

1 DR. PATTERS: It can be if you like.

2 DR. MERCURI: I didn't know quite how to work this
3 answer in but this gives me an opportunity to answer the
4 question. As someone else said, I appreciate, obviously,
5 the problems that these patients have. I have been dealing
6 with these patients on a clinical basis, on a daily basis,
7 for the past ten years so I think I can speak from
8 experience.

9 These patients are the most difficult patients to
10 deal with, not from a character flaw. They just have a
11 significantly difficult clinical problem to deal with and it
12 is multifactorial, as we have talked about.

13 I hear the good side of this. We talked about
14 bias before. Maybe it is a bias that these patients come
15 back and they say they are doing very well. When I see a
16 patient that comes back in eight years and the patient says
17 that they are doing extremely well, it is a much different
18 experience than what we have been hearing.

19 I would like to panel not to think that all of the
20 patients who have temporomandibular-joint implants, be they
21 be TMJ Concepts implants or be they be the Christensen
22 implants, are not doing well. My biggest concern is that we
23 may be overstating how bad these patients are doing.

24 These patients do well, or as well as they
25 possibly can do, based on the disease process. I think Dr.

1 Bertrand and Dr. Gonzales have a very good point. This is a
2 different group of patients that we are dealing with here.

3 The other thing is that someone made the point
4 that we need to inform these patients. It states right in
5 the documentation that the patient gets as well as the
6 consent that they get, and I am quoting, "Unfortunately the
7 complete elimination of pain is not possible." It is not
8 possible. We never go in with the idea that these patients
9 are going to have their pain completely eliminated.

10 So I will leave it at that unless there is another
11 question.

12 MR. ULATOWSKI: I had to make a bureaucratic point
13 of order but I think that, this being the closed committee
14 discussion, we need to keep the discussion within the panel
15 so that the manufacturer isn't turning a one-hour
16 presentation into a two-hour presentation over time here.

17 DR. PATTERS: Could I address that, then, to the
18 oral surgeons that are on the panel as to what they think
19 the success rate of these generic devices are.

20 DR. STEPHENS: I am not sure that I know the
21 answer to that across the board but I can speak from
22 personal experience. We have, in the group with which I
23 work, a very high success rate but it is really tied, I
24 think, in large part, to the fact that they are mated to a
25 very aggressive chronic-pain management group because,

1 clearly, in the group of patients who have that first
2 operation, for example, for ankylosis, they do very well.

3 In fact, a great reason that they do well is the
4 fact that they have not had multiple procedures which, in
5 themselves, generate problems. In the patients who have had
6 multiple operations, we have always looked at the total
7 joint, itself, as the one point that you can use as a
8 starting point to stabilize their occlusion, to approve
9 their function, to make them look better, to get patients to
10 generally feel better about themselves as a part of a
11 chronic-pain management approach.

12 We have found that they very well. I would say
13 that our success rate is--I know that it is greater than 90
14 percent, but it is very hard to know, across the board,
15 because I think that also the surgery is very much surgeon-
16 dependent. I think that it is very technique-sensitive.

17 DR. HEFFEZ: I have had so many patients who have
18 come to me who have been multiply operated and they just
19 tell me, "Get me back the way I was when I first walked in
20 to the office before I got my first surgery."

21 So I would say today the majority of treatment
22 that we are doing is to correct iatrogenic disease. I would
23 say that is the majority of times that we are operating.

24 As far as success, I take it patient-by-patient.
25 I try to identify the patients complaints and try to gauge

1 what I can do for that particular patient. It is not that
 2 easy to be able to say how that patient is going to benefit
 3 from a procedure. There lies, I think, experience and where

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it sort of crosses the border between art and
 5 science and it becomes more of an artistic sense of knowing
 6 when to operated on a patient and when to say, "I can't
 7 offer you anything anymore."

8 We have to, I think, identify the complaints and
 9 then see, in our minds, if we can identify the etiology for
 10 that complaint. Sometimes, the etiology is a closed
 11 vertical dimension. If you can direct that vertical
 12 dimension, that patient may be okay. Sometimes, a patient's
 13 chronic complaints of pain are due to foreign microbe
 14 particulate, foreign body material, where there is no way
 15 you can remove all that foreign body material.

16 You can remove the gross amount but there is no
 17 way you can remove that micro-particulate matter. Sometimes
 18 they have parafunctional habits that are not properly
 19 controlled. And that impact on the symptomatology is
 20 difficult to know.

21 So it has to be patient-by-patient. I have a good
 22 number of failures, I will tell you, and I have a good
 23 number of successes. But for me to just bring it and lump
 24 it up into one study would be very difficult. Hence, the
 25 problem with all these studies is that it is a heterogeneous

1 population. I truly believe you need an option, you need an
2 alloplastic option for the patients.

3 You wish you could control the practitioner to
4 determine when it should be used or not.

5 DR. JANOSKY: Dr. Burton, do you have a response?

6 DR. BURTON: I would just like to add to that I
7 think that the other issue is just time frame and length of
8 time. I think that what Dr. Heffez says is very true, it is
9 a multifactorial problem and there certainly is not
10 question, at least in the institutional setting where we see
11 patients from a broad number of practitioners that it
12 certainly is surgeon-specific to a degree.

13 I think that, in the short term, the success with
14 these types of devices looks pretty good. I think that the
15 problem is that there has been a real paucity of any data
16 that is very long-term. When you talk about a group which
17 demographically is very commonly either 30 to 40-year-old
18 age bracket, and you are looking at something that has a one
19 or a two or a three-year time frame, it doesn't give you
20 much of a feeling for what is going to happen at that five-
21 year, ten-year or fifteen-year point.

22 I think that that is when you ask about what is
23 the success. The real question is what is it at that point.
24 Our job is really not to make that determination, maybe to
25 give some insight into that if it was possible. But I think

1 that that is where the real question of whether it is
2 successful or not--I think that short-term, probably, from
3 what I have seen, the success of these devices is well up in
4 the 90 percent brackets.

5 Was it as high as, perhaps, hips? I don't think
6 that it is. It is probably more like the low 90th
7 percentile rank. But the problem is that most of those,
8 again, are short-term data. When you start to get beyond
9 two or three years, the numbers drop off so radically that
10 you really probably don't know what the five-year-or-greater
11 success is.

12 I don't think anyone knows the answer to that
13 right now.

14 DR. PATTERS: Can you address the people that have
15 had multiple implants and have had them replaced over and
16 over again. Can you address those issues? Do you think
17 that was poor surgical judgment?

18 DR. STEPHENS: I think, frankly, in patients who
19 have had multiple procedures, oftentimes one of the major
20 problems is that they are not followed. When they come into
21 the group--and, again, this is a personal approach to doing
22 it in the center with which I am associated, but I find that
23 one of the things that is most settling for patients is
24 assuring them that they are in a group that is going to stay
25 with them, that is going to stick with them if there is a

1 problem.

2 There are so many factors. As an example, in a
3 total-joint patient who, a year or two down the line, is
4 having uncontrolled pain, the joint really doesn't matter if
5 it is really a muscle-spasm problem. But, on the other
6 hand, the patient doesn't know either.

7 So it is very important that there is continuity
8 in their care. So I think the problem with the multiply
9 operated patients is--I think there are many reasons for it.
10 I don't know that you can really pin it down.

11 DR. BERTRAND: I think, if there have been
12 multiple surgeries, the primary etiology was never addressed
13 in the first place and people are just overlooking whatever
14 may have caused that problem initially. I think that is
15 what Dr. Heffez is talking about. We are trying to correct
16 a desperate group of patients who have had the change and
17 they can't function.

18 But I think it is very important to go back and
19 ask, what was the original group of problems that have been
20 magnified by the repeated surgical insults that do created
21 post-surgical neuropathies as well as saying, "This area
22 hurts. I am not going to let you use that part of my body
23 and I am going to look for other patterns of muscle
24 activity." That is what we are not seeming to look at and
25 that is what we need to characterize right from the

1 beginning.

2 With the group of patients we are talking about in
3 this dataset right here, they have not been characterized
4 enough as to what is interfering with their life and how
5 their pain is affecting them from day 1 through day 1,000.
6 There are ways to do that. There are people that can
7 characterize this.

8 It is not psychogenic or psychosomatic. It is
9 neurogenic or neurosomatic and what is actually happening.

10 DR. JANOSKY: Before calling for a motion, Ms.
11 Scott is going to remind us of the recommendation options.
12 We will move into the motion phase now.

13 MS. SCOTT: This document that I am about to read
14 is in the panel packet so if you would like to pull this
15 from your packet and read along as I read it.

16 "Panel recommendation options for premarket
17 approval applications. The Medical Device Amendments to the
18 Federal Food, Drug and Cosmetic Act require that the Food
19 and Drug Administration obtain a recommendation from an
20 outside expert advisory panel on designated medical device
21 premarket approval applications that are filed with the
22 agency.

23 "The PMA must stand on its own merits and your
24 recommendation must be supported by safety and effectiveness
25 data in the application or by applicable publicly available

1 information. Safety is defined in the Act as reasonable
2 assurance based on valid scientific evidence that the
3 probable benefit to health under conditions of use outweigh
4 any probable risk.

5 "Effectiveness is defined as reasonable assurance
6 that in a significant portion of the population, the use of
7 the device for its intended uses and conditions of use when
8 labeled will provide clinically significant results.

9 "Your recommendation options for the vote are as
10 follows: approval; there are no conditions attached. The
11 resulting agency action; if the agency agrees with the panel
12 recommendation, an approval letter will be sent to the
13 applicant.

14 "The second option is approvable with conditions.
15 You may recommend that the PMA be found approvable subject
16 to specified conditions such as resolution as clearly
17 identified deficiencies which have been cited by you or by
18 FDA staff prior to voting. All of the conditions are
19 discussed by the panel and listed by the panel chair.

20 "You may specify what type of follow up to the
21 applicant's response to the conditions of your approval
22 recommendation you want; for example, FDA or panel follow
23 up. Panel follow up is usually done through homework
24 assignments to the primary reviewers of the application or
25 to other specified members of the panel.

1 "A formal discussion of the application at a
2 future panel meeting is not usually held. If you recommend
3 post-approval requirements to be imposed as a condition of
4 approval, then your recommendation should address the
5 following points: A, the purpose of the requirement; B, the
6 number of subjects to be evaluated; and, C, the reports that
7 should be required to be submitted. Agency action; if FDA
8 agrees with the panel recommendation, an approvable with
9 conditions letter will be sent.

10 "The third option; not approvable. Of the five
11 reasons that the Act specifies for denial of approval, the
12 following three reasons are applicable to panel
13 deliberations : A, the data do not provide reasonable
14 assurance that the device is safe under the conditions of
15 use prescribed, recommended or suggested in the proposed
16 labeling; B, reasonable assurance has not been given that
17 the device is effective under the conditions of use
18 prescribed, recommended or suggested in the labeling; and,
19 C, based on a fair evaluation of all the material facts and
20 your discussions, you believe the proposed labeling to be
21 false or misleading. If you recommend that the application
22 is not approvable for any of these stated reasons, then we
23 ask that you identify the measures that you think are
24 necessary for the application to be placed in an approvable
25 form.

1 "Agency action; if FDA agrees with the panel's
2 not-approvable recommendation, we will send a not-approvable
3 letter.. This is not a final agency action on the PMA. The
4 applicant has the opportunity to amend the PMA to supply the
5 requested information. The amended application will be
6 reviewed by the panel at a future meeting unless the panel
7 requests otherwise.

8 "Finally, tabling. In rare circumstances, the
9 panel may decide to table an application. Tabling an
10 application does not give specific guidance from the panel
11 to FDA or the applicant thereby creating ambiguity and delay
12 in the progress of the application. Therefore, we
13 discourage tabling of an application. The panel should
14 consider a not-approvable or approvable with conditions
15 recommendation that gives clearly described corrective
16 steps.

17 "If the panel does not vote to table a PMA, the
18 panel will be asked to describe which information is missing
19 and what prevents an alternative recommendation.

20 "Following the vote, the chair will ask each panel
21 member to present a brief statement outlining the reasons
22 for their vote."

23 DR. JANOSKY: At this time, I would like to call
24 for a motion.

25 DR. GONZALES: I would like to make a motion.

1 Since pain is not an indication by the company, I would
2 motion that if the device is approved regarding the
3 nonclinical aspects and now focussing on the clinical
4 aspects that the device should be approved if, one, a
5 prospective study that measures pain and pain relief and
6 medication to be used to modify pain be performed, since
7 pain is still a significant factor in patient's going to
8 oral surgeons for this device that, two, patients should be
9 told that the studies do not yet reveal that pain is
10 significantly modified and that, three, patients with ten or
11 more surgeries should be told that the implant will not help
12 them since the information provided by the company indicates
13 that.

14 So the motion is a little bit complex in saying
15 that, first, if the device is approved in terms of its
16 characteristics, device characteristics, non-clinical
17 characteristics, that, then, the device be approved but with
18 the conditions one, two and three that I have just stated.

19 DR. JANOSKY: If I am understanding you correctly,
20 then, you are proposing a motion for approvable with
21 conditions; is that correct?

22 DR. GONZALES: Yes.

23 DR. JANOSKY: The conditions being one, a
24 propsective study with very detailed information concerning
25 pain be assessed. Two--I am reading this as a labeling

1 concern in terms of the device not modifying pain or not
2 having an impact on pain.

3 DR. GONZALES: That means you should be told that
4 the studies at the present time do not yet reveal that pain
5 is significantly modified. That isn't to say that, in the
6 future, the study won't show that. And that, three,
7 patients with ten or greater surgeries should be told that
8 the implant will not help them with their pain because those
9 individuals may end up going through the surgery for other
10 reasons, function reasons.

11 DR. JANOSKY: Just to get it clear in my mind; is
12 number 3 a suggestion for a labeling issue or for an
13 indication-for-use issue, where you are talking about
14 patients with greater than or equal to ten surgeries?

15 DR. GONZALES: I think that patients should be
16 told, however that would take place, whether it is a
17 labeling issue or some mandatory issue. But it is clear
18 that patients with ten or greater surgeries do not have
19 improvement in their pain and, therefore, they should not be
20 told that that is going to be the case, that they will not
21 have improvement.

22 DR. HEFFEZ: Could I make a suggestion. Could we
23 maybe limit the motion to whether it falls into one of these
24 three categories and then be specific on what we want the
25 conditions to be?

1 DR. JANOSKY: I am understanding him to say that
2 it is approvable with conditions and that he is listing the
3 conditions. I don't want to speak for you, but--is that
4 correct?

5 DR. GONZALES: That's correct.

6 DR. HEFFEZ: Are we voting on the entire package
7 or just the fact--

8 DR. JANOSKY: Right now we are just discussing the
9 motion. It is just a discussion of the motion currently.

10 DR. HEFFEZ: His motion is very specific. Could
11 he initially just make his motion approvable with conditions
12 and then, later on, be more specific because it will be hard
13 for everybody to want--they may want to add additional
14 conditions as well and make it very hard for the panel.

15 DR. BURTON: In past votes, though, in other
16 panels, this format of making a motion with conditions;
17 that's fine. I can also make the motion now that the device
18 be approved with conditions.

19 DR. JANOSKY: As I am understanding it again, the
20 motion currently is approvable with conditions and then, so
21 far, three conditions were proposed. Any other discussion?
22 A second?

23 DR. BURTON: I would like to make an amendment to
24 that. I was going to make a motion for approval with
25 conditions. However, one, I think that there should be a

1 study done looking at particulate levels in a test-lab
2 situation so we would have some kind of a feeling for what
3 is produced particulatewise in a lab-bench situation and,
4 secondly, since, at this point in time, the current study is
5 only approximately three years old, that that be continued
6 to the five-year point for reporting purposes and that,
7 again, lastly due to the small number of patients involved
8 with these devices that there be a maintained registry of
9 patients so that there be some longer-term issues so that we
10 have some way of identifying both the numbers placed and the
11 type of implants placed.

12 So my three conditions are one, particulate levels
13 being done on a lab-bench; two, longer-term follow-up with
14 completion of the current study to five years; and, three,
15 establishment of registry of all patients where these
16 implants are utilized.

17 DR. JANOSKY: Any additional modifications? We
18 will go through the motion again and call for a second.

19 DR. LI: I'm sorry. I am confused a little bit
20 now. Are we adding our conditions now? Is that what we are
21 doing?

22 MR. ULATOWSKI: I would agree with the comment
23 about a clean vote on one of the three types and then
24 discuss the conditions separately.

25 DR. JANOSKY: Let's return, then. There was a

1 motion that was placed on the table that said approvable
2 with conditions.

3 [Seconded.]

4 DR. JANOSKY: That has been seconded. Let's call
5 for a vote. Let's start on this side. Again, it is
6 approvable with conditions.

7 DR. PATTERS: Point of order. How could one vote
8 if they don't know what the conditions would be?

9 DR. JANOSKY: Could you give us some direction
10 again, please.

11 MR. ULATOWSKI: You can discuss at this point in
12 time before you vote as you go around.

13 DR. JANOSKY: So approvable with conditions,
14 again. Discussion.

15 DR. BERTRAND: I have some discussion. I am very
16 curious about the patients who there isn't follow up on. I
17 would like for any future patients in a prospective study to
18 be characterized by life interferences, depression, anxiety,
19 things like that. I would recommend that if we are going to
20 do prospective studies, employ somebody who can assess it in
21 patients so you can see before and after.

22 Perhaps that would give us an idea of why certain
23 patients are not doing follow up. There may be also a way
24 that we can assess what is the degree of financial
25 constraints that prevents people from doing follow ups in

1 situations like this.

2 The best of all worlds would be to do studies
3 where there is some financial incentive. I don't know if
4 that is really possible.

5 DR. PATTERS: I would like to see one of the
6 conditions being that, in order to gather the follow-up data
7 that the sponsors take the responsibility of the surgeon's
8 fee rather than the patients. To me, that is an enormous
9 detriment to collecting absolutely critically needed follow-
10 up data.

11 DR. HEFFEZ: Do you mean the actual initial
12 surgery or the follow up.

13 DR. PATTERS: The follow-up data so patients are
14 not lost to follow up because they have to pay the surgeon
15 to return to the office. I think the company should bear
16 that, the sponsor should bear that, burden so that we can
17 get the follow-up data out to multiple years.

18 DR. HEFFEZ: When you talk about cost, do you
19 include transportation costs and fee for a consultation?

20 DR. PATTERS: That is how we do it? Our sponsors
21 compensate the patient for their inconvenience for them to
22 come in for us to collect this data.

23 DR. HEFFEZ: I understand. I just want to be
24 clear whether you are including transportation costs.

25 DR. PATTERS: Yes.

1 DR. HEFFEZ: I feel it would be important to study
2 the material as it pertains to different diagnoses, whether
3 it is related to the failed Proplast/Teflon implant, whether
4 it is related to an inflammatory disease, tumor
5 reconstruction. I think the data has to be separated out.

6 DR. JANOSKY: We have two motions on the table,
7 both of them with different conditions, but the motions,
8 themselves, have been approvable with conditions. In our
9 discussion, we have suggested other conditions. So I am
10 asking that Dr. Gonzales and Dr. Burton either revise their
11 motion or withdraw them and someone else present one with
12 the additional conditions.

13 DR. BURTON: I will withdraw mine.

14 DR. GONZALES: I don't understand. You want a
15 retraction?

16 DR. JANOSKY: A modification to include all of
17 these. But we need to call for it as an additional motion
18 and withdraw the other two.

19 DR. GONZALES: Can you state all of the conditions
20 and modifications and then we can actually vote?

21 DR. JANOSKY: I can state them--

22 DR. LI: Excuse me; a question before we do that.
23 Do I understand that we should say all our conditions now if
24 we have them? Yes? Then I have got some conditions.

25 DR. JANOSKY: Okay.

1 DR. LI: I thought we were voting in the general
2 sense. So I think my wish list, some of which Dr. Burton
3 already said, was to bring the materials and wear testing up
4 to what we would consider to be state of the art for today,
5 not from whatever the understanding that the test might have
6 been done long ago.

7 But it is 1999 and we know a lot more about wear
8 and performance of materials now than prior. So, with that
9 preamble, I think I would want more wear testing with more
10 appropriate measures of wear. This would include by weight
11 loss. It would certainly would include analysis of
12 particles.

13 An area we haven't talked about is that they have
14 a cobalt-chrome component attached to a titanium-vanadium-
15 aluminum component. The issue of mixed metals, crevice
16 corrosion has not been raised. I don't know if this is an
17 issue they find clinically or not but is one that occurs in
18 total hip replacement and has been unmentioned for most of
19 today.

20 This has a ramification of either weakening the
21 titanium taper that it is on or, in the worst of cases,
22 could create another form of particulate debris.

23 I think the materials testing should be, for lack
24 of a better word, a little tightened up. The material
25 source is specified right as simply 4150HP polyethylene but

1 its source, whether or not it is extruded or compression
2 molded, who does that, whether or not it was preaniled.
3 Those details at least were not in the packet of information
4 that I had and should be included and/or specified, the
5 ramifications of altering from those material sources.

6 I think analysis of retrieved devices is going to
7 be the only way that you can, in the end of it all, validate
8 any laboratory testing that you do. For whatever reason
9 that comes out, whether or not be it for infection after a
10 week or somebody just wants it out after some time, I think
11 it behooves you to analyze those devices. Otherwise, you
12 won't really know how the device fails.

13 Lastly, I think the applicant should take all the
14 technologies available today as going on in reducing wear in
15 total hips and knees to see which of those technologies
16 actually would apply to your joint today rather than using a
17 device or a method that you picked some time ago and just
18 sticking with it because that is what you started with.

19 MR. ULATOWSKI: I think Dr. Runner might want to
20 summarize all the bullets once we get them all down here.

21 DR. JANOSKY: Maybe we can do it together. Do we
22 have an overhead we can write on?

23 DR. RUNNER: I think I have them all down if you
24 want me just to list them again.

25 DR. JANOSKY: Yes; if you can, that would be fine.

1 DR. RUNNER: I had the list starting with a
2 prospective study that would measure pain; that the patients
3 would be told with ten or greater surgeries that this will
4 not help their pain; patients should be told that studies
5 have not been completed to indicate that there is a decrease
6 in pain long-term; there should be an additional particulate
7 study. I am sort of combining a few here now with state-of-
8 the-art wear testing, weight loss, analysis of particles,
9 tighter material sourcing, addressing the issue of diverse
10 metals with specs being tightened; the continued follow up
11 of patients that are presently in the study to five years; a
12 registry of patients; any prospective study should study
13 life interferences; there should be some payment for
14 patients participating in follow-up visits; and there should
15 be some attempt to study the different conditions and their
16 relationship to the type of success or failure that happens
17 and separating out the conditions that lead to implant
18 placement.

19 DR. REKOW: And one more; the analysis of
20 retrieval.

21 DR. RUNNER: Oh, right; analysis of retrieved
22 implants.

23 DR. LI: And sterilization methodology.

24 DR. JANOSKY: So as I understand the motion, it is
25 approvable with conditions, with the conditions that were

1 just read to us by Dr. Runner. Any other discussion?

2 DR. PATTERS: Yes. Dr. Runner, I just suggested
3 that the sponsor bear the cost. It doesn't mean to
4 compensate the patient necessarily, but to bear the cost of
5 follow-up visits rather than the patient bear that cost.

6 DR. HEFFEZ: I would like to ask the rest of the
7 panel members how they feel, if they feel that the device is
8 a temporary device or a permanent device.

9 DR. BURTON: I think, in my consideration, it is a
10 permanent device. I don't think we should be considering it
11 at this juncture as a temporary device. The patient would
12 need to understand that potentially it could be replaced at
13 some point in time but I don't think that the intent, at
14 least from what I can gather and certainly what I have seen
15 thus far that it would be considered a temporary device.

16 We have looked at that issue in the past but I
17 don't think that is the case here.

18 DR. HEFFEZ: How does the orthopedic literature
19 view hip prostheses? Do they feel that it is a temporary or
20 permanent device, or is that age-specific?

21 DR. LI: It is a shifting question. The average
22 age of a double-hip patient ten years ago was 72 and now it
23 is 67 and dropping. So, before, the life of the implant was
24 near the life of the patient but that is rapidly changing.
25 So, now, in a 40-year-old, it is a totally different

1 question.

2 So I think it is an evolving question for total
3 hips. But, clearly, if you are under the age of 60, chances
4 are you are going to get more than one in your lifetime.

5 DR. BURTON: I understand that. But I guess my
6 question is, even though it may not last the rest of your
7 lifetime, I am not sure that that makes it a temporary
8 device.

9 DR. HEFFEZ: Perhaps "temporary" is not an
10 appropriate word, but I think the patient should be at least
11 advised that the younger you are when you have this implant
12 placed the more likely it is that you will need another
13 operation.

14 DR. REKOW: Maybe the way to resolve that is to
15 say, "a projected lifetime of the implant is--" or, "the
16 expected service life of it is--"

17 DR. HEFFEZ: I think you are always concerned as a
18 surgeon when you have that because if you fall below that,
19 you are at risk.

20 DR. JANOSKY: Additional discussion? Dr. Gonzales
21 or Dr. Burton, would you state the motion? We can list the
22 conditions as read into the record by Dr. Runner.

23 DR. GONZALES: Do you want the motion that--

24 DR. JANOSKY: That this is approvable with
25 conditions, I think.

1 DR. GONZALES: This is approvable with the
2 conditions that have been listed. I guess that is all of
3 ten conditions.

4 DR. JANOSKY: Right; that Dr. Runner had read into
5 the record. Do I have a second on the motion?

6 DR. BURTON: I will second it. My question is is
7 the FDA able to live with being able to clean--my thing
8 right now the language is a little confusing, even listening
9 to this. Is this something that you can, then, work with to
10 produce something that is--

11 DR. RUNNER: The recommendations are--the panel's
12 vote is a recommendation to the agency. We, then, take into
13 consideration the intent of what you have said in the panel
14 proceedings and proceed to work with the company to come to
15 closure.

16 DR. BURTON: I second the motion.

17 DR. JANOSKY: So the motion is approvable with
18 conditions, the conditions as Dr. Runner had read to us. It
19 has been seconded by Dr. Burton. I would like to call for a
20 vote, please, starting on the right with Dr. Patters and
21 working around.

22 DR. PATTERS: I vote in favor of the motion
23 because I believe the data, as presented, supports approval
24 with the listed conditions.

25 DR. LI: I vote for approval with conditions.

1 DR. GONZALES: I vote for approval with the
2 conditions.

3 DR. REKOW: I vote for approval with conditions
4 but I have to say that telling a company they have to pay
5 for it, I think, is micromanaging.

6 DR. BURTON: I vote for approval with conditions.

7 DR. HEFFEZ: I vote approve with the conditions
8 listed.

9 DR. STEPHENS: I vote for approval of the motion.

10 DR. BERTRAND: I vote for approval with the
11 conditions.

12 DR. JANOSKY: So the motion carries.

13 Can we, then, please go around the table once
14 again and state again the reason for why you voted, if you
15 hadn't stated it earlier.

16 Dr. Patters. You had stated. Dr. Li.

17 DR. LI: I think this device is obviously
18 necessary for a group of patients that have little
19 alternative. The device may or may not be actually suitable
20 for the task right now. Unfortunately, the data just really
21 doesn't lend itself to make a decision. So my additional
22 amendments, hopefully, given that data, would be a much
23 clearer picture on the outcome.

24 DR. GONZALES: I voted in favor of approval
25 because I think this is the best that is available right

1 now. But I think that the caveat of continuing to measure
2 patients in terms of their pain, their function, is still
3 very important. I think it is also very important to
4 caution patients what they can expect, and what they can
5 expect is improved function but not necessarily other
6 improvement such as pain.

7 DR. REKOW: I think that there is a definite need
8 and I agree with Gilbert that this is probably the best that
9 is available but the data is very limited and that is of
10 particular concern to me because of the relative young age
11 of these patients and the lifetimes that they are going to
12 have to deal with an implant that will never be as good as
13 the ideal situation. That is what prompted my decision.

14 DR. BURTON: I voted for approval with conditions
15 because I again felt it is a very necessary device for a
16 small number of patients. However, the data as presented
17 was not conclusive enough to show that it had been
18 adequately studied in terms of both its efficacy and its
19 design factors. I think that the guidance that we have
20 tried to give back to the company will, hopefully, improve
21 that.

22 DR. HEFFEZ: I voted approval with conditions
23 because there is a small subset of patients who definitely
24 need this option. The data still needs to be collected and,
25 therefore, doesn't merit an approval-without-conditions

1 status.

2 DR. STEPHENS: I voted for approval with
3 conditions. I think this is clearly a necessary therapy for
4 a group of patients and that the conditions that we have
5 attached to protect patient safety and efficacy is still to
6 be established.

7 DR. BERTRAND: I voted for approval with
8 conditions based on the need for this desperate group of
9 patients and the fact that the conditions start to outline
10 data collection that can make us better understand what is
11 afflicting these patients.

12 DR. JANOSKY: One final decision. For the
13 information for follow up, return to panel or can the FDA
14 evaluate? I hear a response to FDA evaluate, follow up for
15 the information that we have requested.

16 DR. BURTON: I think we can return it to the FDA.

17 DR. JANOSKY: Any requests to return it to panel?
18 No? So the recommendation is to return it to FDA.

19 Thank you.

20 One other item of business; any more information
21 that the panel feels must be made of those conditions
22 premarket?

23 DR. HEFFEZ: Is there a time limit that is placed
24 on acquiring these conditions?

25 DR. RUNNER: Because these are 515(b)s, we have

1 180 days to review the data and we would, therefore, have to
2 complete the negotiations within 180 days of when we
3 received the application which was sometime in January, I
4 believe. So it will be completed with the company by
5 sometime in July, I believe. July 6.

6 DR. BURTON: Point of clarification; is the
7 product currently on the market at some level?

8 DR. RUNNER: Yes.

9 DR. BURTON: That is my understanding, anyway.

10 DR. RUNNER: The product is on the market.

11 DR. BURTON: The product is currently on the
12 market so I guess I am not sure what the question is.

13 DR. RUNNER: The question is, after the 180 days,
14 they would not be able to remain on the market unless they
15 met these conditions of approval or agreed to a plan to meet
16 these conditions of approval.

17 DR. JANOSKY: The recommendation of the panel
18 premarket?

19 MR. ULATOWSKI: Some, by their very nature, are
20 premarket. Some are labeling statements and things of that
21 sort. Some of the other things are, by their nature,
22 postmarket in terms of the follow-up studies and so on.

23 DR. JANOSKY: So it is sufficient as we have it
24 stated, then?

25 MR. ULATOWSKI: It is kind of self-regulating

at

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1 premarket/postmarket in a sense.

2 MS. SCOTT: This concludes our meeting for this
3 evening and I thank all of our panels for their
4 participation today. Tomorrow, we will reconvene at
5 8 o'clock a.m. to continue or panel meeting to discuss the
6 next submission that has been submitted to the FDA.

7 Thank you.

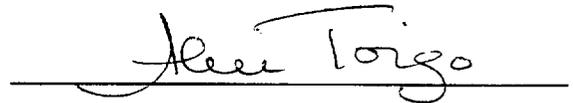
8 [Whereupon, at 6:30 p.m, the meeting was recessed,
9 to be resumed on May 11, 1999 at 8 o'clock a.m.]

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C E R T I F I C A T E

I, **ALICE TOIGO**, the Official Court Reporter for Miller Reporting Company, Inc., hereby certify that I recorded the foregoing proceedings; that the proceedings have been reduced to typewriting by me, or under my direction and that the foregoing transcript is a correct and accurate record of the proceedings to the best of my knowledge, ability and belief.

A handwritten signature in cursive script, reading "Alice Toigo", is written over a horizontal line.**ALICE TOIGO**