Guidance for Industry

Errors and Accidents Regarding Saline Dilution of Samples Used for Viral Marker Testing

Comments and suggestions regarding this document may be submitted at anytime to Stephen Ripley, Center for Biologics Evaluation and Research (HFM-17), Food and Drug Administration, 1401 Rockville Pike, Rockville, MD 20852-1448. For questions regarding this document, contact Sharon O'Callaghan, CBER, Office of Compliance and Biologics Quality, Division of Inspections and Surveillance (HFM-650), (301) 827-6220.

Additional copies are available from the Office of Communication, Training and Manufacturers Assistance (HFM-40), 1401 Rockville Pike Rockville, MD 20852-1448, or by calling 1-800-835-4709 or 301-827-1800, or from the Internet at http://www.fda.gov/cber/guidelines.htm

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GUIDANCE FOR INDUSTRY[1]

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Inspections by Food and Drug Administration (FDA) personnel have identified instances in which the integrity of samples intended to be used for viral marker testing has been compromised by saline during collection of blood and blood components with automated pheresis instruments when the saline reinfusion protocol was utilized. FDA has noted instances where samples for testing were diluted by saline as a result of three separate problems. These problems involved inadvertent keypad entries that caused the tubing to be rinsed with saline during sample collection, improper installation of tubing into a valve clamp, or failure to clamp the saline line that caused saline to be added to the collection bag during collection. The use of saline diluted samples is potentially significant in that it could contribute to obtaining false negative results for viral marker testing, and result in the transfusion or further manufacture of potentially infectious blood and blood products.

Title 21, Code of Federal Regulations, Section 600.14(a), states that the Director, Office of Compliance and Biologics Quality (formerly Office of Compliance), Center for Biologics Evaluation and Research (CBER), shall be promptly notified of errors or accidents in the manufacture of biological products that may affect the safety, purity, or potency of the product. Additional guidance was issued to blood establishments by memorandum dated March 20, 1991, advising that notification is necessary when the unsuitable product has been distributed or made available for distribution.

Any unexplained discrepancy or failure of a unit, lot, or batch to meet any of its specifications shall be thoroughly investigated, including identification of associated products that may also be affected, regardless of whether or not product was distributed. A written record of the investigation must be made including the conclusions and follow-up (See 21 CFR 606.100(c), 606.160(b)(7)(iii), 211.192, and 211.198).

CBER is issuing this document to notify blood and plasma establishments that saline dilution of samples intended for viral marker testing should be reported as an error or accident if the products are made available for distribution or the product has been distributed. In this context,

[1] This guidance document represents the Agency's current thinking on the need for reporting errors and accidents related to saline dilution of samples used for the viral marker testing of blood and blood components. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternate approach may be used if such approach satisfies the requirements of the applicable statute, regulations, or both.

available for distribution means that the blood product/component has been determined to meet all release criteria and is being held for distribution, and that no additional review of release criteria will be performed.

Questions concerning errors and accidents in the manufacture of biological products should be directed to Sharon O'Callaghan, CBER, Office of Compliance and Biologics Quality, Division of Inspections and Surveillance (HFM-650) at (301) 827-6220.