Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/clinical-practice/cardiology/acacia-hcm-what-do-the-phase-3-results-show/61113/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

ACACIA-HCM: What Do the Phase 3 Results Show?

Opening:
You're listening to GLC on ReachMD. This activity, titled 'ACACIA-HCM: What Do the Phase 3 Results Show?', is provided by Global Learning Collaborative.

Dr. Masri:
Hello, my name is Ahmad Masri. I'm a cardiologist at Oregon Health and Science University in Portland, Oregon, United States, and I'm here at TSC 2026, where we just presented the ACACIA-HCM trial.

ACACIA-HCM tested aficamten versus placebo in patients with non-obstructive hypertrophic cardiomyopathy. We enrolled patients with non-obstructive hypertrophic cardiomyopathy that were symptomatic with limited exercise capacity and randomized them to aficamten versus placebo. We enrolled 517 patients, followed them up to 72 weeks on treatment with 4 weeks of washout, and our primary endpoints were assessed at week 36, and the trial continued until the last patient crossed week 36.

What happened in the trial is that aficamten led to improvement in the Kansas City Cardiomyopathy Questionnaire, which is the first of the dual primary endpoint. There was a 3-point difference at week 36 with a *P* value of 0.021. Also, at multiple other time points, there was a difference in KCCQ clinical summary score between aficamten and placebo, with a range of 4.8 to 7 points on the KCCQ clinical summary score.

The second dual primary endpoint also was positively affected by aficamten, which is peak VO2. It had improved by 0.67 with a significant *P* value. And 3 of the 5 secondary endpoints also were improved with aficamten; that includes NYHA Class, NT-proBNP, and the comprehensive exercise performance Z score, which is a combination of peak VO2 for maximal exercise capacity and VE/VCO2 for submaximal exercise capacity.

In terms of safety, aficamten was generally well tolerated, and no new signal of treatment-emergent adverse event was observed. Of the patients on aficamten, 10% had reduction in their LVEF to less than 50% compared to 1% on placebo. However, the majority of these patients remained on aficamten at the same or lower dose throughout the trial. The second thing is that the average reduction in LVEF in the whole aficamten population was 4.4%, which is similar to what was seen in previous aficamten trial.

Finally, in terms of patients who had heart failure during the trial on aficamten, there was 4.7% of these patients compared to 1.2% on placebo. But all these heart failure events happened in the titration phase before week 12. And imagine this: these are patients who have this disease for a very long time, and we're introducing this new cardiac contractility modulating agent. The good news here is that the majority of these patients were treated with a short course of diuretics, and the majority of them remained on the trial. That's a lot of safety data for you. To summarize it, though, only 3% of patients on aficamten had to hold their drug during the study.

And so in conclusion, in the ACACIA-HCM trial, aficamten was superior to placebo on the dual primary endpoint of KCCQ clinical summary score and peak VO2. And longer-term data is currently being generated in the FOREST-HCM trial, where more than 80% of these patients from ACACIA-HCM elected to enroll in the study.

Closing:

You have been listening to GLC on ReachMD. This activity is provided by Global Learning Collaborative. Thank you for listening!