GSK plc

GSK plc presents at Goldman Sachs 44th Annual Global Healthcare Conference

Tuesday, June 13, 2023 12:20 PM

Event Participants

Analysts 1
Chris Shibutani

Executives 1
Tony Wood

Chris Shibutani Analyst

And we're back. Welcome, everybody, to our third session this morning at the Goldman Sachs Healthcare Conference. My name is Chris Shibutani along with the team, especially the team that's based in London, [indiscernible]. Thank you very much.

We're very pleased that GlaxoSmithKline, GSK, can join us today. Today, we have Tony Wood, who is the Chief Scientific Officer. The focus of our conversation, there's so much that we can always talk about with GSK in terms of portfolio strategy, et cetera. But I always like to make sure that we focus the relatively short time that we have here, a 30-minute discussion, to being able to go a little bit more into depth.

There's a lot of critical areas from the clinical development standpoint and the pipeline that is really sort of your power alley, and then we're also going to beg you to ask, comment on some things that are clearly relevant from that pipeline standpoint in the HIV side. But to begin with, just to familiarize the room a little bit about who we're talking to, tell us about you, your professional journey.

Tony Wood Executive

Thanks. Okay. So first of all, hi, everyone. Pleased to be here. Sorry, we're just a few minutes late.

So yes, my professional journey. I'm now more than 30 years in the industry. I guess I'd describe myself as a drug [indiscernible] and a technologist. Six now of those years at GSK, before that 25 years at Pfizer. I grew up initially as an additional chemist then led technology

groups, history in HIV.

I discovered an HIV medicine in my early career.

And through that career at Pfizer increasingly was involved not just with technology and therapeutic area focus but also later-stage development, large-scale development platforms and led their immunology group for a little while. And then 6 years ago, moved to GSK. What I saw there was an opportunity to lead a broader technology platform with an organization that has a good track record of applying technologies. I joined just as about the same time as Hal did, and so he and I were sort of part of that last 5-year journey of really turning R&D productivity around the GSK focusing on decision-making, for example.

My role at that point in time was to broaden out the modality base. I arrived in an organization that was essentially a small molecule inhaled organization we built in biologics, we built in functional genomics, AI/ML, things like that. I'll pause there because it's too easy for me to go for a long time on that.

Chris Shibutani Analyst

Yes. No, actually you're giving us plenty of raw material to go on into and particularly with your vast industry experience and your purview and whatnot, maybe we'll begin with a discussion in terms of strategy from the R&D standpoint and portfolio there. There's been an identification by GSK of a therapeutic focus, right, on infectious diseases, HIV, immunology, respiratory and oncology.

You had mentioned actually the word modality. And so when you pick these therapeutic areas of focus, talk to us a little bit about the modalities, and how you feel about what you're currently equipped with. And what we might be able to see you consider building further upon as you strengthen the portfolio and fortify it, even possibly through either partnerships or acquisitions. Talk to us about sort of the modality basis within these identified therapeutic areas.

Tony Wood Executive

Sure. So why don't I bookend that first by starting with the therapeutic focus very much in Vaccines and Specialty. Now when you look across those 2 areas, I'll divide the modalities in that way. Look, I think we're in a strong position as far as vaccines is concerned. Actually, we have obviously a well-established track record in protein subunit vaccines and in particularly in adjuvants.

And that's an area that we'll continue to develop both in terms of the application of structure-based vaccinology in the subunit design and also in terms of us continuing to invest in understanding adjuvant technology to work on the reactogenicity versus immunogenicity proposition.

Behind that, of course, very excited about the deal, the acquisition of Affinivax which brings in, I think, a unique capability and platform technology to get access to the pneumococcal market, one that we didn't play in, and of course, is the second largest vaccines market after COVID. I could double-click on the Affinivax technology, but perhaps we'll wait if you want to

do that later.

Very pleased with the way our collaboration with CureVac is going with regards to mRNA. Nice initial data that they've described in the context of monotherapy setting for reactogenicity versus immunogenicity in both flu and COVID. And again, really a focus there for me for the high-dose flu -- probably high-dose flu plus COVID is an area that we don't play in.

So Vaccines has a very strong technological basis. We've built out AI/ML capability there in terms of design. Actually for nanoparticles, we hold some of the original IP in Lipid Nanoparticles from the Novartis organization. And we'll continue to look for technologies in vaccines. They're really, for me, about the broadening applicability of mRNA, bearing in mind that I think we're still on a little bit of a tipping point with regards to reactogenicity and immunogenicity if you want to get into high-dose flu plus COVID plus other seasonal vaccines.

So that might be an example of what we're looking for in that area. But largely speaking, I think we're very well set in Vaccines.

If you now then pivot over to Specialty Medicines, what we've built there, as I mentioned earlier, obviously, with strong capabilities in medicinal chemistry. We've built out, over the past 4 years, I think competitive capability in protein engineering, monoclonals, both in discovery and in manufacturing. I might point to Nucala, depemokimab and sotrovimab as examples of performance in that particular field.

And then an emerging presence in the other end of RNA oligonucleotide, if you like. We're now witnessing, I think, the fundamental addition of nature's third molecule to the armamentarium of drug discovery and development. And we have in our chronic hepatitis B treatment bepirovirsen, an oligonucleotide that has a unique profile in functional cure in HBV. Behind that in the clinical portfolio, collaboration with Arrowhead on an enzyme target that is the PCSK9 equivalent for liver disease and, of course, a recent collaboration with Wave Therapeutics, who I think have a unique oligonucleotide technology.

So you can think about the build, in terms of modalities, well set in Vaccines, looking for what I need if the reactogenicity/immunogenicity question around seasonal vaccination becomes important in the pharma world. Well established in the 2 core modalities, building out oligos. Obviously, we've had a presence in cell and gene therapy. We retained some of the basic capabilities there, and we'll continue to monitor that field as it develops.

Chris Shibutani Analyst

In particular on the vaccine front and thinking about sort of how much the landscape has been altered by the emergence, obviously, of the commercialization of the mRNA-based COVID vaccines, it does bring to bear this question of relative competitiveness. And you've made reference to the reactogenicity, immunogenicity dynamic. With candor, share with us what you think GSK's current equipment from a capability standpoint will position you from a competitiveness standpoint. And what is your hypothesis in terms of the ultimate view on what the immunogenicity and reactogenicity could play out like with these multiple combination of seasonal vaccine?

Tony Wood Executive

Yes. So look, I think we're in a competitive position is slightly behind from a timing standpoint with respect to high-dose flu in COVID. The recent Moderna results, particularly when you look at strain B immunogenicity, put them back slightly. Our technology, judging as one can, from or rather the CureVac technology and collaboration, judging as where one can, from the Phase I data that we see, I think, places us in a very similar position as far as that is concerned. And we're moving quickly now into multivalent flu studies with the objective that we can establish a presence in the high-dose flu market on a time scale which is competitive.

When I look at the broader proposition and if you allow me to just get into a little bit of numbers here, if you look at the total RNA load that you might need to do 4-valent or 8-valent flu to compensate for B-strain differentiation plus COVID plus perhaps RSV, if you're considering adding that, then you're looking at a total RNA load, which is, I think, exceeding the current therapeutic index possibilities for reactogenicity versus immunogenicity.

And whilst that might have been acceptable in COVID to have Grade 3 reactions that meant you're off work for a couple of days, I don't think that's going to hold in a regularly administered seasonal vaccine. So I think we're going to need to see a bit of a shift, let's say, about a fivefold shift. And the question to be asked, of course, is, is it determined by total RNA load or is it determined by sequence? All of that yet still to be worked through. But if you -- where do I see the greatest possibility for us?

It's high-dose flu plus COVID. Probably need additional technology to extend it beyond that. And I would put that across the entire field at the moment.

Chris Shibutani Analyst

Okay, great. From a time line standpoint, front and center, RSV, tremendous opportunity innovation. GSK as well as Pfizer. A lot of regulatory hurdles have been passed, and we're literally, this month, going to see the ACIP. Can you update us whether or not there's going to be any incremental data, particularly in the older adult population kind of 50-plus or whatever?

Gosh, it's that older adult. I think that's just adult.

Tony Wood Executive

I was pleased you said that.

Chris Shibutani Analyst

And naturally, the Street is all trying to contemplate how we should think about the end game, what the market share could be like. And it clearly starts with product profiles, it starts with data sets and how those are interpolated by the regulators, et cetera. Walk us through.

Tony Wood Executive

Okay. So let me just sort of step back and describe things as I see them currently. So obviously, we're delighted with the overall profile of our vaccine and the VRBPAC vote, which I think really substantiated that. As you point out, ACIP coming out. We have second season

data in-house that will present at ACIP.

I think as we stand right now, I'm more focused on the 60 to-- is it 60 or is it 65-plus? Obviously, there's a question of the GBS matter, which needs to be considered. We have, I think, stronger data there, small numbers.

And then flu COVID and the broader strength of our package. In fact, if you look at the labels, we have secondary data in our label. We have flu COVID in our data in our label [indiscernible]. Another important thing to consider is presentation from a human factor standpoint. Our vaccine is a 4-stage presentation.

Pfizer's is a 9-stage presentation. We'll continue to build out the data set where we are running studies now looking at the 50 to 59 population, and this will just be part of an ongoing program. Obviously, seasonality is going to take longer to play out as well.

Chris Shibutani Analyst

And is there anything that you can just make memorable, the key differentiating factors in your view of GSK versus Pfizer and versus the Moderna product?

Tony Wood Executive

Yes. I would say it's back to the point that I made earlier that we have. And it's probably actually before I get there, if you don't mind, I just want to underscore a few things about the Phase III program that underpin all of this because without it, I wouldn't be able to say what I'm about to. And that is you were very careful to use epidemiological modeling. When we started the study in 2019, recognizing that COVID would disrupt the normal status for RSV epidemiology.

What that meant was that we were able, on a study that is about the same size as Pfizer, as to really target a mix in severe population, which gave us the strength of the data that you see. We also called the interim, I think at just the right point, too. So we end up with 94% vaccine efficacy in the at-risk population. So they really are -- if you remember, the CDC has published on this. These are the folks who end up hospitalized and -- from RSV infection.

We have a strong data package, A versus B. We have a strong data package for the subgroups and secondary endpoints beneath that. And as I mentioned earlier, that's reflected in the label that you see. We also have a strong data package in the context of flu COVID, We'll be adding adjuvant as a high dose to that. And we will continue to explore the efficacy of the vaccine in the younger population, starting from 50 to 59.

But I very much see that as, if you like, the scientific differentiators and then there's the presentation point that I made earlier of a 4-step versus 9-step vaccination.

Chris Shibutani Analyst

Okay, terrific. Maybe a little bit on the commercialization preparation launch time lines. I think Pfizer has talked about being able to consider posting some revenues in the fourth quarter. How do you feel in terms of what's the house view in terms of communicating time lines for potential revenue?

Tony Wood Executive

Yes, very much. I mean, this is all done with the intention of being ready for the '23 season. So very much prepared for that. And probably another thing to stress in terms of platform approaches, we apply that we have a digital twin model for manufacturing, and that means we're unconstrained for vaccine supply.

Chris Shibutani Analyst

And then you made reference to this a little bit earlier about expanding the potential opportunity set across the different age group subpopulations here. Remind us in terms of whether or not you're considering exploring anything in the sort of the 2-years to 18-years population group. And also historically, I think there had been a maternal vaccine candidate, pregnant individuals, to address the risk of infection amongst infants. There have been a prior pause owing to safety considerations. Does the team contemplate considering continuing to re-navigate the development of that?

Tony Wood Executive

Yes. Look, in terms of that expansion, as I mentioned earlier, very much, at the moment, the target for us is the 50 to 59 population. We don't see the maternal market as being a substantial component of it, so not with the current construct. We will -- I don't expect us to go back into maternal.

Chris Shibutani Analyst

Okay, great. And then finally, on RSV, combination vaccines. How do you see these impacting the space? I mean, we talked about some of the scientific risk considerations that you think are important to be aware of. What would be the impact of having the combinations out there?

There certainly seems to be this simple notion of convenience, et cetera, combining these things. But what's your view?

Tony Wood Executive

Yes. I mean, look, I think it boils down to really how do you trade vaccine efficacy, particularly for the at-risk population versus convenience? And as I mentioned earlier, we really don't know the proposition with regards to let's call it, multipathogen seasonal vaccination with regards to reactogenicity or vaccine efficacy. And so right now, I think, as I mentioned, the real differentiating feature of our vaccine is its 94% vaccine efficacy and those who are at most risk of hospitalization and mortality as a consequence of infection.

And right now, I think that plays out again today an as-yet to be determined convenience proposition. Although obviously, we're evaluating the seasonal vaccination market in terms of looking at the optionality for multiple presentation in seasonal vaccines.

Chris Shibutani Analyst

Okay, great. Let's transition over to HIV. Normally questions I would be probably addressed to the R&D head of ViiV, but you're being a good sport, so let's talk about the dynamics here. On

the competitive front, obviously, there's like well-established franchises with you guys, with Gilead. We see them entering the long-acting space with approval of lenacapavir for multidrug-resistant HIV.

Allows for a 6-month dosing. How do you see this potentially impacting cabotegravir for both treatment and for PrEP in the future?

Tony Wood Executive

Yes. I mean let me just sort of step back, if you like, and give you a sense of how I see the ViiV strategy, then I promise I'll get directly to answering your questions. So our strategy at the moment is very much about having led innovation in the area going from 3- to 2-drug regimens. Our strategy is very much then about the next wave of innovation moving over to long-acting regimens, be the at-home treatment, be the treatments which are phased with physician visits or extension of PrEP. I think what's important to consider in all of that is what is the foundational medicine that is part of your 2-drug treatment.

And what we have in cabotegravir and ultimately potentially in the third-generation integrase is a mechanism which is solidly proven to have very, very substantial characteristics in terms of robustness with respect to resistance. And I think if you look at the proportion of individuals living with HIV who are currently treated, more than 70% of those have dolutegravir as a background regimen. So I think the credentials of integrase inhibitors is the foundation of a long-acting regimen which is robust with regards to resistance are extremely strong. Capsid, of course, is interesting, but doesn't have anywhere near that level of supporting evidence. And of course, we have a capsid and the maturation inhibitor in our portfolio as well.

And what we've said is that we will make decisions on the components of longer-acting regimens in the middle of next year. And before I finish on that, I should also stress the interesting emerging, I think, quite exciting data for the broadly neutralizing antibody that we disclosed at Glasgow last year. This is the first example of a single antibody that gives substantial coverage and one that gives efficacy at a dose which is in a sort of realm that you could imagine would be effective for a longer-acting treatment. So in headline, although we haven't yet decided on exactly what those various regimens would look like, we have a number of different studies and ongoing evaluation of the pharmaceutical properties that -- or the pharmaceutical proposition that one requires for a long-acting agent. The details of all of that and Deborah and Kim haven't disclosed, but they will all come together, as you said, in the middle of the next year with the choice on what is the right regimen.

As far as lenacapavir concerned, it's going to need another medicine on top of it in order to be a robust regimen and we'll wait to see what that is.

Chris Shibutani Analyst

Okay. So a year from now, when GSK is on the stage being grilled by the Goldman team, we'll hopefully have more insight in what the next go forward.

Tony Wood Executive

That's helpful.

Chris Shibutani Analyst

Within HIV PrEP obviously, a fascinating market. Gilead mentioned in their first quarter earnings call that of patients were eligible for PrEP in the U.S., actually only 25% are receiving treatment. Just curious to know what you're seeing from a market perspective and how you think perhaps there's an opportunity to enhance the penetration here. And in particular, looking at how original expectations have been framed and how the reality of the commercial market has played out.

Tony Wood Executive

Yes, I would say, look, I mean, obviously, a question that I'm sure Deborah could answer in greater detail. But the way I think about this in terms of that is it's both a matter of reshaping. And if you let me go back to the treatment market for a minute, in the U.S., still something like 37,000 new infections every year. Less than 50% of people living with HIV are fairly suppressed. So there's an opportunity not only in reshaping the, let's call it, the components of the market between oral and long-acting but seeing greater penetration to ensure a shifting of that proposition to one that is more like the European one, where I think it's 95% of individuals are suppressed.

Obviously, all of that work sits alongside establishing the credentials of a long-acting PrEP agent, which, again, plays to another segment of patient choice or indeed of medical need that we see. But as regards to strategies for expanding the market, I'm not entirely sure what Deborah has described, so perhaps you'll allow me to leave that answer at that point.

Chris Shibutani Analyst

Okay. A little bit more on the vaccine front and the infectious disease. Shingrix, complications obviously addressing of the legacy infectious situation here. A tremendous franchise for GSK. There's some other sort of presentations that are coming up, Pfizer, BioNTech have an mRNA-based candidate, Phase I/II.

How do you view the outlook for potential different modality entrants competitively impacting the Shingrix franchise?

Tony Wood Executive

Yes. I mean, 10 years protection and counting out to 12, I think that is going to be a high hurdle to beat. And from our standpoint, what we're very much interested in Shingrix is beginning to ask the questions about, again, is there -- are there other populations that could be eligible, for example, Luke is building out in broader terms. But I would say that the 10-year protection gives us a substantial benefit over new entrants.

Chris Shibutani Analyst

Another dynamic which is very exciting but once again, a situation where some of the stalwarts in the space are potentially going to be competing here, Meningococcal ABCWY here. We have a regulatory decision coming up for Pfizer in the second half of this year.

Anticipated launch next year. Comment about relative comparative profiles and how you see that shaping up?

Tony Wood Executive

Yes. And look, I mean, I think just to start with in meningococcal disease, I think the first thing to do is to stress that between Bexsero and Menveo, we have 2 great vaccines, greater than 80% vaccine efficacy. And in the case of Bexsero, of course, a [indiscernible] too schedule, which is critically important for the adolescent population. But bearing in mind that most of the burden of invasive disease in the U.S., I believe, is in the 15- to 23-year-old. So having said that, as we look at the convenience, let's say, and perhaps therefore increased penetration because I think we're still only about 30% of penetration there, the convenience of the pentavalent proposition obviously very important.

But if I take you back to the comment that I made earlier around vaccine efficacy, this is another infectious disease in which the invasive disease has significant consequences, and therefore, vaccine efficacy and in particular, strain coverage, I think, is very, very important. So what we're focusing on in our pentavalent vaccine is demonstrating improved strain coverage. We recently described the headline data. We were delighted we've hit all 11 endpoints, and we're working across a B strain proposition that covers more than 100 strains in contrast to Pfizer, which looked at 4. So we're very much focused there on building on the basis of what we already have with Menveo and Bexsero and delivering a next-generation broader agent, which is not only more convenient, but has a very strong proposition in terms of strain coverage, given the invasive disease consequences.

Chris Shibutani Analyst

Okay. Another category, pneumococcal, very well-established presence out there, of course, obviously, with Pfizer's Prevnar, Merck's vac [indiscernible] as well. I think you guys are in position to commence the Phase III trials for adult [next year] Any updates on the infant trial in terms of status and how on track you are with that?

Tony Wood Executive

Yes. Let me just sort of step back, first of all, just remind everyone quickly about the platform. This is a unique platform with regards to -- if I do very quickly to 2 or 3 components. First of all, it's chemical complexation, not chemical conjugation. What that means is getting beyond 20 to 30 is a much easier proposition than it is with chemical conjugation.

It also means that because of the way the antigens are presented, we see improved antigenicity -- sorry, immunogenicity. And then you see that our data compared to Prevnar 13 and Prevnar 20 immunogenic responses, which are anchored in being better than Prevnar 13. I would remind everyone that based on what I've just said, Prevnar 20 is less immunogenic. So we have advantageous immunogenicity. We also have advantageous strain 3 coverage.

What pneumococcal strain 3 does it cuts the glycoprotein, so unless you have a vaccine which is aimed at protein components, you won't see efficacy in strain 3. The Affinivax platform brings us this. So we're on -- in terms of the manufacturing scale up to get to the 24-valent proposition, we're making great progress there. I'm very happy with the acceleration

we've seen. You will note that we paused the infant program and the 24-valent.

That was simply because of a need to ensure that we move from a fill-finish operation that was anchored in a Phase I/Phase II clinical setting into a fill-finish operation that would allow us to move into a larger scale and some ultimately commercial setting. So I'm not concerned about that. I see it more as the sort of ins and outs of taking an early program and then accelerating it to ensure that we end up with something that will reach the market as soon as possible. And everything I've stressed about the immunogenicity profile of the vaccine, I remain confident in.

Chris Shibutani Analyst

Okay, terrific. I mean, infectious disease and HIV really constitutes 2/3, roughly speaking, in terms of the portfolio. The last dimension of that is in antibiotics. And boy, is there a tremendous challenge, it seems, academically recognized Burroughs Wellcome trust talks about bacteria, don't care, with the drugs that we have that they're becoming resistant to. And the statistics are actually quite horrifying from a humanity standpoint in terms of somebody dying every 5 minutes, I think, from a serious bacterial infection for which we do not have an effective agent.

And yet the dynamics of the business of antibiotics is just a target in terms of just so many meddlesome difficulties, just the business proposition is improbable and paradoxical, very difficult. And yet you guys persist. Do you philosophically have a sense that continued clinical development of antibiotics can ultimately yield of a valid business proposition?

Tony Wood Executive

Yes. And look, a couple of ways to answer that one. Let me just start, first of all, anchored in the reality of what we have been doing. So the bolt-on acquisition of tebipenem in complicated urinary tract infection juxtaposed with gepo in uncomplicated urinary tract infection. I'll deal with Brexafemme for candidiasis.

These are all examples of actually where we can make the economics work, if you look at it from a sort of a bundling standpoint from Luke's world. So we'll continue to, if you like, make those or look for those tuck-in opportunities where we can build that presence and have the economics make sense. As far as the broader proposition is concerned the fact that I hang on to is, I think antibiotics have saved 200 million lives in their total presence of existence. And as you point out, there is increasing resistance. At some point in time, I think that has to pivot.

And then the question is how well placed are you to be able to respond to it, right? Are these tuck-ins and the presence of our capabilities, I think, places us well in that regard. So it's sort of positioning ourselves with deals that do make sense from a financial standpoint, ready to be able to respond when a pivot takes place.

Chris Shibutani Analyst

Yes. No, I would argue that one of the few global houses that would be well equipped to remain dedicated to having the lights on across the spectrum of research and

commercialization. So wish you well in that resilience. How tenure oncology, there seems to be less of a focus here beyond momelotinib. Should we expect more to come with oncology?

Is that TBD? Where does oncology sit?

Tony Wood Executive

Yes. I mean let me just sort of -- because it's not so much less of a focus, as you'll just hear me talking less about it, because I'm going to talk about things in proportion to where we're seeing capital allocation in the portfolio. Look, we still see oncology as an emerging area. And despite the headwinds, when you look at the amount of investment that's gone into that area, it will still create opportunity. I think we've got to be realistic about our ability to compete relative to the larger players.

And for me, that boils down to, if I very quickly sort of give you 3 tranches, you mentioned, momelotinib. For niraparib, it's very much focused on getting OS data in PRIMA so that we have a setting which supports the all-comers label for that molecule. In the IO field, the credentials of Jemperli continuing to build those credentials, in a setting where Jemperli efficacy is going to deliver, let's call them, transformational results. You see that in the rectal cancer data. You see it potentially in the first-line endometrial cancer, in the dMMR population.

And PERLA for example, although it wasn't designed to show superiority. I think that's Jemperli very much in a favorable light. So we'll continue to be very thoughtful about where to invest in Jemperli, bearing in mind it has a much longer runway on loss of exclusivity, but we need to see efficacy that would justify its use, largely driven from biomarkers. We're monitoring the CD226 axis very, very closely. We have our own internal platform studies, and interims from those will dictate the path we decide to take towards the end of the year when we also see competitive data emerge.

Early in oncology, that will be very much focused on smaller scale deals, which are identifying agents which gave demonstrable efficacy in Phase Ib. And that pretty much boils down to tumor targeting the [indiscernible] CD3 bispecific deal that we signed with Wuxi and other related areas.

Chris Shibutani Analyst

Got it. And for a final question, the most recent captive brought into the portfolio of [indiscernible] and recurrent chronic cough. The MOA here, thinking about the P2S3s, tolerability is something that has to be navigated and we're seeing it through clinical development, et cetera. As a Chief Scientific Officer, what's your perspective about being able to come up with a maybe more preferred because kind of demographically, the numbers are extraordinary. So how do you thread that needle coming up with a therapeutic that will be broadly adopted?

And is that scientifically possible based on the mechanism?

Tony Wood Executive

Look, I mean, I think there's a really strong foundation to believe that, and it's borne out in

Phase II data. If I just do it quickly, the selectivity profile for camlipixant for P2X3 versus P2X2 is orders of magnitude greater than gefapixant. And you actually see it in reported disco in the Phase II studies, which is around about 6% for camlipixant and it's high 60s for gefapixant. So it's a very straightforward proposition and something that I really like because I can anchor clinical results in what I know about the preclinical profile of the molecule.

Chris Shibutani Analyst

Terrific. Well, we're out of time. We appreciate your overview. Tremendous focus. Headlines will be coming in terms of RSV, so wish you and the GSK team well.

Thank you for joining us.

Tony Wood Executive

Thanks.