EXHIBIT 47

08-I-99343 sh

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

IN RE: Seroquel Products Liability Litigation
MDL DOCKET NO. 1769

This document relates to all Group One Trial Cases:

Janice Burns v. AstraZeneca LP, et al. Case No. 6:07-cv-15959
Sandra Carter v. AstraZeneca LP, et al. Case No. 6:07-cv-13234
Connie Curley v. AstraZeneca LP, et al. Case No. 6:07-cv-15701
Linda Guinn v. AstraZeneca LP, et al. Case No. 6:07-cv-10291
David Haller v. AstraZeneca LP, et al. Case No. 6:07-cv-15733
Hope Lorditch v. AstraZeneca LP, et al. Case No. 6:07-cv-12657
Eileen McAlexander v. AstraZeneca LP, et al. Case No. 6:07-cv-10360
Clemmie Middleton v. AstraZeneca LP, et al. Case No. 6:07-cv-10949
Charles Ray v. AstraZeneca LP, et al. Case No. 6:07-cv-11102
William Sarmiento v. AstraZeneca LP, et al. Case No. 6:07-cv-10425
Richard Unger v. AstraZeneca LP, et al. Case No. 6:07-cv-15812
Linda Whittington v. AstraZeneca LP, et al. Case No. 6:07-cv-10475

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ORAL DEPOSITION OF

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looked at some of the Clozapine data because they were head-to-head data. I also looked at -- now, you're talking about just first generation?

Q. Yeah.

A. Oh, okay. Then haloperidol was the main drug, and then there are a few trials that looked at perphenazine.

Q. Okay. Do you think haloperidol is an effective medication in treating mental illness?

A. Yes.

Q. Would you agree with me that first-generation antipsychotic drugs, as a group, are associated with certain movement disorders?

A. Some of them, yes. And some are worse than others, but, yes. In fact, that's how -- if you read my report, I try to start out with sort of a primer on pharmacology. And Goodman & Gilman teaches that there are -- the reasons the second-generations were developed was to try to improve on that safety profile.

Q. So --

MR. ALLEN: Hold on. Take a little break.

(Recess from 12:26 p.m. to 12:27 p.m.)

Q. (BY MR. BROWN) The -- so, as a group, second-generations were studied and ultimately marketed because they had better side effect profiles with respect to movement disorders, correct?

A. I don't know they were ultimately marketed. But that was one of the impetus, looking for drugs that had less of a propensity to produce some of these movement disorders. But what was interesting is if you look at the labeling for the drugs, that statement is not allowed to be put into the labeling. In other words, I don't believe that the evidence has shown head to head, at least to the sufficiency of the FDA, that any one drug has a specific percent advantage over another.

I would agree with you as a class, in general, when you look at first generation versus second, that as a general rule, you expect the second-generations to have less propensity, but that doesn't mean they have no propensity.

Q. Let me ask this question: Have you -- do you have an opinion with respect to whether haloperidol has a better EPS profile than Seroquel?

A. I haven't formed that opinion. I believe that haloperidol has a propensity to produce it and I believe Seroquel does as well.

Q. In doing a risk-benefit analysis, you have to consider side effects, correct?

A. Yes.

Q. Wouldn't you need to know whether one caused EPS more frequently than the other to actually make that assessment?

A. It depends. If you're doing -- it depends what

you're doing with the risk-benefit assessment. My issue -- and maybe this will help you: When I did the risk-benefit assessment here for Seroquel, I was looking for what were the general -- what were the types of risks that had been associated routinely with Seroquel and what were the benefits that were shown? And then when I'm looking at that drug, I make an assessment based upon whether I think the risks outweigh the benefits.

Now, I'm not saying that the risks outweigh the benefits for this drug such that it should be removed from the market. That's not what I'm saying. I'm saying that when I -- and if you look at what my statement is, I believe there are safer alternatives. I believe that if you look at Seroquel, it should not be a first-line agent necessarily because the metabolic risks of this drug are different from some of the other drugs, and that is above and beyond the neuromuscular risks.

That's not to say that there isn't a patient that Seroquel could be given to safely, and it's possible that it is, but I don't think it should be a first-line treatment.

Q. So, it must be so, based on what you just told me, that you have an understanding of the side effect profile of first-generation antipsychotics, correct?

A. Yes.

Q. And you've researched it in forming your opinions

here today, correct?

A. Yes. In general terms, yes.

Q. And do any of the materials you have brought to the dep today or identified in your report discuss the side effect profiles of first-generation antipsychotics?

A. Many of the published articles talk about that. My textbook talks about that. And then you also even have head-to-head clinical data on Seroquel versus some of these other first-generations that talk about side effect profile. So, absolutely, yes.

Q. And you mentioned that there are safer alternatives to Seroquel, correct?

A. I believe there are, yes.

Q. And what are the safer alternatives to Seroquel?

A. I believe that haloperidol would be a safer alternative to Seroquel. I believe that ziprasidone would be a safer alternative to Seroquel, and possibly -- I can't think of the generic name, but Abilify.

Q. And have you carefully reviewed the side effect profiles for haloperidol?

A. I have reviewed the -- I don't know what you mean by "carefully." I certainly, for my perspective in forming my opinions, have reviewed the side effect profile for haloperidol. And in addition to that -- I'm basing my opinions in part on some of the head-to-head studies that I've provided

here for you in my literature and on those disks.

Q. Okay. Do you know what head-to-head studies you looked at that compared haloperidol to Seroquel?

A. I'd have to go through my pile to tell you. I mean, there -- but it's certainly ones -- some of them are cited in my report and then there's others that are on the PDF files that I've given you. But they wouldn't necessarily be cited as a head-to-head study. I'm just telling you that there are studies that -- I know some of the ones in there have haloperidol versus -- usually versus quetiapine and something else as well.

Q. Does haloperidol cause diabetes?

A. I believe that haloperidol has been shown to have some patients that have shown up with metabolic effects certainly because it can produce some weight gain and some of those things. However, I have not formed an opinion in the same way as I have with Seroquel. I have formed the opinion that I think that Seroquel, Zyprexa, and Risperdal -- and I've been very clear on this in my presentation in the New Jersey Education Day -- appear to have a greater and unique risk over a drug like haloperidol and even over, like, ziprasidone and some of the other second-generation drugs.

Q. Did some of the epi literature you rely on quantify the increased risk of diabetes with haloperidol?

A. I'm sure they did because that was a comparative drug

in some of the epi literature.

Q. Would you agree with me that there are a number of studies that show the risk of diabetes is greater for haloperidol versus Seroquel?

A. I'd have to look at the individual studies to answer that, so I don't want to agree with you or disagree with you. If you want to talk about specific numbers like that, I would want to pull the studies out. And if you want to --

Q. We'll do it today.

A. -- show me one, we can look at it.

Q. Would that surprise you? Based on your opinion, would that surprise you that haloperidol had a greater risk, at least in some epi studies, than Seroquel?

A. Not necessarily surprise me. I'd have to look at the individual study though to interpret the data.

Q. And ziprasidone and Abilify are the other two products you think are safer alternatives?

A. I think they could be. Again, it's a patient-specific decision. But I think that based upon the profile I see, they could be safer alternatives.

Q. And as a non-medical doctor, you're never asked for a particular patient what the best medication is, correct?

A. I'm answering this as a pharmacologist. So, if you ask me as a pharmacologist, based upon the information I see, that's how I answer the question, right. I'm not a physician,

so I don't -- I would not make that decision for an individual patient.

Q. Would you agree with me that all drugs have some risk?

A. Yes. I would say that that's a common -- common thing for anything I can think of. Even water has a risk.

Q. So, no drug's a hundred percent safe, correct?

A. That's right.

Q. All drugs have some level of side effects to varying degrees?

A. Yes, some levels, and they differ in severity and occurrence rates.

Q. Medical doctors consider the risks of a medication when they prescribe it, correct?

A. I assume they do and I would hope they do, and I certainly taught my medical students in pharmacology that they should do that.

Q. So, a medical doctor in his or her office today here in Houston, if they're making a determination about what medication's appropriate -- Seroquel, haloperidol, ziprasidone -- they should be doing -- looking at the side effects and the possible benefits and making a determination based on that with that particular patient?

A. Well, again, I think you'd have to ask a doctor what they do. But I certainly would expect my doctor to be familiar

with the side effect profile, as well as the efficacy profile, for any drug that he was to prescribe or attempt to prescribe for me.

Q. Would you agree with me based on your review of all this literature that mentally ill patients are difficult to treat?

A. What do you mean by "difficult to treat"?

Q. That often doctors -- would you agree with me that doctors often need to try a number of different medications in the schizophrenic population -- let's talk about those folks for one minute -- before they can find one that will work?

A. I'm, again, not a physician. I can only speak from what I have read. And certainly from what I have read, I see that doctors often switch patients from one to another. In other words, there's a discontinuation. Doesn't work, you try a different drug, yeah.

Q. Okay. Turn to Paragraph 16 in your report.

A. 16?

Q. Yeah.

MR. ALLEN: Okay. I didn't understand you. Did you say --

MR. LASKER: 16.

MR. ALLEN: 16? I thought -- I thought somebody said "60." I didn't remember there being that many.

Q. (BY MR. BROWN) Dr. Plunkett, I wanted to look at