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(Impotence)

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The House of Representatives Standing Committee on Health and Ageing
PO Box 6021
Parliament House ACT 2600

Roundtable on Impotence Treatments

We would like to thank the Committee for inviting us to attend the Committee's roundtable on Impotence Treatments.

Background on AMI

Advanced Medical Institute ("AMI") is a medical service provider specialising in the treatment of male sexual dysfunction and has enormous experience in providing treatments for these conditions and marketing these treatments. AMI and its associated companies:

- own and operate a business which has been operating in Australia for approximately 16 years;
- are majority Australian owned;
- are headquartered and managed in Australia;
- are part of a publicly listed group;
- have more than 200 staff;
- have treated more than 500,000 patients with sexual dysfunction conditions;
- are the largest chain of sexual dysfunction clinics in Australia and are a leading provider of treatment programs for erectile dysfunction and premature ejaculation in New Zealand, China and the United Kingdom;
- operate more than 20 facilities in Australia, New Zealand, China and the United Kingdom;
- believe that they have treated more patients for sexual dysfunction than any other treatment provider in Australia; and
- have not had any major regulatory issues in the last 4 years since the group became publicly listed. Prior to this period AMI was sued by the ACCC for breaches of section 52 of the Trade Practices Act (misleading and deceptive advertising). Following that litigation, AMI adopted a trade practices compliance program as part of its corporate governance procedures with a view to ensuring that its operations were in full compliance with all relevant legal requirements. AMI has never breached any regulatory requirements other than section 52 of the Trade Practices Act and has not breached the Trade Practices Act since 2005.

AMI's business strategy is to provide innovative methods of treatment and delivery systems that provide a practical non-invasive method of drug delivery to the body to treat sexual dysfunction. AMI is continuously researching and developing new methods of treating sexual

dysfunction in men and women, including impotence, premature ejaculation, reduced male libido and female sexual dysfunction disorders and AMI has spent more than $3.5 million on this research and development since 2003.

AMI's sexual dysfunction business has 3 components: male erectile dysfunction; male premature ejaculation; and female sexual dysfunction disorders. This submission relates to AMI's male erectile dysfunction and male premature ejaculation businesses as whilst public commentary often refers to impotence businesses the commentary usually relates to both erectile dysfunction and premature ejaculation. The headings in this submission match the discussion points in the paper issued by the Committee prior to the roundtable forum.

Size of the market

In 1999, it was estimated that 152 million men worldwide, including 30 million Americans, 30 million Europeans and 1.5 million Australians suffer from erectile dysfunction, being approximately 20% of the total male population in those areas (Australian Financial Review, 2 October 2004, pg. 25).

In 2003, it was reported that an estimated 2 million Australian men suffer from erectile dysfunction (International Journal of Impotence Research, reported in the Sydney Morning Herald on 27 February 2003).

According to research firm IMS, Australians spent $63 million on Erectile Dysfunction medication in 2006 (Viagra - 52.6%, Cialis – 39.2% and Levitra - 8.1%) (Australian Financial Review, 23 October 2006). During the roundtable discussion, Medicines Australia indicated that they believed that the current size of the Australian erectile dysfunction market was in the order of $97 million per annum. We believe that it is likely that these figures relate solely to sales of Viagra, Cialis and Levitra and do not include AMI's revenue or revenue generated by other parties from the sale of off-label medications. These figures are also unlikely to include internet sales or doctor's consultation fees for treating sexual dysfunction.

AMI's total audited revenue for the year ended 30 June 2008 exceeded $72 million. Approximately 50% of AMI's revenue related to its erectile dysfunction business. There are several other businesses with similar business models to AMI operating in Australia including Boston Medical Group. As a consequence, AMI believes the total revenue for sexual dysfunction treatments in Australia exceeds $200 million per annum once all doctor's consultations and medications are included.

Proportion of persons seeking to be treated using technology based consultations

It is AMI's experience that a significant portion of patients prefer to be treated for sexual dysfunction through technology based consultations (around 50%). AMI's technology based consultations are either conducted over the telephone or through video conferencing facilities. AMI does not conduct any internet based consultations.

AMI is unaware what proportion of patients are treated by other businesses using technology based consultations but notes that the internet advertising of sexual dysfunction treatments is prolific and accordingly believes that a significant proportion of patients are treated using technology based consultations. AMI therefore believes that a substantial portion of patients are treated using internet based consultations.

What factors prevent men from seeking face to face advice on and treatment of impotence from general practitioners

Independent medical research from 2002 indicates that only 11% of men with conditions such as erectile dysfunction or premature ejaculation make themselves available to doctors for treatment (European Urology Journal No. 8, November 2002). This statistic was recently confirmed in a survey conducted by the American Association of Retired Persons which revealed that only 10% of men reported seeking or receiving treatment for sexual problems (International Journal of Impotence Research 2008, 20, Pages 15-20).

In Australia, the Men in Australian Telephone Survey – MATeS – of almost 6,000 randomly selected men aged 40 to 98 found 88% had visited a doctor in the previous 12 months however of the 21% of men participating in the survey who stated that they suffered significant erectile dysfunction only about one third had broached the subject with a health professional.

A survey of more that 3,000 impotent men presented at the conference of the Impotence Association in Britain (2003) showed that most men suffer for 2-3 years before seeking help (Ann Tailor, Director of the Impotence Association in Britain).

These studies clearly demonstrate that a significant portion of the male population which are suffering from erectile dysfunction do not seek medical assistance and that those who do only seek medical assistance some time after they develop severe erectile dysfunction.

A global sex survey presented at the Second Work Congress of Men's Health in Vienna (2002) revealed that only half of Australian men with erectile dysfunction who do eventually speak to a GP about their erectile dysfunction felt that their doctor understood the impact of erectile dysfunction on their lives. This experience or perception of some Australian doctors makes Australian men with sexual dysfunction even more unlikely to initiate a discussion about a sexual or emotional issue (Australian Journal of Pharmacy, 1, 12, 2002 Pages 1-3).

The study conducted by the American Association of Retired Persons concluded that the reluctance to seek treatment may be because of embarrassment or a lack of understanding of the disease or its available treatments (International Journal of Impotence Research 2008, 20, Pages 15-20).

In 2006 a clinical study concluded that many doctors remain uncomfortable taking a sexual history, especially if patients are younger than 18 or older than 65 (Australian Doctor, March 2006, Page 13).

In 2007 another clinical study announced that one in 5 men remain "very uncomfortable" about discussing sensitive issues with their GP and most would not raise these problems with their GP until the problems were very serious (Australian Doctor, August 2007, page 41).

This independent research indicates that patients are very embarrassed by their condition. It also indicates that many GPs are not comfortable taking sexual histories, that many men are not comfortable talking about these issues with their family GP and that many men feel that their family GP does not understand the impact of erectile dysfunction on their lives.

Similarly, independent medical research shows that 50% of men who are provided with a script for erectile dysfunction medication do not follow through to collect that medication and those that do often do not return for a repeat script. This is also partly driven by the embarrassment factor (the need to go into a retail pharmacy to collect medication which pharmacy is often staffed by young women) and partly driven by the effectiveness of the treatment (independent clinical studies indicate that most tablet based erectile dysfunction treatments are only effective in 50-60% of patients).

Just as alarmingly, The Men's Attitudes to Life Events and Sexuality (MALES) phase II study showed that only 16% of men with erectile dysfunction who had spoken with their physician about their sexual dysfunction were currently using oral 5PDE inhibitors (International Journal of Clinical Practice, 03, 04, 2008). There are various reasons why this has occurred, one of which is that these treatments are only effective in 50-60% of patients.

AMI has successfully developed a chain of medical clinics which only deal with patients suffering from sexual dysfunction. AMI believes that it has been successful in developing this business for the following reasons:

- patients prefer dealing with doctors who specialise in treating these types of conditions. They believe that these doctors have extensive experience in dealing with these conditions, that these doctors will not be surprised to hear that the patient has this type of condition, that these doctors will not be embarrassed in their discussions with patients talking about these conditions and that these doctors will not treat these patients in an awkward manner (which behaviour makes patients feel embarrassed);
- patients prefer being treated in situations where they are unlikely to meet family, friends or acquaintances while discussing intimate issues of this nature. When patients attend their family GP there is a reasonable risk that they will meet family or friends before or after their consultation. As a consequence, patients' preference is to deal with this type of issue remotely from their own home or car or as a minimum to deal with them in clinics which do not deal with other issues as this reduces the embarrassment factor. Technology based consultations also enable patients to be treated in a setting in which they have a greater degree of control and comfort giving them enhanced confidence and security;
- technology based consultations are very convenient for patients, enabling them to determine the time and place when they are consulted. The use of technology based consultations also reduce patient waiting times (a clear impediment to men seeking help identified by Professor Marshall in his evidence to the Committee). It also reduces the cost of men obtaining treatment as men do not need to incur travel costs and are less likely to have to take time off work in order to obtain treatment;
- AMI's clinics have private waiting rooms (ie patients are not left sitting in a common area where they may be seen by third parties whilst waiting to see a doctor). This significantly increases their privacy and significantly reduces their embarrassment;
- AMI's advertising is direct and endeavours to destigmatise these conditions; and
- AMI provides a total treatment solution with medication being delivered discretely to a location determined by the patient with patients not being required to go into a retail pharmacy to collect their treatments meaning their condition is not made known to yet another person.

It was suggested during the roundtable discussion that government should consider spending additional funding on raising awareness of these issues. Whilst AMI believes that this might assist to raise awareness of these conditions, AMI does not believe that it will significantly increase the number of men seeking assistance from their family GP in a direct face to face consultation as this type of funding will not address the critical issues which stop patients from going to their family GP. As set out above, those issues include inadequacies in GPs patient handling skills and patients' clear preferences for technology based consultations. Whilst submissions were made during the conference that patient handling skills could be improved with additional training, most GPs treat these conditions infrequently (no more than several times per week) and it is unlikely that additional general training will overcome these problems.

To what extent does the practice of holding consultations and prescribing impotence medications over the telephone affect the quality of the consultation and broader health outcomes

Independent research has shown that sexual dysfunction can lead to major medical and personal catastrophes if it is left untreated including severe depression, alcoholism, violence, sexual abuse, marriage breakdown and suicide in extreme cases. Similarly, erectile dysfunction is often a precursor of serious cardiovascular disease as has been confirmed in a number of leading independent medical studies which were widely publicized last year.

As set out above, independent research indicates that traditional methods of treatment inhibit men from seeking and obtaining treatment for impotence. Even if technology based consultations were not as effective in treating patients (which is not accepted and is discussed in detail below), technology based consultations increase the likelihood that men will seek and obtain treatment for their conditions for the reasons set out above. Encouraging men to seek treatment is important as it enables doctors to advise patients that sexual dysfunction may be a precursor of heart disease and to encourage patients to obtain a general check up for cardiovascular related issues in a face to face consultation.

In terms of the quality of the technology based consultation:

- The current "Guideline on the Pharmacologic Management of Premature Ejaculation" issued by the American Urological Association state that "The diagnosis of PE is based on sexual history alone". In other words, physical examination is not considered necessary. A copy of these guidelines is attached for your information. Contrary to what was stated by Dr Malouf during the roundtable discussion, those guidelines were clearly prepared in relation to the pharmacologic treatment of premature ejaculation as clearly demonstrated by recommendation 4 of the guidelines which sets out in detail the pharmacologic treatment methods which should be adopted in treating these conditions. If it was not intended that the guidelines apply to pharmacological treatment the guidelines would not deal with this issue and would state that they were intended to apply to medical advice only. In addition, the Independent Learning Programme for GP's (Unit 442-443 January/February 2009) issued by the Royal Australian College of General Parishioners (Page 19), recommends – "There are no investigations required if secondary P.E. is the only problem". These guidelines and publications confirm that it is generally accepted practice that there is no need for a physical examination for patients suffering from premature ejaculation rendering a face to face consultation unnecessary in these cases;
- There is a divergence of opinion as to whether a physical examination is required to diagnose and treat erectile dysfunction. In 2004 the Canadian Medical Association Journal reported that "Whereas an extensive investigation was previously common in the management of ED, recent treatment guidelines promote a more minimalist, goal-oriented approach" and "Just a decade or two ago, the routine evaluation of E.D. consisted of an exhaustive biochemical screening panel, psychological assessment and occasional vascular testing. This approach was justified as reasonable at the time because the treatment options available were invasive. In contrast, current recommendations for management rely on history taking and basic screening tests." Similarly, Sexual Medicine, Second International Consultation on Sexual Dysfunction, Paris 2004, page 42 reported that "As all or most other dysfunctions early ejaculation is primarily a self reported diagnosis". Furthermore, in 2007, Boots Pharmacy in the UK was given permission for patients to be prescribed Viagra without the involvement of a doctor at all. This initially started as a trial at 3 pharmacies in the UK midlands and has subsequently been rolled out to all of Boots' pharmacies in the UK (other than Ireland) as a result of the success of the trial. A media report regarding the initial trial is attached for your information. Quite clearly, permitting a pharmacy to provide Viagra

without a prescription or doctor's consultation is inconsistent with a proposed requirement that all patients undertake a physical examination prior to being treated. Whilst some journals and publications report that a physical examination should be undertaken those journals and publications generally predate the Boots Pharmacy arrangements. The Boots Pharmacy arrangements indicate that many sexual health physicians no longer believe physical examination is necessary before commencing treatment of patients with sexual health problems. The reason for these developments is that many physicians believe that it is preferable to put in place flexible arrangements which are more likely to obtain treatment than to maintain arrangements which results in men sitting at home without obtaining treatment at all resulting in an overall worse health outcome. This is a view shared by AMI;

- Face to face consultations rarely result in a physical examinations being conducted by GPs. As set out above, GPs are too embarrassed to ask about sexual history and are even less comfortable asking men to disrobe so they can inspect their genitals. Furthermore, the general quality of consultations conducted by GPs in general medical practices are usually of much lower quality than the quality of consultations conducted in AMI's clinics. Attached for your information is a survey of 30 doctors which was conducted in August 2009. The core conclusions from this study are:
    - Only 2 doctors in the survey conducted a physical examination before prescribing treatments for erectile dysfunction or premature ejaculation. One of those examinations related to a patient with premature ejaculation rather than erectile dysfunction and as set out above no physical examination is recommended under current guidelines in relation to the diagnosis and treatment of premature ejaculation;
    - The quality of questions which doctors asked patients were in all but one case less comprehensive than those asked by AMI doctors during their consultations. Given sexual dysfunction is largely a self diagnosed condition, the taking of medical and sexual history is the most important aspect of diagnosing and treating sexual dysfunction;
    - The duration of AMI's consultations were generally significantly longer than the average duration of consultations during the study. The reason AMI's consultations are longer is the patient questionnaire used by AMI is more thorough than the questions usually asked by general practice GPs, and AMI's doctors are not under the same pressure to push patients out of their consulting rooms in order to start their consultation with the next patient waiting to see them (telephone consultation giuves greater flexibility from a scheduling perspective);
    - One third of doctors did not give any advice regarding side effects and the advice given by many other doctors was limited and did not cover many core risks. In particular, the advice given by these doctors did not include advice regarding the potential for vision impairment, sudden hearing loss or potential cardio related issues which are well known potential side effects which can arise from the use of tablet based erectile dysfunction medications. Some articles regarding these issues are attached for your information;
    - Only one doctor made arrangements to follow up patients during the consultation; and
    - Four doctors prescribed Cialis to treat premature ejaculation. Cialis is not widely recognised as a leading treatment for this condition (anti-depressants or SSRI's are widely recognised as the appropriate treatment). We note that statements were made by Dr Malouf during the roundtable discussion that the American Urological Association Guidelines list the use of oral PDE5 agents (such as Cialis) as a potential treatment for premature ejaculation. AMI acknowledges that there is such a reference in those guidelines however the guidelines do not list these medications as the preferred treatment method (they list clomipramine and other SSRI's as being the preferred treatment). The

guidelines also clearly state that the clinical information supporting the use of PDE5 medications to treat premature ejaculation are very limited. As Dr Malouf acknowledged, these guidelines were issued in 2004. Attached for your information is an article which was published in the Journal of Family Practice in March 2008, some 4 years after the AUA's guidelines were issued. As you will see, the authors of this article undertook a review of 14 clinic trials and concluded that there was no convincing evidence for the use of PDE5 inhibitors in the treatment of men with premature ejaculation (Cialis is a PDE5 inhibitor). We note that one of the studies referred to by the authors is a study conducted by Dr McMahon and others which concluded that there was no statistically significant evidence from a clinical trial conducted by him that Cialis was effective in treating premature ejaculation. This is the prevailing opinion amongst sexual health experts at this time. Given one of these studies was authored by Dr McMahon, we are surprised that Dr McMahon did not raise these subsequent studies when these matters were discussed during the roundtable discussion given his clear knowledge of these issues. We believe that the reason these studies were not raised is that they indicate the clear inconsistencies in the position being put by Dr McMahon and Dr Malouf on these issues. On the one hand they state that AMI is engaging in "bad medicine" because AMI is using a treatment method for erectile dysfunction which they say is not supported by the prevailing view amongst sexual health experts (a view which AMI does not agree with) whereas on the other hand they do not believe general practitioners are engaging in "bad medicine" by using a treatment method for premature ejaculation which is not supported by the prevailing view amongst sexual health experts. These statements are clearly involve double standards. Either it is not "bad medicine" for a doctor to have a different view on treatment methods from the prevailing view or they should be equally critical of these doctors for using a treatment method which differs from the prevailing view.

AMI's study clearly demonstrates that AMI's consultations are more thorough than those performed by the third party GPs involved in AMI's study and AMI's study indicates that requiring face to face consultations will not result in patients being given physical examinations. The doctors in this survey (with the exception of Dr McMahon) were selected at random. AMI believes that the study is of sufficient size to be statistically significant contrary to the claims made by some of the persons attending the discussion. Furthermore, whilst AMI's critics suggest that these study is not representative of general practice, it is telling that Dr McMahon himself failed to conduct a physical examination during both of the consultations he performed during the study;

- Contrary to the claims made during the discussion that telephone consultations are not as effective as face to face consultations, independent research indicates that this is not the case. Earlier this year, the Cochrane Collaboration published a study by F. Bunn and others regarding 9 clinical studies of telephone consultations. That study concluded that telephone consultation was safe and patients were just as satisfied using the telephone as going to see someone face to face. A copy of the study is attached for your information; and
- Contrary to the claims made by Dr Malouf during the roundtable discussion, we think it is more important to use technology based consultations in the initial treatment of patients rather than in subsequent treatments. The reason for this is that the greatest difficulty experienced by sexual health professionals is getting men to come to see them for an initial consultation with patients being more likely to return once an initial consultation has occurred. Similarly, the suggestion that technology based consultations be limited in Australia is impractical – Australia is a very large country with a significant portion of its population based in remote and regional areas. Very few of these remote and regional areas are regularly serviced by urologists or other

sexual health specialists and men in these locations are the very people who are least willing to speak with their family GP about these issues given the closeness of these communities.

Having regard to the matters outlined above, prohibiting technology based consultations will simply reduce the number of people seeking treatment for this serious issue and will not result in any improvement in the quality of consultations being conducted. On the contrary, based on our recent survey of general GPs consultations, it will reduce the quality of consultations provided to patients and will also result in a greater number of patients obtaining internet prescriptions from unregulated and unsafe providers. Based on the independent publications referred to above, it will also result in patients being treated by doctors who are uncomfortable in asking patients questions about their sexual history, who are uncomfortable in performing physical examinations, who are unlikely to perform a physical examination (the very reason stated for requiring a face to face consultation) and who patients feel do not understand them or the effect sexual dysfunction is having on their lives. It will also require patients to do so in settings which are uncomfortable and embarrassing for them. This is clearly not in the patients' best interests and will significantly reduce the quality of health outcomes. In any event, independent research indicates that telephone consultations are safe and effective methods of consulting patients.

In terms of broader health outcomes, AMI's use of technology based consultations is also saving the public purse millions of dollars in Commonwealth health funding. Technology based consultations are not covered by Medicare and AMI does not charge fees to patients who elect to not proceed with a treatment. Face to face consultations are covered by Medicare whether a patient elects to proceed with a treatment or not. AMI conducts more than 50,000 consultations per year, so the cost saving involved is significant. A significant portion of these costs would need to be borne by the Commonwealth if any change to the existing regulatory regime is made. AMI also believes that the introduction of sexual health clinics to the market by AMI's predecessor in 1993 substantially increased competition in this market and substantially lowering the price paid by consumers for this type of assistance. Any change to the existing regulatory regime is likely to increase the direct and indirect cost of obtaining treatment by consumers (eg travel costs), a matter which is likely to be of significant detriment to the community.

Furthermore, in terms of the criticism that AMI's consultations do not involve AMI testing patients for cardiovascular disease, AMI's doctors routinely advise erectile dysfunction patients that erectile dysfunction is a precursor of heart disease and that patients should obtain appropriate tests for this issue from their GP. None of the doctors involved in AMI's third party doctor survey performed comprehensive cardiovascular tests or recommended patients obtain a proper check up. AMI accordingly believes that its approach to this issue is superior to the approach adopted by the doctors involved in its survey. Finally, as set out above, the suggestion that the use of technology based consultations be restricted appears to be at odds with changes being made in other leading jurisdictions such as the UK where it is no longer necessary for patients to consult a doctor at all prior to receiving a treatment for erectile dysfunction.

Finally, AMI contacted the NSW Medical Board in July 2001 regarding the use of technology based consultations and obtained the approval of the NSW Medical Board to undertake consultations in this manner (a copy of the letter approving the use of such consultations is attached for your information). AMI has subsequently treated many thousands of men without any major adverse health outcomes. Whilst Dr Malouf and others have given anecdotal evidence of adverse health outcomes for several AMI patients and claimed that AMI has acted inappropriately, AMI's critics have not provided any substantive evidence to back their claims and those claims should not be believed without any such evidence. To the contrary, as discussed below, AMI's patient database confirms that the level of adverse health outcomes

arising form AMI's treatments are in line with international standards for the types of treatments it provides.

What adverse health outcomes can arise from inappropriately prescribed medication for impotence

The medications ordinarily prescribed by AMI for erectile dysfunction are apomorphine, phentolamine, papaverine and prostaglandin and the medications used by AMI to treat premature ejaculation are clomipramine and tramadol. These medications are delivered in a number of forms including nasal sprays, injectibles, intra-urethral gels, topical gels, lozenges and suppositories. The quantity of active ingredients utilised in these medications are sub-therapeutic doses by reference to the recommended dose of these treatments in tabular form to treat other conditions and are low in comparison to the quantity of active ingredients used in tablet based medications. The reason the quantum of active ingredients are low relates to the method of delivery of these medications. Contrary to the claims made by Dr Malouf, nasal delivery is a much more efficient method of delivery of medication than tablet delivery as delivery through the nasal mucous involves delivery directly into the patient's bloodstream whereas tablet based medications are delivered through the stomach and can be affected by food and alcohol intake with significant portions of the medication passing through the patient without being absorbed into the patient's bloodstream. In this respect we attach several articles for your information which confirm the efficacy of delivering medication (including apomorphine) through the nasal system.

With the exception of injectibles, the side effects arising from the use of AMI's impotence medications are not significant and include headaches, flushing, nasal congestion, nasal crusting, dizziness and drowsiness.

In the case of injectibles there is a very low risk of priapism which can result in penile scarring and deformity if left untreated. Long term independent studies indicate that the risk or priapism from the use of injectible erectile dysfunction is very low ranging from 0.14% to 0.3% (see for example the 8 year study conducted by Virag and others: Intracavernous Self-Injection of Vasoactive Drugs in the Treatment of Impotence: 8 Year Experience with 615 Cases, H. Virag, K. Shoukry, J. Floresco, F. Nollet and E. Greco, The Journal of Urology Vol 145, pages 287-293, February 1991 or see Long Term evaluation of local complications of self intracavernous injections (SICI), R. Virag, F. Nollet, E. Greco and J. Floresco – International Journal Res. (1994) 6, Suppl. 1). Furthermore, where priapism occurs, priapism is generally able to be dealt with without any major long term effects providing appropriate treatments are undertaken without delay.

AMI provides a detailed instructional DVD to all patients who are provided with injectible medication as well as providing them with written explanatory material and a 24 hour 7 day per week help line with staff available to assist patients as required. This material is very comprehensive and has been designed to reduce the likelihood of any major issues. It is much more comprehensive than the material ordinarily issued by GPs to patients they are treating with sexual health issues. A copy of AMI's patient booklets is attached for your information.

In the last 18 months AMI treated more than 6,000 patients using injectible medications. Over that period 19 patients experienced a priapism, ie 0.3% of total patients. Of those patients 13 continued to use AMI medications without any ongoing difficulties. From 2005-2007 a further 19 patients suffered a priapism and 15 of these patients continued to use AMI's medications after suffering priapism without any ongoing issue. These statistics are in line with or better than international statistics for these health outcomes and confirm that AMI's practices are appropriate and do not result in adverse health outcomes.

In relation to the side effects arising from the use of AMI's premature ejaculation medications, the side effects are similar to those for its impotence medications but can also include anxiety, cardiac problems, tinnitus and hypotension. However, as set out above, AMI uses sub-therapeutic doses of anti-depressants in its premature ejaculation treatments (again by reference to the recommended dose of these treatments in tabular form to treat other conditions) and as a result the likelihood of any major issues is very low.

AMI and its associated companies have treated more than 500,000 patients in its 16 years of operation. AMI is unaware of any fatalities arising from the use of its medication in this period. AMI is also unaware of any major adverse side effects other than the infrequent incidents of priapism referred to above, which risks are well known, advised to patients and do not appear to occur any more frequently for AMI patients than third party patients. If there had been widespread public health issues arising from the use of AMI's treatments, these matters would have been widely reported in the press, would have resulted in major litigation against AMI and would have resulted in proceedings being taken against AMI and/or its compounding pharmacy. The fact that none of these things has occurred clearly demonstrates that there are no such issues.

Attached for your information are some print outs from the website of Sydney Urology, Dr Malouf's own urology practice. Also attached for your information are some print outs from Andrology Australia's website. The pages from Sydney Urology's website clearly state that Dr Malouf uses off label injectible medications to treat patients with erectile dysfunction (trimix is an off label injectible medication). They also clearly state that Andrology Australia considers off label injectible medications to be an appropriate treatment for erectile dysfunction. These treatments are substantially the same as the injectible treatments used by AMI. In the circumstances, any suggestion that AMI's injectible treatments are inappropriate should not be accepted as these parties are basically using the same types of treatment as AMI. This material clearly validates AMI's statements that its injectible treatments are safe and widely used by sexual health professionals.

AMI's critics frequently make comments regarding individual patients treated by AMI. These comments appear to focus on a very limited number of individual patients. AMI is obviously unable to comment on the treatment of particular patients where details of the patients are not provided. AMI requests that the Committee not draw adverse inferences from any such comments in circumstances where these critics fail to provide AMI with a reasonable opportunity to respond to the complaints and the circumstances in which any issues arose. AMI notes that there may be a reasonable explanation for the health outcome in those particular cases. Having said this, AMI accepts that, as is the case with most health professionals, mistakes can be made in individual cases and it would be very rare for any health organisation to have treated more than 500,000 patients without making any mistakes. As set out above, the quantum of cases which have resulted in adverse health outcomes are very limited in comparison to the number of patients which have been treated.

In terms of the claims made regarding the efficacy and safety of AMI's other treatments, those treatments use medications which have been approved for alternate uses. Contrary to the claims by Dr Malouf and others that there is no evidence to support the use of these medications to treat erectile dysfunction and/or premature ejaculation:

- Clomipramine is widely recognised as the leading medication to treat premature ejaculation – see The Journal of Family Practice, March 2008 which specifically deals with this issue. AMI delivers clomipramine through a nasal spray. Some independent scientific articles regarding the appropriateness of nasal sprays as a delivery method are attached for your information. As you will see, nasal delivery is recognised as an appropriate efficient and effective method of delivering sexual dysfunction medications;

- AMI's erectile dysfunction treatments generally use a combination of apomorphine and phentolamine (other medications include Levitra). AMI's critics frequently cite studies regarding the withdrawal of Uprima from the market as evidence that AMI's treatments are ineffective. Uprima was a sublingual apomorphine tablet which was introduced to the market by Abbott and subsequently withdrawn because of concerns regarding the efficacy of this particular treatment. As set out above, AMI's treatments generally use a combination of apomorphine and phentolamine rather than apomorphine on its own. Clinical studies conducted by Repros Technologies (formerly known as Zonagen) indicate that apomorphine and phentolamine act synergistically when used in combination and this is consistent with AMI's own research and clinical experience. A copy of a clinical study conducted by Zonagen is included for your information. Numerous other clinical studies indicate that phentolamine is a safe and effective treatment for erectile dysfunction (see International Journal of Impotence Research, The Journal of Sexual Medicine, Volume 20 Number 2 March/April 2008 which summarises the efficacy of various erectile dysfunction medications). Furthermore, contrary to the statements made by AMI's critics, clinical studies conducted by Vectura, Nastech and others indicate that nasally and pulmonary delivered apomorphine is effective in treating erectile dysfunction. Vectura's studies were conducted as recently as 2007 some 3-4 years after Uprima was withdrawn from the market. A copy of reports relating to those trials and the efficacy of Vectura's apomorphine treatments are attached for your information. AMI believes that Uprima's lack of efficacy predominantly relates to the method of delivery of that medication however as stated above AMI uses a combination of phentolamine and apomorphine to treat erectile dysfunction and as a result Uprima's lack of efficacy is not evidence of any lack of efficacy of AMI's treatments. In this respect, attached for your information are copies of some of the patient testimonials provided to AMI by its patients in 2003/04 when AMI commenced providing nasal spray treatments to patients. AMI has covered over the patients' names and contact details in line with requests received from these patients that these details not be publicly disclosed. As you will see, those testimonials indicate clear patient satisfaction from AMI's nasal treatments. This is also confirmed by internal patient reviews which AMI has conducted which indicate that the proportion of patients seeking to switch from a nasal spray treatment to an injectible treatment;
- Whilst it is difficult to determine the exact cause of female sexual dysfunction and to ascertain a treatment which will be effective for particular patients, Apomorphine is recognised as being an effective medication for the treatment of sexual dysfunction in women (see attached articles); and
- Nasal delivery is widely recognised as an extremely efficient method of delivering medication to the body. One of the reasons it is efficient is that it enables delivery of medication directly into the patient's bloodstream (reducing the period for onset of action and lowering the quantity of medication required to deliver an effective treatment). A second reason is that this method of delivery bypasses the blood-brain barrier enabling medication to be delivered into the central nervous system.

As should be clear from the material referred to above, there is a wealth of independent clinical studies and publications which confirms that the medications used by AMI to treat patients have clinical efficacy for those conditions. This is not to say that treatment is effective in all cases. It is widely accepted that no sexual dysfunction treatment has 100% efficacy.

Furthermore, contrary to the statements made by Dr Malouf during the roundtable discussion, AMI does not generally use injectible agents as a first line therapy for the treatment of sexual dysfunction. Injectible agents are only prescribed by AMI in approximately 15% of patients. Injectible agents are generally used in these cases as other treatments are contraindicated or have been found to be ineffective. Furthermore, the relatively low level use of these agents

also demonstrates that AMI has not needed to move vast numbers of its patients from nasal sprays to injectibles are a result of nasal spray treatment efficacy issues.

Can a negative experience of impotence treatment prevent men from seeking assistance for other health problems

AMI does not believe that there is any data supporting any such conclusion. In any event, as discussed below, the vast majority of complaints relating to AMI do not relate to medical efficacy and predominantly relate to patients changing their minds about whether to proceed with treatment for their condition.

Why do we need telephone prescribing of medications? What are the regulations of telephone prescribing of medications? Are these regulations sufficient?

The regulation of telephone prescribing of medications is governed by general medical practice as well as the General Principles of Technology Based Patient Consultations approved by the Ministry of Health in 2007.

AMI believes that these regulations are sufficient and that no further regulations are required for the reasons set out above.

AMI has treated many thousands of men using technology based consultations in Australia without any major health issues over the past 5 years.

The benefits of telephone consultations are treated in detail above.

Any tightening of the use of telephone consultations is out of step with developments in other leading jurisdictions and will only result in worse health outcomes for patients with fewer patients seeking assistance and with no improvement to the standard of treatment being provided. Any such change is also likely to result in patients seeking treatments from unregulated internet based suppliers resulting in adverse health outcomes for consumers or in failing to obtain treatment at all which is also clearly a worse health outcome.

The existing system of regulation provides appropriate protections and safeguards to patients and there have not been any systemic problems arising from the existing system of regulation.

Should the regulation of over the telephone prescribing of impotence medications be subject to more stringent regulations? If so, what needs to be changed?

No. See above.

Is the supply and dispensing of impotence medications adequately regulated?

Yes.

In Australia the principles of quality, safety, efficacy and risk management are applied to compounded medicines under a system guided by professional practice standards and legislation governing the practice of pharmacy. Prescribers and dispensers of compounded medicines accept responsibility for evaluation and ensuring the quality, safety and efficacy of these classes of medicines. AMI's compounding pharmacy is the leading compounding pharmacy in Australia and has the appropriate experience, expertise and systems to provide the goods and services which it has historically provided. There have not been any instances of major adverse health outcomes arising from the provision of medications which would suggest that any change to the existing system of regulation is warranted.

Each of the drugs that are commonly used by AMI in the treatment of sexual dysfunction are listed in table 1 of the International Journal of Impotence Research 2008, 20, 127-134 as having good evidence of efficacy for the purpose for which those drugs are being used. A copy of that publication is attached for your information. Furthermore, all medications used in AMI's compound treatments are registered on the TGA's Australian Register of Therapeutic Goods and all medications on that register must go through exhaustive safety tests before being included.

Off-label use is often standard accepted medical practice – there are no TGA registered treatments for premature ejaculation presently available in Australia and as demonstrated by the material set out above off-label use of medications in the treatment of erectile dysfunction is widely recognised.

Furthermore, a deep belief in allowing physicians autonomy to practice their art as they feel fit, combined with a belief that innovative off-label uses can lead to important medical breakthrough, has resulted in the policy decision not to use regulatory powers to inhibit such prescribing.

At times a pioneering off-label use can prelude to additional clinical trials leading to approvals of the drug or device for additional indications, but given the cost of obtaining such additional approval, manufacturers often calculate that they can get almost as much sales volume for the same indications without getting formal recognition of their products effectiveness in that use. The prohibitive cost of undertaking clinical trials inhibits pharmaceutical companies and medical service providers from obtaining formal approval of drugs which have been in use for off-label uses over an extended period of time. The failure to register these compounds has not arisen due to a lack of efficacy or safety – it has arisen because the cost of registering compound formulations of already approved drugs is prohibitive and totally out of proportion to the financial benefits associated with registering the formulations (the cost of registration is in the tens or hundreds of millions of dollars per formulation and no commercial operator is prepared to undertake this expenditure without being able to take advantage of monopoly patent protection, which protection is generally not available in relation to the erectile dysfunction treatments used by AMI as those treatments have been in the market for an extended period of time – patent protection is only available where there has been no prior commercial use). Furthermore, as discussed by Professor Marshall during the roundtable forum, medicines which are included on the TGA register always have inclusion and exclusion criteria. The critical issue is not whether a medication is included in the register but whether it has therapeutic benefit and whether it is appropriate for the particular patient for whom it is proposed to be used. There are many patients for whom TGA registered treatments are not effective and changing the regulatory regime will simply result in patients being unable to be treated for a serious health issue.

Off-label use will continue to be a big part of the practice of medicine and the sales of drugs and devices. The core question is how to encourage what is clever and useful and positive, while at the same time discouraging those uses which do harm either directly or because they have precluded more effective treatments. That will continue to be the core question for decades to come (New from Script – off-label Prescribing; Strategies, Risks and market challenges, 2007).

The term "off-label" is an FDA regulatory term, not a negative implication of its medical use (International Journal of Impotence Research 2008, 20, 135-144). The suggestions made by Dr Malouf and others that physicians are or should be required to use medications that are registered with the TGA in preference to well accepted off label medications is not broadly supported as demonstrated by this publication. Similarly, independent publications state that injectible medications (which are off label medications) remain the safest and most efficacious medications for these conditions despite the widespread use of tablet based medications (see

the attached article regarding the comparison of Sildenafil Citrate (Viagra) Versus Trimix Intracavernosal Injection as Treatment for Erectile Dysfunction). The use and availability of tablet based erectile dysfunction medications is well known by consumers. Furthermore, AMI's standard patient questionnaire specifically asks patients whether they have used Viagra, Cialis or Levitra. The reality is that a significant portion of AMI's customers have already tried Viagra, Cialis or Levitra and found that they were ineffective or want to try another form of medication to see if it is better.

Contrary to the claims made by Mr Mackey during the roundtable forum that compounded medications is limited (no more than one percent of patients), the use of compounded medications is widespread.

In terms of that use, 46% of prescriptions written for anticonvulsants in the USA were for off-label uses, 80% of the patients in a neonatal unit in Australia received off-label medications and 33% of the prescriptions written by Paris – based paediatricians were for unapproved uses.

There is no disputing the fact that off-label sales are big business. One analysis of the top selling 25 prescription drugs in the USA found that in 2003, almost US$13 billion of their sales – close to 25% - were for off-label use. Other studies have suggested that three quarters of the prescriptions written for Rituximab are for off-label uses and a staggering 98% of sales for the psychotropic Gabapentin were for unapproved uses.

In the sexual health space there are no medications registered with the TGA for a premature ejaculation indication. As set out above, 50% of AMI's sexual health business relates to the treatment of premature ejaculation. Other sexual health providers also commonly treat patients for this condition demonstrating that the off label prescription of medication in the sexual health space is widespread.

The FDA has specifically stated that its procedures and requirements have no effect on the practice of medicine and that the FDA does not prohibit doctors from prescribing drugs in an off-label manner.

The FDA's approval of a drug is immaterial to the effectiveness in the drug's off-label use, in fact prescribing medication in an off-label manner can constitute the standard of care in many cases.

As set out above, the side effects arising from AMI's treatments are generally minor with the exception of priapism and in the case of priapism the incidence of adverse events is very low and is fully disclosed to patients prior to them commencing treatment with AMI.

AMI's medications are prepared by Australian Custom Pharmaceuticals, the largest compounding pharmacy in Australia. ACP's facilities are regularly inspected by the TGA and there have not been any major issues arising from these inspections. Similarly, very few incidents of adverse health consequences have arisen from AMI's treatment of patients despite AMI having treated more than 500,000 people over a 16 year period. The health risks associated with using AMI's treatments are clearly explained to patients before the treatments are provided and are set out in detail in the written material provided to those patients.

The lack of any major health issues arising from AMI's treatment history does not suggest that any change in the manner of regulation is warranted.

Is the supply and dispensing of impotence medications adequately regulated?

Yes in relation to AMI's treatments. See above.

Is the sale of extemporaneously compounded medications for impotence adequately regulated? If not, how can it be improved?

Yes. See above.

General

Whilst the forum was papers listed the issues discussed above, AMI's critics raised a series of other issues regarding AMI's practices during the forum. These issues included the following:

- "AMI locks patients into long term contracts". AMI does not believe that this claim is correct. The average length of AMI's patient contracts is less than 6 months, a relatively short period of time. Premature ejaculation and erectile dysfunction are complicated conditions which are often unable to be resolved by taking a pill on a one off basis. As a result, treatment which extends beyond a one off consultation is usually necessary and is in line with general practice recommendations that AMI should follow up its patients and that patients should have continuity of healthcare. Any ongoing healthcare for patients needs to be on a pre agreed basis and AMI's arrangements with consumers simply sets out the basis on which such treatment will be provided. AMI's contractual arrangements also enables those patients to defer part of the costs associated with their treatment over a longer period rather than paying the full cost upfront. If AMI were unable to have ongoing contractual arrangements with patients it would need to charge those patients a larger upfront sum, and any such change is clearly not in the patient's best interest;
- "AMI charges patients prohibitive sums". AMI arranges for patients to be provided with medical treatments and medications. Most cost comparisons made by AMI's critics focus on the cost of medication only and do not take into account the cost of medical consultations. AMI's average contract sum is less than $2,000. Furthermore, AMI does not charge consumers at all for their initial consultation unless they agree to sign up for ongoing treatment. Dr McMahon charges patients $150 for a 10-15 minute consultation and Viagra costs around $20 per tablet. AMI believes that its contract charges are competitive in comparison to its competitors and notes that consumers are not obliged to obtain treatment from AMI and may do so from Dr McMahon, Dr Malouf or any other treatment provider. The cost of AMI's treatments is also low in comparison to the amounts charged to consumers for other medical treatments including cosmetic surgery, skin cancer, hair replacement and other surgical procedures;
- "AMI acts inappropriately". AMI acts in accordance with all relevant laws and regulations. In addition, AMI has adopted a range of procedures and policies which go well beyond its legal obligations. Firstly, AMI does not cold call consumers. The only people who deal with AMI are those consumers who voluntarily call AMI and choose to make an appointment with an AMI doctor. Secondly, AMI has a voluntary 48 hour cooling off period for consumers, a policy it is not legally obliged to offer. AMI adopted this policy because of the inaccurate claims made by some critics that AMI pressures consumers to enter into contractual arrangements with it. Thirdly, AMI frequently agrees to vary contractual arrangements where customers encounter financial or other difficulties (eg loss of employment) despite being legally entitled to require patients to comply with their contractual arrangements. This behaviour is inconsistent with the false claims made by third parties that AMI takes advantage of consumers. Fourthly, AMI declines to provide treatments where treatment is contraindicated as evidenced by AMI declining to provide treatment to approximately one third of potential patients due to contraindications. These practices are not consistent with a party acting inappropriately and are completely at odds with the inaccurate claims that AMI places profits above patient care. Fifthly, AMI operates a not for profit division

under the name 'Rocket Launch" which provides sexual dysfunction treatments and services on a not for profit (often free) basis for patients who are paraplegics and quadriplegics. Rocket Launch's website is publicly accessible at rocketlaunch.com.au. Once again, this corporate activity is not consistent with the inaccurate claims made by AMI's critics that AMI places profit above patient care. As far as AMI is aware it is the only organisation offering services to these types of patients on this basis and any changes to the existing regulatory regime have the potential to affect AMI's ability to continue funding this initiative on an ongoing basis;

- "AMI is flooded with complaints". Oral erectile dysfunction medications are only effective in 50-60% of patients. AMI believes that its nasal spray treatments are effective in 65% of cases. As erectile dysfunction treatments are not effective in 100% of cases it is inevitable that some patients will be dissatisfied with the treatments which they have been provided with. This does not mean that the provision of a treatment to those consumers is inappropriate – it is impossible to predict whether a treatment will be effective in all cases prior to the treatment being used by patients. Contrary to the statements made by AMI's critics, most complaints about AMI do not relate to medical efficacy. AMI's analysis of its patient database indicates that only 23% of complaints relate to medical efficacy with the remaining complaints relating to non-medical issues. Of those complaints which have been made regarding medical efficacy it is likely that some of those complaints do not in fact relate to the actual efficacy of the treatment but that efficacy issues have been raised as the patient no longer wants to continue with their contractual arrangements. Some 35% of total complaints (or 45% of non-medical complaints) are received prior to medication being received and simply relate to patients changing their minds. Similarly, whilst AMI acknowledges that it is the subject of consumer complaints, many of these complaints are generated by the inaccurate defamatory comments made by AMI's critics and are completely unrelated to the quality of healthcare and services provided by AMI to its patients. AMI also believes that the level of complaints which it received needs to be assessed with regard to the number of patients it treats and the cost of these types of treatment. Patients are frequently provided with ineffective tablet based erectile dysfunction medication but do not complain publicly about the treatment which they have received as doctor consultation costs are covered by Medicare, part of the pharmaceutical costs are covered by the PBS scheme and the total initial outlay is low. It is telling that a significant proportion of consumers do not return for repeat prescription of tablet based erectile dysfunction treatments. AMI is a well known operator of sexual health clinics and complaints about AMI are often publicly aired because of its size of operation. Complaints about doctors and ineffective tablet based medications are infrequently aired because the number of prescribers are broadly spread and most treating doctors are not high profile;
- "AMI's patients are not consulted by a properly qualified doctor". The treatments provided by AMI are only available on prescription and prescriptions may only be issued by a fully qualified doctor. All AMI patients are consulted by a fully qualified doctor with appropriate expertise and experience in accordance with all relevant regulations and requirements;
- "AMI's doctors are not independent". As set out above, approximately one third of patients are not provided with an AMI treatment as that treatment is contraindicated. Such actions are clearly inconsistent with claims that doctors are not acting independently or are somehow acting inappropriately. Furthermore, doctors are not involved in commercial or contractual discussions with patients;
- "AMI's consultations are of lesser quality than consultations by other doctors". AMI's doctors are fully qualified professionals who typically treat more patients with sexual dysfunction in one year than the average GP treats in a lifetime of practice. It is inconceivable that the extent of this experience results in a lower quality health outcome as clearly demonstrated by the survey of 30 NSW doctors undertaken by us

earlier this year. AMI's doctors frequently receive complaints from patients about their experiences in seeking treatment for premature ejaculation from general practice GPs. Those complaints generally relate to the inability of those GPs to know how to provide an appropriate treatment for this condition as well as complaints about those doctors patient handling skills;

- "Urologists have not been able to ascertain what medications have been provided to AMI patients when questions have been raised about those treatments in relation to particular patients". Firstly, whilst each patient is provided a treatment provided under an individual prescription, the active ingredients typically used in the various treatments used by AMI to treat its patients are listed on AMI's website and are also set out in this submission. Secondly, those active ingredients are well known to doctors practising in this area. Thirdly, no doctor has contacted AMI's CEO to obtain this information. AMI's CEO is well known as are AMI's contact details. If a treating doctor was to make such contact and there was an appropriate clinical reason for the request the information would be provided providing written consent to such disclosure had been obtained from the patient in accordance with the Privacy Act and all other relevant legal requirements. Any suggestion that such information is being withheld is factually incorrect;
- "AMI is a mass manufacturer and advertises prescription medications". AMI advertises medical services and does not advertise prescription medication. Permitting advertising encourages competition and more readily enables patients to obtain lower cost treatment. AMI does not manufacture medication at all. AMI's medications are provided by an arms length third party pharmacy in which AMI has no financial interest. AMI has changed its compounding pharmacy several times during its operating history. AMI's contractual arrangements with patients require it to provide treatment to patients and do relate to any particular form of treatment;
- "AMI's advertising is inappropriate". AMI's advertising is in accordance with all relevant rules and regulations. Its advertising raises awareness of significant health issues and is less sexually oriented than much advertising which has nothing to do with sexual health issues;
- "AMI's patients think they are going to be treated with a nasal spray and end up with an injectible treatment". AMI's terms and conditions clearly state that patients are required to try all treatment options before being provided with a refund. These conditions are clearly explained to patients in plain English before they commit to a treatment arrangement with AMI. In any event, AMI often provides refunds to patients without those patients trying all forms of treatment and the level of patients using injectible treatments is low. Furthermore, AMI's doctors try a number of treatment options (eg lozenges) prior to recommending nasal sprays; and
- "AMI is operating in an unregulated environment". This is simply incorrect. AMI's operations are governed by extensive legal regulation. AMI's advertising is regulated by the Advertising Standards Boards Ethical Code of Conduct, the Trade Practices Act, the State Fair Trading Acts and medical and pharmaceutical regulations including the TGA regulations. Its contracted doctors are subject to medical standards and to review by medical boards and State health care complaints commissions. Its contracted pharmacy is subject to regulation by pharmaceutical professional standards and the TGA Act and regulations. AMI operates in accordance with all of these complex rules and requirements and has not had any major adverse health outcomes during it and its predecessors 16 years of operation after treating more than 500,000 patients.

AMI's critics have not visited AMI and have limited knowledge of its operations or practices. More importantly, AMI's critics are generally competitors or persons who rely on funding or sponsorship from AMI's competitors. This significantly colours their opinion. The criticisms made about AMI are generally based on so called anecdotal experiences which are not supported by objective evidence. For example, it is inconceivable that AMI's critics could not

be aware that Boots pharmacies have obtained permission to provide Viagra in the UK without the intervention of a doctor's consultation given Dr McMahon's frequent attendance of international conferences in sexual dysfunction. Similarly, Vectura's clinical studies have been widely published and should be common knowledge by sexual health experts. The failure of these critics to bring these matters to the Committee's attention indicates that these critics are either uninformed of recent developments in sexual health (and are therefore lacking in expertise) or are not willingly to provide evidence objectively.

The Committee should be mindful of the clear divergence between the practices which Dr McMahon states AMI should comply with and the practices which Dr McMahon and others themselves engage in as demonstrated by AMI's recent survey of NSW doctors. The clear inconsistencies between these practices are very concerning to AMI and clearly indicate Dr McMahon's clear bias and lack of objectivity on these issues. The Committee should also bear in mind Dr McMahon's failure to raise studies undertaken by him regarding the lack of efficacy of Cialis for treating premature ejaculation during the roundtable discussion. Having regard to these matters, AMI requests that the Committee only accept evidence from these parties which is backed by independent third party material which demonstrates the accuracy of the claims made by them.

The regulation of the treatment of sexual dysfunction patients and the regulation of the supply and sale of sexual dysfunction medications is critical to AMI's business. AMI is concerned that criticism is often made regarding AMI and its treatments by persons who are either uninformed about those treatments or have a vested interest in having AMI removed from the market as a competitor. This has resulted in much of the criticism levelled against AMI being based on allegations which are not factual.

AMI complies with all legal and ethical regulations applicable to the operation of its business and welcomes this opportunity to respond to the unwarranted public criticisms which have been made regarding its business and operations. AMI and its advisors are available to discuss any ongoing concerns which the Committee may have in further detail.

Yours sincerely

Jack Vaisman PhD Medical Science
Chief Executive Officer