Summary

18-19 Nov 2019
FDA-IDSA-NIH-Pew Workshop
Enhancing the Clinical Trial Enterprise in the US
Big Messages

• The AMR enterprise is in crisis
• Can’t fix it all here / today, but many key elements are within the scope of this group
• Emerging ideas
• Next steps
The AMR enterprise is in crisis

- Intriguing positive signs in early pipeline
- But, it’s fragile: “Check Engine” light is flashing
- Late-stage commercial failures have occurred and seem likely to continue
- Even when successful, an antibiotic returns far less than any oncology product
Elements within our grasp

*If we focus, we can move the needle*

- What have we learned?
  - Push funding works: CARB-X, BARDA, NIAID, Wellcome Trust, Novo REPAIR have lit a bonfire – and intriguing new products are coming!
  - We can reliably get products to approval with basic studies
  - Those studies generalize reasonably well to the US
  - We can’t generate the same quality of data for all uses: Other possible use(s) of a new drug are important to clinicians but are not (and will not be) discussed in the approved label

- What do we want?
  - (ID) physicians: Access to all the data, preferably interpreted
  - Payors, P&T committees: Ways to judge data quality
  - Patients: Hear their voice! Address how patients feel
  - Companies: Validated, acceptable mechanisms for promoting based on data on resistant pathogens and difficult infections
  - FDA: Labeling per regulations ("Adequate and well-controlled")
Emerging ideas (1 of 2)

• Making clear the limits on data generation
  • We need to explain the limits to our peers
  • This will require some work – it’s easy to wish for more, especially when the constraints on data generation are not obvious
  • If there was a better way to do this, we’d do it

• Making clear the limits on labeling
  • Without rules, we would have arbitrary unpredictable decisions
  • “Adequate and well-controlled” is the standard

• Sharing the available data: Limits on the label
  • Publish in a major journal! Talk about the nuances of the trial!
  • IDSA can validate by publishing informed critiques of the available secondary data: “What one peer would tell another.”
  • Such reviews would / should be appropriate for discussions with payors, discussions with insurers, and (maybe) promotional use
  • How can we include Europe in this conversation?
Emerging ideas (2 of 2)

• Be clear on the power of the standard indication
  • Modern non-inferiority studies are powerful tools
  • They do detect inferior agents
  • They provide clear safety and efficacy comparisons
  • They facilitate initial approval
  • They provide a basis for additional indications

• Better use of the other data we have / can readily get
  • We need to learn to borrow data across indications
  • Different thresholds may make sense for different settings
  • And, don’t forget PROs and other patient-oriented measures!

• Generate data more efficiently
  • Not a panacea, but platform trials show real potential to reduce cost and speed data generation
  • This seems particularly true after initial approval is achieved: studies in pediatrics and rare infections would seem good a fit
Next steps

• This has been an excellent conversation!
• Many thanks to all who participated
  • Shout out to Sunita Shukla for herding the cats!
• Nothing is set, but a subsequent debate seems needed on ways to better use the data we have
  • Borrowing data across indications
  • Different thresholds for different settings
  • Including Europe in this conversation
• Stay tuned…