



UNIVERSITY OF LEEDS

This is a repository copy of *A Phase II Trial of Lutikizumab, an Anti–Interleukin-1 α / β Dual Variable Domain Immunoglobulin, in Knee Osteoarthritis Patients With Synovitis*.

White Rose Research Online URL for this paper:
<http://eprints.whiterose.ac.uk/140668/>

Version: Accepted Version

Article:

Fleischmann, RM, Bliddal, H, Blanco, FJ et al. (17 more authors) (2019) A Phase II Trial of Lutikizumab, an Anti–Interleukin-1 α / β Dual Variable Domain Immunoglobulin, in Knee Osteoarthritis Patients With Synovitis. *Arthritis & Rheumatology*, 71 (7). pp. 1056-1069. ISSN 2326-5191

<https://doi.org/10.1002/art.40840>

© 2019, American College of Rheumatology. This is the peer reviewed version of the following article: Fleischmann, RM, Bliddal, H, Blanco, FJ et al. (17 more authors) (2019) A Phase II Trial of Lutikizumab, an Anti–Interleukin-1 α / β Dual Variable Domain Immunoglobulin, in Knee Osteoarthritis Patients With Synovitis. *Arthritis & Rheumatology*, 71 (7). pp. 1056-1069. ISSN 2326-5191, which has been published in final form at <https://doi.org/10.1002/art.40840>. This article may be used for non-commercial purposes in accordance with Wiley Terms and Conditions for Self-Archiving. Uploaded in accordance with the publisher's self-archiving policy.

Reuse

Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.



eprints@whiterose.ac.uk
<https://eprints.whiterose.ac.uk/>



A Phase 2 Trial of Lutikizumab, an Anti-Interleukin 1 α / β Dual Variable Domain Immunoglobulin, in Knee Osteoarthritis Patients With Synovitis

Journal:	<i>Arthritis & Rheumatology</i>
Manuscript ID	ar-18-0665.R2
Wiley - Manuscript type:	Full Length
Date Submitted by the Author:	n/a
Complete List of Authors:	<p>Fleischmann, Roy M.; University of Texas Southwestern Medical Center, ; Bliddal, Henning; Musculoskeletal Statistics Unit, The Parker Institute, Department of Rheumatology; Copenhagen University Hospital, Frederiksberg Blanco, Francisco; INIBIC-Hospital Universitario A Coruña, Servicio de Reumatología Schnitzer, Thomas; Northwestern University, Feinberg School of Medicine; Peterfy, Charles; SpireSciences, Chen, Su; AbbVie Inc., Wang, Li; AbbVie Inc. Feng, Sheng; AbbVie Inc. Conaghan, Philip Berenbaum, Francis; Sorbonnes Universités, UPMC University Paris 06, INSERM, APHP hôpital Saint-Antoine, Centre de Recherche Saint-Antoine (CRSA), DHU i2B Pelletier, Jean-Pierre; Osteoarthritis Research Unit, University of Montreal Hospital Research Centre (CRCHUM), Martel-Pelletier, Johanne; Osteoarthritis Research Unit, University of Montreal Hospital Research Centre (CRCHUM), Vaeterlein, Ole; Bioclinica Kaeley, Gurjit; University of Florida College of Medicine - Jacksonville Liu, Wei; AbbVie Inc. Kosloski, Matthew; AbbVie Inc. Levy, Gwen; AbbVie Inc. Zhang, Lanju; AbbVie Inc. Medema, Jeroen; AbbVie Inc., Levesque, Marc; AbbVie,</p>
Keywords:	Inflammation, Cytokines, DMOADs (biologic), knee osteoarthritis, interleukin-1 inhibition
Disease Category: Please select the category from the list below that best describes the content of your	Osteoarthritis

manuscript.:	

SCHOLARONE™
Manuscripts

A Phase 2 Trial of Lutikizumab, an Anti–Interleukin 1 α / β Dual Variable Domain Immunoglobulin, in Knee Osteoarthritis Patients With Synovitis

Roy M. Fleischmann,¹ Henning Bliddal,² Francisco J. Blanco,³ Thomas J. Schnitzer,⁴ Charles Peterfy,⁵ Su Chen,⁶ Li Wang,⁶ Sheng Feng,^{6,*} Philip G. Conaghan,⁷ Francis Berenbaum,⁸ Jean-Pierre Pelletier,⁹ Johanne Martel-Pelletier,⁹ Ole Vaeterlein,¹⁰ Gurjit S. Kaeley,¹¹ Wei Liu,⁶ Matthew P. Kosloski,⁶ Gwen Levy,⁶ Lanju Zhang,⁶ Jeroen K. Medema,⁶ Marc C. Levesque⁶

¹University of Texas Southwestern Medical Center at Dallas, Metroplex Clinical Research Center, Dallas, TX, United States; ²Parker Institute, Bispebjerg-Frederiksberg Hospital, University of Copenhagen, Copenhagen, Denmark; ³INIBIC-Instituto de Investigaciones Biomédicas de A Coruña-Complejo Hospitalario Universitario de A Coruña, A Coruña, Spain; ⁴Northwestern Medicine, Feinberg School of Medicine, Chicago, IL, United States; ⁵Spire Sciences, Inc., Boca Raton, FL, United States; ⁶AbbVie Inc., North Chicago, IL, United States; ⁷Leeds Institute of Rheumatic and Musculoskeletal Medicine, University of Leeds & NIHR Leeds Biomedical Research Centre, Leeds, United Kingdom; ⁸Sorbonne Université, Inserm, and DHU i2B, APHP, Hospital Saint-Antoine, Paris, France; ⁹Centre Hospitalier de l'Université de Montréal, Montréal, QC, Canada; ¹⁰Bioclinica, Hamburg, Germany; ¹¹University of Florida College of Medicine, Jacksonville, FL, United States

*At the time that the study was conducted.

Running Head: Lutikizumab efficacy and safety in knee OA

Corresponding author:

Roy Fleischmann, MD

Department of Internal Medicine
University of Texas Southwestern Medical Center at Dallas
Metroplex Clinical Research Center
8144 Walnut Hill Lane, Suite 810

Dallas, TX 75231, United States
RFleischmann@arthdocs.com
Telephone: +1 214-540-0645
Fax: +1 214-540-0611

Coauthors:

Henning Bliddal, MD, DMSci
Parker Institute
Bispebjerg-Frederiksberg Hospital
University of Copenhagen
Copenhagen, Denmark
henning.bliddal@regionh.dk

Francisco J. Blanco, MD
INIBIC-Instituto de Investigaciones Biomédicas
de A Coruña-Complejo Hospitalario Universitario de A Coruña
A Coruña, Spain
fblagar@sergas.es

Thomas J. Schnitzer, MD, PhD
Northwestern Medicine
Feinberg School of Medicine
Chicago, IL, United States
tjs@northwestern.edu

Charles Peterfy, MD, PhD

Spire Sciences, Inc.
Boca Raton, FL, United States
charles.peterfy@spiresciences.com

Su Chen, PhD
Data and Statistical Sciences
AbbVie Inc.
North Chicago, IL, United States
su.chen@abbvie.com

Li Wang, PhD
Development Design Center
AbbVie Inc.
North Chicago, IL, United States
li.wang1@abbvie.com

Sheng Feng, PhD
Exploratory Statistics, Data Science and Statistics
AbbVie Inc.
North Chicago, IL, United States
f012345@yahoo.com

Philip G. Conaghan, MD, PhD
Leeds Institute of Rheumatic and Musculoskeletal Medicine
University of Leeds, & NIHR Leeds Biomedical Research Centre
Leeds, United Kingdom
p.conaghan@leeds.ac.uk

Francis Berenbaum, MD, PhD
Department of Rheumatology
Sorbonne Université, Inserm, and DHU i2B AP-HP Hôpital Saint-Antoine

Paris, France

francis.berenbaum@aphp.fr

Jean-Pierre Pelletier, MD

Centre Hospitalier de l'Université de Montréal

Montréal, QC, Canada

dr@jppelletier.ca

Johanne Martel-Pelletier, PhD

Centre Hospitalier de l'Université de Montréal

Montréal, QC, Canada

jm@martelpelletier.ca

Ole Vaeterlein, MD

Bioclinica

Hamburg Germany

ole.vaeterlein@bioclinica.com

Gurjit S. Kaeley, MRCP, RhMSUS

Department of Medicine

Division of Rheumatology and Clinical Immunology

University of Florida College of Medicine

Jacksonville, FL, United States

gurjit.kaeley@jax.ufl.edu

Wei Liu, PhD

Clinical Pharmacology and Pharmacometrics

AbbVie Inc.

North Chicago, IL, United States

wei.liu@abbvie.com

Matthew P. Kosloski, PhD
Clinical Pharmacology and Pharmacometrics
AbbVie Inc.
North Chicago, IL, United States
matthew.kosloski@abbvie.com

Gwen Levy, MD
Pharmacovigilance and Patient Safety
AbbVie Inc.
North Chicago, IL, United States
gweneth.levy@abbvie.com

Lanju Zhang, PhD
Data and Statistical Sciences
AbbVie Inc.
North Chicago, IL, United States
lanju.zhang@abbvie.com

Jeroen K. Medema, MS
Immunology Development
AbbVie Inc.
North Chicago, IL, United States
jeroen.medema@abbvie.com

Marc C. Levesque, MD, PhD
Immunology Development
AbbVie Inc.
North Chicago, IL, United States
marc.levesque@abbvie.com

Funding Source:

AbbVie Inc. funded this study.

Conflict of Interest/Disclosure Information:

AbbVie Inc. contributed to the design of the study and was involved in the collection, analysis, and interpretation of the data and in the writing, review, and approval of the publication.

R. Fleischmann has received grant/research support and consulting fees or other remuneration from AbbVie, Acea, Amgen, AstraZeneca, Augurex, Bristol-Myers Squibb, Celltrion, GlaxoSmithKline, Janssen, Eli Lilly, Merck, Novartis, Pfizer, Samumed, Roche, Samsung, Sanofi Aventis-Regeneron, and UCB and was involved in the collection, analysis, and interpretation of the data and in the writing, review, and approval of the publication.

H. Bliddal has received consulting fees or other remuneration from AbbVie Inc., Roche, Pfizer, and Lilly. The Parker Institute is sponsored by the Oak Foundation.

F. J. Blanco has received consulting fees or other remuneration from AbbVie Inc., Pfizer, UCB, Bristol-Myers Squibb, Roche, Bioiberica, Sanofi, Grünenthal, GlaxoSmithKline, Lilly, Janssen, Regeneron, and TRB Chemedica (for the DISSCO study).

T. J. Schnitzer has received grant/research support and consulting fees or other remuneration from AbbVie, Regeneron, Pfizer, Flexion, and GlaxoSmithKline.

C. Peterfy is an employee of Spire Sciences, Inc., and is on the speakers bureau for Amgen and Bristol-Myers Squibb.

P. G. Conaghan has received consulting fees or other remuneration from AbbVie Inc., Bristol-Myers Squibb, Flexion Therapeutics, GlaxoSmithKline, Medivir, Merck Serono, Novartis, and Pfizer and is on the speakers bureau for AbbVie Inc., Novartis, Pfizer, and Samumed.

F. Berenbaum has received consulting fees or other remuneration from AbbVie, Expanscience, Flexion, IBSA, Janssen, Merck Serono, Novartis, Sanofi, Servier, TRB Chemedica, UCB, Pfizer, and Regeneron.

J-P Pelletier has received consulting fees or other remuneration from AbbVie.

J. Martel-Pelletier has received consulting fees or other remuneration from AbbVie.

O. Vaeterlein is an employee of Bioclinica.

G. S. Kaeley is a consultant for AbbVie and Novartis.

S. Chen, L. Wang, W. Liu, M. P. Kosloski, G. Levy, L. Zhang, J. K. Medema, and M. C. Levesque are employees of AbbVie and may own AbbVie stock and/or stock options.
S. Feng is a former employee of AbbVie and may own AbbVie stock and/or stock options.

For Peer Review

Abstract

Objective: To assess the efficacy and safety of the anti-interleukin (IL)-1 α/β dual variable domain immunoglobulin lutikizumab (ABT-981) in subjects with knee osteoarthritis (OA) and evidence of synovitis.

Methods: Subjects (N=350; 347 analyzed) with Kellgren-Lawrence grade 2–3 knee OA and synovitis (determined by magnetic resonance imaging [MRI] or ultrasound) were randomized to placebo or lutikizumab 25, 100 or 200 mg subcutaneously every 2 weeks for 50 weeks. The co-primary endpoints were change from baseline in Western Ontario and McMaster Universities Osteoarthritis (WOMAC) pain index at week 16 and change from baseline in MRI synovitis at week 26.

Results: WOMAC pain at week 16 improved significantly versus placebo with lutikizumab 100 mg ($P=0.050$) but not 25 or 200 mg. Beyond week 16, WOMAC pain was reduced in all groups but was not significantly different for lutikizumab and placebo. Changes from baseline in MRI synovitis at week 26 and other key symptom- and most structure-related endpoints at weeks 26 and 52 were not significantly different for lutikizumab and placebo. Injection site reactions, neutropenia, and discontinuations due to neutropenia were more frequent with lutikizumab versus placebo. Neutrophil and high-sensitivity C-reactive protein reductions plateaued at lutikizumab 100 mg. Immunogenicity to lutikizumab did not meaningfully affect systemic lutikizumab concentrations.

Conclusion: The limited improvement of WOMAC pain and the lack of synovitis improvement with lutikizumab, together with published trial results for other IL-1 inhibitors, suggest that IL-1 inhibition is not an effective analgesic/anti-inflammatory therapy in most patients with knee OA and associated synovitis.

Keywords: DMOADs (biologic), knee osteoarthritis, inflammation, cytokines, interleukin-1 inhibition

For Peer Review

INTRODUCTION

Osteoarthritis (OA) is the most common arthritis,(1) and main cause of disability among US adults.(2) OA is commonly considered a non-inflammatory arthritis but at least half of patients with knee OA have ultrasound or magnetic resonance imaging (MRI) evidence of synovitis.(3, 4) Synovitis is associated with a risk of developing radiographic knee OA,(5, 6) greater knee pain,(7, 8) and total joint replacement.(9)

Interleukin (IL)-1 α and IL-1 β are pro-inflammatory cytokines and pain mediators that are thought to be involved in the pathogenesis of OA.(10, 11) IL-1 β is secreted by innate immune cells after cleavage by caspase-1.(10) In contrast, IL-1 α is stored intracellularly or membrane bound,(10) is released in an active form upon cell damage,(11) and can induce IL-1 β activation and production of other cytokines important in the pathogenesis of OA.(10) IL-1 α and IL-1 β bind to the same receptor, IL-1R1, resulting in inflammatory and pain responses.(10, 12, 13)

IL-1 α and IL-1 β are expressed in the cartilage and synovial membrane, and are elevated in sera and synovial fluid in patients with OA.(14-16) Synovial macrophages are an important source of IL-1 in patients with knee OA.(17) IL-1 may promote structural damage associated with OA, because IL-1 activates enzymes involved in cartilage destruction,(18) inhibits collagen synthesis,(19) and promotes osteoclastogenesis.(10, 20) The IL-1 pathway may mediate OA pain through pathways in the peripheral and central nervous systems.(12, 13) In some, but not all animal models of OA, blocking the IL-1 pathway improves OA manifestations.(21) However, in clinical trials in subjects with knee OA not selected for synovitis, an IL-1 receptor antagonist

(anakinra)(22) or an antibody to the IL-1R1 (AMG 108)(23) did not meet the primary symptom-based study endpoints.

Lutikizumab (ABT-981) is a novel human dual variable domain immunoglobulin (DVD-Ig) that has been shown to bind and inhibit IL-1 α and IL-1 β .(24) In mouse OA models, a mouse anti-IL-1 α/β DVD-Ig increased the threshold for pain and reduced cartilage degeneration to a greater extent than inhibition of either IL-1 α or IL-1 β alone.(25) In phase 1 studies of ≤ 8 weeks in healthy subjects and subjects with knee OA, single and multiple doses of lutikizumab were well tolerated; the most frequently reported adverse events (AEs) were injection site reactions and headache.(26, 27) Among the knee OA subjects in a phase 1 study, lutikizumab therapy was associated with reductions in serum inflammatory biomarkers.(27)

The current trial enrolled subjects with knee OA and MRI and/or ultrasound evidence of synovitis, a population presumed to be at high risk of progression, to test the hypothesis that dual inhibition of IL-1 α and IL-1 β would demonstrate efficacy and safety in knee OA with inflammation.

METHODS

Study Design

The objective was to determine the efficacy and safety of lutikizumab in subjects with knee OA and synovitis. The study was conducted in accordance with International Conference on Harmonization guidelines and the Declaration of Helsinki. This phase 2, randomized, double-blind, placebo-controlled, parallel-group study (NCT02087904; ILLUSTRATE-K) was approved

by institutional review boards, and signed informed consent was obtained from all subjects. After screening and washout periods totaling approximately 45 days (**Supplemental Figure 1**), eligible subjects were randomized (1:1:1:1) to double-blind lutikizumab 25, 100, or 200 mg or matching placebo subcutaneously every 2 weeks for 52 weeks (last dose of study medication, week 50).

Rescue medication included acetaminophen (maximum, 3000 mg/d) during the washout period through week 26, and ibuprofen (maximum, 1200 mg/d), with or without acetaminophen, during weeks 16 to 26 for breakthrough knee pain, although analgesics were stopped ≥ 48 hours before the first dose of study drug and 24 hours before each pain assessment. From weeks 26 to 52, oral standard-of-care (SOC) medications for knee OA including non-steroidal anti-inflammatory drugs (NSAIDs), non-opioid analgesics, and nutraceuticals (e.g., glucosamine, chondroitin sulfate, shark cartilage, diacerein, soy extract) were permitted; SOC medications for knee OA were stopped ≥ 24 hours before each pain assessment.

Subjects

Adult subjects (35–74 years old) with radiographic evidence of knee OA in the medial compartment of the index knee with Kellgren-Lawrence (KL) grade 2 or 3 (28) were eligible if meeting other inclusion criteria including signs and symptoms of active inflammation (e.g., localized pain, stiffness, swelling, or effusion) in the index knee; presence of synovitis in the index knee by either ultrasound (local reader, per an ultrasound guide) or MRI (central reader); pain score ≥ 4 and ≤ 8 (11-point numeric rating scale [NRS-11], 0–10 representing no pain to

worst possible pain)(29) in the index knee for ≥ 14 days over the past 30 days; and patient global assessment of arthritis status ≥ 4 (NRS-11, 0–10 representing best to worst disease status).(30)

Key exclusion criteria included other inflammatory arthritis (e.g., rheumatoid arthritis, psoriatic arthritis, or gout) or a painful myofascial syndrome such as fibromyalgia (**Supplemental Methods**).

Subjects must have discontinued use of all analgesics, NSAIDs, and nutraceuticals for ≥ 5 half-lives of the longest-acting therapy or 48 hours, whichever was longer, before the first dose of study drug. Subjects receiving concomitant medications for indications other than OA (if allowed by the protocol) had to be on stable doses for ≥ 1 month before the first dose of study drug.

Efficacy

The co-primary endpoints were (1) change from baseline in Western Ontario and McMaster Universities Osteoarthritis index (WOMAC) pain score (0–50 scale; NRS-11 subscales)(31) at week 16 and (2) change in MRI synovitis from baseline in the index knee at week 26. To meet the latter co-primary endpoint, we required reductions in all 3 of the following measurements: (a) quantitative synovial membrane thickness,(32) (b) quantitative synovial fluid volume,(33) and (c) semi-quantitative synovitis/effusion score measured on a scale of 0 to 3 using the Whole-Organ Magnetic Resonance Imaging Score (WORMS).(34)

Secondary endpoints included changes from baseline in WOMAC pain scores at weeks 26 and 52(31); Intermittent and Constant Pain (ICOAP) score(35) at weeks 16, 26 and 52; and 3 types of pain intensity measures using NRS-11 scales (**Supplemental Methods**).

Exploratory endpoints included Outcome Measures in Rheumatology Clinical Trials/Osteoarthritis Research Society International (OMERACT/OARSI) response(36) at weeks 16, 26 and 52; radiographic medial and lateral joint space narrowing (JSN; centralized measurement of the minimum joint space width compared with baseline in the index knee at week 52; and changes from baseline to week 26 in synovitis as assessed by dynamic contrast-enhanced MRI (DCE-MRI).(37)

Imaging

Patients were screened for presence of synovitis using MRI or musculoskeletal ultrasound (**Supplemental Methods**), which has shown good to excellent inter- and intra-reader agreement in detecting knee synovitis.(38, 39) Posteroanterior weight-bearing radiographs of the target knee were acquired at screening and at week 52. MRI of the target knee was performed using 1.5- or 3.0-T whole-body scanners and commercial knee coils at screening, week 26, and week 52. Given the limitations associated with non-contrast-enhanced MRI for assessment of synovitis,(8) dynamic contrast-enhanced MRI (DCE-MRI) was performed as an exploratory substudy (n=39), as described previously.(37)

Pharmacokinetics

Blood samples were collected throughout the 52 weeks to assess concentrations of lutikizumab and anti-drug antibody (ADA) responses in serum as previously described.(26)

Pharmacodynamics

Blood neutrophil counts and serum high-sensitivity C-reactive protein (hsCRP) levels (ICON, ARCHITECT platforms C8000 or C16000, Abbott Laboratories, Abbott Park, IL, United States) were measured repeatedly from baseline to week 52; other biomarkers were measured at baseline and weeks 16, 26 and 52. Serum concentrations of free IL-1 α and IL-1 β were determined using the Singulex Erenna (MilliporeSigma, Billerica, MA, United States) and SIMOA platforms (Quanterix, Lexington, MA, United States), respectively, using AbbVie proprietary capture and detection antibodies. Other biomarkers were measured by BioClinica Molecular Marker Lab (Lyon, France) using validated enzyme-linked immunosorbent assays (from Nordic Bioscience [Herlev, Denmark; metalloproteinase-degraded collagen types I and III and matrix metalloproteinase-generated fragment of CRP], Corgenix [Broomfield, CO, United States; hyaluronic acid], EMD Millipore [Darmstadt, Germany; N-propeptide of collagen IIA], and Roche Diagnostics [Indianapolis, IN, United States; C-terminal telopeptide fragments of type II collagen]), adhering to standard operating procedures from regulatory guidance for clinical studies.

Safety

Adverse events, vital signs, physical examinations, and laboratory data were assessed throughout the study. AEs were coded using the *Medical Dictionary for Regulatory Activities, version 19.0*,

preferred term, and system organ class. AE severity was classified according to the Common Terminology Criteria for Adverse Events, version 4.03.(40)

Statistics and Analyses

The co-primary and secondary efficacy outcomes were analyzed in the modified intent-to-treat population, comprising randomized patients who received ≥ 1 dose of study drug. Continuous efficacy assessments were analyzed with analysis of covariance (ANCOVA) with main factors of treatment, age group, and KL grade and covariates of baseline values, except analysis of daily rescue medication use, which was analyzed with analysis of variance (ANOVA). Categorical variables analysis used the Cochran-Mantel-Haenszel test with age group and KL grade as stratification factors. Last-observation-carried-forward (LOCF) imputation of missing values was used for non-imaging co-primary and selected secondary endpoints. The non-imaging co-primary endpoint was also assessed using multiple imputation (MI) for missing values in a post hoc analysis. In this phase 2 study, there was no adjustment for multiplicity of assessments. The safety analysis set included subjects who received ≥ 1 dose of study drug. To identify factors associated with the development of neutropenia (defined as at least one episode where absolute neutrophil count [ANC] $< 1,500$ cells/ μL), explanatory variables significant at the $P < 0.1$ level in univariate analyses were tested in a multiple logistic regression model.

A sample size of approximately 80 subjects per treatment group was estimated to provide $\geq 80\%$ power to detect a significant difference between lutikizumab and placebo, based on a significance level of 0.05, for each of the two co-primary endpoints (WOMAC pain and synovial inflammation based on synovial membrane thickness by MRI).

RESULTS

Subjects

Of 1571 subjects screened, 350 were eligible and were randomized; 347 received ≥ 1 dose of study drug (June 2014 to November 2016) and were analyzed for efficacy and safety (**Figure 1**). The most common reasons for screen failure were clinical history related to entry criteria, absence of KL-2 or KL-3 radiographic evidence of knee OA, lack of synovitis on ultrasound or by non-contrast-enhanced MRI, and severe knee malalignment.⁽⁴¹⁾ Most subjects (229; 65.4%) were enrolled based on ultrasound evidence of knee synovitis; 118 (33.7%) were enrolled based on MRI evidence (**Supplemental Table 1**). Among the subjects enrolled based solely on screening ultrasound, 185/220 (84.1%) had baseline MRI evidence of synovitis per WOMBS scoring conducted at the end of the study. Demographics, baseline disease characteristics, and use of medications were generally well matched across treatment groups (**Table 1**). Of the randomized subjects, 60/85 (70.6%) who received placebo and 202/265 (76.2%) who received lutikizumab completed the 52-week study (**Figure 1**). The major reasons for discontinuation included AEs, lack of efficacy, and withdrawal of consent.

Efficacy

Co-primary Endpoints

The co-primary endpoint of WOMAC pain at week 16 (and at most early time points) improved significantly, compared with placebo, for the lutikizumab 100 mg dose group ($P=0.050$) but not for the lutikizumab 25 mg ($P=0.834$) and 200 mg ($P=0.415$) dose groups (**Figure 2A, Table 2, Supplemental Figure 2A**). Post hoc analysis for WOMAC pain using MI yielded results

consistent with those of LOCF (**Supplemental Figure 3**). WOMAC pain reduction in all lutikizumab groups, as well as placebo, was sustained from weeks 16 to 52, but differences between lutikizumab and placebo for WOMAC pain were not significant between weeks 16 and 52 (**Figure 3A**).

The other co-primary endpoint, change in synovitis (as measured by synovial membrane thickness, synovial fluid volume, and WOMS synovitis/effusion score) from baseline to week 26, did not differ between the lutikizumab and placebo groups (**Table 2**).

Post hoc analyses were performed to determine efficacy including only subjects with a baseline WOMS synovitis/effusion score >0, indicating MRI evidence of synovitis. Results in this post hoc population were not substantially different from those in the original, prospective population enrolled on the basis of positive MRI or ultrasound (**Supplemental Figure 4, Supplemental Table 2**).

Other Signs and Symptoms Endpoints

WOMAC function (**Figure 2B, Supplemental Figure 2B**) and OMERACT/OARSI response were numerically better but not significantly different between the placebo and lutikizumab treatment groups (**Table 2**) at 16, 26 and 52 weeks. Change from baseline in WOMAC function was significantly different ($P \leq 0.01$) from placebo with lutikizumab 100 mg at weeks 4 and 8 (**Figure 2B**). OMERACT/OARSI placebo responses were high, e.g., 60%–71%, at weeks 26 and 52, respectively (**Table 2, Figure 2**).

Other Structural Endpoints

Among secondary and exploratory endpoints, other than medial ($P=0.017$) and lateral ($P=0.005$) JSN with lutikizumab 25 mg at week 52 (**Table 2**), there were no structural endpoints statistically significantly different between placebo and the lutikizumab dose groups. MRI assessments of cartilage volume, thickness, and WOMBS scores were nearly identical in all treatment groups at baseline, week 26 and week 52. Synovitis, as assessed by DCE-MRI, also demonstrated no differences between subjects treated with placebo versus each dose of lutikizumab (**Supplemental Table 3**).

Rescue Medication Use

The proportion of subjects receiving concomitant pain medication (acetaminophen, ibuprofen) during the study was generally similar among treatment groups (**Supplemental Table 4**). The least squares mean daily dose of rescue acetaminophen up to week 16 was similar in the placebo (511 mg, $n=58$) and lutikizumab 25 mg (500 mg, $n=53$), 100 mg (413 mg, $n=63$) and 200 mg (426 mg, $n=67$) dose groups. Similarly, the least squares mean daily dose of rescue ibuprofen between weeks 16 and 26 was not significantly different between the placebo (200 mg, $n=18$) and lutikizumab 25 mg (104 mg, $n=18$), 100 mg (241 mg, $n=19$), and 200 mg (155 mg, $n=24$) dose groups.

Pre-planned Efficacy Subgroup Analyses

In pre-planned subgroup analyses, there were no meaningful differences in WOMAC pain scores at weeks 16, 26, and 52 based on age, gender, race, or body weight. In the 100 mg dose group, there were statistically significantly greater decreases in WOMAC pain scores compared with

placebo, among subjects with an index knee KL grade of 3 (but not KL grade of 2) (week 26, $P=0.029$; week 52, 0.016) and among subjects who did not use concomitant medications for index knee pain through week 26 (week 16, $P=0.027$; week 26, 0.045). This was not noted in the 25 mg or 200 mg dose group.

Pharmacokinetics

Lutikizumab trough concentrations were stable between weeks 6 and 52 and consistent with assessments of steady-state in previous studies (**Supplemental Figure 5A**).^(26, 42) A greater ADA incidence was observed for the lutikizumab 25 mg dose group (46%) compared with the 100 mg and 200 mg dose groups (32% and 23%, respectively). Lutikizumab serum concentrations were generally similar among subjects with and without ADAs for each dose group (**Supplemental Figure 5B**); thus, the immunogenic response did not appear to have a meaningful impact on lutikizumab pharmacokinetics.

Pharmacodynamics

Mean blood neutrophil counts (ANC) decreased with lutikizumab 100 mg and 200 mg treatment at all time points and with lutikizumab 25 mg at most time points relative to baseline and placebo (**Figure 3A**); neutrophil counts were similar in the 100 mg and 200 mg dose groups throughout the study. There was an exposure-response relationship between ANCs and lutikizumab blood levels (**Supplemental Figure 6**). In a similar way, hsCRP levels were reduced at most time points in the lutikizumab groups compared with baseline and placebo (**Figure 3B**), reaching statistical significance at several time points for the 25 mg and 100 mg doses but with high variability.

Serum levels of IL-1 α and IL-1 β at baseline were low and most were below the lower limits of quantification. In subjects with detectable levels at baseline, IL-1 α and IL-1 β levels were reduced within 2 weeks of treatment initiation to a greater extent in subjects receiving lutikizumab compared with subjects receiving placebo (**Supplemental Figure 7, Supplemental Table 5**). Changes in other biomarkers are shown in **Supplemental Figure 8**. With lutikizumab treatment, compared with placebo, there were reductions in metalloproteinase-degraded collagen type I (C1M), metalloproteinase-degraded collagen type III (C3M), matrix metalloproteinase-generated fragment of CRP (CRPM), IL-6, and alkaline phosphatase.

Safety

Similar proportions of subjects receiving placebo or lutikizumab experienced a treatment-emergent AE or serious AE during the study (**Table 3**). Serious infections were infrequent and had similar incidences among treatment groups, including placebo. A greater proportion of subjects in the lutikizumab total treatment groups compared with the placebo group had injection site reactions (25.2% vs 15.3%) and neutropenia (27.5% vs 2.4%). The incidence of both events increased in a dose-dependent manner. All reported neutropenia laboratory abnormalities were grade 3 or less; there was no grade 4 neutropenia. One subject who received lutikizumab 25 mg and 6 subjects who received lutikizumab 200 mg discontinued study treatment because of neutropenia.

Treatment-emergent AEs of malignancy were reported in 5 subjects (1.9%; 2.2 events per 100 patient-years) in the total lutikizumab group and in no subjects in the placebo group. Basal cell carcinoma was reported in 3 of these 5 subjects.

DISCUSSION

This study assessed the efficacy and safety of blocking IL-1 α and IL-1 β with lutikizumab in subjects with knee OA and associated synovitis. To our knowledge, this is the first study to test the hypothesis that a systemic anti-inflammatory, anti-cytokine therapy may be effective in knee OA patients with synovitis. Lutikizumab met the co-primary clinical endpoint of reduction in WOMAC pain compared with placebo at week 16 in only the 100 mg dose group, but not in the 25 mg and 200 mg dose groups, and the differences compared with placebo were not sustained past week 16 for any dose. In the subgroup of patients treated with lutikizumab 100 mg with KL grade 3 knee OA and among the subgroup of subjects not using rescue or off-protocol pain medications, compared with placebo, the change from baseline at weeks 26 and 52 in WOMAC pain was significantly greater; the reason why this occurred only in the 100 mg dose group and only at these time points is unclear. The co-primary endpoint, change from baseline in synovitis as measured by synovial membrane thickness, synovial effusion volume, and semiquantitative MRI synovitis/effusion (WORMS) at week 26, was also not significantly different for lutikizumab versus placebo. Furthermore, when compared with placebo, lutikizumab was not associated with improvements or slowing in the rates of JSN and MRI cartilage thickness changes. These results indicate that lutikizumab had no significant impact on structural endpoints that were assessed. The analytical assay used to quantify lutikizumab serum concentrations required at least one free binding site for each molecule of IL-1 α and IL-1 β .(26) The modest

impact of ADAs on trough concentrations (**Supplemental Figure 5B**) suggested that development of ADAs did not interfere with the biological activity of lutikizumab, and thus they were unlikely to have impacted efficacy.

The unexpected lack of an effect of IL-1 inhibition on synovitis may signify that, although the synovium is an important source of IL-1,(43) IL-1 by itself may not be required to sustain synovitis. Other factors, such as cartilage degradation products and adipokines may have a greater role in the development and maintenance of synovitis.(44) Overall, these observations are consistent with a recent study using a medial meniscectomy animal model that found that IL-1 may not play a role in the structural progression of OA.(21) A phase 2 study of lutikizumab in erosive hand OA also was negative.(42)

The reason(s) for the failure to demonstrate a sustained beneficial analgesic effect of lutikizumab compared with placebo in this study is not clear. Lutikizumab serum concentrations were stable throughout the duration of the study, unaffected by development of ADAs and at exposures consistent with a previous phase 1 study.(27) The probability of achieving positive results might have been improved by using a flare study design, although a difference in effect size has not been shown to be statistically significant versus a non-flare study design.(45) Although serum IL-1 α and IL-1 β levels could not be reliably quantified, similar reductions in absolute neutrophil count and hsCRP between the lutikizumab 100 mg and 200 mg dose groups suggested that both dose groups achieved maximum suppression of IL-1 α and IL-1 β . However, it is possible that these systemic pharmacodynamic endpoints are not reflective of target engagement within the joint.

As there was no positive control treatment in this study, it is not clear whether lutikizumab did have a positive effect masked by a placebo response. The use of SOC therapies following week 26 may have masked any lutikizumab treatment effects and could account for the lack of sustained WOMAC pain differences between the lutikizumab 100 mg treatment group and the placebo group, but would not explain the inefficacy of the 25 mg and 200 mg doses. The pre-planned subset analyses suggested that the use of rescue medication affected the WOMAC pain co-primary endpoint results; however, meta-analysis has concluded that acetaminophen has little if any analgesic effect in OA.(46) Another pre-planned subset analysis suggested that subjects with KL grade 3 knee OA (in contrast to subjects with KL grade 2 knee OA) had statistically significant WOMAC pain treatment effects, implying that knee OA subjects with greater amounts of structural disease may benefit from IL-1 inhibition. The hypothesis that the concomitant use of pain medication and the degree of radiographic damage could predict response to lutikizumab would have to be proven in a well-designed prospective study.

The lack of a clear lutikizumab treatment effect may have also been due to a strong, sustained placebo effect (**Figure 3A**). Placebo response rates are high in knee OA trials (e.g., 40%–50% using OMERACT-OARSI criteria)(47); placebo response rates in this trial were 60%, 62% and 71% at weeks 16, 26 and 52 (**Table 2**). High placebo responses have been reported in studies of injectable drugs.(48)

There were no unexpected AEs compared with other IL-1 inhibitors,(23) except that there were 5 malignancies in the combined lutikizumab treatment groups versus no malignancies in the

placebo group. While immunosuppression is associated with a risk of malignancy, two published studies of IL-1 inhibitors (CANTOS and RESURGE) have not identified an increased risk of malignancies.(49, 50) The CANTOS study of subjects treated with the IL-1 β inhibitor canakinumab identified a significantly lower risk of incident lung cancer.(49) Given the CANTOS and RESURGE study data and the low numbers of malignancies observed in our study, it is currently unclear how best to interpret the greater number of malignancies in the combined lutikizumab treatment groups compared with the placebo group. Any future studies of lutikizumab should carefully monitor the incidence of malignancy to determine whether the findings observed in the present study are replicated.

Strengths of this study include the measurement of efficacy and pharmacodynamic endpoints in the same subjects. Plateauing of neutrophil decreases from baseline between the lutikizumab 100 mg and 200 mg dose groups suggested that systemic IL-1 was maximally suppressed; similar reductions in neutrophil levels were achieved with the IL-1R inhibitor AMG 108.(23) Another strength was enrichment for subjects with evidence of inflammation using ultrasound, MRI, and clinical characteristics, with the assumption that this increased the likelihood of treating subjects with elevated joint levels of IL-1. Multiple signs and symptoms and structural endpoints were evaluated over 52 weeks, which maximized the opportunity to demonstrate an effect of lutikizumab. Confounding by other potentially disease-modifying agents was minimal. Further investigation could probe whether subgroups of patients with knee OA have a significant clinical response to lutikizumab.

Several limitations of this study should be noted. Importantly, levels of lutikizumab, IL-1 α , and IL-1 β in the synovial fluid of the knee joint could not be assessed. In addition, approximately two-thirds of subjects had relatively mild radiographic changes (KL-2, 62.8%) and none had severe disease (KL-4, 0%). Studies of tanezumab, a monoclonal antibody that targets nerve growth factor, enrolled a higher percentage of subjects with KL-3 and KL-4 disease (38.6%–46.9% and 14.1%–27.7%, respectively),^(47, 51) suggesting that patients with more severe disease may be more responsive to treatment, consistent with the pre-planned sub-analysis of subjects with KL grade 3 in the present study. This suggests that, by enrolling subjects with a lower average KL grade, the likelihood of observing significant pain improvements may have been reduced in the current study. As noted previously, a robust placebo response was found, possibly enriched by the allowance of rescue pain medication and the frequent study visits with subcutaneous drug administration. Another potential limitation of our study was highlighted by the discrepancy between ultrasound and MRI grading of synovitis. Of the limited number of cases (n=6) where an ultrasound and MRI were both submitted to screen for synovitis prior to enrollment, all 6 subjects were positive by ultrasound and only 3 of the 6 were positive by non-contrast-enhanced MRI, supporting the idea that the lack of contrast-enhancement may have limited our ability to detect changes in synovitis with lutikizumab therapy.

In conclusion, although the 100 mg dose of lutikizumab met the co-primary endpoint of reduction in WOMAC pain at week 16 compared with placebo, neither the 25 mg nor the 200 mg dose did so, and the difference from placebo was not sustained after week 16. Measures of synovitis, cartilage thickness, and other structural endpoints were similar between lutikizumab and placebo at all time points and with all 3 doses evaluated. The safety profile of lutikizumab

was consistent with the AEs reported for other IL-1 inhibitors, including neutropenia and injection site reactions. The results of this study suggest that IL-1 inhibition is not an effective disease-modifying therapy in patients with knee OA. Whether subgroups of knee OA patients might have symptomatic benefit from IL-1 inhibition remains an open question.

For Peer Review

ACKNOWLEDGMENTS

AbbVie funded this study (NCT02087904). Medical writing support was provided by Richard M. Edwards, PhD, and Michael J. Theisen, PhD, of Complete Publication Solutions, LLC (North Wales, PA, United States), a CHC Group company. AbbVie funded the medical writing support. Lutikizumab is an investigational product. AbbVie and the authors thank the patients who participated in the clinical trial and all study investigators for their contributions. HB was supported by the Oak Foundation. PGC is supported in part by the UK National Institute for Health Research (NIHR) Leeds Biomedical Research Centre; the views expressed in this publication are those of the authors and not necessarily those of the National Health Service, the NIHR, or the Department of Health. The results of this article were presented in part at the OARSI World Congress on Osteoarthritis (April 27–30, 2017; Las Vegas, NV) and the American College of Rheumatology/Association of Rheumatology Health Professionals Annual Meeting (November 3–8, 2017; San Diego, CA).

AbbVie is committed to responsible data sharing regarding the clinical trials we sponsor. This includes access to anonymized, individual and trial-level data (analysis data sets), as well as other information (e.g., protocols and Clinical Study Reports), as long as the trials are not part of an ongoing or planned regulatory submission. This includes requests for clinical trial data for unlicensed products and indications.

This clinical trial data can be requested by any qualified researchers who engage in rigorous, independent scientific research, and will be provided following review and approval of a research proposal and Statistical Analysis Plan (SAP) and execution of a Data Sharing Agreement (DSA).

Data requests can be submitted at any time and the data will be accessible for 12 months, with possible extensions considered. For more information on the process, or to submit a request, visit the following link: <https://www.abbvie.com/our-science/clinical-trials/clinical-trials-data-and-information-sharing/data-and-information-sharing-with-qualified-researchers.html>.

AUTHORSHIP

All authors contributed to the development of the content, all authors and AbbVie reviewed and approved the final manuscript, and the authors maintained control over the final content.

For Peer Review

References

1. Centers for Disease Control and Prevention. Osteoarthritis. Available at: <https://www.cdc.gov/arthritis/basics/osteoarthritis.htm>. Accessed October 12, 2017.
2. Centers for Disease Control and Prevention. Prevalence and most common causes of disability among adults--United States, 2005. *MMWR Morb Mortal Wkly Rep* 2009;58(16):421-6.
3. D'Agostino MA, Conaghan P, Le Bars M, Baron G, Grassi W, Martin-Mola E, et al. EULAR report on the use of ultrasonography in painful knee osteoarthritis. Part 1: prevalence of inflammation in osteoarthritis. *Ann Rheum Dis* 2005;64(12):1703-9.
4. Roemer FW, Kassim Javid M, Guermazi A, Thomas M, Kiran A, Keen R, et al. Anatomical distribution of synovitis in knee osteoarthritis and its association with joint effusion assessed on non-enhanced and contrast-enhanced MRI. *Osteoarthritis Cartilage* 2010;18(10):1269-74.
5. Atukorala I, Kwok CK, Guermazi A, Roemer FW, Boudreau RM, Hannon MJ, et al. Synovitis in knee osteoarthritis: a precursor of disease? *Ann Rheum Dis* 2016;75(2):390-5.
6. Felson DT, Niu J, Neogi T, Goggins J, Nevitt MC, Roemer F, et al. Synovitis and the risk of knee osteoarthritis: the MOST study. *Osteoarthritis Cartilage* 2016;24(3):458-64.
7. Baker K, Grainger A, Niu J, Clancy M, Guermazi A, Crema M, et al. Relation of synovitis to knee pain using contrast-enhanced MRIs. *Ann Rheum Dis* 2010;69(10):1779-83.
8. Guermazi A, Roemer FW, Hayashi D, Crema MD, Niu J, Zhang Y, et al. Assessment of synovitis with contrast-enhanced MRI using a whole-joint semiquantitative scoring

- system in people with, or at high risk of, knee osteoarthritis: the MOST study. *Ann Rheum Dis* 2011;70(5):805-11.
9. Conaghan PG, D'Agostino MA, Le Bars M, Baron G, Schmidely N, Wakefield R, et al. Clinical and ultrasonographic predictors of joint replacement for knee osteoarthritis: results from a large, 3-year, prospective EULAR study. *Ann Rheum Dis* 2010;69(4):644-7.
 10. Schett G, Dayer JM, Manger B. Interleukin-1 function and role in rheumatic disease. *Nat Rev Rheumatol* 2016;12(1):14-24.
 11. Garlanda C, Dinarello CA, Mantovani A. The interleukin-1 family: back to the future. *Immunity* 2013;39(6):1003-18.
 12. Miller RE, Miller RJ, Malfait AM. Osteoarthritis joint pain: the cytokine connection. *Cytokine* 2014;70(2):185-93.
 13. Ren K, Torres R. Role of interleukin-1 β during pain and inflammation. *Brain Res Rev* 2009;60(1):57-64.
 14. Farahat MN, Yanni G, Poston R, Panayi GS. Cytokine expression in synovial membranes of patients with rheumatoid arthritis and osteoarthritis. *Ann Rheum Dis* 1993;52(12):870-5.
 15. Towle CA, Hung HH, Bonassar LJ, Treadwell BV, Mangham DC. Detection of interleukin-1 in the cartilage of patients with osteoarthritis: a possible autocrine/paracrine role in pathogenesis. *Osteoarthritis Cartilage* 1997;5(5):293-300.
 16. Sohn DH, Sokolove J, Sharpe O, Erhart JC, Chandra PE, Lahey LJ, et al. Plasma proteins present in osteoarthritic synovial fluid can stimulate cytokine production via Toll-like receptor 4. *Arthritis Res Ther* 2012;14(1):R7.

17. Bondeson J, Wainwright SD, Lauder S, Amos N, Hughes CE. The role of synovial macrophages and macrophage-produced cytokines in driving aggrecanases, matrix metalloproteinases, and other destructive and inflammatory responses in osteoarthritis. *Arthritis Res Ther* 2006;8(6):R187.
18. Brennan FM, McInnes IB. Evidence that cytokines play a role in rheumatoid arthritis. *J Clin Invest* 2008;118(11):3537-45.
19. Goldring MB, Birkhead J, Sandell LJ, Kimura T, Krane SM. Interleukin 1 suppresses expression of cartilage-specific types II and IX collagens and increases types I and III collagens in human chondrocytes. *J Clin Invest* 1988;82(6):2026-37.
20. Jules J, Zhang P, Ashley JW, Wei S, Shi Z, Liu J, et al. Molecular basis of requirement of receptor activator of nuclear factor kappaB signaling for interleukin 1-mediated osteoclastogenesis. *J Biol Chem* 2012;287(19):15728-38.
21. Nasi S, Ea H-K, So A, Busso N. Revisiting the role of interleukin-1 pathway in osteoarthritis: interleukin-1 α and -1 β , and NLRP3 inflammasome are not involved in the pathological features of the murine meniscectomy model of osteoarthritis. *Front Pharmacol* 2017;8:282.
22. Chevalier X, Goupille P, Beaulieu AD, Burch FX, Bensen WG, Conrozier T, et al. Intraarticular injection of anakinra in osteoarthritis of the knee: a multicenter, randomized, double-blind, placebo-controlled study. *Arthritis Rheum* 2009;61(3):344-52.
23. Cohen SB, Proudman S, Kivitz AJ, Burch FX, Donohue JP, Burstein D, et al. A randomized, double-blind study of AMG 108 (a fully human monoclonal antibody to IL-1R1) in patients with osteoarthritis of the knee. *Arthritis Res Ther* 2011;13(4):R125.
24. Lacy SE, Wu C, Ambrosi DJ, Hsieh CM, Bose S, Miller R, et al. Generation and characterization of ABT-981, a dual variable domain immunoglobulin (DVD-IgTM)

- molecule that specifically and potently neutralizes both IL-1 α and IL-1 β . MABs 2015;7(3):605-19.
25. Kamath RV, Simler G, Zhou C, Hart M, Joshi S, Ghayur T, et al. Blockade of both IL-1A and IL-1B by a combination of monoclonal antibodies prevents the development and reverses established pain in a preclinical model of osteoarthritis [abstract]. *Osteoarthritis Cartilage* 2012;20:S62.
 26. Kosloski MP, Goss S, Wang SX, Liu J, Loebbert R, Medema JK, et al. Pharmacokinetics and tolerability of a dual variable domain immunoglobulin ABT-981 against IL-1 α and IL-1 β in healthy subjects and patients with osteoarthritis of the knee. *J Clin Pharmacol* 2016;56(12):1582-90.
 27. Wang SX, Abramson SB, Attur M, Karsdal MA, Preston RA, Lozada CJ, et al. Safety, tolerability, and pharmacodynamics of an anti-interleukin-1 α/β dual variable domain immunoglobulin in patients with osteoarthritis of the knee: a randomized phase 1 study. *Osteoarthritis Cartilage* 2017;25(12):1952–61.
 28. Kellgren JH, Lawrence JS. Radiological assessment of osteo-arthrosis. *Ann Rheum Dis* 1957;16(4):494-502.
 29. Hawker GA, Mian S, Kendzerska T, French M. Measures of adult pain: Visual Analog Scale for Pain (VAS Pain), Numeric Rating Scale for Pain (NRS Pain), McGill Pain Questionnaire (MPQ), Short-Form McGill Pain Questionnaire (SF-MPQ), Chronic Pain Grade Scale (CPGS), Short Form-36 Bodily Pain Scale (SF-36 BPS), and Measure of Intermittent and Constant Osteoarthritis Pain (ICOAP). *Arthritis Care Res (Hoboken)* 2011;63 Suppl 11:S240-52.

30. Nikiphorou E, Radner H, Chatzidionysiou K, Desthieux C, Zabalan C, van Eijk-Hustings Y, et al. Patient global assessment in measuring disease activity in rheumatoid arthritis: a review of the literature. *Arthritis Res Ther* 2016;18(1):251.
31. Bellamy N. WOMAC Osteoarthritis Index User Guide X; 2012.
32. Pelletier JP, Raynauld JP, Abram F, Haraoui B, Choquette D, Martel-Pelletier J. A new non-invasive method to assess synovitis severity in relation to symptoms and cartilage volume loss in knee osteoarthritis patients using MRI. *Osteoarthritis Cartilage* 2008;16 Suppl 3:S8-13.
33. Li W, Abram F, Pelletier JP, Raynauld JP, Dorais M, d'Anjou MA, et al. Fully automated system for the quantification of human osteoarthritic knee joint effusion volume using magnetic resonance imaging. *Arthritis Res Ther* 2010;12(5):R173.
34. Peterfy CG, Guermazi A, Zaim S, Tirman PF, Miaux Y, White D, et al. Whole-organ magnetic resonance imaging score (WORMS) of the knee in osteoarthritis. *Osteoarthritis Cartilage* 2004;12(3):177-90.
35. Hawker GA, Davis AM, French MR, Cibere J, Jordan JM, March L, et al. Development and preliminary psychometric testing of a new OA pain measure--an OARSI/OMERACT initiative. *Osteoarthritis Cartilage* 2008;16(4):409-14.
36. Pham T, van der Heijde D, Altman RD, Anderson JJ, Bellamy N, Hochberg M, et al. OMERACT-OARSI initiative: Osteoarthritis Research Society International set of responder criteria for osteoarthritis clinical trials revisited. *Osteoarthritis Cartilage* 2004;12(5):389-99.
37. Gait AD, Hodgson R, Parkes MJ, Hutchinson CE, O'Neill TW, Maricar N, et al. Synovial volume vs synovial measurements from dynamic contrast enhanced MRI as measures of response in osteoarthritis. *Osteoarthritis Cartilage* 2016;24(8):1392-8.

38. Abraham AM, Goff I, Pearce MS, Francis RM, Birrell F. Reliability and validity of ultrasound imaging of features of knee osteoarthritis in the community. *BMC Musculoskelet Disord* 2011;12:70.
39. Zayat AS, Freeston JE, Conaghan PG, Hensor EM, Emery P, Wakefield RJ. Does joint position affect US findings in inflammatory arthritis? *Rheumatology (Oxford)* 2012;51(5):921-5.
40. National Cancer Institute. Common Terminology Criteria for Adverse Events v4.0 (CTCAE); 2009 May 28.
41. Levesque MC, Chen S, Peterfy C, Wang L, Medema JK. Baseline characteristics of knee osteoarthritis subjects enrolled in the ILLUSTRATE-K study of the anti-interleukin-1 α / β dual variable domain immunoglobulin ABT-981 and factors associated with exclusion from the trial. *Osteoarthritis Cartilage* 2017;25(suppl 1):S350-S1.
42. Kloppenburg M, Peterfy C, Haugen IK, Kroon F, Chen S, Wang L, et al. A phase 2a, placebo-controlled, randomized study of lutikizumab, an anti-interleukin-1 α and -1 β dual variable domain immunoglobulin, in patients with erosive hand osteoarthritis. *Ann Rheum Dis* 2018:Epub ahead of print.
43. Kapoor M, Martel-Pelletier J, Lajeunesse D, Pelletier JP, Fahmi H. Role of proinflammatory cytokines in the pathophysiology of osteoarthritis. *Nat Rev Rheumatol* 2011;7(1):33-42.
44. Mathiessen A, Conaghan PG. Synovitis in osteoarthritis: current understanding with therapeutic implications. *Arthritis Res Ther* 2017;19(1):18.
45. Smith TO, Zou K, Abdullah N, Chen X, Kingsbury SR, Doherty M, et al. Does flare trial design affect the effect size of non-steroidal anti-inflammatory drugs in symptomatic

- osteoarthritis? A systematic review and meta-analysis. *Ann Rheum Dis* 2016;75(11):1971-8.
46. da Costa BR, Reichenbach S, Keller N, Nartey L, Wandel S, Juni P, et al. Effectiveness of non-steroidal anti-inflammatory drugs for the treatment of pain in knee and hip osteoarthritis: a network meta-analysis. *Lancet* 2017;390(10090):e21-e33.
47. Brown MT, Murphy FT, Radin DM, Davignon I, Smith MD, West CR. Tanezumab reduces osteoarthritic knee pain: results of a randomized, double-blind, placebo-controlled phase III trial. *J Pain* 2012;13(8):790-8.
48. Ilnyckyj A, Shanahan F, Anton PA, Cheang M, Bernstein CN. Quantification of the placebo response in ulcerative colitis. *Gastroenterology* 1997;112(6):1854-8.
49. Ridker PM, MacFadyen JG, Thuren T, Everett BM, Libby P, Glynn RJ, et al. Effect of interleukin-1 β inhibition with canakinumab on incident lung cancer in patients with atherosclerosis: exploratory results from a randomised, double-blind, placebo-controlled trial. *Lancet* 2017;390(10105):1833-42.
50. Sundy JS, Schumacher HR, Kivitz A, Weinstein SP, Wu R, King-Davis S, et al. Rilonacept for gout flare prevention in patients receiving uric acid-lowering therapy: results of RESURGE, a phase III, international safety study. *J Rheumatol* 2014;41(8):1703-11.
51. Schnitzer TJ, Ekman EF, Spierings EL, Greenberg HS, Smith MD, Brown MT, et al. Efficacy and safety of tanezumab monotherapy or combined with non-steroidal anti-inflammatory drugs in the treatment of knee or hip osteoarthritis pain. *Ann Rheum Dis* 2015;74(6):1202-11.

Figure Legends

Figure 1. Patient disposition. Q2W, every 2 weeks; SC, subcutaneous. *Major protocol violations: (1) actual treatment is not according to randomization assignment, (2) premature unblinding, (3) use of a narcotic or non-steroidal anti-inflammatory drug for >50% of the days before week 16, (4) baseline index knee pain intensity <4 (11-point numeric rating scale), and (5) absence of synovitis in the index knee by ultrasound or magnetic resonance imaging during screening. †Study completion at 52 weeks.

Figure 2. LS mean change from baseline over time for WOMAC pain (A) and WOMAC function (B). LS, least squares; Q2W, every 2 weeks; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index. * $P \leq 0.05$ vs placebo; † $P \leq 0.01$ vs placebo.

Figure 3. Time course of mean total neutrophils (A) and mean hsCRP levels (B) from baseline (week 0) to week 52. hsCRP, high-sensitivity C-reactive protein; Q2W, every 2 weeks. * $P < 0.05$ or a higher level of significance compared with placebo.

A Phase 2 Trial of Lutikizumab, an Anti–Interleukin 1 α / β Dual Variable Domain Immunoglobulin, in Knee Osteoarthritis Patients With Synovitis

Roy M. Fleischmann,¹ Henning Bliddal,² Francisco J. Blanco,³ Thomas J. Schnitzer,⁴ Charles Peterfy,⁵ Su Chen,⁶ Li Wang,⁶ Sheng Feng,^{6,*} Philip G. Conaghan,⁷ Francis Berenbaum,⁸ Jean-Pierre Pelletier,⁹ Johanne Martel-Pelletier,⁹ Ole Vaeterlein,¹⁰ Gurjit S. Kaeley,¹¹ Wei Liu,⁶ Matthew P. Kosloski,⁶ Gwen Levy,⁶ Lanju Zhang,⁶ Jeroen K. Medema,⁶ Marc C. Levesque⁶

¹University of Texas Southwestern Medical Center at Dallas, Metroplex Clinical Research Center, Dallas, TX, United States; ²Parker Institute, Bispebjerg-Frederiksberg Hospital, University of Copenhagen, Copenhagen, Denmark; ³INIBIC-Instituto de Investigaciones Biomédicas de A Coruña-Complejo Hospitalario Universitario de A Coruña, A Coruña, Spain; ⁴Northwestern Medicine, Feinberg School of Medicine, Chicago, IL, United States; ⁵Spire Sciences, Inc., Boca Raton, FL, United States; ⁶AbbVie Inc., North Chicago, IL, United States; ⁷Leeds Institute of Rheumatic and Musculoskeletal Medicine, University of Leeds & NIHR Leeds Biomedical Research Centre, Leeds, United Kingdom; ⁸Sorbonne Université, Inserm, and DHU i2B, APHP, Hospital Saint-Antoine, Paris, France; ⁹Centre Hospitalier de l'Université de Montréal, Montréal, QC, Canada; ¹⁰Bioclinica, Hamburg, Germany; ¹¹University of Florida College of Medicine, Jacksonville, FL, United States

*At the time that the study was conducted.

Running Head: Lutikizumab efficacy and safety in knee OA

Corresponding author:

Roy Fleischmann, MD

Department of Internal Medicine
University of Texas Southwestern Medical Center at Dallas
Metroplex Clinical Research Center
8144 Walnut Hill Lane, Suite 810
Dallas, TX 75231, United States
RFleischmann@arthdocs.com
Telephone: +1 214-540-0645
Fax: +1 214-540-0611

Coauthors:

Henning Bliddal, MD, DMSci
Parker Institute
Bispebjerg-Frederiksberg Hospital
University of Copenhagen
Copenhagen, Denmark
henning.bliddal@regionh.dk

Francisco J. Blanco, MD
INIBIC-Instituto de Investigaciones Biomédicas
de A Coruña-Complejo Hospitalario Universitario de A Coruña
A Coruña, Spain
fblagar@sergas.es

Thomas J. Schnitzer, MD, PhD
Northwestern Medicine
Feinberg School of Medicine
Chicago, IL, United States
tjs@northwestern.edu

Charles Peterfy, MD, PhD

Spire Sciences, Inc.
Boca Raton, FL, United States
charles.peterfy@spiresciences.com

Su Chen, PhD
Data and Statistical Sciences
AbbVie Inc.
North Chicago, IL, United States
su.chen@abbvie.com

Li Wang, PhD
Development Design Center~~Predictive Analytics and Statistics~~
AbbVie Inc.
North Chicago, IL, United States
li.wang1@abbvie.com

Sheng Feng, PhD
Exploratory Statistics, Data Science and Statistics
AbbVie Inc.
North Chicago, IL, United States
f012345@yahoo.com

Philip G. Conaghan, MD, PhD
Leeds Institute of Rheumatic and Musculoskeletal Medicine
University of Leeds, & NIHR Leeds Biomedical Research Centre
Leeds, United Kingdom
p.conaghan@leeds.ac.uk

Francis Berenbaum, MD, PhD
Department of Rheumatology
Sorbonne Université, Inserm, and DHU i2B AP-HP Hôpital Saint-Antoine

Paris, France

francis.berenbaum@aphp.fr

Jean-Pierre Pelletier, MD

Centre Hospitalier de l'Université de Montréal

Montréal, QC, Canada

dr@jppelletier.ca

Johanne Martel-Pelletier, PhD

Centre Hospitalier de l'Université de Montréal

Montréal, QC, Canada

jm@martelpelletier.ca

Ole Vaeterlein, MD

Bioclinica

Hamburg Germany

ole.vaeterlein@bioclinica.com

Gurjit S. Kaeley, MRCP, RhMSUS

Department of Medicine

Division of Rheumatology and Clinical Immunology

University of Florida College of Medicine

Jacksonville, FL, United States

gurjit.kaeley@jax.ufl.edu

Wei Liu, PhD

Clinical Pharmacology and Pharmacometrics

AbbVie Inc.

North Chicago, IL, United States

wei.liu@abbvie.com

Matthew P. Kosloski, PhD
Clinical Pharmacology and Pharmacometrics
AbbVie Inc.
North Chicago, IL, United States
matthew.kosloski@abbvie.com

Gwen Levy, MD
Pharmacovigilance and Patient Safety
AbbVie Inc.
North Chicago, IL, United States
gweneth.levy@abbvie.com

Lanju Zhang, PhD
Data and Statistical Sciences
AbbVie Inc.
North Chicago, IL, United States
lanju.zhang@abbvie.com

Jeroen K. Medema, MS
Immunology Development
AbbVie Inc.
North Chicago, IL, United States
jeroen.medema@abbvie.com

Marc C. Levesque, MD, PhD
Immunology Development
AbbVie Inc.
North Chicago, IL, United States
marc.levesque@abbvie.com

Funding Source:

AbbVie Inc. funded this study.

Conflict of Interest/Disclosure Information:

AbbVie Inc. contributed to the design of the study and was involved in the collection, analysis, and interpretation of the data and in the writing, review, and approval of the publication.

R. Fleischmann has received grant/research support and consulting fees or other remuneration from AbbVie, Acea, Amgen, AstraZeneca, Augurex, Bristol-Myers Squibb, Celltrion, GlaxoSmithKline, Janssen, Eli Lilly, Merck, Novartis, Pfizer, Samumed, Roche, Samsung, Sanofi Aventis-Regeneron, and UCB and was involved in the collection, analysis, and interpretation of the data and in the writing, review, and approval of the publication.

H. Bliddal has received consulting fees or other remuneration from AbbVie Inc., Roche, Pfizer, and Lilly. The Parker Institute is sponsored by the Oak Foundation.

F. J. Blanco has received consulting fees or other remuneration from AbbVie Inc., Pfizer, UCB, Bristol-Myers Squibb, Roche, Bioiberica, Sanofi, Grünenthal, GlaxoSmithKline, Lilly, Janssen, Regeneron, and TRB Chemedica (for the DISSCO study).

T. J. Schnitzer has received grant/research support and consulting fees or other remuneration from AbbVie, Regeneron, Pfizer, Flexion, and GlaxoSmithKline.

C. Peterfy is an employee of Spire Sciences, Inc., and is on the speakers bureau for Amgen and Bristol-Myers Squibb.

P. G. Conaghan has received consulting fees or other remuneration from AbbVie Inc., Bristol-Myers Squibb, Flexion Therapeutics, GlaxoSmithKline, Medivir, Merck Serono, Novartis, and Pfizer and is on the speakers bureau for AbbVie Inc., Novartis, Pfizer, and Samumed.

F. Berenbaum has received consulting fees or other remuneration from AbbVie, Expanscience, Flexion, IBSA, Janssen, Merck Serono, Novartis, Sanofi, Servier, TRB Chemedica, UCB, Pfizer, and Regeneron.

J-P Pelletier has received consulting fees or other remuneration from AbbVie.

J. Martel-Pelletier has received consulting fees or other remuneration from AbbVie.

O. Vaeterlein is an employee of Bioclinica.

G. S. Kaeley is a consultant for AbbVie and Novartis.

S. Chen, L. Wang, W. Liu, M. P. Kosloski, G. Levy, L. Zhang, J. K. Medema, and M. C. Levesque are employees of AbbVie and may own AbbVie stock and/or stock options.

S. Feng is a former employee of AbbVie and may own AbbVie stock and/or stock options.

For Peer Review

Abstract

Objective: To assess the efficacy and safety of the anti-interleukin (IL)-1 α / β dual variable domain immunoglobulin lutikizumab (ABT-981) in subjects with knee osteoarthritis (OA) and evidence of synovitis.

Methods: Subjects (N=350; 347 analyzed) with Kellgren-Lawrence grade 2–3 knee OA and synovitis (determined by magnetic resonance imaging [MRI] or ultrasound) were randomized to placebo or lutikizumab 25, 100 or 200 mg subcutaneously every 2 weeks for 50 weeks. The co-primary endpoints were change from baseline in Western Ontario and McMaster Universities Osteoarthritis (WOMAC) pain index at week 16 and change from baseline in MRI synovitis at week 26.

Results: WOMAC pain at week 16 improved significantly versus placebo with lutikizumab 100 mg ($P=0.050$) but not 25 or 200 mg. Beyond week 16, WOMAC pain was reduced in all groups but was similar-not significantly different for lutikizumab and placebo. Changes from baseline in MRI synovitis at week 26 and other key symptom- and most structure-related endpoints at weeks 26 and 52 were not significantly different similar for lutikizumab and placebo. Injection site reactions, neutropenia, and discontinuations due to neutropenia were more frequent with lutikizumab versus placebo. Neutrophil and high-sensitivity C-reactive protein reductions plateaued at lutikizumab 100 mg. Immunogenicity to lutikizumab did not meaningfully affect systemic lutikizumab concentrations.

Conclusion: The limited improvement of WOMAC pain and the lack of synovitis improvement with lutikizumab, together with published trial results for other IL-1 inhibitors, suggest that IL-1 inhibition is not an effective analgesic/anti-inflammatory therapy in most patients with knee OA and associated synovitis.

Keywords: DMOADs (biologic), knee osteoarthritis, inflammation, cytokines, interleukin-1 inhibition

For Peer Review

INTRODUCTION

Osteoarthritis (OA) is the most common arthritis,(1) and main cause of disability among US adults.(2) OA is commonly considered a non-inflammatory arthritis but at least half of patients with knee OA have ultrasound or magnetic resonance imaging (MRI) evidence of synovitis.(3, 4) Synovitis is associated with a risk of developing radiographic knee OA,(5, 6) greater knee pain,(7, 8) and total joint replacement.(9)

Interleukin (IL)-1 α and IL-1 β are pro-inflammatory cytokines and pain mediators that are thought to be involved in the pathogenesis of OA.(10, 11) IL-1 β is secreted by innate immune cells after cleavage by caspase-1.(10) In contrast, IL-1 α is stored intracellularly or membrane bound,(10) is released in an active form upon cell damage,(11) and can induce IL-1 β activation and production of other cytokines important in the pathogenesis of OA.(10) IL-1 α and IL-1 β bind to the same receptor, IL-1R1, resulting in inflammatory and pain responses.(10, 12, 13)

IL-1 α and IL-1 β are expressed in the cartilage and synovial membrane, and are elevated in sera and synovial fluid in patients with OA.(14-16) Synovial macrophages are an important source of IL-1 in patients with knee OA.(17) IL-1 may promote structural damage associated with OA, because IL-1 activates enzymes involved in cartilage destruction,(18) inhibits collagen synthesis,(19) and promotes osteoclastogenesis.(10, 20) The IL-1 pathway may mediate OA pain through pathways in the peripheral and central nervous systems.(12, 13) In some, but not all animal models of OA, blocking the IL-1 pathway improves OA manifestations.(21) However, in clinical trials in subjects with knee OA not selected for synovitis, an IL-1 receptor antagonist

(anakinra)(22) or an antibody to the IL-1R1 (AMG 108)(23) did not meet the primary symptom-based study endpoints.

Lutikizumab (ABT-981) is a novel human dual variable domain immunoglobulin (DVD-Ig) that has been shown to bind and inhibit IL-1 α and IL-1 β .(24) In mouse OA models, a mouse anti-IL-1 α/β DVD-Ig increased the threshold for pain and reduced cartilage degeneration to a greater extent than inhibition of either IL-1 α or IL-1 β alone.(25) In phase 1 studies of ≤ 8 weeks in healthy subjects and subjects with knee OA, single and multiple doses of lutikizumab were well tolerated; the most frequently reported adverse events (AEs) were injection site reactions and headache.(26, 27) Among the knee OA subjects in a phase 1 study, lutikizumab therapy was associated with reductions in serum inflammatory biomarkers.(27)

The current trial enrolled subjects with knee OA and MRI and/or ultrasound evidence of synovitis, a population presumed to be at high risk of progression, to test the hypothesis that dual inhibition of IL-1 α and IL-1 β would demonstrate efficacy and safety in knee OA with inflammation.

METHODS

Study Design

The objective was to determine the efficacy and safety of lutikizumab in subjects with knee OA and synovitis. The study was conducted in accordance with ~~the~~ International Conference on Harmonization guidelines and the Declaration of Helsinki. This phase 2, randomized, double-blind, placebo-controlled, parallel-group study (NCT02087904; ILLUSTRATE-K) was approved

by institutional review boards, and signed informed consent was obtained from all subjects. After screening and washout periods totaling approximately 45 days (**Supplemental Figure 1**), eligible subjects were randomized (1:1:1:1) to double-blind lutikizumab 25, 100, or 200 mg or matching placebo subcutaneously every 2 weeks for 52 weeks (last dose of study medication, week 50).

Rescue medication included acetaminophen (maximum, 3000 mg/d) during the washout period through week 26, and ibuprofen (maximum, 1200 mg/d), with or without acetaminophen, during weeks 16 to 26 for breakthrough knee pain, although analgesics were stopped ≥ 48 hours before the first dose of study drug and 24 hours before each pain assessment. From weeks 26 to 52, oral standard-of-care (SOC) medications for knee OA including non-steroidal anti-inflammatory drugs (NSAIDs), non-opioid analgesics, and nutraceuticals (e.g., glucosamine, chondroitin sulfate, shark cartilage, diacerein, soy extract) were permitted; SOC medications for knee OA were stopped ≥ 24 hours before each pain assessment.

Subjects

Adult subjects (35–74 years old) with radiographic evidence of knee OA in the medial compartment of the index knee with Kellgren-Lawrence (KL) grade 2 or 3 (28) were eligible if meeting other inclusion criteria including signs and symptoms of active inflammation (e.g., localized pain, stiffness, swelling, or effusion) in the index knee; presence of synovitis in the index knee by either ultrasound (local reader, per an ultrasound guide) or MRI (central reader); pain score ≥ 4 and ≤ 8 (11-point numeric rating scale [NRS-11], 0–10 representing no pain to

worst possible pain)(29) in the index knee for ≥ 14 days over the past 30 days; and patient global assessment of arthritis status ≥ 4 (NRS-11, 0–10 representing best to worst disease status).(30)

Key exclusion criteria included other inflammatory arthritis (e.g., rheumatoid arthritis, psoriatic arthritis, or gout) or a painful myofascial syndrome such as fibromyalgia (**Supplemental Methods**).

Subjects must have discontinued use of all analgesics, NSAIDs, and nutraceuticals for ≥ 5 half-lives of the longest-acting therapy or 48 hours, whichever was longer, before the first dose of study drug. Subjects receiving concomitant medications for indications other than OA (if allowed by the protocol) had to be on stable doses for ≥ 1 month before the first dose of study drug.

Efficacy

The co-primary endpoints were (1) change from baseline in Western Ontario and McMaster Universities Osteoarthritis index (WOMAC) pain score (0–50 scale; NRS-11 subscales)(31) at week 16 and (2) change in MRI synovitis from baseline in the index knee at week 26. To meet the latter co-primary endpoint, we required reductions in all 3 of the following measurements: (a) quantitative synovial membrane thickness,(32) (b) quantitative synovial fluid volume,(33) and (c) semi-quantitative synovitis/effusion score measured on a scale of 0 to 3 using the Whole-Organ Magnetic Resonance Imaging Score (WORMS).(34)

Secondary endpoints included changes from baseline in WOMAC pain scores at weeks 26 and 52(31); Intermittent and Constant Pain (ICOAP) score(35) at weeks 16, 26 and 52; and 3 types of pain intensity measures using NRS-11 scales (**Supplemental Methods**).

Exploratory endpoints included Outcome Measures in Rheumatology Clinical Trials/Osteoarthritis Research Society International (OMERACT/OARSI) response(36) at weeks 16, 26 and 52; radiographic medial and lateral joint space narrowing (JSN; centralized measurement of the minimum joint space width compared with baseline in the index knee at week 52; and changes from baseline to week 26 in synovitis as assessed by dynamic contrast-enhanced MRI (DCE-MRI).(37)

Imaging

Patients were screened for presence of synovitis using MRI or musculoskeletal ultrasound (**Supplemental Methods**), which has shown good to excellent inter- and intra-reader agreement in detecting knee synovitis.(38, 39) Posteroanterior weight-bearing radiographs of the target knee were acquired at screening and at week 52. MRI of the target knee was performed using 1.5- or 3.0-T whole-body scanners and commercial knee coils at screening, week 26, and week 52. Given the limitations associated with non-contrast-enhanced MRI for assessment of synovitis,(8) dynamic contrast-enhanced MRI (DCE-MRI) was performed as an exploratory substudy (n=39), as described previously.(37)

Pharmacokinetics

Blood samples were collected throughout the 52 weeks to assess concentrations of lutikizumab and anti-drug antibody (ADA) responses in serum as previously described.(26)

Pharmacodynamics

Blood neutrophil counts and serum high-sensitivity C-reactive protein (hsCRP) levels (ICON, ARCHITECT platforms C8000 or C16000, Abbott Laboratories, Abbott Park, IL, United States) were measured repeatedly from baseline to week 52; other biomarkers were measured at baseline and weeks 16, 26 and 52. Serum concentrations of free IL-1 α and IL-1 β were determined using the Singulex Erenna (MilliporeSigma, Billerica, MA, United States) and SIMOA platforms (Quanterix, Lexington, MA, United States), respectively, using AbbVie proprietary capture and detection antibodies. Other biomarkers were measured by BioClinica Molecular Marker Lab (Lyon, France) using validated enzyme-linked immunosorbent assays (from Nordic Bioscience [Herlev, Denmark; metalloproteinase-degraded collagen types I and III and matrix metalloproteinase-generated fragment of CRP], Corgenix [Broomfield, CO, United States; hyaluronic acid], EMD Millipore [Darmstadt, Germany; N-propeptide of collagen IIA], and Roche Diagnostics [Indianapolis, IN, United States; C-terminal telopeptide fragments of type II collagen]), adhering to standard operating procedures from regulatory guidance for clinical studies.

Safety

Adverse events, vital signs, physical examinations, and laboratory data were assessed throughout the study. AEs were coded using the *Medical Dictionary for Regulatory Activities, version 19.0*,

preferred term, and system organ class. AE severity was classified according to the Common Terminology Criteria for Adverse Events, version 4.03.(40)

Statistics and Analyses

The co-primary and secondary efficacy outcomes were analyzed in the modified intent-to-treat population, comprising randomized patients who received ≥ 1 dose of study drug. Continuous efficacy assessments were analyzed with analysis of covariance (ANCOVA) with main factors of treatment, age group, and KL grade and covariates of baseline values, except analysis of daily rescue medication use, which was analyzed with analysis of variance (ANOVA). Categorical variables analysis used the Cochran-Mantel-Haenszel test with age group and KL grade as stratification factors. Last-observation-carried-forward (LOCF) imputation of missing values was used for non-imaging co-primary and selected secondary endpoints. [The non-imaging co-primary endpoint was also assessed using multiple imputation \(MI\) for missing values in a post hoc analysis.](#) In this phase 2 study, there was no adjustment for multiplicity of assessments. The safety analysis set included subjects who received ≥ 1 dose of study drug. To identify factors associated with the development of neutropenia (defined as at least one episode where absolute neutrophil count [ANC] $< 1,500$ cells/ μL), explanatory variables significant at the $P < 0.1$ level in univariate analyses were tested in a multiple logistic regression model.

A sample size of approximately 80 subjects per treatment group was estimated to provide $\geq 80\%$ power to detect a significant difference between lutikizumab and placebo, based on a significance level of 0.05, for each of the two co-primary endpoints (WOMAC pain and synovial inflammation based on synovial membrane thickness by MRI).

RESULTS

Subjects

Of 1571 subjects screened, 350 were eligible and were randomized; 347 received ≥ 1 dose of study drug (June 2014 to November 2016) and were analyzed for efficacy and safety (**Figure 1**). The most common reasons for screen failure were clinical history related to entry criteria, absence of KL-2 or KL-3 radiographic evidence of knee OA, lack of synovitis on ultrasound or by non-contrast-enhanced MRI, and severe knee malalignment.⁽⁴¹⁾ Most subjects (229; 65.4%) were enrolled based on ultrasound evidence of knee synovitis; 118 (33.7%) were enrolled based on MRI evidence (**Supplemental Table 1**). Among the subjects enrolled based solely on screening ultrasound, 185/220 (84.1%) had baseline MRI evidence of synovitis per WOMMS scoring conducted at the end of the study. Demographics, baseline disease characteristics, and use of medications were generally well matched across treatment groups (**Table 1**). Of the randomized subjects, 60/85 (70.6%) who received placebo and 202/265 (76.2%) who received lutikizumab completed the 52-week study (**Figure 1**). The major reasons for discontinuation included AEs, lack of efficacy, and withdrawal of consent.

Efficacy

Co-primary Endpoints

The co-primary endpoint of WOMAC pain at week 16 (and at most early time points) improved significantly, compared with placebo, for the lutikizumab 100 mg dose group ($P=0.050$) but not for the lutikizumab 25 mg ($P=0.834$) and 200 mg ($P=0.415$) dose groups (**Figure 2A, Table 2, Supplemental Figure 2A**). [Post hoc analysis for WOMAC pain using MI yielded results](#)

consistent with those of LOCF (Supplemental Figure 3). WOMAC pain reduction in all lutikizumab groups, as well as placebo, was sustained from weeks 16 to 52, but differences between lutikizumab and placebo for WOMAC pain were not significant between weeks 16 and 52 (**Figure 3A**).

The other co-primary endpoint, change in synovitis (as measured by synovial membrane thickness, synovial fluid volume, and WOMS synovitis/effusion score) from baseline to week 26, did not differ between the lutikizumab and placebo groups (**Table 2**).

Post hoc analyses were performed to determine efficacy including only subjects with a baseline WOMS synovitis/effusion score >0, indicating MRI evidence of synovitis. Results in this post hoc population were not substantially different from those in the original, prospective population enrolled on the basis of positive MRI or ultrasound (Supplemental Figure 4, Supplemental Table 2).

Other Signs and Symptoms Endpoints

WOMAC function (**Figure 2B, Supplemental Figure 2B**) and OMERACT/OARSI response were numerically better but not significantly different between the placebo and lutikizumab treatment groups (**Table 2**) at 16, 26 and 52 weeks. Change from baseline in WOMAC function was significantly different ($P \leq 0.01$) from placebo with lutikizumab 100 mg at weeks 4 and 8 (**Figure 2B**). OMERACT/OARSI placebo responses were high, e.g., 60%–71%, at weeks 26 and 52, respectively (**Table 2, Figure 2**).

Other Structural Endpoints

Among secondary and exploratory endpoints, other than medial ($P=0.017$) and lateral ($P=0.005$) JSN with lutikizumab 25 mg at week 52 (**Table 2**), there were no structural endpoints statistically significantly different between placebo and the lutikizumab dose groups. MRI assessments of cartilage volume, thickness, and WORMS scores were nearly identical in all treatment groups at baseline, week 26 and week 52. Synovitis, as assessed by DCE-MRI, also demonstrated no differences between subjects treated with placebo versus each dose of lutikizumab (**Supplemental Table 32**).

Rescue Medication Use

The proportion of subjects receiving concomitant pain medication (acetaminophen, ibuprofen) during the study was generally similar among treatment groups (**Supplemental Table 43**). The least squares mean daily dose of rescue acetaminophen up to week 16 was similar in the placebo (511 mg, n=58) and lutikizumab 25 mg (500 mg, n=53), 100 mg (413 mg, n=63) and 200 mg (426 mg, n=67) dose groups. Similarly, the least squares mean daily dose of rescue ibuprofen between weeks 16 and 26 was not significantly different between the placebo (200 mg, n=18) and lutikizumab 25 mg (104 mg, n=18), 100 mg (241 mg, n=19), and 200 mg (155 mg, n=24) dose groups.

Pre-planned Efficacy Subgroup Analyses

In pre-planned subgroup analyses, there were no meaningful differences in WOMAC pain scores at weeks 16, 26, and 52 based on age, gender, race, or body weight. In the 100 mg dose group, there were statistically significantly greater decreases in WOMAC pain scores compared with

placebo, among subjects with an index knee KL grade of 3 (but not KL grade of 2) (week 26, $P=0.029$; week 52, 0.016) and among subjects who did not use concomitant medications for index knee pain through week 26 (week 16, $P=0.027$; week 26, 0.045). This was not noted in the 25 mg or 200 mg dose group.

Pharmacokinetics

Lutikizumab trough concentrations were stable between weeks 6 and 52 and consistent with assessments of steady-state in previous studies (**Supplemental Figure 5A3A**). (26, 42) A greater ~~anti-drug antibody~~ ADA incidence was observed for the lutikizumab 25 mg dose group (46%) compared with the 100 mg and 200 mg dose groups (32% and 23%, respectively). Lutikizumab serum concentrations were generally similar among subjects with and without ~~anti-drug antibodies~~ ADAs for each dose group (**Supplemental Figure 5B3B**); thus, the immunogenic response did not appear to have a meaningful impact on lutikizumab pharmacokinetics.

Pharmacodynamics

Mean blood neutrophil counts (ANC) decreased with lutikizumab 100 mg and 200 mg treatment at all time points and with lutikizumab 25 mg at most time points relative to baseline and placebo (**Figure 3A**); neutrophil counts were similar in the 100 mg and 200 mg dose groups throughout the study. There was an exposure-response relationship between ANCs and lutikizumab blood levels (**Supplemental Figure 64**). In a similar way, hsCRP levels were reduced at most time points in the lutikizumab groups compared with baseline and placebo (**Figure 3B**), reaching statistical significance at several time points for the 25 mg and 100 mg doses but with high variability.

Serum levels of IL-1 α and IL-1 β at baseline were low and most were below the lower limits of quantification. In subjects with detectable levels at baseline, IL-1 α and IL-1 β levels were reduced within 2 weeks of treatment initiation to a greater extent in subjects receiving lutikizumab compared with subjects receiving placebo (**Supplemental Figure 75**, **Supplemental Table 45**). Changes in other biomarkers are shown in **Supplemental Figure 86**. With lutikizumab treatment, compared with placebo, there were reductions in metalloproteinase-degraded collagen type I (C1M), metalloproteinase-degraded collagen type III (C3M), matrix metalloproteinase-generated fragment of CRP (CRPM), IL-6, and alkaline phosphatase.

Safety

Similar proportions of subjects receiving placebo or lutikizumab experienced a treatment-emergent AE or serious AE during the study (**Table 3**). Serious infections were infrequent and had similar incidences among treatment groups, including placebo. A greater proportion of subjects in the lutikizumab total treatment groups compared with the placebo group had injection site reactions (25.2% vs 15.3%) and neutropenia (27.5% vs 2.4%). The incidence of both events increased in a dose-dependent manner. All reported neutropenia laboratory abnormalities were grade 3 or less; there was no grade 4 neutropenia. One subject who received lutikizumab 25 mg and 6 subjects who received lutikizumab 200 mg discontinued study treatment because of neutropenia.

~~A multiple logistic regression model was used to identify factors associated with the development of neutropenia. In addition to lutikizumab dose ($P < 0.0001$), baseline neutrophil~~

count (odds ratio [OR], 0.19; 95% CI, 0.12–0.30; $P < 0.0001$), age < 62 (OR, 2.11; 95% CI, 1.09–4.09; $P = 0.027$), and female sex (OR, 2.86; 95% CI, 1.34–6.10; $P = 0.007$) were significantly associated with the development of neutropenia (Supplemental Table 5). Grade 3 or 4 lymphopenia and hypertriglyceridemia occurred in a few subjects, without clear patterns; there was no grade 3 or 4 thrombocytopenia or hypercholesterolemia.

Treatment-emergent AEs of malignancy were reported in 5 subjects (1.9%; 2.2 events per 100 patient-years) in the total lutikizumab group and in no subjects in the placebo group. Basal cell carcinoma was reported in 3 of these 5 subjects.

DISCUSSION

This study assessed the efficacy and safety of blocking IL-1 α and IL-1 β with lutikizumab in subjects with knee OA and associated synovitis. To our knowledge, this is the first study to test the hypothesis that a systemic anti-inflammatory, anti-cytokine therapy may be effective in knee OA patients with synovitis. Lutikizumab met the co-primary clinical endpoint of reduction in WOMAC pain compared with placebo at week 16 in only the 100 mg dose group, but not in the 25 mg and 200 mg dose groups, and the differences compared with placebo were not sustained past week 16 for any dose. In the subgroup of patients treated with lutikizumab 100 mg with KL grade 3 knee OA and among the subgroup of subjects not using rescue or off-protocol pain medications, compared with placebo, the change from baseline at weeks 26 and 52 in WOMAC pain was significantly greater; the reason why this occurred only in the 100 mg dose group and only at these time points is unclear. The co-primary endpoint, change from baseline in synovitis

as measured by synovial membrane thickness, synovial effusion volume, and semiquantitative MRI synovitis/effusion (WORMS) at week 26, was also not significantly different for lutikizumab versus placebo. Furthermore, when compared with placebo, lutikizumab was not associated with improvements or slowing in the rates of JSN and MRI cartilage thickness changes. These results indicate that lutikizumab had no significant impact on structural endpoints that were assessed. The analytical assay used to quantify lutikizumab serum concentrations required at least one free binding site for each molecule of IL-1 α and IL-1 β .⁽²⁶⁾ The modest impact of ADAs on trough concentrations (**Supplemental Figure 5B3B**) suggested that development of ADAs did not interfere with the biological activity of lutikizumab, and thus they were unlikely to have impacted efficacy.

The unexpected lack of an effect of IL-1 inhibition on synovitis may signify that, although the synovium is an important source of IL-1,⁽⁴³⁾ IL-1 by itself may not be required to sustain synovitis. Other factors, such as cartilage degradation products and adipokines may have a greater role in the development and maintenance of synovitis.⁽⁴⁴⁾ Overall, these observations are consistent with a recent study using a medial meniscectomy animal model that found that IL-1 may not play a role in the structural progression of OA.⁽²¹⁾ A phase 2 study of lutikizumab in erosive hand OA also was negative.⁽⁴²⁾

The reason(s) for the failure to demonstrate a sustained beneficial analgesic effect of lutikizumab compared with placebo in this study is not clear. Lutikizumab serum concentrations were stable throughout the duration of the study, unaffected by development of ~~anti-drug antibodies~~ ADAs and at exposures consistent with a previous phase 1 study.⁽²⁷⁾ The probability of achieving

positive results might have been improved by using a flare study design, although a difference in effect size has not been shown to be statistically significant versus a non-flare study design.(45) Although serum IL-1 α and IL-1 β levels could not be reliably quantified, similar reductions in absolute neutrophil count and hsCRP between the lutikizumab 100 mg and 200 mg dose groups suggested that both dose groups achieved maximum suppression of IL-1 α and IL-1 β . However, it is possible that these systemic pharmacodynamic endpoints are not reflective of target engagement within the joint.

As there was no positive control treatment in this study, it is not clear whether lutikizumab did have a positive effect masked by a placebo response. The use of SOC therapies following week 26 may have masked any lutikizumab treatment effects and could account for the lack of sustained WOMAC pain differences between the lutikizumab 100 mg treatment group and the placebo group, but would not explain the inefficacy of the 25 mg and 200 mg doses. The pre-planned subset analyses suggested that the use of rescue medication affected the WOMAC pain co-primary endpoint results; however, meta-analysis has concluded that acetaminophen has little if any analgesic effect in OA.(46) Another pre-planned subset analysis suggested that subjects with KL grade 3 knee OA (in contrast to subjects with KL grade 2 knee OA) had statistically significant WOMAC pain treatment effects, implying that knee OA subjects with greater amounts of structural disease may benefit from IL-1 inhibition. The hypothesis that the concomitant use of pain medication and the degree of radiographic damage could predict response to lutikizumab would have to be proven in a well-designed prospective study.

The lack of a clear lutikizumab treatment effect may have also been due to a strong, sustained placebo effect (**Figure 3A**). Placebo response rates are high in knee OA trials (e.g., 40%–50% using OMERACT-OARSI criteria)(47); placebo response rates in this trial were 60%, 62% and 71% at weeks 16, 26 and 52 (**Table 2**). High placebo responses have been reported in studies of injectable drugs.(48)

There were no unexpected AEs compared with other IL-1 inhibitors,(23) except that there were 5 malignancies in the combined lutikizumab treatment groups versus no malignancies in the placebo group. While immunosuppression is associated with a risk of malignancy, two published studies of IL-1 inhibitors (CANTOS and RESURGE) have not identified an increased risk of malignancies.(49, 50) The CANTOS study of subjects treated with the IL-1 β inhibitor canakinumab identified a significantly lower risk of incident lung cancer.(49) Given the CANTOS and RESURGE study data and the low numbers of malignancies observed in our study, it is currently unclear how best to interpret the greater number of malignancies in the combined lutikizumab treatment groups compared with the placebo group. Any future studies of lutikizumab should carefully monitor the incidence of malignancy to determine whether the findings observed in the present study are replicated.

Strengths of this study include the measurement of efficacy and pharmacodynamic endpoints in the same subjects. Plateauing of neutrophil decreases from baseline between the lutikizumab 100 mg and 200 mg dose groups suggested that systemic IL-1 was maximally suppressed; similar reductions in neutrophil levels were achieved with the IL-1R inhibitor AMG 108.(23) Another strength was enrichment for subjects with evidence of inflammation using ultrasound, MRI, and

clinical characteristics, with the assumption that this increased the likelihood of treating subjects with elevated joint levels of IL-1. Multiple signs and symptoms and structural endpoints were evaluated over 52 weeks, which maximized the opportunity to demonstrate an effect of lutikizumab. Confounding by other potentially disease-modifying agents was minimal. Further investigation could probe whether subgroups of patients with knee OA have a significant clinical response to lutikizumab.

Several limitations of this study should be noted. Importantly, levels of lutikizumab, IL-1 α , and IL-1 β in the synovial fluid of the knee joint could not be assessed. In addition, approximately two-thirds of subjects had relatively mild radiographic changes (KL-2, 62.8%) and none had severe disease (KL-4, 0%). Studies of tanezumab, a monoclonal antibody that targets nerve growth factor, enrolled a higher percentage of subjects with KL-3 and KL-4 disease (38.6%–46.9% and 14.1%–27.7%, respectively),(47, 51) suggesting that patients with more severe disease may be more responsive to treatment, consistent with the pre-planned sub-analysis of subjects with KL grade 3 in the present study. This suggests that, by enrolling subjects with a lower average KL grade, the likelihood of observing significant pain improvements may have been reduced in the current study. As noted previously, a robust placebo response was found, possibly enriched by the allowance of rescue pain medication and the frequent study visits with subcutaneous drug administration. Another potential limitation of our study was highlighted by the discrepancy between ultrasound and MRI grading of synovitis. Of the limited number of cases (n=6) where an ultrasound and MRI were both submitted to screen for synovitis prior to enrollment, all 6 subjects were positive by ultrasound and only 3 of the 6 were positive by non-

contrast-enhanced MRI, supporting the idea that the lack of contrast-enhancement may have limited our ability to detect changes in synovitis with lutikizumab therapy.

In conclusion, although the 100 mg dose of lutikizumab met the co-primary endpoint of reduction in WOMAC pain at week 16 compared with placebo, neither the 25 mg nor the 200 mg dose did so, and the difference from placebo was not sustained after week 16. Measures of synovitis, cartilage thickness, and other structural endpoints were similar between lutikizumab and placebo at all time points and with all 3 doses evaluated. The safety profile of lutikizumab was consistent with the AEs reported for other IL-1 inhibitors, including neutropenia and injection site reactions. The results of this study suggest that IL-1 inhibition is not an effective disease-modifying therapy in patients with knee OA. Whether subgroups of knee OA patients might have symptomatic benefit from IL-1 inhibition remains an open question.

ACKNOWLEDGMENTS

AbbVie funded this study (NCT02087904). Medical writing support was provided by Richard M. Edwards, PhD, and Michael J. Theisen, PhD, of Complete Publication Solutions, LLC (North Wales, PA, United States), a CHC Group company. AbbVie funded the medical writing support. Lutikizumab is an investigational product. AbbVie and the authors thank the patients who participated in the clinical trial and all study investigators for their contributions. HB was supported by the Oak Foundation. PGC is supported in part by the UK National Institute for Health Research (NIHR) Leeds Biomedical Research Centre; the views expressed in this publication are those of the authors and not necessarily those of the National Health Service, the NIHR, or the Department of Health. The results of this article were presented in part at the OARSI World Congress on Osteoarthritis (April 27–30, 2017; Las Vegas, NV) and the American College of Rheumatology/Association of Rheumatology Health Professionals Annual Meeting (November 3–8, 2017; San Diego, CA).

AbbVie is committed to responsible data sharing regarding the clinical trials we sponsor. This includes access to anonymized, individual and trial-level data (analysis data sets), as well as other information (e.g., protocols and Clinical Study Reports), as long as the trials are not part of an ongoing or planned regulatory submission. This includes requests for clinical trial data for unlicensed products and indications.

This clinical trial data can be requested by any qualified researchers who engage in rigorous, independent scientific research, and will be provided following review and approval of a research proposal and Statistical Analysis Plan (SAP) and execution of a Data Sharing Agreement (DSA).

Data requests can be submitted at any time and the data will be accessible for 12 months, with possible extensions considered. For more information on the process, or to submit a request, visit the following link: <https://www.abbvie.com/our-science/clinical-trials/clinical-trials-data-and-information-sharing/data-and-information-sharing-with-qualified-researchers.html>.

AUTHORSHIP

All authors contributed to the development of the content, all authors and AbbVie reviewed and approved the final manuscript, and the authors maintained control over the final content.

For Peer Review

References

1. Centers for Disease Control and Prevention. Osteoarthritis. Available at: <https://www.cdc.gov/arthritis/basics/osteoarthritis.htm>. Accessed October 12, 2017.
2. Centers for Disease Control and Prevention. Prevalence and most common causes of disability among adults--United States, 2005. *MMWR Morb Mortal Wkly Rep* 2009;58(16):421-6.
3. D'Agostino MA, Conaghan P, Le Bars M, Baron G, Grassi W, Martin-Mola E, et al. EULAR report on the use of ultrasonography in painful knee osteoarthritis. Part 1: prevalence of inflammation in osteoarthritis. *Ann Rheum Dis* 2005;64(12):1703-9.
4. Roemer FW, Kassim Javid M, Guermazi A, Thomas M, Kiran A, Keen R, et al. Anatomical distribution of synovitis in knee osteoarthritis and its association with joint effusion assessed on non-enhanced and contrast-enhanced MRI. *Osteoarthritis Cartilage* 2010;18(10):1269-74.
5. Atukorala I, Kwok CK, Guermazi A, Roemer FW, Boudreau RM, Hannon MJ, et al. Synovitis in knee osteoarthritis: a precursor of disease? *Ann Rheum Dis* 2016;75(2):390-5.
6. Felson DT, Niu J, Neogi T, Goggins J, Nevitt MC, Roemer F, et al. Synovitis and the risk of knee osteoarthritis: the MOST study. *Osteoarthritis Cartilage* 2016;24(3):458-64.
7. Baker K, Grainger A, Niu J, Clancy M, Guermazi A, Crema M, et al. Relation of synovitis to knee pain using contrast-enhanced MRIs. *Ann Rheum Dis* 2010;69(10):1779-83.
8. Guermazi A, Roemer FW, Hayashi D, Crema MD, Niu J, Zhang Y, et al. Assessment of synovitis with contrast-enhanced MRI using a whole-joint semiquantitative scoring

- system in people with, or at high risk of, knee osteoarthritis: the MOST study. *Ann Rheum Dis* 2011;70(5):805-11.
9. Conaghan PG, D'Agostino MA, Le Bars M, Baron G, Schmidely N, Wakefield R, et al. Clinical and ultrasonographic predictors of joint replacement for knee osteoarthritis: results from a large, 3-year, prospective EULAR study. *Ann Rheum Dis* 2010;69(4):644-7.
 10. Schett G, Dayer JM, Manger B. Interleukin-1 function and role in rheumatic disease. *Nat Rev Rheumatol* 2016;12(1):14-24.
 11. Garlanda C, Dinarello CA, Mantovani A. The interleukin-1 family: back to the future. *Immunity* 2013;39(6):1003-18.
 12. Miller RE, Miller RJ, Malfait AM. Osteoarthritis joint pain: the cytokine connection. *Cytokine* 2014;70(2):185-93.
 13. Ren K, Torres R. Role of interleukin-1 β during pain and inflammation. *Brain Res Rev* 2009;60(1):57-64.
 14. Farahat MN, Yanni G, Poston R, Panayi GS. Cytokine expression in synovial membranes of patients with rheumatoid arthritis and osteoarthritis. *Ann Rheum Dis* 1993;52(12):870-5.
 15. Towle CA, Hung HH, Bonassar LJ, Treadwell BV, Mangham DC. Detection of interleukin-1 in the cartilage of patients with osteoarthritis: a possible autocrine/paracrine role in pathogenesis. *Osteoarthritis Cartilage* 1997;5(5):293-300.
 16. Sohn DH, Sokolove J, Sharpe O, Erhart JC, Chandra PE, Lahey LJ, et al. Plasma proteins present in osteoarthritic synovial fluid can stimulate cytokine production via Toll-like receptor 4. *Arthritis Res Ther* 2012;14(1):R7.

17. Bondeson J, Wainwright SD, Lauder S, Amos N, Hughes CE. The role of synovial macrophages and macrophage-produced cytokines in driving aggrecanases, matrix metalloproteinases, and other destructive and inflammatory responses in osteoarthritis. *Arthritis Res Ther* 2006;8(6):R187.
18. Brennan FM, McInnes IB. Evidence that cytokines play a role in rheumatoid arthritis. *J Clin Invest* 2008;118(11):3537-45.
19. Goldring MB, Birkhead J, Sandell LJ, Kimura T, Krane SM. Interleukin 1 suppresses expression of cartilage-specific types II and IX collagens and increases types I and III collagens in human chondrocytes. *J Clin Invest* 1988;82(6):2026-37.
20. Jules J, Zhang P, Ashley JW, Wei S, Shi Z, Liu J, et al. Molecular basis of requirement of receptor activator of nuclear factor kappaB signaling for interleukin 1-mediated osteoclastogenesis. *J Biol Chem* 2012;287(19):15728-38.
21. Nasi S, Ea H-K, So A, Busso N. Revisiting the role of interleukin-1 pathway in osteoarthritis: interleukin-1 α and -1 β , and NLRP3 inflammasome are not involved in the pathological features of the murine meniscectomy model of osteoarthritis. *Front Pharmacol* 2017;8:282.
22. Chevalier X, Goupille P, Beaulieu AD, Burch FX, Bensen WG, Conrozier T, et al. Intraarticular injection of anakinra in osteoarthritis of the knee: a multicenter, randomized, double-blind, placebo-controlled study. *Arthritis Rheum* 2009;61(3):344-52.
23. Cohen SB, Proudman S, Kivitz AJ, Burch FX, Donohue JP, Burstein D, et al. A randomized, double-blind study of AMG 108 (a fully human monoclonal antibody to IL-1R1) in patients with osteoarthritis of the knee. *Arthritis Res Ther* 2011;13(4):R125.
24. Lacy SE, Wu C, Ambrosi DJ, Hsieh CM, Bose S, Miller R, et al. Generation and characterization of ABT-981, a dual variable domain immunoglobulin (DVD-IgTM)

- molecule that specifically and potently neutralizes both IL-1 α and IL-1 β . MABs 2015;7(3):605-19.
25. Kamath RV, Simler G, Zhou C, Hart M, Joshi S, Ghayur T, et al. Blockade of both IL-1A and IL-1B by a combination of monoclonal antibodies prevents the development and reverses established pain in a preclinical model of osteoarthritis [abstract]. *Osteoarthritis Cartilage* 2012;20:S62.
 26. Kosloski MP, Goss S, Wang SX, Liu J, Loebbert R, Medema JK, et al. Pharmacokinetics and tolerability of a dual variable domain immunoglobulin ABT-981 against IL-1 α and IL-1 β in healthy subjects and patients with osteoarthritis of the knee. *J Clin Pharmacol* 2016;56(12):1582-90.
 27. Wang SX, Abramson SB, Attur M, Karsdal MA, Preston RA, Lozada CJ, et al. Safety, tolerability, and pharmacodynamics of an anti-interleukin-1 α/β dual variable domain immunoglobulin in patients with osteoarthritis of the knee: a randomized phase 1 study. *Osteoarthritis Cartilage* 2017;25(12):1952–61.
 28. Kellgren JH, Lawrence JS. Radiological assessment of osteo-arthrosis. *Ann Rheum Dis* 1957;16(4):494-502.
 29. Hawker GA, Mian S, Kendzerska T, French M. Measures of adult pain: Visual Analog Scale for Pain (VAS Pain), Numeric Rating Scale for Pain (NRS Pain), McGill Pain Questionnaire (MPQ), Short-Form McGill Pain Questionnaire (SF-MPQ), Chronic Pain Grade Scale (CPGS), Short Form-36 Bodily Pain Scale (SF-36 BPS), and Measure of Intermittent and Constant Osteoarthritis Pain (ICOAP). *Arthritis Care Res (Hoboken)* 2011;63 Suppl 11:S240-52.

30. Nikiphorou E, Radner H, Chatzidionysiou K, Desthieux C, Zabalan C, van Eijk-Hustings Y, et al. Patient global assessment in measuring disease activity in rheumatoid arthritis: a review of the literature. *Arthritis Res Ther* 2016;18(1):251.
31. Bellamy N. WOMAC Osteoarthritis Index User Guide X; 2012.
32. Pelletier JP, Raynauld JP, Abram F, Haraoui B, Choquette D, Martel-Pelletier J. A new non-invasive method to assess synovitis severity in relation to symptoms and cartilage volume loss in knee osteoarthritis patients using MRI. *Osteoarthritis Cartilage* 2008;16 Suppl 3:S8-13.
33. Li W, Abram F, Pelletier JP, Raynauld JP, Dorais M, d'Anjou MA, et al. Fully automated system for the quantification of human osteoarthritic knee joint effusion volume using magnetic resonance imaging. *Arthritis Res Ther* 2010;12(5):R173.
34. Peterfy CG, Guermazi A, Zaim S, Tirman PF, Miaux Y, White D, et al. Whole-organ magnetic resonance imaging score (WORMS) of the knee in osteoarthritis. *Osteoarthritis Cartilage* 2004;12(3):177-90.
35. Hawker GA, Davis AM, French MR, Cibere J, Jordan JM, March L, et al. Development and preliminary psychometric testing of a new OA pain measure--an OARSI/OMERACT initiative. *Osteoarthritis Cartilage* 2008;16(4):409-14.
36. Pham T, van der Heijde D, Altman RD, Anderson JJ, Bellamy N, Hochberg M, et al. OMERACT-OARSI initiative: Osteoarthritis Research Society International set of responder criteria for osteoarthritis clinical trials revisited. *Osteoarthritis Cartilage* 2004;12(5):389-99.
37. Gait AD, Hodgson R, Parkes MJ, Hutchinson CE, O'Neill TW, Maricar N, et al. Synovial volume vs synovial measurements from dynamic contrast enhanced MRI as measures of response in osteoarthritis. *Osteoarthritis Cartilage* 2016;24(8):1392-8.

38. Abraham AM, Goff I, Pearce MS, Francis RM, Birrell F. Reliability and validity of ultrasound imaging of features of knee osteoarthritis in the community. *BMC Musculoskelet Disord* 2011;12:70.
39. Zayat AS, Freeston JE, Conaghan PG, Hensor EM, Emery P, Wakefield RJ. Does joint position affect US findings in inflammatory arthritis? *Rheumatology (Oxford)* 2012;51(5):921-5.
40. National Cancer Institute. Common Terminology Criteria for Adverse Events v4.0 (CTCAE); 2009 May 28.
41. Levesque MC, Chen S, Peterfy C, Wang L, Medema JK. Baseline characteristics of knee osteoarthritis subjects enrolled in the ILLUSTRATE-K study of the anti-interleukin-1 α / β dual variable domain immunoglobulin ABT-981 and factors associated with exclusion from the trial. *Osteoarthritis Cartilage* 2017;25(suppl 1):S350-S1.
42. Kloppenburg M, Peterfy C, Haugen IK, Kroon F, Chen S, Wang L, et al. A phase 2a, placebo-controlled, randomized study of lutikizumab, an anti-interleukin-1 α and -1 β dual variable domain immunoglobulin, in patients with erosive hand osteoarthritis. *Ann Rheum Dis* 2018:Epub ahead of print.
43. Kapoor M, Martel-Pelletier J, Lajeunesse D, Pelletier JP, Fahmi H. Role of proinflammatory cytokines in the pathophysiology of osteoarthritis. *Nat Rev Rheumatol* 2011;7(1):33-42.
44. Mathiessen A, Conaghan PG. Synovitis in osteoarthritis: current understanding with therapeutic implications. *Arthritis Res Ther* 2017;19(1):18.
45. Smith TO, Zou K, Abdullah N, Chen X, Kingsbury SR, Doherty M, et al. Does flare trial design affect the effect size of non-steroidal anti-inflammatory drugs in symptomatic

- osteoarthritis? A systematic review and meta-analysis. *Ann Rheum Dis* 2016;75(11):1971-8.
46. da Costa BR, Reichenbach S, Keller N, Nartey L, Wandel S, Juni P, et al. Effectiveness of non-steroidal anti-inflammatory drugs for the treatment of pain in knee and hip osteoarthritis: a network meta-analysis. *Lancet* 2017;390(10090):e21-e33.
47. Brown MT, Murphy FT, Radin DM, Davignon I, Smith MD, West CR. Tanezumab reduces osteoarthritic knee pain: results of a randomized, double-blind, placebo-controlled phase III trial. *J Pain* 2012;13(8):790-8.
48. Ilnyckyj A, Shanahan F, Anton PA, Cheang M, Bernstein CN. Quantification of the placebo response in ulcerative colitis. *Gastroenterology* 1997;112(6):1854-8.
49. Ridker PM, MacFadyen JG, Thuren T, Everett BM, Libby P, Glynn RJ, et al. Effect of interleukin-1 β inhibition with canakinumab on incident lung cancer in patients with atherosclerosis: exploratory results from a randomised, double-blind, placebo-controlled trial. *Lancet* 2017;390(10105):1833-42.
50. Sundy JS, Schumacher HR, Kivitz A, Weinstein SP, Wu R, King-Davis S, et al. Rilonacept for gout flare prevention in patients receiving uric acid-lowering therapy: results of RESURGE, a phase III, international safety study. *J Rheumatol* 2014;41(8):1703-11.
51. Schnitzer TJ, Ekman EF, Spierings EL, Greenberg HS, Smith MD, Brown MT, et al. Efficacy and safety of tanezumab monotherapy or combined with non-steroidal anti-inflammatory drugs in the treatment of knee or hip osteoarthritis pain. *Ann Rheum Dis* 2015;74(6):1202-11.

Figure Legends

Figure 1. Patient disposition. Q2W, every 2 weeks; SC, subcutaneous. *Major protocol violations: (1) actual treatment is not according to randomization assignment, (2) premature unblinding, (3) use of a narcotic or non-steroidal anti-inflammatory drug for >50% of the days before week 16, (4) baseline index knee pain intensity <4 (11-point numeric rating scale), and (5) absence of synovitis in the index knee by ultrasound or magnetic resonance imaging during screening. †Study completion at 52 weeks.

Figure 2. LS mean change from baseline over time for WOMAC pain (A) and WOMAC function (B). LS, least squares; Q2W, every 2 weeks; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index. * $P \leq 0.05$ vs placebo; † $P \leq 0.01$ vs placebo.

Figure 3. Time course of mean total neutrophils (A) and mean hsCRP levels (B) from baseline (week 0) to week 52. hsCRP, high-sensitivity C-reactive protein; Q2W, every 2 weeks. * $P < 0.05$ or a higher level of significance compared with placebo.

Table 1. Demographics, Baseline Disease Characteristics, and Prior Medications

Characteristic	Placebo (n=85)	Lutikizumab SC Q2W, mg		
		25 (n=89)	100 (n=85)	200 (n=88)
Age, y	59.5±8.9	61.6±7.5	60.2±8.2	59.1±10.3
Women, n (%)	52 (61.2)	63 (70.8)	53 (62.4)	57 (64.8)
Race, n (%)				
White	78 (91.8)	78 (87.6)	70 (82.4)	79 (89.8)
Black	4 (4.7)	8 (9.0)	10 (11.8)	7 (8.0)
Other	3 (3.5)	3 (3.4)	5 (5.9)	2 (2.3)
BMI, kg/m ²	28.6±3.6	28.7±3.8	29.0±3.5	28.7±3.5
OA duration, y	7.9±8.0	7.6±9.0	7.9±8.7	8.7±8.6
KL grade,* n (%)				
2	53 (62.4)	57 (64.0)	52 (61.2)	56 (63.6)
3	32 (37.6)	32 (36.0)	33 (38.8)	32 (36.4)
WOMAC total (scale 0–240; higher scores indicate worse condition)	128.7±40.3	132.7±43.5	134.7±36.0 [†]	132.3±39.2 [†]
WOMAC pain (scale 0–50)	26.2±8.0	27.0±9.3	28.4±8.4 [†]	27.1±8.6
WOMAC function (scale 0–170)	90.8±31.2	93.7±31.8	94.7±26.4 [†]	93.1±29.1 [†]
WOMAC stiffness (scale 0–20)	11.7±3.8	12.0±4.1	11.7±3.8 [†]	11.9±4.2
Synovial membrane thickness, mm	0.88±0.28 [‡]	0.84±0.28 [§]	0.89±0.31 [‡]	0.84±0.26 [‡]
Synovial fluid volume, mL	16.4±15.0	15.5±11.6 [¶]	17.3±19.8 [#]	15.2±15.0 ^{**}
WORMS semiquantitative synovitis/effusion (scale 0–3)	1.2±0.8	1.3±0.7	1.1±0.8 ^{††}	1.2±0.7 [†]
WORMS total (scale 0–400; higher scores indicate worse condition)	108.8±73.3 ^{‡‡}	109.1±70.4 ^{‡‡}	108.1±76.9 ^{§§}	103.4±69.0
WORMS total BML (scale 0–45)	3.6±2.8 [†]	3.0±2.6 [†]	2.9±2.7 ^{‡‡}	2.5±2.1 [#]
WORMS total osteophytes (scale	13.6±13.5 [†]	13.6±11.9 [#]	14.2±13.8 [¶]	13.9±12.7 [†]

0–112)				
ANC, × 10 ⁹ /L (normal, 1.80–7.00 × 10 ⁹ /L)	3.9±1.2	3.7±1.3	3.8±1.6	3.6±1.2
hsCRP, mg/L	3.0±2.7	4.3±6.4	4.0±7.9	2.9±3.1
Prior knee OA therapy, n (%) ^a				
NSAID	38 (44.7)	31 (34.8)	32 (37.6)	40 (45.5)
Intra-articular corticosteroid	1 (1.2)	1 (1.2)	0	0
Narcotic ^{¶¶}	4 (4.7)	3 (3.4)	2 (2.4)	3 (3.4)
Concomitant knee and systemic pain medication at baseline	79 (92.9)	70 (78.7)	71 (83.5)	78 (88.6)

Data are mean ± SD except where noted.

ANC, absolute neutrophil count; BMI, body mass index; BML, bone marrow lesions; hsCRP, high-sensitivity C-reactive protein; KL, Kellgren-Lawrence; NSAID, non-steroidal anti-inflammatory drug; OA, osteoarthritis; Q2W, every 2 weeks; SC, subcutaneous; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index; WORMS, Whole-Organ Magnetic Resonance Imaging Score.

*KL grade 2: definite osteophytes and possible joint space narrowing on anteroposterior weight-bearing radiograph. KL grade 3: multiple osteophytes, definite joint space narrowing, sclerosis, possible bony deformity.

†1, ‡9, §10, ||7, ¶6, #2, **5, ††3, ‡‡4, and §§8 subjects with missing data.

||Prior or concomitant therapy with intra-articular hyaluronan was not excluded, and 1 subject reported prior hyaluronan therapy and 2 patients reported intra-articular hyaluronan therapy after the study started.

¶¶Subjects could have taken more than 1 kind of narcotic previously. Hydrocodone with acetaminophen (n=7), oxycodone (n=2), oxycodone with acetaminophen (n=2), codeine with acetaminophen (n=1), hydrocodone (n=1), and oxycodone with naloxone (n=1).

Table 2. Changes From Baseline in Efficacy Endpoints

Signs and Symptoms Endpoints (LOCF Data)								
Endpoint (Full Scale)	Week 16				Week 52			
	PBO (n=85)	Lutikizumab SC Q2W, mg			PBO (n=85)	Lutikizumab SC Q2W, mg		
		25 (n=89)	100 (n=85)	200 (n=88)		25 (n=89)	100 (n=85)	200 (n=88)
<i>Co-primary endpoint</i>								
WOMAC pain (0–50; higher scores indicate worse condition)	–8.9 (–11.0, –6.9)	–9.2 (–11.2, –7.2)	–11.8 (–13.8, –9.8)	–10.1 (–12.1, –8.1)	–10.0 (–12.2, 7.7)	–11.0 (–13.3, –8.8)	–12.1 (–14.4, –9.8)	–12.2 (–14.5, –10.0)
Difference vs PBO		–0.3 (–3.13, 2.53)	–2.9 (–5.73, 0.01)	–1.2 (–4.00, 1.66)		–1.1 (–4.26, 2.08)	–2.2 (–5.39, 1.05)	–2.3 (–5.46, 0.88)
<i>P</i> value vs PBO		0.834	0.050*	0.415		0.500	0.186	0.157
<i>Secondary endpoint</i>								
WOMAC function (0–170; higher scores indicate worse condition)	–28.7 (–35.3, –22.2)	–29.8 (–36.3, –23.3)	–36.3 (–42.9, –29.7)	–32.1 (–38.6, –25.6)	–32.9 (–40.7, –25.1)	–36.1 (–43.8, –28.5)	–38.7 (–46.5, –30.9)	–39.7 (–47.4, –32.0)
Difference vs PBO		–1.1 (–10.22, 8.08)	–7.6 (–16.83, 1.69)	–3.4 (–12.58, 5.76)		–3.2 (–14.03, 7.59)	–5.8 (–16.77, 5.11)	–6.8 (–17.63, 4.04)
<i>P</i> value vs PBO		0.818	0.109	0.465		0.558	0.295	0.218
<i>Exploratory endpoint</i>								
OMERACT/OARSI response, % [†]	60.0 (49.6, 70.4)	67.0 (57.2, 76.9)	72.6 (63.1, 82.2)	65.5 (55.5, 75.5)	70.6 (60.9, 80.3)	69.3 (59.7, 79.0)	71.4 (61.8, 81.1)	72.7 (63.4, 82.0)
Difference vs PBO		7.0 (–7.3, 21.4)	12.6 (–1.5, 26.7)	5.5 (–8.9, 19.9)		–1.3 (–14.9, 12.4)	0.8 (–12.8, 14.5)	2.1 (–11.3, 15.6)
<i>P</i> value vs PBO		0.311	0.080	0.435		0.824	0.964	0.763
Structural Endpoints (Observed Data)								
Endpoint	Week 26				Week 52			
	PBO	Lutikizumab SC Q2W, mg			PBO	Lutikizumab SC Q2W, mg		
		25	100	200		25	100	200
<i>Co-primary endpoint</i>								
Synovial membrane thickness, mm	–0.05 (–0.11, 0.01)	0.01 (–0.05, 0.07)	–0.08 (–0.13, –0.02)	0.01 (–0.05, 0.07)	–0.07 (–0.14, –0.01)	–0.04 (–0.10, 0.02)	–0.05 (–0.11, 0.01)	–0.02 (–0.08, 0.05)
n	59	65	59	63	50	59	55	53
Difference vs PBO		0.06 (–0.02, 0.14)	–0.03 (–0.11, 0.06)	0.06 (–0.02, 0.14)		0.03 (–0.06, 0.12)	0.02 (–0.07, 0.11)	0.06 (–0.03, 0.14)
<i>P</i> value vs PBO		0.145	0.520	0.159		0.474	0.637	0.221
Synovial fluid volume,	0.03	0.26	–1.04	–1.49	–1.90	1.17	–0.67	–1.83

mL	(-2.50, 2.56)	(-2.11, 2.62)	(-3.42, 1.35)	(-3.87, 0.90)	(-5.03, 1.23)	(-1.78, 4.12)	(3.59, 2.25)	(-4.82, 1.16)
n	60	69	67	68	53	60	60	58
Difference vs PBO		0.22	-1.07	-1.52		3.08	1.23	0.07
<i>P</i> value vs PBO		(-3.19, 3.64)	(-4.52, 2.38)	(-4.95, 1.92)		(-1.16, 7.32)	(-3.02, 5.49)	(-4.21, 4.35)
WORMS	0.07	-0.01	-0.08	-0.07	-0.05	-0.05	-0.06	-0.01
semiquantitative synovitis/effusion volume	(-0.06, 0.19)	(-0.13, 0.11)	(-0.21, 0.04)	(-0.20, 0.05)	(-0.18, 0.09)	(-0.18, -0.08)	(-0.19, 0.08)	(-0.14, 0.12)
n	70	76	70	75	59	66	62	66
Difference vs PBO		-0.08	-0.15	-0.14		0.00	-0.01	0.04
<i>P</i> value vs PBO		(-0.25, 0.10)	(-0.32, 0.03)	(-0.31, 0.03)		(-0.19, 0.18)	(-0.20, 0.18)	(-0.15, 0.22)
<i>Secondary endpoint</i>		0.384	0.095	0.106		0.967	0.923	0.692
Cartilage volume, mm ³								
n	58	65	53	66	49	57	50	56
Total	-326.0	-325.5	-322.4	-359.0	-557.0	-598.7	-554.3	-583.1
	(-400.8, -251.1)	(-397.1, -253.8)	(-400.2, -244.6)	(-429.7, -288.4)	(-659.9, -454.1)	(-694.7, -502.8)	(-654.9, -453.6)	(-678.9, -487.2)
Difference vs PBO		0.5	3.6	-33.1		-41.7	2.7	-26.1
<i>P</i> value vs PBO		(-101.6, 102.6)	(-104.0, 111.1)	(-134.8, 68.7)		(-180.5, 97.0)	(-140.9, 146.3)	(-165.5, 113.3)
Medial	-166.9	-159.5	-163.1	-153.7	-286.8	-317.3	-266.7	-310.9
	(-209.7, -124.1)	(-200.6, -118.5)	(-207.7, -118.6)	(-194.1, -113.3)	(-353.3, -220.3)	(-379.4, -255.3)	(-331.8, -201.6)	(-372.8, -249.0)
Difference vs PBO		7.4	3.8	13.2		-30.5	20.1	-24.0
<i>P</i> value vs PBO		(-51.1, 65.8)	(-57.8, 65.3)	(-45.0, 71.4)		(-120.2, 59.1)	(-72.8, 112.9)	(-114.0, 65.9)
Lateral	-159.6	-166.3	-158.0	-204.1	-270.7	-280.9	-287.9	-271.1
	(-214.2, -104.9)	(-218.5, -114.0)	(-214.8, -101.3)	(-255.7, -152.4)	(-336.3, -205.1)	(-342.1, -219.7)	(-352.0, -223.7)	(-332.3, -210.0)
Difference vs PBO		-6.7	1.6	-44.5		-10.2	-17.2	-0.4
<i>P</i> value vs PBO		(-81.2, 67.9)	(-76.9, 80.0)	(-118.7, 29.8)		(-98.7, 78.3)	(-108.7, 74.3)	(-89.4, 88.5)
<i>Exploratory endpoint</i>		0.860	0.969	0.239		0.820	0.711	0.992
JSN, mm								
n	-	-	-	-	58	70	64	68
Medial	-	-	-	-	0.00	-0.18	-0.11	-0.06

					(-0.110, 0.119)	(-0.287, -0.079)	(-0.218, -0.003)	(-0.165, 0.047)
Difference vs PBO						-0.19	-0.12	-0.06
						(-0.341, -0.034)	(-0.272, 0.041)	(-0.218, 0.090)
<i>P</i> value vs PBO	-	-	-	-		0.017*	0.148	0.415
Lateral	-	-	-	-	-0.16	0.14	-0.07	0.04
					(-0.310, -0.005)	(-0.003, 0.275)	(-0.216, 0.073)	(-0.106, 0.177)
Difference vs PBO						0.29	0.09	0.19
						(0.089, 0.498)	(-0.123, 0.295)	(-0.012, 0.399)
<i>P</i> value vs PBO	-	-	-	-		0.005*	0.418	0.065

Data are least squares means (95% CI).

JSN, joint space narrowing; KL, Kellgren-Lawrence; LOCF, last observation carried forward; OMERACT/OARSI, Outcome Measures in Rheumatology Clinical Trials/Osteoarthritis Research Society International; PBO, placebo; Q2W, every 2 weeks; SC, subcutaneous; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index; WORMS, Whole-Organ Magnetic Resonance Imaging Score.

* $P \leq 0.05$ vs PBO. Continuous variables compared with analysis of covariance with treatment, age, and KL grade as main factors and baseline as covariate. Categorical variables compared with Cochran-Mantel-Haenszel test with age group and KL grade as stratification factors.

†OMERACT/OARSI response defined as either (1) $\geq 50\%$ relative and $\geq 20\%$ absolute improvement from baseline in WOMAC pain or function or (2) $\geq 20\%$ relative and $\geq 10\%$ from baseline in at least 2 of 3 measures (WOMAC pain, WOMAC function, and patient global assessment).

Table 3. Safety Results

AE, n (%)	Placebo (n=85)	Lutikizumab SC Q2W, mg		
		25 (n=89)	100 (n=85)	200 (n=88)
Any AE	78 (91.8)	78 (87.6)	77 (90.6)	81 (92.0)
Discontinuation of study drug due to AE	10 (11.8)	5 (5.6)	5 (5.9)	12 (13.6)
Deaths	0	0	0	0
Serious AE	8 (9.4)	11 (12.4)	8 (9.4)	4 (4.5)
Serious AE occurring in ≥ 2 subjects/arm				
Infection*	2 (2.4)	2 (2.2)	1 (1.2)	0
Fracture and injury*	4 (4.7)	3 (3.4)	3 (3.5)	1 (1.1)
Malignancy	0	3 (3.4)	1 (1.2)	2 (2.3)
Basal cell carcinoma	0	3 (3.4)	0	0
Invasive ductal breast carcinoma	0	0	0	1 (1.1)
Lung cancer metastatic	0	0	0	1 (1.1)
PSA increased [†]	0	0	1 (1.2)	0
Any infection	39 (45.9)	34 (38.2)	42 (49.4)	49 (55.7)
Serious infection	2 (2.4)	2 (2.2)	1 (1.2)	0
Appendicitis	0	1 (1.1)	0	0
Diverticulitis	1 (1.2)	0	0	0
Peritonitis	0	1 (1.1)	0	0
Pneumonia	0	0	1 (1.2)	0
Urinary tract infection	1 (1.2)	0	0	0
Injection site reaction	13 (15.3)	16 (18.0)	21 (24.7)	29 (33.0) [¶]
Laboratory Abnormality, n (%)				
Neutropenia (grade 2, 3, or 4)	3 (3.5)	18 (20.5) ^{,¶}	26 (30.6) [¶]	33 (37.5) [¶]
Neutropenia (grade 2; 1000–<1500/mm ³)	3 (3.5)	17 (19.3) ^{,¶}	25 (29.4) [¶]	28 (31.8) [¶]
Neutropenia (grade 3; 500–<1000/mm ³)	0	1 (1.1)	1 (1.2)	5 (5.7)
Neutropenia (grade 4; <500/mm ³)	0	0	0	0
Neutropenia leading to discontinuation of study drug	0	1 (1.1)	0	6 (6.8) [¶]
Lymphopenia (grade 3 or 4 [‡])	1 (1.2)	1 (1.2)	1 (1.2)	2 (2.3)
Hypertriglyceridemia (grade 3 or 4 [§])	0	3 (3.4)	1 (1.2)	2 (2.3)

AE, adverse event; Q2W, every 2 weeks; PSA, prostatic specific antigen; SC, subcutaneous.

*A patient who reported 2 or more different preferred terms which are in the same system organ class was counted only once in the total.

[†]The PSA was described by the site investigator as “slightly elevated.” A prostate biopsy was performed and described as “normal.” For coding purposes, the elevated PSA is listed under

malignancies in this table, but the total number of malignancies is reported as 5, rather than 6, elsewhere in the article.

‡Grade 3, 200–<500 /mm³; grade 4, <200/mm³.

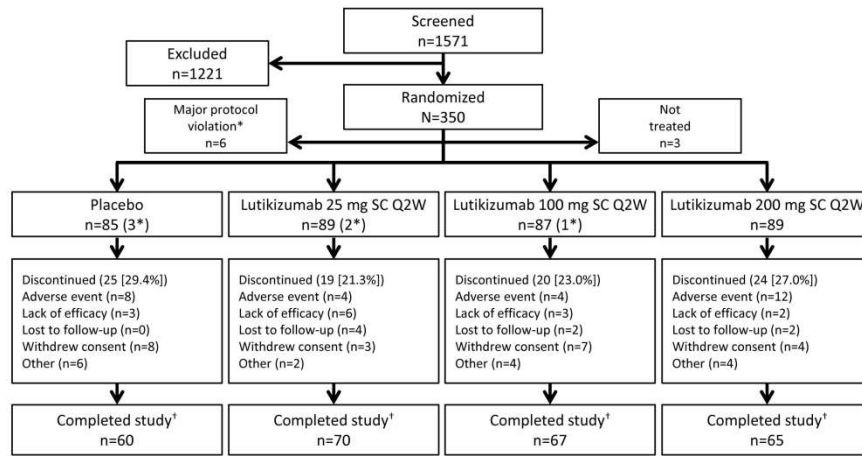
§Grade 3, >500–1000 mg/dL; grade 4, >1000 mg/dL.

||Data missing for 1 patient.

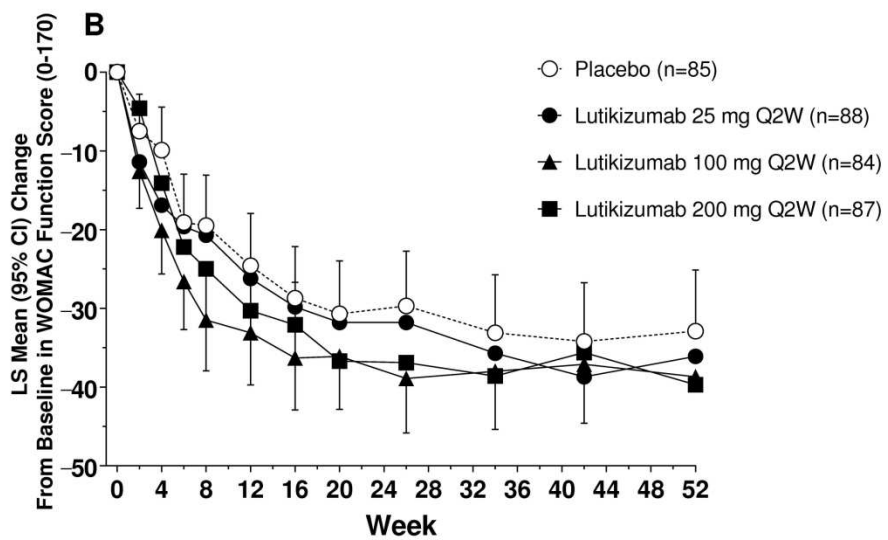
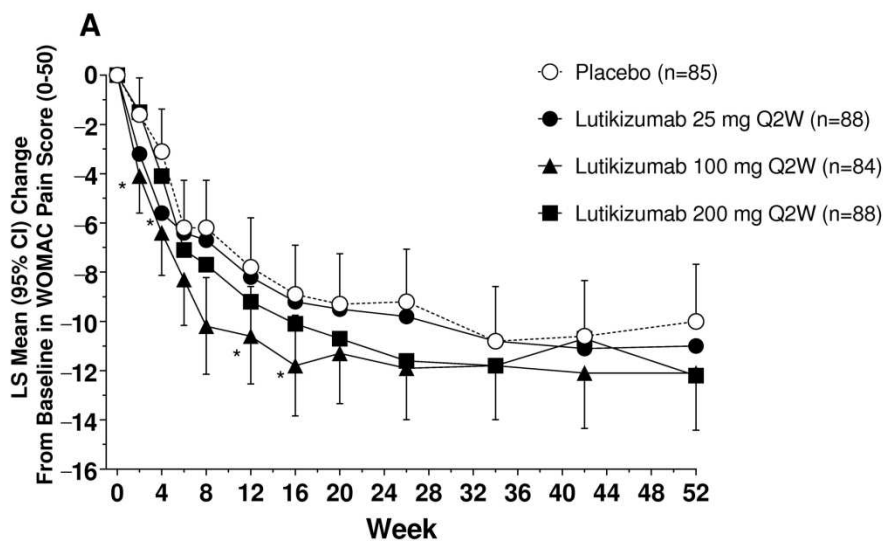
¶ $P < 0.05$ for comparison with placebo, Fisher exact test.

Grades for laboratory abnormalities were defined by Common Terminology Criteria for Adverse Events, version 4.03.(40)

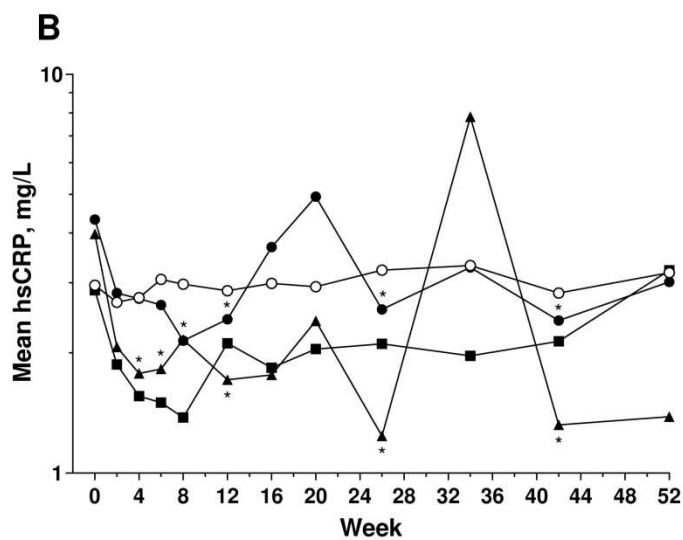
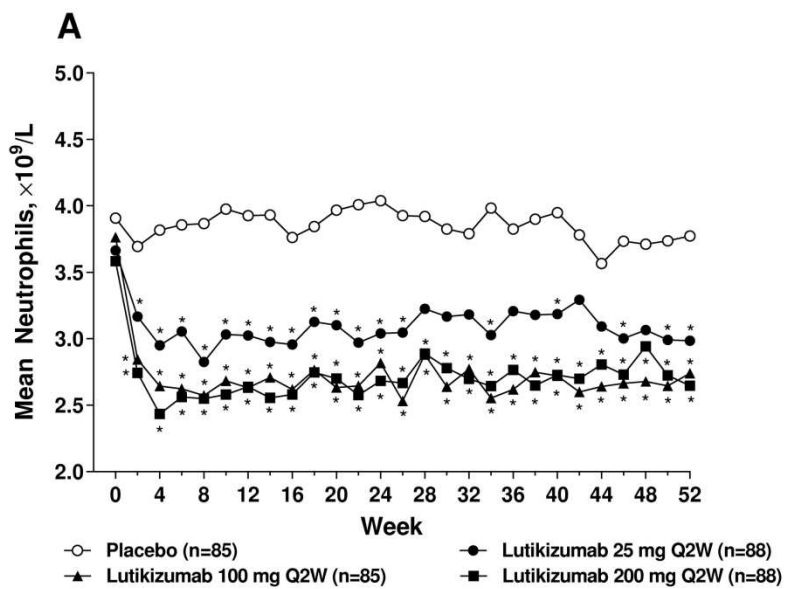
For Peer Review



253x142mm (300 x 300 DPI)



200x256mm (300 x 300 DPI)



198x282mm (300 x 300 DPI)

Supplemental Methods

Subjects

Key exclusion criteria included significant trauma or surgery to the index knee within the last year or arthroscopy of the index knee within 6 months of the initial screening visit; severe knee malalignment, either $>4.0^\circ$ in varus or $>8.0^\circ$ in valgus angulation in the index knee; previous exposure to anti-IL-1 treatment; intra-articular corticosteroids within 3 months or via another route within 1 month before screening; and use of any investigational or immunosuppressive therapy within 1 month or 5 half-lives, whichever was longer, before the first dose of study drug.

Subject disposition was calculated for the intent-to-treat population, comprising all randomized patients.

Efficacy

Secondary endpoints included 3 types of pain intensity measures using 11-point numeric rating scales (NRS-11's; patient-rated pain from 0 ["no pain"] to 10 ["worst possible pain"]) in which subjects were asked about the average pain intensity during the past week (7-day recall period), worst pain during activity over the past 24 hours (activity pain), and pain intensity before and after a 40-meter walk (performance pain) at weeks 16, 26, and 52; Western Ontario and McMaster Universities Osteoarthritis (WOMAC) physical function scores (0–170 scale, NRS-11 subscales)(1) at weeks 16, 26, and 52; patient global assessment of arthritis at weeks 16, 26, and 52; Whole-Organ Magnetic Resonance Imaging Score (WORMS) bone marrow lesion(s)(2) at

weeks 26 and 52; and magnetic resonance imaging (MRI) cartilage volume and thickness at weeks 26 and 52.

Ultrasound

Patients meeting criteria for B-mode synovial hypertrophy or power Doppler were selected for further screening. For selection and quality assurance, sonographers were asked to submit test scans for B-mode and power Doppler images. B-mode frequency started at 12 MHz and could be reduced for penetration. Gain was set at approximately 50%. Using the index fingertip, Doppler settings were optimized for respective equipment to show vascularity in at least one third of the finger pulp. The pulse repetition frequency was set in a range between 400 to 600 Hz, with Doppler box to cover recess and superficial tissue, and gain just above noise. Doppler frequency was adjusted for the highest sensitivity. The knee was placed in 30° flexion, and the B-mode synovial hypertrophy was measured at the suprapatellar recess and parapatellar recesses.(3, 4) The following cutoffs were used to select patients for further screening: distension of midline suprapatellar recess ≥ 3.6 mm, medial parapatellar recess ≥ 3.0 mm, lateral parapatellar recess ≥ 3.3 mm. Since the suprapatellar recess is insensitive to Doppler inspection for synovitis, the medial and lateral parapatellar recesses were chosen. Scans were acquired using a gel standoff assuring minimal pressure on the recess. Semiquantitative scoring was used: grade 0, no signal; grade 1, ≤ 3 single vessels; grade 2, >3 single or confluent blood vessels in less than half the synovial area; grade 3, vessel signals in more than half the synovial area. In addition to meeting the B-mode criteria for inclusion, a power Doppler score of ≥ 2 at the parapatellar recesses was one of the independent cutoffs for further screening.

Posteroanterior weight-bearing radiographs of the target knee were acquired at screening and at week 52, using the fixed-flexion technique with 10° caudal beam angulation using a positioning frame and calibration phantom. Knee joint space width (JSW) measurements were made using a computer-assisted algorithm (KneeAnalyzer, Optasia Medical, Manchester, United Kingdom) that identified the contours of the femoral condyles and tibia plateau. A single radiologist (O.V.) reviewed computer-generated contours and adjusted them, if necessary. Software then computed the minimum JSW in the weight-bearing region of the medial and lateral compartments. The method was highly reproducible, with intraclass correlation coefficient (ICC) of 0.98 and root mean square coefficient of variation of 0.18 mm.

Magnetic Resonance Imaging

Pulse sequences included sagittal 2-dimensional (2D) proton-density weighted (PD-w) fast spin echo (FSE) with spectral fat saturation (FS), axial 2D in/out-of-phase T1-weighted gradient echo (GRE), sagittal 3-dimensional T1-weighted GRE with FS or selective water excitation, coronal 2D PD-w FSE with FS, and axial 2D PD-w FSE with FS. The same scanners were used at baseline and follow-up.

All WORMS assessments were performed with multiple time points viewed simultaneously by a single central radiologist who was blinded to time point order. WORMS inter-reader ICCs have previously been shown to range from 0.61 to 0.99, depending on the feature.(2)

The extent of synovitis was assessed by measuring its thickness in mm in 4 regions of interest: the medial and lateral recess and the medial and lateral border of the suprapatellar bursa.(5) The intra-reader and inter-reader correlation coefficients were $r=0.91$ and $r=0.82$, respectively ($P<0.0001$).

The synovial fluid volume was assessed using a fully automated system as described (6) with a correlation coefficient with manual quantification of $r=0.98$ ($P<0.0001$) and direct aspiration $r=0.88$ ($P=0.0008$).

Semi-automated cartilage volume/thickness was measured as previously described.(7-9). The change in knee cartilage volume/thickness was obtained by subtracting the initial (baseline) volume/thickness from follow-up volume/thickness and calculated compared with initial (baseline) volume/thickness in percentage values. Between-reader agreement of measurement had ICCs ranging from 0.958 to 0.997 ($P<0.0001$) for global knee cartilage. Test-retest reliability of within-reader measurements had Pearson correlation coefficients ranging from 0.978 to 0.999 ($P<0.0001$).(8) Automated cartilage volume/thickness was assessed as described and validated (10, 11) with a test-retest measurement error of $0.3\% \pm 1.6\%$ for the global knee (10).

Dynamic Contrast Enhanced Magnetic Resonance Imaging

The following parameters were defined for quantitative analysis of the dynamic changes in synovial fluid using dynamic contrast enhanced MRI (DCE-MRI):

- Initial rate of enhancement (IRE): slope of the enhancement versus time curve from initial onset of enhancement to the time of plateau or until the end of acquisition if a plateau pattern is not observed. IRE is computed for each voxel in the image stack and the mean IRE is calculated for all voxels within the measurement volume of interest
- Maximum enhancement (ME): maximum increase in enhancement from precontrast images to the time point of maximum enhancement. ME is computed for each voxel in the image stack and the mean ME is calculated for all voxels within the measurement volume of interest
- Enhancing volume (E_VOL): volume of tissue (in mL) demonstrating plateau or washout characteristics. E_VOL is equal to the product of the number of enhancing voxels within the volume of interest, plateau, or washout) and the volume of an individual voxel, determined by the area of a voxel in-plane and the slice separation
 - E_VOL with persistent uptake: $E_VOL \times \text{number of pixels with persistent uptake/classified pixels}$
 - E_VOL with plateau uptake: $E_VOL \times \text{number of pixels with plateau uptake/classified pixels}$
 - E_VOL with washout uptake: $E_VOL \times \text{number of pixels with washout uptake/classified pixels}$
- IAUGC60: initial area under the gadolinium curve at time 60 seconds
- DEMRIQ ME Score (DEMRIQ_ME): $\text{mean ME} \times E_VOL$
- DEMRIQ IRE score (DEMRIQ_IRE): $\text{mean IRE} \times E_VOL$
- Ktrans: rate contrast for the diffusion of contrast between locally defined blood and tissue regions of interest

- VE: proportion (0–1) of extravascular extracellular space present in the tissue region of interest

The analysis of the DCE MRI scans used 2 independent readers and a third reader for adjudication of discrepancies. For each single measurement, if there was only 1 raw read, it was used as the measurement value; if there were 2 reads, they were averaged; if there were 2 raw reads and 1 adjudicator read, the adjudicator read was averaged with the closest raw read.

References

1. Bellamy N. WOMAC Osteoarthritis Index User Guide X; 2012.
2. Peterfy CG, Guermazi A, Zaim S, Tirman PF, Miaux Y, White D, et al. Whole-organ magnetic resonance imaging score (WORMS) of the knee in osteoarthritis. *Osteoarthritis Cartilage* 2004;12(3):177-90.
3. Mandl P, Brossard M, Aegerter P, Backhaus M, Bruyn GA, Chary-Valckenaere I, et al. Ultrasound evaluation of fluid in knee recesses at varying degrees of flexion. *Arthritis Care Res (Hoboken)* 2012;64(5):773-9.
4. Zayat AS, Freeston JE, Conaghan PG, Hensor EM, Emery P, Wakefield RJ. Does joint position affect US findings in inflammatory arthritis? *Rheumatology (Oxford)* 2012;51(5):921-5.
5. Pelletier JP, Raynauld JP, Abram F, Haraoui B, Choquette D, Martel-Pelletier J. A new non-invasive method to assess synovitis severity in relation to symptoms and cartilage volume loss in knee osteoarthritis patients using MRI. *Osteoarthritis Cartilage* 2008;16 Suppl 3:S8-13.

6. Li W, Abram F, Pelletier JP, Raynauld JP, Dorais M, d'Anjou MA, et al. Fully automated system for the quantification of human osteoarthritic knee joint effusion volume using magnetic resonance imaging. *Arthritis Res Ther* 2010;12(5):R173.
7. Kauffmann C, Gravel P, Godbout B, Gravel A, Beaudoin G, Raynauld JP, et al. Computer-aided method for quantification of cartilage thickness and volume changes using MRI: validation study using a synthetic model. *IEEE Trans Biomed Eng* 2003;50(8):978-88.
8. Raynauld JP, Kauffmann C, Beaudoin G, Berthiaume MJ, de Guise JA, Bloch DA, et al. Reliability of a quantification imaging system using magnetic resonance images to measure cartilage thickness and volume in human normal and osteoarthritic knees. *Osteoarthritis Cartilage* 2003;11(5):351-60.
9. Raynauld JP, Martel-Pelletier J, Berthiaume MJ, Labonté F, Beaudoin G, de Guise JA, et al. Quantitative magnetic resonance imaging evaluation of knee osteoarthritis progression over two years and correlation with clinical symptoms and radiologic changes. *Arthritis Rheum* 2004;50:476-87.
10. Dodin P, Pelletier JP, Martel-Pelletier J, Abram F. Automatic human knee cartilage segmentation from 3D magnetic resonance images. *IEEE Trans Biomed Eng* 2010;57:2699-711.
11. Martel-Pelletier J, Roubille C, Abram F, Hochberg MC, Dorais M, Delorme P, et al. First-line analysis of the effects of treatment on progression of structural changes in knee osteoarthritis over 24 months: data from the osteoarthritis initiative progression cohort. *Ann Rheum Dis* 2015;74(3):547-56.

Supplemental Table 1. Qualification for Study Entry Based on Evidence of Knee Synovitis

Evidence Source, n	Placebo	Lutikizumab SC Q2W, mg				Total
		25	100	200	Untreated	
Ultrasound or MRI	84	89	84	87	3	347
Ultrasound	53	56	55	63	2	229
Without MRI	48	56	54	60	2	220
With positive MRI	3	0	1	2	0	6
With negative MRI	2	0	0	1	0	3
MRI	31	33	29	24	1	118
None	0	0	1*	0	0	1*
Missing	1	0	1*	0	0	2*

MRI, magnetic resonance imaging; Q2W, every 2 weeks; SC, subcutaneous.

*Inadvertently enrolled despite the lack of evidence of synovitis; 1 of these 3 subjects had synovitis at baseline based on the Whole-Organ Magnetic Resonance Imaging Score assessment.

Supplemental Table 2. Changes From Baseline in Efficacy Endpoints in Subjects With Positive WORMS Synovitis/Effusion at Baseline

Signs and Symptoms Endpoints (LOCF Data)								
Endpoint (Full Scale)	Week 16				Week 52			
	PBO (n=72)	Lutikizumab SC Q2W, mg			PBO (n=72)	Lutikizumab SC Q2W, mg		
		25 (n=78)	100 (n=65)	200 (n=79)		25 (n=78)	100 (n=65)	200 (n=79)
<i>Co-primary endpoint</i>								
WOMAC pain (0–50; higher scores indicate worse condition)	–8.1 (–10.44, –5.79)	–10.3 (–12.58, –8.08)	–11.7 (–14.17, –9.26)	–11.9 (–14.11, –9.66)	–9.1 (–11.60, –6.57)	–12.1 (–14.48, –9.62)	–11.9 (–14.58, –9.27)	–12.5 (–14.88, –10.07)
Difference vs PBO		–2.2 (–5.43, 1.00)	–3.6 (–6.98, –0.22)	–3.8 (–6.97, –0.56)		–3.0 (–6.44, 0.51)	–2.8 (–6.50, 0.81)	–3.4 (–6.86, 0.07)
<i>P</i> value vs PBO		0.176	0.037*	0.021*		0.094	0.127	0.055
<i>Secondary endpoint</i>								
WOMAC function (0–170; higher scores indicate worse condition)	–29.1 (–36.46, –21.82)	–31.4 (–38.53, –24.34)	–36.3 (–43.99, –28.53)	–32.6 (–39.61, –25.52)	–31.0 (–39.62, –22.36)	–39.2 (–47.59, –30.87)	–39.0 (–48.13, –29.91)	–40.4 (–48.65, –32.05)
Difference vs PBO		–2.3 (–12.44, 7.84)	–7.1 (–17.76, 3.52)	–3.4 (–13.53, 6.68)		–8.2 (–20.18, 3.70)	–8.0 (–20.57, 4.50)	–9.4 (–21.27, –2.55)
<i>P</i> value vs PBO		0.656	0.189	0.506		0.176	0.208	0.123
<i>Exploratory endpoint</i>								
OMERACT/OARSI response, % [†]	59.7 (48.4, 71.1)	68.8 (58.5, 79.2)	71.9 (60.9, 82.9)	65.4 (54.8, 75.9)	68.1 (57.3, 78.8)	74.0 (64.2, 83.8)	73.4 (62.6, 84.3)	73.4 (63.7, 83.2)
Difference vs PBO		9.1 (–6.2, 24.5)	12.2 (–3.6, 28.0)	5.7 (–9.8, 21.1)		6.0 (–8.6, 20.5)	5.4 (–9.9, 20.6)	5.4 (–9.2, 19.9)
<i>P</i> value vs PBO		0.253	0.123	0.457		0.448	0.577	0.484

Structural Endpoints (Observed Data)

Endpoint	Week 26				Week 52			
	PBO	Lutikizumab SC Q2W, mg			PBO	Lutikizumab SC Q2W, mg		
		25	100	200		25	100	200
<i>Co-primary endpoint</i>								
Synovial membrane thickness, mm	–0.06 (–0.12, 0.01)	0.03 (–0.03, 0.09)	–0.07 (–0.13, –0.003)	–0.00 (–0.06, 0.06)	–0.08 (–0.15, –0.01)	–0.03 (–0.09, 0.03)	–0.05 (–0.12, 0.02)	–0.02 (–0.09, 0.04)
n	49	56	49	59	44	52	46	50
Difference vs PBO		0.08 (–0.01, 0.17)	–0.01 (–0.10, 0.08)	0.05 (–0.03, 0.14)		0.05 (–0.04, 0.14)	0.03 (–0.07, 0.12)	0.05 (–0.04, 0.15)
<i>P</i> value vs PBO		0.064	0.819	0.219		0.291	0.554	0.247

Synovial fluid volume, mL	-0.01 (-2.99, 2.96)	0.07 (-2.58, 2.73)	-0.75 (-3.60, 2.10)	-2.15 (-4.82, 0.52)	-2.38 (-5.94, 1.18)	0.88 (-2.38, 4.13)	-0.45 (-3.92, 3.02)	-2.33 (-5.64, 0.98)
n	49	62	53	61	46	55	48	53
Difference vs PBO		0.09 (-3.87, 4.04)	-0.74 (-4.84, 3.37)	-2.13 (-6.11, 1.84)		3.26 (-1.52, 8.04)	1.93 (-3.04, 6.90)	0.05 (-4.78, 4.88)
<i>P</i> value vs PBO		0.966	0.724	0.291		0.181	0.444	0.984
WORMS semiquantitative synovitis/effusion volume	0.09 (-0.05, 0.23)	-0.02 (-0.16, 0.11)	-0.08 (-0.23, 0.06)	-0.12 (-0.25, 0.02)	-0.06 (-0.20, 0.09)	-0.07 (-0.21, 0.07)	-0.08 (-0.23, 0.07)	-0.06 (-0.20, 0.07)
n	58	67	57	68	51	58	51	61
Difference vs PBO		-0.11 (-0.31, 0.08)	-0.17 (-0.37, 0.03)	-0.20 (-0.40, -0.01)		-0.02 (-0.22, 0.19)	-0.02 (-0.23, 0.18)	-0.01 (-0.20, 0.19)
<i>P</i> value vs PBO		0.255	0.098	0.039		0.880	0.813	0.955

Data are least squares means (95% CI).

KL, Kellgren-Lawrence; LOCF, last observation carried forward; OMERACT/OARSI, Outcome Measures in Rheumatology Clinical Trials/Osteoarthritis Research Society International; PBO, placebo; Q2W, every 2 weeks; SC, subcutaneous; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index; WORMS, Whole-Organ Magnetic Resonance Imaging Score.

* $P \leq 0.05$ vs PBO. Continuous variables compared with analysis of covariance with treatment, age, and KL grade as main factors and baseline as covariate. Categorical variables compared with Cochran-Mantel-Haenszel test with age group and KL grade as stratification factors.

†OMERACT/OARSI response defined as either (1) $\geq 50\%$ relative and $\geq 20\%$ absolute improvement from baseline in WOMAC pain or function or (2) $\geq 20\%$ relative and $\geq 10\%$ from baseline in at least 2 of 3 measures (WOMAC pain, WOMAC function, and patient global assessment).

Supplemental Table 3. Change From Baseline in DCE-MRI Parameters in Synovial Membrane at Week 26

Parameter, LS Mean (%) Change	Placebo (n=7)	Lutikizumab SC Q2W, mg		
		25 (n=10)	100 (n=10)	200 (n=12)
IRE*	-0.002 (-25.0)	-0.002 (-5.5)	0.002 (46.3 [‡])	-0.003 (-7.9)
ME*	-0.040 (-3.2)	0.030 (2.4)	0.119 (9.5)	-0.096 (-3.3)
E_VOL, mL*	0.337 (67.7)	0.711 (273.9)	7.001 (28.6)	-6.950 (15.3)
Persistent uptake*	0.049 (7.1)	0.129 (113.0)	-0.136 (27.1)	-0.023 (59.2)
Plateau uptake*	-0.363 (87.3)	0.672 (379.2)	7.254 (37.6)	-5.091 (18.1)
Washout uptake*	0.872 (106.3)	-0.214 (244.5)	-0.240 (16.4)	-1.519 [§] (37.1)
IAUGC60, mmol•s [†]	-0.519 (-20.4)	0.191 (0.8)	1.241 (61.6)	-1.134 (7.2)
DEMRIQ ME score, mL*	-0.140 (67.2)	4.025 (318.6)	20.505 (35.1)	-18.734 (34.0)
DEMRIQ IRE score, mL*	-0.134 (35.9)	-0.091 (342.9)	0.188 (56.1)	-0.242 (49.8)
Ktrans, min ^{-1†}	-0.058 (-51.5)	-0.003 (25.5)	0.052 (329.9)	-0.045 (319.1)
VE [†]	-0.391 (23.6)	0.169 (20.9)	-0.515 (5.5)	-0.545 (38.3)

DCE-MRI, dynamic contrast-enhanced magnetic resonance imaging; DEMRIQ, DCE-MRI quantification; E_VOL, enhancing volume; IAUGC60, initial area under the gadolinium concentration-time curve over 60 s; IRE, initial rate of enhancement; KL, Kellgren-Lawrence; Ktrans, volume transfer coefficient; LS, least squares; ME, maximal enhancement; Q2W, every 2 weeks; SC, subcutaneous; VE, fractional extracellular extravascular space.

*n=5, 8, 10, and 10 and [†]n= 5, 6, 10, and 10 for placebo and lutikizumab 25 mg, 100 mg, and 200 mg, respectively.

[‡]P=0.016 and [§]P=0.043 vs placebo from analysis of covariance with treatment, age, and KL grade as main factors and baseline as covariate.

Supplemental Table 4. Concomitant Medication Use During the Treatment Period*

n (%)	Placebo (n=85)	Lutikizumab SC Q2W, mg		
		25 (n=89)	100 (n=85)	200 (n=88)
Any concomitant medication, n (%)	84 (98.8)	87 (97.8)	82 (96.5)	87 (98.9)
Ibuprofen	37 (43.5)	26 (29.2)	29 (34.1)	39 (44.3)
Acetaminophen	75 (88.2)	66 (74.2)	68 (80.0)	78 (88.6)

Q2W, every 2 weeks; SC, subcutaneous.

*First study drug dose through 14 days after the final study drug dose.

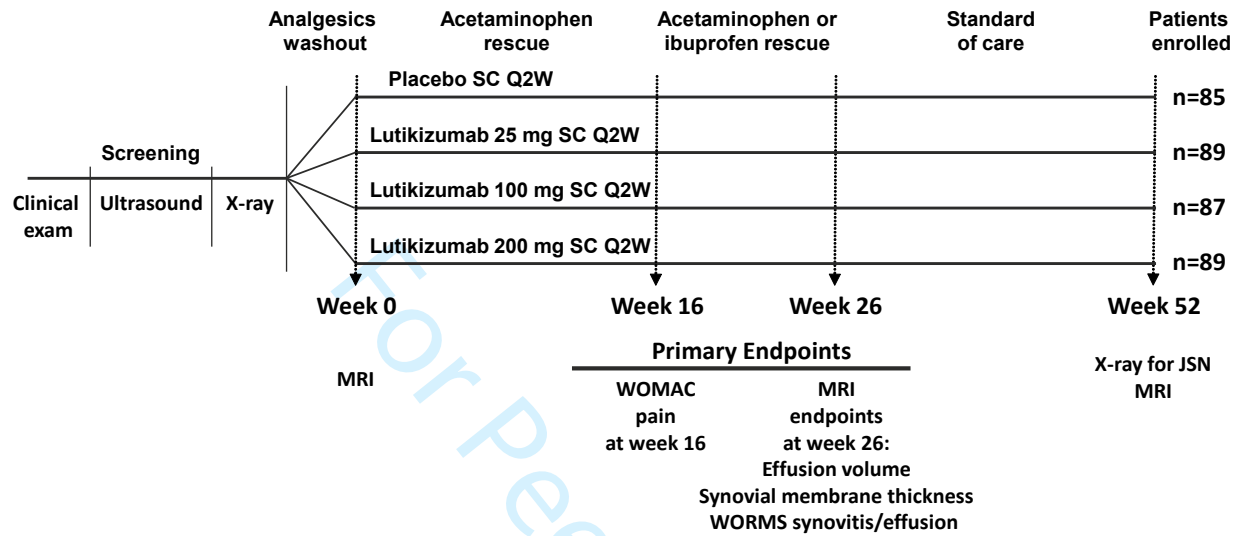
For Peer Review

Supplemental Table 5. Proportion of Subjects With Decreases From Baseline in IL-1 β 2 Weeks After Initiating Treatment With Placebo or Lutikizumab

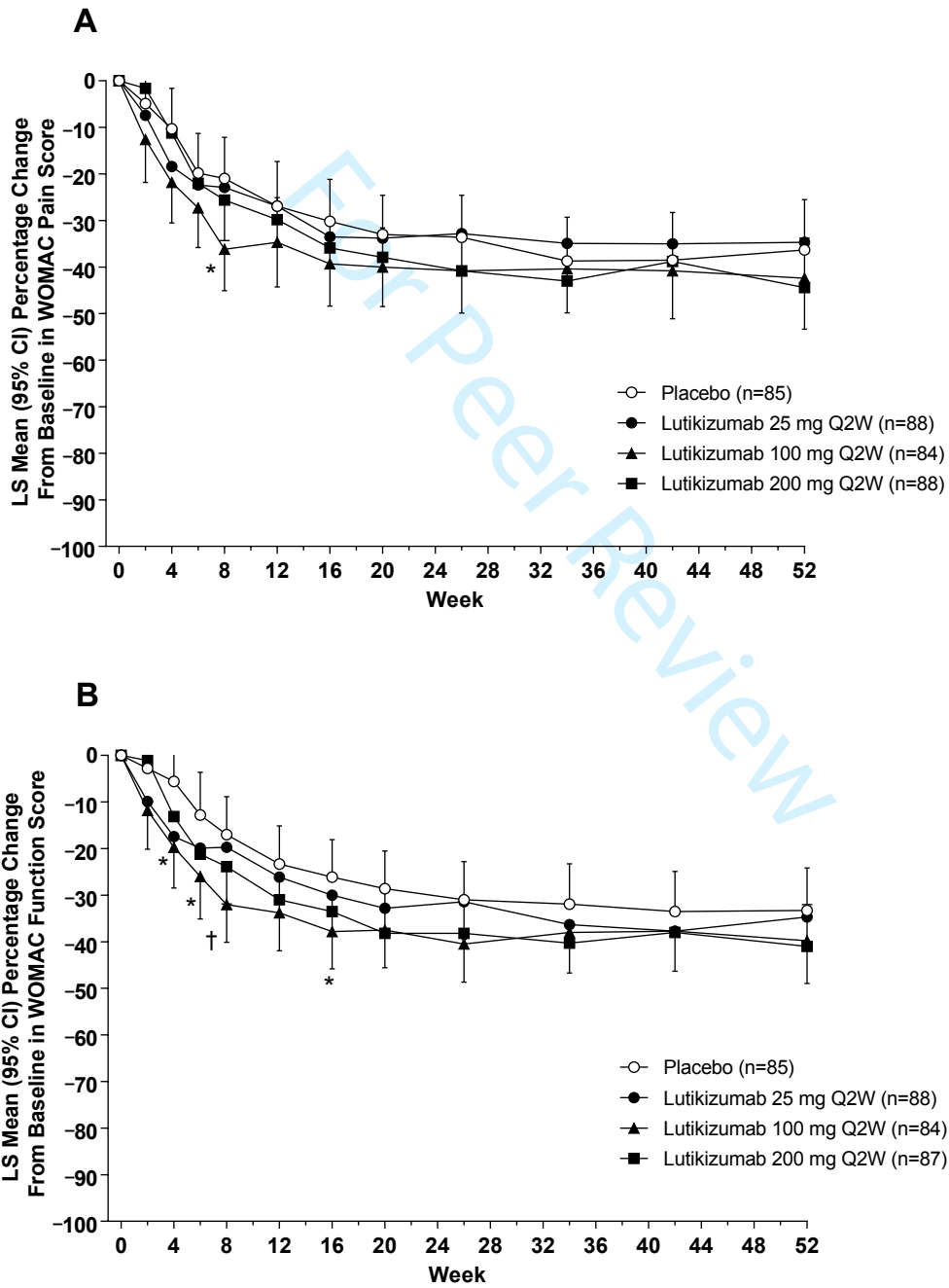
Treatment	Subjects, n/N (%)
Placebo	4/40 (10.0)
Lutikizumab 25 mg SC Q2W	17/37 (45.9)
Lutikizumab 100 mg SC Q2W	10/34 (29.4)
Lutikizumab 200 mg SC Q2W	11/40 (27.5)

IL-1 β =interleukin-1 β ; Q2W, every 2 weeks; SC, subcutaneous.

Supplemental Figure 1. Study design. JSN, joint space narrowing; MRI, magnetic resonance imaging; Q2W, every 2 weeks; SC, subcutaneous; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index; WORMS, Whole-Organ Magnetic Resonance Imaging Score.

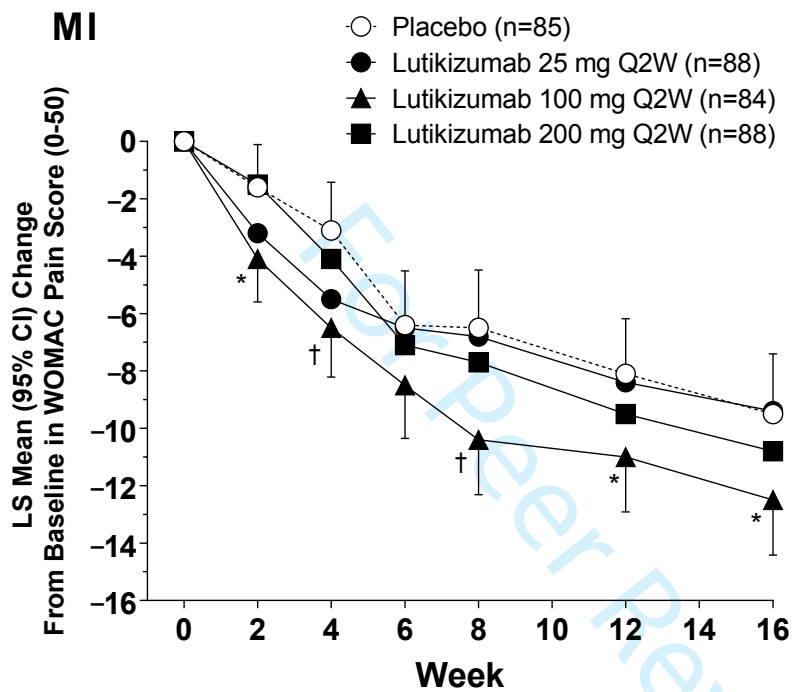


Supplemental Figure 2. LS mean percentage change from baseline over time for WOMAC pain (A) and WOMAC function (B). LS, least squares; Q2W, every 2 weeks; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index. * $P \leq 0.05$ vs placebo; † $P \leq 0.01$ vs placebo.

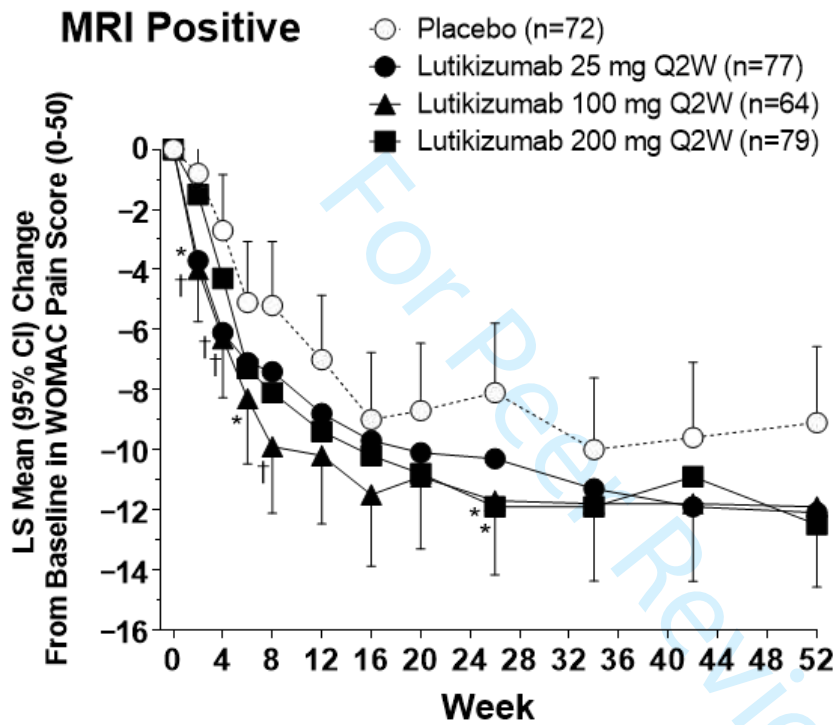


Supplemental Figure 3. LS mean change from baseline over time for WOMAC pain using MI.

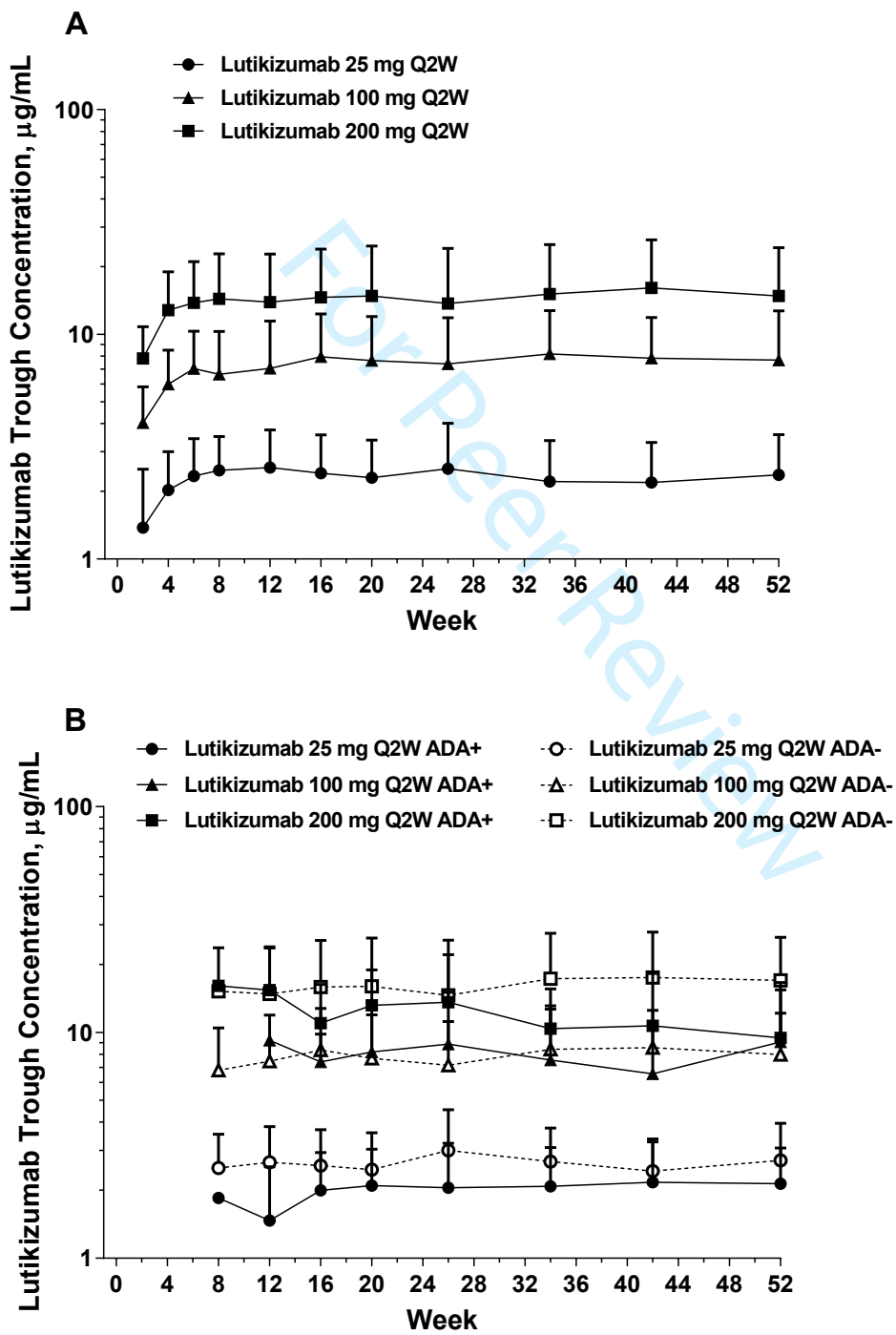
LS, least squares; MI, multiple imputation; Q2W, every 2 weeks; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index. * $P \leq 0.05$ vs placebo; † $P \leq 0.01$ vs placebo.



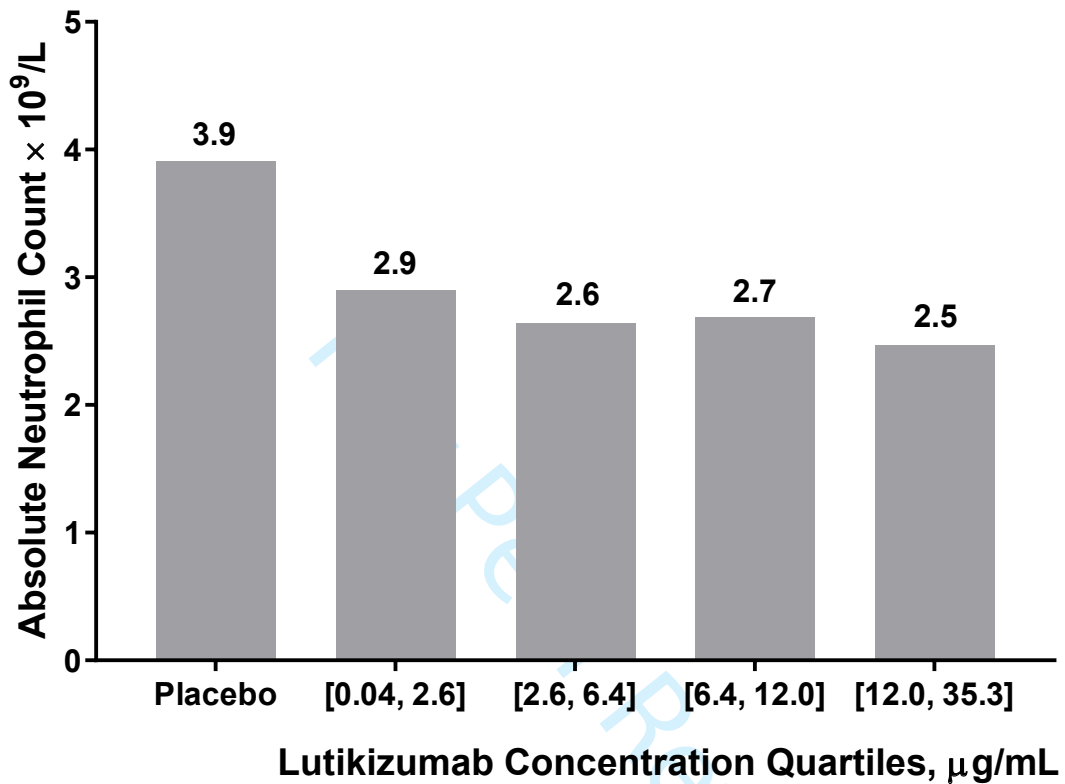
Supplemental Figure 4. LS mean change from baseline over time for WOMAC pain in subjects with positive WORMS synovitis/effusion at baseline. LS, least squares; Q2W, every 2 weeks; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index; WORMS, Whole-Organ Magnetic Resonance Imaging Score. * $P \leq 0.05$ vs placebo; † $P \leq 0.01$ vs placebo.



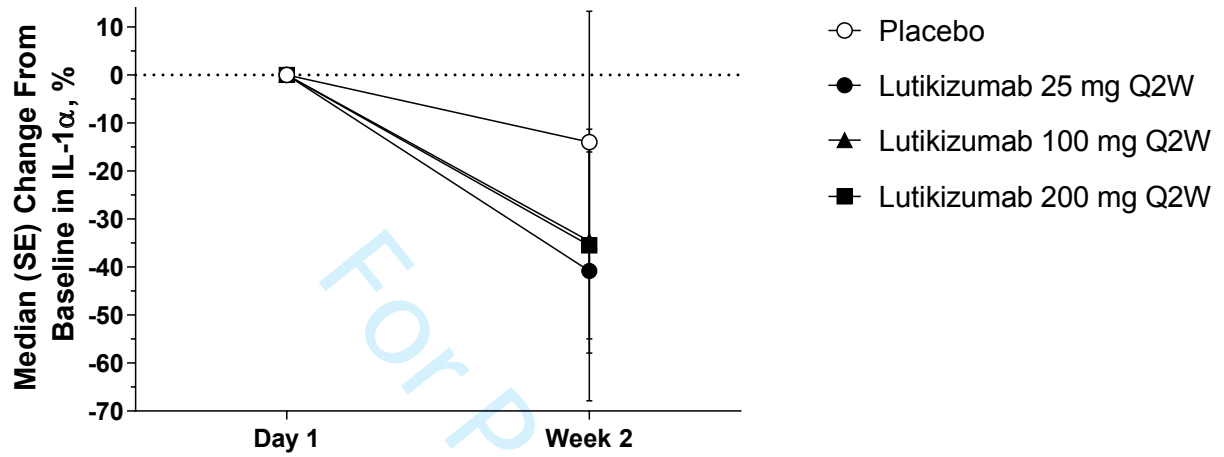
Supplemental Figure 5. Mean (SD) trough serum concentrations of lutikizumab over time for all subjects (**A**) and separated by presence of ADAs (**B**). ADA, anti-drug antibody; Q2W, every 2 weeks.



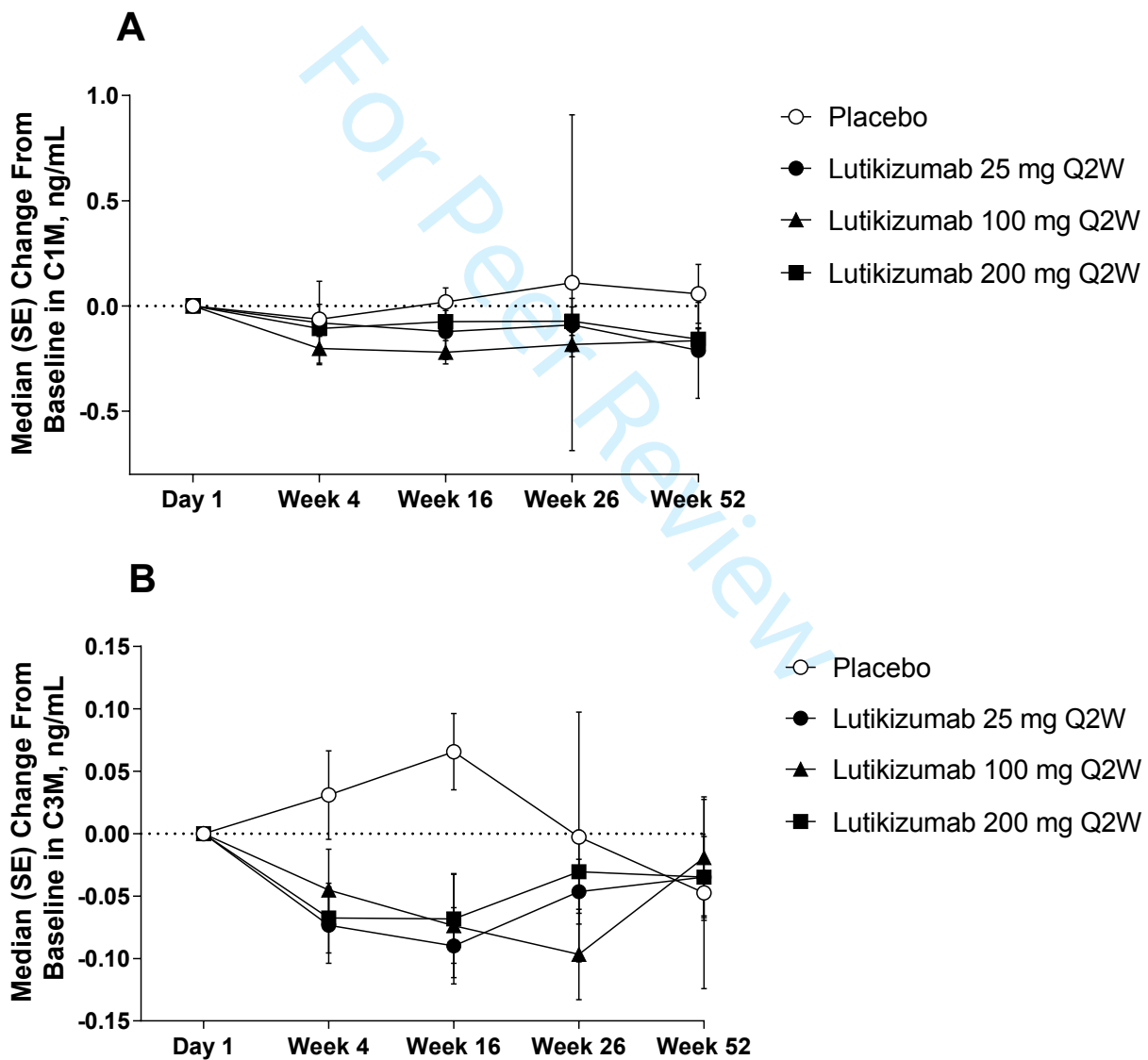
Supplemental Figure 6. Median absolute neutrophil counts for placebo and lutikizumab serum concentration quartiles at week 52 (observed cases).



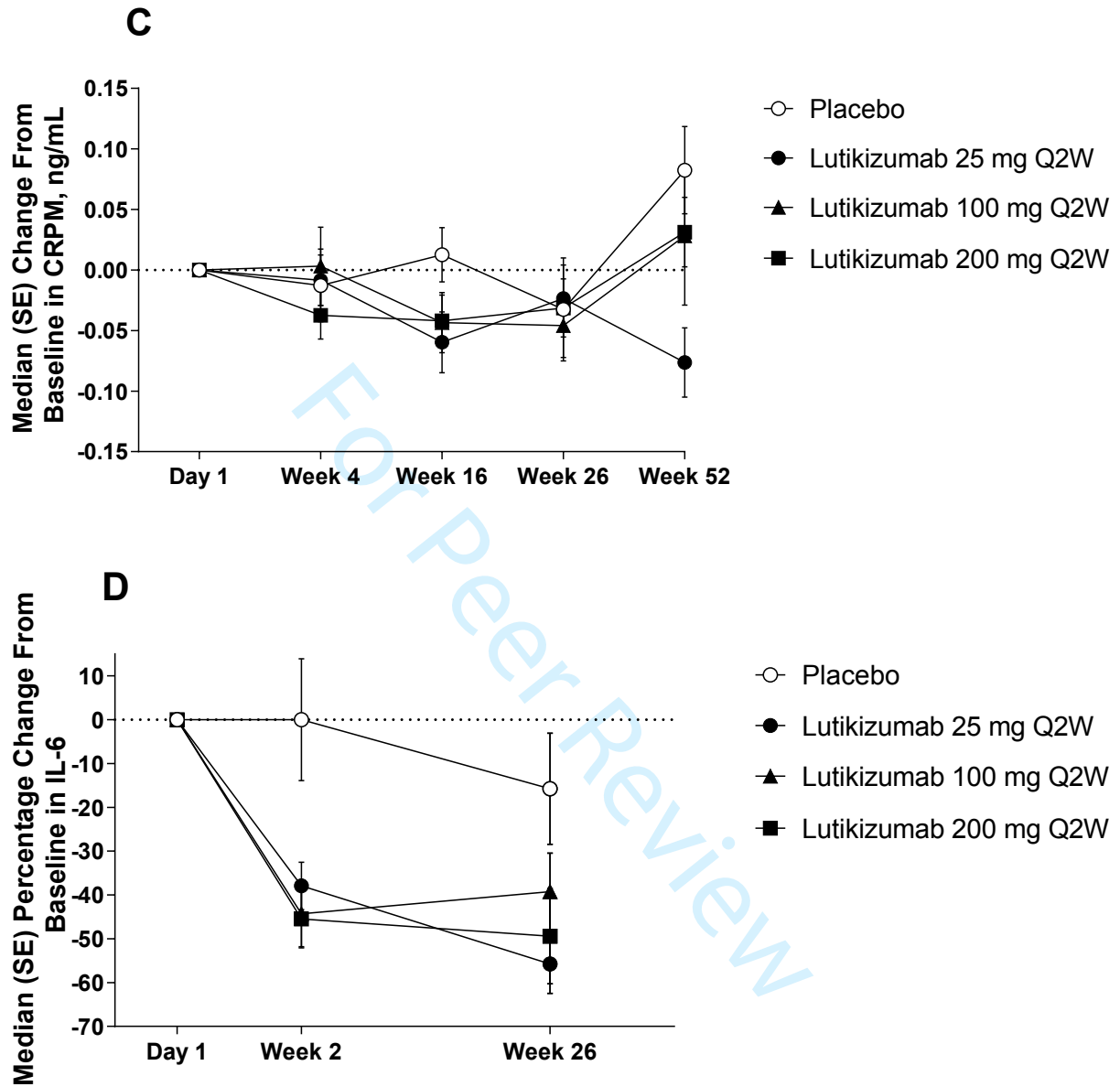
Supplemental Figure 7. Change From Day 1 in Serum IL-1 α Levels at 2 Weeks After Initiating Treatment With Placebo or Lutikizumab. IL-1 α =interleukin-1 α ; Q2W=every 2 weeks.



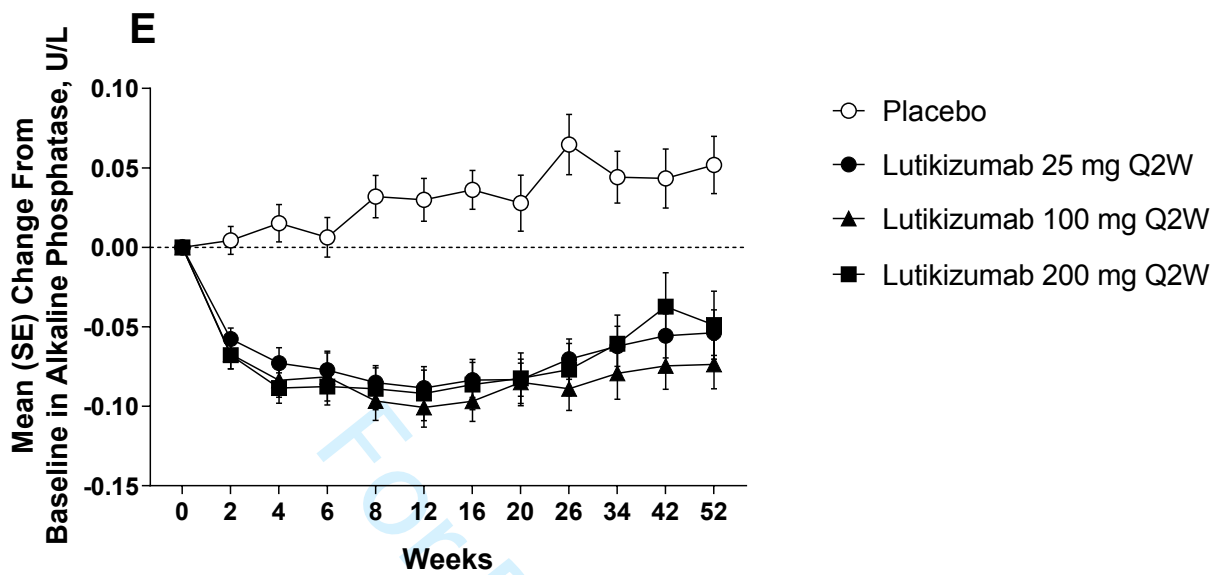
Supplemental Figure 8. Median change from baseline over time for the biomarkers C1M (A), C3M (B), and CRPM (C), median percentage change from baseline over time in IL-6 (D), and mean change from baseline over time in alkaline phosphatase (E). C1M, metalloproteinase-degraded collagen type I; C3M, metalloproteinase-degraded collagen type III; CRPM, matrix metalloproteinase-generated fragment of C-reactive protein; IL-6, interleukin-6; Q2W, every 2 weeks.



Supplemental Figure 8 continued.



Supplemental Figure 8 continued.



Supplemental Methods

Subjects

Key exclusion criteria included significant trauma or surgery to the index knee within the last year or arthroscopy of the index knee within 6 months of the initial screening visit; severe knee malalignment, either $>4.0^\circ$ in varus or $>8.0^\circ$ in valgus angulation in the index knee; previous exposure to anti-IL-1 treatment; intra-articular corticosteroids within 3 months or via another route within 1 month before screening; and use of any investigational or immunosuppressive therapy within 1 month or 5 half-lives, whichever was longer, before the first dose of study drug.

Subject disposition was calculated for the intent-to-treat population, comprising all randomized patients.

Efficacy

Secondary endpoints included 3 types of pain intensity measures using 11-point numeric rating scales (NRS-11's; patient-rated pain from 0 ["no pain"] to 10 ["worst possible pain"]) in which subjects were asked about the average pain intensity during the past week (7-day recall period), worst pain during activity over the past 24 hours (activity pain), and pain intensity before and after a 40-meter walk (performance pain) at weeks 16, 26, and 52; Western Ontario and McMaster Universities Osteoarthritis (WOMAC) physical function scores (0–170 scale, NRS-11 subscales)(1) at weeks 16, 26, and 52; patient global assessment of arthritis at weeks 16, 26, and 52; Whole-Organ Magnetic Resonance Imaging Score (WORMS) bone marrow lesion(s)(2) at

weeks 26 and 52; and magnetic resonance imaging (MRI) cartilage volume and thickness at weeks 26 and 52.

Ultrasound

Patients meeting criteria for B-mode synovial hypertrophy or power Doppler were selected for further screening. For selection and quality assurance, sonographers were asked to submit test scans for B-mode and power Doppler images. B-mode frequency started at 12 MHz and could be reduced for penetration. Gain was set at approximately 50%. Using the index fingertip, Doppler settings were optimized for respective equipment to show vascularity in at least one third of the finger pulp. The pulse repetition frequency was set in a range between 400 to 600 Hz, with Doppler box to cover recess and superficial tissue, and gain just above noise. Doppler frequency was adjusted for the highest sensitivity. The knee was placed in 30° flexion, and the B-mode synovial hypertrophy was measured at the suprapatellar recess and parapatellar recesses.(3, 4) The following cutoffs were used to select patients for further screening: distension of midline suprapatellar recess ≥ 3.6 mm, medial parapatellar recess ≥ 3.0 mm, lateral parapatellar recess ≥ 3.3 mm. Since the suprapatellar recess is insensitive to Doppler inspection for synovitis, the medial and lateral parapatellar recesses were chosen. Scans were acquired using a gel standoff assuring minimal pressure on the recess. Semiquantitative scoring was used: grade 0, no signal; grade 1, ≤ 3 single vessels; grade 2, >3 single or confluent blood vessels in less than half the synovial area; grade 3, vessel signals in more than half the synovial area. In addition to meeting the B-mode criteria for inclusion, a power Doppler score of ≥ 2 at the parapatellar recesses was one of the independent cutoffs for further screening.

Posteroanterior weight-bearing radiographs of the target knee were acquired at screening and at week 52, using the fixed-flexion technique with 10° caudal beam angulation using a positioning frame and calibration phantom. Knee joint space width (JSW) measurements were made using a computer-assisted algorithm (KneeAnalyzer, Optasia Medical, Manchester, United Kingdom) that identified the contours of the femoral condyles and tibia plateau. A single radiologist (O.V.) reviewed computer-generated contours and adjusted them, if necessary. Software then computed the minimum JSW in the weight-bearing region of the medial and lateral compartments. The method was highly reproducible, with intraclass correlation coefficient (ICC) of 0.98 and root mean square coefficient of variation of 0.18 mm.

Magnetic Resonance Imaging

Pulse sequences included sagittal 2-dimensional (2D) proton-density weighted (PD-w) fast spin echo (FSE) with spectral fat saturation (FS), axial 2D in/out-of-phase T1-weighted gradient echo (GRE), sagittal 3-dimensional T1-weighted GRE with FS or selective water excitation, coronal 2D PD-w FSE with FS, and axial 2D PD-w FSE with FS. The same scanners were used at baseline and follow-up.

All WORMS assessments were performed with multiple time points viewed simultaneously by a single central radiologist who was blinded to time point order. WORMS inter-reader ICCs have previously been shown to range from 0.61 to 0.99, depending on the feature.(2)

The extent of synovitis was assessed by measuring its thickness in mm in 4 regions of interest: the medial and lateral recess and the medial and lateral border of the suprapatellar bursa.(5) The intra-reader and inter-reader correlation coefficients were $r=0.91$ and $r=0.82$, respectively ($P<0.0001$).

The synovial fluid volume was assessed using a fully automated system as described (6) with a correlation coefficient with manual quantification of $r=0.98$ ($P<0.0001$) and direct aspiration $r=0.88$ ($P=0.0008$).

Semi-automated cartilage volume/thickness was measured as previously described.(7-9). The change in knee cartilage volume/thickness was obtained by subtracting the initial (baseline) volume/thickness from follow-up volume/thickness and calculated compared with initial (baseline) volume/thickness in percentage values. Between-reader agreement of measurement had ICCs ranging from 0.958 to 0.997 ($P<0.0001$) for global knee cartilage. Test-retest reliability of within-reader measurements had Pearson correlation coefficients ranging from 0.978 to 0.999 ($P<0.0001$).(8) Automated cartilage volume/thickness was assessed as described and validated (10, 11) with a test-retest measurement error of $0.3\% \pm 1.6\%$ for the global knee (10).

Dynamic Contrast Enhanced Magnetic Resonance Imaging

The following parameters were defined for quantitative analysis of the dynamic changes in synovial fluid using dynamic contrast enhanced MRI (DCE-MRI):

- Initial rate of enhancement (IRE): slope of the enhancement versus time curve from initial onset of enhancement to the time of plateau or until the end of acquisition if a plateau pattern is not observed. IRE is computed for each voxel in the image stack and the mean IRE is calculated for all voxels within the measurement volume of interest
- Maximum enhancement (ME): maximum increase in enhancement from precontrast images to the time point of maximum enhancement. ME is computed for each voxel in the image stack and the mean ME is calculated for all voxels within the measurement volume of interest
- Enhancing volume (E_VOL): volume of tissue (in mL) demonstrating plateau or washout characteristics. E_VOL is equal to the product of the number of enhancing voxels within the volume of interest, plateau, or washout) and the volume of an individual voxel, determined by the area of a voxel in-plane and the slice separation
 - E_VOL with persistent uptake: $E_VOL \times \text{number of pixels with persistent uptake/classified pixels}$
 - E_VOL with plateau uptake: $E_VOL \times \text{number of pixels with plateau uptake/classified pixels}$
 - E_VOL with washout uptake: $E_VOL \times \text{number of pixels with washout uptake/classified pixels}$
- IAUGC60: initial area under the gadolinium curve at time 60 seconds
- DEMRIQ ME Score (DEMRIQ_ME): $\text{mean ME} \times E_VOL$
- DEMRIQ IRE score (DEMRIQ_IRE): $\text{mean IRE} \times E_VOL$
- Ktrans: rate contrast for the diffusion of contrast between locally defined blood and tissue regions of interest

- VE: proportion (0–1) of extravascular extracellular space present in the tissue region of interest

The analysis of the DCE MRI scans used 2 independent readers and a third reader for adjudication of discrepancies. For each single measurement, if there was only 1 raw read, it was used as the measurement value; if there were 2 reads, they were averaged; if there were 2 raw reads and 1 adjudicator read, the adjudicator read was averaged with the closest raw read.

References

1. Bellamy N. WOMAC Osteoarthritis Index User Guide X; 2012.
2. Peterfy CG, Guermazi A, Zaim S, Tirman PF, Miaux Y, White D, et al. Whole-organ magnetic resonance imaging score (WORMS) of the knee in osteoarthritis. *Osteoarthritis Cartilage* 2004;12(3):177-90.
3. Mandl P, Brossard M, Aegerter P, Backhaus M, Bruyn GA, Chary-Valckenaere I, et al. Ultrasound evaluation of fluid in knee recesses at varying degrees of flexion. *Arthritis Care Res (Hoboken)* 2012;64(5):773-9.
4. Zayat AS, Freeston JE, Conaghan PG, Hensor EM, Emery P, Wakefield RJ. Does joint position affect US findings in inflammatory arthritis? *Rheumatology (Oxford)* 2012;51(5):921-5.
5. Pelletier JP, Raynauld JP, Abram F, Haraoui B, Choquette D, Martel-Pelletier J. A new non-invasive method to assess synovitis severity in relation to symptoms and cartilage volume loss in knee osteoarthritis patients using MRI. *Osteoarthritis Cartilage* 2008;16 Suppl 3:S8-13.

6. Li W, Abram F, Pelletier JP, Raynauld JP, Dorais M, d'Anjou MA, et al. Fully automated system for the quantification of human osteoarthritic knee joint effusion volume using magnetic resonance imaging. *Arthritis Res Ther* 2010;12(5):R173.
7. Kauffmann C, Gravel P, Godbout B, Gravel A, Beaudoin G, Raynauld JP, et al. Computer-aided method for quantification of cartilage thickness and volume changes using MRI: validation study using a synthetic model. *IEEE Trans Biomed Eng* 2003;50(8):978-88.
8. Raynauld JP, Kauffmann C, Beaudoin G, Berthiaume MJ, de Guise JA, Bloch DA, et al. Reliability of a quantification imaging system using magnetic resonance images to measure cartilage thickness and volume in human normal and osteoarthritic knees. *Osteoarthritis Cartilage* 2003;11(5):351-60.
9. Raynauld JP, Martel-Pelletier J, Berthiaume MJ, Labonté F, Beaudoin G, de Guise JA, et al. Quantitative magnetic resonance imaging evaluation of knee osteoarthritis progression over two years and correlation with clinical symptoms and radiologic changes. *Arthritis Rheum* 2004;50:476-87.
10. Dodin P, Pelletier JP, Martel-Pelletier J, Abram F. Automatic human knee cartilage segmentation from 3D magnetic resonance images. *IEEE Trans Biomed Eng* 2010;57:2699-711.
11. Martel-Pelletier J, Roubille C, Abram F, Hochberg MC, Dorais M, Delorme P, et al. First-line analysis of the effects of treatment on progression of structural changes in knee osteoarthritis over 24 months: data from the osteoarthritis initiative progression cohort. *Ann Rheum Dis* 2015;74(3):547-56.

Supplemental Table 1. Qualification for Study Entry Based on Evidence of Knee Synovitis

Evidence Source, n	Placebo	Lutikizumab SC Q2W, mg				Total
		25	100	200	Untreated	
Ultrasound or MRI	84	89	84	87	3	347
Ultrasound	53	56	55	63	2	229
Without MRI	48	56	54	60	2	220
With positive MRI	3	0	1	2	0	6
With negative MRI	2	0	0	1	0	3
MRI	31	33	29	24	1	118
None	0	0	1*	0	0	1*
Missing	1	0	1*	0	0	2*

MRI, magnetic resonance imaging; Q2W, every 2 weeks; SC, subcutaneous.

*Inadvertently enrolled despite the lack of evidence of synovitis; 1 of these 3 subjects had synovitis at baseline based on the Whole-Organ Magnetic Resonance Imaging Score assessment.

Supplemental Table 2. Changes From Baseline in Efficacy Endpoints in Subjects With Positive WORMS Synovitis/Effusion at Baseline

Signs and Symptoms Endpoints (LOCF Data)

Endpoint (Full Scale)	Week 16				Week 52			
	PBO (n=72)	Lutikizumab SC Q2W, mg			PBO (n=72)	Lutikizumab SC Q2W, mg		
		25 (n=78)	100 (n=65)	200 (n=79)		25 (n=78)	100 (n=65)	200 (n=79)
<i>Co-primary endpoint</i>								
WOMAC pain (0–50; higher scores indicate worse condition)	-8.1 (-10.44, -5.79)	-10.3 (-12.58, -8.08)	-11.7 (-14.17, -9.26)	-11.9 (-14.11, -9.66)	-9.1 (-11.60, -6.57)	-12.1 (-14.48, -9.62)	-11.9 (-14.58, -9.27)	-12.5 (-14.88, -10.07)
Difference vs PBO		-2.2 (-5.43, 1.00)	-3.6 (-6.98, -0.22)	-3.8 (-6.97, -0.56)		-3.0 (-6.44, 0.51)	-2.8 (-6.50, 0.81)	-3.4 (-6.86, 0.07)
<i>P</i> value vs PBO		0.176	0.037*	0.021*		0.094	0.127	0.055
<i>Secondary endpoint</i>								
WOMAC function (0–170; higher scores indicate worse condition)	-29.1 (-36.46, -21.82)	-31.4 (-38.53, -24.34)	-36.3 (-43.99, -28.53)	-32.6 (-39.61, -25.52)	-31.0 (-39.62, -22.36)	-39.2 (-47.59, -30.87)	-39.0 (-48.13, -29.91)	-40.4 (-48.65, -32.05)
Difference vs PBO		-2.3 (-12.44, 7.84)	-7.1 (-17.76, 3.52)	-3.4 (-13.53, 6.68)		-8.2 (-20.18, 3.70)	-8.0 (-20.57, 4.50)	-9.4 (-21.27, -2.55)
<i>P</i> value vs PBO		0.656	0.189	0.506		0.176	0.208	0.123
<i>Exploratory endpoint</i>								
OMERACT/OARSI response, % [†]	59.7 (48.4, 71.1)	68.8 (58.5, 79.2)	71.9 (60.9, 82.9)	65.4 (54.8, 75.9)	68.1 (57.3, 78.8)	74.0 (64.2, 83.8)	73.4 (62.6, 84.3)	73.4 (63.7, 83.2)
Difference vs PBO		9.1 (-6.2, 24.5)	12.2 (-3.6, 28.0)	5.7 (-9.8, 21.1)		6.0 (-8.6, 20.5)	5.4 (-9.9, 20.6)	5.4 (-9.2, 19.9)
<i>P</i> value vs PBO		0.253	0.123	0.457		0.448	0.577	0.484

Structural Endpoints (Observed Data)

Endpoint	Week 26				Week 52			
	PBO	Lutikizumab SC Q2W, mg			PBO	Lutikizumab SC Q2W, mg		
		25	100	200		25	100	200
<i>Co-primary endpoint</i>								
Synovial membrane thickness, mm	-0.06 (-0.12, 0.01)	0.03 (-0.03, 0.09)	-0.07 (-0.13, -0.003)	-0.00 (-0.06, 0.06)	-0.08 (-0.15, -0.01)	-0.03 (-0.09, 0.03)	-0.05 (-0.12, 0.02)	-0.02 (-0.09, 0.04)
n	49	56	49	59	44	52	46	50
Difference vs PBO		0.08 (-0.01, 0.17)	-0.01 (-0.10, 0.08)	0.05 (-0.03, 0.14)		0.05 (-0.04, 0.14)	0.03 (-0.07, 0.12)	0.05 (-0.04, 0.15)
<i>P</i> value vs PBO		0.064	0.819	0.219		0.291	0.554	0.247

<u>Synovial fluid volume,</u>	<u>-0.01 (-2.99,</u>	<u>0.07 (-2.58,</u>	<u>-0.75 (-3.60,</u>	<u>-2.15 (-4.82,</u>	<u>-2.38 (-5.94,</u>	<u>0.88 (-2.38,</u>	<u>-0.45 (-3.92,</u>	<u>-2.33 (-5.64,</u>
<u>mL</u>	<u>2.96)</u>	<u>2.73)</u>	<u>2.10)</u>	<u>0.52)</u>	<u>1.18)</u>	<u>4.13)</u>	<u>3.02)</u>	<u>0.98)</u>
<u>n</u>	<u>49</u>	<u>62</u>	<u>53</u>	<u>61</u>	<u>46</u>	<u>55</u>	<u>48</u>	<u>53</u>
<u>Difference vs PBO</u>		<u>0.09 (-3.87,</u>	<u>-0.74 (-4.84,</u>	<u>-2.13 (-6.11,</u>		<u>3.26 (-1.52,</u>	<u>1.93 (-3.04,</u>	<u>0.05 (-4.78,</u>
		<u>4.04)</u>	<u>3.37)</u>	<u>1.84)</u>		<u>8.04)</u>	<u>6.90)</u>	<u>4.88)</u>
<u>P value vs PBO</u>		<u>0.966</u>	<u>0.724</u>	<u>0.291</u>		<u>0.181</u>	<u>0.444</u>	<u>0.984</u>
<u>WORMS</u>	<u>0.09 (-0.05,</u>	<u>-0.02 (-0.16,</u>	<u>-0.08 (-0.23,</u>	<u>-0.12 (-0.25,</u>	<u>-0.06 (-0.20,</u>	<u>-0.07 (-0.21,</u>	<u>-0.08 (-0.23,</u>	<u>-0.06 (-0.20,</u>
<u>semiquantitative</u>	<u>0.23)</u>	<u>0.11)</u>	<u>0.06)</u>	<u>0.02)</u>	<u>0.09)</u>	<u>0.07)</u>	<u>0.07)</u>	<u>0.07)</u>
<u>synovitis/effusion</u>								
<u>volume</u>								
<u>n</u>	<u>58</u>	<u>67</u>	<u>57</u>	<u>68</u>	<u>51</u>	<u>58</u>	<u>51</u>	<u>61</u>
<u>Difference vs PBO</u>		<u>-0.11 (-0.31,</u>	<u>-0.17 (-0.37,</u>	<u>-0.20 (-0.40,</u>		<u>-0.02 (-0.22,</u>	<u>-0.02 (-0.23,</u>	<u>-0.01 (-0.20,</u>
		<u>0.08)</u>	<u>0.03)</u>	<u>-0.01)</u>		<u>0.19)</u>	<u>0.18)</u>	<u>0.19)</u>
<u>P value vs PBO</u>		<u>0.255</u>	<u>0.098</u>	<u>0.039</u>		<u>0.880</u>	<u>0.813</u>	<u>0.955</u>

Data are least squares means (95% CI).

KL, Kellgren-Lawrence; LOCF, last observation carried forward; OMERACT/OARSI, Outcome Measures in Rheumatology Clinical Trials/Osteoarthritis Research Society International; PBO, placebo; Q2W, every 2 weeks; SC, subcutaneous; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index; WORMS, Whole-Organ Magnetic Resonance Imaging Score.

* $P \leq 0.05$ vs PBO. Continuous variables compared with analysis of covariance with treatment, age, and KL grade as main factors and baseline as covariate. Categorical variables compared with Cochran-Mantel-Haenszel test with age group and KL grade as stratification factors.

†OMERACT/OARSI response defined as either (1) $\geq 50\%$ relative and $\geq 20\%$ absolute improvement from baseline in WOMAC pain or function or (2) $\geq 20\%$ relative and $\geq 10\%$ from baseline in at least 2 of 3 measures (WOMAC pain, WOMAC function, and patient global assessment).

Supplemental Table 23. Change From Baseline in DCE-MRI Parameters in Synovial Membrane at Week 26

Parameter, LS Mean (%) Change	Placebo (n=7)	Lutikizumab SC Q2W, mg		
		25 (n=10)	100 (n=10)	200 (n=12)
IRE*	-0.002 (-25.0)	-0.002 (-5.5)	0.002 (46.3 [‡])	-0.003 (-7.9)
ME*	-0.040 (-3.2)	0.030 (2.4)	0.119 (9.5)	-0.096 (-3.3)
E_VOL, mL*	0.337 (67.7)	0.711 (273.9)	7.001 (28.6)	-6.950 (15.3)
Persistent uptake*	0.049 (7.1)	0.129 (113.0)	-0.136 (27.1)	-0.023 (59.2)
Plateau uptake*	-0.363 (87.3)	0.672 (379.2)	7.254 (37.6)	-5.091 (18.1)
Washout uptake*	0.872 (106.3)	-0.214 (244.5)	-0.240 (16.4)	-1.519 [§] (37.1)
IAUGC60, mmol•s [†]	-0.519 (-20.4)	0.191 (0.8)	1.241 (61.6)	-1.134 (7.2)
DEMRIQ ME score, mL*	-0.140 (67.2)	4.025 (318.6)	20.505 (35.1)	-18.734 (34.0)
DEMRIQ IRE score, mL*	-0.134 (35.9)	-0.091 (342.9)	0.188 (56.1)	-0.242 (49.8)
Ktrans, min ^{-1†}	-0.058 (-51.5)	-0.003 (25.5)	0.052 (329.9)	-0.045 (319.1)
VE [†]	-0.391 (23.6)	0.169 (20.9)	-0.515 (5.5)	-0.545 (38.3)

DCE-MRI, dynamic contrast-enhanced magnetic resonance imaging; DEMRIQ, DCE-MRI quantification; E_VOL, enhancing volume; IAUGC60, initial area under the gadolinium concentration-time curve over 60 s; IRE, initial rate of enhancement; KL, Kellgren-Lawrence; Ktrans, volume transfer coefficient; LS, least squares; ME, maximal enhancement; Q2W, every 2 weeks; SC, subcutaneous; VE, fractional extracellular extravascular space.

*n=5, 8, 10, and 10 and [†]n= 5, 6, 10, and 10 for placebo and lutikizumab 25 mg, 100 mg, and 200 mg, respectively.

[‡]P=0.016 and [§]P=0.043 vs placebo from analysis of covariance with treatment, age, and KL grade as main factors and baseline as covariate.

Supplemental Table 43. Concomitant Medication Use During the Treatment Period*

n (%)	Placebo (n=85)	Lutikizumab SC Q2W, mg		
		25 (n=89)	100 (n=85)	200 (n=88)
Any concomitant medication, n (%)	84 (98.8)	87 (97.8)	82 (96.5)	87 (98.9)
Ibuprofen	37 (43.5)	26 (29.2)	29 (34.1)	39 (44.3)
Acetaminophen	75 (88.2)	66 (74.2)	68 (80.0)	78 (88.6)

Q2W, every 2 weeks; SC, subcutaneous.

*First study drug dose through 14 days after the final study drug dose.

For Peer Review

Supplemental Table 54. Proportion of Subjects With Decreases From Baseline in IL-1 β 2 Weeks After Initiating Treatment With Placebo or Lutikizumab

Treatment	Subjects, n/N (%)
Placebo	4/40 (10.0)
Lutikizumab 25 mg SC Q2W	17/37 (45.9)
Lutikizumab 100 mg SC Q2W	10/34 (29.4)
Lutikizumab 200 mg SC Q2W	11/40 (27.5)

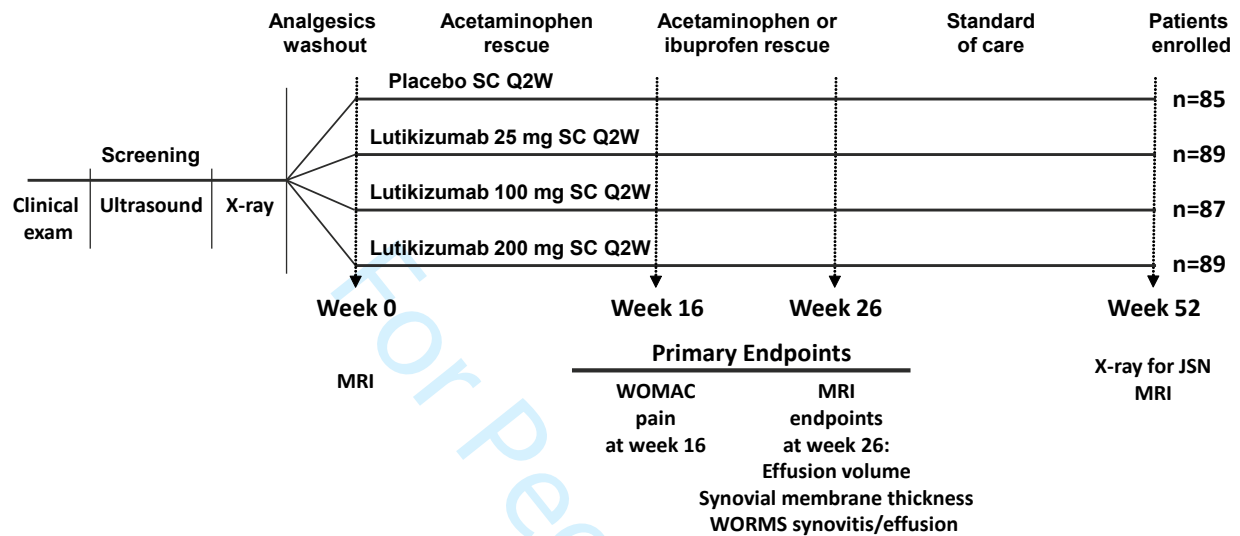
IL-1 β =interleukin-1 β ; Q2W, every 2 weeks; SC, subcutaneous.

Supplemental Table 5. ORs for Factors Associated With the Development of Neutropenia During Lutikizumab Treatment Based on a Multiple Logistic Regression Model

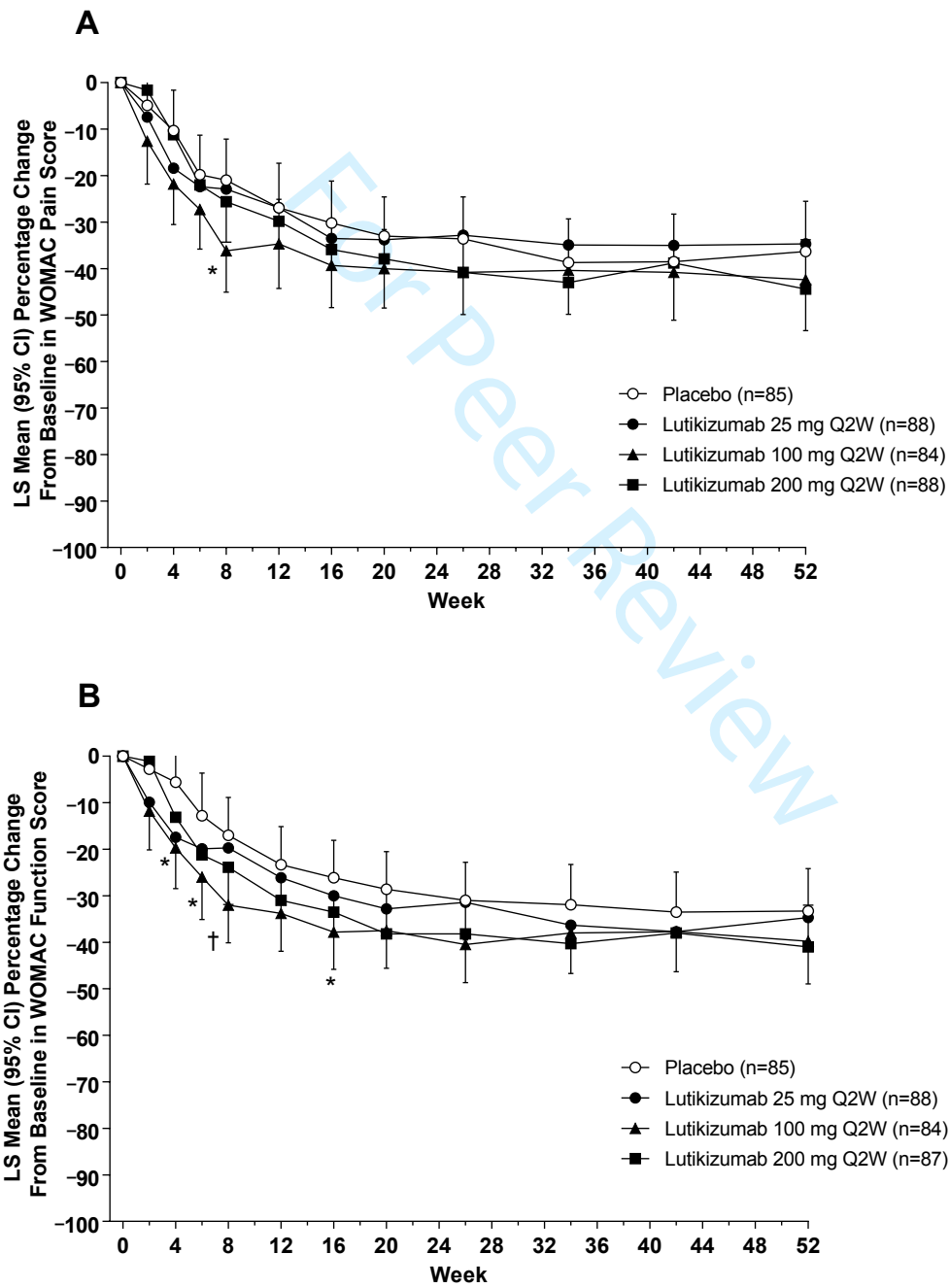
Variable	OR	95% CI	P Value
Treatment group			<0.0001
Lutikizumab 25 mg SC Q2W	5.99	1.52–23.69	
Lutikizumab 100 mg SC Q2W	14.84	3.80–57.98	
Lutikizumab 200 mg SC Q2W	24.36	6.24–95.05	
Baseline ANC	0.19	0.12–0.30	<0.0001
Age <62 y	2.11	1.09–4.09	0.027
Female sex	2.86	1.34–6.10	0.007

ANC, absolute neutrophil count; OR, odds ratio; Q2W, every 2 weeks; SC, subcutaneous.

Supplemental Figure 1. Study design. JSN, joint space narrowing; MRI, magnetic resonance imaging; Q2W, every 2 weeks; SC, subcutaneous; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index; WORMS, Whole-Organ Magnetic Resonance Imaging Score.

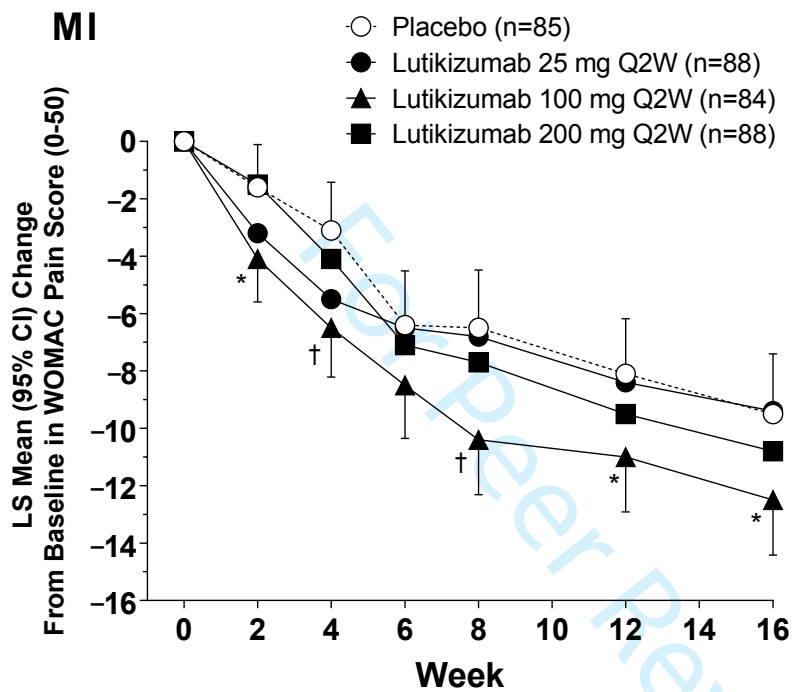


Supplemental Figure 2. LS mean percentage change from baseline over time for WOMAC pain (A) and WOMAC function (B). LS, least squares; Q2W, every 2 weeks; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index. * $P \leq 0.05$ vs placebo; † $P \leq 0.01$ vs placebo.

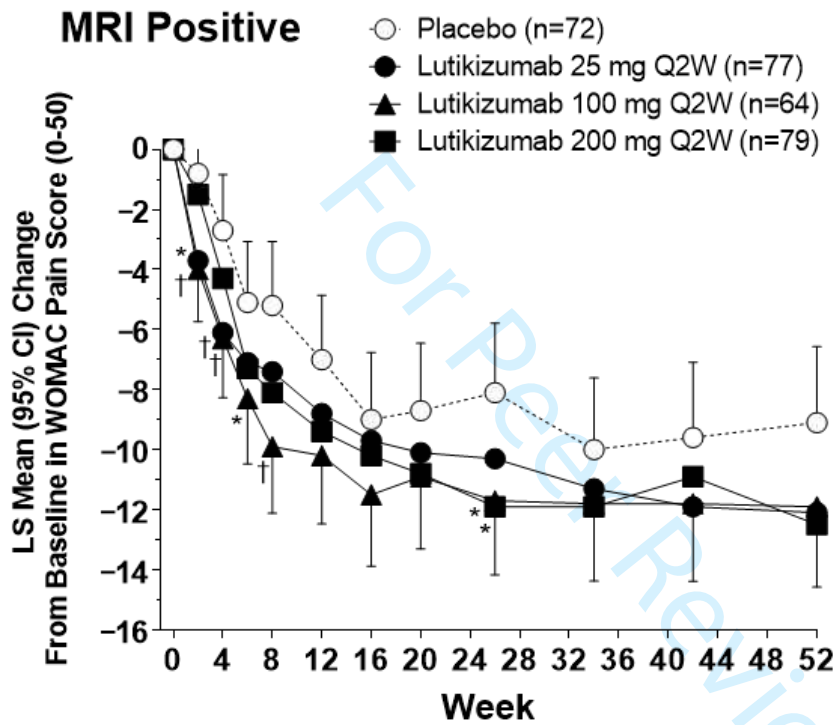


Supplemental Figure 3. LS mean change from baseline over time for WOMAC pain using MI.

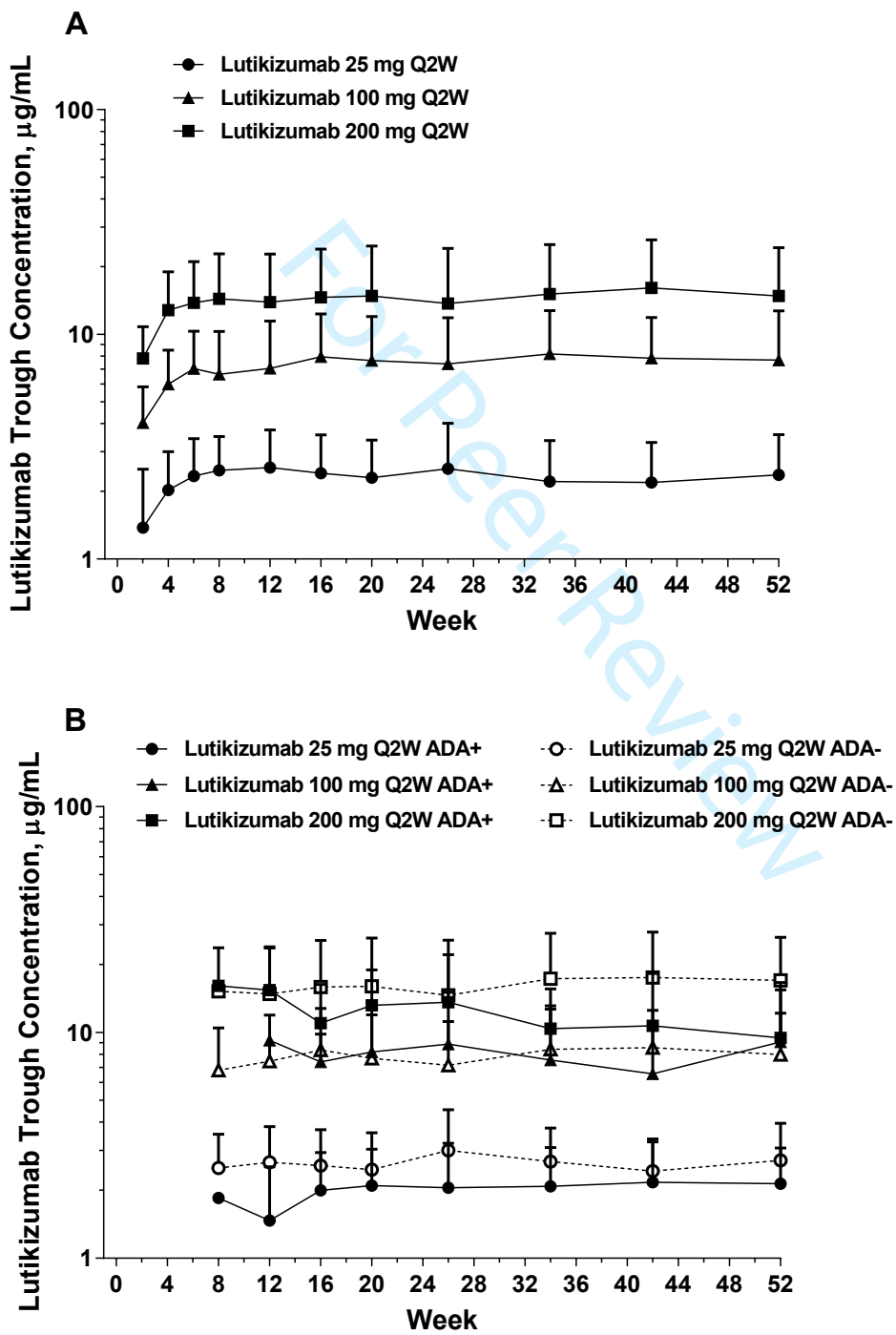
LS, least squares; MI, multiple imputation; Q2W, every 2 weeks; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index. * $P \leq 0.05$ vs placebo; † $P \leq 0.01$ vs placebo.



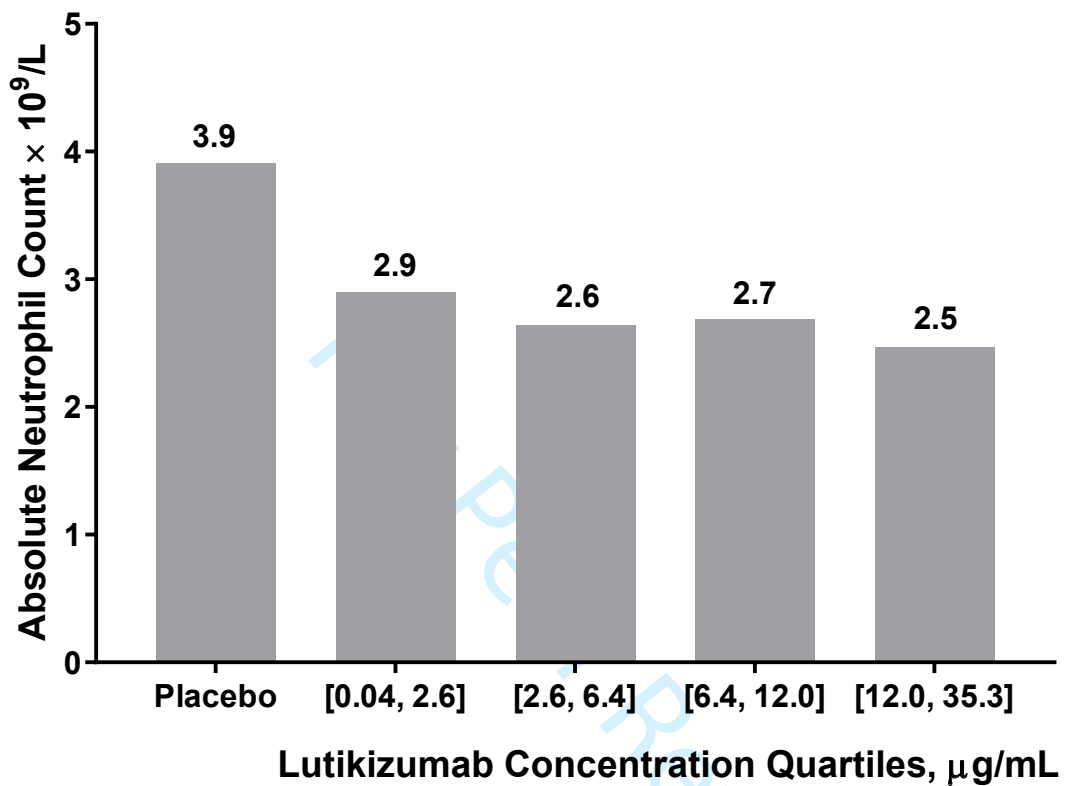
Supplemental Figure 4. LS mean change from baseline over time for WOMAC pain in subjects with positive WORMS synovitis/effusion at baseline. LS, least squares; Q2W, every 2 weeks; WOMAC, Western Ontario and McMaster Universities Osteoarthritis index; WORMS, Whole-Organ Magnetic Resonance Imaging Score. * $P < 0.05$ vs placebo; † $P < 0.01$ vs placebo.



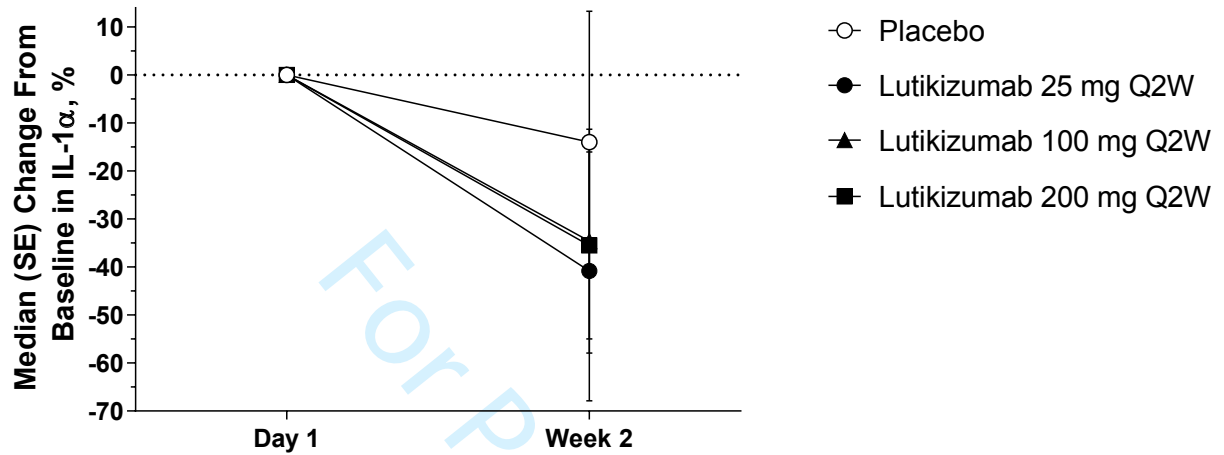
Supplemental Figure 53. Mean (SD) trough serum concentrations of lutikizumab over time for all subjects (A) and separated by presence of ADAs (B). ADA, anti-drug antibody; Q2W, every 2 weeks.



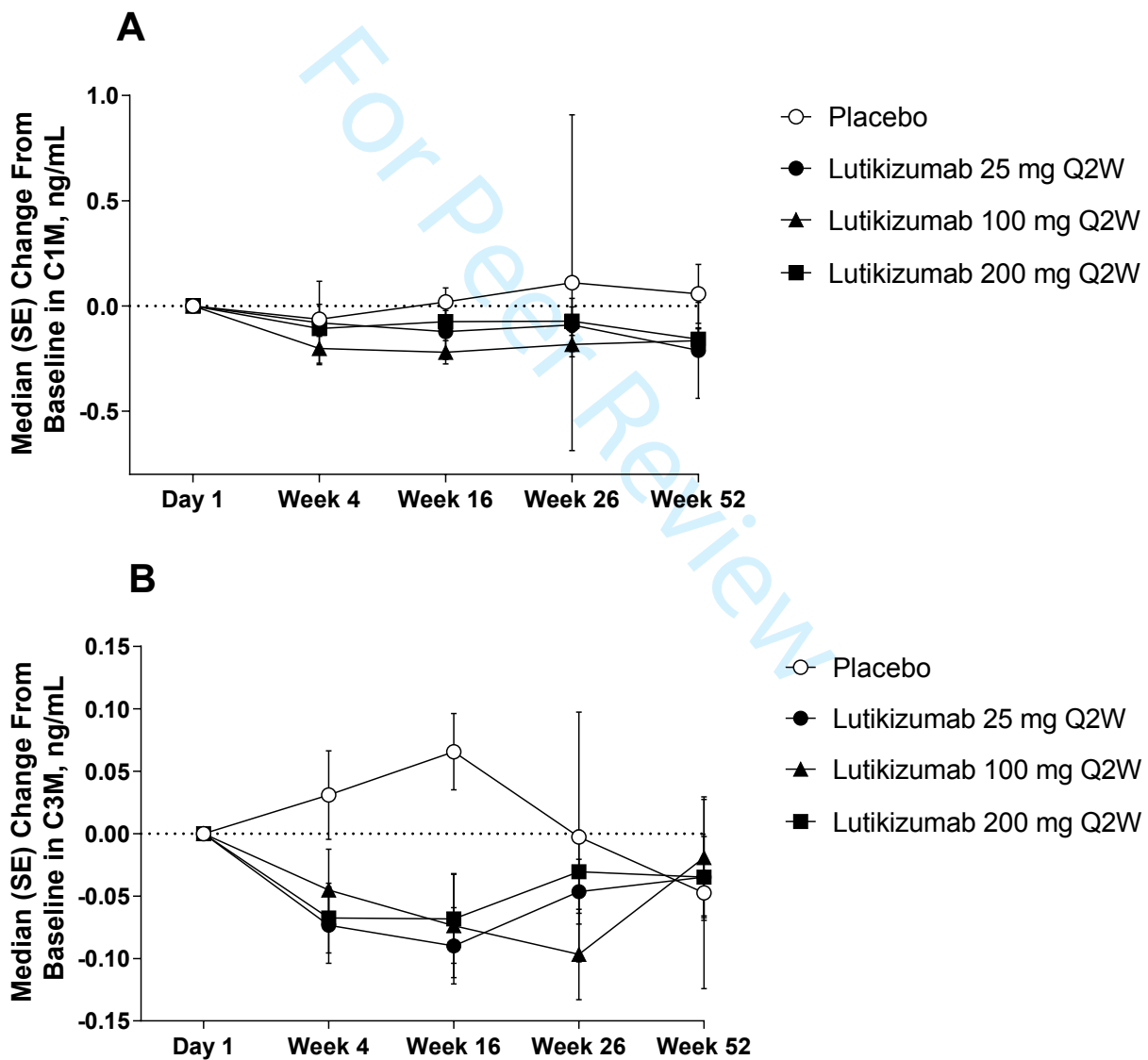
Supplemental Figure 64. Median absolute neutrophil counts for placebo and lutikizumab serum concentration quartiles at week 52 (observed cases).



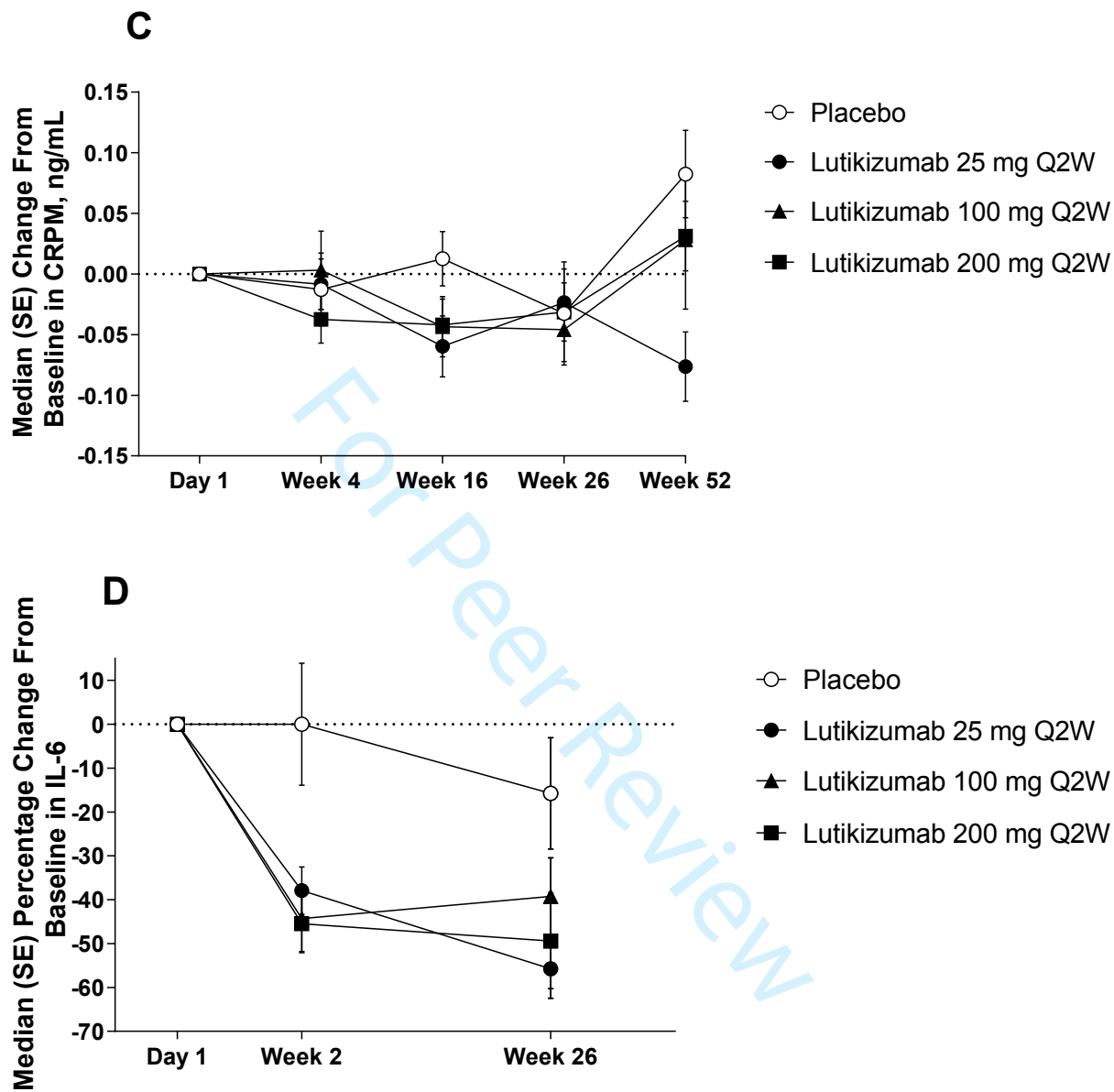
Supplemental Figure 75. Change From Day 1 in Serum IL-1 Levels at 2 Weeks After Initiating Treatment With Placebo or Lutikizumab. IL-1 α =interleukin-1 α ; Q2W=every 2 weeks.



Supplemental Figure 86. Median change from baseline over time for the biomarkers C1M (A), C3M (B), and CRPM (C), median percentage change from baseline over time in IL-6 (D), and mean change from baseline over time in alkaline phosphatase (E). C1M, metalloproteinase-degraded collagen type I; C3M, metalloproteinase-degraded collagen type III; CRPM, matrix metalloproteinase-generated fragment of C-reactive protein; IL-6, interleukin-6; Q2W, every 2 weeks.



Supplemental Figure 68 continued.



Supplemental Figure 68 continued.

