1 But in fact, people enter over an extended
2 period of time. So what you're seeing is a wave of
3 people come in. The first person who comes in may
4 already be due for their one year visit, but the last
5 person who comes in might be only due for a three
6 month visit.
7 So when you see those numbers gradually
8 decrease, what you're observing is the consequence of
9 people entering over a course of time, the inability
10 to accrue all of the subjects instantaneously. So
11 it's a standard thing that happens in clinical trials,
12 that after one year the people who are available are
13 those who entered one year before. They have their
14 one year visit. But the person who entered only six
15 months before, they can't possibly be due for anything
16 other than their six months visit.
17 DR. BURKHARDT: I understand, I think.
18 CHAIRMAN WHALEN: Any other questions for
19 FDA?
20 Ms. Dubler.
21 MS. DUBLER: I'm confused on a number of
22 points, but among the ones on which I'm most confused

1 is explantation. On the second page of your slides,
2 it seems to say that 30 percent were explanted.
3 DR. HUDSON: The statistician's slides?
4 MS. DUBLER: Ah, that's the MAUDE
5 reporting, ah. Okay. So 30 -- that 30 percent --
6 tell me what that 30 percent means.
7 DR. HUDSON: Sure, sure. Of those reports
8 that are in the MAUDE database, of the 3,104 reports,
9 30 percent were explantation; 929 would be about 30
10 percent.
11 PARTICIPANT: It's not from the study.
12 MS. DUBLER: Well, then on page 8, on the
13 bottom left-hand slide, it says explantation 4.2
14 percent. I don't understand how all the different
15 explanation numbers relate to each other.
16 CHAIRMAN WHALEN: The MAUDE percentage is
17 the percentage of the reported problems, not a percent
18 of patients who have experienced the complication.
19 MS. DUBLER: So that MAUDE can have
20 multiple problems represented.
21 CHAIRMAN WHALEN: For instance, if every
22 single one of the MAUDEs reported was an explant, it

1 would be 100 percent.

2 MS. DUBLER: Okay.

3 CHAIRMAN WHALEN: Does that clarify it?

4 PARTICIPANT: MAUDE is not from a study.

5 MS. DUBLER: I think so.

6 CHAIRMAN WHALEN: It's not a percent of --

7 the denominator is not the number of patients who had

8 an implantation. The denominator is the number of

9 patients who have had a reported problem.

10 MS. DUBLER: Thank you very much.

11 DR. BURKHARDT: So has it now been

12 reported on the patient follow-up in the French study,

13 the due evaluated with data figures are not correct?

14 It looks very, very good.

15 DR. HUDSON: The evaluated for

16 augmentation were 353 and 29 for revision.

17 DR. BURKHARDT: I'm sorry. I don't think

18 we're looking at the same page. I'm looking at the

19 patient follow-up French study where the figures for

20 due, evaluated, and with data are all identical like

21 little soldiers.

22 DR. HUDSON: Right, right.

1 DR. BURKHARDT: Is that not correct?

2 DR. HUDSON: That's not correct.

3 DR. BURKHARDT: Do you have those figures?

4 MS. CHEN: I think that you refer to my

5 slide, the three rows are perfectly identical.

6 DR. BURKHARDT: Yes, that's my concern.

7 MS. CHEN: That is what the sponsor

8 reported.

9 DR. BURKHARDT: That's very, very good.

10 CHAIRMAN WHALEN: Ms. Chen, while you are

11 up, if I could ask you a question, please.

12 Does the elimination of the reconstruction

13 as an indication from a purely statistical point of

14 view, when an N of 1,000 was desirable in the study,

15 does that from a purely statistical point of view in

16 your opinion change anything? Would it have been then

17 -- do you look at it statistically as 800 patients

18 would have been the ideal to achieve if 20 percent

19 were going to be reconstructed patients, when that's

20 eliminated from the mix or is that specious to

21 suggest?

22 MS. CHEN: I do not quite understand your

1 question. You're referring to the UA study?

2 CHAIRMAN WHALEN: Yes.

3 MS. CHEN: Yes.

4 CHAIRMAN WHALEN: The original design of

5 the study included 20 percent were hopefully going to

6 be reconstruction patients, and when apparently -- and

7 we don't need to go into motivation -- when apparently

8 such low enrollment was achieved, that was pulled out

9 of the mix in terms of the sponsors asking for that as

10 an indication.

11 MS. CHEN: Well, then pull off the 20

12 percent. That still have be 800 patients.

13 CHAIRMAN WHALEN: And from your point of

14 view it's still --

15 MS. CHEN: No.

16 CHAIRMAN WHALEN: -- weak with the 364 or

17 whatever the number is for 800?

18 MS. CHEN: That's right. That's right.

19 CHAIRMAN WHALEN: Any other questions of

20 FDA?

21 (No response.)

22 CHAIRMAN WHALEN: Very well. We'll go

1 into panel deliberations beginning with the comments
2 from the panel lead reviewers, which will include
3 mechanical testing by Dr. Li, the clinical study by
4 Dr. Chang, and statistical considerations by Dr.
5 Blumenstein.
6 We begin with Dr. Li.
7 DR. LI: Let me begin perhaps on a note
8 that I'm quite disappointed actually with the
9 information supplied in your PMA. The first
10 disappointment comes from actual device description.
11 In the next few minutes I'm going to
12 highlight several items that I was unable to find in
13 your PMA. So if they're there, they're hidden to a
14 point where I couldn't find them and I apologize, but
15 the reviewers from the FDA also could not find these
16 items.
17 One is a device description. Oddly enough
18 I actually don't have model numbers. I don't have how
19 many volumes there are. I don't know what sizes there
20 are. You state the range of thickness was provided,
21 but we still can only find an average thickness value.
22 So actually I have no idea how many products you've

1 got and exactly what they are.

2 You do say you have a high profile and a

3 low, but again, I'm not exactly sure if the difference

4 between them is always constant. For instance, for a

5 given volume as the high profile components seem to

6 range from 100 to 680 cc's and the lower profiles

7 range from 95 to 765.

8 So given an equal volume, I'm not sure

9 what the difference is between high profile and low

10 profiles, or in some cases is there almost no

11 difference between high profile and low profile? I

12 just couldn't tell.

13 Some are textured. The texturing, again,

14 I saw no specifications for the texturing, and I don't

15 know what the average pore size is. I don't know what

16 the average pore size distribution is. I don't know

17 what the depth is.

18 The method of manufacture seems to be a

19 manual dispersion of either sugar solution or sugar

20 crystals onto the device shell, and then somehow they

21 are removed in some unspecified fashion, leaving a

22 pore size, but I have no idea what the variation of

1 those pores is in all of this, nor do I have
2 variations for all of the others, including the fact
3 that you prefill these. So I don't know what the
4 variation is given a particular size for the internal
5 pressures, say, due to the difference in volumes and
6 wall thicknesses that one might have.
7 The chemistry of the device -- let me just
8 say this. We found specs. for the raw materials going
9 into the device, but I found no final specifications
10 for the final as sold, sure, ready to go device, and
11 this actually is reflected in one of the FDA charts
12 where all of those chemical analyses were incomplete.
13 Most of those speak to the final finished
14 product. Now, one might think this is kind of
15 nitpicking of these details. Surprisingly, I can't
16 believe they're not here because it seems like if
17 you're making it for two years, these things should be
18 readily available to you, but the issue here is if you
19 don't have a baseline set of data that you can
20 quantify and use as a go-no go comparison, you
21 actually can't guarantee to anybody tomorrow you made
22 the same device that you made today, or if you make

1 them in France or make then -- I have no idea. I
2 don't know if you have multiple manufacturing sites.
3 I just have no idea what any of that is.
4 One of the reasons I didn't really harp on
5 the mechanical testing is largely because I didn't
6 know what it was you were testing. So I didn't know
7 what it was exactly chemically, and I certainly didn't
8 know what it was dimensionally. In all of your tests
9 you actually don't, as near as I can tell, tell me
10 what size, volume, wall thickness are being tested,
11 regardless of what the test is.
12 So I didn't ask a lot of questions about
13 the results of the test because it didn't quite matter
14 because I didn't know what it was you were testing.
15 I'm surprised that even the most basic
16 data like the tensile testing data, ultimately
17 elongation data, which are very standard, relatively
18 easy to do, exceedingly cheap data, are provided just
19 as values, and there's no sense of how they were
20 sampled, how many were tested, what's the lot to lot
21 variation. None of that was actually included.
22 So we're not talking about even some of

1 the more advanced tests for discussion like fold flaw,
2 but even the simplest tests are not really reported in
3 a fashion that would be accepted by a manufacturing
4 facility or a publication.
5 I'm not going to really talk about any of
6 the average results that you provide for the reasons
7 I just specified.
8 Several tests were not addressed. Fold
9 flaw was not addressed. Static rupture was not
10 addressed. You don't have a valve. So that really
11 wasn't an issue, but the FDA does have guidance and
12 suggestions for all of these tests, and as much as
13 I've criticized the other companies for the results of
14 those tests, at least they have gone through and
15 provided us some indication of the performance of
16 those things, given either a suggested test that the
17 FDA ran or a negotiated test that they themselves came
18 up with.
19 I will say the fatigue rupture testing is
20 perhaps the most confusing. You've designed a test
21 for which I'm not actually sure what the rationale was
22 of developing it.

1 For those of you who didn't read the
2 details, this test takes an implant of unknown size
3 and shape and puts it not only in compression, but
4 somehow one of the plates is moving 40 millimeters or
5 20 millimeters, but the test is written so that I
6 don't know even if it means 20 millimeters in each
7 direction from a center line or 40 millimeters
8 altogether. I just couldn't decide even what that
9 kinematic was, and I'm not sure how it was decided
10 that you should apply shear to the actual compression
11 with this, and because of that, I have no idea what an
12 applied force versus number of cycles does.
13 So maybe this is a great test; maybe it
14 isn't. But I don't think we could accept it just on
15 the face value that you ran it and here are the
16 results.
17 Let's see. Fold flaw testing was not
18 addressed at all. The abrasion testing, again, lack
19 of information on this and rationale. You describe it
20 as a Tabor abrader, but that doesn't really describe
21 the loading, the actual roughness of the components,
22 which samples you tested, how large the samples you

1 tested. Particles weren't examined. So there are
2 some numbers there, but again, I actually have no idea
3 what to do with those numbers.
4 Perhaps let me stop there and without
5 going into any other details like sterilization and
6 where the things tested sterilized or not sterilized.
7 I have no idea. None of that I could find anywhere in
8 here.
9 And the question is: so what should these
10 rather specific material and engineering properties
11 have to do with the device?
12 I think it's everything. I don't know how
13 I could guarantee -- you know, let's give them the
14 benefit of the doubt for the second that everything
15 was safe and effective as far as the clinical data.
16 In the absence of this material property description,
17 final device specification, and final device testing,
18 there's no way to insure that the next lot of
19 material, the next batch of material won't, in fact,
20 provide you that same performance.
21 I'll stop there.
22 CHAIRMAN WHALEN: Thank you.

1 Dr. Chang.

2 DR. CHANG: I must say that there was a
3 comfort level in previous considerations of two other
4 sponsors in that I personally have held in my hand,
5 have personally clinically used examples of the
6 products that were under consideration in the other
7 two sponsors, and I must say that I don't have that
8 comfort level that would weigh any lack of data, loss
9 of patients to follow-up to balance insufficient or
10 dropouts in patient follow-up. So I don't have the
11 advantage of physically seeing one of the products in
12 making --

13 CHAIRMAN WHALEN: Excuse me a second.

14 Dr. Witten.

15 DR. WITTEN: Yeah, I just want to say we
16 want to concentrate on the product at hand and what we
17 know about the product at hand and not our experience
18 with any other products.

19 CHAIRMAN WHALEN: Yes.

20 DR. CHANG: I'm directing my comments
21 towards clinical aspects of the device being
22 considered. So I consider the data being presented

1 for clinical follow-up as a work in progress.

2 Most concerning is the prospective study,

3 again, as stated, has a small percentage of the

4 cohorts. Regarding the prospective study being done,

5 there is 50 patients, for example, in the augmentation

6 group at 12 months, and that would constitute of the

7 original 500 suggested in the guidelines by the FDA of

8 being ten percent or 27 percent of the cohort.

9 In the prospective study, the revision

10 patients number eight as having data, and this is,

11 again, 27 percent of the cohort. So this is a work in

12 progress.

13 If we were to then consider data regarding

14 safety and were to look at both the follow-up by U.S.

15 clinical surgeons' experience, as well as the French

16 two year study, by my calculation rather than 1,600 of

17 the patients available for follow-up there was a total

18 -- and if we were to included 50 of the prospective

19 study, 1,180 patients available for follow-up, and I

20 have a deflation rate of two percent to 2.3 percent

21 for the augmentation patient.

22 So that is impressive in that it is

1 certainly comparable to published reports and
2 comparable to other devices on the market.
3 Now, the one question about this two
4 percent reported deflation rate at two years, as
5 reported in the French study, is that all of these
6 implants are textured implants, and we've just been
7 told that for the thicker, textured implants the
8 minimum thickness is .63 millimeters, and as a rough
9 calculation -- I don't have a calculator -- for U.S.
10 standards that would be .022 to about 22 to 24/1000 of
11 an inch thickness.
12 So although I am impressed by the two
13 percent deflation rate at two years, a question
14 perhaps that you could answer is: do you have any
15 data on the smooth implants, follow-up on the smooth
16 implants? How long were the follow-up and what is the
17 deflation rate of the smooth?
18 Because the minimum thickness of those
19 we've been given as about 15/1000 of an inch or .37
20 millimeters.
21 Folds is listed as not perhaps a
22 complication per se. It is something that I was told

1 patients do notice. They may be concerned that it is
2 a lump or tumor, and it is something that patients may
3 be aware of through motion or the location, action of
4 muscles.
5 However, we've seen also data, a
6 suggestion from other public speakers that suggest
7 that wrinkles or folding in the implant may, indeed,
8 be a risk factor for future abrasion or erosion,
9 thinning or failure and leaks in the implants. So I
10 would say clinically we definitely need a longer term
11 follow-up for these devices.
12 These devices are prefilled with sterile
13 saline, and the fact that they are valveless is
14 certainly very attractive, attractive in that, again,
15 as noted, there is a convenience, less time to use,
16 and also less risk of introducing organisms.
17 However, the down side of it certainly is
18 that there is a more difficulty in fine tuning the
19 volume, and for myself it would be more difficult to
20 guesstimate how I would match the expectations of the
21 patient.
22 So I do note that in the French study

1 there was a 27 percent rate of asymmetry. So, again,
2 that's a bit more difficult. My question is: what are
3 the increments for the sizers? We would be dependent
4 on sterile sizers to help us determined the ultimate
5 size volume of implant that we would select. Are they
6 at 20 cc's increments, 50 cc increments, to help us in
7 this clinical use?
8 Another down side or I was not able to
9 determine what is the shelf life of the implant.
10 There are closed and sterilely wrapped, but a question
11 that I don't know if can be answered or not is what
12 risk is there for introduction of contaminants with
13 the implant sitting wrapped up on the shelf or to sit
14 there for four and a half or five years.
15 Certainly we've seen that explanted shells
16 last a very long time, but that question remains.
17 What is the shelf life of these products?
18 And then finally, those are my comments
19 regarding safety issues. I feel that with the --
20 brief as the protocol was, with an 88 percent and 97
21 percent satisfaction rate, that certainly these
22 implants appear to be efficacious.

1 CHAIRMAN WHALEN: Since they were directly
2 addressed questions, would sponsor care to answer
3 those now or if you're not prepared to we'll go on to
4 statistical and you can answer them all at that time
5 when we're done with that?
6 We'll go on. Dr. Blumenstein.
7 DR. BLUMENSTEIN: Well, i think Ms. Chen
8 gave us a pretty good idea of some of the limitations.
9 It gives me one more opportunity to promote the use of
10 true cumulative incidence instead of the one minus
11 Kaplan-Meier estimates as a better methodology for
12 approaching the estimation of complication rates.
13 But then I am going to get real short
14 here. It seems to me that the PMS -- the PMA --
15 (Laughter.)
16 DR. BLUMENSTEIN: -- the PMA absolutely
17 requires the U.S. study. The U.S. study is immature.
18 CHAIRMAN WHALEN: Thank you.
19 While sponsor is still preparing some
20 answers to Dr. Chang's questions, if there are any
21 other questions from any of the panel members for
22 either sponsor or FDA, now would be the time to ask

1 those questions.

2 DR. BURKHARDT: Could I make a comment?

3 MS. DUBLER: Ms. Dubler and then I'll be

4 back to you.

5 MS. DUBLER: I'm just a little puzzled.

6 I don't have the copies in front of me, but a number

7 of slides were presented by the sponsor that showed

8 zero infection, et cetera, when it seems clear in the

9 slides we got from the FDA using the same data that

10 that didn't seem to be the case.

11 I just wondered what the origin of the

12 slides with the big zero on them were.

13 DR. O'LEARY: (Inaudible.)

14 MS. DUBLER: I'm afraid I can't recall.

15 DR. BIGGS: That possibly was my report to

16 you, and --

17 MS. DUBLER: No, no, no, no. No, it

18 wasn't.

19 DR. O'LEARY: We're not exactly sure which

20 study you're talking about, but I think that once

21 we're there, we were comparing our studies that had

22 zero percent for like hematoma, seroma, things like

1 that --

2 MS. DUBLER: Right, right. That was the

3 one.

4 DR. O'LEARY: And what they had, I think,

5 was the MDR reporting. I'm not sure, but it may have

6 been that.

7 Other than that we're not sure where their

8 data were.

9 MS. DUBLER: Okay. Sorry.

10 CHAIRMAN WHALEN: Dr. Burkhardt.

11 DR. BURKHARDT: On an entirely personal

12 level, I would like very much to see this implant

13 remain available to patients in the United States. I

14 think it has the potential, not demonstrated yet, but

15 the potential for a dramatically reduced leakage rate

16 compared to some of the other implants that we're

17 using, and probably for a significantly reduced

18 palpability because of its shape and contours and so

19 forth.

20 I find it very difficult to understand why

21 a parent company that has apparently sold over 35,000

22 implants worldwide would allow you to come to a

1 meeting like this, a regulatory meeting in the United
2 States, as ill prepared as you appear to be to meet
3 our usual, customary, and necessary engineering and
4 statistical standards. It really blows me away that
5 this has happened.
6 In addition, just one point. I find it
7 very difficult to believe that in the French study 100
8 percent of patients were seen at two years and were
9 evaluated. I've never seen that in any other
10 published study.
11 That may be true. I'm not saying it's
12 not, but if it -- you may need to support that later
13 on.
14 DR. GOUDEAU: Excuse me, but in the French
15 study at two years, we didn't say there were 100
16 percent of the people follow-up because for
17 augmentation we had 400-and something cases, and at
18 two years we were down to 370 or whatever. We had 82
19 percent left.
20 DR. BURKHARDT: Well, I guess maybe
21 there's a semantic difference here, but you saw 100
22 percent of patients who were due for follow-up were

1 seen? I think that's really remarkable, and I did not
2 realize this was your personal study. Were there
3 other people involved in this?
4 DR. GOUDEAU: Yes. We were six surgeons.
5 DR. BURKHARDT: And you got 100 percent
6 follow-up of patients who were due at a given time?
7 DR. GOUDEAU: No. At the follow-ups --
8 get the exact correct -- we started for augmentation
9 out of the six French surgeons. We had 406 cases of
10 augmentation, and at two years we had only 353
11 patients. So that was not 100 percent follow-up, but
12 87 percent follow-up.
13 DR. BURKHARDT: Then the statistical slide
14 that was presented by the FDA was incorrect?
15 DR. GOUDEAU: Yes. It was due to the fact
16 that we -- there was a mistake in France, and we
17 corrected that mistake, and we sent back the
18 corrective data because somebody did something wrong.
19 They count with 100 percent at two years, and when I
20 realized that, when I had the files, I said this is
21 wrong.
22 So we went back through all of the data in

1 all of the files, and we sent back to the FDA the
2 correction a few weeks or --
3 DR. BURKHARDT: All right. Because that's
4 a big, red flag.
5 DR. GOUDEAU: Yes.
6 CHAIRMAN WHALEN: But the data that was
7 provided to Ms. Chen is as it was put on the slides
8 for you.
9 Just for any subsequent questions, if each
10 of the sponsor's representatives could identify
11 themselves again for the record.
12 MS. CHEN: As I read --
13 MR. HAWK: I just want --
14 CHAIRMAN WHALEN: If Ms. Chen could
15 answer --
16 MR. HAWK: Sure.
17 CHAIRMAN WHALEN: -- and then we will give
18 you an opportunity, sir.
19 MS. CHEN: I'm Judy Chen, reviewing
20 statistician, FDA reviewing statistician.
21 As I read in the submission is as follows.
22 There are a total of 521 patients entered the study,

1 okay, and not all 521 had the two year follow-up
2 merely due to the length of the follow-up because some
3 people who haven't had the whole two year follow-up
4 yet, and this is the 427 who had two year follow-up.
5 Out of the 427, each and every one of them
6 are evaluated and have data, every adverse event.
7 CHAIRMAN WHALEN: Just to reiterate one
8 more time, Ms. Chen, in terms of the data that was
9 provided to you, 100 percent of evaluable patients
10 were, indeed, evaluated.
11 MS. CHEN: Yes.
12 CHAIRMAN WHALEN: Thank you.
13 Is that in conflict with what sponsor is
14 claiming?
15 DR. BURKHARDT: So there were no patients
16 lost to follow-up?
17 MR. HAWK: The information that Ms. Chen
18 is stating is correct at the time that she evaluated
19 the information. We have sent into the FDA subsequent
20 information and clarification to that data.
21 As has been alluded to or not alluded to,
22 but discussed by Mr. Hudson, that we have sent in data

1 on February 26th that address a lot of the issues that
2 have been brought up by the panel today.
3 DR. BURKHARDT: Well, let's cut to the
4 chase. Are these figures correct or wrong?
5 MR. HAWK: Those figures are wrong.
6 DR. BURKHARDT: Good. Okay. That's fine.
7 CHAIRMAN WHALEN: Thank you.
8 Further questions.
9 DR. WITTEN: Excuse me. But they were
10 what was reported --
11 DR. BURKHARDT: Oh, I understand. I
12 understand.
13 DR. WITTEN: -- that the time that Ms.
14 Chen saw the information.
15 DR. BURKHARDT: I understand.
16 CHAIRMAN WHALEN: All right. Were there
17 any unanswered questions still hanging out there in
18 the breeze that we still have to clear up before we
19 proceed? Not comments; I'm talking about directly
20 asked questions that still need to be answered.
21 Sir, would you identify yourself.
22 DR. O'LEARY: -- was talking about the

1 different --

2 CHAIRMAN WHALEN: Will you identify

3 yourself, please?

4 DR. O'LEARY: I'm Pat O'Leary.

5 She was talking about the French clinical

6 data that only had textured implants, and the

7 implication was that those were thicker than the

8 smooth implants and that the smooth implants would be

9 worse, but I need to explain a little bit of how the

10 implants are actually manufactured, which is all of

11 the implants are manufactured as smooth implants,

12 period.

13 Then some of the smooth implants, some of

14 the texture is put on them. So when you go and you

15 measure the smooth implant, it has one thickness.

16 When you measure the textured implant, it's the same

17 thickness as the smooth, but it happens to have a

18 little bit of texture but it's really the smooth

19 thickness that counts.

20 So they should be identical. Does that --

21 DR. CHANG: Do you have any testing on

22 smooth implants?

1 DR. O'LEARY: As far as?

2 DR. CHANG: Clinical use or mechanical

3 testing on the smooth versus --

4 DR. O'LEARY: On mechanical, yes, and let

5 me explain. Let me get it for you.

6 DR. CHANG: So for right now the answer,

7 were there any clinical studies or follow-up on

8 patients who had smooth implants?

9 DR. O'LEARY: Yes, but not in the French

10 data.

11 DR. CHANG: Thank you.

12 DR. O'LEARY: It's in the other two data.

13 DR. CHANG: Thank you

14 DR. O'LEARY: We, first of all, want to

15 thank the FDA for allowing us to present a lot of data

16 since the October 15th deadline, but there's a

17 plethora of data that's into the FDA which they are in

18 the process of evaluating that you may or may not be

19 aware of. An exam --

20 DR. WITTEN: Excuse me.

21 CHAIRMAN WHALEN: That data --

22 DR. WITTEN: Pardon me. That's not

1 information that you can present at this meeting.

2 DR. O'LEARY: I'm not presenting it.

3 DR. WITTEN: Okay.

4 CHAIRMAN WHALEN: Very well. We'll

5 proceed to the review of the FDA questions. If I

6 could ask that the questions as I read them be

7 projected, and these questions are somewhat different

8 than the other two sets that we've encountered.

9 The first is that the sponsor has not

10 completed carcinogenicity testing, chronic toxicity or

11 implantation testing, nor have these provided

12 information regarding the pharmacokinetics and

13 biodegradation properties of their device.

14 In addition, the sponsor has not conducted

15 complete chemical analyses, that is, they have data on

16 concentrations of extractable D3 and D4 only. Please

17 comment on the importance of these tests when

18 evaluating the safety and effectiveness of their

19 implant.

20 Dr. Li.

21 DR. LI: I'll let the others speak about

22 the -- well, I will speak about them all. I take it

1 back.

2 I think the tests are absolutely crucial.

3 if not so much to determine performance, I think they

4 are absolutely crucial in describing quantitatively

5 what it is they're making, and in the absence of that,

6 there's no assurance that whatever quality they're

7 getting in performance, that that quality is

8 repeatable.

9 CHAIRMAN WHALEN: Are there any other

10 comments from any other panel members on question

11 number one?

12 (No response.)

13 CHAIRMAN WHALEN: Dr. Witten, the subject

14 matter expert on the panel feels that such data are

15 critical.

16 Is that a satisfactory answer?

17 DR. WITTEN: Yes.

18 CHAIRMAN WHALEN: Thank you.

19 DR. WITTEN: And as you move on to

20 questions two and three, I'd like to suggest that you

21 might want to ask people to answer them both together.

22 CHAIRMAN WHALEN: Okay.

1 DR. WITTEN: For the reason that I know
2 you're going to read out question two and three, but
3 let me just say question two summarized is -- oh, I
4 don't mean two and three. I take that back. Three
5 and four. So go ahead with two.
6 CHAIRMAN WHALEN: I will.
7 (Laughter.)
8 DR. WITTEN: I'm sorry.
9 CHAIRMAN WHALEN: Question number two,
10 while the sponsor provided no long term clinical data
11 on their implant, fatigue testing and fold flaw
12 testing provides some information on the long term
13 rupture/leakage of the implants.
14 The sponsor only provided a fatigue
15 testing methodology. Please comment upon this
16 methodology. Please comment on the importance of
17 these tests when evaluating the safety and
18 effectiveness of their implant.
19 Again, our engineer to start, please, Dr.
20 Li.
21 DR. LI: Again, I think -- actually let me
22 back up one before you get to fatigue testing and fold

1 flaw testing. I don't see a question that goes back
2 to the more basic engineering materials descriptions:
3 tensile, modular elongation. The most basic of
4 material properties need to gathered first, and I have
5 put that also in the critical item column.
6 The fatigue test that they provided,
7 although technically interesting, has no support or
8 rationale for its ability to either predict anything
9 that happens clinically or that it's even a reasonable
10 test to perform on any of these implants; that it has
11 not been used in any fashion that I can see for any
12 other implant around.
13 So I think the methodology is at best
14 unproven and at worst has no relevance, and I believe
15 though, however, based on Dr. Burkhardt's knee-jerk
16 response that it just looks like an implant that you
17 wouldn't want to use at first blush; that if the
18 geometries and things are close enough to that, then
19 I would think fatigue testing and fold flaw testing of
20 some part are also critical.
21 CHAIRMAN WHALEN: Are there any other
22 panel members who wish to comment upon question number

1 two.

2 (No response.)

3 CHAIRMAN WHALEN: Seeing none, Dr. Witten,

4 you have just heard that the answer is that the

5 methodology that was outlined is at the very least

6 suspect and perhaps worst, and that really a wealth of

7 chemical and physical data which was not forthcoming

8 would be important.

9 Does that answer your question?

10 DR. WITTEN: Yes, thank you.

11 CHAIRMAN WHALEN: Thank you.

12 I think we'll now combine questions three

13 and four.

14 DR. WITTEN: Yes, I'd like to suggest

15 that.

16 CHAIRMAN WHALEN: Question number three,

17 in order to demonstrate that their device is safe and

18 effective for its intended uses, PIP is using clinical

19 information from three sources: the French clinical

20 study, the U.S. discretionary post marketed

21 surveillance or DPS clinical study, and the U.S.

22 surgeon case experience survey.

1 Please comment as to whether the data are
2 sufficient to determine if the device is safe and
3 effective for each of the indications for use.
4 And then if we could just proceed to
5 question number four, thank you.
6 Given the data provided for augmentation
7 and revision patients, is there reasonable assurance
8 as defined in 21 CFR 860.7 that the product is both
9 safe and effective for augmentation and revision
10 patients?
11 Dr. Blumenstein, would you care to start
12 the discussion on this?
13 DR. BLUMENSTEIN: The U.S. DPS study would
14 be essential. It would be essential to have mature
15 data from that study in order to be able to compute
16 the kinds of complication rates and so forth that
17 would be needed to characterize this product; that the
18 U.S. DPS study is not mature.
19 CHAIRMAN WHALEN: Saying that certain --
20 both answering safety and effectiveness not being?
21 DR. BLUMENSTEIN: That's correct, both
22 safety and effectiveness.

1 CHAIRMAN WHALEN: Thank you.

2 Dr. Boykin.

3 DR. BOYKIN: Well, I would agree.

4 CHAIRMAN WHALEN: Thank you.

5 Dr. Bandeen-Roche.

6 DR. BANDEEN-ROCHE: I would agree. I'd
7 like to make the two additional comments that the
8 French study, I think, does not at all stand on its
9 own merits because it does only represent six
10 surgeons, and moreover, more than two-thirds of the
11 patients were two surgeons. So that does not
12 generalize to the U.S. population of patients.

13 And then the second comment is that the
14 U.S. study is not only incomplete, but to date it has
15 very poor follow-up, you know, about 50 percent at
16 each follow-up so far. That would definitely need to
17 be improved before that provides data that could
18 reasonably assure safety and effectiveness.

19 CHAIRMAN WHALEN: And also before we leave
20 either you or Dr. Blumenstein, would either of you
21 care to directly comment upon the utility of the U.S.
22 surgeon case experience survey in evaluating this

1 product?

2 DR. BLUMENSTEIN: No comment.

3 DR. BANDEEN-ROCHE: I'd say its weaknesses

4 were already well described.

5 CHAIRMAN WHALEN: Thank you.

6 Dr. Burkhardt, as to questions three and

7 four?

8 DR. BLUMENSTEIN: No.

9 CHAIRMAN WHALEN: Thank you.

10 Dr. Chang?

11 DR. CHANG: I concur. No.

12 CHAIRMAN WHALEN: Dr. Morykwas.

13 DR. MORYKWAS: I also concur no.

14 CHAIRMAN WHALEN: Ms. Dubler.

15 MS. DUBLER: No.

16 CHAIRMAN WHALEN: Dr. Robinson.

17 DR. ROBINSON: No.

18 CHAIRMAN WHALEN: Ms. Brinkman.

19 MS. BRINKMAN: No.

20 CHAIRMAN WHALEN: Ms. Domecus.

21 MS. DOMECUS: I would say no, too, and

22 just add that I think that if the regulatory hurdles,

1 if I interpret the regulatory history correctly, were
2 outlined in a 1994 letter from Dr. Alper of the FDA,
3 and she outlined, you know, over 500 patients in a
4 retrospective study, one year follow-up on 3,000
5 patients in a large, simple trial and a three year
6 follow-up, and the first two manufacturers, I think,
7 have met those requirements, and this one hasn't, and
8 I think it would be an unfair advantage and unlevel
9 playing field if we were to approve this PMA.
10 CHAIRMAN WHALEN: Thank you.
11 Dr. Witten, as regards questions three and
12 four both as to each of the subsets of the data's
13 adequacy, the answer -- the consensus of the panel is
14 no, and directly then in answering whether it is felt
15 that the data provided justifies either safety or
16 efficacy of the product, the answer is no in both
17 instances.
18 DR. WITTEN: Thank you.
19 CHAIRMAN WHALEN: Thank you.
20 Question number five, given that the
21 sponsor's data show increasing cumulative rates over
22 time for the majority of complications for both

1 revision and augmentation patients, please comment on
2 whether there is adequate follow-up data to
3 characterize the frequency and types of long term
4 adverse events. Please address the following
5 pertaining to long term adverse events:
6 (a) Minimum duration of follow-up;
7 (b) Type of visit as active or passive;
8 and
9 (c) Which types of complications should
10 be assessed.
11 Starting with Dr. Boykin, please.
12 DR. BOYKIN: I think we've earlier
13 established that a ten year follow-up would be very
14 important to have. That may not be possible here, but
15 certainly all follow-up should be active for as long
16 as possible, and the complications, of course,
17 directed to the device failure, leakage, rupture
18 rates, et cetera, asymmetry as we pointed out.
19 CHAIRMAN WHALEN: Thank you.
20 Dr. Bandeen-Roche.
21 DR. BANDEEN-ROCHE: I concur.
22 CHAIRMAN WHALEN: Dr. Burkhardt.

1 DR. BURKHARDT: I agree.

2 CHAIRMAN WHALEN: Dr. Chang.

3 DR. CHANG: I agree with Dr. Boykin's

4 comments.

5 CHAIRMAN WHALEN: Dr. Morykwas.

6 DR. MORYKWAS: I also agree with Dr.

7 Boykin's comments.

8 CHAIRMAN WHALEN: Ms. --

9 MS. DUBLER: Agreed.

10 CHAIRMAN WHALEN: Dr. Robinson.

11 DR. ROBINSON: Agreed.

12 CHAIRMAN WHALEN: Ms. Brinkman.

13 MS. BRINKMAN: Agreed.

14 MS. DOMECUS: Agreed.

15 CHAIRMAN WHALEN: Dr. Li.

16 DR. LI: Agreed.

17 CHAIRMAN WHALEN: And Dr. Blumenstein.

18 DR. BLUMENSTEIN: Agreed.

19 CHAIRMAN WHALEN: Thank you.

20 Dr. Witten, as regards the question number

21 five and its subpoints, the committee feels that a ten

22 year period of follow-up should be a minimum, that we

1 should strive to have active follow-up, and that the
2 complications as regard device failure and leakage, et
3 cetera, should be the ones that should be followed up.
4 Is that considered an adequate answer to
5 your question?
6 DR. WITTEN: Yes. Thanks.
7 CHAIRMAN WHALEN: Question number six, the
8 sponsor's French clinical study was not designed to
9 provide information on the following long-term issues
10 of pertinence to women with implants.
11 DR. BURKHARDT: I don't know if it's
12 appropriate for me to ask a question of the FDA panel
13 in regard to this question. They're specifically only
14 wanting us to look upon this answer for the French
15 study and not for any other data?
16 DR. WITTEN: Well, I think it probably --
17 the data as a whole I suppose we could say.
18 DR. BURKHARDT: Thank you.
19 CHAIRMAN WHALEN: The data provided as a
20 whole was not designed to provide information on the
21 following long term issues of pertinence to women with
22 implants:

1 Number one, interference with the ability
2 of screening mammography to detect tumors in breasts
3 with implants;
4 Number two, interference with lactation;
5 and
6 Number three, the effects on offspring
7 from women with implants.
8 Please discuss whether the sponsor should
9 evaluate these issues as a condition of approval. If
10 so, please discuss the appropriate methods for
11 addressing these issues, starting with Dr. Bandeen-
12 Roche.
13 DR. BANDEEN-ROCHE: Per this morning's
14 comments, I don't believe it's a necessary condition
15 of approval to evaluate these issues because the study
16 is not designed to study them, other than certainly to
17 note problems. Similarly, long term follow up should
18 have active surveillance for such problems.
19 CHAIRMAN WHALEN: Thank you.
20 Dr. Burkhardt.
21 DR. BURKHARDT: Yeah, I don't think these
22 need to be pursued.

1 CHAIRMAN WHALEN: Thank you.

2 Dr. Chang.

3 DR. CHANG: The answer is no.

4 CHAIRMAN WHALEN: Dr. Morykwas.

5 DR. MORYKWAS: No.

6 CHAIRMAN WHALEN: Ms. Dubler.

7 MS. DUBLER: No.

8 CHAIRMAN WHALEN: Dr. Robinson.

9 DR. ROBINSON: No.

10 CHAIRMAN WHALEN: Ms. Brinkman.

11 MS. BRINKMAN: No.

12 CHAIRMAN WHALEN: Ms. Domecus.

13 MS. DOMECUS: No.

14 CHAIRMAN WHALEN: Dr. Li.

15 DR. LI: No.

16 CHAIRMAN WHALEN: Dr. Blumenstein.

17 DR. BLUMENSTEIN: No.

18 CHAIRMAN WHALEN: And Dr. Boykin.

19 DR. BOYKIN: No.

20 CHAIRMAN WHALEN: Why weren't you guys

21 like this last night?

22 (Laughter.)

1 CHAIRMAN WHALEN: Sorry.

2 Dr. Witten, as regards question number
3 six, consistent with prior opinions, but with specific
4 for this PMA, the committee does not feel that those
5 issues, while important, need to be considered in
6 discussing whether or not we should approve the PMA.

7 DR. WITTEN: Thank you.

8 CHAIRMAN WHALEN: Thank you.

9 Question number seven, given the
10 heterogeneity of surgical practices and postoperative
11 management of mammary implantation, please comment on
12 the important issues which should be included in
13 physician training.

14 I open the floor for anyone who wishes to
15 answer the question.

16 Dr. Burkhardt.

17 DR. BURKHARDT: I think you have to leave
18 that to the chief of the service.

19 CHAIRMAN WHALEN: Any other opinions,
20 consonant or dissonant?

21 PARTICIPANT: Ditto.

22 CHAIRMAN WHALEN: Dr. Witten, as regards

1 herding cats, it is the opinion of the panel that
2 these issues, while important, need to be left to the
3 particular training institutions.
4 DR. WITTEN: Thank you.
5 CHAIRMAN WHALEN: The final question, of
6 the patients enrolled in the U.S. DPS study, 253
7 patients were due for one year follow-up. The
8 reported one year incidence of asymmetry is 25 percent
9 or 13 of the 53 patients evaluated, and the reported
10 one year incidence of a change in nipple sensitivity
11 is 42 percent, being 27 of the 64 patients evaluated.
12 Should the labeling contain a statement
13 regarding the risk of asymmetry and/or the risk of
14 change in nipple sensitivity?
15 Dr. Burkhardt?
16 DR. BURKHARDT: I don't think it needs to
17 -- I don't think the fact that you put the same
18 implant, the same size implant in both sides means
19 that you're going to get asymmetric breasts. If
20 you're not put in the right place, you'll get
21 asymmetric breasts, such I think that's a problem that
22 is a problem of technique rather than a problem that's

1 associated with the device.

2 So far as the change in nipple

3 sensitivity, I'd be inclined to say the same thing,

4 that that's a problem that's related to the operation

5 rather related to the device, and I don't know whether

6 that sort of thing has to be included in the product

7 labeling or not.

8 CHAIRMAN WHALEN: I might also interject

9 just in the flow of discussion that if the data is

10 considered insufficient to evaluate bad things, using

11 our parlance from this morning, it's insufficient to

12 evaluate good or bad things, and to extrapolate for

13 labeling is difficult thereby.

14 Dr. Chang.

15 DR. CHANG: I think this belongs more in

16 the realm of informed consent. These are important

17 issues for a physician to discuss with the patient.

18 CHAIRMAN WHALEN: Dr. Morykwas.

19 DR. MORYKWAS: I agree with Dr. Chang. I

20 think the patient should be made aware of these, but

21 I don't know if it should be on informed consent or

22 the label.

1 CHAIRMAN WHALEN: Ms. Dubler,
2 appropriately informed consent comes to you.
3 MS. DUBLER: Well, this raises the theme
4 that I've been harping on a bit over the days, and
5 that is since there's patient, the device, and the
6 surgeon and technique, it's often hard to distinguish
7 one from the other.
8 However, I think the patient should know
9 anything there is to know, and if these are the data
10 that we have, I would -- I would urge us to tell the
11 patient, and if we think that these are related to
12 surgical technique.
13 I mean it's interesting that these data
14 are the result of the technique of so few surgeons,
15 but were we to have really good data and we could say
16 that this appears to be related to technique and not
17 to the device and you'd better find yourself a really
18 good surgeon.
19 CHAIRMAN WHALEN: Dr. Robinson.
20 DR. ROBINSON: I don't believe we even
21 have sufficient data to look at the numbers in a
22 serious way, and whatever they are, the patient should

1 know about them.

2 CHAIRMAN WHALEN: Ms. Brinkman.

3 MS. BRINKMAN: Well, I have strong

4 feelings that this kind of information needs to be

5 given to patients, and it's our responsibility to make

6 sure that at least we provide this information. We

7 obviously can't assure that patients actually get it,

8 but we need to do it.

9 CHAIRMAN WHALEN: Just I'm sorry because

10 I'm a surgeon, and I'm sometimes dense. You think

11 this should be incorporated in the labeling based upon

12 this data that's presented?

13 MS. BRINKMAN: Absolutely, absolutely.

14 CHAIRMAN WHALEN: Thank you.

15 Ms. Domecus.

16 MS. DOMECUS: I think once the studies are

17 completed that rates of all complications should be in

18 the labeling. I think that's standard.

19 CHAIRMAN WHALEN: Thank you.

20 Dr. Li.

21 DR. BURKHARDT: Could I comment? Oh, go

22 ahead. Go ahead. I'm sorry.

1 CHAIRMAN WHALEN: Dr. Li?

2 DR. LI: I'll defer to my colleagues.

3 CHAIRMAN WHALEN: Dr. Blumenstein?

4 DR. BLUMENSTEIN: I think that what we
5 have here is a small sample size. However, this is
6 information that needs to be put out.

7 CHAIRMAN WHALEN: Dr. Boykin.

8 DR. BOYKIN: I agree that this information
9 is going to be valuable.

10 CHAIRMAN WHALEN: Dr. Bandeen-Roche?

11 DR. BANDEEN-ROCHE: I agree with Dr.
12 Blumenstein.

13 CHAIRMAN WHALEN: And although we're not
14 going to go around a full second time, we will have
15 Dr. Burkhardt one more time answer.

16 DR. BURKHARDT: You know, the most likely
17 problem here. All plastic surgeons will recognize
18 that putting in a prefilled implant through an
19 axillary approach into a retromuscular position is
20 prone to produce a higher incidence of asymmetry
21 because of the technique of insertion, and I think all
22 the plastic surgeons have seen that.

1 I can't imagine that this would be related
2 to the inability to adjust implant size, and for that
3 reason I don't think it's device related, and I don't
4 think it should be on the label.
5 CHAIRMAN WHALEN: Dr. Witten, I think I
6 can sum up the opinion of the panel in that there is
7 strong suspicion about the data which is cited in this
8 question, but it's important to add that if we were to
9 be comfortable with the data showing rates as high as
10 this, that we would definitely want it involved in the
11 labeling.
12 Does that answer your question?
13 DR. WITTEN: Thank you.
14 CHAIRMAN WHALEN: That completes answering
15 the FDA questions.
16 We are now going to summations. Are there
17 any further comments from FDA?
18 DR. WITTEN: No. Thank you.
19 CHAIRMAN WHALEN: Thank you.
20 The sponsor, therefore, if you desire, has
21 a ten minute period of time in which summations may be
22 delivered, and I would ask that the timer be employed

1 for that end, from when they start, of course.

2 MR. HAWK: I'd like to read a statement of

3 PIP implants and then my summary statement as well.

4 The design of the PIP prefilled saline

5 prosthesis has addressed many of the design defects of

6 the saline filled breast implants, namely, elimination

7 of the filling of the valve and, therefore, valve

8 leakage. No saline filling of the implant at the

9 surgical site or while the patient is in surgery.

10 Saline within the implant is sterilized at

11 the manufacturing process.

12 Design eliminates the need for the implant

13 shell to be breached during surgery for filling, thus

14 eliminating contamination of the saline, the bacteria,

15 the fungus, or blood.

16 The implant design provides for the

17 optimum fill of each prosthesis size, thus eliminating

18 either overfill or under fill.

19 Implant design eliminates air bubbles

20 which may occur during the filling procedure of an

21 inflatable saline implant in the operating room,

22 therefore eliminating any sloshing the patient may

1 note.

2 In summation, I'd like to address as well

3 that there is data in front of the agency today that

4 addresses a lot of the concerns that have been brought

5 by the panel today, and PIP appreciates the advisory

6 panel's interest and effort in reviewing our PMA.

7 There's been a number of questions been

8 raised this afternoon, and PIP is committed to working

9 in conjunction with the FDA to resolve them to the

10 agency's satisfaction.

11 Nonetheless, we believe the data before

12 the panel supports the conclusion that there is a

13 reasonable assurance of PIP's implant's safety and

14 effectiveness. This is not to state that additional

15 data are unnecessary. It is to say the threshold for

16 an approvable recommendation has been met.

17 PIP believes that based on the information

18 presented today, labeling can be drafted that

19 appropriately informs physicians and patients about

20 the PIP implant and insures the device's safety and

21 effective use.

22 Importantly, such labeling may reflect

1 data from the PMA and applicable literature data,
2 whether or not cited in the PMA. We, therefore,
3 request that you fully consider the PMA, the relevant
4 medical literature, and the fact that the PIP's
5 implant has been used safely and effectively in the
6 United States for over the last four years in
7 determining the continued availability of another safe
8 and effective implant option for women.
9 Thank you.
10 CHAIRMAN WHALEN: Thank you, sir.
11 We now proceed to the voting, and Dr.
12 Krause will read the voting instructions for the
13 panel.
14 DR. KRAUSE: Thank you, Dr. Whalen.
15 The medical device amendments to the
16 Federal Food, Drug, and Cosmetic Act, as amended by
17 the Safe Medical Devices Act of 1990, allows the Food
18 and Drug Administration to obtain a recommendation
19 from an expert advisory panel on designated medical
20 device pre-market approval applications that are filed
21 with the agency.
22 The PMA must stand on its own merits, and

1 your recommendation must be supported by safety and
2 effectiveness data in the application or by applicable
3 publicly available information.
4 Safety is defined in the Act as reasonable
5 assurance based on valid scientific evidence that the
6 probable benefits to health under conditions on
7 intended use outweigh any probable risks.
8 Effectiveness is defined as reasonable
9 assurance that in a significant portion of the
10 population the use of the device for its intended uses
11 and conditions of use, when labeled, will provide
12 clinically significant results.
13 The options are as follows.
14 Option number one: approval. This is
15 approval if there are no conditions.
16 Option number two is approvable with
17 conditions. The panel may recommend that the PMA be
18 found approvable subject to specified conditions, such
19 as physician or patient education, labeling changes,
20 or a further analysis of existing data.
21 Prior to voting, all of the conditions
22 should be discussed by the panel.

1 The third option is the option of not
2 approvable. The panel may recommend that the PMA is
3 not approvable if the data do not provide a reasonable
4 assurance that the device is safe or if a reasonable
5 assurance has not been given that the device is
6 effective under the conditions of use prescribed,
7 recommended or suggested in the proposed labeling.
8 Following the voting, the chair will ask
9 each panel member to present a brief statement
10 outlining the reasons for their vote.
11 CHAIRMAN WHALEN: Thank you, Dr. Krause.
12 Is there a motion?
13 Dr. Chang.
14 DR. CHANG: I would echo Dr. Burkhardt's
15 sentiments that personally I would love to have this
16 prefilled implant available as an alternative, but I
17 have to make the motion to not approve because the
18 data are much too preliminary, particularly the U.S.
19 study.
20 CHAIRMAN WHALEN: The motion has been made
21 for a recommendation to the FDA that this PMA is not
22 approvable. Is there a second to that motion?

1 Dr. Li seconds the motion.

2 Is there any further discussion of the

3 motion?

4 (No response.)

5 CHAIRMAN WHALEN: Would all those in favor

6 of that motion signify by raising their hands and

7 keeping their hands elevated?

8 (Show of hands.)

9 CHAIRMAN WHALEN: The motion is unanimous.

10 Before formally announcing the decision,

11 I would like to go around the panel and ask for a

12 brief statement as to why the panel voted as they did.

13 Dr. Chang, I know you already gave some

14 statement. Is there anything further you wish to say?

15 DR. CHANG: Just to reiterate, when data

16 comes through, I think it would still be important to

17 describe results in smooth versus results in textured,

18 if there is a difference in the thickness of the

19 shell. That is, whether the base is the same or not,

20 the thickness is going to be different, and properties

21 may not be assumed to be equivalent. So that is one

22 deficiency that I found in the data today.

1 And again, just to state that the results
2 are preliminary. The study is in process, and I could
3 not in good conscience vote for conditional approval
4 with the status of the present United States
5 prospective study.
6 CHAIRMAN WHALEN: Thank you.
7 In going to Dr. Morykwas, as Dr. Chang
8 just did, as you state your reasons for voting, if you
9 could, if there is anything you wish to state about
10 conditions which would make this approvable, were the
11 sponsor wish to reapply, I would appreciate it.
12 Thank you.
13 Dr. Morykwas.
14 DR. MORYKWAS: I just agree with Dr. Chang
15 that I just think there is not sufficient data really
16 to base even -- the laundry list of conditions would
17 be too long. So I'd say I agree that no.
18 CHAIRMAN WHALEN: Thank you.
19 Ms. Dubler.
20 MS. DUBLER: I hope they do come back to
21 us when they have the data. I think that the fact
22 that surgeons think this will be valuable for patients

1 is important.

2 And I want to thank the FDA for having had

3 very clear rules that set forth goals that permitted

4 us to evaluate the data that we're presented.

5 CHAIRMAN WHALEN: Thank you.

6 Dr. Robinson.

7 DR. ROBINSON: I voted to disapprove on

8 the general sense that I don't think we should hold

9 one sponsor to lower standards than another. Dr. Li

10 and I have had some friendly differences on ex vivo

11 data. However, he is completely correct on this one.

12 I will not argue with him on that one, friendly.

13 Two, the astounding loss to follow-up in

14 the U.S. study suggests the sponsor needs to get a lot

15 more serious about evaluating these patients.

16 So I voted to disapprove it.

17 CHAIRMAN WHALEN: Thank you.

18 The non-voting reps., if there's anything

19 that you would like to suggest in terms of making this

20 approvable, I would ask you to say that.

21 Ms. Brinkman.

22 MS. BRINKMAN: I agree. I think it's

1 probably a very good -- it would be a very valuable
2 product, and I'm sorry you just didn't have the
3 opportunity to do what you needed to do to present
4 today. Get on it and do it.
5 CHAIRMAN WHALEN: Ms. Domecus.
6 MS. DOMECUS: Conceptually the product
7 design seems like it might actually be beneficial, ut
8 they just need to complete the studies.
9 CHAIRMAN WHALEN: Dr. Li.
10 DR. LI: Pretty much the same answer. I
11 think the goals, at least the first level goals here,
12 at quite clear. There's guidance and laundry lists of
13 basic material properties, device descriptions that
14 are just a matter of course and standard. It's
15 unfortunate we came here without any of those, but I
16 think it's quite possible this device would be fine,
17 but I think you would need that as a bare minimum to
18 do the next round of evaluation.
19 CHAIRMAN WHALEN: Dr. Blumenstein.
20 DR. BLUMENSTEIN: I voted nonapproval
21 because I feel like the data are not there to be able
22 to develop a sufficient package insert to properly

1 inform the patient.

2 I've also had one more thought, and that

3 is related to this asymmetry complication, as we've

4 called it, and I'm wondering if that's not really

5 efficacy, and so I would just throw that thought out.

6 CHAIRMAN WHALEN: Thank you.

7 Dr. Boykin.

8 DR. BOYKIN: Yeah, I don't believe that

9 we're ready to approve this at this time. Obviously

10 the mechanics of the device and its description need

11 to be clearly understood. We need to double this

12 enrollment at one and two years, get some good data.

13 I would certainly look forward to seeing this come

14 back.

15 CHAIRMAN WHALEN: Thank you.

16 Dr. Bandeen-Roche.

17 DR. BANDEEN-ROCHE: I voted not to approve

18 because I don't believe that the data met a reasonable

19 threshold of assuring women of safety, effectiveness,

20 or being able to give them risk-benefit information.

21 The U.S. study needs to mature. Follow-up

22 needs to be improved, and I would also comment that

1 the representativeness of the doc. population in that
2 study also does not look terribly good from its state
3 distribution. So there might be a consideration of
4 trying to get a little bit more geographic
5 distribution in the docs. who are participating.
6 CHAIRMAN WHALEN: Thank you.
7 Dr. Burkhardt.
8 DR. BURKHARDT: Like it or not, we have a
9 regulatory threshold which is probably higher or at
10 least different than it is elsewhere in the world, and
11 I think in order to get your product approved, you're
12 just going to have to bite your tongue and meet that
13 threshold.
14 One of the things that really concerned me
15 about the U.S. study particularly was the low follow-
16 up rate, and I don't know how you get the hook in your
17 cooperating surgeons, but you're going to have to put
18 some pressure on.
19 If you're giving implants to these people
20 at a discount, they owe you more than they're giving
21 you.
22 CHAIRMAN WHALEN: Thank you.

1 The opinion of the panel is that the pre-
2 market approval application for saline prefilled
3 breast prostheses from Poly Implants Prostheses be
4 recommended as not approvable.
5 We have, therefore, completed the second
6 day's activities, and we'll meet here again tomorrow
7 morning at 8:00 a.m.
8 Thank you.
9 (Whereupon, at 5:47 p.m., the meeting was
10 adjourned, to reconvene at 8:00 a.m., on Friday, March
11 3, 2000.)
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CERTIFICATE

This is to certify that the foregoing transcript in the

matter of: MEETING

Before: GENERAL AND PLASTIC SURGERY DEVICES PANEL

Date: MARCH 2, 2000

Place: GAITHERSBURG, MARYLAND

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

Rebecca Davis