NHS
Blood and Transplant

To: Consultant Haematologist in charge of the blood transfusion laboratory

06 September 2006

Dear Colleague,

Variant Creutzfeldt-Jakob Disease (vCJD) and Plasma Products: further look back and patient notification

The National Blood Service and Health Protection Agency (HPA) are co-ordinating a further patient notification exercise for vCJD implicated batches of plasma products. This notification relates to four batches of plasma products that were issued from BPL in the late 1980s and were manufactured using plasma from donors who later developed vCJD. They include two batches of albumin 4.5%, one batch of Factor VIII and one batch of Factor IX. None of the implicated batches is within shelf life. These four batches were not included in the previous vCJD plasma product patient notification exercise in 2004, because, at the time, records for fate of the products could not be identified. Since then, due to further intensive work between BPL and the NBS, it has been possible to trace the likely fate of these products.

The CJD Incidents Panel (Panel) has assessed the risk of vCJD from these batches of plasma products. The Panel advises that some of the patients who were treated with these batches of plasma products may have been exposed to a vCJD infection risk. These recipients should now be traced and instructed to take specific public health precautions to reduce the risk of spreading vCJD to other people.

Our records show that your hospital received some products from the implicated batches, details are shown on the enclosed sheet.

Table 1: vCJD implicated batches of plasma product

Plasma product	Batch Number	Date of release	Expiry Date	Vial Size	Please report patients who received at least:
Albumin 4.5%	AD1667	09/12/1987	01/06/90	400 ml	8,700 ml
Albumin 4.5%	AD1668	12/11/1987	01/06/90	400 ml	8,700 ml
Factor VIII (8Y)	FHC0059	06/09/1988	13/07/89	240 iu	1 vial
Factor IX (9A)	FJA0020	06/10/1988	17/08/89	485 iu	1 vial

We need you to take the following actions:

1 Acknowledge receipt of this letter by completing the confirmation slip enclosed and returning it to the Quality Department at your local blood centre

2 Use the batch details supplied to search blood bank and other records e.g. pharmacy, haemophilia centre for the details of any patients in receipt of these products

3 Identify, by search of each patients record, whether the patient is still alive

4 Arrange for completion of the individual patient assessment form which will then be returned to the HPA, where a risk assessment will be carried out.

We do not need you to inform us of the fate of each product. We would be grateful if you would pass this notification on to appropriate individuals within the Trust to action. The Medical Director of your Trust has received a separate notification from the Health Protection Agency/ CJD Incidents Panel and a copy of that letter is enclosed. Please ensure that you work with the Director of Infection Protection and Control and the Medical Director in completion of this tracing exercise.

This notification completes the actions from all known cases of vCJD who have been identified to date and were blood donors prior to developing vCJD. There are no other outstanding batches from previously notified cases and any further notifications will only relate to newly diagnosed cases of vCJD.

If you have any queries regarding the above, please do not hesitate to contact your local Hospital Liaison Manager or either of us, using the details below.

Copies of this letter will be available shortly on the NBS hospital website at:

www.blood.co.uk/hospitals

Yours sincerely,

GRO-C

GRO-C

Dr. Mike Murphy
National Medical Lead - Hospital Liaison
Tel: GRO-C
email: mike.murphy@ GRO-C

Teresa Allen
Head of Hospital Liaison
Tel: GRO-C
email: teresa.allen@ GRO-C