Pharmacogenetic study in patients with multiple sclerosis
Responders and nonresponders to IFN-β

ABSTRACT

Objectives: We aimed to investigate the association between polymorphisms located in type I interferon (IFN)-induced genes, genes belonging to the toll-like receptor (TLR) pathway, and genes encoding neurotransmitter receptors and the response to IFN-β treatment in patients with multiple sclerosis (MS).

Methods: In a first or screening phase of the study, 384 polymorphisms were genotyped in 830 patients with MS classified into IFN-β responders (n = 416) and nonresponders (n = 414) according to clinical criteria. In a second or validation phase, the most significant polymorphisms associated with IFN-β response were genotyped in an independent validation cohort of 555 patients with MS (281 IFN-β responders and 274 nonresponders).

Results: Seven single nucleotide polymorphisms (SNPs) were selected from the screening phase for further validation: rs320302 (GABRR3; p = 0.0006), rs6597 (STUB1; p = 0.019), rs3747517 (IFIH1; p = 0.010), rs2277302 (PELI3; p = 0.017), rs10958713 (IFNAR1; p = 0.030), and rs4422395 (CCL11; p = 0.017). None of these SNPs were significantly associated with IFN-β response when genotyped in an independent cohort of patients. Combined analysis of these SNPs in all patients with MS (N = 1,385) revealed 2 polymorphisms associated with IFN-β response: rs2277302 (PELI3; p = 0.008) and rs832032 (GABRR3; p = 0.006).

Conclusions: These findings do not support an association between polymorphisms located in genes related to the type I IFN or TLR pathways or genes encoding neurotransmitter receptors and the clinical response to IFN-β. Nevertheless, additional genetic and functional studies of PELI3 and GABRR3 are warranted.

GLOSSARY

EDSS = Expanded Disability Status Scale; GABA = γ-aminobutyric acid; IFN = interferon; MS = multiple sclerosis; SNP = single nucleotide polymorphism; TLR = toll-like receptor.

Interferon β (IFN-β) is one of the most widely prescribed disease-modifying therapies for patients with relapsing-remitting multiple sclerosis (MS) and has demonstrated positive effects on reducing disease activity.1 However, IFN-β is only partially effective, and a significant proportion of patients with MS do not respond to this treatment.2 Despite

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Supplemental data at Neurology.org/nn

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many efforts to identify allelic variants influencing the response to IFN-β, to date there is a lack of genetic biomarkers reliably associated with therapeutic response.

A previous IFN-β transcriptomic study conducted by our group (Cemcat) implicated genes belonging to the type I IFN pathway and genes related to the toll-like receptor (TLR) pathway in the clinical response to IFN-β. The 2 genome-wide pharmacogenomic studies published thus far in relation to the response to IFN-β reported the involvement of type I IFN-responsive genes and the overrepresentation of genes coding for glutamate and γ-aminobutyric acid (GABA) receptors among the polymorphisms that best discriminated between IFN-β responders and nonresponders, suggesting a relationship between neuronal excitation and response to IFN-β.

Building on these observations, in the present study we aimed to genotype an extensive panel of polymorphisms located in genes related to the type I IFN and TLR pathways and genes coding for GABA and glutamate receptors in a multicenter cohort of IFN-β responders and nonresponders in order to investigate their potential association with the response to this treatment.

**METHODS** Definition of response to IFN-β therapy.

Patients with relapse-onset MS treated with IFN-β and with a follow-up of at least 2 years were classified as responders and nonresponders. Responders were patients with no relapses and no increase in the Expanded Disability Status Scale (EDSS) score over the follow-up period. Nonresponders were patients having 1 or more relapses during the follow-up period and an increase in the EDSS score over the follow-up period. Nonresponders were patients according to the number of relapses during the first 2 years of treatment without considering EDSS progression. Responders had no relapses during the follow-up period.

Two different criteria were considered for nonresponders: (1) 1 or more relapses during the 2-year follow-up (criteria 1), and (2) 2 or more relapses over the follow-up period (for this criterion, patients with only 1 relapse were not considered in the analysis; criteria 2).

Information on the IFN-β neutralizing antibody status was not available for patients included in the study.

**Single nucleotide polymorphism selection.** Genes related to the type I IFN and TLR pathways and genes coding for GABA and glutamate receptors were selected through bibliographical searches, and a total of 384 biologically informative single nucleotide polymorphisms (SNPs) were selected for genotyping using Select Your SNPs, an online tool for selecting tagSNPs from a roster of candidate genes.

**Study design.** In a first or screening phase of the study (phase I), 384 SNPs were genotyped in 830 patients with MS classified according to their response to IFN-β. There were 416 responders and 414 nonresponders. Genomic DNA samples were obtained using standard methods and genotyping was performed using an Illumina GoldenGate assay at Progenika Biopharma SA (Bizkaia, Spain).

Overall genotyping success rate was 95%. The full list of SNPs and probes is provided as table e-1 at Neurology.org/nn.

In a second or validation phase of the study (phase II), the most significant SNPs obtained in phase I were genotyped in an independent cohort of 555 patients with MS (281 responders and 274 nonresponders to IFN-β). Genotyping was performed using TaqMan assays at the Cemcat (Barcelona, Spain). Genotyping success rate was 97%.

A summary of demographic and baseline clinical characteristics of all patient cohorts is shown in table 1.

**Statistical analysis.** Data processing, missingness, Hardy-Weinberg analysis, and allele frequency comparisons between responders and nonresponders to IFN-β were performed with SNPator (www.snpator.org). Possible stratification owing to different population origin was assessed using the Cochran-Mantel-Haenszel test implemented in PLINK (http://pngu.mgh.harvard.edu/~purcell/plink/).

**RESULTS** In the first phase of the study, a total of 384 SNPs were genotyped in 830 patients with MS classified according to their clinical response to IFN-β treatment. The results of the allelic association analysis for all the study cohorts (combined and stratified by MS center) are shown in table e-2. The most significant SNPs associated with the response to IFN-β were selected for further validation (table 2): (1) rs832032 (GABBR3; p = 0.0006), (2) rs6597 (STUB1; p = 0.019), (3) rs3747517 (IFIH1; p = 0.010), (4) rs2277302 (PELI3; p = 0.017), (5) rs10958713 (IKBKB; p = 0.003), (6) rs2834202 (IFNARI; p = 0.030), and (7) rs4422395 (CXCL1; p = 0.017).

In a second phase of the study, these 7 SNPs were genotyped in an independent cohort of 555 patients with MS classified according to the same clinical criteria as in phase I. As depicted in table 2, allelic analysis in this validation cohort showed a lack of statistically significant associations between selected polymorphisms from phase I and the response to IFN-β (figure e-1). Combined analysis in the whole cohort of patients with MS (N=1,385; table 2) revealed 2 SNPs associated with the response to IFN-β with p values below 0.01: rs2277302, a synonymous polymorphism located in the PELI3 gene; and rs832032, a polymorphism located in the GABBR3 gene that results in a premature stop codon and protein truncation.
### Table 1  Summary of demographic and baseline clinical characteristics for all the cohorts of patients with MS (responders and nonresponders to IFN-β treatment)

<table>
<thead>
<tr>
<th>Phase</th>
<th>Sets</th>
<th>N</th>
<th>Female/male (% female)</th>
<th>Age, y</th>
<th>Disease duration, y</th>
<th>EDSS</th>
<th>IFN-β (1/2/3)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toulouse</td>
<td></td>
<td>67</td>
<td>53/14 (80.1)</td>
<td>28.9 (8.0)</td>
<td>4.5 (5.4)</td>
<td>15/39/13</td>
<td></td>
</tr>
<tr>
<td>Serbia</td>
<td></td>
<td>24</td>
<td>17/7 (70.8)</td>
<td>31.9 (6.4)</td>
<td>3.6 (3.5)</td>
<td>0.9 (0.8)</td>
<td></td>
</tr>
<tr>
<td>Bochum</td>
<td></td>
<td>4</td>
<td>2/2 (50.0)</td>
<td>37.8 (4.6)</td>
<td>3.8 (3.8)</td>
<td>2.1 (1.1)</td>
<td></td>
</tr>
<tr>
<td>Rostock</td>
<td></td>
<td>43</td>
<td>36/7 (83.7)</td>
<td>40.9 (9.9)</td>
<td>5.0 (4.8)</td>
<td>1.8 (1.6)</td>
<td></td>
</tr>
<tr>
<td>Newcastle</td>
<td></td>
<td>32</td>
<td>25/7 (78.1)</td>
<td>42.0 (11.1)</td>
<td>6.3 (9.1)</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>San Francisco</td>
<td></td>
<td>2</td>
<td>2/0 (100)</td>
<td>40.5 (6.4)</td>
<td>1.9 (0.9)</td>
<td>1.0 (1.4)</td>
<td></td>
</tr>
<tr>
<td>Milan</td>
<td></td>
<td>6</td>
<td>4/2 (66.7)</td>
<td>39.6 (8.8)</td>
<td>3.7 (5.1)</td>
<td>1.5 (0.8)</td>
<td></td>
</tr>
<tr>
<td>Madrid PH</td>
<td></td>
<td>20</td>
<td>12/8 (60.0)</td>
<td>37.7 (8.3)</td>
<td>4.6 (2.7)</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Madrid SC</td>
<td></td>
<td>29</td>
<td>21/8 (72.4)</td>
<td>33.4 (7.4)</td>
<td>5.3 (4.8)</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Malaga</td>
<td></td>
<td>32</td>
<td>23/9 (71.9)</td>
<td>40.0 (9.5)</td>
<td>16.0 (4.0)</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Bilbao</td>
<td></td>
<td>28</td>
<td>21/7 (75.0)</td>
<td>36.5 (9.8)</td>
<td>8.0 (7.4)</td>
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<td></td>
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<tr>
<td>Barcelona</td>
<td></td>
<td>129</td>
<td>103/26 (79.8)</td>
<td>40.8 (8.8)</td>
<td>13.7 (7.2)</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>All phase I</td>
<td></td>
<td>416</td>
<td>319/97 (76.7)</td>
<td>37.5 (4.1)</td>
<td>6.4 (7.0)</td>
<td>2.7 (1.1)</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Madrid RC</td>
<td></td>
<td>33</td>
<td>27/6 (81.8)</td>
<td>38.0 (9.4)</td>
<td>6.2 (6.1)</td>
<td>1.8 (0.8)</td>
<td></td>
</tr>
<tr>
<td>Malaga</td>
<td></td>
<td>129</td>
<td>82/47 (63.6)</td>
<td>45.5 (11.1)</td>
<td>16.3 (7.9)</td>
<td>1.4 (1.5)</td>
<td></td>
</tr>
<tr>
<td>Rostock</td>
<td></td>
<td>43</td>
<td>36/7 (83.7)</td>
<td>37.7 (10.2)</td>
<td>3.0 (0.9)</td>
<td>2.2 (1.1)</td>
<td></td>
</tr>
<tr>
<td>Amsterdam</td>
<td></td>
<td>76</td>
<td>55/21 (72.3)</td>
<td>35.5 (8.3)</td>
<td>4.0 (4.2)</td>
<td>2.5 (1.3)</td>
<td></td>
</tr>
<tr>
<td>All phase II</td>
<td></td>
<td>281</td>
<td>200/81 (71.2)</td>
<td>40.6 (11.0)</td>
<td>9.8 (8.7)</td>
<td>2.2 (1.5)</td>
<td></td>
</tr>
<tr>
<td>Both phases</td>
<td></td>
<td>698</td>
<td>519/178 (74.5)</td>
<td>38.6 (10.6)</td>
<td>6.9 (8.0)</td>
<td>2.7 (2.1)</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: EDSS = Expanded Disability Status Scale; IFN = interferon; Madrid PH = Hospital Universitario Puerta de Hierro, Madrid; Madrid RC = Hospital Ramón y Cajal, Madrid; Madrid SC = Hospital Clínico San Carlos; NR = nonresponder; R = responder.

Unless otherwise indicated, data are expressed as mean (SD).

*IFN-β (1a intramuscular/1b subcutaneous/1a subcutaneous).
### Table 2 Summary of results of allele association analysis

<table>
<thead>
<tr>
<th>SNP</th>
<th>Chr</th>
<th>Gene</th>
<th>MAF</th>
<th>p Value (OR, CI)</th>
<th>Ad</th>
</tr>
</thead>
<tbody>
<tr>
<td>rs832032</td>
<td>3</td>
<td>GABRR3</td>
<td>0.21</td>
<td>0.0006</td>
<td>1.55</td>
</tr>
<tr>
<td>rs10958713</td>
<td>8</td>
<td>IKBKB</td>
<td>0.36</td>
<td>0.0030</td>
<td>1.38</td>
</tr>
<tr>
<td>rs4747517</td>
<td>2</td>
<td>IFNAR1</td>
<td>0.26</td>
<td>0.0104</td>
<td>1.35</td>
</tr>
<tr>
<td>rs2277302</td>
<td>11</td>
<td>PELI3</td>
<td>0.15</td>
<td>0.0173</td>
<td>1.37</td>
</tr>
<tr>
<td>rs3747517</td>
<td>2</td>
<td>CXCL1</td>
<td>0.15</td>
<td>0.0173</td>
<td>1.37</td>
</tr>
<tr>
<td>rs2277302</td>
<td>11</td>
<td>STUB1</td>
<td>0.12</td>
<td>0.0303</td>
<td>1.29</td>
</tr>
<tr>
<td>rs4422395</td>
<td>4</td>
<td>IFNAR1</td>
<td>0.12</td>
<td>0.0303</td>
<td>1.29</td>
</tr>
<tr>
<td>rs6597</td>
<td>16</td>
<td>CXCL1</td>
<td>0.12</td>
<td>0.0303</td>
<td>1.29</td>
</tr>
<tr>
<td>rs2834202</td>
<td>21</td>
<td>CXCL1</td>
<td>0.12</td>
<td>0.0303</td>
<td>1.29</td>
</tr>
<tr>
<td>rs2834202</td>
<td>21</td>
<td>PELI3</td>
<td>0.27</td>
<td>0.0303</td>
<td>1.29</td>
</tr>
</tbody>
</table>

**Abbreviations:** Chr = Chromosome; CI = confidence interval; IFN = interferon; MA = minor allele frequency; MAF = minor allele; MA = minor allele frequency; OR = odds ratio; SNP = single nucleotide polymorphism.

**GABRR3** (gamma-aminobutyric acid [GABA] C receptor, subunit 3) rs832032 is located in the untranslated region of the GABRR3 gene, which codes for a subunit of the GABA(C) receptor. It is interesting that this polymorphism results in a premature stop codon and subsequent protein truncation. At present, there is no evidence in the literature of a functional relationship between GABA(C) receptors and IFN-β mechanism of action.

**PELI3** (pellino E3 ubiquitin protein ligase family member 3) gene, which codes for an E3 ubiquitin protein ligase involved in TLR signaling. In a recent publication, Pel3-deficient mice expressed increased levels of endogenous IFN-β in response to TLR3 activation, and an autoregulation mechanism was proposed in which PELI3 inhibited type I IFNs by targeting IFN regulatory factor 7. These findings are in agreement with previous data from our group revealing...
increased baseline levels of endogenous IFN-β in peripheral blood cells from IFN-β nonresponders.\textsuperscript{11}

Overall, results from this study do not support an association between polymorphisms positioned in genes belonging to the type I IFN or TLR pathways or genes coding for GABA or glutamate receptors and the clinical response to IFN-β. Findings with rs832032 and rs2277302 polymorphisms warrant further studies exploring the role of \textit{GABRR3} and \textit{PEL13} in the response to IFN-β in larger cohorts of patients with MS.

**AUTHOR CONTRIBUTIONS**

M.F. Bustamante: study concept and design, manuscript drafting and revision, genotyping, analysis and interpretation of the data. C. Moreillo-Suárez: manuscript drafting and revision, statistical analysis, analysis and interpretation of the data. S. Malhotra: manuscript revision, genotyping. J. Rio: manuscript revision, contribution of patients and clinical data. L. Leyva: manuscript revision, contribution of patients and clinical data. O. Fernández: manuscript revision, contribution of patients and clinical data. D. Brassat: manuscript revision, contribution of patients and clinical data. J. Killestein: manuscript revision, contribution of patients and clinical data. A. Alvarez-Lafuente: manuscript revision, contribution of patients and clinical data. M. Comabella: manuscript revision, contribution of patients and clinical data. J. Redondo: manuscript revision, contribution of patients and clinical data. J.C. Alvarez-Cermeto: manuscript revision, contribution of patients and clinical data. X. Farré: manuscript revision, statistical analysis supervision, analysis and interpretation of the data. J. Lechner-Scott: manuscript revision, contribution of patients and clinical data. K. Vandenbroeck: manuscript revision, contribution of patients and clinical data. M. Cornette: manuscript revision, contribution of patients and clinical data. A. Rodriguez-Antigüedad: manuscript revision, contribution of patients and clinical data. J.S. Drulovic: manuscript revision, contribution of patients and clinical data. F. Martinielli Boneschi: manuscript revision, contribution of patients and clinical data. A. Chan: manuscript revision, contribution of patients and clinical data. J. Oksenberg: manuscript revision, contribution of patients and clinical data. A. Navarro: manuscript revision, statistical analysis supervision, analysis and interpretation of the data. X. Montalban: manuscript revision, contribution of patients and clinical data, study concept and design, analysis and interpretation of the data. M. Comabella: manuscript drafting and revision, study concept and design, analysis and interpretation of the data, study supervision.

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REFERENCES
Pharmacogenomic study in patients with multiple sclerosis: Responders and nonresponders to IFN-β
Marta F. Bustamante, Carlos Morcillo-Suárez, Sunny Malhotra, et al.
Neurol Neuroimmunol Neuroinflamm 2015;2;
DOI 10.1212/NXI.0000000000000154

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