REVIEW

Therapeutic role of dual inhibitors of 5-LOX and COX, selective and non-selective non-steroidal anti-inflammatory drugs

J Martel-Pelletier, D Lajeunesse, P Reboul, J-P Pelletier

Dual 5-LOX/COX inhibitors are potential new drugs to treat inflammation. They act by blocking the formation of both prostaglandins and leukotrienes but do not affect lipoxin formation. Such combined inhibition avoids some of the disadvantages of selective COX-2 inhibitors and spares the gastrointestinal mucosa.

Inflammation is a complex process occurring through a variety of mechanisms, leading to changes in local blood flow and the release of several mediators. These mediators account for local effects at the site of inflammation—that is, vasodilatation, increased vascular permeability, and migration of leucocytes into the affected area, and for general phenomena in the vascular systems of the body, including the cardiovascular system and the renal apparatus.

"Leukotrienes have a major role in the inflammatory process"

The mediators arising from the cyclo-oxygenase (COX) cascade and the role of biologically active prostaglandins in the inflammatory process and body homeostasis have been extensively studied. In addition, there is a growing body of evidence that the complex pathway of arachidonic acid metabolism in inflammation involves a variety of mediators other than the COX, all of which have a role in the overall process. Leukotrienes, which are the second main family of arachidonic acid derivatives, are synthesised from the activity of 5-lipoxygenase (5-LOX) and have a major role in the inflammatory process (fig 1).

The discovery of two different COX isoforms, COX-1 and COX-2, and evidence that arachidonic acid derivatives other than those formed in the classical COX pathway (for example, leukotrienes and lipoxins) exhibit or modulate inflammatory properties, has contributed to a better understanding of the cell mediators and effects triggered during an inflammatory response. As a consequence, there has been a drive for a better understanding of these pathways and development of new drugs to intervene in them. Hence, new dual 5-LOX/COX inhibitors are now being studied as potential new drugs, post-COX-2 selective inhibitors, to treat the inflammatory processes.

THE SYNERGISTIC FUNCTIONS OF COX-1 AND COX-2

Cyclo-oxygenase converts arachidonic acid to prostaglandin H2 (PGH2) which, in turn, is transformed into a series of final active products in different cell types and with different expressions. For example, thromboxane A2 (TXA2) is a potent vasoconstrictor and a stimulator of platelet aggregation, prostacyclin (PGI1) is expressed in the vascular endothelium and inhibits platelet aggregation, PGE2 and PGJ1 are potent vasodilators which account for the increased blood flow in inflamed areas. On the other hand, the vasodilating properties of PGE2 and PGJ1 contribute to increasing mucus secretion and reducing acidity and pepsin content in the stomach, thus protecting the integrity of the gastric mucosa. In the kidneys, PGE2 and PGJ1 increase blood flow in response to factors inducing vasoconstriction and contribute to modulating the glomerular filtration rate in the event of volume depletion.

Two COX isofoms, COX-1 and COX-2, have been identified. They are encoded by two different genes, and it has been postulated that while COX-1 is expressed in mammalian cells, particularly in endothelium, platelets, and kidneys in pathological conditions, COX-2 is inducible in pathological conditions by inflammatory stimulation. It has, therefore, been suggested that constitutive COX-1 is involved in homoeostatic processes, whereas COX-2 is the isomerase that plays a major part in the inflammatory process and the pain associated with it. On the basis of this assumption, selective COX-2 inhibitors were developed; these were intended to have the anti-inflammatory properties of classical non-steroidal anti-inflammatory drugs (NSAIDs) but without altering renal function and without affecting the integrity of the gastric mucosa. Nevertheless, there is accumulating evidence that COX-1 and COX-2 have overlapping actions and that both isoforms are involved in homoeostasis processes, just as both are modulators of inflammatory reactions.

Recent findings have shown that COX-2 is constitutively expressed in some tissues, including the brain and kidneys. In addition, COX-2

Abbreviations: AUC, area under the curve; COX, cyclo-oxygenase; FLAP, 5-lipoxygenase activating-protein; GI, gastrointestinal; IL, interleukin; 5-LOX, 5-lipoxygenase; LT, leukotriene; LX, lipoxin; NO, nitric oxide; NSAIDs, non-steroidal anti-inflammatory drugs; PG, prostaglandin; PMN, polymorphonuclear cell; TXA2, thromboxane A2.
COX-2 activity leads to the synthesis of renal prostaglandin I2 (PGI2) which causes vasodilation and inhibits platelet aggregation. Patients at risk for cardiovascular events require scrutiny, particularly considering that COX-2 is uniquely involved (for example, platelet aggregation for COX-2) and others in which both isoenzymes function together (for example, carcinogenesis, inflammation). As COX-2 is induced during the resolution phase of inflammation COX-2 may have a more significant role.

Leukotrienes (LTs) play a major part in the inflammatory process (fig 2). They are synthesised via the 5-LOX. However, this enzyme requires the presence in intact cells of the 5-LOX activating-protein (FLAP). Indeed, the activity of 5-LOX is activating-protein (FLAP). Indeed, the activity of 5-LOX is required for COX-1, ovulation for COX-2) and others in which both isoenzymes function together (for example, carcinogenesis, inflammation). As COX-2 is induced during the resolution of an inflammatory response, it then produces anti-inflammatory, not proinflammatory PGs. Indeed, cellular infiltration and oedema are present for longer in COX-2 deficient mice than in wild-type mice, indicating that during the resolution phase of inflammation COX-2 may have a more significant role.

There are also physiological events in which one COX normally functions but for which the other can compensate when the first is lacking (for example, parturition and remodelling of ductus arteriosus). The mechanisms by which compensatory responses normalise prostanoid biosynthesis remain to be elucidated.

**EFFECTS OF LEUCOTRIENES IN INFLAMMATION**

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**Figure 1** Products and enzymes of arachidonic acid metabolism involved in the inflammatory process.
membrane association of 5-LOX. A radiolabelled analogue of MK-866 in neutrophils was used to identify an 18 kDa protein, and complementary DNAs, isolated from rat and human, of an encoded novel protein, FLAP. This protein, FLAP, has three membrane spanning regions and two hydrophilic loops. Both 5-LOX and FLAP are required for LT production in cells stimulated by the ionophore A23187 (without exogenous arachidonic acid addition).

“Inhibition of COX may lead to a shunt of the arachidonic metabolism towards the leucotriene pathway”

The final and biologically active metabolites of the 5-LOX cascade are LTB₄ and the so-called cysteinyl LTs (LTC₄, LTD₄, and LTE₄), formerly known as a slow reacting substance related to anaphylaxis, which are derived from the unstable intermediate LTA₄. Leucotrienes are potent mediators of inflammation; table 2 summarises their specific functions. The target of the biological effects of LTB₄ has been found to be primarily inflammatory cells: LTB₄ is a potent stimulator of leucocyte activation, and adhesion of these cells to vascular endothelium, elicits chemokinetic and chemotactic responses. During brief exposure to LTB₄, polymorphonuclear leucocytes (PMN) are predominantly recruited, whereas during prolonged exposure, as probably occurs when LTB₄ is formed in vivo, other granulocytes, including neutrophils and eosinophils, are found in tissues and exudates. Furthermore, LTB₄ has been shown to be involved in the pathogenesis of a variety of inflammatory diseases. It has been observed that this LT stimulates the production and release of proinflammatory cytokines from macrophages and lymphocytes, and, recently, from synovial membrane.

Cysteinyl LTs (LTC₄, LTD₄, and LTE₄) have long been known to be involved in the pathogenesis of bronchial asthma, but their role in other inflammatory conditions has always been ignored. However, their proinflammatory effects in conditions other than asthma have recently been reconsidered. It has been shown that neutrophil activation causes synthesis of a significant proportion of LTC₄ from the intermediate metabolite LTA₄. Additionally, the derived cysteinyl LTs can induce significant functional and morphological changes, consisting of endothelial cell contraction leading to oedema and smooth muscle contraction, as shown in isolated heart in animal models. Furthermore, experimental trials have demonstrated that cysteinyl LTs may participate in the damage of gastric mucosa by inducing mucosal microvascular injury and gastric vessel vasoconstriction, promoting breakdown of the mucosal barrier and stimulating the secretion of gastric

Table 1

<table>
<thead>
<tr>
<th>Physiological/pathological process</th>
<th>COX-1</th>
<th>COX-2</th>
<th>PGs involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ovulation</td>
<td>Not essential</td>
<td>Essential</td>
<td>PGE₂</td>
</tr>
<tr>
<td>Implantation</td>
<td>Not essential</td>
<td>Essential</td>
<td>PG₁</td>
</tr>
<tr>
<td>Parturition</td>
<td>Essential</td>
<td>Compensatory</td>
<td>PGE₂, 15-deoxy-PG₂</td>
</tr>
<tr>
<td>Inflammatory signs</td>
<td>Essential in some kind of inflammation</td>
<td>Essential</td>
<td>Not specified</td>
</tr>
<tr>
<td>Inflammation resolution</td>
<td>Not essential</td>
<td>Essential</td>
<td>PGE₂, PGD₂, TXA₂</td>
</tr>
<tr>
<td>Platelet aggregation</td>
<td>Essential</td>
<td>No role</td>
<td>TXA₂</td>
</tr>
<tr>
<td>Perinatal kidney development</td>
<td>Not essential</td>
<td>Essential</td>
<td>Not specified</td>
</tr>
<tr>
<td>Kidney function</td>
<td>Essential</td>
<td>Essential</td>
<td>PG₁</td>
</tr>
<tr>
<td>Ductus arteriosus remodelling</td>
<td>Compensatory</td>
<td>Essential</td>
<td>TXA₂, TXA₁/PG₁</td>
</tr>
<tr>
<td>Gl mucosa protection</td>
<td>Essential under inflammatory condition</td>
<td>Stage specific</td>
<td>PGE₂</td>
</tr>
<tr>
<td>Gastric ulceration</td>
<td>Inhibition of both isoforms necessary</td>
<td>Essential</td>
<td>Several PGs</td>
</tr>
<tr>
<td>Ulcer healing</td>
<td>Not essential</td>
<td>Essential</td>
<td>PGE₂</td>
</tr>
<tr>
<td>Intestinal cancer</td>
<td>Essential</td>
<td>Essential</td>
<td>Several PGs</td>
</tr>
<tr>
<td>Crypt stem cell survival</td>
<td>Compensatory</td>
<td>Essential</td>
<td>PGE₂</td>
</tr>
</tbody>
</table>

Dual inhibitors of 5-LOX and COX and NSAIDs

Figure 2

Products and enzymes of the 5-LOX pathway.
acid, as well as the production of interleukin 1 (IL1) and proinflammatory cytokines. As confirmation of these findings, inhibition of neutrophil adhesion through modulation of nitric oxide (NO) formation or through monoclonal antibodies reduced the synthesis of cysteinyl LTs and prevented the effects on vascular tone and permeability induced by neutrophil activation.

Overall, these studies demonstrate that besides LTB₄, cysteinyl LTs induced by activation of neutrophilic 5-LOX may be responsible for vascular permeability changes occurring during acute inflammation and may play a part in NSAID induced gastrointestinal (GI) damage. Importantly, because the inhibition of COX may lead to a shunt of the arachidonic acid metabolism towards the 5-LOX pathway, treatment with NSAIDs may increase the formation of LTs, which can induce gastric damage and ulceration.50–53

In LX formation, 15-LOX is a pivotal enzyme that initiates LX biosynthesis and converts the LT intermediate LTA₄ to LX.58 Indeed, Levy et al demonstrated that preincubation of PMN with PGE₂ switched the predominant LO activity of PMN from 5-LOX to 15-LOX after five hours. Moreover they showed that this switch is under the regulation of 15-LOX gene expression, meaning that 15-LOX is also an inducible enzyme.59

### EMERGING ROLE OF LIPOXINS

Lipoxins (lipooxygenase interaction products (LXs)) are yet another group of lipid mediators formed during arachidonic acid metabolism. They are generated during the cellular interactions that occur as part of the multicellular host response to inflammation. Lipoxins are formed by transcellular metabolism from an intermediate derivative (5(6)-epoxytetraene), which gives rise to the metabolically active products, LXA₄, LXB₄, or 15(R)-HETE for 15-epi-LXs (aspirin triggered LXs) (fig 3). They are synthesised not only through the 5-LOX pathway, but also by the action of two other enzymes, 12-LOX and 15-LOX.55–57

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**Table 2** Specific functions of leucotrienes

<table>
<thead>
<tr>
<th>Leucotriene</th>
<th>Function</th>
<th>Organ/cell</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTB₄</td>
<td>Chemotaxis</td>
<td>Neutrophils, eosinophils, lymphocytes, monocytes</td>
</tr>
<tr>
<td></td>
<td>Aggregation</td>
<td>Neutrophils, eosinophils</td>
</tr>
<tr>
<td></td>
<td>Recruitment, migration, adhesion</td>
<td>Granulocytes</td>
</tr>
<tr>
<td></td>
<td>Degranulation with superoxide generation</td>
<td>Granulocytes</td>
</tr>
<tr>
<td></td>
<td>Increase cytokine production and release</td>
<td>Granulocytes</td>
</tr>
<tr>
<td></td>
<td>Increase cytotoxicity and cytokine production (IL5, IL6, IL8)</td>
<td>T cells, macrophages?</td>
</tr>
<tr>
<td></td>
<td>Inhibition of transformation and secretion</td>
<td>T cells</td>
</tr>
<tr>
<td></td>
<td>Increase of proliferation, activation, and immunoglobulin production</td>
<td>B cells</td>
</tr>
<tr>
<td></td>
<td>Increase of permeability</td>
<td>Microvasculature</td>
</tr>
<tr>
<td></td>
<td>Hyperalgesia</td>
<td>Afferent nerves</td>
</tr>
<tr>
<td></td>
<td>Role in extracellular matrix synthesis</td>
<td>Bone tissue</td>
</tr>
<tr>
<td></td>
<td>Increase bone resorption</td>
<td>Bone tissue</td>
</tr>
</tbody>
</table>

**LTC₄, LTD₄, LTE₄**

| | Function | Organ/cell |
| | Contraction | Smooth muscle, coronary arteries distal segment of the pulmonary arteries, mesenteric vasculature, gastrointestinal muscle, bronchi |
| | Mucus secretion and oedema | Bronchi |
| | Increase permeability | Microvasculature |
| | Recruitment of inflammatory cells | Lymphocytes, eosinophils |
| | Stimulation of secretion of glycoproteins | Lung |
| | Airway remodelling in chronic allergic inflammation | Lung |

LTC₄, LTD₄ are biologically equipotent, while LTE₄ is less active.

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**Figure 3** Products and enzymes of the LX pathway.
Table 3: Actions of lipoxins on human leucocytes

<table>
<thead>
<tr>
<th>Lipoxin</th>
<th>Leucocytes</th>
<th>Action</th>
</tr>
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<tbody>
<tr>
<td>LXA₁</td>
<td>PMN</td>
<td>Blocking of emigration, transmission, and chemotaxis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Down regulation of CD 11/18, IP₃, Ca²⁺</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inhibition of PMN and endothelial cells and epithelial cell interactions</td>
</tr>
<tr>
<td></td>
<td>Eosinophils</td>
<td>Inhibition of chemotaxis (PAF, FMLP)</td>
</tr>
<tr>
<td></td>
<td>NK cells</td>
<td>Inhibition of cytotoxicity</td>
</tr>
<tr>
<td></td>
<td>Monocytes</td>
<td>Stimulation of chemotaxis and adherence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stimulation of myeloid progenitors</td>
</tr>
<tr>
<td>LXB₁</td>
<td>PMN</td>
<td>Blocking of emigration, transmission, and chemotaxis</td>
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<td>Stimulation of myeloid progenitors</td>
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</table>

LXs can be considered as stop-signal mediators, which possess anti-inflammatory effects: in particular, LXA₁ and LXB₁, have an inhibitory action on LT mediated effects in inflammation by reducing the production and chemotaxis of granulocytes and by stimulating monocyte activation. 15-Epi-LXA₁ and 15-epi-LXB₁ are formed after the administration of aspirin because the aspirin induced COX inhibition shunts arachidonic acid metabolism to form an LX intermediate. These LXs are potent blockers of neutrophil function and cell proliferation.²³ Table 3 summarises the actions of LXs on human leucocytes. Importantly, the inhibitory actions of aspirin induced LXs are dependent on both tissue and the delivery site and can produce their anti-inflammatory effect at sites distant from the point of delivery.²⁴

Based on this new information on the actions of LXs, it is reasonable to presume that their production can counteract the inflammatory effects of LTs and that the induction of aspirin triggered 15-epi-LX should provide additional anti-inflammatory benefits.

DUAL INHIBITORS: RATIONALE FOR USE

Both the conventional NSAIDs and the selective COX-2 inhibitors primarily exert their activity by reducing the production of PGs induced in the inflammatory process. In recent years, it has been clarified that PG synthesis is only one part of the arachidonic acid pathway, this precursor being a substrate that gives rise to many other lipid mediators, such as the LTs and the LXs. Leucotrienes themselves have a major role in the development and persistence of the inflammatory process, and it is now clear that PGs and LTs have complementary effects, whereas the production of LXs can counteract the inflammatory actions of LTs.

In view of these concepts, it has been suggested that blocking both LT and PG production might have synergistic effects and achieve optimal anti-inflammatory activity. In addition, taking into account the roles of LTs and cysteinyl LTs (against which neither selective nor non-selective NSAIDs are effective) in the inflammatory process, dual inhibition of the COX and 5-LOX pathways could produce a wider spectrum of anti-inflammatory effects (fig 4).

Dual inhibition of COX and 5-LOX may limit the vascular changes seen during inflammation and leucocyte induced GI damage.

It has been suggested that cysteinyl LTs, by inducing local vasoconstriction and thus reducing blood flow, can enhance the susceptibility of gastric mucosa to injury, whereas LTB₄ can potentiate this damaging process by its effects on leucocyte infiltration.⁴³ However, it can be expected that blocking both pathways would limit the potential for COX-1/COX-2 inhibitors, NSAIDs, to produce an excess of LTs in a shunt process.⁴⁴ This would thereby exert a protective effect on GI mucosa. Moreover, a shunt effect has also been demonstrated in vitro on human osteoblasts from the subchondral bone. Indeed long term treatment of cells with a COX-2 specific inhibitor (NS-398, 10 μM) increased the level of LTB₄ fourfold. Interestingly, the PGE₂ levels were no more reduced than after a short treatment.⁴⁵ The concentration of NS-398 is well within the doses used in vivo,⁴⁶ ⁴⁷ ⁴⁸ organ culture,⁴⁹ or in vitro experiments.⁵⁰ ⁵¹ suggesting that within the physiological doses of COX-2 inhibitors the shunt observed with osteoblasts in vitro could be observed in vivo.

The biological properties of LTs, together with their formation in a variety of diseases, suggest that 5-LOX inhibitors should have a therapeutic potential in a range of allergic and inflammatory conditions, such as asthma, rheumatoid arthritis, ulcerative colitis, etc. However, the search for selective 5-LOX inhibitors has been on the whole rather disappointing,⁵² ⁵³ because of their toxicity or lack of effect in vivo. Zileuton, an orally active 5-LOX inhibitor, significantly reduces allergen induced nasal congestion; it selectively blocks LT release in the nasal lavage fluids of patients with allergic rhinitis after challenge with specific allergens,⁵⁴ but in other studies in rheumatoid arthritis and in ulcerative colitis, the administration of this drug did not differ statistically from placebo.⁵⁵ ⁵⁶ ⁵⁷

5-LOX/COX blockers have an excellent preclinical GI safety profile⁵⁸

All these studies seem to indicate that the use of 5-LOX inhibitors might represent an insufficient single therapeutic model in inflammatory diseases other than asthma. Thus, the discovery of compounds that can inhibit both the main metabolic pathways of the arachidonic acid metabolism is worthy of interest. Moreover, dual inhibition of 5-LOX/COX does not block the 12-LOX and 15-LOX pathways, which contribute to the synthesis of metabolically active LXs; thus, the non-inhibited production of LXA₁, LXB₁, and 15-epi-LXs, continues to attenuate any remaining LT effects (fig 4).

In the past few decades, several compounds have been developed to block both COX and 5-LOX, but their use was abandoned owing to liver toxicity.⁵⁸ This side effect, however, was not ascribed to their pharmacological mode of action. However, common molecular features of these substances, either redox active features or the presence of the di-tert-butyl moeity or hydroxamic acid, could be responsible for this side effect.

Prototype experimental dual inhibitors (such as BW 755C or SF&F 86002) have proved effective in preventing the production of both PGs and LTs and the consequent inhibition of migration and activation of inflammatory cells (mainly PMN and monocyte macrophages) into inflamed sites. Importantly, the inhibition of migration of inflammatory cells towards the affected sites has translated into a reduction of tissue damaging or necrosis in a model of tissue damage and foreign body rejection.⁵⁹ In this model subcutaneously implanted polyester sponges in rats were rejected after a mean of 12 days under basal conditions. Indometacin did not
significantly change the time to rejection, but BW 755C prolonged rejection to a mean of 22 days as also did dexamethasone. No effects on cell migration have been observed with conventional doses of COX inhibitors. An interesting activity profile has been also noted for ER-34122, an orally administered dual inhibitor. This compound had a more pronounced anti-inflammatory effect than indometacin at the usual pharmacological doses (0.3–3 mg/kg) in a model of arachidonic acid induced ear inflammation because, in addition to its COX inhibitory activity, it inhibited LOX product generation, as shown by the inhibition of oedema formation or PMN leucocyte infiltration. ER-34122 also has anti-inflammatory activity in the early stage of spontaneous arthritis in MRL/MpJ-lpr/lpr mice (a mouse strain that develops a generalised autoimmune disease that is similar to human systemic lupus erythematosus). The compound suppresses progression of PMN infiltration, sub synovial soft tissue oedema, and multiplication of synovial lining cells in the early stage of arthritis, whereas indometacin (1 mg/kg) has no effect. The effect of ER-34122 in this animal model may be due to the inhibition of LT production, and in fact arachidonic acid metabolites, including L Ts, may be important in the pathogenesis of autoimmune disease in this mouse strain.

Tepoxalin, an inhibitor of COX and 5-LOX, has a potent anti-inflammatory activity with an excellent gastric tolerance pattern in animal models treated for long periods at doses higher than those required to produce anti-inflammatory effects. Pretreatment with this compound also prevented the GI side effects induced by normally gastrotoxic doses of indometacin. Some studies in humans demonstrated that this compound inhibits COX and LOX after oral administration, and that single doses up to 800 mg and multiple doses up to 400 mg are well tolerated. Licofelone (formerly known as ML3000) is a novel dual 5-LOX/COX inhibitor today in phase III clinical development that effectively inhibits leucocyte transcellular metabolism and adhesion, as well as the synthesis of cysteinyl LTs. This compound is a pyrroline derivative and an arachidonic acid substrate analogue that inhibits both enzymes. This compound has shown a good pattern of tissue distribution, with highest tested levels being reached in the lung, liver, kidneys, heart, and large and small intestine. Moreover, this compound did not show hepatotoxicity either in preclinical or clinical studies.

In animal models, licofelone exhibits anti-inflammatory, analgesic, and antipyretic properties at a dosage that causes no GI damage. The anti-inflammatory activity has been mainly studied in the rat model of adjuvant arthritis. This model showed that the reduction of the experimentally induced secondary lesions and paw swelling obtained with licofelone was similar to that seen with indometacin, and that the compound can reduce synovial cell proliferation, histological damage, and joint erosions in an affected ankle joint. The effects of licofelone on experimentally induced osteoarthritic cartilage lesions were also studied in a dog model (osteoarthritis was induced by anterior cruciate ligament section); compared with placebo licofelone significantly reduced the severity of erosions and histological damage by exerting an inhibitory effect on the production of collagenase-1 in cartilage, IL1β in synovial membrane, LTB4 in synovium, and PGE2 in synovial fluid. Licofelone was also shown in this model to be, in vivo, effective in reducing the level of chondrocyte death. This effect is likely mediated by a decrease in the level of caspase-3 activity, which may be related to the reduced production of two major factors involved in chondrocyte apoptosis, NO and PGE2. The gastric tolerance of licofelone given in single and repeated doses has been compared with that of indometacin and with that of diclofenac in animals. The
results showed that the drug generates minimal GI damage and is significantly better than ulcerogenic reference drugs. Unlike the comparator drugs, licofelone significantly reduced LTB4, levels in the paw and did not induce leukocyte adherence, thereby suggesting that inhibition of the 5-LOX pathway may explain the gastric sparing effects of dual inhibitors. Licofelone has also been directly compared with celecoxib in an assessment of the effects of these two drugs on the gastric mucosa in aspirin treated rats. Celecoxib, but not licofelone, increased the gastric mucosal damage when given to aspirin treated rats and caused a marked increase of aspirin induced myeloperoxidase activity. It therefore seems that the effectors synthesised by the 5-LOX pathway provide a sustained contributory effect to gastric injury.

In summary, the 5-LOX/COX blockers have an excellent preclinical GI pharmacological safety profile. Moreover, the present findings in phase II and III studies of the clinical development of licofelone indicate that this drug also has an excellent GI profile, which was better than conventional NSAIDs such as naproxen and equivalent to specific COX-2 inhibitors.

Tolerability was studied in healthy volunteers after 200 or 400 mg twice a day for four weeks in comparison with naproxen 500 mg twice a day; the gastric mucosa was completely normal in 93% (200 mg twice a day), 89% (400 mg twice a day), 90% (placebo), 37% (naproxen) of patients. In a study of osteoarthritic patients treated for 12 weeks with licofelone 200 mg twice a day or with naproxen 500 mg twice a day, licofelone showed a comparable efficacy to conventional NSAIDs but with excellent GI and general tolerability. No ulcers were present in either the licofelone or placebo group, while in the naproxen group ulcers occurred in 20%. GI adverse events were reported by 13% (licofelone) and by 26.3% (naproxen) of patients. The combined inhibition of both COXs and of 5-LOX avoids some disadvantages of selective COX-2 inhibitors (thromboembolic risk), but spares also the GI mucosa. A study of the pharmacokinetics, safety, and tolerability of licofelone (200 mg twice a day for five days with a final dose of 200 mg in the morning of day 6 after a standardised meal) was performed in young and elderly healthy volunteers.

Maximum plasma concentration was achieved 0.74–4 hours after the dose. After the first dose, Cmax (mean (SD)) was essentially identical for young (1663 (1151) ng/ml) and elderly (1637 (903) ng/ml) subjects. The mean area under the curve (AUC; 0–12) was about 23% higher in elderly than in subjects (5646 (2073) v 4582 (1927) ng.h/ml). Pharmacokinetic analysis in the steady state also demonstrated a similarity of Cmax,ss (young 1727 (829) ng/ml, elderly 1744 (616) ng/ml) and a 20% higher AUC in elderly subjects than in young subjects. A 20% higher value for the AUC in the elderly is not expected to be clinically significant in light of the minimal accumulation upon twice a day dosing. Licofelone was well tolerated in both study groups.

CONCLUSIONS
The pharmacological properties and unwanted side effects (GI ulcerogenic activity and bronchoconstriction) of classical NSAIDs and aspirin-like products which act, respectively, through non-reversible and reversible inhibition of COX activity, and the conversion of arachidonic acid into biologically active PGs and TXs, have been well established. Classical NSAIDs and selective COX-2 inhibitors block the cascade originating from arachidonic acid that leads to the production of PGs. Besides their inflammatory properties, PGs generated by COX-2 are also involved in several physiological functions, such as protecting the integrity of the gastric mucosa, homoeostasis of renal blood flow, and anti-aggregation of platelets. Consequently, the inhibition of COX-2 produces a lower rate of GI adverse effects, but may impair gastric ulcer healing and may result in altered glomerular function and platelet properties. Furthermore, COX inhibition probably shunts arachidonic acid metabolism towards an excess production of LTs.

The proinflammatory role of LTB4, and cysteinyl LTs, their chemoattractant action, and their recruitment of inflammatory cells have recently been elucidated. Furthermore, it has been shown that metabolically active LXs, also derived from arachidonic acid metabolism, have anti-inflammatory properties; 5-LOX blockage does not impair the synthesis of LXs, which are the products of the activation of other enzymatic pathways.

The dual 5-LOX/COX inhibitors act by blocking the formation of both PGs and LTs without affecting FX formation. The sparing effects on the gastric mucosa are probably due to the inhibition of the synthesis of 5-LOX products. It can, therefore, be expected that dual blockers induce an enhanced anti-inflammatory effect without damaging the GI mucosa.


Dual inhibitors of 5-LOX and COX and NSAIDs


Therapeutic role of dual inhibitors of 5-LOX and COX, selective and non-selective non-steroidal anti-inflammatory drugs

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doi: 10.1136/ard.62.6.501

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