got to write it up, and they have got to submit it to the agency.

And we have then got to review it, and then that is going to be a boat load of data, and so again that is how I am kind of coming up with a year. That is very rough.

DR. SNIDER: Karen, could I just sort of press you a little bit more on the accelerated approval issue.

DR. GOLDENTHAL: Sure.

DR. SNIDER: Because I understand what you are saying, and the way that it has been described to us before in the accelerated approval is that there is one study, and then there is the confirmatory study.

DR. GOLDENTHAL: Well, in some cases it is even the same study.

DR. SNIDER: Okay. That was my next question. Could you design one study that would allow you then to be looking at more than one endpoint, and then as things evolve make hopefully appropriate decisions about whether to continue on, or --

DR. GOLDENTHAL: Well, theoretically, yes. CDER has definitely done that with AIDS drugs, and so on and so forth. Obviously you are blinding and all that would have to be just so. I would not again have

an issue with that trial continuing prior to approval.

The issue would be whether -- well, we would need a high level of assurance that things are going to get done.

CHAIRMAN DAUM: I think we are going to go to Ms. Fisher, Dr. Fleming, and Dr. Kohl, and then we are going to conclude Dr. Goldenthal's presentation. We will have an opportunity to revisit these issues in as much depth as you like, but we are looking to clarify what Dr. Goldenthal is telling us how about the questions and FDA procedures, and what they would like to hear about. Ms. Fisher.

MS. FISHER: If this is the first vaccine that is going to potentially be subject to the accelerated approval process, how does the accelerated approval process impact on the gathering of safety data prior to licensure?

DR. GOLDENTHAL: Well, I would -- you know, that is a very good question, and we would have to at FDA consider what is the minimum amount of safety data, and I would prefer that it be randomized prior to approval. So that is a very good question.

MS. FISHER: Well, if we were to give the indication to the FDA that we wanted an accelerated approval process here, we have not had any discussion

in any depth about safety. In other words is there going to be another meeting that is going to talk about safety data?

DR. GOLDENTHAL: Well, we did not have a specific advisory committee meeting planned, but since that would be a factor in -- again, this meeting is focused on the endpoint question because that seemed to be the most -- you know, where the most, if you will, controversy had been coming up.

But if you have views about the amount of safety data for this particular product needed prior to traditional approval, or accelerated approval, please feel free to speak up. But I do want to make sure that we do cover the endpoint issue in this meeting.

CHAIRMAN DAUM: We will. Dr. Fleming, please.

DR. FLEMING: Actually, I wanted to continue on the line of questioning that I had done earlier, and actually in a sense follow up with a thought similar to Dixie's thought.

The question that I had asked earlier I know was a difficult question, and that is if you randomize -- and let's say hypothetically 10,000 women who are about age 20, who are HPV negative, and you

follow ahead, and you design a trial, and targeting CIN-2/3, and you are looking at needing to detect a reduction in this rate at let's say 3 to 4 years follow-up.

It is my sense that if you followed those people beyond three years for an additional two years, that the number of cases of CIN-2/3 should increase linearly. You are starting at time zero with pristine negative cohort, and during that first three years those people will begin to have HPV infection.

And some of them will be rapid progressors, and some of them more slow progressors. But logic would tell me that if you take a cross-sectional snapshot of those people at 3 years, you are going to have a cohort more advanced than the pristine time zero cohort at randomization.

And the additional 2 years from -- and let's say from your 3 to your 5, could readily yield much more than the number of CIN-2/3 cases that you saw in the first 3 years. Why is that relevant?

Well, it is related to the point that Dixie was stating, which is in essence might the same trial in essence -- and even at the same endpoint, be an accelerated approval endpoint, versus a full approval endpoint?

Specifically, if you were looking at the zero -- and as Dr. Goldenthal had pointed out, if you were designing a trial to simply rule out no reduction, when in truth you expect an 80 percent reduction, it takes a relatively small number of actual cases, on the order of 20 to 23.

Well, there are some disadvantages to this, even if we said CIN-2/3 is in essence an acceptable surrogate endpoint, if you are only looking at the very earliest emergence of CIN-2/3, and you show a reduction in that earliest emergence, that is in essence also just a surrogate for the more global protective effect against CIN-2/3.

And so one approach might well be to design a trial that is targeting CIN-2/3 over a longer time frame, such as 5 to 6 years, where at 3 years, when you have enough evidence to rule out a quality on the CIN-2/3 endpoint, you have accelerated approval, possibly backed up with persistent infection evidence as well at that point, which would be adequately powered because that would take a smaller sample size.

And the backing up by persistent infection would be giving you a bit of a more global perspective of what you might be anticipating in future years on CIN-2/3.

Then you have a cohort that is well under way, and so even if accelerated approval kicks in with access to cross-in's, it will have a less deluding effect on what your ultimate assessment might be 2 or 3 years later, where you might have 2 to 3-fold the number of cases.

And if you do, now if you have 50 cases to 60, now you can look at a test of .5 versus .8, and specifically if you have 80 percent vaccine efficacy now at 5 years, you can rule out that you have less than 50 percent, which is a very relevant issue.

Often with vaccines we expect this. We expect to be able to say not only is there 80 percent protection, but actually I am convinced that there is at least 50 percent protection. So there is a very tangible significant payoff in exchange for what will be a very broad exposure program.

So just to plant the seed, one approach that could be taken here would in essence be to do one trial that would still only have to be of the size of 10 to 15 thousand people, but you get the additional data by additional follow-up, which is consistent with the concept of accelerated approval.

You are getting the answer in the earlier time for an accelerated approval, and you are then

continuing for additional time to get a more global reliable sense of what the effect is.

CHAIRMAN DAUM: All right. That is a very helpful comment. Thank you very much, Dr. Fleming. I think at this point that we will thank Dr. Goldenthal very much for her presentation, and turn to the open public hearing portion of our meeting.

We have three speakers scheduled to address the committee, the first of which is Ms. Cindy Pearson, from the National Women's Health Network, and her comments are related to the considerations that we have had today. Ms. Pearson. She has been asked and been budgeted for 10 minutes to present to us.

MS. PEARSON: I am Cindy Pearson, and I am the executive director of the National Women's Health Network. Our disclosure statement is that we are an independent, non-profit consumer advocacy group, supported by small progressive foundations, and a national membership of approximately 9,000 women, who live in all 50 States.

We do not accept any financial support from drug companies, or device manufacturers. We are frequent visitors to FDA advisory committee meetings, although not to this one. We are more commonly active in reflective health drugs and OB-GYN devices, and

metabolic and endocrine drugs.

It is interesting to come here and testify today because in my actual 13 years of visiting FDA advisory committee meetings, I think this is the only one that has not had its sponsor presentation open to the public.

And I will just share that comment with you. That is an interesting choice, and I understand what guidelines the FDA has that allow it to have closed meetings and when they are useful and even necessary. But just to give you that feedback.

From the perspective of a woman's health group that brings the voice of average women to places where decisions are made in Washington, D.C., we are delighted to see sponsors coming to the FDA and supporting the interests and efforts that have been made by the public health community in the quest for a preventive vaccine for HPV disease.

I don't want to repeat anything that you have heard 17 times already today about how important this disease is worldwide, and how important it is in the United States.

I will just make a point that I haven't heard made this afternoon, which is that it is particularly important I think to low income women and

women of color in the United States. African-American women are less likely to be screened routinely, and have the opportunity to find changes early when they can be treated more effectively than less basically.

And particularly new Asian immigrant women, Vietnamese-American women, have the highest rate of cervical cancer in the United States, and much more reflecting the rate of cervical cancer in the country from which they have come, and other new Asian immigrants.

So even though overall we look at cases of cancer and likelihood of death from cervical cancer that are very small in, and you might say low on the priority list for women in the U.S.

But as a broad-based consumer group, we are aware that for certain groups of women in the United States that it is much higher on the priority list.

So I want to be specific in our comments about the endpoint question, because that is what you are struggling with here today.

And I think we have a perspective that might be useful to you in the average woman's views. I would say to put it very, very -- and oversimplified to the average woman, whether this prevents HPV

infection isn't really all that important, because the average woman is probably infected with HPV, and has it resolved, and never knows.

A very common experience though -- and I acknowledge -- is that a woman is told that she has an HPV inspection, and she has what she is told a very bad pap, and there is some follow-up, and she gets her HPV infection results, and then has some worry about the commonly known association with cervical cancer.

But I would still put forth the perspective from our consumer group that a vaccine that is either approved preliminarily through accelerated approval, or finally through final approval based on its ability to prevent either infinite infection or persistent infection, isn't really making that much of a difference in women's lives.

And obviously ideally the real difference would be to prevent those cases of cervical cancers that have the possibility of killing women. But we are as aware as you of the long, long time that it would take for the need to do it in a country where resources are so low that that is almost all that you can measure.

Probably the best -- from our perspective

the best way to go in what would be potentially a multi-country trial, possibly involving the United States, is the point at which -- having the endpoint of the vaccine prevention trial be the point at which most women would face treatment if this vaccine never came into use in the country in which it is being tested.

We all heard that most women automatically face the definitive treatment if they are diagnosed with CIN-2/3 or HSIL, and in well-insured women in the United States, many women are getting a lot more treatment that has been pointed out a couple of times, in follow-up studies and treatments that they probably don't need.

And I recognize that a well-intentioned person could make a strong argument for having an endpoint being earlier at the LSIL point, or the CIN-1 point. I think we would probably not want to sort of cave in to the fact that there is a lot of over-treatment and over-use of repeat testing in the United States, and push the endpoint back earlier just because that is the reality in the United States. But it is not the appropriate reality, even though it is the reality.

And I also wanted to comment on something

that I thought I heard inside, is that there may be a context in which the FDA has asked you all to come and work hard, and think hard, and give advice, which might lead to you recommending an endpoint which 2 or 3 years from now doesn't exist anymore in the United States because of looming guidelines that may be issued by primary care groups, who you may think may be posed to recommend treatment long before any of these endpoints come into play.

I would argue from the consumers' perspective that it is the FDA and its own deliberative process that gets to the true public health benefit of treatment, drugs, devices, and preventive vaccines, more than the specialty societies with their day to day contact with people who are already being treated or are suffering from late-stage disease.

That this is the one place we have as a society to bring in the balances and checks that help us have a conversation about what the product in the end can really make the most difference in women's lives.

So those are the thoughts that we wanted to share with you, and we appreciate the opportunity to do so; and if anyone wants to ask me a question,

you're welcome.

CHAIRMAN DAUM: Thank you very much, Ms. Pearson.

MS. PEARSON: You're welcome.

CHAIRMAN DAUM: Our next presenter is --

DR. HILDESHEIM: I have one or two comments.

CHAIRMAN DAUM: We will permit one or two comments. We don't usually do that in open public hearings.

DR. HILDESHEIM: I just wanted to state that I am with the National Cancer Institute and we are sponsoring one of the trials, which is publicly financed, and we share your desire for open sessions.

And our trial is open and you are welcome to have any information that you would like of the protocol and details you might want.

MS. PEARSON: Thanks.

CHAIRMAN DAUM: Thank you very much, Ms. Pearson. Our next speaker is Ms. Karen Forschner, a representative or member at least of the Lyme Disease Foundation, who has some comments on LYMErix vaccine, and has asked and been budgeted for between 6 and 10 minutes. Ms. Forschner, welcome.

MS. FORSCHNER: Thank you for having me

today. I think most of the committee members have a copy of the statement. What you will be receiving is each of the exhibits sometime in the next week from Nancy Cherry, I believe.

And she will be making copies for you that go along with this. I am Karen Vanderhoof-Forschner, a mother whose child was born with, handicapped by, and died from Lyme disease.

In 1988, before he died, I co-founded the Lyme Disease Foundation with a team of distinguished leaders who trailblazed into the world unaware of Lyme disease, and within two years, made Lyme disease a household term.

The LDF has always fostered vaccine development, and we have always appreciated the value of vaccines in preventing terrible illnesses. My son had received all his childhood vaccines. My daughter is current in all of her vaccines.

My aunt, who suffered from polio, could have had a much richer life if there was a vaccine that she had taken. I take the flu vaccine every year, and our pets have always been fully vaccinated.

And many of you may remember me from the 1998 vaccine meeting, where LYMErix was approved for us. I am back. Based on the new data that we have

seen in the last 6 months, and the data that you will be receiving later, I believe that the OspA-Vaccine represents an imminent and substantial hazard to the public health, and needs to be immediately recalled.

I believe that the vaccine process has been seriously flawed. Information has been withheld from the vaccine advisory committee, and possibly the FDA, and that experts that could have helped provide information were never invited to participate, enough to compromise all of the trial data, and even to cast doubts on the integrity of the investigators.

Please take this as a clear warning to you, the FDA, and the vaccine advisory committee, that we are asking you to demand that the manufacturers fully complete all safety and efficacy studies and never again let them promise you a study tomorrow for your approval today.

The FDA's decisive action is important to pull this from the product. Let me cover several sections that I believe are important. As you know, there has been great concern about the OspA vaccine having a cross-reactive effect to certain genetically vulnerable populations.

In May of '95, even the principal investigator in the vaccine stated that he felt a

small number of people in the vaccine were having vaccine related adverse reactions.

In '98, he published finding the actual potential autoantigen to the OspA-vaccine. There was a meeting in January of this year, an excellent meeting, to take a look at the safety.

Unfortunately, and in cases of adverse events related to the vaccine were published and presented at scientific meetings. What you didn't know was that in the fall of '99, scientists that were involved in trials found that they modify the polypeptides in the OspA-vaccine and knew exactly which ones to modify to reduce side effects that could be attributed to the vaccine, and then patented this.

The patent was on the web and you can see the genetic codes that they modified, and you can see the test that they performed, comparing regular OspA-vaccine to their new modified, safer vaccine.

And indeed in the patent it says there exists an urgent need for an improved vaccine for the prevention of Lyme disease, and they were able to show that the OspA-vaccine causes increased self-binding, increased human T-cell proliferation response, increased cytokine production compared their safer vaccine.

I believe at this point the theory is ended and we now know that there is a threat. There are also violation entries or violations of entry criteria.

Instead of healthy people as an entry, and then the exclusion of those having associated joint swelling and musculoskeletal problems, which indeed they enroll people in the study within six weeks, about 20 percent of those people are in violation to the entry criteria.

This includes people with osteoarthritis, clinical depression, multiple sclerosis, Parkinson's Disease, abnormal movement disorders, and the list goes on.

The concern we have is that by a 20 percent violation, which has as far as we know not been reported to IRB, or to the patients themselves, you put a vulnerable population at risk.

I also included in this a sample of some of the people, their prior history, and what was attributed to the vaccine or not. Anyone that had a prior history of any musculoskeletal problems that then had a problem during the vaccine process, it was declared not related.

The only one that I could find in an FOI

was a woman who had menopause, and at that point her adverse reaction was attributed to possibly the vaccine. There are serious concerns from the FDA data on the protocol itself, and on how the data was reported.

According to SmithKline, there are two people with neurologic Lyme disease that came out of this study. Unfortunately, they had serious flaws, and they had the right to choose, to decline to do spinal taps, and EMGs on patients, and without that, the patients that had neurologic Lyme could not be categorized as definite Lyme.

So of those two that were reported as having Bell's palsy, there happened to be an additional 414 that were all of a sudden reported that still don't show up on the slide shows and presentations that are given.

The problem that SmithKline said was that they found that they had not included a code for facial nerve disorder, and therefore, they weren't reportable. And for those that did have Bell's palsy, they decided to report them only if they had an EM rash at the same time.

Through the FOI, we found repeated problems, including the fact that there was a patient

diagnosed with meningoencephalitis that did not receive a spinal tap, and received oral medication which is outside the standard of care for this protocol.

There was a patient that was in the hospital with diagnosed Lyme meningitis, and a spinal tap was performed and not tested. Those people were not afforded. Indeed, there was an analysis of those with the Western positive versus Western block negative that showed those who were Western block positive had an increased incident of late adverse events, including skin and appendage disorder, musculoskeletal system disorder, central and peripheral nervous system disorders, autonomic nervous system disorders, psychiatric disorders, gastrointestinal disorders, white cell and RES disorders, and resistant disorders.

This information did not make the package insert.

There are people that I am suggesting for any other vaccine advisory committee when the next generation of Lyme vaccine comes along, and I am concerned that the vaccine committee who I have called members that were on as expert witness in January were unaware of any of this data that I presented to you so far.

They were also unaware that the pediatric data was available, and that the Connaught vaccine data was available. They were unaware that we had been told, the Lyme Disease Foundation, that there was a Harvard study -- not the Harvard Pilgrim study, a study that was done earlier that showed some of these adverse events, and whether or not they were related, and it has not been published, and it has not been presented.

In July, after this meeting, we found a press clipping where GlaxoSmithKline indicated that they were about ready to start another Phase III trial with 10 to 15,000 people. New York had legislation introduced to mandate this vaccine for all the pediatric population in the State.

OSHA was working on a mandate, and there was a mandate in the Federal Government for legislation for Medicare to cover the vaccine. Even the fundamental rule of a vaccine and how it works is not even correct.

As you know the vaccine works by your immunonized blood going into the tick. If you read the study which I have presented in the packet, it takes the tick 4 days of feeding, and 10 days of sitting before the bacteria is eliminated in the tick.

It takes 2 to 3 days to transmit the disease to you. So the method of action that is publicized and in the package insert by the own publication that it references, doesn't work.

I am concerned, too, that there was blood taken out of this trial and patented for personal profit, and for other people that were not in the trial, and I am concerned about our ability to get FOI information from the FDA, which is heavily redacted.

However, I would like to say that Karen Mittune -- and I don't know if she is here, or if I am even saying her name right -- had an incredibly tough job, and from the paper trail that we saw, every day was busy trying to protect the public interest in this material.

It was an extraordinary effort, and I am telling you that I am glad that I am paying her salary with my tax dollars, and I would gladly raise my tax dollars if you guys would give her a raise and more power. I am not done. One second.

CHAIRMAN DAUM: I think we all share that view.

MS. FORSCHNER: In conclusion, I believe that it is now time to recall the vaccine. If anyone wanted a vaccine it would be me, and if anyone

believes that this vaccine, based on the science and not emotion, is not fit for consumption it would be any of us that are in the community, the scientific community.

I believe that the FDA and the Vaccine Advisory Committee should never ever let a pharmaceutical get away with promising studies tomorrow, for an approval today, and what I call the Whimpy effect, which if you remember him from Popeye was constantly promising to pay tomorrow for the hamburger today.

I would thank you for the time speaking today, and I hope that you can take this under advisement as a committee and as an FDA. Thank you.

CHAIRMAN DAUM: Ms. Vanderhoof-Forschner, we thank you, and our third speaker --

MS. FISHER: Dr. Daum, I would like to make just a comment. As a consumer representative, I really feel like I need to make the comment if I could.

CHAIRMAN DAUM: Well, we have representatives from all different factions, Ms. Fisher. Why does that make you any different?

MS. FISHER: You allowed a comment on the last statement.

CHAIRMAN DAUM: Please make your comment.

MS. FISHER: Thank you. As I said, as a consumer representative, I think I do need to make a comment. I know Karen Forschner, and the work that she has done for many years to promote the development of a safe and effective Lyme disease vaccine that would prevent other children from dying like her son did.

And I don't think that she would be coming forward here today if she did not have good evidence about the licensed Lyme vaccine and that it was hurting people.

Her assertion in this document, which I only saw a couple of minutes ago, unfortunately, that there was an application for a patent for Lyme disease vaccine filed in March of 2000 that indicated that there is a population of individuals who are genetically at risk for developing autoimmune after vaccination is a very serious assertion.

And if this was known nearly 2 years ago, then the FDA and this Committee should have been given the information so that at the very least there could have been a labeling change made, because in the last two years there have been many people who have gotten the vaccine, and they could have been given the

information that they were genetically at risk for having a reaction.

And I don't know at this point what procedure is followed, but I think that the committee does need to reconsider all of the information so that we can potentially do something about it.

CHAIRMAN DAUM: Thank you very much, Ms. Fisher. Our third and last to my knowledge speaker for the open public hearing is Mr. Sheller, of the law firm of Sheller, Ludwig & Badey, who has asked to speak to the Committee also about Lyme disease vaccine, I believe, for 5 minutes. Mr. Sheller, welcome.

MR. SHELLER: Yes, thank you. I might mention that I am somewhat familiar with the other issues, the gynecological issues, that you are talking about, and I might suggest to the committee unrelated to my comments on LYMErix, but related, that you should consider calling for your own advice Dr. Charles Magnan, a gynecological oncologist.

And my background is that my wife did the original logo for the gynecological oncology surgery group. And John Macuda. I think they have some opinions on this, because we have talked about this, and I think you need to start to look at bringing

outside people in and not just those that the FDA presents on their agenda.

I think you will get some really good information from these people. Those are top surgeons in gynecological oncology from Philadelphia. They have an opinion on this, and would love to help you with it.

Let me get on with my comments. On January 31st of this year, I was privileged to have the opportunity to address this Committee to discuss the numerous serious adverse reactions that have been experienced by individuals vaccinated with SmithKline's (sic) vaccine, LYMErix.

At the conclusion of that meeting, many of you made serious significant and substantial recommendations to the FDA to help better inform the medical community and protect the general public from the potential serious risks of this vaccine.

Now, 10 months later, the FDA has yet to implement any of these recommendations, nor has the manufacturer taken heed of the committee members' admonitions regarding both the safety and efficacy of LYMErix.

The circumstances surrounding FDA's approval and continual endorsement of this vaccine are

now becoming disturbingly reminiscent of the case of Lottronex, another GlaxoSmith (sic) product which was recounted in a commentary in the May 19th, 2001 issue of the journal, Lancet, entitled, "Lotronex and the FDA: A Fatal Erosion of Integrity."

It was noted that in the case of Lotronex that private communications appear to have subverted official procedures, while suppressed scientific debate has superseded a full and open review process.

The FDA's and FlaxoSmithKline's failure to act upon your recommendations is even more troubling given the information that has come to light in the past 10 months, much of which was known at the time of your hearing in January, and even at the time of the hearing in 1998, and not brought to your attention.

Let me bring to your attention the fact that there in the Journal of Rheumatology, in the November 2001 issue, a case report series by Dr. Carlos Rose, and Paul Fawcett, and Kathleen Gibney, at the Alfred DuPont Hospital for Children, confirming the adverse reactions of arthritis caused by this vaccine.

You can read the article if you haven't read it already. Dr. Fawcett and Dr. Rose offered to come to this FDA meeting, and offered to come to the

FDA and talk to Dr. Mittune and to whoever they want, as did Dr. Donald Marx, M.D., Ph.D., head of the Connaught Research Study, as did Dr. Schell, and as did numerous other medical professionals who know as much as anybody in the world about this LYMErix vaccine.

The FDA refused to meet with them. I think that is disgraceful. Now, I don't know what their reasons are, but that has got to stop, and it is up to this committee not to be manipulated into just accepting the material which is put in front of their nose and having the people come before them that the FDA's representatives has chosen to allow you to hear.

Now, let me take you back a step, and I am skipping over the statement. You can read a lot of it. Some of it comes from the New England Journal, and I recommended that some of those people should have been called in here.

And you ought to ask why Dr. Steere didn't come in and tell you why he is not getting the vaccination himself. Interesting, isn't it? He lives in Boston, I think, and I think he visits Cape Code I would assume.

Now, let me take you back. The FDA has a study of the risk of LYMErix, which continues to

proceed at a slower than a snail's pace, and although I was unable to attend the American College of Rheumatology meeting this month in San Francisco, I understand the presentation of Dr. Platt's Phase IV cohort study of LYMErix continues to suffer from low enrollment, well below the 25,000 vaccinee target established by the FDA, and shows no signs of acceleration.

The FDA's own study of a small portion of the vaccine adverse event reporting system reports, initially discussed by Dr. Robert Ball of the FDA at the January 31st meeting, continues to raise serious questions.

Initially the study only appears to be looking at reports of arthritis and arthralgia, and not the non-specific pain syndromes and developments of Lyme disease-like symptoms, including neurological conditions such as Bell's palsy, optic neuritis, and acute transverse myelitis.

We have heard from numerous individuals who experienced these symptoms shortly after vaccination with LYMErix. In fact, you heard that a large group of them come in here on January 31st, and I can tell you that several of them have gotten worse and none have gotten better.

However, this large population of adverse reactions is apparently being ignored at this time. The FDA has reportedly identified 415 VAERS reports which are coded as arthralgia or possibly arthritis.

However, as of the Rheumatology convention in mid-November of this year, they had only completed the interviews of 49 of these people, and had complete medical records only 31 of those 49.

Therefore, even the very limited study of this small arthritis subgroup was proceeding very slowly. However, despite these problems in the study design and implementation by the FDA, it nevertheless identified out of these 31 people on whom they have complete interviews and collected full medical records, 14 with physician-diagnosed definite arthritis.

According to the FDA, 7 of those 14 cases of physician diagnosed definite arthritis could not plausibly be attributed to any other cause or concomitant condition other than LYMErix. Nothing is in the label about this.

Now, I can go on. There were other cases they identified, and they were eliminated possibly because they had some familiar history of the immune-mediated disease or inflammatory arthritis.

These seven people also may very well constitute cases of LYMErix induced arthritis, which would bring the incidence rate of arthritis of 45.2 percent, 14 of 31 completed interviews with records; and projected out to a total of 187 cases of LYMErex induced arthritis for this small group of 415 reports.

That would present much higher numbers than those which prompted Dr. Wayne Ray to make his comment back in January of the unusually high number of adverse reactions in VAERS reports that he found that is a red flag, and I am quoting his words, "red flag."

When one considers the generally accepted notion that as few as 10 percent of all adverse reactions are ever reported, together with the fact that FDA has excluded from its study the Lyme disease like adverse reactions which have actually been reported, and the fact that many of the individuals who have reported adverse reactions have never been contacted.

And I keep writing to the FDA on how come you have not contacted most of my clients, like 95 percent of them. It is clear that the results of this study will grossly understate the actual occurrence of serious and severe adverse reactions.

In fact, beyond the issue of arthritis and Lyme-like symptoms, I am aware of several individuals who have experienced crippling acute transverse myelitis, ALS-like symptoms, and other de-myelinating syndromes which were undoubtedly triggered by the immune response to the OspA.

In light of the questionable and short-term efficacy of the vaccine, according to the manufacturer's own principal investigator, a vaccine which poses such risks should not be on the market.

And to the extent that the FDA is taking the position that individuals with a familial history of immune-mediated disease or inflammatory arthritis, and prior history of physician-diagnosed Lyme disease, cannot have their post-LYMErix arthritic symptoms accurately diagnosed, and at the very least LYMErex should be contraindicated for such people because of that.

The FDA's failure to bring the critical information outlined in this submission to the attention of the committee, and the substantial flaws in the FDA's own study of VAERS reports, and the FDA's failure to insist that GlaxoSmithKline comply with its Phase IV safety surveillance obligation, or withdraw the LYMErix until such compliance is achieved, raises

the specter of the subversion of official procedures and suppression of scientific debate complained of in the Lancet this year in May.

As is demonstrated in that article, the FDA essentially sacrificed the credibility and integrity of CDER to accommodate the wishes of GlaxoSmithKline for Lontronex. I fear the same may be happening here, and I would commend to you that there is a representative of NCI here.

And I was heavily involved in this NCI report that issued yesterday on smoking, and light, and low-tar cigarettes. I was the guy who discovered the documents that led to this report, and I can tell you that they have a much more open process.

Much more open. They bring in people from all over to get information. Judy Wokenfell from the FDA, who is now retired, she was terrific. She didn't wait. She asked for anybody that had information to come into the FDA and talk to them, and bring them the documents, and bring them what they had to know, and that was on February 3rd of 1999.

Don Shopplip, from NCI, what he did, he was at those meetings, as was NCI and FDA people, and that is what you should be doing as this committee. You need to hear from the experts and others who have

information, and not just those who the FDA vaccine people want to put in front of your nose. Thank you.

CHAIRMAN DAUM: Thank you very much, Mr. Sheller, and in the spirit of fairness, we will offer one comment if there needs to be one from a committee member or sponsor. Okay. Thank you very much.

So I think in terms of addressing the FDA questions that are the agenda of the meeting today, we have made a lot of progress, and I think we are prepared to explore tomorrow morning issues which we are uncertain about, and then move on to hearing from each temporary voting member and committee member about their views on the two FDA questions.

We will also have an open session on the laboratory of bacterial toxins here at FDA, and I have arranged for that review and discussion to follow our completion of discussion on the two questions related to HPV.

So I am hoping to start promptly at 8:30, and that everybody will be bright-eyed and ready to go, and thank you very much for you participation and comments today.

(Whereupon, at 5:08 p.m., the Open Session Meeting was concluded.)

CERTIFICATE

This is to certify that the foregoing transcript

in the matter of: VACCINES AND RELATED BIOLOGICAL PRODUCTS ADVISORY COMMITTEE

Before: FOOD AND DRUG ADMINISTRATION
CENTER FOR BIOLOGICS EVALUATION AND RESEARCH

Date: NOVEMBER 28, 2001

Place: HOLIDAY INN
8120 WISCONSIN AVENUE
BETHESDA, MARYLAND

represents the full and complete proceedings of the aforementioned matter, as reported and reduced to typewriting.