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MSBT 9/4

ADVISORY COMMITTEE ON THE MICROBIOLOGICAL SAFETY OF BLOOD AND TISSUES FOR TRANSPLANTATION (MSBT)

MINUTES OF THE MEETING HELD ON 2 JULY 1996

Chairman :	Dr J S Metters
Members present:	Dr D W Gorst Dr D B L McClelland (items 4-9 only) Dr P Mortimer Dr R J Perry (items 4-9 only) Dr E A Robinson Dr T J Snape Dr R E Warren Professor J D Williams Professor Zuckerman (items 1-4, 8 only)
Observers:	Mrs J Dhell Dr P Doyle Dr G Mock (items 1-5 only) Dr I H Nicholas Dr J Purves Mr J S Sloggem
Secretariat:	Dr A S M Rejman Mr P Pudlo Miss A Towner Mr L Levy Mr M Harvey

1. Chairman's Introduction and Welcome

The Chairman welcomed those present and explained that the meeting had been arranged to deal with three important items of business before the summer break.

2. Apologies for absence

Apologies were received from Dr Cant, Dr Keel and Dr Ludlow.

3. Minutes of the eighth meeting held on 2 May 1996(Paper MSBT 8/6)

In response to a letter from Professor Thomas, it was agreed to amend paragraph 4.3 of the minutes to read :

> "Professor Thomas said that there was evidence of neonatal transmission (50-75% PCR positive). There was also evidence that the virus was present in lymphoid cells. 10-40% of patients who are viraemic have been shown to have elevated ALT. A paper in the press indicated that 1 in 17 fulminant hepatitis cases were

HepG positive. There was no evidence that viral inactivation worked but because of the similarity of HGV to HCV it was reasonable to assume that it did. "

Subject to that amendment, the minutes were agreed.

HTLV Testing

4.1 Dr Robinson introduced paper MSBT 9/1. Apart from the covering note from the Secretariat, this included the minutes of the special SACTTI meeting in May about HTLV testing, and selected papers. Dr Robinson highlighted two factors. Firstly, Graham Taylor's paper indicated that the spectrum of disease associated with HTLV was probably greater than had previously been believed. Secondly, Lorna Williamson's paper showed that the risk could not be eliminated by filtration (leucodepletion), the age of components apparently being the principal factor determining whether infection was transmitted.

4.2 SACTTI had recommended that universal testing for HTLV be operated for at least two years, during which time information about prevalence and sero-conversion rates would be collected. In the light of that experience SACTTI felt it could then be decided whether to move to first pass testing.

4.3 The Secretariat's covering note asked MSBT members whether there had been developments justifying a change in their previous advice to Ministers not to introduce testing for HTLV, and whether further work on feasibility and timing was required.

4.4 Dr Robinson said that the blood service would be unable to introduce screening within available resources.

4.5 Key points made in discussion were :

* there was a dearth of information about prevalence of HTLV infection in the donor population in the UK. The scale of infection in Japan, from which some data was drawn, was quite disproportionate. There was only one known case of illness resulting from HTLV infection in the UK where blood transfusion may have been the cause- a case of tropical spastic paraparesis;

* had it been established that the diseases apparently associated with HTLV, besides TSP and ATLL, were clinically severe, and that they were definitely linked to HTLV ?

* some other European countries were screening for HTLV - (Denmark, Finland,France, parts of Germany, Luxembourg, Netherlands (3rd year of research project), Sweden (new donors only)and probably Portugal;

* methylene- blue would not be effective in eliminating cell-associated viruses such as HTLV1;

* even with (initial) universal testing, donors would need to be tested twice to establish sero-conversion rates;

* it could be hard to defend reverting later from universal screening to a first pass system, but to go straight to first pass testing would be unique;

* it was doubtful if the blood service IT systems could handle any decision to implement a first pass system from the outset;

* if universal testing were to be agreed, implementation could probably require a 6 month lead period;

* decisions would also need to be made about how to handle improved sensitivity in test kits;

* if testing were also to involve organ donors, this might lead to unnecessary loss of organs:

* given NBA's broad estimate of £3.8m costs per year for England (recoverable from charges for blood), costs for the whole of the UK might be in the order of £5m. These costs would need to be refined, with the help of the Department's economic advisors. As it was agreed that if screening were introduced for blood, this should also apply to tissues, this would further increase costs.

4.6 The Chairman said that as additional costs were involved the issue would need to go the Management Board of the NHS Executive, who would be able to consider the proposal in context of competing demands on NHS finances, before a recommendation went to Ministers. The Board would want not only costings, but information about which other countries tested, and prevalence of infection there.

4.7 An alternative approach to universal testing which would be relevant to other low prevalence transfusion infection would be to provide compensation to the few who developed disease as a result of infection by blood. Or special safety measures could be restricted to those especially at risk, eg neonates, the immuno-suppressed, maternity cases. The first group were dealt with in paper MSBT 9/2 (see below). The two approaches were not mutually exclusive.

4.8 Ministers were likely to be concerned about the potential for public criticism were testing not introduced. While numbers suffering ill effects might be low, the consequences for each patient could be severe, and would be likely to attract public sympathy.

4.9 The Chairman summarised the views of MSBT as being that - with reservations on the part of two members - they now considered that there was a good medical case for HTLV screening. It was accepted that selective screening was not feasible (as at paragraph 3 of paper MSBT 9/1). MSBT would therefore recommend universal screening at the outset,

indicating that it might be possible subsequently to move to first pass testing, depending on information gathered eg about sero-conversion rates.

4.10 The aim would be to put MSBT's proposals to the Executive Boards in Scotland, Wales and Northern Ireland at the time at they went to the Board for England, and to keep progress in step also thereafter.

4.11 Dr Robinson favoured a look-back, which would enable transmission rates to be ascertained. Dr Perry suggested those infected had a right to know. Other did not favour a lookback. The Chairman summarised the majority view of MSBT as being that there should be no look-back exercise, as there was at present no treatment that could be offered to those identified as infected to prevent them from developing clinical disease, while knowledge of infection could blight aspects of the life of those informed.

4.12 MSBT members would be given the chance to comment in writing on a draft paper to the Executive Board, with discussion at a later meeting should concerns merit this.

4.13 Dr McClelland would write to the Secretariat with his suggestion for a project to reduce the cost of blood tests generally by looking for improved technology. This could be referred for consideration as a research project.

ACTION - Secretariat to draft paper for Executive Board recommending universal screening for HTLV (initially), and to circulate to members for written comment.

Red cell transfusion products for neonates

4.14 Members welcomed the proposals in Dr McClelland's paper MSBT 9/2, which suggested procedures to improve the safety of blood given to neo-nates. Some of these were already accepted good practice and in operation in some areas. It was agreed that concerns about charges of introducing a two-tier system were answered by the special clinical need of this group (para 2.2 of the paper).

4.15 It was agreed that Dr Rejman and Mr Pudlo work with Dr McClelland and Dr Robinson to prepare a summary, for discussion at the next meeting, with a view to encouraging implementation by the transfusions services. The proposals might not be costs-neutral, but costs should be fairly low.

4.16 MSBT could consider later any suggestion that special safety measures be extended, if feasible, to other groups particularly at risk, eg the immuno-suppressed.

ACTION - Secretariat and Drs McClelland and Robinson to prepare draft paper for MSBT members to agree as being good practice.

5. CJD

5.1 The Chairman proposed two issues for consideration. Firstly whether the Committee wished to modify the conclusion reached at the previous meeting regarding the deferral of relatives of patients who had died of CJD. Secondly to update the Committee on progress on the proposed CJD "Lookback".

5.2 In response to a query about practice in the USA, Dr Purves confirmed that the EU had taken a different view on withdrawal of product from the market.

5.3 The Committee reaffirmed its earlier conclusion that while exclusion criteria must follow Council Of Europe requirements, in practice this should be taken to mean parents, children and siblings of CJD sufferers.

5.4 The Chairman asked Dr Robinson to report on progress on the "Lookback" proposal. Dr Robinson tabled a paper (MSBT 9/3) prepared by Jack Gillon, Patricia Hewitt and Bob Will as a first draft of a protocol. She drew attention to a proposal to expand the original protocol additionally to trace those CJD patients who had received a blood transfusion to see if they had received blood from a known CJD patient.

5.5 Dr Robinson added that two issues had been examined. Firstly Professor Ian Kennedy had been consulted on the ethical issues. His advice had been that the recipients of blood from a CJD patient should not be informed, but that the position should be reviewed in the event of the development of either a diagnostic test or effective intervention. The Chairman commented that such advice could not obviate the need to refer the protocol to a Ethics Committee. Secondly legal advice had been that the exchange of information between the CJD unit and the transfusion service needed to be considered in the light of the latter's duty of confidentiality to donors.

5.6 Members questioned whether it was feasible or necessary to undertake the second lookback with regard to CJD patients who had had a blood transfusion. Dr Robinson considered that it was both practical and desirable in terms of gaining information about the possible transmissibility of CJD. The two exercises would proceed in parallel. After further discussion the Chairman concluded that the message from the Committee was that the main priority should be the lookback based on those CJD patients who were blood donors, and where their donations went.

6. Fresh Frozen Plasma

Dr Robinson reported that PHLS and NBA had carried out a study to estimate the residual risk for the transmission of HIV, HCV and HBV in FFP from UK blood donors. A paper with provisional data had been presented to the 1 July meeting of SACTTI. It was agreed that MSBT would need to address the following

questions when the paper was finalised:

* does the data available on epidemiology of donor population lead to the conclusion that single donor FFP (in 4 to 12 donation lots) represents a risk of virus transmission?

* does pooled S-D treated plasma represent an improvement in respect of risk of virus transmission (bearing in mind non-enveloped viruses not inactivated by S-D)?

* if pooled S-D treated plasma preferable, should MSBT indicate a preference for pooled S-D plasma from UK voluntary, non-remunerated donors?

It was noted that FFP was not licensable whereas SD-treated pooled plasma was.

ACTION - Dr Robinson to provide validated data and the Secretariat to circulate it for members to consider the above questions before the next meeting

7. EU activities relevant to the Committee

Dr Purves reported that discussions on the introduction of PCR testing for HCV were continuing; this was being given priority. It could be another six months or so before the outcome was known. There were problems with the test method.

8. Any Other Urgent Business

Professor Zuckerman reported that hepatitis G RNA had been found in three samples of virally inactivated Factor 9 finished product tested by PCR at Edinburgh Fractionation Centre. However, the level of hepatitis G positivity found in haemophiliacs was less than 10%, which suggested that infectivity was low. The NBS and the SNBTS together with their respective fractionaters would consider this.

ACTION - Dr Robinson, in consultation with Dr Perry, to provide validated data for the Committee to consider at its next meeting