

Giaconda Milestones

Giaconda Limited is the company set up by our own Professor Tom Borody to commercialise the extensive research generated by the CDD. All of Giaconda's products were discovered at the CDD. Giaconda maintains close links with the CDD and Tom is Giaconda's Chief Medical Officer as well as being Director at the CDD. Giaconda's role is to bring the products to market across the globe so that all patients can benefit from the discoveries made at the CDD. Since the last newsletter Giaconda Limited successfully listed on the Australian Stock Exchange in September under the ticker symbol GIA. The progress since listing has been excellent and the team at Giaconda are optimistic about the future of the company. The main focus of operations since listing has been on commercializing Myoconda[®] as the company's lead product for the treatment of Crohn's disease. In December, with the support of a BioBusiness Program Grant from the NSW Government, Giaconda made presentations to the FDA (US Food and Drug Administration) and the MHRA (UK's Medicines and Healthcare Products Regulatory Agency) on its lead product Myoconda[®]. The purpose of these meetings was to establish the best clinical development path for Myoconda[®] to obtain an IND in the USA and to guide our development efforts for registration in Europe. An IND (Investigational New Drug) filing is an integral part of registering a new

product in the US markets. The presentations were well received and Giaconda gained excellent guidance concerning the plans for registering Myoconda[®] in these markets. A further clinical analysis of Myoconda[®] in 53 patients was presented at the Australian Gastroenterology Week meeting in Brisbane. The analysis was undertaken by Professor Tom Borody, Giaconda's Chief Medical Officer and Director of CDD. The results of the retrospective analysis of these 53 patients treated with the Myoconda[®] combination for a minimum of six months demonstrated some of the highest efficacy levels ever shown in the treatment of Crohn's Disease. 65% of the patients showed complete remission while over 95% showed marked improvement (defined as a reduction in Crohn's Disease Activity Index – CDAI – of 70 or more points and/or a significant reduction in inflammation in the mucosa of the colon). One patient has been in remission for nine and a half years. These data demonstrated that the treatment of *Mycobacterium avium ssp. paratuberculosis* (MAP) infection in Crohn's disease can aid in patient's recovery. To date, there has been no effective treatment for a large number of Crohn's patients. These results with Myoconda[®] are extremely encouraging. In December, Giaconda convened its first Scientific Advisory Board meeting and added Professor Nick Talley to its roster of international members.

Professor Richard Hunt was also appointed Chairman of the Scientific Advisory Board. The Scientific Advisory Board represents some of the most prestigious names in gastroenterology from around the world and their contributions to the company provide Giaconda with unmatched clinical expertise. Giaconda's Phase II clinical study results with Heliconda[®] in patients with drug resistant *Helicobacter pylori* were published in the February 2006 issue of *Alimentary Pharmacology and Therapeutics*. In the study, Heliconda[®] achieved eradication in 90.8% of 130 patients who had failed one or more *Helicobacter pylori* eradication attempts using standard triple antibiotic therapy. The presence of clarithromycin or metronidazole resistant strains had no significant impact on the eradication rates. In light of the increasing patient resistance to antibiotics used in the present standard of care therapy, this study proves that Heliconda[®] can be an important addition to the armamentarium of the physician who actively treats *H. pylori*. It reduces the concern about resistant strains of *H. pylori* and this is especially important

for the Primary Care Physician who does not normally test for resistance. There have been no reported strains of rifabutin resistant *H. pylori* so it has been substantiated that Heliconda[®] can be used effectively as a rescue therapy. It may even be used as first line therapy in patients with a history of frequent antibiotic use with less concern about the resistance issue. Dr. Antony Wettstein participated in the study completed at CDD and presented the results in detail to physicians attending the opening of the new facility on April 4th. In April, Giaconda received a non-binding letter of intent to license Myoconda[®] from Forest Laboratories UK, representing the first stage in the process of a full license agreement. Forest Laboratories will undertake due diligence with the intention of acquiring exclusive rights to commercialize Myoconda[®] in the UK and Ireland. In the BioShares Company Index, which covers over 120 companies in the sector, Giaconda is listed at number 37 in terms of market capitalization. This is an impressive ranking for a company that has been publicly listed for less than 12 months.

Giaconda's Product Pipeline

Product	Disease Indication	Status
Myoconda	Crohn's Disease	Phase III
Hepaconda	Hepatitis C	Phase II
Heliconda	Resistant <i>Helicobacter pylori</i> infection	Phase III
Ibaconda	Irritable Bowel Syndrome [constipation predominant]	Phase II
Picoconda	Bowel preparation for colonoscopy	Phase III



"Giaconda Limited Board and Management celebrate listing on the Australian Stock Exchange – 28 September 2006"



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THE Inside Story



Evicting the resistant
Helicobacter pylori
Capsule
Endoscopy

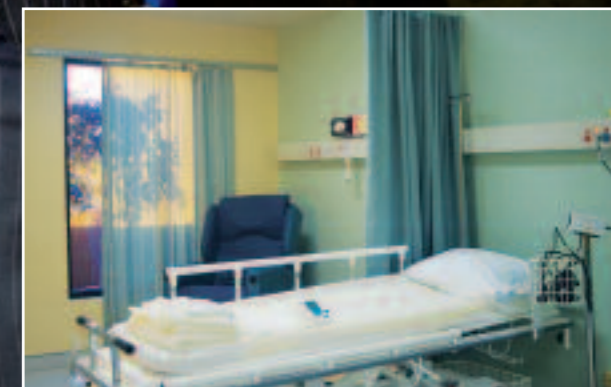
Now covered by Medicare!
CT Colography
Current status

Future Projects
Department of Research
and Innovation

Professor Borody
Speaks to Crohn's Colitis
Foundation of America (CCFA)

The Centre
of Attention

Your new centre is now open!



Evicting the resistant *Helicobacter pylori*

Helicobacter is a pathogenic bacterium found in the mucous lining of the stomach. It is the ultimate aim to eradicate this bacterium in patients who have peptic ulcers and Helicobacter-associated gastritis.

The World Health Organisation categorises *H. pylori* as a carcinogen and thus to reduce the incidence of gastric cancer, its eradication is recommended. As with many other bacterial infections, resistance to standard treatments is a growing problem. Usually two antibiotics in combination with an acid-

suppressing drug – a proton pump inhibitor – are recommended. This still has only an 80-85% eradication rate. The eradication rate is reduced if patients are female, have resistant *H. Pylori* bacteria, have had previous failed eradication attempts, or are poorly compliant to the medication regime. There are numerous alternative treatment options in patients who fail first line (standard) treatments. It is our preference at the Centre for Digestive Diseases to use a rifabutin salvage therapy in such patients. Our study shows that we can achieve over a 90% eradication rate using rifabutin at relatively low doses in combination with high doses of standard amoxicillin and a proton pump inhibitor for 10 days. The chance of successful eradication is not affected by how many previous failed standard treatments were given. Equally high eradication rates were also achieved in patients who had proven multi-resistant strains. Unlike

previous published studies using rifabutin-based eradication treatment, the reported side effects in our study were low. We believe this is because we were able to reduce the dose of rifabutin without a reduction in

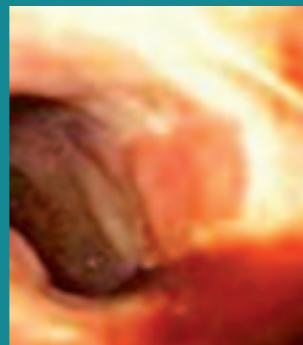
The chance of successful eradication is not affected by how many previous failed standard treatments were given.

overall efficacy of the treatment. Resistant *H. Pylori* strains are an increasing problem in clinical practice in Australia. Rifabutin salvage therapy has shown itself to be a safe and effective alternative for patients who have previously failed standard treatment.

Call us on 9713 4011 to find out more.



Gastric cancer



Ulcer Disease

Capsule Endoscopy Now covered by Medicare!



Capsule actual size: 26 mm (L) x 11 mm (D)

Capsule endoscopy is used to detect, among other disorders, small bowel polyps, cancer, ulcers and angioectasia lesions. Eligible patients are those who have iron deficiency anaemia and have had a negative colonoscopy and a negative endoscopy within the last six months, without a specific bleeding cause found. In such patients, capsule endoscopy will be largely covered by Medicare fees. Please keep in mind when referring patients for the investigation of iron deficiency anaemia that they need to have both endoscopy and colonoscopy carried out as routine 'pre-capsule' investigation. It is a good idea to let the patients know ahead that they may then undergo capsule endoscopy to complete their investigation of anaemia.

Current status of CT Colography

CT colography, also known as CT colonoscopy or virtual colonoscopy, has emerged as an alternate method for bowel cancer screening. Using advanced spiral CT and sophisticated 3-D computer technology an image is constructed of the bowel walls. Specially trained radiologists can, with relative accuracy, diagnose larger clinically important colonic polyps. This technique requires no sedation but does require a full bowel preparation as would be required for a standard colonoscopy. Patients are alert during the CT colography, but there may be problems with tolerance because of abdominal discomfort during insufflation with gas via a rectal catheter. Other limitations of CT colography are the significant radiation dose known to be associated with increased incidence of other tumours and the absence of a Medicare rebate. Being a non-invasive radiological procedure, no immediate intervention to remove any detected polyps is possible. The patient

would need to be re-booked for a standard colonoscopy with a bowel preparation. Even though in dedicated, highly trained, expert research centres the accuracy of CT colography has been said to be high, this has been called into question in clinical practice. One of the major problems is that there can be confusion and missed diagnosis of a polyp when inadvertently detecting a segment of stool. These technical issues may be improved in the future if the stool can be labelled radiologically and digitally subtracted. For the above reasons, CT colography has not been accepted as a method for colon cancer screening. Its main use at this stage is for further investigation of patients who have had failed standard colonoscopy either for technical reasons or because of an obstructive cancer. The two recommended methods for population-based colon cancer screening are still 'faecal occult blood testing' and/or standard colonoscopy.

The Centre of Attention

The Centre for Digestive Diseases has successfully moved to the new premises at Level 1, 229 Great North Road, Five Dock NSW 2046

The new premises are almost twice the size in surface area, doubling the Recovery Area in size and enlarging the Procedure Rooms, both of which can now be used simultaneously. Patients therefore have a reduced waiting period and are treated in the usual "royal" fashion with our current state of

the art medical equipment and fitout. Our aim of delivering a service that is of the highest quality and efficiency to our patients has remained unchanged. Complete with soothing paint colours and furnishings, the new Centre for Digestive Diseases is indeed a "Centre of Attention".



One of two Procedure Rooms



Our new open plan Recovery Area



Our new stylish Reception Area

DRI Department of Research and Innovation

The Department of Research and Innovation at CDD is involved in projects aimed at providing new and innovative medicines or devices that will help improve patient care. Successful past projects included the 'Triple Therapy' (Helidac) - the first ever product to cure ulcers, Anti-MAP treatment for Crohn's disease, the Oxyguard to oxygenate patients during procedures, and Glycoprep-C for bowel cleansing. The Department is currently conducting projects which include:

- A trial on patients with chronic *Clostridium difficile* infections - involving a new polymer product being tested to see how well it absorbs *C. difficile* toxins.
- A trial on patients with Erosive Oesophagitis - testing a new slow-release acid suppressant that allows greater relief of reflux symptoms in erosive oesophagitis.
- A trial on testing a new detection method for *Helicobacter pylori* using a non-invasive breath test in patients with indigestion.

In addition, trials that will commence in the near future include: a trial using a safer method for delivering oxygen to patients undergoing procedures; a trial on a new cost-effective diagnostic method for testing the presence of *Helicobacter pylori* on biopsies of patients; and a new method of treatment for Crohn's disease. Many of the trials conducted by the department are aimed at developing new medicines or devices in-house, but a number are pharmaceutical company sponsored.

Professor Borody Speaks to Crohn's Colitis Foundation of America (CCFA)

In response to an invitation to speak at the CCFA meeting in Florida Professor Borody delivered results of studies on the new antibiotic therapy for Crohn's disease. Sixty world experts on Inflammatory Bowel Disease listened to the presentation and a similar lecture was later given at a gathering of 730 Crohn's patients in Commack Long Island, New York. The lecture was a resounding success, and several newspaper articles followed. A new therapy is one of the treatments that Giaconda will be marketing throughout the world.

your team

The medical team is lead by Professor Tom Borody and includes a number of full-time and part-time medical practitioners. Among them are:

- **Emeritus Professor Robert Llewellyn Clancy AM.** Professor of Pathology in the Faculty of Medicine and Health Sciences at the University of Newcastle and Clinical Academic at the Hunter Immunology Unit of John Hunter Hospital.
- **Dr Andrew Finckh.** Senior Staff Specialist at St Vincent's Hospital with a Bachelor of Arts from Macquarie University and Medicine from the University of Sydney. He holds the position of Emergency Physician at St Vincent's Hospital and Liverpool Hospital.
- **Dr Simon Benstock.** Graduated from the University of NSW and is a fellow of the Royal Australia Society of Physicians in Gastroenterology.
- **Dr Sanjay Ramrakha.** Graduated in Medicine from the University of NSW in 1986. He is a fellow of both the Royal Australian College of General Practitioners and Australasian College for Emergency Medicine. He holds the position of Emergency Physician at RPA & Liverpool Hospital.
- **Dr John Saxon.** Graduated from the University of NSW in 1985 and has been the senior sedationist at CDD since 1995, with some 20,000 patients to date.
- **Dr Antony Wettstein.** Graduated with Honours from the University of NSW. He is a Fellow of the Royal Australian Society of Physicians in Gastroenterology working at CDD and St Vincent's Hospital, Sydney.