From: LEFKOWITH, JAMES B. [PHR/1825]
Sent: Friday, September 08, 2000 8:56 AM
To: ARBE, EMILIO [PHR/5430]
Subject: RE: CLASS Data

Emilio-
I think that it might be a good idea for you to discuss your concerns with me directly before making any more statements regarding the issues that concern you. I believe that you do not fully understand the data and the analysis.
Jim Lefkowith

-----Original Message-----
From: ARBE, EMILIO [PHR/5430]
Sent: Friday, September 08, 2000 6:57 AM
To: SHIELD, MICHAEL J [PHR/5430]; JADERBERG, MAGNUS [PNU/GBMKEPO1]; FORREST, DAVID [PNU/GBMKEPO1]
Cc: LEFKOWITH, JAMES B. [PHR/1825]; HAMELIN, PAUL R. [/1820]
Subject: RE: CLASS Data

The results I quote are lifted from the study report. I will double-check that all the figures are correct and I haven't made any gross misinterpretations. Emilio

-----Original Message-----
From: SHIELD, MICHAEL J [PHR/5430]
Sent: Thursday, September 07, 2000 8:23 AM
To: JADERBERG, MAGNUS [PNU/GBMKEPO1]; FORREST, DAVID [PNU/GBMKEPO1]
Cc: LEFKOWITH, JAMES B. [PHR/1825]; HAMELIN, PAUL R. [/1820]; ARBE, EMILIO [PHR/5430]
Subject: RE: CLASS Data

EXHIBIT
28
1-12-07 DS

Magnus,
I haven't seen these data presented in this way before so I cannot judge properly the validity of what Emilio is stating. I would agree that the analyses reported in JAMA are not exactly as stated in the original protocol. There are though I understand from the R&D group good reasons for what has been done. In my notes from the presentation made here last week by Jim Lefkowith I see that he used the term "refined" as applied to the subsequent data analyses. The six months issue, as explained by Jim was to set a point which all patients had completed (taking into account earlier withdrawals up to that time). I don't know whether you were at the EULAR conference(June 2000) but if you were and attended the Searle/Pfizer symposium then you would have heard the considerable debate there was re what constituted "intent-to-treat". In a true "intent-to-treat" there is actually a need to follow-up ALL patients for the ENTIRE treatment period (whatever period is defined) whether or not they have withdrawn from the original test medications. In practice this is rarely done and these debates about "intent-to-treat" are largely semantic ones. In the real world one wants to know, beyond reasonable doubt, whether or not a treatment produces a desired effect and whether or not there are undesirable effects of any consequence.

Emilio's statements that there are no differences between Celebrex and the comparator NSAIDs re serious GI events I find somewhat surprising, and as indicated above I haven't seen the data portrayed in this way before. From what I have seen I am satisfied that in the non-aspirin group (which comprises almost 80% of the patients treated and which is comparable to the VIGOR study in the sense that patients in the Merck study did not use aspirin, except by protocol violation)
that we have a statistically significant outcome for Celebrex versus Ibuprofen and Diclofenac. When combining the results for both NSAIDs one does not see statistically significant differences for Celebrex vs NSAID in the apsirin taking population. My only comments about that are twofold. First, that is what one would expect in that Celebrex doesn't have any protective effect against aspirin (unlike say the misoprostol component in Arthrotec) so I would expect to see exactly the same sort of result in takers of a drug like paracetamol which as far as we know is non-GI damaging. The second point is that I believe our data is actually better than we have currently

presented in the public domain in that when one looks at the separate NSAIDs there is a greater GI-event rate on diclo+aspirin than on celebrex+ aspirin. This, I believe, is readily explicable in terms of the differing pharmacodynamic effects of celebrex and diclofenac on platelet function (beneficial towards Celebrex). This, though,I am happy to set to one side as the R&D folks have done to save unduly complicating the message, though in doing so we do lose to some extent a potential advantageous ppoint.

Consequently in summary re the GI event rates everything I have seen demonstrates, to me at least, that we have clear separation of celebrex from diclo and ibuprofen. The Kaplan-Maier plots which take into account differential exposure times show that very elegantly.

Re the tolerability profile I think it has to be stressed, from the outset, that the CLASS study was never intended to be other than a study to focus on whether or not the drug retained COX-2 specificity CLINICALLY and to demonstrate that it was decided (in fact demanded by the FDA) that twice the maximum therapeutic dose should be used. Consequently if one does obtain reasonable tolerability at this dose that in itself would be remarkable given that no NSAID can be used at twice its maximum therapeutic dose without causing SEVERE intolerance (e.g what tolerability profile would you expect to see at 300mg/day of diclofenac). Consequently an overall GI symptom profile for Celebrex 800mg/day which was unquestionably better (statistically so) than diclofenac at 150mg/day and which was virtually the same seen with ibuprofen has I think to be regarded as a good result. Additionally re both diclo and ibuprofen Celebrex demonstrated, at this dose, a better profile re biochemistry (LFTs and renal)and on BP and on potential to cause anaemia as detected by Hb changes.

Emilio's point re rash really singles out one item that is very readily dismissed. To take the incidence of rash in the CLASS study as an indicator of tolerability appears to me to be erroneous for the following reasons. As pointed out in the original Integrated Safety Summary (ISS) prepared for registration submissions by R&D (page 332, document N49-98-07-819)and as is reflected in the "Skin" adverse events section (p243/4) of the "Celecoxib Clinical Summary" which I wrote for the EU submission, celecoxib demonstrates a dose-related increase in rash. This is distinct from the LACK of dose response seen, with celecoxib, as far as I am aware, for any other adverse event. The ISS on page 332 states: "There was an increase in incidence of rash at higher celecoxib doses, with the maximal incidence of 3.4% associated with the 400mg BID dose, thus suggesting a dose-response relationship". Emilio certainly has access to, and I thought had seen, both of these documents. If the mechanism, which as yet is unknown, is exposure-duration related then obviously in longer studies at high dose (above the therapeutic dose currently recommended) the incidence will increase. As pointed out above, the CLASS study was not there to examine the overall side effect profile of celecoxib. That was very satisfactorily done in the registration studies. The findings re rash in the CLASS study merely confirm what we already know about the product. I have no hesitation in recommending that on this basis we can focus on the GI-event rates from CLASS without having to focus on the other findings for the reasons stated. The TOLERABILITY PROFILE and other ADE profile from the extensive database we have at theraputic doses is perfectly satisfactory, and in fact is better than the CLASS data, for our medical & marketing colleagues to use to demonstrate our superiority over NSAIDs. (I made the latter point at last week's UK marketing meeting with Jim Lefkowith).

I am a great believer in such discussion points being out in the open and also in encouraging people to raise their issues so that they can be addressed. Consequently I think it is only fair that Jim Lefkowith should have the opportunity to see and respond to Emilio's points since Jim has lived with and breathed the CLASS data over the past several months and has seen the data in much greater depth than me - hence I have copied Jim on this reply to you Magnus. In that way hopefully we can focus on the facts and see exactly where the truth lies. I would hope that in this process discussion can be held without any parties personalising the discussion. A lack of objectivity is always dangerous.

Regards
Michael

-----Original Message-----
From: JADERBERG, MAGNUS [PNU/GBMKEPO1]
Sent: 07 September 2000 05:01
To: SHIELD, MICHAEL J [PHR/5430]; FORREST, DAVID [PNU/GBMKEPO1]
Subject: CLASS Data

Please see Emilio's comments below - any comments from Michael who has followed this study from the beginning?
The rest of us have a lot to catch up on and so not that easy to advice Emilio although it is clearly of concern to hear someone on 'the inside' express these views.
Magnus

_____ Forward Header _____

Subject: CLASS Data
Author: EMILIO ARBE at Exchange
Date: 04/09/2000 10:19

Dear Magnus,

Since you brought up the subject this morning, here is what I think about CLASS. The study was set out to demonstrate that based on a withdrawal rate of up to 35%, patients would experience clinically significant UGI adverse evens at a rate of 0.3% per year with SC-58635 and 1.2% per year with NSAIDs as a group. The protocol did not specify that the endpoint would be assessed at 6 months only. An interim analysis was planned, but this was only to make sure that enough events had occurred so that the differences would be statistically significant by the end of the study, which was 12 months.

There are several flaws in the way that we present the data. We claim that we cannot compare the groups at 12 months because the drop out rate was so much higher in the diclofenac group. In fact at 26.5 % it was lower than expected and not that different from celecoxib with 22.4% and ibuprofen 23%. The total number of events required, which was 37, was actually met as there were 38 in total, 17 with celcoxib, 10 with diclofenac and 11 with ibuprofen. Considering that twice as many patients had been treated with celecoxib, this equated to annual rates of 0.43%, 0.50% and 0.55% percent. None of the differences were statistically significant. If one looks at the subset of patients who did not take aspirin, which we so much publicise, the rates were 0.26%, 0.26% and 0.64%, again with no statistically significant differences.

With a bit of data massage, what Steve Geis and his team have done is to focus on the 6 month data, for no other reason that it happens to look better, and this time they concentrate on the non aspirin treated patients, and ignore the fact that at no time interval did we see a statistically significant difference with diclofenac, whether one looks at patients taking aspirin or not, at 6 or at 12 months. Unfortunately, UK doctors would only be interested in looking at the rate of GI events with diclofenac since such a high dose of ibuprofen is rarely used.

In terms of tolerability the results are also disappointed, in that the rates of withdrawal due to dyspepsia were 3.8%, 4.4% and 3.9% for celebrex, diclofenac and ibuprofen. To top up the lot we had a 6.2% of rash, which was statistically significantly greater to that seen for the diclofenac and ibuprofen groups. So much for our delivering lasting control in arthritis claim based on improved tolerability and safety profiles.

In my opinion though, these results do not say much about Celebrex used at therapeutic doses, and hence our interest in collecting some more meaningful data through a SAMM study. Probably then, the annual complication rate is 0.3%

as expected and there is probably a tolerability advantage as seen in the Emery study, celebrex 200 mg bid vs diclofenac 75 mg bid over 6 months in RA.

The point I am trying to make though is that I don't see what is so great about CLASS. Personnally I find it bizarre that we would want to roll out the data to opinion leaders who aren't necessarily dupe and I wouldn't feel too comfortable presenting a fudged version of the facts. Any guidance from your side is of course welcome.

Kind regards,

Emilio

From: Wahba, Mona M
Sent: Tuesday, May 22, 2001 5:17 PM
To: Cristo, Stephen
Subject: CBX-0234902_FW: CLASS manuscripts for review: Urgent attention required

Importance: High

Follow Up Flag: Follow up
Due By: Monday, May 21, 2001 12:00 PM
Flag Status: Flagged



CBX-0234903_CELECOXIB CV ver2....
CBX-0234904_COX-2 Inhibitor Up...
CBX-0234905_CLASS manuscript 2...

fyi

-----Original Message-----
From: Wahba, Mona M
Sent: Monday, May 21, 2001 2:03 PM
To: Denton, James; Harris, Andrew; Silber, Beth Ann; Pettitt, Dan; Sirota, Eric; Bahrt, Kenneth; Shafner, Lori S; Fletcher, Mark P; Cary, Meg; Gavigan, Michael; Gandelman, Mitchell; McElwee, Newell
Subject: FW: CLASS manuscripts for review: Urgent attention required
Importance: High

Dear All,

Please see my comments attached, i'd recommend to refer to the conclusions of the second attachment in the CVS ms.

In my opinion, the GI ms is apologetic, weak and not convincing, since cx did not show statistical difference from Diclo even using the combined endpoint. We are also cherry picking the data (using 6 m as study duration).
There is a need to sharpen the story around the effect of GI withdrawals in the diclo group and the effect of ASA as a confounding factor on the expanded endpoint if we decide to publish this ms.

Do we have the newly created tables supporting these 2 ms to QA the #s?

Mona M. Wahba, M.D.
Pfizer Global Research and Development
Office: 860 441 8950
Mobile: 860 625 9356
Fax: 860 715 8463
<mailto:mona_m_wahba@groton.pfizer.com>

EXHIBIT 22 1-12-07 DS

-----Original Message-----
From: Denton, James
Sent: Sunday, May 20, 2001 5:36 PM
To: Sadosky, Alesia; Byer, Alicia; Harris, Andrew; Silber, Beth Ann; Prestel, Betina; Pettitt, Dan; Nickerson, David F; Alemayehu, Demissie; Shapiro, Elyse R; Sirota, Eric; Lee, Fleur; Ancona, Frank; Cawkwell, Gail; Lymburner, Jeffrey; Plofchan, Jennifer N; Goldman, Jonathan; Dicker, Joy; Bahrt, Kenneth; Levy, Lisa; Shafner, Lori S; Fletcher, Mark P; Horn, Mark; Cary, Meg; Gavigan, Michael; Gandelman, Mitchell; Wahba, Mona M; McElwee, Newell; Sobel, Rachel; Reynolds, Robert; Nelson,

Rooney; Miller, Tina; Quinn, Tricia; Leishman, Valarie
Subject: FW: CLASS manuscripts for review: Urgent attention required

Please forward comments to Beth and me by Wednesday May 23.
Jim

-----Original Message-----
From: Cornick, David [mailto:dcornick@hbase.com]
Sent: Thursday, May 17, 2001 4:01 AM
To: Fort, John; Denton, James; 'Tim Walbert'
Cc: Markind, Jan E; 'Jim Lefkowith'; Donovan, Dan
Subject: CLASS manuscripts for review: Urgent attention required
Importance: High

Dear All,

Please find attached two draft CLASS manuscripts (GI and CV) from Jim Lefkowith's group. I would appreciate it if you could review the attached
documents and return your comments to Jan Markind and I by Thursday 24th May
at the latest.

Jim, I would very much appreciate it if you could consolidate all the Pfizer
comments into one e-mail prior to returning them to Jan and I. Many thanks
for your help.

Look forward to hearing from you all in due course

Regards

Dave Cornick
Editorial Leader
PPS International Communications
Phone +44 (0)1903 288131
Fax +44 (0)1903 282707
E-mail: dcornick@hbase.com

-----Original Message-----
From: MARKIND, JAN E [GPB/1820] [mailto:jan.e.markind@pharmacia.com
<mailto:jan.e.markind@pharmacia.com>]
Sent: 17 May 2001 02:20
To: 'Cornick, David'
Subject: FW:
Importance: High

Dave,

Please send out for review to Jim Denton, John Fort, and Tim Walbert. Please ask Pfizer to consolidate all comments for each manuscript into 1 e-mail. Please use the abstracts from these as we discussed; alter as needed.

Thanks,

Jan
-----Original Message-----

From: LEFKOWITH, JAMES B. [PHR/1825]
Sent: Wednesday, May 16, 2001 8:56 AM
To: MARKIND, JAN E [GPB/1820]
Subject:

Jan-
Please distribute these draft copies to the Publication Team. I would like
to limit the review process to 7 business days.
JL

Subject: Updated: CLASS Steering Committee
Location: II-3213

Start: Mon 02/21/2000 8:30 AM
End: Mon 02/21/2000 10:00 AM

Required Attendees: MONTWILL, RICH [PHR/1820]; OSTERHAUS, JANE T [PHR/1820]; GEIS, GEORGE S. [PHR/1825]; ISAKSON, PETER C [PHR/1005]; MARKIND, JAN E [PHR/1820]; WILSON, CAROLYN F. [PHR/1825]; KUNDEL, SUSAN P [PHR/1820]

Weekly Call in number for these meetings is as follows:

800-707-9574, Access code 8424*

Attending: E. Noshay, C. Wilson, R. Montwill, M. Fleming, J. Markind, S. Walker

Upcoming Deadlines:
April 15 AOA
April 17 AAOS: Will this need an orthopod to author? J. Markind to confirm if this will be required.
April 5: Abstract from data to be available. E. Noshay to confirm w/ J. Lefkowith

Weekly Meeting: What updates are needed for tomorrow's meeting: AH Celebrex Weekly Council?
Priorities
1. Ensuring all are clear on strategy going forward and contingencies. Prepare slides and pass to Lee Simon, et.al. Strategies and contingency plans are a deliverable for tomorrow morning's meeting. Strategy contingency layout - M. Fleming.

- Option 1: Decision is that we are going out first, going out quickly to provide motivation for reps. Do not want Merck to start with the story.
  - Results/Issues
    - Recognize that we are dependent on three critical results: primary endpoints of serious AE
      - Contingency: primary endpoints do not deliver M. Fleming
      - Contingency: Primary endpts deliver but the other two/three do not. R. Montwill
    - Diagnostic events
    - GI tolerability
    - HTN & edema
  - Trial design/Issues
    - Need current CI on VIGOR trial. Ours is US theirs is internat'l? Ours is 8000 theirs is larger ?? M. Fleming/N Strait then take information to J. Lefkowith.
    - Number of events: greater p value or not 90 % reduction, how do we speak to the trial design? May need to depend on background rates.
    - Worse case: we have to attack the trial design if we do not see the results we want.
    - Best case: Data is all we want and we go forward; will need to justify our trial design.
    - If other endpoints do not deliver, we will also need to strategize on how we provide the data.
  - Definitions/Issues
    - All measures that have been used historically need to be documented so that there is a good educational piece built on the definitions. For MAMS, etc. Used in PR, Security Analyst release, etc. To be prepared to defend the standard we are setting.
  - Execution

From: Zwillich, Samuel H
Sent: Tuesday, May 23, 2000 6:59 PM
To: Wahba, Mona M
Subject: CBX-0082360_ RE: Good News on Celebrex

Mona:

Thanks. They swallowed our story, hook, line and sinker...

Samuel H. Zwillich
Clinical Research / CRAII

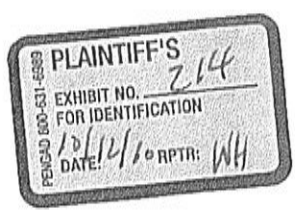
-----Original Message-----
From: Wahba, Mona M
Sent: Tuesday, May 23, 2000 1:40 PM
To: Forster, Eliot R; Murphy, Patrice L; Meyers, Laraine L; Zwillich, Samuel H
Subject: FW: Good News on Celebrex

In case you did not see.

-----Original Message-----
From: Leishman, Valarie
Sent: Tuesday, May 23, 2000 9:47 AM
To: Wahba, Mona M
Subject: FW: Good News on Celebrex

-----Original Message-----
From: Leishman, Scott (LNG-MBC) [mailto:Scott.Leishman@bender.com]
Sent: Tuesday, May 23, 2000 8:25 AM
To: Val Leishman (E-mail)
Subject: Good News on Celebrex

Findings from Celebrex(R) Safety Study Show Traditional NSAID Comparators
Can Cause Serious GI Complications Within First Few Days of Treatment
No
Increased Risk of GI Complications Observed for H. Pylori Positive Patients
on Celebrex
<http://ads.msn.com/ads/redirect.dll/CID=0007cbf51056c6b600000000/AREA=INVIM
S?image=http://ads.msn.com/ads/INVIMS/00201740163_SM.gif> <<...>>
<http://ads.msn.com/ads/redirect.dll/CID=0007cbf51056c6b600000000/AREA=INVIM
S?image=http://ads.msn.com/ads/INVIMS/00201740163_SM.gif>
May 23, 2000 08:03 AM Eastern Time
SAN DIEGO, May 23 /PRNewswire/ -- New data from the Celebrex(R) (celecoxib
capsules) long-term safety study presented during Digestive Disease Week (DDW) revealed that the risk for serious gastrointestinal complications with
the NSAID comparators ibuprofen and diclofenac can start within the



first
few days after treatment begins. Further, study patients who were H. pylori
positive had a two times greater risk of developing both symptomatic ulcers
and ulcer complications when taking the NSAID comparators than did H. pylori
negative patients. No such increase was observed with patients taking
Celebrex, regardless of H. pylori status. "This study reinforces what
gastroenterologists have always suspected -- that even short-term therapy
carries risks. Many physicians feel that patients requiring short-term
administration of traditional NSAIDs are not at risk for a serious
gastrointestinal event. These results tell a different story, highlighting
that many of the events caused by traditional NSAIDs occurred within the
first few weeks," said Jay Goldstein, MD, Associate Professor of Medicine at
the University of Illinois at Chicago and Chairman of the GI Events
committee of the Celebrex long-term arthritis safety study, who presented
the findings at a satellite symposium sponsored by Searle and Pfizer Inc
during DDW. The Celebrex long-term arthritis safety study, an approximately
13-month, multi-center, randomized, double-blind outcomes trial of about
8,000 arthritis patients -- 5,800 with osteoarthritis (OA) and 2,200 with
rheumatoid arthritis (RA) -- was designed to mirror everyday clinical
practice by enrolling a broad spectrum of patients, including adult patients
of all ages and disease severity, and patients taking low-dose aspirin for
cardioprotection. The study, designed to obtain a rigorous assessment of
Celebrex safety, compared four times the recommended OA dose of Celebrex
(800 mg daily) to typical daily doses of ibuprofen (2400 mg daily) and
diclofenac (150 mg daily). The Celebrex study dose is twice the highest
recommended RA dose. Impact on Required Medical Care Studied Under the
real-world conditions of the study, significant decreases in the use of
medical resources were shown in the Celebrex group versus the other NSAIDs
studied. On four times the recommended Celebrex OA dose, 12.6 percent of
patients required office visits for blood work and evaluation versus 16
percent of patients on usual doses of the NSAID comparators; approximately
twenty percent of each group were referred to a specialist, most requiring
endoscopy and a complex medical work-up. This amounted to 25 percent fewer
office visits and complex work-ups for patients taking Celebrex. "This is an
important finding with respect to the increased burden on our medical system
and the healthcare resources needed to treat these patients - especially
given the finding that serious complications can occur early in treatment,"
noted Dr. Goldstein. New Treatment Withdrawal Findings Withdrawal from the
study due to GI symptoms for patients on Celebrex versus traditional NSAIDs
was also assessed in the trial. Tolerability data were presented that
indicate diclofenac patients had a more difficult time remaining on
treatment due to increases in moderate to severe GI symptoms. Significantly
more patients on diclofenac were forced to withdraw from treatment as a
result of these side effects, as compared with patients on Celebrex.

Additionally, significantly more patients on ibuprofen than on Celebrex were forced to withdraw from treatment due to lack of efficacy. These data highlight that arthritis patients need both efficacy and tolerability from their therapy in order to stay with treatment. Blood Loss Data Have Broad Implications As reported at the symposium, study data show that there was an increased incidence of blood loss -- equivalent to two pints or more - among patients on the NSAID comparators versus Celebrex, even among those without bleeding ulcers. The rate of blood loss with the NSAID comparators was 5.0 percent, and with Celebrex was 2.4 percent. In the original Celebrex clinical trials, the rate of blood loss with placebo was 1.6 percent. "Importantly, the lower incidence of GI blood loss has implications for a patient's overall health," Dr. Goldstein noted. Chronic GI blood loss, which often goes undetected, can result in anemia. Less total blood in the body means less oxygen is circulating through the body. To compensate, a patient's heart must work harder and faster to pump more blood through the system. Left untreated, anemia can exacerbate underlying coronary artery disease and precipitate heart attacks and heart failure. According to Dr. Goldstein, "Blood loss of this kind is often difficult to pinpoint. When discovered, however, patients may be forced to discontinue treatment, thereby preventing them from getting effective relief from their arthritis symptoms. Obviously we'd prefer to avoid such an outcome." Cardiovascular Findings The long-term safety study also indicated that four times the recommended OA dose of Celebrex, taken with or without aspirin, posed no increased risk of heart attacks or strokes compared with ibuprofen and diclofenac. Approximately 70 percent of the aspirin group and 50 percent of non-aspirin users had cardiovascular risk factors such as hypertension, high cholesterol, tobacco use and a history of heart attacks. Among study participants not taking aspirin, the incidence of heart attack for Celebrex was 0.2 percent, and 0.1 percent for the NSAID comparators. For the same group of patients, the incidence of stroke was less than 0.1 percent for Celebrex, and 0.3 percent for the NSAID comparators. Among study participants taking aspirin, the incidence of heart attack for Celebrex was 0.5 percent, and 0.4 percent for the NSAID comparators. For the same group of patients, the incidence of stroke was 0.2 percent for Celebrex and 0.5 percent for the NSAID comparators. None of the differences were statistically significant. Celebrex is not a substitute for low-dose aspirin used for cardioprotection. Aspirin: An Independent Risk Factor for Ulcers Among non-aspirin users, patients on Celebrex taking four times the recommended dose for OA experienced significantly fewer ulcer complications compared with ibuprofen and diclofenac. Patients who needed aspirin were allowed to participate in this study since a large number of patients

with
arthritis take low-dose aspirin for cardioprotection, as did one-in-five patients in this study. Excluding aspirin patients from the analysis, however, offers a clearer picture of the impact of Celebrex on GI safety since aspirin is an independent risk factor for GI complications. These patients experienced three-fold fewer (64 percent) ulcer complications, a
statistically significant difference from the NSAID comparators. When patients taking aspirin for cardioprotection were added to the analysis, those on Celebrex experienced two-fold fewer ulcer complications versus the
traditional NSAID comparators, narrowly missing statistical significance.
Patients who have a known allergic reaction to celecoxib, certain sulfa drugs called sulfonamides, aspirin or NSAIDs, or who are in their third trimester of pregnancy should not use Celebrex. As with all NSAIDs, serious
GI tract ulcerations can occur without warning symptoms. Physicians and patients should remain alert to the signs and symptoms of GI bleeding. As
with all NSAIDs, Celebrex should be used with caution in patients with fluid
retention, hypertension, or heart failure. The most common side effects of
Celebrex were dyspepsia, diarrhea and abdominal pain, which were generally
mild to moderate. Celebrex is co-promoted by Searle, now part of Pharmacia
Corporation, and Pfizer Inc. Pharmacia Corporation PHA
</investor/common/quoteredir.asp?Symbol=PHA> is a leading global pharmaceutical company created through the merger of Pharmacia & Upjohn with
Monsanto Company and its G.D. Searle unit. Pharmacia has a broad product portfolio, a robust pipeline of new medicines, and an annual investment of
more than $2 billion in pharmaceutical research and development. Pfizer Inc
PFE </investor/common/quoteredir.asp?Symbol=PFE> is a research-based, global
pharmaceutical company that discovers, develops, manufactures and markets
innovative medicines for humans and animals. The company reported revenues
of more than $16 billion in 1999 and expects to spend about $3.2 billion on
research and development this year. For more information on Pfizer, access
<http://www.pfizer.com > For complete prescribing information on Celebrex,
access <http://www.celebrex.com> or call toll-free 888-735-3214. SOURCE
Pharmacia Corporation and Pfizer Inc