DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADVISORY COMMISSION ON CHILDHOOD VACCINES (ACCV)

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Agenda Item: Welcome & Unfinished Business from Day 1, Charlene Gallagher, Chair

MS. GALLAGHER: Good morning, everyone. I'm sorry about the slight delay. And we are now going to reconvene the meeting of the Advisory Commission on Childhood Vaccines continuing from yesterday, June 10th, 2010.

Our first order of business is to welcome everybody and thank you for your patience. We did introduce the commissioners and the ex-officio members yesterday, and so I don't think that I need to go through that again.

We have some unfinished business from yesterday, and that is related to the Rotavirus Vaccine Information Statement. And I just want to be sure whether Charles Wolfe is on the line, so if you're there could you please say good morning to everyone?

MR. WOLFE: Good morning.

MS. GALLAGHER: Thank you very much. Now we're going to continue with that VIS. Dr. Fisher, would you like to begin with your comments.

DR. FISHER: Sure. It's Meg Fisher. Thanks for the opportunity to review this. The things that we noted about the other statements would be the same for this one.

So if we could lose the “many” before vaccines are available in Spanish and other language. And then, under number 7, update the information about filing a claim, so that they’ll be in sync.

In this one under number 1, the very last two lines there: “your baby can become infected by being around other children who have rotavirus diarrhea.” I think that’s probably an unnecessary line and could easily be eliminated. And then under number 2, where you get to the boxed part about the porcine circovirus. The website that you’ve given is the main page of the FDA. And if you go there you get nothing about porcine circovirus. So if you could give a little more specific link, I think that would be very important. It’s not that easy to navigate that, having just tried to do it recently. It would be much nicer to have a more specific link there.

MR. WOLFE: Yes, I agree. Actually this came from FDA, so I assumed maybe a link with a more specific link was going to change or something. I don’t -- but I’ll go ahead and look and see if I can find something that goes to that directly.

DR. FISHER: That’d be great. And then under number 3, “babies who get the vaccine may be fed normally afterwards,” again seems unnecessary. I’m not sure why the subject matter expert wanted it, but I think it’s just kind

of sitting there and seems a bit odd. And I think it would actually bring up more questions than answer.

MR. WOLFE: I assume that -- I don't know either. I assumed it must be a question that parents ask, but maybe they don't, because the subject matter experts aren't necessarily clinicians, so maybe they don't know what parents are concerned about.

DR. FISHER: And then under the people who should not get rotavirus vaccine or should wait, the new contraindication, as was pointed out yesterday, is babies with Severe Combined Immunodeficiency. And that doesn't make the first page, and it's not even really in the second page. So then the first thing on the back side is check with you doctor if your baby's immune system is weakened. I think that area could be shortened, and that really a bullet on the front page that specifically talks about Severe Combined Immunodeficiency should be added, since that is now a contraindication and a black box warning for both vaccines.

MR. WOLFE: Right. I think technically it's probably covered by the first bullet on the second page, but I agree --

DR. FISHER: But it says check with your doctor. It doesn't say they should not get it. You see, it's different from all of those others. In fact, you would

immunize a child with HIV, you would immunize a child, you know, you might give it to somebody on steroids. And how often do children under six months have any of those things anyway. So I think this is different.

MR. WOLFE: Right. Presumably the provider will check for that. And, you know, the thing is most people are not going to know what SCID is. On the other hand, somebody who's got it will know. So I guess it's okay to put it there. People who don't know what it is will just ignore that sentence.

DR. FISHER: And the other thing is, that will now be included, or at least it's been recommended to be included in neonatal screening.

MR. WOLFE: Oh, good.

DR. FISHER: So as that comes into place -- now, not all the states are going to accept that recommendation immediately, but it will start being tested from -- it probably is already being tested in several states. So I think that given that it's recommended as national screening and it is an absolute contraindication, I just would single that out.

MR. WOLFE: I agree.

DR. FISHER: And then under number 5, the last paragraph about "if rare reactions occur with any new product," I mean to me that seems -- you could say that

about anything, anywhere. It just seems an unnecessary paragraph and not something that we mentioned otherwise.

MR. WOLFE: I think this was an earlier version of the Rotavirus VIS, was the first time we used that, because there were no -- when the vaccine came out there were no post-licensure data. So we just wanted to say, to reassure people that we were watching for rare reactions. You're right. It may not be necessary after a while.

DR. FISHER: And then the English in some of these is, again, a little bit convoluted. So under mild problems, the first line, "babies may be slightly more likely to be irritable," just seems like a very wordy way to say a rather simple thing, like babies may be irritable.

MR. WOLFE: Yes.

DR. FISHER: I don't think we need the slightly more likely. And then the "or have mild temporary diarrhea." So I think you could just get rid of the words and make it just as understandable.

MR. WOLFE: It's a constant compromise, between making things simple and making them acceptable to epidemiologists.

DR. FISHER: Right. And then even at the end, the part about who did not get the vaccine, well, you know, I'd just say they may be irritable and have temporary diarrhea. And kind of let it go at that. That would just

be a more --

MR. WOLFE: Yes, I agree. I'll see if we can get that to fly.

DR. FISHER: And those were the ones I had, and actually I did have some input from Sarah and Sherry Drew, and I think we really do appreciate the opportunity to look at these things in real time and ahead of time as much as possible.

MR. WOLFE: Now that I know that you're willing to do them on an ad hoc basis I'll -- that will make things a lot easier. I had assumed that you could only review things during your scheduled meetings.

Let me ask a question about the box on the second page where we talk about rotashield and intussusception. Eventually I imagine we're going to be able to get rid of that, since it's not really a practical issue anymore. The reason it's there is basically to, for the sake of people who remember rotashield and want to be reassured that these vaccines are not associated with intussusception. After -- because of how much time, I think we'll probably be able to remove that because people won't remember rotashield anymore.

DR. FISHER: I agree with you a hundred percent.

MR. WOLFE: Do you know what your opinion is on that, when we might be able to do that?

DR. FISHER: I think absolutely you could, but I would wait a minimum of five years, and maybe more like ten years.

MS. GALLAGHER: All right. Are there any more comments?

MS. DREW: Sherry Drew. The only other comment I have, is if you do get rid of that black box, I assume you will include, you will not eliminate the fact that if a baby has had the condition they are more likely, and the doctor should be discussing it with the patient.

MR. WOLFE: As long as that's a precaution it will stay in there.

MS. BERNSTEIN: I just have one thing. Jessica Bernstein from NIH, sitting in for Barbara Mulach. The one item about if rare reactions occur, which we did talk about possibly removing. If it stays, it shouldn't be under mild problems.

MR. WOLFE: Okay.

DR. FISHER: Yet another reason to eliminate it.

MR. WOLFE: Yes.

MS. HOIBERG: It would need to go under number 6.

MR. WOLFE: Okay.

MS. GALLAGHER: But I think we have a fairly strong recommendation to consider taking it out.

MR. WOLFE: I will do that and hope nobody misses

it.

MS. GALLAGHER: All right, Skip. Now is there anyone else who has a comment or a suggestion? All right. And thank you very much, Skip, for making yourself available again this morning. We really appreciate it, and I think we were all very pleased to get an opportunity to review this now.

MR. WOLFE: Thank you very much for your comments. We'll see you next time.

MS. GALLAGHER: And next I would like to just bring up a matter of housekeeping, Geoff, because a couple of commissioners about a suggestion for the next meeting. Because the Chief Special Master has invited us to the Judicial Conference, the commissioners were wondering if the date of the meeting to accommodate attendance at both the Judicial Conference and at this meeting.

DR. EVANS: I have not had a chance to think about this, nor consult with the staff on logistics. I will tell you that we budget for four meetings a year.

MS. GALLAGHER: No, we were suggesting September be moved to coincide with the Judicial Conference. I know that this is just going to give you an administrative nightmare -- and Kay, I apologize but I thought it was a suggestion worthwhile enough to bring it up with the whole group.

DR. EVANS: That's a different question, because the last time this came up, it was a matter of whether we were going to have the December meeting in addition to the Judicial Conference that was that November. And we eventually cancelled the December meeting. No, I think that's something we could certainly try to work out. And it would put the meetings much closer together, the third and fourth meeting. I don't know if there are other advisory committee meetings that week. We'll have to look at that. But we'll take it under consideration and discuss it with the agenda committee in the subsequent weeks.

MS. GALLAGHER: I knew you couldn't give us an answer today, but I think it was either consider cancelling the September meeting or cancelling the December meeting because several commissioners have expressed a desire to attend the Judicial Conference and hear what were really excellent presentations last times when we did attend.

MS. TEMPFER: I think we've done it the two other times, and it's really a great experience to be able to actually see the other, you know, the petitioners' attorneys and just the whole issues involved with them.

DR. EVANS: No, I agree. And it probably would make more sense to cancel the December meeting, as we did last time. Okay.

MS. HOIBERG: I would cancel September and just

do, I mean, because all it does it move it one month. It would give you guys, it would give us more time to prepare -- do you know what I mean?

DR. EVANS: Okay. My only question is: is the December meeting the first week?

MS. HOIBERG: Yes.

DR. EVANS: Okay. So we're talking about a five-week gap.

MR. SCONYERS: Nine weeks. No, what you're saying is from the Judicial Conference to December.

DR. EVANS: Exactly. Right. That's why it doesn't make sense to me.

MR. SCONYERS: There's more time between the scheduled September meeting and the Judicial Conference than there is between the Judicial Conference and the December meeting. So it would make more sense to do the back-to-back of December of Judicial Conference, than wait essentially five months for our meeting.

MS. HOIBERG: If we did attend the Judicial Conference and have the October meeting, Banyon's report would be ready. So we would be able to review that. I think that would be a good thing.

MS. GALLAGHER: Okay. Thank you very much for considering it and working on that and getting back to us.

I think the next thing on our agenda is the DVIC

Clinical Case Update. So Dr. Johann-Liang, could you please come up here to the podium because we understand the acoustics are much better. And I'll just remind everyone, try to remember to speak distinctly and loudly and into the microphones so that everyone on the phone can hear you very well. Thank you very much.

Agenda Item: DVIC Clinical Case Update, Rosemary Johann-Liang, M.D., DVIC

DR. JOHANN-LIANG: Good morning everyone. Thank you very much for letting me share with you some information regarding our medical analysis group.

Yesterday you heard some statistics about the program both from Dr. Evans and also from Mark Rogers of DOJ. Dr. Evans presented the overall numbers of what is happening with the program. And Mark Rogers showed you the last quarter information regarding what's happening at the court end, you know, which cases were settled, which cases were conceded, et cetera, and discussed some of the decisions.

So what I wanted to do was to give you the perspective from the medical reviewers of the program. So these are -- when the cases first come to the program there is a full medical analysis by a member of our team. And so the numbers are different, and I don't want you to get confused. When records come in, even though there may be a

case assignment when a medical officer goes to open that case, there may not be enough information to actually do an analysis; so that case would wait for critical missing records to come it. So that's really the main reason as to why the numbers may be off.

So what I am going to show you are actually numbers of new reports, so new case analysis that has been performed by the medical team within the time periods that I will show you. And remember also that this information is much more timely information, right. Because you saw yesterday on the tables from Mark Rogers that it takes some months, usually years for the actual end of the case, the resolution to happen.

What I will show you would be information that's more new, something that's more recent. The cases have come in, we've looked at them, this is what we're seeing. So keep in mind, because these are cases that are under development and that we're reviewing, we really are very careful of protecting the confidentiality of the folks that come into our program, so I will not be talking about any specific cases at all, but rather so we can all understand more of a de-identified group information, just so we can all get an understanding and be, as you asked, to be much more transparent about what's going on in our program.

So the first slide, I'm not sure if you've seen

this from Dr. Evans, but this is just to give you a perspective of the workload that the medical officers, that our team is undergoing. So let me just walk through with you these lines. Obviously the blue line is the number of cases in total that we've been reviewing in the last five years. And you can see it's a steep rise.

But the components of why the workload is increasing, it takes a little bit of time to explain. So let me go through that. The red line is the non-autism cases. So in 2007 there was quite a bolus of cases from the influenza that had to come in because of the deadline. So we had a big increase in workload because of the influenza vaccines. And then things kind of trailed off a bit. And then during the last year, and this is continuing into 2010, the non-autism cases are on the rise.

So that's it right here. So this red line is continuing to increase and really it has to do with, and I'll show you the demographics later of the age bracket. It is adult cases that are coming in more and more. And that's the bulk of the non-autism cases.

Moving on to the solid orange line -- well, actually lets skip that for just a second. Let's do the dotted autism cases. The reason why here it's going down like this -- because I'm sure you've seen Dr. Evans' big year-by-year cases coming in -- this is the big Omnibus

Autism Proceeding cases. These are autism cases coming in, and you know that it was tremendous numbers coming in over here, and it really has gone down here.

With the Omnibus Autism Proceedings, the actual hearings, the court hearings that started right here in 2007 -- and I guess because of media and et cetera -- there was a slight rise again in the number of newly filed -- that's what we're calling them -- autism cases have come in. So that made the rise in workload here. We did have a lot more autism cases in 2008 to review.

The solid orange line here are what we're calling activated autism cases. And just so that you won't get confused, there is a break over here, because many of these cases are now what are going to be labeled as activated autism cases. And these are cases that have come in over the years, thousands of cases that are on the shelf waiting for adjudications. Kevin Conway talked about those cases as well.

As you already heard, in 2007 following the first Omnibus Autism hearing, the special masters said starting January of 2008 these shelved cases should be activated. So these are older cases that are being activated by the court. The Department of Justice is undergoing jurisdictional reviews, and then for cases that are timely we have also started to do medical reviews as we are able

to, as well.

So that's how the workload is from the medical teams perspective, breaking out. Any questions? Do you want me to keep going and you'll ask questions later? Okay.

You have seen this data before, but at the request of Dr. Evans we've put them together, the ten years apart. So the blue are the age brackets for 1998, and the orange is ten years later, the 2008. And this is really just to illustrate the tremendous difference in the landscape of the petitions coming into the program over the years. Remember also, because 1998, this is pre-autism, we're comparing non-autism age brackets. If you added all the autism cases in, then this would totally dwarf everything else, obviously the babies.

MR. SCONYERS: Excuse me. For this slide, the thing I wondered is how this correlates to the rate of vaccination. So, what's the relationship of these population bands to the number of vaccinations administered?

DR. JOHANN-LIANG: Right. So it's always very difficult to actually get -- and I don't think there's an actual national data as to exactly how many people actually got a vaccine. But we do have data for the distribution of vaccines, how many got distributed here and there. And I

think that's how they are able.

And I think -- I don't know the exact numbers for this. That's a very good question. We could try to overlay that next time. But as far as we know the ACP recommendations for influenza, which is a childhood cover vaccine, but the population for that vaccine has been increasing. You know, initially it was just for people who had medical issues. And then it expanded now to adults, as well as children, and now to everyone.

So the distribution of vaccines to populations that are outside of the childhood range is really probably exactly why we are seeing the different age brackets, the petitions coming in. Also, for the adolescent groups, as more HPV continues to increase in its distribution to the adolescent population, that middle group will probably rise as well, the orange.

And this is just to update the numbers for FY 2009. What we are seeing is a similar kind of trend as 2000, and what we saw 2008, except that our older group population, the 50 to 85, we're having more and more of those much older bracket people.

Okay. So that was kind of a background of the age demographic and fiscal year in the last five years of what's being analyzed by the medical groups. But from henceforth periodically I'm going to come before you and

give you an update so you can get some real time information of what's happening.

DR. FISHER: Can I stop you just or another minute. This is Meg Fisher. I guess the age that's most surprising to me is the 30 to 49, because that's -- up until this year it hasn't even been a universal influenza vaccine for them. It's hard to envision what in the world vaccine that has to do with. So presumably it is all influenza.

DR. JOHANN-LIANG: It's influenza, hepatitis B -- and the reason is that age bracket actually has a lot of health professionals. So folks who are nurses, physicians, medical techs, we actually do seem to get a disproportionate number of folks filing in that age bracket who are healthcare professionals, and they're required to take these vaccines. And they actually, I guess, know to file.

DR. FISHER: So it may be awareness?

DR. JOHAHN-LIANG: Yes.

DR. FISHER: That's an interesting thing for our outreach group.

MR. SCONYERS: I think that Dr. Fisher's point is it's hard to make sense of what these numbers mean without understanding how they compare to rates, so they're just numbers until you can correlate them to the actual

vaccination rates.

DR. JOHANN-LIANG: That's true, but the purpose of this is really just to give you an overall sense of what are the demographics of the folks coming into the program, not really to provide an analysis with other databases, et cetera. So what would be helpful, I agree, is to actually see what the distribution of different vaccinations for different years. And the other thing with that is that data lags behind also. So it's a little bit difficult to overlay in real time.

And so the purpose of the information here is to really try to update you as the case is coming in, because we are the first ones to be looking at the petitions as they come in to give you a flavor of what we are seeing. Okay. So that's the purpose.

So for fiscal year 2010 we had eight months for far into this fiscal year -- remember we started in October of 2009. So these are new medical reports, so analysis of records that have been generated. Remember also, not all of them, even though there may be enough records for me to sign off on a report, there still may be records missing. We have many petitions with actual vaccination record not in the records.

So that's something that we really need to confirm, so. There's enough information there to maybe

generate a report, but that doesn't mean they're really finalized. But those are the new reports that have been generated, and of those 155 are the older autism cases that were deemed timely filed by the Department of Justice team, and that came to us with enough records for us to review. So this is in the fiscal year our workload.

So just in the last -- from now on I'm just going to be giving you a picture of the last quarter. Since you all met in the last ACCV meeting, Dr. Evans and I had a talk about providing you these sort of periodic updates. So this is information that we try to gather starting this quarter, okay, and then we can do those as we move forward.

So for March through May these were the claims that have come in. This is just showing you of those claims that have come in during the last quarter and were available to assign -- we don't even assign a case to a medical officer until there is some records, okay? So many of these cases I think you've heard from Mark Rogers yesterday, what is the big delay? One of the sort of time points that there is an issue is really because a petition is filed -- and there's a lot of electronic filing now, so I think this is going to be an increasing problem. A petition is filed, but there aren't even enough records for anyone to do anything with. But it's still filed, the clock starts to run. And so that's a big issue I think

that from our perspective that we've been struggling with.

So for the last quarters, again, of all the cases that we were able to have substantive records to be able to review, these were the ages. Obviously the autism kids are all pediatric. So autism and non-autism kids are the pediatric folks. And then the rest, it's close to almost 50 percent are adults, even accounting for the autism reviews that we have done this quarter.

All right. So this is actually showing you in the last quarter of the non-autism cases. Now autism, what kind of vaccines they allege and all of that, that's a little bit -- that's a very different analysis I think than looking at non-autisms. I'm just providing you what vaccines the petitioners are alleging of the non-autism group.

So again it is flu that's 45 percent of all the vaccines alleged are flu. Now, keeping in mind, if they allege a specific vaccine as the culprit, that's what I'm giving you the proportions of. When it says multiple at the bottom, that's if someone comes in saying it could have been any of these vaccines. And there are many petitions like that where they list a whole slew of vaccinations alleging kind of nonspecifically that any of these could have injured me. So that's what's showing down at the bottom. That's about 12.5 percent.

But our biggest vaccine alleged is influenza, followed by HPV. That is now starting to really -- the claims are starting to catch up. So remember from the time that it started to be covered by the program, there's a little bit of lag. And then the petitions started coming in. The first petitions to come to the program started in 2008, and the numbers each year are increasing. That's because of the usage of the vaccination out there.

So as Jeff Sconyers mentioned, it may be interesting to just overlay -- even though the years will be a little bit behind -- the distribution data so we can actually show that this correlates with the amount of vaccine usage out there.

Next are tetanus, hepatitis B, MMR, rotavirus, -- these are what's being alleged -- meningococcal vaccine, and varicella. And then again, as I mentioned, 12.5 percent of these petitions just alleged a whole slew of vaccines as -- and for pediatrics it's very common for parents to allege the whole childhood vaccines series, you know, DTaP, and hepatitis B, and the whole childhood series, and that's what considered under multiple.

And then for what kind of adverse events are we looking at, looking from the alleged injury perspective, again, GBS is the most common adverse event, and then other demyelinating. So as you are aware by now Guillain–Barré

syndrome is an illness that's characterized by what we call the destruction of the myelin that covers our nerves. So and for Guillain–Barré it's considered what's called a peripheral disease. But we also see besides Guillain–Barré other illnesses that are under the demyelinating group, such as transverse myelitis, Acute disseminated encephalomyelitis, multiple sclerosis, et cetera. So that really is the next most common adverse event that's being alleged.

We have lots of skin complaints. And then of interest, I'm going to be talking a little bit more about this purpose shaded row here just for the purposes of categorizing. There are a lot of injury complaints regarding the shoulder and arm, including brachial neuritis, which as you know is a table injury for tetanus. But also we're seeing more and more of what's called the chronic regional pain syndrome, and also something else that we saw that we'd like to share with you in a couple of slides. Encephalitis, seizures, and encephalopathy are there.

We also have claims of adverse events that come in as death. As you know there are death claims. Many of theses cases also come in with all different kinds of allegations, but it turns out that there are various underlying disorders that these folks have.

So, they can be anywhere from metabolic type of disorder to genetic disorder to -- for even adults, we had a lot of discussion about even diabetes, diabetic neuropathy, and how do you look at that in the context of someone coming in complaining of all the sort of neuropathies, when they already have a diabetic neuropathy as their underlying disorder. We do have a lot of autoimmune, rheumatological, and immunological adverse event allegations as well.

And the miscellaneous, that's a big bracket. But it's just because there's a slew of all different sort of adverse events, it's a little bit hard to categorize them together. And one example would be, you guys talked about there's the rotavirus, even though we do not have rotashield anymore and we have the other two now, we still receive inttususception allegation injury claims. We have various cardiac, hematologic sort of -- like the thrombocytopenic purpura, et cetera. So that's that constitutes the most recent adverse events that have come in. That really hasn't changed very much. I mean, things like the shoulder/arm, the CRPS, I think those are some new things. The fact that the majority of our adverse events are neurological and demylinating in nature, that continues to be -- so there are some interesting things to see here.

And we'll see -- as we keep track of these things

as they come in we'll see if things change, if they're -- and what I really hope to do also is highlight for you if there are some particularly interesting medical group information. Again, I don't want to do any kind of individual case discussion, but this is really to give you a flavor of what we are looking at as a group.

DR. FISHER: Could I just ask you for a couple letters? CIDP and NMO? I knew all of the other ones; the ones that you mentioned I knew, but those two are new to me.

DR. JOHANN-LIANG: So it's chronic inflammatory demyelinating polyneuropathy. So one way to look at CIDP is it is a peripheral chronic demyelinating illness. So it's sort of your corollary to the acute monophasic illness of GBS. For MS, which is a chronic remitting demyelinating disease, multiple sclerosis, that's a central nervous system problem. That sort of correlates more with your transverse myelitis, which is an acute monophasic central lesion. So even though the demyelinating diseases are kind of grouped as a group, as a group they are incredibly diverse, and there is a whole array of different kinds of illnesses that are going on.

So we're being very simplistic in categorizing central versus peripheral, acute illness versus chronic and remitting illness. So that's one way to kind of -- that's

my way of trying to categorize and organize them. But every one of them has a lot of -- GBS has a huge number of, I mean, there's all different kinds of variants of GBS, too, right? They're not all the same. There's Miller-Fisher variant.

Neuromyelitis optica is NMO. And that is a very similar type of illness to MS, but it is distinct now, and there are actually antibodies. But, again, there is a whole array of these things and it's hard to categorize.

Are there any other questions? I'm almost done, so we can --

All right. So I talked about how I wanted to give you an update whenever you guys want to hear it, or quarterly, or bi-annually, or whatever. But I thought what would be really interesting is to kind of hone in on a couple of interesting things that we're seeing. This is really I think part of what the program should be doing as part of the vaccine safety, in the sense that you heard a lot about VAERS yesterday from Karen Broder, and I think there were a couple of other speakers. I mean you hear about VAERS all of the time, you hear about VSD and all of those.

Every one of those different types of databases has a different part to play. I mean, VAERS is a passive surveillance system, so you're trying to pick up if there's

any signal there. You have large HMO databases that you can get good control data from. Obviously the program is really -- everyone is alleging an injury, so you're really getting even a higher level of the numerator. We don't have any denominators here; so that's something -- and I think that's your point exactly. We're just showing numerator data. And part of showing the demographic is showing how does this compare to how much vaccine is being used out there

So as numerators go, with just numerator alone, you really can't say much about it. It is, I believe, one source of a database that can serve in the whole vaccine safety network of a signal. And also, because there is, once we're able to get it, a very detailed medical record available as compared to like even in VAERS. It's very difficult to get a complete set of records when folks are doing a VAERS case investigation. We're able to look at the case -- analyze each of these numerator cases in a more thorough manner.

So we think it's very important that we bring to you and sort of look at it from a group perspective and see if there's anything that we see as interesting. And for HPV we're simply bringing this, we're looking at this in a little bit in close attention, just because we're able to really get our hands around it. We have started looking at

these claims right from the very first one that have come in, and we're trying to keep track of a group data as it comes in.

So we have 54 claims that have come in thus far. And as I mentioned to you before, these are all in active review right now, so there's no, you know -- and various stages of the life cycle of the claim, going through us, and then to Department of Justice, and ultimately to the Special Master. And of the 54, five are death claims. And the average age of the petitioners are -- they're teenage, 16.5 years. And they're all females with a range of 12 to 27 years. There's been only one male claim thus far. And this is obviously the outlier right now.

But now that you know the HPV has been licensed for males as well, we'll see how this changes. So once again that's putting this numerator information into the contest of ACIP is doing and what the --

MS. HOIBERG: I have a question. Why was he over 50? I thought it was -- no, it's really just kind of in a scope, I know with women it's just like up to 24 years of age. Why would a 50-year-old male be receiving?

DR. JOHANN-LIANG: If we have a bunch of more of these things I can actually give you a nicer analysis of the group information. But I really don't want to go into just that one particular claim. It is fairly new, and

we're still looking at it, but it does sound like it's an off-label shot, isn't it.

MR. SCONYERS: To my earlier question, that could represent a 100 percent rate of claim for this particular demographic. There can't be that many men over 50 receiving HPV.

DR. JOHANN-LIANG: No, you're right. So we're trying to give it to you in the context of the information of what HPV claims have come in. We're not trying to do any epidemiologic analysis. This is simply the numerator information that has come in this new vaccine.

So moving on, we'll see if more men aged over 50 come in as a claim. Only time will tell. This is breaking news here, so.

And the next line is about how many -- third, third, third is people receiving one vaccine versus two in a series and three in a series. And these are the people who have petitioned to the program. And 16 percent of the 54 cases have come into the program concurrent -- they received concurrent vaccines as well, and these are the concurrent vaccines they received when they received HPV. But for the majority -- well, all 54 are alleging that HPV was what caused their injury.

And these reviews again are ongoing, but this is what we're seeing at the current time. Again, various

sorts of neurologic injuries is what's being claimed, including seizures, a couple of cases of seizures. Remember, again, to keep the scope and perspective, we're giving you proportions because we want to give you as much of a de-identified, group information as possible. But this is 54 cases, okay, so 24 percent of 54 cases.

GBS is common, as well, as are other demyelinating diseases. You guys are all familiar now with these acronyms, TM, ADEM. So, rheumatologic, there are a lot of rheumatologic injury complaints in these folks. And under the rheumatologic something that we're seeing also is connective tissue disorder, that's CTD. There is fibromyalgia, and rheumatoid arthritis, and all sort of other rheumatologic -- lots of pains, aches and issues.

And then something of interest is Syncope. As you are all very aware, any vaccination can cause someone to faint -- or a blood draw or whatever. But it does appear that in the adolescent population this is heightened. So, since HPV as well as meningococcal vaccines are primarily given to teenagers and young folks, this VC syncopal alleged injury in this age bracket. And actually with syncope you faint and you get better, you're fine. You really can't jurisdictionally come into the program for that. You really have to have a six-month sequelae.

But the syncope folks that we're actually seeing -- well not all of them -- but a good proportion of them actually do have sequelae, meaning they fainted and then there was an injury, because -- you know, one child fell and had dental injuries, had to get dental surgery. Another person got in the car and had a syncope episode. These are quite serious sequelae that we really think probably could deserve more public outreach and information.

Especially if you are vaccinating, and especially vaccinating a young teenager, you really need to monitor them for a little while before you send them out the door, because they do result from serious sequelae. Not from the fainting per se, but from what comes out of the fainting.

So, and the miscellaneous, you know, lots of gastrointestinal, like remember this is the age group with irritable bowel syndrome, cardiac panic attacks, et cetera.

And death claims are always of interest to us. We look at death even more -- well, we look at everything carefully -- but death is something very serious. And these, we have five, but actually on many of these we're still waiting for lots of records on these death cases. And we also really take all of the autopsy reports and try to do an independent assessment of those tissue blocks. So we're waiting for those requested slides.

It does appear there may be a couple of them, there's a question of hypercoagulable state. Remember this is also the age bracket that uses oral contraceptives, and as you know you can have hyper-clotting, so your blood clots more. And so that's an issue of this population as well. As they're claiming injury, how does that play into, how did that contribute, or was that part of the death that occurred? And it is a young population; not our influenza, a very older population in the 80s et cetera. But this is the teenagers, so we would really like to get these slides and do an independent pathology review.

MR. SCONYERS: Before you leave this slide just a couple of questions. Can you just say a little bit more about what you're classifying under the rheumatologic definition, because that's a fairly big number, as opposed to the connective tissue disorders and the demyelinating conditions. So what falls into the rheumatologic category that doesn't fall into one or the other of those?

DR. JOHANN-LIANG: Okay. So connective tissue disorder is if the reviewer specifically mentions if the treating doctors give the person a specific connective tissue disorder, like Sjogren's for example, or a specific diagnosis is given.

Rheumatologic would be sort of a more broad category of everything else, like at I mentioned,

fibromyalgias, arthritis, arthralgias, and et cetera. And so CTD, I just point it out because there are several cases that actually specify that this was, you know, dematomyositis, which is a specific connective tissue disorder or disease, so.

MS. HOIBERG: You had mentioned the death cases and the possibility of oral contraceptives. Are you saying that the oral contraceptives could have possibly interacted with the shot to cause the problem? And then would it be a case where the family could both go through the program and then sue the pharmaceutical company for issues with the -- undisclosed issues with contraceptives. I mean, I feel that that's something that should be very much looked at, if oral contraceptives are possibly causing an interaction with the shot.

DR. JOHANN-LIANG: I think the oral contraceptives and the hypercoagulable state, which means more clotting, is -- there has been a lot of work done in that area. All the different kinds of oral contraceptives, I mean there are many different ones. And how much estrogen seems to be in them? And there's a lot of work that's already been done in the OTC arena.

And it's risk factors for clotting, such as if you're a smoker, you know, et cetera. So that's one entity. I don't think there's anything anywhere to date

that would say that a vaccine like human papillomavirus would be a contributing factor to someone having a hypercoagulable state. Right now we're looking at -- when we do the medical analysis obviously we're looking for what happened. And part of figuring out what happened is what does this person, what did they have, or what other things are going on, right?

I don't think we're anywhere near to say that there's any sort of interaction with vaccines or any kind of an addition something that the vaccines would be contributing. In fact, if I can recall for one, I think it's just one case, it's probably the timing from the vaccination to when the death occurs is probably very far away. So it's not a state of someone having the vaccine and then the death occurs like within a couple of days. It's not even like that.

So all of this is still obviously under review, but to date in the medical literature anywhere in vaccine safety that I know of I don't think the contribution of vaccines such as HPV to someone's hyperclotting state has really been worked out. But who knows, I mean, medicine always moves forward, and we always try to look and see if there's anything that we can see, if there's any type of signaling, and then try to work from there. But death claims are something that we take a very careful look at.

MR. SCONYERS: I'm trying to put together all the different pieces of data we're getting, and it's fascinating and I really appreciate the analysis and the comparison that you've done. You're talking about claims since '08. Yesterday when Mr. Rogers was making his presentation, the last several slides that he showed had to do with stipulated claims. And when we were looking at the closure rate on those claims, most of them were resolved in two years or less. So claims that were filed in '08, it's been a couple of years. So I'm just -- and when I look at his list here, I see one HPV claim on here.

So I'm wondering, what I understood you to say at the start is that these are all still open and being reviewed.

DR. JOHANN-LIANG: In various stages; some have resolved.

MR. SCONYERS: Okay. So I'm trying to correlate what Mr. Rogers was talking about yesterday in terms of the pace at which cases are getting resolved, and what you can say about these claims and the pace at which they're getting resolved. One of my desires all the way along has been that cases move through the system quickly to resolution out of fairness to petitioners.

DR. JOHANN-LIANG: You know, and I have to say that in every possible way the medical team, we are -- as

soon as we get the records it's reviewed in a timely manner. We try everything that we can to really push those cases forward. Maybe I didn't explain correctly. The reason why I'm saying these are open is because we're discussing this as 54 in entirety, in a sort of looking at what the picture shows. And the majority of the cases are still going through its life cycle, so it's hard to specifically talk about.

Yes, I also did notice about the HPV on the stip list yesterday. So a few of them have been resolved and closed out. And you can imagine things like syncope, and there was sequelae, then we compensate. We don't -- there's no haggling. We say this person was injured and we go. So, some of them have been conceded, and others are in various stages of review and process.

DR. EVANS: Let me add something to that, Jeff. If you look at the stips that Mark reviewed you'll see that they're predominantly influenza, influenza and TD. And influenza vaccines that are found in far greater numbers than HPV. HPV is a much newer licensed vaccine than influenza, even though influenza changes every year. So the experience is -- there's a much different dynamic with the conditions that are alleged and the history of the vaccine and so on. So the HPV vaccine is going to be taking longer for those claims to go through.

MR. SCONYERS: I'm just trying to understand the different pieces of data that we get. Yes, I'm just trying to understand all of the different reports that we get, and to address my primary concern, which is the resolution of claims on behalf of petitioners in a timely way. So that's what I'm trying to understand how this presentation relates to that concern, and to other pieces of data that we get.

DR. JOHANN-LIANG: And to add to that, again, the HPV, many of the records are still not available. It's hard for us to really do any analysis if we don't have records to review. So even though the petition has come in and the year is marked '08, that doesn't mean we can actually even review until the records come in. So that's a big factor in the analysis.

MR. SCONYERS: I understand. And when Mr. Rogers was talking yesterday he was talking about the date on which the petition was filed, so presumably that's a problem with all petitions -- or with petitions for all vaccines. And yet, you know, again we're looking at the pace with which they're resolved. And so whether that's somebody else's fault or yours, it still is an impediment to resolving the claims, and so it's something that we as a Commission might want to focus attention. I'm just trying to understand what's going on.

DR. JOHANN-LIANG: Okay. So I think what Geoff

was just saying is very important, because not all -- HPV is a newer vaccine and these are just the beginning claims. So it's going to take time for us to see how it plays out. But GBS is our most common claim that comes in, with flu, that combination.

And we really try to expedite those reviews with the records are available. So, I don't think there's any -- I don't know if you're looking for some sort of a magic answer. It really depends -- we really try to push everything forward as much as possible. It depends on what vaccine, it depends on what injury that's being claimed, it depends on what injury turns out to be when you review the data, and where we are with the life cycle of the case. Okay. So we're going to move on.

Another thing that I wanted to share with you is something that we have noticed as we were reviewing these cases in the last three years. So I think this is from 2006 to 2009, cases that were reviewed. As part of reviewing cases we do a lot of literature searches and try and look at what vaccine safety information is available. And one thing that we saw, it was a two patient case report in the Journal of Vaccine in 2007, where these folks described -- a person in the 70s and a person in the 80s who received pneumococcal vaccine and a flue vaccine and reported really severe pain within two days, 48 hours

following vaccination.

And they point out that if you inject the vaccine way too high on your shoulder, could it be actually injecting into the bursa under this bone here? And if the vaccine antigen goes into the bursa, then it probably doesn't do much if it's your first vaccine. But if you, for example, if receive a hepatitis series, there is 1, 2, 3, right?

And influenza, even though every year the antigen, the three antigens that go into it is different, there's probably enough commonality that if you get another shot, perhaps there's a risk, sort of immune response, even at the level of the bursa, the pocket that holds with the fluids, the bone that sits on top of your shoulder. And perhaps that can get inflamed, and what the patients end up having is sort of restriction of shoulder movement.

And it comes to the doctors as rotator cuff injuries, shoulder tears, tendonitis, et cetera, and they end up getting steroid shots, and some of them even end up going to surgery. And we were thinking, have we seen cases like this as we undergo review? And we think we have. We think there are about eleven claims thus far that possibly fit into this type of picture.

So the only article that's really been described is that Boulder article. So we're trying to pull that

information together. These were mainly females.

DR. HERR: On that kind of an instance where there's question of whether the shots are being perhaps given in the incorrect place. I mean is it worthy to think about a blast fax to providers or something, or an output reminding people exactly where these vaccines and these shots should be given? Since you're starting to see an increased number, perhaps a little signal.

DR. JOHANN-LIANG: That's what we're trying to do. We want to try to -- it's hard to just go by one case and say is this it, but yes, that's exactly right.

DR. HERR: Just something to put in your mind.

DR. JOHANN-LIANG: No, that's what we plan to do. We plan to pull this information together and get it out there as information for not only the physicians, but actually the people who are injecting the shots.

So, what we think may be happening is, if you are sitting down, and the person who's giving the shot is sort of standing over you, then the angle of the shot is probably too high and angled. And also, the length of the needle, that's something else we really want to remind people, that it should not be more than half an inch.

And also we're seeing this more I think because if you are sort of a thin, older person, it's probably harder to get good deltoid muscle to inject the vaccine.

So we do think that this is something that we really need to communicate. And we're right in the middle of doing the analysis to try to pull this together and get that written up and send it out.

And because in particular, it's not something that if this really happens -- now there are many other things going on with the shoulder. We talked about all the different kinds of things. And this is a very, very, very rare event probably that this happens. Most people do it right. Most people do not -- even if you shot it really high, it's not long enough for it to get into the -- it has to be exactly, and you have to have seen the antigen before. So there are many issues. But if this is in fact what's going on, then we are concerned, because it does have long-term sequelae. It's not something that you just get better from. These people that we're seeing seem to have restriction of movement, pain for quite some time.

DR. FISHER: Meg Fisher, just a comment on that. I think it's fascinating and I'm glad you're looking at it. The thing that, with the needle length, the problem of course is with the obesity epidemic, at the one time you're looking for longer needles to make sure that you actually get it in the muscle and don't deposit it in fat.

At the same time you don't, you probably do need to look at the body mass index of the person you're

immunizing when we pick needle lengths. And I don't think that that's anything that's in our literature, or even on our radar. So I think this could be a very valuable thing to really change in general the way we give immunizations, to really look at body mass index and take that into account when we're picking needle length.

MR. SCONYERS: That's a really great insight.

DR. EVANS: One comment about the denominator data that Jeff was talking or looking for. We've asked CDC and they've responded very nicely over the years in giving us distribution data on an annual basis. That data usually arrives for the previous year sometimes around the summer, early summer. So June, July we expect the '09 data to be coming. But those are just gross numbers by vaccine. I don't know that there's any insight at all in terms of age group, other than looking for example at DTaP, which is just approved for a certain age range. You can draw the inference about children versus adults that are receiving that vaccine. So I don't know that there's the data by age group that's as finally honed as you would like, because influenza obviously universal recommendation, hepatitis B, across various age ranges, and so on.

MR. SCONYERS: So I guess my comment then would be I'm not sure what stratifying by age does for you if you can't associate it with the rate. It's just a number.

DR. JOHANN-LIANG: Right, but what it does is that it shows you, the Commission, how the program is changing. I mean, the age, the injuries, the vaccines, the presentation of how these petitions come in is very influenced by how old they are. I mean, an elderly person who received flu vaccine with all the comorbid injuries claiming a certain demyelnating disease is very different than a young child and their set of issues.

So I think it's just for awareness. And I don't think that we need to keep bringing this up any more, but this is just to catch you up to say the landscape of the demographics has really changed over time, from a very young child, seizures, that type of picture, to much more neurological, older age bracket, now with a lot of adolescents, and I think that's important information for you all to have as you think about other issues.

DR. EVANS: You still have a quizzical look on your face, but I think what you're trying to get at is can we be some kind of reliable or semi-reliable indicator of adverse event causality of a pattern in the population, and we can't be, because this is a skewed population. We have a situation now where if you look at the stipulations, you would think that we have enormous numbers of GBS cases throughout the country, because that's predominantly what we're seeing with influenza vaccine.

Well, it also turns out that influenza vaccine is given in very, very large numbers, greater than a hundred million doses are distributed. It accounts for more than a third of the vaccines given every year. So, are we seeing a disproportionate number of cases? I don't think so. But we certainly do have a lot of influenza, GBS allegations made, and a lot of these cases, high percentage, are GBS cases and some temporal association of influenza vaccine, whether it's two days, two weeks, or two months later. So, it's a rough science, but it is what it is. And Rosemary's point is that this is just a reflection of what we're seeing, and you have to put it in that context.

MS. GALLAGHER: Well, thank you very much for an extremely thought-provoking presentation. I thought that it raised a lot of issues and comments that we'll have to follow up on later. But I really appreciate you putting it together. It was well done. Thank you.

(Brief recess.)

Agenda Item: IOM Committee on Vaccine Adverse Events Update, Kathleen Stratton, Ph.D., Study Director, Institute of Medicine

MS. GALLAGHER: Hello, we're back. Now I would like to present Dr. Kathleen Stratton who is going to give us an update on the IOM Committee on Vaccine Adverse Events.

DR. STRATTON: It's always a pleasure to come to ACCV. And in about a year when this report comes out we'll have great fun and I'll be able to tell you a lot. Unfortunately, as those of you who have followed IOM projects in the past, there is much I can't say until the report comes out.

But we do have about five ways that we can share information, and that's what I'd like to talk to you about today. In your folder you have a little handout. I don't have slides. And it just starts with the committee roster, and I know you've seen this before. But as a reminder to you and to people who are listening, we have put together a quite spectacular committee. Half of the committee are epidemiologists, and half are clinical researchers, or basic science researchers.

Of the epidemiologists, most of them actually also still actively see patients on a very regular basis. So they bring the clinical expertise to the review of the epidemiologic literature as well, and that's always a nice perspective to have. They're still seeing patients. Even though you think of them as number crunchers, they are still clinicians.

And you know the expertise ranges -- there are several neurologists, child neurology as well as adult neurology. Thinking of Rosemary's presentation of the

sorts of things that you're looking at, I think the kind of adverse events that they're reviewing and the claims the program has and the concerns you all have really can be addressed by these people with their expertise.

So there are rheumatologists, there are allergists, there are neurologists, there are internists, and I think that every -- and obviously we put together the committee with this expertise, because we know what kind of concerns there are around vaccines, and they were definitely tailored to have the clinical and scientific expertise to address the kind of conditions in front of you.

So one thing that we can do to give you some insight into how the committee might be working is to inform you about the membership. And their bios are posted on our website, as many of you know. And we'll get to the website in a minute.

The other thing that we can share with you is not the next page that you'll see, but the working list of the adverse events. Now this is obviously what was given to the committee by HRSA as the charge to the committee, which is to look at the epidemiologic, clinical, and biologic literature related to specific vaccines and specific adverse events.

And what you have is a two-page set of tables.

As you know, we started off with a charge of looking at four of the vaccines, and then thanks to an infusion of funds provided by CDC to supplement the money that HRSA gave us, we were able to now look at eight of the vaccines on the table. And you see them here. The adverse events were provided by HRSA based, as I think Rosemary has explained in the past -- based on the kind of claims that they see.

And they range from anaphylaxis to the rheumatologic diseases, autism is on the list for the DTaP and MMR vaccines, so I think that most of these are pretty predictable, what would have been on this list. There are some smaller conditions that are a little unusual. The committee is free to add adverse events if it sees a need to, and I believe they will be adding a few conditions that they are reviewing that aren't on this list.

In the literature review -- and we'll get to that in a minute -- articles came up that weren't specific to these conditions, but they were about another related condition. The committee thought that was important enough in some cases to actually add to the list, and they will be covering them. It's not a huge number, and they probably aren't huge, big surprises because they're related to the kind of conditions that are on here, but you will see a few adverse events in the final report that didn't start out on

our list. Sarah?

MS. HOIBERG: When seizure disorder was taken off of the table for, I believe it was DTaP and -- but seizure disorder was taken off of the table; am I correct?

DR. EVANS: For pertussis containing vaccines.

MS. HOIBERG: Is there a possibility that you would be putting that back on the table?

DR. STRATTON: Well, to be clear, the IOM doesn't put things on or off the table. That's the responsibility of the Secretary. The IOM reviews literature and makes conclusions about the nature of the relationship: is it causal, not causal, or indeterminate? And that scientific information is used by the Secretary to decide what to put on the table.

If you look at the first page of this table of working lists, convulsions are on the list for the DTaP and other tetanus containing vaccines, and many of the vaccines, so those literature are being reviewed. We are not reviewing wholesale pertussis vaccine, the data on wholesale pertussis vaccine, but we are on all of the other ones. And so there will be statements about that from this committee, and what the Secretary does with that is way beyond what this committee's responsibility is.

We earlier had asked for comments on the list of adverse events, if there was anything that people were

concerned about that weren't on here, people could write in. And I'll get a little bit more into that later. And no one has written in, I don't believe, with a concern that isn't already on the table. But we have that opportunity, and that will continue until the report comes out or is almost done when there's still time to amend it. So please look at both pages of this. I think it's almost a hundred vaccine adverse relationships, each one being looked at individually. So if there is something of concern to you or to your community and you don't see it on here, send us an email and the committee will consider adding it to their review.

So the other way we share information is this list, and so you can see what it is that the committee is looking at. The next thing we can do, and I think, I think it was launched yesterday -- I hope so anyway -- which was we published on our website and through our listserve, the bibliography that the committee has generated. And you will see the text on the third page really, of the handout that went out with this announcement. If you go to the website, you will find a PDF, a very, very, very long PDF of over 12,000 bibliographic citations.

The bibliography is extensive. The bibliography is broken into two main sections. And for those of you who use PDFs a lot, use Adobe a lot, you can get hyperlinks on

the left to take you to different sections, and actually we've broken them alphabetically so that you can easily hop around this 12,000 list, or you can use the search function, of course, in Adobe.

But the PDF is broken into two sections. One is the approximately 1,500 unique bibliographic citations that the committee is reviewing in depth. And you can see the search strategy, we're looking from the beginning of bibliographic time in our search. We are using a professional medical librarian, so this isn't like going on Google and trying to find the top ten articles. I mean, there are people who are professionally trained to do this on staff at the National Academies, and that's who we use. The search strategies will be published in the final report so you can see how they got to all of those citations.

The second of the bibliography is slightly over 11,000 citations that the committee -- we've reviewed the citations and they do not appear to be original research directly related to the committee's charge. You do a search that is deliberately broad, and then you hone down. So, for example there could be, under the MMR search, we may have come up with studies using the Urabe strain of the mumps vaccine, and that's not what we use here, and it's not being reviewed, so those papers didn't make it into the first set of 1,500.

When you do a meningococcal vaccine search you can get studies that only look at meningococcal B, which is used in some countries, but not here. So the committee is not reviewing papers on meningococcal that only deal with meningococcal B. So it's that sort of a thing.

I believe, although I didn't check this -- I'm sorry -- before for I came here. It looks like about ten percent of the citations are really the primary, directly relevant papers. It think that's about typical for these big evidence based reviews that are done, they do have about a 1 in 10 hit rate for the papers that make it in.

I will say that the committee is not only reviewing articles in English, it is reviewing the articles in foreign languages. And I will say that Google Translate is a wonderful way to screen articles to be able to see if they really are directly relevant. If the Google Translate doesn't provide a translation that is useful enough to the committee -- and there are some character-based languages it doesn't do well -- we are paying for professional translation services so that the committee is looking at articles in Chinese, Russian, Romanian, and you name it, they're looking at it. So they are not excluding the foreign language literature, which I think not all evidence-based reviews that are done do that, but the committee is.

So we have just launched -- I believe it was done yesterday -- the bibliography, with a request for people if they have articles that they think are directly important and they don't see them on the committee's list, let us know. I mean searches I think are pretty good, but I don't think, for example, we came up with that Bodor citation, because shoulder injuries aren't directly one of the things that we looked at, but that might be really interesting. So that didn't come up. There could be things that we've missed, and we would like to know about it. So if there are papers that are about a specific vaccine and a specific adverse event that you think the committee needs to read, please send a message to our email address.

One of the things that you do when you do these kind of evidence based reviews after you do your searches, is that for what appear to be really well-documented articles of primary research, or good review articles, you go through the citation list and then you check to make sure that the committee has all of those citations. And then we do that with major articles as well. And I think we found one or two that were referenced by somebody else that for some reason didn't come up in our search. And so then we'd got out and get those. So we could have missed something; please let us know.

The reason we split them into the two parts was

so you can see what the committee is -- the 1,500 the committee is reading in depth. And we also have the links alphabetically so that you can just quickly go, you know, if you have an article by Smith, you can quickly hop to the "S's" and look at see whether it's in the committee's list.

So, we welcome comments. We will do another search at the end of 2010 to see whether there were any articles published since the first search was done. This, again, is typical when you're doing evidence-based reviews. We try to keep up with it on a regular basis, so I look at the VAERS bibliography that comes out every month to see if there's anything new, and a few things have been added that came out since the original search, but we will rerun the search at the end of the year. And that will probably be the cutoff, the end of 2010. The report is due out about a year from now. So we can't be incorporating a new article that was published in May of 2011 if the report is going to come out in June. So there will be a cutoff and I think it will be the end of 2010.

So there you have the literature review. Another way we try to share as much as we can is that we have -- when the committee meets with anyone who is not a member of the committee or the staff, then those meetings are open to the public. And so the committee has had three open meetings. One was a very short open meeting, and it was

Dr. Johann-Liang giving the charge to the committee and having the initial discussion. But in two subsequent meetings the committee invited in a few speakers that they identified for some areas that they felt they really wanted to explore.

And there were nine such speakers at two meetings, and those meetings were open to the public, the transcript is available on the website, and those slides which they had gave us permission to show are also on our website. Slides that we would have whited out would have been things that were copyright protected, and we had no legal ability to share them publicly. So there are some slight redactions on some of the slides, but for very mundane reasons. So you can see all of those.

Then finally we have a public access file. And there is something in your books, I believe, about our public access file. Is that right, Geoff?

DR. EVANS: We have the letter and the response.

DR. STRATTON: Okay. So that gets to that. That's what I was checking.

Every project in the National Academies, the Institute of Medicine that is providing consensus recommendations has to keep a public access file. And what that means is that any material that is given to the committee not by themselves or staff, from the outside,

that material goes into a public access file and anyone can request to see what has been sent to the committee.

So the 12,000 citations aren't in there because we generated that list; the committee generated that list. But anything anyone sent us or gave us from outside of the committee or staff is available to the public. It's not available on a website, but you have to go through a public access record.

We have 65 items in our public access file at the moment. Some of them are these presentations from speakers. That's something that was given to the committee from the outside. Some of them are emails. There were two major spurts of email input to the committee. One was about he composition of the committee. And anyone who sent emails, that is in there. And then there was a second spurt of activity around a misunderstanding I think, which was a little unfortunate, about whether the committee was looking at autism or not, because the committee had already been charged by HRSA to look at autism with respect to the DTaP and the MMR. But someone had started a campaign to write into the committee to say please look at autism.

So it was slightly unnecessary. But that's fine, because it was already was on the list and the committee must look at something that was given to us by HRSA. So there are a great number of emails from people just really

impressing upon the committee how important it is to look at autism. Those are in there. And there are a few others that are in there.

There had been a request to look at our public access file -- I forget when it was; you have the dates in the letter in your file -- from Mr. Maglio. I'm sorry, and I've totally forgotten the name of the organization that he represents. The Petitioner's Attorney's Bar. He had requested to look at our public access file, and that was given to him and I think he was, I'm guessing because there were just 64 items -- his is the 65th, his letter -- with not a lot of information there about what the committee was reviewing, was concerned that the committee had a very narrow view of information.

We had always intended, and in fact it was in our contract that we would publish our bibliography on our website, but that hadn't been done yet. And so he requested a day of the committee's time to present information to the committee. And as you can see, the committee politely directed him to our website once this big set of information was out, because I think looking at the public access file, you only see what the outside has sent in. You don't see what the committee has generated itself.

So I would say that you can't look at a 12,000-

page bibliography, and know that they are in-depth studying at a minimum 1,500 articles right now, and feel that the committee has a narrow view. So hopefully the publishing of that bibliography will help people have a better view of the extreme breadth and depth that the committee's reviewing things.

And so the public access file is that other way -- I don't think it's particularly informative with this particular committee. You know, some committees the public access files are huge. And people are sending in papers left and right or giving grey literature, or presenting their own views of things. In this one I don't think it's particularly helpful to give you an insight into what the committee's doing, but it is something that we do, and anyone who sends anything in gets put in that public access file.

We do check with people, because we don't know that everyone who sends an email to the committee knows that by sending it to us, what is in that email, and their name, and their email address, and any identifying information will be made public. So we do check back with everyone who sends something in that says before I send this to the committee for their information you need to know that it will go in a public access file. Do you really wish for this to be shared? Because we don't want

people to send in information about their child's health, which does happen, not realizing that it's then made public and their email is made public. So once someone says, yes, I'm willing for you to put this in the public access file and it is shared with the committee.

From here on in I know it's always frustrating to people who are watching the IOM and National Academies process that there isn't much more we can share. I can tell you the committee has met six times. They're going to meet again in August, they're going to meet again in November, and they will probably meet again in January. They are moving along and a year from now you'll have their report, and then you'll know a lot more. But it's just I've probably shared everything I can share with you about what they're doing and what they're reviewing.

MS. DREW: Kathleen, what are the chances that the report will be in time for the June 2011 meeting?

DR. STRATTON: And what date would that be?

DR. EVANS: Well let's say it's the first week.

DR. STRATTON: You know, that's helpful to know. I hadn't been thinking about this. I don't think we have committed to a firm deadline for when the report would come out, because at first we didn't know if we were looking at four vaccines, or six vaccines, or eight vaccines.

I will keep that in mind. It would be good to

make that, I understand. And I will say that we will try. There's a lot of the end game of the report generation is out of my control on the staff, and even the committee's control. So while I can say it's a great thing to strive for, I can't promise. And one of those things is the external peer review process. So every report goes out to reviews that are supposed to be confidential, and 99 percent of the time do remain confidential. That one percent is really a problem for us.

But, you know, this is a lot of material. It's going to be a big book. People have to review it and they're doing it on a volunteer basis, and they're very busy, and sometimes the reviewers can't get their work done in the timeframe we need to be able to then consider all the comments, finalize the report, and get it published. So there are times that we're on track and then it gets slowed down in review. But we'll try to leave enough time to try for that.

I should say that the peer review process is blind to the committee during the process. They don't know who has been selected as a peer reviewer. And when they reviews come in, they don't know who made which comments. When the report is published, in the front of the book the names of the external peer reviewers are published. And that is when the committee finds out who it was that

reviewed their work. So it is a blind process.

MS. GALLAGHER: Well, thank you very much. And of course you know we are all looking forward to the report whenever it does come out.

DR. STRATTON: And you will be hearing from Dr. Clayton, the chair, when the report comes out. We'll bring in the big guns, the committee, for the initial set of briefings. You know, it would be hard to bring Dr. Clayton here every quarter to do this particular update. But once the report is released it will be in the committee's hands, and I think you'll enjoy it.

MS. GALLAGHER: Well, thank you very much and we will look forward to it. Now, Sarah Hoiberg, I think it's time for us to have an update on the Communications and Outreach Working Group. And if you wouldn't mind coming up front so we get that good quality audio that everyone's striving for. Thank you.

Agenda Item: ACCV Communications and Outreach Workgroup Report, Sarah Hoiberg, ACCV Member.

MS. HOIBERG: I guess it's still good morning. Sarah Hoiberg, Chair for the Outreach and Communications Working Group. We actually had a meeting before the meeting yesterday with the workgroup and the IT department. And we got a lot of things clarified that were pretty foggy for us, which were things that consisted of the minutes and

the transcripts and everything being posted in a timely manner. And we found out that it takes up to two months, I believe Kay said, to actually receive the transcripts. So now we know why it takes so long to get them up on the web.

Also, there's an issue of things being Section 508 compliant. So that's why it's been difficult to get presentations. But this time it seemed that we got everything we wanted in a timely manner, and I would like to thank the staff for getting that for us. We would like to continue to get that so we can all do our jobs betters.

As far as the communications side, that's my report on that. Outreach, I'm very excited to be able to sit in on the Banyan update calls. Thank you Kay and Geoff, for allowing me to do that. All I can say to that is that they are on schedule and they've gotten a lot of great information, and I look forward to seeing their report. And hopefully if we actually have our meeting in October instead of September we may actually be able to have that report in-hand, so that will make for a very exciting meeting.

But that concludes my report if anybody has any questions.

DR. FISHER: What is Section 508?

MS. HOIBERG: Section 508 is an American's with Disability Act. And there are many people out there that

can't -- have difficulty seeing, or have the use of their hands, and so the Section 508 compliancy makes it to where the readers -- a lot of them have readers on their computers, programs that actually read the presentation to them. And when you have lots of graphs with different colors and whatnot, they can't -- the reader doesn't know how to, you know, can't say, oh, in the red pie chart -- so they have to have, it's something that has to be coded into the presentation.

They're going to be, HRSA is going to be, or the web team is going to be providing a checklist for the presenters to be able to do that. Thank you.

MS. GALLAGHER: Thank you very much for your report, and we're very happy with the progress your team has been making.

All right. Operator, we would like to open the lines for anyone who has public comment to make at this time.

Agenda Item: Public Comment

OPERATOR: Thank you. If you would like to make a comment, please press *1 on your touchtone phone. You may withdraw your request by pressing *2. And the first comment from the phone line is from Jim Moody. Your line is open.

MR. MOODY: Thank you, and thank you again

members of the committee. I'll be very brief. This relates to Dr. Stratton's report. One of the comments we filed and requested a request for information on adverse events addressed a couple of points which are relevant. One is the need -- a concern that we have that the standard of review the committee is biologic plausibility -- or evidence of mechanism, and it's a five-part test of evidence of mechanism.

And one of the concerns is that is not exactly the program standard, as articulated most recently by the Court of Appeals in a series of cases in 2005 going forward, which is evidence bearing on the question of biologic plausibility. So, it would be more useful I think to help advise the program if the Institute of Medicine would be tasked to assess the state of scientific information with respect to the actual program standard, as opposed to what we think is a much more rigorous burden of proof, which Congress has said, and the Courts have said is not applicable in the program.

The second point is that, we're very happy of course that autism is being looked at, although it's referred to as secondary autism on many of the adverse events.

And the third point is I think it would be very, very helpful -- this I guess I would make as a point of

scientific due process. It would be very helpful if the IOM would, in reviewing the evidence, articulate gaps in the science that need to be filled. You know, there are several groups, NVAC, and this committee, which are tasked with various aspects of looking at vaccine safety, and then find of course the gap in science or lack of data on baseline of unvaccinated children.

But I think it would be very helpful if IOM would weigh in on this rather than just saying there is or isn't evidence. Because at least in the incidence of unvaccinated data, unvaccinated children, we know because we've tried very, very hard to get funding for that kind of study, and have $16 million dollars in the budget with the Interagency Autism Committee -- it was taken out. And so one of the concerns, and this is relevant to ACCV, is that the science isn't being done and isn't being funded anyway by the government in a neutral way. Because Dr. Insel, when he asked that money be taken out specifically said the reason for taking it out was there was a conflict of interest, and the government shouldn't be seen to be funding science relating to finding out how much autism is caused by vaccines while these cases are all still pending in court.

Of course, I think that's dangerous and wrong. The government should be obliged to fund, especially

science to get to the answers of questions that are coming up in the program, rather than shy away from that. I think IOM, rather than just neutrally look at the evidence should weigh in a more positive way and address what science isn't being done and what needs to be done in order to get to the answers to make this program work much better in pursuit of the Congressional goals of protecting the national commitment to vaccination. Thanks very much.

MS. GALLAGHER: Again, thank you for your comments. Is there anyone else on the line who wishes to make a public comment?

OPERATOR: (Reminder of instructions for callers.) Ma'am, at this time I'm showing now further comments from the phone lines.

MS. GALLAGHER: Thank you very much. Then I will move on to the next agenda item, which is our future agenda.

Agenda Item: Future Agenda Items

MS. GALLAGHER: And I would first request volunteers, any Commission member who is willing to volunteer for the agenda committee.

MS. HOIBERG: (Volunteers)

MS. GALLAGHER: So, Sarah Hoiberg.

DR. HERR: I can do it.

MS. GALLAGHER: And Tom Herr. Anybody else wish to be on it? Okay. So I think that's sufficient.

At this time I'd like to know if anybody has any present suggestions from among the members of the Commission as to agenda items they'd like to see. And I guess we don't know exactly when our next meeting is going to be, because Geoff's going to help us out with which meetings we'll move or can move, if it's possible to accommodate the Judicial Conference.

DR. FISHER: So I think we asked before for the results of the H1N1, both the national and the international information. So, kind of an update on whether there's anything from the international groups, and also on the alternate program that's looking at compensating people for H1N1 injuries.

MS. GALLAGHER: All right. Thank you very much. I'll look into that.

DR. EVANS: I took that to mean Tawny wanting a CICP update, and that will be very good timing, because there will be kind of a transition at that particular time going into the next flu season.

DR. FISHER: And I think Jane also had some information for international information, which could be very useful.

MS. GALLAGHER: Anybody else have any present

suggestions?

MS. TEMPFER: I think we're having a number of regular reviewers on. I'd like to see what Rosemary did. That was really good to have an ongoing update. And the IOM certainly should be an ongoing update. The ISO also, and then what Dan also does. Those are all really important reports to receive.

MS. HOIBERG: Yes, I second the motion for Rosemary to come back. I think it's very interesting to hear what they're studying and looking at.

MS. GALLAGHER: Yes. She did an excellent presentation. I think that was very thought provoking.

DR. FISHER: And of course the VISs

MS. GALLAGHER: And Elizabeth I'm going to ask you if you can work behind the scenes to come up with some sort of process. And then maybe we can have you present on what process you've come up with and what will accommodate the quick turn around so that we get to see them in a timely fashion and they get out to healthcare providers when they need to.

Anybody have anything else at this point? If anything occurs to you later, contact Sarah, Tom, or else Sherry or me. And we will be the agenda committee, and we'll setup the meeting for getting the agenda out in advance again, so we can't post it in advance.

DR. HERR: Charlene, can we, as we talked at our little meeting before two days ago, is it possible just to remind the commission members maybe a week or two before our conference call for the agenda subcommittee or whatever, if they have any ideas for next meeting, that we can have that prior to our meeting.

MS. GALLAGHER: The communications, part of the working group had said instead of after we have the agenda together in draft form sending it out, we would contact all the other members about a week before our conference call and say we're ready to have a conference call, give us anything that's occurred to you at this time, so we wouldn't have to then wait to circulate it afterwards. So we all thought that was a great suggestion, and that's what we're planning to do this time.

Okay. If there's nothing else that anyone wishes to discuss or any questions that need to be raised, I'll look forward to a motion.

(Motion to adjourn, seconded and approved.)

I think that has gotten the unanimous agreement of the committee, therefore the meeting is adjourned.

(Whereupon, at 10:53 A.M., the meeting was adjourned.)