Mangafodipir as a cardioprotective adjunct to reperfusion therapy: a feasibility study in patients with ST-segment elevation myocardial infarction

Jan-Erik Karlsson¹,²*, Walid El-Saadi¹, Mustafa Ali¹,³, Werner Puskar³, Patrik Skogvard¹, Jan E. Engvall⁴,⁵, Rolf G. Andersson⁶, Eva Maret³,⁷, and Per Jynge⁶,⁸

¹Department of Internal Medicine, County Council of Jönköping, Ryhov County Hospital, Jönköping SE-551 85, Sweden; ²Department of Medical and Health Sciences, Faculty of Health Sciences, Linköping University, Linköping, Sweden; ³Department of Radiology, County Council of Jönköping, Jönköping, Sweden; ⁴Department of Medical and Health Sciences, Faculty of Health Sciences, Linköping University, Linköping, Sweden; ⁵Department of Clinical Physiology, County Council of Östergötland, Östergötland, Sweden; ⁶Division of Drug Research, Department of Medical and Health Sciences, Faculty of Health Sciences, Linköping University, Linköping, Sweden; ⁷Department of Clinical Physiology, Karolinska University Hospital, Stockholm, Sweden; and ⁸MedPharma AB, Stockholm, Sweden

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Abstract

The aim of the present study was to examine the feasibility of applying the catalytic antioxidant mangafodipir [MnDPDP, manganese (Mn) dipyridoxyl diphosphate] as a cardioprotective adjunct to primary percutaneous coronary intervention (pPCI) in patients with ST-segment elevation (STE) myocardial infarction (STEMI). Both MnDPDP and a metabolite (Mn dipyridoxyl ethyldiamine) possess properties as mitochondrial superoxide dismutase mimetics and iron chelators, and combat oxidative stress in various tissues and conditions.

Methods and results

The study tested MnDPDP (n = 10) vs. saline placebo (n = 10), given as a brief intravenous (i.v.) infusion prior to balloon inflation during pPCI in patients with STEMI. Mangafodipir was well tolerated and did not affect heart rate or blood pressure. Despite longer ischaemic time (205 vs. 144 min, P = 0.019) in the MnDPDP group, plasma biomarker releases were identical for the two groups. With placebo vs. MnDPDP, mean STE resolutions were 69.8 vs. 81.9% (P = 0.224) at 6 h and 73.1 vs. 84.3% (P = 0.077) at 48 h. Cardiac magnetic resonance revealed mean infarct sizes of 32.5 vs. 26.2% (P = 0.406) and mean left ventricular (LV) ejection fractions of 41.8 vs. 47.7% (P = 0.617) with placebo vs. MnDPDP. More LV thrombi were detected in placebo hearts (5 of 8) than MnDPDP-treated hearts (1 of 10; P = 0.011).

Conclusions

Mangafodipir is a safe drug for use as an adjunct to reperfusion therapy. A tendency to benefit of MnDPDP needs confirmation in a larger population. The study revealed important information for the design of a Phase II trial.

Keywords

Cardiac reperfusion injury • Primary PCI • STEMI • Oxidative stress • Mitochondrial superoxide dismutase • Small molecular catalytic antioxidants

Introduction

Reperfusion therapy by thrombolysis or primary percutaneous coronary intervention (pPCI) has reduced infarct size (IS) and improved clinical outcome in acute myocardial infarction (AMI). Still there is a need for improvement, particularly in ST-segment elevation (STE) AMI (STEMI). Importantly, the benefit of pPCI may be increased by avoiding reperfusion injuries when blood and oxygen return to the ischaemic myocardium. Of recent concern is a lethal injury, which nonetheless may be ameliorated experimentally by activating endogenous protection in the form of conditioning. Oxidative stress with uncontrolled release of reactive oxygen species (ROS) and impaired calcium homoeostasis followed by inflammation are main causes behind reperfusion injury. Unfortunately, targeting ROS and calcium by drugs have largely failed. However, agents acting via nitric oxide (NO) may be more promising by activating survival pathways when applied within the time limits for viability of the ischaemic myocardium. Also, measures taken after the onset of STEMI, or just prior to pPCI or during the first few minutes thereafter, may reduce the final IS. Thus, stepwise reperfusion and inducing postconditioning by remote ischaemia or by drugs are cardioprotective.
**Table 1** Baseline characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Placebo</th>
<th>MnDPDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Age (years)*</td>
<td>60.1 ± 10.8</td>
<td>64.1 ± 8.7</td>
</tr>
<tr>
<td>Male/female</td>
<td>10/0</td>
<td>8/2</td>
</tr>
<tr>
<td>Body mass index (%)*</td>
<td>25.9 ± 2.5</td>
<td>27.7 ± 3.3</td>
</tr>
<tr>
<td>Previous CHD</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Smoking</td>
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<td>4</td>
</tr>
<tr>
<td>Hypertension</td>
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<td>3</td>
</tr>
<tr>
<td>Haemoglobin (gL)*</td>
<td>155 ± 11</td>
<td>152 ± 14</td>
</tr>
<tr>
<td>Creatinine (µmol/L)*</td>
<td>87 ± 22</td>
<td>82 ± 17</td>
</tr>
<tr>
<td>Total cholesterol (mmol/L)*</td>
<td>4.9 ± 0.7</td>
<td>5.6 ± 0.7</td>
</tr>
<tr>
<td>LDL-cholesterol (mmol/L)*</td>
<td>2.9 ± 0.7</td>
<td>3.4 ± 0.6</td>
</tr>
<tr>
<td>Occluded vessel</td>
<td>LAD 6/RCA 4</td>
<td>LAD 6/RCA 3/LCX 1</td>
</tr>
<tr>
<td>TIMI grade 1 before pPCI</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>TIMI grade 2 after pPCI</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Ischaemic time (min)*</td>
<td>144 ± 72</td>
<td>206 ± 82</td>
</tr>
</tbody>
</table>

Blood chemistry at admission.
CHD, coronary heart disease; LAD, anterior branch of left coronary artery; LCX, left circumflex artery; LDL, low-density lipoprotein; pPCI, primary percutaneous coronary intervention; RCA, right coronary artery.

*Mean ± SD.

Methods

Twenty patients, admitted to the County Hospital of Jönköping, Sweden, were recruited to MANAMI 1-0924 between December 2009 and June 2013. They all suffered their first attack of AMI and were apparently free from angina pectoris. Inclusion criteria were: STE in two neighbour vessels, and a TIMI grade 2–3 was achieved. Further treatment of both groups was given by using a computer diagnostic program (Marquett SL-12, GE Healthcare), ST-segment elevation prior to reperfusion and at 6 h thereafter was expressed in µV.

Cardiac magnetic resonance protocol and analysis

Cardiac magnetic resonance with measurements of IS and LVEF was scheduled to be performed at routine clinical follow-up (6–10 weeks) after the coronary attack (late CMR). After eight patients had been included, the time point for CMR was changed to within 1 week (± 1 days) post-STEMI (early CMR). The reason for change of the time point was to gain information about the myocardium at risk (MAR), utilizing a then recently adopted T2-weighted imaging sequence. All 10 patients in the MnDPDP group underwent CMR (six early and four late), but only 8 patients in the placebo group (four early and four late) as two patients refrained from scanning.

Cardiac magnetic resonance was performed on a 1.5-T scanner (Magnetom Avanto, Siemens Healthcare, Erlangen, Germany) with use of a six-element phased-array body matrix coil. Ten to 12 short-axis slices were applied to cover the left ventricle from base to apex, with identical positions for all relevant examinations. Left ventricular chamber volumes, LVEF, and LV muscle volume and mass were assessed in short- and long-axis images by use of an ECG-triggered balanced steady-state precession cine CMR sequence. Late gadolinium-enhanced (LGE) images for measurement of IS were obtained 10 min after i.v. injection of 0.2 mmol/kg b.w. gadopentate dimeglumine (Magnevist, Bayer Schering Pharma, Berlin, Germany). An ECG-triggered phase-sensitive inversion recovery and a T2-weighted imaging sequence were used to measure the MAR. All CMR sequences were analysed using a computer freeware ‘Segment’ v 1.9 R2939 (http://segment.heiberg.se). One observer analysed all CMR images blinded from clinical data. T2-weighted measurements of the MAR were also undertaken by a second investigator blinded from the other investigator’s results.
Myocardial volumes (mL) were converted to mass (g) by using the factor 1.05. Infarct size and MAR were expressed in percentage of the total LV myocardium. The myocardial salvage index (MSI) was calculated as follows: MSI = IS/MAR. The presence of microvascular obstruction (MVO) and thrombi in the LV cavity was noted in a yes or no manner without quantification of volumes.

**Analysis of data**

All data and results obtained were analysed by use of standard non-parametric and parametric programs using the StatPrism software version 6.03 (Graph Pad Software, Inc., La Jolla, CA, USA). Statistical significance was noted when Mann–Whitney tests reported two-tailed P < 0.05. Results are presented as the median ± interquartile range in figures and tables, and as the mean values in the text.

**Results**

**Background characteristics**

Patient background was similar in both groups, except for two main factors (Table 1). First, duration of ischaemia (symptom-to-balloon time) was significantly (P = 0.037) longer in the MnDPDP group (mean 206 min) than the placebo group (mean 144 min). Secondly, some small residual CBF before pPCI was present in placebo hearts (TIMI grade 1 in three patients), but not in MnDPDP hearts. Also, the placebo group consisted of 10 males, whereas the MnDPDP group included eight males and two females. At admission, two patients in the placebo group were treated with statins for cardiovascular disease and a third patient was treated with corticosteroids for Crohn’s disease of the colon. In the MnDPDP group, two patients were on treatment with angiotensin-converting enzyme inhibitors either combined with a calcium antagonist or with a statin and a β-adrenergic antagonist.

**Clinical observations**

The 2–5 min i.v. infusion of MnDPDP prior to balloon inflation was well tolerated in all patients without any changes recorded in blood pressure, heart rate or ECG. Hypotension or arrhythmias were not encountered during administration of MnDPDP as well as saline placebo. During the stay in hospital after pPCI, no differences in haemoglobin, creatinine, liver enzymes, blood pressure, occurrence of arrhythmias or heart failure were observed. Especially, the incidence of heart failure routinely assessed by echocardiography was similar in both groups as expressed by the scale no/mild/moderate, placebo 2/3/5 and MnDPDP 2/4/4. There were no differences in medical treatment at peri-PCI or at discharge.

**Biomarker release**

Peak release to plasma of cardiac TnT (cTnT) and CK-MB revealed no differences between groups, whether prior to reperfusion or thereafter (Figure 1). Mean cTnT values were: at 6 h placebo 6063 ng/L and MnDPDP 6473 ng/L; and at 48 h placebo 3532 ng/L and MnDPDP 2906 ng/L. Mean CK-MB values were: at 6 h placebo 258 µg/L and MnDPDP 288 µg/L; and at 48 h placebo 14 µg/L and MnDPDP 13 µg/L. The mean accumulated (0–48 h) releases were also much similar: for cTnT, placebo 211 526 ng/L and MnDPDP 207 094 ng/L; and for CK-MB, placebo 211 526 ng/L and MnDPDP 207 094 ng/L.

**ST-segment elevation and resolution**

ST-segment elevation was closely similar in both groups prior to pPCI (Figure 2). Following reperfusion, a tendency (n.s.) to a more rapid (6 h) and more complete (48 h) STE resolution might be observed with MnDPDP. Mean STE resolutions were: at 6 h, placebo 69.8% and MnDPDP 81.9% (P = 0.138); and at 48 h, placebo 73.1% and MnDPDP 84.3% (P = 0.077).

**Cardiac magnetic resonance examinations**

The mean IS was lower (n.s.) in the MnDPDP group, 26.2%, than in the placebo group, 32.5%, and the mean LVEF was higher (n.s.) with MnDPDP, 47.7%, than with placebo, 41.8% (Figure 3). Left ventricular volume assessments revealed higher (n.s.) mean values of LV end-diastolic volume and LV end-systolic volume in placebo hearts than...
in the MnDPDP-treated hearts (Table 2). Microvascular obstruction was present in 3 of the 8 placebo hearts and in 3 of the 10 MnDPDP hearts. Thrombi in the LV chamber were significantly more frequent in placebo hearts (5 of 8) than in MnDPDP hearts (1 of 10). Collected data from both groups (n = 18) showed a highly significant correlation (P = 0.0009) between IS and LVEF.

Discussion

The main finding was that MnDPDP can be safely administered i.v. as an adjunct to pPCI in patients during AMI. This was expected from prior clinical reports, but the study became the first documentation of MnDPDP given safely as a brief i.v. infusion to critically ill cardiac patients. Reported adverse reactions with MnDPDP as a contrast agent releasing paramagnetic Mn ions for MRI are mild and related to NO-induced vasodilation like flushing and headache. Also, the drug may induce hypotension followed by an adrenergic activation (by Mn ions) with transient rise in blood pressure and heart rate. Neither of these possibilities nor allergic reactions were observed. However, the administered dose was lower (2 μmol/kg) than commonly applied for MRI (5 – 10 μmol/kg).

The primary endpoint, reduction of biomarker release to plasma, was not met, whereas other findings, in light of a skewed population (see below), appeared more positive and justify testing in a larger clinical trial. Thus, ECG and CMR examinations may indicate a tendency to potential improvement by MnDPDP. Importantly, valuable information was obtained for planning of a Phase II trial.

Baseline characteristics differed between groups with a longer symptom-to-balloon time with MnDPDP and a tendency to residual CBF prior to pPCI with placebo. However, ischaemic time based on
symptoms and signs may be questionable, and a more objective parameter like system-to-balloon time, recorded from first contact to the healthcare system, may be preferable. Even then a major confounder in reperfusion–protection studies remains, unnoticed angina inducing preconditioning. Also, TIMI grade 1 prior to pPCI may behave similarly. In a study on the use of CMR to assess myocardial salvage, there was a tendency to higher MSI with TIMI grade 1 (47%, n = 118) than with TIMI grade 0 (40%, n = 14). Although speculative, an apparent skewness in disfavour of MnDPDP may explain why plasma TnT and CK-MB failed to show any differences between the groups. In contrast, tendencies to a potential benefit of MnDPDP were at least partly observed in other indices.

STE resolution, seemingly more complete with MnDPDP, is a predictor of patency of reopened culprit arteries, indicates that microvascular perfusion is restored, is consistent with a low early mortality in patients with STEMI and has proved to be a predictor of freedom from reinfarction at 30 days and at 1 year. In the present study, STE resolution together with CMR findings may indicate a positive effect on the microcirculation. Especially, the significantly less frequent LV thrombi with MnDPDP may be consistent with improved subendocardial perfusion, possibly mediated by conservation of NO.9,18,20

There was also a tendency (n.s.) to smaller IS and higher LVEF with MnDPDP in pooled data from late and early CMR. Interestingly, the MSI was almost similar, but the IS was smaller with MnDPDP compared with placebo. Whereas smaller MAR with MnDPDP may be a random consequence of a too limited number of patients, it may also be speculated that it resulted from tissue protection. If so, the present CMR data from a few patients may reflect discrepancies between the MAR–MSI pair and the preferably more robust IS–LVEF pair of parameters, as have recently become a concern in reperfusion–protection trials.14,34,35

In line with the above, how and when CMR is applied in reperfusion studies may be questioned. On the one hand, LGE is the gold standard for measuring IS, and combined with cine CMR, IS and LVEF stand out as the most accurate parameters to assess the outcome of a serious coronary attack.26,27 As expected, they also showed a close inter-

relationship in the present study. However, both are time-dependent, IS as the LGE zone shrinks gradually while the LVEF may improve by remodelling. The time-dependence in STEMI patients examined at 1, 7, 42, 182 and 365 days indicated a compromise at 42 days when the LGE zone was reduced by ~35% and LVEF increased by ~11%.

Early CMR is applied in reperfusion trials mainly to measure the MAR and thereby assess the MSI.29 As seen from Figure 4, the T2 imprint of the MAR is much larger than the LGE imprint of IS, indicating a considerable MSI. However, as reviewed by Croisille et al.34 T2-weighted imaging to delineate the MAR is problematic, and Thuny et al.35 showed that stepwise reperfusion reduced the MAR when assessed by T2-CMR (after pPCI), but not when assessed by X-ray ventriculography (prior to pPCI). Also, a warning has been given by basic physiologists against T2-based CMR to measure the MAR in reperfusion–protection studies. Whereas this situation calls for other techniques to measure the MAR, it also questions the need for CMR examination during the acute phase of AMI. Thus, a clinical trial may benefit from a single CMR measurement of IS and LVEF undertaken at an intermediate stage, i.e. after early repair but before remodelling becomes far advanced, like at 3–6 weeks. If desirable, the MAR may be detected before reperfusion by use of ECG22 and X-ray-based techniques.11,28,37

To the best of our knowledge, MANAMI 1-09 is the first clinical study using a small molecular antioxidant with catalytic and metal-binding properties to combat cardiac reperfusion injury. Preclinical studies have revealed that MnDPDP or MnPLED protects against oxidative stress in normal tissues during chemotherapy for cancer and in liver tissue during acetaminophen poisoning.16 In patients with cancer of the colon treated with oxaliplatin, MnDPDP provided neuroprotection and conserved white blood cells.16,21,22 Of direct relevance for the present study, MnDPDP reduced enzyme release and improved contractile function during hypoxia–reoxygenation in isolated rat hearts.19 In anaesthetized pigs with occlusion/deoxygenation (30/120 min) of the anterior descending branch of the left coronary artery, MnPLED reduced the ensuing IS by 55%. It also improved cardiac function and abolished arrhythmias. In that study, MnPLED
was applied as an i.v. bolus at the end of ischaemia followed by a continuous infusion.

In explaining protective mechanisms in myocardial ischaemia–reperfusion, MnDPDP and metabolite MnPLED mimic mitochondrial superoxide dismutase (MnSOD), the first-line defence against oxidative stress in mitochondria.16,19,23,38–41 Mitochondrial superoxide dismutase converts superoxide to hydrogen peroxide and oxygen and protects beneficial NO from superoxide-induced conversion to damaging peroxynitrite. During ischaemia, however, native MnSOD is inactivated by protein tyrosine nitration.39 Thus, a rationale exists for use of small molecular MnSOD mimetics,40 which may access targets inside endothelial cells and cardiomyocytes. Intriguingly, MnDPDP has been shown to prevent MPTP opening in cell models of severe oxidative stress.41 Being potent iron chelators,16 MnDPDP and MnPLED also inhibit iron-driven conversion of hydrogen peroxide to highly injurious hydroxyl radicals.6,16,23 Thus, they have the advantage to attack reperfusion injury at various levels in the hierarchy of oxidative stress reactions. The lack of a similar broad pharmacodynamic platform may explain why the single target MPTP inhibitor TRO 40303 did not improve the outcome after pPCI in STEMI patients, as recently reported.42 This situation may call for other agents or measures or that a combination of drugs are applied. Also the timing, dose and mode of administration need to be considered.

The major limitations of the study were the low number of patients and that, as might be expected from a feasibility study, the collected small material did not allow any firm conclusion to be drawn on the efficacy of the examined drug. Other limitations were an apparent skewedness in the background of patients, and that CMR did not include all patients and was undertaken at either of two time points.

In conclusion, MnDPDP is a safe drug for use as an adjunct to reperfusion therapy. A tendency to benefit of MnDPDP needs confirmation in a larger population. The study revealed important information for the design of a Phase II trial.

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**Conflict of interest:** R.G.A. is a board member of PledPharma AB. P.J. is a shareholder and advisor on cardiovascular disease in PledPharma AB. The other authors have no conflict of interest.

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**References**

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