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PMON163

Effect of osilodrostat on androgens and adrenal hormones in patients with Cushing's disease: Long-term findings from the Phase III, prospective LINC 3 study

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Introduction

- Osilodrostat decreases cortisol production by inhibiting 11β-hydroxylase (CYP11B1) and aldosterone synthase (CYP11B2), which increases levels of adrenal hormones and androgens above the level of enzyme blockade[1] (**Figure 1**)
- Efficacy and safety profile of osilodrostat in patients with Cushing's disease has been confirmed in the prospective Phase III, LINC 3 study (NCT02180217) over a median treatment period of 130 weeks[2,3]
- **Based on the mechanism of action of osilodrostat, this poster describes the effects of osilodrostat on adrenal hormone and androgen levels and any adrenal hormone precursor accumulation-related AEs in the LINC 3 study**

CONCLUSIONS

- **Adrenal hormones and androgen levels can increase upon initiation of osilodrostat treatment, but stabilize during long-term maintenance treatment**
- **Adrenal hormone precursor accumulation-related AEs were reported during the LINC 3 study; most occurred during the initial dose titration and maintenance periods**
- **These AEs were mostly manageable, with few (1.5%) patients discontinuing treatment because of these AEs**
- **Testosterone levels in females decreased toward baseline levels during long-term treatment; hirsutism score improved from baseline or remained unchanged in most patients, with very few patients experiencing a worsening in hirsutism score**
- **Osilodrostat is an effective and well-tolerated long-term treatment option for patients with Cushing's disease; any AEs that occur during osilodrostat treatment should be closely monitored, and treatment for these AEs should be initiated as needed to achieve optimal patient outcomes**

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Disclosures

This study was sponsored by Novartis Pharma AG; however, as of July 12, 2019, osilodrostat is an asset of Recordati AG

*Potential conflict of interest may exist. Refer to the Meeting App

References

1. Pivonello R *et al. Front Endocrinol* (Lausanne) 2020;11:648
2. Pivonello R *et al. Lancet Diabetes Endocrinol* 2020;8:748–61
3. Fleseriu M *et al. Endocrine Abstracts* 2021;73:OC8.2 (oral presentation at ECE 2021)

Abbreviations

AE, adverse event; DBP, diastolic blood pressure; DHEAS, dehydroepiandrosterone sulfate; EOT, end of treatment; F, female; LOV, last observed value; M, male; QR, quick response; SBP, systolic blood pressure; SD, standard deviation; ULN, upper limit of normal; W, week

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Methods

Figure 1. Osilodrostat mechanism of action

Stars show adrenal hormones and androgens that are reported here

Assessments

- Adrenal hormone and androgen levels were assessed centrally at baseline and at regular intervals
  - Adrenal hormone and androgen levels reported here are highlighted with stars in **Figure 1**
  - Scan QR code for further information on methods used to measure adrenal hormone and androgen levels
- Hirsutism score (females) was assessed at regular intervals and rated locally by investigators on a semi-quantitative scale: 0=absent; 1=mild; 2=moderate; 3=severe
- Serum potassium was also measured regularly
- Safety was continually assessed from core study baseline to study end by monitoring AEs
  - Scan QR code for classification of adrenal hormone precursor accumulation-related AEs
- Scan QR code for LINC 3 study design figure

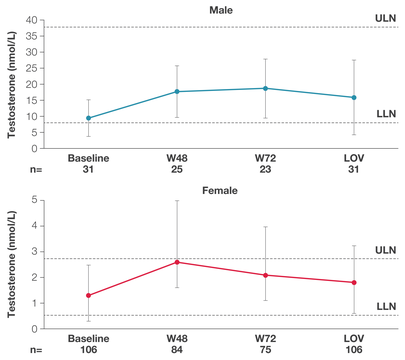
Results

Median osilodrostat exposure: 130 weeks (range 1–245)

Average median osilodrostat dose: 7.4 mg/day (range 0.8–46.6)

1. Following an increase during the core phase, mean testosterone levels stabilized in males and decreased toward baseline in females during long-term treatment

Figure 2. Mean (SD) testosterone levels in males and females

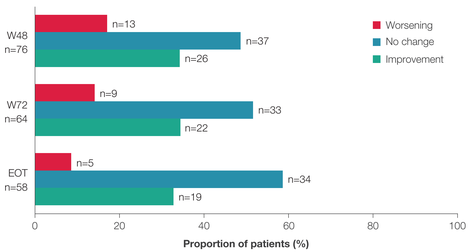


Error bars show SD. Dashed lines represent LLN and ULN; male: LLN, 8.4 nmol/L and 8.7 nmol/L; ULN, 38.2 nmol/L (or lower); female: LLN, 0.1 nmol/L and 0.7 nmol/L; ULN, 2.6 nmol/L (or lower)

LOV, last observed value

- Hirsutism score improved from baseline or remained unchanged in most female patients throughout the study, with few patients experiencing a worsening in hirsutism score

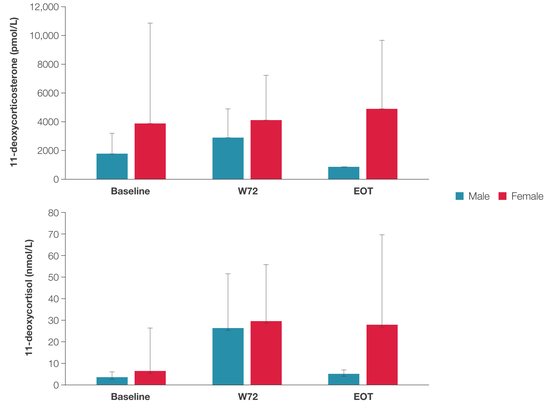
Figure 3. Change in hirsutism score from baseline to week 48, week 72 and EOT



- Scan QR code for hirsutism scores in female patients with normal testosterone levels (<ULN) and elevated testosterone levels (>ULN)

2. Mean 11-deoxycortisol and 11-deoxycorticosterone increased during the core phase and stabilized during long-term treatment

Figure 4. Mean (SD) 11-deoxycortisol and 11-deoxycorticosterone levels*



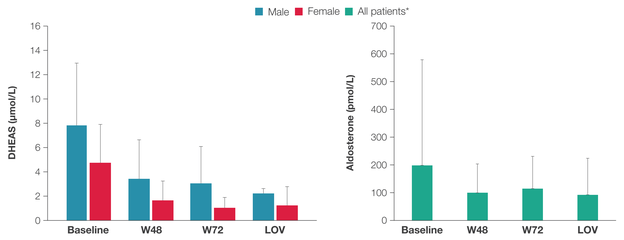
Error bars show SD. ULN for 11-deoxycorticosterone: male, 484.2 or 455 pmol/L; female, 696 pmol/L (mid-cycle); ULN for 11-deoxycortisol: male, 3.92 nmol/L (or lower depending on age); female, 3.1 nmol/L (or lower depending on age)

*Week 48 data not available

EOT, end of treatment

3. Mean DHEAS and aldosterone levels decreased during the core phase and stabilized during long-term treatment

Figure 5. Mean (SD) DHEAS and aldosterone levels



Error bars show SD. ULN for DHEAS: male, 18.8 µmol/L (or lower depending on age); female, 10.6 µmol/L (or lower depending on age); ULN for aldosterone: ≤777 pmol/L (upright)

*Data presented by overall population rather than male/female as data for week 48 and LOV not available by male/female

LOV, last observed value

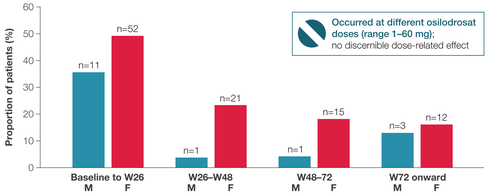
4. Adrenal hormone precursor accumulation-related AEs were reported in 58.4% (n=80/137) of patients; most occured during the first 26 weeks of treatment (period 1: dose titration; period 2: therapeutic osilodrostat dose)

Table 1. Most common adrenal hormone precursor accumulation-related AEs (≥10% of patients) from baseline to end of study

AE	All grades, n (%)	Grade ≥3, n (%)
Hypertension	24 (17.5)	15 (10.9)
Peripheral edema	22 (16.1)	0
Hypokalemia	18 (13.1)	5 (3.6)
Increased blood testosterone	16 (11.7)	0

- Despite adrenal hormone precursor accumulation-related AEs of hypertension, peripheral edema and hypokalemia, mean potassium levels remained stable throughout the study (scan QR code)

Figure 6. Occurrence of adrenal hormone precursor accumulation-related AEs by time interval



5. Concomitant medication was used to manage adrenal hormone precursor accumulation-related AEs in 36.5% (n=50/137) of patients

Table 2. Adrenal hormone precursor accumulation-related AEs managed with concomitant medication (>1 patient)

AE	All patients N=137 n (%)	
Hypertension	17 (12.4)	
Hypokalemia	14 (10.2)	
Acne	8 (5.8)	
Peripheral edema	6 (4.4)	10 (7.3)
Edema	4 (2.9)	
Hirsutism	4 (2.9)	

- Only two patients (1.5%) discontinued because of these AEs, both during the core phase

Increased SBP and DBP (grade 3)

Hypokalemia (grade 3)