Randomized Trial of Clazosentan in Patients With Aneurysmal Subarachnoid Hemorrhage Undergoing Endovascular Coiling

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Background and Purpose—Clazosentan, an endothelin receptor antagonist, has been shown to reduce vasospasm after aneurysmal subarachnoid hemorrhage (aSAH). CONSCIOUS-3 assessed whether clazosentan reduced vasospasm-related morbidity and all-cause mortality postaSAH secured by endovascular coiling.

Methods—This double-blind, placebo-controlled, phase III trial randomized patients with aSAH secured by endovascular coiling to 14 days intravenous clazosentan (5 or 15 mg/h) or placebo. The primary composite end point (all-cause mortality; vasospasm-related new cerebral infarcts or delayed ischemic neurological deficits; rescue therapy for vasospasm) was evaluated 6 weeks postaSAH. The main secondary end point was dichotomized extended Glasgow Outcome Scale (week 12).

Results—CONSCIOUS-3 was halted prematurely following completion of CONSCIOUS-2; 577/1500 of planned patients (38%) were enrolled and 571 were treated (placebo, n=189; clazosentan 5 mg/h, n=194; clazosentan 15 mg/h, n=188).

The primary end point occurred in 50/189 of placebo-treated patients (27%), compared with 47/194 patients (24%) treated with clazosentan 5 mg/h (odds ratio [OR], 0.786; 95% CI, 0.479–1.289; P=0.340), and 28/188 patients (15%) treated with clazosentan 15 mg/h (OR, 0.474; 95% CI, 0.275–0.818; P=0.007). Poor outcome (extended Glasgow Outcome Scale score ≤4) occurred in 24% of patients with placebo, 25% of patients with clazosentan 5 mg/h (OR, 0.918; 95% CI, 0.546–1.544; P=0.748), and 28% of patients with clazosentan 15 mg/h (OR, 1.337; 95% CI, 0.802–2.227; P=0.266). Pulmonary complications, anemia, and hypotension were more common in patients who received clazosentan than in those who received placebo. At week 12, mortality was 6%, 4%, and 6% with placebo, clazosentan 5 mg/h, and clazosentan 15 mg/h, respectively.

Conclusions—Clazosentan 15 mg/h significantly reduced postaSAH vasospasm-related morbidity/all-cause mortality; however, neither dose improved outcome (extended Glasgow Outcome Scale).

Clinical Trial Registration—URL: http://clinicaltrials.gov. Unique identifier: NCT00940095.

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Key Words: aneurysmal subarachnoid hemorrhage ■ clazosentan ■ CONSCIOUS-3 ■ phase III ■ placebo-controlled ■ randomized ■ endovascular coiling

A ngiographic vasospasm is an important cause of mortality and disability following aneurysmal subarachnoid hemorrhage (aSAH).1 Vasospasm contributes to delayed ischemic neurological deficits (DIND) that occur in up to 40% of aSAH cases, and half of patients with DIND develop ischemic infarctions.2 As vasospasm after aSAH is unpredictable, common, difficult to manage, and associated with poor outcome, prevention is a highly desired management strategy; prophylactic nimodipine is widely used, although its efficacy is limited.3

Clazosentan is a selective endothelin receptor antagonist, which was investigated for prevention of angiographic vasospasm in patients with aSAH in the phase Ib CONSCIOUS-1 (Clazosentan to Overcome Neurological Ischemia and Infarct Occurring After Subarachnoid Hemorrhage) study.4 In CONSCIOUS-1, clazosentan (1, 5, and 15 mg/h doses)
produced a dose-dependent reduction in moderate or severe angiographic vasospasm, with a 65% relative risk reduction with the highest dose (P<0.0001); this suggests that endothelin-1 plays an important role in the pathogenesis of angiographic vasospasm.5,6

On the basis of CONSCIOUS-1, 2 phase III studies (CONSCIOUS-2 and CONSCIOUS-3) were designed to assess the effect of clazosentan on the incidence of cerebral vasospasm-related morbidity and all-cause mortality, and clinical outcome, in patients with aSAH. In CONSCIOUS-2, patients who had their aneurysm secured by clipping received placebo or clazosentan 5 mg/h; however, no significant effect was seen with clazosentan.7,8 Use of 15 mg/h clazosentan in CONSCIOUS-3 was based on CONSCIOUS-1, where the effect of clazosentan was less with 5 mg/h in patients with aneurysms secured by coiling than by clipping, as explained in detail previously.4,8

CONSCIOUS-3 was initiated on July 10, 2009. Recruitment was halted prematurely (October 2010) after completion of CONSCIOUS-2, in part because the 5 mg/h dose did not achieve its primary end point in clipped patients; also, this dose had a similar relative risk reduction in angiographic vasospasm in CONSCIOUS-1 as did the highest dose (15 mg/h) being tested in CONSCIOUS-3 in coiled patients.7 In addition, stopping the study was recommended by the Data and Safety Monitoring Board.

**Methods**

This was a phase III, prospective, multicenter, international, randomized, double-blind, placebo-controlled trial (NCT00940095; Figure 1). Eligible patients were age 18 to 75 years with aSAH caused by ruptured saccular aneurysm, which was secured by endovascular coiling; they had any thick clot (short axis ≥4 mm) on baseline computed tomographic (CT) scan, World Federation of Neurological Surgeons (WFNS) grades I-IV before coiling procedure, and were able to start study drug within 56 hours of aneurysm rupture. Women of childbearing potential were included only following a negative pregnancy test. Written informed consent was obtained.

Exclusion criteria included: giant aneurysms (largest diameter ≥25 mm); intraventricular or intracerebral blood in the absence of subarachnoid blood; vasospasm on precoiling angiogram; a major complication during coiling procedure; current ruptured aneurysm previously secured (successfully or not) by clipping; missing digital subtraction angiography at the end of the coiling procedure; or several aneurysms, among which the ruptured one was not identifiable with certainty and that were not all secured during the coiling procedure. Intravenous nimodipine or intravenous nicardipine within 4 hours, or intravenous fasudil within 24 hours, before study drug initiation, was not permitted.

After coiling, patients were randomized (1:1:1) to receive intravenous clazosentan (5 or 15 mg/h) or placebo for up to 14 days postaSAH; the investigator completed a randomization form on an interactive, independent, Web-response system, which assigned a randomization number for each patient according to a predefined scheme. Randomization was stratified by site. The randomization code was only available to authorized individuals with no involvement in study conduct or analysis until the time of unblinding.

Sites managed patients according to guidelines developed for the study and were consistent with published recommendations.3,8 Early detection and management of lung complications were addressed. Drugs or procedures not considered standard care were prohibited. Oral, but not intravenous, nimodipine was permitted.

The study protocol was approved by local Institutional Review Boards and was completed in accordance with Good Clinical Practice guidelines, the Declaration of Helsinki, and with the laws and regulations of the country in which the clinical research was conducted.

**Assessments**

Before the coiling procedure, all patients underwent CT scan and digital subtraction angiography or CT angiography. Additional CT scans were performed 12 to 48 hours after the coiling procedure (a 12-hour postprocedure CT scan was mandatory for sedated patients; up to 48-hours for neurologically assessable patients), at discharge (unless this occurred after the 6-week visit; a scan at 14 days postaSAH was also acceptable), 6 weeks after aSAH, and in cases of worsening neurological condition or DIND. Angiograms were performed after coiling to document the completeness of occlusion, or with symptoms suggestive of DIND and/or cerebral infarct. In patients who were sedated or in whom neurological scales were not assessable, an angiogram was performed at 9±2 days postaSAH. When neurological worsening occurred, investigators performed investigations to determine whether medical complications (including, but not limited to: hydrocephalus, neurological or systemic infection, hypotension, adult respiratory distress syndrome, pulmonary edema, renal failure, multiorgan failure, metabolic disorders, myocardial infarction, diffuse brain swelling, intracerebral hemorrhage, seizures, and/or rebleeding) were the primary or contributing cause.

After treatment, neurological assessments were performed every 6 hours until day 14 (irrespective of study drug duration) using the modified Glasgow Coma Scale and the abbreviated National Institutes of Health Stroke Scale.9,10 Assessment of Glasgow Outcome Scale, extended version (GOSE), and modified Rankin Scale12 were carried out at week 12 by trained centralized interviewers via a structured telephone interview.

Clinical and imaging data were reviewed by a centralized Critical Events Committee.8 The Critical Events Committee included an image review committee of neuroradiologists, who provided independent evaluation of CT scans and angiograms (each brain image was reviewed by 2 neuroradiologists, with a third adjudicating if discrepancies occurred), and a Clinical Review Committee (CRC; cases were reviewed by 2 neurosurgeons and 1 neurointensivist from a pool of 9 CRC members; unanimity or consensus agreement was required). Consensus meetings were held to discuss cases where
there was disagreement; if unanimity was not achieved after the consensus meeting, the CRC chairman (or should the chairman already be involved in the primary review, the deputized neurointensivist) adjudicated the case, made the final assessment, and documented the assessment in a CRC adjudication form. The CRC made the final assessment via a Web-based system, which provided electronic access to the brain images, whereas the image review committee reported on the clinical data for each patient under review. Operating through a charter, the CRC considered whether emergent adverse events (AE).

Safety end points included death up to week 12 and treatment-related adverse events (AE) due to treatment with clazosentan or placebo. Treatment-related AEs were those which occurred during treatment, required treatment discontinuation, and were considered related to the study drug by the investigator. Emergent AEs were those events that were documented after the primary review of the data and raised concerns with respect to patient safety. Emergent AEs were reviewed by the CRC, the Data and Safety Monitoring Board, and the sponsor, and a decision was reached on whether to continue or stop the study. The study was halted prematurely after nonsignificant results from CONSCIOUS-2 became apparent, and after recommendations from the Data and Safety Monitoring Board; as such, planned confirmatory analyses were not performed, and formal testing of the global null hypothesis was not carried out. Treatment effect of the 2 clazosentan doses was tested in an exploratory manner using logistic regression adjusting for WFNS grade (III, IV) assessed at admission, and was described using OR with corresponding 95% CIs. The incidence rates of the individual components of the composite primary end point are displayed together with the exact 95% CIs, and the relative risk reduction in each dose group with the corresponding 95% CIs (normal approximation). Dichotomized GOSE was analyzed using the same statistical methods as for the primary end point.

In the case of a missing assessment for the morbidity component of the primary end point, or missing information on the vital status, the worst case (ie, presence of vasospasm-related morbidity and mortality) was assumed. For GOSE, if no score was available, a score of 5 was assigned when there was no clinical evidence of vasospasm-related morbidity and all-cause mortality within 6 weeks postSAH, as defined by at least 1 of: death; vasospasm-related cerebral infarction (where vasospasm was the primary cause or a relevant contributing factor); DIND caused by vasospasm (where vasospasm was the primary cause or a relevant contributing factor); or neurological signs or symptoms, in the presence of a positive angiogram, leading to rescue therapy. DIND was defined as a decrease of ≥2 modified Glasgow Coma Scale points or an increase of ≥2 points on the abbreviated National Institutes of Health Stroke Scale lasting for ≥2 hours. For patients in whom neurological scales were not assessable, DIND was defined as administration of valid rescue therapy, which included initiation or increase in dose of an intravenous vasopressor with or without fluid therapy, intra-arterial vasodilator, or balloon angioplasty.

The main secondary end point was the GOSE, dichotomized as good (>4) or poor (≤4), at week 12. Additional secondary end points included occurrence of the individual components of the composite primary end point and total volume of all new or worsened cerebral infarcts at week-6 postSAH. Planned supplementary analyses assessed the impact of subgroups (WFNS grade, clot size, age, and sex) on the primary and main secondary end point. Safety end points included death up to week 12 and treatment-emergent adverse events (AE).

Statistical Analyses

Assuming a relative risk reduction of 30% (odds ratio [OR], 0.603) with at least 1 dose of clazosentan (5 or 15 mg/h) and a placebo event rate of 35%, sample size of 1,470 was calculated. A 2-group, continuity-corrected Chi-square test had approximately 90% power to reject the null hypothesis (comparison-wise, 2-sided, error rate of 2.5%). Assuming that 2% of enrolled patients would not receive treatment, the planned sample size was 1,500 patients.

This trial was halted prematurely after nonsignificant results from CONSCIOUS-2 became apparent, and after recommendations from the Data and Safety Monitoring Board; as such, planned confirmatory analyses were not performed, and formal testing of the global null hypothesis was not carried out. Treatment effect of the 2 clazosentan doses was tested in an exploratory manner using logistic regression adjusting for WFNS grade (III, IV) assessed at admission, and was described using OR with corresponding 95% CIs. The incidence rates of the individual components of the composite primary end point are displayed together with the exact 95% CIs, and the relative risk reduction in each dose group with the corresponding 95% CIs (normal approximation). Dichotomized GOSE was analyzed using the same statistical methods as for the primary end point.

In the case of a missing assessment for the morbidity component of the primary end point, or missing information on the vital status, the worst case (ie, presence of vasospasm-related morbidity and mortality) was assumed. For GOSE, if no score was available, a score of 5 was assigned when there was no clinical evidence of previous neurological impairment, and a score of 3 was given in any other situation when a patient was alive at week 12. Baseline demographics were analyzed using descriptive statistics; all values are mean and SD, or percent.

Efficacy analyses were based on the full analysis set, defined as all treated patients (ie, all those randomized and who started infusion). Patients exposed to treatment, with at least 1 postbaseline safety measurement, were included in the safety data set.

Additional information on the rationale, study design, and methodology has been published.8

Results

Baseline Characteristics

CONSCIOUS-3 was conducted between July 10, 2009 and January 26, 2011 (last patient, last visit) at 106 centers in 27 countries; 577 of 1,500 patients (38% of the planned sample size) had been randomized at the time of study termination, and 571 patients (placebo, n=189; clazosentan 5 mg/h,
n=194; clazosentan 15 mg/h, n=188) had received treatment. Participant flow is shown in Figure 2. AEs were the most common reason for discontinuation of study drug in all arms; administrative/other reasons included: stopping drug by mistake, early hospital discharge, and other technical/logistical reasons. Demographic and clinical characteristics were similar across all groups at baseline (Table 1).

Patients received study treatment for a mean±SD of 12±2 days, 12±3 days, and 12±3 days in the placebo, clazosentan 5 mg/h, and 15 mg/h groups, respectively; treatment commenced 18±12 hours, 20±12 hours, and 18±12 hours, respectively, after aneurysm coiling. Oral nimodipine was administered to 94% (placebo), 95% (clazosentan 5 mg/h), and 95% (clazosentan 15 mg/h) of patients.

### Table 1. Baseline Demographic and Disease Characteristics (All-Treated)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Placebo n=189</th>
<th>Clazosentan 5 mg/h n=194</th>
<th>Clazosentan 15 mg/h n=188</th>
<th>Total n=571</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>55 (29)</td>
<td>59 (30)</td>
<td>58 (31)</td>
<td>172 (30)</td>
</tr>
<tr>
<td>Mean (SD) age, y</td>
<td>54 (11)</td>
<td>52 (11)</td>
<td>53.6 (11)</td>
<td>53.1 (11)</td>
</tr>
<tr>
<td>Age range, y</td>
<td>23 to 75</td>
<td>23 to 75</td>
<td>19 to 76</td>
<td>19 to 76</td>
</tr>
<tr>
<td>WFNS admission grade</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade I</td>
<td>96 (51)</td>
<td>99 (51)</td>
<td>103 (55)</td>
<td>298 (53)</td>
</tr>
<tr>
<td>Grade II</td>
<td>56 (30)</td>
<td>48 (25)</td>
<td>53 (28)</td>
<td>157 (28)</td>
</tr>
<tr>
<td>Grade III</td>
<td>6 (3)</td>
<td>5 (3)</td>
<td>3 (2)</td>
<td>14 (3)</td>
</tr>
<tr>
<td>Grade IV</td>
<td>24 (13)</td>
<td>37 (19)</td>
<td>26 (14)</td>
<td>87 (15)</td>
</tr>
<tr>
<td>Grade V</td>
<td>5 (3)</td>
<td>4 (2)</td>
<td>2 (1)</td>
<td>11 (2)</td>
</tr>
<tr>
<td>Motor deficit present at admission</td>
<td>19 (10)</td>
<td>21 (11)</td>
<td>18 (10)</td>
<td>58 (10)</td>
</tr>
<tr>
<td>No. of aneurysms secured (ruptured and unruptured)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>183 (97)</td>
<td>183 (94)</td>
<td>177 (94)</td>
<td>543 (95)</td>
</tr>
<tr>
<td>2</td>
<td>6 (3)</td>
<td>10 (5)</td>
<td>10 (5)</td>
<td>26 (5)</td>
</tr>
<tr>
<td>&gt;2</td>
<td>0</td>
<td>1 (&lt;1)</td>
<td>1 (&lt;1)</td>
<td>2 (&lt;1)</td>
</tr>
<tr>
<td>Size of coiled ruptured aneurysm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤15 mm</td>
<td>183 (98)</td>
<td>193 (100)</td>
<td>181 (97)</td>
<td>557 (98)</td>
</tr>
<tr>
<td>&gt;15 mm</td>
<td>5 (3)</td>
<td>1 (&lt;1)</td>
<td>6 (3)</td>
<td>12 (2)</td>
</tr>
<tr>
<td>Key locations of ruptured aneurysms</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Supraclinoid ICA</td>
<td>19 (10)</td>
<td>22 (11)</td>
<td>31 (17)</td>
<td>72 (13)</td>
</tr>
<tr>
<td>MCA</td>
<td>16 (9)</td>
<td>19 (10)</td>
<td>23 (12)</td>
<td>58 (10)</td>
</tr>
<tr>
<td>ACA</td>
<td>10 (5)</td>
<td>21 (11)</td>
<td>13 (7)</td>
<td>44 (8)</td>
</tr>
<tr>
<td>ACoA</td>
<td>74 (39)</td>
<td>62 (32)</td>
<td>62 (33)</td>
<td>198 (35)</td>
</tr>
<tr>
<td>PCoA</td>
<td>31 (16)</td>
<td>39 (20)</td>
<td>35 (19)</td>
<td>105 (18)</td>
</tr>
<tr>
<td>Distal VA</td>
<td>11 (6)</td>
<td>5 (3)</td>
<td>8 (4)</td>
<td>24 (4)</td>
</tr>
<tr>
<td>Basilar artery</td>
<td>22 (12)</td>
<td>22 (11)</td>
<td>15 (8)</td>
<td>59 (10)</td>
</tr>
<tr>
<td>Clot size at baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diffuse thick</td>
<td>116 (61)</td>
<td>118 (61)</td>
<td>111 (59)</td>
<td>345 (61)</td>
</tr>
<tr>
<td>Local thick</td>
<td>58 (31)</td>
<td>54 (28)</td>
<td>56 (30)</td>
<td>168 (30)</td>
</tr>
<tr>
<td>Diffuse thin</td>
<td>12 (6)</td>
<td>17 (9)</td>
<td>17 (9)</td>
<td>46 (8)</td>
</tr>
<tr>
<td>Local thin</td>
<td>3 (2)</td>
<td>2 (1)</td>
<td>4 (2)</td>
<td>9 (2)</td>
</tr>
<tr>
<td>Unable to assess</td>
<td>0</td>
<td>2 (1)</td>
<td>0</td>
<td>2 (&lt;1)</td>
</tr>
<tr>
<td>Common CT findings at baseline</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Intraventricular hemorrhage</td>
<td>162 (85.7)</td>
<td>161 (83.4)</td>
<td>156 (83.0)</td>
<td>479 (84.0)</td>
</tr>
<tr>
<td>Hydrocephalus</td>
<td>122 (64.6)</td>
<td>117 (60.6)</td>
<td>115 (61.2)</td>
<td>354 (62.1)</td>
</tr>
<tr>
<td>Intraparenchymal hemorrhage</td>
<td>35 (18.5)</td>
<td>36 (18.7)</td>
<td>32 (17.0)</td>
<td>103 (18.1)</td>
</tr>
</tbody>
</table>

Values are n (%) unless otherwise stated.

WFNS indicates World Federation of Neurological Surgeons; ICA, internal carotid artery; MCA, middle cerebral artery; ACA, anterior cerebral artery; ACoA, anterior communicating artery; PCoA, posterior communicating artery; CT, computed tomography; VA, vertebral artery.
患者在氯扎索坦15 mg/h组（2例患者，GOSE
评分3；1例患者，GOSE评分5）。

**Efficacy**

血管痉挛相关并发症和全因死亡在全部治疗人群中的发生率分别为50/189例（27%）的安慰剂组、47/194例（24%）和28/188例（15%）的5 mg/h和15 mg/h氯扎索坦组，分别显著改善了15 mg/h氯扎索坦（OR，0.474；95% CI，0.275–0.818；P<0.007），但5 mg/h氯扎索坦（OR，0.786；95% CI，0.479–1.289；P=0.340；图3A）。

事件率在全部治疗人群中，每个个体成分的复合终点结果在图3B中显示；安慰剂组患者（21%）需要救援疗法的比例高于5 mg/h（15%）和15 mg/h（7%）氯扎索坦组。DIND显著减少与氯扎索坦15 mg/h（10%）相比，安慰剂组（21%）。血管痉挛相关的新大脑中风患者13%、16%，以及7%与氯扎索坦5 mg/h和氯扎索坦15 mg/h，分别无治疗效果在治疗期间没有存在（6周内）。

**Safety and Tolerability**

在研究中，91%、86%和92%的患者服用氯扎索坦5 mg/h和15 mg/h，分别经验≥1 AE。严重AE incidence was 25%（安慰剂）28%（氯扎索坦5 mg/h），29%（氯扎索坦15 mg/h）；AEs考虑由研究者被判定是治疗的主导因素24%、34%、37%、分别。比例较高为患者服用氯扎索坦（5 mg/h和15 mg/h）提前停用或停药治疗与安慰剂组主要原因是从研究药物 AE（图2）。发生AEs的特异性因素在表2中显示。与安慰剂、肺部并发症、低血压、贫血等更常见于氯扎索坦；低血压在15 mg/h剂量组更常见于5 mg/h剂量组。

所有治疗患者中，6%（安慰剂），4%（氯扎索坦5 mg/h），6%（氯扎索坦15 mg/h）在12周内死亡为SAH；原因报告为>1%的患者在任何一组中存在大脑中风（2%、<1%和3%），脑血管痉挛（2%、<1%和<1%），以及脑水肿（2%、<1%和<1%），分别。

**Discussion**

这项随机、双盲、安慰剂对照的III期试验研究了氯扎索坦5或15 mg/h在SAH患者通过血管内电凝手术治疗后对血管痉挛相关并发症和全因死亡的影响。因非显著的比较结果，CNSCIOUS-2电凝手术研究已提前终止。氯扎索坦5 mg/h在复合主要终点（全部治疗，端点替代；计划分析，次要端点）对血管痉挛相关并发症或全因死亡7周后无显著影响，但15 mg/h氯扎索坦显著减少血管痉挛相关并发症或全因死亡7周后。氯扎索坦15 mg/h显著降低救援疗法比例，可能因为对应的DIND显著减少。然而，
reduction in the primary end point did not lead to improved outcome at week 12, as measured by GOSE.

Despite an impressive and significant effect on vasospasm-related ischemic events, some explanations for the lack of effect of 15 mg/h clazosentan dose on GOSE can be hypothesized. The most important is that because of early stopping of this trial, the planned number of patients was not enrolled; therefore, its low statistical power may explain the lack of effect observed with 15 mg/h of clazosentan. The possibility exists that the tolerability profile of the drug negated any therapeutic benefit, or that interaction with oral nimodipine contributed to AEs. For example, intravenous nimodipine is associated with low blood pressure, and it is possible that oral administration of nimodipine with clazosentan may have contributed to the higher rate of hypotension in the active treatment groups compared with placebo. Microthromboembolism, microcirculatory dysfunction, cortical spreading ischemia, and delayed neuronal injury have been postulated to contribute to DIND and outcome, and might not be prevented by clazosentan. Indeed, although clazosentan has been shown to be effective on large-artery vasospasm, little is known about its effect on microcirculation. Rescue therapy may provide a positive effect on outcome that obscures the benefit of clazosentan. Assuming rescue therapy prevents ischemia from vasospasm and improves clinical outcome, the 3-fold-more frequent use of rescue therapy (composite end point component) in the 15 mg/h group compared with the placebo arm could account for the lack of treatment effect observed on GOSE.

The results from CONSCIOUS-2 and CONSCIOUS-3 raised questions regarding the efficacy of endothelin-1 antagonists in preventing vasospasm; however, the possibility remains that these agents may have clinical utility as part of a complex treatment regimen for aSAH. For future trials, investigating different (eg, shorter) durations of clazosentan...
administration could be considered to attempt to separate the positive effects from any deleterious consequences of treatment. In addition, restricting the use of nimodipine concomitantly with clazosentan may help to determine the relevant contributions of each agent to changes in cerebral vasospasm-related morbidity and all-cause mortality, and in functional outcome. Initiating surgical procedures as early as possible, and ensuring that this is coupled with the appropriate pharmacological interventions, remains the current focal points for treatment of patients with aSAH.

Adverse events (lung complications, hypotension, and anemia) were consistent with those observed in CONSCIOUS-1 and CONSCIOUS-2; it is likely that these side effects could be managed using appropriate adjunct therapy. There were no new safety concerns in this study compared with in the previous 2 trials. An equal proportion of patients in the clazosentan 15 mg/h and placebo groups died during the study, with cerebral infarction being the most frequently reported primary cause of death in these groups.

**Conclusions**

Clazosentan 15 mg/h reduced cerebral vasospasm-related morbidity and all-cause mortality. However, clazosentan did not improve outcome, possibly because of increased rescue therapy in the placebo group. Compared with placebo, pulmonary complications, anemia, and hypotension were more common in patients receiving clazosentan. Although clazosentan does not appear to provide benefit in clinical outcome, it prevented DIND and rescue therapy, which could be further investigated based on analysis of the patients treated in the clazosentan studies.

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**References**

Randomized Trial of Clazosentan in Patients With Aneurysmal Subarachnoid Hemorrhage Undergoing Endovascular Coiling

R. Loch Macdonald, Randall T. Higashida, Emanuela Keller, Stephan A. Mayer, Andy Molyneux, Andreas Raabe, Peter Vajkoczy, Isabel Wanke, Doris Bach, Aline Frey, Pegah Nowbakht, Sébastien Roux and Neal Kassell

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背景および目的: エンドセリン受容体拮抗薬 clazosentan は、動脈瘤性くも膜下出血 (aSAH) 後の血管収縮を抑制することが明らかにされている。CONSCIOUS-3 試験では、clazosentan が、血管内コイル塞栓術によって治療された aSAH 後の血管収縮に関連する罹病率と全死因による死を抑制するか否かを評価した。

方法: 本二重盲検プラセボ対照第 III相試験では、血管内コイル塞栓術を施行した aSAH 患者を、14 日以下の静脈内 clazosentan (5 mg または 15 mg/時) またはプラセボ投与に無作為に割り付けた。主要複合評価項目（全死因による死亡、血管収縮に関連する新たな脳梗塞または遅発性虚血性神経障害、血管収縮に対する救済療法）を aSAH 後 6 週時に評価した。主な副次評価項目は二分した拡張グラスゴー・アウトカムスケール (12 週時) であった。

結果: CONSCIOUS-3 試験は、CONSCIOUS-2 試験の完了後、早期に中止された。予定された 1,500 例中 577 例 (38%) が登録され、571 例に試験投与が実施された (プラセボ 189 例、clazosentan 5 mg/時 194 例、clazosentan 15 mg/時 188 例)。プラセボ群では 189 例中 50 例 (27%) に主要評価項目が発生したのに対し、clazosentan 5 mg/時群では 194 例中 47 例 (24%) [オッズ比 (OR) = 0.786, 95% CI: 0.479 ~ 1.289, p = 0.340]、また clazosentan 15 mg/時群では 188 例中 28 例 (15%) (OR = 0.474, 95% CI: 0.275 ~ 0.818, p = 0.007) に主要評価項目が発生した。予後不良 (拡張グラスゴー・アウトカムスケールスコア≦ 4) となったのは、プラセボ群の 24%、clazosentan 5 mg/時群の 25% (OR = 0.918, 95% CI: 0.546 ~ 1.544, p = 0.748) および clazosentan 15 mg/時群の 28% (OR = 1.337, 95% CI: 0.802 ~ 2.227, p = 0.266) の患者であった。肺合併症、貧血および低血圧は、プラセボを投与した患者よりも clazosentan を投与した患者に多く認められた。12 週時の死亡率は、プラセボ群、clazosentan 5 mg/時群および clazosentan 15 mg/時群でそれぞれ 6%, 4%および 6%であった。

結論: clazosentan 15 mg/時は aSAH 後の血管収縮関連の罹病率・全原因死を有意に抑制したが、いずれの用量の clazosentan によっても転帰 (拡張グラスゴー・アウトカムスケール) は改善されなかった。

臨床試験登録: URL: http://clinicaltrials.gov。固有登録番号:NCT00940095。
혈관내 코일링으로 치료한 동맥류성 거미막혈출혈 환자에서 clazosentan의 무작위시험

Randomized Trial of Clazosentan in Patients With Aneurysmal Subarachnoid Hemorrhage Undergoing Endovascular Coiling

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(Stroke. 2012;43:1463-1469.)

Key Words: aneurysmal subarachnoid hemorrhage ■ clazosentan ■ CONSCIOUS-3 ■ phase III ■ placebo-controlled ■ randomized ■ endovascular coiling

배경과 목적

엔도혈관 수용체 결손제인 clazosentan은 동맥류성 거미막혈출혈(aSAH) 이후의 혈관연속소를 감소시킨다. CONSCIOUS-3는 aSAH를 혈관내 코일링으로 치료한 환자 중 clazosentan이 혈관연속과 관련된 이환율과 사망률을 감소시키는지를 평가했다.

방법

이 두가지 일반 위약제 3상시험은 혈관내 코일링으로 치료한 aSAH 환자를 14일 이내의 clazosentan 정주 또는 위약으로 무작위배정하였다. aSAH 발생 6주 후에 일차복합결절(사망, 혈관연속 관련 심들어뇌형성, 지연된 허혈성심장질환, 혈관연속에 대한 구조적결손)을 평가하였다. 주요결정결과는 이 환자군에서 extended Glasgow Outcome Scale (12주)였다.

결과

CONSCIOUS-3는 CONSCIOUS-2의 원래 후 조기결과로 되어, 계획한 1,500명 중 577명을 등록하였고 571명을 치료하였다(위약, n=189; clazosentan 5 mg/h, n=194; clazosentan 15 mg/h, n=188). 일차결정결과 위약군의 환자 50/189 (27%)에게, clazosentan 5 mg/h 치료환자(OR, 0.786; 95% CI, 0.479~1.289; P=0.340)의 47/194 (24%)에게, clazosentan 15 mg/h 치료환자(OR, 0.474; 95% CI, 0.275~0.818; P=0.007)의 28/188 (15%)에서 발생했다. 질병된 결과(extended Glasgow Outcome Scale score ≤4)는 위약으로 치료된 환자의 24%, clazosentan 5 mg/h로 치료한 환자(OR, 0.918; 95% CI, 0.546~1.544; P=0.748)의 25%, clazosentan 15 mg/h으로 치료한 환자(OR, 1.337; 95% CI, 0.802~2.227; P=0.266)의 28%에서 발생했다. 호흡기 및 체외, 전형, 저혈압 위약군보다 clazosentan군에서 더 적었다. 12주 후의 사망률은 위약군에서 6%, clazosentan 5 mg/h군에서 4%, clazosentan 15 mg/h군에서 6%였다.

결론

Clazosentan 15 mg/h은 aSAH 이후의 혈관연속 관련 이환율, 사망률을 의미있게 감소시켰다. 그러나 어떠한용량도 결과(extended Glasgow Outcome Scale)를 호전시키는 역할은 없었다.

Clinical Trial Registration