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**Full title: Long-term effect of first-line injectable multiple sclerosis treatments: input of a time-dependent propensity score**

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## Abstract (250 words)

**Purpose:** The long-term effect of beta-interferon and glatiramer acetate on multiple sclerosis (MS) disability progression has resulted in controversial results, probably due to a lack of appropriate control of biases as raised in observational studies. In particular, the time of the therapeutic decision is difficult to define when the controls are not treated.

**Methods:** This retrospective observational study was based on a series of patients from the MS expert center in Rennes, France. We used a time-dependent propensity score defined as the linear predictor of a Cox model estimating the hazard of being treated at each time from MS onset. The matching procedure resulted in two groups: patients matched as treated and as not yet treated. The restricted mean times (RMST) to reach a moderate level of disability or worsening of the disability were compared between the two groups in an intention-to-treat analysis.

**Results:** Of the 2,383 patients included in the study, 556 were matched as treated. The matching procedure provided a good balance of both the time-fixed and the time-dependent covariates. A slight difference was observed for the time to reach a moderate level of disability, in favor of the “not yet treated” group (difference in the RMST: -0.62 [-0.91; -0.33]) while no difference was found in terms of worsening of the disability (-0.03 [-0.24; 0.33]).

**Conclusion:** This unexpected result is probably due to unmeasured confounders. However, this time-dependent PS warrants consideration in long-term effectiveness studies.

**Keywords:** Multiple sclerosis, disability progression, effectiveness, observational study, propensity score

### Key points

- No benefit of interferon- $\beta$  and glatiramer acetate on disability progression in multiple sclerosis were showed in this study
- The time of the therapeutic decision, i.e. the baseline in comparative effectiveness study, is hard to identify when the controls are untreated.
- Time-fixed propensity scores are often used while confounders are time-dependent.
- The time-dependent propensity score is a useful tool that warrants consideration in treatment effectiveness studies in a chronic disease context.

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Lefort M, Foucher Y, Lenain R, Vukusic S, Edan G, Leray E. Long-term effect of interferon- $\beta$  and glatiramer acetate in real-world settings use on disability progression: input of time-dependent propensity score. The 35<sup>th</sup> International Conference on Pharmacoepidemiology & Therapeutic Risk Management (ICPE). Oral presentation. Philadelphia, Pennsylvania, United States of America, August 24-28, 2019.

Lefort M, Foucher Y, Lenain R, Vukusic S, Edan G, Leray E. Long-term effect of first-line injectable multiple sclerosis treatment using time-dependent propensity score matching. The 41<sup>st</sup> Annual Conference of the international society for clinical biostatistics (ISCB). Oral presentation. Kraków 2020, Poland, August 23-27, 2020 (Virtual congress).

**Poster**

Lefort M, Foucher Y, Vukusic S, Edan G, Leray E. Long-term effect of interferon- $\beta$  and glatiramer acetate in real-world settings on disability progression: input of time-dependent propensity score. The 26<sup>th</sup> annual meeting of the European Charcot Foundation. Poster. Baveno, Italy, November 15-17, 2018.

**Abbreviation:**

MS: multiple sclerosis

RRMS: relapsing-remitting multiple sclerosis

$\beta$ -IFN: beta-interferon

EDMUS: European database for multiple sclerosis

EDSS: expanded disability status scale

GA: glatiramer acetate

ITT: intention to treat

PS: propensity score

RMST: restricted mean survival time

SD: standard deviation

SMD: standardized mean differences

# Main text

## Introduction

Comparative effectiveness research allows treatments in real-life conditions to be studied when randomized clinical trials are lacking or not feasible. It needs to take into account specific issues related to the control of bias. Treatment options for multiple sclerosis (MS) have become more diverse and more complex over the past twenty years. This context necessitates up-to-date and rigorous assessment of the effectiveness of such treatments.

MS is a chronic disease that affects the central nervous system. This lifelong disease often starts in early adulthood, and it affects more women than men<sup>1</sup>. Relapsing-remitting MS (RRMS), characterized by the occurrence of relapses<sup>2</sup>, is the most common phenotype. In the long run, the symptoms accumulate and lead to irreversible disability. Thus, most patients ultimately convert to secondary progressive MS.

The first available MS disease-modifying agents, beta-interferon ( $\beta$ -IFN) and glatiramer acetate (GA), were approved in France in November 1995 and January 2002, respectively<sup>3,4</sup>. They are safe and they are still often prescribed. Their efficacy compared to placebo in the short- and medium-term, especially in terms of reducing relapses, has been shown in randomized clinical trials as well as by observational studies<sup>5,6</sup>. Nevertheless, their long-term effects remain less clear.

The studies comparing treated versus treatment-naïve patients have mostly demonstrated a beneficial effect of  $\beta$ -IFN and GA, as concluded in a recent meta-analysis<sup>7</sup>. Very different results, however, have been obtained with hazard ratios for the time to having a need for a walking aid ranging from 0.14 to 1.30. In observational studies, results can be skewed by several biases<sup>8</sup>, in particular, indication bias, resulting in non-comparable characteristics of the treated versus the control patients. The methods to control for bias have evolved over the past several decades. In particular, propensity scores (PS) are a commonly used solution to control for indication bias, aiming to mimic a randomized clinical trial<sup>9</sup>. Nevertheless, the time of the therapeutic decision is difficult to define when the controls are not treated. It relates to the theoretical and unobserved time at which an untreated patient would have been treated. Consequently, previous studies focusing on the  $\beta$ -IFN and GA effects on MS disability progression may have suffered from the time-dependent confounding.

The use of a time-dependent PS may solve these issues<sup>10</sup>, as it enables control patients to be identified who are comparable to the treated patients when the latter start treatment. In the present study, we propose to assess the effectiveness of  $\beta$ -IFN and GA in MS using a matching method originally devised by Lu<sup>11</sup>.

## Materials & Methods

### *Study population*

This retrospective study was based on a series of patients from the MS expert center in Rennes, France<sup>12</sup>. Patients who are monitored by private neurologists can schedule consultations at expert centers, when needed. In Rennes, data have been systematically compiled since 1976 in the European Database for Multiple Sclerosis (EDMUS) software<sup>13</sup>. This information is updated at each consultation<sup>14</sup>, and in May 2017, it comprised data for a total of 5,150 patients. Information on the treatments and relapses are collected at each consultation. The frequency of a consultation is patient dependent. MS-related disability is measured using the Expanded Disability Status Scale (EDSS), which ranges from 0 (normal) to 10 (death due to MS)<sup>15</sup>. All of the enrolled patients provided informed consent for participation and for their data to be stored and used for research. Data confidentiality and safety were ensured according to the recommendations of the French “Commission Nationale Informatique et Libertés” (CNIL).

All of the patients with MS according to the Poser<sup>16</sup> or the McDonald<sup>17</sup> criteria; a relapsing MS onset before December 31<sup>st</sup> 2005; and who were treatment-naïve before 30 November 1995 (the date when  $\beta$ -IFN was approved in France), did not reach an irreversible EDSS score of 3, and did not convert into secondary progressive MS before November 30<sup>th</sup> 1995, were included in the present study.

### *Exposure*

Over the study period, four preparations of  $\beta$ -IFN were available: interferon beta-1b (Betaseron®, 250  $\mu$ g), interferon beta-1a (Avonex®, 30  $\mu$ g and Rebif®, 22  $\mu$ g and 44  $\mu$ g) and one preparation of GA (Copaxone®, 20 mg). As all these preparations have similar indications and presumed equivalent effectiveness, all patients that were exposed for at least one day were considered in a single group<sup>18–20</sup>.

### *Outcomes*

Three outcomes were defined as follows: (1) the time from matching to reaching an irreversible EDSS score of 3, which corresponds to moderate disability<sup>15</sup>, (2) the time from matching to the first worsening of the EDSS, and (3) the number of relapses within 5 and 10 years following matching.

An EDSS score was considered to be irreversible when it persisted for at least 6 months, and until the last consultation. A relapse was defined as the occurrence of new symptoms or the worsening of symptoms that had occurred previously, for at least 24 hours. Worsening of the EDSS was defined as an increase by 1½ points when the initial EDSS score was 0, by 1 point when the initial score was comprised between 1 and 5½, or ½ a point if the initial score was more than 5½.

### *Time-dependent propensity score*

We used the method initially proposed by Lu<sup>11</sup>. This method consisted of matching treated patients with untreated patients who had the same chance of being treated at the same time. This procedure is divided into two steps. The first step consisted of modeling the time from the disease onset to the first prescription of  $\beta$ -IFN or GA using a cause-specific updated Cox regression. The times were right-censored at the earliest of the four following events: initiation of a treatment other than  $\beta$ -IFN or GA, conversion to secondary progressive MS, assignment of an irreversible EDSS score of 3, or the last visit entered in the database at the extraction date. The time-dependent PS was defined as the linear predictor of this Cox model with time-dependent covariates.

As recommended<sup>21</sup>, this model was adjusted for variables associated with the outcome. Thus, a PS model was specified for each of the three outcomes. The following variables were considered: sex, age, the year of MS clinical onset, the number of relapses in the past 12 months, the EDSS score, the EDSS variation since the last consultation, and the delay since the first consultation at the MS expert center. The number of relapses in the past 12 months, the EDSS score, the EDSS variation, and the delay since the first consultation were time-dependent covariates. The number of relapses was divided into 5 modalities: zero, one, two, three, and more than three. The EDSS score was categorized as:  $\leq 1$ , 2-3, and  $\geq 4$ . The EDSS variation was categorized as: (1) improvement if there was a decrease by 1 point when the initial EDSS was  $< 5.5$ , or 0.5 a point when the initial score was  $\geq 5.5$ ; (2) worsening when there was an increase by 1 point if the initial EDSS was  $< 5.5$ , or 0.5 a point when the initial score was  $\geq 5.5$ , and (3) stable in all other cases. The delay since the first consultation at the MS expert center was categorized into 3 modalities: (1) none, if no consultation, (2) recent, if the delay from the first consultation was less than 3 years, and (3) old, if it was more than 3 years.

### *Matching procedure*

The second step of the procedure consisted of matching treated patients at the time of treatment start with untreated patients who had a comparable PS value at that time. According to the positivity assumption, all of the patients should have a not-null probability of being treated in order to be matched. Thus, only time points after both MS clinical onset and treatment availability in France (i.e., 30 November 1995) were considered. As patients from the untreated group can initiate treatment later in the disease course, this group is referred to as the “not yet treated” group. Nearest neighbor matching at random, with a caliper of 0.2 of the standard deviation without replacement, was used<sup>22</sup>. If a treated patient was matched as “not yet treated” at a time before his own treatment initiation, he was excluded from the set of treated patients and could not be matched as treated later. To check the balance in the matched cohort, standardized mean differences (SMD) were computed, with 10% being considered as an acceptable difference<sup>23</sup>. Regarding the time-

dependent variables, SMD were calculated using the value at matched time for “not yet treated” and “treated” patients.

Baseline was the time of matching, i.e. the decision of treatment start for patients matched as treated and the corresponding time for patients matched as “not yet treated”.

### ***Main analyses from the matched cohort***

The median follow-up duration from matching was estimated using the reverse Kaplan-Meier method<sup>24</sup>. The distributions of time-to-events were estimated using the Kaplan-Meier estimator. The area under this survival curve up to 10 years represented the restricted mean survival time (RMST)<sup>25</sup>. This interval of 10 years was determined according to the follow-up duration available in the dataset. Moreover, the numbers of relapses within 5- and 10-years following matching were analyzed using a negative binomial regression, with the log-transformed observation time as offset.

After matching, an intention to treat (ITT) analysis was performed (all the subjects remained in their treatment group regardless of any post-matching events such as treatment modification). Moreover, bootstrapping (1,000 samples) was used to obtain the confidence intervals and to handle the randomness of the matching (i.e. each random matching that led to a different matched sample). The analyses were performed using R software (R 3.4.0).

## **Results**

A total of 2,383 patients were included in the present study (Figure 1), of whom 933 were treated with  $\beta$ -IFN or GA. Overall, the matching procedure led to the exclusion of 1,271 patients, although the matched population (including 556 of the 933 treated patients) approached the distribution of the initial cohort in terms of sex, age, and the period of MS clinical onset (Table 1).

*Figure 1 here*

*Table 1 here*

### ***Characteristics of the matched dataset***

As shown by the standardized mean differences in Table 2, the matching procedure resulted in a good balance of both the time-fixed and the time-dependent covariates. The mean age at matching was  $34 \pm 9.9$  years, and 77% were women. The median follow-up duration was 9.5 years (95% CI from 9.1 to 10.0). It was 9.3 years (95% CI from 8.6 to 10.0) and 9.8 years (95% CI from 9.2 to 10.5) for the  $\beta$ -IFN/GA-treated patients and the “not yet treated” patients, respectively.

*Table 2 here*



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### ***Comparisons of the outcomes***

The survival curves for the probabilities of not reaching an irreversible EDSS 3 and of not having a worsening of the EDSS are presented in Figures 2A and 2B. As summarized in Table 3, no difference was found for worsening of the disability, and a slight difference was observed for the time to reach EDSS 3, albeit in favor of the “not yet treated” group.

Analysis of the number of relapses indicated that the incident rate ratio was 1.23 [1.07; 1.40] over 5 years and 1.16 [1.01; 1.32] over 10 years, in favor of the “not yet treated” group.

*Figure 2 here*

### ***Therapeutic sequences in the two groups***

In the treated group,  $\beta$ -IFN/GA was initiated after a median time of 3.4 years (interquartile range: 1.2–7.9) after MS clinical onset, and its median duration was 2.0 years (interquartile range: 1.0 – 4.6). The reason for stopping treatment (known for 364 of the patients) was inefficacy for 36% and intolerance for 57%. As shown in Figure 3A, after the initial exposure to  $\beta$ -IFN or GA, 22% of the patients in the treated group switched to another first-line treatment and 12% switched to a second- or third-line treatment.

Of the 556 patients from the “not yet treated” group, 259 were treated with  $\beta$ -IFN/GA later in the disease course. The  $\beta$ -IFN/GA-treatment-free survival is presented in Figure S1. The cumulative probability of being treated was 18% (95% CI from 15% to 22%) at one year and 47% (95% CI from 42% to 51%) at 5 years. The RMST over 10 years showed that treatment was delayed by 5.7 years (95% CI from 5.3 to 6.1) for the “not yet treated” patients. Moreover, patients from the “not yet treated” group could have received other treatments, as shown in Figure 3B.

*Figure 3 here*

## Discussion

In this study, we investigated how to assess long-term treatment effectiveness in real-life settings. As discussed previously<sup>8,10</sup>, this issue entails considerable challenges, such as the choice of the appropriate control group. The novelty of the present study was the application of a time-dependent PS to compare patients with MS who had received  $\beta$ -IFN or GA treatment to patients who had not yet initiated treatment but who had the same probability of being treated at that time.

The use of a time-fixed PS (i.e., classical PS) to compare treated patients to never treated ones would have been an intuitive and well-known methodology. But, on the one hand, patients who were never treated are probably patients who did not need treatment due to a benign course. On the other hand, patients who were never treated could be patients who had no chance of being treated, either because treatment was not available (such as patients from a historical control cohort) or because they were not eligible for treatment (such as secondary progressive MS patients). In addition, a time-fixed PS needs to identify the therapeutic decision time, which is difficult to define for untreated patients. Thus, the choice of the baseline date is often questionable and may lead to biased results. Indeed, the time-points for patient inclusion differed between the studies, and they did not correspond to the therapeutic decision. For instance, inclusion could be at MS onset<sup>26,27</sup> or at the first consultation at the MS expert center<sup>28</sup>. In our opinion, patient characteristics could have changed between these baseline dates and the time of therapeutic decision. The response to treatment could have been impacted by events such as relapses or disability worsening before treatment initiation. These two issues, being the control group and baseline, led us to explore the interest of a time-dependent PS. The time-dependent PS implies that patients can be matched as untreated although they could be treated later in the disease course (here, 259 patients), leading to a control group being referred to as “not yet treated”. Thus, this methodology offers a design where the controls are patients with a delayed treatment. This appears to be suitable in many research contexts and corresponds better to the care management of chronic diseases in the real-life, especially when treatments are largely prescribed over time.

When applied to MS, this method yielded results that were in accordance with previous studies<sup>28,29</sup> but that were nonetheless unexpected. Indeed, the previously mentioned meta-analysis<sup>7</sup> pooled data from 10 observational studies and 4 long-term extensions of randomized clinical trials and showed a beneficial effect of  $\beta$ -IFN or GA, with a hazard ratio of 0.56 (95% CI from 0.46 to 0.68) for the time to reach irreversible EDSS 4. However, it was based on different designs and methods that are subject to varying degrees to potential biases<sup>8</sup>, especially indication bias.

For instance, in the first publication published in 2007, the patients were included at different time points according to their treatment status, since the treated patients were included at treatment initiation while the control patients were included at the first consultation at the MS expert center<sup>30</sup>. This difference

could have biased the results and favored the treatment since events that occurred from the first consultation to treatment initiation were excluded from the analysis only for the treated group, leading to immortal time bias<sup>8,29</sup>. When an attempt at correction was carried out<sup>29</sup>, the conclusion changed, with a new HR estimate of 2.02 instead of 0.73.

In addition, the timing when potential confounders are assessed is important. Several situations have been observed in the literature: assessment at different times<sup>30</sup>, not necessary at baseline, and sometimes after the treatment start. Such practices have been shown to lead to misspecification in the PS model<sup>31</sup>. Moreover, randomized clinical trials do not include parameters measured after baseline as covariates.

The study period may have also impacted the results. For instance, a Canadian study<sup>28</sup> used a contemporary control cohort (July 1995 – December 2004) and a historical control cohort (April 1985 – June 1995) and provided inconsistent results. Use of a historical control cohort implies that the comparison was performed between two different periods, as the treated patients were compared to the patients followed-up before treatment availability and who were hence, by definition, not treated. This type of design could lead to biased results<sup>32,33</sup> due to changes over time, for instance in diagnostic criteria, disease progression, standard of care practices, or the quality of the data collection<sup>34</sup>. In the present study, the inclusion period was 1996-2006 and hence corresponded to outdated therapeutic practices of French neurologists. Indeed, the patients were treated after a mean MS duration of 5 years, while the current recommendations are to treat as soon as possible after MS onset<sup>35</sup>. This long delay could also be related to the fact that the first symptoms of MS do not always lead to a consultation with a neurologist, and a delayed diagnosis typically results in delayed access to MS-specific care. The number of therapeutic options has increased in recent years and most of the new drugs have been shown by randomized clinical trials to exhibit comparable or higher efficacies than  $\beta$ -IFN/GA. In addition, when the first treatment was made available in 1996, an assumption that more severe patients were treated at the time compared to later or current practices could be made. To reduce the potential bias linked to changes over the study period, the year of MS onset was considered in the PS.

In our opinion, our study suffered from unmeasured confounding. We were not able to balance groups based on MRI data due to a high rate of missing values, as MRI was not systematically done or collected over the study period. The E-value associated with the analysis of the time to reach EDSS 3 suggests that the minimum strength of association, regarding the risk that an unmeasured confounder could fully explain the treatment-outcome association would be 2.3<sup>36</sup>. This value seems compatible with our assumption since the MRI is now known as a central prognostic factor, and the measures of association with the time to reach EDSS 3 ranged from 1.2 [0.5 -2.9] to 4.4 [2.4 – 8.0], according to the number of lesions (1-3 to  $\geq 10$ ) in the Barcelona cohort<sup>37</sup>. This limitation is not related to the PS method and would have affected the results no matter which methods were used. Moreover, due to its monocentric design, the size of our study cohort was small, and exclusions due to matching contributed to its reduction. Our study probably also

suffers from a lack of power. Therefore, only a significant effect of treatment on the disability worsening could have been shown with this sample size. In addition, due to the MS expert center recruitment, our study is not population-based and may lack full representation<sup>34,35</sup>. Lastly, the present study did not require any specific rhythm in the follow-ups and used the visits as data collected. The frequency of these visits differed from one patient to another.

However, we do think that this innovative methodology based on time-dependent PS warrants consideration in long-term effectiveness studies. These kinds of applicative studies contribute to the knowledge of such methods based on matching with time-dependent treatments, which induces many questions<sup>10</sup>. It would be interesting to see it applied to additional datasets or other chronic disease registries, particularly with regular follow-up data from differing contexts to better appreciate its strengths and potential limitations.

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## Tables

**Table 1: The characteristics of the study population (N=2,383) and comparison of the matched and the excluded patients at disease clinical onset, according to the main outcome (EDSS 3)**

		<b>All</b>	<b>Matched</b>	<b>Excluded</b>	<b>p<sup>†</sup></b>
		<b>N=2,383</b>	<b>N=1,112</b>	<b>N=1,271</b>	
<b>Sex</b>	Women	75%	77%	73%	0.014
<b>Age at MS<sup>‡</sup> clinical onset</b>	Mean (SD <sup>§</sup> )	30 (9.3)	29 (8.8)	31 (9.6)	<10 <sup>-4</sup>
<b>Year of MS<sup>‡</sup> onset</b>	Before 1998	56%	44%	67%	<10 <sup>-4</sup>
	[1998, 2001]	23%	27%	20%	
	[2002, 2005]	21%	29%	13%	

<sup>†</sup> p-value of Fisher's test or Student's t-test comparing the matched and the excluded patients

<sup>‡</sup> Multiple sclerosis

<sup>§</sup> Standard deviation

**Table 2: The baseline (= matching) characteristics of the matched cohort (N=1,112) for studying the time to reach EDSS 3, overall and according to the exposure group**

		<b>All</b>	<b>Treated</b>	<b>Not yet treated</b>	<b>SMD<sup>†</sup></b>
		<b>N=1,112</b>	<b>N=556</b>	<b>N=556</b>	
<b>Age at matching</b>	Mean (SD <sup>‡</sup> )	34 (9.9)	34 (9.7)	35 (10.1)	4.3%
<b>Relapses in the past 12 months</b>					7.6%
	0	27%	27%	27%	
	1	43%	42%	44%	
	2	22%	21%	22%	
	3	6%	6%	6%	
	More than 3	2%	3%	2%	
<b>EDSS score</b>					6.3%
	[0,1]	42%	43%	41%	
	[2,3]	42%	42%	43%	
	4 and more	15%	15%	16%	
<b>EDSS variation since the last consultation</b>					2.3%
	Improvement	7%	8%	7%	
	Stable	81%	80%	82%	
	Worsening	11%	12%	11%	
<b>Delay since first consultation at the expert center</b>					2.5%
	None	46%	46%	45%	
	Recent	33%	33%	33%	
	Old	21%	21%	22%	

<sup>†</sup> SMD: standardized mean differences between the treated and the “not yet treated” patients

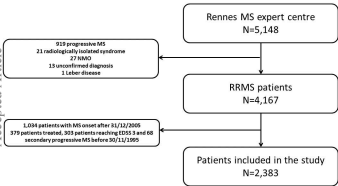
‡ SD: Standard deviation

**Table 3: The mean time before reaching outcomes in the two exposure groups, over a 10-year period**

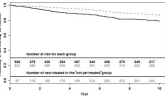
	Mean	95% CI
<b>EDSS<sup>†</sup> 3</b>		
RMST <sup>‡</sup> for treated	8.82	[8.59; 9.05]
RMST <sup>‡</sup> for “not yet treated”	9.44	[9.26; 9.59]
Difference	<b>-0.62</b>	<b>[-0.91; -0.33]</b>
<b>Disability progression</b>		
RMST <sup>‡</sup> for treated	9.12	[8.90 ; 9.32]
RMST <sup>‡</sup> for “not yet treated”	9.09	[8.88; 9.30]
Difference	<b>0.03</b>	<b>[-0.24; 0.33]</b>

<sup>†</sup> EDSS: Expanded Disability Status Scale

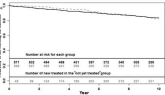
<sup>‡</sup> RMST: restricted mean survival time

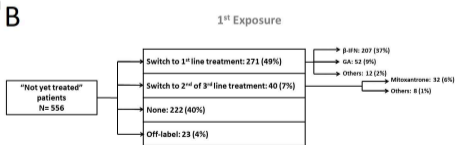
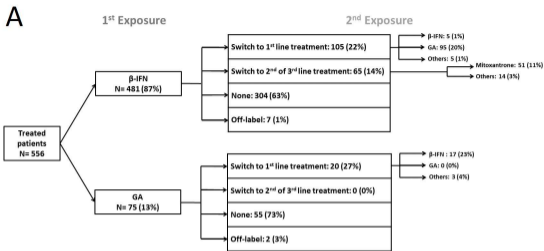


A



B





## Figure legends

**Figure 1: Flowchart of the study population (n=2,383)**

**Figure 2: Kaplan-Meier estimates of the time to reach A: an irreversible EDSS score of 3 and B: the first worsening of the EDSS**

*Legend:*

*A: Time before reaching an irreversible EDSS score of 3;*

*B: Time before the first worsening of the EDSS;*

*Notes:*

*For all of the subfigures, the black line represents the survival curve for the treated patients; the grey dotted line represents the survival curve for the “not yet treated” patients. The number of at risk patients is indicated in black for the treated and grey for the “not yet treated” patients. The number of newly treated patients in the “not yet treated” group is indicated for informational purposes, but the analysis was performed using an intention-to-treat frameworks.*

**Figure 3: The characteristics of exposure after matching for the treated patients and the “not yet treated” patients**

*Legend:*

*A: The characteristics of exposure for the treated patients after matching;*

*B: The characteristics of exposure for the “not yet treated” patients after matching*

*The first-line treatment group included beta-interferon, glatiramer acetate, dimethyl fumarate, teriflunomide, and peg-interferon; The second- and third-line treatment groups included mitoxantrone, natalizumab, and fingolimod; Off-label treatments included azathioprine, cladribine, cyclophosphamide, and methotrexate.*