RTD(83)8

REGIONAL TRANSFUSION DIRECTORS' COMMITTEE

WORKING PARTY ON TRANSFUSION-ASSOCIATED HEPATITIS

This Working Party was constituted on 27th September, 1982, with the following membership:-

Dr. H.H. Gunson (Chairman)
Dr. J. Barbara (Secretary)
Dr. J. Craske
Dr. B. Cuthbertson
Dr. R.S. Lane
Dr. D.B.L. McClelland
Dr. R. Mitchell
Dr. S. Polakoff
Dr. H.C. Thomas

Its terms of reference were agreed as follows. "To promote the investigations of the epidemiology of transfusion-associated hepatitis, to promote research into the methods of prevention and to make recommendations to the Directors of the U.K. Transfusion Service regarding procedures and screening tests necessary for its prevention."

The Working Party has met on three occasions and a summary of the matters discussed are given below.

1) Recognition of Transfusion-Associated Hepatitis

It is essential that an effective reporting system is devised since members of the Working Party felt that information on this subject was haphazard and the quarterly reports to the D.H.S.S. were unlikely to give a complete picture.

R.T.D.'s in England, Wales and Northern Ireland are, therefore, requested to

(a) Provide the Secretary of the Working Party with details of their present practices with respect to the investigations undertaken when,

(i) a positive result is obtained in the HBsAg testing of blood donations or when a positive result is reported to them from B.P.L. following tests on plasma pools submitted for fractionation.

(ii) a patient receiving blood or blood products is reported to have developed jaundice (or transaminitis).

In particular, actions taken with respect to donors involved would constitute important observations.

(b) R.T.D.'s should consider the best means within their region for acquiring information on transfusion-associated hepatitis, e.g., consultant haematologists, microbiologists or regional P.H.L.S. laboratory.

It is suggested that active consultation takes place with District Hospitals to encourage reporting of transfusion-associated hepatitis.

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(c) The Working Party will collate the results of the submissions from R.T.D.'s in an attempt to provide as uniform a system as possible, but at this stage would regard the following as a minimum in the follow-up of a reported case of transfusion-associated hepatitis.

(i) Upon receipt of information from the hospital about a case, a pro-forma is sent requesting full details (an example of a suitable pro-forma is appended to this report).

(ii) The recipient's serum should be tested for Hepatitis A and B markers (including IgM specificity if necessary) and possibly EBV and CMV markers also.

(iii) Stored donor samples, if available, or samples following donor recall should be tested for appropriate markers. Such investigations could usefully include anti-HBc, anti-HBs and ALT estimations and anti-HAV (and IgM tests) if indicated.

(d) An annual summary of cases investigated should be sent to the Working Party who will compile a register for circulation.

R.T.D.'s in Scotland are recommended to carry out similar investigations through the S.N.B.T.S. Directors' Committee and contribute to the annual report by the Working Party.

2) Prospective Studies on non-A, non-B Hepatitis

It has been learnt that the samples obtained in the 1974 M.R.C. Hepatitis Study, have been lost and unfortunately these will not be available for examination by any satisfactory marker tests when they are developed. It is considered urgent, therefore, to institute a suitable prospective study so that a library of putative non-A, non-B hepatitis positive samples can be made available. Dr. McClelland and Dr. Polakoff are investigating the possibility of undertaking studies on various aspects of this condition and will be reporting to the Working Party in due course.

3) Use of anti-HBs immunoglobulin (HBsIg)

R.T.D.'s have been informed of the shortage of source plasma for the preparation of HBsIg. Supplies are still precarious and every effort to increase them should be made.

4) Hepatitis in Haemophiliacs

This is being closely monitored by the Haemophilia Directors, and a report is in preparation.

5) AIDS

The Working Party has followed carefully the information from the U.S.A. on AIDS and has considered the recommendations with respect to donor screening and use of cryoprecipitates. To date there have been no cases reported following transfusion of blood or blood products. It has been agreed that, until further information is available, the Working Party will not recommend changes to present practices for donor selection or use of blood products.

6) New Pamphlet; A guide to hygienic skin piercing. Dr. N. Noah, CDSC.

H.H. GUNSON, CHAIRMAN
J. BARBARA, SECRETARY

28/4/83

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THE BRITISH SOCIETY OF GASTROENTEROLOGY

ABSTRACT FORM - SPRING MEETING - LONDON - 20 - 22 April 1983

TITLE A PROSPECTIVE STUDY OF POSSIBLE NON A NON B POST TRANSFUSION HEPATITIS IN BRITAIN

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TYPE TEXT OF ABSTRACT (DOUBLE SPACED) IN BOX BELOW - BE SURE TO STAY WITHIN BORDER

TITLE A PROSPECTIVE STUDY OF POSSIBLE NON A NON B POST TRANSFUSION HEPATITIS IN BRITAIN

We carried out a prospective study of post transfusion hepatitis in 248 patients undergoing cardiac surgery. Each had preoperative LFTs and serum stored for virology. Total blood transfused was 1559 units, total platelets 22 units, total fresh frozen plasma 215 units. 2 patients died during operation. 18 died within 6/12. 228 were followed to 6/12. All had serial LFTs and virology until discharge or death and at 6 months postop. 44/228 living nearest the hospital had monthly LFTs.

Results: 27 patients had elevated AST and ALT 1-4/52 postop. In 25/27 these were normal within 6/52 and remained so at 6/12. One patient with persistently abnormal LFTs had liver biopsy at 6/12 showing very mild chronic persistent hepatitis; the other patient had abnormal preoperative LFTs and full features of alcoholic liver disease but refused biopsy. Of the remaining 203 patients none had abnormal AST or ALT after 1 or 6 months postop. In addition 49 patients developed jaundice within 2 days postop not associated with other evidence of hepatitis (12 died). This settled within 8 days in survivors. In the 18 patients who died, the 27 patients with transient or persistent transaminaemia and the 49 with jaundice, there was no serological evidence of fresh infection with HAV (IgM) HBV (new HBsAg or anti HBc) nor new infection or reactivation of Cytomegalovirus, Epstein Barr virus or Herpes virus.

The brief elevation of transaminases in the 1-4/52 postop period in 27 patients was possibly caused by an NANB virus. We cannot exclude a brief transaminaemia following this period in other patients. We conclude: post transfusion NANB hepatitis is rarely severe and probably leads to significant chronic liver disease very rarely indeed in Britain.

REFERENCES (1)
OMIT NAMES (2)
OF AUTHORS (3)

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(TRANSFUSION ASSOCIATED HEPATITIS).

Surname _____ Hospital _____

Forename(s) _____ Ward _____

Address _____ Consultant _____

_____

Sex _____ Age _____ Ethnic origin _____

Reason for transfusion _____

Date(s) of transfusion(s) _____

Serial numbers of blood units transfused

_____

_____

_____ Total units _____

Other blood products transfused

Presenting signs/symptoms were:- _____

_____ on _____

If jaundiced, date this first noticed _____

Results of laboratory tests _____

Patient's condition at present _____

_____

Any comments e.g. your opinion on the validity of a diagnosis of hepatitis ? any non viral cause.

Signed _____

Date _____

Please return completed form to:

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No.	Name	Recipient Data	Donor Data	Conclusion
J1/81	GRO-A at Royal Free Hospital. Reported by Dr. M. Bamber.	2 units blood, 31st December 1980. 'Hepatitis' 30th January 1981. Incubation period; 1 month. Royal Free reported recipient IgM neg for anti-HAV (January 81 sample). Middx. results (sample received late and tested 24th July 1981) : HBV markers neg. HAVAB pos, IgM neg.	Both donors negative for HBV markers, with normal LFTs.	Probable nonA, nonB P.T.H. (J.E. complete).
J2/81	GRO-A at Royal Free Hospital. Reported by Dr. Tuddenham.	>200 Donors involved. Recipient HBV } neg. and anti-HepA } (Middx, and Royal Free tests). Transfused from March to April 1981. 1st symptoms : 8 May 81 Jaundiced : 12 May 81.	D.S.D. recommended no donor follow-up, nor annotation of 101 cards.	Probable nonA, nonB P.T.H. (J.E. not followed up).
J3/81	GRO-A at National Heart Hospital. Reported by Dr. Lawson-McDonald.	6 units blood, 26th January 81. Jaundiced March 1981. (Still jaundiced May 81) ? gall stones. Samples tested at Middx; not HBV or HAV infection; recipient immune to both (but IgM negative).	All 6 donors RIA neg for all HBV markers. 1 donor had GPT 46 on follow-up sample. (Zealey, C.W; no follow-up) Donor moved 1 yr ago: no forwarding address.	? nonA, nonB P.T.H. (J.E. complete).
J4/81	GRO-A at Coppett's Wood Hospital. Reported by Dr. R. Edmond.	5 units of blood on 23rd March 81. Jaundiced on 27th April 1981. Incubation period; 1 month Coppett's Wood report HBsAg neg, and diagnose nonA, nonB hepatitis, following 'subsequent virological studies'.	All 5 donors had normal LFTs. Middx. Waiting to test samples till they receive a sample of the recipient for confirmation.	Probable nonA, nonB P.T.H. (J.E. still in progress).
J5/81	GRO-A at National Heart Hospital. reported by Prof. Harris	10 units of blood on 25th March 81. General Malaise and nausea with ↑ LFTs noticed on 31st May 81. Incubation period; 1 month. Middx., report negative for A or B markers.	All 10 donors negative for all HBV markers. LFTs for 7 could be tested. 1 donor had GOT 64. (Fensom, V; follow up : enzymes destroyed in post.	Probable nonA, nonB P.T.H. (J.E. complete).