Effects of the Oral Direct Thrombin Inhibitor Ximelagatran on P-Selectin Expression and Thrombin Generation in Atrial Fibrillation

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Abstract
This study investigated the pharmacodynamic effects of the oral direct thrombin inhibitor ximelagatran on platelet activation and thrombin generation in patients with nonvalvular atrial fibrillation. Using an open, group-matched study design, the effects of ximelagatran (36 mg twice daily for 5 days) were studied in 12 patients with permanent nonvalvular atrial fibrillation and in 12 healthy controls. After ximelagatran for 5 days, elevated platelet P-selectin expression in atrial fibrillation patients was lowered to that during coumarin treatment or in controls but had no effect in control subjects. Using the endogenous thrombin potential as a marker, ximelagatran decreased and delayed thrombin generation in both groups.

Introduction
Atrial fibrillation is the most frequent sustained arrhythmia and is associated with thromboembolic events [1, 2]. Current guidelines recommend antithrombotic therapy for primary prevention of thromboembolic events in patients with atrial fibrillation at risk for complications [3]. A hypercoagulable state can be detected in patients with permanent atrial fibrillation, even with currently available oral anticoagulant therapy, as shown by increased expression of the platelet membrane adhesion receptor P-selectin [4, 5] and elevated levels of soluble P-selectin, plasma von Willebrand factor, and fibrinogen [6].

Thrombin plays a major role in thrombus formation through its ability to catalyze fibrin formation and rapidly activate platelets [7–9] and is, therefore, a key target for anticoagulation treatment. The primary action of thrombin inhibitors is to block thrombin activity directly, without the requirement of cofactors such as antithrombin [10]. Potent thrombin inhibitors have also been shown to decrease thrombin generation via inhibition of thrombin’s positive feedback activation of other coagulation
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Study Design
The study followed an open, nonrandomized, group-matched study design and consisted of a 6-day treatment period (fig. 1). The preexisting oral anticoagulant treatment with the vitamin K antagonist coumarin in atrial fibrillation patients was discontinued at study entry, at an international normalized ratio (INR) of between 2.1 and 3.1 (median 2.4). Treatment with melagatran was started at an INR of ≤ 2.0, which was between 3 and 9 days (median 7 days) after study entry. All subjects received a 10-min intravenous infusion of 2.66 mg melagatran on the first study day (day 1), followed by 36 mg oral ximelagatran twice daily at 12-hour dosing intervals on the 5 subsequent study days. As the half-life of melagatran is approximately 4–5 h in atrial fibrillation patients after oral dosing with ximelagatran [18], a 5-day treatment period of repeated dosing was considered adequate to reach steady state.

Blood Sampling
The INR was measured from citrated venous plasma at study entry and on day 1 employing routine laboratory methods. Citrated venous blood samples (0.5 ml 3.8% sodium citrate) for the determination of platelet P-selectin expression, ETP and activated partial thromboplastin time (APTT) were taken at study entry, on day 1 before initiation of melagatran, and 2 h after the morning dose of ximelagatran on day 6.

Analyses
Plasma Melagatran. Plasma concentrations of melagatran were measured using liquid chromatography-mass spectrometry [19]. The limit of quantification was 0.010 µmol/l.
Platelet P-Selectin Expression. Platelet P-selectin (CD62P) analysis was performed after incubation of citrated blood with fluorescein isothiocyanate-labeled anti-P-selectin antibody (Immunotech, Marseille, France) using flow cytometry (fluorescence-activated cell sorter scan; Becton Dickinson, San Jose, Calif., USA) [20]. An isotype-specific monoclonal antibody was used to set a threshold for positive platelets (IgG1; Immunotech), and the fluorescein-positive number expressed as percentage of total platelets analyzed.
Endogenous Thrombin Potential. ETP was determined as previously described [15] and as follows: 100 µl prewarmed platelet-poor plasma was combined with 15 µl thrombin chromogenic substrate H-b-Ala-Gly-Arg-pNA (5 mmol/l), 12.5 µl fibrin polymerization inhibitor H-Gly-Pro-Arg-Pro-OH-AcOH (36 mg/ml), and 100 µl
Thromborel S (diluted 1:20), and the change in absorbance was recorded at 405 nm over a period of 20 min (Spectra MaxPlus microtiterplate reader; Molecular Devices, Sunnyvale, Calif., USA). Thrombin activity was calculated from the optical density trace with the computer program Pure Thrombin (AstraZeneca, Mölndal, Sweden) using the concentration and kinetic constants of the thrombin chromogenic substrate H-β-Ala-Gly-Arg-pNA (K_m = 1.95 mmol/l, k_cat = 1.91/s) [12]. The total amidolytic activity over time was then corrected for the presence of thrombin-2-macroglobulin complexes. The algorithm calculates the time constant, k, from the conversion of thrombin into its complex with 2-macroglobulin for each individual sample. The ratio of k_cat/k_cat is also calculated for each individual sample, where k_cat is the time constant for the conversion of the substrate into product by thrombin, k_cat is the time constant for the conversion of the substrate into product by the α-macroglobulin-thrombin complex. As thrombin generation continues, all thrombin is finally converted into the complex between α-macroglobulin and thrombin, and as the time constant k_cat is known, the activity of this complex can be calculated and subtracted.

**Activated Partial Thromboplastin Time.** APTT measurements were performed using Thrombolytic Assessment System-APTT assay cards with an automated Thrombolytic Assessment System card reader (TASTM; Pharmanetics, Morrisville, N.C., USA) [13]. The Thrombolytic Assessment System-APTT technique results in APTT values that are higher than those that would be obtained using conventional APTT methods.

**Safety Evaluations**

All subjects were given a complete health examination (including physical examination and laboratory screening) at study entry and at follow-up 2–5 days after the last study day, and all adverse events were recorded.

**Statistical Analysis**

Descriptive statistics were calculated for all pharmacodynamic variables. The matched pairs were used for comparisons of the levels of P-selectin and analysis of parameters of the ETP and time to thrombin peak between the two groups. For P-selectin and ETP, changes within groups between measurement occasions and changes between groups on each measurement occasion were determined and given as means with 95% confidence intervals (95% CIs). Group differences/ratios were considered statistically significant at 2-tailed level of 0.05 (p < 0.05) when the 95% CIs of the differences/ratios did not cross 0.0/1.0 (excluding 0.0/1.0). No corrections were to be made for multiple comparisons performed in this study. A linear model was fitted for patients and controls on day 6 to investigate the relationship between the APTT ratio (expressing APTT as a ratio of pre-dose values) as the dependent variable and with plasma concentrations of melagatran, health status (patient no/yes), and the interaction between plasma concentration of melagatan and health status (patient no/yes) as explanatory variables. Previous studies have shown that a linear relationship with APTT ratio is produced when a square-root transformation of plasma concentrations of melagatran is used rather than a curvilinear relationship with absolute melagatan concentrations.

**Results**

**Subjects**

A total of 12 patients with permanent nonvalvular atrial fibrillation and 12 healthy control subjects were included in the study. All subjects were Caucasians; 7 pairs were men and 5 pairs were women. The median (range) age of the atrial fibrillation patients was 65 years (37–77) and of the matched controls 63 years (32–77). The median (range) body mass index values were 29.8 kg/m² (24.3–37.6) and 28.0 kg/m² (20.3–38.1) for patients and controls, respectively. After discontinuation of coumarin treatment in patients with atrial fibrillation at study entry, the INR decreased to between 0.9 and 2.0 (median 1.5) before melagatran dosing.

### Table 1.

<table>
<thead>
<tr>
<th>P-selectin expression</th>
<th>Patients</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study entry</td>
<td>9.8 (7.0; 12.6)</td>
<td>8.2 (5.8; 10.7)</td>
</tr>
<tr>
<td>Baseline (day 1)</td>
<td>10.9 (9.0; 12.9)*</td>
<td>7.5 (5.3; 9.7)</td>
</tr>
<tr>
<td>Ximelagatran (day 6)</td>
<td>9.2 (6.2; 12.1)</td>
<td>7.0 (5.2; 8.8)</td>
</tr>
</tbody>
</table>

Data are presented as mean (95% CI), n = 12. *p < 0.05 vs. controls.

### Table 2.

<table>
<thead>
<tr>
<th>ETP, nmol/l-min</th>
<th>Patients</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study entry</td>
<td>921 (653; 1188)*</td>
<td>1601 (1085; 2117)</td>
</tr>
<tr>
<td>Baseline (day 1)</td>
<td>1271 (948; 1594)</td>
<td>1336 (1022; 1651)</td>
</tr>
<tr>
<td>Ximelagatran (day 6)</td>
<td>777 (603; 950)*</td>
<td>846 (644; 1047)*</td>
</tr>
</tbody>
</table>

**Time to thrombin peak, min**

<table>
<thead>
<tr>
<th>Time entry</th>
<th>Study entry</th>
<th>Baseline (day 1)</th>
<th>Ximelagatran (day 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.48 (2.64; 4.33)*</td>
<td>2.42 (1.93; 2.92)*</td>
<td>4.63 (2.99; 6.28)*</td>
</tr>
</tbody>
</table>

Data are presented as mean (95% CI), n = 12. *p < 0.05 vs. study entry; ++ p < 0.05 vs. day 1.
Table 3. APTT and plasma melagatran concentrations in patients with permanent nonvalvular atrial fibrillation and controls after 5 days of oral ximelagatran treatment (day 6) at predose, and after 36 mg oral ximelagatran

<table>
<thead>
<tr>
<th>APTT, s</th>
<th>Plasma melagatran, µmol/l</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>patients</td>
</tr>
<tr>
<td>Predose</td>
<td>54 ± 12</td>
</tr>
<tr>
<td>2 h</td>
<td>66 ± 16</td>
</tr>
<tr>
<td>3 h</td>
<td>79 ± 29</td>
</tr>
<tr>
<td>6 h</td>
<td>66 ± 11</td>
</tr>
<tr>
<td>8 h</td>
<td>59 ± 10</td>
</tr>
<tr>
<td>12 h</td>
<td>46 ± 9</td>
</tr>
</tbody>
</table>

Data are presented as mean ± SD, n = 12. The APTT was measured using a bedside Thrombolytic Assessment System-APTT, which tends to overestimate the APTT prolongation as compared with conventional APTT assays.

Platelet P-Selectin Expression
Platelet P-selectin data are summarized in table 1. In atrial fibrillation patients, P-selectin expression on platelets was slightly higher at baseline (day 1) compared with study entry and was lower during ximelagatran treatment (day 6). However, these within-group changes were small and did not reach statistical significance. The control group had relatively constant P-selectin levels in the absence and presence of melagatran. Platelet P-selectin expression on day 1 was significantly higher (approximately 45%) in atrial fibrillation patients when the international normalized ratio was ≤ 2.0 than in control subjects (mean difference 3.41, 95% CI: 0.59; 6.24). On day 6, this difference was no longer detectable (mean difference 2.14, 95% CI: −0.47; 4.75).

Endogenous Thrombin Potential
ETP results are shown in table 2. Within atrial fibrillation patients, ETP was slightly higher (p > 0.05) and time to thrombin peak shorter (p < 0.05) at baseline on day 1 with an INR of ≤ 2.0 compared with values at study entry. In control subjects, ETP and time to thrombin peak were comparable at study entry and day 1. Ximelagatran treatment (day 6) significantly decreased ETP versus day 1 in both patients (mean difference −495; 95% CI: −747; −242) and controls (−491, 95% CI: −739; −243). Time to thrombin peak was prolonged between day 1 and day 6 in patients (mean difference 2.21; 95% CI: 0.76; 3.67) and controls (1.2; 95% CI: 0.43; 1.97). Between-group differences were detectable at study entry, where patients had a lower ETP (mean difference −680, 95% CI: −1,235; −125) and longer time to thrombin peak (1.42, 95% CI 0.46; 2.38) than the control group. Before dosing with melagatran on day 1, ETP was comparable in patients and controls, but time to thrombin peak was still prolonged in atrial fibrillation patients (0.57, 95% CI: 0.04; 1.1) compared with controls. ETP parameters were comparable between groups during ximelagatran treatment on day 6.

Activated Partial Thromboplastin Time
On day 1, after discontinuation of oral anticoagulant treatment with coumarin and at an INR of ≤ 2.0, the mean (range) APTT was comparable between patients with permanent atrial fibrillation (33.8 s; 26.4–52.1 s) and controls (29.4 s; 23.7–34.7 s). Ximelagatran on day 6 increased plasma melagatran concentrations and prolonged the APTT in patients and controls, with a similar response to ximelagatran in both groups (table 3, fig. 2).

Safety
Patients with atrial fibrillation reported more adverse events during the study than controls: 3 minor bleeding events, blood in sputum, gingival bleeding and a mild hematoma were reported by 3 patients during study treat-
ment, and 1 case of mild epistaxis was reported during the follow-up period. There were no bleeding events in control subjects.

**Discussion**

In this study, oral administration of ximelagatran at steady state reduced platelet expression of P-selectin to that during coumarin treatment or that observed in controls and decreased the ETP and prolonged time to thrombin peak in patients with permanent nonvalvular atrial fibrillation. Ximelagatran significantly lowered platelet P-selectin expression in patients to that of healthy matched controls, whereas parameters assessed from plasma thrombin generation were altered with both groups to a similar degree. These effects were observed in the presence of similar prolongations of the APTT in patients and controls, confirming a consistent anticoagulant effect of ximelagatran between these two groups. The small number of individuals in this study makes it difficult to interpret the significance of the 3 minor bleeds observed in the patient group versus none in the control group during treatment with ximelagatran.

The elevation of platelet P-selectin expression in atrial fibrillation patients (at INR $\leq 2.0$) suggests a higher degree of systemic platelet activation than in controls and is consistent with other reports [4, 5, 21]. Interestingly, platelet activation and atrial fibrillation are not related to increases in heart rate by exercise [22] or by ventricular pacing or increased right atrial pressure [5] but are associated with the risk for embolism [23, 24]. This finding is also consistent with studies on venous plasma concentrations of soluble P-selectin, which are consistently increased in permanent atrial fibrillation [4, 6, 22, 25, 26] irrespective of the site of blood sampling [27]. Enhanced plasma concentrations of soluble P-selectin were reported in a recent study after 6 weeks of warfarin treatment in patients with atrial fibrillation, despite reduced prothrombin fragment 1 + 2 and $\beta$-thromboglobulin concentrations [26]. Since soluble P-selectin may not only indicate platelet activation but is also related to platelet destruction by the reticuloendothelial system, the relevance of this finding is unclear and must be interpreted cautiously. The present study is the first describing the actions of direct thrombin inhibitors on platelet P-selectin expression in patients with atrial fibrillation. Our results showing that ximelagatran can reduce elevated platelet P-selectin expression in atrial fibrillation patients to that of controls is in line with the decrease in soluble P-selectin by unfractionated heparin in healthy men reported previously [28]. Although the mechanism of platelet activation in atrial fibrillation appears to be related to thrombin formation, the exact regulation of the platelet P-selectin membrane expression is complex [29] and, to our knowledge, has not been investigated in detail. The involvement of thrombin and the importance of anticoagulation in atrial fibrillation were recently demonstrated in a study in which warfarin therapy was found to be effective at reducing plasma indices of thrombogenesis and platelet activation in atrial fibrillation patients, whereas aspirin-clopidogrel combination therapy failed to reduce plasma indices of thrombogenesis and platelet activation [26]. Understanding and comparing the degree of inhibition of thrombin generation and platelet activation by antithrombotic drugs may help guide the selection of effective doses as regards P-selectin expression on platelets.

To date, the in vitro plasma potency to generate thrombin as measured by the ETP has not been used to determine coagulability in routine laboratories. In several studies, thromboembolic risk, associated with oral contraceptive therapies [30], coronary artery disease [31], hyperhomocysteinemia [32] and factor V Leiden in women [33], has been assessed. The observation in the present study of decreased thrombin generation and delayed peak thrombin burst during oral anticoagulation in atrial fibrillation patients with vitamin K antagonists is consistent with previous data [31]. The discontinuation of oral anticoagulation in atrial fibrillation patients resulted in an ETP that approximated those of controls, clearly demonstrating its dependency on concomitant anticoagulant therapy. Thus, even if hypercoagulability is present in permanent atrial fibrillation, there is little if any impact on plasma thrombin generation parameters, contrary to P-selectin expression and other parameters reflecting thrombogenicity.

It has been demonstrated in vitro and ex vivo that the direct thrombin inhibitor hirudin delayed thrombin generation [14, 34, 35] and in one study also decreased ETP [35], whereas the low-molecular-weight heparin dalteparin reduced ETP but had only a negligible effect on the time to thrombin peak [35]. In contrast, melagatran both delays time to the thrombin peak and inhibits ETP efficiently ex vivo. This was demonstrated in a clinical setting in healthy subjects, where the melagatran-induced reduction in the area under the thrombin generation curve was dose-dependent [35]. After a single dose of 30 or 60 mg ximelagatran, ex vivo ETP decreased to approximately 71 and 52% of baseline values at a mean melagatran plasma concentration of 0.25 and 0.46 $\mu$mol/l, respectively. These experiments are consistent with the decrease of
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Ximelagatran on P-selectin and ETP in atrial fibrillation has been shown to increase platelet membrane P-selectin expression in patients with an INR $\leq 2.0$ versus controls. Direct thrombin inhibition with ximelagatran lowered elevated P-selectin expression and inhibited parameters of thrombin formation of the plasma thrombin generation curve.

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**References**

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