ValveXchange, Inc.

The Lifetime Tissue Valve Company

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ValveXchange, Inc. products have not been approved by the U.S. FDA or any other Regulatory Agencies. This newsletter contains forward looking statements which represent management's best judgment, but are speculative and may not occur as projected or not at all.

NEWS RELEASE March/April/May 2011

From the Desk of Ivan Vesely, Ph.D.

Dear Colleagues,

We hit the ground running in January and we haven't stopped yet. Working towards a First-In-Man target for later this year has been, and will surely continue to be, a long-distance sprint. With that goal in mind, we are pleased to announce the launch of our first Clinical Trial. The trial is called "Evaluation of Safety and Performance of the **V**alveXchange V**I**tality Aor**T**ic Peric**A**rdia**L** Bioprosthesis - ("**VITAL**"). It is scheduled to take place in the fall of 2011, and our countdown clock has started (see the ValveXchange home page). As the clock shows, the target date for this trial is September 30. Additional details about this trial are presented in the "Press Release" section.

Along the way, a number of very notable milestones have been achieved. We've begun our series of human cadaveric heart studies using the Two-Step™ implant approach (see Press Release), we've had a controlled environment room built at an FDA registered and ISO certified subcontractor, and we have processed over 200 pericardial sacs from which to build our valves. On top of that, we have achieved a remarkable durability milestone for our valve in our hydrodynamic tester - 200 million cycles, under conditions far more severe than what is required by the FDA (see Technology Report).

Getting to the First-In-Man milestone involves evolving from a versatile and nimble R&D company to one where rigorous Product Development and Manufacturing standards are practiced and documented. In the last issue, I introduced you to Todd Campbell and Kevin Morningstar. These two gentlemen have helped us transform ourselves into this important new mode. Our focus now is on our quality system, and the QSRs (Quality

System Regulations). That involves a lot of documentation. We project that by the time we are in FIM, we will have generated well over 250 independent product specification and control documents.

In the midst of this push towards our first human implants, we continue to have a strong presence at national and international scientific meetings. In late February, I was invited to present at the CRT meeting in Washington, DC. In late March, I participated in a Web-based seminar exploring the future of cardiovascular devices, and in early April we attended the ACC meeting in New Orleans, primarily to witness the revealing of the PARTNER cohort A data. Indeed, it is the Cohort A data on which this issue's Reality Check column is based.

Most recently, we attended the AATS meeting in Philadelphia and had a display booth. At that meeting, we validated our FIM plans with our advisors and confirmed many of the surgical / handling aspects of our Vitality™ valve design. Conference visits will continue in the coming months. Our CEO, Larry Blankenship, will present at the IBF Medical Technology Investing Conferencein Minneapolis this month, and in June we will be at the SHVD meeting in Barcelona where I have two oral presentations - one on the Vanguard technology and the other on our first transapical leaflet exchange study. I hope to see some of you at these upcoming meetings!

For those new to this Newsletter, ValveXchange is an emerging technology company based in Colorado. We call ourselves "The Lifetime Tissue Valve Company" and are developing the first-of-its-kind "serviceable" bioprosthetic valve. By offering periodic, minimally invasive exchange of the worn-out leaflet set, young and physically active patients can avoid the use of a mechanical valve and the associated Coumadin® anticoagulation therapy. By adhering to the time-proven design tenets of conventional bovine pericardial valves, we believe that the ValveXchange system will offer the best combination of least-invasive techniques and greatest valve longevity and durability.

Press Release

ValveXchange Tests its Two-Step™ Valve Implant Approach in Cadaveric Hearts

March, 2011. Denver - ValveXchange Inc. is pleased to announce the first successful two-stage implant of its exchangeable Vitality™ bioprosthetic heart valve in a human cadaveric heart. The two-piece design of the VXi Vitality™ is important for leaflet exchangeability at the end of its normal service life. It also lends itself to a two-step implant technique that is potentially faster for the surgeon. We believe it will allow a smaller incision, less cross-clamp time and will thus be safer for the patient. Traditional one-piece bioprosthetic valves are challenging to implant because of the risk of leaflet damage during implantation and lack of clear access to the inflow side of the valve when seating the valve into position. The tissue leaflets are delicate and there is always the risk that they may be damaged during conventional valve implantation if a suture were to be accidentally dragged across the leaflet, or when touched by a surgical instrument. They also

cannot be allowed to dry out. In practice, a technician periodically squirts saline onto the valve as the surgeon is implanting it. All of these issues make valve implantation a delicate procedure that needs to be well managed. With the VXi Vitality™ two part valve, the leaflet set stays in the rinsing solution container the entire time the valve base is being sutured in place. There is never the risk of the leaflet set drying out. Additionally, since the delicate leaflet set is not in the way when the base is being sutured in, the surgeon can work faster - one does not need to worry about accidentally damaging the leaflets during installation. The end result is a faster, safer implant procedure for the valve, for the physician and ultimately for the patient. As a first test of this two-step implant feature set, a 23 mm VXi Vitality™ was implanted into a cadaveric heart using the VXi proprietary Two-Step™ tool set. This procedure was performed by Dr. Lars Svensson, of The Cleveland Clinic, and assisted by Dr. Murray Sheldon, a consultant to ValveXchange, and former Medical Director of Arbor Surgical. Even in its early evolution, the Two-Step™ tool set was shown to be effective and easy to use, and also allowed a mock leaflet exchange to be carried out. The Two-Step™ tool set will be used in the upcoming VITAL trial to confirm the implant efficiency and exchangeability of the ValveXchange Vitality™ valve in human use.

ValveXchange Launches its First-In-Man Program

April, 2011. Denver - ValveXchange Inc. is pleased to announce the launch of its First-In-Man Clinical Trial. The trial is called "Evaluation of Safety and Performance of the **V**alveXchange V**I**tality Aor**T**ic Peric**A**rdia**L** Bioprosthesis - ("**VITAL**"). Details of this trial are as follows:

Investigational Device: ValveXchange Vitality™ Aortic Pericardial Bioprosthesis

Description: Early safety and feasibility evaluation of the ValveXchange Aortic Pericardial Heart Valve in patients who are candidates for open surgical heart valve replacement.

Purpose: The primary purpose of this study is to provide a means for treatment of patients with aortic valve disease who are deemed suitable candidates for open surgical heart valve replacement. The Vitality™ device will be placed surgically as a replacement of the patient's native aortic valve. The Vitality™ base will be installed followed by the Verification Leaflet Set. The proper installation of the Verification Leaflet Set will be confirmed, the Verification Leaflet Set will be removed and a Clinical Leaflet Set will be immediately installed. This Clinical Leaflet Set will remain in the patient.

Study Design: The study is designed to be a prospective, single-center, non-randomized trial including up to 20 patients.

Patient Population: Subjects who require replacement of their native aortic valve and are considered candidates for open surgical heart valve replacement.

Follow-up: Patients will be followed at discharge, 30 days, 90 days, and at 1 year post procedure for clinical assessments and echo per protocol.

Study Objectives: The objectives of the study are to evaluate:

- The technical feasibility and safety of implantation of the investigational device.
- The technical feasibility and safety of replacing the investigational device leaflets.
- The ability of the investigational device to reduce aortic valve stenosis/regurgitation.

Primary Endpoint: Safety - Freedom from device or procedure-related Major Adverse Events (MAE) defined as a combined clinical endpoint of death, myocardial infarction, cardiac tamponade, stroke, the need for traditional aortic valve replacement, PV leak, valve dehiscence, valve fracture/failure, thrombus detected on echo, septicemia, and device-related embolic events at discharge and 30-days post-procedure.

Performance: Technical success defined as the safe implantation of the investigational device and the immediate exchange of the leaflet set intraoperatively.

Through this trial, ValveXchange Inc. will demonstrate that the two-part, exchangeable valve can be safely implanted into patients that are typically younger, and would otherwise be candidates for mechanical valve prostheses. The ValveXchange technology will thus enable a Coumadin-free lifestyle alternative for patients of all ages.

The manufacture of our clinical grade valves has begun. We have set up a clean-room in a local FDA registered and ISO certified manufacturing facility and are building valves in sizes 19 mm and 23 mm. The 19 mm valves are for additional animal trials and the 23 mm valves are intended for human use in our **VITAL** trial. A photo of our Clean Room facility is shown below.

Technology Report

200 million cycles and counting.....

Current standards require a tissue valve to withstand 200 million cycles of opening and closure in a hydrodynamic accelerated wear tester before it is approved for human use. We have now accomplished that, and more.

According to international standard ISO 5840, "flexible heart valve substitutes will remain functional for 200 million cycles." The standard also states "It is recommended that a pressure difference of 100 mm Hg or greater should be maintained across the closed valve for at least 20 % of the duration of the cycle."

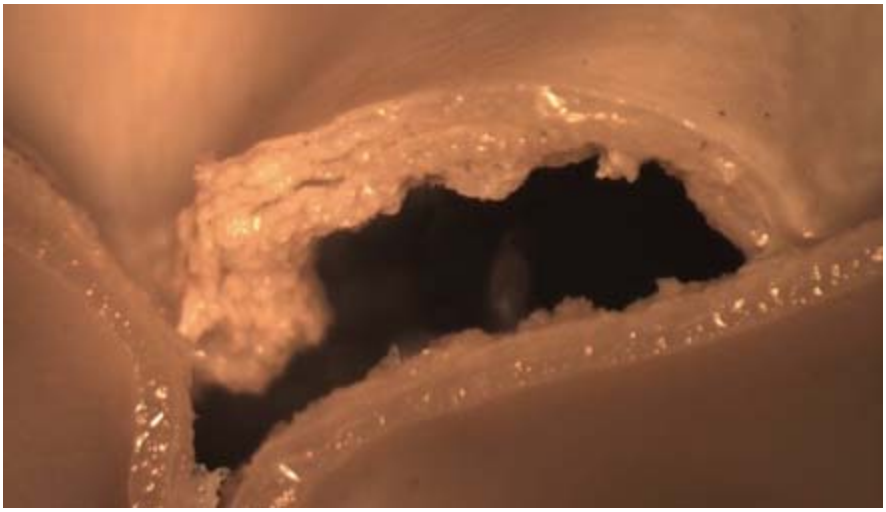
We have **not** been testing our valves to 100 mmHg, we have been loading our valves to 200 mmHg. Yes, our valves have now passed 200 million cycles at a closing pressure of 200 mmHg! Why did we do this? The main reason for these extreme testing conditions has been our desire to shorten the development cycle times. We expected the first valve design to fail early from some form of defect. In fact it did. The very first iteration failed at 25 million cycles. The second iteration failed at 65 million cycles, and the current iteration hasn't failed yet. The reason for pushing the closing pressure to 200 mmHg, instead of just 100 or 120 mmHg, is because we wanted the early prototypes to fail sooner than later. Had we run our durability tester at 100 mmHg, the first failure may not have happened at 25 million cycles, but perhaps at 50 million or more. With cycles accumulating at about 1 million per day, plus the occasional down time for inspection, it is likely that the first failure would have occurred at 2 months, rather than at one month. The second failure would have occurred 130 or 150 days later - that is 5 months! So by pushing the valves harder, we were able to induce valve failure sooner. We have thus given ourselves the opportunity to correct potential defects faster. What we did not expect is that after two design iterations, our valves would actually survive the full 200 million cycles at double the closing pressure. But they clearly did. We have thus achieved a very high level of confidence in our design.

More importantly, our valves did not only pass the 200 million cycles at 200 mmHg closing pressure, they passed with flying colors! From the image at right, you can see that at the critical commissural region where the tissue has the greatest amount of tensile load and flexural deformation, the tissue is absolutely clean. There are no surface defects, no delamination, no structural degeneration whatsoever.

Why? Strict adherence to good valve design principles. Besides our previously stated adherence to the "Three Tenets of Good Valve Design" - (i) flexible stent posts, (ii) precise control of central gap, and (iii) absolute 120° degree symmetry, there are also other, more subtle, but equally important design features that we have implemented to assure a high quality, high durability valve.

Perhaps the most important of these is the quality of the pericardium used in the bioprosthesis. In the early days of our product development cycles, we used thinner tissue that was obtained from a transcatheter valve

manufacturer - that tissue failed after 25 million cycles. The second tissue was thicker, but again, was obtained from a "*third party*". It was obtained from a different supplier that fabricated tissue using a proprietary fixation system whose details were unknown to us. That tissue lasted 65 million cycles. That tissue also had multiple areas of leaflet delamination and mechanical disruption (see image below).



After this dismal experience with commercially available pericardial tissue, we set out to develop our own in-house tissue fixation system. Our approach implements (i) a controlled stress environment during fixation and (ii) mechanical and microstructural matching of the leaflet tissue for each valve. Indeed, we are very particular about what tissue goes into our clinical grade valves. We currently select only small region of space within an entire pericardial sac and we then match three identical pieces of tissue - often from three different sacs - to make a single valve. This is the level of sophistication to which we have gone to make the best valve possible, and this is why our valves have now lasted 200 million cycles at 200 mmHg closing pressure.

Reality Check

The PARTNER Cohort A gets a B minus...

In the Cohort A component, high risk but still operable patients were randomized between conventional surgical aortic valve replacement (SAVR) and the transcatheter valve that was inserted either transfemorally or transapically. The objectives of this trial were to demonstrate "Non-inferiority" to the gold standard which is SAVR. In that sense, the end-points were met. In terms of one-year survival, patients receiving a transcatheter valve did equally well as those undergoing surgery. To flip it around - the same number of

End point	TAVI (%)	Surgery (%)
30-d mortality	3.4	6.5
1-y mortality	24.2	26.8

patients died at 1 year after TAVI as after SAVR. Twenty-five per cent, to be exact (see table right). On the down side, there were three times as many strokes in the TAVI group as there were during SAVR (see table below right).

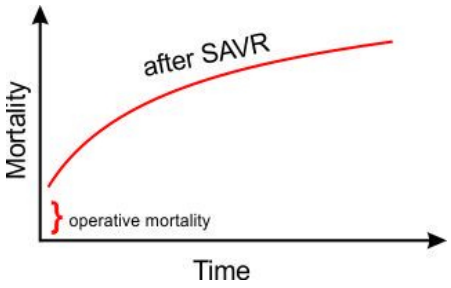
End point	TAVI (%)	Surgery (%)	p
Major stroke, 30 d	3.8	2.1	0.20
Major stroke, 1 y	5.1	2.4	0.07
All stroke or TIA, 30 d	5.5	2.4	0.04
All stroke or TIA, 1 y	8.3	4.3	0.04

And then the excuses began. "*Well yes, but that was with a large diameter catheter, the new ones are smaller and there will be less strokes with the new systems....."*

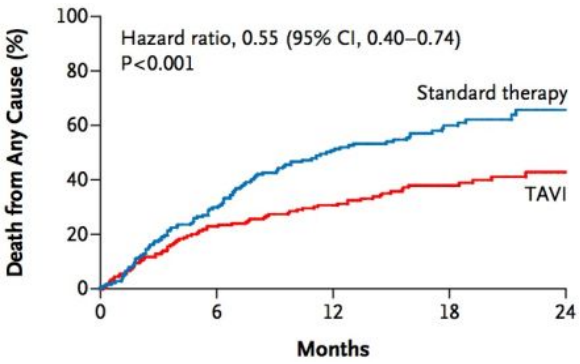
So better outcomes are expected for the future? Well, maybe. But lets examine the PARTNER Cohort A data a bit more closely.

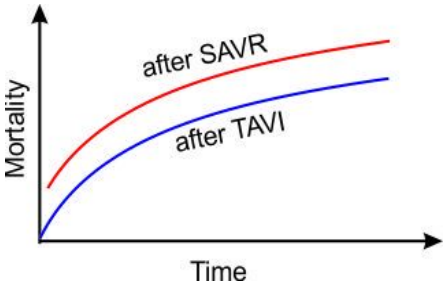
First of all, why the "*same number of deaths*" at one year between the two approaches? Isn't the whole point of TAVI the elimination of surgical mortality by avoiding the cardiopulmonary bypass, the trauma of cracking open the chest, the arrest of the heart, etc.? If TAVI eliminates operative mortality, shouldn't TAVI actually be better than SAVR? Lets look at it graphically.

The perioperative and post-operative prognosis of these very sick patients is that they will slowly die of other complications. That fact can be represented by the curve at right. This curve shows that at the time of surgery, or shortly thereafter, a finite number of patients die from the trauma of surgery and its associated complications - this is what happens to High Risk Patients. Then as time goes on, some of these patients continue to die from their pre-existing comorbidities. That curve has a logarithmic, convex shape in the short term. Eventually, the curve bends upwards again as more patients die from other disease as they simply reach their end of life. In the short term, the shape of this curve is similar to what was shown in the Cohort B data previously (see image right). Again, note that there should be some finite immediate mortality during SAVR that is not present during the installation of a transcatheter valve. The red curve cannot cross the y-axis at zero. This upward shift of the red curve represents those patients who die during, or shortly after the procedure - they are High Risk patients and a small percentage of them do not make it out of the ICU. For example, Grossi reports a 7.8% mortality for SAVR on high-risk octogenarian patients.

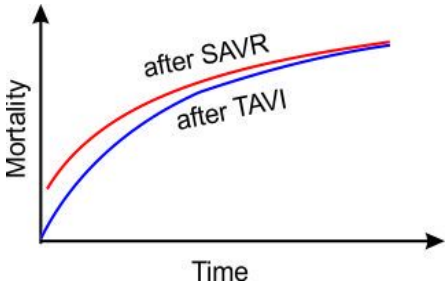


What TAVI is supposed to do is deliver a prosthetic valve non-surgically. As shown by PARTNER Cohort B, the presence of this new valve cures the disease immediately, and can be done with nearly zero operative mortality. For example, in the Cohort B data, Leon et al. report a procedural mortality of only 1.1% during the first 24 hours after TAVI (see image above). It is also reasonable to assume that shortly after the TAVI procedure, the initial functional quality of the transcatheter valve is very similar to that of a surgical valve. Post operatively, any given patient that receives a transcatheter valve should thus do equally well (or equally poorly, depending on their co-morbidities), regardless of whether they get a surgical valve or a transcatheter valve. The only difference between the two procedures should be the sparing of the surgical trauma, and presumably, the immediate operative mortality. The TAVI curve should thus be nearly identical to the SAVR curve, but shifted downward, eliminating the surgical mortality. This is shown on the curve at right.



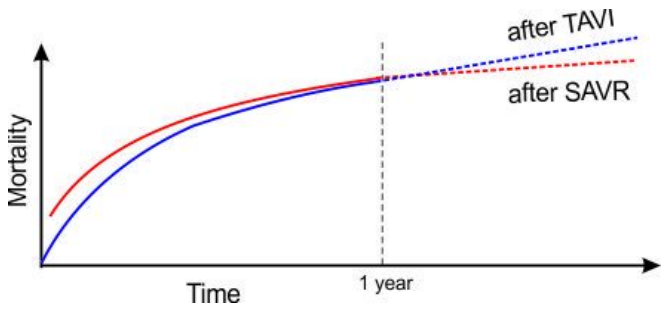


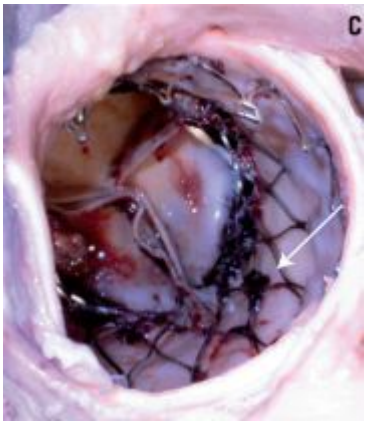
But this is not what happened. During the first few months of the study, the TAVI data caught up to the SAVR data, so that ultimately at the end of the 1-year period, the total mortality was nearly identical (see figure at right).



To me, this is profoundly disappointing. What these PARTNER A data suggest is that while 30-day mortality after TAVI was better than after SAVR (3.4% vs. 6.5%), the TAVI patients were actually dying at a faster rate over the subsequent 11 months until their death rate caught up to the SAVR patients. Why were these patients dying faster after TAVI? Why is the one-year death rate after TAVI not better than that for SAVR if you eliminate the operative mortality? These are clearly questions that will need to be answered in the coming years with additional analysis or subsequent trials.

What concerns me more, however, is whether the long-term death rate after TAVI is actually greater than the long-term death rate after SAVR. Does the one-year death rate predict the death rate over the subsequent years? Does the curve beyond one year actually look like that shown above?





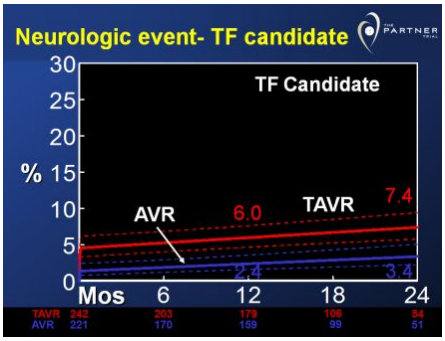
There are, in fact, a good number of reasons why the death rate after TAVI may very well continue to be greater than that after SAVR. For one, the device itself may be the source of persistent, low grade thromboembolism. Having lived with TAVI for over 5 years, we now know that the metal struts of transcatheter valves do not always fully grow over with fibrotic tissue. Histopathological reports have shown evidence of thrombus on explanted CoreValve devices (image left). Perhaps these non-cloth covered metal components continue to shed thrombi and patients thus have a greater cumulative rate of death due to strokes. Long-term follow-up studies should be able to shed some light on this.

Perhaps it is the presence of persistent low-grade perivalvular regurgitation that leads to long-term complications. Perhaps the perivalvular jets activate platelets and lead to increase rates of embolic events. Perhaps this persistent regurgitation prevents the ventricle from recovering completely and patients with transcatheter valves simply have less healthy hearts and die of ventricular failure faster than those with non-leaky valves. Indeed, moderate to severe perivalvular regurgitation was present in over 10% of patients in the Cohort B trial. These mechanism are all speculative, of course, but they are nevertheless important questions to ask. Are high-risk but operable patients truly better after TAVI?

In terms of one-year mortality, they are clearly not any worse off. At one year, the same number of patients have lived, and those that have lived do not have a scar down the front of their chest. But those that have lived have had more strokes. Indeed, strokes are the single greatest complication of TAVI, and this is shown clearly by the Cohort A data (see table above). The stroke rates of TAVI are essentially double that of surgery. And again, this is where the excuses came in right after the data were revealed. The most common one is that *"delivery systems are getting smaller and that is expected to reduce the stroke rates significantly."* Perhaps not.

End point	TAVI (%)	Surgery (%)	p
Major stroke, 30 d	3.8	2.1	0.20
Major stroke, 1 y	5.1	2.4	0.07
All stroke or TIA, 30 d	5.5	2.4	0.04
All stroke or TIA, 1 y	8.3	4.3	0.04

In the opening talk at the recent AATS conference, Dr. Craig Miller, one of the PARTNER investigators, presented the stroke data in more detail than was revealed at the ACC. Even though both the surgical and the transcatheter cohorts had a high atherosclerotic burden and were thus at ongoing risk for strokes after the procedure, the total number of strokes after TAVI was three times greater than that after SAVR. Moreover, Dr. Miller showed that while the risk of stroke after SAVR went down to baseline levels, the risk of stroke after TAVI continued at a significantly greater than baseline value for the duration of the study (see image below right). It would thus appear that strokes were not induced during the valve implant procedure alone, but continued to manifest in the transcatheter valve cohort over the life of the study. The risk of death after SAVR was thus reduced to baseline levels, while the risk of death after TAVI continued to be higher (see graphs below). This finding supports the notion that it is the valve, not the procedure that is the cause of the strokes. The excuses about smaller catheters causing less strokes in the future is thus not supported by the findings of PARTNER A - it is not only the catheter but also the valve.



The argument that smaller future devices will be safer is further refuted by recent data from [Dr. Bavaria's group from U. Penn, presented at the STSA 57th Annual Meeting in November 2010]. Over the course of the PARTNER trial, the group performed intraoperative neuromonitoring for embolic events using transcranial Doppler on 24 patients. These data show that the highest embolic exposure, in terms of HITS measured (High Intensity Transient Signals), occurs during guide wire placement and insertion of the device (see table below). If the valve is inserted transapically (TA) the number of HITS is less than ¼ of that which occurs when the valve is inserted transfemorally (TF). However, 1/3 of the embolic events occur when the wire is passed over the aortic arch into the ventricle. Smaller devices may reduce embolic events of the valve insertion phase, and will certainly reduce the vascular complications, but they are unlikely to reduce the emboli associated with passing the wire or ballooning the stenotic native valve.

	TA	TF	P
Age	81.8±7.4	85.9±6.3	0.197
STS score	11.8±3.6	12.7±4.3	0.659
Total HITS	547±312	718±472	0.366
HITS during:			
Guidewire insertion*	158±103	143±140	0.794
BAV	83±89	27±33	0.083
Device Insertion*	65±26	280±193	<.001
Device Deployed	61±49	90±70	0.314

*TA: Delivery of guidewire device through heart, AV. TF: Delivery through aortic arch, AV.

The earliest commentary on the PARTNER Cohort A data is available on the web at the following link. This report was the source for the stroke tables above. That web site also has an interesting interview of Dr. Craig Smith (Columbia University, NY), who presented the Cohort A data at the ACC conference. Dr. Smith, a supporter of these types of new technologies, makes the important comments that *"For patients who are near the high risk group, TAVI is a very good alternative, even in its current form".* He continues though, stating that what is still unclear is "*How far down the risk threshold we should continue to move and how fast*." He also comments that the observed to expected mortality ratio was 0.68, meaning that the surgeons involved in this study had outstanding outcomes. This implies that as we move down the risk scale, one needs to take into account that for both TAVI and for SAVR, it is the operator who makes good outcomes happen.

More to the point, SAVR - when done truly well - generates outcomes that rival those of TAVI. In a recent paper by Lawrence Cohn's group from Brigham and Women's Hospital, Harvard Medical School, minimally-invasive surgery on patients with STS scores of 11% had an operative mortality of 3% and a one-year mortality of 9%. Although this was not a randomized comparison between surgery and TAVI, it is interesting to note that the acceptance criteria for the PARTNER Cohort A was an STS score of at least 10% (similar to that of Cohn's group) but the TAVI one-year mortality was 24% - nowhere near the 9% of Dr. Cohn's group. As we move down the *"risk threshold",* TAVI is likely to lose out to SAVR.

One interesting outcome from the comparison of the PARTNER Cohort A data to the previously released Cohort B data, was the relative importance of stroke. Since the Cohort B data showed a huge improvement in mortality over medical therapy, one could argue that "*strokes are a small price to pay for the huge mortality gain".* Not so for the somewhat lower risk patients. Both Dr. Smith and Dr. Robert Bonow (Northwestern University, Chicago) pointed out that *"stroke is the thing his patients worry about most when considering going forward with valve treatment..... stroke is something these elderly patients fear more than death itself."*

Finally, Dr. Michael Mack (Medical City Dallas Hospital, TX) pointed out that both surgery and TAVI came out looking very good after the PARTNER trial. He also noted that even though the TAVI data from both Cohort B and Cohort A looked good, one should keep in mind that *"you still have a therapy in which between 25% to 35% of patients are dead at one year. So you have to ask, is that an appropriate use of expensive technology?"*

Closing:

The argument for TAVI is born out of the need to deliver less invasive procedures to patients. This is simply what they want. It is well known that patients would much rather opt for a less effective therapy if it avoids having their chest cracked open. Currently, that thirst for less invasive therapies appears to be satisfied by catheters and TAVI, even though when all things are combined, they may be less effective than conventional valve implantation surgery. Perhaps what patients really need is a new therapy; a coalescence of surgical and catheter based approaches; a new valve technology that allows less invasive delivery without sacrificing safety, efficacy and longevity....

We are working on that.

Sincerely,

Ivan Vesely, Ph.D.
Founder and Chief Scientific Officer
ValveXchange Inc.
ivesely@valveXchange.com

Recent News Releases

February 14, 2011. Denver - ValveXchange Inc. is pleased to announce that Mr. Kevin Morningstar has joined the VXi team as Senior Director, Regulatory Affairs and Quality Assurance. Read More.

January 17, 2011. Denver - ValveXchange Inc. is pleased to announce that Mr. Todd Campbell has joined the VXi team as Senior Executive Director of Product Development. Read More.

October, 2010. Denver - ValveXchange Inc. is pleased to announce that Blase Carabello, M.D., has joined the VXi Medical Advisory Board. Read More.

October, 2010. Denver - ValveXchange Inc. is pleased to announce that Bonnie Vivian has joined the VXi Board of Directors. Read More.

September, 2010. Denver - ValveXchange Inc. is pleased to announce that Carlos Ruiz, M.D., Ph.D., has joined the VXi Medical Advisory Board. Read More.

August 19, 2010. Denver - ValveXchange Inc. is pleased to announce the receipt of a $1.3 million Small Business Innovation Research (SBIR) grant from the National Institutes of Health (NIH) under the Fast Track program. The Fast Track program is reserved for highly innovative and competitive projects with a short time-line to commercialization. This is VXi's 5th NIH SBIR Grant.

June, 2010. Denver - ValveXchange Inc. is pleased to announce that Lars G. Svensson, MD, PhD, has joined the VXi Medical Advisory Board. Read More.

April 13, 2010. Minneapolis - Dr. Ivan Vesely, the founder of ValveXchange Inc., presented a review paper entitled "The Three Tenets of Good Valve Design: Where transcatheter Valves Fail", at the 2010 Design of Medical Devices conference in Minneapolis, Minnesota. Other noted invited speakers were Manny Villafona, the founder of St.Jude Medical, and Dr. Robert Levy, a pioneer in understanding prosthetic valve calcification. Dr. Vesely's presentation can be viewed here.

January, 2010. Denver - ValveXchange Inc. is pleased to announce that it has received a $250,000 grant from the State of Colorado under the Bioscience Discovery Evaluation Grant Program (BDEGP). Read More.