DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
FOOD AND DRUG ADMINISTRATION

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: DERMATOLOGIC DRUGS ADVISORY COMMITTEE :

: SUBCOMMITTEE ON LINDANE :

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Thursday, October 20, 1983

Conference Room L
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Baker, Hames & Burkes Reporting, Inc.
202 347-8865

P A R T I C I P A N T S

SUBCOMMITTEE MEMBERS PRESENT:

William Eaglstein	Subcommittee Chairperson
James Rasmussen, M.D.	Member

FDA REPRESENTATIVES:

David Bostwick
Edward Tabor, M.D.
C. Carnot Evans, M.D.

PUBLIC PARTICIPANTS:

Leslie Kenny	National Pediculosis Association
Debra Alstschuler	National Pediculosis Association
Dr. McIlreath	Reed and Carnrick

C O N T E N T S

P R O C E E D I N G S

(2:00 p.m.)

MR. BOSTWICK: Okay.

DR. EAGLSTEIN: We have suggestions from Dr. Arundell, Dr. Allen --

MR. BOSTWICK: Oh, Dr. Allen, good. That's great.

DR. EAGLSTEIN: -- Dr. Goldner and Dr. Haserick.

MR. BOSTWICK: Maybe the best thing to do is -- I don't know how feasible it is to do this, but maybe the best thing to do is just to go through their suggestions and I'll try to make a rough draft of what they suggest and maybe we can put it in some sort of order.

I guess probably what we are going to have to do with the committee tomorrow is present these alternatives and, you know, I kind of hope maybe we shake some of them down so we could have a more cohesive idea of what the sub-committee thought. But if Dr. Rasmussen isn't here, I don't know.

DR. EAGLSTEIN: Well, I've got them into three categories of suggestions.

MR. BOSTWICK: Okay.

DR. EAGLSTEIN: One category are suggestions that relate to -- well, actually, I've got four -- that relate to revisions of the label or revision of the label.

MR. BOSTWICK: Okay.

DR. EAGLSTEIN: And under that, one is "Remove pediculosis as an indication for the cream and lotion."

MR. BOSTWICK: For both the cream and lotion.

DR. EAGLSTEIN: I think that was --

MR. BOSTWICK: I think we already voted that.

DR. EAGLSTEIN: Okay. Two, contradict the use of the shampoo, cream and lotion for infants, pregnant women and lactating women.

Now, these are suggestions based on the four notes I received and my thoughts. There was, of course, information suggesting that maybe this isn't the right move. I am summarizing --

MR. BOSTWICK: Sure, I understand. I don't think we have to -- I don't think it is possible to make a decision here because we just don't have the kind of feedback we need, but at least it would give us a starting point. Do you have an idea of what you mean by infants? That was another thing we talked about last time. What constitutes the classification infants?

DR. EAGLSTEIN: I don't know what the people meant exactly. The new suggested labeling by Reed and Carnrick suggest that it be restricted in the case of prematures, premature. In other words, that's the new suggestion. From what I have received in writing, they would not agree to the idea that it should be restricted in infants, meaning

any young children.

MR. BOSTWICK: This is your correspondence?

DR. EAGLSTEIN: This is correspondence to the sub-committee, right.

MR. BOSTWICK: Okay, fine. Why don't we just say for infant, and I guess infants are going to have to be determined later. And pregnant women. What was the other category?

DR. EAGLSTEIN: Okay. Infants, pregnant women and lactating women.

MR. BOSTWICK: Okay.

DR. EAGLSTEIN: So, that is the second of the suggestions on the revision of the label.

The third would be to warn -- to place on the label a warning against using the shampoo in the bathtub or shower.

MR. BOSTWICK: The idea behind that is that they use it at the sink?

DR. EAGLSTEIN: Right. That would be more difficult for the pubic, but actually the instructions in the label are separate for the pubic and the head.

MR. BOSTWICK: Oh, I see.

DR. EAGLSTEIN: So, they could be--

MR. BOSTWICK: They could really just be using it for head lice?

DR. EAGLSTEIN: Against using the shampoo of the

scalp in the tub or a shower.

MR. BOSTWICK: Oh, I see.

DR. EAGLSTEIN: The idea is to avoid getting it on the other areas of the skin that don't need treatment, but do serve as areas for absorption.

MR. BOSTWICK: Okay, for head lice.

DR. TABOR: Can I ask a question. Do the contra-indications that you just mentioned for premature infants, pregnant women, lactating women only apply to the pediculosis indication?

DR. EAGLSTEIN: No.

DR. TABOR: For everything?

DR. EAGLSTEIN: Everything with Lindane. This is an extraction of the comments.

MR. BOSTWICK: This is sort of what you boiled down from the suggestions of the committee members?

DR. EAGLSTEIN: Right.

MR. BOSTWICK: Well, that is really one of the things I wanted to do anyway. We've already done that, and I guess were are ahead of the game. That's great.

DR. EAGLSTEIN: Four, would be to warn against unnecessary skin contact. That was the -- by implication in three, but this would be a general warning on the label somewhere.

MR. BOSTWICK: Okay.

DR. EAGLSTEIN: And five would be warn against using after a warm bath or shower.

MR. BOSTWICK: The label used to say you should do that, right?

DR. EAGLSTEIN: It used to say you should, and now the proposed label says -- it says not to -- it says to take a warm bath and then cool off. But I think it is probably better to say take a cool bath and then cool off.

MR. BOSTWICK: Is that in the dosage and administration where it says to take a warm bath?

DR. EAGLSTEIN: Let me check there.

MR. BOSTWICK: Oh, yes. With the scabies, it says, "If a warm bath to use, allow the skin to dry and cool for applying the cream."

DR. EAGLSTEIN: Right. And I actually had some suggested alternatives. I had said after a -- if crusted lesions are present, a cool bath preceding the medication is helpful.

MR. BOSTWICK: Okay.

DR. EAGLSTEIN: And then after the bath -- but this is going beyond the synopsis that I am presenting here.

MR. BOSTWICK: Okay. Well, let's see the synopsis first.

DR. EAGLSTEIN: Let's see, where are we. Five, warn against the bath.

MR. BOSTWICK: Right.

DR. EAGLSTEIN: Six, warn against using on open cuts and excoriations, which I think is in the proposed labeling except on the shampoo. It probably needs to be put there as well.

And there's Dr. Rasmussen.

MR. BOSTWICK: Oh, hello, Dr. Rasmussen. So glad to have you.

DR. EAGLSTEIN: And warn assistants to protect -- and this would be number seven. Warn assistant to protect themselves by wearing rubber gloves and other protective clothing.

MR. BOSTWICK: Assistants like mothers?

DR. EAGLSTEIN: Right.

MR. BOSTWICK: Okay.

By wearing rubber gloves.

DR. EAGLSTEIN: And I guess the general idea that they would be concerned about getting it on their skin.

MR. BOSTWICK: Okay.

DR. EAGLSTEIN: And then warn against using the shampoo cream and lotion prophylactically.

MR. BOSTWICK: Okay, right.

DR. EAGLSTEIN: I am reading my extraction of the thoughts sent to me by committee members, and, briefly, I had put them into four large groups and the first group is

revision of the label and we've already mentioned -- you'll know all these, Jim. Remove pediculosis as an indication for the cream and lotion and contraindicate the use of shampoo, cream and lotion for infants, pregnant women and lactating women. This is what many suggested, but the company has sent some information suggesting this not be done.

The third was to warn against using the shampoo in the bathtub or shower.

Fourth is warn against unnecessary skin contact.

Fifth is warn against using after a warm bath or shower.

Sixth is warn against using on open cuts and excoriations.

Seventh, warn assistants to protect themselves by wearing rubber glovers and other protective clothing.

Eight, warn against using the shampoo, cream and lotion prophilactically.

Nine, emphasize the need for combing out nits after shampooing.

MR. BOSTWICK: Right. Excuse me. Dr. Rasmussen, did you get of this thing that I sent out early last week? It is a memo from Dr. McIlreath?

DR. RASMUSSEN: Uh-huh.

MR. BOSTWICK: Okay. The necessity for combing out.

DR. EAGLSTEIN: To emphasize this in the label. Emphasize the need for combing out the nits after shampooing.

Ten would be, the direction should indicate that one ounce or less should be used for a treatment. I think this relates especially to the shampoo.

MR. BOSTWICK: Yes, I would think so.

DR. EAGLSTEIN: And, eleven, the pharmacist should be instructed not to refill more than once. I don't know if that is part of the revision of the label, or how that works.

MR. BOSTWICK: I don't know either. I would imagine that a refill is probably up to the physician.

Is Dr. McIlreath here?

DR. McILREATH: Yes.

MR. BOSTWICK: Does the label say anything about refills?

DR. McILREATH: No. I don't know how we handle that.

DR. EAGLSTEIN: Is it ordinary for labels to say anything about --

MR. BOSTWICK: No, it is not normal.

DR. McILREATH: Regulations.

DR. EAGLSTEIN: Well, I somehow stuck it there. That was one of the suggestions that one or more of the people who were on the committee and did send in suggestions.

So, my next big group would be containers.

MR. BOSTWICK: Okay, fine.

DR. EAGLSTEIN: People suggested the following: That the unit package dosing should be used for the shampoo. And it was furthermore suggested that there should only be one ounce packages.

MR. BOSTWICK: Okay. One ounce. That would take care of -- I don't know how it is used really. How would you write a prescription. If you only had one ounce unit dose; then, would you have to have three or four unit doses in a prescription? I don't know it would work.

DR. EAGLSTEIN: I guess so.

As it now stands, what are they? There's one that's a two ounce and --

DR. McILREATH: Two ounce.

DR. EAGLSTEIN: -- then there's a big one.

DR. McILREATH: Sixteen ounce.

DR. EAGLSTEIN: Well, that was the suggestion. Now, it's a two ounce and what else, a 16 ounce.

DR. McILREATH: Sixteen ounce.

DR. EAGLSTEIN: I think people were quite concerned in the last meeting, it seemed apparent to me, and I guess that's the basis for this that by having 16 ounce containers around, you led to abuse more easily, or misuse?

DR. McILREATH: Well, the 16 is just for the pharmacists, and he wants that because it takes up less space. It's more economical to buy it that way.

MR. BOSTWICK: The consumer never gets hold of the 16 ounce?

DR. McILREATH: If they do, I'd be surprised. I suppose anything is possible.

MR. BOSTWICK: It's possible.

DR. McILREATH: But it was never meant for that.

DR. EAGLSTEIN: Somebody told a story, and it's a story about going to a nursing home -- to a children's home and they found a big bottle.

Was that you?

MS. ALTSCHULER: No.

DR. EAGLSTEIN: Somebody did it.

MS. ALTSCHULER: When I did it, by the third time, they asked me how much I would like? I told them as much as you'll give me.

MR. BOSTWICK: Do you have these ladies' names here?

THE REPORTER: Yes.

DR. EAGLSTEIN: I would say that that's the sort of context out of which this suggestion comes.

DR. McILREATH: We found -- we've done a lot of studies --

MR. BOSTWICK: Maybe you might as well have a seat here, Mr. McIlreath, you probably are going to be in this a lot.

DR. McILREATH: We have done a lot of studies with

new pediculicides and when this suggestion came up in June, we went back and looked at and we found that with children listed as having short hair, the amount of material was slightly less than one ounce. Medium hair was between one and two ounces. And very long hair, we found that it took about two ounces, or perhaps a little more.

So, it could be that if you went to a one ounce, you might not have enough for children with long hair, or anybody with long hair.

DR. EAGLSTEIN: Is that the basis for reaching the two ounce?

DR. McILREATH: No, the two ounce as many, many, many years ago.

DR. EAGLSTEIN: Well, that was one of the other suggestions and actually -- May I ask you, it kind of fits at this point. You are supposed to put it on dry. What happens if you put it on wet?

DR. McILREATH: If you put it on wet -- the Lindane is not very soluble in water and if you add it to water it precipitates out, and it also dilutes it. And we have evidence, laboratory basis; that is, the dilution goes down below 1 percent. The pediculicidal activity drops off also. And when you get down around .3 percent, it drops off precipitously. So, if you put it on a wet hair, you run the risk of putting on a sublethal dose to the lice.

MR. BOSTWICK: Dr. Eaglstein, do you know Ms. Kenny and Ms. Altschuler. They are from --

DR. EAGLSTEIN: I think so. I met them at the last meeting.

MR. BOSTWICK: -- right. Well, we normally don't do things this way, but it seems to me to be the most constructive manner for everybody to sit around from both sides and sort of hammer out what is going on as far as Lindane, and I don't want to encourage everybody to get into a free for all, but if there is something you can help Dr. Eaglstein with, I wish you would feel free to call on him. We can maybe get all of the viewpoints out that way.

MS. KENNY: We had a suggestion to Mr. McIlreath, I think it was probably early June, late May about almost a sliding scale dosage as a possible way to go on this. We are suggesting a certain amount for short hair, or very young children with not much hair.

DR. EAGLSTEIN: You mean as a label? As an instruction?

MS. KENNY: As instructions. A certain amount for medium and a certain amount for long.

DR. McILREATH: I had forgotten where that came back and it was a meeting we had together and it was after that that we went back and looked at all these case report forms and found that when people have written in to us since

then, we have recommended that when people wanted to know how much to use. And I think in revised directions for use, we would certainly consider that.

MS. KENNY: Maybe we could just standardize that on the package if that would be possible.

DR. EAGLSTEIN: So, in that case, it would be a revision of instructions on the label --

MS. KENNY: Uh-huh.

DR. EAGLSTEIN: -- in the directions.

MS. KENNY: Rather on the container or container --

DR. McILREATH: Yes. It should be something that goes to the user.

MR. BOSTWICK: Well, why don't I enter that here under these labeling revisions.

DR. EAGLSTEIN: All right.

MR. BOSTWICK: This is something we can consider anyway.

DR. EAGLSTEIN: This label that we're discussing is the package label to the pharmacists and physicians. It is not a patient label?

MR. BOSTWICK: Right.

DR. McILREATH: That's right. This label is the package insert that goes with it by regulation.

MS. KENNY: So, it would be a consumer.

DR. EAGLSTEIN: No.

DR. McILREATH: What we are talking about now would

have to be in a direction for use or a patient package insert, something of that sort.

DR. EAGLSTEIN: But this label that we are discussing right now is the -- it could be the --

MR. BOSTWICK: Physician label.

DR. EAGLSTEIN: -- it could be either.

DR. McILREATH: Yes, that's right.

DR. EAGLSTEIN: But a physician/pharmacist package insert, not a mandatory patient label.

DR. McILREATH: There is not a mandatory patient label. There is directions for use. There are directions for use that are attached to this, and depending on the size of the container the pharmacist gets, he has one direction for use or 16 directions for use.

DR. EAGLSTEIN: Okay.

DR. McILREATH: That is no guarantee that the patient gets that.

DR. EAGLSTEIN: Right. So, back to continue this. There was the idea of the unit packaging and furthermore the one ounce.

Second, would be that the container be child proof.

DR. McILREATH: We will be submitting -- I told you we were doing stability studies and we will submit a supplement to the NDA tomorrow morning on the safety closure.

DR. EAGLSTEIN: And, third, the container should

have non-removable labels indicating that the contents are poison. To be kept out of the reach of children, not to be reused and to be discarded in a safe place.

MR. BOSTWICK: Okay. Indicating that it contains a poison. That it is kept out of the reach of children.

MS. KENNY: And also non-removable.

MR. BOSTWICK: Okay.

DR. EAGLSTEIN: And discarded in a safe place.

Fourth, the pharmacist should not place a label over these warnings.

MR. BOSTWICK: How does that work.

DR. EAGLSTEIN: It's a little like the one, the pharmacist shouldn't refill it more than once.

MR. BOSTWICK: Oh, okay. Don't blot out the warning. There's nothing wrong with that one.

DR. EAGLSTEIN: I did this in the middle of the summer --

MR. BOSTWICK: Are we through with containers now?

DR. EAGLSTEIN: Yes.

MR. BOSTWICK: Okay.

DR. EAGLSTEIN: And I think actually the other big category -- I said there were four, but there are really three. I had developed it as four because I was going, at one time, to go ahead and make try to implement the suggestions on the label, which I did do on some of the other information.

But the other people suggested the following, and I called it under additional studies.

They asked that the sponsor be encouraged to, one, gather follow-up information on the people who have had convulsions. Who were known to have had convulsions, I guess.

And that the sponsor sponsor -- that the sponsor sponsor more sensitive studies of neurotoxicity in humans then have been performed in the past.

I remember Dr. Allen asked you if you had done EKGs on people, any electroencephalograms. And I think several of the articles that are quoted widely did point out that there have not been sensitive studies for possible effects, neurologic effects short of gross things like seizures or irritability, I guess.

So, that really is my summary of the comments I received and I guess that is entered in this record.

MR. BOSTWICK: Right. Probably what I should do is I should get a copy of that for Dr. Rasmussen and maybe we could enter into whether he is in agreement that all these suggestions are pertinent, or whether he has anything to add.

I thought I would go get you a copy of that and then maybe we could -- do we have --

There he is, this is Dr. Evans, who I presume everyone knows.

Dr. McIlreath is filling your space, but you can

sit here anyway.

I don't know, do you think that is worthwhile? Do you think we should just enter into what we've got now, or do you want to go into more specific discussions on the labeling rather than these general discussions? Or do you think we would rather now discuss this first list of suggestions that the committee gave us.

DR. EAGLSTEIN: My impression of what the committee -- how the committee works is that it would be better if we do this now.

MR. BOSTWICK: I think so too. I think it would be, from my point of view, and I don't know what Dr. Evans feels or Dr. Tabor, if we could minimize the amount of material we have to present to the committee. I don't want to throw anything useful out. But I don't want to generate a big mass of material and throw it at them at 1:30 tomorrow afternoon and say, well, here, what are we going to do with all this. I don't know if any of this is -- if it's possible to throw any of this down, or maybe it is a better idea to try to make specific labeling recommendations in general. I don't have a clue as to what the best -- I'm looking for the most efficient method of presenting this material to the committee tomorrow and I don't know in the short run what the best thing to do is. Whether we should try to get specific now, or just try and get rid of the more general suggestions.

What do you suggest?

DR. EAGLSTEIN: I would suggest that we let Dr. Rasmussen look at these and see which of these he agrees with, and actually I'd comment as well that I might not agree altogether in some of these.

MR. BOSTWICK: Right. I want to --

DR. EAGLSTEIN: And once we have agreed on these principal -- calling these principals, I think certain revisions will follow rather naturally and we can do that today.

MR. BOSTWICK: -- that is what I would like to do.

Give me a couple of minutes, and I'll get five copies of this so everybody knows what we are talking about.

DR. EAGLSTEIN: I think the most critical one is this one about the contraindications. Now, the suggestion is to -- the suggestion I extracted from these comments and from the minutes was the idea that the label contraindicate the use of the shampoo cream and lotion for infants, pregnant women and lactating women. The sponsor agrees that we should contraindicate these for prematures, but does not agree on shampoo cream and lotion.

So, maybe we could --

MR. BOSTWICK: You could tackle that. I'll be right back.

DR. EAGLSTEIN: -- continue and tell us what you

think of that.

DR. RASMUSSEN: Well, I don't agree with that for a wide variety of reasons. Do you want me to lay it out, or how -- I don't know what the format is.

DR. EAGLSTEIN: I think you can lay them out.

DR. RASMUSSEN: Okay. One, I use Lindane on everybody with the exception of premature infants which practically it never occurs because head lice and scabies in children who are still in the nursery is almost nonexistent. I've certainly never seen a case of it. I do have a contraindication of children who have epilepsy. There are a few reports of people who have had seizures -- who have had baseline seizures and then had been treated and on several separate occasions have have had the same type of seizures they had before; so, that would be a consideration that I would put in there.

I use, except for those situations; that is, premature infants, which never occurs in my practice, or those who have convulsions from other causes. I use Lindane on everybody and I have all of my professional life and I have never seen a significant toxic reaction. I've seen dermatitis and things like. So, there would be two possible reasons for considering -- in my opinion, for considering eliminating its use. One would be because there is a safer alternative, and two would be because of the inherent toxicity of the drug itself. And taking the second one first, the inherent toxicity

of the drug itself, there is no doubt in my mind that Lindane can cause convulsions, but it almost always occurs in the presence of ingestion or misuse of the drug. There are two examples of patients who have had what sounded like legitimate convulsions, but if you look at the use experience of the drug in terms of millions -- literally millions, it's been estimated that there have been between 20 and 40 million people who have used Lindane for head lice, pubic lice, scabies, and probably for diseases that aren't responsive to it on the basis of this diagnosis like exzema and psoriasis, and things like that. And out of those, there are probably fewer than four or five people who had convulsions and have not had abuse or ingestion. So, I think that's a fairly reasonable safety record.

It would be very difficult for any of us to name another drug that had been used millions and millions and millions of times and have had fewer side effects.

Now, there is no question that convulsion is a very serious side effect; however, the literature that I have seen both published and unpublished and follow-up on people who have had convulsions have not indicated any permanent neurological sequalae, but I'll be very candid and admit that there have not been very satisfactory studies. Nobody has gone back and done intelligent IQ testing and EEGs, and that type of stuff.

To my knowledge, there has only been one death, as far as I know. I can't say that for sure, but I think that

that was after an ingestion. There has never been a reported fetal abnormality following the use of Lindane for any indication that somebody was pregnant -- at least to my knowledge there hasn't been -- nor has there ever been a reported abortion, spontaneous abortion after the drug has been used. So, I think you have a very reasonable record of safety, an extremely small record of toxic abnormalities in spite of very substantial use.

Now, the other side of the coin is, let's take some -- let's make some restrictions because Lindane -- because there are safer alternatives, and I would just put the ball back in the court of people who say that there are safer alternatives by saying that none of these other agents, of which there are only three, crotamiton, which is sold as Eurax, pyrethrins, and piperonyl butoxide, which are sold under brand names like A-200 and Rid, and probably many others, and malathion, .5 percent malathion, which is a new addition in the U.S. anyway, which is sold as Prioderm. Those are the only three that you can actually buy that are marketed. You can make concoctions out of sulfur and benzyl benzoate; so, if you just take those three marketed or maybe five total drugs that have been used far less extensively, I mean, like 1/20th to 1/50th or 1/100th the use and there have been certainly side effects reported with those other agents. For people who think that pyrethrins are harmless, many of them are marketed in vehicles

which contain petroleum distillates; that is, kerosene, for example or other light oils and those things have some potential as carcinogenic agents which is the same problem as people consider are the same group of -- people consider Lindane as a possible carcinogen. Certainly, they all can be irritating. Kwell, Lindane -- I mean, pyrethrins containing products, malathion, and so on and so forth. They can all irritate it, get placed on mucous membranes. So, it doesn't seem to make any sense to me to avoid a drug that is used extensively, has an extremely small toxicity and used as a substitute drug, which has been less well studied, and also in rare instances have been associated with toxicity.

Also, I should like to add that Lindane is sold over the counter in a very wide range of very well developed countries and some not so well developed. There are hard, good published reports of toxic experiences in those countries, with the exception of a vew few of them, and just to give you a couple of names, Australia, it's over the counter, Austria, Canada, Israel, many countries in Africa, many countries in South America, it's in Switzerland as an OTC, and I have written to practically every correspdonding FDA unit -- they are not FDAs, but whatever they call them -- and I haven't received many replies back, but the ones I have received indicated that there is a substantial number of patients who have been un-reported who have had convulsions following the use of Lindane.

In fact, there was a letter to the editor in the Journal of the American Academy of Dermatology by a Canadian by the name of Jack Poriez (phonetic) who stated that Lindane had been OTC in Canada for 20-some years and that he was not aware of a single toxic reaction and he gave some examples of people who had been using it every day for six months or a year, or something like that.

So, I am not at all impressed that Lindane is a toxin. And the the final thing, and I'll be quiet here. I speak all over the country on Lindane and somehow or other the story had gotten around that I am an Reed and Carnrick consultant. I would like to state it for the record and I would be glad to discuss it with anybody personal or privately, on or off the record, that I am not a Reed and Carnrick consultant. I have never received a thin dime from Reed and Carnrick. The only thing that I have ever done in association with them was to help put out a symposium on the treatment of scabies which was subsequently in QTUS (phonetic) and I have a large number of copies of these if anybody would like to see them and as the price for my doing this, I insisted that Reed and Carnrick publish a statement of my independence. I paid my own way down there and I paid for my own meals. I paid for my own cab and my own lodging and the the asterisk next to my name says that, "The editors express their appreciation to the University of Michigan

for their funding of Dr. Rasmussen's participation in the symposium. His participation is unrelated to the sale or manufacture of any product mentioned in this paper." And it also seen next to my name where the actual article comes out.

At the last meeting we had on this subject, it was stated and implied that I was a consultant to Reed and Carnrick, implying that my opinions were not arrived at independently and were not reasonable and independent. And I can assure that that is absolutely untrue and I would be glad to discuss it with anybody on or off the record.

DR. EAGLSTEIN: It's the independent part.

MS. KENNY: Can I just get back to the thing about pregnant women for a second. If Reed and Carnrick is willing to say that there can be danger to premature infants and that they are willing to restrict the product voluntarily for use in premature infants, what infant can be considered more premature than the one who is in utero. And if we understand that Lindane does penetrate skin and enter the bloodstream; then we have to also believe that it passes to the fetus. And it just seems that any product with CNS altering possibilities is going to be -- have a negative effect on a developing fetus, particularly one that is in the process of developing a central nervous system. It just seems baseline common sense that a product like this, which is a poison, no matter how you cut it,

it's a lethal substance to some living forms. It is not going to have a good effect on the developing fetus, and I just think it has to be common sense that it is restricted in this way.

DR. EAGLSTEIN: So, before that is picked up upon, you're the record, aren't you, down there. Do you want a copy of Dr. Rasmussen's spoken statement. Would it be appropriate with the record?

THE REPORTER: No, it does not go with the record.

DR. EAGLSTEIN: Okay.

So, your point is that the pregnant women is having some penetration and the material gets to the -- in utero?

MS. KENNY: If Lindane enters her bloodstream; then, it enters that fetus' bloodstream as well.

DR. RASMUSSEN: I agree with you. It probably does.

MS. KENNY: So, how can you be against restricting it to pregnant women?

DR. EAGLSTEIN: Would you then want to restrict it for pregnant women?

DR. RASMUSSEN: If there were some animal toxicology that indicated that it had CNS effects, I would be very agreeable. I'm not categorically stating, and I don't believe that Lindane is non-toxic. If you can show me some laboratory data that suggests that it is CNX toxic in developing animals, I would certainly appreciate seeing that.

On the plane down here, I read about a 60 page

toxicology report which reviewed the studies that had been done. None of them --

DR. EAGLSTEIN: The way I think I hear it, why would you then be restricting it to prematures?

MS. KENNY: To prematures.

DR. RASMUSSEN: Well, the basis for prematurity is really almost an anecdotal type of situation. It is basically concerns one single report which was published by Ron Hanson in the Archives of Dermatology about three or four years ago in which a premature child with multiple other medical problems, pneumonia, failure to cry, weight loss developed scabies and was treated with Urex for one to two days. Did not respond. Was treated with Lindane one and had what was sort of vaguely described as a convulsion and the blood levels were much higher than would be expected in a term infant, the idea being that it can clearly show that the skin of premature infants is more permeable than adults although that permeability comes very close to adult level, if not higher, within about two to four weeks after birth, the degree of prematurity. So, that is the basis for that statement as far as I know.

DR. EAGLSTEIN: In one of Kligman's paper, it has been quoted he, I think,alleged that part of the French experience with those children that had the problem was that part of their problem was that they all -- they, too, were prematures and it was the powder on the diaper areas; so, I

guess there are more than just -- I'm saying that there are several of these experiences with the premature, right?

DR. McILREATH: Yes. I think what Dr. Rasmussen has said is true. In the first few weeks after they are born, premature infants do not have the dermal protection that normal children do. And there were a couple of other people, Kligman for one, that says that in a normal term infant, the skin barrier is the best it is ever going to be in life, and we would agree that a theoretical basis for caution is probably worthwhile. But I would also agree that it is very, very rare that it would be used on a premature infant.

DR. EAGLSTEIN: I think what we are focusing on here in the pregnant woman who is passing via blood to the premature infant.

DR. McILREATH: If you look at all of the animal studies that have been, there is really no good evidence that it is a fetotoxic and there is now, I learned today, a new study, three generation reproduction study that was reviewed by EPA with no evidence of any reproductive toxicity. There's no good evidence that says it is reproductive. We've never seen any. The amount that would be absorbed is going to be quite small.

DR. EAGLSTEIN: Reproductive meaning birth defects?

DR. McILREATH: Birth defects mainly.

DR. EAGLSTEIN: Is that what you had in mind. I mean seizures may not --

MS. KENNY: Seizures may not follow. And gross birth defects may not be evident either, but there may in fact be damage that's rather refined in nature and shows up later. I just don't think with studies or no studies. I mean, if we talk about pregnant women not taking aspirin, perhaps not drinking coffee, if these things are all affecting; then, it it is really hard to be able to justify letting a toxic substance enter. I know you are going to come back and say it is not a toxic substance --

DR. RASMUSSEN: No, no, I agree --

MS. KENNY: -- entering the bloodstream of the fetus.

DR. RASMUSSEN: -- I agree with your position. I think that you -- if you take the idea that no -- absolutely no drug other than food and water are things that a pregnant lady should take, I would agree with that. The problem is if you put that label on Lindane, then you can bring up the same problem about every other drug that you use for scabies. What would you do for a pregnant lady with scabies? What do you give them? Because anything is going to be absorbed. Any thing that you put on that is an effective scabicide is going to be absorbed. And we don't have any good data for any of these products so then you are left with the dilemma of what is there to do? And I don't know the answer to that.

MS. ALTSCHULER: But you don't justify using it for lice because of scabies. I mean, you may want to relabel

it specifically for scabies, but what seems to be happening to me here is that we are back to the original meeting that took place back in June of just a general discussion of the evils, or the non-evils of Lindane when in fact, we felt that the meeting ended last time with an understanding that when you discuss reported patients and used properly, and all that, that at least our testimony and the textbooks available to physicians and the consumer books made it quite clear that there was no way for people to get accurate information. So rather than to justify necessarily what should or should not be something that -- well, what I am trying to say is that we've got to give the people that use this product every benefit to make an informed decision. So, maybe it is true that you won't be able to document with reported cases X number of children born deformed, or whatever, as a result of having used Lindane, but certainly a pregnant woman should have an opportunity to know not to abuse it and how to use it properly.

DR. RASMUSSEN: Well, I agree 100 percent.

MS. ALTSCHULER: But getting back to that then, you probably wouldn't be as opposed to giving her that by having it on the labeling?

DR. RASMUSSEN: I think that your point should be applied to all things that are given to pregnant women if that is the way that you want to look at it. When I practice

dermatology, when I see women, I tell them, you know, this is a dilemma. That nobody really has a hard or fast answer. Nobody has done a long-term study with lots of adults and looked very sophisticatedly for Lindane or for any other.

MS. ALTSCHULER: But this is a unique kind of a problem because we're talking about in the case of lice, we're talking about epidemic numbers. We're talking about people responding in a panic. We are talking about physicians unknowingly giving out erroneous information and they are estimating 12 to 14 million Americans this year, last year had lice. Then it opens up the great possibility, knowing what we know already, for lots of abuse.

DR. EAGLSTEIN: Are you trying to say that Lindane should be contraindicated for pregnant women if they have head lice?

MS. KENNY: Yes.

MS. ALTSCHULER: I'm saying -- he's talking about scabies, you can't justify leaving it on carte blanche for everyone because it is the only thing that he feels may be will treat scabies. If there are alternatives for lice; then, perhaps it should be.

MS. KENNY: In other words, you did talk about separating creams and lotions and shampoos?

DR. EAGLSTEIN: Right. I understand. I think she is refining this point two --

MS. KENNY: Right.

DR. EAGLSTEIN: -- and saying, well, what about a proposal that would contraindicate the use of Lindane in the pregnant woman --

MS. ALTSCHULER: Since there do seem to be --

DR. EAGLSTEIN: -- if she's suffering in treating lice as compared to scabies.

DR. McILREATH: And in the case of scabietic person, you are putting material on the entire body. We know blood levels of this. In adults, they are very low. In children, they go up to around 30. In the case -- the same measurements have been made following the shampoo under slightly exaggerated conditions and we find that it is less than a tenth of the amount that this scabietic person absorbs -- is absorbed in the case of somebody exposed to the shampoo under exaggerated conditions. We feel that that by itself is reduced, the absorption.

MS. KENNY: I think one of the problems, certainly, with lice infestation is that because of some of the exaggerated claims of all the pediculicides, I mean, there is a definite cycle of self-reinfestation that happens with lice. And if the person who is treated once with the Lindane shampoo is going to end up being treated again if not a week later then -- it almost never happens that you don't have to re-treat and retreat a few times and may end up that the dose that the fetus gets and that the pregnant woman gets is greater

than the one time dose.

DR. EAGLSTEIN: Right. But what I think is being said is that the shampoo, if done properly, and that's one of the issues --

MS. KENNY: It's a big one.

DR. EAGLSTEIN: -- which isn't the sponsor's -- within the sponsor's ability to control perfectly.

MS. KENNY: Right.

DR. EAGLSTEIN: But anyway, even if it is used three or four times, but if it is used properly each time, it is one-tenth of what a treatment for scabies is.

MS. ALTSCHULER: We have just put out information to the population around our area to give parents a better shot at using Lindane properly and we wrote it up to state that -- we separated it out and said, "Lindane containing shampoos are not merely medicated shampoos, they are prescription pesticides and should be used carefully, but, more importantly, they should not be confused with Lindane creams and lotions which are used to control scabies." And by doing that, hopefully, we already get rid of the one major abuse, which is the mother who picks up the shampoo with the directions for the lotion and we hear about that time and time again. And also doesn't allow it to be used.

DR. EAGLSTEIN: Haven't you avoided the problem?

MS. ALTSCHULER: By alerting the parents, as well as

the pharmacists that shampoos, the shampoos alone are for the lice and that the creams and lotions are for the scabies and that they can't hand out directions for lotions to patients that they give shampoo to.

DR. EAGLSTEIN: Okay. So, that's within the area that we have generally agreed to.

MR. BOSTWICK: Right.

DR. EAGLSTEIN: The shampoo won't -- the cream and lotion won't be used for the lice.

MS. ALTSCHULER: All right. So, I got off on the thing for a moment, sorry.

DR. EAGLSTEIN: In the pregnant women, we're not so far apart. I think, anyway, there is a general agreement on the premature and, I gather, the epilepsy seems to be acceptable.

MR. BOSTWICK: I missed that part. The premature infants --

DR. EAGLSTEIN: And those who have had a seizure.

MR. BOSTWICK: -- all right. Okay.

DR. McILREATH: And those prone to seizures.

MR. BOSTWICK: Seizure disorders, okay.

DR. EAGLSTEIN: So, we were on the pregnant woman and saying that here child is premature and shouldn't be exposed. And the answer was, well, she's going to use something.

DR. EVANS: And this was in pediculosis, you're

talking about?

MS. KENNY: No. I think Dr. Rasmussen was talking about the scabies indiction which is more limiting as far as alternative treatments.

DR. RASMUSSEN: Either one, it wouldn't make any difference.

MS. KENNY: But the factors in the case of pediculosis there are less -- probably are things that we could agree would be less toxic as alternative treatment.

DR. EVANS: We did not agree that it might be prudent in the pregnant females even in pediculosis in might be prudent to use alternatives even though we may not know quite as much about it. The OTC products that we have on the market seem to be reasonably safe and it doesn't seem like a big thing -- I can't see where this is any large part of the market and it seems as though it may be just prudent to include that as one of those that shouldn't use it.

DR. McILREATH: But how do you know who is pregnant?

MS. KENNY: I think the people know.

DR. EVANS: They buy a pregnancy test. People who are obviously pregnant.

MS. KENNY: Obviously, there are a few weeks before you know that you are pregnant.

DR. McILREATH: It wouldn't be the responsibility --

MS. KENNY: It's not your responsibility. It just

says those who are pregnant and know it, should proceed this way if they wish to.

DR. EVANS: I think while we realize there's not a lot of information on any of the other products and we know what we know about Lindane, it seems prudent that even in pediculosis, it might be worthwhile to have that as one of the contraindications for its use during this period because I think that there is a consensus that it is effective and should be used later in the game and I think with these kind of small concessions, I think maybe we can make some progress for pediculosis and then see where we need to go for scabies.

DR. EVANS: Without trying to be on the side of the devil and against motherhood, there's nothing in the literature on 40 years approximately of usage that says that it has ever been a problem. Scientifically, the amount that is absorbed is miniscule. You can't quantitate it to a prematurely born because the fetus is not getting it through the skin as much as it is through circulation.

MS. KENNY: But my guess is that when you talk about a premature's thing -- I mean, you're not talking about the skin so much as to what penetrates the skin and enters the bloodstream and therefore the body's tissues. I mean, if it enters right directly through the bloodstream via the mother's bloodstream, I mean, you're just to the same place. You've just excluded the skin passage.

DR. McILREATH: Except that what it is getting from the mother is far less than it would get if you applied it to the skin.

MS. ALTSCHULER: I would probably agree with you if used as directed, but that goes back to the other point. We are assuming that nobody is using --

DR. McILREATH: Well, you can't guarantee that. You know, I can tell you the number of convulsions or the number of deaths with aspirin or with many over the counter drugs and my only is that we not -- we do this on the basis of logic rather than emotion.

MS. ALTSCHULER: Well, it is factual that people don't know how to use this; so, we have to assume that they are going to abuse it.

DR. EAGLSTEIN: I think we are getting to the abuse by the proposals for changing the label and presumably the idea is going to be put forth that there be an insert to the patient, although I don't know --

DR. RASMUSSEN: If you put that on the label, as a physician, what choice does that leave me, because obviously you've said that I shouldn't use that drug and yet -- so that means that I have to use something else. Now, I feel very comfortable with Lindane. I have read piles of epidemiology, toxicology and have extensive clinical experience with it. Where is my next step going to be. If you say I can't use

this, you leave me with three other choices about which probably 1/10th to 1/50th is known. So, how do I manage that dilemma. What do I do with a pregnant woman who comes to me who says, you know, I don't want to use this drug because I just read this. So, now what do I do?

MS. ALTSCHULER: Well, I would suggest, first of all, simply combing with an adequate combing tool. And, second to that, in the case of a real problem, I would suggest a pyrethrin product.

DR. RASMUSSEN: But suppose with combing, the pyrethrins don't work?

MS. ALTSCHULER: There is not any product on the market that we know of right now that works 100 percent anyway because none of them are totally ovicidal. So, you've got to figure without combing, you are going to have to re-treat no matter what. Bit even mentioning the reinfestation from the environment.

DR. RASMUSSEN: But suppose the pregnant lady then says, my husband happens to be toxicologist --

(Laughter.)

DR. RASMUSSEN: -- just a moment now. Pyrethrins are in petroleum distillates --

MS. KENNY: I think only one of them is.

DR. RASMUSSEN: -- no, they both are. If you read the label. One of them says kerosene and the other one says petroleum distillates.

MS. ALTSCHULER: Okay, go ahead.

DR. RASMUSSEN: Now, petroleum distillates doesn't mean gasoline. It is something refined. One of them is very similar to mineral oil. Now, both of those agents are either known or very highly suspected carcinogens. Both of them are known to be toxic if taken in excessive amounts. Where do you get safety from something like that?

MS. ALTSCHULER: I'm not sure I understand your question.

DR. RASMUSSEN: In other words, Rid and A-200 are -- as a constituent intervehicle they have petroleum distillates. One of them specifically says kerosene, the other one says petroleum distillates. And when you actually check, it is a very light oil very similar to a machine oil, or mineral oil, or something like that.

Now, both of those agents -- I don't have the reference, but I'm sure I can dig it up -- I've dug it up for kerosene -- has been suspected or at least in animal models shown far more carcinogenicity than any of these other stuff that we've got in Lindane. What do you do in that situation?

MS. KENNY: I think that kerosene vehicle is being discontinued by that company for starters. That product wouldn't necessarily be my recommendation anyway. I believe Dr. McIlreath's company makes another over the counter product which is based in a shampoo base as opposed to any of these

others. So, I mean, it's not that the alternatives aren't available. There are alternatives available. I think the other product that his company makes is a fine and safe product.

MS. ALTSCHULER: But in answer to your question, the -- it's the lesser of the evils. We view all the pediculicides as pesticides. I mean, we would choose not to use any of them on ourselves or our children; so, you have a certain educated shot at using the least potentially toxic.

DR. RASMUSSEN: Where do you get the basis for saying that that's the least potentially toxic?

MS. ALTSCHULER: Just from the literature. When you look at the contraindications and the side effects in the studies, it just appears that the only major contraindications right now available for pyrethrins is a potential allergy to ragweed, or something like that, or, of course, putting it in, you know, a child's eyes or ingesting it are the same thing for any kind of a chemical substance. But the contraindications and the studies and the letters and the documentations for abusive use of Lindane are there, you know.

DR. RASMUSSEN: Show me a case where somebody has had an abortion?

MS. KENNY: We obviously can't --

MS. ALTSCHULER: No. I hope that it never does.

DR. RASMUSSEN: You said that your documents supported your position.

MS. ALTSCHULER: I have them.

DR. RASMUSSEN: You have letters of abortions?

MS. ALTSCHULER: No, no, no. I didn't know we were back to abortions.

DR. RASMUSSEN: We were just talking about safety and pregnancy.

MS. ALTSCHULER: Okay.

DR. RASMUSSEN: I am not aware of any. I've written the FDA. They sent me nothing. Reed and Carnrick have sent me nothing. There's nothing published in the medical literature, and yet we're considering taking this drug and --

MS. ALTSCHULER: But if we went out into the public right now and asked for public health official numbers on life infestation, we would probably come back with numbers that would say we have no problem when, in fact, we have a terrible problem.

DR. RASMUSSEN: Well, I agree we have lice. We have it all over the place.

DR. EAGLSTEIN: One thing. There is this article by, I guess, Ginsburg and in one of his articles he ends up something when -- I think it's pregnant -- use sulfur.

DR. McILREATH: That was his first article.

DR. EAGLSTEIN: And in this article, Pharmacology and Therapeutics in '83, there's an interesting statement. "Lastly, it seems likely, but not proven that percutaneous

absorption of drug following application of shampoo is not noted to children. Because of this and the putative teratogenic effects of the drug, it seems prudent that GBH in any form should be used with caution during pregnancy."

I never understood using cautious like if you put it on lightly.

(Laughtly.)

DR. EAGLSTEIN: What does putative teratogenic effects mean?

DR. McILREATH: I don't know. He wrote that completely on his own with no help or suggestions from us.

MS. KENNY: It just seems hard to talk to any toxicologist -- almost any toxicologist that we know of, or have met who doesn't say that the GBH is --

DR. EAGLSTEIN: Putative means generally accepted.

DR. TABOR: No, it doesn't.

DR. EAGLSTEIN: I think it does.

DR. McILREATH: It means that there's a possibility of.

DR. TABOR: It means alleged.

DR. EAGLSTEIN: But not necessarily --

DR. TABOR: Perhaps stronger than alleged.

DR. McILREATH: Just one brief comment on the use of the pyrethrins. Maliathion was considered -- or protamiton was considered as a safe alternative and now on the basis

of the amount that's been used, thre has been a case of convulsions with protamiton. Now, the incidence of that is the same or perhaps slightly greater than the incidence with Lindane.

It only took one convulsion compare to the amount of uses of that product.

MS. KENNY: I know that this committee and other people who are physicians and scientists are, you know, strongly rely on reports in the medical literature, but I think that for every one that's reported, which are few obviously, hundreds of incidents happen and are not documented and are not reported, and based on the reports that we get from phyicians, including Ron Hanson at the Health Science Center in Arizona, you know, he has written to us of several things that have happened in his case loads since the one report that he made on the premature. But I think that hundreds of incidents happen are not documentable or not reported, don't come back to -- don't get to Reed and Carnrick for validation and, you know, these things happen. And they may not reach the literature, but it doesn't mean that they don't happen.

DR. McILREATH: We are not saying that what we have constitutes everything, but the same applies to any other drug.

MS. KENNY: That's right.

DR. EAGLSTEIN: But it seems to me that you would

really prefer that Lindane not be around.

MS. ALTSCHULER: For use in pediculosis, right.

MS. KENNY: We can't say that about scabies. We are not prepared to say that about scabies.

MS. KENNY: The fact is, Dr. Eaglstein, we didn't really feel that way in June, but we feel that way now.

MS. ALTSCHULER: After the EPA banned it for the use on dogs, we had to say that.

DR. McILREATH: But they didn't ban it.

DR. EAGLSTEIN: What I'm saying is, the people, I think, who constitute this committee would probably agree with you that it is important to give people who use this proper information so that they can make judgments. But then if you take it away, you've made the judgment that they shouldn't have it. You've contraindicated it for use in --

MS. ALTSCHULER: Okay. I see what you're seeing.

DR. EAGLSTEIN: -- you don't give them the chance to make that choice. Now, you have made the choice. It's not form them to make. And to do that, I suspect the committee would want the sort of documents we're talking about.

MS. ALTSCHULER: Right.

DR. EAGLSTEIN: That is the way they are trained and that's the technique that is employed.

MS. ALTSCHULER: Unfortunately, we can't come up with those kind of documents and we wrote -- once, again, we wrote

up our piece, we took the step of referring pregnant women back to their obstetricians and let the obstetricians have the responsibility of helping them make their decision, but at least let the obstetricians have an educated shot at given them proper information. Right now, we have obstetricians in our area who tell mothers to shampoo on Monday and then on Tuesday and then --

DR. RASMUSSEN: That's a real problem because I read the Lindane literature extensively, and, to my knowledge, there is nothing, absolutely zero in that OB literature.

MS. ALTSCHULER: Well, obstetricians usually have a general across the board philosophy about women coming in to contact with any potential toxic anything. Of course, breathing the air these days probably doesn't --

DR. RASMUSSEN: But what I mean was that they don't really know -- if they are not kept up to date on developments and proper information, I see the same thing that you do, people -- obstetricians, you call them up some crazy drug that they've got their patient that I happen to know is a problem and they never heard of it.

MS. ALTSCHULER: But, see, we are talking about a public health epidemic right now, which when people say to us, how can we get so excited and upset and everything about lice when we have kidney disease, and this and that, and everything else. I mean, you know, it's apples and oranges.

You can't take everything and lump it into this right now because lice are an epidemic and they are also -- there's no protection in the environment against getting them again and again and again. And if it were a one-shot deal where the patient was cured and that was the end of it, it would be fine, but if you've got a mother with preschool children and who is pregnant, probably pregnant again and again and will probably have lice in her home six, eight times a year. So, it is a unique situation. It can't be lumped up, lumped in, whatever.

DR. EAGLSTEIN: Well, you have gotten rid -- if you want ot think of it that way -- the cream and the lotion are no longer indicated -- are not presumably going to be indicated for the lice.

DR. RASMUSSEN: Would it be reasonable to say that the safety or whatever, toxicity, or something has never been proven to be safe and put that in big -- great big letters so that people should strongly consider the possible potentials for whatever that this is used.

I could buy something like that because I am very concerned about it. I don't want to give people the impression that I just pass it out. I give people all kind of information on it and I tell them that nobody knows the answer. What is the right choice.

DR. EAGLSTEIN: So, you are saying for the shampoo

for the pregnant woman?

DR. RASMUSSEN: I think that would be a very reasonable statement to say and you could flash it or put it in as big as letters that you wanted it. That it's not -- certainly it is not shown to be effective -- I mean safe.

MR. BOSTWICK: It says -- it's got big letters. "Should be used with caution especially around infants, children and pregnant women."

MS. KENNY: Physicians get that, consumers do not.

MR. BOSTWICK: But nonetheless, the physician label now has a fairly emphatic warning concerning caution. It doesn't say not to use it, but caution.

DR. RASMUSSEN: But, see, caution is just what Bill said, what does that mean? Does it mean a thin coat, leave it on, or dab it on with gloves on.

MR. BOSTWICK: I agree.

DR. RASMUSSEN: It is a very legalistic type of term, but in medicine it doesn't mean any. It means your heart beats faster when you put it on.

(Laughter.)

MS. KENNY: Right. And the point is that it also doesn't reach the consumer now. People who are calling their pediatricians to get this information, how many pediatricians -- I can think of none of the hundreds of women we talk to -- whoever say to the women, are you pregnant when you put this

on your kid or use on yourself when you're pregnant. I mean, that just is not a question that they routinely ask and are not educated to ask.

DR. RASMUSSEN: It probably is not limited to pediatricians.

MS. KENNY: Well, usually they are the ones -- I would say in pediculosis, they are the ones who are writing the prescriptions with regard to pediculosis and not for scabies, more dermatologists perhaps. But pediatricans do not ask this question of the applier, the mother. They don't. And so the consumer has to know it at her --

DR. RASMUSSEN: Well, I would feel quite comfortable with something like that being given --

MS. KENNY: On the box?

DR. EAGLSTEIN: What I am trying to say is I think everybody would agree with you, and certainly I would, that education is our biggest problem.

MS. KENNY: Uh-huh.

DR. EAGLSTEIN: Now, that means education, let them make a choice based on reasonable information and this is a question of are you going to let them choose to use it if they are pregnant. I mean, you don't want to let them make that choice and Dr. Rasmussen and others will say, well, they are going to use something.

MS. KENNY: Well, you know, of course you can only

tell them. You can't police what people do, but if it says on the box, you know, this product might be dangerous to pregnant women, nursing women, I guess you can only hope that it has the effect that --

MS. ALTSCHULER: If he is asking for a commitment from us in terms of what -- I mean, our position right now has evolved over the summer in the course of our experience through the summer that we see no necessity to ever use Lindane for the treatment of lice period. So, we would have to say yes that we would choose to have it contraindicated for pregnant women. However, we would be far more grateful to have something there than as has been in the past, which is nothing.

DR. EAGLSTEIN: Well, it is there now.

MR. BOSTWICK: It is not contraindicated.

MS. ALTSCHULER: It says caution, but it doesn't necessarily give why and yet at the same time you've got up at the top of that the same thing applies to the fish and a mouse. You've got to kind of look at the whole picture and finish the form before you can --

DR. EAGLSTEIN: Okay.

MR. BOSTWICK: Be that as it may, the committee has already made it's opinion known that they feel it should be avaialble as a shampoo for pediculosis. And I don't think we're going to back up and start on that again.

MS. ALTSCHULER: Right.

MR. BOSTWICK: The question we have now is what we should do -- Dr. Eaglstein, and Mr. Rasmussen get to vote on this, or maybe they can't agree, but the question is: what shall we do about pregnant women and the use of Lindane in pediculosis especially.

As far as scabies goes, I don't know. I gather that is not as big a question.

DR. EVANS: I think we ought to decide them separately.

MR. BOSTWICK: Right.

DR. EVANS: The dialogue, I think, we are kind of mixing up the patient package insert with the indication for scabies and pediculosis --

MS. ALTSCHULER: It is not a simple matter.

DR. EVANS: -- no, no, but I think we ought to consider them one at a time. And it would seem as though we could start it off with pediculosis and the physicians' label should reasonably state for this indication. The committee already said that it should be used -- that only the shampoo should have this as an indication and the cream and ointment --lotion should not. So, that's a head start. Now, should the physician package insert, even for the shampoo, has certain contraindications or precautions. Now, if so, what should they be? Should there be warnings and precautions as there are to some degree now which address pregnancy and

premature infants and seizures?

MR. BOSTWICK: The draft label has a contraindication, the current draft label has a contraindication for premature infants and I am presuming that they would be greatly disturbed by the patients prone to seizure disorder.

DR. RASMUSSEN: I was just going to say when you use the term not be used for premature infants, you have the probability of confusing that with someone who was premature six years ago.

MR. BOSTWICK: Right.

DR. McILREATH: I think we said premature neonates.

MR. BOSTWICK: Oh, neonates, okay.

DR. RASMUSSEN: But a consumer isn't going to know what a neonate is.

MS. KENNY: Is the committee not going to address consumer package insert, or they are?

MR. BOSTWICK: Oh, yes, we will, but first we need to --

MS. KENNY: I didn't realize it was going to be one or the other, or both.

MR. BOSTWICK: I guess our problem is what do we do about contraindicating this product in pregnant women. Where do we have statement to the effect that pregnant women should use other devices or drugs or methods first.

DR. RASMUSSEN: If you do that, you imply that something else is safer.

MR. BOSTWICK: Right. That's exactly right.

DR. RASMUSSEN: And that is a tough thing to substantiate. It is even a difficult thing for me to feel. I only know that I feel comfortable with Lindane.

MR. BOSTWICK: I guess what we need to know is, do you and Dr. Eaglstein feel comfortable with recommending anything concerning this? Or do you just want to to throw it out to the committee and let them chew on it? I don't know. Concerning specific women specifically. It looks to me that all of us set a recommendation, but the big problem is women, pregnant women and lactating women for whatever reason. I would agree with Dr. Evans, it doesn't seem like a big part of the market, but there may be some other reason for psychologically not stating that point.

Is there anything that you and Dr. Eaglstein could agree on concerning pregnant women and Lindane? Do each of you have a feeling it should be?

DR. EAGLSTEIN: I think I could agree that they can use it as a shampoo.

MR. BOSTWICK: Use it as a shampoo.

DR. RASMUSSEN: With some sort of a warning that it shouldn't be repeated within a certain time period or a certain number of times per pregnancy or something so that you just don't have people doing what you suggested is re-treating it. There's no question that head lice just keep

ping-ponging around and they'll come back.

MS. KENNY: Can we talk about nursing infants for just a second. I mean, if we talk about ingestion --

MR. BOSTWICK: I want to do that, but first I want to be sure we're talking about pregnant women. We would allow it to be used with pregnant women, but we would want something in the labeling concerning reuse, correct?

MS. ALTSCHULER: Yes.

DR. RASMUSSEN: Yes.

MS. ALTSCHULER: But would you also agree that that would be included in the general instructions. I mean, nobody should reuse it or abuse it. It wouldn't necessarily have to be listed specifically for pregnant women, but for everyone.

DR. RASMUSSEN: I would agree with that, but I think if you are really concerned about pregnant or lactating women, that you ought to hit it again.

MS. ALTSCHULER: Say it again.

DR. RASMUSSEN: Or box it, or black letter or or stamp it someplace.

MS. ALTSCHULER: Okay.

MR. BOSTWICK: Now --

MS. KENNY: Well, what I was going to say is that ingestion of Lindane has seemed to be a problem and has been the factor that produced the most seizure problems. Then, even if it is a small amount, I mean, even if you have a small

amount of Lindane in the breast milk, which just about everything gets into breast milk, if you have a small amount of Lindane in the breast milk and you have a very tiny person ingesting that small amount, it still seems like its a negative for that tiny person. I just would like to say lactating women included in there.

DR. RASMUSSEN: But you are having a double dilution factor. You put a certain quantity on to a person, a half a cup of milk in a gallon of water and then take a half a cup out of that mixture and pour it into a pint of water, and you still have a further dilution factor.

DR. EAGLSTEIN: What are the -- I am very uninformed about this -- can't, in most case, lactating women -- can't their children be fed formula for a while while they are treating?

DR. RASMUSSEN: They can use a breat pump.

MS. ALTSCHULER: They could be. There will probably be a lot of women that that would further complicate and emotionalize the issue if they were put in that situation, but I think pregnant --

DR. TABOR: That is a very common procedure though in women who are on medication for short periods of time.

MS. ALTSCHULER: -- but lactating women should at least be informed that --

DR. EAGLSTEIN: I'm saying, that you could say not to

do it if you are lactating. If you are lactating, you should do something to feed your child another way during treatment with Lindane.

MS. KENNY: Well, I'd be happy enough if it said that because that --

MS. ALTSCHULER: Yes, right.

MS. KENNY: -- I think that would prevent the person from using it.

MS. ALTSCHULER: That would drive the point home.

DR. McILREATH: Our position on that, we have in our proposed labeling had said, lay it out to indicate that there have been many reports in people not exposed to Kwell products that have found Lindane in human milk as high as 113 ppb. The amount that they would get, we calculated under extreme circumstances is less than a tenth of a percent of what they'd get had you treated the child itself with Lindane. So, we feel that the amount of Lindane they are getting from the mother's milk is really going to be insignificant because we figure is the other is safe on the child directly, it is not going to get even a tenth of that, or less than a tenth of that, would not be effective. But we also suggest if someone is concerned that they use an alternate method of feeding for about three days.

MR. BOSTWICK: That is something that you would have to have in a patient labeling. The woman would have to have

that information available if she were to make that choice.

DR. McILREATH: I agree. I have no problems with that.

DR. RASMUSSEN: That would in de facto almost accomplish what you are trying to do because most women wouldn't be willing to put up with that since their kids wouldn't like the change in tast and they don't like the change in temperature.

MS. KENNY: Exactly. I think a woman who is nursing would rather treat herself different than stop nursing.

MS. ALTSCHULER: Right. If she understands that product gets into the milk. A lot of mothers just assume it is called a shampoo, it's a benign nothing, you know, fluffy Prell type product. If they finally understand that they are dealing with a pesticide that is going to pass into their milk; then, they will probably make an educated healthy choice to choose an alternative.

MR. BOSTWICK: Okay. Let me see if I've read this right. I think we've pruned the contraindications to premature neonates and those prone to seizure disorders and that pregnant women and lactating women are going to go under warnings rather than contraindications. Does that seem -- I mean, as far as what the subcommittee will recommend to the full committee? Doesn't that seem where we're headed?

DR. RASMUSSEN: I'm comfortable with that.

DR. EAGLSTEIN: Or exempting lactating women.

MR. BOSTWICK: So, are you contraindicating it for --

DR. EAGLSTEIN: In other words, this is not like the other case where something else is going to be done. The woman can really avoid giving the child Lindane.

MR. BOSTWICK: We could contraindicate in nursing. Those who are actively nursing.

DR. EAGLSTEIN: Nursing mothers, yes.

DR. RASMUSSEN: Well, it the nursing mother, however, had scabies, most people would try and treat the kid anyway, maybe not with Lindane, but with something because the usual philosophy is that everybody in the family living situation is treated whether they are symptomatic or not, at least, that's one that I certainly use.

DR. EAGLSTEIN: I think they generally spread it to everybody.

DR. RASMUSSEN: Yes. That is my specific suggestion is that if one family member -- I tell them to treat everybody in that living situation.

MS. KENNY: This is a six week asymptomatic and incubation type?

DR. RASMUSSEN: Yes.

DR. RASMUSSEN: It really wouldn't make any difference. I mean, if you did that then you would have to extend your limitations even further because finally the kid who is getting the breast milk would be extremely small compared to the

quantity that he would get if that medicine was actually placed on the kid's skin. So, there's the dilemma with that problem.

DR. McILREATH: But our calculations were based on total body exposure. So, if you decrease that by -- we're talking about the shampoo, you've diluted it another tenfold.

DR. RASMUSSEN: For practical purposes, I think most women would probably quit breast feeding about five or six months. Is that -- I'm not a pediatrician.

MS. ALTSCHULER: No.

MS. KENNY: I think that varies quite a lot in different parts of the country and economic status --

DR. RASMUSSEN: But as an average, it's about that, isn't it?

MS. KENNY: -- I don't know. I couldn't say.

MR. BOSTWICK: I think some women breast feed up to a year.

MS. KENNY: Or try two sometimes.

DR. EAGLSTEIN: What do you think is going to happen with a woman who is breast feeding and has scabies. Do you think she would stop breast feeding and treat herself and not treat the child?

MS. ALTSCHULER: She should just be given the information to do with as she pleases. Give her the best information you have.

DR. RASMUSSEN: If you decided to treat both the

mother and the little kid; then, you could theoretically point out that the kid might be getting an extra added dose from breast milk. In other words, you are going to put some on and you are also going to nurse. So, in that situation, you might consider using another agent for that segment of the population only, at least from my point of view, because it would dipping twice into the same bucket.

MS. ALTSCHULER: At least if it is on the labeling for the physician and the pharmacist, they are going to, I would hope, raise the issue with the patient when they describe it and hopefully choose an alternative at that point.

DR. EAGLSTEIN: But that is in proposed literature?

DR. McILREATH: Yes. Alternative method.

MR. BOSTWICK: What is this? What are we talking about?

DR. EAGLSTEIN: That the physician and pharmacist who read this are informed of the possibility of using alternative methods or that they are aware of the fact that the mother's milk --

MR. BOSTWICK: Oh, I see. I find the information concerning the mother's milk under pregnancy and nursing mothers. And if that is satisfactory to everyone, what I was wondering was whether we should have a separate statement concerning lactating women in the warning section or are we satisfied with the information that's in here?

The information concerning this and others is quite well laid out under the nursing mothers subsection on page 3. My question is: given the fact that we -- I take it that we are no longer going to recommend that it be contraindicated in nursing mothers. Is there any reason to think that there should be something special in the warning section concerning nursing mothers, or are you satisfied with the labeling the way it now -- the draft of the way it now reads.

MS. ALTSCHULER: Could you read that?

MR. BOSTWICK: Under nursing mothers, not any warnings or contraindications, but under a group of things called precautions.

MS. ALTSCHULER: Thank you. I've got it now.

MR. BOSTWICK: Okay. It says, "Lindane is secreted in human milk and low concentrations"-- we've had quite a useful discussion -- "levels of Lindane found in human milk ranging from zero to 113 ppb.

Is there any reason for any of that information to be in the warning section or do both of you gentlemen that there is sufficient information concerning nursing mothers?

DR. McILREATH: In the package insert?

MR. BOSTWICK: We are only talking about the physician label now.

DR. McILREATH: Okay.

MR. BOSTWICK: I don't have any feeling one way or

the other. I just want to know whether Dr. Eaglstein got from the other members of the committee the feeling that we might want to contraindicate in lactating mothers. I think we decided that that isn't necessary.

Do you want to move it down once to a warning, or are you just leave it the way it is proposed now?

MS. ALTSCHULER: This sure dilutes the whole message.

DR. McILREATH: Regulations say that that's where it goes.

MR. BOSTWICK: It has to be there. That has to be part of the label. The question is, whether something else needs to be put in the warning section.

DR. EAGLSTEIN: Do you mean dilutes that there is putting it here dilutes it, or there's too much --

MS. ALTSCHULER: There is too much information there. I mean, by the time you're done, you sort of think, well --

DR. McILREATH: You have to think in terms of the physician.

MS. ALTSCHULER: -- I am. I am. I am.

DR. EAGLSTEIN: I think her point is well taken. It starts outs as though it is going to tell you everything is great, and then it really does say everything is great, but it says if you are still not happy, you can use another method. It would probably be more likely to get the message across if the last sentence was the first sentence. Or the

last idea that an alternative method could be used was right up front.

MS. ALTSCHULER: He would go ahead --

DR. McILREATH: The only reason to put it there is why you would consider an alternative method because it does get into the milk. That's why we put --

DR. EAGLSTEIN: Put it second?

DR. McILREATH: -- yes.

DR. EAGLSTEIN: But I do think that doctors --

MS. ALTSCHULER: They're not going to miss it.

DR. EAGLSTEIN: -- they start getting numb after a while.

(Laughter.)

DR. TABOR: There would be very little lost if you went straight from the first sentence to the last sentence.

MS. ALTSCHULER: Right.

DR. EAGLSTEIN: That would undilute it.

MS. ALTSCHULER: And then they can read between the lines.

DR. EAGLSTEIN: Do you want to put something in the warning, say, see pregnant women or see nursing mothers?

MR. BOSTWICK: That's only a formality. I just want to know whether we are happy with that information where it is, or do you want to have something else about it in there? If you want to leave it where it is, that's fine with me.

DR. EAGLSTEIN: Is that all right with you there?

MS. ALTSCHULER: Yes.

DR. EAGLSTEIN: As a separate section, but not in the warnings?

MS. ALTSCHULER: Yes.

MR. BOSTWICK: Okay, fine. And we would include some sort of statement in the warnings concerning pregnant women as specifically -- concerning the dnager of reuse. Is that the sense of what I got about our discussion?

DR. EAGLSTEIN: We have kind of been stuck on this one issue, which I think is the major area.

MR. BOSTWICK: And I think we may have about gotten it. We may have actually beaten it to death here. I don't know for sure.

DR. EVANS: We ought to go and take a position on it and then let the committee know tomorrow that we have a difference of opinion.

MR. BOSTWICK: Right.

MS. ALTSCHULER: I have one question. I haven't known when to bring it up because I didn't want to change the subject again, but included in the pregnant women, has there been mention made of protecting their hands when doing applications?

MR. BOSTWICK: There may be later, but I don't think that would fit into warnings. We're going to include something about pregnant women in the warning section. That might come

under precautions or something later, but I don't think we would include that information in the warnings.

MS. ALTSCHULER: Okay.

DR. EAGLSTEIN: We are just adopting these as sort of principles, right?

MR. BOSTWICK: Yes. We don't have to get reared down. We just want to know when we go to the committee tomorrow, should we say, look, we'd like to have something in the warning section concerning pregnant women.

Is that the sense of what we're doing here?

DR. McILREATH: Say that again?

MR. BOSTWICK: Well, what I want to know is: when we talk to the committee tomorrow, we have a warning -- a proposed section for the physician labeling, which does not now say anything specifically concerning reuse in pregnant women. What it says is, "Shampoo should be used according to recommended dosage,especially on infants, children and pregnant women."

Okay, the infants, children. Now, do we want to say anything in there about reuse, or are we satisfied with the way this warning section starts out?

Because I thought -- maybe I made this up in my head but I thought we had said something earlier about warning against reuse in pregnant women.

DR. EAGLSTEIN: I think that's been --

MS. ALTSCHULER: That was in general.

DR. EAGLSTEIN: -- just in general?

MS. ALTSCHULER: Right.

DR. EAGLSTEIN: Okay.

MR. BOSTWICK: Okay. Pass that.

DR. EAGLSTEIN: So, now, I think we've agreed that we are going to contraindicate in the premature at the epileptic?

MR. BOSTWICK: Right. And that's the only thing we're going to be adding in the contraindiction section. And one of them we won't even add because it's -- at least in the motion, there's already a statement in there concerning premature neonates.

DR. EAGLSTEIN: So, in the abstraction that I presented, actually we had decided against what was recommended.

MR. BOSTWICK: Well, as far as pregnant women and lactating women, we have decided that we are not going to recommend they be contraindicated.

DR. EAGLSTEIN: But we are going to for prematures, and we're not going to for infants?

MR. BOSTWICK: Right. In the warning section as it is proposed by Reed and Carnrick, "Kwell cream should be used according to recommended dosage (see directions for use) especially on infants, children and pregnant women."

We don't have any substantive recommendations to make concerning that?

MS. KENNY: Except that they don't offer any

recommended dose.

DR. EAGLSTEIN: I think that when it comes to the specific wording that the committee sent -- these four people who sent in their thoughts did want people who read this to be warned against certain things.

MR. BOSTWICK: Right.

DR. EAGLSTEIN: You're saying that wouldn't go in the warning section?

MR. BOSTWICK: No. All I'm saying is that the warning section, as we read it now, the draft warning section, do we have any problems with that? You and Dr. Rasmussen, are you -- do you want to make any recommendations to the committee concerning the way the draft warning section is now written?

DR. EAGLSTEIN: I would. And I would start out with the words "Warning: -- may occur because of skin penetration."

MR. BOSTWICK: Okay. I think that's good, but it does not deal specifically with pregnant women, and as far as pregnant women go, we are going to leave it roughly the way it is. And we may add some additional warnings.

I am relatively satisfied with that. What I want to do is get your summary typed up again. And number two, would just be contraindicate the use of the shampoo cream and lotion for premature infants and those prone to seizures.

DR. EAGLSTEIN: Why was this in the proposed label? It didn't seem that you gave a --

DR. McILREATH: Which?

DR. EAGLSTEIN: -- studies indicate that potential toxic effects applied Lindane are greater in the young." It seems like --

MS. KENNY: It's contradictory --

DR. EAGLSTEIN: -- they don't want to agree with that.

DR. McILREATH: Well, that's been there, and I think that that's a statement that you can say about every single drug available, in my opinion, and I think the opinion of toxicologists.

DR. EVANS: That's right. That's been in there for a number of years. And at that time there was a feeling that maybe up to a year to so there was a difference in absorption and toxicity.

DR. EAGLSTEIN: There is still that information on the brain of the young people concentrating Lindane better than --

DR. McILREATH: Well, we don't know. There is a study that show high concentration to the brain, but we don't know whether that is normal or not. And there are many studies that show unlike other chlorinated hydrocarbons, it is not stored there for long periods of time. It does in and goes right back out. Several studies of lifetime feeding, we find that two weeks after stopping feeding, we can assay the fat and you don't find any Lindane.

DR. EAGLSTEIN: All right. Shall we go over the rest of these?

MR. BOSTWICK: I think the rest of these are going to be a lot easier. I hope so.

You seem very upset.

MS. KENNY: I am. I think it's just being left as it is. It is certainly not strengthened in any way as far as pregnant and lactating women are concerned. I mean, I'm just disappointed.

DR. EVANS: Let me ask you. If these proposed recommendations for Lindane which are used for safety. Now, these are for which label and for what indication?

MR. BOSTWICK: That's for the physician label and for, in general, I think that the shampoo, cream and lotion, all three.

And it is true that basically the Read and Carnrick under these set of recommendations is unchanged -- basically unchanged for pregnant and lactating women. It will stay the way it now is.

DR. EAGLSTEIN: It would stay the way the proposed label is?

MR. BOSTWICK: Right, the proposed label is, yes.

DR. EAGLSTEIN: Which had this large section on the nursing mother?

MR. BOSTWICK: Right.

Now, the shampoo label presently does not contain those two contraindications for premature infants and those with seizure disorders and that presumably is something we are going to recommend that the Kwell shampoo label include those contraindications.

But we haven't changed the language for the thrust of the pregnant women and the lactating women.

DR. McILREATH: Except that that is not in there now.

MR. BOSTWICK: Right. And it would be.

DR. McILREATH: It would be put in.

MR. BOSTWICK: And these recommendations are prone to discussion too. I mean, obviously somebody from the committee felt strongly enough about them to write Dr. Eaglstein about them.

DR. EAGLSTEIN: I think that was the sense of the committee last time.

MR. BOSTWICK: Right. Well, I know this. I know that there was disquiet about infants, what constituted at infant as far as use. And it was generally agreed that premature infants were candidates for contraindication, but how young an infant should be or how old an infant should before it should be used best. That's a tough question.

MS. ALTSCHULER: Excuse me. Other than scabies, what justification is there to use any of these products on infants considering that very few of them have that much

hair anyway? I mean, why when there are effective combing tools would one still compel to douse a child with a pesticide? Any child? I mean, I'm just --

DR. RASMUSSEN: You mean other diseases?

MS. ALTSCHULER: -- no, no, no, pediculosis.

MS. KENNY: Just because they have been doing it for years doesn't make it right.

DR. McILREATH: Well, the justification is the same as it has been. There is a safety record now established.

DR. RASMUSSEN: Well, I think in terms of actual medical indications, it would be extremely uncommon for somebody under 1 or 2 to get head lice. I certainly have never seen it. It would depend on the country that you're in. In certain parts of the world, particularly third world nations it is endemic, it is sort of like gonorrhea, syphillis, or infantago, or something that practically everybody has, but in the United States that would not be true. And I think it would be almost a moot point. I mean, in hardly any situation other than in the sense of having a little kid, say, a six year old or a seven year old in a family who has head lice, my suggestion is that everybody is treated. I just do it prophylactically because --

MS. ALTSCHULER: Oh, well, he said it.

DR. RASMUSSEN: -- no, no, no.

DR. McILREATH: I don't think he means prophylactically.

MS. KENNY: Because he said the word.

MS. ALTSCHULER: That's all right. Some man in my son's school got up and said that he was Joel's somebody's mother.

DR. RASMUSSEN: Well, I did not say that I was his mother, but I'm shooting myself in the foot. I really mean it in the sense of prophylaxis in the sense that the child could be potentially, but not visibly infected, you could use the term treated, but not obviously infected.

MS. ALTSCHULER: Well, that was the exact point I wanted to bring out was that the literature in terms of school blurbs that go out and everything else seem to have one thing in common and they have that old notion that if one person has it, treat everybody; so, the regardless just gets it.

DR. RASMUSSEN: I would still agree with that in the school setting. If you had 15 or 10 percent of the class involved, I think one of the best ways to break that cycle is to treat them. I wouldn't propose treating everybody with Lindane, but I'm saying that you probably want to treat them with something.

MS. KENNY: But the question is: do you want to then treat their 8-month old sibling all prophalactically?

DR. RASMUSSEN: It's a tough issue. I don't know.

MS. ALTSCHULER: No way.

MS. KENNY: We have to say that you don't. I spoke to two women this week who did treat seven and eight month old infants respectively, and I have to say to them, please don't do that again. I mean, with little kids like that, you can deal with them by hand.

MR. BOSTWICK: Okay. I don't know if that is something we can resolve here. I would like to try and get through the rest of recommendations.

The third one is a warning against using the shampoo in the bathtub or the shower.

MS. KENNY: You mean, the implication meaning confine the area -- to the area of need.

MR. BOSTWICK: Does anybody see any problem with that?

DR. EAGLSTEIN: Where does that go? Would that go under warning?

MR. BOSTWICK: That wouldn't go under warning. That would go under directions for use.

MS. ALTSCHULER: Just for the record so that it would be understood. CDC has unfortunately put out a blurb that is used nationwide that that's the first instruction and a great majority --

DR. RASMUSSEN: In the tub?

MS. ALTSCHULER: Place your child in the tub or shower stall and what happens is mothers fill the tub in all of this; so, I mean, that's more background.

DR. RASMUSSEN: It may have been more concerned about a place that you can rinse down after you finish shampooing.

MS. ALTSCHULER: Right. I mean, I don't think they thought about --

DR. RASMUSSEN: Because I have never heard anybody advocate taking a bath or a shower for head lice.

MS. KENNY: They are treated inside the bath tub, but what they do is they --

DR. RASMUSSEN: So, they can rinse the place down and clean it off. Isn't that what they are trying to do there?

MS. KENNY: They are not leaning over the tub; so, that just their head gets shampooed. They sit them in the tub; they fill the tub, and they bathe them in shampoo, but with Lindane.

DR. EAGLSTEIN: Okay. So, it is warning against using it in the shower.

MR. BOSTWICK: Well, that goes under direction for use. I suppose the rest of these would too down to about five or six, unnecessary skin contact. Warn against using after a warm bath or shower --

DR. RASMUSSEN: Or any bath or shower. It doesn't have to be warn.

MS. ALTSCHULER: Right.

MR. BOSTWICK: In any event, these next two anyway, skin contact and warning about the shower and probably warning

of the assistance. I don't know about open cuts and excoriations. Let's skip that. But 4,5 and 7 probably would go into the directions for use. Excuse me, 3,4, 5 and 7.

Does anybody have any difficulty with those?

(No response.)

MR. BOSTWICK: If we say to the committee that we feel these should be added.

DR. RASMUSSEN: Do we have any idea if rubber gloves actually prevent the absorption of that stuff?

MR. BOSTWICK: No, I have no idea.

DR. RASMUSSEN: Because many hydrocarbons are solvents, in a sense, hydrophobic like plastic --

MS. KENNY: That's why they don't package it in plastic, I assume.

DR. McILREATH: It's the solvent.

MR. BOSTWICK: Okay, six is the warning, do not use on open cuts and excoriations. I'm not sure if that is properly --

DR. RASMUSSEN: That's going to be a tough one. Everybody with head lice scratches.

MS. KENNY: You could talk about bad excoriations; for instance, the person who has, you know, it seems like a more severe cut or a really severe dermatitis, exzema, really open, weepy exzema type, that type of excoriation.

DR. McILREATH: You have to have it severe over the

entire scalp because the amount that would get involved in one cut, it would be impossible to measure the amount that could be in contact and be absorbed.

MS. KENNY: I guess we are just always going to disagree with you on that.

DR. McILREATH: Somebody talks about not letting your child suck their thumb, but, again, the amount of Lindane that you could get off that thumb is so small that you'd never know that you got anything. So, I think that unless it was a really wide open sores at which time, they would probably be treating the open sores and not worry about the lice until sometime later.

DR. EAGLSTEIN: Wasn't that already in the --

MR. BOSTWICK: Open cuts?

MS. ALTSCHULER: No.

DR. EAGLSTEIN: I had thought it was, but anyway I also thought maybe we should use the word massively.

MS. KENNY: Massively excoriated.

DR. RASMUSSEN: Again, that's kind of a nebulous term, Bill.

DR. EAGLSTEIN: But it gives some idea of the magnitude. It means not just a scratch or two, but it is really consequential.

DR. McILREATH: But if it were that serious, don't you think that they would go to a physican and the physician

would start treating that as the primary indication?

DR. RASMUSSEN: Well, they have to go to a physician anyway, because Lindane is an RX.

MS. KENNY: They don't go though. They call. Just because it's 90 percent over the phone, the physician doesn't see this.

MR. BOSTWICK: Well, what do we do with this?

MS. ALTSCHULER: I wouldn't be opposed to dropping excoriations only because unfortunately,by definition,often times a child with lice is excoriated.

DR. EAGLSTEIN: Who you say a cut --

MS. ALTSCHULER: I'd rather say an open wound, but open cut, anything that would indicate to look for something beyond --

DR. EAGLSTEIN: I thought we just agreed on massive. You don't like that?

MS. ALTSCHULER: Oh, we did. I'm sorry. I thought that someboey pooh-poohed that one. It's all right with me.

MR. BOSTWICK: So, how are we going to state it against using it on an excoriated scalp?

DR. EAGLSTEIN: Open cuts or massive excoriations.

MS. ALTSCHULER: Okay.

MR. BOSTWICK: Open cuts or massive, okay.

DR. McILREATH: That sounds funny.

MR. BOSTWICK: Yes, it does. It sounds a little odd, doesn't it?

DR. EVANS: Try extensive rather than massive.

MS. ALTSCHULER: Extensive, okay.

DR. EAGLSTEIN: It is just funny sounding and we're not used to it.

MR. BOSTWICK: I don't think that that necessarily has to go in the warning section. It probably needs to go somewhere in precautions.

DR. RASMUSSEN: How about awesome, Carnot, that's a word you use?

(Laughter.)

MS. KENNY: That's what your children use to describe the flavor of gum.

MR. BOSTWICK: Or radical. Okay. Well, I think we can find a place for that, for that particular extensive recommendation.

What about using the shampoo, cream or lotion prophylactically? Where would be a suitable place to put that on the label? I don't think that is properly a warning.

DR. RASMUSSEN: If you mean it as a device to prevent infection, I agree with you. It shouldn' be prophylactically. If you mean using it in the non-visibly infected family members, I would disagree with its use. I use the term that she caught me on, "prophylactically," probably a little bit inappropriately, but I would give it to all of the children or other adults, or other people living in the family who had a single individual

with head lice or scabies.

MS. KENNY: There are, however, hundreds of individuals who say, oh, there's lice in my kid's class; I'm going to put the stuff on them and then that should protect them. I mean a lot of people feel that.

DR. McILREATH: I would think that we would be more than happy to add that to directions for use or a patient package insert to advise that this will not protect against you getting them and should not be used that way.

MR. BOSTWICK: All right. Why don't we suggest this, we put this in the directions for use along with obviously combing out the nits.

DR. RASMUSSEN: What you could say in there is that this shouldn't be used prophylactically because it has no residual effects. I mean, that type of thing. You can't put it on and expect it to stay there for a week and kill everything that happens to be coming by. I mean, that's the sense, isn't it, that you are trying to get?

MS. KENNY: Yes.

DR. RASMUSSEN: It's not like spraying something around the house so that the ants won't come back.

DR. McILREATH: We had some information recently that suggested that it does do that.

DR. RASMUSSEN: Hush up.

DR. EAGLSTEIN: Why wouldn't it go under warning

actually?

MR. BOSTWICK: Well, that's what I don't know. I don't know how drastic -- how quickly do you want the physician to have this information? That's the question.

DR. RASMUSSEN: The warning gets sent out --

MR. BOSTWICK: No. But the warning is theoretically the first thing in the insert and the physician is going to wear out. Maybe he'll read that warning before he gets --

DR. RASMUSSEN: I think you have far stronger messages that you want to sock to people.

MR. BOSTWICK: -- I would think so, too.

DR. RASMUSSEN: If you put too many things in the warning, it just loses its impact.

MS. ALTSCHULER: That is not a important message to the consumer when you do that one.

MR. BOSTWICK: Well, all right. Well, let's leave it in directions for use.

MS. ALTSCHULER: The physician shouldn't write a prescription prophylactically anyway.

MR. BOSTWICK: All right. Emphasizing the need for combing out the nits. I think that is already in the physician --

DR. EAGLSTEIN: It says you can/may do.

MS. KENNY: It says they may be removed.

MS. ALTSCHULER: What page?

MR. BOSTWICK: Page 4.

MS. KENNY: It says by fine tooth combing or tweezers. It says they may be removed, but my guess is it should say, they should be removed.

MR. BOSTWICK: Should be, all right.

MS. ALTSCHULER: And there has to be an explanation why on that one.

DR. EVANS: This is physicians.

MR. BOSTWICK: Yes.

MS. ALTSCHULER: Forgive us. But they honestly do not understand that the Kwell -- they believe the Kwell does the whole job and it doesn't and, for that reason, they don't encourage people to remove nits.

DR. RASMUSSEN: I would have thought they would just to get them out just to remove the stigma. That is one of criteria for going back to school.

MS. KENNY: There are certainly people who believe that you definitely should.

MS. ALTSCHULER: The only thing that makes them cooperate on nit removal is when they finally understand that Lindane is not 100 percent ovicidal when used safely.

DR. RASMUSSEN: Nor is any pediculicide, not just Lindane.

MS. ALTSCHULER: Contrary to all the old literature, they have to understand that if you don't remove the nits that are still alive, they are going to have to use Lindane

again, or whatever product it is they prescribed. So, just to say removing nits, leaves it wide open for all the old bad information that is out there.

DR. RASMUSSEN: What would you propose?

MS. ALTSCHULER: I would propose to explain why. That, you know, nit removal is part of total treatment.

DR. RASMUSSEN: Give me a sentence?

MS. KENNY: I think you could just add to prevent self-reinfestation.

MS. ALTSCHULER: No. No, it has to be stronger than that. The nits must be removed -- the nit removal must be included as part of treatment to remove those nits not killed by Lindane still viable -- well, I can't give you a sentence.

DR. EVANS: To prevent self-reinfestation.

DR. RASMUSSEN: Yes, that sounds good.

MS. KENNY: Everybody here is concerned that the doctors are going to get tired before they read all this stuff.

MS. ALTSCHULER: Well, hopefully, when they read it once, they won't have to read it again. This is just re-educating them basically to old information.

MR. BOSTWICK: To prevent reinfestation.

DR. EVANS: That's self-reinfestation.

MR. BOSTWICK: Self-reinfestation.

DR. EAGLSTEIN: You can say, when hair is dry, remove any or many nits or nit shells.

DR. RASMUSSEN: You want to say a procedure to do with what, because if you say a fine tooth comb, what most people have at home is a fine tooth comb --

MS. KENNY: A cradle cap comb.

DR. RASMUSSEN: -- it is totally ineffective.

MS. ALTSCHULER: You have to say, a combing tool manufactured for this purpose.

DR. RASMUSSEN: Or just say a nit comb, or something like that.

MS. ALTSCHULER: There are combs sold on the market that are cradle cap and they are passed off as fine tooth. that is exactly right.

MR. BOSTWICK: Okay. It should say something about a device to be used.

DR. TABOR: Can I make a comment about the prophylactic statement?

MR. BOSTWICK: Yes.

DR. TABOR: I think Dr. Rasmussen's comments are -- illustrate, I think, a certain ambiguity in the term "prophylactically." I think a lot of physicians will use prophylactic -- the term "prophylactically" the same way he used it and it might be that some more explicit wording would make it clearer.

DR. McILREATH: Yes, I would agree.

DR. RASMUSSEN: It really isn't proper. Isn't it

prophylaxis?

DR. TABOR: Yes.

DR. RASMUSSEN: It is sort of treating subclinical infections, although you could theoretically -- if you had strep throat in the family and if you gave everybody penicillin for ten days while the patient was being treated, that truly would be prophylactic use, or could be.

MS. ALTSCHULER: Right.

In our wording, we changed it to, "Shampooing with these products will not prevent lice infestation," to get rid of the ambiguity of prophylactic.

DR. RASMUSSEN: Or you could say shampooing will not prevent subsequent lice infestation, something like that.

MS. ALTSCHULER: As well, but it certainly won't prevent the first one.

DR. McILREATH: Protect against future.

MS. ALTSCHULER: Right.

MR. BOSTWICK: All right. To warn against using the shampoo, cream or lotion as a device to prevent future lice infestation.

Then we've got left, the directions should indicate -- now, here's one. I don't know about this -- should indicate that one ounce or less should be used for treatment. Is that feasible?

MS. ALTSCHULER: No.

MS. KENNY: No.

MR. BOSTWICK: Is there any way to make that work out?

DR. McILREATH: Well, I think we will propose based on, you know, experience that we have what -- perhaps give you with short hair, use this amount. With medium length hair, with long hair, it may require up to.

DR. EAGLSTEIN: You are going to go with the sliding scale?

DR. McILREATH: I think so.

MS. ALTSCHULER: Great.

DR. EAGLSTEIN: So, that will be specific, not quantitative?

MS. ALTSCHULER: Right.

DR. McILREATH: That's right, yes. Give approximately, or less than.

DR. EAGLSTEIN: Which I think you feel is the best way?

MS. ALTSCHULER: Right, yes.

MR. BOSTWICK: A specific dosage, what, according to hair length, is that they way we're working --

MS. ALTSCHULER: Yes.

MR. BOSTWICK: -- according to hair length should be used.

I don't know about the last one. I don't know how we are going to make that work.

MS. ALTSCHULER: That's a toughy too.

I would like to raise the point that perhaps -- and I don't know if it is applicable to be put here, but there should be some way that the physician should be alerted or keep some handle on how many times he is writing that stuff. I mean, I got four prescriptions in two months and he didn't know the difference.

MR. BOSTWICK: I guess we've got to leave the poor doctor with some kind of responsibility. I don't think Food and Drug is going to enter into this process of telling a physician of how often he can prescribe.

DR. RASMUSSEN: But you can certainly with the little FDA bulletin that comes out, you could certainly make a news note or whatever you want to call that to remind people.

MR. BOSTWICK: Public education or physician education.

MS. ALTSCHULER: That would be wonderful

DR. RASMUSSEN: And you could actually -- it is sort of an aside here, a little late in the day, but it probably wouldn't be too bad an idea for the advertisement for this product to be more open and direct about those types of things because what you usually see is a great big giant picture of a mite that covers three-quarters of the page and then a little fine print down at the bottom to the new stuff that's coming up --

MS. ALTSCHULER: I thought you were going to say

nitty-gritty.

DR. RASMUSSEN: -- and I think those things would be very pertinent because I think what happens is that a lot of things that we are going to discuss today, unfortunately get stuck in the third page, fifth paragraph of small dark print and quite honestly, you ask 99 percent of 100 doctors about any drug that they commonly use, or this one, they had never read the PDR. Their professors taught them how to use it. Their medical students or their residents may have quizzed them a little bit about it, but I make a point of quizzing my residents. I have never found none who has read a PDR on any drug other than just a brief little segment to look up the dose maybe. They can't remember the dosage, or they want to look up, does it make your kidneys fall out or something; so, they'll read -- look for kidneys.

So, you have to find a little more effective way of getting your information out to people. You just can't presume that somebody is going to be conscientious and say, oh, it's time for me to read about Lindane. I'll pick up a PDR and read about Lindane.

DR. EVANS: That is the reason we've had these alerts to go out before.

DR. RASMUSSEN: I think that is a good place to put some of these rather than putting the stuff in some place like the Federal Register where absolutely nobody is going to

see it. Nobody who treats scabies and head lice is going to see it.

MR. BOSTWICK: I think these -- I'll say two things. First, I think these are good viable suggestions that we can get into shape to present to the committee tomorrow is what the subcommittee would like to see happen, and satisfy that everybody, at least as far the labeling goes got their quarter in on the deal.

Now, the other thing I would suggest about this is that it seems to be the basis for a patient package insert, not necessarily written in this style, of course, but, I think a lot of the points that your group was trying to bringing out.

There is one thing you should know is that the Food and Drug cannot mandate Reed and Carnrick to print a patient package insert. It's voluntary on Reed and Carnrick's part. And so if the committee does say, look, we think it needs a patient package insert, you should say these thing, Reed and Carnrick has to take that home and think about it and do basically what they want to about it.

On the other hand, I presume they are going to take the suggestions seriously.

DR. McILREATH: I certainly --

MR. BOSTWICK: I'm sorry, Dr. McIlreath.

Well, I don't know how -- how much more deeply we want to get into the question of a patient package insert. I

don't know how much time we have and I don't know how useful it is, because we don't really have a basis to go on right now.

DR. EVANS: What about the patient package insert that you folks put together?

MS. KENNY: It's here on the table if you want to take a look at it. This is now being used in the drug chain of 52 stores throughout New England and it is just basically being stuck in with all Lindane prescriptions and it is on the shelves, literature shelves in their pharmacies as well.

MS. ALTSCHULER: Well, we try to tell people when they call on our hot line that their physician has recommended that they use Lindane products, we don't pass second judgment on that other than to say, please before you do, pick up one of our safety guidelines so that you can use it.

MS. KENNY: Which is basically the points that we have been trying to make today.

MR. BOSTWICK: If this is agreeable to Dr. Eaglstein and Dr. Rasmussen, I could make some copies of this too and we could show it to the committee and say, look, here's --

MS. KENNY: We have enough of those for every committee member.

MR. BOSTWICK: Oh, do you, good.

And we can see here is the kind of thing that it is being proposed --

MS. KENNY: Although, I would sort of see it smaller, a more compact form with no pictures. The drug chain insisted on pictures. It's monosyllable.

MR. BOSTWICK: Do you have a script version of this?

MS. ALTSCHULER: No, not right now. This is all we've got for you.

MR. BOSTWICK: Okay. Well, we can certainly hand this around and let the folks take a look at it.

DR. EVANS: I think this gives us a start.

MR. BOSTWICK: Gives us a start. And, as I say, we -- all we can do is say to Reed and Carnrick, well, look, here are some suggestions that we think would help and hopefully they would adopt at least some or them or most of them, depending on how feasible they are.

And we still have the container business to go through. I would like to get some sort of a feel about -- well, I think number four is a loss. I don't think the pharmacist should place a label over the warnings.

The other three, unit packaging dosing, and I think is a tough issue for probably Reed and Carnrick. And it is for me in that I don't know exactly how often the physician -- how often is a patient treated commonly for one case of head lice?

DR. RASMUSSEN: How often is he treated?

MR. BOSTWICK: Is an individual person treated, or --

DR. RASMUSSEN: They treat everybody in the family?

MR. BOSTWICK: Okay. One person, how often is the individual treated excluding the family. Just one time with Lindane?

DR. RASMUSSEN: Yes, that's all I do.

MS. ALTSCHULER: In a lifetime?

MR. BOSTWICK: No, I'm just talking about one case. For an episode. If you had one patient who had head lice and you gave them one ounce of the stuff --

MS. KENNY: We've already talked about the sliding scale thing which would negate that.

MR. BOSTWICK: But in most cases, you want to treat most members of the family, or all members of the family?

DR. RASMUSSEN: I do, yes.

MR. BOSTWICK: How feasible is unit package dosing under these conditions, I don't know. Is it something that we want to recommend to the committee, or is it something that if we do recommend it, it would never get used?

DR. McILREATH: The only thing I can say about unit dose packaging across the board, companies have tried with a lot of drugs and the pharmacists just won't buy it. They don't want it. When I was at Searle, we tried it with Flagyl, we tried it with other things with unit dosage, and you're sitting there with a warehouse full of unit doses. The pharmacist is not interested in that. He wants a bottle

of vials and tablets that occupies a little space.

DR. RASMUSSEN: Is that's what is done with the 16 ounce one, they dispense from that?

DR. McILREATH: Yes, they dispense from that.

DR. TABOR: The reason for wanting unit packaging if maybe twofold. One is to prevent misuse and one is to prevent ingestion perhaps and the revised labeling and and warnings should take care of the misuse and the child proof packaging is going to take care of the ingestion as much as many other toxic medications.

MS. KENNY: Well, I will see that one thing that can be very helpful in this instance is a cap on the bottom that holds one ounce, because sometimes it is very hard when you are juggling all your kids over the sink and you are trying to do this kind of a treatment thing to find something in the kitchen that holds an ounce.

DR. RASMUSSEN: The other way you can do that is to have the bottle marked.

MS. KENNY: Something like that.

DR. RASMUSSEN: So you can put that down to look to see where your line is.

MR. BOSTWICK: Well, is it agreeable to scrub the unit dose packaging as a concept?

MS. ALTSCHULER: As long as everything else goes through.

DR. EAGLSTEIN: Aren't the, for example, topical

steroids, aren't they, be definition, a unit dose?

DR. McILREATH: No, they are in tubes that you would use many times. It's not --

DR. EAGLSTEIN: I meant there's a unit. It's not a unit, that's a dose.

DR. McILREATH: There is a unit, it is not a dose.

DR. EAGLSTEIN: The patient doesn't start out with a barrel of the stuff and then dispense it?

DR. McILREATH: No, but they started out with a two ounce tube.

DR. RASMUSSEN: That is not true, because our pharmacy buys Trisimalone (phonetic) in its brand name in five pound tubs and spoons it into one pound tubs, half pound tubs. The only thing we don't do is stuff it in tubes.

DR. EAGLSTEIN: But not if you get the tubes from the manufacturer.

DR. McILREATH: It is a tube from the manufacturer. Unless you get a sample, the sample would be a unit dose.

MS. ALTSCHULER: You know, I've always sort of been uncomfortable with unit dosage even though we may have brought it up at some point in time and that is because I have sort of a gut feeling that it is going to lend itself more to abuse because mothers are not going to have -- fathers are not to have as much of a handle of how much they are using and they will tend to hoard it when they get it. Instead, you know, I

have a bottle at home, it's this big (indicating) and until I learn not to use it, I could, you know, have some sort of an idea of how much I've gone through. But if I had dose packaging, they would have been gone and I wouldn't have realized it. And knowing the way neighbors share Kwell, and panic when it hits their house and they don't want to call their doctor in the middle of the night, I just somehow have visions of somebody collecting them, and it's just a gut feeling, non-scientific, everything else, but unit dosage, with the understanding that everything else is going to be included, I agree with Dr. --

MR. BOSTWICK: Well, these are reccomendations and the committee is free to do what they will with them. We will type these up and present them to the committee.

Okay. The container should be child proof and I think Reed Carnrick is making is taking some steps toward that, isn't that correct?

DR. McILREATH: Yes.

MR. BOSTWICK: Non-removable labels indicating that the contents are poison. Kept out of the reach of children, not reused and discarded in a safe place.

DR. RASMUSSEN: I had problems with poison.

MR. BOSTWICK: It is a poison.

MS. KENNY: It kills living forms.

MR. BOSTWICK: The question is --

DR. McILREATH: So does everything else.

MS. KENNY: But I mean it is being manufactured for the purpose of killing.

DR. McILREATH: Antibiotics is manufactured for the purpose of killing bacteria viruses.

DR. RASMUSSEN: Can be poison if it is misued or ingested.

MR. BOSTWICK: Yes.

This is not like a can of that Lindane.

DR. McILREATH: How many children die of aspirin every year as compared to the number of children that die from Lindane?

DR. RASMUSSEN: But I don't think that there's a hearing that the product can cause toxicity, which is what people -- they're not going to understand toxicity as much as poison. You tell them that if you drink it or misuse it, --

DR. McILREATH: I don't have any problems with that.

DR. RASMUSSEN: -- you are going to get deathly ill. That's a pretty good warning. I mean that's not bad. It certainly would go a long way to prevent abuse.

MS. KENNY: I would want to see that same label Clorox.

MR. BOSTWICK: Okay. How should we word it. Products can be poisonous --

DR. McILREATH: If they are misused.

DR. RASMUSSEN: Ingested or misused.

MR. BOSTWICK: Okay.

MR. BOSTWICK: Okay.

DR. RASMUSSEN: I like it.

MR. BOSTWICK: Oh, good, I'm glad.

DR. McILREATH: We have a little problem with the containers having that molded into the container itself.

MR. BOSTWICK: Rather than a paste on label?

DR. McILREATH: Yes, because we buy those and we'd have to have special molds made. Right now we use that bottle for several different products.

DR. RASMUSSEN: Can't you get a label that won't come off?

DR. McILREATH: Oh, we could get -- I don't have a problem putting on a label, I have a problem in buying a bottle with that is embossed on the bottle.

MR. BOSTWICK: Why does it have to be embossed?

DR. McILREATH: Well, this suggestion says a non-removable --

MR. BOSTWICK: Non-removable label.

DR. RASMUSSEN: They are talking about the type that if you pull it on one end, it is only glued on one end. It's a can of fruit label is what they are talking about.

MR. BOSTWICK: Well, something that doesn't off easily.

MS. KENNY: Easily. It's glued on.

DR. RASMUSSEN: There are labels which are glued like a produce label can. I'ts glued on one side. You cut

that little thing and it comes right off. Pharmacists commonly use that to peel off labels. But you could put them glued all the way around and then you would have actually have to sit there and scrape --

MR. BOSTWICK: That is what we are talking about, right?

DR. RASMUSSEN: -- well, something that you just can't flip off and stick another label on.

MR. BOSTWICK: How about labels that are not easily removable?

MS. ALTSCHULER: Didn't you say that you were looking into different container than the glass?

DR. McILREATH: Yes, we are.

MS. ALTSCHULER: Oh, you are, okay.

DR. TABOR: I have a little bit of a problem with the word poisonous. Is there a standard labeling used on other products harmful or fatal if swallowed?"

DR. McILREATH: According to -- yes, that's true. And according to the definitions of OSHA or EPA, it's not a poison.

DR. TABOR: Why not say harmful or fatal if swallowed or misued? Or ingested is the big word. It's a short word that's not commonly used.

MR. BOSTWICK: Does --

DR. McILREATH: I like that better.

MR. BOSTWICK: I thought you would.

DR. TABOR: Something like harmful or fatal if swallowed or misused.

MS. KENNY: Misused is too vague --

MS. ALTSCHULER: How about substituting pesticide for poison? That's certainly accurate.

MR. BOSTWICK: Well, you can't really say -- you can say it consitutes as far as pesticides. I don't know how useful that is compared to saying that it can't be harmful or --

MS. ALTSCHULER: If it is emphasized and can be?

(Laughter.)

DR. TABOR: I mean, I personally don't think pesticide is is an appropriate word either.

MS. ALTSCHULER: What would you call it then?

MS. KENNY: Well, the point is that most consumers that it's a shampoo. That it is not unlike Selsun Blue or Head and Shoulders.

DR. TABOR: But if you say may be harmful or fatal. I mean, I don't know what the rest of the label should read, but if you say may be harmful or fatal, they're not going to consider it like, you know, Johnson's Baby Shampoo.

DR. RASMUSSEN: Well, you can say, it can be harmful or fatal if swallowed or applied too frequently.

MS. ALTSCHULER: Or abused.

DR. EAGLSTEIN: Wouldn't that be true of other shampoos?

MR. BOSTWICK: Sure.

DR. EAGLSTEIN: I think the point is that it is an uphill fight with Lindane, because people were predisposed to think of things that you put on your skin and it is not very dangerous.

DR. RASMUSSEN: I don't think any other shampoos are going to be harmful if you swallow them.

DR. EAGLSTEIN: No.

MR. BOSTWICK: They are harmful here, but if you put in fatal, I think you are making a point that people will pay attention to.

DR. RASMUSSEN: But certainly, you don't see that type of stuff on Head and Shoulders and Selsun Blue, tar shampoos, things like that.

MR. BOSTWICK: Can be harmful or fatal if swallowed. Now, the patient -- does that cover that container section, too?

MS. ALTSCHULER: That's fine. I love it.

MR. BOSTWICK: Patient package insert will be more or less similar by using the sample here and I think it is just as good as anything we're liable to generate here for the time being.

Then, initial studies -- well, this is something we're