Minutes of the 26th meeting of the CJD Incidents Panel

Thursday 22nd January 2009

Chairman	**Expertise**
Mr David Pryer	Lay Chairman
Deputy Chairman	
Professor Don Jeffries	Virology
Members	
Dr Miles Allison	Gastroenterology
Mr John Barker	Sterile Service Management
Ms Patricia Cattini	Infection Control Nursing
Professor Bobbie Farsides	Ethics
Dr Pat Hewitt	Blood Safety
Professor James Ironside	TSE Infectivity, Neuropathology
Professor John Lumley	General Surgery
Professor Theresa Marteau	Health Psychology
Dr Simon Mead	Neurology
Dr Bernadette Nazareth	Consultant in Communicable Disease Control
Dr Mike Painter	Public Health Medicine
Mr Ian Pearce	Ophthalmology
Dr Patrick Radford	Anaesthesiology
Dr Geoff Ridgway	Microbiology
Dr Roland Salmon	Epidemiology
Professor John Saunders	Medical Ethics
Mr Alun Tomkinson	ENT Surgery
Ms Gillian Turner	Patient Support
Dr Hester Ward	Epidemiology
Professor Bob Will	Neurology
Ms Kate Woodhead	Theatre Nursing

Dr Tim Wyatt	Microbiology
Visitors	
Mrs Fiona Carley (item 8ii)	Medical Director, Manchester Eye Bank
Ms Gillian Elam (item 11)	Independent researcher
Prof Frank Hill (items 9 and 10)	UK Haemophilia Centre Doctors' Organisation
Dr Elizabeth Howarth (item 8i)	
Observers	
Dr Peter Bennett	HPIH&SD Analytical Team, Department of Health
Dr Stephen Dobra	HPIH&SD Analytical Team, Department of Health
Miss Charlotte Mirrielees	Scientific Secretary, ACDP TSE Working Group
Mr Mark Noterman	Department of Health
Secretariat	
Dr Nicky Connor	Health Protection Agency Centre for Infections
Ms Dominique Brookes	Health Protection Agency Centre for Infections
Professor Noel Gill	Health Protection Agency Centre for Infections
Ms Helen Janecek	Health Protection Agency Centre for Infections
Dr Akram Zaman	Health Protection Agency Centre for Infections
Apologies	
Dr Gerry Bryant	Public Health Medicine
Professor Geoff Craig	Dental Surgery
Dr Sara Hayes	National Assembly of Wales
Mrs Diana Kloss	Law
Mr Henry Marsh	Neurosurgery
Dr Elizabeth Mitchell	DHSSPS – Northern Ireland
Mrs Caroline Ness	Lay Member
Dr Andrew Riley	Scottish Executive Health Department
Dr Douglas Russell	General Medical Practice

1. Welcome and apologies (CJDIP 26/01)

The Chairman welcomed participants to the meeting and announced apologies from the members and observers listed above. Dr Geoff Ridgway was congratulated on having received an OBE in the New Year's Honours and Mrs Diana Kloss on having received an MBE.

2. Minutes of the 25th meeting on 04th September 2008 (CJDIP 26/02)

The draft minutes of the previous meeting were agreed, subject to the following amendment:

Page 11, Section 11, first sentence to read, "The Transfusion Medicine Epidemiology Review is a collaborative project between the National CJD Surveillance Unit and the UK Blood Services through which donors of blood to and recipients of blood from CJD cases are traced in order to determine whether there is any link between CJD and blood transfusion."

ACTION: Secretariat

3. Public summary of the 25th meeting on 10th September 2008 (CJDIP 26/03)

The draft public summary of the previous meeting was approved, subject to making the same amendment.

4. Matters arising

4.i Peer-reviewed publication of Panel incidents

The Panel noted an oral synopsis of the proposed article for the BMJ. It was suggested that the article might be submitted at the same time as a proposed paper on the qualitative study (item 11) since the BMJ prefers, where possible, to publish more than one piece on a particular topic. It was agreed that the draft article would be circulated to the Panel for comment by mid-February.

ACTION: Secretariat

4.ii Surveillance of occupational exposure to TSEs

The developing surveillance project comprised two components:

- a questionnaire to senior scientists and health and safety advisors working in the field of TSEs
- a collaboration with the National CJD Surveillance Unit to identify hospitals where surgical procedures had been performed on patients with human prion disease and approach them for data.

A number of people working in the relevant disciplines had been involved in the development of the surveillance system and, at the final draft stage, occupational health staff would be invited to comment.

A number of comments and suggestions were made:

- It was important to include morticians undertaking post-mortems as well as laboratory staff involved in clinical diagnosis and research.
- The questionnaire might help ascertain exposures not reported through fear of stigma.
- Although advice had been obtained from an HPA Caldicott Guardian that no formal ethical approval was necessary, on the basis that this is clinical surveillance rather than research, concerns were expressed about the disclosure of information concerning healthcare workers. It was therefore suggested that clarification of the need for ethical advice and endorsement should be sought from the chair of an ethics committee.

It was agreed that the final draft of the surveillance protocol and questionnaire would be presented to the Panel and the ACDP TSE Working Group for approval.

ACTION: Secretariat, HPA

4.iii Revised Panel advice concerning gastro-intestinal endoscopes

At the previous meeting, the Secretariat had been asked to check that the local teams for the five incidents involving gastro-intestinal endoscopes reported to the Panel in the past were aware of the option for refurbishment. It was confirmed that the local teams for these incidents had been contacted and made aware of this option.

4.iv Proposed feasibility study to identify recipients of tissue and organs from vCJD cases (CJDIP 26/4)

The Panel noted the letter to Dr George Galea, Scottish National Blood Transfusion Service, dated 25.09.2008, endorsing the proposal to assess the feasibility of tracing the donors and recipients of tissues and organs, including bone marrow, from vCJD cases. It was reported that the study was expected to start imminently.

4.v Panel annual report for 2007

Following the completion of changes to the CJD part of the HPA website, the Panel annual report for 2007 would be posted on the Panel web pages. The Panel was invited to comment on the new version of the web pages.

ACTION: Panel members

5. Summary of incidents reported to Secretariat in 2008 (CJDIP 26/05)

It was noted that 40 incidents had been reported to the Panel in 2008, only one involving a patient with vCJD.

6. Response times for Panel advice (CJDIP 26/06)

The Panel noted the analysis of the time taken to issue first Panel advice letters since the previous meeting. A revised version of the report would be circulated following the meeting. Long delays between notification and the issue of formal advice are caused by largely unavoidable factors. However, it was agreed that the Secretariat would add to the table a column for the date when a completed incident reporting form was received and produce a report on the procedure for managing ongoing incidents.

ACTION: Secretariat

7. Endorsement of advice provided since previous meeting

7.i Surgical incidents involving contactable patients (CJDIP 26/07a,b)

The Panel had advised that patients should be considered 'at risk' of CJD/vCJD in 21 surgical incidents, including PI 466: item 8ii below. The number of patients known to have been contacted in connection with a surgical incident remained at 62. The Secretariat was asked to review the number of incidents involving cataract operations where denotifications had not been advised.

ACTION: Secretariat

There were three ongoing incidents which might lead to patients being notified: PI 340, PI 456 and PI 466. (See also item 8ii).

7.ii Endorsement of advice based on precedent (CJDIP 26/08c)

Letters reviewed: PI 432/1, PI 470/1, PI 479/1, PI 482/1, PI 484/1, PI 487/1, PI 488/1, PI 490/1, PI 493/1, PI 494/1. PI 496/1.

The Panel endorsed the 11 letters giving advice based on precedent which had been issued since the previous meeting. In relation to PI 490 involving a case of definite sporadic CJD where the index patient had donated blood, it was confirmed that although the Panel advises that no action needed to be taken in relation to recipients of blood from donors who subsequently develop sporadic or

inherited CJD, it had been agreed that the HPA would inform the UK Blood Services of any patients with sporadic or inherited CJD who had donated blood.

8. Surgical incidents for discussion

8.i PI 340: 'at risk' transfusion patient (CJDIP 26/08a)

This incident, first reported to the Panel in 2005, involved a recipient of vCJD-implicated blood components who was considered at risk of vCJD and presumed infected for public health purposes. The patient had undergone 11 laparotomy procedures and 30 oesophageal dilatations since the blood component transfusion in 2003. With the assistance of the local incident management team, the Panel had conducted a risk assessment. A Panel letter dated 25.08.2005 had advised the local incident management team to identify when instruments used in medium-risk procedures had been used on subsequent patients. These patients would then need to be notified. Following further correspondence and a meeting with the Panel Chairman and Secretariat on 24.04.2007, the local incident management team completed its investigations and identified 30 patients to be notified in connection with the endoscopes used in the oesophageal dilatations. There had originally been 35 patients but five of them had died. Four of the 30 patients were <16 years of age. It was not possible to trace patients in relation to the laparotomies as it was not possible to trace the instruments. (Instrument tracing systems are now in place.)

The local incident management team had now asked the Panel to review its advice to notify patients on two grounds:

1. Inconsistencies in the Panel advice to notify patients: was it ethical to notify the patients in relation to the oesophageal dilatations when the laparotomy patients were not able to be notified? It was also pointed out that the recipients of blood components donated by a surgical contact in PI 341 (at the same trust) had not been required to be notified.
2. Lack of expertise and capacity in both the trust and the local health protection unit to support and counsel 30 patients.

1. Alleged inconsistencies in Panel advice

In order to protect other patients, the Panel had always issued advice on the basis of risk reduction in relation to onward CJD/vCJD transmission. Four children and 14 people over the age of 60 years were in the group of 30 patients to be notified. The Panel agreed that there was no upper or lower

age limit for being at risk of CJD. If the laparotomy patients had been traceable, the Panel would have advised that they, too, should be notified. One of the surgical contacts who was informed that they were at risk in PI 341 had been a blood donor. The Panel agreed that there was no need to trace the recipients of this donated blood, as they would be contacts of contacts.

The Panel therefore agreed that there was no justification for changing the Panel advice which had been issued.

2. Notifying the 'at risk' patients

Dr Mead offered to assist the local incident management team by providing access to the support of the National Prion Clinic's counsellor. She would help them to build local capacity to inform and support the patients who required to be contacted.

ACTION: Secretariat, Dr Mead

8.ii PI 466: corneal graft recipient (CJDIP 26/08b)

The Panel's advice had been requested by an eye bank in relation to an individual with confirmed sporadic CJD who had received a corneal graft. A subgroup had been convened by teleconference on 07.08.2008 to consider the following questions:

- How likely was the corneal graft to be the cause of the recipient's CJD?
- Should the two other eye tissue recipients (one of cornea and sclera, the other of sclera only) be notified that they were at risk of CJD?

At the previous meeting, the Panel had accepted the subgroup's recommendation that the two other recipients of eye tissue from the donor should be notified that they were 'at risk of CJD for public health purposes' and the Secretariat had issued an advice letter dated 16.10.2008 accompanied by the minutes of the subgroup meeting[1].

The eye bank was now asking the Panel to reconsider its advice for the following reasons:

- There had been only two reported cases of sporadic CJD following a corneal graft. In both cases there had been evidence of neurological impairment before the donor's death. The donor to the index patient had had no neurological symptoms.
- Assessment of sporadic CJD cases occurring in corneal recipients in other countries has concluded that these are likely to occur occasionally by chance, and are not considered to be

[1] It was agreed that the words, "The stored residual tissue from the donor had not yet been tested." should be removed from paragraph 2.3 of the minutes since no residual tissue had been retained from this donor.

iatrogenic. Whilst there is a risk that sclera grafts may be contaminated by retinal tissue, sclera itself is not thought to be infectious.

- The option of graft removal and regrafting could not realistically be recommended to the recipients because of the high risk of failure of a subsequent graft and the inability to guarantee that the replacement tissue was free from the risk of CJD.
- Concern about the impact on future ocular donation.

It was noted that any remaining tissue from this donor had been discarded.

The Panel discussion included the following points:

- The WHO table of CJD infectivity is based on the findings in patients with clinical disease, not on the distribution of infectivity in asymptomatic individuals incubating CJD. In sporadic CJD, infectivity appears in tissues outside the brain relatively late in the incubation period.
- The decision of the Panel and the August subgroup had been very finely balanced and had been based on the statistical probabilities that sporadic CJD could occur in the recipient, and in the donor, of the corneal graft. However, the epidemiology indicates that one case of sporadic CJD in a corneal graft patient would be expected to occur by chance every 15 years in the UK.

It was felt that the original Panel decision had failed to give sufficient weight to these two points. The Panel therefore agreed to change the advice given in this incident and that accordingly the other two recipients of eye tissue from the donor of the cornea to the index patient should not be considered to be at risk of CJD for public health purposes and need not be notified.

ACTION: Secretariat

8.iii PI 496: patient with inherited CJD (CJDIP 26/08c)

The advice given in this incident had been based on Panel precedent. However, it was considered timely to draw the Panel's attention again to an important issue raised by this incident where the index patient had three surviving siblings and six grandchildren. In the UK, there is an unidentified group of patients who may have a 50% risk of developing inherited prion disease. Interim guidance issued by the Panel in January 2007 advises that public health precautions should be taken in relation to relatives only if they have been informed that they are at risk of inherited prion disease. The Panel discussed whether the National Prion Clinic should be asked to take steps to record

details of relatives who have been informed that they are at risk of inherited prion disease, to assist with the implementation of public health precautions.

The National Prion Clinic's patients have a range of inherited prion disorders. The family networks of these patients include several hundred people. Patients seen by the National Prion Clinic are advised to share information with their families and asked to take public health precautions. Because of personal sensitivities in such cases, and in common with centres dealing with other genetic conditions, it is considered inappropriate for the clinic to trace patients' relatives. However, it might be possible to find a way of recording relatives who have been informed of their risk through those patients who are followed up.

It was agreed that the Secretariat should meet with the National Prion Clinic to discuss this matter further and bring a proposal to a future Panel meeting. It was suggested that the organisation Genethics might be able to provide a useful viewpoint on this difficult area.

ACTION: Secretariat

9. Blood incidents for discussion

<u>9.i vCJD infection in a patient with haemophilia</u> (CJDIP 26/09a)

The National CJD Surveillance Unit and the UK Haemophilia Centre Doctor's Organisation's study of tissue samples from deceased haemophilia patients had detected PrP^{res} in the post-mortem spleen sample from one patient 74 year old patient who died with no symptoms of vCJD or any other neurological condition. All of the other 23 samples from the patient, including other spleen samples, had tested negative. The Western Blot result showed a configuration very similar to that in the heterozygous non-clinical case of vCJD infection following a blood transfusion from a donor who later went on to develop clinical vCJD, where samples from both the spleen and one lymph node had tested positive for PrP^{res}. The haemophilia patient had received Factor VIII, including one batch that included plasma donated by an individual (TMER 123) who had subsequently developed vCJD. The haemophilia patient had since 1998 also received blood transfusions from at least 14 other donors. Investigations into these and other donations and possible surgical and dietary routes of infection, had yet to be completed. In the meantime, preliminary statistical analysis indicated that this asymptomatic vCJD infection was likely to have occurred through exposure to contaminated blood or plasma products.

A Panel subgroup teleconference had been held on 14.01.2009 to give urgent consideration to any immediate action which needed to be taken. It had been agreed that further information was needed before the Panel could issue definitive advice concerning the case and its wider implications. In particular, it had been agreed that:

- NHS Blood and Transplant would receive a formal request from the Panel to work with the UK Haemophilia Centre Doctors' Organisation to identify the blood donors to the haemophilia patient. NHSBT would then work with the National CJD Surveillance Unit to determine whether any of the blood donors appeared on the vCJD database. In the meantime, any further donations from these donors would not be used until this investigation had been completed.
- The UKHCDO would work with haematologists and the haemophilia patient's records to investigate the index patient's full treatment history.
- The UKHCDO would also work with the local haematologist and the infection control team to investigate the patient's surgical history. The Panel would consider whether any potentially exposed patients should be traced and informed that they are at risk of vCJD.
- The HPA would work with the UKHCDO to draft letters to haemophilia centre doctors and their patients to inform them about the incident. The UKHCDO would organise a special meeting of representatives of specialised care centres to consider the communication strategy.

It was important to investigate all possible routes of transmission. If any batches of the implicated Factor VIII had been exported abroad, foreign contact organisations would be informed about the case and any public health actions taken in the UK.

9.ii Report of a plasma donation from a donor who subsequently developed sporadic CJD

(CJDIP 26/09b)

The Panel was informed that further investigations established that the donor did not have CJD.

10. Notifications of individuals 'at risk' of vCJD

10.i Highly transfused patients: update on implementation of Panel recommendations

(CJDIP 26/10a)

At the previous meeting, the Panel had considered the outputs from the subgroup which had met on 31st July to discuss the detailed strategy for identifying and notifying highly transfused patients via pre-assessment for surgery involving high-risk tissue. As a result of concerns about the implications of identifying highly transfused patients with ≥80 donor exposures via high-risk surgery, the Panel

and the ACDP TSE Working Group, which met the following day, agreed to recommend to the Chief Medical Officer a two-pronged approach to the patient notification exercise as follows:

- Implementing a strategy for the prospective notification of very highly transfused patients with ≥800 donor exposures as the first phase of a staged approach to enable haematologists to inform this group of their risk and enable public health precautions to be taken in respect of both medium- and high-risk procedures.
- Continuing with the primary strategy of identifying and notifying highly transfused patients with ≥80 donor exposures only if they present for high-risk surgery.

The Panel Chairman sent this proposal to the Chief Medical Officer in a letter dated 15.10.2008 and the proposal was accepted by the Chief Medical Officer in his reply dated 04.11.2008. An implementation subgroup would meet on 5th February to give detailed consideration to the implementation of the dual strategy.

ACTION: Secretariat, HPA

10.ii Card for people at increased risk of CJD (CJDIP 26/10b)

The Panel considered the first draft of a card to be issued to individuals at risk of CJD/vCJD to assist with the implementation of public health precautions. It had been modelled on the card issued to people who have registered as organ donors. The Panel agreed that this was a useful initiative and made the following suggestions for its development:

- A great deal more work was needed to produce a card suitable for the proposed purpose. Expertise was available within the HPA to assist with the development of a suitable card.
- The card should be issued to all 'at risk' patients, potentially by their GP or specialist doctor.
- The issue was raised as to whether it was appropriate for the card to be issued under the aegis of the Panel or by another relevant organisation, such as the HPA.
- The third bullet point of the covering letter required correcting.

ACTION: HPA

11. Qualitative research on impact of notification (CJDIP 26/11)

The Panel noted the final draft of the report of the qualitative research on the impact of notification which incorporated comments from the May 2008 meeting when the Panel considered the interim findings. Although the sample was small (11 patients) the findings were consistent with similar

research in other fields where it has been found that psychologically frail individuals find it more difficult to deal with bad news than other people.

One important aspect of the findings concerned the implementation of actions to protect the public health. The study sample fell into three groups: those who followed the guidance each time they had medical or dental treatment; those who followed the guidance some of the time; and those who never followed the guidance. One contributory factor to the incomplete implementation of public health action apparent in the report was the common assumption that once the patient's 'at risk' status has been recorded in their medical notes, all healthcare professionals with whom they come into contact have access to this information. Given that the primary objective of CJD/vCJD patient notification exercises is to prevent secondary transmission to other patients, aids and obstacles to the implementation of the guidance might merit further evaluation and/or research. In the meantime it was suggested that additional systems should be explored for future notifications to ensure that public health precautions were in fact taken.

The research steering group would meet within the next few weeks to discuss a peer-reviewed paper to be submitted to the BMJ. The full report would be posted on the HPA website once it had been finalised.

ACTION: Qualitative research steering group, Secretariat

12. Enhanced surveillance of individuals 'at low or uncertain risk' of CJD/vCJD

It was reported that implementation of this research programme continued. The main focus of the programme was currently the recipients of implicated blood components.

13. Mapping out the consequences of screening blood donations for PrP^{Sc} (CJDIP 26/12)

The Panel had previously considered two versions of a paper prepared by the Department of Health HPIH&SD Analytical Team exploring the implications of introducing a vCJD screening test for blood donors. In view of current progress in the development of such a test, it was proposed, subject to the Panel's approval, that a revised version of the paper should be published on the Department of Health website, to support public debate. It was also proposed to develop a peer-reviewed paper for publication. The Panel agreed to these proposals subject to the following suggestions regarding the current draft:

- Tailoring the language to the intended audience, with an eye to Plain English.

- The addition of a glossary.
- Checking the legal aspects.
- Emphasising the importance of the positive predictive value of any test and positioning the text concerning this issue at the beginning of the document.
- Referencing the reports of the seminar on the ethical aspects of introducing the test and the resulting consultation.

ACTION: Department of Health

14. Information update

The articles circulated for information were noted. To date there had been 167 vCJD cases in the UK and 43 cases in other countries. These included a fifth case recently reported in Spain, in a different region from the previously reported cases. In the UK, a possible case of vCJD had been reported in an individual in their 30's and MV heterozygous at codon 129. The case was being fully investigated following the recent death, but consent had not been given for a post-mortem to be undertaken. The case and its implications would be considered by the Panel when investigations had been completed.

ACTION: Secretariat

15. Date of next meeting

The next meeting would be held on Wednesday 20th May in London.