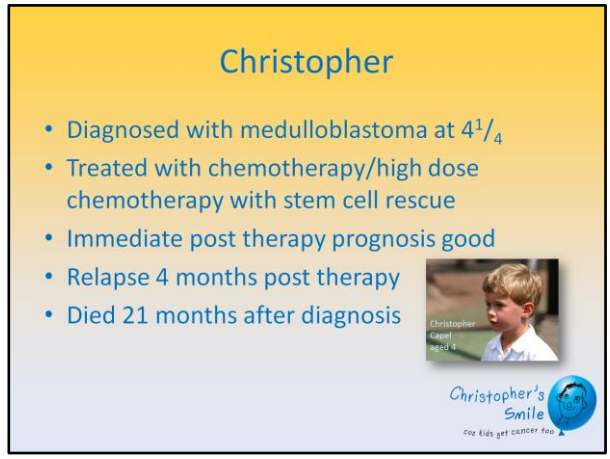
Thank you for invitation to join you today.

Talking from perspective of parents of a child who had cancer AND as funders of paediatric research.

Kevin and Karen are dual stakeholders – parents and funders of paediatric research



Almost 7 yrs to the day Christopher died. He was 5 years old.

We should have been **celebrating** Christopher's birthday as a family on Sunday – our family has been ripped apart and we are a couple again. There was not much to celebrate – only memories of a short life.

Almost 2 years of our son's life were spent fighting an aggressive brain tumour.

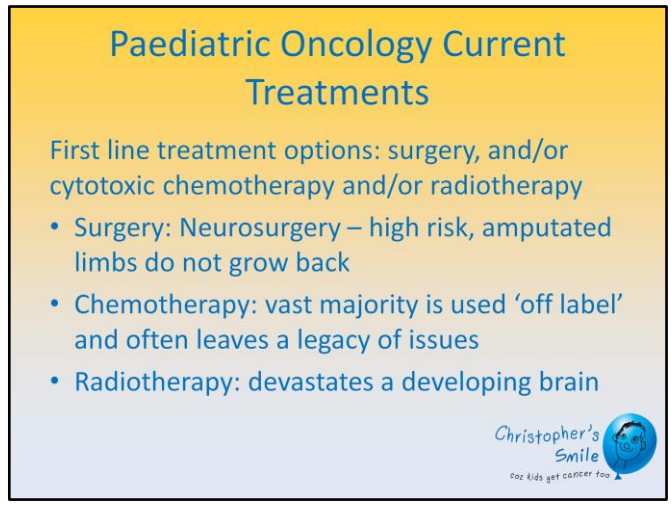
Each day of 21 months from diagnosis we lived in **fear**, in **pain** BUT with **HOPE**. HOPE that the aggressive drugs which damaged his hearing, immune system, his development would save his life. **THEY DIDN'T**.

We saw how much a helpless little body can tolerate – day after day, month after month being battered with the harsh drugs we hoped would save him from this equally harsh and cruel disease which was ravaging his body.

Can't be much **harder & cruel experience for any parent** than to sit **beside your child & watch them suffer** – see them unable to move, unable to eat, unable to function independently. Our son reverted to being baby-like in his abilities – this was consequence of treatment, not the cancer.

The situation looked brighter for a few short months, **then time and the treatment options ran out.**

We could only wait for our son to die.



We were **thrust** into a new world - a **parallel existence** to "normal" life. We were faced with very **limited choices** in terms of available treatment - **confronted with decisions no parent should have to make.**

Yes, of course we wanted our son to live but there was a high price to pay in the way of side effects.

Neuro surgery always comes with a risk of damage to the brain.

Take chemotherapy – Mostly used off label – each time more drugs were offered we had to sign a consent form. We hoped to save our child's life but there appeared to be numerous pay offs - loss of hearing, possible heart issues, kidney problems, weak immune system, cancer later in life.
Radiotherapy – we were told our son's level of radio would need to be so high he would never be able to lead an independent life afterwards.

Often the child who goes into treatment is not the same child afterwards.

Those of you in the room who have children may want to reflect upon this for a moment.

Let's take a **closer look at chemotherapy**….

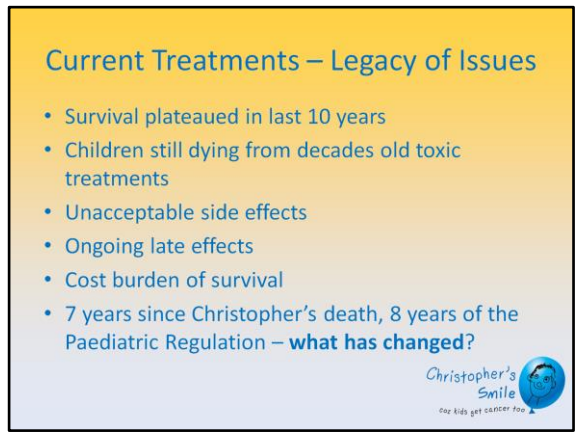
Many of these **drugs are known to cause cancers** in later life – children (if they survive) have lives ahead of them therefore good chance of being subjected to a second cancer

When Christopher died, "targeted therapy development" was in early stages. Science & technology have progressed at a fast pace since 2008 and we frequently hear about new drugs for *adults* coming through pipelines into frontline use.
Not for children though.

It was hard enough having to accept our son was going to die because there simply were no drugs anywhere which could save his life.

What must it feel like today to sit beside your child waiting for them to die – in the knowledge there could be potentially life saving treatments to save them? **Treatments which are not being made available for children?**

Should we allow this to continue?



From our perspective the concerns are NOT ONLY about "whilst a family is going through treatment" . **The challenges for a family are ongoing**.

There has been recent "**headline news**" in UK about **improvements in cancer survival**. For **children there has been a PLATEAU for the past 10 yrs**. Any increase in children's survival has been in the most common leukaemia but in many cancers there SIMPLY HASN'T BEEN IMPROVEMENT.
We are STILL dealing with a KILLER DISEASE.

Children not only die from the **disease –there's worse**…. Children are still **dying from the treatments . In 2015 should we be hearing about children's deaths resulting from treatment side effects? WE DO.**

Living **life in the "main stream**" for some children will never be a reality again as their needs are so great.

Then we have the **issue of late effects**….We may be talking about "survival success" for young patients treated for leukaemia now, but what about in the next 5-10 years or later? We now know cancer treatment at a young age can mean increased chances of 2nd cancers due to chemotherapy.

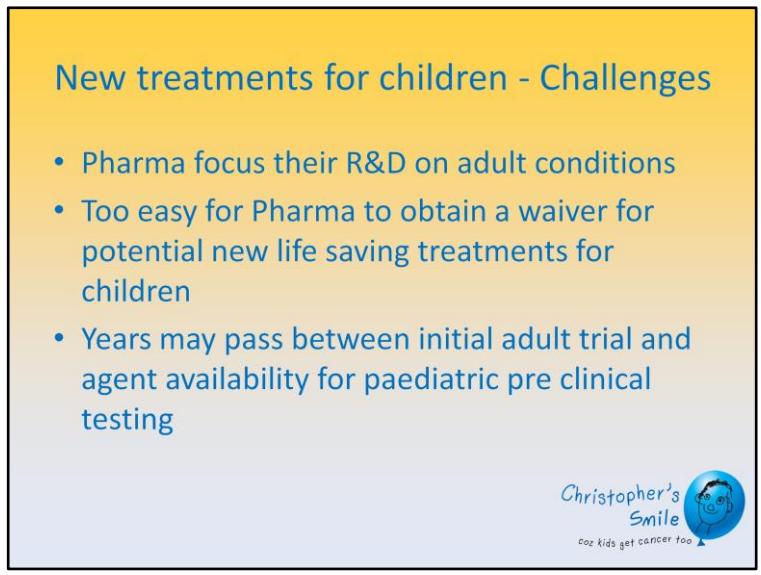
And what about the cost to society of all of this?

I think if **we** ask ourselves honestly what has changed **since our son died; since the introduction of the Paediatric Regulation**. The answer is ….. **VERY LITTLE.**

We believe we are failing our children with cancer.

The Parent community are extremely disappointed with the rate of introduction of new drugs.

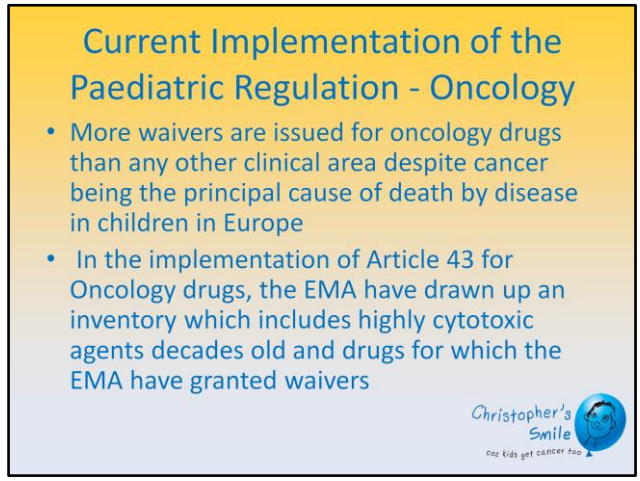
We **are** in a position to make changes - knowledge is there – drugs are there – we need the willingness to act to provide new safe and effective treatments for children which surely is the objective of the Paediatric Regulation.



The pharmaceutical industry focus their development activities towards adult cancers as these present a very large market.

Currently waivers to develop a drug in the paediatric population are issued based on whether an adult disease occurs in children. Modern targeted oncology drugs are designed to target specific abnormalities that could occur in a range of cancers.

Once a waiver to develop a drug in the paediatric population is granted there is no obligation for the drug's manufacturer to supply the drug to paediatric researchers so the potential use in children is not explored.

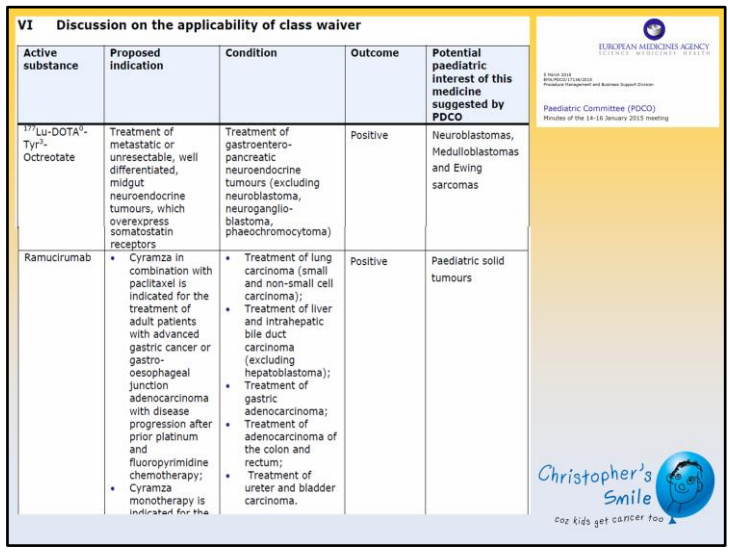


We believe the current implementation of the Paediatric Regulation with respect to the issuance of waivers is not complementary with the objectives of the Paediatric Regulation.

The implementation of Article 43 – the production of an inventory by the EMA of paediatric drugs – contains drugs which have known life threatening side effects and drugs that are currently the subject of a waiver.

The 6 drugs shown here have been granted a waiver by the EMA. At the same time they are listed on the EMAs inventory of drugs in everyday paediatric use.

This does not make sense and begs the question “why?”



VI Discussion on the applicability of class waiver

Active substance	Proposed indication	Condition	Outcome	Potential paediatric interest of this medicine suggested by PDCO
^{177}Lu-DOTA^{0}-Tyr^{3}-Octreotate	Treatment of metastatic or unresectable, well differentiated, midgut neuroendocrine tumours, which overexpress somatostatin receptors	Treatment of gastroentero-pancreatic neuroendocrine tumours (excluding neuroblastoma, neuroganglio-blastoma, phaeochromocytoma)	Positive	Neuroblastomas, Medulloblastomas and Ewing sarcomas
Ramucirumab	• Cyramza in combination with paclitaxel is indicated for the treatment of adult patients with advanced gastric cancer or gastro-oesophageal junction adenocarcinoma with disease progression after prior platinum and fluoropyrimidine chemotherapy; • Cyramza monotherapy is indicated for the	• Treatment of lung carcinoma (small and non-small cell carcinoma); • Treatment of liver and intrahepatic bile duct carcinoma (excluding hepatoblastoma); • Treatment of gastric adenocarcinoma; • Treatment of adenocarcinoma of the colon and rectum; • Treatment of ureter and bladder carcinoma.	Positive	Paediatric solid tumours

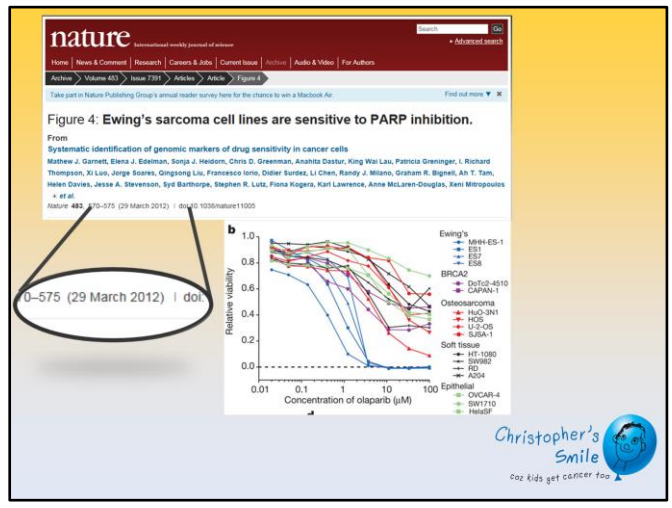
EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

Paediatric Committee (PDCO)
Minutes of the 14-16 January 2015 meeting

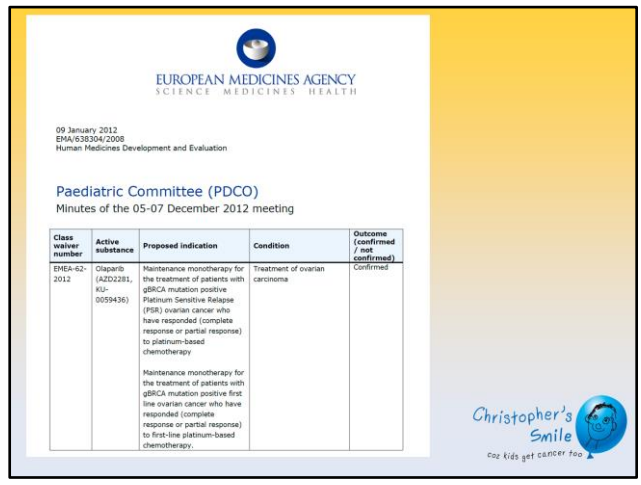
Christopher's Smile
'coz kids get cancer too

If we look at the Paediatric Committee minutes from Jan 2015

Two drugs have been identified as having potential paediatric use yet waivers were issued for both products



The drug Olaparib was the subject of a published article in March 2012 stating that Olaparib could potentially be of therapeutic use for Ewings Sarcoma



EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

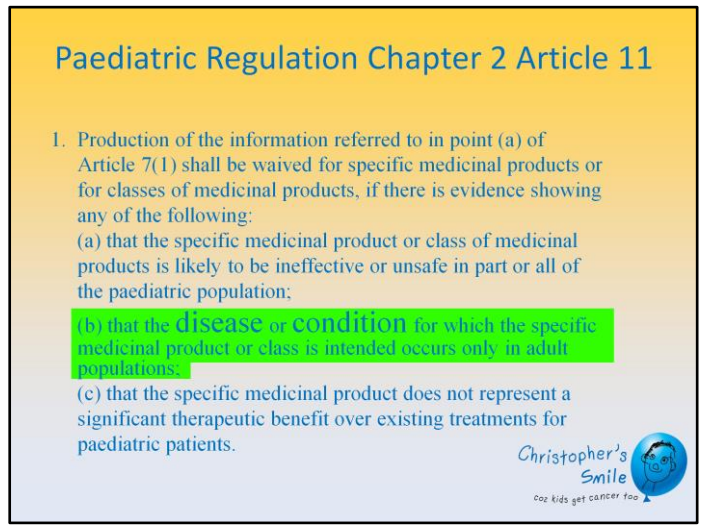
09 January 2012
EMA/638304/2008
Human Medicines Development and Evaluation

Paediatric Committee (PDCO)
Minutes of the 05-07 December 2012 meeting

Class waiver number	Active substance	Proposed indication	Condition	Outcome (confirmed / not confirmed)
EMEA-62-2012	Olaparib (AZD2281, KU-0059436)	Maintenance monotherapy for the treatment of patients with gBRCA mutation positive Platinum Sensitive Relapse (PSR) ovarian cancer who have responded (complete response or partial response) to platinum-based chemotherapy Maintenance monotherapy for the treatment of patients with gBRCA mutation positive first line ovarian cancer who have responded (complete response or partial response) to first-line platinum-based chemotherapy.	Treatment of ovarian carcinoma	Confirmed

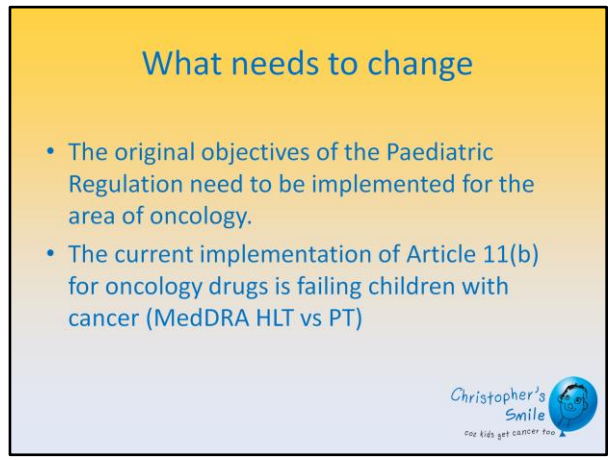
In the following December (2012) the PDCO granted a waiver for Olaparib. Was this in keeping with the objectives of the Paediatric Regulation with regards to 'facilitating the development and availability of medicines for children aged 0 to 17 years'?

This means that children with the deadly childhood cancer Ewings Sarcoma are being denied a potential drug that could extend or save their lives.



The implementation of Article 11 is defined in:
EMA document
Policy on the determination of the condition(s) for a Paediatric Investigation Plan/Waiver (scope of the PIP/waiver)

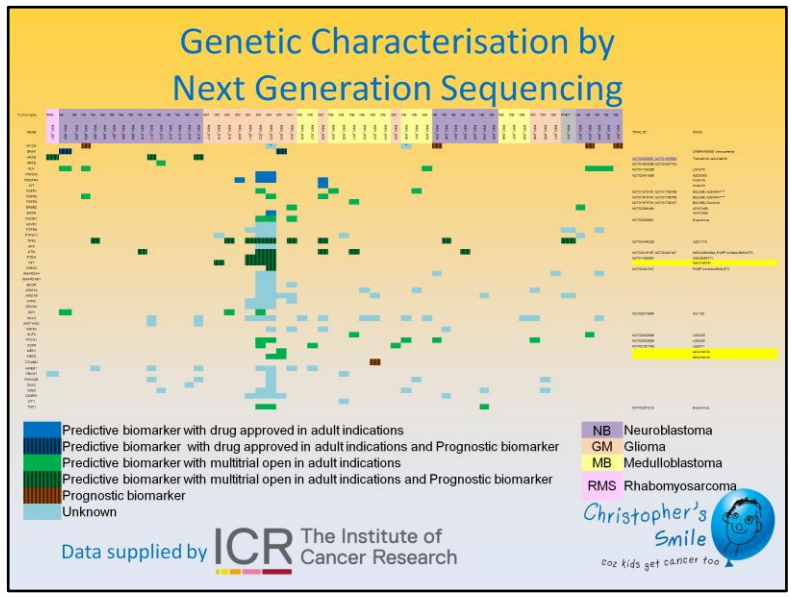
This document specifies at which level in a hierarchical classification the adult condition is defined. We want this level to change to reflect a genetic or biological abnormality.



We believe the Paediatric Regulation's objective is to **improve the health of children in Europe by facilitating the development and availability of medicines for children aged 0 to 17 years.**

This still has to be delivered for children with cancer.

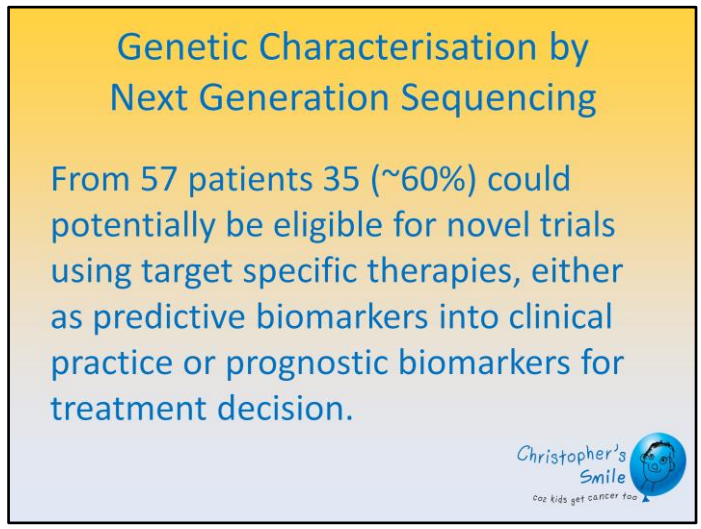
The EMA use the MedDRA classification system for defining the term 'condition' for the granting of waivers. The current classification in our opinion is outdated and needs to change to reflect current scientific advancement especially in the area of genetic classification using Next Generation Sequencing.



Christopher's Smile has recently funded Genetic Sequencing work and this slide shows the output from Next Generation Sequencing on 57 tissue samples.

These samples are from 4 tumour types but they show an amazing difference in genetic abnormalities.

The coloured blocks show genetic abnormalities by sample. On the left is a list of genes and on the right, current trials that are open in adults for either drugs or biomarkers.



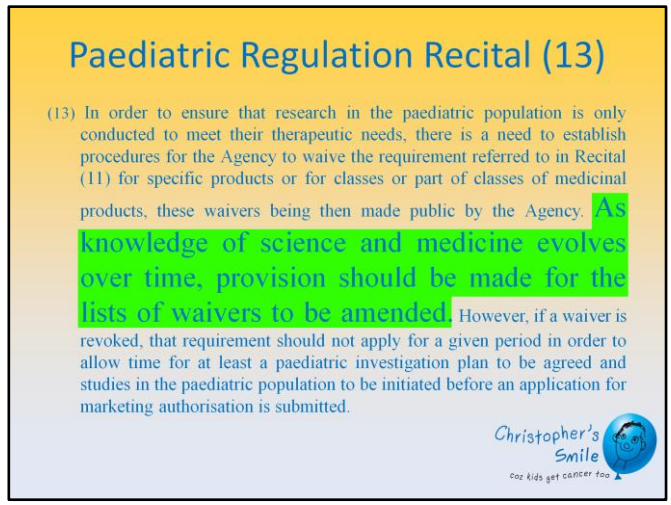
Unless we change the implementation of Article 11 (b) this, and subsequent data will not be taken into account by the EMA thereby denying children access to potentially life saving drugs.

Genetic Abnormalities are terms used in the mass media. Thanks to Angelina Jolie – the world knows about BRCA-1 and BRCA-2 mutations that increases a ladies chance of developing breast and/or ovarian cancer.

Same two genetic faults – two completely different cancers

Yet the EMA still uses a single adult disease as the basis for granting a waiver.

The time has come for us to use the genetic abnormality that a drug targets as the basis for a waiver. Certainly for Paediatric Oncology.



This sentence was obviously a prediction for what needs to happen with drugs for Paediatric Oncology.

We have

The technology - Next Generation Sequencing

We have

An area of unmet need (EMA description of paediatric oncology)

We have

Children dying every day (cancer is the biggest killer of children by disease in Europe)

We have

A Paediatric Regulation whose implementation can be changed

Do we have

The will to change?

To summarise – We want to see actions as a result of today. Actions speak louder than words!

We want to have answers to WHAT, WHO & WHEN with regard to the 3 points on this slide.
Let us not over-complicate what can be done thereby losing precious time.
Want to see the following actions:

We want the European Commission to instruct the EMA & the PDCO to implement Article 11 (b) to issue waivers based on Condition where Condition is defined by biological or genetic abnormality;

We want a full review of the Class waiver list & removal of all diseases where biological or genetic mutation occurs in the paediatric oncology population (not just a cosmetic change currently under consideration)

We want MEPS to work with the Commission to ensure these changes are made at earliest opportunity.

Let's not forget that cancer is still the biggest killer by disease of children in Europe. One thing these children do not have is….time. The time for talk is over.

The call for change has been made many times – but with no success. We now have a REAL CHOICE: Make CHANGES or HAVE a Paediatric Regulation which does NOT meet its original objectives.
Our son would have been 13 years old on Sunday. There wasn't much for us to celebrate.
We want something to celebrate for other children and their families.
We believe they deserve this.