MINUTES OF THE MEETING OF THE HEPATITIS ADVISORY GROUP HELD ON 11 JANUARY 1971 IN ROOM D110 ALEXANDER FLEMING HOUSE

Present:
Lord Rosenheim (Chairman)
Professor Sir Hedley Atkins
Mr P J Dewar
Professor J P Duguid
Sir James Howie
Dr J H Jones
Professor A C Kennedy
Miss M H Magowan
Dr W d'A Maycock
Dr J S Robson
Miss G M Westbrook
Dr R S Williams
Professor Sir Michael Woodruff

Dr C N Dennis, Mr W G Robertson } Secretaries

In Attendance:
Dr J R Ascott, Dr F C Stallybrass, Mr C R Watt, Miss E White } D.H.S.S.

Dr I S MacDonald S.H.H.D.

Dr Weir (vice Dr B E Swain) MHSS Northern Ireland.

APOLOGIES

Professor de Wardener; Dr G E G Smith; Mr Gidden; Dr Bunje; Dr Gareth Jones; Dr Swain.

1. MINUTES OF THE PREVIOUS MEETING

a. Item 4b

Page 3, last line: delete "the proportion of staff accidents who had become".

b. Item 4d

Substitute: "line from the bubble trap to the venous pressure gauge".

c. Subject to these changes, the minutes and Annexe were approved.

2. MATTERS ARISING

a. HEPATITIS IN THE COMMUNITY (ITEM 4b)

Dr MacDonald reported that SHHD were pursuing inquiries of the Edinburgh City Hospital. They would endeavour to establish the proportion of Au positives as well as the incubation period.

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b. INCIDENCE AMONG STAFF (ITEM 6c)

The Secretariat were still pursuing inquiries. The Chairman drew attention to a report in the Lancet of 8th January 1971 which suggested that Au positivity could penetrate associated departments.

c. HAG (70)8 - ANNEXE. (UNIT PRECAUTIONS IN EDINBURGH)

This paper was noted.

3. TREATMENT OF HEPATIC FAILURE

Dr Williams explained that it was his intention to publish the substance of the paper in the B.M.J. He hoped that this would be done soon enough for the Group to be able to refer to a published paper. He thought there might be advantage in the Group's report mentioning the possibilities in treating hepatic failure, which were not widely known, in order to inform clinicians.

The Group a: took note

b: agreed that the report should contain suitable reference on these lines.

4. CODE OF PRACTICE (HAG(70)5; HAG(70)8 AND ANNEXE: HAG(70)11; and HAG(71)1).

a. To avoid confusion, the Group decided to eschew the phrase "the Marmion Report" for the document circulated as HAG(70)7. This was a document specially prepared for the Group by Professor Marmion and Dr Robson. It was broadly based on the Marmion Report which was formally submitted to the Scottish South Eastern Regional Hospital Board. If shorthand were needed, the "Marmion-Robson memorandum" would be more apt. Similarly, HAG(70)11 should not be referred as the "technical Marmion Report", but as the "Edinburgh laboratory code of practice".

The Group took note of HAG(70)11.

b. Dr Ascott explained that the draft code of practice circulated as HAG(71)1 was essentially a consensus of the views generally held in dialysis units. Further inquiries were being made of renal transplant units.

c. The Group agreed

i that this meeting's discussion should be only preliminary, so as to allow time for fuller consideration of the draft and background papers;

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ii to concentrate therefore on listing points which a code should cover before forming views on these points;

iii to regard even the Group's considered views, when formed, as being tentative until there had been opportunity to take the views of clinicians outside the Group; and

iv to make clear in the published report the basis of knowledge upon which the recommendations had been founded.

5. The Group made amendments to HAG(71)1 which are not reproduced in detail in these minutes but in HAG(71)1 REVISE. The following substantive points were made in discussion.

6. SAFE BLOOD

(a) Dr Maycock reported that his technical working party had agreed on the approach of defining safe blood by exclusion of proven Au positive donors. The present view was that Au positivity should be established by two successive independent tests of a blood sample in two laboratories: there was some doubt as to feasibility. It was probable - but not certain - that donors who had had transient positivity eventually became safe. The long term aim was to have all blood Au tested, but in the meantime, a panel of safe donors should be drawn up. Dr Maycock would report further when his party had come to a considered view. He was also making inquiries of Massachussetts about their view on the Tullis techniques and other means of freezing blood.

(b) In discussion, attention was drawn to the recent Lancet report of the Glasgow mass-screening of blood which broadly confirmed an earlier estimate of Au positivity incidence in the donor population of 1/800.

(c) The position of blood donors found to be positive was also discussed. Edinburgh experience suggested some resistance to the idea of Au testing, possibly a result of anxiety in that city, whereas in Glasgow the general donor response was good. The view was expressed that the BTS doctor - donor relationship was a clinical one and therefore confidential. There would be a need, however, to inform the donor's g.p. if he were Au positive, as was the practice with other conditions detected in blood tests.

(d) In answer to a question, Dr Maycock explained that reconstituted frozen 'blood' was not whole blood but a suspension of erythrocytes in plasma or albumen. It could not be assumed to be virus free.

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(e) The Group agreed to await further information from Dr Maycock before forming a view.

7. THE STATE OF RISK

The Group discussed the alternative definitions of 'infectious' and 'possibly infective'.

Views expressed, particularly by Professor Duguid and Dr Williams, favoured the latter. There was also general agreement that a state of potential infectivity could be established only upon a full clinico-pathological profile. In particular, full liver function tests (LFTs) including SGOT, SGPT, and bilirubin estimarion should be carried out. There was some discussion about the value of raised transaminase as an indicator in the absence of other signs. Dr Robson quoted cases where excessive SGPT turned out to be Au negative and due to influenza. Further Dr Robson voiced a hypothesis that renal failure patients in a 'maiden' unit (one which had never had hepatitis) would be found to have enhanced transaminase levels. Professor Kennedy said that his unit was 'maiden'. His impression was that his patients presented the normal range of levels, but he would look into it and present his considered views.

8. NON SELECTION FOR TREATMENT AND EXCLUSION

a. Sir Michael Woodruff suggested that the code should concentrate on the main point of excluding risk rather than spelling out technical detail which might soon become obsolete. Dr Robson said that he would find it very difficult personally to refuse to offer treatment if there was available capacity on the grounds of suspicious indications alone: ideally he would like to have 3 areas in a unit, white, yellow (for confirmed cases) and grey for suspects, especially new cases. The grey area might well use peritoneal dialysis. This view found some support, but a contrary view was expressed ~~by Sir Michael Woodruff~~ that such a complex would create difficulties for the laboratory services and would be difficult to staff, in view of the inherent likelihood of risk in the grey area.

b. The general view was that evidence of hepatitis, if it could be defined, should be a contra-indication to acceptance for treatment in one-area unit, where 'whites' and 'yellows' could not be segregated. It was also the general view that there was a need in every unit to be able to segregate 'yellows', which should not overlook the need to carry out minor surgical procedures on infected patients. This implied isolation facilities in every unit.

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9. TESTING OF PATIENTS

a. The report should contain a short exposition of the different techniques of test.

b. A view was expressed that testing should be done by the hospital for new patients as a speedy result was necessary.

c. As to the frequency of testing, one month in 'clean' and one week in 'dirty' units were determined by laboratory resources. Sir James Howie referred to a possible pattern of 9 or 10 reference centres over the country.

d. As to continuity of weekly tests on patients showing positive, Dr Maycock said that human volunteer experiments suggested that infectivity commenced before clinical illness and continued until the patient had become well again. This implied continuing weekly tests until that stage. Dr Williams thought there was some case for testing new patients weekly for 7/8 weeks after admission, but Dr Robson argued that there was no evidence to prove that chronic uraemic cases were more vulnerable that the general population.

10. TESTING OF STAFF

a. PRE ENTRY TEST

There was some division of view as to the value of pre-entry testing Miss Westbrook and Miss Magowan supported the idea. Miss Magowan pointed out that nursing staff (especially agency nurses) were very mobile between hospitals, and it would be possible for a nurse from an infected unit to apply for a post with a clean unit. Such a case had occurred in her experience, with a girl from Guy's who had shown as Au positive on a test by St. Thomas'. Professor Kennedy and Dr Williams agreed generally: tests at entry would provide a baseline as to the normal state of a staff member, which might prove invaluable if he had to be tested later in abnormal circumstances. Professor Duguid also concurred generally. As to morale, Professor Kennedy said that he carried out such tests. His staff were in favour, since this demonstrated objectively that they were taking all possible steps to exclude infection. The opposite view was maintained by Dr Robson and Mr Dewar. Dr Robson argued that a very strong case would have to be made for a recommendation assuming that healthy people could be a hazard. On the best information available, the risk would be 1/800 if staff were a representative sample. Morale might suffer.

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Mr Dewar pointed out that the question would arise of what tasks, if any, staff shown to be Au positive could undertake. Such a recommendation could only be made on a clear definition ~~of the suspicious factors.~~ Mr Dewar's feeling was that acceptable arrangements could be worked out only at local or unit level. Summing up this part of the discussion, the Chairman said that it did not seem possible to reach agreement on this occasion. The balance of argument seemed to be that pre-entry tests were desirable, but there was not yet a consensus that they were essential. Given the present state of knowledge, the Group should have to discuss further and try to form a general view, with good arguments for whatever course it recommended. On the position of staff shown to be a risk - however that were defined - he pointed out that this was not a novel problem: it was already established practice to suspend from duty hospital staff with staphylococcal infection.

The group agreed to discuss further.

b. SCOPE OF STAFF TESTING

Without prejudice to the question of whether there should be a test (10a above), the Group discussed the extent to which testing should be applied, namely

i to all staff in a hospital with a renal failure unit

ii to staff in the renal failure areas only; or

iii to staff in such areas and associated departments.

Sir Michael Woodruff expressed the view that option (i) would be going too far; ~~in default of comparative information about the degree of risk in other areas, it had to be presumed that renal failure was the high risk area.~~ Perhaps there was a case for sample checking outside these areas. Dr Robson agreed generally but said that other classes of patients received immunosuppressive therapy and theoretically were as much at risk: comparative information would help to put the renal failure risk in prospective. What was needed was machinery to detect a lateral spread from the renal failure areas.

The Group agreed to discuss further.

11. BRIEFING PATIENTS ON THE RISKS

There was a general view expressed by physician members of the Group that patients should not be informed of the risks. The Group also noted, however, that there was some risk of spread to relatives: in the Guy's outbreak, 10 relatives of patients and 1 relative of a staff member had

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hepatitis. Miss Westbrook suggested that most patients and their relatives were in fact knowledgeable about the risks.

MOVEMENT BETWEEN UNITS

Whilst the recommendation against such movement, seemed generally sound, the Group should be careful not to prejudice the position of units which formed a single functional complex eg the Western and Royal Infirmary units in Glasgow and the Nuffield Transplant Centre and the Royal Infirmary in Edinburgh.

13. HOME DIALYSIS PATIENTS

The Group should produce a code in simple lay language for the guidance of such patients. It was the general view that the advantages of home dialysis should be emphasized, and not only from the point of view of defence against infection. Professor Kennedy pointed out that there would be some residual cases who, for social or other non-clinical reasons, might not be suitable for home dialysis. It was also the general view that home dialysis patients should be routinely Au tested.

NEW ITEMS

14. DISPOSABLE COILS

Although there was in the field a general belief that disposable coils were safer than kiils, this had not yet been objectively demonstrated in the European Dialysis and Transplant Association (EDTA) or any other forum. Further, there might be practical difficulties in expecting staff and patients trained to use kiils to change at short notice to coils.

15. TREATMENT OF STAFF PROVEN INFECTIVE

There was discussion as to whether such cases should be treated in the general hospital of which the renal unit formed part or in isolation facilities. The general view seemed to favour the latter.

16. PROTECTIVE CLOTHING

There was some discussion about the relative merit of impermeable clothing. Whilst it would seem preferable to give detailed guidance on this, it was not clear that an objective case would be made for each item. Sir Hedley Atkins commented that a good analogy was to be found in theatre precautions: the value of each individual measure was arguable, but what was incontrovertible was the value of the approach, of the attitude of mind, of insisting rigorously on a comprehensive drill which was scrupulously observed.

The Group agreed to recommend in this sense.

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17. ALERT STATE

Views expressed on the duration of an alert state included 60 - 70 days (Sir James Howie, Dr Robson, and Dr Jones); 180 days (Dr Maycock). As to the suggested bar on admission of new patients, Dr Williams suggested it should be open to units with a second site to continue to admit, away from the locus of infection; and Sir James Howie thought there would be a case for a 48-hour 'orange' rather than 'red' alert whilst the unit would be decontaminated and confirmatory laboratory investigations carried out. Professor Kennedy expressed the view that an objection to further admissions was not so much the risk as the load on clinical management in treating patients.

The Group agreed to discuss further.

18. GENERAL

Professor Duguid observed that the hepatitis hazard was not only an anxiety for renal units: it was a matter for the whole hospital and others to concern themselves with. Communication was vital; and material to be communicated. It therefore followed that records of tests and incidents should be kept assiduously. He undertook to prepare a passage for the report in this sense. The Group agreed to include a recommendation in this sense: it would be for later consideration whether this should more appropriately be entered in the general body of the report, or the code, or both.

19. OTHER BUSINESS

a. DRAFT REPORT

The Chairman said that he had instructed the Secretariat to submit possible headings to him, with a view to a first draft being circulated in time for the next meeting. The Group took note.

b. Mr Dewar reported on contact with Mr Leighton-Young, the Chief Technician in the London Hospital who had approached the Chairman. The chief point made by Mr Leighton-Young was a lack of awareness in both senior and junior laboratory staff about the risks in this field. Commenting, Professor Duguid said that he found this depressingly plausible. Containment of infection was not a hospital strong point. There should be one named person with responsibility as control of infection officer: control committees were not, in his view, of much value. Dr Maycock said that a booklet was about to be issued under the aegis of the Central Pathology Committee on general hazards in laboratories.

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c. HAG(71)2.

Mr Watt's technical note was remitted for separate discussion by the Chairman, Dr Jones, Professor Kennedy, and Dr Robson. The tentative conclusion was that the main report should contain suitable reference to the need for further technical development to reduce still further the possibility of risk in the hardware and fitments.