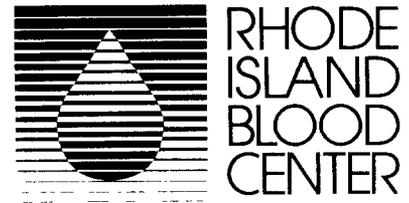


12/30/05



Division of Dockets Management (HFA-305)
Food and Drug Administration
5630 Fishers Lane, rm 1061
Rockville, MD 20852-1448

1043 6 JAN -3 09:20

RE:Docket No. 2005D-0330

Dear Dr. Orton:

Thank you for reviewing these comments from Healthcare Provider Services Inc., d.b.a. Rhode Island Blood Center (127007/878) pertaining to the FDA draft guidance, Collection of Platelets by Automated Methods, dated September 2005.

Collection of platelets by automated methods: Comments

Page 3, 3rd bullet:

Quality control testing described in 21 CFR 640.25(b)(1)-(3), contains requirements that each month four units prepared from different donors be tested at the end of the storage period for the platelet count, pH of not less than 6.0 measured at the storage temperature of the unit, and the volume.

Comment: Issues regarding not using the same donor for products to be QC'd –

1. **Difficult to track and monitor which donors have donated units that are tagged for monthly QC.**
2. **Donors that do doubles may come in more than once each month. If they are at a satellite site, the number of donors are limited and we may not be able to obtain 4 units for that month (if we need to eliminate products for QC) thereby putting us out of compliance (4 products or 100%).**
3. **QC testing should not depend on whether different donors' or the same donors' products are used in some of the testing, but should be based solely on the product.**

Page 6, Section 2, 2nd bullet:

You should collect no more than 24 total Platelets, Pheresis components in a 12-month period. Two components collected from a double collection of Platelets, Pheresis and three components collected from a triple collection of Platelets, Pheresis would be counted as two components and three components respectively.

Comment: Our donors have been doing doubles and triples for many years. Donors have pre platelet counts, hcts, and white counts performed with each donation. We evaluate their pre counts and defer appropriately. We have reviewed and looked specifically at those donors who do multiple components and have not seen any significant change in their pre counts. We have data to confirm that multiple component donors do not have any changes in their pre donation counts. We also

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closely monitor their volume losses to ensure they comply with current FDA standards for red cell and plasma loss.

Multiple component donations account for approximately 21% of our collections. Minimizing the amount of donations would greatly impact our ability to provide an adequate supply of SDP. We feel our donors are monitored closely and there are enough safeguards in place to protect our donors

Data: The following data supports our comment that there exists no significant change in pre counts for multiple component donors (see charts on next page).

Multiple Component Donors

Doubles			Range of Pre Platelet Count	Range of Successful Product Yield
Donor	Approximate Frequency	Between Dates		
1	biweekly	7/20/05 - 11/09/05	225 - 254	7.1 - 8.5
2	monthly/bimonthly	2/20/04 - 6/24/05	228 - 295	7.1 - 12.2
3	every 3 weeks	2/09/05 - 11/09/05	278 - 310	6.7 - 8.5
4	biweekly	5/27/05 - 11/10/05	334 - 397	4.3 - 8.7
5	biweekly	4/08/05 - 11/04/05	214 - 284	6.5 - 10.7
6	biweekly (7 month gap)	12/29/03 - 11/16/05	230 - 295	4.6 - 8.7
7	biweekly	6/09/05 - 11/17/05	326 - 392	7.8 - 9.0
8	biweekly	7/01/05 - 11/18/05	249 - 293	6.8 - 8.0
9	biweekly	7/06/05 - 11/16/05	240 - 290	6.9 - 8.2
10	monthly/bimonthly	6/26/04 - 9/10/05	294 - 362	6.3 - 7.4

Triples			Range of Pre Platelet Count	Range of Successful Product Yield
Donor	Approximate Frequency	Between Dates		
1	monthly (17 month gap)	3/01/03 - 11/14/05	303 - 353	4.3 - 11.3
2	every 3 weeks	2/23/05 - 8/11/05	327 - 402	6.9 - 11.7
3	monthly/bimonthly	11/10/04 - 10/19/05	260 - 316	7.8 - 11.7
4	biweekly	7/11/05 - 12/05/05	296 - 345	6.6 - 12.2
5	biweekly	6/17/05 - 10/21/05	317 - 410	6.6 - 11.5
6	monthly	5/11/05 - 12/2/05	304 - 413	6.8 - 12.0
7	monthly	3/26/05 - 11/19/05	271 - 322	6.2 - 11.7
8	biweekly	7/12/05 - 12/13/05	236 - 259	6.6 - 12.8
9	biweekly (4 month gap)	11/16/04 - 8/08/05	324 - 355	6.8 - 11.7
10	biweekly	8/03/05 - 12/07/05	240 - 290	7.0 - 8.2

Page 6, Section 2, last bullet:

A post-donation platelet count should be performed after each collection.

Comment: Timing for sampling is not specified. Pre counts on following visit could be considered post for previous donation.

Taking another WB tube at the end of the procedure involves access devices not currently available with needle guards and could put phlebotomists at risk. More than one tube would be drawn to “clear the line”.

Page 7, Section D:

We believe that a physician should be present on the premises during the collection of Platelets, Pheresis to ensure that necessary medical treatment be available to the donor in a timely fashion.

Comment: Automated collections is a safe procedure and the recommendation for a physician to be physically available within 15 minutes is unnecessary. Even in the small state of Rhode Island, we have satellite sites that perform apheresis collections that are greater than 15 minutes away. The recommendation adversely impacts the ability of a blood collection facility to provide platelets by apheresis. To protect donor safety, our center already has a physician available by pager 24 hours a day, 7 days a week. We have found that the most common type of reaction is a citrate reaction which is easily treated by slowing down the procedure. The likely outcome of this recommendation for medical coverage would decrease the ability to collect apheresis platelets everywhere without providing added safety for the donor. In a rare instance of a life-threatening donor reaction, an emergency response team through 911 would be the optimal choice for medical care with transportation to another facility for further treatment if necessary, rather than waiting for a physician to be on-site within 15 minutes.

Page 8, Section V A:

In addition, the phlebotomy must be performed by a single uninterrupted venipuncture with minimal damage to, and minimal manipulation of, the donor's tissue (21 CFR 640.22(d)).

Comment: The FDA issued a guidance for the use of sterile connecting device (SCD) with fluid filled tubing, “Use of Sterile Connecting Devices in Blood Bank Practices,” in Nov 2000. We have followed that guidance and inspected all of our welds as stated in the guidance. Our SCD is approved to weld liquid filled tubing. This recommendation would be conflicting with an already established guidance. To not allow sterile docking would also interfere with our ability to reinfuse red cells if there was an infiltrate.

Page 11, last bullet:

Test one third of the components collected for qualification during the first third of the dating period; one third during the second third of the dating period, and one third the day of outdate. For example, for Platelets, Pheresis with a 5-day dating period, test one third at 1-2 days, one third at 3-4 days and the final third on day 5 after collection.

Components that expire may be used for qualification if tested within 12 hours after expiration.

Comment: Sampling for residual WBC's must take place on day 1, additional sampling for bacterial detection is also timed, to sample again on different days during the shelf life adds to the risk of air contamination and requires multiple calculations for final platelet counts. Multiple release days can be confusing to staff and may be changed because of product need.

Units for qualification must be selected on day zero in order to capture the residual WBC. A qualification or QC designation has to be made on day one in order to complete full testing

Page 12, Table 1:

pH: Acceptance Criteria $\geq 6.0/\geq 6.2$

Comment: Criteria for pH target is confusing. Is it 6.0 or 6.2?

Page 17, Section B 1

You should notify your Medical Director when a donor has a post collection platelet count less than 100,000/uL, and you should defer the donor until his/her platelet count has returned to at least 150,000/uL.

Comment: Post collection platelet counts are not currently required. All guidelines for pre counts are followed. Pre platelet counts are performed to ensure the donor and product safety. Donors with pre counts < 150,000/ul are deferred and must have a pre count > 150,000 prior to donating.

Page 18, Table 2: RBC loss per collection

More than 200 mL but less than 300 mL - Eligibility states that the donor is not eligible to donate for 8 weeks

Comment: This is discordant with Page 18, 1st sub-bullet which follows

Page 18, 1st sub-bullet:

Donors who donate a single concurrent RBC unit with the Platelets, Pheresis should be deferred from all collections for at least 8 weeks unless the extracorporeal red blood cell volume during a subsequent collection of Platelets, Pheresis is expected to be less than 100 mL (Ref. 4).

Comment: The technology that we currently utilize has an extracorporeal red cell volume of less than 100mls if the red cells are not reinfused. We monitor red cell and plasma volume losses for 8 weeks and on an annual rolling calendar basis to ensure current limits are not exceeded. A rolling calendar is reviewed for blood loss and pre counts are reviewed to ensure donor safety. If these measures are performed the donor is protected and deferral for 8 to 16 weeks is not necessary.

Page 19, Section 2, 1st paragraph:

Each month four units prepared from different donors must be tested at the end of the storage period for the platelet count, pH of not less than 6.0 measured at the storage temperature of the unit, and volume (21 CFR 640.25(b)(1)-(3)). We interpret four to be a minimum number to be tested, and testing "at the end of the storage period" to include testing at the time of issue.

Comment: We interpret this to mean only 4 units per month are to be tested. Is this number relative to the collection facility site, particular apheresis machine or the type of donation such as single, double or triple?

When is "time of issue" at a Blood Center? When all donor testing, including bacterial detection, is complete and the product is available to label? Or when the Blood Center is about to ship to a consignee?

Page 19, Section 2, 2nd paragraph:

Under 21 CFR 211.160(b), laboratory controls must include the establishment of scientifically sound and appropriate specification, standards, sampling plans and test procedures.

Comment: With the following criteria a current practice, and requirements of minimum guidelines being met and exceeded, we believe it is not necessary to include complicated Scan statistics or any equivalent. In our blood center where platelet apheresis rarely fails (approx. <1/600), this type of statistical analysis would provide no relevance.

Page 19, Section 2, 4th bullet:

Include testing of components collected on each individual automated blood cell separator device.

Comment: Please clarify. Do you mean each type of manufacturer's device? Or do you mean 4 units from each machine in service per month?

Page 19, Section 2, 5th bullet:

Allow for testing at the maximum allowable storage time for the container system used (or representing the dating period). 21 CFR 640.25(b) specifies that QC testing be performed at the end of the storage period.

Comment: Since we are a blood collection facility and distributor, this will cause a substantial loss of product because the product would be non recoverable post-QC testing. This could have a negative impact on the facilities we supply by causing a shortage of available product.

Page 20, 1st bullet:

Test for percent component retention.

Comment: Is this retention of platelets or product volume post filtration, if applicable?

Page 20, 3rd bullet:

Calculate the volume of the component on day of QC testing.

Comment: Is that the day of collection or 24 hours after collection, in addition to "end of storage period".

Page 20, Acceptance criteria, 4th bullet:

The volume in each container for double collections should be 50%+/- 5%; for triple collections 33+/-3%, or per the manufacturer's specifications.

Comment: The volume is calculated using scales which have a range of acceptable error. Labeling in general allows for a 10% leeway. Each container should contain 3.0×10^{11} platelets and if the volume is within the ranges validated to support the number of platelets that should suffice.

Page 30, Appendix A, 2nd paragraph:

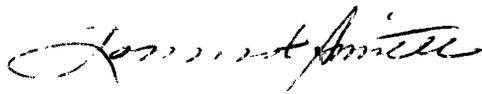
We recommend that you define a plan for the random selection of 10% of your annual collections to be tested.

Comment: We feel we have a sound scientific method for testing our platelet apheresis. Clarify why you would recommend 4 units per month for QC testing and

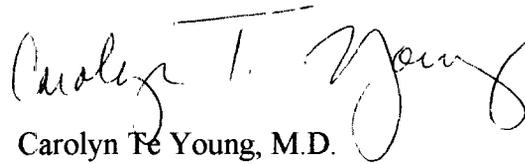
additionally recommend 10% of collections for statistical analysis. A center would therefore need to ultimately perform QC testing on 10% of annual collections, which in our case would be more than the recommended amount on page 19 of this draft. In addition, this would reduce the availability of products for transfusion since our expiration rate for these components is low (3.8%). Having to do 10% QC would definitely affect our ability to provide this product.

If you have any questions or require additional information, please contact Carol Perry at 401-453-8599.

Sincerely,



Lawrence F. Smith
President & Chief Executive Officer
Rhode Island Blood Center



Carolyn Te Young, M.D.
Vice-President & Chief Medical Officer
Rhode Island Blood Center