CONFIDENTIAL TO COMMITTEE MEMBERS MSBT 18/

MEETING OF THE ADVISORY COMMITTEE ON THE MICROBIOLOGICAL SAFETY OF BLOOD AND TISSUES FOR TRANSPLANTATION (MSBT)

MINUTES OF THE MEETING HELD ON 3 JUNE 1999

Chairman: Dr Jeremy Metters

Members present:

Dr A J Cant
Dr P Mortimer
Dr R J Perry
Dr A Robinson
Dr T J Snape
Dr R E Warren
Dr T Wyatt

Observers

Dr McGovern
Dr Keel
Dr Salter
Dr Rothlat
Dr Brecker
Ms de Zoete

Secretariat

Gwen Skinner, Ann Willins.

APOLOGIES FOR ABSENCE

1. Apologies had been received from Dr McClelland, Dr Gorst, Professor MacMaster, Professor Zuckerman, Mr Forsythe, Dr Nicholas and Dr Wingfield.

MINUTES OF THE MEETING HELD ON 16 FEBRUARY 1999

2. The minutes were agreed subject to the removal of TTV from paragraph 37 as it was not a "screening gap".

MATTERS ARISING FROM THE MINUTES

Leucodepletion (MSBT (18)3)

3. Dr Robinson advised that all blood collected after 31 October and issued as red cells or platelets would be leucodepleted. All red cell stocks would be leucodepleted by the end of the first week in December. She indicated that the process of introducing leucodepletion had proved to be extremely complex. There had been difficulty in validating a filter that worked from the time of collection, most worked after 24 hours of storage. As yet no filter suitable for FFP had been found but every effort was being made to match the deadline for red cells and platelets. Members noted that the leucodepletion of FFP might continue to present technical problems.

4. Dr Keel advised that Scotland had an earlier target date for universal leucodepletion and that she would check further on progress. The NBA and SNBTS were working closely together, although they were using different methods. There was shared contingency planning. It was agreed that although health issues including blood had been devolved to the Scottish Parliament, and both the Scottish Parliament and the Welsh Assembly would have their individual debates, there remained a need for a UK approach.

5. Members agreed that the scale of the leucodepletion task had not been fully appreciated. Working practices in all blood centres needed to be re-engineered and available filters and their associated blood packs had to be validated for cost, quality, large scale availability and clinical effectiveness. NEQAS had been involved to ensure that 99% of components were leucodepleted to the required specification because quality control was based on sampling. An early warning system was being devised so that whole batches would not be wasted.

6. Dr Robinson reminded members of the before and after study of leucodepletion which the NBS was carrying out, exploring the additional benefit. There was possible advantage in waiting up to 2 hours to remove the white cells because of the likelihood that they would have taken up any circulating bacteria by then. A further study was investigating the effect of leucodepletion on HTLV1 transmission. It was also possible that CMV would be removed. This would have implications for HTLV1 and CMV screening. It would be important for the NBA and the SNBTS to liaise on active pharmacosurveillance and haemovigilance.

Blood products

7. Dr Snape advised that BPL began issuing non-UK plasma derived Anti D from 24 May and that the supply was now secure. The sourcing of the remaining hyperimmune products from non-UK plasma would be completed in July for tetanus and September for rabies immunoglobulins. The hepatitis B intravenous immunoglobulin might be delayed. Any remaining products sourced from UK plasma were unlicensed. The overall picture was therefore that all licensed

products were now sourced from non-UK plasma. Recovery of the UK derived hyperimmune products would begin in the month following the issue of the US derived ones. The UK derived normal immunoglobulin products would be recovered at the same time.

8. Dr Perry advised that the SNBTS had completed their recover and replace exercise for the main products. The Anti D exchange programme was on target for 28 June. For this, and the other hyperimmune products, SNBTS was about 4 weeks behind BPL.

Risk Assessment

9. Dr Metters reported that the DNV risk assessment had been published on 18 February. It was currently being discussed at the FDA's TSEAC Advisory Committee. There had been very little reaction to the publication. SEAC would keep the risk assessment under review.

RCOG guidelines

10. Dr McGovern reminded members that the RCOG guidelines on the use of Anti D for antenatal prophylaxis had originated at the Edinburgh consensus conference in 1997. The Department had supported the guidelines but had asked the College not to publish them until adequate supplies of non-UK plasma derived Anti D became available. The situation had been made more complicated by the publication of guidelines by a breakaway group in February 1999. Consideration was being given to how best to endorse the RCOG's guidelines, either by referring them to NICE or to the St George's group. This would be important as there was a difference of opinion within the profession about the evidence in support of antenatal prophylaxis. Dr Snape said that the licensed indication for BPL and PFC's Anti D to be used in routine antenatal prophylaxis was reinstated by the MCA with the introduction of the US plasma derived product. Members agreed that there should be a UK approach on the use of Anti D in routine antenatal prophylaxis.

Donors who have received implicated blood

11. The NBA had asked for legal advice on giving information to potential donors who had received nvCJD implicated blood and a copy had been sent to the Department. This raised some difficult issues in relation to the 3 individual recipients of nvCJD implicated blood who could potentially present themselves as blood donors. Lawyers had indicated that it could be very difficult legally to flag the donor and defer them without informing them why they were being deferred so until this ethico-legal issue has been resolved no flags have been entered onto the NBA donor database.

12. Dr Metters advised that the Department had taken the view informed by best ethical advice that there was no duty to inform individuals that they had received vCJD implicated blood products because there was as yet no screening test, nor

any treatment for vCJD. Informing such people would raise issues such as the worried well, life insurance and mortgage applications. The position would change with scientific knowledge about transmission through blood/blood products , the development of a screening/diagnostic test and an effective treatment for vCJD. Meanwhile the possible harm outweighed the common law responsibility to inform those who had received implicated blood or blood products. Dr Robinson said that the NBA would need a specific direction from the Department on managing this situation. It was agreed that the Department would seek legal advice on this and give a clear direction to the NBA.

13. Dr Salter and Dr Doyle indicated that the position on tissue donors should also be included in the DH advice.

FDA TSEAC Meeting

14. Dr Metters gave a report of this meeting on 18 December 1998 in Washington. The meeting was held in public. TSEAC debated what to do about accepting blood donations from people who had visited or had been resident in the UK. The experts included Bob Will and Professor Aguzzi. Representatives from the Canadian regualtory authority were present also. The FDA's Health and Human Resources Committee and the Armed Forces argued strongly against deferral, as they thought it disproportionate to the risk. However, TSEAC voted 6-3 in favour of deferring potential blood or plasma donors, for those who had been resident in or visited the UK. The precise detail of deferral would be decided and agreed at further FDA meetings scheduled for 1999, including the start and end date for the period of residency. Canada had accepted deferral in principle, and Haemo Quebec had already introduced deferral criteria.

15. The UK could not of course introduce a similar measure as this would effectively exclude all current donors and create the need to reprovision for 2.5 million units of blood from outside the UK. It would be especially hard to do so if other European countries deferred UK donors and depleted their own stocks. If vCJD were proven to be transmissible through blood, however, there would be great pressure to outsource labile blood components as well as plasma. It was agreed that before any action was taken to assess potential spare capacity elsewhere Ministers would be asked whether this should be explored formally.

16. Variant CJD (vCJD) also raised concerns about tissues for transplantation (the UK was neither a net importer nor exporter) and bone marrow in particular. Dr Snape reminded members that BPL and PFC had learnt a great deal through outsourcing plasma, and that the key requirements were to have a guaranteed supply and sources where good quality systems were in place.

FFP/Octoplas

17. Dr Robinson sought the Committee's advice on preparing guidance for clinicians on FFP. Some eminent haematologists had signed a document advocating the use

of virally inactivated 'FFP' only, following a meeting arranged by Octapharma. Clinicians needed central advice and guidance on what they should be using.

18. Dr Metters reminded the Committee that MSBT's advice had been that clinicians should have a choice and that the NBA should work towards virally inactivated FFP. As long as clinicians wanted a choice, then it should be available, which meant retaining the non-virally inactivated FFP sourced from UK donors for the present. However, members raised questions about the clinician's liability where two products were available, one virally inactivated and assumed to be safer

19. Members discussed the implications of the continued availability of unlicensed single donor non virally inactivated FFP in the context of a licensed product being widely available. They noted that HIV had been transmitted from a single donor unit of FFP in the recent past. Members discussed whether a pooled virally inactivated product was safer than a single donor NAT tested component. The licensing of the pooled product was a requirement of the manufacturing process.

20. Members agreed that Dr Robinson was seeking a consensus risk assessment of FFP and commercially available pooled plasma. Some members said that where single dose FFP was used in small amounts the balance of risk was in its favour. Dr Robinson asked members whether British plasma should in that case be used for FFP, and whether the NBA should look for 300,000 single units of voluntarily donated FFP from a non UK source.

21. Dr Metters suggested that it would be unwise to change MSBT's position radically and members agreed. A small refinement could, though, be made to what was previously agreed as MSBT's view, to say that the NBA and SNBTS should work towards developing virally inactivated FFP and while there remained demand for single dose FFP it should continue to be made available by the national blood services. A paper setting out the issues would be prepared for the next meeting. Additionally, the blood services would explore the availability of non-UK fresh frozen single unit plasma and report back.

Testing for hepatitis B core antibody

24. At the February MSBT meeting hepatitis B surface antigen mutants was discussed. BPL was working with Professor Tedder on testing imported US plasma for PCR. Dr Snape updated members on progress - since August 1998 out of 304,000 plasma donations from 56,000 donors, 16 were found to be hepatitis B DNA reactive (and antibody negative). This was a much higher incidence than expected. BPL had arranged for the excluded donations to be returned to the U.S. Professor Tedder thought that caution was needed before conclusions were drawn. His preliminary view was that the problem was not hepatitis B mutants but drift in infection levels. The pattern was not that which was normally associated with mutants. The key issue in the present circumstances was that none of the plasma was entering the manufacturing chain.

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04/06/99 17:48

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KEY POINTS FROM MSBT MEETING 3 J