(P008) A FIRST IN HUMAN, SINGLE ARM, OPEN LABEL PHASE 1/2 STUDY EVALUATING ECUR-506 IN NEONATAL OTC DEFICIENCY: INITIAL OBSERVATIONS

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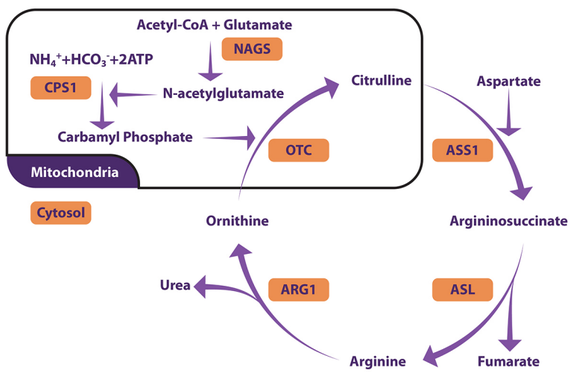
INTRODUCTION

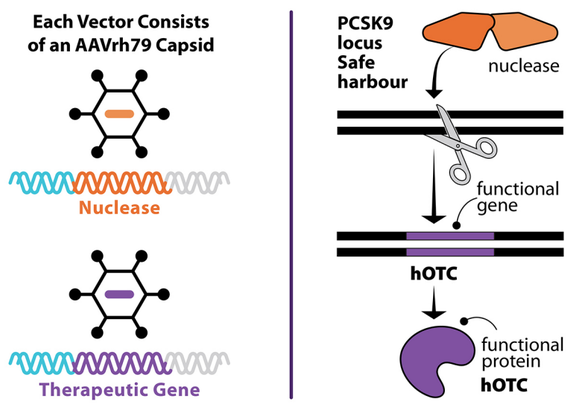
Urea cycle disorders (UCDs) are a group of biochemical diseases caused by deficiency of one of six enzymes necessary to convert toxic ammonia into urea. As a result, UCD participants are prone to developing hyperammonemia and progressive encephalopathy leading to lethargy, seizures, coma and/or death. Developmental delay is common among survivors.

Figure 1: The Urea Cycle



Ornithine transcarbamylase deficiency (OTCD) is an X-linked disorder and the most common UCD with a prevalence rate of 1:56,500[1]. Neonatal onset represents the most severe form of the disease with symptoms typically presenting in the first 48-72 hours of life. Management may include renal replacement therapy acutely, and nitrogen scavengers and protein restriction both acutely and long-term. Orthotopic liver transplantation is the only curative option.

Figure 2: ECUR-506 Dual AAV Construct



ECUR-506 is a liver-directed, investigational gene editing product being developed for the treatment of neonatal onset OTCD. The therapy comprises of two vectors, an ARCUS® (Precision BioSciences, Durham, NC) nuclease vector which encodes a meganuclease responsible for targeted gene editing of the well characterized PCSK9 gene locus and a donor vector that inserts the desired functional OTC gene. ARCUS® is a single component protein containing both a site-specific DNA recognition interface and endonuclease activity.

Administered as a single dose by intravenous (IV) infusion, ECUR-506 is designed to allow for integration of an OTC transgene into the hepatocyte genome for long-term expression of OTC in transduced hepatocytes and their progeny.

METHODS

OTC-HOPE (NCT06255782) is a 24-week, first in human, single arm, Phase 1/2, open-label, global, multi-center trial designed to assess the safety and efficacy of ECUR-506 in male participants with genetically confirmed neonatal onset OTCD who are <9 months of age and 3.5 kg to 10 kg at the time of dosing. Dose levels were informed by nonclinical studies.

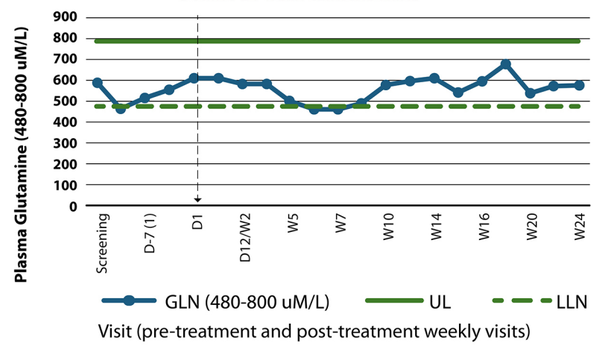
The initial dose level was effective in a murine model of OTCD. Subsequent doses will be based on an assessment of the totality of the safety and efficacy data accumulating in the trial. Study participants will be included in a long-term 14.5-year follow-up study.

RESULTS

The first participant dosed in the study experienced a hyperammonemic crisis (HAC) shortly after birth with ammonia levels reaching 16X ULN. Infant underwent dialysis and standard of care treatment was initiated. A known OTC pathogenic variant, c.77G>C (Arg26Pro), was identified. The participant experienced a second HAC at 3.5 months of age and subsequently underwent ECUR-506 (1.3 x 10^{13} GC/kg) infusion at 6.5 months of age. The infusion was generally well-tolerated. Four weeks post dose, the participant experienced Grade 3 asymptomatic transaminitis. Immunosuppressive therapy was initiated and transaminitis resolved by 4 weeks.

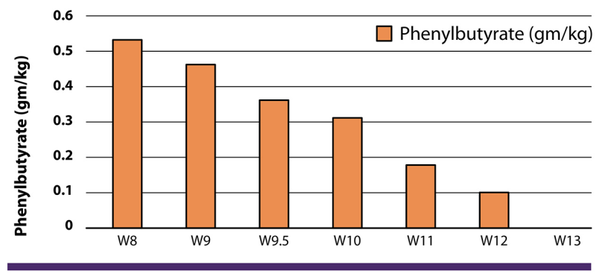
Despite being administered corticosteroids, which have been known to induce hyperammonemia in UCD participants, ammonia and glutamine levels remained controlled during this time.

Figure 4: Participant Glutamine Levels
DURING 24-WEEK CLINICAL TRIAL



Continued control of glutamine levels prompted the weaning of nitrogen scavenger therapy. Discontinuation of nitrogen scavenger was achieved 12 weeks post ECUR-506 administration.

Figure 5: Participant Nitrogen Scavenger Dose



Ammonia and glutamine levels remained in normal range post discontinuation of nitrogen scavenger therapy which allowed for complete protein intake liberalization.

Figure 6: Protein Intake Pre and Post ECUR-506 Dosing

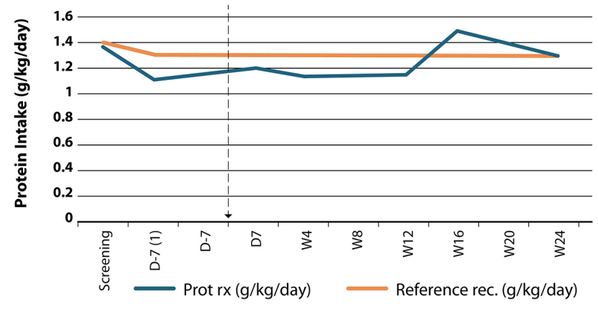


Figure 3: Participant Clinical Journey

PARTICIPANT AGE	1 WEEK	3.5 MONTHS	6.5 MONTHS	7.5 MONTHS	8.0 MONTHS	8.5-12 MONTHS
ECUR-506	PRE-TREATMENT	PRE-TREATMENT	WEEKS 0-4 DOSED	WEEKS 4-6	WEEKS 6-8	WEEKS 8-24
	After birth, developed symptomatic encephalopathy with ammonia levels of 16x ULN (HAC). Underwent dialysis to manage hyperammonemia and was transitioned to oral treatment and placed on a protein restricted diet. OTC pathogenic variant c.77G>C (Arg26Pro) identified. Mean BUN levels within normal limits.	Experienced an SAE (hypophagia) and lethargy requiring hospitalization, prior to exposure to ECUR-506, with peak ammonia levels at 2.2x ULN (HAC#2). Clinical course stabilized and was discharged from hospital. Mean BUN levels within normal limits.	Received ECUR-506 via IV administration at a dose of 1.3x10^{13} GC/kg. Tolerated the infusion well. Clinical course following ECUR-506 exposure was uneventful and remained clinically stable. Mean ammonia levels within normal limits. Mean BUN levels within normal limits.	Experienced transaminitis of ALT>3x ULN (Grade 2) prompting IV corticosteroid treatment, Safety Review Trigger, voluntary clinical halt, and Data Monitoring Committee meeting. Treated with IV corticosteroid and hospitalized for monitoring (Grade 3, SUSAR). Transitioned to oral corticosteroid treatment and continued as transaminitis fluctuated but persisted. Mean ammonia levels within normal limits. Mean BUN levels within normal limits.	Liver biopsy showed acute inflammation with T lymphocyte infiltration. ALT peaked at 5x ULN and Rx transitioned to higher dose in-patient IV corticosteroids. Tacrolimus subsequently added to reduce steroid exposure. Transaminitis resolved at week 8 and steroid taper initiated. Mean ammonia levels within normal limits. Mean BUN levels within normal limits.	Normal mean plasma ammonia concentrations. Increased blood urea nitrogen (BUN). Stable protein intake, and consistent weight gain. Stable mean plasma glutamine levels <600 uM. Tapering of daily scavenger medicine dose completed. Mean ammonia levels within normal limits. Mean BUN levels within normal limits. Remains clinically stable.

Mean ammonia levels remain within normal limits during the 6-month clinical trial. The participant remained off standard of care therapy (nitrogen scavenger + protein restriction) beginning at week 16 through the end of study visit (week 24). The participant did not experience an HAC following treatment with ECUR-506.

Figure 7: Mean Plasma NH3 Pre and Post ECUR-506 Dosing

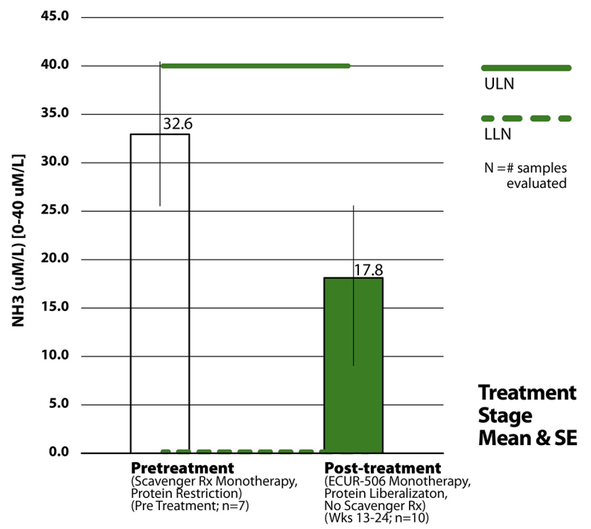
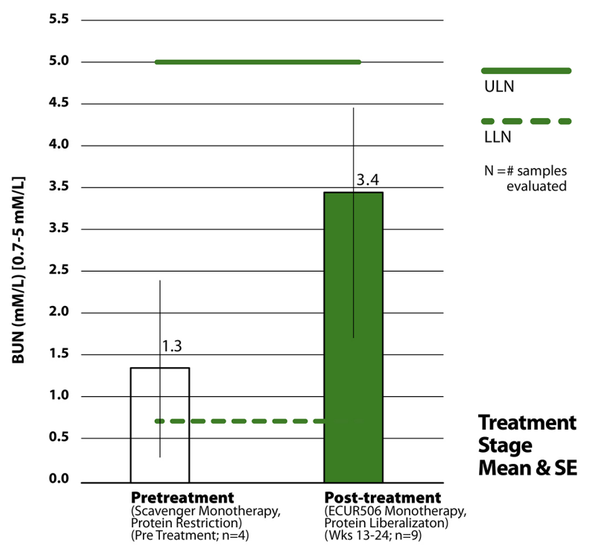


Figure 8: Mean BUN Levels Pre and Post ECUR-506 Dosing



CONCLUSION

These data represent the first infant to complete the OTC-HOPE study. ECUR-506 achieved a complete clinical response, by study definition. These data support the continued evaluation of low dose ECUR-506 (1.3 x10^{13} GC/kg) in the clinical trial.

REFERENCES

1. Ah Mew N, Simpson KL, Gropman AL, et al. Urea Cycle Disorders Overview. 2003 Apr 29 [Updated 2017 Jun 22]. In: Adam MP, Feldman J, Mirzaa GM, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2024. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1217/