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December 7, 1999

Dockets Management Branch  
Division of Management Systems and Policy  
Office of Human Resources and Management Services  
Food and Drug Administration  
Room 1061 (HFA-305)  
5630 Fishers Lane  
Rockville, MD 20852

Re: Docket No. 99D-2726; Draft Guidance on Labeling for Laboratory Tests

Dear Sir or Madam:

These comments are submitted by Becton, Dickinson and Company in response to the Food and Drug Administration's (FDA's) draft guidance entitled "Guidance on Labeling for Laboratory Tests". BD is a multi-national corporation that manufactures and sells a broad range of medical supplies, devices and diagnostic systems. The company serves health care professionals, medical research institutions, industry, and the general public.

BD appreciates the opportunity to provide the following comments on this document:

1. The draft guidance appears to be an attempt to create subclasses within the existing medical device classes that can be brought to market through the 510(k) premarket notification process. While the regulatory requirement is to provide evidence of substantial equivalence (SE) to a legally marketed predicate device, this draft guidance describes a two-tiered approach in which the manufacturer establishes equivalence to "operational truth" or equivalence to a legally marketed predicate device.

This approach raises many issues, including the following:

- Does FDA have the authority to make this change by issuing guidance rather than through rulemaking procedures?
- Does this two-tiered approach represent the least burdensome means of allowing appropriate product development and review of a product without unnecessary delays and expense to manufacturers?

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- Will manufacturers who do not have the resources to conduct studies comparing their devices to "operational truth", but only to a legally marketed predicate device, be unfairly penalized?
  - How does FDA intend to handle promotion and advertising issues that will inevitably arise when "operational truth" devices are positioned as being better than "laboratory equivalence" devices?
  - Does the additional labeling content suggested by the guidance (e.g., Receiver Operating Characteristic curves) add value to a package insert whose content is already so extensive that it obscures information that the user needs and wants to have?
  - How will the user be educated on what the new terminology means (e.g., operational truth versus laboratory equivalence, percent sensitivity versus percent co-positivity) and on how to compare this information with that provided in labeling for older devices?
  - Does an FDA-defined "operational truth" add value to the medical community's understanding of a device's performance, given that clinicians other than those performing point-of care testing rarely read an *in vitro* diagnostic device package insert? Their understanding of a device's performance and its limitations is based on what is published in peer-reviewed medical journals, and, unless the medical community chooses to embrace FDA's terminology, these publications will continue to use traditional terms such as sensitivity and specificity.
2. We recognize there are challenges in defining an appropriate reference method to which a device can be compared, particularly when the device is based on a more sensitive or more specific technology. It may be totally appropriate for the manufacturer to work with FDA to define this reference as a combination of multiple laboratory tests and, in some situations, pieces of clinical information. Nevertheless, we do not believe it is necessary or helpful to the user to create new terms to describe performance characteristics of a legally marketed predicate device.

As long as the reference method is clearly explained in the labeling, the user will have the information needed to understand the device's performance and the limitations, if any, of the comparison. It is hard to imagine that the user will find value in distinguishing between percent co-positivity and percent sensitivity when they are calculated in the same way. Moreover, 2 x 2 formats should be provided in the labeling, as they have been in the past, so that the user can quickly and accurately see where the discrepancies occurred.

3. We also recognize that finding statistically acceptable ways of looking at discrepant results has been a challenge. If a manufacturer chooses to compare his device to a legally marketed predicate device and if a statistically acceptable method is used to analyze discrepancies, then the manufacturer should be allowed to include this information in the submission and in the labeling. If such a method cannot be identified, but additional information is available about the discrepant results, then that information could be included in the labeling as anecdotal data with appropriate disclaimers.

In summary, we believe that the reference used in establishing substantial equivalence, whether it is a legally marketed predicate device or a combination of laboratory tests and clinical information, can be adequately described in labeling without resorting to the two-tiered approach described in FDA's draft guidance. Moreover, performance characteristics can be calculated and described using terms that are consistent with terms used in the medical community and that accurately convey the results of the comparative study. We recommend that the draft guidance be withdrawn.

In addition to these comments, we wish to state our support for the comments offered by the Health Industry Manufacturers Association (HIMA).

Sincerely,



Constance A. Finch, Dr.P.H.  
Director, Regulatory Affairs  
BD Biosciences

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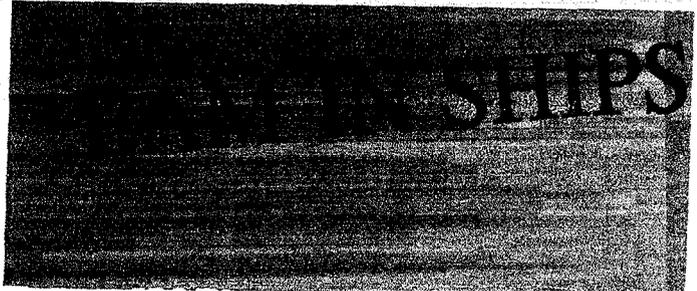
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