



DEPARTMENT OF HEALTH AND HUMAN SERVICES

T2083M
Food and Drug Administration
Atlanta District Office

T2083M

60 8th Street, N.E.
Atlanta, Georgia 30309

August 18, 1998

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

John B. Brennan
President/Owner
Medical Packaging Technologies, Inc.
1211 Lakewood Drive
Greensboro, North Carolina 27410

WARNING LETTER

Dear Mr. Brennan:

An inspection of your drug manufacturing facility located at 4300 Northeast Expressway in Doraville, Georgia, was conducted on July 22, 23, 27, & 29, 1998, by Investigator Leah M. Andrews. Our inspection revealed numerous significant deviations from the Current Good Manufacturing Practice Regulations (GMPs) as set forth in Title 21 of the Code of Federal Regulations (21 CFR), Part 211. These deviations cause your drug products to be adulterated within the meaning of Section 501(a)(2)(B) of the Federal Food, Drug and Cosmetic Act (the Act).

You have failed to conduct an appropriate laboratory determination of satisfactory conformance to final specifications for your drug products, including the identity and strength of active ingredients, prior to release. You could provide no documentation that any of your drug products had ever been tested for the presence or strength of an active ingredient. Your firm does not own equipment capable of conducting assays of active ingredients.

You have failed to establish and implement appropriate laboratory controls to include scientifically sound specifications, standards, sampling plans, and test procedures designed to assure that your drug products conform to appropriate standards for identity, strength, quality, and purity. You have failed to establish and follow written procedures designed to prevent objectionable microorganisms in your susceptible products. Your microbiological testing was seriously deficient in that samples are not incubated at a temperature suitable to support growth, there are no positive controls, and there are no established specifications. A comparison of the products manufactured since June 1997 and the laboratory testing notebook revealed that most lots are not tested. In some cases the product and lot number are recorded but there are no test results. There are large unexplained gaps in the dates of testing. The actual temperatures and the hours of incubation are rarely recorded.

You have failed to conduct other testing specified for your products prior to release. None of the antiperspirant lots had specific gravity testing and approximately half of the lots had no pH results recorded. The dandruff shampoo lots had no testing for specific gravity or total solids for the last two lots manufactured. You also failed to appropriately investigate and respond to out of specification (OOS) analytical results noted during finished product release testing. You have neglected to conduct failure investigations as required. Any failure of a batch, or any of its components, to meet any of its specifications must be thoroughly investigated, whether or not the batch has been distributed. Six lots of antiperspirant failed pH specifications and the above two lots of dandruff shampoo had failing analytical results. In several cases, there was no indication that the OOS results had been detected at all.

You have failed to establish adequate master production records to assure uniformity from batch to batch for your drug products. You have not established appropriate finished product release specifications for your products. The production records maintained were woefully inadequate. You failed to include all significant steps involved in the manufacture of your drugs such as mix times, mix temperatures, and filling procedures. Batch records lacked any record of the lot number of raw materials, identity of major equipment used, in-process laboratory results, reconciliation of the theoretical and actual yields, labeling utilized, labeling reconciliation, inspection of labeling area, and the double check of significant steps by a second responsible individual. Rework of drug products was not recorded in the batch records. Several batch records requested by the investigator could not be located. There have been no procedures established to address the rework of drug products. In fact, you have failed to establish written procedures for the majority of operations at the firm. Some of the operations not addressed include complaint handling, investigation and handling of OOS results, and cleaning operations. The available procedures were vague and seriously deficient.

You have failed to maintain adequate component, drug product container, and closure records. There is no documentation of a visual examination of incoming materials. Incoming raw materials are not sampled or tested for identity. Components are not identified as to their status. No individual inventory is maintained of components, closures, and containers. You have failed to implement sufficient testing of the potable water used to manufacture your drug products. No procedures have been established addressing the testing of this component. A review of the laboratory records found only one water sample since May 1997.

You have failed to implement an appropriate calibration and maintenance program for laboratory and production equipment. The thermometers used in production and in the test laboratory have never been calibrated. All scales, with the exception of the receiving area scale, have never been calibrated.

You have failed to maintain your production facility in a clean and sanitary condition to prevent the contamination of equipment, components, and drug products. You have failed to implement meaningful procedures to prevent product contamination and possible mixups. You have failed to adhere to the most rudimentary sanitation requirements for drug manufacturers. In addition, the overhead lights throughout the production area are not covered. Doors leading to the outside

were open at all times during production. Dust covered fans were found throughout the facility. Unlabeled containers and tanks were noted routinely at the facility. Floors and equipment all over the facility were covered with baby powder, including the filling line directly above opened containers of antiperspirants. Baby powder is used on production floors to keep employees from slipping. Operations are not performed within specifically defined or segregated areas.

You have failed to maintain records of cleaning for the manufacturing and filling equipment. The majority of production equipment is not dedicated. Plastic transfer hoses were noted to be stored on the floor when not in use, which was described as a common practice. Equipment located in all areas of the facility was noted to be dusty and to contain residual powder. Some equipment is not maintained in a manner that would facilitate cleaning.

You have failed to assure that each person engaged in the manufacture, processing, and packaging of your drug products has the education, training, and experience to enable that person to perform their assigned functions. No one at this facility exhibited a basic knowledge or understanding of the GMPs. Your QC Manager stated that he had never read the GMPs. No employee involved in the production of your drug products had been trained in GMPs. The laboratory technician responsible for performing microbiological testing had received no training in microbiology. This lack of training and understanding could possibly explain the confusion exhibited by key personnel at your firm about which products at your firm should be considered as drug products.

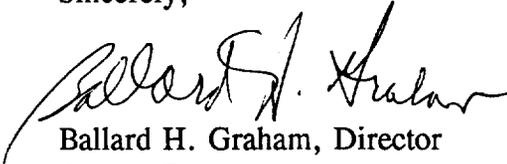
Many of the above deviations were included on the FDA 483 (Inspectional Observations) which was issued to, and discussed with, Ken Roberts, Chief Operating Officer, at the conclusion of the inspection. A copy of the FDA 483 is enclosed for your review. The violations noted in this letter and in the FDA 483 are clearly symptomatic of serious underlying problems in your firm's manufacturing and quality assurance systems. The deviations discussed above and included on the FDA 483 should not be construed as an all inclusive list of violations which may be in existence at your firm. It is your responsibility to ensure adherence to each requirement of the Act.

You are responsible for investigating and determining the causes of the violations identified by FDA. You should take immediate actions to correct these violations. Failure to promptly correct these deviations may result in legal sanctions provided by the law such as product seizure and/or injunction, without further notice to you. Federal agencies are advised of the issuance of all warning letters involving drugs so that they may take this information into account when considering the award of contracts.

You should notify this office in writing, within fifteen (15) working days of receipt of this letter, of any additional steps you have taken to correct the noted violations, including an explanation of each step being taken to prevent the recurrence of similar violations. If corrective action cannot be completed within 15 working days, state the reason for the delay and the time within which corrections will be completed. Your response should address the reason for the misleading information provided to our investigator about the scope of drug manufacturing at

your facility. In light of some of the confusion exhibited to our investigator during the course of the inspection, you may want to arrange a meeting to discuss these observations in greater detail at our office. Although a response was promised to Ms. Andrews, we have heard nothing from responsible management. We are also submitting copies of the labeling of your firm's drug products to the Center for Drug Evaluation and Research for further review. We will forward any pertinent comments from the Center to you. Your response should be addressed to Philip S. Campbell, Compliance Officer, at the address noted in the letterhead.

Sincerely,



Ballard H. Graham, Director
Atlanta District

Enclosure

cc: Kenneth G. Roberts, COO
Medical Packaging Tech., Inc.
4300 Northeast Expressway
Doraville, GA 30340