Clinical Genomic Cases

Pharmacogenetics of Clopidogrel
An Unresolved Issue

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Clinical Case
A 58-year-old male was presented with an ST-elevation inferior myocardial infarction. Emergency medical services administered 325 mg of aspirin and sublingual nitroglycerin en route to the emergency room.

In the emergency room, the patient received 600 mg of clopidogrel and a heparin bolus. Coronary angiography revealed complete occlusion of the distal right coronary artery with thrombus. Intravenous epifibatide was given at the start of the percutaneous coronary intervention (PCI). Intravascular ultrasound demonstrated significant soft atheroma and ruptured plaque in the distal right coronary artery at the crux. A drug-eluting stent was deployed with an excellent angiographic result.

Postintervention, the patient’s chest pain and ECG demonstrated complete resolution of the previous ischemic changes. Approximately 11 hours after being treated in the emergency room, the patient developed recurrent chest pain. He was restarted on epifibatide and heparin, and repeat coronary angiography demonstrated total occlusion at the origin of the right coronary artery stent (Figure 1).

Thrombectomy was performed, removing huge amounts of atherothrombotic material (Figure 2). Intravascular ultrasound did not demonstrate stent edge dissection or stent malapposition.

A drug-eluting stent with 1-mm overlap with the distal edge of the previous stent was deployed. The patient was felt to have failed clopidogrel therapy and was transitioned to prasugrel therapy. The patient was screened for genetic variants in CYP2C19, the gene encoding the cytochrome P450 enzyme CYP2C19 that metabolizes clopidogrel.

Pharmacogenetic Test Results
A Luminex assay using a polymerase chain reaction was used to test for the presence or absence of CYP2C19*17, *4, *8, *6, *9, *3, *10, *2, *7, and *5 alleles. Genetic testing revealed a genotype of CYP2C19 *1/*17 or heterozygosity for CYP2C19*17 (rs12248560). Prodrugs, such as clopidogrel, may be activated to the therapeutic metabolite to a greater degree by individuals, who carry the CYP2C19*17 allele. Genetic testing for CYP2C19 variants did not explain clopidogrel failure or the propensity for stent thrombosis in this patient, paradoxically the CYP2C19*17 allele should have potentially predisposed the patient to increased bleeding complications. Unlike patients with CYP2C19*17 genotype, patients who are CYP2C19 poor metabolizers, that is those who are carriers of CYP2C19 loss of function (LOF) variant alleles such as *2 or *3, have been shown to have a significantly increased risk for stent thrombosis.

Clopidogrel Pharmacogenetics
Clopidogrel is a prodrug and is metabolized by CYP2C19 into active thiol metabolites by a 2-step oxidative biotransformation process. Only the active metabolite of clopidogrel targets the P2Y12 receptor for ADP on platelets. The most common LOF variant alleles are CYP2C19*2 and *3 alleles that result in nonfunctional proteins. The haplotype CYP2C19*2 comprises the variant rs4244285, which is a synonymous single-nucleotide polymorphism affecting the amino acid residue proline at position 227 in exon 5. Although guanine substitution by adenine does not change the proline amino acid, it creates an aberrant splice site, resulting in a premature stop codon. The single-nucleotide polymorphism rs4986893 (G636A) comprising the CYP2C19*3 haplotype results in guanine substitution by adenine and substitution of the TGG codon that encodes tryptophan by TGA, a stop codon in exon 4 resulting in a truncated nonfunctional protein. The minor allele frequency of CYP2C19*2 varies as per ethnic group, being most prevalent in East Asians (29%) and with approximately equal frequency in both the subjects of African (15%) and European (15%) origin. CYP2C19*3 is rare in subjects of European and African ancestry (minor allele frequency <1%); however, it is more common in East Asians (minor allele frequency =9%). CYP2C19*2 and *3 account for ≥99% of the LOF alleles in a multiethnic population.

CYP2C19 Genotype and Clopidogrel Pharmacokinetics
LOF alleles in CYP2C19 result in lower clopidogrel active metabolite levels. The area under the plasma concentration curve during 0 to 24 hours and maximum plasma concentration Cmax for the active metabolite of clopidogrel for CYP2C19*2 heterozygote carriers was 54% and 60% that of wild-type subjects. In a separate study by Umemura et al that in addition to CYP2C19*2 included subjects with the CYP2C19*3...
CYP2C19 Genotype and Clopidogrel Pharmacodynamics

The presence of an LOF CYP2C19 allele has been associated with high-residual platelet reactivity on clopidogrel therapy. In a meta-analysis involving 4341 subjects who received a 600-mg loading dose of clopidogrel, there was a significant high-residual platelet reactivity that seemed to reflect a gene-dose effect in carriers of CYP2C19*2 genotype when compared with noncarriers. In a collaborative meta-analysis that primarily focused on patients who underwent PCI, involving 9685 study participants receiving clopidogrel (91.3% with PCI, 54.5% with acute coronary syndromes), carriers of 1 (hazard ratio, 1.55) or 2 (hazard ratio, 1.76) CYP2C19 LOF alleles had a significantly increased risk of the composite end point of cardiovascular death, myocardial infarction, or stroke. Pertinent to the case described, there was also an increased risk of stent thrombosis for heterozygotes (hazard ratio, 2.67) and for homozygotes (hazard ratio, 3.97). A subsequent meta-analysis by Holmes et al evaluating 32 studies of 42016 patients, a treatment-only analysis revealed that carriers of 1 or 2 CYP2C19 LOF alleles were at a higher risk for cardiovascular events (relative risk, 1.18; absolute risk increase of 8–12 events per 1000 individuals). When this analysis was restricted to studies with ≥200 events, the relative risk of increased events was not significant.

Alternatives to Clopidogrel

Newer antiplatelet drugs, such as prasugrel and ticagrelor, have shown benefits over clopidogrel in patients with acute coronary syndrome but also increase the risk of major bleeding. Common genetic variation in CYP2C19 does not seem to affect prasugrel or ticagrelor pharmacokinetics, its effect on platelet aggregation, or clinical outcomes. Therefore, these therapies may be useful alternatives to clopidogrel in carriers of CYP2C19 LOF genetic variants. Ticagrelor has to be dosed twice daily and causes dyspnea in 15% of patients, an adverse event that is responsible for 55% of drug withdrawal. Prasugrel cannot be administered to patients with a history of stroke or transient ischemic attacks and is not recommended for patients ≥75 years of age. Current American College of Cardiology (ACC)/American Heart Association (AHA) guidelines for the use of antiplatelet therapy in acute coronary syndromes (2014), ST-elevation myocardial infarction (2013) and PCI (2011) continue to recommend the use of clopidogrel as a class I, level of evidence B drug. Reflective of these guidelines, clopidogrel remains the most widely prescribed antiplatelet drug both in the United States and Canada.
Recommendations for CYP2C19 Genotyping With Clopidogrel Use

The Food and Drug Administration have issued a black box warning advising practitioners to consider alternative treatment in patients identified as CYP2C19 poor metabolizers and note that these patients can be identified by genotyping. However, routine clinical use of genotyping to identify CYP2C19 LOF alleles in patients treated with clopidogrel is not recommended in the latest guidelines published by the ACC, AHA, and Society for Cardiovascular Angiography and Interventions (SCAI). Clopidogrel treatment failure may be multifactorial and recognition of noncompliance, drug–drug interactions, and relevant comorbidities is critical when addressing treatment success. With these factors in mind, genotyping for CYP2C19 variant alleles is not recommended by the ACC, AHA, and SCAI because of lack of prospective evidence from randomized clinical trials that could adjust for these confounding factors in a systematic way. The 2011 ACC/AHA/SCAI PCI guidelines have recommended (as class Ib) that CYP2C19 genetic testing may be considered in patients at high risk for poor clinical outcomes. To address the gap in clinical evidence, large, prospective randomized clinical trials, TAILOR-PCF and POpular Genetics study, of genotype-directed antiplatelet therapy compared with routine care are underway.

In contrast to ACC/AHA guidelines, the Clinical Pharmacogenetics Implementation Consortium (CPIC) guidelines recommend that patients with acute coronary syndrome who undergo PCI and are identified to have 1 or 2 CYP2C19 LOF alleles are considered to be intermediate and poor metabolizers, respectively, and should be treated with alternative antiplatelet therapy, such as prasugrel or ticagrelor. The strength of the recommendation was considered moderate for the polymorphism of (S)-mephentoin metabolism in Japanese. The Pharmacogenetics Implementation Consortium guidelines for cytochrome P450 2C19 (CYP2C19) genotype and clopidogrel therapy. Clin Pharmacol Ther. 2011;90:328–332. doi: 10.1038/cpt.2011.132.


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