

Rev 1: September 2018
FSN Ref: FSN-2024-01
FSCA Ref: FSCA-2024-01

Date: 18/06/2024

Urgent Field Safety Notice
Papenzyme Plus, Catalogue No. 441010

For Attention of*:Lorne's valued customers

Contact details of local representative (name, e-mail, telephone, address etc.)*

Name: Redisa Zeqo

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Urgent Field Safety Notice (FSN)
Papenzyme Plus, Catalogue No. 441010
Risk addressed by FSN

1. Information on Affected Devices*	
1.	1. Device Type(s)* Lorne's Papenzyme-Plus reagent is an IVDMD. Papenzyme-Plus is a ready to use liquid preparation of stabilized papain. The reagent is standardized by serological methods for use in blood group antibody investigations. The reagent does not contain or consist of CMR substances, or endocrine disrupting substances or that could result in sensitization or an allergic reaction by the user. The reagent is supplied at optimal dilution for use with all the recommended techniques stated in the reagent's IFU without need for further dilution or addition.
1.	2. Commercial name(s) Papenzyme-plus
1.	3. Unique Device Identifier(s) (UDI-DI) Not available
1.	4. Primary clinical purpose of device(s)* The reagent contains an enzyme that is capable of enhancing blood group agglutination reactions in the detection of anti-erythrocytic antibodies when tested in accordance with the recommended techniques as described in the reagent's IFU.
1.	5. Device Catalogue number* 441010
1.	6. Software version N/A
1.	7. Affected serial or lot number range 441103-A1
1.	8. Associated devices N/A

2 Reason for Field Safety Corrective Action (FSCA)*	
2.	1. Description of the product problem* Following a single customer complaint received on 19 -March-2024 suggesting that the enzyme treatment of the red blood cells with Lorne's Papenzyme-Plus, Lot 441103-A1 was unsuccessful, Lorne proceeded to test the customer returned reagent and that of Lorne's retained sample, as part of the investigation of the complaint, the end user complaint was substantiated. Lorne confirmed that Papenzyme Plus- LOT 441103-A1 has demonstrated a decrease in enzymatic activity, leading to weak results and therefore doesn't meet the performance claims as per IFU. Root cause analysis has shown several potential root causes which are being addressed by the manufacturer to avoid a recurrence of this problem.
2.	2. Hazard giving rise to the FSCA* Taking into consideration the intended use of the reagent, the event might lead to incorrect diagnosis and could pose harm to the patient especially in the case of failing to enhance Kidd antigens leading to haemolytic transfusion reaction and (rarely HDF). Indeed, as the reagent is capable of enhancing Kidd antigens, failure to do so, may lead to weak to false negative reaction of the enzyme-treated red cell when tested with Anti-Jka or Anti-Jkb reagents. Alloanti-Jka and Jkb may cause severe immediate or delayed/haemolytic transfusion reaction. Despite their haemolytic potential they rarely cause severe mild to moderate HDFN. Based on the above information, Lorne have taken the decision to issue a Field Safety Corrective Action (FSCA-2024-01) to relevant competent authorities and inform the customers with a FSN (FSN-2024-01), a "FSN-2024-01 Distributor/Importer Reply" form for the Distributors/Importers and a "FSN-2024-01-Customer Reply" form for the end-users of the affected lot.
2.	3. Probability of problem arising Every time the reagent is used (377 vials from the affected lot were supplied to 12 of Lorne's customers across 10 countries).
2.	4. Predicted risk to patient/users

	end-users with 15 calendar days upon FSN receipt)	
3.	5. Action Being Taken by the Manufacturer <input type="checkbox"/> Product Removal <input type="checkbox"/> On-site device modification/inspection <input type="checkbox"/> Software upgrade <input type="checkbox"/> IFU or labelling change <input checked="" type="checkbox"/> Other <input type="checkbox"/> None The manufacturer is undertaking several corrective actions and a preventative action with regards to the identified problem. Those are described in the relevant FSCA. As part of the corrections, Lorne identified and segregated the affected lot, is informing the customers, distributors and importers of the affected lot (with the current FSN), carried out a reportability assessment and informed the relevant competent authorities.	
3	6. By when should the action be completed? ASAP	
3.	7. Is the FSN required to be communicated to the patient /lay user?	No
3	8. If yes, has manufacturer provided additional information suitable for the patient/lay user in a patient/lay or non-professional user information letter/sheet?	
	Choose an item. N/A	

4. General Information*		
4.	1. FSN Type*	New
4.	2. For updated FSN, reference number and date of previous FSN	N/A
4.	3. For Updated FSN, key new information as follows:	
	N/A	
4.	4. Further advice or information already expected in follow-up FSN? *	No
4	5. If follow-up FSN expected, what is the further advice expected to relate to:	
	N/A	
4	6. Anticipated timescale for follow-up FSN	N/A
4.	7. Manufacturer information (For contact details of local representative refer to page 1 of this FSN)	
	a. Company Name	Lorne Laboratories Ltd.
	b. Address	Unit 1 Cutbush Park Industrial, Estate, Danehill, Lower Earley, Berkshire
	c. Website address	https://www.lornelabs.com/
4.	8. The Competent (Regulatory) Authority of your country has been informed about this communication to customers. *	
	Yes	
4.	9. List of attachments/appendices:	
4.	10. Name/Signature	Name: Redisa Zeqo Title: Quality Assurance and Regulatory Coordinator

Transmission of this Field Safety Notice	
	This notice needs to be passed on to all those who need to be aware within your organization or to any organization where the affected LOT of Papenzyme-plus have been transferred (where applicable). Please transfer this notice to other organizations on which this action has an impact (where applicable). Please maintain awareness of this notice and resulting action for an appropriate period to ensure effectiveness of the corrective action. (if appropriate).