

BRIEF REPORT

Patient-Customized Oligonucleotide Therapy for a Rare Genetic Disease

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SUMMARY

Genome sequencing is often pivotal in the diagnosis of rare diseases, but many of these conditions lack specific treatments. We describe how molecular diagnosis of a rare, fatal neurodegenerative condition led to the rational design, testing, and manufacture of milasen, a splice-modulating antisense oligonucleotide drug tailored to a particular patient. Proof-of-concept experiments in cell lines from the patient served as the basis for launching an “N-of-1” study of milasen within 1 year after first contact with the patient. There were no serious adverse events, and treatment was associated with objective reduction in seizures (determined by electroencephalography and parental reporting). This study offers a possible template for the rapid development of patient-customized treatments. (Funded by Mila’s Miracle Foundation and others.)

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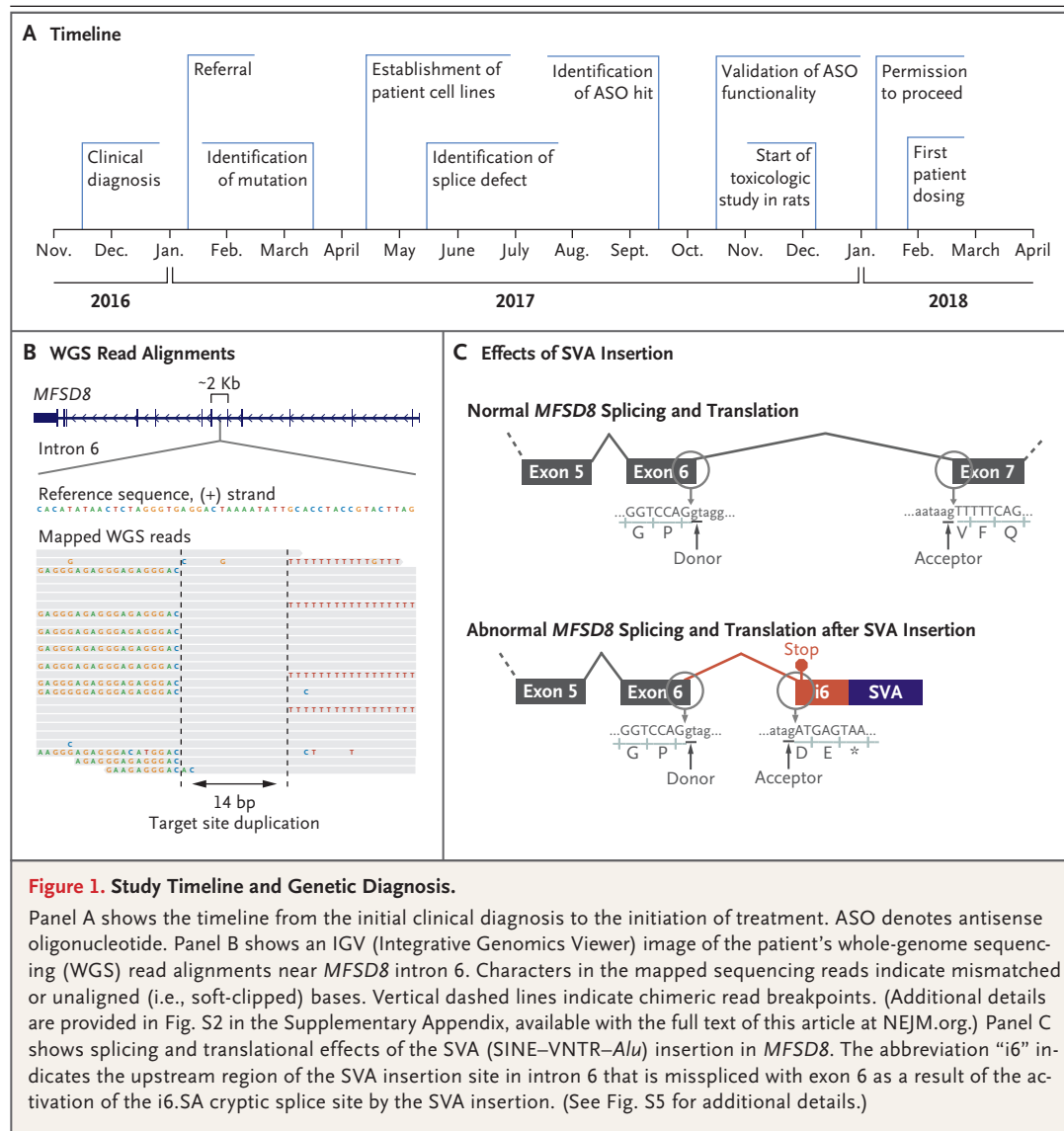
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RARE DISEASES IN AGGREGATE AFFECT APPROXIMATELY 30 MILLION PERSONS in the United States alone.¹ Although next-generation sequencing is revolutionizing their diagnosis, the sheer number of distinct conditions (more than 7000 [<https://globalgenes.org/rare-list/>]) and the limited number of patients affected by each rare disease present major challenges for drug development.

This report shows a path to personalized treatment for patients with orphan diseases. It describes the identification of a novel mutation in a child with neuronal ceroid lipofuscinosis 7 (CLN7, a form of Batten’s disease), a rare and fatal neurodegenerative disease.^{2,3} Identification of the mutation was followed by the development and clinical deployment, within 1 year, of a tailored drug to treat the patient (Fig. 1A).

CLINICAL PRESENTATION

A 6-year-old girl presented with the insidious onset of blindness, ataxia, seizures, and developmental regression. The parents’ first concerns dated back to when the girl was 3 years of age, when her right foot began to turn inward. When she was 4 years of age, her family noticed her pulling books close to her face at bedtime. At 5 years of age, she came to medical attention because of modest language and social regression, as well as increased clumsiness and stumbling. In the months before she turned 6 years of age, the progression of symptoms accelerated, and she was



hospitalized after the rapid development of loss of vision, frequent falls, dysarthria, and dysphagia. Magnetic resonance imaging (MRI) of the head revealed mild cerebral and cerebellar atrophy (Fig. S1A), and 24-hour electroencephalography (EEG) revealed several subclinical generalized seizures. An extensive laboratory workup for mitochondrial or metabolic diseases was initially unrevealing, until a skin biopsy was performed. The biopsy showed abnormal, electron-dense, lysosomal inclusions in a swirling fingerprint pattern (Fig. S1B).³ This pattern was recognized to be diagnostic of Batten's disease, which is autosomal recessive and affects the retina and the central nervous system (CNS). Genetic panel

testing (including deletion–duplication analysis) for known Batten's disease genes revealed heterozygosity for a single known pathogenic mutation (NM_152778.3: c.1102G→C; ClinVar accession number, RCV000149775.5) in the gene *MFSD8* (also known as *CLN7*). No second mutation could be found. The family was offered enrollment in a research study for further diagnostic workup.

METHODS

After obtaining written informed consent from the patient's parents, we obtained blood and skin samples for genomic and molecular characterization under an appropriate human subjects re-

search protocol approved by the institutional review board of Boston Children's Hospital. A full description of the methods of the subsequent workup is provided in the Supplementary Appendix.

After informed consent was obtained from the patient's parents, treatment was conducted under an expanded-access investigational clinical protocol authorized by the Food and Drug Administration (FDA), with the concurrence of the chair of the Boston Children's Hospital institutional review board. All the authors vouch for the accuracy and completeness of the data and for the fidelity of the study to the protocol, available at NEJM.org.

RESULTS

MUTATION IDENTIFICATION

Whole-genome sequencing was undertaken to search for the missing second mutation, which was hypothesized to be a noncoding mutation or a structural variant missed by standard clinical sequencing. Careful inspection of sequencing data revealed a cluster of chimeric reads deep in *MFSD8* intron 6 (Fig. 1B), detected in both the proband and the mother (Fig. S2A). Chimeric reads in this cluster were fused either to unmapped poly-T sequences on one end or to unmapped hexameric repeat sequences (AGAGGG) on the other end, which suggested the presence of a DNA insertion beginning and ending with these motifs. Chimeric breakpoints were offset by 14 bp, suggesting duplication of an endogenous target sequence (Fig. 1B).

We deduced that these features were consistent with the insertion of an SVA (SINE–VNTR–*Alu*) retrotransposon.⁴ Indeed, amplification by polymerase chain reaction (PCR) across the breakpoints revealed an approximately 2-kb insertion in the proband and the mother that was confirmed by RepeatMasker analysis to be an SVA retrotransposon. The segregation of the variant within this family was confirmed in a Clinical Laboratory Improvement Amendments–certified laboratory to match recessive inheritance (the proband is compound heterozygous for the SVA insertion and c.1102G→C, and the parents are heterozygous carriers). The SVA insertion was also correctly detected by automated analysis with the

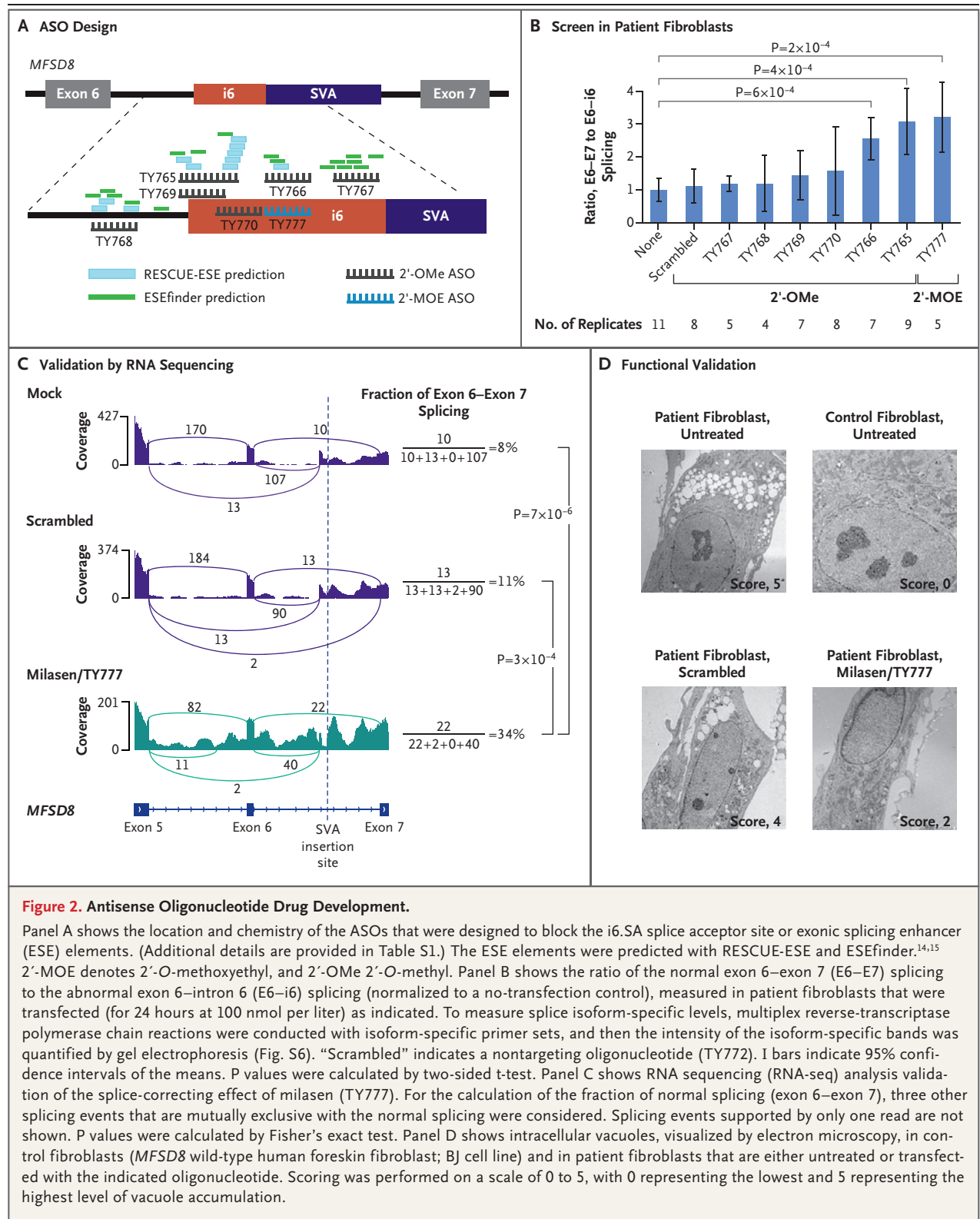
Tea algorithm.⁵ This insertion has not been reported in the literature and does not appear in dbRIP, a database of retrotransposon insertions in the human population.⁶ Its absence was also confirmed in more than 800 persons by Tea analysis of publicly available human whole-genome sequencing data sets. (Additional details of the results of these analyses are provided in Figs. S2 through S4.)

Because SVA insertions have been reported to modulate splicing of nearby genes,⁷ we examined splicing patterns in the patient's family. RNA sequencing (RNA-seq) and reverse-transcriptase–PCR analyses revealed missplicing of exon 6 into a cryptic splice-acceptor site (i6.SA) in *MFSD8* intron 6, in a location 119 bp upstream from the SVA insertion site, in blood samples and lymphoblasts from the proband and mother (but not the father or an unaffected sibling). This missplicing precisely segregated with the SVA insertion (Fig. 1C and Fig. S5) and was predicted to lead to premature translational termination, which supported the pathogenicity of the insertion.

DEVELOPMENT OF AN ANTISENSE OLIGONUCLEOTIDE DRUG

Nusinersen is an FDA-approved antisense oligonucleotide drug for spinal muscular atrophy^{8–10} that changes the splicing pattern of the *SMN2* RNA.^{11–13} Reasoning that an antisense oligonucleotide might be similarly used to correct missplicing and restore *MFSD8* expression in our patient, we designed antisense oligonucleotides to target the i6.SA cryptic splice-acceptor site and nearby splicing enhancers (Fig. 2A). When we tested these antisense oligonucleotides in patient fibroblasts, we identified three that boosted normal:mutant splicing ratios by a factor of 2.5 to 3. TY777 was the most efficacious (Fig. 2B) and became our lead candidate; we dubbed it “milasen.”

Milasen is a 22-nucleotide antisense oligonucleotide with the same backbone and sugar chemistry modifications (phosphorothioate and 2'-*O*-methoxyethyl) as nusinersen.^{8,13} Dose-response analysis indicated that its half-maximal potency was in the nanomolar range. RNA-seq from patient fibroblasts showed that milasen treatment more than tripled the amount of normal (exon 6–exon 7) splicing (Fig. 2C). Com-



puter-based sequence analysis of milasen showed little potential for off-target binding in the human genome.

Fibroblasts from the patient had several cellular phenotypes characteristic of lysosomal dysfunction, including intracellular vacuolation,¹⁶ increased total lysosomal mass,¹⁷ autofluorescence, miscompartmentalization of lysosomal enzyme activity, and reduced autophagic flux¹⁸ (Fig. 2D). All these phenotypes were alleviated by milasen administration, indicating that treatment could rescue not only splicing but also function. (Additional details regarding the analyses we performed during the development of milasen are provided in Tables S1 and S2 and Figs. S6 through S12.)

STUDIES IN SUPPORT OF AN INVESTIGATIONAL NEW DRUG APPLICATION

The patient's condition continued to deteriorate. Clinical evaluation at 7 years of age revealed an inability to make discernible words, dysphagia (prompting gastrostomy tube placement), the need for substantial support to walk, and 15 to 30 overt seizures per day. She did, however, remain alert and reactive to familiar stimuli and responded happily to hearing her favorite books and songs.

In the largest published case series of CLN7 Batten's disease, the mean age of patients at onset was 3.3 years, and seven patients died at a mean age of 11.5 years.¹⁹ Considering our patient's clinical prognosis, and after appropriate scientific and ethics review, we filed for FDA permission to initiate clinical investigational treatment under an Expanded Access Investigational New Drug application. Milasen drug substance (18 g) was manufactured and formulated for clinical administration. To identify potential hazards, we administered milasen to rats by intrathecal injection at three doses: 0.06 mg, 0.25 mg, and 1.0 mg (approximately 2.5 times, 10 times, and 42 times, respectively, the typical clinical dose of nusinersen, after compartmental scaling considerations). No adverse effects were observed in the group that received 0.06 mg. At higher doses, some animals (half of those in the group that received 0.25 mg and most of those in the group that received 1.0 mg) had hindlimb weakness, which resolved by approximately 24 hours after each dose. (For additional details, including multidose experiments, see Fig. S13

and Supplementary Text.) These results provided translatable indicators of potential toxic effects that could be readily monitored and guided our clinical protocol design.

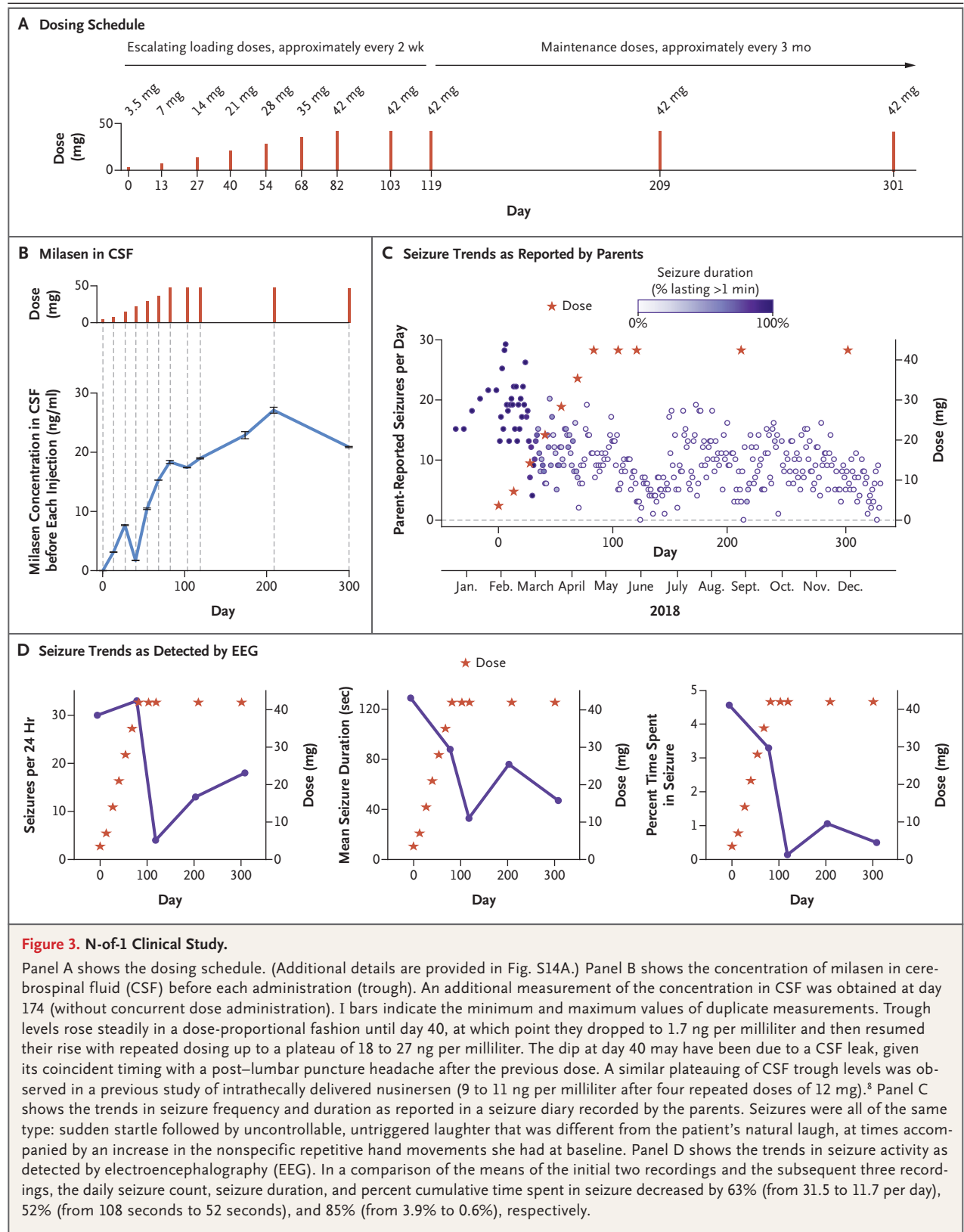
CLINICAL STUDY

We initiated a clinical study of milasen in our patient 1 month after we started the toxicology studies in animals (Fig. 1A). Our regimen was roughly modeled after nusinersen,⁸⁻¹⁰ because of the parallels between the two drugs (i.e., they are similarly sized antisense oligonucleotides with identical chemical modifications, targeting the same tissue [the CNS]). Milasen was given by intrathecal bolus injection, starting at 3.5 mg and increasing approximately every 2 weeks up to 42 mg (Fig. 3A and Fig. S14A). A dose of 42 mg was chosen because antisense oligonucleotides administered intrathecally to humans or nonhuman primates distribute to the brain (the target of milasen) with approximately one third the efficiency with which they distribute to the spinal cord (the target of nusinersen),^{8,13} and 42 mg of milasen is the molar equivalent of 3 times the typical nusinersen dose (12 mg). After dose escalation, two additional loading doses were administered, followed by maintenance dosing approximately every 3 months.

CLINICAL OUTCOMES

Adverse Events, Pharmacokinetics, and Imaging

Through the first year of treatment, no serious adverse events occurred. No clinically significant adverse changes were observed in vital signs; in the results of physical examination, including assessments of strength, gait, and sensory testing; or in clinical laboratory test profiles. Pharmacokinetic analysis indicated a general trend of dose-proportional increases in drug levels in cerebrospinal fluid (Fig. 3B) with only limited systemic exposure. MRI of the head showed continued brain volume loss 7 months after treatment initiation, extending a trend that had been observed over the previous 3 years. In a previous study of gene therapy for CLN5 Batten's disease, animals treated after symptom onset continued to have brain volume loss over a period of 20 months, despite treatment slowing the progression of symptoms.²⁰ (Details of the results of these analyses in our study are provided in Tables S3 through S5 and Figs. S14 through S18.)



Neurologic and Neuropsychological Assessments

Testing with the use of Vineland Adaptive Behavior Scales, Second Edition (Vineland-II), showed declines in 7 of 11 neurologic and neuropsychological subscores between day -100 and day -6. Of the 4 subscores that did not decline, 2 remained the same and 2 improved in the 3 months before the initiation of the clinical study. These declines represented ongoing losses of some of the patient's few remaining adaptive skills in the domains of communication, daily living skills, and socialization. Subscores tended to stabilize in the period from the start of the clinical study to approximately 3 months (3 declined, 6 remained the same, and 2 improved from day -6 to day 107) and from 3 months to 6 months (4 declined, 2 remained the same, and 5 improved from day 107 to day 203). The results of testing with the Bayley Scales of Infant and Toddler Development, Third Edition; Global Motor Function Measure-88 (GMFM-88) scores; and results of sensory threshold testing remained stable throughout treatment. (Details of these results are provided in Tables S4 and S5 and Figs. S15 through S17.)

Seizures

At baseline, our patient was having approximately 15 to 30 seizures per day, each lasting 1 to 2 minutes (Fig. 3C). Over the course of the clinical study, the frequency decreased to between 0 and 20 seizures per day, and the duration of each seizure decreased to less than 1 minute. These trends were corroborated by overnight electroencephalographic monitoring (Fig. 3D), which indicated that both the frequency and duration of seizures decreased by greater than 50% (comparing the initial two recordings and the subsequent three recordings). The percent cumulative time spent in seizure decreased by greater than 80%. No changes were made to the patient's antiepileptic drug regimen (topiramate, 72 mg twice a day), and serum drug levels of topiramate remained stable throughout treatment (10 to 12 μ g per milliliter at days 13, 68, 209, and 301).

DISCUSSION

Over the course of treatment to date, milasen appears to have had an acceptable side-effect profile, with no safety concerns. These findings are consistent with those of previous clinical studies of

intrathecal delivery of an FDA-approved antisense oligonucleotide for spinal muscular atrophy and investigational antisense oligonucleotides for amyotrophic lateral sclerosis and Huntington's disease, which had similarly acceptable side-effect profiles.^{8-10,21-23} Treatment has also been accompanied by objective reductions in the frequency and duration of seizures.

Rapid development of milasen in this case was possible in large part because of the urgency of the patient's clinical situation, the fact that antisense oligonucleotide drugs can be customized in a sequence-specific fashion,²⁴ the precedent of nusinersen (with the same backbone, sugar, and base chemistries) having been safely administered to infants with spinal muscular atrophy,²⁴ the favorable uptake and long half-life of this class of drugs in the CNS,^{13,25} and the relative simplicity of manufacturing oligonucleotide drugs (as compared with small molecules or biologics), allowing for timely small-batch manufacturing.

Milasen itself remains an investigational drug, and it is not suited to the treatment of other patients with Batten's disease because its design is customized to our patient's specific mutation. Nonetheless, this experience indicates that antisense oligonucleotides may deserve consideration as a platform for the rapid delivery of individualized treatments. Further exploration of this approach will continue to require careful case-by-case consideration of a number of scientific, clinical, and ethical issues (Table S6), and expectations need to be tempered by the fact that this approach bears substantial risks. At this time, it should be contemplated only in the context of exceptionally serious or life-threatening circumstances. It should also be recognized that only a minority of patients are likely to have mutations that are amenable to the "mRNA splice-switching" strategy deployed here. More generally, this approach is at present probably scalable to only a limited number of patients, given current limitations on systemic and infrastructural issues (e.g., regulatory burden, manufacturing capacity, cost, and reimbursement).

This study illustrates the ability to rationally design, test, and deploy a novel therapeutic agent for a patient with a rare disease on the basis of an understanding of her specific pathogenic mutation. It is an example of individualized genomic medicine.

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APPENDIX

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