R.B.T.O. 1/48.

REGIONAL BLOOD TRANSFUSION OFFICERS

Minutes of a meeting of Regional Blood Transfusion Officers held at 2.15 p.m. on Wednesday, January 14th, 1948, in Room 85 Caxton House West, Tothill Street, S.W.1.

Present:

Dr. W. d'A. Maycock (in the Chair)		Ministry of Health
Miss M. E. Marrian		
Dr. Westwater	-	Department of Health for Scotland
Dr. Mourant	-	Blood Group Reference Laboratory
Dr. Boon	- Region 1	Regional Blood Transfusion Officers
Dr. Marshall	- " 2	
Dr. Walker	- " 4	
Dr. Grant	- " 6	
Dr. Pote (deputy)	- " 7	
Dr. Weiner	- " 9	
Dr. Lehane	- " 10A	
Dr. Stratton	- " 10B	
Dr. Shone	- London North	
Dr. Murphy	- London South	

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1. Matters arising from previous meeting

(a) Drivers' Uniforms: Miss Marrian reported that the Ministry of Supply hoped to send a representative to each depot to measure drivers for uniforms, but that she was unable to give any indication when the uniforms would be made available. R.B.T.Os. asked that due notice should be given of the intended visit of the Ministry of Supply representative so that they could arrange for the drivers to be available, if necessary in shifts.

It was pointed out that the drivers at Manchester were in immediate need of uniforms and Miss Marrian suggested that Dr. Stratton should send a requisition to Mr. Simpkin for Civil Defence Uniforms, to be used as an interim measure.

(b) Rations: In reply to a question from Dr. Westwater, Dr. Maycock said that he had at present no further information.

(c) Salaries: Dr. Maycock reported that he had received only 4 replies to his circular letter regarding the payment of M.Os. saláries; R.B.T.Os. Oxford and Leeds gave verbal replies at the meeting.

2. Choice of a level of haemoglobin to be used in the selection of donors.

At the previous meeting Dr. Drummond suggested a haemoglobin level of 90% for both sexes, whereas Dr. Maycock suggested 90% should be the lowest level for male donors, and 85% for female donors. After considerable discussion it was agreed that 85% should be the level for both sexes, but each region reserved the right to apply higher level if desired.

3. Haematogenous Hepatitis

Dr. Maycock reported that during the last 18 months or so, 78 cases of haematogenous hepatitis had been reported to the Ministry, of which some 25% had died, but there was no record of the outcome of about half of the

remaining cases. In view of the importance of collecting as much accurate information as possible of cases of haematogenous jaundice, he had prepared a report form for completion in such cases, which was submitted and approved by the meeting with the exception of paragraph number 4 of the report which should read:-

"Transfused on .....19.. at ....."

R.B.T.Os. agreed that they would try to collect the information asked for, in all cases of jaundice reported to them.

R.B.T.Os. were informed of a fatal case of hepatitis occurring in a patient about 11 weeks after transfusion with 1 bottle of plasma and 1 bottle of blood, following a road accident. The relatives were considering taking legal action against the Ministry. Dr. Maycock impressed upon R.B.T.Os. the need for ensuring that all hospitals were warned from time to time of the dangers of the indiscriminate use of plasma, and that the advantages to be gained by transfusion of plasma should be weighed against the risk of transmitting hepatitis, whenever the use of plasma was contemplated. He also asked R.B.T.Os. to see that the warning labels printed in August, 1946, were regularly included in all shipments of plasma, and emphasized that every opportunity must be taken to remind the medical profession of the dangers of haematogenous hepatitis.

Dr. Weiner suggested that labels should be affixed to <u>each bottle</u> of plasma, a practice which was already in being in Region 10A, although the warning labels in use were rather too large for this purpose. It was agreed that a warning label of suitable size and wording, for affixing to a bottle, should be prepared. Dr. Shone suggested that it might be advisable to get plasma scheduled as a dangerous drug, and Dr. Maycock agreed to look into this possibility. He also suggested that the standard label used on bottles of dried plasma should incorporate a warning of the risk of jaundice.

Dr. Marshall reported a case of haematogenous jaundice after transfusion with Army plasma of the following batches:- P.110, P.230, P.234, P.119, P.224, P.202 and R.B.T.Os. were asked to withdraw any bottles belonging to these batches.

Dr. Marshall reported that he had begun to use thymol turbidity tests routinely on the sera of donors, and was arranging to follow up the donors on whom positive results were obtained. He was also planning to follow up patients transfused with blood from such donors, and asked if all plasma from Region 2 dried at the Lister, might be returned to that region so that the survey might include plasma pools containing blood from such donors. Dr. Weiner mentioned that in an investigation of cases receiving plasma in Birmingham, an increased urobilinogen was found in some of them following the transfusion.

4. <u>Other business</u>.

(a) <u>Brochure</u>: A draft of the brochure was circulated. Dr. Maycock said that about one million would be printed and that they would be distributed free. Owing to shortages of paper and labour it was unlikely that they would be ready for some months.

(b) <u>Form of address for supplies</u>: Dr. Maycock said that he had received a letter from Dr. Tovey asking that packages should be addressed impersonally to the R.B.T.O., in order to avoid delay in opening in case of absence. All present agreed that an impersonal form of address would be acceptable.

(c) <u>Advice notes</u>: Dr. Maycock informed R.B.T.Os. that he had heard from the British Red Cross Society stores that advice notes had not been received for some of the packages of distilled water and giving sets sent for shipment to India and Pakhistan. He asked that in future an advice

note should be sent, in addition to fixing a label on the outside showing the contents of the package, and the Centre from which it was sent. This was agreed.

(d) Rubber Tubing: Dr. Maycock said that Supplies Division were endeavouring to obtain a better quality rubber tubing but asked R.B.T.Os. to ensure that care was taken with packing sets in order to prevent kinking of the tubing. Dr. Marshall said that he had experienced no difficulty with regard to kinking but found that the tubing lost its elasticity after autoclaving. He also enquired whether it was possible to obtain a stirrup pump and bucket combined for washing tubing and needles after use on "bleeds", these also being required by Regions 6 and 9. Dr. Maycock agreed to approach Supplies Division with regard to this.

(e) Suprarenal haemorrhage: Dr. Maycock said that he had received an enquiry from Scotland concerning suprarenal haemorrhage in cases transfused with infected blood, and asked R.B.T.Os. whether they could recall cases in which this lesion was found. Dr. Shone suggested that Dr. Camps, the pathologist at Chelmsford, might be able to assist, and Dr. Marshall mentioned two cases investigated by Dr. Mollison.

(f) Microscopes: A Watson "Kima" microscope which had been in use in the Blood Group Reference Laboratory was on view at the meeting and Dr. Mourant reported that this was a most satisfactory instrument for routine serological use, and could replace more elaborate instruments. This is a monocular instrument with x 5 and x 15 eye-pieces, 2/3" objective, and two-lens substage condenser. It was agreed that one x 10 eye-piece would suffice and that the condenser was not necessary.

Dr. Maycock asked R.B.T.Os. to review their holding of microscopes and send him a list showing (a) all instruments possessed by their centre, (b) which of these might with advantage be replaced by the simpler "Kima" model and (c) an estimate of future needs.

(g) Cardboard boxes: Dr. Maycock reported that he had received replies from all regions regarding cardboard boxes, but he thought it desirable to choose 2 sizes which would be suitable for all regions, to be supplied centrally. The following sizes were chosen:-

No. 5 $5\frac{5}{8}$" x $4\frac{1}{8}$" x $3\frac{5}{8}$"
No. 6 4" x 2" x $1\frac{3}{4}$"

together with the Unit set box and "50A test-tube box" in use at Liverpool. Special consideration would have to be given to the requirements of the Blood Group Reference Laboratory.

(h) Specimen tube labels: Dr. Marshall explained that a great deal of inconvenience had been caused at his centre by the variety of labels which were attached to blood specimens received from ante-natal clinics. He had accordingly prepared a sample label which he desired to have printed for use in his region, and which was approved by other R.B.T.Os., the requirements of the various regions over a 6 monthly period being:-

Newcastle	- 5,000	Manchester	- 3,000	Sutton	- 5,000
Birmingham	- 10,000	Leeds	- 6,000		

(i) Needle Stillettes: Samples of surgical needle stillettes, received by Dr. Marshall from a firm in Leeds, were shown to the meeting, but there was general agreement that these were too expensive and too fragile to be put into general use.

(j) Blood Group Survey: Dr. Maycock reported that at a recent meeting held to discuss the possibility of a blood group survey, Dr. Fraser-Roberts of the London School of Hygiene had asked whether R.B.T.Os. were willing to make their donor panel records available to him for this purpose. R.B.T.Os.

expressed their desire to co-operate in this survey although it was pointed out that in several centres the older records had been destroyed.

Dr. Westwater thought that the Scottish Blood Transfusion Association might also co-operate and suggested that Dr. Fraser-Roberts should write a formal letter to the Secretary of the Association.

5. Date of Next Meeting

Monday, 1st March, 1948, at 2.15 p.m.

EMS.200/20/31.

Ministry of Health.

February, 1948.