

National Committee for Clinical Research

BULLETIN

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2010

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The NCCR bulletin aims to disseminate information on latest clinical research policies and guidelines as well as to feature articles on Malaysia's progress and pioneering attempts in this industry. The content is prepared or compiled by the members of the National Committee for Clinical Research (NCCR) who consist of Ministry of Health personnel, academicians and industry professionals actively involved in clinical research activities in Malaysia. The compilation of articles in each issue reflects the diverse range of clinical research areas and thus offers readers the opportunity to appreciate various perspectives on issues related to clinical research in Malaysia.

IN THIS ISSUE we discuss the new directions for the clinical trial industry in 2011. With the National Key Economic Area programme in place, exciting things are in the horizon. We also highlight the clinical trial endeavours of the University Malaya Medical Centre (UMMC) in its investigation centre and feature in our published research section, UMMC's top research publications. Our complementary section focuses on a traditional Malay massage and its effect on post-stroke patients. For Good Laboratory Practice, we report the results of the National Pharmaceutical Control Bureau's visits to a few test facilities in Malaysia. We also include an update of the latest revision to the Malaysian Good Clinical Practice and a review of a guide for Ethics Committee.

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FOREWORD

by Director-General of Health, Malaysia

As we begin the New Year, it is good for us to reflect on past achievements and future prospects for improvement. For contract research, a lot has transpired over the years. More challenges and changes are expected in the coming years. These changes are necessary and are in tandem with the current exciting developments in our country as well as globally. Obviously, whatever changes we make, must be for the better. There is a move to corporatise the contract research arm of the Clinical Research Centre (CRC). This is a big step and will only be successful if we do not compromise on standards and flout the ethics of research. The new entity, when approved, should continue with the good work done hitherto by the present set-up at CRC. What it now needs to do is to enhance the functions of CRC and address existing limitations. The new set-up, called the Clinical Research Malaysia (CRM), will cater for industry-sponsored clinical trials from any institution in Malaysia, not just those conducted at Ministry of Health's facilities. Not surprisingly, there is scepticism as to whether such a model will work. We of course welcome discussions and dialogues between the industry and the Government to look into all possible areas of concern.

The National Committee for Clinical Research will continue to play its role to ensure that clinical trials are conducted properly, with adherence to Good Clinical Practice guidelines.



We must be mindful of the role of CRM and it is my hope that CRC will continue to take the lead in ensuring that the message is clearly conveyed to these stakeholders. The CRC will continue to assist in the research development of the Ministry of Health's facilities and encourage investigator-initiated research (IIR) which should also be given priority. For us to achieve a

developed country status, we must encourage our researchers to plan and conduct their own research activities. I urge our researchers to interact with the industry and come up with trials of their own so that the research that we do are good enough to be published in international peer reviewed journals. It is high time that we move from being followers to leaders. I know many investigators who have produced exemplary work in Malaysia and many more who have produced great work overseas. If we provide them with the opportunity and the assistance in Malaysia, many will return to our shores to do us proud in the area of clinical research.

Let us make 2011 a great year for clinical research in Malaysia.

I wish you all a blessed New Year.

Thank you

**Tan Sri Dato' Seri Dr Haji
Mohd Ismail bin Merican**

Industry-Sponsored Clinical Research in Malaysia: New Chapter in 2011

According to the Economic Transformation Programme Roadmap, Malaysia only averages 100 clinical trials per year, which is a mere fraction of what Taiwan, a country similar in population size to Malaysia is doing. This is in spite of Malaysia's large multi-ethnic patient population with unique biometric identifier, good healthcare infrastructure, nationwide network of local Clinical Research Centres (CRCs), large numbers of highly trained/experienced healthcare workforce and established disease registries. It is indeed surprising that with such an ideal environment for clinical research, Malaysia is not achieving more.

As recently indicated in *Clinical Trial Magnifier*, a journal dedicated to clinical research activities, Malaysia is one of the emerging regions for clinical research which should be able to attract at least 300 trials per year. Malaysia was the highlight of *Clinical Trial Magnifier's* June issue which featured a series of articles on the country's clinical trial performance and potential. Article 1 discussed Malaysia's healthcare and clinical research infrastructure; the country's strengths and weaknesses were also mentioned here. The challenges as outlined in the article include ensuring fair contract and transparent financial transactions, lack of clinical research awareness among potential Ministry of Health investigators, regulatory and ethics review timelines and the need for better support in business development, contract and budgeting,

financial administration, site personnel and other resources at investigative sites.

In the 2nd article, the number of industry-sponsored clinical trials in Malaysian between 2008 and 2009 was measured according to application information submitted to the Ministry of Health's Institutional Review Board (IRB). This IRB reviews mostly applications from investigators from the government hospitals and clinics. Each major medical university and some of the private hospitals have their own IRBs. The authors of this article believed, that with a strong clinical research infrastructure, the number of clinical trials in Malaysia will increase 8-fold and total revenue to be generated is estimated at US\$136.6 million.

The Malaysian government had a similar perception of clinical trial industry as potential economy driver. By giving it more precedence, 2011 will bring a string of changes. Some of these changes have been thought of as ambitious or even ambiguous. But in reality, these were not decisions that were rashly made as the strategies are based on in depth research and analysis of the existing clinical research environment. One major transformation in the horizon is the corporatisation of the Clinical Research Centre's contract research unit. Known as the One Stop Centre (OSC), this division was set up several years ago to provide a single point of contact and facilitate industry's access to investigators

and patients for industry sponsored clinical research (also known as contract research). The OSC provides infrastructure and practical plan to support professional and efficient clinical trials. This model has been found effective, but in order to cater to more than just Ministry of Health facilities, it needs to be transformed to be a corporatised entity. It will still be 100% government owned like the Health Tourism Council and Health Promotion Board. In addition to managing contract research, this business entity (which will be known as Clinical Research Malaysia), will do marketing and business development, hiring and retaining of industry 'talents', partner commercial contract research organisations/site management organisations, etc.

The CRM also aims to meet industry expectations of speedy ethical approvals, outperform rivals in patient recruitment and improve data quality, support and logistical services. Finally it will coordinate the promotion of Malaysia as a high quality and high performing clinical research site in the ASEAN region.

As the Economic Transformation Programme brings Malaysia closer to achieve its 2020 vision, we need to bear in mind that there is only ten years left for this major economic overhaul. But as contract research has been identified as 'quick wins', which means it can be achieved within a relatively short amount of time because it need moderate involvement from the private sector, it seems that we are on track. Nevertheless, despite needing only moderate private sector involvement, just like any economic endeavors, collaboration is vital as the government will not

be able to do it on its own. The investigators and the industry play crucial roles; without their full commitment and cooperation, the dream of Malaysia as a conducive environment for clinical research will remain a dream.

More on CRM and the future of contract research in Malaysia in our next issue.

Resources:

1. Economic Transformation Programme: A Roadmap for Malaysia. Creating Wealth Through Excellence in Healthcare. pp 552–587.
2. Goh PP *et al.* A Case Study: Refining Clinical Research Infrastructure Clinical Trial Magnifier 2010; 3: 203–218.

Conducting Clinical Trials through CIC, UMMC

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The Clinical Investigation Centre (CIC) is a dedicated unit for conducting clinical trials at University Malaya Medical Centre (UMMC), a 927-bed referral centre and Malaysia's premier teaching hospital. The CIC was established in February 1999 and was officially launched on 21st August 1999 by the former Vice Chancellor of University of Malaya, the late Yang Berbahagia Tan Sri Dato' Dr Abdullah Sanusi Ahmad. A one-day seminar was held in conjunction with the launch, and keynote lectures were delivered by Sir Collin Dollery, former Pro Vice Chancellor of the University of London and Professor Dan M. Roden of Vanderbilt University and member of the Cardiorenal Advisory committee, U.S. Food and Drug Administration.

The CIC aims to serve pharmaceutical and biotechnology companies by providing a unique combination of academic excellence and experience to expedite safe and quality trials in Malaysia. It provides an integrated network of top performing clinical investigators and an access to UMMC's large pool of potential research subjects, and serves as a resource for apprenticeship for young clinical investigators. Good Clinical Practice (GCP) workshops endorsed by Malaysia's Ministry of Health are organised by CIC biannually.

The CIC is governed by an Advisory Committee appointed by the Dean of the Faculty of

Medicine, University of Malaya. It is staffed by a director, a manager, a scientific officer, a research officer, a part-time accountant and clerical staff. Currently, there are 34 principal investigators and 27 research coordinators, the numbers of which may fluctuate depending on the number of studies which are conducted through CIC.

To provide a carefully controlled, patient-centered research environment, all clinical trials conducted at CIC observe current standards of research ethics. Safe and high quality clinical trials under the auspices of CIC are ensured through heedful governance by a medical ethics committee which operates in accordance to ICH-GCP guidelines and the Declaration of Helsinki, and frequent monitoring and auditing by sponsors. The CIC is included in the U.S. FDA Investigational Site database and has obtained a Federalwide Assurance FWA00007865 with the U.S. Department of Health & Human Services.

The UMMC is recognised as an outstanding institution for its long-term commitment and experience in conducting safe and international-caliber clinical research through CIC. In July 2010, a strategic alliance agreement with Quintiles was officially announced, making UMMC the first Asia Pacific hospital in Quintiles' Prime Site Program, an initiative to

help accelerate the development of new and more effective medicines.

The cumulative number of contracted clinical studies at CIC since its inception is well over 200. For 2010 alone, more than 20 international multicentre clinical trials of various phases are conducted, taking the number of active ongoing studies to 113. Most of these studies are IND/NDA trials for FDA and EMEA.

To date, CIC's list of therapeutic areas includes but not limited to:

- Cardiology (ischaemic heart diseases, hypertension, heart failure, interventional studies)
- Endocrinology (diabetes, osteoporosis, obesity)
- Infectious Disease (HIV, hepatitis, sepsis, dengue)
- Respiratory Medicine (asthma, COPD)
- Neurology (stroke, epilepsy)
- Paediatrics (vaccine studies, asthma, diabetes, bronchiolitis)
- Oncology (breast, lung, head and neck)
- Gastroenterology
- Urology
- General Surgery
- Orthopaedic Surgery.

Refer to the Published Research section for some of UMMC's top papers.

A Qualitative Study on *Urut Melayu* – The Traditional Malay Massage

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Objective

We conducted this study to gain an insight into the experiences and views of practitioners of *urut Melayu*, the traditional Malay massage, which will be used in developing a preliminary framework of the *urut Melayu* process.

Design

We adopted a qualitative study design. We carried out a total of five focus group discussions (FGD) comprising of 6–10 *urut Melayu* practitioners each.

Location

We carried out three FGDs at the Traditional and Complementary Medicine Division, Ministry of Health and two FGDs at a district Health Clinic.

Subjects

All participants of the FGDs were *urut Melayu* practitioners registered with the Ministry of Health. Three FGDs consisted of all females while two comprised all males. A total of 12 males and 24 females participated in the study.

Results

We identified six themes from the study, namely indications for *urut Melayu*, the technique, other treatments in conjunction with *urut Melayu*, outcome, ethics and practitioners' source of skills and knowledge.

Conclusion

Urut Melayu is a unique form of massage carried out for various purposes. Although it is a common belief that there are vast differences in the way it is performed from one practitioner to another, this study revealed that similarities do exist; hence there is potential to develop a standard framework for *urut Melayu* for regulation and training purposes.

***Urut Melayu* for Post-Stroke Patients: A Qualitative Study**

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Background

Urut Melayu, the traditional Malay massage had been introduced in three pioneer hospitals in Malaysia as part of the integrated hospital programme. Its primary aim was for the rehabilitation of post-stroke patients. After almost three years since it was first implemented, there are currently plans to extend it to other hospitals in the country. Information from this study will contribute towards better future implementation plans.

Objective

We conducted this study to gain an insight into the experiences and views of post-stroke patients and their *urut Melayu* practitioners.

Method

We adopted a qualitative study design. We carried out a total of 17 semi-structured in-depth interviews with post-stroke patients who were undergoing *urut Melayu* treatment at one of the three integrated hospitals. We solicited information from their accompanying carers whenever necessary. The two *urut*

Melayu practitioners at the hospital were also interviewed. All the interviews were carried out in Malay by the authors, at the Traditional and Complementary (T&CM) Unit of the relevant hospital. The interviews were audio-taped, transcribed and coded into categories through a constant comparison method of data analysis. Illustrative quotations were identified to supplement the narrative descriptions of the themes.

Results

We found that *urut Melayu* was sought by patients who had experienced stroke brought about by various factors. They reported the unique characteristics of *urut Melayu* and their positive experiences with it.

Conclusion

Urut Melayu has potential as a complementary therapy for post-stroke patients. It is recommended that the number of practitioners at the T&CM unit be increased to provide optimum care for post-stroke patients.

Effective and efficient reviews for safe and ethical clinical trials

The ethics committee (EC) is one of the four main parties in a clinical trial; the other three being the drug regulatory authority, the trial sponsor and the clinical researcher. The EC's role is thought of as the most noble as its primary function is to ensure that the rights, safety and well-being of potential clinical trial participants are protected. But with such great power comes great responsibility (pardon the pun), as one concern is the quality of a committee's review especially in terms of detecting ethical problems. But other than the effectiveness of the review, the time taken for a protocol review is just as crucial. Clearly, a great review is worth less if it takes too long to be completed especially in a clinical research setting where everything has strict deadlines. As these are global issues, the team in Clinical Trial Magnifier, a journal dedicated to clinical research activities, has produced a comprehensive manual that addresses these problems. *Reviewing Clinical Trials: A Guide for the Ethics Committee* also caters for countries with less resource for clinical research especially in terms of providing adequate training for ethics committee members.

The primary objective of the manual is to promote human research protection of participants in clinical trials. Additionally, the editors hope to use this manual as course material for training programmes conducted in collaboration with top academic institutions. In line with this, Malaysia hosted the Clinical Trial Magnifier 2010 Conference with Clinical Research Centre

as the local organiser. One of the workshops was on research ethics. Of the 23 people who were trained, many were not EC members, as the manual is relevant and useful for all clinical research professionals; investigators, research nurses, research support staff, ethics committee administrators, contract and budget development administrative staff, monitors, project managers, biostatisticians, clinical data managers, regulators or inspectors.

Highlights from *Reviewing Clinical Trials: A Guide for the Ethics Committee*

- An EC review considers the science, ethics and data quality. Members are to ensure that a trial adds new information to existing body of knowledge but does not put participants at risk without reason.
- Special attention to trials with vulnerable participants such as children and people without the capacity to make a decision.
- Determining the risk and benefit of a trial is difficult. But in cases which the EC feels the results generated will not be useful, it is the EC's duty to reject the protocol as unethical.
- An EC to review and decide on the fate of a protocol in a timely manner. The committee is advised to have follow-up reviews at appropriate intervals.
- An EC does not have to be concerned with the Clinical Trial Agreements and budgets.
- This manual includes 50 ethics committee scenarios covering many ethical issues in

human research such as ethics of clinical trials, risk-benefit balance, informed consent process, vulnerable participants, privacy and confidentiality, data safety monitoring, participant recruitment procedures, qualification of investigators, conflict of interest, clinical trial insurance and indemnity, essential clinical trial documents and clinical trial registration dissemination of trial results. For example, in one scenario, the sponsor assumed that even if one EC rejects its protocol, another may accept it. Ethical committees are advised to consult other ECs involved in the review of the same protocol.

- This manual does not overrule local laws, regulations and guidance but ECs are to be allowed to act in accordance to the Declaration of Helsinki and the ICH GCP E6 guideline.

Source

Karlberg J, Speers MA. Enhancing the Quality and Efficiency of Ethical Review. *Clinical Trial Magnifier* 2010; 3:12–32



This manual can be obtained free of charge as a pdf file (sign up as a subscriber to the Clinical Trial Magnifier at www.ClinicalTrialMagnifier.com) or for a fee as a printed version. Translations into other languages are underway.

Updates on Malaysian Guidelines for Good Clinical Practice (3rd Edition)

Tee Khim Boon

National Pharmaceutical Control Bureau



First row from left: Dr Kamaruzaman Saleh, Dr S Asmaliza Ismail, Professor Dr Abd Rashid Abd Rahman, Dr Goh Pik Pin
Second row from left: Ms Tee Khim Boon, Dr Ho Tze Ming, Dr Hasenah Ali, Professor Datin Dr Zahurin Mohamed, Dr Ong Loke Meng, Dr Sivabalan Sivanesan, Dr Sharmila Ramachandran, Dr Goh Bak Leong, Dr Sarojini Sivanandam, Ms Yam Pei Ching

Following the 2004 success of the Malaysian Guidelines for Good Clinical Practice (2nd Edition), we further improved and refined the guidelines according to current clinical trials practice in Malaysia. The committee met and went through the guidelines in the National Pharmaceutical Control Bureau on 1st of October 2010.

The major changes for this 3rd Edition are the newly added Introduction section and the inclusion of the World Medical Association Declaration of Helsinki in Appendix III. Other changes were minor amendments tailored to the practice of clinical trials in Malaysia.

Common Good Laboratory Practice (GLP) Non-Compliance Seen in Test Facilities Requesting to be in the National Pharmaceutical Control Bureau (NPCB) GLP Compliance Monitoring(CM) Programme (Part I)

Hasenah Ali and Kamaruzaman Saleh

Malaysia has been a provisional member to the Organization for Economic Co-operation and Development (OECD) Council Decision on Mutual Acceptance of Data (MAD) in assessing chemicals since 2008. The National Pharmaceutical Control Bureau (NPCB) Ministry of Health Malaysia was appointed by the cabinet as the National Compliance Monitoring Authority (CMA) for monitoring compliance to OECD Principles of Good Laboratory Practice (GLP) for the non-clinical safety testing of test items contained in pharmaceutical products, cosmetic products, veterinary drugs and food additives. Since then, NPCB has been working together with test facilities towards achieving full membership to the OECD MAD system.

The NPCB had conducted infrastructure visits to a few test facilities in Malaysia in 2009 and 2010. The objectives of the visits were to gauge the readiness of the test facilities in Malaysia and their commitment towards complying with GLP requirements. There were many deficiencies and weaknesses found during these visits. This article will be in two parts. For this issue, we will focus on part 1; common non-compliances seen in the Organisation and Personnel, Quality Assurance Program, Facilities, Apparatus, Materials and Reagents and Test Systems.

Test Facility Organisation and Personnel

The first element in the GLP principle is the Test Facility Organisation and Personnel. The role and responsibility of the test facility management is very important in ensuring all studies conducted in the facilities comply with the principle of GLP. However this was not adequately addressed.

From our visits, we found that the person identified as the test facility management was not really involved in the GLP management. He/She was the director or chief executive officer of the facility who was not involved in GLP studies. He/She did not play the role of test facility management as required in the principle.

There was also misconception regarding the role of test facility management, study director and principle investigator in some facilities. The management did not identify deputies for key personnel in, for example, quality assurance and archiving.

Even though the management had provided training for study personnel, it either did not keep the records or did not update it. The staff's curriculum vitae were also not updated and the training procedures were not comprehensive.

Many of the training/records were focusing on the understanding of the principle of GLP only. There were no specific training/records on specific skills involved in GLP studies such as handling of animal, necropsy, staining slides, passaging/splitting cells, sterile technique and others.

The management needs to keep the latest organisation chart reflecting all personnel and area of expertise involving GLP studies. Key personnel who were supposed to report directly to the management were not indicated in the chart. The organisation chart was found not to be updated whenever there were changes made in personnel and duties.

A good facility lay-out plan is important to show the areas in a facility where it can provide information on type of activities involving either GLP or non-GLP studies. This form of good facility lay-out was found to be lacking in many facilities.

Poor maintenance of a Master Schedule was also seen in many facilities. This includes insufficient information in the Master Schedule, unrestricted access, incorrect information and no person responsible for it.

Quality Assurance (QA) Program

One of the important principles in GLP is the presence of a Quality Assurance (QA) program in the facilities. The QA program should be carried out by an individual or individuals designated by and directly responsible to the management and who are familiar with the test procedures. Even though this was known to

facilities, some of them do not have dedicated teams to perform the QA role.

The visit exposed many QA units that did not have their own documented QA program. Procedures for qualification, training, maintaining copies of documents and inspections were not available. The QA units did not keep copies of all documents and did not prepare inspections schedule for the facilities. As required by the principles, the inspection results must be promptly reported to the management and study director. This is to ensure the management always keeps abreast with the status of the ongoing studies in the facilities and the study director to correct the findings. However, we found that reporting was not done promptly as required.

Even though the QA statement in the Final Report must be prepared and signed by the QA, only a few QA units followed this requirement.

Facilities

The compliance on facilities requirements is another important principle in GLP. This include the general requirements, separate facilities for handling test item and references, test systems, archiving and handling of waste materials.

Even though many test facilities have separate areas for these, they were still not complying with some of the GLP requirements. Rooms for animal test systems for quarantine, housing and breeding were not clearly separated. For test system which involved cell-line and bacteria, clear isolation and separation were not exercised. Power back-up was also not

considered in case of power supply cut-off in the facilities. Storage areas for test items was not properly maintained. Clear separation to prevent contamination or mix-up between test item and references and other materials were not addressed. As archive is an important aspect in GLP, a special room should be allocated for it. Visits found that the archive rooms were not properly secured and not protected from untimely deterioration. Many facilities also appeared not to have proper procedures and storage areas for handling and disposal of waste materials.

Apparatus, Materials and Reagents

Apparatus, materials, chemicals and reagents are used in all studies for the generation of data and in the controlling of the environment. They should be suitably located and stored. However, many facilities did not have proper storage areas for different category of chemicals and materials. This involved consumables, organic, flammable, corrosive and other harmful reagents and materials. Labeling of chemicals and reagents were not according to GLP requirements.

Equipments which require calibration were not calibrated correctly. Terminology on calibration and verification was used interchangeably in some facilities. Records of maintenance, cleaning and calibration of equipments were not maintained.

Test Systems

GLP studies involved the use of test systems can either be physical or biological. Both test systems should comply with the GLP

requirements. For biological test systems, the visits found that many facilities have a separate area for housing the test systems. However, newly received test systems were not isolated or quarantined until their health status (animal test system) or performance checking (bacteria) had been evaluated. Record of source, date of arrival and arrival condition of test systems were not maintained.

All relevant information needed to identify the test system were not appearing on the container/housing or were inadequate. For example, the flasks which store the bacteria suspension in the incubator were not labeled accordingly.

Any materials that come in contact with the test systems should be free from contaminants at a level that would interfere with the study. Therefore, facilities have to ensure all those in contact with the test systems should be checked and ensured to be contaminant-free. Some facilities did not change the bedding as required by sound husbandry practice. Many admitted that water supplies to animals were not checked frequently for contaminations. Records on cleaning and sanitising activity were not maintained.

The common GLP non-compliance found in Test Facilities requesting to be in the NPCB GLP Compliance Monitoring Programme will be continued in the next issue.

Reference

OECD Document Number 1 - OECD principles on Good Laboratory Practice (revised 1997)

University of Malaya (UM)'s Top Clinical Research Publications

Novel mechanism of drug resistance in childhood acute lymphoblastic leukemia

Although L-Asparaginase plays a vital role in treating childhood acute lymphoblastic leukaemia (ALL), patients still exhibit a variety of responses to the drug as not much is known of its metabolism. Some have good plasma levels initially but do not maintain adequate plasma levels for subsequent exposures. Others may not produce good response at the beginning but develop sufficient asparaginase activity at subsequent exposures. There are also those who do not develop therapeutic plasma levels at any stage of the treatment. In order to shed some light on the mechanism of the drug resistance, researchers designed this prospective clinical trial to evaluate whether asparaginyl endopeptidase (AEP) expression in patients on multidrug therapy correlates with reduction in asparaginase activity, increase in antibody formation and reduction in response to therapy. They identified the N24 residue on the flexible active loop as the primary AEP cleavage site and proposed that sole changes at this site will cause ASNase (one of the commercially available sources of L-asparaginase; produced from *Escherichia coli*) to be resistant to AEP cleavage. Understanding this novel mechanism may further optimise asparaginase therapy, which will hopefully decrease morbidity and improve outcome of childhood ALL.

Source

Patel N, Krishnan S, Offman MN, Moss CL, van Delft FW, Holland M, Liu JZ, Alexander S, Dempsey C, Ariffin H, Essink M, Eden TOB, Watts C, Bates PA, Saha V. A dyad of lymphoblastic lysosomal cysteine proteases degrades the antileukemic drug L-asparaginase. *J Clin Invest* 2009;119: 1964–1973.

Tibolone increases the risk of recurrence in breast cancer patients

Researchers randomly assigned women surgically treated for a histologically confirmed breast cancer to receive either tibolone 2.5 mg daily or placebo. The study involved 245 centres in 31 countries. Tibolone, a synthetic drug used to treat menopausal symptoms, is effective in reducing the side effects of vasomotor symptoms and bone loss that are associated with adjuvant treatment for breast cancer (significant improvement compared with placebo). But the researchers found an increased risk of cancer recurrence, i.e. 15.2% of women (237 of 1556) on tibolone compared with 10.7% of patients on placebo. This difference between both groups was significant. ($p=0.001$).

Source

Kenemans P, Bundred NJ, Foidart JM, Kubista E, von Schoultz B, Sismondi P, Vassilopoulou-Sellin R, Yip CH, Egberts J, Mol-Arts M, Mulder R, van Os S, Beckmann MW and on behalf of the LIBERATE Study Group. Safety and efficacy of tibolone in breast-cancer patients with vasomotor symptoms: a double-blind, randomised, non-inferiority trial. *Lancet Oncology* 2009;10:135–146.

Three simple models to predict short-term disease progression in HIV-infected patients receiving combination antiretroviral therapy at resource-limited settings

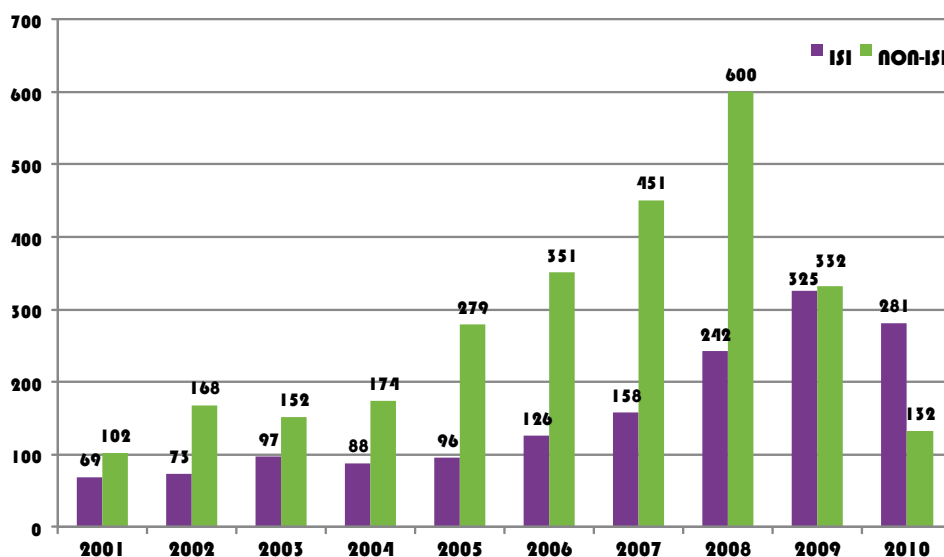
Researchers developed short-term predictive risk equations for AIDS or death in Asian populations receiving Antiretroviral Therapy (ART) and their analyses was based on data from patients enrolled in a collaborative observational cohort study involving 17 sites in the Asia-Pacific region. The three models developed are suitable for settings with limited resources and are simple enough for busy clinics. The first is a clinical model (only clinical data were used). Patients with severe anaemia or a body mass index ≤ 18 were categorised as very high risk; patients who were aged < 40 years or were male and had mild anaemia were categorised as high risk. The second is a CD4 cell count model (both clinical data and CD4

cell counts were used). Patients with a CD4 cell count < 50 cells/ μL , severe anaemia, or a BMI ≤ 18 were categorised as very high risk; patients who had a CD4 cell count of 51–200 cells/ μL , were aged < 40 years, or were male and had mild anaemia were categorised as high risk. The third is a CD4 cell count and HIV RNA level model (clinical data, CD4 cell counts and viral loads were used). Patients with a CD4 cell count < 50 cells/ μL , a detectable viral load, severe anaemia, or a BMI ≤ 18 were categorised as very high risk; patients with a CD4 cell count of 51–200 cells/ μL and mild anaemia were categorised as high risk.

Source

Srasuebkul P, Lim PL, Lee MP, Kumarasamy N, Zhou J, Sirisanthana T, Li PC, Kamarulzaman A, Oka S, Phanuphak P, Vonthanak S, Merati TP, Chen YM, Sungkanuparph S, Tau G, Zhang F, Lee CK, Ditangco R, Pujari S, Choi JY, Smith J, Law MG. Short-term clinical disease progression in HIV-infected patients receiving combination antiretroviral therapy: results from the TREAT Asia HIV observational database. *Clin Infect Dis* 2009;48:940–950.

UM Faculty of Medicine ISI and NON-ISI PUBLICATIONS FOR 2001 – 2010



Note: ISI journals are journals that are tracked by the Institute for Science Information. The listing which is based on specific criteria is a key indicator of journal impact and quality.

Clinical Research-related Events in 2011

Good Clinical Practice (GCP) workshops

Organiser: Clinical Research Centre (CRC)

Summary: The CRC's nationwide tour is to ensure that every potential clinical researcher has the opportunity to learn from the experts and the experienced. Participants are taught on ICH GCP and Malaysian GCP, clinical research ethics, informed consent, clinical trial protocol and investigator's brochure, investigator's responsibilities and relationship with sponsor, adverse event monitoring and reporting, etc.

Dates (City)

21–23 February (Klang Valley)

23–25 March (Seremban)

18–20 April (Kangar)

11–13 May (Klang Valley)

19–21 June (Klang Valley)

4–6 July (Penang)

20–22 July (Melaka)

20–22 September (Kota Bharu)

17–19 October (Klang Valley)

15–17 November (Kota Kinabalu)

5–8 December in (Klang Valley)

Specific venues will be confirmed soon.

For content details, log on to http://www.acrpm.com.my/default.asp?page=/gcp_home&subpage=/gcp_contents

Email: contact@crc.gov.my

Website: www.crc.gov.my

National Conference for Clinical Research (NCCR) 2011

Organiser: Clinical Research Centre

Summary: If you are a clinical investigator, researcher or scientist, sponsor or industry expert, institutional review board member, regulator, policy maker or any professional involved in clinical research, NCCR is the annual event for you. Gearing for its fifth year, NCCR 2011 will once again have local and international experts gathered together to provide latest information on clinical research. And as always, the conference will have a vast array of pre conference workshops, symposia and meetings such as GCP, ethics, clinical trial management, registry-related courses, biostatistics and medical writing.

Dates (City)

Main conference:

22–24 June (Klang Valley)

Pre conference workshops:

19–21 June (Klang Valley)

Specific venue and programme will be confirmed soon

Email: contact@crc.gov.my

Website: www.crc.gov.my

9th MOH-AMM Scientific Meeting 2011 (incorporating the 14th Scientific Meeting of the National Institutes of Health)

Organiser: Academy of Medicine and National Institutes of Health Malaysia

Summary: The National Institutes of Health Malaysia comprises six research institutes (Institute of Medical Research, Clinical Research Centre, Institute for Public Health, Institute for Health Systems Research, Institute for Health Management and Institute for Health Behavioural Research). Their scientific meeting, now in its 14th year, provides participants a variety of research genres. No other conference in Malaysia has such a mix of research culture. In its spirit of collaboration, the NIH meeting in 2011 will be held in conjunction with the 9th MOH-AMM Scientific Meeting 2011.

Date: 23–25 September 2011

Venue: will be confirmed soon.

A smashing success in 2010



NIH meeting joined the National Conference for Clinical Research

Compulsory for all clinical investigators to be GCP-certified

A recent circular from the Director-General of Health Malaysia to all research ethics committees in Malaysia stipulates that all clinical investigators need to be GCP certified. Without assurance that the investigators have undergone and passed the test, the Clinical Trial Import Licence or/and the Clinical Trial Exemption for drug-related trials will not be issued. Previously, this requirement was only for the Principal Investigators. This latest move by the Ministry of Health is to assure the public that the clinical trials are conducted by those who are well versed with the Declaration of Helsinki and other recognised international code of ethics. Moreover, ensuring that all researchers understand GCP will improve data integrity, which will in turn enhance our credibility as an attractive clinical trial location in the region.

Source
Director-General of Health Malaysia Circular KKM-55/BPF/401/007/02(3) (Dated: 8 October 2010)

MOH requests Ministry of Higher Education to push for universities to embrace the National Medical Research Register

The National Medical Research Register (NMRR), which is an online database that captures information on the nation's medical research, needs to incorporate data from universities before it can truly be considered a national database. At the moment, the bulk of research that are currently registered involve Ministry of Health sites. This undoubtedly underestimates the level of clinical research activity in our country as only 25% of the projects registered thus far are from the university. Clearly, there is a lot of research from the various public and private universities that could not be tabulated because of this lukewarm response. As 2011 is the year that the New Economic Area programme for clinical research goes full steam ahead, the hope is that all industry-sponsored trials conducted in Malaysia, whether from the hospitals or the academic institutions, are registered in the NMRR (www.nmrr.gov.my), so as to ensure a true reflection of the country's clinical trial performance and potential.

About NCCR

Established in 1997 to coordinate and encourage clinical trials in Malaysia, the National Committee for Clinical Research (NCCR) supports the enhancement and regulation of the quality of biomedical research as well as clinical research practice in Malaysia. The NCCR is headed by Tan Sri Dato' Seri Dr Hj Mohd Ismail Merican, Director-General of Health and it is managed by the Clinical Research and Compliance Section of the National Pharmaceutical Control Bureau, Ministry of Health Malaysia who acts as secretariat. The members of this committee consist of experts from Ministry of Health (MOH), various national universities, the Malaysian Pharmaceutical Society (MPS), the Pharmaceutical Association of Malaysia (PhAMA), the Malaysian Organisation of Pharmaceutical Industries (MOPI), and other non-governmental organizations. www.nccr.gov.my

Contact Us

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