A PROOF OF CONCEPT STUDY EVALUATING THE EFFECT OF ADX10059, A METABOTROPIC GLUTAMATE RECEPTOR-5 NEGATIVE ALLOSTERIC MODULATOR, ON ACID EXPOSURE AND SYMPTOMS IN GASTRO-ESOPHAGEAL REFLUX DISEASE.

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Key words: Gastro-esophageal reflux disease, pH monitoring, transient lower esophageal sphincter relaxation, metabotropic glutamate receptor-5

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ABSTRACT

Background: In preclinical models, antagonism of metabotropic glutamate receptor 5 (mGluR5) reduces transient lower esophageal sphincter relaxations (TLESRs) and increases LES pressure. This study evaluated the effect of ADX10059, a potent, selective, negative allosteric modulator (NAM) of mGluR5, on esophageal pH-metry and clinical symptoms in GERD. Methods: Two groups of GERD patients (N=12 per group) underwent 24-hour esophageal pH-metry on 2 sequential treatment days. The patients received oral placebo t.i.d. 30 min before a high fat meal on Day 1 and oral ADX10059 50 mg (Group 1) or 250 mg (Group 2) t.i.d. 30 min before a high fat meal on Day 2. The primary variable was acid exposure (%time pH<4). Secondary variables included number and duration of reflux episodes, number and duration of symptomatic episodes and symptoms recorded in diaries. Comparisons were made for Day 2 (active) versus Day 1 (placebo) treatment and for Group 1 versus Group 2

Results: ADX10059 250 mg t.i.d. significantly decreased the percentage of time with pH<4 from 7.2% to 3.6% (p=0.01). ADX10059 250 mg t.i.d. reduced pH-metry measured esophageal acid exposure, throughout the 24-hour period, nocturnally and post prandially and significantly reduced the number and duration of symptomatic reflux episodes (p=0.03). ADX10059 50 mg t.i.d. was not significantly superior to placebo. ADX10059 was generally well tolerated. Conclusion: The mGluR5 NAM ADX10059 reduced acid reflux which was associated with improvement in clinical symptoms in GERD patients. ADX10059 appears to have a potential role in clinical management of GERD.
INTRODUCTION

Proton pump inhibitors (PPIs), are the cornerstone of medical therapy for gastro-esophageal reflux disease (GERD) (1-3). However, it has been estimated up to 30% of GERD patients remain symptomatic on standard dose (once daily) of PPIs (4-8), and the majority of these will continue to experience GERD symptoms on even higher doses of PPIs (4-8). Hence, there is a need for novel therapeutic approaches to GERD.

The most frequent mechanism underlying reflux events is transient lower esophageal sphincter relaxation (TLESR), which is an attractive target for the treatment of GERD (9). TLESRs involve a vago-vagal reflex pathway which is activated by gastric distension and integrated in the brain stem to result in relaxation of the lower esophageal sphincter smooth muscle. A wide variety of transmitters and receptors are expressed centrally and peripherally in the vagal pathway that mediates lower esophageal sphincter control (9-11).

Glutamate is the primary neurotransmitter involved in signalling from visceral and somatic primary afferents to the central nervous system (11). Anatomical studies of vagal afferents have revealed expression of metabotropic glutamate receptors, including mGluR5, in the nodose ganglia of several species, including humans, and evidence suggests possible localization in peripheral gastric vagal afferent terminals (11). Recent studies in animal models identified selective antagonists of mGluR5 as potent inhibitors of TLESRs and reflux episodes (12,13). It has been argued that peripheral mGluR5, expressed in gastro-esophageal vagal afferent endings, play a more prominent role in control of TLESRs as compared to central mGluR5 (10). These preclinical findings support a role for mGluR5 in the direct control over TLESRs, providing a mechanistic basis for the clinical development of mGluR5 antagonists for the treatment of GERD.

ADX10059 is a potent selective negative allosteric modulator of the mGluR5 receptor. Rather than acting directly blocking the glutamate orthosteric binding site, ADX10059 modulates the activity of the mGluR5 receptor by binding to a site distinct from the glutamate binding site (i.e. an allosteric site), and diminishes the intracellular signal created when glutamate binds to the receptor. The inhibitory effects of a negative allosteric modulator, unlike an orthosteric inhibitor, are non-competitive. Hence, the magnitude and duration of effect of a negative allosteric modulator are not determined solely by its pharmacokinetics. As the negative allosteric modulator acts dynamically with the natural ligand on the receptor function, the effect is more a modulation of physiological responses.

As well as being expressed in the GI tract, mGluR5 expression is predominant in areas of the mammalian brain involved in emotional processes, such as the dentate gyrus regions within the hippocampus; regions of the basal ganglia (striatum and nucleus accumbens) and in the dorsal horn of the spinal cord, suggesting a role for these receptors in affective disorders such as anxiety and depression (14,15). The mGluR5 is also implicated in central pain processing pathways in the trigeminal nucleus caudalis and spinothalamic tract. ADX10059 is also centrally effective, and is additionally being tested in the treatment of migraine. Effects on emotion centers and central pain processing may also be of relevance in the symptomatic treatment of
GERD. The present study was a proof-of-concept study aimed at investigating the efficacy, safety and tolerability of the selective mGluR5 antagonist ADX10059 in reducing acid reflux and clinical symptoms in symptomatic GERD patients.

MATERIALS AND METHODS

Study Design and Objectives

The study was a randomized, single (patient)-blind, placebo-controlled, sequential treatment trial in GERD patients. The duration of the trial was approximately 4 to 5 weeks per subject and comprised 3 Visits; Screening (Visit 1), two consecutive Study Treatment Days, (placebo followed by active treatment – Visit 2), and a follow up visit (Visit 3) one to two weeks after dosing. As each patient received both placebo and active treatment he/she acted as his own control.

The primary objective of the study was to explore the effect of ADX10059 on esophageal acid exposure measured by 24-hour esophageal pH monitoring. The secondary objectives of the study were: 1) to explore the effect of ADX10059 on diurnal, nocturnal and postprandial episodes of acid reflux, 2) to evaluate the effect of ADX10059 on clinical symptoms of reflux, 3) to evaluate the safety and tolerability of ADX10059 in GERD patients, and 4) to evaluate the 0-4 hour post dose plasma concentrations of ADX10059 in patients with gastro-esophageal reflux disease.

Conduct of the study

The study was conducted in a single center (SGS Aster, Paris, France) in an inpatient setting and was performed in accordance with the ethical principles stated in the Declaration of Helsinki as revised by 52nd General Assembly in Edinburgh, 2000 and with the French Huriet law. After Ethics Committee approval, the study was conducted between September and November 2006 in accordance with Good Clinical Practice (GCP) and standard operating procedures (SOP) for clinical investigation and documentation in force at the clinical trial center.

Patients

The patients were recruited from a specialist gastroenterology clinic in Paris. All patients had a prior diagnosis of symptomatic GERD made by a gastroenterologist and all had to have a history of good control of heartburn, regurgitation and other GERD symptoms with acid suppressant therapy. Patients who were on acid suppressants at the time of screening, had to stop treatment for at least two weeks before the study treatment days. Eligible patients were Caucasian men and women aged 18 to 65 years, weighing between 50 and 100 kg with a body-mass index (BMI) between 18 and 35 kg/m², who were non-smokers or light smokers (<5 cigarettes per day), with normal arterial blood pressure and heart rate.

Patients were excluded if they had any clinically significant acute or chronic disease or significant abnormality in pre-study laboratory tests and physical examination; if they had received any experimental drug within 30 days prior to screening; if they
were known or suspected alcohol or drug abusers, if they had undergone surgery or
had donated blood within 1 month prior to study start; if they had received any drug
known to affect hepatic metabolism within 1 month or any drug known to affect renal
tubular secretion or gastrointestinal motility, within 2 weeks prior to the first study
dose administration. Patients with a history of esophageal stricture, gastrointestinal
bleeding or gastrointestinal surgery were also excluded.

**Procedures**

**Screening and randomization**

Within 3 weeks of the first study treatment day patients attended a screening visit.
After they had provided their written informed consent, the patients’ medical history
and demographic data were recorded and safety screening was performed. Eligible
patients were randomized to one of two treatment groups: Group 1 Placebo (Study
Day 1) followed by ADX10059 50 mg t.i.d. (Study Day 2) or Group 2, Placebo (Study
Study Day 1) followed by ADX10059 250 mg t.i.d. (Study Day 2). The choice of
doses was based on the pharmacokinetic and tolerability data from a previous
repeated dose study in healthy subjects (ref study ADX10059-102, data on file),
using the same immediate release formulation i.e. simple drug powder-filled capsules
with no excipients.

**Study drug dosing and pH monitoring days**

Patients were admitted to the clinical pharmacology unit on the evening prior to study
drug dosing i.e. Day -1. Prior to dosing on study Days 1 and 2, patients fasted
overnight for a minimum of ten hours. Standardized high fat meals were provided for
breakfast, lunch and supper and patients had 30 minutes to consume each meal. To
normalize intake, a fixed amount of water (1500 mL) was supplied and was required
to be consumed within each 24-hour period. The ambulatory oesophageal pH
monitoring was performed using an antimony pH electrode with a separate skin
reference electrode (Digitrapper pH100, Medtronic, Tolochenas, Switzerland). The
ambulatory pH monitoring unit was calibrated before each use, using standard
buffers. The esophageal pH probe was inserted via one nostril to a distance of
approximately 5 cm above the lower esophageal sphincter. Online continuous pH
monitoring was used to locate the position of the lower esophageal sphincter for each
patient.

On Study Days 1 and 2 the probe was inserted and monitoring started about 10
minutes prior to the first dose administration. The probe was removed after
approximately 24 hours. Patients had a 30 minute pH monitoring-free period, with
removal of the catheter, between the two Study Days so that they could go and take
a shower and change their clothes if they wished.

On each Study Day, the patients were administered a single oral dose of study
medication on three occasions, 30 min before each meal. On Study Day 1 they
received placebo and on Study Day 2, they received ADX10059 50 mg (Group 1) or
250 mg (Group 2). The patients took the capsules with 240 mL of water at room
temperature and were dosed while standing. After dosing, the patients remained on
their bed sitting at approximately 45 degrees. The patients were not allowed to lie flat
for 4h following the morning and midday doses, except for study procedures or if clinically indicated.

The timetable of procedures on Study Days 1 and 2 was as follows:

- 07:20 start esophageal pH recording
- 07:30 study medication Dose 1
- 08:00 breakfast
- 12:30 study medication Dose 2
- 13:00 lunch
- 19:30 study medication dose 3
- 20:00 dinner
- 22:00 to approx 07:00 bedtime
- 07:00 approx, end of pH monitoring period on Day 1 (on Day 2 end of pH monitoring period was at 07:30)

Pharmacodynamic Efficacy Measures

24 h esophageal pH measurement

Esophageal pH was recorded for approximately 24 hours starting on Study Day 1 and Study Day 2. pH measurements were captured every 4 seconds resulting in approximately 21,600 measurements for each 24 hour period. Each variable was calculated for the 24-hour recording period and for the upright diurnal period (07:30 to 22:00) and the supine nocturnal period (22:00 to 07:30 approx). The percentage time for esophageal pH < 4 was calculated from the continuous online monitoring.

Reflux episodes number and duration

The number and total duration of gastro-esophageal reflux episodes was recorded. In accordance with the standards of the clinical pharmacology unit, a reflux episode was defined as 7 consecutive measures with a pH < 4 i.e. at least 28 seconds. The total duration of reflux episodes was the sum of all actual times of reflux episodes ≥ 28 seconds. The number of gastro-oesophageal reflux episodes and the total duration of time with gastro-oesophageal reflux episodes was summarized for the 24 hour, diurnal and nocturnal periods. Esophageal acid clearance was expressed as the mean duration of acid reflux events.
Post prandial reflux episodes

The post prandial periods were defined as the period of 4 hours following each meal i.e. from 08:00 to 12:00am, 01:00 to 05:00pm and, 8:00 to 12:00pm. Post prandial reflux episodes were documented by a pH drop to < 4 for at least 28 secs and as food has an effect on neutralising stomach acid, pH drops ≥ 1 for at least 28 sec were also used to measure post prandial reflux. The number and duration of post prandial reflux events were summarized for each treatment. In addition, the number and total duration of pH drops ≥1 were summarized for the 24 hour and nocturnal periods.

Clinical symptoms of reflux

Patients recorded the occurrence and duration of symptomatic reflux episodes in a diary on each treatment day. Patients were asked to note when they experienced typical GERD symptoms. Heartburn and regurgitation were not evaluated separately. The number and duration of symptomatic reflux events were summarized for the 24 hour period.

Safety and Pharmacokinetic Measures

Safety assessments were made at screening, at follow up and at regular time points during the study drug administration days. The safety measures comprised full physical examination, urinalysis, pregnancy testing (screening and follow up only), heart rate, blood pressure, hematology, biochemistry, 12-lead ECG and regular adverse events enquiry.

Blood samples for plasma concentrations of ADX10059 were taken on both Study Days (to maintain the blinding to the patient) pre-dose and at 0.5, 1.0, 2.0, 3.0 and 4.0 hours after each dose. From the plasma concentration versus time profiles the following pharmacokinetic parameters were assessed: t_{max}, C_{max}, \text{AUC}_{0-4} and \text{AUC}_{0-\infty}.

Statistical Methods

The primary efficacy variable was the percentage of time with esophageal pH < 4 comparing ADX10059 with placebo. Secondary variables included: 1) the percentage of time with esophageal pH < 4 in the nocturnal and diurnal periods; 2) the number and duration of reflux episodes (esophageal pH < 4) during the 24 hour, nocturnal, and the 4 hour post prandial periods; 3) the number and total duration of pH drop ≥1, during the 24 hour, nocturnal and the 4 hour postprandial periods ; 4) esophageal acid clearance and 5) the number and total duration of symptomatic episodes of GERD.

The analysis populations were as follows: The Safety Population included all randomized patients, who received the study drug and had post-dosing data. The Pharmacodynamic Population included all patients who completed the study without
major protocol violations or events implying a bias for PK evaluation and with two complete pH-metry profiles (Study Day 1 and 2).

Intra-individual comparison between placebo and active drug was performed during the two successive assessments. Statistical analysis for efficacy was performed on the Pharmacodynamic Population. For the primary and secondary endpoints, all parameters were analysed on the change from baseline (placebo Day 1 value) by analysis of covariance (ANCOVA) using dose level as a fixed effect and baseline as covariate. Estimates (Least Square means) of dose effects and differences between doses were provided with their respective 95% confidence interval. Quantitative parameters were described per group, dose level and time point using N (number of observations), mean, median, standard deviation (SD), minimum, and maximum. The 95% confidence interval of the mean was included for changes from baseline. All statistical tests were two-tailed and the significance threshold was set at the 5% level.

The study was an exploratory study without a formal statistical sample size calculation. A total of 12 patients per dose group was deemed to be sufficient to obtain meaningful data on the pharmacodynamic effect of ADX10059 on 24-hour pH and clinical symptoms in this proof of concept study.

**RESULTS**

**Patient demographics**

Thirty-two patients were screened, of which 24 were randomized (8 were not eligible, 4 had abnormal lab values, 3 withdrew consent and 1 had an abnormal ECG). All 24 randomized patients (12 in Group 1 comparing ADX10059 50 mg to placebo, and 12 in Group 2 comparing ADX10059 250 mg to placebo) completed the study and were included in the safety and pharmacokinetic analyses. One male patient in Group 2 was excluded from the Pharmacodynamic Population due to missing pH metry data on Study Day 1 when his pH probe became displaced. Subject disposition is in Figure 1. The treatment groups had similar demographic and baseline characteristics (Table 1).

**Table 1: Patient demographic characteristics**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Group 1 N=12</th>
<th>Group 2 N=12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race (Caucasian)</td>
<td>12 (100%)</td>
<td>12 (100%)</td>
</tr>
<tr>
<td>Sex (female)</td>
<td>3 (25%)</td>
<td>2 (16.7%)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>44.6</td>
<td>45.1</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>77.9</td>
<td>79.8</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>26.1</td>
<td>26.2</td>
</tr>
<tr>
<td>Light smokers (&lt;5 cigarettes/day)</td>
<td>3 (25.0%)</td>
<td>2 (16.7%)</td>
</tr>
<tr>
<td>Previous GERD medications</td>
<td>6 (50%)</td>
<td>10 (83.3%)</td>
</tr>
</tbody>
</table>
The majority of the patients were men (9 in Group 1 and 10 in Group 2) with an average age of approximately 45 years. In Group 1 50% of patients and in Group 2 83% of patients, were previously using regular acid suppression therapy.

**Primary efficacy – percentage of time pH < 4 in 24 hours**

At baseline patients in Group 1 tended to have a greater percentage of time pH < 4 in the 24-hour period, but this difference was not significant (14.9±13.9% Group 1; 7.2±5.8% Group 2, p = n.s.). There was no significant effect of ADX10059 50 mg t.i.d. on percentage of time pH < 4. (Table 2). ADX10059 250 mg t.i.d. significantly decreased the percentage of time that pH was < 4 in the 24-hour period to 3.6±3.2% (p=0.0144) and in the nocturnal period from 9.7±10.2% to 3.7±6.0% (p=0.0028).

**Table 2: Percentage time pH < 4**

<table>
<thead>
<tr>
<th>Treatment Group</th>
<th>% time pH &lt; 4 in 24h</th>
<th>% time pH &lt; 4 diurnal</th>
<th>% time pH &lt; 4 nocturnal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1 n=12</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo</td>
<td>14.9</td>
<td>9.5</td>
<td>22.7</td>
</tr>
<tr>
<td>ADX10059 50 mg</td>
<td>15.1</td>
<td>12.8</td>
<td>18.9</td>
</tr>
<tr>
<td>Estimate change from baseline</td>
<td>2.71</td>
<td>4.75</td>
<td>0.19</td>
</tr>
<tr>
<td>95% CI</td>
<td>[-2.05; 7.48]</td>
<td>[0.14;9.37]</td>
<td>[-5.88; 6.26]</td>
</tr>
<tr>
<td>P value</td>
<td>ns</td>
<td>0.0442*</td>
<td>Ns</td>
</tr>
<tr>
<td><strong>Group 2 n=11</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo</td>
<td>7.2</td>
<td>5.2</td>
<td>9.7</td>
</tr>
<tr>
<td>ADX10059 250 mg</td>
<td>3.6</td>
<td>3.4</td>
<td>3.7</td>
</tr>
<tr>
<td>Estimate change from baseline</td>
<td>-6.41</td>
<td>-3.41</td>
<td>-10.37</td>
</tr>
<tr>
<td>95% CI</td>
<td>[-11.4; -1.42]</td>
<td>[-8.24; 1.42]</td>
<td>[-16.73; -4.01]</td>
</tr>
<tr>
<td>P value</td>
<td>0.0144</td>
<td>ns</td>
<td>0.0028</td>
</tr>
</tbody>
</table>

* increased compared to placebo

**Secondary efficacy measures**

**Number and duration of acid reflux episodes – 24 hour and nocturnal periods**

At baseline, there were no significant differences between the treatment groups for either the number or total duration of gastro-esophageal acid reflux episodes during the 24-hour period.

Compared to placebo, ADX10059 50 mg t.i.d. in Group 1 did not significantly alter the mean number of acid reflux episodes or the total duration of episodes, in all time periods (Table 3). The average esophageal acid clearance was not altered by ADX10059 50 mg t.i.d. (3.9±0.4 vs. 3.4±0.4 min, NS).
### Table 3: Group 1; ADX10059 50 mg t.i.d. number and duration of reflux episodes and clinical symptoms

<table>
<thead>
<tr>
<th>Efficacy variable</th>
<th>ADX10059 50mg t.i.d. N=12</th>
<th>Placebo t.i.d. N=12</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD) number reflux episodes (pH&lt; 4) in 24h</td>
<td>65.3 (48.9)</td>
<td>51.9 (43.3)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mean (SD) total duration of reflux episodes (pH&lt; 4) in 24 hour (min)</td>
<td>185.3 (136.4)</td>
<td>184 (172.6)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mean (SD) number nocturnal reflux episodes (pH&lt; 4)</td>
<td>28.6 (26.9)</td>
<td>21.4 (20.7)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mean (SD) total duration of reflux episodes (pH&lt; 4) nocturnal period (min)</td>
<td>97.1 (76.6)</td>
<td>118 (113.3)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mean (SD) number symptomatic episodes</td>
<td>5.3 (3.3)</td>
<td>6.6 (4.6)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mean (SD) duration of symptomatic episodes (min)</td>
<td>28.7 (43.9)</td>
<td>43.2 (81.0)</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

In Group 2, ADX10059 250 mg t.i.d. significantly decreased the mean total duration of acid reflux episodes during the 24-hour period (mean (±SD) 40±39, vs placebo 86±72 min p=0.0132) and during the nocturnal period (mean (±SD) 16±29 vs placebo 49±54 min, p=0.0021) - Figure 2. There was also a trend towards a decrease in the number of episodes of acid reflux at all time points, but the differences were not statistically significant (Table 4). The average esophageal acid clearance was not significantly altered by ADX10059 250 mg t.i.d. (3.0±0.3 vs. 2.4±0.3 min, NS).
Table 4: Group 2; ADX10059 250 mg t.i.d. number and total duration of reflux episodes and clinical symptoms

<table>
<thead>
<tr>
<th>Efficacy variable</th>
<th>ADX10059 250mg t.i.d. N=11</th>
<th>Placebo t.i.d. N=11</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD) number reflux episodes (pH&lt; 4) in 24h</td>
<td>20.5 (19.4)</td>
<td>32.7 (20.3)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mean (SD) total duration of reflux episodes (pH&lt; 4) in 24 hour (min)</td>
<td>39.9 (38.7)</td>
<td>86 (72.2)</td>
<td>0.0132</td>
</tr>
<tr>
<td>Mean (SD) number nocturnal reflux episodes (pH&lt; 4)</td>
<td>6.4 (9.9)</td>
<td>13.6 (12.3)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mean (SD) total duration of reflux episodes (pH&lt; 4) nocturnal period (min)</td>
<td>16.4 (29)</td>
<td>48.7 (54)</td>
<td>0.0021</td>
</tr>
<tr>
<td>Mean (SD) number of symptomatic episodes</td>
<td>1.9 (3.8)</td>
<td>7.0 (13.8)</td>
<td>0.031</td>
</tr>
<tr>
<td>Mean (SD) duration of symptomatic episodes (min)</td>
<td>5.2 (12.6)</td>
<td>13.9 (20.1)</td>
<td>0.031</td>
</tr>
</tbody>
</table>

Total duration pH drops ≥1 - 24 hour and nocturnal

Overall, in Group 2 there was a reduction in the total duration of pH drop ≥1 in 24 hours, from a mean (±SD) 118±57 min with placebo to a mean (±SD) 75±46 min during active treatment (p=0.054) of which the nocturnal duration significantly decreased from a mean (±SD) 58±42 min to a mean (±SD) 31±34 min (p=0.0049).

In Group 1, the 50 mg dose of ADX10059 did not significantly alter the number or duration of pH drops ≥1 in the postprandial periods, the nocturnal or the 24-hour period.

Postprandial reflux

In Group 1, the 50 mg dose of ADX10059 did not significantly alter the number or duration of reflux episodes using either esophageal pH < 4, or pH drops ≥1, in the 4 hour postprandial periods.

Using pH drops ≥ 1, in Group 2 ADX10059 250 mg t.i.d. significantly decreased either the number or duration of reflux episodes in the postprandial periods.

The number of drops of pH ≥ 1 significantly decreased in the post breakfast period (mean (±SD) 6.8±5.4 vs placebo 9.7±4.0 p=0.041). Post lunch and dinner the differences in the number of episodes of pH drops ≥ 1 were not statistically
significant. The duration of pH drops ≥ 1 significantly decreased in the post lunch
(mean (±SD) 8.1±5.3 vs placebo 15±8.3 mins, p=0.0371) and post dinner periods
(mean (±SD) 5.1±4.6 vs placebo 13.5±9.7 mins, p=0.0146) (Figure 3).

In Group 2, using esophageal pH < 4 to determine post prandial reflux, ADX10059
showed a numerical reduction in the number and duration of episodes but none
achieved statistical significance.

Clinical symptoms of reflux

The mean number of patient reported symptomatic reflux episodes was significantly
lower than the total number of reflux episodes detected by means of pH monitoring.

ADX10059 250 mg t.i.d. resulted in a statistically significant reduction in the number
and duration of symptomatic reflux episodes (Table 4). The number of episodes was
reduced from 7±13.8 on the placebo baseline day to 1.9±3.8 on the active treatment
day (p=0.031) and the mean total duration of symptomatic reflux was reduced from
13.9±20.1 to 5.2±12.6 minutes (p=0.031) In the ADX10059 50 mg group, the number
of symptomatic episodes was not significantly reduced (Table 3).

Pharmacokinetics

The mean plasma concentration-time curves are shown in Figure 4. Following oral
administration, ADX10059 was rapidly absorbed and was detectable in plasma
30 minutes after dosing in the majority of patients. There was inter-individual
variability in plasma exposure (CV approx 50% for both doses for AUC0-16). For
ADX10059 50 mg, the geometric mean Cmax ranged from 27.3 ng/mL after dose 1 to
35.4 ng/mL after dose 3 and for ADX10059 250mg, ranged from 221 ng/mL after
dose 1 to 283 ng/mL after dose 3. The time to reach maximum plasma concentration
was variable and ranged between 0.5 and 4 hours regardless of dose and
administration number.

Correlations of plasma concentration with reflux episode duration in the whole 24-
hour period and in each of the postprandial periods were performed. Although drug
effect seems to increase with increasing ADX10059 dose, no clear
pharmacodynamic/pharmacokinetic relationship could be seen.

Safety and tolerability:

ADX10059 given as three doses in one day was generally well tolerated by the
patients with GERD. No serious adverse events (AEs) were reported. One patient in
Group 1 reported flatulence after receiving placebo. The incidence of AEs was higher
in Group 2, the 250 mg t.i.d. group, 11/12 (91.6%) than in the 50 mg t.i.d. group 2/12
(16.7%). In Group 1 somnolence, cough and rhinorrhea were reported in 1/12
patients (8%). In Group 2, the most commonly reported AEs were related to the
central nervous system and the most common single adverse event was dizziness
(9/12 patients, 75%). The dizziness was accompanied by nausea in 4/12 (33%) of the patients. In addition 2 (17%) patients reported dysuria and other events occurring in 1/12 (8%) patients were tinnitus, visual accommodation disorder, dry mouth, vomiting, paresthesia, hyposthesia, feeling drunk and hot flush. All AEs except for one occurred following the first or second dose, none of the events was described as severe and all of them resolved without sequelae. No clinically significant changes in safety monitoring parameters for hematology, blood chemistry, urinalysis, vital signs, physical examination or 12-lead ECG were reported.

**DISCUSSION**

Inhibition of mGluR5 has been shown to reduce transient lower esophageal sphincter relaxation episodes and increase lower esophageal sphincter tone in animals (12,13), a mechanism which could have application in the prevention of gastro-esophageal reflux in humans. To our knowledge, the effect of mGluR5 inhibition on TLESRs and reflux events has not been reported in humans. The aim of the present study was to assess the effect of ADX10059 on gastro-esophageal reflux in GERD patients, using pH-metry to detect episodes of acid reflux and hence indirectly study LES function.

To this end, 24 patients with GERD diagnosed in a specialist gastroenterology clinic were randomized in two groups of 12 patients (Groups 1 and 2). In each Group, the effect of ADX10059 (50 mg t.i.d. or 250 mg t.i.d. for one day) was compared with placebo. The doses of ADX10059 were selected based upon the pharmacokinetic and tolerability data from a previous repeated dose study in healthy subjects (ref study ADX10059-102 data on file). The upper and lower extremes of the doses from that study were chosen for this study to explore the safety, tolerability and pharmacodynamics across a dose range that might have therapeutic potential in GERD patients. In both Groups, each patient received placebo treatment on Day 1 and then ADX10059 on Day 2 in a single-blind fashion, and therefore acted as his/her own control. Patients were blinded as to the treatment sequence so that they could objectively evaluate their clinical symptoms on each treatment day.

Consistent with previous results obtained with the immediate release, powder-filled capsule, ADX10059 was quite rapidly absorbed with a median plasma peak occurring between 1.0 and 2.0 hours following administration. As already observed in healthy subjects, there was a large inter-individual variability for plasma concentrations and PK parameters. No clear relationship was drawn from the review of drug exposure and drug effect. The safety and tolerability profile was also consistent with that observed at these doses in previous single and repeated dose studies of ADX10059 in healthy subjects (refs. Data on File, studies ADX10059-101, 102 and 103). The central nervous system effects (eg dizziness) seen in the 250 mg t.i.d. group are consistent with the mechanism of action and the rapid absorption following dosing using the immediate release capsule. The side effect profile in the higher dose group is considered undesirable for long term treatment of GERD, therefore a modified release formulation which is less rapidly absorbed and which has been shown to reduce the occurrence of CNS side effects (data on file Study ADX10059-104), has been developed and will be used for subsequent studies. While the 50 mg of
ADX10059 t.i.d. had no statistically significant effect, the 250 mg dose of ADX10059 t.i.d. produced significant improvement in pH-metry derived reflux and in the symptomatic expression of GERD. To our knowledge, this is the first study in man to support the findings of previous animal studies on the effect of mGluR5 antagonism on reflux events. Hence the concept that the mGluR5 NAM may reduce reflux and have therapeutic potential in GERD was supported by the findings of this study.

Based on animal studies with other mGluR5 NAMs, MTEP and MPEP, the effects of ADX10059 on esophageal acid exposure are expected to reflect inhibition of TLESRs through a peripheral mode of action (10). The decrease in acid reflux events in the postprandial period, when TLESRs occur most frequently (9), is compatible with such a mechanism of action. It is less clear whether the inhibition of nocturnal reflux events is also attributable to inhibition of TLESRs, or whether other factors, such as an increase in resting LES pressure which was apparent from animal studies using MTEP and MTEP (12), may play an additional role. Inhibition of nocturnal reflux has also been observed with baclofen, which inhibits TLESRs through gamma amino butyric acid type B receptor agonism (9, 16, 17). Although the 250 mg dose of ADX10059 significantly decreased the total duration of acid reflux events, this was not associated with a significant decrease of the number of reflux events for the 24-hour measurement period. This observation suggests shortening of reflux episodes, which could be due to improved esophageal clearance (although this was not observed in this study) or to a smaller volume of refluxed material during reflux events. Elucidating the mechanisms underlying the anti-reflux effects of ADX10059 will require additional studies.

This study was an initial exploratory study and as such the authors recognise that there are features of the design which could potentially impact the interpretation of the results and for which the rationale should be explained. A single-blind sequential day dosing regimen was chosen principally for logistic reasons, so that the patients would not have to undergo pH monitoring for an extended duration or have to undergo repeated admissions to the unit, which would have been required if the study had been a randomised cross-over design. The patients were blinded to the treatment sequence and underwent exactly the same procedures on Study Days 1 and 2 (including blood sampling for pharmacokinetics) in order to minimise any effect on subjective symptom reporting. As the majority of evaluations were objective physiological measures, the single-blind design should not affect these. However, it is possible that the measures on Study Day 2 could differ to those on Study Day 1 due to the study conditions and it would normally be preferable to randomize the treatment order to mitigate this. Overall, using the 250 mg dose, significant decreases in acid reflux parameters and in reflux-related symptoms were observed. Although esophageal pH monitoring shows considerable intra-individual day-to-day variability, systematic order effects with lower acid exposures on Study Day 2 are not found (18-27). Also, the consistent effects in the 250 mg dose group were not seen in the 50 mg dose group suggesting a dose response effect. Hence the study design is not considered to significantly impact the overall interpretation of the results.

The definition of reflux events as 7 consecutive episodes of oesophageal pH < 4 was one that was standard for the clinical pharmacology unit. It is recognised that this may lead to under-reporting of the number of reflux events and only acid reflux events can be captured in this way. The total percentage of pH < 4 was derived from...
the continuous pH monitoring and so reflux events that were less than 28 seconds, were captured in this measurement. Furthermore, as food may neutralise the stomach pH, drops in pH of ≥ 1 for ≥ 28 seconds were used, in addition to the measure of pH < 4 for ≥ 28 seconds, to more accurately identify post prandial reflux events. Impedance pH monitoring is a more sensitive measure of reflux events capturing all types of reflux event and this will be used for subsequent studies.

CONCLUSIONS

To our knowledge, this is the first study to report on the effects of a mGluR5 NAM in patients with GERD. ADX10059 250 mg t.i.d. reduced acid reflux as measured by pH-metry, and this was associated with improvement in clinical symptoms. The study confirms the potential for the mGluR5 NAM ADX10059 in the treatment of GERD. Potential therapeutic applications to be evaluated include add-on therapy in GERD patients with incomplete response to PPIs, or monotherapy in those for whom PPIs are unsuitable.

Acknowledgements

The authors would like to thank Brigitte Elharrar MD who acted as the principal investigator, Eric Evène PhD who was responsible for the analysis of the pH traces and Beatrice Néau who performed the statistical analysis of the results.

Conflict of Interest and clarifications:

• Charlotte Keywood and Mark Wakefield are employees of Addex Pharma.
• The statistical analysis of the entire data sets pertaining to efficacy (specifically primary and secondary major efficacy endpoints) and safety have been independently confirmed by a biostatistician who is not employed by the corporate entity.
• The corresponding had corresponding author had full access to all of the data and takes full responsibility for the veracity of the data and analysis.
• Addex Pharma was the sponsor of this study and determined the design of the study. Data collection and analysis was performed by a clinical research facility.
• Data interpretation was performed by Jan Tack.

Competing Interest: None to declare

FIGURE LEGENDS

Figure 1: Patient disposition
Figure 2: Mean total duration of reflux episodes
Figure 3: Mean duration of postprandial episodes of pH drop ≥ 1
Figure 4: Mean plasma concentration versus time profiles following repeated oral doses three times daily of 50 mg or 250 mg of ADX10059 for one day (linear scale)
References

Figure 1

32 screened
- 8 not eligible
- 4 abnormal lab values
- 3 consent withdrawn
- 1 abnormal ECG

24 randomized

24 single-blind treatment

12 ADX10059 50 mg tds
- 12 completed 2 Day Study
- 12 included in safety and pharmacodynamic populations

12 ADX10059 250 mg tds
- 12 completed 2 Day Study
- 1 excluded abnormal pH profile
- 12 included in safety population
- 11 included in pharmacodynamic populations
Figure 2

![Bar chart showing mean total duration of reflux - pH < 4 (min) for Placebo and ADX 10059 250 mg t.i.d. groups.](chart.png)
Figure 3

Mean (SD) duration of episodes pH drop > 1 (mins)

- Placebo
- ADX10059 250 mg

* p < 0.05
Figure 4
A Proof Of Concept Study Evaluating The Effect Of ADX10059, A Metabotropic Glutamate Receptor-5 Negative Allosteric Modulator, On Acid Exposure And Symptoms In Gastro-Esophageal Reflux Disease

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Gut published online May 20, 2009