Delta Hepatitis: An Overview & Update

Roxana Bodin, MD
Assistant Professor of Clinical Medicine at New York Medical College
Attending Transplant Hepatologist at Westchester Medical Center
Disclosures

• Consulting:
  – Arrowhead, Arbutus, Assembly, Gilead, GSK, Janssen, Roche, Takeda

• Research funding:
  – Janssen, Eiger
Outline – Delta Hepatitis (HDV)

• Definition
• Epidemiology
• Risk factors
• Diagnosis and Natural History
• Treatment
Hepatitis Delta

- Caused by the hepatitis delta virus (HDV)
- “Satellite virus”
  - Infects only those with hepatitis B (HBV)
- Can lead to acute or chronic disease
- May be acquired simultaneously with HBV as co-infection OR may be acquired by chronically infected HBV patients as super infection
Epidemiology
HDV Worldwide Prevalence: 15 – 20 Million

• Common in Eastern Europe, Southern Europe, Mediterranean region, Middle East, West and Central Africa, East Asia, Amazon Basin
  – > 100K in US
  – > 200K in EU
  – > 2M in China

• In US, at least 4% of HBV infected patients have HDV
4.5% - 15% of HBV population coinfected with HDV

HDV Worldwide Prevalence: 15 – 20 Million

### HDV Has 8 Genotypes

<table>
<thead>
<tr>
<th>Genotype</th>
<th>Commonly Found</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>North America, Europe, Middle East, North Africa</td>
</tr>
<tr>
<td>2 and 4</td>
<td>East Asia</td>
</tr>
<tr>
<td>3</td>
<td>Amazon Basin of South America</td>
</tr>
<tr>
<td>5,6,7,8</td>
<td>West and Central Africa</td>
</tr>
</tbody>
</table>
HDV Geographic Footprint Is Growing

U.S. major metro hotspots identified

Top 10 U.S. Cities in 2016
1. Chicago, Illinois
2. Berwyn, Illinois
3. Brooklyn, New York
4. Corona, New York
5. Waukegan, Illinois
6. New York, New York
7. Bronx, New York
8. Jamaica, New York
9. Lombard, New York
10. Aurora, Illinois

Increased screening leads to increased HBV and HDV diagnosis

* 11.8% of HBV Patients Co-Infected with HDV

HDV: Most Rapid Progression of Viral Hepatitis

Progression to Cirrhosis

<table>
<thead>
<tr>
<th>Virus</th>
<th>Progression Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV</td>
<td>10 – 20% within 20 Years</td>
</tr>
<tr>
<td>HBV</td>
<td>20% within 5 Years</td>
</tr>
<tr>
<td>HDV</td>
<td>70% within 5 – 10 Years</td>
</tr>
</tbody>
</table>

Adverse Outcomes More Common With HDV/HBV Than HBV Alone

**Table 3. Associated risks of chronic hepatitis D**

<table>
<thead>
<tr>
<th>Clinical outcome</th>
<th>Approximate relative risk increase*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cirrhosis [58, 90, 110]</td>
<td>2- to 3-fold</td>
</tr>
<tr>
<td>Hepatocellular carcinoma [58, 61, 78, 90, 111–113]</td>
<td>3- to 6-fold</td>
</tr>
<tr>
<td>Liver transplantation [48]</td>
<td>2-fold</td>
</tr>
<tr>
<td>Hepatic decompensation [111]</td>
<td>2-fold</td>
</tr>
<tr>
<td>Mortality [42, 78, 90, 111]</td>
<td>2-fold</td>
</tr>
</tbody>
</table>

*Compared with hepatitis B mono-infection.
HDV Causes Most Rapid Disease Progression

At diagnosis, > 50% of HDV patients are cirrhotic

Evolution from Chronic Active Hepatitis to Cirrhosis

Risk Factors
Hepatitis Delta Risk Factors

- Birth to an infected mother
- Intravenous drug use
- Sex with an infected partner
- Contact with blood from or open sores of an infected person
- Needle sticks or exposures to sharp instruments
- Sharing items (razors, toothbrushes, etc.) with an infected person
- HDV endemic country of origin
- Elevated ALT despite suppressed HBV DNA
Populations at Risk For HDV Infection

- People chronically infected with HBV
- Infants born to mothers with HDV
- Sex partners of persons infected with HDV
- MSM
- Injection drug users
- Household contacts of people with HDV
- Health care and public safety workers at risk for occupational exposure to blood or blood-contaminated fluids
- Hemodialysis patients
HDV: Signs/Symptoms

- Fever
- Fatigue
- Loss of appetite
- Nausea
- Vomiting
- Abdominal Pain
- Dark urine
- Clay-colored stools
- Joint pain
- Jaundice

These signs typically appear 3-7 weeks after infection.

Prevention

- Risk factor avoidance
- Hepatitis B vaccine
- No vaccine available for HDV
Molecular Biology
HDV Structure

• Positive single stranded circular RNA genome of ~1700 nucleotides
• HDV RNA genome is ~74% of paired bases giving it a rod-like structure
• Encodes HDAg, in 2 forms
  – Small (S-HDAg)
  – Large (L-HDAg)
  – HDAg associated with HDV genome forming a ribonucleoprotein (RNP)
  – RNP is enveloped by HBsAg
Hepatitis D Virus (Delta): The Most Pathogenic Hepatitis Virus

15-C isoprenoid lipid added to small HDAg to form large HDAg (prenylation)

HDV Requires HBsAg to Complete Virus Assembly

• Assembly with HBsAg is mediated by large delta antigen prenylation

HDV consists of a single stranded, circular RNA genome, with an envelope made up of HBsAg.
HDV Life Cycle

- HDV genome encodes for a single protein, the hepatitis delta antigen.
- HDV relies on host cell machinery for replication.
- New virions can be assembled only in the presence of hepatitis B virus.
Diagnosis & Natural History
HDV: Diagnostic Tests

- HDV antibodies (IgG, IgM)
- HDV RNA
- HBsAg

Testing Algorithm

HDV Antibody
- No HDV
- HDV RNA
- No active HDV infection (25%)
- Active HDV infection (75%)
HDV RNA Quantification is the Gold Standard in HDV Diagnosis and Management

• Available in Quest - a leading provider of diagnostic services
  – Over 2,200 patient service centers across the US
  – Highly targeted patient and physician outreach
  – HDV testing program for HBV-positive patients

• HDV RNA quantification

• HBV/HDV reflex testing
other causes of chronic liver disease should be systematically excluded including co-infections with hepatitis D virus (HDV), hepatitis C virus (HCV) and HIV.

Emerging consensus: All HBsAg+ patients should have a one-time test for HDV!
HBV/HDV Coinfection

- Simultaneous infection with HBV and HDV
- Usually resolves
- > 5% develop chronic disease
- **Acute Liver Failure** more common with HDV/HBV than HBV alone

WHO 2019
HDV Superinfection

- Occurs when a person already with chronic HBV acquires HDV
- Results in rapid progression to cirrhosis and liver failure
  - 15% in 1-2 years
  - 70-80% in 5-10 years
- Higher risk of HCC
  - 3-6 fold increase
- Higher risk of mortality
  - 2 fold increase


HDV: A devastating disease with no approved treatment

25% of People on Waiting List Die Each Year Before Receiving a Liver Transplant

Treatment
HDV Treatment

- No FDA approved therapy for HDV
- PEG IFN alpha is only drug with any demonstrated efficacy
- 20-25% response rate and rarely achieve sustained viral clearance
- Suboptimal due to:
  - Significant side effects (including cytopenias)
  - Limited efficacy
  - High long-term relapse rates
• ~2.5 log decline in median HDV RNA at EOT
• 25% neg 24 wks post Rx in patients receiving PEG-IFN
• 0% with nucleoside analog alone (no effect on HBsAg)

HIDIT-II: PEG IFN + Tenofovir/Placebo for HDV Infection
96 Weeks of Treatment, 24 Weeks Follow up

N=120

>50% of “24-week SVRs” relapse at 4 years: not like HCV!

Late Relapse is Common with PEG IFN alpha

- Long term f/u of HIDIT-1
- Of 16 patients that were negative for HDV RNA at 6 months after therapy ended, 9 will test positive during long term f/u

HBV Functional Cures Will Not Eradicate HDV

- Approved HBV nucleos(t)ide treatments only suppress HBV DNA
  - They do not affect HBsAg and have no effect on HDV
- Investigational HBV treatments target functional cure
  - Not expected to completely eliminate HBsAg needed by HDV
HDV Treatments in Development
# HDV Treatments in Development

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Company</th>
<th>Stage of Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lonafarnib</td>
<td>EIGER</td>
<td>Daily Oral</td>
</tr>
<tr>
<td>Peginterferon Lambda</td>
<td>EIGER</td>
<td>Weekly SQ injection</td>
</tr>
<tr>
<td>Bulevirtide</td>
<td>Gilead</td>
<td>Daily SQ injection</td>
</tr>
<tr>
<td>Rep-2139</td>
<td>replicor</td>
<td>Weekly IV infusion</td>
</tr>
</tbody>
</table>
Bulevirtide (Myrcludex, Hepcludex)
A Novel HBV Entry Inhibitor

- Synthetic 47 aa lipopeptide resembling pre-S1 portion of HBsAg, binds to bile acid receptor (NTCP), blocking viral entry
- Development program evaluated BLV 2 mg or 10 mg alone, with or w/out PEG IFN and PEG IFN alone
- Targets NTCP (bile acid receptor)
- Subcutaneous dosing
- Approved in Europe mid-2020 at 2 mg dose SQ daily based on early results in ~150 patients

**Phase 2b, Open-Label Bulevirtide / TDF Study**

**Primary Endpoint**
- HDV RNA < LLOD at 24 weeks post-tx (Week 72)

**Secondary Endpoint**
- HDV RNA < LLOD at Week 48
- ALT nl at Week 48, 72
- HDV RNA > 2 log decline and ALT nl at Week 48, 72
- HBsAg undetectable or > 1 log decline at Week 48, 72

Phase 2b, Open-Label Bulevirtide / TDF Study

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Median HDV RNA Change from Baseline at Week 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>2mg MyrB/TDF</td>
<td>-1.75</td>
</tr>
<tr>
<td>5mg MyrB/TDF</td>
<td>-1.60</td>
</tr>
<tr>
<td>10mg MyrB/TDF</td>
<td>-2.70</td>
</tr>
<tr>
<td>TDF</td>
<td>-0.18</td>
</tr>
</tbody>
</table>

MYR301: Phase 3, Randomized, Open-label Trial of Bulevirtide Monotherapy for Patients with Chronic Hepatitis Delta

Key inclusion criteria:
- CHD with/without cirrhosis and CPT ≥7
- ALT >1x to <10x ULN
- Platelets ≥60,000/mm³
- Controlled HIV coinfection allowed

Wedemeyer H, et al. EASL 2022. #GS006
Behrendt et al. Liver International 2022, epub ahead of print
MYR301: Phase 3, Randomized, Open-label Trial of Bulevirtide Monotherapy for Patients with Chronic Hepatitis Delta

Key efficacy outcomes at Weeks 24 and 48

- Combined response: *P<0.0001 vs delayed treatment arm; Combined response defined as undetectable HDV RNA or ≥2 log IU/mL decline from baseline and ALT normalization

- Undetectable HDV RNA: Primary endpoint
  - Week 24: 37%, 28%
  - Week 48: 45%, 48%

- Undetectable HDV RNA or ≥2 log decline from baseline
  - Week 24: 4%, 4%
  - Week 48: 55%, 71%

- Undetectable HDV RNA
  - Week 24: 71%
  - Week 48: 76%

- ALT normalization at Weeks 24 and 48
  - Week 24: Delayed treatment (n=51), BLV 2 mg (n=49), BLV 10 mg (n=50)
    - Delayed treatment: 53%
    - BLV 2 mg: 38%
    - BLV 10 mg: 51%
  - Week 48: Delayed treatment (n=50), BLV 2 mg (n=48), BLV 10 mg (n=42)
    - Delayed treatment: 56%
    - BLV 2 mg: 51%
    - BLV 10 mg: 55%

- Change from baseline in liver stiffness at Week 48
  - Delayed treatment (n=45), BLV 2 mg (n=48), BLV 10 mg (n=42)
    - Delayed treatment: -3.08
    - BLV 2 mg: -3.08
    - BLV 10 mg: -3.17

*P<0.0001 vs delayed treatment arm; †P<0.0001 vs delayed treatment arm

Wedemeyer H, et al. EASL 2022. #GS006
Behrendt et al. Liver International 2022, epub ahead of print
MYR301: Phase 3, Randomized, Open-label Trial of Bulevirtide Monotherapy for Patients with Chronic Hepatitis Delta

### Data are n (%)

<table>
<thead>
<tr>
<th>Data</th>
<th>Delayed treatment (n=51)</th>
<th>BLV 2 mg (n=49)</th>
<th>BLV 10 mg (n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any AE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 3/4</td>
<td>39 (77)</td>
<td>40 (82)</td>
<td>44 (88)</td>
</tr>
<tr>
<td>SAE</td>
<td>1 (2)</td>
<td>2 (4)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>AEs leading to discontinuation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TRAEs</td>
<td>0</td>
<td>24 (49)</td>
<td>36 (72)</td>
</tr>
<tr>
<td>AEs of interest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>0</td>
<td>9 (18)</td>
<td>10 (20)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>0</td>
<td>2 (4)</td>
<td>2 (4)</td>
</tr>
<tr>
<td>Nausea</td>
<td>2 (4)</td>
<td>3 (6)</td>
<td>4 (8)</td>
</tr>
<tr>
<td><strong>Pruritus</strong></td>
<td>0</td>
<td>6 (12)</td>
<td>8 (16)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>1 (2)</td>
<td>5 (10)</td>
<td>8 (16)</td>
</tr>
<tr>
<td>ISRs</td>
<td>0</td>
<td>8 (16)</td>
<td>15 (30)</td>
</tr>
</tbody>
</table>

- No deaths
- ISRs mild to moderate in severity
- Asymptomatic total serum BA and eosinophils elevations in BLV arms

*Injection site reactions

Wedemeyer H, et al. EASL 2022. #GS006
Myrcludex Monotherapy in Compensated Cirrhotics With HDV: Safety and Effectiveness Beyond 2 Years of Treatment

1 patient with recurrent viremia after stopping therapy

2 patients who remained on therapy had persistent viral suppression with normalization of ALT
Improved clinical outcomes noted (resolution of varices)

• These data may be a sign of how bulevirtide will be used...as a long-term maintenance therapy

Loglio A et al, J Hepatology 2022;76:464-469
Nucleic acid polymers (NAPs) are oligonucleotides with broad spectrum in vitro antiviral activities

- Reported to act via entry inhibition in other viruses
- Also proposed to bind to amphipathic protein structures
- These amphipathic protein structures are common in viral proteins, but are also found in key host cell proteins
- REP 2139 inhibits secretion of HBsAg from cells
 Phase 2 REP 301 Study

- 12 HDV pts in Moldova
- Anti-HDV/RNA +
- HBsAg > 1000
- Non-cirrhotic

- Responses mostly maintained on interferon
- 5 patients rebound with cessation of IFN (EASL 2017)
- Responses maintained to date (EASL 2018)

- Responses mostly maintained on interferon

First-in-Class Treatments in Development for HDV

Multiple Options to Treat HDV

- Lonafarnib
- PEG IFN Lambda

**Daily Oral Therapy**
- Lonafarnib / Ritonavir

**Combination Therapy**
- Lonafarnib / Ritonavir + PEG IFN Lambda

**Weekly SQ Monotherapy**
- PEG IFN Lambda
Lonafarnib

- Small molecule, first-in-class, oral prenylation inhibitor
- Well-characterized through Phase 3
  - > 2,000 subjects dosed in oncology program by Merck (Schering)
  - Dose limiting toxicity is GI (class effect)
- Over 120 HDV patients dosed across international sites
- US & EU Orphan Designation, FDA Breakthrough and EMA PRIME Designation
- Broad range of lonafarnib + ritonavir doses and durations studied
- US and multiple international sites
Lonafarnib inhibits prenylation

15-C isoprenoid lipid added to small HDAg to form large HDAg (prenylation)

Compared to PEG-IFN-alfa-2a Alone

- LNF 50 mg BID + RTV (N=12)  
  \textit{LOWR-2 STUDY}

- PEG IFN-alfa-2a ± tenofovir (N=91)  
  \textit{HIDIT-1 STUDY}

- LNF 50 mg BID + RTV + PEG IFN-alfa-2a (N=4)  
  \textit{LOWR-2 STUDY}

Peg IFN Lambda: A Better Tolerated Interferon

- A novel, first-in-class Type III interferon
- Binds to a unique receptor versus Type I interferons
  - Highly expressed on hepatocytes
  - Limited expression on hematopoietic cells and CNS cells
- Uses similar downstream signaling pathway as Type I interferons
- Studied in > 3,000 subjects across 17 clinical trials (HCV / HBV)
- Comparable antiviral activity with less of the typical IFN alfa related side effects

LIMT: Phase 2 Lambda Study

Primary Endpoint:
• Evaluate Safety, Tolerability, Efficacy

Secondary Endpoint:
• Proportion of Patients with HDV RNA BLQ 24 weeks after EOT

A Better Tolerated Interferon for HDV Monotherapy

On-treatment
48 weeks

Post-treatment
24 weeks

Lambda 120 mcg QW

Lambda 180 mcg QW

Study Complete

Peginterferon Lambda Activity Through Week 48

Lambda 180 mcg has Comparable Antiviral Activity to Alfa 180 mcg with Improved Tolerability

Peginterferon Lambda: 36% Durable Virologic Response

DVR Endpoint = BLQ at 24 Weeks Post-Treatment

Week 48
End of Treatment

Week 72
End of Follow-up

Etzion et al, EASL 2019, LIMT Phase 2 Study; Robogene® 2.0 HDV RNA PCR assay, LLOQ = 14 IU/mL; DVR = BLQ at 24 Weeks Post-Treatment
LIFT: Phase 2 Lambda & Lonafarnib Combination Study

A Better Tolerated Interferon for Combination

On-treatment

24 Weeks

Lambda 180 mcg QW
Lonafarnib 50 mg BID
Ritonavir 100 mg BID

Follow Up

Post-treatment

24 Weeks

N=26

Primary Endpoint:

• ≥ 2 Log HDV RNA reduction at EOT

Secondary Endpoint:

• Histological Improvement (biopsy confirmed)

• Dosing
• End of Treatment Data Q4’19

• Median Decline of HDV RNA: -3.4 Log at Week 24
• 95% of Patients Achieve > 2 Log Decline in HDV RNA at Week 24
• > 50% of Patients Achieve Undetectable or BLOQ HDV RNA at Week 24

Koh C et al, AASLD 2019
Lonafarnib, Ritonavir, and Lambda Interferon for HDV: Interim End-of-Treatment Results – the LIFT Study

Aims:
Evaluate the safety and antiviral effects of therapy with lonafarnib (LNF), ritonavir (RTV), and lambda interferon (LMD) in patients with chronic hepatitis D

Methods:
Phase 2a, open-label, prospective treatment trial in 26 patients for 24 weeks, with 24 weeks of post-therapy follow-up

Main Findings:
At the end of therapy (19 of 26 patients), the median HDV RNA decline was 3.4 log IU/ml ($p<0.0001$) with 10 (53%) patients achieving undetectable or BLOQ HDV RNA in serum.

Conclusions:
Triple combination therapy with LNF/RTV/LMD in chronic HDV patients appears to be safe and tolerable for up to 6 months in most patients.

Koh C, et al., Abstract LO8

58% of patients achieved undetectable or BLOQ* HDV RNA by the end of therapy
Summary

- HDV is the most severe form of viral hepatitis
- HDV remains underdiagnosed
- HBV vaccination is protective against acquiring HDV
- HDV/HBV infection causes more rapid disease progression as compared to HBV monoinfection
- New therapies being developed based upon HDV life cycle
- Several HDV therapies currently in phase 2 and 3 development
  - Bulevirtide and Lonafarnib
- Promising future!
The Near Future For HDV Therapy?

- Hoped for new treatments: Bulevirtide, Ionafarnib, PEG IFN lambda, nucleic acid polymers (NAPS)
- Bulevirtide approved in Europe, possibly in US soon
- Viral suppression enhanced with addition IFN alpha for bulevirtide, Ionafarnib
- Issue is whether rates of sustained response will be significantly enhanced with combination therapy and whether IFN will improve this
- Maintenance therapy with a safe monotherapy not associated with resistance may be preferred by some clinicians and patients