January 2025 Final Mtb Guidance	May 2025 Draft Mtb Guidance
This guidance is for immediate implementation. FDA is issuing this guidance for immediate implementation in accordance with 21 CFR 10.115(g)(3) without initially seeking prior comment because the agency has determined that prior public participation is not feasible or appropriate. FDA invites comments on this guidance. Submit one set of either electronic or written comments on this guidance at any time. **January 2025**	**This guidance is for comment purposes only.** Omitted FDA invites comments on this guidance. Submit one set of either electronic or written comments on this guidance by the date provided in the Federal Register notice announcing the availability of the draft guidance. **May 2025**
INTRODUCTION This guidance represents the current thinking of the Food and Drug Administration (FDA or Agency) on this topic. This guidance identifies Mtb as a relevant communicable disease agent or disease (RCDAD) as defined in 21 CFR 1271.3(r)(2) and supplements the recommendations contained in other DE guidance documents for donors of HCT/Ps.[3] FDA is implementing this guidance without prior public comment because the Agency has determined that prior public participation is not feasible or appropriate (see 21 CFR 10.115(g)(2)). FDA made this determination because there is an urgent public health need to reduce the risk of transmission of Mtb by HCT/Ps. FDA identified a safety concern when investigating reports of Mtb infections in recipients of allograft bone products.[4] These multi-state outbreaks indicated that there is a risk of transmission of Mtb infection by HCT/Ps. This guidance document is being implemented immediately, but it remains subject to comment in accordance with the Agency's good guidance practices (see 21 CFR 10.115(g)(3)).	**INTRODUCTION** This draft guidance, when finalized, will represent the current thinking of the Food and Drug Administration (FDA or Agency) on this topic. FDA identified a safety concern when investigating reports of Mtb infections in recipients of allograft bone products.[3] These multi-state outbreaks indicated that there is a risk of transmission of Mtb infection by HCT/Ps. This guidance, when finalized, will identify Mtb as a relevant communicable disease agent or disease (RCDAD) as defined in 21 CFR 34 1271.3(r)(2) and will supplement the recommendations contained in other DE guidance documents for donors of HCT/Ps. When finalized, this guidance will provide specific recommendations to reduce the risk of transmission of Mtb by HCT/Ps. [5]

The use of the word should in FDA's guidances means that something is suggested or recommended, but not required.	The use of the word "should" in FDA's guidances means that something is suggested or recommended, but not required.
BACKGROUND TB is a global health problem with a significant disease burden that can lead to chronic disability, and it is one of the top 10 causes of death worldwide (Refs. 1-7). During 2022, 8,300 new cases of TB disease were reported in the U.S., compared with 7,874 cases during 2021 (Refs. 8-10). Whether or not an individual develops TB infection or disease following an exposure is a function of their immune response to the inoculum of Mtb bacilli, and might lead to latent infection, a state in which Mtb bacteria survive in the body in a dormant state and there is no evidence of clinical disease (i.e., LTBI) (Refs. 1-2, 25). Risk factors for TB infection and disease include common conditions associated with impaired immunity (e.g., chronic kidney disease, diabetes mellitus, malignancy, immunosuppressive therapy, etc.), behavioral factors including substance abuse, tobacco use, and malnutrition, and environmental factors leading to increased exposure to individuals with infectious tuberculosis (e.g., living or working in crowded facilities such as homeless shelters, long-term care facilities and nursing homes, incarceration in jails, prisons, correctional facilities, and other congregate settings) (Refs. 11, 26-30).	**BACKGROUND** TB is a global health problem with a significant disease burden that can lead to chronic disability, and it is one of the leading causes of death worldwide and the leading cause of death from a single infectious agent (Refs. 1-7). During 2024, 10,347 new cases of TB disease were provisionally reported in the U.S., compared with 9,633 cases during 2022 (Refs. 8-10). Whether or not an individual develops TB infection or disease following an exposure is in part a function of their immune response to the inoculum of Mtb bacilli, and might lead to latent infection, a state in which Mtb bacteria survive in the body in a dormant state and there is no evidence of clinical disease (i.e., LTBI) (Refs. 1-2, 25). Risk factors for TB infection and disease include common conditions associated with impaired immunity (e.g., chronic kidney disease, diabetes mellitus, malignancy, immunosuppressive therapy, etc.), behavioral factors including substance abuse, tobacco use, and malnutrition, and environmental factors leading to increased exposure to individuals with infectious tuberculosis (e.g., living or working in crowded facilities such as homeless shelters, long-term care facilities and nursing homes, jails, prisons, correctional facilities, and other congregate settings) (Refs. 11, 26-30)
Risk of Transmission There is a risk of transmission of Mtb by HCT/Ps. This is supported by evidence that Mtb can disseminate to organs and tissues via	**Risk of Transmission** Identical verbiage

hematogenous, lymphatic, or contiguous spread which may result in infection of bone, ocular tissues, skin, and connected networks such as the central nervous system, and genitourinary tract (Refs. 1-2, 37), and congenital (perinatal) TB is transmitted in utero (Refs. 38-43). Mtb has been transmitted by transplantation of allograft bone, heart valves, and dura mater (Refs. 31, 78-85). In 2021, a national outbreak of Mtb infection occurred in the U.S. associated with transplantation of a bone allograft product that resulted in significant morbidity and mortality (Ref. 31). A similar outbreak of donor-derived TB transmitted by a bone allograft product occurred in 2023 (Refs. 84-85). Mtb transmission via ocular tissue has not been reported; however, Mtb has been detected in ocular tissues (i.e., cornea, sclera, and conjunctival tissues), and in fluids that have contact with ocular tissues, using mycobacterial cultures and/or PCR for Mtb DNA from individuals with systemic TB, LTBI, primary ocular TB, and retinal vasculitis due to Mtb (Refs. 98-101). Surgical procedures used during the recovery of corneas and sclera can potentially lead to cross contamination if Mtb organisms are present in the donor's blood or ocular fluids, particularly when whole globes are enucleated (Ref. 100). HCT/Ps that are known to have transmitted Mtb are bone, heart valves, and dura mater. Because Mtb organisms have been detected in other HCT/P types, there remains a potential risk of Mtb transmission from HPCs, gestational cells and tissues, reproductive cells and tissues, skin, and corneas or sclera. In addition, TB has sufficient incidence and/or prevalence to affect the potential HCT/P donor population.	 Mtb has been transmitted by transplantation of allograft bone, heart valves, and dura mater (Refs. 31, 78-85). In 2021, a national outbreak of TB disease occurred in the U.S. associated with transplantation of a bone allograft product that resulted in significant morbidity and mortality (Ref. 31). A similar outbreak of donor-derived TB transmitted by a bone allograft product occurred in 2023 (Refs. 84-85). Mtb is a risk not only to tissue transplant recipients, but also to healthcare personnel who are exposed to Mtb and may be infected when caring for infected recipients and when handling the tissues. Identical verbiage. Identical verbiage.

Severity of Effect As described earlier, TB is one of the top 10 causes of death worldwide (Refs. 1-7). TB disease is associated with a risk for development of several complications including, but not limited to, neurological diseases, pulmonary disease, renal failure, heart failure, adrenal failure, thyroid dysfunction, osteomyelitis, sepsis, infertility, miscarriage, and complications in newborns from perinatal transmission (Refs. 102-126).	**Severity of Effect** As described earlier, TB is one of the leading causes of death worldwide and the leading cause of death from a single infectious agent (Refs. 1-7). TB disease is associated with a risk for development of several complications including, but not limited to, neurological diseases, pulmonary disease, renal failure, adrenal failure, osteomyelitis, sepsis, infertility, miscarriage, and complications in newborns from perinatal transmission (Refs. 102-126).
Availability of Appropriate Screening and/or Testing Measures There are FDA-approved diagnostic products that can detect an immune response to TB antigens; examples include FDA-approved purified protein derivative (PPD) of tuberculin antigens injected intradermally for the tuberculin skin test (TST), and interferon-gamma release assay (IGRA) blood tests (e.g., T-SPOT.TB test and Quantiferon-TB Gold Plus test). Both types of tests measure immune sensitization to mycobacterial protein antigens that occurs following exposure to mycobacteria, and these tests should be used in conjunction with clinical risk assessment, radiography, and other medical and diagnostic evaluations to aid in the diagnosis of Mtb infection. These additional medical and diagnostic evaluations are essential to diagnosing TB disease and LTBI. When using the TST and IGRA tests, the person tested must have viable intact immune cells to produce an accurate result, which makes them impractical for evaluating TB risk for a cadaveric (non-heart beating) donor. A variety of factors can affect TST and/or IGRA test performance, including recent infection (i.e., testing before a cell-mediated immune response has developed), age, receipt of Bacillus Calmette-Guerin (BCG) vaccine, and impaired immunity, specifically, T-lymphocyte mediated cellular immunity (Refs. 130-136). Negative tests results do not exclude LTBI or TB disease.	**Availability of Appropriate Screening and/or Testing Measures** There are FDA-approved diagnostic products that can detect an immune response to TB antigens; examples include FDA-approved purified protein derivative (PPD) of tuberculin antigens injected intradermally for the tuberculin skin test (TST), and interferon-gamma release assay (IGRA) blood tests (e.g., T-SPOT.TB test and Quantiferon-TB Gold Plus test). Both types of tests measure immune sensitization to mycobacterial protein antigens that occurs following exposure to mycobacteria, and these tests should be used in conjunction with clinical risk assessment, radiography, and other medical and diagnostic evaluations to aid in the diagnosis of Mtb infection. These additional medical and diagnostic evaluations are essential to diagnosing TB disease and LTBI. When using the TST and IGRA tests, the person tested must have viable intact immune cells to produce an accurate result, which makes them impractical for evaluating TB risk for a cadaveric (non-heart beating) donor. A variety of factors can affect TST and/or IGRA test performance, including recent infection (i.e., testing before a cell-mediated immune response has developed), age, receipt of Bacillus Calmette-Guerin (BCG) vaccine (can affect TST but does not affect IGRA), and impaired immunity, specifically, T-lymphocyte mediated cellular immunity (Refs. 130-136). Negative tests results do not exclude LTBI or TB disease.

Detection of acid-fast bacilli (AFB) in stained and acid-washed smears examined microscopically may provide initial bacteriologic evidence of the presence of mycobacteria in clinical specimens. However, AFB smears should be collected on three consecutive days to increase sensitivity, AFB smears may produce false negative results due to a variety of reasons (e.g., low levels of Mtb in the specimen, microscope and technologist issues, etc.), and negative results from smears do not exclude LTBI or TB disease (Refs. 127-130). Mycobacterial cultures to detect AFB require specific growth media and may take 4 to 8 weeks to grow the bacilli organism (Ref. 128).	Detection of acid-fast bacilli (AFB) in smears examined microscopically may provide initial bacteriologic evidence of the presence of mycobacteria in clinical specimens. However, AFB smears of respiratory specimens should be collected on three consecutive days to increase sensitivity, AFB smears may produce false negative results due to a variety of reasons (e.g., low levels of Mtb in the specimen, microscope and technologist issues, etc.), and negative results from smears do not exclude TB disease (Refs. 127-130). Mycobacterial cultures to detect AFB require specific growth media and may take up to 8 weeks to grow the bacilli organism (Ref. 128).
Screening a Donor for Risk Factors and Conditions for Mtb Infection In accordance with 21 CFR 1271.75(d), you must determine to be ineligible any potential HCT/P donor who is identified as having a risk factor for Mtb infection. The following should be considered risk factors: 1. A positive test for TB infection or a medical diagnosis of TB disease, TB infection, or LTBI (Refs. 31-36, 38-43, 62, 78-86, 91-97). During review of relevant medical records, including the donor medical history interview, the following information should also be obtained and considered, in light of other information about the donor (Refs. 11, 16-20, 23, 26-31): • Persons who were born in, have ever lived in, or ever traveled to areas of the world where TB is common (e.g.,	**Screening a Donor for Risk Factors and Conditions for Mtb Infection** In accordance with 21 CFR 1271.75(d), you must determine to be ineligible any potential HCT/P donor who is identified as having a risk factor for Mtb infection. The following should be considered a risk factor: 1. A positive test for TB infection or a medical diagnosis of TB disease, TB infection, or LTBI (regardless of treatment) (Refs. 31-36, 38-43, 62, 78-86, 91-97) During review of relevant medical records, including the donor medical history interview, the following information should also be obtained and considered, in light of other information about the donor (Refs. 11, 16-20, 23, 26-31): • Persons who were born in or frequently traveled to areas of the world where TB is common (e.g., most countries in Latin America, the Caribbean, Africa, Asia, Eastern Europe, and Russia);

most countries in Latin America, the Caribbean, Africa, Asia, Eastern Europe, and Russia); • Persons who have ever lived in or worked in high-risk congregate settings (e.g., jails, prisons, correctional facilities, long-term care facilities, homeless shelters); • Persons who ever lived with, or have been a close contact with, another person who has TB; or • Persons who have certain medical conditions (e.g., diabetes, chronic kidney disease/end stage renal disease with or without dialysis), or are on medication, that can impair immune function.	• Persons who have ever lived in or worked in high-risk congregate settings (e.g., jails, prisons, correctional facilities, long-term care facilities, homeless shelters); • Persons who have ever lived with, or have been a close contact with, another person who has TB; or • Persons who have certain medical conditions (e.g., diabetes, chronic kidney disease/end stage renal disease with or without dialysis), or are on medication, that can impair immune function.
A donor who falls into any of the categories described in the bullets above might be eligible provided there is no clinical or physical evidence, or suspicion, of LTBI or TB disease, and no communicable disease risks have been identified (discussed in section IV. B. and C. of this guidance).	Identical verbiage
Screening a Donor for Clinical Evidence of LTBI and TB Disease	**Screening a Donor for Clinical Evidence of LTBI and TB Disease**
Unless an exception identified in 21 CFR 1271.90(a) applies, you must review relevant medical records for clinical evidence of RCDADs (21 CFR 1271.75).	Identical verbiage
For cadaveric (non-heart beating) donors, establishments should: • Determine whether an autopsy was not performed due to a perceived risk of transmission of a communicable disease, including TB, or, • If an autopsy was performed, whether any special precautions were taken that would suggest there was special concern regarding the risk of transmission of TB from the donor.	Identical verbiage

If an autopsy was performed, you should wait for the final autopsy report unless it would compromise the utility of the tissue, for example, because your HCT/P (e.g., cornea) needs to be released within a limited timeframe.	
In accordance with 21 CFR 1271.75(d), you must determine to be ineligible any potential HCT/P donor who exhibits clinical evidence of Mtb infection (Refs. 17, 31-36, 38-43, 48-62, 78-101, 127-136). Examples of clinical evidence of Mtb infection: 1. Persons who have ever had a medical diagnosis of TB disease or LTBI; or 2. Persons who have ever had a positive test for TB infection or TB disease. For example, a positive blood test such as Interferon Gamma Release Assay (IGRA) (e.g., T-SPOT.TB, QuantiFERON-TB Gold Plus, QuantiFERON-TB Gold In-Tube), a positive tuberculin skin test (TST) (also known as PPD, Mantoux, or tine test), or a positive test for TB infection on any specimen (i.e., mycobacterial culture, NAAT or PCR for Mtb DNA).	In accordance with 21 CFR 1271.75(d), you must determine to be ineligible any potential HCT/P donor who exhibits clinical evidence of LTBI or TB disease (Refs. 17, 31-36, 38-43, 48-62, 78-101, 127-136). Examples of clinical evidence of LTBI or TB disease: 1. Persons who have ever had a medical diagnosis of TB disease or LTBI or TB disease (regardless of treatment); or 2. Persons who have ever had a positive test for LTBI or TB disease. For example, a positive blood test such as Interferon Gamma Release Assay (IGRA) (e.g., T-SPOT.TB, QuantiFERON-TB Gold Plus, QuantiFERON-TB Gold In-Tube), a positive tuberculin skin test (TST) (also known as PPD, Mantoux, or tine test), or a positive test for TB infection on any specimen (i.e., mycobacterial culture, NAAT or PCR for Mtb DNA).
A person with TB disease may have a number of symptoms or signs that can mimic or overlap with other medical conditions. A person with symptoms of TB disease may have one or more of the following types of clinical evidence of Mtb infection that should be considered when making a donor eligibility determination (Refs. 2-3, 43-46, 98-127): • cough lasting 3 weeks or longer; • chest pain; • coughing up blood (hemoptysis) or sputum (pulmonary TB); • weakness or fatigue;	A person with TB disease may have a number of signs or symptoms that can mimic or overlap with other medical conditions. If a person falls into any of the categories described in the bullets in section IV. A., or if there is physical evidence, or suspicion of LTBI or TB disease, the presence of any of the following symptoms or signs of TB disease should be considered when making a donor eligibility determination. (Refs. 2-3, 43-46, 98-127): • radiographic imaging (e.g., x-ray or CT scan) suggestive of TB disease, • cough lasting 3 weeks or longer; • chest pain;

• unexplained weight loss or muscle wasting (cachexia or consumption); • loss of appetite; • fever, chills, night sweats; • generalized or localized lymphadenopathy or lymphadenitis; • blood in the urine (renal TB); • headache or confusion (TB meningitis); • back pain (TB of the spine); • hoarseness (TB of the larynx); or • radiographic imaging (e.g., x-ray or CT scan) suggestive of TB disease. When a potential donor has one or more symptoms or signs above, you should document your communication with their primary treating physician to obtain additional information regarding their patient's potential for TB infection or LTBI, unless TB has already been ruled out by the patient's primary treating physician.	• coughing up blood (hemoptysis) or sputum (pulmonary TB); • weakness or fatigue; • unexplained weight loss or muscle wasting (cachexia or consumption); • loss of appetite; • fever, chills, night sweats; • generalized or localized lymphadenopathy or lymphadenitis; • Sterile pyuria (presence of white blood cells in the urine) with or without hematuria (blood in the urine) (renal TB); • headache or confusion (TB meningitis); • back pain (TB of the spine); or • hoarseness (TB of the larynx) If a person has any of the signs or symptoms listed above and either (1) falls into any of the categories described in the bullets in section IV.A., or (2) there is physical evidence or a suspicion of LTBI or TB disease, when feasible and appropriate, you should communicate (and document your communication) with the potential donor's primary treating physician to obtain additional information regarding their patient's potential for TB infection or LTBI (unless TB has already been excluded and an alternative diagnosis has been established by the patient's primary treating physician). If a living donor appears healthy and there is no suspicion or medical history of LTBI or TB disease (including no prior medical diagnosis of TB disease or LTBI, and no positive test for TB infection), the donor is not considered to have a risk of TB infection.

Screening a Donor for Physical Evidence of Mtb Infection Relevant medical records (21 CFR 1271.3(s)) include the report of the physical assessment of a cadaveric (non-heart beating) donor (21 CFR 1271.3(o)) or the physical examination of a living donor. Unless an exception identified in 21 CFR 1271.90(a) applies, in accordance with 21 CFR 1271.75(d)(1), you must determine to be ineligible any potential HCT/P donor who has risk factors for or clinical evidence of TB infection. The following are examples of physical evidence associated with TB infection: 1. Generalized lymphadenopathy (Refs. 111-112). 2. Unexplained cutaneous lesions that may be consistent with tuberculosis (Refs. 44-52).	**Screening a Donor for Physical Evidence of Mtb Infection** Identical verbiage
Testing a Donor for Evidence of Mtb infection Following investigations of TB outbreaks linked to HCT/Ps, FDA recognizes the public health need to reduce risk of Mtb transmission by HCT/Ps, given the morbidity and mortality experienced after recent, multistate outbreaks. We also recognize that, with the current absence of FDA-licensed, cleared, or approved donor screening tests for Mtb, HCT/P establishments may wish to use products described in section III.C, such as FDA-cleared diagnostic tests, to test HCT/P donors to help reduce risk of transmission. In light of these considerations, FDA does not intend to object if an establishment chooses to collect a specimen from a living donor of HCT/Ps (or while the donor's heart is still beating) and test for evidence of Mtb infection using a test discussed in section III.C, even though such tests are not FDA-licensed, cleared, or approved as donor screening tests.[8] FDA would not consider a negative or nonreactive test result obtained from such testing to override other clinical and physical evidence of, and risk factors for, Mtb infection discussed in section IV. A., B., and C. of this guidance. In addition, when making a donor eligibility determination, you	**Testing a Donor for Evidence of Mtb infection** Following investigations of TB outbreaks linked to HCT/Ps, FDA recognizes the public health need to reduce risk of Mtb transmission by HCT/Ps, given the morbidity and mortality experienced after recent, multistate outbreaks. We also recognize that, with the current absence of FDA-licensed, cleared, or approved donor screening tests for Mtb, HCT/P establishments may wish to use products described in section III.C, such as FDA-cleared diagnostic tests, to test HCT/P donors to help reduce risk of transmission, particularly if the potential donor presents with symptoms or signs of TB disease, falls into any of the categories described in the bullets in section IV. A., or if there is physical evidence, or suspicion, of LTBI or TB disease, unless the patient's primary treating physician has excluded TB disease and an alternative diagnosis has been established. In light of these considerations, FDA does not intend to object if an establishment chooses to collect a specimen from a living donor of HCT/Ps (or while the donor's heart is still beating) and test for evidence of Mtb infection using a test discussed in section III.C, even though such tests are not FDA-licensed, cleared, or

should consider any negative or nonreactive test result obtained using the tests described above along with such clinical and physical evidence, and risk factors. FDA expects establishments to use appropriate licensed, approved, or cleared Mtb donor screening tests once such tests are available.	approved as donor screening tests.[9] FDA would not consider a negative or nonreactive test result obtained from such testing to override other clinical and physical evidence of, and risk factors for, TB disease discussed in section IV. A., B., and C. of this guidance. In addition, when making a donor eligibility determination, you should consider any negative or nonreactive test result obtained using the tests described above along with such clinical and physical evidence, and risk factors. You should follow your procedures for sharing with other establishments information pertaining to possible contamination or potential for transmission of communicable disease, and you are responsible for sharing this information with other establishments that recovered or received HCT/Ps from the same donor (21 CFR 1271.160(b)(2)(i)). FDA expects establishments to use appropriate licensed, approved, or cleared Mtb donor screening tests once such tests are available.
Additional Risk Reduction Measures During the investigation of both Mtb outbreaks in the U.S., mycobacterial cultures of bone product specimens showed growth, including when PCR testing was negative (Refs. 31, 85). Based on this information and considering the type of HCT/Ps that are known to have transmitted Mtb, performing AFB cultures for bone, heart valves, and dura mater can help mitigate the risk of Mtb transmission. Therefore, as an interim measure, until appropriate FDA-licensed, approved, or cleared donor screening tests for Mtb are available, we recommend: 1. Manufacturers that process bone[9], heart valves, or dura mater should select appropriate liquid and solid mycobacterial cultures (AFB cultures) to test for presence of Mtb using appropriate pre-processing donor specimens when the disinfection or sterilization process used has not been validated to demonstrate the capability to eliminate	**Additional Risk Reduction Measures** Identical verbiage 1. Manufacturers that process bone[10], heart valves, or dura mater should select appropriate liquid and solid mycobacterial cultures (AFB cultures) to test for presence of Mtb using appropriate pre-processing donor specimens when the disinfection or sterilization process used has not been validated to demonstrate the capability to eliminate

contamination with Mtb. Both liquid and solid mycobacterial cultures should be performed, rather than either culture method alone (Refs. 127-130).	contamination with Mtb. Both liquid and solid mycobacterial cultures should be performed, rather than either culture method alone (Refs. 444 127-130).
The specimen selected for testing should be representative of the HCT/P to be evaluated. FDA recommends manufacturers evaluate the suitability of both AFB culture methods regarding use of adequate controls to detect inhibition and to use voluntary standards from a Standards Development Organization (Ref. 128).	Identical verbiage
2. If a donor specimen selected for testing, as described above, has a positive AFB culture (shows growth), you should discard not only the bone, heart valves, or dura mater from that donor that has a positive AFB culture, but also all HCT/P types recovered from that donor. If growth is a mixed culture, an assessment for contamination is recommended (Ref. 128). If the donor specimen has a negative AFB culture (no growth), you should consider the potential for false negative culture results (Refs. 127-129).	Identical verbiage
While we do not consider these additional steps to be part of the donor testing required under 21 CFR 1271.80, FDA believes that performing AFB culture, as recommended above, is an important interim measure to address safety concerns regarding TB transmission from HCT/Ps.[10] You should follow your procedures for sharing with other establishments information pertaining to possible contamination or potential for transmission of communicable disease, and you are responsible for sharing this information with other establishments that recovered or received HCT/Ps from the same donor (21 CFR 1271.160(b)(2)(i)).	While we do not consider these additional steps to be part of the donor testing required under 21 CFR 1271.80 and 21 CFR 1271.85, FDA believes that performing AFB culture, as recommended above, is an important interim measure to address safety concerns regarding TB transmission from HCT/Ps.[11] Identical verbiage

IMPLEMENTATION FDA recommends that you implement the recommendations in this guidance as soon as feasible, but not later than 4 weeks after the guidance issue date.	**IMPLEMENTATION** Section omitted
REFERENCES **1 - 136**	**REFERENCES** Identical