

Administration of serelaxin to patients with acute heart failure: are there any differences across RELAX-AHF subgroups?

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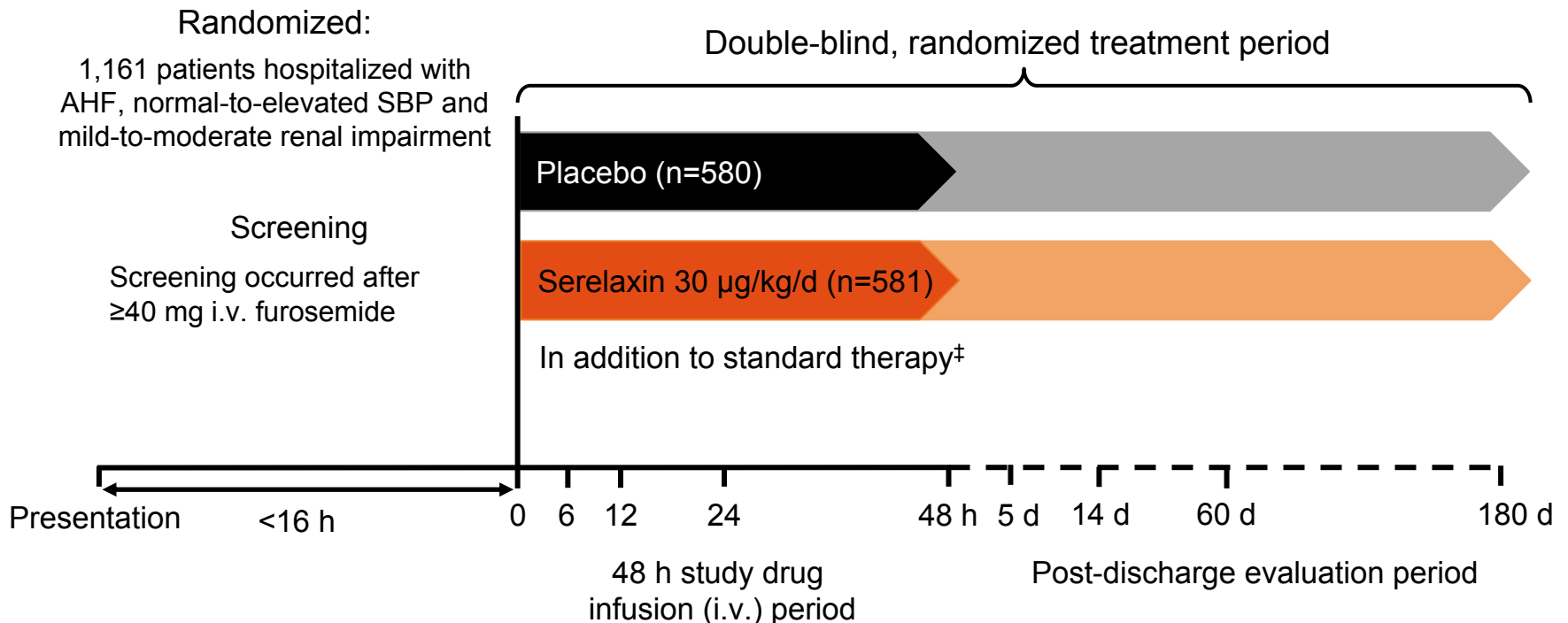
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Disclosures

- M.M. received consulting income from Novartis, Amgen, Bayer, Daiichi-Sankyo, Servier and Trevena and received speaker honoraria from Abbott Vascular and Novartis
- P.P. received consulting income from Abbott Vascular, Amgen, Bayer, J&J, Novartis, Servier, Cardioentis, Vifor, Cibiem, Momentum Research and Respicardia; received speaker honoraria from Abbott Vascular, Novartis, Servier, Vifor, Pfizer, Merck-Serono and Boehringer Ingelheim and received research grant support from Vifor
- G.C. and B.D. are employees of Momentum Research, which has received research grants from Novartis, Corthera Inc. (a Novartis Company), Sorbent Therapeutics, ChanRx, Amgen, Cardio3 Biosciences, Trevena and Anexon and have received travel support from Momentum Research
- G.M.F. received consulting income from Novartis, Amgen, Otsuka and Trevena; received research grant support from Amgen and Otsuka; received payment for participation in review activities (e.g. data monitoring boards, endpoint committee, etc.) from Novartis and received payment for development of educational presentations from Novartis
- G.F. received consulting income from Corthera Inc. (a Novartis company), Bayer and Cardioentis; received speaker honoraria from Novartis and received research grant support from Amgen, Nanosphere and the European Union
- B.H.G. received consulting income from Novartis, Celladon and Zensun; received payment for participation in review activities (e.g. data monitoring boards, endpoint committee, etc.) from St. Jude's Medical, Actelion, Amgen, Bayer and Gambro; and received payment for development of educational presentations from Novartis
- T.A.H. and T.S. are employees of Novartis, and receive salary and stock options from Novartis Pharmaceuticals Corporation and Novartis Pharma AG, respectively
- E.U. was former employee of the sponsor, Corthera Inc. (a Novartis Company)
- A.A.V. received consulting income from Novartis; received speaker honoraria from Novartis and received research grant support from Novartis
- J.R.T. received consulting income from Novartis, Trevena and Amgen/Cytokinetics and received research grant support from Novartis and Amgen/Cytokinetics

RELAX-AHF: study design

- A Phase III, multicentre, randomized, double-blind, placebo-controlled study to assess the efficacy and safety of serelaxin, in addition to standard therapy, in subjects hospitalized for AHF



[‡]Standard therapy permitted at physician's discretion

AHF=acute heart failure; d=day; h=hour; i.v.=intravenous; SBP=systolic blood pressure

Teerlink et al. Lancet 2013;381:29–39; Ponikowski et al. Am Heart J 2012;163:149–55; ClinicalTrials.gov identifier: NCT00520806

Summary of the RELAX-AHF results

- Serelaxin, compared with placebo:
 - improved the primary efficacy endpoint of dyspnoea relief through Day 5 assessed by the Visual Analogue Scale AUC ($p=0.007$)
 - provided a numerical increase of the proportion of patients reporting moderately or markedly improved dyspnoea (Likert scale) at 6, 12 and 24 hours ($p=0.70$)
 - had no effect on secondary efficacy endpoints (CV death or rehospitalization for HF or renal failure through Day 60, or days alive and out of hospital to Day 60)
 - reduced CV (efficacy endpoint) and all-cause 180 Day mortality (safety endpoint) by 37% (HRs [95%CIs], 0.63 [0.41, 0.96], $p=0.028$ and 0.63 [0.43, 0.93], $p=0.02$, respectively)

RELAX-AHF: subgroup analyses

- Patients hospitalized for AHF differ with respect to many clinical characteristics
- The aim of the present analysis is to compare the effects of serelaxin versus placebo in multiple pre-specified and other subgroups of interest, with respect to:
 - the two primary endpoints of dyspnoea relief (VAS and Likert scale)
 - the secondary endpoint of cardiovascular (CV) death or rehospitalization for heart failure or renal failure through day 60
 - CV death and all-cause death through day 180
- The possible differential effect of serelaxin was tested using a separate regression model for each outcome and covariate

Patients' characteristics at baseline

Characteristic	Placebo (N=580)	Serelaxin (N=581)
Male, %	62	63
Age, %		
≥65 years	79	75
≥75 years	49	46
Region, %		
Eastern Europe	49	48
Western Europe	17	18
South America	6	6
North America	10	10
Israel	18	18
Race, %		
White / Caucasian	95	94
Other	5	6
Hospitalization for heart failure in past year, %	31	37
Systolic blood pressure ≥140 mmHg, (N) %	(N=578) 51	(N=577) 48
Heart rate ≥80 bpm, %	49	46
LVEF <40%, (N) %	(N=539) 55	(N=552) 55
History of ischaemic heart disease, %	53	51
History of ICD or CRT, %	24	26
History of diabetes mellitus, %	47	48
History of atrial fibrillation, %	53	51
Atrial fibrillation at screening, (N) %	(N=579) 42	(N=580) 40

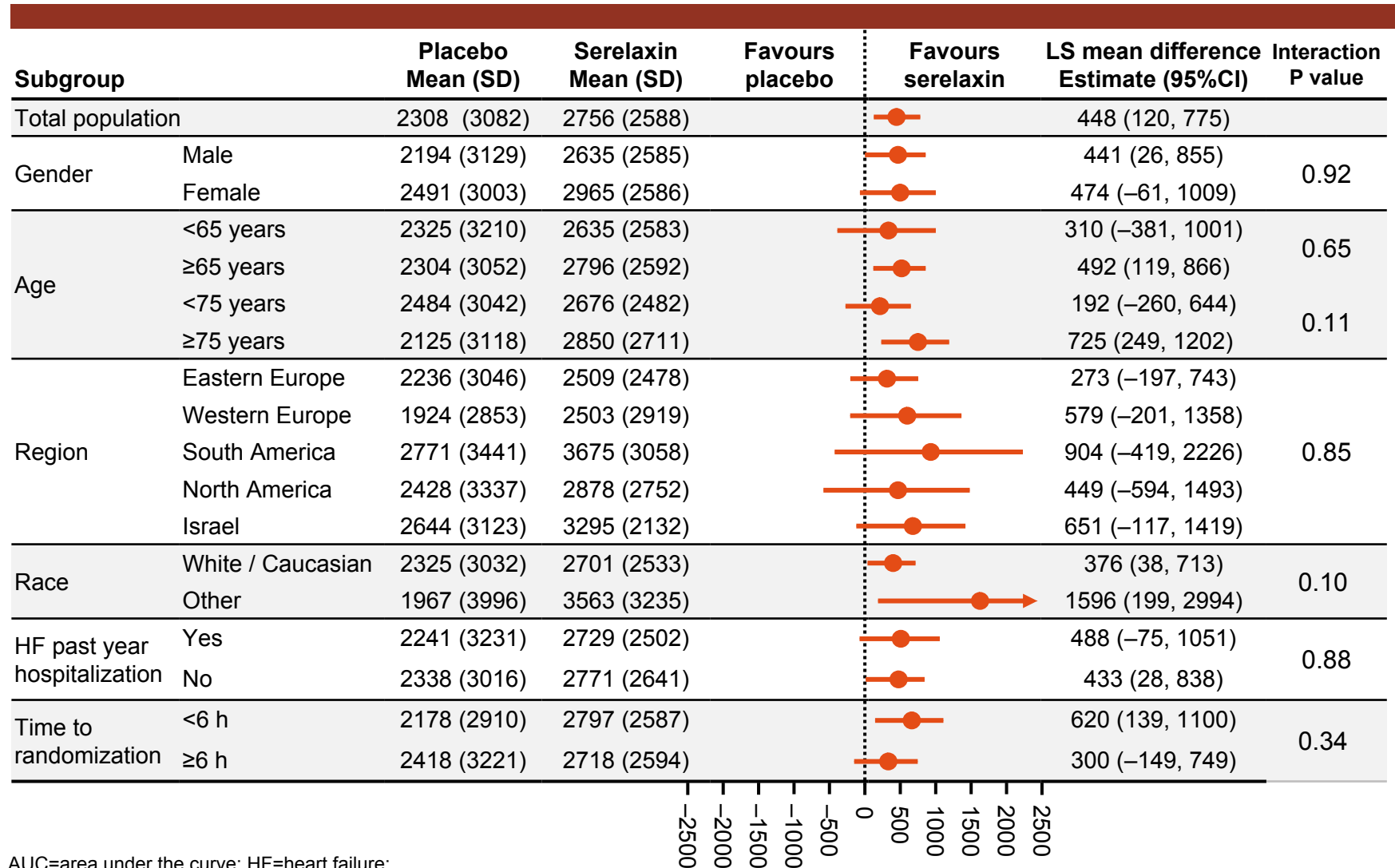
Patients' characteristics at baseline (continued)

Characteristic	Placebo (N=580)	Serelaxin (N=581)
ACEI/ARB use at baseline, %	69	67
Beta-blocker use at baseline, %	70	67
Mineralocorticoid receptor antagonist use at baseline, %	30	33
Intravenous nitrates at baseline, %	7	7
Lymphocytes at baseline $\leq 12\%$, (N) %	(N=536) 24	(N=535) 21
Troponin T at baseline, (N) %	(N=541)	(N=541)
$\leq 0.024 \mu\text{g/L}$	31	33
$0.025\text{--}0.045 \mu\text{g/L}$	36	34
$> 0.045 \mu\text{g/L}$	33	33
NT-proBNP at baseline, (N) %	(N=551)	(N=550)
$< 5000 \text{ ng/L}$	51	52
$\geq 5000 \text{ ng/L}$	49	48
$\leq 3346 \text{ ng/L}$	34	32
$3347\text{--}7281 \text{ ng/L}$	32	35
$> 7281 \text{ ng/L}$	34	33
Cystatin C at baseline, (N) %	(N=551)	(N=550)
$\leq 1.26 \text{ mg/L}$	33	34
$1.27\text{--}1.65 \text{ mg/L}$	35	33
$> 1.65 \text{ mg/L}$	33	33
eGFR at baseline, (N) %	(N=568)	(N=564)
$< 60 \text{ ml/min/1.73m}^2$	72	73
$< 50 \text{ ml/min/1.73m}^2$	48	48

ACEI=angiotensin converting enzyme inhibitor; ARB=angiotensin receptor blocker; eGFR=estimated glomerular filtration rate;
NT-proBNP=N-terminal prohormone B-type natriuretic peptide

RELAX-AHF subgroup analyses:

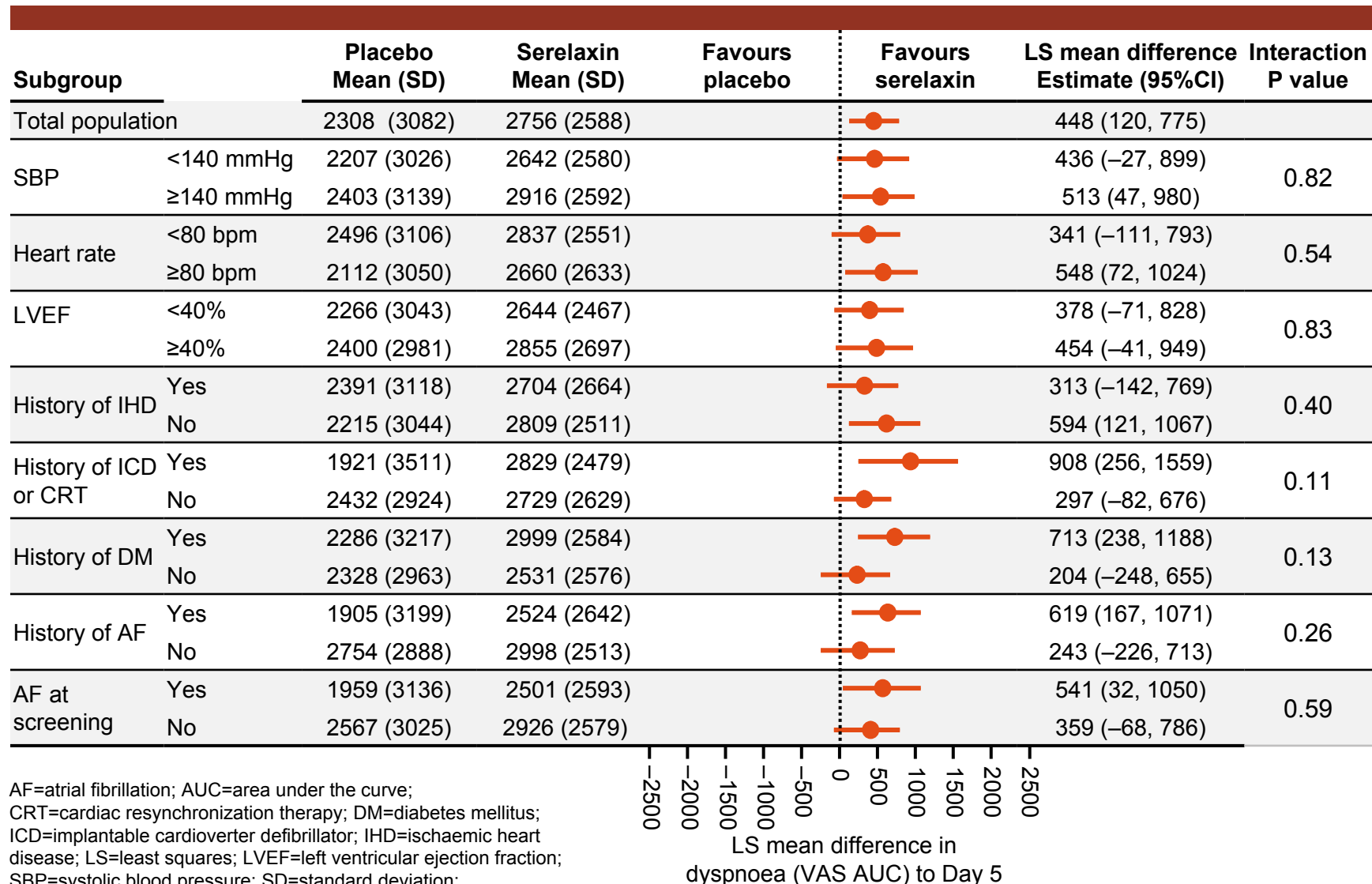
Dyspnoea VAS AUC by general baseline characteristics



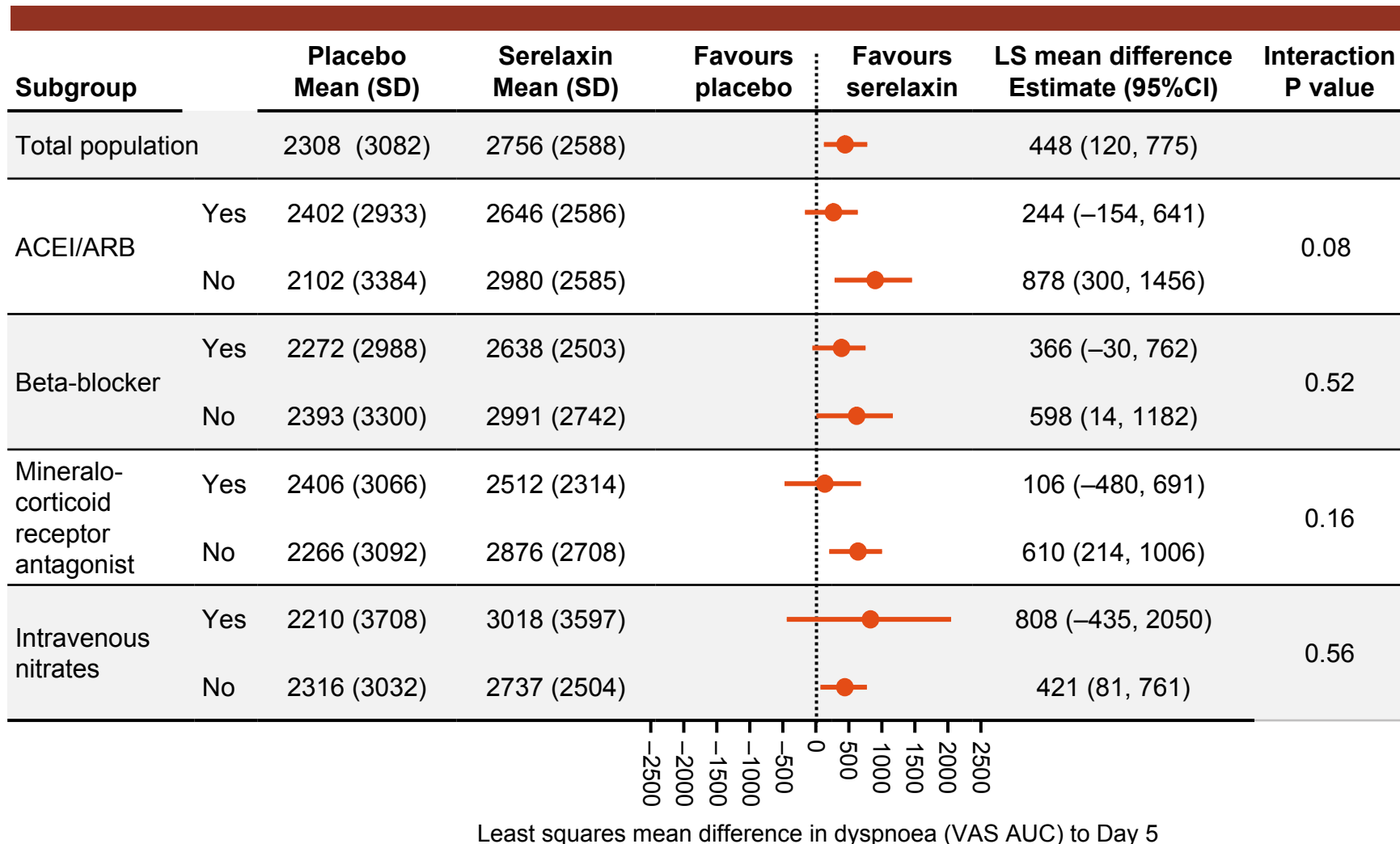
AUC=area under the curve; HF=heart failure;
 LS=least squares; VAS=visual analogue scale;
 SD=standard deviation

LS mean difference in dyspnoea (VAS AUC) to Day 5

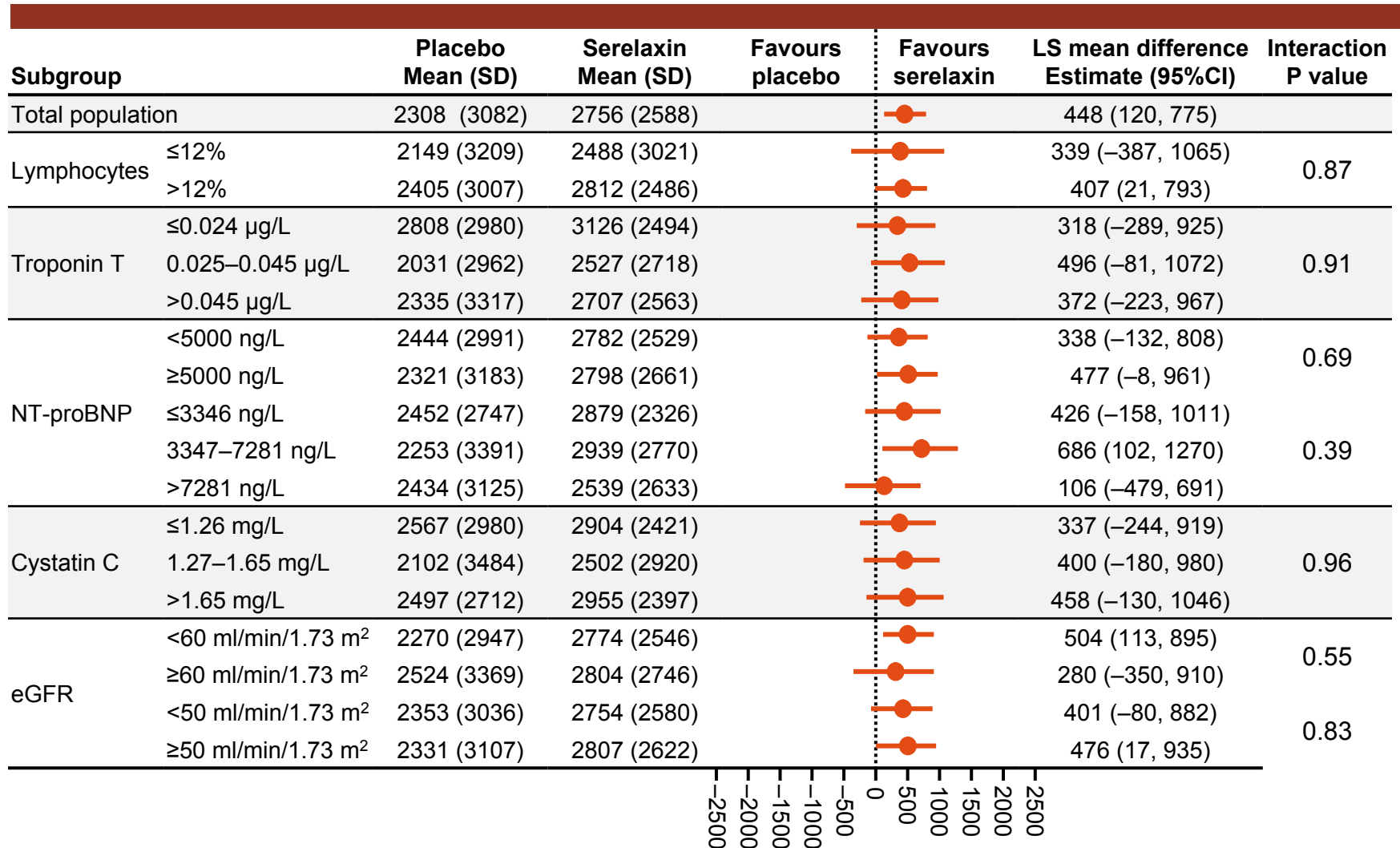
RELAX-AHF subgroup analyses: Dyspnoea VAS AUC by clinical signs and comorbidities



RELAX-AHF subgroup analyses: Dyspnoea VAS AUC by baseline therapies



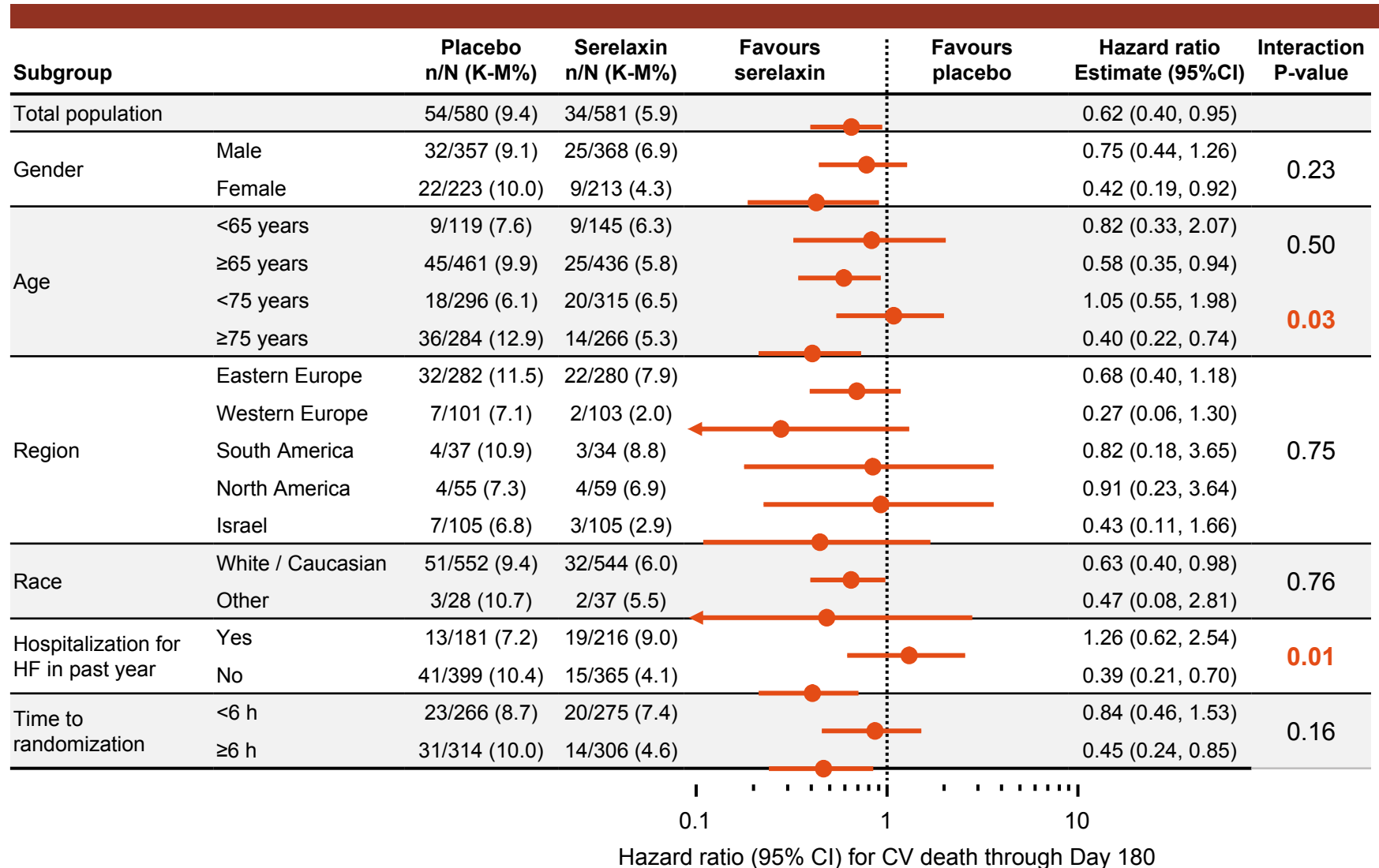
RELAX-AHF subgroup analyses: Dyspnoea VAS AUC by biomarkers at baseline



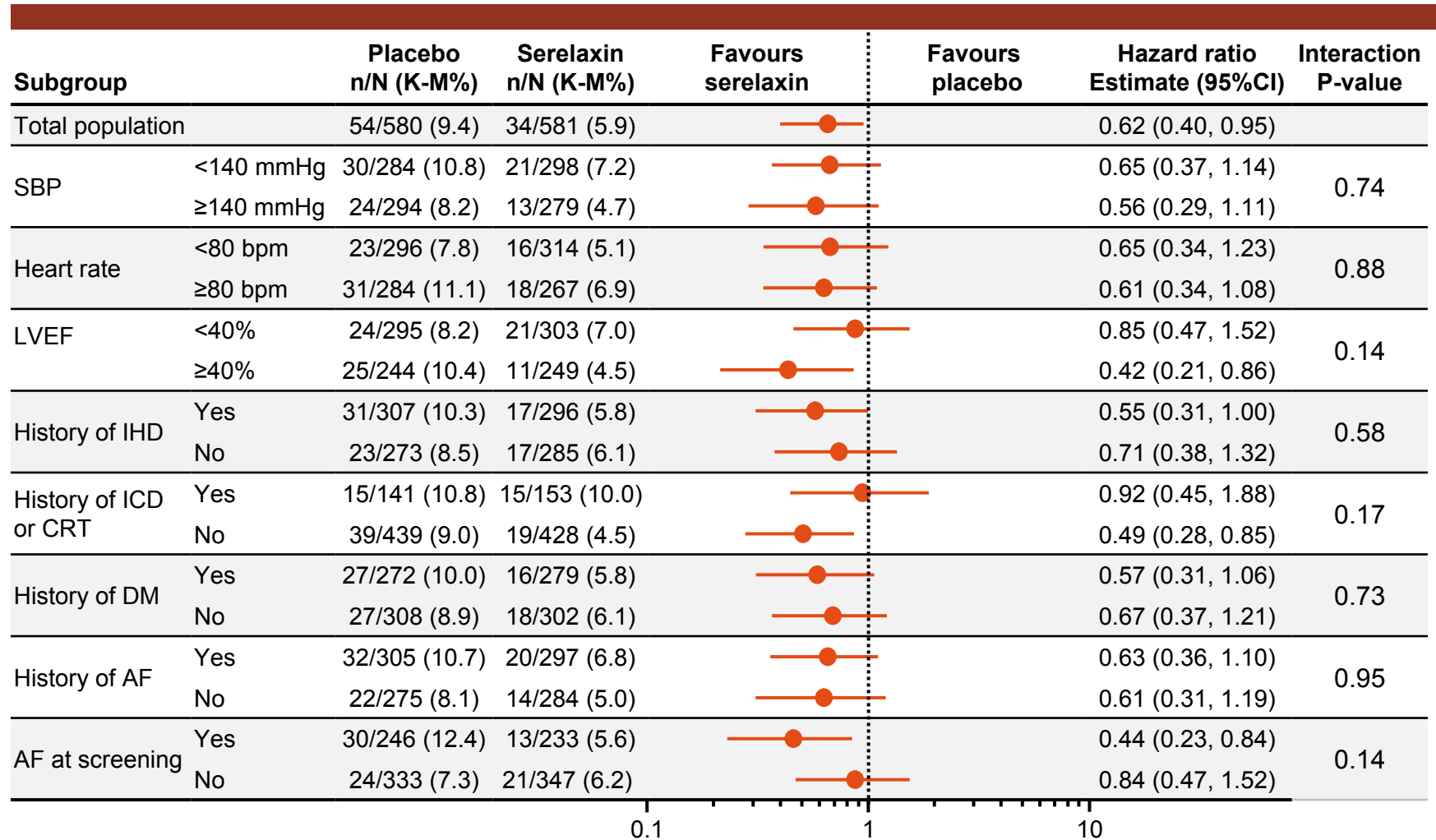
AUC=area under the curve; eGFR=estimated glomerular filtration rate;
LS=least squares; NT-proBNP=N-terminal prohormone B-type natriuretic
peptide; SD=standard deviation; VAS=visual analogue scale

LS mean difference
in dyspnoea (VAS AUC) to Day 5

RELAX-AHF subgroup analyses: CV death by general characteristics at baseline



RELAX-AHF subgroup analyses: CV death by clinical signs and comorbidities



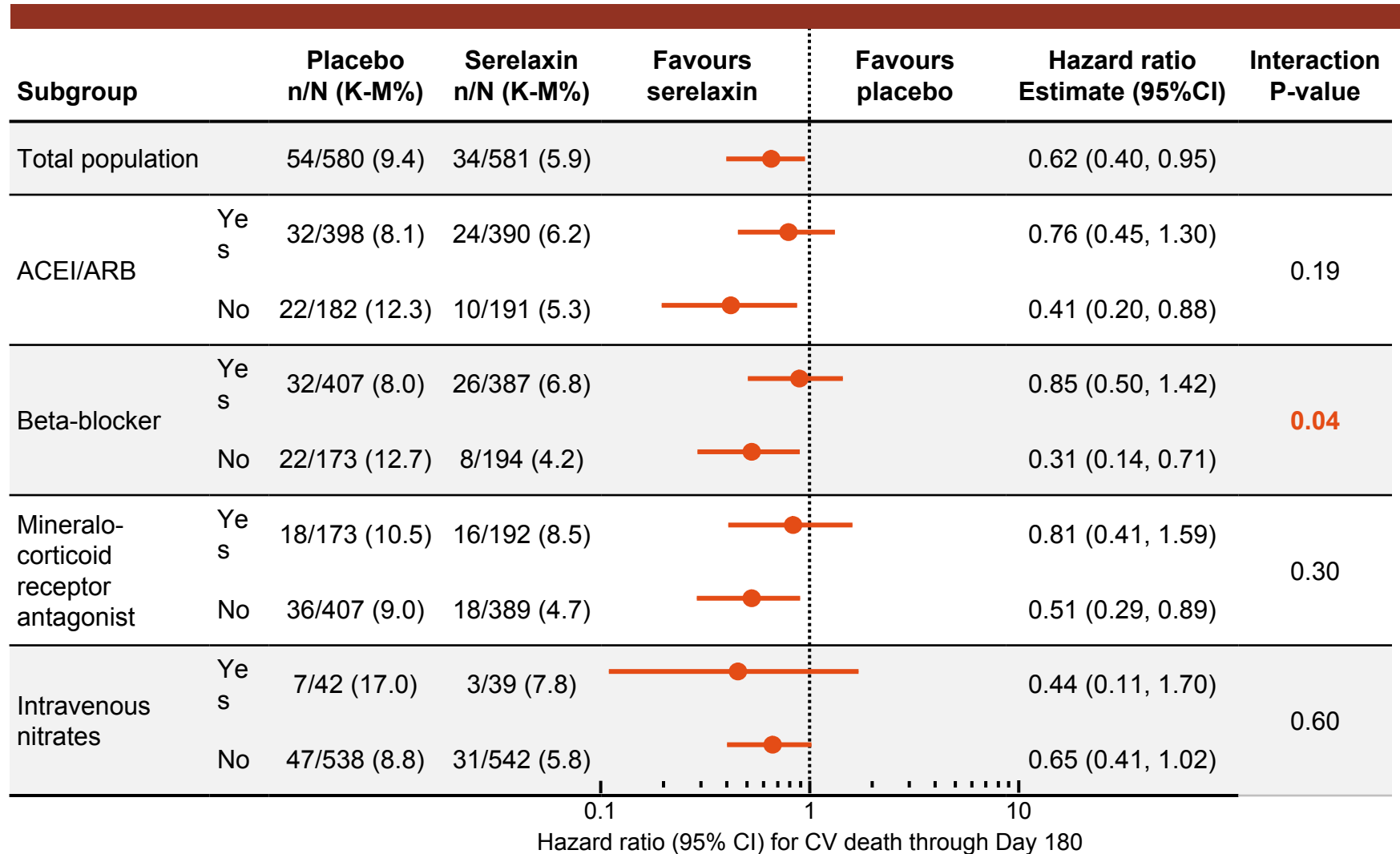
AF=atrial fibrillation; AUC=area under the curve;

CRT=cardiac resynchronization therapy;

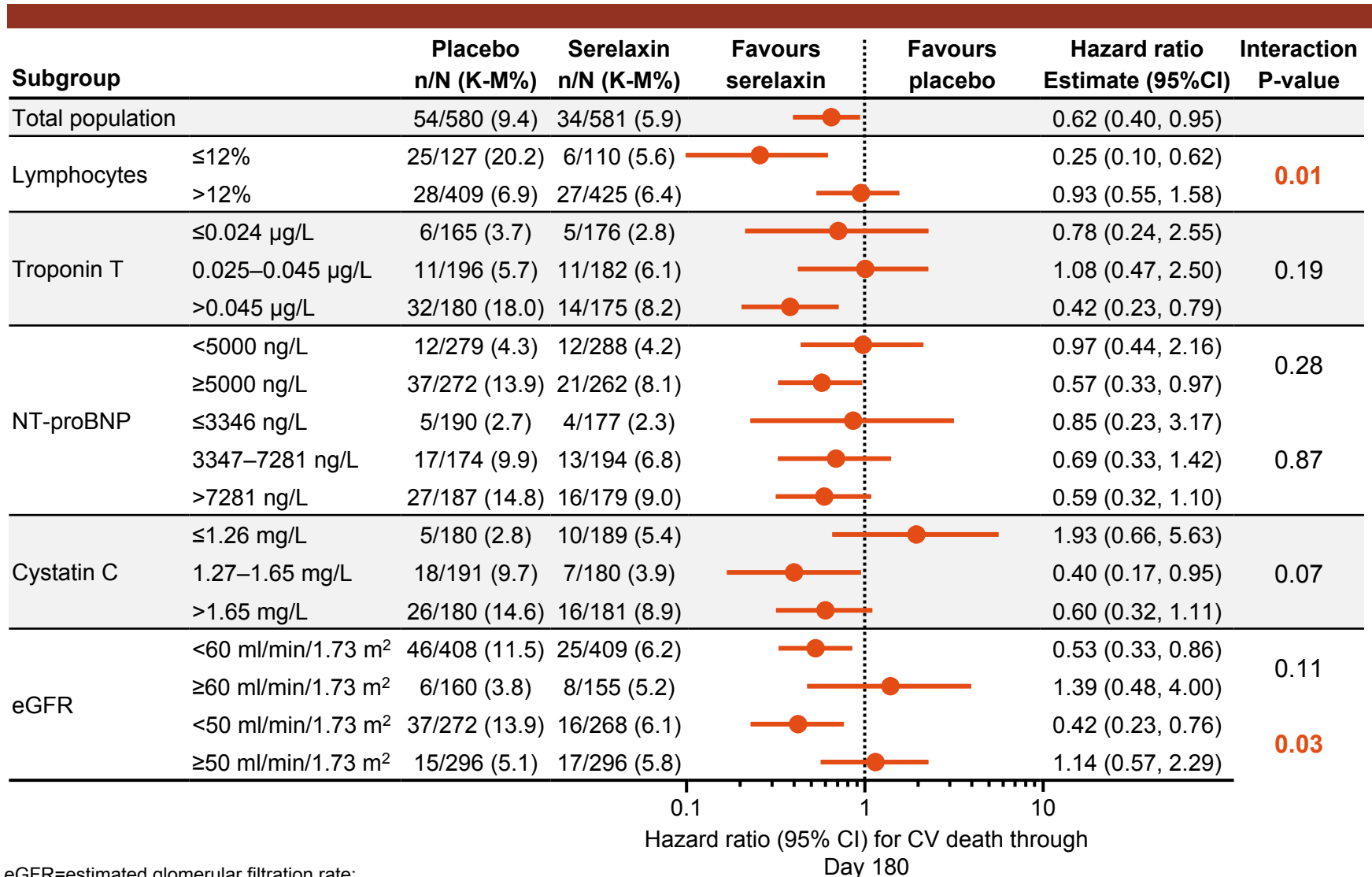
DM=diabetes mellitus; ICD=implantable cardioverter defibrillator;

IHD=ischemic heart disease; LVEF=left ventricular ejection fraction; SBP=systolic blood pressure

RELAX-AHF subgroup analyses: CV death by baseline therapies



RELAX-AHF subgroup analyses: CV death by biomarkers at baseline



Summary

- The effects of serelaxin versus placebo were homogenous across multiple subgroups with respect to the endpoints of the study, including 180-day CV mortality
- Potentially larger mortality benefits were seen in the patients with:
 - older age
 - no previous HF hospitalization
 - not treated with beta-blockers at the time of randomization
 - signs of inflammation (lymphopenia)
 - more severe renal impairment
- The present study is underpowered for the subgroup analyses, particularly for mortality data. These results must be considered as hypothesis-generating.

RELAX-AHF subgroups analysis: Simultaneous publication in the *European Heart Journal*



European Heart Journal
doi:10.1093/eurheartj/ehs371

FASTTRACK CLINICAL RESEARCH

Heart failure/cardiomyopathy

60

Effects of serelaxin in subgroups of patients with acute heart failure: results from RELAX-AHF

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Received 5 July 2013; revised 8 August 2013; accepted 9 August 2013

Study Organization

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- **Steering Committee:** KF Adams (US), M Dorobantu (RO), L Grinfeld (AR), G Jondeau (FR), A Marmor (IL), J Masip (ES), PS Pang (US), K Werdan (DE)
- **DSMB:** BM Massie-Chair (US), M Böhm (DE), E Davis (US), G Francis (US), S Goldstein (US)
- **Sponsor:** Corthera Inc. (a Novartis affiliate company)
- **Coordinating Center:** Momentum Research Inc.

RELAX-AHF Investigators

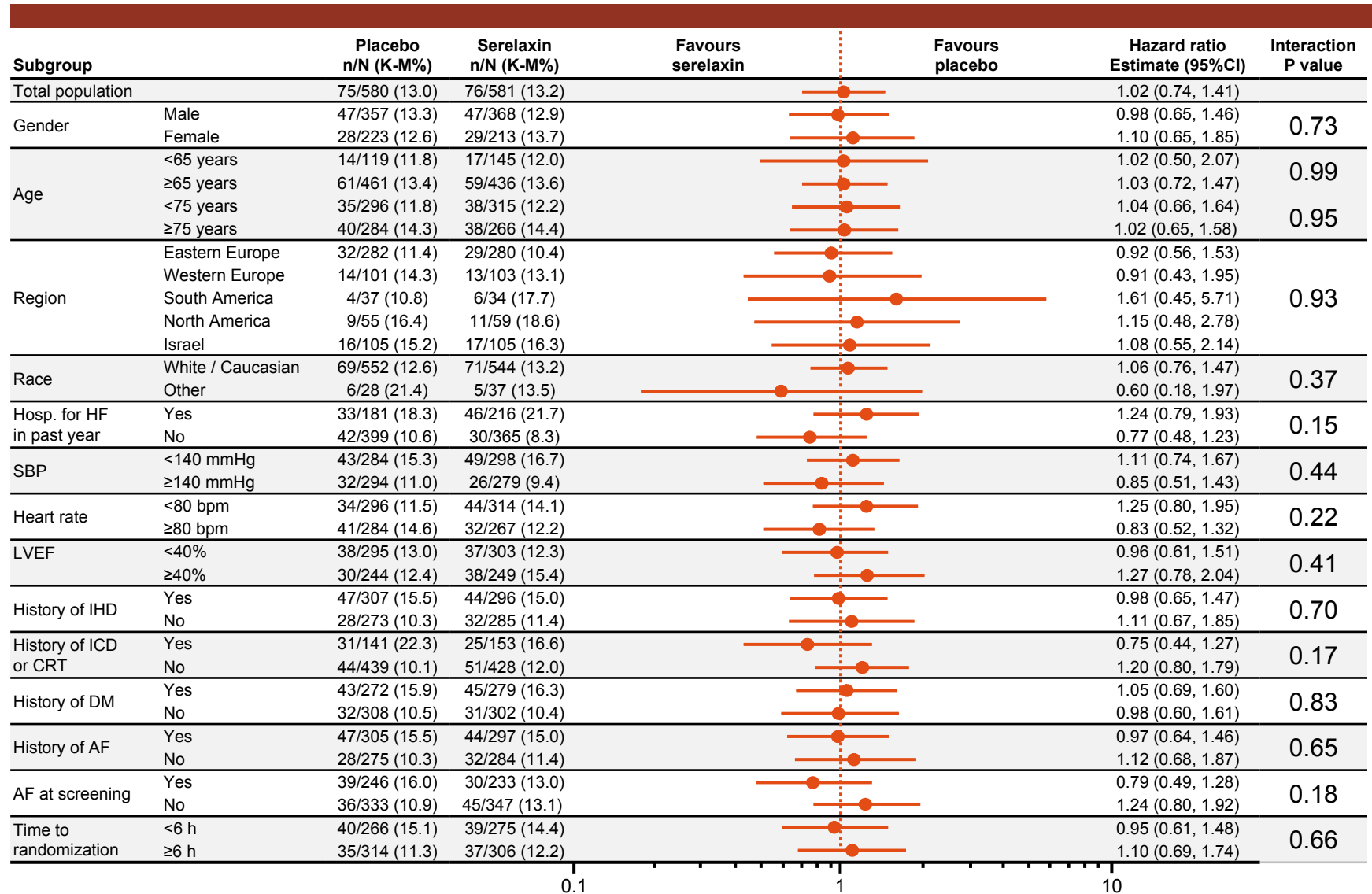
<u>Country (number of patients)</u>	<u>Principal investigators</u>
Argentina (71):	GM Ferrari; A Quiroga; A Fernandez; E Perna; MS Ramos; L Guzman; G Cursack; O Allall; MG Masuelli; C Rapallo.
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Hungary (151):	J Tomcsányi; D Apró; K Tóth; A Vértes; G Lupkovics; Z László; A Cziraki.
Israel (210):	A Marmor; S Goland; A Katz; R Zimlichman; D Aronson; A Butnaru; M Omary; XA Piltz; D Zahger.
Italy (77):	M Metra; A Mortara; M Balbi; F Cosmi; S DiSomma; MC Brunazzi.
Netherlands (10):	AA Voors; PEF Bendermacher; G-J Milhous; PL van Haelst; P Dunselman.
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BACK-UP SLIDES

RELAX-AHF: key inclusion criteria

- SBP >125 mmHg
- Hospitalized for AHF, defined as including all of the following at screening:
 - dyspnoea at rest or with minimal exertion
 - pulmonary congestion by chest X-ray
 - BNP $\geq$ 350 pg/mL or NT-proBNP $\geq$ 1400 pg/mL
- Able to be randomized within 16 hours from hospital presentation (including the ED)
- Received i.v. furosemide $\geq$ 40 mg (or equivalent) between presentation to the hospital and screening
- Mild-to-moderate renal impairment (eGFR 30–75 mL/min/1.73 m²)

RELAX-AHF subgroup analyses: CV death or rehospitalization for HF or RF through Day 60



Hazard ratio (95%CI) for CV death or rehospitalization due to heart failure or renal failure through Day 60

RELAX-AHF subgroup analyses:

CV death or rehospitalization for HF or RF through Day 60

