EXTENSIONS OF REMARKS

ENERGY POLICY CRITICALLY IMPORTANT TO FARMERS

HON. DOUG BEREUTER

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 5, 2001

Mr. BEREUTER. Mr. Speaker, this Member commends to his colleagues the following opinion piece written by Mr. Bryce Neidig, president of the Nebraska Farm Bureau Federation, which appeared in the November 27, 2001, York News-Times. Mr. Neidig makes a convincing case for passing legislation which would implement a national energy policy. As Mr. Neidig stresses, farmers are heavily reliant on petroleum products and could suffer great hardship if Congress fails to develop a meaningful energy policy

On August 2, 2001, the House approved an energy bill which would diversify our energy sources and create greater energy reliability and independence for the United States. Now is the time to enact a long-term energy policy. Congress must help assure farmers and all Americans of the increased development of diverse, reliable, and affordable energy sources.

NATIONAL ENERGY POLICY NEEDS FARMERS' SUPPORT

American agriculture is intensely dependent on petroleum. In fact, it's the lifeblood of farming. Our nation is facing an energy crisis, and farmers stand to suffer as a result—unless federal legislation is passed soon to end the crisis.

The House of Representatives adopted a comprehensive energy package in August—the National Energy Security Act 2001—that holds many keys to solving the nation's energy dilemma. It includes fuel alternatives, incentives to reduce consumption, aid to low-income fuel programs, and a provision for oil exploration and production in a tiny portion of the Coastal Plain in the Arctic National Wildlife Refuge (ANWR). The Senate needs to pass the act this year.

Farmers could be among the hardest hit if we fail to enact a national energy policy. Oil or gas shortages, scarcity, or worse, embargoes, could send the price of energy soaring. Higher input costs and low commodity prices are squeezing many producers at this time.

Petroleum products and natural gas provide heating oil and diesel to run equipment and they are a key ingredient in virtually all fertilizers and many other production inputs. Increases in energy prices ripple through the entire farm economy, spiking the costs to run farms and ranches.

Conservation and development of alternative fuels are important components of the legislation and are critical to agriculture's support for a national energy policy. However, exploration and production of domestic oil and gas are a critical part of this proposed act as well. As our nation grows and as the economy expands, so grows the need for more oil and gas. More oil and gas production is a must in order to stabilize energy prices for farmers and consumers, which is why many producers support the environmentally safe development of domestic and off-shore oil production.

It is my understanding that there could be upwards of 16 billion barrels of recoverable oil under Alaska's Coastal Plain. At full production, some estimates indicate that Coastal Plain oil could contribute about 25 percent of our energy needs. What Coastal Plain oil provides as well is a secure source of domestic energy. Farmers who lived through the Arab oil embargo of the early 1970s and the energy supply problems of the last two years can testify to the disruption and economic pain caused by an unstable oil supply. Coastal Plain oil could serve as a buffer against Iraqi or Iranian led embargoes, for example.

Farmers and ranchers work long, hand hours to keep their operations successful. The hard reality is that for most farmers, the line between success and failure is thin. Sudden spikes in energy prices because of shortages or embargoes could spell doom for many of America's farmers.

The National Energy Security Act 2001 is our nation's best opportunity to chart a course out of a crisis that was many years in the making. Farmers and all of us who make our living through agriculture need to encourage our members of Congress to back this legislation, for the sake of our families and farms.

EXPRESSING SENSE OF HOUSE OF REPRESENTATIVES THAT VETERANS DAY CONTINUE TO BE OBSERVED ON NOVEMBER 11

SPEECH OF

HON. BRIAN D. KERNS

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 4, 2001

Mr. KERNS. Madam Speaker, I rise today in strong support of H. Res. 298, a resolution to preserve the spirit and true intention of Veterans' Day. Throughout the course of our Nation's history, courageous men and women have stepped forward in times of war and peace to serve in our Armed Forces. They have done so to protect the freedoms that we, as Americans, are blessed with each day.

Their service has often taken them far away from their homes, their family, and their friends, and has placed them in harms way. Whenever and wherever called upon they answered that call to duty, and their blood has been shed in defense of our liberty.

Now, as our Nation is leading the war on terrorism, the heroic acts of our American service men and women overseas and the 48 million who came before them to defend our country, deserve nothing less than a commitment by the Congress to preserve the sanctity and true mission of Veterans' Day.

While we can never adequately repay our men and women in uniform for the sacrifices they have made to keep America free, we can honor and thank them for their service. With our way of life, our freedoms, under attack at home and abroad, now more than ever, it is imperative that we guarantee that our veterans are honored. I urge my colleagues to support this resolution and maintain November 11 as Veterans' Day—a special day of national observance that we, as a nation, set aside to remember our veterans and the sacrifices they made to uphold our freedoms.

MEDICATIONS FOR DIABETES

HON. LINDSEY O. GRAHAM

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 5, 2001

Mr. GRAHAM. Mr. Speaker, for years too many Americans have suffered the ravaging effects of Diabetes. While there have been many promising advancements in the diabetes research field, there have also been many disappointing setbacks.

One key to proper treatment of Diabetes has been the development and the use of new medications. However, the Congress, questions have been raised about the safety of Rezulin and other medications approved by the Food and Drug Administration (FDA) for this use.

In my home state of South Carolina, Mrs. Francis Geddings took Rezulin as a treatment from April 1997 to January 1998. She was hospitalized in 1999 and tragically passed away from liver failure last year. She left behind her husband, Eugene, and many questions about the safety of this drug.

Rezulin was eventually removed from the market, but many questions remain. To avoid future tragedies like the one that visited the Geddings family, we must continually review how medication is made available for public use. Attached are documents that show only a small part of the Rezulin story. It is up to Congress to continue doing everything we can to make the FDA approval process as safe and open as possible.

Americans need to know that according to an FDA document created by several of the FDAs premier scientists, 1 in 1,000 patients who took Rezulin for more than one year will die of fatal liver disease. Pharmaceuticals companies everywhere can learn from the tragic history of Rezulin.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH SERVICE, FOOD AND DRUG ADMINISTRATION, CENTER FOR DRUG EVALUATION AND RESEARCH.

December 19, 2000.

From: David J. Graham, MD, MPH, Associate Director for Science, Office of Postmarketing Drug Risk Assessment (HFD–400), Lanh Green, RPh. MPH, Safety Evaluator, Division of Drug Risk Evaluation II (HFD–400).

Through: Martin Himmel, MD, MPH, Deputy Director, Office of Postmarketing Drug Risk Assessment (HFD–400).

To: David G. Orloff, MD, Director, Division of Metabolic and Endocrine Drug Products (HFD–510).

Subject: Final Report: Liver Failure Risk with Troglitazone (Rezulin®), NDA: 20–720.

EXECUTIVE SUMMARY

The following report summarizes the activities of the Office of Postmarketing Drug Risk Assessment and its evaluation of the

risk of acute liver failure (ALF) with the use of troglitazone for the treatment of diabetes. The report is divided into topical areas related to varying aspects of the issue.

We estimated the background rate of acute liver failure in the general population to the about 1 case per million persons per year (person-years). Using case reports data supplemented by usage data from a large multislate managed care organization, we estimated the rate of ALF with troglitazone to be about 1 case per 1000 person-years (accounting for underreporting). From three postmarketing clinical studies, the incidence of ALF ranged from about 1,200 to 17,000 per million person-years. Survival analysis suggested that the cumulative risk of ALF with troglitazone increased with continuing use of the drug. The implications of this for a product intended to bee used for decades should not be overlooked.

Based on a number of different analyses, underreporting of ALF with troglitazone was extensive. This highlights the limitations of voluntary (spontaneous) reporting systems. It also illustrates the danger of using changes in reporting over time as a message of success of an intervention. Reporting naturally decreases quickly after the start of marketing so that one cannot cite a decline in number of case reports as evidence that a safety problem has been successfully managed.

Multiple labeling revisions and ''Dear Healthcare Professional'' letters recommending monthly liver enzyme monitoring did not improve the safety profile of troglitazone. Enzyme monitoring was not performed regularly or reliably even after the July 1998 relabeling. Analysis of case reports suggested that even had monitoring been performed, it probably would not have prevented many, or perhaps any, cases of troglitazone-induced ALF. The ''point of no return,'' that is, of irreversibility and inevitable progression to liver failure appeared to be reached within about a month or less of a time when liver enzymes were normal.

Troglitazone appeared to confer a substantially greater risk of ALF than rosiglitazone. However, the risk of ALF with rosiglitazone appeared to be higher than the expected background rate.

BACKGROUND ON ACUTE LIVER FAILURE

Acute liver failure is a rapidly progressive disorder characterized by hepatic encephalopathy, and frequently, coagulopathy (both platelets and clotting factors), methobilic derangements (lactic acidosis, hypoglycemia, electrolyte abnormalities), high output hypovolemic heart failure, renal failure and sepsis. Survival without transplant is below 25%.

Drug-induced ALF is usually more aggressive than viral forms, with survival rates around 10% without transplant. There are several competing classification systems for ALF, each relying on the length of time it takes for a patient to progress from initial symptoms (US) or jaundice (UK, France) to hepatic encephalopathy. The U.S. definition classifies ALF as progressive from initial symptoms of liver dysfunction to encephalopathy within 6 months. In Europe, progression from jaundice to encephalopathy within 12 weeks is classified as ALF. In subsequent work, we used the European criteria. We choose the latter criteria because their shorter time-window more closely reflected the fulminant nature of the cases we were receiving. Also, the onset of jaundice is a clearer and more definite time-point from which to begin counting compared with initial symptoms, the onset of which might be vague and hence unlikely to be reported accurately in case reports.

The etiology of ALF varies somewhat by country (slide 2). Until recently, about 70% of ALF in the U.S. was due to viral hepatitis (primarily hepatitis B), with 15% due to acetaminophen and about 10% due to other drugs and toxins.

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The Diabetes Prevention Program (DPP) was a NIH-sponsored clinical trial performed on patients with impaired glucose tolerance (IGT), but not diabetes. Its purpose was to study whether treatment of IGT with oral hypoglycemic agents could prevent or delay the onset of diabetes. One arm of the trial included 585 patients treated with troglitazone on average for one year. From this group, one patient died of fulminant ALF, for an incidence rate of 1,724 per 10^6 person-years (95% confidence interval 44–9,569).

The REACH study was a Warner-Lambert/Parke-Davis sponsored postmarketing study to collect additional information on efficacy and safety of troglitazone. At the time when 2,433 patients were enrolled in the study, with an average duration of treatment <4 months, one patient died of fulminant ALF, for an incidence rate of 1,274 per 10^6 person-years (95% CI 32–7,077).

Another Warner-Lambert/Parke-Davis postmarketing study, Protocol II, was conducted to study the effect of troglitazone use on the insulin does required by diabetic patients enrolled in the study. There were 233 patients enrolled in this randomized double-blind placebo-controlled trial, each treated for a maximum of 6 months. Of this group, one died of liver failure. Of note, this patient developed liver enzyme abnormalities in November 1998 and was withdrawn from the study. His liver enzymes did not normalize and in early March 1999, the blind was broken for this patient to see whether he had received troglitazone or placebo. He had been treated with troglitazone. He was in hospital for evaluation of his liver disease on the day of the March 1999 advisory meeting, and died of liver failure three days after the meeting. Assuming that 50% of randomized patients were treated with troglitazone for a maximum of 6 months, the incidence rate in this study was about 16,949 per 10^6 person-years (95% CI 429–90,855).

In each of these three studies, fatal liver failure was observed at an extremely high rate, ranging from 1,274 to 16,949 per 10^6 person-years. Based on data from the published literature discussed above, we would expect about 1 case of ALF per 10^6 person-years meaning that the occurrence of liver failure in these studies was from about 1,300/ to 17,000/times greater than would be expected by chance.

In the original troglitazone NDA, there were 2 cases of jaundice/hepatitis (one of which was hospitalized) and 1 other patient hospitalized with drug-induced hepatitis, but no cases meeting our definition of ALF. This finding is still compatible with an ALF incidence rate of 2,584 per 10^6 person-years.

These studies demonstrate that liver enzyme monitoring on a monthly basis does not prevent the occurrence of ALF with troglitazone. Furthermore, they collectively support the conclusion that the underlying incidence rate of ALF due to troglitazone is extremely high, probably in the range of 1,000 to 2,000 per 10^6 person-years, representing about a 1,000- to 2,000-fold increase in liver failure risk. Another way of stating this is that 1–2 out of every 1,000 patients (1/500=–1/1,000) who use troglitazone for one year will die of ALF.

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DISCUSSION

The data presented here provide a comprehensive picture of liver failure risk with troglitazone. Premarketing clinical trial data from the company's NDA for troglitazone showed that ALT elevation above 3 ULN occurred in 1.9% of treated patients. More importantly, it provided an estimate of the incidence of hospitalized drug-induced hepatitis that was more than 50-fold greater than the background rate suggested by the literature.

Soon after US marketing began, FDA began receiving case reports of ALF in patients who were using troglitazone. A series of labeling revisions and ''Dear Healthcare Professional'' letters followed, recommending increasing performance of liver enzyme monitoring as a means of reducing or eliminating risk of ALF. Despite those interventions, cases continued to be steadily reported to FDA.

Our analyses of the original 43 US cases found that there were no apparent risk factors by which to identify patients who might be at increased risk of developing ALF while using troglitazone. Furthermore, the onset of liver disease was usually heralded by the appearance of jaundice, by which time, irreversibility had been passed in these cases who usually progressed quickly to encephalopathy: Examination of 12 cases with adequate liver enzyme monitoring prior to onset of liver disease showed that in 75%, patients went from having normal liver enzymes to irreversible progression towards liver failure within the recommended monitoring interval. In the three other cases, the patients remained on troglitazone after the first recorded enzyme abnormally so that it was not possible to identify when the point of irreversibility was passed. Of note, there were no differences between the 12 ''rapid risers'' and the remaining 31 cases for whom we lacked data on the time-course of their liver enzyme elevations. From these data, we concluded that it was not possible to prevent ALF by patient selection or to predict who was at risk. Also, monthly liver enzyme monitoring would probably fail to prevent at least 75% and perhaps 100% of cases.

The cases reported to FDA were also used to estimate the pattern of ALF risk over time of continued use of troglitazone. This too was presented at the March 1999 advisory meeting. Analysis showed a marked rise in risk beginning with the first month of troglitazone use. With continued follow-up after the advisory meeting, our expectation was confirmed that heightened ALF risk continued for as long as troglitazone was used. In other words, the risk of ALF did not disappear after the first few months or even first 18 months of use. The pattern suggested that cumulative risk of ALF would continue to rise for as long as troglitazone was used, having important implications for a drug intended to be used for 20, 30 or 40 years or longer.

Against this backdrop of case reports, epidemiologic data suggested that the expected incidence rate of ALF in the general population was about 1 case per million per year. The data from case reports were markedly higher than this. At the March 1999 advisory meeting, we presented data showing that if we assumed there was no underreporting, the cumulative risk of ALF was about 1 case per 15,000 patients who used troglitazone for at least 8 months. If we factored into the analysis that only 10% of cases had been reported, the cumulative risk became 1 case per 1,500 at 8 months (about 1 case per 1,000 per year). With an additional year's worth of case reports (through December 1999), the cumulative risk was 1 case per 7,000 patients after 18 months of troglitazone use, assuming no underreporting. With 10% reporting, this would be 1 case per 700 patients at 18 months (about 1 case per 1000 per year). The first analysis through 8 months of use led us to conclude prior to the March 1999 advisory meeting that the risk of ALF with

troglitazone was probably increased at least 1000-fold over the expected background rate.

Independent population-based data prior to the March 1999 advisory meeting supported this. In two separate postmarketing clinical studies, one conducted by the National Institutes of Health and one conducted by the company, a case of fatal ALF occurred among small numbers of patients treated with troglitazone. This was highly statistically significant, and suggested that the incidence rate of ALF with troglitazone could range from 1,200 to 1,700 per million per year, with upper bounds approaching 10,000 cases per million per year. These data, in combination with case reports data, formed the basis for this medical officer's recommendation prior to the March 1999 advisory meeting that troglitazone be removed from the market. Subsequent to the advisory meeting, FDA learned of a third postmarketing study, this one randomized and double blinded, in which a patient treated with troglitazone died of ALF just three days after the advisory meeting. The incidence rate of ALF in this study was over 17,000 per million per year.

An important component in the troglitazone analysis was an assessment of the effect of FDA interventions in the form of labeling changes recommending periodic liver enzyme monitoring as a means of managing the ALF risk of troglitazone. The FDA study from UnitedHealth Group found that monitoring was not regularly or reliably performed and that repeated labeling revisions had not meaningfully improved the performance of monthly liver enzyme testing. Based on the data at hand prior to the March 1999 advisory meeting, we concluded that FDA labeling had not had a clinically important effect on medical practice and that monthly enzyme testing was largely not being performed. From our case analysis, we concluded that monitoring, were it performed, would fail to prevent most or all cases of troglitazone ALF.

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CHARITABLE LANDMARK: ON VERGE OF EXTINCTION

HON. CLIFF STEARNS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 5, 2001

Mr. STEARNS. Mr. Speaker, today I rise in recognition of a Washington institution. In this city of lawmakers and policy, Sholl's Cafeteria has adopted a policy of its own: for over 70 years, the downtown landmark has never turned away a hungry soul. This cafeteria, this ''triumph of charity,'' has fed thousands with warm, free meals. In recent months, however, Sholl's has faced dire straits with the recent economic downturn. Declining tourism and rising rent have forced Sholl's Cafeteria to consider closing its doors to the thousands of devoted patrons who have frequented the famed eatery. With all that Scholl's Cafeteria has done for our community, it is time for us to give back and maintain what has become a 70-year tradition. With that said, Mr. Speaker, I submit to the CONGRESSIONAL RECORD a letter written by Sholl's Chairman Jim McGrath to the Washington Post on October 14, 2001.

[From the Washington Post, Oct. 14, 2001]

ON THE EDGE OF EXTINCTION

As the nation mobilizes to combat the insidious foe of terrorism, another drama of a far different kind and scope is playing itself out in downtown Washington—the struggle for survival of Sholl's Cafeteria. Despite heroic sacrifice and Herculean labors by many—most notably its beloved proprietors, George and Van Fleishell—absent a substantial financial remedy, Sholls will be forced to close its doors as soon as Oct. 31.

The Sholl's story could easily get lost amid the tumult of our national preoccupation and suffering in the wake of Sept. 11, but that would be a profound shame, because the cafeteria's story has been one of special triumphs: of old-fashioned, all-American food, wonderfully prepared and wonderfully served; of humane pricing, so that nearly anyone can afford to eat there, of multiculturalism, with terrific employees, many there for generations, reflecting every spectrum of the human family; of kindness, with an atmosphere that welcomes everyone. It is a story of the triumph of charity—Sholl's has given away enough free food to feed an army 100 times over.

During the past several years, however, Sholl's has suffered from the decline in downtown dining. Its tour-bus trade has eroded because of the weak economy. It has endured bus-unfriendly parking restrictions. It has had to deal with prolonged building renovation and reconstruction while paying a huge rent. It has been put through the economic wringer.

Now another mobilization is needed to save this beloved institution. I am not alone in expressing those sentiments. They have been voiced by many, from the high and the mighty to the mighty humble. They have come from legions of senior citizens, bus loads of squealing kids and homeless people.

On Aug. 10, 1999, for example, the World Bank wrote to the cafeteria's owner: ''You are correct characterize Sholl's as a charitable landmark. It would be a significant loss to our neighborhood if you were to close your doors, particularly for the large number of senior citizens, young kids, disabled and homeless people whom you serve.''

On July 8, 1998, U.S. Sen. Max Cleland of Georgia read into the Congressional Record, ''Patrons of Sholl's have described members of the Sholl family, who have owned and operated Sholl's over the last 70 years, as having the biggest hearts in Washington.''

On March 7, 1999, Mike Kirwan, the late, great apostle to the homeless, said, ''The stories I've heard from people on the streets, their quiet moments of dignity, respect, warmth and a full and nourishing meal at the hands of this wonderful cafeteria could fill a book of essays.''

Possibly, the one who said it best, though, was a child who, on arrival from Pennsylvania on a school bus, told a WTOP reporter. ''If it weren't for Sholl's Cafeteria, we couldn't afford to come to Washington.''

The hour is late, and the odds are long. Although some say the time for Sholl's has passed, I profoundly disagree, and I hope others do too. Long live Sholl's Cafeteria.

JIM MCGRATH,
Chairman of the Save Our
Sholl's Cafeteria Committee.

THE 150TH BIRTHDAY OF SEATTLE, WASHINGTON

HON. JAY INSLEE

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 5, 2001

Mr. INSLEE. As our country recently prepared for its annual commemoration of the first Thanksgiving, my state was also honoring those who founded the city of Seattle 150 years ago. On November 13, 1851, the Denny Party, composed of 22 men, women, and children arrived at Alki Point in the pouring rain. They arrived only to find the cabin which the leader's brother, David Denny was supposed to prepare, unfinished and without a roof. David Denny himself lay sick and feverish.

Like those who survived the first tough winter in Plymouth, the Denny Party persevered. Their dreams of a city would not have survived, however, without the help of Native Americans. As the sopping wet and nearly helpless Denny Party struggled to survive, the Duwamish tribe, led by Chief Sealth, chose to camp around the party in order to protect them.

While Seattle celebrates the landing of the Denny Party, we must also remember those who lived here before- and continue to live here today. Without the assistance of Chief Sealth, the Duwamish tribe, and other tribes, the Denny Party could not have achieved their dreams of a city; a city named for the Chief who protected and helped those early settlers in their quest for a new home.

HONORING THE 40TH ANNIVERSARY OF WEST SPRINGFIELD CIVIC ASSOCIATION

HON. TOM DAVIS

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 5, 2001

Mr. TOM DAVIS of Virginia. Mr. Speaker, I would like to take this opportunity to honor the West Springfield Civic Association for forty years of exceptional service to the Northern Virginia community. Its dedication throughout our region has been, and will continue to be, an asset to the residents of the West Springfield area.

The West Springfield Civic Association was formed in 1961 by residents of West Springfield, Westview, and Keene Mill Manor neighborhoods. The motto of the association is Utile Dulci, Latin for ''the useful with the pleasant.'' This civic association, together with many other area civic associations, formed the Greater Springfield Community Council.

With the growth of the community, a need for a new high school became evident. The civic association was influential in naming West Springfield High School after its community, rather than being named for a famous Virginian like most other Northern Virginia high schools are.

Within the community, the West Springfield Civic Association worked hard to keep the area filled with trees. It was also instrumental in the creation of bike paths and sidewalks along main roadways, and replaced a plank bridge covering the railroad tracks.

Since its inception in 1961, the members of the West Springfield Civic Association has always been a positive force for the development, progress and recognition of the Greater Springfield area. Not only has this organization held many meritorious events, but has also served in informing the residents of current issues affecting the community. In addition, the members of the Association have created a website which provides news, information, and events in the area, in addition to previous newsletters and minutes from past.