CJD INCIDENTS PANEL

To:
Members of the CJD Incidents Panel highly transfused implementation subgroup

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CONFIDENTIAL

16th October 2008

Dear Colleagues

Highly transfused patients and secondary transmission of vCJD

The highly transfused implementation subgroup met on 31st July to consider the detailed approach to identifying highly transfused patients with ≥80 donor exposures via surgery on high-risk tissues. Concerns were expressed at the meeting about the difficulties of confining the notification of highly transfused patients just to those undergoing high-risk surgery.

The CJD Incidents Panel at its meeting on 10th September considered the recommendations of the implementation subgroup, including draft documentation to support the identification and notification of highly transfused patients. The Panel took very seriously the concerns of the implementation subgroup regarding implementation of its recommendations, particularly in view of the uncertain assumptions underlying the notification strategy. The Panel therefore made a proposal to the ACDP TSE Working Group for consideration at its meeting the following day that, in addition to the identification of highly transfused patients via pre-surgery assessment, there should be prospective notification of all very highly transfused individuals with ≥800 donor exposures.

The ACDP TSE Working Group supported the Panel proposal but suggested that the prospective notification of very highly transfused individuals should be implemented first, and the outcomes assessed, before proceeding with the identification of highly transfused individuals via pre-surgery assessment.

Accordingly, the Panel Chairman has written to the Chief Medical Officer suggesting a modified strategy for highly transfused patients based on the ACDP TSE Working Group's recommendations. You will find enclosed the letter dated 15th October: please note that this is confidential and not for wider circulation. I shall let you know what is decided in due course.

Yours sincerely,

Mr David Pryer
Chairman, CJD Incidents Panel

CJD INCIDENTS PANEL

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15th October 2008

Dear Sir Liam,

Highly transfused patients and secondary transmission of vCJD

Further to my letter dated 11th June, I am writing to update you on the Panel's progress in implementing its recommendations for highly transfused patients.

In my previous letter I informed you that the Panel planned to develop a strategy to identify and notify highly transfused patients who have received blood from 80 or more donors. This would be done during pre-surgery assessment for surgical procedures on high-risk tissue, and would be expected to involve in the region of 50 patients a year in the UK.

An implementation subgroup met on 31st July to discuss the details of this approach. The outputs from the subgroup were considered by the Panel and the ACDP TSE Working Group at their meetings on 10th and 11th September respectively.

The implementation group included clinicians working in neurosurgery and haematology. This group advised that it was inevitable that clinicians would choose to identify prospectively many of their highly transfused patients, not just the few that required high risk surgery. The implementation group also advised that many patients would become aware of the process and would choose to identify themselves to the health services as at risk of variant CJD. Therefore, an unknown proportion of the estimated 30,000 highly transfused patients living in the UK could become involved in the notification.

The Panel agreed with the implementation subgroup's assessment of the planned notification, and had further concerns as follows:

- The numbers of highly transfused patients living in the UK (as cited above) are uncertain. This is because the estimates are derived from four years of data from Scotland. These estimates have been directly extrapolated to patients living in the UK. They have then been applied to patients living in the UK who have received blood from 80 or more donors since 1980. However, there is little evidence to support these additional estimates.
- The uncontainable nature of the notification means that it is quite possible that hundreds or thousands of these patients could be identified as at risk of variant CJD for public health purposes. This would have great impact on these patients and the health professionals supporting them. It would also have a large financial cost to hospitals serving them. This is because infection control guidance advises that instruments used in many types of medium-risk surgery should be destroyed after use on patients 'at risk of variant CJD'.
- The risk to highly transfused patients is calculated using variant CJD prevalence estimates. Should the estimated prevalence of variant CJD fall, some highly transfused patients would no longer be considered 'at risk of variant CJD'. This would then require a wide-scale de-notification process.

The Panel has advised against a prospective notification of the several thousand highly transfused patients alive in the UK. The Panel is now concerned that pre-surgical screening might evolve into just such a wide-scale notification.

Because of these problems, the Panel proposes prospectively notifying patients who have received blood from 800 or more donors. This is a change from the Panel's previous position as described in my last letter. This reflects the Panel's desire to manage the risk from people who have received blood from many donors, without notifying excessive numbers of patients.

This proposal is also difficult as the threshold level of 800 donors is fairly arbitrary and lacks a scientific justification. It was chosen because:

- It reflects a public health risk that is much higher than the risk from 80 donor exposures.
- It is likely to involve a far smaller number of patients, and have a smaller effect on the health service.
- It would be less likely to require wide-scale de-notification if prevalence estimates fall.

Extrapolation from the Scottish data indicates that there could be around 600 people living in the UK who have received blood from 800 or more donors. However, the evidence for this figure is weak.

Table 1 compares the possible impact of the two notification strategies. The estimates are based on a 4.25 year snapshot of Scottish data. Direct extrapolation to the UK population underestimates the true numbers as many patients receive transfusions over a number of years. These data have then been extrapolated to include transfusions received by UK patients since 1980. There is little evidence to support this methodology, but it is consistent with data from one NHS Trust on patients who have received blood from 80 or more donors.

Table 1: Number of patients in the UK who have received blood from 80 and 800 donors, and number of surgical procedures undergone in one year[1].

Estimated numbers in UK	80 donor exposures		800 donor exposures	
	Direct extrapolation[a]	**Estimates for total donor exposures since 1980[b]**	Direct extrapolation[a]	**Estimates for total donor exposures since 1980[b]**
Living recipients	13,000	**31,000**	80	**600**
Medium risk surgery (excl endoscopy)	600	**1,400**	3	**25**
Endoscopy (medium risk)	700	**1,700**	4	**30**
High risk surgery	23	**56**	0	**1**
Infection risk for an individual[c]	2.0%	**2.0%**	18.1%	**18.1%**

[a] Direct extrapolation from Scottish data (4.25 year period) to UK population.
[b] Estimates of donor exposures since 1980 in UK (extrapolated from 4.25 years of Scottish data).
[c] Assuming transmission from an infected donor is certain, and the variant CJD prevalence is 1: 4,000.

Despite these problems, the Panel suggests taking forward both options – prospectively notifying people who have received blood from 800 or more donors, and screening patients attending for neurosurgery and eye surgery (high-risk tissues) to identify people who have received blood from 80 or more donors. This was considered by the TSE Working Group on 11th October.

The Working Group shared the Panel's concerns and broadly agreed with the proposal. The Working Group suggested that the prospective notification of people who have received blood from 800 or more donors should be carried out first. The impact of this notification exercise on patients and health services could then be assessed.

This would inform any decisions to:

- notify a further set of patients who have received blood from a lower number of donors e.g. 600, and

[1] Highly Transfused: Estimate of numbers of highly transfused, the number of those undergoing medium- or high-risk surgery and risk of vCJD infection at given levels of donor exposure. Stephen Dobra, DH HPAT.

- carry out pre-surgical screening of patients who have received blood from 80 or more donors who require high-risk surgery. This would need to be accompanied by firm guidance to clinicians that they should not notify patients who do not require high-risk surgery.

I would like your advice on whether to implement these patient notification strategies as described above.

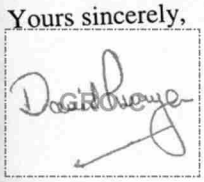
- Should we implement the prospective notification of patients who have received blood from 800 or more donors?

If so,

- Should we then notify patients who have received blood from a lower number of donors? (threshold to be agreed once the initial notification has been assessed)
- Should we then screen patients attending for neurosurgery and eye surgery to identify patients who have received blood from 80 or more donors?

I acknowledge that the Panel has taken a long time to consider these issues. I hope that you will appreciate how difficult it is to find a workable and proportionate response to the public health risks surrounding highly transfused people.

Yours sincerely,



Mr David Pryer
Chairman, CJD Incidents Panel

cc Dr Harry Burns, Dr Tony Jewell, Dr Michael McBride
Professor Don Jeffries, Miss Charlotte Mirrielees
Mr Mark Noterman, Dr Peter Christie, Dr Elizabeth Mitchell, Dr Sara Hayes