Assessing Supplement Safety — The FDA's Controversial Proposal

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Assessing Supplement Safety — The FDA’s Controversial Proposal

Pieter A. Cohen, M.D.

Recently, a well-respected dietary-supplement company in Utah announced the recall of Zotrex, a sexual enhancement supplement labeled as containing “Ophioglossum polyphyllous.” The problem with Zotrex was twofold: not only is no species of ophioglossum (adder’s tongue) an established dietary ingredient, but Zotrex actually contained sulfoaildenafil, an analogue of sildenafil that has never been tested in humans.† By the time of the recall, the company had distributed nearly 14 million capsules containing, among other things, sulfoaildenafil (under a variety of trade names, including Stiff Nights and OMG), and thousands of customers may have inadvertently consumed the untested analogue. Although Zotrex represented a particularly brazen violation of the law, surprisingly, many new supplement ingredients are introduced into the market as Ophioglossum polyphyllous was, without any regulatory oversight.

Each year, Americans spend more than $28 billion on supplements assuming that they are both safe and effective. More than 100 million Americans consume vitamins, minerals, herbal ingredients, amino acids, and other naturally occurring products in the form of dietary supplements. By law, dietary supplements with established ingredients — ingredients that were sold in the United States before 1994 — may be marketed without any evidence of efficacy or safety. This principle is enshrined in the Dietary Supplement Health and Education Act of 1994 (DSHEA), which created the modern regulatory framework for dietary supplements. DSHEA also stipulates that for new ingredients (those introduced since 1994) manufacturers must provide the Food and Drug Administration (FDA) with evidence supporting a “reasonable expectation of safety.”† Regrettably, this aspect of DSHEA has thus far not been enforced.

Since DSHEA became law, the number of available dietary supplements has skyrocketed from an estimated 4000 to more than 55,000. It is not known how many of the estimated 51,000 new supplements now on the market include novel (post-1994) ingredients, but the FDA has received adequate notification for only 170 new supplement ingredients since 1994 — undoubtedly a small fraction of the ingredients for which safety data should have been submitted. Indeed, both the industry and the FDA acknowledge that many new prod-
ucts have been introduced without any assessment of safety. To rectify the situation, last July the FDA proposed new guidance designed to help it assess the new ingredients.\(^3\)

The proposed guidance clarifies the level of evidence the FDA would use to assess safety. Specifically, the safety of supplements would be evaluated according to three key factors: documented history of use (e.g., in foods or in supplements or herbal medicines sold outside the United States), formulation and proposed daily dose (e.g., more or less than was formerly consumed), and the recommended duration of use (e.g., intermittent or long-term). The FDA’s guidance provides a thoughtful framework for evaluating the safety of new ingredients (see table), and if implemented it would lead to substantial improvement in safety. For example, the FDA would require in vitro, animal, and tolerability testing for products that would be marketed for consumption at doses greater than those historically ingested. The guidance would also clarify what’s considered an old ingredient and what’s considered a new one. Any ingredient prepared or formulated in a novel manner would be considered a new ingredient. For example, a synthetically produced replica of a botanical compound would be considered a new ingredient. (Whether synthetically produced botanical products should be considered supplements at all is a separate, perhaps more important, question.)

The new guidance represents an important step in the right direction; the FDA has decided to implement the law before a public health crisis forces it to do so. However, I do not believe the FDA has gone far enough.

The agency should not accept evidence of historical use in lieu of experimental data. DSHEA requires the FDA to count documented history of use in the United States as proof of safety for old ingredients. For ingredients introduced after 1994, DSHEA gives the FDA discretion to determine whether the documented history of use is adequate to provide a reasonable expectation of safety. History of use is relevant only if one would have expected to detect adverse effects, which is often not the case. The Institute of Medicine has found that “even widespread historical use without documented ill effects is no guarantor of long-term safety.”\(^4\)

However, according to the guidance, companies could introduce a new ingredient on the basis of historical data alone (see table).

Furthermore, the FDA would not require studies in humans for ingredients lacking documented historical use. Under the guidance, not even single-dose tolerability studies in humans would be required for these novel ingredients. Finally, the guidance would not mandate that all data — both favorable and unfavorable — be submitted to the FDA; a manufacturer could perform multiple studies and submit only the favorable data.

Even as it stands now, the guidance has come under attack from the supplement industry. In the months since the guidance was proposed, industry supporters have aggressively petitioned the FDA, which has received more than 146,000 pages of comments, arguing that the guidance is overly stringent and should be withdrawn. According to industry advocates, the requirement for scientific evidence of safety (e.g., in vitro and animal toxicology testing) undermines the law be-
Improving Childhood Vaccination Rates
Douglas S. Diekema, M.D., M.P.H.

Recently, the mother of a young child confessed to me that she didn’t know any parents who were following the recommended immunization schedule for their children. She said that when she told her pediatrician she’d like to follow an alternative schedule, the physician had simply acquiesced, leading her to assume that the recommended schedule had no advantage over the one she suggested.

Despite the phenomenal success of childhood vaccination, thousands of U.S. parents refuse selected vaccines or delay their administration. Some choose not to vaccinate their children at all. These parents are not a homogeneous group: some object to immunization on religious or philosophical grounds, some are avoiding an apparently painful assault on their child, and others believe that the benefits of at least some immunizations don’t justify the risks. Since parents today have little or no experience with vaccine-preventable diseases such as polio, Hemophilus influenzae type b, or measles, they can’t easily appreciate the benefits of vaccination or the risks of not vaccinating.

In 2010, California reported over 9000 cases of pertussis — more than the state had seen since 1947. Of these, 89% occurred among infants younger than 6 months, a group too young to be adequately immunized and largely dependent on herd immunity for protection from infection. Ten of these infants died from their infection.

At first glance, U.S. vaccination rates appear reasonable: coverage among children entering kindergarten exceeds 90% for most recommended vaccines. A closer look, however, reveals substantial local variation. In Washington State’s San Juan County, for example, 72% of kindergartners and 89% of sixth graders are either non-compliant with or exempt from...