The effects of sildenafil on ciliary beat frequency in patients with pulmonary non-tuberculous mycobacteria disease: phase I/II trial

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ABSTRACT

Rationale Pulmonary non-tuberculous mycobacterial (PNTM) disease has increased over the past several decades, especially in older women. Abnormal mucociliary clearance and abnormal nasal nitric oxide (nNO) have been associated with PNTM disease in other patient cohorts. Mucociliary clearance can be affected by NO-cyclic guanosine monophosphate signalling and, therefore, modulation of the pathway may be possible with phosphodiesterase inhibitors such as sildenafil as a novel therapeutic approach.

Objective To define ex vivo characteristics of PNTM disease affected by sildenafil.

Methods Subjects with PNTM infections were recruited into an open-label dose-escalation trial of sildenafil. Laboratory measurements and mucociliary measurements—ciliary beat frequency, nNO and 24-hour sputum production—were collected throughout the study period. Patients received sildenafil daily during the study period, with escalation from 20 to 40 mg three times per day.

Measurements and main results Increased ciliary beat frequency occurred after a single dose of 40 mg sildenafil and after extended dosing of 40 mg sildenafil. The increase ciliary beat frequency was not seen with 20 mg sildenafil dosing. There were no changes in sputum production, nNO production, Quality of Life-Bronchiectasis-NTM module (QOL-B-NTM) questionnaire or the St George’s Respiratory Questionnaire during the study period.

Conclusion Sildenafil, 40 mg, increased ciliary beat frequency acutely as well as with extended administration.

INTRODUCTION

Pulmonary non-tuberculous mycobacteria (PNTM) disease in otherwise healthy individuals is increasing in industrialised countries and has been shown to have both environmental and genetic associations.1-5 The clinical syndrome generally occurs in postmenopausal women, with lower body mass indices and without significant immunological abnormalities.6,7 Familial clustering as well as high rates of genetic variants affecting immune, respiratory, ciliary, cystic fibrosis transmembrane conductance regulator and connective tissue genes in patients with PNTM disease suggest a genetically complex aspect to the syndrome.8-10 Patients with PNTM infections may have abnormalities in respiratory ciliary function and moderately reduced nasal nitric oxide (nNO) levels.11 Previous work demonstrated that the decreased baseline ciliary beat frequency (CBF) present in ex vivo PNTM patient’s respiratory epithelial cells could be increased through the ex vivo addition of phosphodiesterase V inhibitor, sildenafil.

Mucus clearance rates are associated with linear changes in CBF and nitric oxide (NO) is known to be involved in regulating CBF through NO synthase and the activation of soluble guanylate cyclase leading to increased concentrations of cyclic guanosine monophosphate (cGMP).12-14 Increases in cGMP concentration can also stimulate numerous other metabolic pathways leading to a myriad of effects on respiratory epithelium, as well
as vascular smooth muscles. The ex vivo observation that sildenafil leads to an increase in CBF in primary respiratory epithelial cells obtained from PNTM-infected patients led us to hypothesise that oral administration of sildenafil to patients with PNTM infection may result in increased CBF in vivo secondary to an increase in cGMP signalling. Considering the safety profile of sildenafil, we hypothesise that the augmentation of CBF could have potential benefits on mucociliary clearance and PNTM lung disease course; however, the first step was to determine if the previously demonstrated ex vivo effects could be replicated in vivo.

**MATERIALS AND METHODS**

**Patient recruitment**

PNTM-infected patients were recruited over a 6-month period from March to August (2013) at the Clinical Center, National Institutes of Health (NIH), Bethesda, Maryland, USA. All patients (n=9) provided informed consent under an NIAID IRB-approved protocol (13-I-0075, NCT01853540) (figure 1) and had microbiological and radiographical evidence of longstanding pulmonary NTM infection consistent with the American Thoracic Society (ATS) criteria for PNTM disease.8 15 16 All study participants in the study design were enrolled. Sildenafil dosing schedule is graphically displayed for the clinical trial. PNTM, pulmonary nontuberculous mycobacteria.

**Collection of respiratory epithelium**

Primary human respiratory epithelial cells were collected as previously described.11 Primary patient epithelial samples were visualised at the time of collection (day of collection). Primary human respiratory epithelial cells were collected by scraping the inferior nasal turbinate using a Rhino-Probe (Arlington Scientific). Harvested nasal tissue was suspended in Dulbecco’s modified essential medium, high glucose, without phenol red (DMEM-H; Invitrogen) supplemented with gentamicin (50µg/mL, Sigma), amphotericin (50µg/mL, Sigma), ceftazidime (100µg/mL, Sigma), tobramycin (80µg/mL, Sigma), vancomycin (100µg/mL, Sigma), nystatin (100U/mL, Sigma) and fluconazole (25µg/mL, Sigma). After collection, the respiratory epithelial cells were resuspended in a hormonally supplemented respiratory epithelial cell medium (Lonza, Walkersville, Maryland, USA) and keep at 37°C until imaging.

**Analysis of CBF**

The time interval between the harvest of respiratory epithelial cells and the measurement of CBF was between 60 and 180 min. Cells and cilia were visualised using transmitted light in bright-field mode with a 63 × (NA 1.3) glycerol objective on a Leica DM IRBE inverted scope (Leica Microsystems) on a vibration dampened table. Images and videos were captured using a Model A602F-2 Basler area scan high-speed monochromatic digital video camera (Basler AG) at a sampling rate of 100 frames/s with a resolution of 640×480 pixels. The images were analysed using the Sisson-Ammons Video Analysis (SAVA) system V.2.1.15 (Ammons Engineering). All imaging was done at 37°C. Temperature and humidity conditions were maintained through the use of a heated insert, S-2 incubator chamber and objective heater (PeCon). For each respiratory epithelial sample, 20 different field views were continuously recorded for 2.5 s at 100 frames/s. The videos and images were compressed and stored for later analysis. CBF of the de-identified videos was determined by region of interest (ROI) analysis in which CBF was determined by the SAVA software system (Ammons Engineering, Michigan, USA).17 ROI was independently determined by two blinded investigators on the de-identified videos. Multiple videos and ROI were analysed for each time point. The CBF between the two investigators were then averaged for a final CBF per time point.

**Measurement of nasal airway NO**

nNO was measured in concordance with ATS guidelines by direct sampling through a NO analyser (model 280i, 10.1136/bmjresp-2020-000574 on 12 March 2020. Downloaded from http://bmjopenresp.bmj.com/ BMJ Open Resp Res: first published as 10.1136/bmjresp-2020-000574 on 12 March 2020. Downloaded from
Sievers Instrument, Boulder, Colorado, USA) and reported as steady-state production of NO in nL/minute.28

Sputum collection and measurement
Twenty-four-hour sputum collections were performed and weights recorded at days 0, 7 and 30 as previously described.19

Questionnaires
Self-administered quality of life and functional questionnaires were administered throughout the study period. The Quality of Life-Bronchiectasis-NTM module (QOL-B-NTM) questionnaire quantifies disease-specific symptom severity and quality of life and was performed as previously described at baseline, day 7 and day 30.20 The St. George’s Respiratory Questionnaire (SGRQ) evaluates the health-related quality of life in subjects with the chronic pulmonary disease with a 30-day recall. The SGRQ was performed at baseline, day 30 and day 45.21

Patient and public involvement
Patient care at the Clinical Centre, NIH, is performed as part of clinical studies. Patients and the public are involved during study design as part of the NIAID IRB approval process. There was no patient involvement in the recruitment and conduct of the study. Patients were not invited to contribute to the writing.

Statistical analysis
Data, including figures, are expressed as mean±SD, statistical testing was done using the two-tailed Student t-test with Welch’s correction and one-way analysis of variance (ANOVA) with Dunnett correction.

RESULTS
Demographics
Nine patients with PNTM disease were enrolled, age 63±8 years (range: 58 to 80 years); all were Caucasian women. The mean body mass index was 20.8±3.2 kg/m². All patients reported chronic cough and had radiographically demonstrated bronchiectasis prior to enrolment. Sixty-six per cent (n=6) reported haemoptysis and 44% reported sinusitis, but only one had a history of otitis media. Thirty-three per cent (n=3) reported a remote history of smoking. Twenty-two per cent (n=2) had joint hypermobility (Beighton Hypermobility score), 11% (n=1) a positive thumb-wrist sign (self-reported)22 and none had echocardiography-proven mitral valve prolapse. The mean forced expiratory volume in 1 s (% predicted) was 85%±24%. Mutations in cystic fibrosis transmembrane conductance regulator, determined by full gene sequence (Ambry Genetics, Aliso Viejo, California, USA), were absent in 33% (n=3), present on a single allele in 22% (n=2) and unknown in 44% (n=4). At the time of respiratory epithelial collection, 56% (n=5) were on NTM-associated medications (clarithromycin, azithromycin, rifampin, rifabutin, rifapentine, ethambutol, amikacin, isoniazid, imipenem, meropenem, tigecycline, cefoxitin, linezolid, clofazimine or moxifloxacin) and all had positive NTM cultures. NTM was isolated from all the patients at some time prior to enrolment: 45% (n=4) of the patients had mycobacterium avium complex; NTM, non-tuberculous mycobacteria.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Patients with PNTM disease (N=9)</th>
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<tbody>
<tr>
<td>Mean age, mean±SD (years)</td>
<td>63±8</td>
</tr>
<tr>
<td>Female gender, n (%)</td>
<td>9 (100)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
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<tr>
<td>White, n (%)</td>
<td>9 (100)</td>
</tr>
<tr>
<td>Never smokers, n (%)</td>
<td>3 (33)</td>
</tr>
<tr>
<td>CFTR carriers, n (%)</td>
<td>2 (22)</td>
</tr>
<tr>
<td>Scoliosis, n (%)</td>
<td>3 (33)</td>
</tr>
<tr>
<td>Joint hypermobility, n (%)</td>
<td>2 (22)</td>
</tr>
<tr>
<td>Positive thumb-wrist sign, n (%)</td>
<td>1 (11)</td>
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<tr>
<td>Mitral valve prolapse, n (%)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Cough, n (%)</td>
<td>9 (100)</td>
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<tr>
<td>Bronchiectasis, n (%)</td>
<td>9 (100)</td>
</tr>
<tr>
<td>Previous history of NTM-positive sputum, n (%)</td>
<td>9 (100)</td>
</tr>
<tr>
<td>On NTM therapy at collection, n (%)</td>
<td>5 (56)</td>
</tr>
<tr>
<td>Elevated inflammatory markers at collection, n (%)</td>
<td>5 (56)</td>
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<tr>
<td>Macrolide exposure at collection, n %</td>
<td>4 (44)</td>
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<tr>
<td>Immunomodulatory drugs, n %</td>
<td>0 (0)</td>
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<tr>
<td>BMI, mean±SD</td>
<td>20.8±3.2</td>
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<tr>
<td>Mycobacteria, n (%)</td>
<td></td>
</tr>
<tr>
<td>MAC</td>
<td>4 (45)</td>
</tr>
<tr>
<td>MAB</td>
<td>3 (33)</td>
</tr>
<tr>
<td>MAC &amp; MAB</td>
<td>2 (22)</td>
</tr>
</tbody>
</table>

BMI, body mass index; CFTR, cystic fibrosis transmembrane conductance regulator; MAB, mycobacterium abscessus; MAC, mycobacterium avium complex; NTM, non-tuberculous mycobacteria.

Adverse events
There were no serious adverse events, adverse events leading to treatment discontinuation or death noted in the study. All adverse events during the study were grade ≤2. Adverse events in patients associated with study drug included: 44% (n=4) headache that spontaneously resolved within 15 min of study drug, and 22% (n=2) nasal congestion. Adverse events occurring in more than one study patient included: 22% (n=2) decreased serum albumin, 22% (n=2) hypomagnesaemia, 22% (n=2) lymphopenia and 22% (n=2)
thrombocytopenia (n=2). No other adverse event occurred in more than one patient.

**Immediate effects of in vivo addition of sildenafil on CBF**

To determine if CBF in PNTM patient respiratory epithelium could be increased by in vivo inhibition of phosphodiesterase V with sildenafil, patients were administered either 20 mg sildenafil (n=3) or 40 mg sildenafil (n=5). Patients with PNTM disease had a mean CBF of 8.96±1.2 Hz, with no significant difference between the two groups prior to sildenafil dose. The 40 mg sildenafil group’s CBF was significantly elevated to 10.79±0.6 Hz (p<0.008, two-tailed t-test) post sildenafil.

**Effects of in vivo addition of sildenafil on nNO**

Patients with PNTM disease have been previously shown to have moderately reduced nNO levels in vivo. The patients with PNTM disease enrolled in the clinical trial had a mean nNO level of 232±61 nL/min at the time of consent. There was no significant change in the average nNO throughout the trial (figure 3A,B).

**Effects of in vivo addition of sildenafil on sputum production**

We measured sputum weight over time in patients with PNTM disease, as enhanced ciliary clearance might be expected to alter sputum production. Previous research has demonstrated that patients with PNTM disease have variable sputum production. The 24-hour sputum weights before and during exposure to study the drug
DISCUSSION

NO donors have been previously shown to rapidly increase mucociliary activity ex vivo. We have previously shown that patients with PNTM infection have decreased nNO and their respiratory epithelial cells’ CBF is reduced when compared with healthy controls or other respiratory disease states. We have also recently shown that mycobacterial infection of respiratory epithelial cells reduces the expression of ciliary-related genes. Therefore, we hypothesised that modulation of the NO-cGMP pathway might be attractive in this patient population, even though the precise role of mucociliary clearance in PNTM infection is undefined.

Sildenafil increases intracellular concentrations of cGMP through the inhibition of phosphodiesterase V, which affects the NO-cGMP pathway. The modulation of cGMP by sildenafil has been extensively studied in the cardiovascular system, as well as in the treatment of pulmonary arterial hypertension. It has also been studied as a therapy for patients with chronic obstructive pulmonary disease.

We found a significant increase in ex vivo CBF with a single oral dose of 40 mg of sildenafil (figure 2A), which was not seen with the 20 mg dose. Prolonged dosing of sildenafil noted a significant increase in CBF only after the final dose of sildenafil 40 mg (figure 2B), suggesting that continued dosing of sildenafil did not lead to tachyphylaxis or downregulation of the effect of sildenafil on the NO-cGMP pathway. The absence of sustained response and the non-significance of the predose sample collection at day 30 could be due to the timing of the last dose of sildenafil. The terminal half-life of sildenafil is approximately 4 hours. The day 29 previous dose of sildenafil would have been >10 hours prior to sample collection.

No significant increase in nNO in PNTM-infected patients treated with sildenafil was noted (figure 3A,B). This was consistent with our previous demonstration of the absence of a linear correlation between CBF and nNO levels. It is interesting to note the trend toward increased nNO at treatment day 30, which corresponds to the increased CBF seen with higher sildenafil dosing (figure 3B). Sputum production was quite variable throughout the study period (figure 3C), possibly secondary to the difficulty of adequately measuring sputum production while accounting for saliva production and the small sample size of the study.

Patient-reported outcomes of physical function, emotional state and social interactions are important in a chronic disease such as PNTM infection and are likely to be important markers in the development of new therapies. Patients with PNTM infection have decreased health-related quality of life compared with healthy controls. The QOL-B-NTM questionnaire showed no significant difference during the study period in frequency, severity of disease-specific symptoms or physical impact of the disease (figure 4). SGRQ detected a clinical reduction in symptoms, but showed no significant trend during the study period (figure 3C).

Self-administered questionnaires

Self-administered quality of life and functional questionnaires were completed throughout the study period. We found no significant changes in the reports of symptoms on the QOL-B-NTM during the course of the clinical trial (figure 4A–C). Similarly, we found no significant trends in the SGRQ over the course of the study (figure 4D).
it was not significant (figure 4D). The dosing and/or the time course of the study could be too short to note changes in patient-reported clinical outcomes. Enrollment of patients with well-established PNTM disease can provide a cohort with a well-defined disease state, but the chronic infection stage may not be an optimal period for intervention with this type of therapy. The patient-reported measures were included in the study as secondary outcomes to assess feasibility, as well as to assist with future study directions. Importantly, sildenafil did not appear to worsen any patient’s self-reported outcomes.

CONCLUSIONS

The abnormality in CBF in PNTM infection that we have identified is modest, aligning with the fact that most aspects of life are relatively normal in patients with PNTM infection until the fifth or sixth decades. The abnormalities in the NO-cGMP pathway seen previously ex vivo in patients with PNTM disease are measurable and modifiable in vivo with sildenafil. This novel therapy has a strong safety record and appears to have minimal adverse events. Although further studies will be necessary to assess the potential effect of modulating the NO-cGMP pathway in the disease course of patients with PNTM infection, this class of medication may offer a novel therapeutic approach or alternative study direction for research in patients with PNTM infection.

Descriptors

Nontuberculous Mycobacterial Disease; Mycobacterial Disease; Host Defenses; Mucosal Immunity of the Respiratory Tract

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Contributors

CF: designed experiments, analysed data and composed manuscript. U-W: assisted with data analysis. RS and CS: extracted clinical values and coordinated patient recruitment. LB: ensured IRB compliance. CB: provided valuable input throughout the process. KO and SMH: treated patients and were responsible for overall design of the project as well as revision of the manuscript.

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Competing interests

None declared.

Patient consent for publication

Not required.

Provenance and peer review

Not commissioned; externally peer reviewed.

Data availability statement

No data is publicly available. Due to the nature of the phase II clinical trial, data would be available for collaboration upon reasonable request.

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