

METHODS AND COMPOSITIONS FOR TREATING SLEEP APNEA

CLAIM OF PRIORITY

This application claims the benefit of U.S. Patent Application Serial Nos. 62/491,504, filed on April 28, 2017, and 62/558,814, filed on September 14, 2017. The entire contents of the foregoing are hereby incorporated by reference.

5 **FEDERALLY SPONSORED RESEARCH OR DEVELOPMENT**

This invention was made with Government support under Grant No. HL095491 awarded by the National Institutes of Health. The Government has certain rights in the invention.

TECHNICAL FIELD

10 The present invention is based, at least in part, on the discovery of methods and compositions for the treatment of conditions associated with pharyngeal airway collapse while the subject is in a non-fully conscious state, e.g., snoring and sleep apnea, comprising administration of a norepinephrine reuptake inhibitor (NRI) and a muscarinic receptor antagonist.

15 **BACKGROUND**

Obstructive Sleep Apnea (OSA) is a common disorder¹ caused by collapse of the pharyngeal airway during sleep. OSA can have serious health consequences.

SUMMARY

20 The present disclosure is based upon the surprising discovery that the administration of noradrenergic and antimuscarinic drugs can increase pharyngeal muscle activity in sleeping humans and reduce snoring and sleep apnea severity, e.g., in OSA patients.

25 Thus, provided herein are methods for treating a subject having a condition associated with pharyngeal airway collapse while the subject is in a non-fully conscious state. The methods include administering to a subject in need thereof an

effective amount of (i) a norepinephrine reuptake inhibitor (NRI) and (ii) a muscarinic receptor antagonist.

In some embodiments, the NRI is a norepinephrine selective reuptake inhibitor (NSRI), e.g., an NSRI selected from the group consisting of Amedalin, Atomoxetine, CP-39,332, Daledalin, Edivoxetine, Esreboxetine, Lortalamine, Nisoxetine, Reboxetine, Talopram, Talsupram, Tandamine, and Viloxazine.

In some embodiments, the NRI is a norepinephrine non-selective reuptake inhibitor (NNRI), e.g., an NNRI selected from the group consisting of Amitriptyline, Amoxapine, Bupropion, Ciclazindol, Desipramine, Desvenlafaxine, Dexmethilphenidate, Diethylpropion, Doxepin, Duloxetine, Imipramine, Levomilnacipran, Manifaxine, Maprotiline, Methylphenidate, Milnacipran, Nefazodone, Nortriptyline, Phendimetrazine, Phenmetrazine, Protryptiline, Radafaxine, Tapentadol, Teniloxazine, and Venlafaxine.

In some embodiments, the NRI is selected from the group consisting of Atomoxetine and Reboxetine.

In some embodiments, the NRI is Atomoxetine, and in specific embodiments, the dosage of Atomoxetine is 20 – 100 mg, e.g., 25-75 mg.

In some embodiments, the muscarinic receptor antagonist is an M2 receptor agonist, e.g., is selected from the group consisting of atropine, propantheline, bethanechol, solifenacin, darifenacin, tolterodine, fesoterodine, trospium, and oxybutynin.

In some embodiments, the muscarinic receptor antagonist is selected from the group consisting of Anisotropine, Benztropine, Biperiden, Clidinium, Cycrimine, Dicyclomine, Diphemanil, Diphenidol, Ethopropazine, Glycopyrrolate, Hexocyclium, Isopropamide, Mepenzolate, Methixene, Methscopolamine, Oxyphencyclimine, Oxyphenonium, Procyclidine, Scopolamine, Tridihexethyl and Trihexyphenidyl.

In some embodiments, the muscarinic receptor antagonist is in an immediate release formulation.

In some embodiments, the muscarinic receptor antagonist is in an extended release formulation.

In some embodiments, the muscarinic receptor antagonist is Oxybutynin, and in specific embodiments, the dosage of Oxybutynin is 2-15 mg.

In some embodiments, the Oxybutynin is in an immediate release formulation, e.g., with a dose of 2.5 – 10 mg.

In some embodiments, the Oxybutynin is in an extended release formulation, e.g., with a dose of 5 – 15 mg.

5 In some embodiments, the disease or disorder is Obstructive Sleep Apnea (e.g., AHI of ≥ 10 events per hour) or Simple Snoring.

In some embodiments, the non-fully conscious state is sleep.

In some embodiments, the NRI and the muscarinic receptor antagonist are administered in a single composition.

10 In some embodiments, the single composition is an oral administration form.

In some embodiments, the oral administration form is a syrup, pill, tablet, troche, or capsule.

In some embodiments, the single composition is a transdermal administration form, e.g., a patch.

15 Also provided herein are pharmaceutical compositions comprising (i) a norepinephrine reuptake inhibitor (NRI) (ii) a muscarinic receptor antagonist, and (iii) a pharmaceutically acceptable carrier.

In some embodiments, the NRI is a norepinephrine selective reuptake inhibitor (NSRI), e.g., selected from the group consisting of Amedalin, Atomoxetine, CP-
20 39,332, Daledalin, Edivoxetine, Esreboxetine, Lortalamine, Nisoxetine, Reboxetine, Talopram, Talsupram, Tandamine, and Viloxazine. In some embodiments, the NRI is a norepinephrine non-selective reuptake inhibitor (NNRI) selected from the group consisting of Amitriptyline, Amoxapine, Bupropion, Ciclazindol, Desipramine, Desvenlafaxine, Dexmethylphenidate, Diethylpropion, Doxepin, Duloxetine,
25 Imipramine, Levomilnacipran, Manifaxine, Maprotiline, Methylphenidate, Milnacipran, Nefazodone, Nortriptyline, Phendimetrazine, Phenmetrazine, Protryptiline, Radafaxine, Tapentadol (Nucynta), Teniloxazine (Lucelan, Metatone) and Venlafaxine.

In some embodiments, the NRI is selected from the group consisting of
30 Atomoxetine and Reboxetine.

In some embodiments, the NRI is Atomoxetine, and in specific embodiments, the dosage of Atomoxetine is 20 – 100 mg.

In some embodiments, the muscarinic receptor antagonist is an M2 antagonist, e.g., selected from the group consisting of atropine, propantheline, bethanechol, solifenacin, darifenacin, tolterodine, fesoterodine, trospium, and oxybutynin.

In some embodiments, the muscarinic receptor antagonist component of the pharmaceutical composition is selected from the group consisting of Anisotropine, 5 Benztropine, Biperiden, Clidinium, Cycrimine, Dicyclomine, Dipheganil, Diphenidol, Ethopropazine, Glycopyrrolate, Hexocyclium, Isopropamide, Mepenzolate, Methixene, Methscopolamine, Oxyphencyclimine, Oxyphenonium, Procyclidine, Scopolamine, Tridihexethyl and Trihexyphenidyl. In some 10 embodiments, the muscarinic receptor antagonist is in an immediate release formulation. In some embodiments, the muscarinic receptor antagonist is in an extended release formulation.

In some embodiments, the muscarinic receptor antagonist is Oxybutynin. In some embodiments, the Oxybutynin is in an immediate release formulation, e.g., with 15 a dose of 2.5 – 10 mg. In some embodiments, the Oxybutynin is in an extended release formulation, e.g., with a dose of 5 – 15 mg.

Also provided are the compositions described herein for use in treating a subject having a condition associated with pharyngeal airway collapse while the subject is in a non-fully conscious state. In some embodiments, the disease or disorder 20 is sleep apnea or Simple Snoring. In some embodiments, the disease or disorder is Obstructive Sleep Apnea.

In some embodiments, the non-fully conscious state is sleep.

In some embodiments, the NRI and the muscarinic receptor antagonist are administered in a single composition.

25 In some embodiments, the single composition is an oral administration form.

In some embodiments, the oral administration form is a pill, tablet, troche, or capsule.

Also provided herein are a norepinephrine reuptake inhibitor (NRI) and a muscarinic receptor antagonist, for use in treating a subject having a condition 30 associated with pharyngeal airway collapse while the subject is in a non-fully conscious state.

Further, provided herein are kits comprising a norepinephrine reuptake inhibitor (NRI) and a muscarinic receptor antagonist, e.g., for use in method described

herein, e.g., for treating a subject having a condition associated with pharyngeal airway collapse while the subject is in a non-fully conscious state. The kit can comprise, e.g., separate pharmaceutical compositions of any of the individual active drugs claimed herein with a pharmaceutically acceptable salt or carrier wherein said
5 kit may contain (a) separate or common bottles or packets allowing potentially separate dosaging and (b) optionally a set of kit instructions.

Unless otherwise defined, all technical and scientific terms used herein have the same meaning as commonly understood by one of ordinary skill in the art to which this invention belongs. Methods and materials are described herein for use in
10 the present invention; other, suitable methods and materials known in the art can also be used. The materials, methods, and examples are illustrative only and not intended to be limiting. All publications, patent applications, patents, sequences, database entries, and other references mentioned herein are incorporated by reference in their entirety. In case of conflict, the present specification, including definitions, will
15 control.

Other features and advantages of the invention will be apparent from the following detailed description and figures, and from the claims.

DESCRIPTION OF DRAWINGS

FIG. 1. Graphic illustration of an obstructive apnea. The top channel shows
20 the electroencephalogram (EEG) pattern of sleep. The next channel represents airflow. The next three channels show ventilatory effort by movements of the rib cage and abdomen and changes in esophageal pressure, all of which reflect contraction of respiratory muscles. The last channel indicates oxyhemoglobin saturation.

FIGs. 2A-2B. Pharyngeal muscle activity decreases from wake to sleep in the
25 presence of a placebo (2A). In contrast, Atomoxetine + Oxybutynin preserves pharyngeal muscle activity near awake values during sleep (2B).

FIGs. 3A-3B. Participants received treatment (Atomoxetine 80 mg + Oxybutynin 5 mg) or placebo in randomized order 30 minutes before sleep. The results showed that the combination of Atomoxetine and Oxybutynin reduced the
30 apnea hypopnea index (AHI) from 31 [10-54] to 8 [2-18] (3A). Data are expressed as median [25th-75th percentile]. When analysis of OSA severity was limited to the 15

subjects with an AHI>10 events hour, the effect of the combination of Atomoxetine/Oxybutynin was even greater (-78% of AHI compared to placebo) (3B).

FIG. 4. The combination of Atomoxetine and Oxybutynin increased ventilation during sleep. Ventilation was calculated on placebo and drugs night as % of eupneic ventilation at normal ventilatory drive.

FIG. 5. OSA patients improved overnight lowest oxygen blood level from 84 [79 – 92] on placebo to 94 [89 – 95] during the Atomoxetine/Oxybutynin night.

FIGs. 6A-6B. Total sleep time (6A) and sleep efficiency (6B) were also improved on Atomoxetine/Oxybutynin night compared to placebo for the subjects with an AHI>10.

FIG. 7. Only the combination of Atomoxetine and Oxybutynin showed a significant reduction in AHI compared to placebo, while Atomoxetine or Oxybutynin alone did not improve the AHI.

FIG. 8. In subjects with a mild to moderate upper airway collapsibility, Atomoxetine and Fesoterodine was as effective as Atomoxetine and Oxybutynin in reducing AHI.

FIG. 9. In 6 subjects not treated with CPAP, administration of an Atomoxetine and Oxybutynin combination (Ato 80 mg /Oxy 5 mg) provided a 63% reduction in AHI after 1 week.

FIGs. 10A-10B. (10A) Group data showing the effect of Atomoxetine plus Oxybutynin (ato-oxy) on genioglossus muscle responsiveness. Shaded areas represent interquartile range of the slopes. Horizontal error bars illustrate interquartile range of baseline Pes; baseline values (EMG_{GG}=100%) are offset vertically to facilitate visualization of error bars. (10B) Example raw data are shown to provide context. Signals illustrate a spontaneous increase in genioglossus muscle activity with increasing Pes swings during sleep. EMG_{GG}: electromyography of genioglossus; mta: moving time average; Pes: esophageal pressure.

DETAILED DESCRIPTION

In humans, the pharyngeal airway region has no bone or cartilage support, and it is held open by muscles. When these muscles relax during sleep, the pharynx can collapse resulting in cessation of airflow. As shown in Fig. 1, ventilatory effort continues and increases in an attempt to overcome the obstruction, shown by an

increase in esophageal pressure change. Rib cage and abdominal movements are in the opposite direction as a result of the diaphragm contracting against an occluded airway, forcing the abdominal wall to distend out and the chest wall to cave inward.

Increasing efforts to breathe lead to an arousal from sleep, visualisable on an EEG (Fig. 1), and result in opening of the airway and a resumption of normal breathing. The lack of airflow during the apnea also causes hypoxia, shown by a drop in oxyhemoglobin saturation (Fig. 1). Severity is generally measured using the apnea-hypopnea index (AHI), which is the combined average number of apneas (cessation of breathing for at least ten seconds) and hypopneas (reduced airflow and oxygen saturation) that occur per hour of sleep. See, for example, Ruehland et al., The new AASM criteria for scoring hypopneas: Impact on the apnea hypopnea index. SLEEP 2009;32(2):150–157.

When a stringent definition of OSA is used (an AHI of ≥ 15 events per hour or $\text{AHI} \geq 5$ events per hour with daytime sleepiness), the estimated prevalence is approximately 15 percent in males and 5 percent in females. An estimated 30 million individuals in the United States have OSA, of which approximately 6 million have been diagnosed. The prevalence of OSA in the United States appears to be increasing due to aging and increasing rates of obesity. OSA is associated with major comorbidities and economic costs, including: hypertension, diabetes, cardiovascular disease, motor vehicle accidents, workplace accidents, and fatigue/lost productivity. See, for example, Young et al., WMJ 2009; 108:246; Peppard et al., Am J Epidemiol 2013; 177:1006.

The present leading treatment^{2,3} is continuous positive airway pressure (CPAP). CPAP is effective in virtually all patients, and approximately 85% of diagnosed patients are treated, but compliance is low. Patients find CPAP uncomfortable and often intolerable; at least 30% of patients (up to 80%) are regularly non-adherent and thus untreated (Weaver, Proc Am Thorac Soc. 2008 Feb 15; 5(2): 173–178). Other treatment modalities with variable rates of success include oral appliances (10%) and surgery (5%), but neither is likely to be effective across the general population. No pharmacologic treatments have been shown to be effective to date.

The search for medicines to activate pharyngeal muscles in sleeping humans has been discouraging; agents such as serotonin reuptake inhibitors, tricyclic

antidepressants, and sedatives have all been tested in humans and shown to be ineffective at reducing OSA severity. See, e.g., Proia and Hudgel, Chest. 1991 Aug;100(2):416-21; Brownell et al., N Engl J Med 1982, 307:1037–1042; Sangal et al., Sleep Med. 2008 Jul;9(5):506-10. Epub 2007 Sep 27; Marshall et al., Sleep. 2008 Jun;31(6):824-31; Eckert et al., Clin Sci (Lond). 2011 Jun;120(12):505-14; Taranto-Montemurro et al., Sleep. 2017 Feb 1;40(2).

Surprisingly, we have discovered that the administration of noradrenergic and antimuscarinic drugs can increase pharyngeal muscle activity in sleeping humans and reduce snoring and sleep apnea severity in OSA patients.

Methods of Treatment

The methods described herein include methods for the treatment of disorders associated with pharyngeal airway muscle collapse during sleep. In some embodiments, the disorder is Obstructive Sleep Apnea (OSA) (defined as an AHI of ≥ 10 events per hour) or Simple Snoring. Generally, the methods include administering a therapeutically effective amount of a norepinephrine reuptake inhibitor and an antimuscarinic agent as known in the art and/or described herein, to a subject who is in need of, or who has been determined to be in need of, such treatment.

As used in this context, to “treat” means to ameliorate at least one symptom of the disorder associated with pharyngeal airway collapse. Often, pharyngeal airway collapse during sleep results in snoring and/or an interruption in breathing (apnea or hypopnea), arousal from sleep, and reduced oxygenation (hypoxemia); thus, a treatment can result in a reduction in one or more of snoring, apneas/hypopneas, sleep fragmentation, and hypoxemia.

Unexpectedly, administration of a therapeutically effective amount of a norepinephrine reuptake inhibitor and an antimuscarinic agent for the treatment of a subject having a condition associated with pharyngeal airway collapse while the subject is in a non-fully conscious state, such as OSA, will result in decreased AHI. In some embodiments, the administration of a therapeutically effective amount of a norepinephrine reuptake inhibitor and an antimuscarinic agent for the treatment of a subject having a condition associated with pharyngeal airway collapse while the subject is in a non-fully conscious state, such as OSA, will result in decreased AHI by 50% or more. In some embodiments, the administration of a therapeutically effective

amount of a norepinephrine reuptake inhibitor and an antimuscarinic agent for the treatment of a subject having a condition associated with pharyngeal airway collapse while the subject is in a non-fully conscious state, such as OSA, will result in decreased AHI by 75% or more. In other further embodiments, the administration of a therapeutically effective amount of a norepinephrine reuptake inhibitor and an antimuscarinic agent for the treatment of a subject having a condition associated with pharyngeal airway collapse while the subject is in a non-fully conscious state, such as OSA, will result in increased ventilation. In yet other embodiments, the administration of a therapeutically effective amount of a norepinephrine reuptake inhibitor and an antimuscarinic agent for the treatment of a subject having a condition associated with pharyngeal airway collapse while the subject is in a non-fully conscious state, such as OSA, will result in increased oxygen blood levels. In still another embodiment, the administration of a therapeutically effective amount of a norepinephrine reuptake inhibitor and an antimuscarinic agent for the treatment of a subject having a condition associated with pharyngeal airway collapse while the subject is in a non-fully conscious state, such as OSA, will result in improved total sleep time, reduced AHI, increased oxygenation, less sleep fragmentation, increased total sleep time, and/or improved subjective sleep quality.

An effective amount of a norepinephrine reuptake inhibitor and an antimuscarinic agent can be administered in one or more administrations, applications or dosages, simultaneously or separately. When administered simultaneously, a norepinephrine reuptake inhibitor and an antimuscarinic agent can be formulated as a single dosage form, e.g., a capsule, tablet or solution, containing both a norepinephrine reuptake inhibitor and an antimuscarinic agent, or as separate dosage forms, e.g., one a capsule, tablet or solution, containing a norepinephrine reuptake inhibitor and another capsule, tablet or solution containing an antimuscarinic agent. Each of the norepinephrine reuptake inhibitor and the antimuscarinic agents can be administered, simultaneously or separately from one or more times per day to one or more times per week; including once every other day. In some embodiments, the norepinephrine reuptake inhibitor and the antimuscarinic agent are administered daily. The skilled artisan will appreciate that certain factors may influence the dosage and timing required to effectively treat a subject, including but not limited to the severity of the disease or disorder, previous treatments, the general health and/or age of the

subject, and other diseases present. Moreover, treatment of a subject with a therapeutically effective amount of the therapeutic compounds described herein can include a single treatment or a series of treatments.

Dosage, toxicity and therapeutic efficacy of the therapeutic compounds (i.e., NRI and muscarinic receptor antagonist, in a single composition or in separate compositions) can be determined by standard pharmaceutical procedures in cell cultures or experimental animals, e.g., for determining the LD50 (the dose lethal to 50% of the population) and the ED50 (the dose therapeutically effective in 50% of the population). The dose ratio between toxic and therapeutic effects is the therapeutic index and it can be expressed as the ratio LD50/ED50.

The data obtained from cell culture assays and animal studies can be used in formulating a range of dosages for use in humans. The dosage of such compounds lies preferably within a range of circulating concentrations that include the ED50 with little or no toxicity. The dosage may vary within this range depending upon the dosage form employed and the route of administration utilized. The therapeutically effective dose can be estimated initially from cell culture assays. A dose may be formulated in animal models to achieve a circulating plasma concentration range that includes the IC50 (i.e., the concentration of the test compound which achieves a half-maximal inhibition of symptoms) as determined in cell culture. Such information can be used to more accurately determine useful doses in humans. Levels in plasma can be measured, for example, by high performance liquid chromatography.

In some embodiments, the methods include administering a dose of 20-100 mg Atomoxetine (or a dose equivalent thereof of another NRI) and a dose of 2-15 mg Oxybutynin (or a dose equivalent thereof of another muscarinic receptor antagonist). In some embodiments, the methods include administering 80 mg Atomoxetine /5 mg Oxybutynin; 75 mg Atomoxetine /5 mg Oxybutynin; 75 mg Atomoxetine /6 mg Oxybutynin; 50 mg Atomoxetine /4 mg Oxybutynin; or 25 mg Atomoxetine/3 mg Oxybutynin. In other embodiments, the methods include administering a dose of 20-100 mg Atomoxetine (or a dose equivalent thereof of another NRI) and a dose of 2-15 mg Oxybutynin (or a dose equivalent thereof of another muscarinic receptor antagonist) within an hour of sleep time. In some embodiments, the methods include administering 80 mg Atomoxetine /5 mg Oxybutynin; 75 mg Atomoxetine /5 mg Oxybutynin; 75 mg Atomoxetine /6 mg Oxybutynin; 50 mg Atomoxetine /4 mg

Oxybutynin; or 25 mg Atomoxetine/3 mg Oxybutynin, 15-60, e.g., 20-45, 15-25, or 20-30 minutes before sleep time.

In further embodiments, the methods include administering Atomoxetine/Oxybutynin in a 12.5 to 1 ratio by weight. In other embodiments, the methods include administering Atomoxetine/Oxybutynin in a 12.5 to 1 ratio by weight at 15-60, e.g., 20-45, 15-25, or 20-30, minutes before sleep time.

Pharmaceutical Compositions and Methods of Administration

The methods described herein include the use of pharmaceutical compositions comprising a norepinephrine reuptake inhibitor and an antimuscarinic agent as active ingredients. The norepinephrine reuptake inhibitor and antimuscarinic agent can be administered in a single composition or in separate compositions. In some embodiments, the methods include administering a norepinephrine reuptake inhibitor and an antimuscarinic agent, and no other active ingredients, i.e., the norepinephrine reuptake inhibitor and the antimuscarinic agent are the sole active agents.

Exemplary norepinephrine reuptake inhibitors (NRIs) include the selective NRIs, e.g., Amedalin (UK-3540-1), Atomoxetine (Strattera), CP-39,332, Daledalin (UK-3557-15), Edivoxetine (LY-2216684), Esreboxetine, Lortalamine (LM-1404), Nisoxetine (LY-94,939), Reboxetine (Edronax, Vestra), Talopram (Lu 3-010), Talsupram (Lu 5-005), Tandamine (AY-23,946), Viloxazine (Vivalan); and the non-selective NRIs, e.g., Amitriptyline, Amoxapine, Bupropion, Ciclazindol, Desipramine, Desvenlafaxine, Dexmethilphenidate, Diethylpropion, Doxepin, Duloxetine, Imipramine, Levomilnacipran, Manifaxine (GW-320,659), Maprotiline, Methylphenidate, Milnacipran, Nefazodone, Nortriptyline, Phendimetrazine, Phenmetrazine, Protryptiline, Radafaxine (GW-353,162), Tapentadol (Nucynta), Teniloxazine (Lucelan, Metatone) and Venlafaxine.

Suitable, but non-limiting, examples of antimuscarinics include Atropine, Propantheline, Bethanechol, Solifenacin, Darifenacin, Tolterodine, Fesoterodine, Trospium, and Oxybutynin, which have activity on the M2 receptor. Other exemplary antimuscarinics include Anisotropine, Benztropine, Biperiden, Clidinium, Cycrimine, Dicyclomine, Diphemanil, Diphenidol, Ethopropazine, Glycopyrrolate, Hexocyclium, Isopropamide, Mepenzolate, Methixene, Methscopolamine, Oxyphencyclimine, Oxyphenonium, Procyclidine, Scopolamine, Tridihexethyl, and Trihexyphenidyl.

In some embodiments, the norepinephrine reuptake inhibitor is Atomoxetine. In some embodiments, the antimuscarinic agent is Oxybutynin (e.g., N-desethyloxybutynin).

Pharmaceutical compositions typically include a pharmaceutically acceptable carrier. As used herein the language “pharmaceutically acceptable carrier” includes saline, solvents, dispersion media, coatings, antibacterial and antifungal agents, isotonic and absorption delaying agents, and the like, compatible with pharmaceutical administration. Supplementary active compounds can also be incorporated into the compositions, e.g., hypnotics including zolpidem, eszopiclone, benzodiazepines, gabapentin, tiagabine, and xyrem.

Pharmaceutical compositions are typically formulated to be compatible with their intended route of administration. Examples of routes of administration include systemic oral or transdermal administration.

Methods of formulating suitable pharmaceutical compositions are known in the art, see, e.g., *Remington: The Science and Practice of Pharmacy*, 21st ed., 2005; and the books in the series *Drugs and the Pharmaceutical Sciences: a Series of Textbooks and Monographs* (Dekker, NY). For example, oral compositions generally include an inert diluent or an edible carrier. For the purpose of oral therapeutic administration, the active compound(s) can be incorporated with excipients and used in the form of pills, tablets, troches, or capsules, e.g., gelatin capsules. Oral compositions can also be prepared using a fluid carrier. Pharmaceutically compatible binding agents, and/or adjuvant materials can be included as part of the composition. The tablets, pills, capsules, troches and the like can contain any of the following ingredients, or compounds of a similar nature: a binder such as microcrystalline cellulose, gum tragacanth or gelatin; an excipient such as starch or lactose, a disintegrating agent such as alginic acid, Primogel, or corn starch; a lubricant such as magnesium stearate or Sterotes; a glidant such as colloidal silicon dioxide; a sweetening agent such as sucrose or saccharin; or a flavoring agent such as peppermint, methyl salicylate, or orange flavoring.

Systemic administration of one or both of the compounds as described herein (i.e., one or both of a norepinephrine reuptake inhibitor and a muscarinic receptor antagonist) can also be by transdermal means, e.g., using a patch, gel, lotion, or thin film, to be applied to the skin. For transdermal administration, penetrants appropriate

to the permeation of the epidermal barrier can be used in the formulation. Such penetrants are generally known in the art. For example, for transdermal administration, the active compounds can be formulated into ointments, salves, gels, or creams as generally known in the art. The gel and/or lotion can be provided in individual sachets, or via a metered-dose pump that is applied daily; see, e.g., Cohn et al., *Ther Adv Urol*. 2016 Apr; 8(2): 83–90.

In one embodiment, the therapeutic compounds are prepared with carriers that will protect the therapeutic compounds against rapid elimination from the body, such as a controlled release formulation, including implants and microencapsulated delivery systems. Biodegradable, biocompatible polymers can be used, such as ethylene vinyl acetate, polyanhydrides, polyglycolic acid, collagen, polyorthoesters, and polylactic acid. Such formulations can be prepared using standard techniques, or obtained commercially, e.g., from Alza Corporation and Nova Pharmaceuticals, Inc. Liposomal suspensions can also be used as pharmaceutically acceptable carriers. These can be prepared according to methods known to those skilled in the art, for example, as described in U.S. Patent No. 4,522,811.

The pharmaceutical compositions can be included in a container, pack, or dispenser together with instructions for administration or use in a method described herein.

EXAMPLES

The invention is further described in the following examples, which do not limit the scope of the invention described in the claims.

Example 1. Pilot Study

In 3 healthy human individuals, the effect of the selective noradrenergic reuptake inhibitor, Atomoxetine 80 mg, in combination with the antimuscarinic drug Oxybutynin 5 mg on genioglossus muscle activity was measured in a pilot study.

Figures 2A–B show data for the three individuals who took the combination of Atomoxetine and Oxybutynin. Figure 2A is the placebo night. The graphs in the first column are the genioglossus muscle activity (EMG_{GG}, quantified as a percentage of maximum) during quiet wakefulness. Each circle represents the peak EMG_{GG} of a single breath and is plotted against the corresponding epiglottic pressure. The graphs in the second column were obtained during stable NREM sleep. Note that there is a

variable but clear reduction in EMG_{GG} activity during sleep on the placebo night. In contrast, when these same three individuals took Atomoxetine + Oxybutynin, the sleep-related reduction in pharyngeal muscle activity was partially or completely prevented (Figure 2B).

5 It is clear from this data that, compared to placebo, the tested drugs yielded a much higher EMG_{GG} activity during NREM sleep. In the subjects exhibiting REM sleep on these drugs, EMG_{GG} activity remained at 49% of the awake value in REM sleep, suggesting that the drugs are also effective in this stage as well.

Example 2. Crossover Study

10 Subsequently, a placebo-controlled, double-blinded, randomized, crossover trial in 20 obstructive sleep apnea (OSA) human patients was performed. Participants received treatment (Atomoxetine 80 mg + Oxybutynin 5 mg) or placebo in randomized order 30 minutes before sleep. The trial showed that the combination of Atomoxetine and Oxybutynin reduced the apnea hypopnea index (AHI) from 31 [10-
15 54] to 8 [2-18]. Data are expressed as median [25th-75th percentile] (Figure 3A). During the trial, 5 subjects showed absence of clinically-significant OSA on the placebo night. If the analysis of OSA severity is limited to the 15 subjects with an AHI>10 events hour, the effect of the combination of Atomoxetine/Oxybutynin is even greater (78% reduction in AHI compared to placebo) (Figure 3B). All OSA
20 patients showed an improvement in OSA severity.

In these subjects, the combination of Atomoxetine and Oxybutynin increased the genioglossus muscle responsiveness to an increase in ventilatory drive compared to placebo from 0.1 to 0.3 %max/cmH₂O, meaning that for each cmH₂O increase in ventilatory drive (measured with esophageal pressure), the genioglossus muscle was
25 activated 2 times more on the drugs compared to placebo. This improved upper airway muscle activity is likely the reason for the reduction in AHI (Figures 3A-B) and for the increased ventilation during sleep in these subjects (Figure 4).

Because of improved ventilation, oxygen levels (SaO₂) were also increased on drugs night. The nadir of SaO₂ went from 84% [79-92] on placebo to 94% [89-96] on
30 drugs (Figure 5), while the oxygen desaturation index (ODI) went from 13 [6-34] during placebo night to 3 [0-8] on the drugs.

In addition, as shown in Figures 6A-B, total sleep time and sleep efficiency were also improved on the Atomoxetine/Oxybutynin night compared to placebo for the subjects with an AHI>10.

Seven OSA patients were studied also on 2 additional nights in which the 2 drugs were administered alone (not in combination). As shown in Figure 7, only the combination of Atomoxetine and Oxybutynin showed a significant reduction in AHI compared to placebo, while Atomoxetine or Oxybutynin alone did not improve the AHI.

Example 3. Fesoterodine Study

To determine whether other antimuscarinic agents could be used in place of Oxybutynin, 4 mg Fesoterodine (a newer, extended-release antimuscarinic drug) was used in combination with 80 mg Atomoxetine in 3 subjects with a mild to moderate upper airway collapsibility (ventilation during sleep with normal effort was above 50% of eupneic ventilation on placebo). In this subgroup of patients, Fesoterodine was as effective as Oxybutynin in reducing the AHI.

In two patients with severe upper airway collapsibility (ventilation during sleep was below 50% of normal ventilation), the combination of Atomoxetine/Fesoterodine did not reduce the AHI, whereas Atomoxetine/Oxybutynin did.

Example 4. Prospective Study

To evaluate the effect of the ato-oxy combination, a prospective study was performed over a week in 6 patients not treated with CPAP. The patients performed a baseline sleep study in hospital; drugs (Ato 80 mg /Oxy 5 mg) were administered for 6 nights at home, and on the 7th night the patients returned to the hospital to repeat the sleep study after taking the medications. These studies were performed with standard montage used for clinical sleep studies including electroencephalogram, electrooculogram, flow measurement with nasal cannula and thermistor, abdominal and thoracic belts, chin electromyography and oxygen saturation. The results, shown in FIG. 9, demonstrated a 63% [53 to 70] reduction in AHI after 1 week of therapy, suggesting that the drugs' effect is durable after a week of treatment.

In three patients we tested lower doses of the combination, i.e., Atomoxetine 80 mg in combination with Oxybutynin 5 mg, Atomoxetine 50 mg in combination

with Oxybutynin 4 mg, and Atomoxetine 25 mg in combination with Oxybutynin 3 mg. The AHI showed a dose-dependent reduction compared to placebo, suggesting that lower doses than 80/5 mg may be effective in treating less severe disease. For the present purposes, we defined mild disease as $5 < \text{AHI} < 15$, and moderate disease as

15 $15 < \text{AHI} < 30$ events/hour.

Group data was obtained using genioglossus electromyography in 16 out of 20 patients who took part to the original trial to determine the effect of Atomoxetine plus Oxybutynin (ato-oxy) on genioglossus muscle responsiveness. Muscle responsiveness reflects the change in genioglossus muscle electromyographic activity (percent of
10 baseline) per change in esophageal pressure (Pes) swings during spontaneous breathing in non-REM sleep (see FIG. 10B for physiological context). Note that the median responsiveness on ato-oxy (slope of solid line) is greater than the responsiveness on placebo (slope of dashed line). FIG. 10B shows exemplary raw data to provide context. The signals illustrate a spontaneous increase in genioglossus
15 muscle activity with increasing Pes swings during sleep. Note the restoration of airflow (Flow) accompanying increasing muscle activity.

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OTHER EMBODIMENTS

It is to be understood that while the invention has been described in conjunction with the detailed description thereof, the foregoing description is intended to illustrate and not limit the scope of the invention, which is defined by the scope of the appended claims. Other aspects, advantages, and modifications are within the scope of the following claims.

What is claimed is:

1. Use of an effective amount of (i) a norepinephrine reuptake inhibitor (NRI) and (ii) a muscarinic receptor antagonist in the preparation of a medicament for the treatment of a condition associated with pharyngeal airway collapse, wherein the medicament is to be administered to a subject in need thereof, while the subject is in a non-fully conscious state.
2. The use of claim 1, wherein the NRI is a norepinephrine selective reuptake inhibitor (NSRI).
3. The use of claim 2, wherein the NSRI is selected from the group consisting of Amedalin, Atomoxetine, CP-39,332, Daledalin, Edivoxetine, Esreboxetine, Lortalamine, Nisoxetine, Reboxetine, Talopram, Talsupram, Tandamine, and Viloxazine.
4. The use of claim 1, wherein the NRI is a norepinephrine non-selective reuptake inhibitor (NNRI) selected from the group consisting of Amitriptyline, Amoxapine, Bupropion, Ciclazindol, Desipramine, Desvenlafaxine, Dexmethylphenidate, Diethylpropion, Doxepin, Duloxetine, Imipramine, Levomilnacipran, Manifaxine, Maprotiline, Methylphenidate, Milnacipran, Nefazodone, Nortriptyline, Phendimetrazine, Phenmetrazine, Protryptiline, Radafaxine, Tapentadol, Teniloxazine, and Venlafaxine.
5. The use of claim 1, wherein the NRI is selected from the group consisting of Atomoxetine and Reboxetine.
6. The use of claim 5, wherein the NRI is Atomoxetine.
7. The use of claim 6, wherein the Atomoxetine is to be administered at a dose of 20 – 100 mg.
8. The use of claim 7, wherein the Atomoxetine is to be administered at a dose of 25-75 mg.
9. The use of claim 1, wherein the muscarinic receptor antagonist is selected from the group consisting of Atropine, Propantheline, Bethanechol, Solifenacin, Darifenacin, Tolterodine, Fesoterodine, Trospium, and Oxybutynin.

10. The use of claim 1, wherein the muscarinic receptor antagonist is selected from the group consisting of Anisotropine, Benztropine, Biperiden, Clidinium, Cycrimine, Dicyclomine, Diphemanil, Diphenidol, Ethopropazine, Glycopyrrolate, Hexocyclium, Isopropamide, Mepenzolate, Methixene, Methscopolamine, Oxyphencyclimine, Oxyphenonium, Procyclidine, Scopolamine, Tridihexethyl and Trihexyphenidyl.
11. The use of claim 1, wherein the muscarinic receptor antagonist is in an immediate release formulation.
12. The use of claim 1, wherein the muscarinic receptor antagonist is in an extended release formulation.
13. The use of any one of claims 1-12, wherein the muscarinic receptor antagonist is Oxybutynin.
14. The use of claim 13, wherein the Oxybutynin is to be administered at a dose of 2-15 mg.
15. The use of claim 14, wherein the Oxybutynin is in an immediate release formulation with a dose of 2.5 – 10 mg.
16. The use of claim 14, wherein the Oxybutynin is in an extended release formulation with a dose of 5 – 15 mg.
17. The use of any one of claims 1-16, wherein the condition is Sleep Apnea or Snoring.
18. The use of claim 17, wherein the snoring is simple snoring.
19. The use of claim 17, wherein the condition is Obstructive Sleep Apnea.
20. The use of claim 1, wherein the non-fully conscious state is sleep.
21. The use of claim 1, wherein the NRI and the muscarinic receptor antagonist are to be administered in a single composition.
22. The use of claim 21, wherein the single composition is an oral administration form.
23. The use of claim 22, wherein the oral administration form is a syrup, pill, tablet, troche, or capsule.

24. Use of a norepinephrine reuptake inhibitor (NRI) and a muscarinic receptor antagonist in the preparation of a medicament for the treatment of sleep apnea.
25. The use of claim 24, wherein the NRI is a norepinephrine selective reuptake inhibitor (NSRI).
26. The use of claim 25, wherein the NSRI is selected from the group consisting of Amedalin, Atomoxetine, CP-39,332, Daledalin, Edivoxetine, Esreboxetine, Lortalamine, Nisoxetine, Reboxetine, Talopram, Talsupram, Tandamine, and Viloxazine.
27. The use of claim 24, wherein the NRI is a norepinephrine non-selective reuptake inhibitor (NNRI) selected from the group consisting of Amitriptyline, Amoxapine, Bupropion, Ciclazindol, Desipramine, Desvenlafaxine, Dexmethylphenidate, Diethylpropion, Doxepin, Duloxetine, Imipramine, Levomilnacipran, Manifaxine, Maprotiline, Methylphenidate, Milnacipran, Nefazodone, Nortriptyline, Phendimetrazine, Phenmetrazine, Protryptiline, Radafaxine, Tapentadol (Nucynta), Teniloxazine (Lucelan, Metatone) and Venlafaxine.
28. The use of claim 24, wherein the NRI is selected from the group consisting of Atomoxetine and Reboxetine.
29. The use of claim 28, wherein the NRI is Atomoxetine.
30. The use of claim 29, wherein the Atomoxetine is in an amount of from 20 – 100 mg.
31. The use of claim 24, wherein the muscarinic receptor antagonist is selected from the group consisting of Atropine, Propantheline, Bethanechol, Solifenacin, Darifenacin, Tolterodine, Fesoterodine, Trosipium, and Oxybutynin.
32. The use of claim 24, wherein the muscarinic receptor antagonist is selected from the group consisting of Anisotropine, Benztropine, Biperiden, Clidinium, Cycrimine, Dicyclomine, Diphemanil, Diphenidol, Ethopropazine, Glycopyrrolate, Hexocyclium, Isopropamide, Mepenzolate, Methixene, Methscopolamine, Oxyphencyclimine, Oxyphenonium, Procyclidine, Scopolamine, Tridihexethyl and Trihexyphenidyl.
33. The use of claim 24, wherein the muscarinic receptor antagonist is in an immediate release formulation.

34. The use of claim 24, wherein the muscarinic receptor antagonist is in an extended release formulation.
35. The use of any one of claims 24-34, wherein the muscarinic receptor antagonist is Oxybutynin.
36. The use of claim 35, wherein the Oxybutynin is in an amount of from 2-15 mg.
37. The use of claim 35, wherein the Oxybutynin is in an immediate release formulation with a dose of 2.5 – 10 mg.
38. The use of claim 35, wherein the Oxybutynin is in an extended release formulation with a dose of 5 – 15 mg.
39. The use of claim 24, wherein the NRI and the muscarinic receptor antagonist are formulated in a single composition.
40. The use of claim 39, wherein the single composition is an oral administration form.
41. The use of claim 40, wherein the oral administration form is a pill, tablet, troche, or capsule.
42. Use of an effective amount of (i) atomoxetine and (ii) oxybutynin in the preparation of a medicament for the treatment of sleep apnea.
43. Use of an effective amount of (i) atomoxetine and (ii) oxybutynin in the preparation of a medicament for the treatment of snoring.