Good morning. My name is Merrill Goozner and I direct the Integrity in Science project at the Center for Science in the Public Interest. I have a structural conflict of interest in that the organization I work for is a well-known advocate for dietary approaches to lowering blood pressure. We receive no money from any firms, period, not to mention firms with a stake in the outcome of these deliberations.

Our concerns about the FDA's proposed Guidance on labeling hypertension drugs are threefold. First, the draft Guidance ignores the National Institute of Health's Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure" (JNC 7), especially the primary role its recommendations give to lifestyle modifications. Second, the draft Guidance misrepresents the findings of JNC 7 and the government-funded Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT), both of which were conducted at great taxpayer expense and, if followed, could save taxpayers billions of dollars through the recently enacted Part D of Medicare (the senior citizen prescription drug benefit), as well as Medicaid and other government programs. And third, the labeling provision of the draft Guidance permits the use of claims that have not been submitted to nor reviewed by the FDA, which, in combination with the previously mentioned flaws in the Guidance, could result in less than optimal physician prescribing patterns and less efficacious health care outcomes.

The draft Guidance points out that labels on the more than 60 drugs in seven or more classes that lower blood pressure are "mute on the clinical benefits expected from

blood pressure reduction." The FDA is considering this Guidance because it feels it would be in the best interest of physicians and patients to spell out those benefits "to encourage appropriate use of these drugs." But as the JNC 7 report points out:

> *Adoption of healthy lifestyles by all persons is critical for the prevention of high blood pressure and is an indispensable part of the management of those with hypertension.*

Why doesn't the FDA put that on the label? The draft Guidance to industry for labeling antihypertensive drugs represents a golden opportunity for the FDA to begin educating the public about the primary and cheapest way of treating this leading cause of heart disease.

The second issue involves the draft Guidance's claim that:

> *Numerous single studies (e.g. ALLHAT) and pooled analyses have tested whether drugs given to achieve the same blood pressure goals have the same clinical benefits. To date such studies have not distinguished the effects of different treatments on* **the** *(emphasis added) major hypertension-related outcomes (strokes, myocardial infarction, and cardiovascular mortality).*

By limiting the primary endpoints to strokes, myocardial infarction, and cardiovascular mortality, this statement inaccurately represents the findings of ALLHAT and JNC 7. There are several differences, but let me point out just one. It leaves out the higher rates of congestive heart failure suffered by patients who take calcium channel blockers, one of the more popular and still expensive classes of antihypertensive drugs. The JNC 7 specifically recommends AGAINST using calcium channel blockers as first-line therapy in patients with congestive heart failure. In the new guidance, heart failure should be considered a major cause of morbidity and mortality, and the guidance should distinguish between drug classes in their effectiveness in treating this condition.

Finally, the draft Guidance's recommendation for labeling concludes "many antihypertensive agents have additional effects – on angina, heart failure, or diabetic kidney disease, for example – and these considerations may guide selection of therapy." The labeling guidance further allows companies to include "a summary of placebo- or active-controlled trials showing the specific drug's outcome benefits in hypertension."

While this could be a positive thing if companies chose to apply it to drugs that are less effective in reducing heart failure or less effective when used in certain subgroups like African-Americans, it opens the door for labeling abuse. The medical literature is filled with studies that measured the antihypertensive effects of specific agents on patient subgroups with particular co-morbidities. While those studies may show the drugs are effective in reducing the co-morbidities as well as reducing high blood pressure, they are rarely tested against other agents to see if they were any more or less

effective in reducing those co-morbidities. These trials, which are usually industry-funded and sometimes referred to as "seeding trials," are a way to broaden the use of a particular drug within a crowded field where there are other, often cheaper alternatives that may well be just as effective or more effective – not just against high blood pressure and its primary effects but the co-morbidity. To allow these trials to be included on labels (and thus fair game for mention to physicians by drug industry marketing representatives) would put the FDA stamp of approval on some of the most abusive sales tactics in today's pharmaceutical marketplace.

Combined with the earlier part of the Guidance that did not distinguish between drugs on a primary outcome like congestive heart failure, the net effect of this Guidance could be a huge setback for public health and the public purse.

Finally, allow me to take a few moments to address the FDA staff about my concerns about this committee's balance. As you are well aware, the Federal Advisory Committee Act requires that committees be balanced. You have interpreted this to mean that the committee should have the specialties and expertise needed to render a qualified judgment. But according to the GAO, that provision also requires that committees be balanced regarding points of view, especially when there is controversy in a field as there is in this case. This committee is singular unbalanced in that regard. Specifically, it contains none of the 11 physicians associated with the National High Blood Pressure Education Program Coordinating Committee that wrote JNC 7. Nor were any of the

physicians who led the ALLHAT trial asked to serve on the committee, including the experts at the National Heart, Lung and Blood Institute.

This is an area where you could easily have found unconflicted, highly qualified experts, yet you chose not to do so. In his testimony before the House Appropriations subcommittee earlier this year, acting commission Andrew von Eschenbach said that the FDA should not be prohibited from including scientists with conflicts of interest from serving on FDA advisory panels because they are frequently the best minds in a particular field. But this appears to be a case where you excluded the best minds in the field, whether they had conflicts or not.

Let me conclude by quoting from a study that appeared in this week's Journal of the American Medical Association, which some are interpreting to suggest that conflicts of interest on FDA advisory committees do not matter. That study found a 10 percent greater likelihood that an advisory committee meeting would favor a drug if it contained a person with a conflict of interest. Yet the authors concluded that "Such a level of bias would never be tolerated in a jury (individual jurors are frequently dismissed simply for reading newspaper coverage of their trial). Decisions reached by advisory committees have much greater social impacts." Let me add to that a personal note. I spent 25 years in the news business, mostly as a business and financial reporter. I would be fired if I owned stock in a company I covered. Why? It wasn't just that I might bias my coverage, which, lord knows, I might and often without even being aware of it. It was that the newspaper's credibility was at stake. What would the reading public think if they knew?

I suggest the people who put these committees together for the FDA start asking themselves the same question.

Thank you.