JAB/vs/jf

21 January 1991

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Dear Jack

As agreed at the recent meeting of the Advisory Committee on Transfusion Transmitted Diseases which you attended, I enclose the North London Blood Transfusion Centre's comments on your documents concerning management of anti-HCV positive donors. I have discussed them with Pat Hewitt, John Barbara and Mary Brennan and here are our joint views.

Overall, we are concerned that the projected recommendations go beyond those for other viruses - even for HIV - and this will add to the already enormous cost of anti-HCV screening. As you know, in our view anti-HCV screening is of questionable benefit anyhow in the UK. We believe that before we commit scarce resources to HCV, we ought to put our HBV house in order. Anyway, to get to specific points relating to the documents discussed:

Document: **"Recommended Procedure for the Management of anti-HCV positive donors."**

Item 2.8 Why is the donor offered a second counselling interview within 1 week? Even for HBV counselling (for those few centres that do it!) this is done only at 1 session. Unlike HIV, the impact of notification is unlikely to call for a repeat counselling for reinforcement. In any case, 1 week may not allow repeat tests to be reported and collated. Would it not be better simply to obtain a serum sample for LFT testing (if not available from the pilot tube of the donation which, we at NLBTC routinely test for ALT in HBsAg positive donors) and then follow-up at 6 and/or 12 months if the ALT levels were elevated? If the ALT levels give cause for concern, we would refer the donor to a specialist after the first counselling session.

Item 3.1. Is there any need to specifically inform the donor of

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the repeat test results unless there is a discrepancy?

Item 4. Discrepancies (item 3) should be extremely rare if the index sample had been subjected to appropriate supplementary/confirmatory testing.

Document: **"SNBTS Working Party on HCV donor counselling".**

P1. Discussion point 1: Management of plasmapheresis donors certainly needs to be addressed. Possibly, donors with two consecutive second generation false-positive results should be withdrawn.

P2. Discussion point 3: Any leaflet including information on the benefits of screening should not encourage 'high-risk' donors to attend. We prefer a general statement that blood will be tested for infectious agents transmissible by blood transfusion.

Discussion point 4, line 26: 'protecting' should be replaced by 'preventing transmission to'.

Last Sentence: The only reliable way of collecting and retrieving data is by follow-up at RTCs.

P2 Discussion point 5: The donor's preference should include an option for referral for the 'worried-well'.

P3 Discussion point 6: Lookback will be extremely expensive and should be costed, together with the cost of Interferon etc, for those with liver disease.

Document: **"Background Information for MOs counselling donors."** (NB Counselling may have to be extended to trained nursing staff)

P4 Item 2: Prevalence of <u>confirmed</u> anti-HCV in UK is likely to be in the order of 1 in 1000. This is similar to HBsAg carrier rates. The problem may be one of confirmation and donor re-entry.

see also:
P5 Item 6: If repeatably false-positive donors are withdrawn, they will also require some form of counselling.

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Informing the Donor

P7 The question of mentioning AIDS in the contact letter needs review. Certainly lack of association with AIDS should be stated early in the counselling interview.

Overall, counselling should be combined with collection of epidemiological data. The guidelines to counselling staff should include ways of assessing the possible aetiology of infection, e.g. past history of blood tranfusion, IVDA, etc. Such data is important for shaping future donor selection criteria.

P8 An anti-HCV-positive test must be differentiated from a 'confirmed' result. PCR (reflecting viraemia) may also have to be taken into account.

P9 We feel that advice to HCV seropositive donors to inform their dentists is contentious. It is extremely difficult for HBsAg carriers to receive dental treatment. Do HIV seropositive donors tell their dentists and doctors?

P9 The counsellor should not mention previous donations by the donor unless he or she asks specifically. It is bad enough to give them the bad news; to tell them that they might have transmitted the agent to a previous recipient might make them feel guilty.

P10 (see item 9): We do not feel that anyone apart from spouses and GPs (or a Specialist) need know about a donor's HCV seropositive status.

With best wishes.

Yours sincerely

MARCELA CONTRERAS

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