



Drug regulatory agencies are responsible for protecting patients, notably by assessing drugs before they are allowed on to the market. Yet in 2010, the European agency (EMA) and EU member states' agencies, including the French agency Afssaps, often failed to fulfil their responsibilities.

At a broader international level, the norms dictated by ICH (International Conference on Harmonisation) also fail to make patient safety their priority. It is this organisation, composed of representatives from the wealthiest countries' drug regulatory agencies and 3 drug company trade associations, that sets the rules governing market access for new drugs (*Prescrire Int* n°108).

**When agencies disagree, drug companies benefit.** Drug regulatory agencies in various countries sometimes come to different decisions concerning approval of a specific drug: one country might wish to withdraw a risky drug, while others will insist on keeping it on the market. There is no valid reason why this should benefit the company rather than patients. Several such situations arose in 2010.

*Rosiglitazone* was withdrawn in the European Union but not in the United States, where the authorities simply demanded modifications in the wording of the SPC (*Rev Prescrire* n°325 and [www.english.prescrire.org](http://www.english.prescrire.org)).

*Nimesulide* was withdrawn from the market in Argentina, Belgium, Spain, Finland, Ireland, Singapore, etc., but not in all European Union member states. The CHMP even requested a study evaluating the hepatic risks in transplant centres, further

### Medicines agencies too often under the influence of drug companies

delaying the decision on market withdrawal (*Rev Prescrire* n°323 and [www.english.prescrire.org](http://www.english.prescrire.org)).

*Parecoxib* was withdrawn from the Swiss market and rejected by the US Food and Drug Administration (FDA), yet it is still authorised in the European Union (*Prescrire Int* n°109).

*Maraviroc* has been authorised for first-line treatment of HIV infection in the United States, but not in the European Union, where the authorities justifiably consider that the assessment is inadequate (*Prescrire Int* n°110).

**Agencies still grant marketing authorisation despite inadequate data.** Accelerated marketing authorisation based on partial data may be justified when patients have no other treatment options and might reap a major benefit. But drug regulatory agencies increasingly approve new drugs on the basis of scant data, without demanding a comparison with an existing reference treatment. It sometimes seems that marketing authorisation is granted as a consolation prize for companies that have submitted multiple applications in various indications.

*Tolvaptan* was authorised for the syndrome of inappropriate antidiuretic hormone secretion, with no proof of efficacy, although the company had initially applied for an indication in heart failure (*Prescrire Int* n°109).

*Gefitinib* was authorised for some lung cancers on the basis of a minimal analysis showing no increase in survival (*Prescrire Int* n°107).

After unfavourable opinions issued by the FDA and EMA based on data presented in 2005, the EMA finally authorised *dronedarone* in atrial fibrillation, despite the lack of convincing data (*Prescrire Int* n°108).

Trials of *raltegravir* in first-line treatment of HIV-infected patients were not designed to show a benefit versus effective antiretroviral combinations (*Prescrire Int* n°110).

The assessment report on *vinflunine* in bladder cancer states that the CHMP authorised this drug on the basis of a majority decision with many dissenters (*Prescrire Int* n°112).

**Opacity: bad habits die hard.** Once again in 2010, *Prescrire* deplored regulatory agencies' lack of transparency.

In particular, the EMA refused to provide us with data used for the reassessment of topical *ketoprofen* gels. We filed a complaint

with the European ombudsman (see [www.english.prescrire.org](http://www.english.prescrire.org)).

Some of the documents obtained by *Prescrire* had been extensively blacked out, masking information of public interest. For example, sales figures and the number of reports of severe allergic reactions to *phloroglucinol* were blacked out by the French agency (*Rev Prescrire* n°316). Certain pages of the report on excessive weight loss linked to *exenatide* were blacked out by the EMA, simply to protect the company's commercial interests (*Prescrire Int* n°321).

In the United States, the FDA's complacency towards a drug company that had failed to publish unfavourable clinical data on *quetiapine*, a neuroleptic, was revealed during legal proceedings initiated by the patients concerned (*Prescrire Int* n°112).

**Conflicts of interest: too many experts with ties to drug companies.** The French agency contracts outside experts to assess marketing applications. In late 2009, it published a review of how conflicts of interest were handled within the agency. This report revealed that regulatory obligations were not fully respected; in particular, more than half of the experts were not required to leave meetings in which they had a major conflict of interest (*Prescrire Int* n°108). These findings highlight the need for independent experts.

In 2010, the pharmaceutical industry was still heavily involved at every step of drug evaluation. And the fact that drug regulatory agencies are largely funded by drug companies (to the tune of 80% in the case of the EMA) rules out the likelihood of objective assessment (*Rev Prescrire* n°319). European citizens must fight for the independence of drug regulatory agencies from the pharmaceutical industry.

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