

Validating and updating

An update on the implications for hospital pharmacists of the clinical trial directive and a new method for validating “spraying in” were among the topics discussed at the joint meeting of the Pharmaceutical Aseptic Services Committee and the Hospital Pharmacists’ Group held in London on 18 November. Rachel Graham reports

With the regulation of clinical trial materials, we are currently in the position that we were with medicinal products back in the early 1960s, according to IAIN FENTON-MAY, specialist principal pharmacist at Quality Control Wales. The new clinical trials rules will change that, he said. They introduce the concept of good manufacturing practice (GMP) into the making of clinical trial products and set out requirements for good clinical practice, labelling, pharmacovigilance and the administration of clinical trials.

The final statutory instrument is not yet enacted, because the good clinical practice directive (which sets out the details of the forms on which to apply, for example, for a clinical trials manufacturing licence) has not been passed in Brussels, Mr Fenton-May said. He went on to describe the draft form of the statutory instrument, paying particular attention to the potential roles for pharmacists.

Mr Fenton-May pointed out that the ethics committee with ultimate responsibility for overseeing clinical trials was at a high level, comprising the senior ministers of the health departments in the United Kingdom. This high level ethics committee will need to delegate work, but it is not clear at the moment whether that will effectively be to the current local ethics committees or whether other organisations will be set up. In any case, ethics committees will almost need to be “mini NICEs”. They will need to “go through all the paperwork and have all the background information on the products”. There must be a pharmacist available to the ethics committee who is aware of everything to do with clinical trials, Mr Fenton-May added.

Sponsors are at the hub of the new trials process – they will be liable for anything that goes wrong. Mr Fenton-May thought this was unlikely to deter pharmaceutical companies from sponsoring trials, because they have new products that need to be tested before reaching the market place. More problematic, he thought, was how large scale, multi-centre, multi-national trials to produce data on existing drugs (for example, the aspirin and magnesium sulphate trials) would come about in the future. The Medical Research Council has said it will not sponsor trials under the new rules, he added. Most trusts have registered as sponsors, but

this is unlikely to help with the multi-centre situation, because trust managers will not want to have responsibility for what goes on in other trusts. “This is a huge problem” Mr Fenton-May said. He is, however, confident that it can be overcome, but is uncertain as to how.

MANUFACTURING FOR TRIALS

Other potential roles for pharmacists under the new rules include becoming a QP (qualified person), with the authority to release products manufactured for use in clinical trials. The QP will need to certify that every batch of IMPs (investigational medical products) complies with GMP and the CTA (clinical trials authorisation), Mr Fenton-May said. The requirements apply to comparators (ie, placebos) as well, he stressed. Under the “grandfather clause” any person engaged as a QP at the time the regulations come into force will be authorised to go on register of QPs for IMPs. Other transitional arrangements include that DDX’s (doctor dentist exemptions) submitted before the directive comes into force (in May) will be honoured.

A licence will be required to manufacture IMPs. Units that hold a special licence are likely to get the CTML (clinical trials manufacturing licence) easily, Mr Fenton-May said. He hoped that staff at National Health Service

units will apply for such licences as soon as the forms became available and take up the “golden opportunity” that the new “medicines act” for clinical trials affords pharmacists.

VALIDATING SPRAYING IN

A new technique for validating “spraying in” (the decontamination undertaken when transferring items into a controlled zone) was proposed by SARAH HIOM, the All Wales specialist pharmacist for research and development. The method involves placing the item to be transferred in a total parenteral nutrition bag and heat-sealing it to form a contained unit for analysis. Recovery diluent is instilled through the additive port of the bag, the bag agitated, and the recovery diluent (now containing the “bioburden”) extracted and filtered through a field monitor. The monitor kit is then cultured in appropriate conditions and the micro-organisms on the filter counted. Validation shows that the method has about an 87 per cent recovery rate, she added.

Dr Hiom and colleagues at other hospitals in Wales have used the new technique to determine how effective current spraying in techniques are for removing microbial contamination from glass bottles with aluminium peel-back vial caps. Their results show that spray and wipe methods were better at removing microbes (particularly fungal and bacterial spores) than methods that use spraying alone, Dr Hiom said. Also, spraying and wiping with the vial cap open was generally more effective at removing microbes than with the vial cap closed.

The results supported the addition of a wiping phase to spraying in procedures, Dr Hiom said. She hoped that others would use the “novel and sensitive” validation technique so that the issue of spraying in could be further investigated and the procedure further validated.

The slides from all the presentations given at the meeting can be found on the Pharmaceutical Aseptic Services Committee website at www.civas.co.uk

A paper based on the update on aseptic error reporting given at the meeting is on p496