

ORIGINAL ARTICLE

## Factors associated with the effect of anamorelin on cachexia in patients with non-small cell lung cancer

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### Abstract

**PURPOSE:** Anamorelin, a ghrelin receptor agonist, is approved in Japan for the treatment of cachexia in patients with lung and gastrointestinal cancer. However, there is limited research on the usefulness of anamorelin in clinical settings.

**METHODS:** A total of 40 patients with non-small cell lung cancer and cachexia who were prescribed anamorelin between July 2021 and November 2022, were retrospectively assessed. A logistic regression analysis was used to analyze the association between background characteristics and early discontinuation of treatment with anamorelin (within 4 weeks).

**RESULTS:** The median age was 67 years (range, 36-88), and 65% of the patients were male. The early discontinuation group included 11 patients (27.5%). An Eastern Cooperative Oncology Group Performance Status (ECOG-PS) score  $\geq 2$  (odds ratio, 7.85; 95% confidence interval, 1.43-43.21;  $P=0.018$ ) was associated with early discontinuation. A total of 18/40 patients were able to continue anamorelin treatment for 12 weeks, and the mean change in body weight was +2.31 kg, which was a significant change from the weight recorded at baseline ( $P=0.027$ ).

**CONCLUSION:** This study indicates that anamorelin is unlikely to be useful for patients with a poor general condition (ECOG-PS score  $\geq 2$ ).

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**Key words:** anamorelin; cachexia; NSCLC.

### Introduction

Lung cancer is one of the most common cancers in the world, with approximately 2.2 million new cases diagnosed in a year, according to statistics from 2020<sup>1)</sup>. Non-small cell lung cancer accounts for 85% of these cases<sup>2)</sup>.

Cancer cachexia is characterized by weight loss, anorexia, inflammation and decreased skeletal muscle mass, and is diagnosed in 50-80% of patients with cancer<sup>3)</sup>. Cachexia not only impairs quality of life, but also decreases the tolerability of anticancer chemotherapy<sup>4)</sup>, and is associated with a poor prognosis<sup>5)</sup>. Cancer

cachexia was defined in 2011 as a multifactorial syndrome characterized by an ongoing loss of skeletal muscle mass, with or without loss of fat mass, that cannot be fully reversed by conventional nutritional support, leading to progressive functional impairment. The diagnostic criteria for cachexia include  $>5\%$  body weight loss or  $>2\%$  weight loss in individuals who have already shown depletion according to their current body weight and height [body mass index (BMI),  $<20 \text{ kg/m}^2$ ] or skeletal muscle mass (sarcopenia)<sup>6)</sup>. Although guidelines for the management of cancer cachexia have recently been published, pharmacological

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treatment for cancer cachexia is limited at present<sup>7,8)</sup>.

Anamorelin is an oral selective ghrelin-like agonist that has received attention as a novel drug for the treatment of cachexia<sup>9-11)</sup>. Ghrelin is a peptide hormone secreted by the stomach that acts as a regulator of hunger and a growth hormone secretagogue<sup>12-15)</sup>. Previous phase 1 and 2 studies have evaluated the safety and efficacy of anamorelin<sup>16-18)</sup>. Global phase 3 studies in patients with non-small cell lung cancer (NSCLC)<sup>19, 20)</sup> and Japanese studies in patients with either NSCLC<sup>21, 22)</sup> or gastrointestinal cancers<sup>23)</sup> have also reported the effects of anamorelin on lean body mass (LBM). In the phase 2 study ONO-7643-04 of NSCLC in Japan, 64.4% of patients maintained or increased their LBM<sup>22)</sup>. Although these studies did not report improvements in physical function, the primary endpoint of increased LBM was notable, leading to the approval of anamorelin in Japan in 2021<sup>24)</sup>.

In the present study, a retrospective evaluation was performed, assessing whether anamorelin provides the same benefit to patients with cachexia as reported in previous clinical trials or if there are patient factors that affect the efficacy of anamorelin in practice.

## Materials and methods

**Study design.** The present study was a retrospective observational study. It was performed in accordance with the Declaration of Helsinki and the regulations of the Japanese Ministry of Health, Labor and Welfare, and was approved by the Ethics Committee of the Hirosaki University Graduate School of Medicine (approval no. 2023-164). Informed consent was obtained from all patients using the opt-out method. A total of 40 patients received 100 mg anamorelin (ADLUMIZ<sup>®</sup>; Ono Pharmaceutical Co., Ltd.) orally once daily. All patients experienced a weight loss of >5% within 6

months and  $\geq 2$  of the following symptoms: i) Fatigue or malaise; ii) muscle weakness; and iii)  $\geq 1$  of the following conditions: >0.5 mg/dl C-reactive protein (CRP), <12 g/dl hemoglobin (Hb) and <3.2 g/dl albumin (Alb).

**Data extraction.** The medical records of the patients treated with anamorelin between July 2021 and November 2022 at Hirosaki University Hospital were screened. The following baseline patient characteristics at the start of anamorelin treatment were obtained from their medical records: Age, sex, histological type of cell carcinoma (squamous/non-squamous), stage<sup>25)</sup>, number of treatment regimens, Eastern Cooperative Oncology Group (ECOG) -performance status (PS) score<sup>26)</sup>, body weight, BMI, Alb, CRP and Hb levels. The reasons behind the discontinuation of treatment with anamorelin within 4 weeks (early discontinuation group) were also obtained. The body weight, LBM and soft lean mass (SLM) of patients who received anamorelin for >12 weeks were measured using InBody770 (InBody Co., Ltd.) at the beginning of the study and then again at week 12. Adverse events that were indefinitely related to anamorelin treatment were recorded using the Common Terminology Criteria for Adverse Events (version 5.0)<sup>27)</sup>.

**Statistical analyses.** Patients were divided into two groups: The early discontinuation group (discontinuation within 4 weeks) and all other patients. The reason for dividing the patients into these two groups was that typical chemotherapy regimens for lung cancer last 3-4 weeks per course, therefore, patients who discontinued anamorelin after only one course were unlikely to benefit from anamorelin. Logistic regression analysis was used to analyze factors associated with early discontinuation. In patients who continued treatment for 12 weeks, a paired Student's t-test was used to compare

**Table 1** Patient characteristics at baseline.

Characteristics	Value
Age, n (range), years	67 (36-88)
Sex, n (%)	
Male	26 (65.0)
Female	14 (35.0)
Histology, n (%)	
Squamous cell carcinoma	11 (27.5)
Non-squamous cell carcinoma	29 (72.5)
Stage, n (%)	
III	6 (15.0)
IV	27 (67.5)
Recurrence after chemoradiotherapy	7 (17.5)
Number of treatment regimens, n (%)	
1	20 (50.0)
≥2	20 (50.0)
Driver mutation, n (%)	
None	28 (70.0)
Yes	12 (30.0)
EGFR	7
BRAF	3
MET	2
ECOG-PS score, n (%)	
0	0 (0.0)
1	24 (60.0)
2	11 (27.5)
3	5 (12.5)
4	0 (0.0)
Body mass index (range), kg/m <sup>2</sup>	19.50 (14.00-27.80)
Serum albumin (range), g/dl	2.90 (2.20-4.20)
C-reactive protein (range), mg/dl	1.80 (0.02-15.10)
Hemoglobin (range), g/dl	11.20 (7.90-16.30)

EGFR, epidermal growth factor receptor. BRAF, V-Raf murine sarcoma viral oncogene homolog B. MET, mesenchymal-epithelial transition. ECOG-PS, Eastern Cooperative Oncology Group-Performance Status.

changes in body weight, LBM and SLM. Statistical analyses were performed using JMP<sup>®</sup> Pro (version 15.2.0; SAS Institute Inc.).  $P < 0.05$  was considered to indicate a statistically significant difference.

## Results

Patient characteristics. Anamorelin is indicated for the treatment of NSCLC and gastrointestinal cancer<sup>24)</sup>, but not for other histological types such as small cell lung cancer, therefore, all patients had NSCLC. The patients' characteristics are presented in Table 1. The median age was 67

years (range, 36-88 years). The proportion of male patients was 65%. Patients' ECOG-PS scores were 1 (n=24), 2 (n=11), and 3 (n=5), including patients with PS scores of 3 or higher who were excluded from the clinical trials 19-22). A total of 12 patients (30%) had driver mutations that could be treated using molecularly targeted drugs. The number of treatment lines was 20 (50%) for first-line treatment and 20 (50%) for second- or later-line treatment, and the regimens are presented in supplemental table 1.

**Table 2** A logistic regression analysis of factors associated with early discontinuation of treatment with anamorelin.

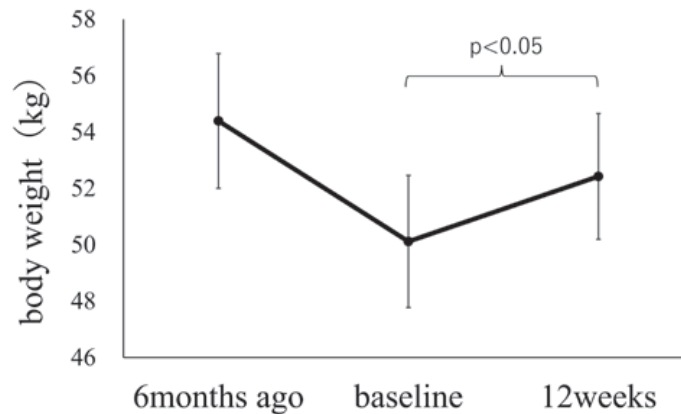
Characteristics	Univariate analysis			Multivariate analysis		
	Odds ratio	95% CI	P-value	Odds ratio	95% CI	P-value
Age	0.90	0.83-0.99	0.040 <sup>a</sup>	1.11	0.99-1.24	0.060
Sex, male vs female	0.92	0.21-3.92	0.910			
Histology, sq vs non-sq	1.79	0.40-8.00	0.440			
Stage, III vs IV/rec	0.72	0.11-4.62	0.730			
Line of chemotherapy, 1 vs ≥2	0.94	0.24-3.73	0.940			
Driver mutation, none vs yes	1.50	0.34-6.54	0.590			
ECOG-PS score, ≥2 vs 0-1	7.00	1.47-33.20	0.014 <sup>a</sup>	7.85	1.43-49.21	0.018 <sup>a</sup>
Body mass index	1.04	0.85-1.27	0.710			
Serum albumin	1.31	0.40-4.29	0.650			
C-reactive protein	0.91	0.75-1.09	0.270			
Hemoglobin	1.01	0.69-1.45	0.970			

P<0.05. sq, squamous cell carcinoma; rec, recurrence after chemoradiotherapy; ECOG-PS, Eastern Cooperative Oncology Group-Performance Status; CI, confidence interval.

**Supplemental table 1** Concomitant treatment.

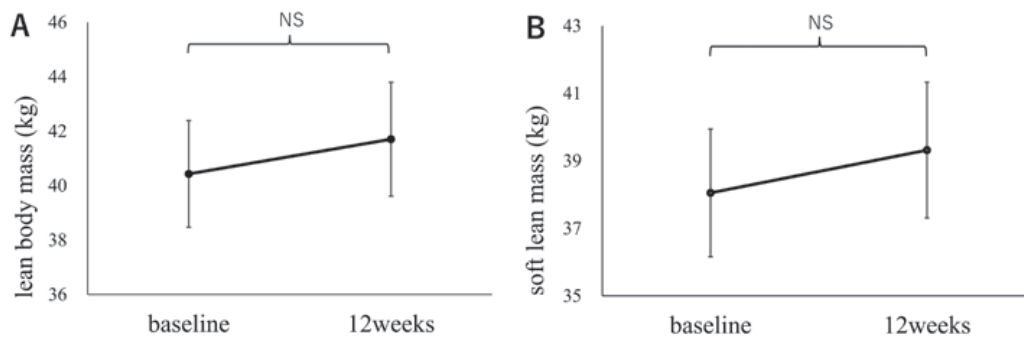
<b>Chemotherapy</b>	
Platinum-doublet	5 (12.5%)
ICI + platinum-doublet	2 (5%)
Cytotoxic monotherapy	11 (27.5%)
ICI monotherapy	4 (10%)
Molecularly-targeted therapy	7 (17.5%)
<b>Chemoradiotherapy</b>	4 (10%)
<b>Best supportive care</b>	7 (17.5%)

Data are expressed as n (%). ICI; immune checkpoint inhibitor

**Figure 1** Changes in body weight of patients receiving treatment with anamorelin for 12 weeks.

**Risk factors for the early discontinuation of treatment with anamorelin.** The duration of anamorelin treatment was <4 weeks in 11 patients (27.5%), 4-12 weeks in 11 patients (27.5%) and >12 weeks in 18 patients (45%).

The reasons for the discontinuation of treatment with anamorelin in the early discontinuation group were as follows: Deterioration of general condition due to cancer progression (n=5); deterioration of general condition due to



**Figure 2** Changes in (A) lean body mass and (B) soft lean mass in patients receiving treatment with anamorelin for 12 weeks. NS, not significant.

chemotherapy-related adverse events (e.g. drug induced interstitial lung disease) (n=3); refusal of treatment by the patient (n=3).

In the early discontinuation group, three patients had an ECOG-PS score 1, three patients had an ECOG-PS score 2 and five patients had an ECOG-PS score 3, indicating that most patients had a poor general condition. Table 2 presents the associations between early discontinuation and patient characteristics. A univariate analysis of every background characteristic of the patients indicated  $P < 0.05$  for a younger age [odds ratio, 0.90; 95% confidence interval (CI), 0.83-0.99;  $P = 0.042$ ] and an ECOG-PS score  $\geq 2$  (odds ratio, 7.00; 95% CI, 1.47-33.20;  $P = 0.014$ ). A multivariate analysis of younger age and an ECOG-PS score  $\geq 2$  demonstrated that only an ECOG-PS score  $\geq 2$  was significantly associated with early discontinuation (odds ratio, 7.85; 95% CI, 1.43-43.91;  $P = 0.018$ ). The number of treatment lines at the beginning of the study was assessed, but no significant differences were revealed (odds ratio, 0.94; 95% CI, 0.24-3.73;  $P = 0.94$ ). There were also no significant differences in the presence of driver gene mutations (odds ratio, 1.5; 95% CI, 0.34-6.54;  $P = 0.59$ ). Sex, histology, BMI and laboratory results on Alb, CRP and Hb levels were not significantly associated with early discontinuation.

**Body weight changes.** The mean change in body weight from baseline in the 18 patients who received anamorelin for 12 weeks was +2.31 kg, which was a significant change ( $P = 0.027$ ; Fig. 1). The weight of a total of 15/18 patients was measured using Inbody at baseline and at 12 weeks, and the mean change in LBM and SLM was +1.97 kg ( $P = 0.14$ ; Fig. 2A) and +1.26 kg ( $P = 0.15$ ; Fig. 2B), respectively.

**Adverse events.** Adverse events possibly related to anamorelin treatment were observed in four patients (10%). A total of two patients experienced a decline in diabetic control, as shown by the increased level of HbA1c, and two patients experienced nausea; both adverse events were of grade 1. No adverse events were observed with respect to cardiac function, such as atrioventricular block or QT interval prolongation. None of the patients required a dose reduction of anamorelin.

## Discussion

In the present study, an evaluation of the effectiveness of anamorelin in clinical settings was performed as in previous clinical trials<sup>19-23</sup>. In the ONO-7643-04 clinical trial, 55/84 patients (65.4%) completed 12 weeks of treatment with anamorelin<sup>22</sup>, compared with only 18/40 patients

(45%) in the present study. Patients in the early discontinuation group who received anamorelin for <4 weeks were considered to have discontinued anamorelin before it became effective.

The main factor associated with early discontinuation of treatment with anamorelin was a poor general condition (ECOG-PS score  $\geq 2$ ). The ONO-7643-04 clinical trial included an ECOG-PS score range of 0-2 among its enrollment criteria, but only 12.0% of patients in the anamorelin group had an ECOG-PS score 2<sup>22)</sup>. There are no restrictions on the administration of anamorelin using the ECOG-PS scores in clinical settings<sup>24)</sup>. In the present study, 16/40 patients (40%) had an ECOG-PS score 2 or 3, which may have led to an increased early discontinuation rate. Although the subgroup analysis of the ONO-7643-04 clinical trial did not report the characteristics of patients who did not complete the full 12 weeks of treatment, the change in LBM was not notably greater for the anamorelin treatment group compared with that in the placebo group in the ECOG-PS score 2 subgroup from baseline to week 12<sup>28)</sup>. This indicated that the efficacy of treatment with anamorelin was reduced in patients with poor general condition. It is possible that the duration of treatment is shorter in patients with poor general condition; therefore the efficacy of anamorelin may not be fully demonstrated.

In the present study, significant changes in body weight were observed in the 18/40 patients who received treatment with anamorelin for 12 weeks. There were no significant changes in either LBM or SLM, but the mean changes after 12 weeks of treatment with anamorelin were +1.97 kg and +1.26 kg, respectively. In the ONO-7643-04 clinical trial, the mean change in LBM after 12 weeks was +1.38 kg in the anamorelin treatment group<sup>22)</sup>, and a trend towards maintenance or mild increase in the LBM was also observed in this study.

Loss of body weight has deleterious effects on the efficacy of anticancer therapies<sup>29-31)</sup>. A previous study reported decreased skeletal muscle mass in patients who responded to palliative chemotherapy as well as in those patients who experienced cancer progression<sup>32)</sup>. Another study reported that molecular-targeted therapy decreased skeletal muscle mass in renal cancer<sup>33)</sup>. The aforementioned studies indicated that the body weight gain effect of treatment with anamorelin may be useful as a supportive therapy.

Cachexia is classified into three stages: Pre-cachexia, cachexia and refractory cachexia<sup>6)</sup>. Pre-cachexia is a condition in which the patient does not meet the body weight loss criteria for cachexia but presents with anorexia and metabolic abnormalities. Although pre-cachexia and cachexia require early multidisciplinary intervention, including exercise, nutrition and medication, refractory cachexia is characterized by progressive catabolism, a poor ECOG-PS score and a predicted survival of 3 months. Refractory cachexia is a common complication in many patients, especially in the terminal stages of cancer. Corticosteroids are often used in patients with refractory cachexia because of their short-term appetite-stimulating and anti-inflammatory effects. ASCO guidelines recommend their use for a short period of time, although they are moderately recommended<sup>8)</sup>. Except for the use of corticosteroids, the intervention is primarily palliative<sup>6)</sup>. In the present study, 8/11 patients in the early discontinuation group had an ECOG-PS score 2 or 3, suggesting that most of them had refractory cachexia. In clinical practice, anamorelin is likely to be prescribed to patients with refractory cachexia, as observed in the present study. However, the present study demonstrated that anamorelin should also be prescribed to patients with cachexia or pre-cachexia.



In a subgroup analysis of the ONO-7643-04 study, the incidence of adverse drug reactions (ADRs) increased with age and ECOG-PS score 2, but there was no increase in severe ADRs<sup>22)</sup>. In the present study, more patients had an ECOG-PS score  $\geq 2$  than in the clinical trials, but there was no increase in ADRs.

To evaluate whether cachexia has improved in a patient, it is important to note changes not only in LBM but also physical function, such as hand grip strength<sup>34)</sup> and the 6-minute walk test (6-MWT). In clinical trials of anamorelin, no notable improvement in hand grip strength<sup>19, 20, 22)</sup> and 6-MWT<sup>22)</sup> was reported. Thus, pharmacological interventions alone do not improve physical function. Multidisciplinary treatment trials combining nutritional and exercise therapies have now been performed<sup>35-37)</sup>. A clinical trial is currently underway to evaluate activities of daily living (ADLs) maintenance of anamorelin treatment in addition to nutritional and exercise interventions (trial registration no. UMIN000033574; University Hospital Medical Information Network Center).

Several limitations are associated with the present study. First, it was a single-center retrospective study, presenting a risk of selection biases. However, anamorelin is currently only approved in Japan, but the present study was conducted in a real clinical setting and may help to understand the types of patients who can benefit most by treatment with anamorelin. Second, the background characteristics of the patients, such as their chemotherapy regimen and the number of treatment lines, varied. It is possible that the efficacy or side effects of chemotherapy contributed to the weight gain or loss in the group of patients who continued for >12 weeks. However, the small number of patients and the heterogeneity of the regimens in the present study made such an analysis challenging. Third, physical function was not assessed, however, clinical trials of anamorelin

have not reported any improvement in physical function, and it is still unclear whether anamorelin improves physical function.

In conclusion, the present study demonstrated that anamorelin may not be significantly effective in patients with a poor general condition (ECOG-PS score  $\geq 2$ ). However, a significant change in body weight was observed in patients who were able to continue anamorelin treatment for 12 weeks, with no safety concerns. As the present study only included a small number of patients, further research on a larger number of patients is required.

**Competing interests:** HT, TM, HS, KT and ST received lecture fees from Ono Pharmaceutical Co., Ltd., however the company had no role in the study design, data collection, analysis or interpretation of data, or in writing the draft version of the manuscript.

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