



# Autoimmunity Research Foundation

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## Presentation on the NIH 'Public Trust Initiative'

Submitted to the NIH Director's Council of Public Representatives, April 28, 2005

by: Dr. Trevor G Marshall, on behalf of the A.R.F. Board of Directors

revision 1.2 April 24, 2005

Over the past few years, the officers of this Foundation have been in close contact with the National Institutes of Health, particularly the Office of Rare Diseases (ORD) and the National Heart, Lung and Blood Institute (NHLBI). Our task would have been much easier if the COPR's Public Trust Recommendations were already in place. This submission is intended to emphasize the importance of quickly implementing the COPR's Recommendations, to request that attention be paid to guiding NIH policy when the science is equivocal, and to suggest more rigor in NIH's use of 'consensus statements.'

**Sarcoidosis** is a member of the class of diseases called 'idiopathic,' those having no known cause, and no known cure. It is a silent killer, having recently taken the lives of NFL star Reggie White, Chicago's NBC5 sports anchor Darrian Chapman, and the noted cardiologist Mark E. Rosenthal. Sarcoidosis also destroys careers and families. Actor Bernie Mac and actress Tisha Campbell-Martin recently announced that they are struggling against this disease. Overall, about 134,000 Americans are having their lives diminished and destroyed by Sarcoidosis.

In 2001 we identified that Sarcoidosis is caused by a special class of antibiotic-resistant bacteria. We published a detailed scientific pathogenesis, and put together a large community-based study of a novel anti-bacterial therapy. The study cohort is recruited and coordinated using the Internet. Last month alone, over 40,000 individuals visited our two Internet study sites.

We recently held an International conference in Chicago, where it was confirmed that our therapy is, in fact, effecting a 'cure' from Sarcoidosis, and further, that exactly the same anti-bacterial therapy is also proving an effective treatment for many of the other chronic idiopathic Th1 'autoimmune' diseases, including Chronic Fatigue Syndrome.

Historically, the NIH has designated the Division of Lung Diseases of the National Heart, Lung and Blood Institute (NHLBI) to oversee Sarcoidosis research, as the disease has some similarity to Tuberculosis, and therefore has often been diagnosed by

pulmonologists following an abnormal chest-xray. It is, however, a systemic disease, and its effects on the psyche, the eyes, the lymph nodes, the liver, the kidneys, the muscles, the spine and the heart, are just as profound as its steady destruction of the lungs.

The NHLBI has been unsuccessful in shepherding Sarcoidosis research, in that the available therapies are ineffective, and have not significantly changed in half a century.

However, Sarcoidosis is somewhat unique amongst the idiopathic diseases, because Congress has precisely defined the duties of the NIH in executing the Public Trust. The Rare Diseases Act of 2002 (The Act) defined NIH's goals (*inter alia*)

1. to increase the national investment in the development of diagnostics and treatments for patients with rare diseases and disorders
2. to promote and encourage the establishment of a centralized clearinghouse for rare and genetic disease information that will provide understandable information about these diseases to the public, medical professionals, patients and families.

We would submit that the NHLBI has failed to pay attention to either of these express goals, let alone effectively implement them.

The DVD record of our conference shows Dr. James Kiley, Director of the NHLBI's Division of Lung Diseases, explaining that NIH's mission extends from the "beginning of time" to "the end of time" and covers "many, many lifetimes." During this period NIH will distribute money to academic researchers who submit grant applications which have been judged (by their peers) as having the potential to advance medical "knowledge."

There is no focus on The Act's goal of developing "diagnostics and treatments," just on advancing "knowledge" and advancing the investigators' "career goals," with NHLBI exercising little or no directional oversight.

Further, it can be argued that a 'cure' is something NHLBI is **not** seeking, as such an outcome would terminate the organization's *raison d'être* before "the end of time."

At our conference it was amazing to see the attendees, both physicians and patients, bubbling with excitement. We had delegates from Europe, Canada and the United Kingdom. There were presentations and panels discussing both the science and the process of recovery from this deadly disease. Yet Dr. Kiley apparently saw and heard nothing. Nobody from NHLBI picked up the telephone and asked "What's going on? Tell us more."

When the foundation eventually phoned Dr. Kiley, we found that there will be no follow-up, that NHLBI has an anachronistic method of conducting its business, and it does not feel under any pressure to listen to the community. **NHLBI sees no duty to investigate whether a cure for any disease has, or has not, been found.** NHLBI perceives its business as purely to fund worthwhile academic research. NHLBI feels no sense of urgency. NHLBI sees no direct role in responsibility for the Public Health, or for health education, or to the Americans suffering from this dreadful degenerative disease.

This shows how important it is to implement Recommendation #1 of the Public Trust Initiative, namely, "Incorporate into the NIH mission and philosophy that it values the involvement of the community in research, and create language that expresses this value." It also shows the degree of institutional resistance that may be expected to the Public Trust Initiative's primary goals of providing "opportunities to participate in priority setting and other NIH activities" and "opportunities to participate in clinical research." It is important to remember that NHLBI is the NIH's second largest Institute.

*Please understand that our analysis of Dr. Kiley's speech and actions in no way implies that he himself may hold to the goals he was presenting on behalf of the NHLBI, as he himself may have an entirely different set of values than he was bound to present in his professional persona. Further, the Foundation greatly appreciates Dr. Kiley's offer to speak at our conference, especially as it came after we had been excluded from NHLBI's PIO meetings.*

The NHLBI has also failed to execute on the second goal, that of patient and physician education. Attached is the booklet "Facts about Sarcoidosis," the only publication that the NHLBI is disseminating to fill the educational void. This booklet is riddled with errors and bad science. Physicians who read it are encouraged not to treat their patients, but to wait for the disease to go away, and, when it does not spontaneously resolve, tell the patient that they are one of the unlucky 'few' who have developed the 'chronic form' of the disease.

Yet NHLBI's own huge "ACCESS" study (conducted between 1994 and 2002) found that Sarcoidosis does not go away, with or without treatment, and noted that 'end-stage' disease can be expected in 10-20 years from diagnosis. None of this is in the "Facts about Sarcoidosis" booklet.

During 2003 and 2004 this foundation carefully documented these errors, and asked the NHLBI to correct them (see attachment 2). The NHLBI's response has been to exclude us from the ongoing document revision process, saying it couldn't afford the manpower to look through the studies we had cited.

When we produced our own leaflet, highlighting key conclusions from the "ACCESS" study that NHLBI had overlooked, we were told that the NHLBI would not help us distribute that leaflet (despite the apparent express intent of The Act).

COPR Recommendations #5 and #9 would have made clear NHLBI's duty to share the best available scientific knowledge with the public, and especially to make sure that patients are honestly informed of the **true** prognosis of this terrible disease, and not misled to believe that they have contracted a mild condition.

Now let me address the issue of **outright betrayal** of the public trust.

In August 2003 we formally notified NHLBI that we had developed a curative therapy for Sarcoidosis, and that the therapy had been derived from understanding the cause of the disease, antibiotic-resistant bacterial pathogens.

We are not the first research team to suspect a bacterial pathogenesis, although we are the first to develop a curative therapy. Our results should have been no surprise to NHLBI.

NHLBI refused to discuss the possibility that Sarcoidosis could be caused by antibiotic-resistant bacteria (see Attachment 2, pp 4/5). They also refused to recognize that the ACCESS study had identified that the disease **appeared to be communicable**, especially transmission between husband and wife. No warnings were issued that spouses or families could be at risk, even though transmission of Sarcoidosis via transplanted organs has been reported several times.

The NHLBI has thus allowed Sarcoidosis to proliferate unchecked, and untreated. We have just been told that NHLBI is apparently saying that, over the last two years, Sarcoidosis has spiraled out of control, and, according to the NHLBI, there may now be more than 200,000 Americans with this disease.

200,000 is the threshold of The Rare Diseases Act, and, if confirmed, this alleged growth in disease prevalence would give back to the NHLBI total control over money for Sarcoidosis research, freeing it from responsibilities defined in the Rare Diseases Act.

We believe that, if the COPR's recommendations were already in place, that NHLBI staff would never have contemplated attempting to perpetrate such politics. No Institute should be rewarded for compromising the health of our community.

### **In summary,**

This Foundation sees no way that the NIH can regain the trust of our community unless it starts producing tangible improvement in our members' health. Our community should not have to struggle to find physicians willing to prescribe the antibiotics necessary to start their recovery, especially when those antibiotics are freely prescribed for teenage Acne. But they are not available, it seems, when needed for this deadly, disabling, disease.

NIH should understand that it must not base policy solely upon the advice of consultants, even 'industry experts,' who may have a financial conflict-of-interest which reduces their incentive to disturb 'the status quo.' This is especially true in the Rare Diseases, when only a handful of 'experts' might be available. The NIH must understand that **these**

**'experts' represent failure** (else the disease would no longer be idiopathic, and a cure would be available). Scientific rigor must be applied to any and all 'consensus' statements.

NIH must be more inclusive, and not exclusive. Significant scientific controversies must be reported to the public, and not swept under the rug. We do not see mention of this issue (reporting controversies) in The Recommendations, and we would urge the Committee to consider guidelines to be followed when the science is equivocal.

We affirm that the NIH needs to become pro-active, defining and executing a viable operational plan that is focused on achieving **measurable** results.

It is clear that the public desperately needs a health agency which encourages the development of **curative** treatments, to balance PhRMA's focus on more profitable **palliative** treatments. Although Recommendation #3 mentions that the public is seeking 'a cure,' we believe that this needs to be emphasized, as none of the NIH staff with whom we have been negotiating would contemplate setting 'cure' as a research goal, and when confronted with our 'cure,' they just don't know what to do.

We believe that the NIH and the Community need to join forces to develop plans for rapid clinical investigation of apparently successful interventions, especially where established NIH Institutes do not seem to have any interest in conducting those evaluations. At the very least, the Community needs assistance to complete comprehensive analyses of study results. We believe that a wide range of diseases are probably in need of such procedures. We offer Sarcoidosis as a model for all diseases with an intervention in need of rapid clinical evaluation. Perhaps this could be a Trans-NIH Roadmap activity to re-shape the NIH clinical research emphasis, and develop an NIH rapid-response clinical investigation unit to oversee such activities.

Respectfully submitted,

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/pro/ Autoimmunity Research Foundation Board of Directors:

Trevor G Marshall, PhD

Frances E (Liz) Marshall, RPh

Belinda Fenter, BS

Meg Mangin, RN

Attachments:

1. Bio – Dr Trevor Marshall - together with a summary of recent papers
2. Partial tabulation of correspondence between the Foundation and NHLBI
3. "Recovering from Chronic Disease" 4 DVD transcript of ARF's Chicago Conference
4. "Sarcoidosis, lessons learned from the NIH ACCESS Study"
5. "Facts About Sarcoidosis" NHLBI booklet

Principal Investigator/Program Director (Last, First, Middle): MARSHALL, Trevor Gordon

**BIOGRAPHICAL SKETCH**Provide the following information for the key personnel in the order listed on Form Page 2.  
Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME MARSHALL, Trevor Gordon		POSITION TITLE Principal Investigator	
EDUCATION/TRAINING <i>(Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)</i>			
INSTITUTION AND LOCATION	DEGREE <i>(if applicable)</i>	YEAR(s)	FIELD OF STUDY
University of Adelaide, Adelaide, South Australia	B.E.	1974	Engineering (statistics)
University of Adelaide, Adelaide, South Australia	M.E.	1978	Engineering
University of Western Australia, Perth, Australia	Ph.D.	1985	Bioengineering

**A. POSITIONS AND HONORS****Citizenship**

Australian Citizen, United States Greencard (Permanent Resident Alien)

**Chronological Employment**

1974: Temporary Tutor, University of Technology, Lae, Papua New Guinea

1975-1981: Lecturer (equiv. to a US 'Tenure Track Professor'), Curtin University (W.A.I.T.), Perth, Western Australia

1981-1982: Biomedical Engineer, Nucleus Limited (a division of Medtronic Inc.), Sydney, Australia. (Nucleus developed the original Cochlear Implant)

1982-1984: Consultant, Cambrian Systems and Consultants, Calabasas, California (Cambrian specialized in design of mass storage for computer systems)

1984-1988: Chief Technical Officer, Definicon Systems Inc, California. (Definicon specialized in the design of high-powered computers and software for medical and scientific research)

1988-2001: Chief Executive Officer, Chief Technical Officer, YARC Systems Corporation, California. (YARC is a publicly traded high-tech technology company specializing in Internet and Publishing technologies)

2001-2004: sabbatical, researching the pathogenesis of Autoimmune Disease

2004-date: President and Director, Autoimmunity Research Foundation, Thousand Oaks, California

**Affiliations**

1. Immediate Past Chairman,  
Institute of Electrical and Electronic Engineers, Engineering in Medicine and Biology, Buenaventura Chapter
2. Managing Editor, Journal Of Independent Medical Research ([www.JOIMR.org](http://www.JOIMR.org))
3. Contributing Editor, BYTE.com (published by CMP Publications Inc)

**B. SELECTED PUBLICATIONS****Selected Recent Papers**

1. Marshall TG, Fenter B, Marshall FE: **Antibacterial Therapy Induces Remission in Sarcoidosis**. Herald MKDTS 2004g; Volume III: Release 1. (The Journal of the Interregional Clinical-Diagnostic Center, Kazan, published in Russian translation). Invited Paper. Special issue on Sarcoidosis. ISSN: 1726-6149
2. Marshall TG, Marshall FE: **Sarcoidosis succumbs to antibiotics - implications for autoimmune disease**. Autoimmunity Reviews,2004; 3(4):295-3001. PMID: 15246025
3. **La thérapie antibactérienne induit une rémission de la sarcoïdose**. Réseau International de Soutien des Malades de la Sarcoïdose. Available from URL <http://tinyurl.com/6al6g>, Last Accessed April 2, 2005.
4. Marshall TG, Fenter B, Marshall FE: **Putative Antibacterial Mechanisms for Angiotensin Receptor Blockers**. JOIMR 2004;2(2):1. Available from URL <http://www.joimr.org/phorum/read.php?f=2&i=53&t=53>
5. Marshall TG, Marshall FE: **Sarcoidosis succumbs to antibiotics - implications for autoimmune disease**. Autoimmunity Reviews,2004; Supplement 2:55 (Abstracts of 4th International Congress on Autoimmunity)
6. Marshall TG, Marshall FE: **Antibiotics in Sarcoidosis – Reflections on the First Year**. JOIMR 2003;1(3):2 Available from URL <http://www.joimr.org/phorum/read.php?f=2&i=38&t=38>
7. Marshall TG, Marshall FE: **Significance of Interferon-Gamma in the Th1 Immune Reaction**. JOIMR 2003;1(3):1 Available from URL <http://www.joimr.org/phorum/read.php?f=2&i=32&t=32>
8. Marshall TG: **Brown, et al, ACCESS Study finds Bacterial Pathogens in Sarcoidosis Patients**. JOIMR 2003; 1(2):2 Available from URL <http://www.joimr.org/phorum/read.php?f=2&i=26&t=26>
9. Marshall TG, Marshall FE: **The Science points to Angiotensin II and 1,25-dihydroxyvitamin D**. JOIMR 2003;1(2):3 Available from URL <http://www.joimr.org/phorum/read.php?f=2&i=24&t=24>

**Selected Recent NetPrint Publications and Letters**

1. Marshall TG, Marshall FE: **New Treatments Emerge as Sarcoidosis Yields Up Its Secrets**. Clinmed 2003 Jan 27; 2003010001 Available from URL <http://clinmed.netprints.org/cgi/content/full/2003010001>
2. Marshall TG, Marshall FE: **Remission in Sarcoidosis**. Clinmed 2002 Aug 22;2002080004 Available from URL <http://clinmed.netprints.org/cgi/content/full/2002080004>
3. Marshall TG: **Puzzling Vitamin D results**. CMAJ 2002 Oct 15;167(8):849 Available from URL <http://www.cmaj.ca/cgi/content/full/167/8/849>
4. Marshall TG, Marshall FE: **Valsartan Dosing Regime Modulates Psychotic Events in Two Sarcoidosis Patients**. Clinmed 2002 Aug 29;2002080006 Available from URL <http://clinmed.netprints.org/cgi/content/full/2002080006>
5. Marshall TG: **Sarcoid Inflammation has a Primary, Homogeneous, Bacterial Pathogenesis**. CHEST eLetter, 4 Aug 2003, from URL <http://www.chestjournal.org/cgi/eletters/124/1/6>
6. Marshall TG: Brown, et al, **ACCESS Study finds Bacterial Pathogens in Sarcoidosis Patients**. CHEST E-letter, Feb 12,2003, available from URL <http://www.chestjournal.org/cgi/eletters/123/2/413>
7. Marshall TG, Marshall FE: **The Science points to Angiotensin II and 1,25-dihydroxyvitamin D**. CHEST eLetter, Feb 6, 2003 available from URL <http://www.chestjournal.org/cgi/eletters/123/1/18>
8. Marshall TG, Marshall FE: **Vitamin D may be Harmful in Rheumatic Disease**. BMJ Rapid Response Jan 13,2003, Available from URL <http://bmj.com/cgi/eletters/326/7379/12/b>

**Selected Early Papers on Insulin-Glucose Metabolism Modeling, Infertility and Cryptorchidism**

1. Marshall TG, Mekheil N, Jackman WS, Perlman K, Albisser AM: **New Microprocessor Based Insulin Controller**. IEEE Transactions on Biomedical Engineering, Vol BME-30, No 11, Nov 1983, pp 689-695 PMID: 6662523
2. Keogh EJ, MacKellar A, Mallal SA, Dunn AG, McColm SC, Somerville CP, Glatthaar C, Marshall T, Attikiouzel J: **Treatment of cryptorchidism with pulsatile luteinizing hormone-releasing hormone (LH-RH)**. J Pediatr Surg. 1983 Jun;18(3):282-3 PMID: 6135766



# Autoimmunity Research Foundation

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July 14, 2004

Barbara Alving, MD, MACP  
Acting Director, NHLBI/NIH  
31 Center Drive  
Bethesda, MD 20892

Via Fax Transmission  
(301) 592-8563

Dear Dr. Alving,

Thank you for our phone conversation on July 1, 2004, following up on our discussion of sarcoidosis on May 4, 2004. One of the things we discussed was remission of sarcoidosis, as presented in NIH Publication No. 02-5060, the Sarcoidosis Fact Booklet. The Booklet contains these comments about the prognosis of sarcoidosis, without citing any clinical studies supporting those statements:

"Sarcoidosis is usually a mild condition that does not result in lasting harm to tissues. In most patients, the inflammation that causes granulomas get better with or without treatment and the lumps go away." page 1

"The course of the disease varies: In most persons, the disease goes away over time." p.3

"Most people with sarcoidosis have no symptoms." p. 3

"Often, no treatment is needed - up to 60% of those with sarcoidosis receive no therapy." p. 6

"Routine care usually lasts for 2-3 years." p. 7

"Most often, the disease goes away within a few years." p. 12

"About 25 percent of all patients have the chronic form of the disease." p. 12

There are clinical studies reporting much lower rates of remission in sarcoidosis than 60%. There are no clinical studies reporting remission rates anywhere near 60%. The ACCESS study, conducted at 10 centers in the US, reported that, among recently diagnosed pulmonary sarcoidosis patients, **the majority of those were the same or worse two years after their diagnosis**, based on pulmonary function tests and dyspnea (refer to the data in table III of the ACCESS report). Only 22% improved during the two-year follow-up period, regardless of therapeutic intervention, and there were no reports of patients being free of the disease.

Two year prognosis of sarcoidosis: the ACCESS experience.

Sarcoidosis Vasc Diffuse Lung Dis. 2003 Oct;20(3):204-11.

PMID: 14620163 [PubMed - indexed for MEDLINE].

The Gottlieb study, which found a 32% rate of spontaneous remission in 337 patients tracked over four years, was also not mentioned in the Fact Booklet, nor was the 1996 British Thoracic Society



Sarcoidosis Study. The British study indicated that, of 149 patients with pulmonary radiography indicative of sarcoidosis, 58 untreated patients (39%) showed radiographic improvement over six months. These are significantly fewer remissions than what was projected in the booklet, as noted above.

Dr. Alving, the first thing that patients deserve to know, once they are diagnosed with sarcoidosis, is what their prognosis is. All treatment decisions are based on their perspective of what they are facing. The NHLBI Booklet is telling patients that 60% of patients require no treatment, and that sarcoidosis usually goes away within a few years. That statement conflicts with results from the ACCESS study, the largest and most comprehensive study of sarcoidosis ever funded by NIH. The ACCESS study followed newly diagnosed patients. How can patients make informed treatment decisions, unless they are given the facts about their prognosis? When sarcoidosis doesn't go away in a few years, patients believe their case is one of the more rare worst-case scenarios, leading to depression and despair. Additionally, the lack of prompt treatment exacerbates the spread of inflammation.

The Booklet's representation about spontaneous remission is only one issue that has been discussed with representatives of NHLBI, and so far, no one in NHLBI has presented scientific evidence either supporting the Booklet information or refuting the citations presented to NHLBI contradicting the Booklet information.

Communications with NHLBI pointing to other errors and omissions in the Booklet, and any responses from NHLBI, are summarized below. The contents and citations in my letters are reliable, because they were thoroughly researched and studied.

-**Dec. 9, 2003** letter to Jonelle Druggan, PhD, MPH, addressing the Booklet's guidance on prognosis, need for treatment and epidemiology and asking about the NHLBI process for input and review of additional information.

-**Dec. 15, 2004** received a phone call with Herbert Reynolds, MD, and Hannah Peavy, MD both on the line. We discussed the issues raised in my Dec. 9 letter, and it was agreed that I would supply citations for review of the issues, for NHLBI's response.

-**Dec. 18, 2003** letter to Herbert Reynolds, MD, and Hannah Peavy, MD, in response to our phone conversation, informing them that the references they had supplied in our phone conversation did not provide scientific data supporting the Booklet statements about remission.

-**Dec. 19, 2003** letter to Herbert Reynolds, MD, and Hannah Peavy, MD, detailing the errors and omissions in the Booklet, as we had discussed by phone, and including detailed citations conflicting with the Booklet information. The Booklet issues were:

- guidance about the rate of autonomic remission in sarcoidosis
- omission of the Nov. 2002 CDC report finding mycobacteria in the tissue from a majority of sarcoidosis patients
- omission of reports that antibiotic therapy induces remission of sarcoidosis
- omission of reports indicating that drugs listed as treatments are ineffective and associated with relapse
- omission of any warning that neglecting to control the abnormal and unregulated production of the hormone 1,25-dihydroxyvitamin D by activated macrophages in sarcoidosis can lead to proliferation of macrophage differentiation, photo-sensitivity, hypervitaminosis D, endocrine irregularities, and bone resorption
- omission of the significance of controlling the proliferation of Angiotensin II on the

progression of fibrosis and the production of TNF-alpha and

- omission of information that 1,25-Dihydroxyvitamin D is a unique marker for the Th1 inflammation of sarcoidosis.

Based on the gravity and number of errors and omissions, too much information is unreliable for guidance. I requested the Booklet be withdrawn until corrections are made.

**-Jan. 5, 2004** letter to Herbert Reynolds, MD, and Hannah Peavy, MD, addressing two other statements in the Booklet, asking for the scientific studies supporting these assertions, and pointing to scientific studies that contradict the statements:

- that "Sarcoidosis is now known to be a common disease" (p. 1) and

- that, "in fact, sarcoidosis is the most common chronic fibrotic interstitial lung disorder." (p1)

**-Jan. 13, 2004** follow-up letter to Herbert Reynolds, MD, including my Jan. 5, 2004 letter, in case it was lost after the holidays.

**-Feb. 6, 2004** letter from James Kiley, Ph.D., saying NHLBI staff had reviewed the concerns, "compared them with scientific literature, including articles that you specifically mentioned; and discussed your objections with expert researchers and clinicians. We concluded the generalizations made in the booklet provide an appropriate perspective on sarcoidosis. We strongly believe that the document as it stands serves an important need and constitutes a useful tool for educating patients, their families, and the general public. It is not intended as a review of the literature or as a guideline for physician practice. As with other areas of science and medicine, many controversies exist, and contradictory findings among researchers can be found. However, we believe that discussion of these issues is beyond the scope of a brief publication developed to provide an overview for people who are just beginning their search for information about this complex and mystifying disease."

**-Feb. 8, 2004** letter responding to James Kiley, Ph.D, noting that it is important to separate anecdote from evidence-based medicine when publishing under the banners of NHLBI, NIH and HHS. I had pointed out scientific errors, and Dr. Kiley responded to characterize these as "controversy," without citations to support that any controversy actually exists. Certainly the Fact Booklet never mentioned any controversy. The booklet provided no disclaimer that it is intended for use by patients, and not doctors. Consensus opinion is anecdotal, and, when matched with a well-conducted, evidence-based study, is not sufficient to generate a "controversy." My efforts have been to address the issues material to the understanding and treatment of sarcoidosis. These had been presented as facts in the Fact Booklet, where there should be no room for controversy, or where controversies should have been noted. I looked forward to citations from the staff or the experts, showing that a reasonable certainty of controversy exists in the issues raised, and also to a plan and timetable ensuring that errors will be corrected and controversies will be noted.

**-Feb. 17, 2004** phone call to James Kiley, Ph.D., but he was out sick.

**-Feb. 19, 2004** follow-up letter to James Kiley, Ph.D., asking when to expect a reply.

**-Feb. 19, 2004** note from James Kiley, Ph.D., saying that staff was still evaluating the points made.

**-March 1, 2004** phone call to James Kiley, Ph.D., but he was out sick.

**-March 2, 2004** letter to James Kiley, Ph.D, hoping he gets well and I am looking forward to working on issues related to the Booklet.

**-March 4, 2004** phoned James Kiley, Ph.D., but was told he was in a meeting and wouldn't be back in the office that day. I left a voice message saying I was looking forward to working on the issues in the Booklet.

**-March 4, 2002** phoned Lawrence Friedman, MD, Assistant to NHLBI Director. Spoke to Cindy Hendersgraff, assistant, who said she has two bosses: Friedman and Roth, and she would have someone call me back that day, but no one did. My question was regarding the ACCESS study, I

told Cindy.

**-March 5, 2004** phoned the number for Lawrence Friedman, MD, and told Cindy that no one had called me. Cindy said she had discussed my concerns with both Roth and Friedman, and that Dr. Carl Roth was handling my concerns. I told her I didn't know who Dr. Roth was. She said, "He is Dr. Kiley's boss." I told her I didn't see how my concern could be addressed without someone first calling me. I asked for and got Dr. Roth's email address.

**-March 5, 2004** letter to Carl Roth, M.D., Ph.D., LLM, noting that I'd learned he was handling my concern, and that, since I'd been told that he was Dr. Kiley's boss, I wanted to note that my concern was not related to Dr. Kiley's handling of issues related to the NHLBI Sarcoidosis Booklet, which is what we had been working on.

**-March 10, 2004** phone call to Carl Roth, MD, Ph.D. His assistant said he is in a meeting. I left my phone number.

**-March 12, 2004** letter from James Kiley, Ph.D., stating, "I want to assure you that my February 6 response to your emails of December 18, 2003, December 19, 2003 and January 5 was based on peer-reviewed sarcoidosis literature and not on anecdotes. As you know, the sarcoidosis literature is extensive and replete with contradictions. Therefore, before replying to you on February 6, we once again examined the literature and consulted with experts in sarcoidosis to determine if the information provided in the Facts about Sarcoidosis booklet (NIH publication 02-5060) was appropriate. We concluded it was."

**-March 15, 2004** phone call to Carl Roth, MD, Ph.D. Cindy Hendergraft said he was out to lunch. I left my phone number.

**-March 15, 2004** letter to Carl Roth, M.D., Ph.D., LLM, explaining that my concerns were "being investigated" without anyone contacting me

**-March 18, 2004** letter to Carl Roth, M.D., Ph.D., LLM, reviewing our phone conversation and asking for additional data related to the two-year follow-up of ACCESS patients that would explain the report summary

**-March 30, 2004** letter to Howard Gadlin, Ph.D., NIH Ombudsman, asking for help connecting to NHLBI

**-March 30, 2004** phone call received from Howard Gadlin, Ph.D., NIH Ombudsman, notifying us our concerns are outside his jurisdiction. When asked, he suggested we contact Dr. Barbara Alving, (acting) director of NHLBI.

**-March 30, 2004** letter to Raynard S. Kington, M.D., Ph.D., NIH Deputy Director, seeking to establish a scientific discussion of the issues raised regarding the NHLBI Booklet.

**-April 27, 2004** letter from Raynard S. Kington, Md, Ph.D., NIH Deputy Director, noting that senior Institute staff have responded appropriately to issues raised, that NHLBI remains open to objective discussions about sarcoidosis research, and that I should direct any further comments or concerns to Dr. Barbara Alving, Acting Director of NHLBI.

I will be happy to supply copies of any correspondence upon request.

I have read NIH fact booklets about other diseases, and their presentation stands in stark contrast to NIH Publication No. 02-5060. Other NIH booklets honestly, and openly describe controversial scientific points, including citations to the supporting scientific studies, and noting strengths or weakness in studies, as well as viewpoints.

I am very concerned that you indicated during our last conversation that neither myself, nor my colleagues, would be included in any review of the brochure because we would want to "promote

our antibiotic ideas." Those "antibiotic ideas" represent a significant leap in knowledge about this disease, a leap acclaimed by experts. Surely you would want to **include** in the deliberative process all those with knowledge of this disease, **especially** those whose peer-reviewed publications are at variance with the current NHLBI document?

There are more patients currently improving and in remission, thanks to Dr. Marshall's antibiotic ideas, than were tracked during the entire ACCESS study follow-up. I am amazed you are not aware of the impact Dr. Marshall's work is having on the Sarcoidosis community. Dr. Marshall's latest paper indexed on PubMed can be found at:

"Sarcoidosis succumbs to antibiotics-implications for autoimmune disease."

Autoimmunity Reviews 2004 Jun;3(4):295-300.

PMID: 15246025 [PubMed - in process]

Please contact me if you have any question about information in any of our communications, or if you would like further information. I am looking forward to speaking with you about these issues, as we agreed, on July 21, 2004.

Sincerely,

Belinda Fenter, BS  
Director, Autoimmunity Research Foundation  
1809 Saxony Rd.  
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