



**Foundation for the Accreditation  
of Hematopoietic Cell Therapy**

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December 20, 1999

Dockets Management Branch (HFA-305)  
Food and Drug Administration  
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To whom it may concern:

The Foundation for the Accreditation of Hematopoietic Cell Therapy (FAHCT) welcomes the opportunity to provide comments on the proposed rule "Suitability determination for donors of human cellular and tissue-based products" 21 CFR Parts 210, 211, 820, and 1271, as published in the Federal Register, vol 64, No. 189, September 30, 1999. The International Society for Hematotherapy and Graft Engineering (ISHAGE) and the American Society for Blood and Marrow Transplantation (ASBMT) established FAHCT in 1994 to promote quality medical and laboratory practice in hematopoietic progenitor transplantation. FAHCT published "Standards for Hematopoietic Cell Collection, Processing & Transplantation" in 1996 based on the input of the experts in the field from its parent organizations. The accreditation program established by FAHCT has inspected 61 centers to date, with 103 additional centers having applications in process.

The determination of donor suitability is an integral part of a safe and effective transplantation program. As such, it is addressed in several parts of the FAHCT standards: specifically in Parts C 1.000 "Donor Evaluation and Selection", C1.200 "Marrow Donors", C1.300 "Peripheral Blood Hematopoietic Progenitor Cell Donors", C1.400 "Cord Blood Donors", and C 1.500 "Donor Consents". Other donor related issues involving the safe operation of the tissue collection centers, processing laboratories, and transplantation units occur throughout the entire standards document.

FAHCT applauds the FDA in addressing concerns of vital interest to the protection of the health of the American public. We feel that our input as the recognized experts in the field can help achieve the objective of promoting safe and effective transplantation practices. The scope of the proposed rule is meant to cover only peripheral blood progenitor cells, cord blood progenitor cells, and marrow that has been more than minimally manipulated or has been combined with drugs or devices. However, efficient operation of medical laboratories, collection operations, and transplantation units require consistency in the handling of donors and donor screening. Therefore, the most stringent criteria for donors will become de facto the standard for all donors. The use of approved or experimental devices for cell selection and expansion of progenitor cells from any tissue source is increasing, which means that the number of donors covered by the proposed rule is also increasing. For this reason, FAHCT feels the issues raised by the proposed must be addressed in a scientific and medically sound fashion. Our comments are outlined below:

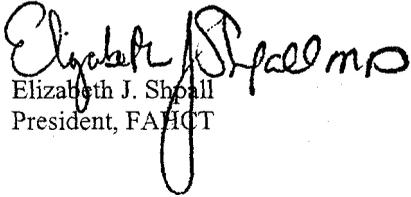
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1. The addition of additional markers for transmissible disease screening of all donors is appropriate. However, it is unclear to us how other “relevant communicable diseases” will be established. At which point and by whom will diseases be designated “sufficiently prevalent among potential donors” or to pose a “significant health risk”?
2. Since the recipient of hematopoietic progenitor cells faces the possibility of death should the donor tissue be deemed unfit for transplant, the transplant physician must be the ultimate authority for the use of tissues from all donors. FAHCT fully supports the exception to donor suitability standards in the case of urgent medical need. The proposed rule acknowledges that the prevalence of CMV positivity in the normal donor population will make this exception widely used.
3. Central to FAHCT's approach to safe operation of transplantation laboratories, collection centers, and transplantation units is the concept that all donors are screened, selected, harvested, processed, and transplanted with the same care and attention to details of transmissible disease regardless of the relationship between donor and recipient. Therefore, the donor of a related sibling collection is held to the same standards as donors of tissues for unrelated transplantation. While FAHCT recognizes that autologous donation for transplantation does not carry the risk of disease transmission to another party, the rules of safe laboratory operation dictate that laboratory personnel be informed of the risks in handling autologous donations as they are in handling allogeneic donations. Since each donation is both lifesaving and irreplaceable for the recipient, the responsibility for the determination of donor selection and suitability is the physician for the transplant recipient. The application of different screening standards based on the degree of relatedness of donor and recipient is artificial and unduly confusing to the transplantation community and the American public. Definition of “family -related allogeneic transplants” as those involving first degree relatives only is not scientifically valid, because it ignores the large number of transplants that take place in which the donor is a related, but second or third degree relative. The search for donors in extended families, especially those with common HLA types, is increasing. The advent of DNA technology makes these searches more important. Therefore, FAHCT believes that family-related transplants should include all transplants in which genetic relatedness can be established.
4. The issue of shortening the period in which transmissible disease markers are tested from the accepted standard of 30 days to 7 days before transplantation is unacceptable to the transplantation community for several reasons. The primary reason is that conditioning regimens are often 14 days or longer. Transplantation centers must know the transmissible disease status of donors before recipient conditioning. Adoption of the proposed rule would then require that donors be tested before conditioning and again 7 days before collection or within 48 hours after collection. This duplicate testing doubles the expense and will unduly burden the collection centers, especially when unrelated donors are used, or when donors must travel long distances to collection or screening centers. Also of concern is blood loss from the donor before collection. Marrow donors may be scheduled for autologous blood unit collection as the safest source of red cells to compensate for blood loss during marrow harvest within 7 days of harvest. Additional blood loss might be detrimental to donors. Finally, these committed donors are unlikely to have a change in infectious disease status in this short period, especially with adequate counseling. FAHCT strongly believes that the time period be retained at the current standard of 30 days before transplantation.
5. The transplantation community has debated the recommendation that the mother and infant of cord blood donations be re-tested at 6 months post donation. It is the consensus that instituting post donation screening at this point in time would cripple the establishment of unrelated cord blood banks and significantly impede the access to transplantation of recipients from minority groups or those with uncommon HLA types. The prospect of 6-month follow up would be a disincentive to mothers, while adding significant costs for the cord blood bank. Additionally, it would impose a mandatory 6-month moratorium on the use of cord blood units, and require withdrawal of units from stock if mothers could not be located. While the acquisition of data on donors and recipients of cord blood units is an important one, FAHCT feels that this issue should be addressed in pilot studies first before being instituted nationwide.

6. While FAHCT supports registration of laboratories and units involved in transplantation with listing of products produced, the addition of twice-yearly product updating is burdensome, introducing more paperwork on typically small staffs. Laboratories do not introduce and validate component production lightly or rapidly. It is unclear to us that twice-yearly product updating would protect the public health beyond a yearly reporting cycle.
7. FAHCT is also troubled by the use of the definition of quarantine in the proposed rule. The intent of quarantine in the proposed rule is preventing unauthorized release of units before transmissible disease testing results are known. We are unsure of how to comply with the rule requiring that the quarantined unit be "physically separated" from all other products. In common laboratory terminology and usage, quarantine of units is done to prevent cross-contamination of transmissible disease agent between stored units. This is commonly done by storing in vapor phase nitrogen, or encasing units in plastic bags. Is this sufficient to meet the intent of the proposed rule? This area of the proposed rule needs clarification.

FAHCT is committed to improving the operation of transplantation units, collection centers, and laboratories. We believe that alteration of the proposed rule to meet the comments above is both scientifically and medically sound.

Sincerely,

  
Elizabeth J. Shoall  
President, FAHCT

  
Phyllis Warkentin  
Chairperson Accreditation

