Market Hunt Episode 10 - Pierre Laurin Transcript

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Thierry Harris: COVID-19, its impact has resonated across the pharmaceutical industry, exposing deficiencies in supply chains everywhere. What pathways exist towards finding a vaccine? What economic and political pitfalls impact companies seeking medical solutions to solve this unprecedented health crisis?

Pierre Laurin: God put on the planet, the mean machine that can infect and put the toy that can defend, and it's up for us to figure out how to use it.

Thierry: On this episode of *Market Hunt,* we chat with pharma industry veteran, Pierre Laurin. Stay tuned.

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Nick Quain: Entrepreneurship is hard, you need to have support there.

Pierre: This is an alarm in the middle of the night, you put your pajama if you want but to get out of the house.

Pierre: Doing things differently requires a lot of resources, money, and willingness of all different stakeholders to move at the same pace.

Thierry: We're coming up with some pretty interesting ideas here.

Andrew Casey: We've solved it. Solved everything.

Thierry: We've solved it all.

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Hi, folks. Thierry Harris here. On this episode of *Market Hunt*, we chat with Pierre Laurin. Pierre built a $2 billion publicly-traded pharmaceutical company, ProMetic Life Sciences, a mini-multinational as he liked to call it. He experienced tremendous professional success, though not without his fair share of challenges, leading a band of loyal co-workers through wave after wave of one crisis after another. After over 20 years at its helm, Pierre stepped back to leave control of the company to other hands but Pierre being Pierre, he couldn't stay out of the game for too long. Let's listen in to our conversation.

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Pierre: You can be on an overdose of adrenaline for 25 years and shut down, right? I did take some time to get back in shape and look after all the problems that a typical house has but after I finished fixing all the problems in the house and finishing all the landscape, I said, it's better for me to get back to it. One of the things that I've been

busy with is called InvHealth Capital, which is a small business unit that behaves almost like a venture cap except that it doesn't manage money for other people. It invested some capital and invest predominantly in business opportunities exclusively in the field of healthcare.

InvHealth is focused on medical solutions that have the potential to provide a tangible improvement over standard of care but I'm very, very focused on healthcare solutions that payers can afford. We're leveraging all our extensive network with pharma and universities that were developed over the past 35 years.

Thierry: Pierre is referring to companies focusing on everything from orthopedic regenerative technologies, allowing us to heal faster from broken bones to protein purification technology, the substitute for traditional meat products to artificial intelligence, enabling eye gazing technology that allows paralyzed patients to communicate with their family members, and eventually, for early detection of MS, ALS, or Parkinson's disease.

Pierre: These are the type of things we've been involved, doing due diligence, performing the necessary due diligence for ourselves or for partners, investing in those companies.

The one that has kept us most busy has been the formation of a new company. We could call it ProMetic 3.0 but its official name is Ingenew Pharma, Ingenew, I-N-G-E-N-E-W which is a new name created to simply mean that we think outside the box. That's the culture that the company will be focused on immunological disorders, oncology, dermatology, and urology to begin with.

Thierry: Pierre discusses the criteria for his investment firm when considering an investment in the medical health field.

Pierre: I've always been amazed sometimes, you have a beautiful technology, and then you wonder is this a technology looking for a disease or there's a disease or an unmet medical need that needs that type of technology? We were quite critical of who's going to pay for that element of any good idea. There is no lack of imagination, but is this one that will create something that people can afford?

Thierry: Pierre discusses his new company, Ingenew, and a term he has coined, adaptive creative research and development.

Pierre: I founded it and of course, the capital is going to be shared with colleagues, some of which were at ProMetic and left ProMetic over the past 15-18 months. I have to say that I'm very happy-- This is why I call it ProMetic 3.0 because ironically, there's at least four or five ex-executives from ProMetic that will find their way in creating value through Ingenew Pharmaceutical.

One of the things that we are very eager to do, thinking outside the box is something that most entrepreneurial company has to apply. I gave it another name and I call it adaptive creative research and development. Adaptive creative, because sometime, we

need to appreciate that there may be solutions that exist out there but they just need a little tweak, they need a complementary technology, a little push to make it affordable or usable instead of reinventing the wheel from scratch.

In order to be able to implement that, you cannot have a not-invented-here syndrome which is typical of a larger organization. There's a lot of tendency to focus on in house portfolio and anything else is the enemy. At Ingenew obviously, by default, we're not looking like that. We're actually very active in business development with partnerships, connecting the dots between the academics and other technologies to really bring solutions eventually to market in a faster way.

Thierry: Pierre has been working on COVID-19 therapies. In April 2020, he was quoted in a *Le Presse* article, citing the potential benefits of Hesperidin as a therapy to treat COVID-19.

Pierre: It started with in house discussions amongst ourselves, colleagues at Ingenew, and for the life of me I couldn't figure out what was the reason behind such excitement around hydroxychloroquine or chloroquine. Because of all things, this is product that you got to take balancing the risk. Now, if you want to prevent catching malaria, which is not a fun disease to catch, then fine, but then just to take it in case perhaps maybe it help you for COVID, I thought it was a bit adventurous. Actually some of the trials that have been performed so far confirmed that patients that use that didn't fare very well.

Nevertheless, this kind of questioning, or where on the earth this first idea came from led us accidentally to review some of the literature that dated back with SARS 2002. When we started looking deeper at what happened, SARS Toronto and Hong Kong back in 2002, we realized that there have been several screening of hundreds of molecules and the one that came out to be the strongest inhibitor of SARS 2002 was Hesperidin, H-E-S-P-E-R-I-D-I-N, Hesperidin.

Now, of course, it's no surprise that it has not attracted the attention of Big Pharma because Hesperidin is a commodity, is a non-proprietary compound extracted from the albedo part of the oranges. Any further validation of this product did not receive Big Pharma funding if you want to say because it can't be protected via patents, it can't be turned around and sold as a $100 pill. I would say this discovery left fairly low profile until then in February it reemerged the notion that the current SARS virus binds to the same bloody site to infect ourselves than the one in 2002. Then that the infamous Hesperidin binds uniquely to the protein that the virus used to infect ourselves and also bind to the regional binding site. You can't design a drug like that. You stumble across it, it's almost like I was saying is it as a joke is God put on the planet the mean machine that can infect and put the toy that can defend, and it's up for us to figure out how to use it. Go on with the game.

We put together a comprehensive document and made actually a video version of it, posted on YouTube. The objective was to really alert the scientists to the seriousness of the possibility here that that molecule which is abundantly available and affordable.

Again, let's think of what can happen to countries that can't afford expensive drugs, expensive vaccine. Our initial attempt was really to bring awareness and do our part that way. We're very happy that there was some very high profile scientists and institutions that contacted us. We're taken by this well, it's not our discovery, but let's put it this intellectual scientific exercise and suggested that we run a clinical trial. We've been pursuing more scientific review and this binding effect is one of the first effect that Hesperidin could have on the virus that is to slow down the rate of replication of the virus.

If you compete with the same site where the virus infect us, then the virus has harder time to replicate itself. If you know you have an exponential curve, if you slow down that exponential curve, initially by 20, 30%, it is a huge difference 7, 10 days later, and it would allow more people to develop a natural immunity against the virus infection.

Moreover, then when we start studying more about that product, we realize it was over 2200 publications on the product and its ability to reduce inflammation and it's controlling some of the cytokines that are blamed and to the cytokine storm of COVID infection, the severe patients some of them are actually not dying of the direct consequence of the infection but more of the exuberant inflammatory response to the infection and that Hesperedin can also modulate that inflammation. It's been demonstrated to do so in with other type of virus infection.

So there you go, listen, we brought this to the attention of people and hopefully, there will be a randomized clinical trial to demonstrate its efficiency in helping people fend off that infection.

Now, someone could actually probably reach a therapeutic dose by drinking a liter and a half of orange juice a day during the infection, which is a bit inconvenient. The idea is to have it in a pill form in a concentrated form. Again, it was funny because one of the physician interviewed by the journalist was basically saying, "Listen, as a scientist, as a physician, I want to prove that it works, but if I get infected, you bet I'm going to drink my orange juice."

Thierry: What was the Canadian pharmaceutical industry response to tackling COVID-19? Pierre elaborates.

Pierre: It's a mixed bag of many things. Obviously, it is a fact that there's still going to be much more death of cancer this year than the result of COVID. One of the problems that we see is obviously some other very serious diseases are not getting the attention that they should. Some of the clinical trials that we're going to start or we're in course are delayed because of the stay home policy. It's not deemed essential so there's been a bit of a drag on other things. The race for a proven solution involves typically the combination of legitimate participants and others that just want to surf on the wave and parasite the wave. It's unfortunate but that's what you see as well.

You have programs that the government puts in place and you'll end up seeing 2500 applicants and you say what? There's not even that number of companies around or researchers that would really qualify for that. It's a bit of a mixed bag.

Supply chain is also affected, it's not a secret that a lot of things, a lot of raw material are originating outside of, especially Canada. Let's look at America as a whole. So much has been over time transferred to China for synthesis of bulk active ingredients. If there were to be a war between those two countries they would just have to shut down that shipping any of this raw material, they would deplete 90% of America's antibiotics and other essential drugs. The supply chain has been affected. It's a critical issue.

Thierry: I asked Pierre if he thought the obstacles to finding COVID-19 solutions were more scientific or more political?

Pierre: It's difficult not to have politics involved in the science. There's always going to be people who not necessarily have the right science, but have the right political contact and vice versa. It's hard to call, it is also very difficult to point fingers because you never know which solution will emerge as being a winning one. There's a notion that if you concentrate on what appears to be the most promising project and apply the right amount of resources behind those, perhaps you have a better chance of seeing something. What if what you left behind actually was the solution that should have been pushed forward? Who's involved in screening those requests and that's where politics could get involved. It's not obvious.

Listen, Canada is a small player in the scheme of things compared to many other efforts. It's playing along, it's pushing its own. It's doing what it can. I think that they've put a lot of initiatives but when you put money available to support initiatives, then you have committees being formed and who formed those committees and who are on those committees and how does that work, is very obscure.

Thierry: Through this politically charged environment, solutions are beginning to emerge. One key focus has been preparation to counter the next wave of COVID-19, or other pandemics that could arise in the near future. The very foundations of our healthcare systems as we know it are being exposed. Fundamentally, what are some steps we can take to prepare for the next pandemic?

Pierre: This is a very good question and one that would require many other competence than the mind to provide a comprehensive answer, but some of the observation that I have is that we tend to forget that when we hit a phase like we are right now, it's not the time to start getting SOPs out and start reading. This is an alarm in the middle of the night, put your pajama if you want, but to get out of the house and follow instruction. My point here is that, for example, convalescent plasma, you're familiar with that expression.

People developing the antibodies to the virus therefore becomes donors of plasma that is enriched with the right antibodies to fight that virus. Well, in China, one of the reason why they've implemented you've seen such a drastic drop of cases in Wuhan is that

pretty much everyone who was deemed to have been infected and responded and came out resolved was automatically a plasma donor. One liter of plasma protects 5 other patients roughly, that's the ratio. You can't call that a vaccine. It's not a vaccine, but it's giving antibodies that help other patients that are severe to fight off the condition.

Here we decided to, "Well, let's run a clinical trial for this." It's going to take a year to run. Okay, I get that there will be a lot of information that will be emerging from that clinical trial, that it would be perhaps optimized, timing, when to give it, who should not be getting it, but meantime, there's a lot of people who have recovered. There's a lot of people that could give plasma and there's a lot of people who could avoid dying. If you're wrong by 5%, you're still right by 95%, and you could still save more lives than we've seen right now.

The Hesperidin example is one that is frustrating the little Jesus out of me because quite frankly, there will be a trial run. The trial may fail. Why? Because the dose was not higher, people were not compliant. There's all kinds of reasons why a trial can fail, or simply it was a good idea but theory didn't translate to practice. Everyone that has a scientific degree that reviews the literature basically says, "Wow, we should have that in tap water. We should have that in all old-home folks. What do you have to lose? Instead of giving them apple juice, give them orange juice, give them a tablet of Hesperidin. This is an extract from fruits. Why do we need the clinical trial to try to save them?" What happened is six months from now we say, "You see, it worked. Okay, well, we could have implemented that faster."

When you combine things such as respect, isolation, countries that were very, very stringent on imposing isolation were very successful. We don't talk much about Taiwan, but Taiwan didn't trust the Chinese, and they implemented the immediate enforcement of lockdown. If there's been 18 cases of deaths in Taiwan, a country of 20 million people, I would be surprised. They were they were immediately locked down and it worked. In the meantime, implementing because you're at a war time. It's not the time to start being very fancy. Would it be nice if we could confirm that in a randomized clinical trial?

There are times to do certain things. You just look at currently, it's scary. Coming up with a vaccine in 15, 18 months sounds long, but that would be five to seven times faster than any other vaccines developed before. As an old veteran like you call me, if I'm facing the needle with a vaccine in it and or the virus, which one do I choose? Do I want to get infected and fight it off or do I want to take that vaccine that would have burned every speed record ever?

You have to think that, "Well, perhaps they broke the speed record because they changed the way that we're thinking about developing products." The risk-benefit is that, "Well, let's do it faster. Let's start things such as scaling up manufacturing ahead of knowing whether it works. If it doesn't work, scrap it. If it works, great. We save years, months." Doing things differently requires a lot of resources, money, and willingness of all different stakeholders to move at the same pace. It's not obvious.

Thierry: In order to accelerate research on COVID-19, governments have been quicker to approve clinical trials. Pierre elaborates.

Pierre: Clearly the Chinese are funding their trials. The Americans are funding trials. The UK is funding trials and Canada is funding some trials as well. Which one are funded? Who chose to fund those? So on, as another question, but there are government funds that have been proposed or deployed for demonstration of efficacy. Now, there's a big focus on vaccines, obviously. That would be the ultimate solution, a reminder that the vaccine doesn't exist for herpes, and it's a Coronavirus. A vaccine was not successfully developed for SARS Toronto, SARS 2002, and perhaps because not as much resources was deployed and this was believed to have gone by the wayside.

My point is that it's not a given that a vaccine will be successful, and how you define successful, well, how long will the immunity last? Is this something that you need to jab yourself every three months, every six months, every whatever? Will it need a booster? Will it need recall shots? It is a reality. Look, with the population age changing, we'll have issues again with measles and mumps. There's less people with antibodies of the old disease. Polio may come back, Tuberculosis may come back with a vengeance, so your question is quite relevant in the sense that the healthcare system has to perhaps redefine whether it is worth thinking about having infectious zones to deal with pandemic-like reaction.

In Canada, we've done remarkably well. I'm obviously quite knowledgeable in the field, knowing so many physicians at different parts of Canada, and the one thing that we've managed to do is to never overwhelm the healthcare system. We cheated a bit because we've done this with the containment, the lockdown in certain big cities and so on, but we've also done that by canceling all elective surgeries, canceling anything else that was not related to COVID. Ideally, what you want to be able to do is to continue some form of business as usual, whilst you have a capacity to handle these pandemic-like cases, which really requires isolation.

If you isolate those patients better, that means that staff doesn't have to gown, re-gown, change and gown. This is when you dress and undress and move from one place to another that you increase the chances of getting infected. There's all kinds of lessons learned here at all levels, for sure. How many a generation will it take for people to forget?

Thierry: It's 100 years since the Spanish flu, and I think that after the First World War, they're saying it was a footnote. Even though it's more people that died after the First World War, in terms of the volume of literature that's been written "war versus Spanish flu", it's not even close. The war took way more ink that was dropped on that as opposed to the Spanish flu, even though the Spanish Flu was deadlier than the First World War, so what's going to happen with this situation?

Pierre, I'm just getting a sense because we're in the middle of this and we do have to talk about it. I'm curious from your poking around and your network within the pharma network and the life sciences network in Canada and internationally, what you really feel

is happening out there. You've been talking about the vaccine. Obviously, there's the diagnostic section and that whole like, "Are we testing? Do people have it or not?" Then there's the therapeutics that go into there as well like, "Can we treat it at least like we can treat herpes without having that golden silver bullet, which is a vaccine, and then striving towards that?

In the meantime, we have to get to some sort of normal and away we go." Let's get back to the business side of the conversation here. You've got a fund, you've got your company that's this thinking outside of the box, how do you evaluate potential markets? When you're taking a look at a market for technology, you're deciding to invest in it, what are some of the criteria that you're mentioning? You did mention that we have some very specific criteria of who we get into a relationship with. What are some of the criterias that you're looking for to evaluate a market potential?

Pierre: Well, there's this catchword that everybody use, but we have to sit down and reflect on what it means, unmet medical need. That would imply that you focus on conditions that the current standard of care is nowhere near satisfactory, but it is what it is. Then the second thing is that is the solution that is proposed going to be disruptive? Disruptive, could be good, disruptive could be a nightmare. Is this something that will change medical practice? In other words, if you're only asking a physician to prescribe something different but he doesn't change his practice, that's one challenge, but if you're asking a physician to change his practice, that's another world altogether.

Back to the affordability, is this something that will replace the existing treatment and therefore, not be additive to existing and current costs or is this something that is on top of the existing costs and what is the sensitivity here? How much are the payers willing to afford for that condition? Now, that this is the delta of improvement and how much value do you attribute to that treatment?

These are type of things that you're going to use some intuition that basically, gets refined as you progress, and you got to make sure you go back to those questions, asking yourself all the time those questions because you may get frustrated as a project that it looks good, on paper, it looks good, it looks superior to the standard of care when you compare the preclinical model.

Then all of a sudden, when you run into a tech transfer, you realize that the manufacturing cost is much higher than you first envisage. Does it still meet the criteria to go forward? These are the type of checks and balances, so people have to do their homework. They really have to do their homework. It's easy to look at the science with the pink goggle and really be attracted by the offering, but there's a lot more that goes to it.

Thierry: It's interesting, Pierre, because you had that drive in ProMedic working on the orphan drugs stuff and the drug companies, you'd said so succinctly they can't live without us, in a sense that they need us to survive because we're taking their drugs that are expiring and then we're modifying them, improving them and then potentially putting them out there so that they can have an added runaway in terms of that drug keeping

going, but you had that other side where you're going after those orphan drugs as they're called, in a sense that there's not enough people who are sick, who have this type of disease that justifies the investment to find a robust solution for it, and now--

Pierre: Thierry, there are some amazing situations where we're reviewing this there are people bringing them to our attention and or for our own screens and there are situations that are not by any stretch of imagination a rare disease. You would thought that if they affect, for example, over 600,000 woman in America, interstitial cystitis, chronic bladder pain, affects over 600,000 women. The last advancement of treatment dates 35,40 years ago, and those women that are prescribed an antidepressant to help cope with the situation because there's nothing really, and you say, "Well, we send people to the moon, we can do all kinds of things." We are talking about genetically modified humans, and we can't fix a chronic pain in the bladder, really?

This is an example of one of the indications we're going to be pursuing. We believe we have a solution and we're going to progress with it. When you look at what's out there, well, we got to approach a urologist to use something else in their procedure. Hopefully, this will translate as we expect in the clinical trial to be superior to what they're currently doing and it will be easy to add on to the protocols, and maybe cut by half the number of woman that requires zombie therapy to deal with their chronic pain.

When you listen to a woman affected by that, they have to go to the bathroom 50 times a day and we had the word debilitating, serious disease and or debilitating because as insignificant one may think, "Okay, well, you have pain in your bladder, big deal, no, no, I have an urge, I have to literally spend my day in the bathroom." It's amazing, so it doesn't have to be a rare disease to make a difference in people's lives.

Thierry: I asked Pierre what some of his measures of success were for his new venture at Ingenew.

Pierre: You got to lay it out. At the end of the day, if you look at the recipe we had at ProMetic, it's always important to have the creme de la creme reviewing the proposal, reviewing the offering, and for that, we never stayed away from working with some of the best advisors. That's one of the first criteria to not be afraid of being told that you're a bunch of idiots, this will never work, but we work with a like a Vanderbilt and Duke and Stanford and McGill and we have great universities across Canada, but we also work with some American and British universities and opinion leaders.

Those opinion leaders are helpful not only to address the scientific rationale, medical rationale but also to help us validate whether we are reading the trend in a given discipline the right way. These individuals become also quite useful because if they are convinced by the science and so on, they carry a lot of weight when you meet with the FDA or the regulators and they serve as sometimes advisors to the same agencies for other matters. You got to have to establish, I would call it baby step milestones there.

We're a private company so we don't have to excite the gallery with a news release to keep the stock going and show the investor that we're gradually de-risking the asset and

which is not insignificant. In our field you could be a long way, away from commercial, but value would increase or decrease depending on how you overcome challenges meet milestones. They've long development and then ultimately, commercial milestones are the real gage on how you are performing.

Equip yourself with the right people to call it quits before you spend too much money on something, and or on the contrary to adjust and, you know crack the whip and attract more resources behind the winners.

Thierry: When heading up ProMetic, Pierre Laurin was able to take the company up to a $2 billion valuation. Despite this, ProMetic was still a minnow compared to the giants of the pharma industry, which at the time of publication, were worth over $50 billion. I asked if you saw the possibility to develop a firm of that size in Canada and what it would take for this to happen.

Pierre: I hope we would. I think that Canada ought to become and has the capability of becoming an America-like country, selling high-value goods, whether tech, software, health care products, solutions. We're still, despite the fact that we're pretty high GDP, we weigh up their tenth economy in the world. A lot of it is still minerals, oil, gas, wheat, and it's pretty amazing.

Canada should have a much higher critical mass of health care companies, much higher critical mass of manufacturing capabilities of both the finish drug dosage form, but also the bulk active ingredient. Currently, I would say that Canada is probably 99% reliant on external sources, and then probably 90% reliant on India and China for most of its raw material drugs. You sit back and think about this and say, "Wow, does that make sense that we get our drugs manufactured in that fashion?

There's a cost to manufacture locally, it would be higher and more expensive but then you would have 2 or 300,000 more people with high wage and paying higher tax than people collecting strawberries in the field. It's a math that I'm sure macroeconomists can run, but it should definitely be something that Canada can do or should do.

Thierry: The cost of not having manufacturing capability in the pharmaceutical industry is hurting Canada. Will future pandemics force the government's hand or will private enterprise step in and seize the opportunity? Time will tell. For now, Pierre is focusing on his rollout at Ingenew.

Pierre: With regard to Ingenew, there are things that we don't have to do like we have to do with ProMetic. With ProMetic, we have no choice but to build a fairly significant infrastructure to be able to collect plasma, process plasma. There is no other participant in the plasma industry that had the either willingness but more importantly, the capacity or capability to integrate our platform technology in their facility to manufacture product for us.

We have to build everything up and this has been quite a task. We don't have to do that with Ingenew. Ingenew doesn't have to have its own manufacturing at least for quite a

while if ever, and we can really focus on our core competency and work in partnership with same size, smaller or bigger than us to advance the product to commercial stage.

We'll have to ask ourselves eventually do we want to have a commercial presence boots in the ground in the US and Canada to commercialize our product or is there a good fit for most product with a commercial partner?

For now, I think that one of the big difference with Ingenew is that we will not have the need to build a manufacturing infrastructure.

We can use local manufacturers that are in existence and performing FDA, EMA certified, and we're in a good position on that front. That requires far less capital, and we can get to our objectives much faster.

Certainly, we have a combination of both novel and also ways to deliver precisely well-established products that currently are going in the veins of patients and causing havoc. You think of chemotherapy and chemotherapy has proven to be quite useful, but it has its limit, mostly due to the toxicity, and sometime patient's inability to tolerate treatment is the limitation of the efficacy of the product.

We were advancing proprietary formulation of established products to improve their efficacy. We're advancing target deliver systems that deliver massive dose at the site of tumor and leave pretty much intact the rest of the body. These are the type of things connecting the dots between complementary technology that could actually take proven established therapy and make it adapted for certain cancer.

If you take of glioblastoma, for example, brain tumor, but most products have a hard time crossing the brain-blood barrier. Well, that's not useful if you want to treat a tumor in the brain. You have to give a big dose to get the effect and the big dose that makes the patient feel much weaker. Those tumors sometime are inoperable, so is there a way to deliver the product in a safe way without creating inflammation in the brain, delivering it and they meter dose matter that zap the tumor and give a longer normal lifespan because giving lifespan with a patient in a coma is no big deal.

There's no real added value here, but can we improve the survival rate and the quality of life associated with that survival rate in such type of patients where a tumor is inoperable, or surgeons can't remove everything because it would be quite debilitating for the patient, but you can combine surgery and localized chemotherapy. These are some of the approaches and oncologies that we're going to deal with. I mentioned urology and the bladder. There's also an applicable, a similar approach for dermatology and topical cancer, melanoma, squamous cell carcinoma, basal cell carcinoma.

We have quite a focus on oncology but it's not exclusive to oncology. It's, I would say to everything that is immunology, inflammation, oncology is really why we're going to really focus and that's the backdrop of how we got involved in COVID. Our understanding of immunology, our understanding of inflammation, and the relevance of Hesperidin as a potential candidate for COVID-19.

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Thierry: After so many years in the industry, I asked Pierre what his motivation was to stay in the game and keep that ball rolling?

Pierre: Well, I have to say that is part in my genes, I guess, but also colleagues of mine. I would say that, whilst I was redoing the landscape and repairing things, as I said, things were percolating in my mind. We're a bit like a MacGyver as my wife call or Mr. Fixit. There's an issue you immediately try to find solutions to fix things, but then comes all of a sudden, by circumstances, colleagues that become available and want to line up and restart a ProMetic 3.0.

That becomes the ultimate motivation because having the pleasure of working with people you respect, enjoy working with, have fun working with is real adventure worth living. You meet all kinds of interesting scientists, all kinds of interesting different disciplines: lawyers, accountants, tax advisors, economists, health economists. And it's a never-ending learning process, and that's what keeps the adrenaline flowing, the adventure.

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