

Clemens

Draft -- Generalization Decision Analysis -- Draft

Q: Is it appropriate to generalize the results from pre-term clinical studies to support products designed for term infants?

A: Results derived from clinical studies of an infant formula in pre-term infants may be generalizable to products for term infants based on a studied analysis of a) the clinical trial and b) other confirmatory evidence available.

Fact: Every ingredient is GRAS or an approved food additive for use in infant formula

What do we know about digestion, absorption, metabolism and excretion of the ingredients in pre-term vs. term infants?

Data Most Meaningful	Data Least Meaningful
Similar (Comparative data exist)	Dissimilar (No comparative data exist)

What is the protocol of the pre-term study?

Data Most Meaningful	Data Least Meaningful
Study initiated late pre-term and extended into term	Short term study conducted in very sick premature babies

What is the quality of the study data (GCP, statistical design, power, etc.)?

Data Most Meaningful	Data Least Meaningful
High	Low

Is pre-term infant consuming more nutrients per kg of body weight?

Data Most Meaningful	Data Least Meaningful
Yes	No

What additional supporting data are available?

Data Most Meaningful	Data Least Meaningful
A great deal of data	Little
International data	
Other clinical studies in other matrices	
Other clinical studies by other manufacturers	

Question 2

Is it appropriate to conclude that a new infant formula supports normal physical growth under its intended conditions of use when there are differences in adverse events between the test and control groups which raise clinical concerns, but the study was not powered to detect?

Yes, it is appropriate to use the data to support growth. If one is doing an appropriate power analysis for growth, the studies are not powered to detect relatively low differences in adverse events. This does not negate the power of the study with respect to supporting growth.

If a difference between study groups in the number of adverse events is observed, whether or not the study is powered to detect that rate, the clinical significance of the difference must be evaluated through good medical practice.

Question 3.

Is it appropriate to conclude that a new infant formula supports normal physical growth under its intended conditions of use when there are large differences in attrition rates between study groups?

Our typical clinical experience suggests that the normal attrition rate in a growth study approximates 25%. The assessment of physical growth is relatively insensitive to attrition rate. For example, study groups with 10% vs. 20% attrition rates do not have the potential to sufficiently bias the assessment of physical growth rates to change the outcome of the study.