Phosphodiesterase inhibition in the treatment of autoimmune and inflammatory diseases: current status and potential

Mindi S Miller
University of Georgia College of Pharmacy, Athens, GA, USA

Abstract: Cyclic nucleotide second messengers adenosine-3′,5′-cyclic monophosphate (cAMP) and guanosine-3′,5′-cyclic monophosphate (cGMP) influence numerous cellular functions, including inflammatory and immune responses. Intracellular levels of these nucleotides are regulated by a diverse group of phosphodiesterase enzymes. Inhibition of the various types of phosphodiesterase enzymes may offer a novel means to manage both inflammatory and autoimmune disorders. Recently, progress has been made in the development of phosphodiesterase inhibitors for a variety of conditions. This article reviews recent developments in the search for phosphodiesterase inhibitors as novel therapeutic agents for inflammatory and autoimmune conditions.

Keywords: phosphodiesterase (PDE) inhibitors, inflammatory disease, autoimmune disease

Introduction

The cyclic nucleotides adenosine-3′,5′-cyclic monophosphate (cAMP) and guanosine-3′,5′-cyclic monophosphate (cGMP) act as intercellular second messengers by facilitating the action of many hormones, neurotransmitters, and inflammatory mediators. These messengers play an integral role in numerous bodily processes, including inflammation, immune response, vascular resistance, cardiac output, gastrointestinal motility, neuroplasticity, reproduction, and vision. The phosphodiesterase (PDE) family of enzymes is responsible for the degradation of cAMP and cGMP, and therefore plays a key role in modulating intracellular levels of the second messengers and, in the process, also become regulators of cell function. The PDE enzymes have been described as a “super family”, comprise at least 21 genes (over 40 isoforms), and are grouped into eleven subfamilies based on amino acid sequence, regulation, pharmacologic properties, and susceptibility to pharmacologic treatments. Because PDEs are located in every cell in the body, the enzymes are considered therapeutic targets for several disease states ranging from sexual dysfunction and congestive heart failure to asthma and chronic obstructive pulmonary disease (COPD) (Table 1).

Since the 1970s, PDE inhibitors have been investigated as potential and actual treatments for numerous medical conditions. These compounds include both non-specific PDE inhibitors such as theophylline as well as moieties that target a specific PDE family such as sildenafil and other PDE5 antagonists. Inflammatory cells seem to be especially sensitive to the effects of increased levels of cyclic nucleotides. In fact, PDE inhibitors demonstrate anti-inflammatory and immunosuppressive effects by suppressing immune cells such as T-cells, basophils, and mast cells. This review focuses on PDE inhibitors as treatment for inflammatory and autoimmune disease.

Journal of Receptor, Ligand and Channel Research downloaded from https://www.dovepress.com/ by 54.70.40.11 on 29-Jun-2020
For personal use only.
Powered by TCPDF (www.tcpdf.org)
### PDE inhibitors in inflammatory disorders

#### Asthma

Asthma is defined as a chronic inflammatory disease of the airways. The disorder is characterized by infiltration of inflammatory cells, including mast cells, eosinophils, T-lymphocytes, and neutrophils. Patients with severe asthma show increased levels of neutrophils and eosinophils in sputum samples, and bronchial mucosa also shows elevated numbers of these cells. In addition, some research has shown that T-lymphocytes, particularly type 2 helper (Th2) differentiated cluster of differentiation (CD)4+ cells, are important in the inflammatory response. Cytokines, which play a role in the cellular response to asthma, are released from the CD4+ cells. These cytokines include interleukin (IL)-4 and IL-13. The inflammatory response may cause bronchial hyper-responsiveness and airway obstruction that contribute to symptoms such as wheezing, dyspnea, coughing, and tightness in the chest.

Theophylline, a nonselective PDE inhibitor, has been used in the treatment of asthma for almost a century. Theophylline (Figure 1A) is a methylxanthine that primarily inhibits PDE3 and PDE4 isoenzymes in airway smooth muscle, causing both bronchodilation and anti-inflammatory effects. It is also a strong adenosine receptor antagonist and an activator of histone deacetylase. Theophylline exhibits an anti-inflammatory response and also may work synergistically with corticosteroids to reduce the inflammatory response seen in asthma. Studies have shown that withdrawal of theophylline in asthmatic patients also taking corticosteroids causes a significant increase in symptoms of asthma. In addition, theophylline withdrawal in these patients results in an increase in T-lymphocytes in lung tissue. Use of theophylline is limited by side effects such as nausea, headache, diarrhea, tachycardia, and arrhythmias. It also has several drug interactions and a narrow therapeutic index.

Most PDE isoenzymes are expressed in lung tissue, including PDE1, PDE2, PDE3, PDE4, PDE5, PDE7, PDE8, and PDE9; however, PDE3 and PDE4 have been the primary targets for drug therapy. The PDE4 isoenzyme is found in most inflammatory and immune cells, including T-cells, eosinophils, neutrophils, B-cells, monocytes, macrophages, and dendritic cells. In several preclinical studies, PDE4 inhibitors have been shown to suppress bronchial hyper-responsiveness, eosinophil infiltration, and production of histamine, leukotrienes, and cytokines.

#### Table 1: Phosphodiesterase superfamily

| PDE family | Substrate | Tissue distribution | Inhibitors | Clinical applications |
|------------|-----------|---------------------|------------|----------------------|
| PDE1       | cGMP>cAMP | Brain, heart, smooth muscle, lung | Vinpocetine, nicardipine, nimodipine | Memory loss, dementia |
| PDE2       | cGMP>cAMP | Adrenal gland, lung, heart, platelets, brain, liver, corpus cavernosum | EHNNA | ARDS, sepsis, memory loss |
| PDE3       | cGMP>cAMP | Heart, liver, lung, platelets, vascular smooth muscle, corpus cavernosum | Cilostamide, cilostazol, milrinone, enoxamone | CHF, pulmonary HTN, thrombosis, glomerulonephritis |
| PDE4       | cAMP      | Lung, mast cells, liver, kidney, brain | Rolipram, cilomilast, roflumilast | Glomerulonephritis, asthma, COPD, bipolar disease |
| PDE5       | cGMP      | Corpus cavernosum, lung, vascular smooth muscle, platelets, brain, esophagus | Sildenafil, tadalafl, vardenafal, zaprinast, dipyridamole | Erectile dysfunction, BPH, pulmonary HTN, chronic renal failure |
| PDE6       | cGMP>cAMP | Retina | Sildenafil, tadalafl, vardenafal, dipyridamole, zaprinast | No clinical applications |
| PDE7       | cAMP>cAMP | Skeletal muscle, T-cells, heart, kidney, brain, pancreas | Dipyridamole | Immunologic disorders, lung disease |
| PDE8       | cAMP      | Testes, thyroid, eye, liver, kidney, heart, skeletal muscle, pancreas, T-cells | Dipyridamole | Immunologic disorders |
| PDE9       | cGMP      | Brain, kidney, liver | Zaprinast | Possible hypoglycemic effects |
| PDE10      | cAMP>cAMP | Brain, testes | Dipyridamole, papaverine | Schizophrenia and psychiatric disorders |
| PDE11      | cAMP>cGMP | Prostate, skeletal muscle, kidney, liver, testes, pituitary, salivary glands | Tadalafl, zaprinast, dipyridamole | Possible improvement in testicular function |

**Notes:** Adapted by permission from Macmillan Publishers Ltd: INTERNATIONAL JOURNAL OF IMPOTENCE RESEARCH, Bischoff E, Potency, selectivity, and consequences of nonselectivity of PDE inhibition, Int J Impot Res. 2004;16(Suppl 1):S11–S14, Copyright © 2004-2005 International Journal of PharmTech Research, Ghosh R, Sawant O, Gangpathy P, Pitre S, Kadam VJ, Phosphodiesterase inhibitors: their role and implications, Int J Pharm Tech Res, 2009;1(4):1148–1160; and Boswell-Smith V, Spina D, Page CP, Phosphodiesterase inhibitors, British Journal of Pharmacology, 2006;147(Suppl 1):S252–S257, published by John Wiley and Sons, Copyright © 2006 British Pharmacological Society.

**Abbreviations:** ARDS, acute respiratory distress syndrome; BPH, benign prostatic hyperplasia; cAMP, adenosine-3′,5′-cyclic monophosphate; cGMP, guanosine-3′,5′-cyclic monophosphate; CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; EHNA, erythro-9-(2-hydroxy-3-nonyl)adenine; HTN, hypertension; PDE, phosphodiesterase.
Inhibitors of PDE4

Rolipram (Figure 1B) is the prototype selective PDE4 inhibitor. It was developed in the 1970s as a potential anti-depressant, but was never marketed due to severe adverse effects such as nausea and vomiting.\textsuperscript{5,16} Although rolipram was unsuccessful as a drug therapy, it launched the search for an effective anti-inflammatory drug with a more favorable side effect profile.\textsuperscript{7} In the last 2 decades, many second-generation PDE4 inhibitors have been studied for use in asthma, but none have reached the asthma market. One of these compounds, CDP840, was developed in 1997 and became the first oral PDE4 inhibitor to show efficacy in asthma without major side effects.\textsuperscript{4} Cilomilast (Figure 1C), an oral inhibitor of PDE4, has been studied for use in asthma. Cilomilast 10 mg twice daily was given to 27 patients for 1 week. A significant reduction (34\%) in exercise-induced bronchoconstriction was seen.\textsuperscript{17} A randomized trial examined 303 asthma patients who were poorly controlled on low-dose corticosteroids. Participants received cilomilast 5 mg, 10 mg, 15 mg, or placebo along with continued inhaled corticosteroids. A greater improvement in forced expiratory volume in 1 second (FEV\textsubscript{1}) was seen with cilomilast 15 mg.
versus placebo, but the difference was not significant except at the 2-week time period. Of the patients receiving cilomilast, 69% reported great improvement in symptoms versus 41% of patients receiving placebo. Clinicians reported improvements in these patients of 59% and 29%, respectively. In a third trial, 211 patients received cilomilast 10 mg or 15 mg twice daily or placebo for 12 months. Non-significant improvements in FEV₁ were seen. Although cilomilast showed promise for the treatment of asthma, it was associated with significant rates of nausea and vomiting in the clinical trials. As a result, studies with cilomilast have been suspended.

Roflumilast (Figure 1D), the only PDE4 inhibitor to receive US Food and Drug Administration (FDA) approval, is indicated for use in COPD. The compound, which is more potent than cilomilast in vitro, has also shown efficacy for asthma in clinical trials. A double-blind, randomized, placebo-controlled, crossover study examined 16 men with exercise-induced asthma. The patients received oral roflumilast 500 µg daily or placebo for 28 days. The mean FEV₁ fall after exercise was reduced by 41% with roflumilast versus placebo (P=0.021). In a randomized, double-blind, double-dummy, noninferiority study with 499 asthmatics, oral roflumilast 500 µg once daily was compared with inhaled beclomethasone 200 µg twice daily for 12 weeks. Both treatment groups showed similar significant improvement in lung function (P=0.001) and reduced asthma symptom score and use of rescue treatments (P=0.001). In a randomized, double-blind, placebo-controlled, crossover trial, 23 patients with mild asthma received oral roflumilast 500 µg, 250 µg, or placebo for 7–10 days. Late asthmatic reactions to allergen challenge were reduced by 43% (P=0.009) in patients taking roflumilast 500 µg and by 27% (P=0.0110) in patients taking roflumilast 250 µg versus placebo. Both doses also significantly reduced attenuated early reactions to allergen challenge versus placebo (28% [P=0.0038] and 25% [P=0.0046], respectively). A larger study examined 693 subjects with mild to moderate asthma. Patients in this double-blind, parallel-group trial were randomized to receive 100 µg, 250 µg, or 500 µg of roflumilast daily for 12 weeks. All doses of roflumilast significantly increased lung function from baseline (P<0.001). As expected, roflumilast 500 µg daily produced the greatest improvements. A more recent double-blind, crossover trial randomized 25 patients with mild allergic asthma to roflumilast 500 µg or placebo once daily for 14 days. On day 14, FEV₁ was measured after allergen challenge. Roflumilast significantly inhibited the maximum percentage fall in FEV₁ compared with placebo (P=0.02). The drug also inhibited the allergen-induced increase in inflammatory cells in sputum samples. In trials that accessed adverse effects, roflumilast was well tolerated. Roflumilast seems to be efficacious for the treatment of asthma and is associated with fewer side effects than its PDE4 inhibitor predecessors.

Inhibitors of PDE3

PDE3 inhibitors have also been evaluated for use in asthma. A small placebo-controlled trial examined the effects of the PDE3 inhibitor MSK492 in 18 patients with atopic asthma. Patients inhaled an allergen 90 minutes after receiving one dose of oral MSK492 20 mg, 40 mg, or placebo. The 40 mg dose of MSK492 was associated with a significant decrease in both the early and the late response to inhaled allergen. The second study examined the effect of an inhaled PDE3 inhibitor for the treatment of asthma. This double-blind study randomized nine asthmatic patients to receive olprinone (a PDE3 inhibitor, Figure 1E), salbutamol (a beta agonist), and placebo. Each patient received all study drugs on 3 separate days. Significant increases in FEV₁ from baseline were seen with both olprinone and salbutamol. Response seen with the two medications did not differ significantly (P=0.28). Finally, eleven elderly patients with stable asthma were randomized to receive the oral PDE3 inhibitor cilostazol 100 mg twice daily or placebo. After 2 weeks of treatment with cilostazol, the patients’ cough threshold after inhaled allergen (capsaicin) was significantly increased compared with placebo (P<0.05).

No significant adverse effects were seen in these studies with PDE3 inhibitors. Although studies with PDE3 inhibitors enrolled few patients, these agents may offer a viable treatment option for patients with asthma. The inhaled route may provide a benefit without systemic side effects commonly experienced with oral drugs.

Inhibitors of PDE3 and PDE4

Research has suggested that PDE3 inhibitors have little effect on T-cell activation, but may potentiate the effect of PDE4 inhibitors on activation of T-cells. In addition, both PDE3 and PDE4 inhibitors must be inhibited to completely suppress macrophage release of tumor necrosis factor (TNF)-α and proliferation of T-cells. Others have suggested that targeting the multiple PDE enzymes in the lung may be required for maximum anti-inflammatory effects. In addition, a combined PDE3/4 inhibitor may have the advantage of providing both a bronchodilator and an anti-inflammatory response.
Previous clinical trials of dual PDE3/4 inhibitors such as benafentrine and zardaverine showed mixed results. Interest in these compounds has recently been renewed with the development of RPL554 (Figure 1F). Three studies in asthma patients (and one trial in COPD) showed that RPL554 is safe and effective. The first study examined 18 healthy men who received inhaled RPL554 (0.003 mg/kg or 0.009 mg/kg) or placebo. This study included an open-label phase in which six nonsmoking men with mild allergic asthma received single inhaled doses of RPL554 (three patients received 0.009 mg/kg and three patients received 0.018 mg/kg). In addition, ten men with mild allergic asthma were randomly assigned to receive RPL554 at 0.018 mg/kg or placebo to assess for safety, bronchodilation, and broncho-protection. Patients with asthma who received RPL554 had rapid bronchodilation, with a 14% increase in FEV1 versus placebo ($P<0.0001$). Also, the dose of methacholine causing a 20% fall in FEV1 was significantly increased in patients receiving RPL554 compared with placebo ($P=0.004$). In study 2, 12 men with clinically stable asthma received inhaled RPL554 at 0.018 mg/kg daily or placebo for 6 days. Results showed that RPL554 resulted in similar increases in FEV1 6 hours after dosing on days 1, 3, and 6 ($P<0.001$). Finally, in a randomized, double-blind, placebo-controlled crossover trial, 21 healthy men received RPL554 0.018 mg/kg and placebo. Sputum was induced in the subjects 6 hours after lipopolysaccharide challenge. The proportion of neutrophils in the sputum samples was similar in both groups ($P=0.15$). These results show that RPL554 has anti-inflammatory properties because it reduces neutrophils and total cells to a similar extent. The drug was well tolerated, and adverse events were mild and similar in frequency to those experienced with placebo. Theoretically, a treatment with both anti-inflammatory and bronchodilator properties might be beneficial in patients with asthma. More studies are needed with the dual inhibitor RPL554 to determine its place in asthma therapy.

**COPD**

COPD is the fourth leading cause of death worldwide. The World Health Organization predicts that COPD prevalence will continue to rise and become the third leading cause of death by 2020. It is characterized by progressive, irreversible airflow restriction, and COPD is associated with pulmonary inflammation that is responsible for obstruction of small airways and destruction of lung tissue. Spirometry is utilized to determine severity of COPD based on FEV1. Unlike the inflammatory process in asthma, cigarette smoke and other chemical irritants cause COPD. Symptoms include dyspnea, cough, sputum production, wheezing, and chest tightness, and, in more severe cases, fatigue, weight loss, and anorexia. The inflammatory response in COPD is distinct from that seen in asthma and is characterized by infiltration of neutrophils, macrophages, and CD8+ T-lymphocytes. In addition, increased levels of pro-inflammatory mediators such as cytokines, chemokines, and growth factors are found in the lung tissue of patients with COPD. Because of the inflammatory nature of COPD, inhaled corticosteroids have been a mainstay of treatment. However, these medications have minimal effect on the inflammation associated with COPD and do not prevent disease progression. PDE inhibitors may provide more efficient anti-inflammatory effects because corticosteroids do not suppress neutrophil activation or production of cytokines and other mediators. Potential therapies for COPD have focused on PDE4 inhibitors and dual PDE3/4 inhibitors.

**PDE4 inhibitors**

Roflumilast, the first (and currently only) PDE inhibitor to be FDA approved for use in COPD, has been evaluated in several phase III clinical trials involving over 4,000 patients. A multicenter, double-blind study randomized 1,411 patients with moderate to severe COPD to receive oral roflumilast (250 µg or 500 µg) or placebo daily for 24 weeks. Both doses of roflumilast significantly improved post-bronchodilator FEV1 ($P<0.0001$) and reduced COPD exacerbations compared with placebo ($P=0.0029$). Roflumilast was generally well tolerated by patients.

A second randomized, placebo-controlled, double-blind trial examined 1,513 patients with severe COPD. Subjects received 500 µg oral roflumilast (n=760) or placebo (n=753) once daily for 1 year. Roflumilast improved post-bronchodilator FEV1 from baseline ($P=0.001$); patients receiving placebo experienced a decrease in lung function. The exacerbation rate overall was comparable between treatments, but a retrospective analysis showed a 36% reduction in roflumilast-treated patients with the most severe stage of disease compared with placebo ($P=0.024$). Adverse events with roflumilast, such as diarrhea, nausea, and headache, usually subsided with continued treatment, but these patients had more withdrawals during the first 4 weeks of roflumilast therapy.

In two double-blind studies with identical design, COPD patients with severe airflow limitations were randomly assigned to receive oral roflumilast 500 µg (n=1,537) or placebo (n=1,554) for 52 weeks. In the pooled analysis, both pre-bronchodilator FEV1 and post-bronchodilator FEV1 significantly increased from baseline in patients taking...
roflumilast compared with placebo ($P<0.0001$). In addition, the rate of moderate or severe COPD exacerbations was reduced with roflumilast ($P=0.0003$). Adverse events (diarrhea, nausea, and headache) were more common in the roflumilast group during the first 4–12 weeks of treatment.\textsuperscript{35}

In two additional double-blind, multicenter trials, patients with moderate to severe COPD were randomly assigned to oral roflumilast 500 µg or placebo once daily for 24 weeks. Patients also received a long-acting bronchodilator: salmeterol (first study) or tiotropium (second study). The primary endpoint was change in prebronchodilator $FEV_1$. In the roflumilast and salmeterol trial, 466 patients received roflumilast and 467 patients received placebo; in the roflumilast and tiotropium trial, 371 patients received roflumilast and 372 patients received placebo. In both trials, significant improvements were seen in prebronchodilator $FEV_1$ in patients receiving roflumilast compared with placebo ($P<0.0001$). Improvements were also seen in post-bronchodilator $FEV_1$ for patients in both trials receiving roflumilast ($P<0.0001$).\textsuperscript{36}

Studies are ongoing for roflumilast in COPD. One such trial is investigating the use of roflumilast in addition to standard therapy for severe COPD. An additional study is examining strategies to improve adherence to roflumilast.

PDE4 inhibitors such as roflumilast and cilomilast have been shown to be effective in the treatment of asthma and COPD, but side effects have been problematic. As previously mentioned, cilomilast and other potential new oral anti-inflammatory drugs have been stopped in development due to patient acceptability. Inhaled PDE4 inhibitors may provide an alternative way to deliver these agents directly to the site of action in lung tissue. Studies are ongoing in this area to determine the efficacy of this novel delivery method.\textsuperscript{32,37}

**Dual PDE3/4 inhibitors**

At least five dual PDE3/4 inhibitors have been developed and studied in clinical trials. Unfortunately, four of these compounds have been discontinued. An inhaled drug, RPL554, shows promise for the treatment of asthma and COPD.\textsuperscript{32} Studies with RPL554 in asthma have been mentioned previously. The safety and efficacy of RPL554 (0.018 mg/kg) was assessed in an open-label, placebo-controlled crossover trial in 12 men with mild to moderate COPD. Safety was a primary endpoint for this study, and efficacy was a secondary endpoint. The study treatment was well tolerated, and side effect rates were similar between RPL554 and placebo. Inhaled RPL554 produced a mean maximum increase in $FEV_1$ of 17.2%.\textsuperscript{30} Further studies are needed with this novel agent.

**Benign prostatic hyperplasia**

The exact mechanism of benign prostatic hyperplasia (BPH), or symptomatic enlargement of the prostate gland, is not known. However, recent evidence has strongly suggested that BPH is an inflammatory process involving activation of $T$-lymphocytes. These cells release cytokines and growth factors, which may induce cell proliferation in the prostate.\textsuperscript{38,39} PDE type 5 inhibitors, effective in erectile dysfunction, have also shown efficacy for use in BPH. In addition to proposed antiproliferative effects, PDE5 inhibitors have been shown to relax prostatic smooth muscle and may improve pelvic blood flow and affect sensory nerve signaling from the bladder and prostate.\textsuperscript{40}

Tadalafil (Figure 1G), the first PDE5 inhibitor with FDA approval for BPH, has been evaluated in several clinical studies. A double-blind placebo-controlled trial examined 281 patients who received tadalafil 5 mg daily for 6 weeks, increased to 20 mg daily for 6 weeks (n=138), or placebo (n=143) for 12 weeks. The patients who received tadalafil showed a significant improvement in lower urinary tract symptoms versus those who received placebo ($P=0.003$). Quality-of-life scores also improved with tadalafil.\textsuperscript{40}

A second double-blind study randomized 1,058 men to receive once-daily treatment with tadalafil 2.5 mg (n=208), 5 mg (n=212), 10 mg (n=216), or 20 mg (n=209), or placebo for 12 weeks. Again, significant improvements were seen in lower urinary tract symptoms in patients receiving tadalafil versus those receiving placebo.\textsuperscript{41} A third double-blind study randomized 200 men to treatment with tadalafil 20 mg or placebo daily for 12 weeks. Patients receiving tadalafil had improvements in lower urinary tract symptoms versus those receiving placebo ($P<0.001$).\textsuperscript{42} An additional trial with 325 participants randomized patients to receive tadalafil 5 mg once daily (n=161) or placebo (n=164) for 12 weeks. Subjects who received tadalafil had significant improvement in lower urinary tract symptoms versus placebo starting after 1 week of treatment ($P=0.004$).\textsuperscript{43}

Sildenafil (Figure 1H) has also been investigated for the treatment of BPH. After two open-label studies and one retrospective study showed efficacy in lower urinary tract symptoms, the PDE5 inhibitor was examined in a randomized double-blind, placebo-controlled trial. Men with erectile dysfunction and BPH received sildenafil 50 mg (n=189) or placebo (n=180) once daily for 12 weeks. The dose of sildenafil was increased to 100 mg daily after 2 weeks. Results showed a significant reduction in lower urinary tract symptoms in patients receiving sildenafil versus those receiving placebo ($P<0.0001$). Quality of life was also improved in these patients.\textsuperscript{44}
Vardenafil (Figure 11) has been investigated for the treatment of BPH in several randomized, double-blind, placebo-controlled trials. A study examined 222 men who received vardenafil 10 mg twice daily (n=109) or placebo (n=113) for 8 weeks. Significant improvement in lower urinary tract symptoms and quality of life were seen in patients receiving vardenafil compared with placebo (P=0.0013). A second clinical trial examined 80 men who were randomized to receive vardenafil 10 mg or placebo twice daily for 12 weeks. Again, patients receiving vardenafil reported significant improvements in lower urinary tract symptoms (P=0.0014) and quality of life.

**Inflammatory bowel disease**

PDE inhibitors have been investigated for treatment of inflammatory bowel disease (IBD), which includes Crohn’s disease and ulcerative colitis. The pathogenesis of IBD involves activated T-cells, which release various cytokines. These cytokines, in turn, facilitate the release of free radicals and destructive enzymes, causing tissue injury in the gastrointestinal tract. PDE type 4 inhibitors have shown efficacy for IBD in animal studies. In addition, tetomilast (Figure 1) has also been evaluated for use in IBD in one phase II and two phase III trials. In the phase II study, 186 patients with mild to moderate ulcerative colitis were randomized to receive tetomilast 25 mg (n=62), tetomilast 50 mg (n=62), or placebo (n=62) by mouth once daily for 8 weeks. A significant improvement in disease activity index (DAI) was seen at 8 weeks in the patients receiving tetomilast 25 mg versus placebo (P=0.041). The most common adverse effects seen with tetomilast were nausea, vomiting, dizziness, fatigue, and headache. Tetomilast was also examined in two phase III clinical trials. In these randomized, controlled, multicenter studies, 750 patients received tetomilast 25 mg, tetomilast 50 mg, or placebo by mouth daily for 8 weeks with or without 5-aminosalicylic acid (5-ASA). Improvements in symptoms were seen with tetomilast versus placebo, but they were not statistically significant.

PDE5 and PDE7 inhibitors may also be investigated in the future as potential treatments for IBD. In summary, various PDE inhibitors have been investigated for inflammatory conditions such as asthma, COPD, BPH, and IBD. Table 2 provides a summary of the clinical data discussed.

**PDE inhibitors in autoimmune disease**

**Systemic sclerosis (scleroderma)**

Systemic sclerosis, also known as scleroderma, is a rare autoimmune connective tissue disease characterized by microvascular injury and fibrosis in the skin and internal organs. Manifestations of systemic sclerosis include Raynaud’s phenomenon, lung fibrosis, and pulmonary artery hypertension (PAH). An immune response is generated by antigens in these patients. T-cells are activated early in the disease process, and these, along with other inflammatory cells such as macrophages, monocytes, mast cells, and eosinophils, infiltrate tissues. Cytokines, growth factors, and autoantibodies cause the development of fibrosis. Raynaud’s phenomenon can cause periods of ischemia in the extremities in response to emotions or cold temperatures. Patients suffer from pain and functional impairment and may develop digital ulceration or gangrene as a result of the ischemic episodes.

PDE5 inhibitors have shown efficacy in the treatment of Raynaud’s phenomenon associated with systemic sclerosis. A recent meta-analysis examined the use of PDE5 inhibitors for treatment of Raynaud’s disease caused by systemic sclerosis. Six randomized, double-blind, placebo-controlled trials were included in the meta-analysis. Three studies examined tadalafil, two studies examined sildenafil, and one study examined vardenafil. The review of PDE5 inhibitors for Raynaud’s phenomenon showed that these drugs significantly decreased symptoms (Raynaud’s phenomenon condition score), frequency, and duration of attacks. The authors conclude that PDE5 inhibitors are effective for treating secondary Raynaud’s disease, but more research is needed.

PDE5 inhibitors have also been studied for PAH secondary to systemic sclerosis and other connective tissue disease. Sildenafil has shown efficacy for PAH in numerous clinical trials and was FDA approved for this indication in June 2005. A recent meta-analysis of sildenafil for PAH reviewed four trials involving over 500 patients. The authors conclude that sildenafil therapy lasting at least 12 weeks improves clinical and hemodynamic outcomes in these patients but does not improve serious adverse events or mortality. Tadalafil received FDA approval for PAH in May 2009. Several clinical trials have shown efficacy of tadalafil for PAH. In the PHIRST (Pulmonary Arterial Hypertension and Response to Tadalafil Study), 405 patients with PAH were randomized to receive placebo or tadalafil 2.5 mg, 10 mg, 20 mg, or 40 mg once daily for 16 weeks. Tadalafil 40 mg significantly improved exercise capacity (P<0.01) and quality of life and reduced clinical worsening (P=0.041) versus placebo. In PHIRST-2, a total of 357 patients who completed PHIRST were randomized to receive tadalafil 20 mg or 40 mg once daily for 52 weeks. Improvements seen in the original study were continued for the duration of the trial. Vardenafil
Table 2 Summary of trials with selective phosphodiesterase inhibitors for inflammatory disorders

| Disease | PDEI | Drug       | Reference                     | Patients (n) | Design                  | Result                                                                 |
|---------|------|------------|-------------------------------|-------------|-------------------------|------------------------------------------------------------------------|
| Asthma  | PDE4i| Cilomilast | Nieman et al1               | 27          | Randomized, DB, PC, 1 week | 34% reduction in exercise-induced asthma                                |
|         |      |            | Compton et al18             | 303         | Randomized, DB, PC, 6 weeks | NS increase in FEV1                                                    |
|         |      |            | Compton et al19             | 211         | Randomized, DB, PC, 12 months | NS increase in FEV1                                                   |
|         |      | Roflumilast| Timmer et al22              | 16          | Randomized, DB, PC, 28 days  | 41% reduction in FEV1 (P<0.021)                                        |
|         |      |            | Bousquet et al23            | 499         | Randomized, DB, PC, 12 weeks | Similar improvements in lung function (P<0.001)                          |
|         |      |            | van Schalkwyk et al24       | 23          | Randomized, DB, PC, 7–10 days | Reduced early and late reactions to allergen                           |
|         |      | Roflumilast| Bateman et al25             | 693         | Randomized, DB, PC, 12 weeks | Increase in lung function (P<0.001)                                    |
|         |      | Gauvreau et al10 |               | 25          | Randomized, DB, PC, 14 days (P<0.02) | Inhibited the maximum fall in FEV1 after allergen challenge             |
| PDE3i   |      | MSK492     | Bardin et al24              | 18          | Randomized, DB, PC        | Decrease in early and late response to allergen                          |
|         |      | Olprinone  | Myou et al27                | 9           | Randomized, DB, PC        | Increase in FEV1 with active treatments vs placebo                      |
|         |      | Salbutamol | Isiura et al28              | 11          | Randomized, DB, PC        | Cough threshold increased (P<0.05)                                      |
| PDE3/4i |      | RPL554     | Franciosi et al20           | 18          | Open-label, PC            | 14% increase in FEV1 (P<0.0001)                                       |
|         |      |            |                               | 12          | Single-blind, PC, 6 days  | Increases in FEV1 (P<0.001)                                             |
| COPD    | PDE4i| Roflumilast| Rabe et al13                | 1,411       | Randomized, DB, PC, 24 weeks | Improved FEV1 (P<0.0001)                                               |
|         |      | Roflumilast| Calverley et al24           | 1,513       | Randomized, DB, PC, 1 year | Improved FEV1 (P<0.001)                                               |
|         |      | Roflumilast| Calverley et al25           | 3,091       | Randomized, DB, PC, 52 weeks | Improved FEV1 (P<0.001)                                               |
|         |      | Roflumilast, salmeterol | Fabbri et al24             | 933         | Randomized, DB, PC, 24 weeks | Improved FEV1 (P<0.001)                                               |
|         |      | Roflumilast, tiotropium | Fabbri et al24             | 743         | Randomized, DB, PC, 24 weeks | Improved FEV1 (P<0.001)                                               |
| BPH     | PDE3/4i| RPL554     | Franciosi et al20           | 12          | Open-label, PC            | Improved FEV1                                                            |
|         | PDE5i| Tadalafil  | McVary et al46              | 281         | Randomized, DB, PC, 12 weeks | Improved IPSS (P=0.003)                                                |
|         |      | Tadalafil  | Roehrborn et al46           | 1,058       | Randomized, DB, PC, 12 weeks | Improved IPSS (P<0.001)                                                |
|         |      | Tadalafil  | Dmochowski et al42          | 200         | Randomized, DB, PC, 12 weeks | Improved IPSS (P=0.001)                                                |
|         |      | Tadalafil  | Porst et al43               | 325         | Randomized, DB, PC, 12 weeks | Improved IPSS (P=0.004)                                                |
|         |      | Sildenafil | McVary et al44              | 369         | Randomized, DB, PC, 12 weeks | Improved IPSS (P<0.0001)                                               |
|         |      | Vardenafil | Stief et al43               | 222         | Randomized, DB, PC, 8 weeks | Improved IPSS (P=0.0013)                                               |
|         |      | Vardenafil | Helmy et al44               | 80          | Randomized, DB, PC, 12 weeks | Improved IPSS (P=0.0014)                                               |
| IBD     | PDE4i| Tetomilast | Schreiber et al49           | 168         | Randomized, DB, PC, 8 weeks | Improved DAI (P=0.041)                                                 |
|         |      | Tetomilast | Saliari-Sharif and Abdollahi | 750         | Randomized, DB, PC, 8 weeks | Improved DAI (not statistically significant)                           |

Abbreviations: BPH, benign prostatic hyperplasia; COPD, chronic obstructive pulmonary disease; DAI, Disease Activity Index; DB, double-blind; FEV1, forced expiratory volume in 1 second; IBD, inflammatory bowel disease; IPSS, International Prostate Symptom Score (measure of lower urinary tract symptoms); MA, meta-analysis; NS, not significant; PC, placebo-controlled; PDE, phosphodiesterase; PDEI, phosphodiesterase inhibitor; QOL, quality of life; 5-ASA, 5-aminosalicylic acid.
was studied for use in PAH in a double-blind trial with 66 patients. Subjects were randomized to receive vardenafil 5 mg once daily for 4 weeks, followed by vardenafil 5 mg twice daily or placebo for 12 weeks. Patients completing the first 12 weeks of treatment were given open-label vardenafil for an additional 12 weeks. Vardenafil was shown to significantly improve exercise capacity and hemodynamics. In summary, PDE5 inhibitors may benefit patients with systemic sclerosis by reducing symptoms, frequency and duration of Raynaud’s attacks, and by improving clinical outcomes in those who suffer from PAH.

Psoriasis and psoriatic arthritis

Psoriasis is a chronic autoimmune disease characterized by inflammation and development of raised plaques with silvery scales. In addition, up to 40% of patients with psoriasis have a systemic component with involvement of joints and other tissues (psoriatic arthritis). Skin manifestations of psoriasis are caused by premature maturation of keratinocytes and inflammatory infiltrates containing dendritic cells, T-cells, and macrophages. Apremilast (Figure 1K) is an oral selective PDE4 inhibitor that suppresses several inflammatory cytokines, including TNF, IL-2, IL-12, and IL-23. Apremilast has also been shown to reduce epidermal thickness. Several clinical trials have assessed the efficacy of apremilast for the treatment of psoriasis. An open-label trial evaluated apremilast in patients with severe plaque psoriasis. A total of 19 patients received apremilast 20 mg orally for 29 days. Epidermal thickness was reduced from baseline, T-cells were reduced in the dermis and epidermis, and 74% of patients demonstrated improvement in Psoriasis Area and Severity Index (PASI) score. In a phase II open-label study, apremilast 20 mg twice daily was assessed in 30 patients with recalcitrant plaque psoriasis. After 12 weeks, epidermal cell thickness (P=0.083) and PASI score were significantly improved. A phase IIb multicenter trial randomized patients with moderate to severe psoriasis to receive oral placebo (n=88) or apremilast 10 mg (n=89), 20 mg (n=87), or 30 mg (n=88) twice daily for 16 weeks. Significant improvements in PASI score were seen in patients who received apremilast 20 mg and 30 mg versus placebo (P<0.001). In a phase II, multicenter, double-blind trial, 259 patients with moderate to severe plaque psoriasis were randomized to receive placebo, apremilast 20 mg once daily, or apremilast 20 mg twice daily for 12 weeks. Significant improvements in PASI score and mean body surface area involvement were seen with apremilast 20 mg twice daily versus placebo (P<0.001). A phase II trial randomized 352 patients with moderate to severe psoriasis to receive placebo or apremilast 10 mg, 20 mg, or 30 mg twice daily for 16 weeks. Significant improvements were seen in quality of life and pruritus scores with apremilast 20 mg and 30 mg versus placebo (P≤0.005). Two phase III clinical trials (ESTEEM 1 and 2) examined a total of 1,250 patients with psoriasis duration of at least 12 months. Subjects were randomized to apremilast 30 mg twice daily or placebo for 16 weeks. Significant improvements in PASI score were seen with apremilast versus placebo.

Apremilast has also been evaluated for the treatment of psoriatic arthritis. A phase II, double-blind study randomized 204 patients to receive placebo (n=68), apremilast 20 mg twice daily (n=69), or apremilast 40 mg once daily (n=67) for 12 weeks. The primary endpoint was the proportion of patients achieving the American College of Rheumatology criteria for 20% improvement (ACR20). At the end of 12 weeks, 43.5% of patients receiving apremilast 20 mg twice daily (P<0.001) and 35.8% of patients receiving apremilast 40 mg once daily (P=0.002) achieved an ACR20 response compared with 11.8% of those receiving placebo. Apremilast was also evaluated in three randomized, double-blind, phase III studies. PALACE-1, PALACE-2, and PALACE-3 included 1,493 patients with active psoriatic arthritis despite treatment with disease-modifying antirheumatic drugs and/or biologics. PALACE-4 included 527 patients with no prior treatment with disease-modifying antirheumatic drugs. Patients in all four trials were randomized to receive placebo, apremilast 20 mg twice daily, or apremilast 30 mg twice daily for 16 weeks. In the first three trials, patients receiving apremilast had significantly higher ACR20 achievement rates than those receiving placebo (19.4%, 31.3%, and 39.8%, respectively). Apremilast was also associated with significant improvement in symptoms and PASI scores. In PALACE-4, apremilast was also associated with significantly improved ACR20 achievement rates (16.9% for placebo, 29.2% for apremilast 20 mg twice daily, and 32.3% for apremilast 30 mg twice daily). Most adverse effects seen in trials with apremilast were mild to moderate in intensity. The most frequent side effects included diarrhea, upper respiratory tract infection, nausea, nasopharyngitis, and headache. Although studies are ongoing, apremilast appears to offer benefit in patients with psoriasis and psoriatic arthritis. Apremilast received FDA approval on 21 March 2014 for the treatment of psoriatic arthritis in adults.

Clinical trials assessing the efficacy of PDE inhibitors have shown benefit in patients with several autoimmune diseases, including systemic sclerosis, psoriasis, and psoriatic arthritis (Table 3). Future research may investigate these drugs in patients suffering from other autoimmune disorders such as ankylosing...
spondylitis, rheumatoid arthritis, systemic lupus erythematosus, sarcoidosis, Alzheimer’s disease, and multiple sclerosis.21

Conclusion

PDE inhibitors increase levels of second messengers cAMP and cGMP in many cells in the body. As a result, these compounds are able to inhibit inflammatory and immune processes that cause or contribute to numerous diseases and conditions. In the last 2 decades, selective PDE inhibitors have shown promise for the treatment of inflammatory lung and bowel diseases, BPH, systemic sclerosis, psoriasis, and psoriatic arthritis. In addition, PDE inhibitors are under investigation in the treatment of other inflammatory conditions such as rheumatoid arthritis, systemic lupus erythematosus, atopic dermatitis, multiple sclerosis, and Alzheimer’s disease. As additional therapies are discovered, the quality of life improves for patients with inflammatory and autoimmune disorders.

Disclosure

The author reports no conflicts of interest in this work.

References

1. Castro A, Jerez MJ, Gil C, Martinez A, et al. Cyclic nucleotide phosphodiesterases and their role in immunomodulatory responses: advances in the development of specific phosphodiesterase inhibitors. Med Res Rev. 2005;25(2):229–244.
2. Moore AR, Willoughby DA. The role of cAMP regulation in controlling inflammation. Clin Exp Immunol. 1995;108(3):387–389.
3. Ghosh R, Sawant O, Ganpathy P, Pitre S, Kadam VJ. Phosphodiesterase inhibitors: their role and implications. Int J Pharm Tech Res. 2009;1(4):1148–1160.
4. Boswell-Smith V, Spina D, Page CP. Phosphodiesterase inhibitors. Br J Pharmacol. 2006;147(Suppl 1):S252–S257.
5. Anwar S, Alchter MH. Cardiovascular and other pharmacological approaches of phosphodiesterase enzyme inhibitors. Int J Adv Pharm Med Bioallied Sci. 2013;1:35–39.
6. Lugnier C. Cyclic nucleotide phosphodiesterase (PDE) superfamily: a new target for the development of specific therapeutic agents. Pharmacol Ther. 2006;109(3):366–398.
7. Jin SL, Ding SL, Lin SC. Phosphodiesterase 4 and its inhibitors in inflammatory diseases. Chang Guang Med J. 2012;35(3):197–210.
8. Essayan DM. Cyclic nucleotide phosphodiesterases. J Allergy Clin Immunol. 2001;108(5):671–680.
9. National Institute of Health, National Heart, Lung, and Blood Institute. National Asthma Education and Prevention Program. Full Report of the Expert Panel Guidelines for the Diagnosis and Management of Asthma (EPR-3). Jul 2007; https://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/. Accessed May 12, 2014.

Table 3 Summary of trials with selective phosphodiesterase inhibitors for autoimmune disorders

| Disease             | PDEi | Drug          | Reference          | Patients (n) | Design               | Result                          |
|---------------------|------|---------------|--------------------|--------------|----------------------|--------------------------------|
| Systemic sclerosis  | PDE5i| Tadalafil, vardenafil, sildenafil (MA) | Roustit et al14 | 244          | Randomized, DB, PC   | Decreased symptoms, frequency, duration of attacks |
| Pulmonary arterial hypertension | PDE5i| Tadalafil (MA) | Galie et al26      | 405          | Randomized, DB, PC, 16 weeks | Improved exercise capacity and QOL (40 mg) |
|                     |      | Tadalafil     | Oudiz et al17      | 357          | Randomized, DB, PC, 1 year | Improved exercise capacity and QOL (40 mg) |
|                     |      | Vardenafil    | Jind et al58       | 66           | Randomized, DB, PC, 12 weeks | Improved exercise capacity (P<0.001) and hemodynamics |
|                     |      |               |                    |              | Open-label, 29 days   | Reduced epidermal thickness, T-cells, and improved PASI |
|                     | PDE4i| Apremilast    | Gottlieb et al82   | 19           | Open-label, 12 weeks  | Improved epidermal thickness (P=0.083) and PASI |
|                     |      | Apremilast    | Gottlieb et al83   | 30           | Open-label, 12 weeks  | Improved PASI for 20 mg and 30 mg (P<0.0001 for both) |
|                     |      | Apremilast    | Papp et al14       | 89           | Randomized, DB, PC, 16 weeks | Improved PASI and mean body surface involvement with 20 mg bid (P<0.001) |
|                     |      | Apremilast    | Papp et al15       | 259          | Randomized, DB, PC, 12 weeks | Improved QOL (P=0.005) and pruritus scores (P<0.005) with 20 mg and 30 mg |
|                     |      | Strand et al44 |                   | 352          | Randomized, DB, PC, 16 weeks | Improved PASI |
|                     |      | Apremilast    | Chaplin81          | 1,250        | (two trials)         | Improved ACR20 with 20 mg bid (P<0.001) and 40 mg qd (P=0.002) |
| Psoriatic arthritis | PDE4i| Apremilast    | Schett et al48     | 204          | Randomized, DB, PC, 12 weeks | Improved ACR 20, symptoms, and PASI scores |
|                     |      | Apremilast    | Poole and Ballantyne87 | 1,493    | (four trials)        | Improved ACR20, symptoms, and PASI scores |

Abbreviations: ACR20, American College of Rheumatology criteria for 20% improvement; bid, twice daily; DB, double-blind; MA, meta-analysis; qd, once daily; PASI, Psoriasis Area and Severity Index; PC, placebo-controlled; PDE, phosphodiesterase; PDEI, phosphodiesterase inhibitor; QOL, quality of life.
10. Gauvreau GM, Boulet LP, Schmid-Wirilitch C, et al. Roflumilast attenuates allergen-induced inflammation in mild asthmatic subjects. *Respir Res.* 2011;12:140.

11. Huang Z, Mancini JA. Phosphodiesterase 4 inhibitors for the treatment of asthma and COPD. *Curr Med Chem.* 2006;13(27):3253–3262.

12. Barnes PJ. Drugs for asthma. *Br J Pharmacol.* 2006;147 Suppl 1: S297–S309.

13. Spina D. Phosphodiesterase-4 inhibitors in the treatment of inflammatory lung disease, *Drugs.* 2003;63(23):2575–2594.

14. Gienbeycz MA. Phosphodiesterase 4 inhibitors and the treatment of asthma: where are we now and where do we go from here? *Drugs.* 2000;59(2):193–212.

15. Spina D. PDE4 inhibitors: current status. *Br J Pharmacol.* 2008;155(3):308–315.

16. Houslay MD, Schafer P, Zhang KY. Keynote review: phosphodiesterase 4 as a therapeutic target. *Drug Discov Today.* 2005;10(22):1503–1519.

17. Nieman RB, Fisher BD, Amit O, Dockhorn RJ. SB207499 (Arilfo), a second generation, selective oral phosphodiesterase type 4 (PDE4) inhibitor, attenuates exercise-induced bronchoconstriction in patients with asthma. *Am J Respir Crit Care Med.* 2007;175:A413.

18. Compton C, Cedar E, Nieman RB, Amit O, Langley SJ, Sapene M. Arilfo improves pulmonary function in patients with asthma: results of a study in patients taking inhaled corticosteroids. *Am J Respir Crit Care Med.* 1999;159(3):A624.

19. Compton C, Duggan M, Cedar E, et al. Arilfo efficacy in a 12 month study of patients with asthma. *Am J Respir Crit Care Med.* 2000;161:A505.

20. Lipworth BJ. Phosphodiesterase-4 inhibitors for asthma and chronic obstructive pulmonary disease. *Lancet.* 2005;365(9454):167–175.

21. Kumar N, Goldmink AM, Kim N, Gottlieb AB. Phosphodiesterase 4-targeted treatments for autoimmune diseases. *BMC Med.* 2013;11:96–103.

22. Timmer W, Leclerc V, Birraux G, et al. The new phosphodiesterase 4 inhibitor roflumilast is efficacious in exercise-induced asthma and leads to suppression of LPS-stimulated TNF-alpha ex vivo. *J Clin Pharmacol.* 2002;42(3):297–303.

23. Boussquert J, Aubier M, Sastre J, et al. Comparison of roflumilast, an oral anti-inflammatory, with beclomethasone dipropionate in the treatment of persistent asthma. *Allergy.* 2006;61(1):72–78.

24. van Schalkwyk E, Strydom K, Williams Z, et al. Roflumilast, an anti-inflammatory, with beclomethasone dipropionate in the treatment of COPD. *J Med Chem.* 2014;57(11):4661–4676.

25. Bostanci Y, Kazzazi A, Montabane S, Laze J, Djavan B. Correlation between benign prostatic hyperplasia and inflammation. *Curr Opin Urol.* 2013;23(1):5–10.

26. McVary KT, Roehrborn CG, Kaminetsky JC, et al. Tadalafil relieves lower urinary tract symptoms secondary to benign prostatic hyperplasia. *J Urol.* 2007;177(4):1401–1407.

27. McVary KT, Elion-Mboussa A, Viktrup L. Tadalafil administered once daily for lower urinary tract symptoms secondary to benign prostatic hyperplasia: a dose finding study. *J Urol.* 2008;180(4):1228–1234.

28. Housley MD, Schafer P, Zhang KY. Keynote review: phosphodiesterase 4 as a therapeutic target. *Drug Discov Today.* 2005;10(22):1503–1519.

29. Roehrborn CG, McVary KT, Elion-Mboussa A, Viktrup L. Tadalafil administered once daily for lower urinary tract symptoms secondary to benign prostatic hyperplasia: Results of an international randomized double-blind placebo-controlled trial. *Eur Urol.* 2011;60:1105–1113.
50. Sinnathurai P, Schriebel L. Treatment of Raynaud phenomenon in systemic sclerosis. Intern Med J. 2013;43(5):476–483.

51. Shenoy P, Agarwal V, Agarwal A, Misra R, Naik S. Potential for phosphodiesterase inhibitors in the management of autoimmune diseases. Drug Dev Res. 2011;72(8):772–778.

52. Viswanath V, Phiske M, Gopalan SV. Systemic sclerosis: current concepts in pathogenesis and therapeutic aspects of dermatological manifestations. Indian J Dermatol. 2013;58(4):255–268.

53. Moore SC, Desantis ER. Treatment of complications associated with systemic sclerosis. Am J Health Syst Pharm. 2008;65(4):315–321.

54. Roustit M, Blaise S, Allanore Y, Carpentier PH, Caglayan E, Cracowski JL. Phosphodiesterase-5 inhibitors for the treatment of secondary Raynaud’s phenomenon: systematic review and meta-analysis of randomised trials. Ann Rheum Dis. 2013;72(10):1696–1699.

55. Wang RC, Jiang FM, Zheng QL, et al. Efficacy and safety of sildenafil treatment in pulmonary arterial hypertension: a systematic review. Respir Med. 2014;108(3):531–537.

56. Galiè N, Brundage BH, Ghofrani HA, et al; Pulmonary Arterial Hypertension and Response to Tadalafil (PHIRST) Study Group. Tadalafil therapy for pulmonary artery hypertension. Circulation. 2009;119(22):2894–2903.

57. Oudiz RJ, Brundage BH, Galiè N, et al; PHIRST Study Group. Tadalafil for the treatment of pulmonary artery hypertension: a double-blind 52-week uncontrolled extension study. J Am Coll Cardiol. 2012;60(8):768–774.

58. Jing ZC, Yu ZX, Shen JY, et al; Efficacy and Safety of Vardenafil in the Treatment of Pulmonary Arterial Hypertension (EVALUATION) Study Group. Vardenafil in pulmonary artery hypertension: a randomized, double-blind, placebo-controlled study. Am J Respir Crit Care Med. 2011;183(12):1723–1729.

59. Palfreeman AC, McNamee KE, McCann FE. New developments in the management of psoriasis and psoriatic arthritis: a focus on apremilast. Drug Des Devel Ther. 2013;7:201–210.

60. Bäumer W, Hoppmann J, Rundfeldt C, Kietzmann M. Highly selective phosphodiesterase 4 inhibitors for the treatment of allergic skin diseases and psoriasis. Inflamm Allergy Drug Targets. 2007;6(1):17–26.

61. Chaplin S. Apremilast for the treatment of psoriasis and psoriatic arthritis. Future Prescriber. 2013;14(1):8–9.

62. Gottlieb AB, Strober B, Krueger JG, et al. An open-label, single-arm pilot study in patients with severe plaque-type psoriasis treated with an oral anti-inflammatory agent, apremilast. Curr Med Res Opin. 2008;24(5):1529–1538.

63. Gottlieb AB, Matheson RT, Menter A, et al. Efficacy, tolerability, and pharmacodynamics of apremilast in recalcitrant plaque psoriasis: a phase II open-label study. J Drugs Dermatol. 2013;12(8):888–897.

64. Papp K, Cather JC, Rosoph L, et al. Efficacy of apremilast in the treatment of moderate to severe psoriasis: a randomised controlled trial. Lancet. 2012;380(9483):738–746.

65. Papp KA, Kaufmann R, Thaci D, Hu C, Sutherland D, Rohane P. Efficacy and safety of apremilast in subjects with moderate to severe plaque psoriasis: results from a phase II, multicenter, randomized, double-blind, placebo-controlled, parallel-group, dose-comparison study. J Eur Acad Dermatol Venereol. 2013;27(3):e376–e383.

66. Strand V, Fiorentino D, Hu C, Day RM, Stevens RM, Papp KA. Improvements in patient-reported outcomes with apremilast, an oral phosphodiesterase 4 inhibitor, in the treatment of moderate to severe psoriasis: results from a phase IIb randomized, controlled study. Health Qual Life Outcomes. 2013;11:82.

67. Poole RM, Ballantyne AD. Apremilast: first global approval. Drugs. 2014;74(7):825–837.

68. Schett G, Wollenhaupt J, Papp K, et al. Oral apremilast in the treatment of active psoriatic arthritis: results of a multicenter, randomized, double-blind, placebo-controlled study. Arthritis Rheum. 2012;64(10):3156–3167.

69. Bischoff E. Potency, selectivity, and consequences of nonselectivity of PDE inhibition. Int J Impot Res. 2004;16 Suppl 1:S11–S14.

70. chemspider.com [homepage on the Internet]. Cambridge: Royal Society of Chemistry; 2014. Available from http://www.chemspider.com. Accessed August 17, 2014.