DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:
Office of Laboratory Animal Welfare
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Home Page: http://grants.nih.gov/grants/olaw/olaw.htm

FOR EXPRESS MAIL:
Office of Laboratory Animal Welfare
Rockledge One, Suite 360
6705 Rockledge Drive
Bethesda, Maryland 20817
Telephone: (301) 496-7163
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May 25, 2017

Re: Animal Welfare Assurance
#A4300-01 [OLAW Case D]

Dr. Peter Marks
Director, Center for Biologics and Research
FDA - Center for Biologics Evaluation & Research
10903 New Hampshire Avenue, Bldg. 71
Silver Spring, MD 20993

Dear Dr. Marks,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your May 24, 2017 letter reporting an instance of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the FDA White Oak Consolidated Animal Program. According to the information provided, OLAW understands that nine mice sustained severe tail vein necrosis and sloughing after having their tails placed in overheated water to induce vasodilation to conduct tail vein injections. Neither the person who conducted the injections nor the vasodilation were described in the approved protocol.

The immediate action taken upon discovery consisted of the veterinarian providing analgesia and amputating the tails of the mice, which subsequently recovered. The Principal Investigator (PI) and staff were counseled by the veterinarians, the animal procedures would now be conducted by the veterinary staff, the research staff was retrained, and the PI may be replaced by a more senior individual. The study in question was concluded and the mice were euthanized.

Based on its assessment of this explanation, OLAW understands that measures have been implemented to correct and prevent recurrence of this problem. OLAW concurs with the actions taken by the institution to comply with the PHS Policy.

Sincerely,

Axel Wolff, MS, DVM

Axel Wolff, M.S., D.V.M.
Director
Division of Compliance Oversight

cc: IACUC Chair

A4300 - D

White Oak Consolidated Animal Program

Food and Drug Administration
10903 New Hampshire Ave. Bldg 71
Silver Spring, MD 20993

Date: May 24, 2017

From: (b) (6) DVM, Ph.D., Chairperson
White Oak Consolidated IACUC

(b) (6)

Through: Peter Marks, MD, Ph.D., Institutional Official

Peter W. Marks -A

Digitally signed by Peter W. Marks -A
DN: c=US, o=U.S. Government, ou=HHS, ou=FDA, ou=People, cn=Peter W. Marks -A, 0.9.2342.19200300.100.1.1=2000932716
Date: 2017.05.23 17:03:27 -04'00'

Subject: Incident Report

To: Axel V. Wolff, MS, DVM, Director, Division of Compliance Oversight, OLAW, NIH

Per our conversation on May 5, I am enclosing the following incident report with the corrective actions taken by the program.

Incident Details:
Mice on an IV vector injection and cancer imaging protocol were reported with severe tail vein necrosis and sloughing. Upon immediate investigation, the PI explained that though he had been trained on IV tail vein injection technique by veterinary staff trainers, he did not feel confident performing the technique for this experiment. His supervisors advised him to ask for assistance from a colleague known to be proficient in the technique. The colleague agreed to perform the IV tail vein injections, although he was not approved to do so on this protocol. The colleague performed vasodilation of the mouse tail veins by heating the tail in water microwaved for 30 seconds. This procedure was not approved on the protocol. Presumably, necrosis of tails occurred because the water was too hot. All 9 affected mice from a total of 20 received pain medication and tail amputation by the facility veterinarian. All mice recovered without further incident.

Corrective and Follow-up actions:

1. The Attending Veterinarian (AV) and the Deputy Director of the Division of Veterinary Services (DVS) held a meeting with the PI, supervisors and the colleague who performed the procedure to discuss the seriousness of this incident. The AV explained DVS should have been contacted as soon as issues were discovered to provide animal procedure advice and technical support to the lab. He also explained that incident would be reported to OLAW

2. The lab was informed that effective immediately; they could not perform any procedures on animals listed on this protocol. Veterinary staff assumed all animal-handling procedures for the lab. The experiment concluded with optical imaging and euthanasia of all study animals.

3. The PI, supervisors, and the colleague not listed on the protocol who performed the procedures will be required to re-take CITI Training Modules for "PI and ASP Writers".

4. The PI and the colleague who performed the tail vein injections are required to be re-trained by DVS on IV tail vein injection prior to working with animals in the facility.

5. The PI of this protocol may be replaced with a more senior person if a suitable person can be identified.

Wolff, Axel (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Wednesday, May 24, 2017 8:10 AM
To: 'WO AP IACUC'
Subject: RE: Incident Report for FDA White Oak Consolidated Animal Program Assurance A4300-01

Thanks for this report, Ms (b) (6) I will send a response soon.

Axel Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight
OLAW

From: WO AP IACUC [mailto:WOAPIACUC@fda.hhs.gov]
Sent: Wednesday, May 24, 2017 7:09 AM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Cc: Dennis, John (FDA/CBER) <John.Dennis@fda.hhs.gov>(b) (6) (FDA/CDER)
(b) (6) @fda.hhs.gov>; Marks, Peter (FDA/CBER) <Peter.Marks@fda.hhs.gov>
Subject: FW: Incident Report for FDA White Oak Consolidated Animal Program Assurance A4300-01

The White Oak Consolidated (WOC) Animal Program and IACUC, is self-reporting a non-compliance incident and corrective action plan for Animal Welfare Assurance A4300-01. Please review the attached Incident Report.

Please contact Dr. John Dennis (b) (6) or Dr. (b) (6) if you have any questions.

(b) (6)
WOC IACUC Administrator
Division of Veterinary Services
(b) (6)