Minocycline reduces chronic microglial activation after brain trauma but increases neurodegeneration

Gregory Scott,1 Henrik Zetterberg,2,3,4 Amy Jolly,1 James H. Cole,1 Sara De Simoni,1 Peter O. Jenkins,1 Claire Feeney,1 David R. Owen,1 Anne Lingford-Hughes,1 Oliver Howes,1 Maneesh C. Patel,5 Anthony P. Goldstone,1 Roger N. Gunn,6 Kaj Blennow,2,3 Paul M. Matthews1 and David J. Sharp1

Survivors of a traumatic brain injury can deteriorate years later, developing brain atrophy and dementia. Traumatic brain injury triggers chronic microglial activation, but it is unclear whether this is harmful or beneficial. A successful chronic-phase treatment for traumatic brain injury might be to target microglia. In experimental models, the antibiotic minocycline inhibits microglial activation. We investigated the effect of minocycline on microglial activation and neurodegeneration using PET, MRI, and measurement of the axonal protein neurofilament light in plasma. Microglial activation was assessed using 11C-PBR28 PET. The relationships of microglial activation to measures of brain injury, and the effects of minocycline on disease progression, were assessed using structural and diffusion MRI, plasma neurofilament light, and cognitive assessment. Fifteen patients at least 6 months after a moderate-to-severe traumatic brain injury received either minocycline 100 mg orally twice daily or no drug, for 12 weeks. At baseline, 11C-PBR28 binding in patients was increased compared to controls in cerebral white matter and thalamus, and plasma neurofilament light levels were elevated. MRI measures of white matter damage were highest in areas of greater 11C-PBR28 binding. Minocycline reduced 11C-PBR28 binding (mean Δwhite matter binding = –23.30%, 95% confidence interval –40.9 to –5.64%, P = 0.018), but increased plasma neurofilament light levels. Faster rates of brain atrophy were found in patients with higher baseline neurofilament light levels. In this experimental medicine study, minocycline after traumatic brain injury reduced chronic microglial activation while increasing a marker of neurodegeneration. These findings suggest that microglial activation has a reparative effect in the chronic phase of traumatic brain injury.

1 Division of Brain Sciences, Department of Medicine, Imperial College London, UK
2 Department of Psychiatry and Neurochemistry, Institute of Neuroscience and Physiology, the Sahlgrenska Academy at the University of Gothenburg, Mölndal, Sweden
3 Clinical Neurochemistry Laboratory, Sahlgrenska University Hospital, Mölndal, Sweden
4 Department of Molecular Neuroscience, UCL Institute of Neurology, London, UK
5 Charing Cross Hospital, Imperial College Healthcare NHS Trust, London, UK
6 Imanova Ltd, London, UK

Correspondence to: Prof David J. Sharp
Computational, Cognitive and Clinical Neuroimaging Laboratory, 3rd Floor, Burlington Danes Building, Imperial College London, Hammersmith Hospital, Du Cane Road, London, W12 0NN, UK
E-mail: david.sharp@imperial.ac.uk

Keywords: traumatic brain injury; microglia; minocycline; neurodegeneration; positron emission tomography

Abbreviations: CMA = chronic microglial activation; DVR = distribution volume ratio; NFL = neurofilament light chain; TBI = traumatic brain injury; V_T = volume of distribution
Introduction

Survivors of traumatic brain injury (TBI) can deteriorate years after injury (Whitall et al., 2006), developing post-traumatic epilepsy (Annegers et al., 1998), brain atrophy (Cole et al., 2015), Alzheimer’s disease (Smith et al., 2013) and chronic traumatic encephalopathy (CTE) (McKee et al., 2013). The protracted effects of TBI suggest a window of opportunity for disease-modifying therapy that extends beyond the acute setting, where many clinical trials have failed (Maas et al., 2004).

The long-term clinical effects of TBI are associated with chronic microglial activation (CMA) (Ramlackhansingh et al., 2011) and progressive neurodegeneration (Sidaros et al., 2009), both of which are seen in white matter tracts affected by the injury (Johnson et al., 2013). Animal models (Loane et al., 2014), neuropathology (Johnson et al., 2013), and molecular imaging (Ramlackhansingh et al., 2011) show that CMA can persist for years after TBI. However, its significance is unclear (Ransohoff, 2016). Microglia are implicated in the pathogenesis of many neurodegenerative diseases (Gentleman, 2013). In rodent TBI models, microglia have a predominantly pro-inflammatory activation phenotype (Loane et al., 2014). However, studies in non-human primates in the chronic phase suggest a reparative role (Nagamoto-Combs et al., 2007, 2010).

PET ligands targeting the translocator protein (TSPO), upregulated in activated microglia, can be used to quantify CMA in vivo (Raghavendra Rao et al., 2000). We previously demonstrated CMA up to 17 years after TBI using the TSPO ligand 11C-PK11195 (Ramlackhansingh et al., 2011). Second-generation TSPO ligands, including 11C-PBR28 (Owen et al., 2014), have a higher signal-to-noise ratio, promising more accurate quantification.

A successful treatment strategy for TBI might be to target CMA. The antibiotic minocycline has anti-inflammatory properties and is neuroprotective in models of TBI (Siopi et al., 2011) and other neurological disorders (Plane et al., 2010). One mechanism of action is the inhibition of microglial activation (Homsi et al., 2010). In models of acute TBI, minocycline reduces microglial activation and improves early functional outcomes (Siopi et al., 2011). Clinical trials in acute stroke and spinal cord injury have shown positive results (Lampl et al., 2007; Casha et al., 2012). However, trials in neurodegenerative diseases have had mixed results (Plane et al., 2010): the largest trial, in amyotrophic lateral sclerosis (ALS), reported a negative effect on functional outcomes (Gordon et al., 2007).

We examined the role of CMA in TBI and the effects of minocycline on microglia and neurodegeneration. We hypothesized that: (i) levels of CMA predict subsequent neurodegeneration; (ii) minocycline reduces CMA; and (iii) inhibiting CMA reduces neurodegeneration. To test these hypotheses, we combined 11C-PBR28 PET with MRI measures of neurodegeneration (atrophy) and measurement of plasma neurofilament light chain (NFL), a marker of axonal injury (Ljungqvist et al., 2017) and active neurodegeneration (Bacioglu et al., 2016a).

Materials and methods

Experimental design

We undertook a cross-sectional study of TBI patients compared to controls, followed by a randomized open-label study of minocycline versus no drug in patients (Fig. 1). 11C-PBR28 PET, MRI, plasma NFL measurement and cognitive testing were performed at baseline. Patients were then randomized to one of two arms (2:1 ratio), balanced for age, gender, TSPO genotype and time since injury. One group (n = 10) received minocycline 100 mg orally twice daily for 12 weeks; the other (n = 5) had no drug. Patients were followed up at 12 weeks (11C-PBR28 PET, MRI, NFL and cognitive testing) and 6 months (MRI, NFL, cognitive testing). The study was approved by the West London and GTAC NHS Research Ethics Committee (13/LO/1813). All participants provided informed consent.

Participants

Patients were recruited from TBI clinics in London, UK. Inclusion criteria were: age between 20–65 years; history of a single moderate-severe TBI (Mayo classification) (Malec et al., 2007) at least 6 months prior; no significant neurological or psychiatric illness prior to the TBI. Exclusion criteria were: use of any medication, substance or alcohol abuse that would interfere with the study or compromise safety; contradiction to MRI scanning; contraindication to PET or arterial line insertion. Three separate groups of healthy controls, age- and gender-matched to the TBI group, were used (Table 1 and Fig. 1). Screening included genotyping for the rs6971 (A1a147Thr) polymorphism in the TSPO gene. This produces three classes of binding affinity for TSPO: high-, mixed- and low-affinity binders (Owen et al., 2012). Low-affinity binders were excluded as they show negligible specific binding of 11C-PBR28. PET controls were matched to patients for TSPO genotype.

Procedures

Study procedures were carried out at the Hammersmith Hospital campus, Imperial College London (London, UK) and Imanova Centre for Imaging Sciences (London, UK). 11C-PBR28 radiopharmaceutical preparation and quality control were performed as in Owen et al. (2014). 11C-PBR28 was injected as an intravenous bolus [mean ± standard deviation (SD) 340.04 ± 18.07 MBq] over ~20 s at the start of a 90 min dynamic PET acquisition. Radial artery blood samples were collected for generation of an arterial plasma input function. Acquisition and reconstruction of PET imaging data, arterial blood sampling, analysis of plasma metabolism, and measurement of blood and plasma radioactivity concentrations were performed as previously described (Owen et al., 2014).

All participants underwent high resolution T1 MRI. Diffusionweighted images were acquired along 64 non-colinear directions

11C-PBR28 radiopharmaceutical preparation and quality control were performed as in Owen et al. (2014). 11C-PBR28 was injected as an intravenous bolus [mean ± standard deviation (SD) 340.04 ± 18.07 MBq] over ~20 s at the start of a 90 min dynamic PET acquisition. Radial artery blood samples were collected for generation of an arterial plasma input function. Acquisition and reconstruction of PET imaging data, arterial blood sampling, analysis of plasma metabolism, and measurement of blood and plasma radioactivity concentrations were performed as previously described (Owen et al., 2014).

All participants underwent high resolution T1 MRI. Diffusionweighted images were acquired along 64 non-colinear directions...
with \( b = 1000 \) s/mm\(^2\) and four averages with \( b = 0 \) s/mm\(^2\), with echo time/repetition time 103/9500 ms, 64 contiguous slices, field of view 256 mm, and voxel size 2 × 2 × 2 mm\(^3\). Baseline structural MRI scans were reviewed by a senior neuroradiologist.

A neuropsychological battery assessed cognitive domains often previously observed to be impaired after TBI (Supplementary Table 2), as in Ramlackhansingh et al. (2011). A venous blood sample was taken on the morning of the 12-week visit for a trough drug level. Plasma concentrations of minocycline were determined using liquid chromatography–mass spectrometry (Antimicrobial Reference Laboratory, Southmead Hospital, Bristol). Venous blood samples were taken for measurement of NFL using the highly-sensitive single molecule array platform.
PET analysis

Motion correction of dynamic PET images, coregistration of PET with structural MRI, and generation of metabolite-corrected plasma input function were performed using previously published methods (Owen et al., 2014) (Supplementary Fig. 1). The Logan graphical method (Logan et al., 1990), using a metabolite-corrected plasma input function, 5% fixed blood volume and a linear start time (T*) at 35 min, was used to generate parametric maps of volume of distribution (V_T).

11C-PBR28 V_T was the primary outcome measure for assessing within-subject drug effects. As in previous studies (Loggia et al., 2015), 11C-PBR28 distribution volume ratio (DVR), the ratio of regional V_T to whole brain V_T, was used as the primary outcome measure for cross-sectional PET analysis to reduce between-subject variability. Analyses were repeated using cerebellar or cortical grey matter as alternative pseudo-reference regions, to determine if the choice of reference region influenced the findings.

T1 MRI images were segmented into grey matter and white matter using SPM12, and warped to an average group template using a diffeomorphic non-linear registration (DARTEL) (Ashburner, 2007) (Supplementary Fig. 1A). Separate templates were created for cross-sectional and longitudinal analyses. Templates were registered to Montreal Neurological Institute (MNI) 152 space. Each individual 11C-PBR28 parametric map (DVR or V_T) was registered to its corresponding subject-space T1, then the individual flow-fields and template transformation from DARTEL were applied to produce MNI space images, without modulation. Normalized maps were spatially smoothed (8 mm full-width at half-maximum (FWHM) kernel).

Images of change in V_T (ΔV_T) were calculated as: ΔV_T = V_T(12 weeks) – V_T(baseline). These ‘delta’ images were calculated after within-subject registration of the 12-week parametric map to the baseline map. Delta images were then normalized to MNI space. Similar results were obtained when delta images were computed in MNI space instead. Lesions apparent on T1 MRI were manually segmented and voxels excluded from all imaging analyses.

Regions of interest were generated from automated volumetric segmentation of T1 images using Freesurfer (Desikan-Killiany atlas) (Fischl, 2012). Co-registered 11C-PBR28 parametric maps (V_T/DVR) were sampled from regions of interest (cerebral white matter, thalamus and cortical grey matter). To improve sampling accuracy, region of interest masks were intersected with thresholded tissue probability maps (P > 0.5). Co-registered 11C-PBR28 parametric maps were sampled from the regions of interest and mean values calculated.

Statistical analysis

Group characteristics were compared using independent sample t-tests (for age), Fisher’s exact test (gender, TSPO genotype) and Mann-Whitney U-tests (time since injury, post-traumatic amnesia duration, visits). Group differences in cognitive performance were assessed using either independent sample t-tests or Mann-Whitney U-tests (where data were not normally distributed according to the Shapiro-Wilk test), with Bonferroni multiple comparisons correction.

Voxelwise cross-sectional comparison of 11C-PBR28 DVR, tissue volumes (VBM) and DTI metrics were performed using non-parametric permutation tests (Nichols and Holmes, 2002) in FSL (10 000 permutations). For all analyses, age was added as a nuisance covariate. For comparisons of 11C-PBR28, TSPO genotype was included as a covariate and, for VBM analysis, intracranial volume. All results were cluster corrected using threshold-free cluster enhancement (TFCE) (Smith and Nichols, 2009) with family-wise error rate of P < 0.05. For 11C-PBR28 region of interest analysis, mean DVR for each region of interest was compared between groups using ANCOVA, with DVR as the dependent variable and genotype and age as covariates, and Fisher LSD post hoc tests.
A mean composite processing speed measure for patients was calculated using separate test scores in this domain (Supplementary Table 2) converted to Z-scores with controls as a reference (control Z-score mean = 0 and SD = 1). Positive scores always corresponded to better performance (i.e. faster reaction time).

In patients, partial correlation was used to assess whether DVR in regions of interest with increased binding were associated with time since injury or composite processing speed, with genotype and age as nuisance covariates. Bonferroni correction was used.

Plasma NFL values were log-transformed before group comparison using an independent sample t-test. Partial correlation was used to assess whether baseline NFL and the white matter region of interest \( ^{11} \text{C-PBR28} \) DVR were associated, with genotype as a nuisance covariate. Spearman’s correlation was used to assess association with time since injury, duration of PTA and information processing speed.

To enable direct comparison of modalities, maps of \( ^{11} \text{C-PBR28} \) DVR, tissue volumes and DTI metrics were converted to Z-score maps (Z-maps). Z-maps were calculated for each patient and modality, using controls as a reference (control Z-map mean = 0 and SD = 1). To create Z-maps of \( ^{11} \text{C-PBR28} \) DVR, adjusted for age and genotype, first a voxelwise regression was performed in FSL on baseline patient and control DVR maps, with age and genotype as covariates. Second, Z-maps for each patient were computed using the voxelwise formula: \( Z = (\text{patient's residual} - \text{mean of residuals in controls}) / \text{SD of residuals in controls}. \) A similar procedure was used to create Z-maps of (modulated) tissue volumes (adjusted for age and intracranial volume) and DTI metrics (adjusted for age). All maps were generated from smoothed MNI space images. Then, to directly compare \( ^{11} \text{C-PBR28} \) DVR with other modalities within a patient, firstly masks of voxels with ‘high’ DVR (thresholded at Z > +2) and ‘normal’ DVR (−1 < Z < +1) were defined. Then, the two masks were used to sample the Z-maps of the other modalities. The mean Z-scores sampled using high and normal masks were then compared in patients using a paired-sample t-test.

Longitudinal changes in tissue volumes were assessed in patients without modelling treatment group. To assess longitudinal changes in total tissue volumes, a one-sample t-test was used on \%Δ/year measures (above), for grey matter and white matter separately. For longitudinal changes in Jacobian determinant, voxelwise analyses on Jacobian determinant images were performed using one-sample t-test (Δ > 0, Δ < 0) equivalents of non-parametric permutation tests.

Voxelwise differences in baseline \( ^{11} \text{C-PBR28} \) binding between treatment groups were assessed using non-parametric permutation tests (as above). Changes in \( V_T \) between baseline and 12 weeks in the two groups were first analysed separately using one-sample t-test equivalent non-parametric permutation tests on \( ΔV_T \) images, with TSPO genotype as a nuisance covariate. The two groups were then directly compared using permutation tests, with genotype as a covariate. For region of interest analysis, the effect of minocycline versus no drug on \( V_T \) for each region of interest was first assessed using repeated-measures ANOVA, with time as the within-subjects factor (baseline and 12-week) and treatment group (minocycline or no drug) and genotype as between-subjects factors. *Post hoc* tests were planned after significant group \( \times \) time interactions. \%Δ\( V_T \) and 95% confidence intervals (CI) for each region of interest were calculated in each group and tested for significance using a one-sample t-test. A partial correlation assessed whether drug levels were associated with regional \( ΔV_T \) with genotype as a nuisance covariate. The effect of treatment group on change in separate cognitive measures was assessed using repeated-measures ANOVA, as above.

### Results

We enrolled 15 patients at least 6 months after a moderate-to-severe TBI (Table 1 and Supplementary Table 1). All patients had one or more focal lesions. None of the patients had undergone neurosurgery.

### Microglial activation after traumatic brain injury

At baseline, regions of abnormally high \( ^{11} \text{C-PBR28} \) DVR, a local measure of binding normalized to whole brain levels, were found in all of the TBI patients. These were prominent in the white matter (Fig. 2A). A voxelwise contrast of patients versus controls showed significant increases in \( ^{11} \text{C-PBR28} \) DVR in frontal and temporal white matter, striatum, thalamus and brainstem in patients (Fig. 2B). Previous studies suggest CMA is prominent in the thalamus and white matter (Ramlackhansingh et al., 2011; Smith et al., 2012; Johnson et al., 2013). Region of interest analysis confirmed this observation. In patients, \( ^{11} \text{C-PBR28} \) DVR was increased in cerebral white matter \( [F(1,38) = 7.42, P = 0.01, \text{partial } \eta^2 = 0.16] \) and thalamus \( [F(1,38) = 5.11, P = 0.03, \text{partial } \eta^2 = 0.12] \). No significant difference was seen in the cortical grey matter region of interest.

### Cognitive impairment and microglial activation

Patients and controls were well matched on the Wechsler Test of Adult Reading, a test of premorbid intellectual ability (Supplementary Table 2). However, patients showed impairment in a range of cognitive domains, including information processing speed and executive function. Composite processing speed correlated negatively with thalamic \( ^{11} \text{C-PBR28} \) DVR in patients \( (r = −0.592, P = 0.026) \), similar to our previous findings (Ramlackhansingh et al., 2011), but was not correlated with white matter DVR.

### Microglial activation and axonal injury

VBM of \( T_1 \) MRI showed widespread reductions in white matter volume in patients versus controls (Fig. 3A). Grey matter volume was also lower within frontal and temporal cortex, hippocampus and subcortical structures (Fig. 3B). Diffusion MRI showed widespread decreases in fractional anisotropy (Fig. 3C), indicating chronic abnormalities in...
white matter tract structure. Regions of volume loss and decreased fractional anisotropy extended far beyond focal lesions (Fig. 3D).

Neuropathological studies suggest CMA co-localizes with white matter damage (Smith et al., 2012; Johnson et al., 2013). Across the whole group, regions showing high baseline $^{11}$C-PBR28 DVR in patients (Fig. 2B) overlapped with areas of reduced white matter volume (Fig. 3A) and lower fractional anisotropy (Fig. 3C). Within individual patients, white matter voxels with high $^{11}$C-PBR28 DVR showed a greater reduction in tissue volume than those voxels with normal DVR (Fig. 3E) ($P = 0.004$). Similarly, white matter voxels with high DVR also had lower fractional anisotropy than voxels with normal DVR (Fig. 3F) ($P = 0.003$).

Microglial activation and neurodegeneration

In patients, we investigated the relationship between baseline CMA and subsequent neurodegeneration over 6 months using repeated volumetric MRI. Across all patients, total white matter volume decreased significantly between baseline...
and 6 months (annualized mean ± SD 1.6 ± 2.8% per year, \(P = 0.039\), scan interval 0.50 ± 0.07 years). There was no change in total grey matter volume. Controls, followed-up over a longer interval (1.11 ± 0.18 years), showed no change in white matter (0.06 ± 0.77% per year, \(P = 0.758\)) or grey matter.

White and grey matter contracted over time in patients to variable extents in different brain regions (Fig. 4A). Atrophic changes (Jacobian determinant < 0) were seen in frontal and subcortical white matter (Fig. 4B), as well as frontal, temporal and subcortical grey matter (Fig. 4C). No significant changes in Jacobian determinant were detected in controls. In patients, the mean Jacobian determinant in white matter voxels with high baseline \(^{11}\)C-PBR28 DVR was more negative than those voxels with normal baseline DVR (\(P = 0.004\)), indicating that parts of the white matter with high CMA at baseline underwent greater atrophy over the subsequent 6 months (Fig. 4D).

**Neurofilament light chain and microglial activation**

Plasma NFL provided a measure of active neurodegeneration. Baseline NFL levels were higher in patients than controls (Fig. 5A) (t = 3.09, \(P = 0.007\)). Levels were negatively correlated with time since injury (\(r = -0.546\), \(P = 0.035\)), but 11/15 patients had elevated levels compared to controls (Fig. 5B). Baseline NFL levels were positively correlated with \(^{11}\)C-PBR28 DVR in cerebral white matter (Fig. 5C) (\(r = 0.519\), \(P = 0.042\)). In contrast, there was no correlation between NFL and duration of post-traumatic amnesia, an indicator of original injury severity (\(r = -0.268\), \(P = 0.377\)), nor between NFL and composite processing speed.

**Minocycline reduces microglial activation**

We next investigated the effect of 12 weeks of minocycline treatment on \(^{11}\)C-PBR28 binding in the TBI patients. One group (\(n = 10\)) received minocycline 100 mg orally twice daily for 12 weeks; the other (\(n = 5\)) had no drug (Fig. 1). Baseline characteristics and cognitive performance were similar between minocycline and untreated groups (Table 2, Supplementary Tables 1 and 2).

The \(^{11}\)C-PBR28 \(V_T\), which provides an absolute measure of uptake (Jucaite et al., 2015; Sandiego et al., 2015), was used as the outcome measure for assessing within-subject drug effects. Voxel-wise changes in \(V_T\) between baseline and 12 weeks (\(\Delta V_T\)) were first analysed in the minocycline and untreated groups separately (Fig. 6A and B). There were no significant baseline differences in \(V_T\) between the two groups. In the minocycline group, \(^{11}\)C-PBR28 \(V_T\) was reduced at 12 weeks compared to baseline across most brain regions (Fig. 6B). \(V_T\) in the untreated patients over the same period did not change (Fig. 6B). \(V_T\) reductions in most of the parenchyma were seen after minocycline
Region of interest analysis showed that minocycline reduced V₁ compared to baseline in the cerebral white matter region of interest by \(-23.30 \pm 19.09\%\) (mean ± SD) (95% CI \(-40.9\) to \(-5.64\%, P = 0.018\)), the thalamus (\(-24.18 \pm 18.71\%, \text{CI} \(-41.48\) to \(-6.90\%, P = 0.014\)) and cortical grey matter (\(-22.05 \pm 19.33\%, \text{CI} \(-39.93\) to \(-4.17\%, P = 0.023\)) (Fig. 6D). There were no significant changes in the untreated group.

A region of interest analysis of cerebral white matter showed a significant treatment group \times time interaction [\(F(1,9) = 7.178, P = 0.025, \text{partial } \eta^2 = 0.444\], with non-significant effects of group, time, genotype and genotype \times time. Post hoc Fisher LSD tests explain this as arising from a V₁ reduction between baseline and 12 weeks in the minocycline group (mean difference standard error \(0.741 \pm 0.190, P = 0.004, 95\% \text{ CI } 1.171\) to \(0.311\)) but no change in the no drug group (\(0.048 \pm 0.225, P = 0.835, 95\% \text{ CI } -0.557\) to 0.461).

Analysis of the thalamus region of interest showed a similar significant group \times time interaction [\(F(1,9) = 7.569, P = 0.022, \text{partial } \eta^2 = 0.457\], mean difference standard error in the minocycline group \(1.097 \pm 0.310, P = 0.006, 95\% \text{ CI } -1.798\) to \(-0.395\), as well as cortical grey matter [\(F(1,9) = 6.255, P = 0.034, \text{partial } \eta^2 = 0.410\], mean difference standard error \(-0.855 \pm 0.245, P = 0.007, 95\% \text{ CI } -1.408\) to \(-0.301\)]).

Compliance with minocycline dosing (defined as the proportion of expected number of tablets taken) was 91% (mean ± SD, range 73–99%). Plasma trough minocycline levels at 12 weeks were \(2.08 \pm 0.55 \text{ mg/l} \) (mean ± SD, range 1.29–2.80 mg/l). There was no significant correlation between drug trough levels or compliance with dosing and ΔV₁ in any of the three regions of interest.

### Minocycline, neurofilament light chain and neurodegeneration

Plasma NFL levels increased after 12 weeks of minocycline compared to the untreated group, then returned to baseline levels at 6 months, after drug discontinuation (Fig. 6E). Repeated-measures ANOVA showed a significant treatment arm \times time interaction [\(F(2,22) = 6.155, P = 0.008, \text{partial } \eta^2 = 0.359\]. Post hoc Fisher LSD tests showed a NFL...
increase between baseline and 12 weeks in the minocycline group (mean difference \( \mu = 0.386 \), standard error \( \sigma = 0.093 \), 95% CI 0.182 to 0.591), but no significant change in the untreated group (\( \mu = 0.0687 \), standard error \( \sigma = 0.125 \), 95% CI 0.343 to 0.209).

Across all patients, change in NFL was negatively correlated with change in white matter \( ^{11}\text{C-PBR28 } V_T \) \((r = -0.562, P = 0.005)\) (Fig. 6G), with a strong correlation seen in the minocycline arm \((r = -0.850, P = 0.004)\).

**Side effects of minocycline**

Minocycline treatment was generally well-tolerated in patients. One patient had mild nausea and vomiting, which was treated initially with anti-emetics and resolved after reducing the minocycline dose to 100 mg once daily. One patient had mild subjective unilateral hearing impairment, which began within days of starting minocycline. This was treated initially with decongestants and resolved spontaneously despite continuation of the minocycline.

**Discussion**

We found CMA after moderate-severe TBI was associated with white matter damage months and years after injury. Areas with higher CMA showed greater progressive atrophy. The antibiotic minocycline reduced microglial activation but increased levels of plasma NFL, a marker of axonal injury and neurodegeneration. These findings suggest that microglial activation has a reparative effect in the chronic phase of TBI.

Increased \( ^{11}\text{C-PBR28 } V_T \) binding was seen in damaged and progressively atrophying white matter. This extended our previous observation of microglial activation in the thalamus and white matter using another TSPO PET ligand, \( ^{11}\text{C-PK11195} \) (Ramlackhansingh et al., 2011). Microglia might be chronically stimulated by the persistence of myelin breakdown products from the initial injury (Johnson et al., 2013; Faden and Loane, 2015), but TSPO PET alone does not clarify their functional effects. Microglial function *in vivo* is heterogeneous and can involve pro-inflammatory and reparative activation phenotypes (Holmin and Mathiesen, 1999; Nagamoto-Combs et al., 2007, 2010; Loane et al., 2014; Ransohoff, 2016). Therefore, depending on the functional phenotype, inhibiting microglia with minocycline would be expected to have distinct effects. Experimental animal work has not clarified this issue, as evidence exists for both damaging and reparative phenotypes in the months after injury (Holmin and Mathiesen, 1999; Nagamoto-Combs et al., 2007, 2010; Loane et al., 2014), and the function of activated cells is likely to change over time (Kumar et al., 2016). Hence, CMA might be either damaging or reparative in the chronic phase. Our findings suggest the latter, because NFL increased following minocycline treatment that dramatically reduced \( ^{11}\text{C-PBR28 } V_T \). However, because the time course of microglial activation phenotype evolves after injury, minocycline treatment at an earlier time point may well produce different effects. Hence, drug treatment may need to be targeted to the dominant microglial phenotype at a specific time since injury, rather than simply attempting to inhibit microglial activation. In addition, the cross-sectional
PET findings may also have differed in a patient cohort studied closer to the time of injury.

Our results suggest that inhibition of CMA after TBI promotes neurodegeneration. Plasma NFL is highly correlated with CSF NFL (Lu et al., 2015; Gisslen et al., 2016; Shahim et al., 2016; Hansson et al., 2017), and elevations in plasma NFL have been observed in a variety of neurodegenerative diseases, including Alzheimer’s disease and amyotrophic...
lateral sclerosis (Gaiottino et al., 2013; Lu et al., 2015; Bacioglu et al., 2016b; Gisslen et al., 2016). Here we show that plasma NFL is elevated in the chronic phase after moderate–severe TBI, and that plasma levels of NFL increased significantly after 12 weeks of minocycline treatment, before returning to baseline after stopping the drug. A direct relationship between CMA and NFL is made more likely by the negative correlation observed between changes in $^{11}$C-PBR28 binding and NFL levels. In addition, the link between NFL and progressive neurodegeneration is strengthened by the presence of a negative correlation between baseline NFL and longitudinal atrophy, such that higher baseline NFL predicted greater white matter atrophy over the subsequent 6 months.

Studies in non-human primates suggest a trophic role for CMA after TBI, which may explain our observations (Nagamoto-Combs et al., 2007, 2010). Long-term follow-up in a primate model of TBI confirmed the presence of persistent microglial activation up to 12 months after injury, which was associated with expression of factors that support cell survival, including BDNF and ERK1/2. In contrast, TNF-$\alpha$, IL-$1\beta$ and IL-6 expression were reduced months after injury, suggesting that the more immediate pro-inflammatory response had subsided. In a primate spinal cord injury model, microglial activation was observed at sites of synaptic sprouting, suggesting a role in promoting axonal regeneration after TBI (Nagamoto-Combs et al., 2010).

Although effects of minocycline on microglia have been demonstrated in vitro and in preclinical models (Garrido-Mesa et al., 2013a), ours is the first study to demonstrate directly that standard clinical doses of 200 mg/day provide an adequate CNS concentration to inhibit microglial activation in the brain. Animal studies have typically used much higher doses (equivalent by weight to ~3–7 g/day in humans), which are likely to be toxic in humans (Plane et al., 2010). The reduction in $^{11}$C-PBR28 binding provides evidence that the standard clinical dose has a pharmacodynamic action on humans comparable to the ~50% reduction in microglial activation seen following administration of pharmacological doses to mice after experimental TBI (Homsy et al., 2010). Here we show a ~25% reduction in $^{11}$C-PBR28 V$_T$ after minocycline. If activated microglia accounted for all of the placeable TSPO binding, this suggests a ~50% reduction in activated microglia, once the non-specific element of $^{11}$C-PBR28 binding has been accounted for (Owen et al., 2014).

Clinical studies of minocycline in other neurological conditions have reported varying results. Two stroke trials showed improved motor outcomes following minocycline treatment in the acute phase (Lampl et al., 2007; Padma Srivastava et al., 2012). However, the largest neurological study of minocycline showed an adverse effect on the progression of patients with amyotrophic lateral sclerosis (Gordon et al., 2007), a condition in which elevated NFL is a poor prognostic indicator (Lu et al., 2015). Minocycline was found to have detrimental effects on functional rating scores in a dose-independent manner (Gordon et al., 2007), suggesting that microglia could have a net reparative phenotype and that inhibition accelerated neurodegeneration. It is also possible that the disparate clinical effects of minocycline are mediated through mechanisms other than microglial modulation.

There are a number of potential limitations to our study. First, we powered our study for $^{11}$C-PBR28, which resulted in sample sizes too small for the assessment of some other outcome measures. This is particularly true for clinical measures of the drug effect, which we have not reported because of this issue. A much larger clinical trial would be required to study the clinical effects of minocycline, but our results suggest that this would be inappropriate if the aim is to reduce long-term neurodegenerative effects of CMA. A larger sample size may also permit exploration of other effects on microglial activation and neurodegeneration, such as gender, age and genetic factors. Second, the study was open label, so investigators were not blinded to an individual’s treatment. However, this is unlikely to have affected our objective neuroimaging and fluid biomarker outcome measures, and is mitigated by the repeat assessment of patients following drug cessation. We have focused on the effects of minocycline on microglia, but the drug is known to have a broad range of actions (Garrido-Mesa et al., 2013b). This potentially complicates the interpretation of our NFL findings, but our results suggest that an effect of the drug on white matter microglia is linked to the increase in plasma NFL seen after treatment. It will be important for future human and basic science work to investigate the causative links between CMA and neurodegeneration measured using markers such as NFL. Analysis of cytokines in blood, in parallel with NFL measurements, may have helped to explain the action of minocycline. However, whilst a recent review of methods to measure neuroinflammation after brain injury highlights some studies linking blood cytokines and functional outcomes (Thelin et al., 2017), peripheral blood markers that directly track microglial function are not established. Finally, our patients had focal lesions, which could potentially have affected our neuroimaging analyses. However, to control for the possible effects of lesions, we excluded lesioned areas from the analysis. Here and in our previous work using $^{11}$C-PK11195 we found binding was reduced in visible lesions, which would have biased the analysis against detecting increases.

Several of our results are potentially clinically important. We have demonstrated CMA accompanying markers of progressive damage following brain trauma. These findings highlight that TBI is not a static insult, but rather a chronic, progressive neurodegenerative disease. Many TBI survivors make a poor recovery or deteriorate long after the injury, but it is not currently possible to identify patients who are likely to do so. A biomarker of disease progression would allow patients at risk of poor outcomes to be identified, and would facilitate clinical studies of long-term sequelae of TBI. Our results suggest that combining...
References


Minocycline and microglia after brain trauma


