

## Understanding Variation Can Improve your Supply Chain

Summary: If you understand variation and its sources you could save money to your organization. This article describes a real life application of variation fundamentals, which were used at a pharmaceutical organization to analyze release and stability failures. This organization increased the reliability of its supply chain and it will save millions by identifying and eliminating the causes of those failures.

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A pharmaceutical company operating in the US had encountered frequent release failures of its top selling product. In addition, it had set up a fairly common stability limit (1), which triggered investigations when an stability point differed in more than 5% from its previous measurement. As a result, in 2005 this organization lost several million dollars in the profit that this product was supposed to generate, there were several supply chain interruptions, which complicated its relationships with some of its main customers, and there were frequent inconclusive stability failure investigations, all of which consumed funds, time, and organizational resources.

Management assembled a cross-disciplinary team with the relevant functional departments and I was hired to manage this team, and to provide quality engineering skills to this organization. Quality engineering is the science of understanding and controlling variation.

### Understanding the fundamentals of variation (2, 3)

In a given specification, the total observed variability is the sum of the variability of the assay plus the variability of the process. Mathematically, this can be expressed as:

$$\sigma_{observed}^2 = \sigma_{process}^2 + \sigma_{assay}^2$$

where  $\sigma_{observed}^2$  is the observed variance,  $\sigma_{process}^2$  is the variance of the process, and  $\sigma_{assay}^2$  is the variance of the assay.

The variance of the assay is given by:

$$\sigma_{assay}^2 = \sigma_{repeatability}^2 + \sigma_{reproducibility}^2$$

where  $\sigma_{repeatability}^2$  is the precision, or the variance obtained when the same assay is performed by the same analyst, in the same equipment, during consecutive measurements, during the same day.  $\sigma_{reproducibility}^2$  is the variation between different analysts performing the same assay, in the same equipment, at different days. Both of these parameters are normally determined as part of the assay validation.

It is good practice to set the release specification range at at least 8 sigmas of the observed variance. The measurement error is six times  $\sigma_{assay}$  and it should be less than 10% of the specification range. In addition, it is recommended that the ratio of the assay to the observed variance be less than 10%.

$\sigma_{assay}$  can be reduced by increasing the number of measurements by using the central limit theorem of statistics, which states that in any population, the variance of means of samples from that population will be the total population variance divided by the square root of the number of samples used to obtain the means. In mathematical terms it is:

$$\sigma_{assay} = \frac{\sigma_{measurement}}{\sqrt{n}}$$

where n is the number measurements.

Through the above concept, one can see that when the sample size increases an assay will produce means closer to the true mean and the spread of the assay results will be narrower.

The capability of a process to meet its specifications can be measured with a term called process capability, which in mathematical terms is expressed as:

$$C_{pk} = \min \left[ \frac{USL - mean}{3\sigma} \text{ or } \frac{mean - LSL}{3\sigma} \right]$$

where USL and LSL are the upper and lower spec limits, respectively.  $\sigma$  is the observed standard deviation (from the process and from the assay).

The higher the Cpk values the better. A Cpk of 1 means that the process is barely meeting its specifications and that there is no room for variability beyond random variation. A Cpk below 1 means that the process is not meeting its specifications, and that out of spec results will be expected. A Cpk above 1 means that the process has room for some variability beyond random variation.

### **Solving the problem of release failures**

Release data from approximately 30 lots was collected to calculate the process averages and the observed variabilities. This allowed the calculations of the Cpk's with the old specifications. This product has several actives, hence one Cpk per active was calculated. Not surprisingly, several of the Cpk's were below 1, which indicated that the specifications were tighter than the normal and random observed variation from both the assays and the process. The solution was then to increase specification ranges of the actives with the lowest Cpk's.

The definition of process capability given before suggests two ways to increase the Cpk. One could increase the range of the specifications (LSL and USL), or one could reduce the observed variance. The first option is preferred because it is cheaper and faster. Sometimes there are market or customer limitations on how wide the specification ranges need to be. For example, there are some toxic drugs on which the nurses must know the drug concentration within very narrow ranges to be able to give exact doses to the patients. Or medical reasons could dictate that drug doses do not exceed certain limits. That was not the case in this product. Therefore, with the approval of the Medical Affairs department of this organization, the specification ranges were increased to +/- four standard deviations from the process averages. By definition, this increased the Cpk's to 1.33.

The option to increase Cpk through reduction in the observed variability is far more complicated, lengthy, and expensive. The assay variability can be calculated from the assay validation reports. The observed variance can be calculated from the release data. Then, from the first formula in this article, the process variance can be deducted as the difference between the observed variance and the assay variance. Depending on which is one is relatively bigger, efforts could then be oriented toward reducing either the assay or the process variances.

In this product the assay variances were significantly bigger than the process variances. Therefore, if the option to increase capability through variance reduction had been pursued, it would have meant higher sample sizes (per the above the observed assay variance is reduced when the sample size increases), or further assay development to identify and eliminate or control assay variation factors.

After the new release limits were suggested several out of specification release results from the old limits were encountered. They were all within the new specification limits, which increased the confidence in the new limits.

Nevertheless, there was the question of what to do with those release failures because the new specification limits required prior approval changes and could not be implemented until approval from the FDA was obtained, which would take months.

Understanding variation helped release those lots and it saved millions to this organization by being able to use those lots, and by not having to put any of them on long term stability at 62 K per lot. Here is how.

The assays of the multiple actives are very expensive. As a result, only one sample per assay is tested for release. As it was demonstrated that the assays variabilities were very significant, when one sample is tested one never knows from which part of the normal curve this one measurement comes from. Hence, the averages are better estimators of the true concentrations of the actives in the lots.

A comparison of the assays variabilities with the old specification ranges demonstrated that seven additional independent samples per active needed to be tested to meet the requirement that six times the assay standard deviation should consume less than 10% of the specification range. Those additional tests were performed and the averages of those samples and the failing results were used instead as estimators of the true concentrations of the actives in those lots. Fortunately, all averages fell within the old specification limits and hence those lots were released.

It is important to point out that these actions did not contradict FDA guidelines on retests. In cases like this where it is proven that the assays variabilities are significant, it is statistically defensible to release a lot based on an averages falling within the specification limits, even if some measurements that were included in the calculation of those average falls outside the specifications (4).

Furthermore, this is in agreement with the FDA guideline on investigation of out of specification test results which states that (5): *“If the samples can be assumed to be homogeneous (i.e., an individual sample preparation designed to be homogeneous), using averages can provide a more accurate result. In the case of microbiological assays, the USP prefers the averages because of the innate variability of the biological test system”*. The product is a liquid, the samples are homogeneous and the actives are well dissolved. Most important, although the assays are HPLC based and not microbiological, the demonstrated assays variabilities parallel the USP and the FDA allowance of the use of average in microbiological assays because in these case averages are better predictors and more reliable than any of the individual results.

These actions are also in line with the Barr decision (6) because there was a limit at which retest stopped (seven additional samples) and there was a clear decision on what to do before the retests: release the lots if averages fall within the old specifications. Reject the lots if those averages fall outside those ranges.

Additional confidence in this decision was gained by using three independent statistical tests to prove by three different methods that there were not statistically meaningful differences between the lots with all passing results, and the lots in which some of the results had fallen outside the old specification limits. Those tests were the probabilities that, given the assays variabilities and the averages, individual results will fall outside the old specs, analysis of variance (ANOVA) and t-test checks, which test the hypothesis that

the averages come from the same populations. The use of hypothesis testing and calculation of normal probabilities are outside the scope of this article. Suffice to say those three independent tests confirmed the validity of the decision to use the lots.

### **Solving the problem of stability failures**

The establishment of statistically defensible stability limits is a fairly complicated topic. Those limits have to be calculated on a case-by-case basis, based on each situation and set of data (7).

This organization had set up stability alerts limits when an stability result differed in more than 5% from a previous value. This is not statistically defensible (1) and it triggered automatic investigations, which were all inconclusive. The calculation of the assay variability with data from the assay validation reports demonstrated that this 5% limit did not make sense because the assay variations of several of the actives were much higher than 5%. As a result, even if the stability concentrations did not change over time, measuring the same sample by different analyst over different days generated the results with a range of six times the assays' standard deviations, many of which were higher than 5%.

Hence, the elimination of this 5% limit will save thousands of dollars in retests and investigations.

### **About the Author**

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