

years, 95 percent CI: 0.85, 1.10). However, there was no significant difference in the rates of confirmed, complicated upper GI clinical events, which include perforations, obstructions and significant bleeding, between ARCOXIA and diclofenac (0.30 vs. 0.32 per 100 patient years).

"We designed the MEDAL Programme to assess the relative cardiovascular safety of two arthritis medicines in a broad range of patients to simulate the general population of arthritis patients," said Christopher Cannon, M.D., MEDAL Steering Committee Co-chair and a cardiologist in the TIMI Study Group at Brigham and Women's Hospital. "The results of the MEDAL Programme are important, as they show that ARCOXIA and diclofenac were similar in terms of thrombotic cardiovascular events."

"Until now, we have not had long-term clinical trials assessing the cardiovascular safety of traditional NSAIDs compared to selective COX-2 inhibitors," said Professor Tore Kvien, Head/Professor, Department of Rheumatology, Diakonhjemmet Hospital, Oslo, Norway. "Now, we have useful cardiovascular safety data comparing ARCOXIA, a selective COX-2 inhibitor, and diclofenac, a traditional NSAID, that will help inform and guide physicians. In addition, it is important to mention that both of these medicines have demonstrated effective pain relief in patients suffering from arthritis."

Conducted at 1,380 sites in 46 countries, the MEDAL Programme was a prospectively designed clinical programme combining thrombotic CV safety data from three trials: MEDAL (largest component), EDGE and EDGE II. The MEDAL Programme is the only arthritis study with thrombotic CV safety as its primary endpoint and represents the largest amount of CV data with a selective COX-2 inhibitor vs. a traditional NSAID. The primary objective of the MEDAL Programme was to perform a non-inferiority analysis of confirmed thrombotic (blood-clotting) CV events following daily treatment of ARCOXIA (60 or 90 mg daily) or diclofenac (150 mg daily) in osteoarthritis (OA) and rheumatoid arthritis (RA) patient populations. The intent of the study was not to assess absolute risk; this would have required a placebo group, which would be unethical in a long-term arthritis study.

The study enrolled patients with OA or RA that were equal to or greater than 50 years of age and if they had a clinical diagnosis of OA of the knee, hip, hand or spine, or a clinical diagnosis of RA that satisfied at least four of the seven of the American Rheumatism Association 1987 revised criteria, and in the judgment of the investigator, would require chronic therapy with an NSAID. These patients were not candidates for acetaminophen (paracetamol) as first-line therapy due to the severity of their symptoms. Patients with a history of myocardial infarction, coronary artery bypass graft surgery or percutaneous coronary intervention more than 6 months preceding enrollment were allowed to participate. Of the 34,701 patients

enrolled, 35 percent were taking low-dose aspirin and 50 percent were taking a gastroprotective agent. The average duration that each patient was on therapy was 18 months.

An independent confirmation of the analyses of the MEDAL Programme was performed by the Frontier Science Foundation of Madison, WI, USA.

Thrombotic Cardiovascular Safety Findings

The MEDAL Programme results indicate the rate of confirmed thrombotic CV events was similar between ARCOXIA and diclofenac. The primary results are expressed as a relative risk, which is a ratio of risk of one treatment compared to the other treatment. Expressing results as a relative risk helps us to understand how close the event rates in the two treatments are to each other; if the event rates are identical, the relative risk equals 1.0.

In the primary pre-specified "per protocol" analysis² of the primary endpoint, the relative risk of confirmed thrombotic CV events between ARCOXIA and diclofenac was 0.95 (95 percent CI: 0.81, 1.11). Among the 34,701 patients enrolled in the MEDAL Programme, 17,412 patients received ARCOXIA and 17,289 patients received diclofenac. In the primary analysis, 320 patients on ARCOXIA (1.24 events per 100 patient years) and 323 patients on diclofenac (1.30 events per 100 patient years) had thrombotic CV events, meeting the pre-specified criterion of non-inferiority. In the "intent-to-treat" analysis (to end of studies), the relative risk of confirmed thrombotic CV events between ARCOXIA and diclofenac was 1.05 (95 percent CI: 0.93, 1.19), consistent with the primary per-protocol analysis³.

Confirmatory analyses of the primary endpoint results, including results of analyses of individual events forming the composite primary endpoint and other secondary CV endpoints, were all consistent with the primary endpoint results. The relative risk for ARCOXIA vs. diclofenac for certain thrombotic CV events (cardiac, cerebrovascular, peripheral) that were part of the composite endpoint also showed no evidence of a difference between the treatment groups. The most common thrombotic CV events were heart attacks, with rates per 100 patient years of 0.43 for ARCOXIA and 0.49 for diclofenac (non-fatal and fatal events) in the primary analysis. Similarly, fatal thrombotic CV events occurred at a rate of 0.17 per 100 patient years in each group. The relative risks for the secondary CV endpoints of thrombotic arterial CV

² In the per-protocol analysis, only those events that occur in patients while they are on study treatment or within 14 days thereafter are analyzed: patients who took study medication less than 75 percent or took non-study NSAIDs more than 10 percent of time while on study medication were excluded from the analysis (approximately four percent of total MEDAL Programme population).

³ In an intent-to-treat analysis (to end of studies), patients are followed to the end of their respective study, no matter when they stopped study medication and no matter what other medications they took after stopping their study medication, and those events which occur are analyzed.

events and APTC (Antiplatelet Trialists' Collaboration) events were 0.96 for each, similar to the primary endpoint results.

In addition, the relative thrombotic CV risk of ARCOXIA vs. diclofenac did not differ across any of the subgroups analysed, including patients with different degrees of CV risk on different doses of ARCOXIA (60 mg or 90 mg), or by disease (OA vs. RA).

All-cause mortality rates were 0.48 and 0.50 per 100 patient years for ARCOXIA and diclofenac in an analysis, which included all patients on study therapy or within 14 days of discontinuing study therapy.

Gastrointestinal (GI) Safety Findings

In the MEDAL Programme, the rate of confirmed upper GI clinical events, which include perforations, ulcers, bleeding and obstructions, was significantly lower with ARCOXIA (0.67 per 100 patient years, 95 percent CI: 0.57, 0.77) than with diclofenac (0.97 per 100 patient years, 95 percent CI: 0.85, 1.10). The relative risk of confirmed upper GI events between ARCOXIA and diclofenac was 0.69 (95 percent CI: 0.57, 0.83). Of note, this result was achieved with 50 percent of patients in the MEDAL Programme on gastroprotective agents (predominately proton pump inhibitors) and 35 percent on low-dose aspirin. However, there was no significant difference in the rates of confirmed, complicated upper GI clinical events, which include perforations, obstructions and significant bleeding, between ARCOXIA and diclofenac (0.30 vs. 0.32 per 100 patient years).

Although this pre-specified endpoint was not the primary focus of the study, data from this large programme showed that etoricoxib was associated with fewer stomach adverse events than the traditional NSAID diclofenac.

Other Safety Findings

In the MEDAL study, the largest component study of the MEDAL Programme, the incidence of discontinuations due to hypertension-related adverse events was less than three percent for any treatment group; however, both ARCOXIA 60 mg and 90 mg demonstrated significantly higher rates of discontinuations for these events than diclofenac. In OA patients randomised to ARCOXIA 60 mg or diclofenac, 146 out of 6,769 patients on ARCOXIA (2.16 percent) discontinued due to hypertension-related adverse events, compared to 109 out of 6,700 patients on diclofenac (1.63 percent). In OA patients randomised to ARCOXIA 90 mg or diclofenac, 55 out of 2,171 patients on ARCOXIA (2.53 percent) discontinued due to hypertension-related adverse events, compared to 24 out of 2,162 patients on diclofenac (1.11 percent). In RA patients randomised to ARCOXIA 90 mg or diclofenac, 69 out of 2,841 patients

on ARCOXIA (2.43 percent) discontinued due to hypertension-related adverse events, compared to 46 out of 2,855 patients on diclofenac (1.61 percent).

Rates of congestive heart failure (CHF) were low in both the ARCOXIA and diclofenac treatment groups. A numerically higher rate of congestive heart failure compared with diclofenac was seen only with the ARCOXIA 90 mg dosage, and not with the 60 mg dose. Specifically, 15 out of 2,171 OA patients on ARCOXIA 90 mg (0.69 percent) experienced congestive heart failure, compared to seven out of 2,162 OA patients on diclofenac (0.32 percent); additionally, 18 out of 2,841 RA patients on ARCOXIA 90 mg (0.63 percent) experienced congestive heart failure, compared to nine out of 2,855 RA patients on diclofenac (0.32 percent). For those patients in the study taking 60 mg ARCOXIA, 19 out of 6,769 OA patients (0.28 percent) experienced congestive heart failure, compared to 14 out of 6,700 OA patients on diclofenac (0.21 percent).

The incidence of discontinuations due to edema-related adverse events was significantly higher only for ARCOXIA 90 mg compared to diclofenac, and not with the 60 mg dose. In the MEDAL study, 41 out of 2,171 OA patients on ARCOXIA 90 mg (1.89 percent) were discontinued due to edema-related adverse events, compared to 17 out of 2,162 OA patients on diclofenac (0.79 percent); moreover, 28 out of 2,841 RA patients on ARCOXIA 90 mg (0.99 percent) discontinued due to edema-related adverse events compared to 16 out of 2,855 RA patients on diclofenac (0.56 percent). For those patients in the study taking ARCOXIA 60 mg, 56 out of 6,769 OA patients (0.83 percent) were discontinued due to edema-related adverse events, compared to 49 out of 6,700 OA patients on diclofenac (0.73 percent).

Results on hypertension, edema and CHF for the EDGE and EDGE II studies were consistent with the results of the MEDAL study.

About Arthritis

Pain relief is an important goal in the treatment of arthritis. Joint diseases affect hundreds of millions of patients throughout the world, causing pain and disability and creating a great impact on families and on society. It is estimated that one in five adults suffer from some form of arthritis. In Europe alone, more than 103 million people are affected by arthritis/rheumatism. More than half a million New Zealanders will have arthritis in their lifetime.

About ARCOXIA

ARCOXIA, developed by Merck Sharp & Dohme, is a selective COX-2 inhibitor for arthritis and pain. ARCOXIA has been under review by the FDA as an investigational selective COX-2 inhibitor since the original NDA was submitted in December 2003 and is currently available in 62 countries in Europe, Latin America, the Asia-Pacific region and Middle

East/Northern Africa. ARCOXIA has been available in New Zealand since October 2002. The primary data from the MEDAL Programme has been provided to the U.S. Food and Drug Administration (FDA), the European Medicines Agency (EMA), and other regulatory agencies in countries where ARCOXIA is approved or under review.

About Merck & Co., Inc. (Whitehouse Station, NJ, USA)

Merck & Co., Inc. which operates in many countries as Merck Sharp and Dohme, is a global research-driven pharmaceutical company dedicated to putting patients first. Established in 1891, Merck currently discovers, develops, manufactures and markets vaccines and medicines to address unmet medical needs. The Company devotes extensive efforts to increase access to medicines through far-reaching programmes that not only donate Merck medicines but help deliver them to the people who need them. Merck also publishes unbiased health information as a not-for-profit service. For more information, visit www.merck.com.

Forward-Looking Statement

This press release, including the attachment, contains “forward-looking statements” as that term is defined in the Private Securities Litigation Reform Act of 1995. These statements are based on management's current expectations and involve risks and uncertainties, which may cause results to differ materially from those set forth in the statements. The forward-looking statements may include statements regarding product development, product potential or financial performance. No forward-looking statement can be guaranteed and actual results may differ materially from those projected. Merck undertakes no obligation to publicly update any forward-looking statement, whether as a result of new information, future events, or otherwise. Forward-looking statements in this press release should be evaluated together with the many uncertainties that affect Merck's business, particularly those mentioned in the cautionary statements in Item 1 of Merck's Form 10-K for the year ended Dec. 31, 2005, and in its periodic reports on Form 10-Q and Form 8-K, which the Company incorporates by reference.

###

MEDAL PROGRAMME RESULTS FACT SHEET

About the MEDAL Programme

- The MEDAL Programme was designed to determine whether ARCOXIA[®] (etoricoxib), a selective COX-2 inhibitor developed by Merck Sharp & Dohme (MSD), is non-inferior, or similar, in terms of thrombotic CV events to diclofenac, the most widely prescribed traditional NSAID in the world.
- The MEDAL Programme is the first arthritis study Programme designed with CV safety as its primary endpoint. It is a prospectively designed clinical Programme combining CV safety data from three trials – the MEDAL, EDGE* and EDGE* II studies – and includes data from more than 34,000 arthritis patients in 46 countries.
- As a pre-specified primary endpoint, the MEDAL Programme was designed to perform a "non-inferiority" analysis of confirmed thrombotic CV events following daily treatment of ARCOXIA (60 or 90 mg daily) or the traditional NSAID diclofenac (150 mg daily) in an arthritis patient population using data from all three component studies. In other words, the primary hypothesis was that the two treatments are not different from each other in terms of confirmed thrombotic CV events.

Results from the MEDAL Programme

Cardiovascular Safety Data

- Cardiovascular safety data from the MEDAL Programme demonstrate the rate of confirmed thrombotic CV eventsⁱ was similar between ARCOXIA and diclofenac, yielding a relative risk of 0.95 (95 percent CI: 0.81, 1.11). Among the 34,701 patients enrolled in the MEDAL Programme, 320 of the 17,412 patients on ARCOXIA (1.24 events per 100 patient years) and 323 of the 17,289 patients on diclofenac (1.30 events per 100 patient years) had thrombotic CV events, meeting the pre-specified criterion of non-inferiority in the "per-protocol" analysis.
 - In the "intent-to-treat" analysis, the relative riskⁱⁱ of confirmed thrombotic CV events between ARCOXIA and diclofenac was 1.05 (95 percent CI: 0.93, 1.19), which was consistent with the primary per-protocol analysis.
- Confirmatory analyses of the primary endpoint, including analyses of individual events forming the composite primary endpoint and other secondary CV endpoints, were all consistent with the primary endpoint.
 - Also, the relative thrombotic CV risk of ARCOXIA vs. diclofenac did not differ across any of the subgroups, including patients with different degrees of CV risk or on different doses of ARCOXIA (60 mg or 90 mg), and were consistent over the entire duration of the study.

Other Safety Data

- Results of the MEDAL Programme confirm the overall favorable gastrointestinal (GI) safety profile of ARCOXIA.
 - In the MEDAL Programme, the rates of confirmed upper GI clinical events (perforations, ulcer, bleeding, obstructions) were significantly lower with ARCOXIA (0.67 per 100 patient years, 95 percent CI: 0.57, 0.77) than diclofenac (0.97 per 100 patient years (95 percent CI: 0.85, 1.10), yielding a relative risk of 0.69 (95 percent CI: 0.57, 0.83). Of note, this result was achieved with 50 percent of patients in the MEDAL Programme on gastroprotective agents (e.g., proton pump inhibitors) and 35 percent on low-dose aspirin. However, there was no significant difference in the rates of confirmed, complicated upper GI clinical events (perforations, obstructions, significant bleeding) between ARCOXIA and diclofenac (0.30 vs. 0.32 per 100 patient years).
- In the MEDAL study (the largest component of the MEDAL Programme), the incidence of discontinuations due to hypertension-related adverse events was less than three percent for any treatment group; however, both ARCOXIA 60 mg and 90 mg demonstrated significantly higher rates of discontinuations for these events than diclofenac.
 - In osteoarthritis (OA) patients randomised to ARCOXIA 60 mg or diclofenac, 146 out of 6,769 patients on ARCOXIA (2.16 percent) discontinued due to hypertension-related adverse events, compared to 109 out of 6,700 patients on diclofenac (1.63 percent).
 - In OA patients randomised to ARCOXIA 90 mg or diclofenac, 55 out of 2,171 patients on ARCOXIA (2.53 percent) discontinued due to hypertension-related adverse events, compared to 24 out of 2,162 patients on diclofenac (1.11 percent).
 - In rheumatoid arthritis (RA) patients randomised to ARCOXIA 90 mg or diclofenac, 69 out of 2,841 patients on ARCOXIA (2.43 percent) discontinued due to hypertension-related adverse events, compared to 46 out of 2,855 patients on diclofenac (1.61 percent).
- A numerically higher rate of congestive heart failure (CHF) compared with diclofenac was seen only with the ARCOXIA 90 mg dosage, and not with the 60 mg dose.
 - Specifically, 15 out of 2,171 OA patients on ARCOXIA 90 mg (0.69 percent) experienced congestive heart failure, compared to seven out of 2,162 OA patients on diclofenac (0.32 percent); additionally, 18 out of 2,841 RA patients on ARCOXIA 90 mg (0.63 percent) experienced congestive heart failure, compared to nine out of 2,855 RA patients on diclofenac (0.32 percent). For those patients in the study taking ARCOXIA 60 mg, 19 out of 6,769 OA patients (0.28 percent) experienced congestive heart failure, compared to 14 out of 6,700 OA patients on diclofenac (0.21 percent).
- The incidence of discontinuations due to edema-related adverse events was significantly higher only for ARCOXIA 90 mg compared to diclofenac, and not with the 60 mg dose.
 - In the MEDAL study, 41 out of 2,171 OA patients on ARCOXIA 90 mg (1.89 percent) were discontinued due to edema-related adverse events, compared to 17 out of 2,162 OA patients on diclofenac (0.79 percent); moreover, 28 out of 2,841 RA patients on ARCOXIA 90 mg (0.99 percent) discontinued due to edema-related adverse events compared to 16 out of 2,855 RA patients on diclofenac (0.56 percent). For those patients in the study taking 60 mg ARCOXIA, 56 out of 6,769 OA patients (0.83 percent)

were discontinued due to edema-related adverse events, compared to 49 out of 6,700 OA patients on diclofenac (0.73 percent).

- Results on hypertension, edema and CHF for EDGE and EDGE II were consistent with the results of the MEDAL study.

Efficacy

- Data from the MEDAL Programme demonstrate that both doses of ARCOXIA provide similar pain relief to that of diclofenac in patients suffering from osteoarthritis or rheumatoid arthritis. This was determined by regular pain assessments completed by both the patient and investigator.

About ARCOXIA

- ARCOXIA is a selective COX-2 inhibitor developed by MSD for arthritis and pain. The New Drug Application for ARCOXIA is currently under review by the U.S. Food and Drug Administration. ARCOXIA is currently available in 62 countries in Europe, Latin America, the Asia-Pacific region and Northern Africa. ARCOXIA has been available in New Zealand since October 2002.

###

ⁱ Includes first occurrence of the following fatal and non-fatal events: heart attack (including silent), unstable angina pectoris, intracardiac thrombus, resuscitated cardiac arrest, thrombotic stroke, cerebrovascular thrombosis, transient ischemic attack, peripheral venous thrombosis, pulmonary embolism, peripheral arterial thrombosis, and sudden and/or unexplained death.

ⁱⁱ A relative risk of 1.00 means that the rate of events in patients in one treatment group is the same as the rate observed in the other treatment group