

OxThera Raises SEK 24 Million in New Round of Financing

Based on the interest in the financing round closed in June 2007, OxThera closes an additional round of financing. The current owners Q-Med and Industrifonden have, together with the new owner Malmsten Invest, decided to invest SEK 24 million in this second closing. The current owners consisting of, inter alia, HealthCap, Scandinavian Life Science Venture, Q-Med and Industrifonden, are thus joined by a new owner.

The capital will primarily be used to finance the company's pivotal clinical trials with Oxabact™, as well as clinical trials with Oxazyme™.

Hjalmarsson & Partners Corporate Finance AB has acted as financial advisers to OxThera in relation to this financing.

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Short facts about OxThera

OxThera is a biotechnology company active in the development of products for the treatment of metabolic disorders resulting from excess levels of oxalate from endogenous and exogenous sources. Currently, OxThera has two products in its pipeline, Oxabact™ for the treatment of primary hyperoxaluria, and Oxazyme™, for the prevention of recurring calcium-oxalate kidney stones due to secondary hyperoxaluria.

The Company is a spin-out from Q-Med AB and is based in Sweden (Uppsala) and Florida (Gainesville).

Oxalate is a metabolic end product in humans. It is endogenously produced by the liver and also derived by absorption from the diet. The majority of oxalate is eliminated from the body through the kidneys and a small percentage is eliminated through the GI-tract. Oxalate forms a calcium-oxalate salt which is insoluble at physiological pH and its accumulation can result in serious renal conditions. Consistent high levels of urinary oxalate are known as "hyperoxaluria", which can result in recurrent kidney stones and renal complications. Hyperoxaluria is classified as:

- Primary hyperoxaluria types I, II and III are rare genetic diseases resulting from overproduction of oxalate in the liver; urinary oxalate excretion is usually greater than 100 mg/day (normal level <40 mg/day).
- Secondary hyperoxaluria due to excessive absorption of dietary oxalate. This is common in patients with excessive absorption of dietary oxalate and in patients with, fat malabsorption due to underlying enteric diseases such as IBD, or cystic fibrosis. Further, it is often seen in patients following jejunioileal bypass surgery or bariatric surgery, and in patients with absorptive hyperoxaluria.

Primary hyperoxaluria is a rare, serious disease with very limited treatment options available. The urine oxalate excretion rate in affected patients is typically three to six times normal with severe clinical consequences. Kidney stones and/or calcification of the kidney occur in childhood or adolescence. Renal injury due to oxalate and consequences of the stones often leads to renal failure. Loss of renal function, if not addressed promptly by transplantation, leads to markedly increased plasma concentrations of oxalate with deposition of calcium-oxalate in body tissues. Resulting organ system dysfunction is the cause of severe morbidity and mortality. Renal failure occurs in 50% of the patients by the age of 15 years and has reached 80% by the age of 30 years.