Thank you.
Very good afternoon.
I think for saving some time, I'll just go a quick description of the slides.
So this study is basically about the Ponzi Gromat, which is a monoclonal antibody inhibitor of
growth differentiation factor 15, which is used in patients with cancer kia kia.
So this study was presented at SMO-conglish, 2024, Barcelona.
So with the conflicts of interest here, and this study funded by Pfizer, these are the
declaration.
And moving ahead, the study was conducted with the introduction to the study is that most
of the patients definitely have kia kia in our patients with cancer.
So what is the actual implication of the pathogenesis is that the GDF-15, that is a growth differentiator
factor 50, which is a stress cytokine, which is mostly increased in these patients, and
that binds to the GF-ral receptor in the hindbrain.
So that can cause the kia kia.
So what does Ponzi Gromat do is it binds to the GDF-15, and thereby, inhibits its binding
to the GF-ral receptor, which is in the hindbrain.
And that's where kia kia improves.
This is a phase 1B study.
So basically it is to see which level of Ponzi Gromat, which can give us the best advantage.
So it's to evaluate the efficacy and safety and tolerability of the Ponzi Gromat compared
with the placebo in patients with cancer kia kia and elevated circulated GDF-15 levels.
The study design was it's a randomized double-blind, multisentric study.
It was randomized into 1 is to 1 into 4 groups, and the 4 groups included Ponzi Gromat was
400 mg subcutaneous, few, few, four weekly, or 200 mg and 100 mg.
And one of the group was the placebo, plus a group group.
So the study visits were the day one and then week four, week eight, week 12.
So the main endpoint was to check the body weight and the other endpoints were the patient-related
outcomes, the physical activity and gait, safety and tolerability, and Lumbus-Celtal
muscle index.
So with these statistical analysis, I'm not going into details of the way the statistical
analysis made, but let's go to the results.
So if we see here, so out of the 281 enrolled, 187 were randomized, many had screening failures,
and then each of the group as said like one is to one manner.
So the patients were almost 45 to 50 in each of these group, and all the 100 percent of
the patients in each group were treated.
And there were some discontinued patients, and most of it was either because of progressive
disease or adverse events or death or global deterioration of health.
So out of which in each group you can see here, at the week 12, almost 70 to 80 percent
could be assessed at the week 12.
And this is the actual study.
So it is also possible that these patients were given an option of extending to up to

one year, so that was an option.
So but here I think we have only week 12 study data with us.
So these are the baseline characteristics which were all matched.
So most of the median age was around 60 to about 60, so 66 to 73.
The sex that's the gender was matched.
Most of the patients had a performance status of 0 to 1, almost around 80 percent.
The rays, again the white were more than the Asians.
So BMI is most of them add a 19 to 20, and percentage weight loss in 6 months before
screening was either categorized into 5 to less than 10 percent or more than 10 percent.
And the BMI adjusted weight loss category.
So this was something that they checked the weight loss in the last 6 months, and the
BMI on the day of inclusion into the study.
So there I categorized into 4 categories, and 4 means the severe catechia.
And GDR 15 levels was a mandatory, so most of them had a high GDR levels.
So the median was almost more than 3,770.
So on the type of cancers that were included were mainly 3, that is the NSCLC, colorectal
and pancreatic.
NSCLC was almost 40 percent, colorectal was almost very 8 to 30 percent, pancreatic was
between 25 to 30 percent.
And most of them were stage 4, that's almost 70 percent, and almost 90 percent were actively
receiving the systemic cancer therapy.
And there were also one more stratification was based on the platinum based chemotherapy,
because apparently there is a notion that the platinum based chemotherapy can increase
the GDR 15, causing the catechia.
So the results here, like we can see the table here, the figures.
It definitely shows this is on treatment, and this is treatment policy that's basically
about the censored result analysis.
So on treatment is based on the censored, and treatment policy is without sensory.
So we can see here this is the placebo, this is the 100, this is the 200 mg of ponsygromap,
this is the 400 mg.
If we see here, there's definitely a statistical, significant increase in the weight in all
the 3 groups, but the 400 mg are actually much significant than the rest.
So the change was almost 1.33 kgs in the 100, a 2.08 mg in the 200 and 3 kgs in the 400 mg group.
So the body weight response was consistent in all of these groups when compared to placebo.
And this response was also seen at 8 weeks itself.
Now coming to the 5 percent gain.
So in comparison to the 100 and 200 mg, the 5 percent weight gain was more significantly
seen in the 400 mg group.
So the green is the 400 followed by the 200 and followed by 100.
So this again tells us that it was consistent against all the subgroups, be it the cancer
type or the level of GDF 15.
So there's the magnitude of GDF 15 does it give a response is something to be reassessed
and reanalyzed, which was not the conclusion of the study.

So but in all the subgroups, be it the platinum based therapy and the BMI BMI adjusted even
in the severe catechxia group, that is BMI adjusted weight loss category of 4.
And irrespective of the systemic inflammation, there was it all favored the poncergromab
use in these patients with cancer catechxia.
So the bed, so that's what the result says.
So the benefits at 400 mg dose was consistent across multiple domains.
And these were the secondary endpoints that is obviously the patient related outcomes.
Now just to explain this, that this is the number of patients.
This is the number of patients who had shown the response.
So definitely the secondary endpoints also had short definite benefit.
And coming to the safety, the safety was that a similar percentage of patients reported
all treatment related to the emergence effects.
Only the things that patients were in the more plasible group had experienced more diarrhea
than the patients who were on the poncergromab group.
Otherwise there were no new safety, emergent treatment related adverse events.
And no deaths were considered treatment event.
So this is same conclusion of the adverse events.
And old limitations of this study were few.
So one thing is that if the second end point that they looked for the physical activation,
they were basically using the digital devices.
But actually those digital devices were not available to every patient at each time.
So that was something that is limitation.
The physical activity and the gate end points were difficult to assist at all time.
And there was a lack of racial diversity.
And the study size and duration may not be sufficient to evaluate the impact and survival.
And statistically there was no adjustment for multiplicity in the statistical analysis.
To conclude, so I think it may definitely going to be a future probably for our patients.
So that is poncergromab improved the body weight, appetite and KKXA symptoms and also
the overall physical activity and skeletal muscle mass compared with plasible in patients
with cancer, KKXA and elevated GDF 15 levels.
That was the mandatory for the result.
So the safety profile was good similar to plasible.
And it is consistent that higher number of systemic cancer therapies would definitely
have a little more side effects.
And so this study supports the use of poncergromab in the GDF 15 high levels and also implicates
that GDF 15 high is a driver for KKXA.
Thank you.
Thank you everyone.