

April 21, 2005

Dear DSaRM Advisory Committee Members and Consultants:

It is my pleasure to welcome you to the May 18 and 19, 2005 Drug Safety and Risk Management (DSaRM) Advisory Committee meeting. The two-day meeting will explore issues related to FDA's risk assessment program for marketed drugs. At this meeting, you will be hearing presentations on a number of methods that FDA uses for risk assessment purposes including review and analysis of spontaneous reports of adverse events and medication error reports, drug use data, healthcare administrative data, epidemiologic and observational studies, clinical trials, and active surveillance systems.

There are a number of methods that FDA uses to monitor the safety of marketed drugs including a passive surveillance system. The internationally compatible Adverse Event Reporting System (AERS) was implemented in 1997. This system is a mandatory reporting program for manufacturers; that is, manufacturers must report within 15 days of hearing about a serious, unlabeled adverse event. The system is a voluntary reporting system for healthcare providers. AERS can be used to very effectively identify serious, unexpected rare events that were not detected during the drug's clinical trials, but the system also has well-known limitations. Challenges to using AERS are:

- AERS reports are not systematically collected
- AERS reports are often missing important clinical information
- Patients may have other drug exposures that make attribution difficult and
- Reporters can be influenced by media or other external pressures.

In addition to clinical review of reported cases, FDA staff also use data mining on the AERS database to assist with signal detection. National estimates of drug use are used in conjunction with AERS reports to generate reporting rates, which provide use-adjusted estimates of the reporting experience of various adverse events. Crude comparisons of reporting rates for a single product to other drugs in the same class or to population background rates can additionally help evaluate an early safety signal.

To augment its passive surveillance system, FDA has recently funded efforts to both employ existing active surveillance programs for detecting drug safety signals, as well as to develop new methods for this purpose. Although the results of these efforts are not yet fully known, it is hoped that these systems may compensate for some of the limitations of the existing passive surveillance system. These programs will be described and the committee will be asked for its opinion on their utility in this arena. Considerations for discussion will include the advantages and disadvantages of the current system for safety signal detection and quantification. You will be asked for your thoughts on how to improve the current system, both in the short term and long term.

Thank you for joining us in this important public health discussion. Background materials are listed below.

Sincerely yours,

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Office of Pharmacoepidemiology and
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