</td>
<td>N = 5,993 (N = 2,987 Tio vs. N = 3,006 Placebo)</td>
<td>No difference in FEV1 slope after 30 days (2 ml/yr, p = 0.21)</td>
</tr>
<tr>
<td>Calverley PM et al. (2009) (34)</td>
<td>Roflumilast vs. Placebo</td>
<td>Time to first COPD exacerbation</td>
<td>N = 3,296 (2 trials combined, individually N = 1,525 and 1,571)</td>
<td>Roflumilast better than placebo, HR 0.89, p = 0.0185</td>
</tr>
<tr>
<td>Albert et al. (2011) (35)</td>
<td>Azithromycin vs. placebo</td>
<td>Time to first exacerbation</td>
<td>N = 1,142</td>
<td>Longer time to 1st exacerbation with azithro, p &lt; 0.0001</td>
</tr>
<tr>
<td>POET (2011) (36)</td>
<td>Tiotropium vs. Salmeterol</td>
<td>COPD exacerbation</td>
<td>N = 7,376</td>
<td>Tio &gt; Salmeterol, HR 0.72, p &lt; 0.001</td>
</tr>
<tr>
<td>LOTT (2016) (37)</td>
<td>Supplemental O₂ vs. No supplemental O₂</td>
<td>Death and/or time to first hospitalization (any cause)</td>
<td>N = 738</td>
<td>No effect, HR 0.94, p = 0.52</td>
</tr>
<tr>
<td>Study</td>
<td>Treatment</td>
<td>Outcome Measure</td>
<td>N</td>
<td>Comparision</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------------------------------------------</td>
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<tr>
<td>IMPACT</td>
<td>Fluticasone Furoate (FF) + Vilanterol (VII) + Umeclidinium vs. double vs. placebo</td>
<td>Annual rate of mod/severe COPD exacerbation</td>
<td>10,355</td>
<td>Triple vs. FF + VII, rate ratio 0.85, p &lt; 0.001</td>
</tr>
<tr>
<td>ETHOS</td>
<td>Budesonide/Glycopyrrolate (Glyco)/Fluticasone Furoate vs. double vs. placebo</td>
<td>Annual rate of mod/severe COPD exacerbation</td>
<td>8,572</td>
<td>Triple vs. Glyco + FF, rate ratio 0.76, p &lt; 0.001</td>
</tr>
</tbody>
</table>
Table 3. Sample Size Estimates for Trials of Augmentation Therapy Using FEV1 as Primary Outcome

<table>
<thead>
<tr>
<th>Duration</th>
<th>Number of Subjects Needed per Treatment Arm by Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Years</td>
</tr>
<tr>
<td>Author(s) (Reference)</td>
<td></td>
</tr>
<tr>
<td>Idell S and Cohen AM$^1$ (39)</td>
<td>377</td>
</tr>
<tr>
<td>Schluchter M, Stoller JK et al.$^2$ (40)</td>
<td>213</td>
</tr>
<tr>
<td>Dirksen A et al.$^3$ (37)</td>
<td>275</td>
</tr>
</tbody>
</table>

$^1$For individuals with FEV1 30-65% pred, calculations assume 90% power, untreated FEV1 decline -89 ml/yr, and 4 measurements/yr.

$^2$For individuals with FEV1 30-65% pred, calculations assumed one-sided test, 90% power, a = 0.05 with FEV1 ml/yr and treatment effect = 24%.

$^3$To achieve a 50% reduction in FEV1 slope.
Table 4. Sample Size Estimates to Show Outcomes Differences (29) Based on the Data from the RAPID Trial

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Observed Difference Between Aug and Placebo in RAPID at 24 Months</th>
<th>Sample Size (per Group) Needed for Observed Difference to Achieve Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEV1% Predicted</td>
<td>0.8% predicted (-3.1% Predicted vs. -2.3% Predicted), p = 0.21</td>
<td>N = 3510 per group (Total N = 7020)</td>
</tr>
<tr>
<td>Exacerbation Frequency</td>
<td>0.28 per year (1.70 vs. 1.42 at 24 months)</td>
<td>N = 1525 – 1929 per group (Total N = 3050-3858)</td>
</tr>
<tr>
<td>SGRQ</td>
<td>0.8 unit benefit in Aug. recipients, p = 0.91</td>
<td>N = 3191 per group (Total N = 6382)</td>
</tr>
</tbody>
</table>

*Thanks to Amy Nowacki, PhD