NORTH WESTERN REGIONAL HEALTH AUTHORITY

NATIONAL BLOOD TRANSFUSION SERVICE

Director:
D. LEE, MD, FRCPI, FRCPath.

Telephone:
061-273 7181 Ext.

FAX:
061-274 3941

REGIONAL TRANSFUSION CENTRE,
PLYMOUTH GROVE,
MANCHESTER,
M13 9LL.

DL/NP

3rd October, 1991

Dr. H.H. Gunson,
National Directorate of the NBTS,
Gateway House,
Piccadilly South,
MANCHESTER,
M60 7LP

Dear Harold,

Thank you for your letter of 25th September requesting information on three topics.

1. Counselling of HCV seropositive donors

1.1 Our intention is to see donors and offer counselling when John Craske's results are RIBA positive. We do not propose to wait for PCR results on these. Where the reference results are indeterminate, the donor will be placed on Lab File and counselling will be deferred until the results of a further donation and/or PCR are available.

1.2 I think I have already answered this question unless I have misunderstood.

2. Anti-HBc testing

2.1 We are not routinely performing anti-HBc tests. We have been carrying them out as part of a study at Lancaster to look at the prevalence of anti-HBc in donors with a history of jaundice but we have had to suspend this trial to accommodate the introduction of HCV testing. We look for anti-HBc as part of the follow-up of post-transfusion hepatitis and we have also decided to look, for the sake of completeness, at the anti-HBc status of donors who will be counselled because they are HCV seropositive.

2.2 Already answered.

2.3 In the case donors taking part in our prevalence trial, we have taken no action because testing for anti-HBc is not a requirement of the guidelines. What action we would eventually take would depend on the outcome of the study. In the follow-up of PTH, where we are looking for a donor with HBV markers, we would probably regard someone with anti-HBc as the target donor, even in the absence of demonstrable HBsAg. In the case of donors being counselled because of HCV seropositivity, no additional action will be taken.

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3. ALT testing

3.1 We are not carrying out ALT tests on any blood or plasma donations routinely. In Lancaster, the biochemistry profile provides us with AST results and where this enzyme is persistently raised, the ALT may also be performed with a view to providing appropriate advice for the donor.

3.2 Already answered.

3.3 We would regard a result of greater than 60 as significantly abnormal.

3.4 If we find a raised ALT in a plasma donor, we would seek to link it with one or more of the factors known to predispose. If we cannot do this, and if the finding is persistent, we would continue to bleed the donor with regular monitoring. Where the result is persistently greater than 90, we would refer the donor to the gastroenterologist for advice about liver function.

With kind regards,

Yours sincerely,

GRO – C

DR. D. LEE,
Director.

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